THOMPSON COE

2005 PROPERTY & CASUALTY INSURANCE LEGISLATION IN TEXAS

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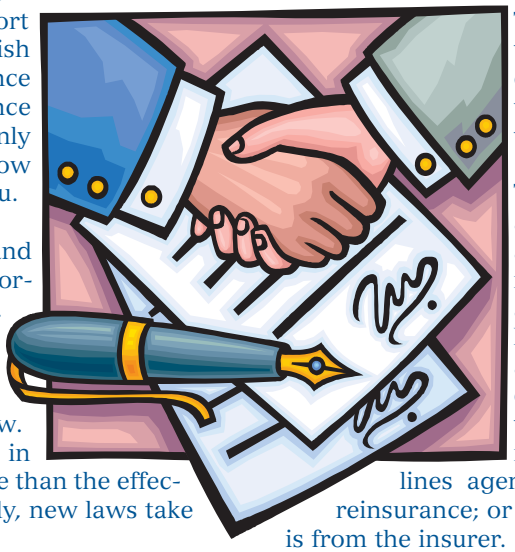
IMPORTANT 2005 PROPERTY/CASUALTY INSURANCE LEGISLATION IN TEXAS

INTRODUCTION

The Texas Legislature meets in odd numbered years beginning the second Tuesday in January and ending 140 calendar days later. This year's adjournment was May 30. During the Session 3,694 House Bills and joint resolutions and 1,935 Senate Bills and joint resolutions were introduced for consideration. Of these, 881 House and 516 Senate measures passed. The Governor vetoed 19 bills compared to 48 in 2003.

This is our biennial report of significant insurance legislation and legislation affecting the insurance business. We think this report will be of interest to you. We publish separate property/casualty insurance and life, health and accident insurance newsletters. If you have received only one and would like both, let us know and we will forward the other to you.



This is a summary report only, and contains brief descriptions of important features of selected new laws. In this report, reference may be made to the effective date of the legislation. This is the date the statute or amendment becomes law. Sometimes the operational changes in the law take effect on a different date than the effective date of the legislation. Generally, new laws take effect September 1, 2005.

We caution that the report is not intended to give legal advice nor is it to be relied on as a complete presentation of the law. Any decision to act or not to act should be made only after review of the entirety of the legislation and consultation with legal counsel.

Clients or others who have questions about any of the insurance legislation recently considered by the Texas Legislature should contact one of our attorneys.

AGENTS

H.B. 2941 This bill arose out of the Spitzer investigation of broker compensation in New York and is largely the NCOIL Model Law. It adds Sec. 4005.004, I.C. to require written or electronic acknowledgement, before a purchase of an insurance product, if an agent is to receive compensation both from the customer and from an insurer or third party, unless the compensation from the customer is for reimbursement of expenses under Sec. 4005.003, I.C., an inspection fee under Sec. 550.001, I.C., or an application fee.

The disclosure must include a description of the method and factors used to compute the compensation the agent will receive from the insurer or other third party for placement of the policy.

The law applies to almost all types of agents, but it does not apply to adjusters, third party administrators, reinsurance intermediaries, risk managers, or agents holding specialty licenses. The law does not apply to: (1) an agent that acts only as an intermediary between an insurer and the customer's agent, including an MGA; (2) a reinsurance intermediary or surplus lines agent placing surplus lines insurance or reinsurance; or (3) an agent whose sole compensation is from the insurer.

The law does not abolish contingency payments nor does it specifically require disclosure of the exact amount of the compensation. The TDI will likely issue disclosure regulations.

S.B. 265 Chap. 4004, I.C. relates to continuing education requirements for agents and amends the statute to authorize the commissioner, by rule, to grant not more than four hours of continuing education credit to an agent who is an

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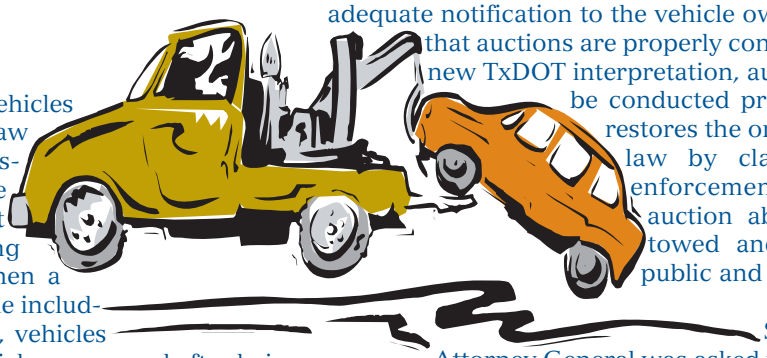
active member of a state or national insurance association. The rule is to specify the types of associations and establish reasonable requirements for active participation. Continuing education credit is not available where classroom hours or ethics are required. Agents are required to file a sworn affirmation on the number of education hours claimed. The agent has must also certify that the agent has either reviewed education materials provided by the association or attended educational presentations sponsored by the association.

S.B. 1214 This bill allows a county with a population of 800,000 or more to select an appropriately licensed agent as a sole broker of record to obtain proposals of insurance in all areas of risk. A broker of record must be paid on a fee basis by the county. A broker may not directly or indirectly receive any other compensation from any other source for the placement of insurance business under the broker of record contract.

S.B. 1564 This bill repeals the current requirement for a $50,000 surety bond as a condition of licensure for surplus lines agents in this state, to streamline the licensing process, to further uniformity and reciprocity among the various states in connection with the licensure of surplus lines agents, and to avoid potential preemption of state law regarding licensure of surplus lines agents.

Auto



H.B. 480 This bill applies to vehicles towed at the direction of a law enforcement agency for purposes of examination or evidence and requires the government agency to pay the cost of towing and storage. It describes when a government agency is not liable including towing for illegal parking, vehicles involved in an accident, or vehicles recovered after being stolen. A storage facility may not refuse to allow the owner of a vehicle to take the car because a government agency has not paid fees for which it is responsible.

H.B. 1137 This bill allows the DPS to enter into agreements with a foreign country where a person over 18 may receive a Class C driver's license. The foreign country and Texas must be parties to a reciprocity agreement on driver's licensing and the license laws must be similar to those in Texas as determined by the DPS. A person, who is not a US citizen, must present documentation issued by the US authorizing that person to be in the US before a license may be issued.

H.B. 1350 This bill amends the definition of salvage motor vehicle in Sec. 501.091(15), I.C. to mean a vehicle that has been damaged or is missing a major component part to the extent the cost of repairs including parts and labor exceed the actual cash value of the vehicle. Repair costs do not include the cost of materials and labor for repainting or sales tax on the total.

H.B. 1572 The bill adds Art. 21.49H, I.C. and applies only to personal automobile subrogation actions. If an insurer brings an action against a responsible third party who is uninsured, the insurer may recover, in addition to payments made by the insurer, attorney fees and court costs.

This bill amends Art. 5.06-3, I.C. to give an insurer that has paid a PIP claim with a right of subrogation against a person causing the loss who does not have insurance as required by the F.R. laws.

H.B. 2630 This bill resolves three issues that arose due to agency interpretations. First, the TxDOT staff reinterpreted some provisions of Chap. 683 (Abandoned Motor Vehicles), T.C., allowing law enforcement only to auction abandoned vehicles that have been towed and stored by the law enforcement agency. Under current law, abandoned vehicles are towed and stored by both public and private entities. When a private company tows or stores an abandoned vehicle, the company notifies the owner of the vehicle and the appropriate law enforcement agency. If the abandoned vehicle is not claimed in a specified period of time, the law enforcement agency takes custody of the vehicle and is responsible for disposal. The law enforcement agency may then auction off the abandoned vehicle. The process was established to insure adequate notification to the vehicle owner and to ensure that auctions are properly conducted. Under the new TxDOT interpretation, auctions will have to be conducted privately. H.B. 2630 restores the original intent of the law by clarifying that law enforcement agencies may auction abandoned vehicles towed and stored by both public and private entities.

Second, the Attorney General was asked to issue an opinion on the constitutionality of Chap. 685, T.C. relating to towing and storage hearings in municipal court where there is no appeals process. H.B. 2630 provides that all such hearings be in justice of the peace courts where there is an appeals process.

Third, current law specifies the amount that may be charged for storage and notification and prohibits "an additional fee that is similar to a notification, impoundment, or administrative fee." Nevertheless, a creative storage facility operator is now assessing something called a "post-tow hookup fee." An administrative hearings officer at TxDOT ruled that such a fee can be charged because it is not "a notification, impoundment or administrative fee." H.B. 2630 states that a facility may not charge any additional fee related to storage of the vehicle other than those found in statute.

H.B. 3300 This bill amends Sec. 551.106, I.C. to allow an insurer to reinstate a personal auto policy that has been canceled for nonpayment of premium. Premium must be

paid no later than 60 days after the date of cancelation. Coverage lapses when canceled and is not effective again until the premium is received by the insurer.

The bill also amends the PIP and UM statutes to provide that coverage previously rejected does not need to be provided in a reinstated policy unless requested in writing by the insured.

S.B. 1670 This bill plants the seed for a motor vehicle financial responsibility verification program to verify compliance with the mandatory insurance requirements of the Motor Vehicle Safety-Responsibility Act. It adds sub-Chap. N to Chap. 601, T.C. to require the DPS, TxDOT, TDI, and the Dep. of Info. Resources to initiate the program. Primary responsibility is on the TDI, in consultation with the other implementing agencies, to establish the program and to select an agent to develop and operate the program. Each insurance company providing motor vehicle liability insurance in Texas will be required to provide policy information to the agent under the program and rules to be adopted by the TDI. The full implementation of the financial responsibility verification program for noncommercial vehicles is required by 12/31/06. Implementation of the program for commercial vehicles is to occur when the implementing agencies determine that it is feasible.

Fraud

H.B. 2388 This bill amends Sec. 701.051, I.C. to require a person who determines or reasonably suspects that insurance fraud has been or is about to be committed to submit a report to TDI within 30 days of the determination or suspicion of fraud. The report must be submitted to the TDI's Fraud Unit in the format prescribed by TDI. A report to TDI constitutes notice to other appropriate authorized governmental agencies. A person may comply with this law by authorizing an organization which investigates and prosecutes insurance fraud on its behalf to report suspected fraud to TDI, but retains liability for the organization's failure to report. Insurance fraud or suspicion of fraud may be reported to TDI anonymously by an individual.

The bill eliminates the requirement that an insurer conducting an investigation of insurance fraud complete the investigation before requesting an investigation by TDI or law enforcement. Sec. 701.052(f), I.C. requiring insurers to exercise "reasonable care" when reporting fraud is repealed.

H.B. 3376 This bill amends the offenses of money laundering and insurance fraud to streamline the investigation and prosecution of those offenses.

Punishments for those offenses are structured to make them consistent with the rest of the Penal Code's "value ladder" (this lowers the penalties compared to current law), and adds them to Engaging in Organized Criminal Activity (which returns the offense level to current law, but only if three or more defendants commit the offense together). Aggregation of amounts is allowed so they can be handled in a single prosecution. The statute of limitations is increased for felony insurance fraud to match the federal period.

S.B. 781 This bill amends Chap. 101, I.C. to change the required culpable mental state for commission of an offense of conducting the business of unauthorized insurance to "reckless, knowing or intentional" from "knowing or intentional".

Medical Professional Liability

H.B. 654 This bill clarifies language in Art. 5.15-1, I.C. that an insurer is authorized to provide professional liability insurance coverage for a volunteer health care provider.

H.B. 655 Volunteer health care providers, although protected from liability under the Charitable Immunity and Liability Act, still need liability policies to cover defense costs. This bill requires the JUA to make medical liability coverage available to volunteer health care providers covered under the Charitable Immunities Act. It must make medical liability insurance or appropriate health care liability insurance available to a volunteer health care provider while acting in the course and scope of the person's duties as a volunteer health care provider as described by Chap. 84 C.P.R.C.

It authorizes a self-insurance trust under Art. 21.49-4, I.C., to offer professional liability insurance to volunteer health care providers rendering services in the course and scope of the person's volunteer duties.

H.B. 2678 This bill makes three changes to Art. 5.15-1, I.C. dealing with professional liability insurance for physicians.

- Prohibits an insurer from when making a decision regarding denial or cancelation of coverage or in rating considering whether, or the extent

to which, a physician or healthcare provider provides services to Medicaid or CHIP recipients.

• Amends the rate standards for determining whether rates are excessive. Under current law, in order to deem a rate for medical professional liability insurance excessive, TDI must prove that the rate is unreasonable for the insurance coverage provided and that "a reasonable degree of competition does not exist". This bill deletes the competition test to determine whether rates are excessive.

• Adds Sec. 13 to prohibit an insurer from using a lawsuit filed against a physician or health care provider as a factor to set premiums or eliminate claims-free discount, if the lawsuit was dismissed and no payment was made to the claimant. The law requires either a refund or the reinstatement of a claims free discount. It does not prohibit an insurer from using aggregate historical loss and expense experience in setting rates. However, an insurer may not assign an insured a particular classification based on lawsuits that have been dismissed.

Privacy

H.B. 160 This bill adds Sec. 547.615, T.C. to require a manufacturer of a new motor vehicle to disclose if the vehicle is equipped with a recording device. Information recorded or transmitted may be retrieved only by the owner or with the owner's consent. Exceptions are made for specific purposes.

H.B. 698 This bill amends Sec. 35.48 B.&C.C. to require a business disposing of business records that contain personal identifying information to shred, erase or use other means to make personal identifying information unreadable or undecipherable. These specific requirements do not apply to insurance companies and agents.

H.B. 1130 This bill adds Sec. 35.581 B.&C.C. to make a privacy policy necessary when a person requires disclosure of an individual's social security number to obtain goods or services or enter into a business transaction. This law does not apply to insurers and agents.

H.B. 1893 The 1994 Federal Crime Act (18 U.S.C. § 1033) makes it a federal crime for an individual who has been convicted of a felony involving dishonesty or breach of trust to be engaged in the business of insurance. As a result, insurance companies must be certain that none of their officers, directors or agents have been convicted of such activity. Texas law currently prohibits the consumer reporting agency from providing a consumer report that discloses an arrest, indictment or conviction of a crime that is more than seven years old. This bill allows a consumer reporting agency to furnish a consumer report that contains information that is more than seven years old, if it is needed by the entity to comply with federal law.

S.B. 99 This bill prohibits a lender, or any other person involved in a transaction, from denying credit or loans or restricting or limiting the credit extended to a person based on the person being a victim of identity theft. This bill provides victims of identity theft with another tool to mend their credit histories and bring state law in line with the Federal Equal Credit Opportunity Act, which prohibits creditors from discriminating against credit applicants who exercise their rights, in good faith, under the Fair Credit Billing Act. Insurers are now authorized to issue Identity Theft Insurance Policies. Forms and rates are regulated under Art. 5.13-2, I.C.

S.B. 122 This bill deals with prevention and punishment of identity theft. Now available to the victim is a report that identifies the name of an identity theft victim, the name of the suspect (if known) and the type of information obtained, transferred or used.

Chap. 48 is added to the B.&C.C. This Chap. makes it an offense to obtain, possess, transfer or use personal identifying information of another person without that person's consent and with the intent to obtain a good, a service, insurance, an extension of credit or a thing of value. This portion of the law does not apply to an entity licensed by the TDI.

The law requires every business to implement and maintain reasonable procedures to protect and safeguard from unlawful use or disclosure any sensitive personal information, which includes an individual's name in combination with a social security number, driver's license or government-issued number, account or credit card number. This portion of the new law does not apply to insurance companies and agents.

The remainder of the bill deals with breaches of security of computerized data and applies to all businesses. A person that conducts business in Texas and owns or licenses computerized data that includes sensitive personal information is required to disclose any breach of system security to any resident whose sensitive personal information was or is reasonably believed to have been acquired by an unauthorized person. A person that maintains computerized data that includes sensitive personal information, that the person does not own, shall notify the owner or license holder of the information of any breach of system security.

A business may delay providing notice at the request of a law enforcement agency. The law has authorized meth-

ods of giving notice, including alternative methods, such as notice published in or broadcast on major statewide media if the cost of providing notice would exceed $250,000, the number of affected persons would exceed 500,000, or the person does not have sufficient contact information.

The law authorizes a person injured by identity theft to file an application with the court and obtain an order declaring the person to be a victim of identity theft. A person violating any portion of this law is liable to the state for a civil penalty of at least $2,000 but not more than $50,000 for each violation and the Attorney General may bring an action to restrain any violation. Unauthorized use or possession of personal identifying information is also identified as a deceptive trade practice.

Property

H.B. 941 This bill amends Art. 5.35-4, I.C. to define an "appliance" to be "a household device operated by gas or" electricity and to include hoses directly attached to the device. Art. 5.35-4 disallows the use of prior appliance related claims as a basis for determining the rate or whether to issue, renew, or cancel an insurance policy, if the prior appliance-related claim was properly remediated, inspected and certified by a person knowledgeable and experienced in remediation of water damage.

H.B. 1744 This bill allows the FAIR Plan to comply with a private letter ruling from the IRS that would exempt the FAIR Plan from federal income taxation.

The various changes in the bill included: (1) TWIA may not participate in the FAIR Plan for any purpose; (2) The board includes five members that represent the interests of insurers, four public members who reside in Texas and two agents. Board members may be removed by the commissioner without cause; (3) Board members may meet by telephone conference calls or other similar telecommunication methods if notice is provided and two-way communication is allowed; (4) members no longer share the "writings, expenses and losses" but may be assessed for losses. Insurers are allowed reimbursement for such assessments or for service fees paid to pay bonds issued under Art. 21.49 A-1, I.C. These amounts may be carried as an admitted asset until recovered by surcharges on policyholders; and (5) Insurers may commence imposing surcharges after 90 days from the date of the payment.

H.B. 1891 Under current law, farm mutuals and a county mutual that writes exclusively industrial fire insurance are exempt from TWIA. At the present time, there is only one county mutual in Texas that qualifies as an industrial fire county mutual. Industrial fire insurance includes coverage on dwellings and typically provides wind coverage. This bill provides that an "affiliated" industrial county mutual is subject to TWIA.

H.B. 2298 This bill repeals Sec. 8E, Art. 21.49, I.C. as recommended by the TDI. Sec. 8E provided rate credits for structures built to a more stringent building code than that applicable to structures provided coverage through the TWIA. In 1997, the TDI adopted the International Residential Code as the standards for windstorm construction.

H.B. 2761 Current law prohibits a lender from requiring an amount of insurance greater than the replacement value of the dwelling. This prohibition is Sec. 549.0551, I.C. However, Secs. 549.056(a) and (d) provide that a lender may require evidence that insurance has been obtained in an amount sufficient to cover the amount of the debt or loan. This conflict between these two sections is resolved by this bill. Lenders are allowed to require evidence of insurance in an amount necessary to cover the debt or loan, except where the requirement would be a condition of financing residential property. In that case, the lender may not require insurance in an amount greater than the replacement value of the dwelling.

H.B. 3048 This bill amends various statutes including TWIA and FAIR Plan to allow insuring of property built over water.

S.B. 1485 This bill adopts the International Building Code (IBC) as the commercial building code for use in Texas. The adoption of a uniform code provides consistency across municipalities and unincorporated areas of Texas counties.

Sec. 214.214, L.G.C., is amended to provide that the National Electrical Code, as it existed on 5/1/01, is adopted as the electrical construction code in this state and applies to all residential and commercial electrical application, except as provided by SubSec. (c). which provides that the National Electrical Code applies to all commercial buildings in a municipality for which construction begins on or after 1/1/06, and to any alteration, remodeling, enlargement, or repair of those commercial buildings.

IBC applies to all commercial buildings in a municipality for which construction begins on or after 1/1/06, and to any alteration, remodeling, enlargement, or repair of those commercial buildings. A municipality must establish certain procedures relating to the IBC.

The law prohibits a local amendment adopted under less stringent building requirements than the requirements

prescribed by the IBC, as it existed on 5/1/03.

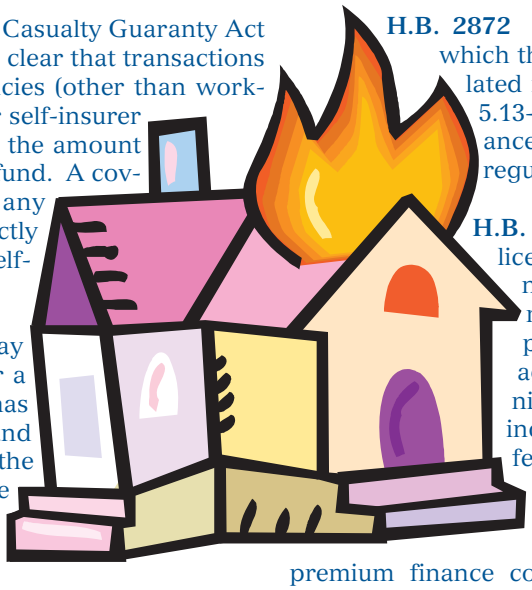
A municipality is authorized to review and consider amendments made by the International Code Council to the IBC after 5/1/03.

Regulatory

H.B. 363 This bill applies only to declinations for fire, homeowners or farm and ranch owner's policies. It prohibits an insurer from considering a "customer inquiry" in deciding whether to issue or decline to issue a policy. "Customer inquiry" is defined to include a call or other communication to an insurer with regard to the terms or coverages under a policy. It includes questions on the process for filing a claim that does not result in an investigation or claim.

H.B. 2157 This bill adopts the *draft* NAIC Insurer Receivership Model Act. The purpose of this bill is to clarify the law and promote cooperation in multi-state receiverships. This bill gives the commissioner authority to act sooner to take control of a failed insurer. This bill repeals the current statute relating to liquidation, rehabilitation and reorganization.

The bill also amends the Property Casualty Guaranty Act in a number of respects. It makes clear that transactions involving captive insurers or policies (other than workers' comp) in which deductible or self-insurer retention is substantially equal to the amount of liability are not covered by the fund. A covered claim does not include any amount that is directly or indirectly due any reinsurer, insurer or self-insurer.



The Guaranty Association may bring an action against a TPA, or a representative of an insurer that has a receiver, to obtain custody and control of information related to the insurer that it is necessary for the Association to carry out its duties. The Association is entitled to attorney fees to obtain information.

The bill makes Travis County venue exclusive for suits by or against the Guaranty Association.

Workers' comp against large employers claims would be handled by the Guaranty Fund. The Guaranty Fund would not handle claims other than workers' comp for such large employers. The Fund has authority to establish procedures for requesting and obtaining financial information from an insured or a claimant on a confidential basis for the purpose of applying the net worth provisions of the law. The bill specifies that an insured or claimant bears the burden of proof concerning its net worth at the relevant time.

H.B. 2437 This bill provides that an insurer is subject to the lesser filing requirements of Art. 5.13-2, I.C. if the insurer and its affiliates meet the following requirements: (1) issues policies only at basic limits; and (2) has a market share of less than 3.5% of the personal automobile insurance market.

H.B. 2565 Art. 5.20, I.C. prohibits rebates in the sale of motor vehicle insurance. This bill makes county mutuals and farm mutuals subject to this anti-rebating law. This bill also changes references in sections that were recodified to make Lloyds, reciprocals, county mutuals and farm mutuals subject to certain recodified provisions of the I.C.

H.B. 2614 This bill subjects Lloyds and reciprocals to TDI requests for information under Sec. 38.001, I.C. and amends Sec. 551.004 to provide that a transfer of a policyholder between admitted companies within the same insurance group is not considered a refusal to renew. This section also applies to written declinations under PIP and UM statutes.

H.B. 2870 This bill adds guaranty bonds to the lines of insurance subject to Art. 5.13-2, I.C.

H.B. 2872 This bill repeals Art. 5.81, I.C. by which the commissioner of insurance regulated multi-peril policies. It amends Art. 5.13-2, I.C. to include multi-peril insurance as a line of insurance subject to regulation under that article.

H.B. 2965 Chap. 651, I.C. regulates licensing of premium finance companies and transactions involving premium finance agreements. This bill puts limitations and restrictions on agents and premium finance companies. The bill places limitations or inducements on sharing of profits and fees.

Currently, Sec. 651.051 requires licenses in order to do business as premium finance company. H.B. 2965 provides that requirement does not apply to a person or entity who purchases or acquires a premium finance agreement from a premium finance company, if the premium finance company: (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 the statute.

An insurance agent or employee may receive an article of merchandise having a value of $10 or less on which there is an advertisement of the premium finance company.

Another exception to the limitations on the sharing of fees and profits is that the restrictions do not apply premiums for commercial lines of insurance under specified circumstances.

S.B. 14

1. Refunds with Interest

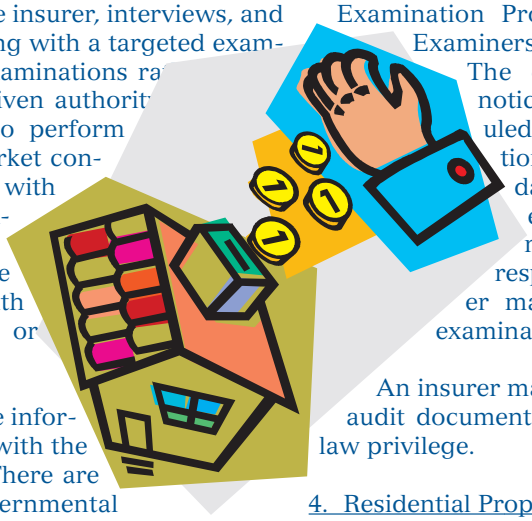
Currently, Art. 5.144 allows the commissioner to order refunds for excessive or unfairly discriminatory premiums for personal auto and residential property insurance. S.B. 14 allows the commissioner to order a refund of premiums plus interest. Interest for any refund ordered is the lesser of 18% or the *sum of 6% and the prime rate* for the calendar year in which the order is issued. Interest is calculated from the date the TDI is notified the insurer that it is allegedly charging an excessive or unfairly discriminatory rate. An insurer may not claim a premium tax credit if it is not in compliance with the refund provisions.

2. Rating Territories

Currently, Art. 5.171 prohibits the use of rating territories that sub-divide a county if the rate for any subdivisions within the county is greater than 15% higher than the rate in other subdivisions. An exception allows the commissioner to allow greater rate differences for residential property or personal automobile. S.B. 14 restricts the application of the statute to an insurer writing residential property or personal auto.

3. Market Conduct Surveillance

S.B. 14 adds Chap. 751, dealing with the regulation of insurer market conduct. It is based on the NCOIL Model Law. This chapter describes how TDI must perform its market conduct oversight. Market conduct examinations must focus on general business practices rather than on individual consumer complaints or infrequent or unintentional random errors. TDI is to consider other actions such as correspondence with the insurer, interviews, and interrogatories before proceeding with a targeted examination and to perform desk examinations ra
on-site examinations. TDI is given authorit
tract with outside personnel to perform
including examinations and market conduct surveillance. Coordination with other states is required and qualified immunity is given for providing information in the course of an examination in good faith and without fraudulent intent or intent to deceive.



The examination reports and the information provided in connection with the examination are confidential. There are exemptions to allow intergovernmental and interagency sharing. The commissioner must disclose to the insurer the fact that the examination has been released to another department or agency within five days after the release of the information.

The commissioner is required to collect and report market data to the NAIC and also to coordinate the department's market analysis and examinations with other states through the NAIC. The commissioner is required to provide information to insureds and agents regarding new laws, rules, enforcement actions and other information relevant to ensure compliance with market conduct requirements.

The commissioner is given the responsibility for conducting market conduct examinations on domestic insurers. The commissioner has the authority to delegate responsibility for market conduct examination to the insurance commissioner of another state and the Texas Commissioner is required to accept a report prepared by an insurance commissioner to whom the responsibility has been delegated. Insurers that are members of a holding company system may be subject to an examination in Texas, but the examination of insurers that are not Texas domestics requires the consent of the insurance commissioners of the domiciliary state of the affiliate.

The commissioner may impose sanctions for violations detected through a market conduct examination and oversight. However, the commissioner must consider whether an insurer is a member and complies with the standards of a best practice organization, as well as the extent to which the insurer maintains an internal self-assessment compliance program.

The law has examination guidelines and requires the department to prepare a work plan that includes a statement of the reasons for the examination, the scope of the examination, an estimate of the time for the examination, and a budget for the examination if the cost is to be billed to the insurer. A target examination is to be conducted in accordance with the Market Conduct Uniform Examination Procedures and the Market Conduct Examiners Handbook adopted by the NAIC. The commissioner must give insurers notice at least 60 days before the scheduled date of examination. Pre-examination conferences are held at least 30 days before the scheduled date of an examination. A final examination report must include an insurer's response to the report. The commissioner may only conduct a market conduct examination once every three years.

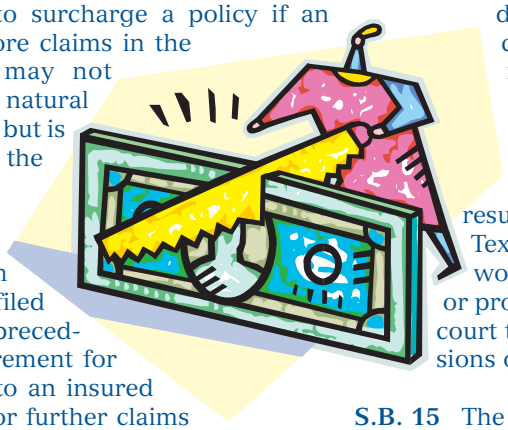
An insurer may not be compelled to disclose a self-audit document or waive any statutory or common law privilege.

4. Residential Property: Claims Free Discounts & Surcharges

S.B. 14 amends Art. 5.43, I.C. This statute permits an insurer to offer discounts to a residential policyholder that has been "claim free" for at least three years. Amended Art. 5.43 provides that a claim may not include

a claim for a loss caused by natural causes that is filed but not paid or payable under the policy, or that an insurer is prohibited from using under Art. 5.35-4. That statute deals with certain water damage and appliance-related claims that have been remediated. Art. 5.43 has been amended to allow tier classification or a discount program that has premium consequences based in whole or in part on claims experience.

Changes in the discount must comply with Sec. 551.107, which was also amended. This section deals with non-renewal and cancelation of personal auto, homeowners and farm and ranch owner's policies. This section currently permits an insurer to surcharge a policy if an insured has filed two or more claims in the preceding year. Claims may not include a loss caused by natural causes or a claim that is filed but is not paid or payable under the policy.



Sec. 551.107 has been amended to allow a premium surcharge if an insured has filed one or more claims in the preceding three years. The requirement for the language of the notice to an insured that may be non-renewed for further claims has been amended to require disclosure of those items that cannot be considered.

The phrase "premium surcharge" has been redefined to mean an additional amount that is added to the base rate. The term *does not include* the reduction of or elimination of a discount previously received by an insured or the reassignment from one rated tier to another or a re-rating of insureds or re-underwriting of an insured using multiple affiliates.

S.B. 1283 All domestic insurers are now subject to the Holding Company Act.

S.B. 1591 This bill gives the TDI greater ability to rely on CPA audits of insurers by amending the I.C. to require CPAs to utilize the procedures in the NAIC Examiner's Handbook. It amends Sec. 12(c), Art. 1.15A, I.C. to prohibit the commissioner from accepting an audited insurer financial report prepared by a firm that has an indemnity agreement with the insurer.

S.B. 1592 This bill adds Art. 1.33 giving the commissioner broad authority to require special deposits. The deposit is in addition to any other deposit required by law.

Tort Reform

H.B. 755 This bill is an attempt to give a trial court more discretion in deciding whether to grant a motion to stay or dismiss a lawsuit under the doctrine of *forum non conveniens*. It removes the prohibition that a case may not be dismissed on grounds of *forum non conveniens* if the injury or death occurred in this state. Instead, the bill requires the court to consider the extent to which an injury or death resulted from acts or omissions that occurred in this state. The amended law requires the court to consider the following factors when determining whether to grant a motion to stay or dismiss for *forum non conveniens*: (1) whether an alternate forum exists in which the claim may be tried; (2) whether the alternate forum provides an adequate remedy; (3) whether maintenance of the claim in the courts of Texas would work a substantial injustice to the moving party; (4) whether the alternate forum, as a result of the submission of the parties or otherwise, can exercise jurisdiction over all the defendants properly joined to the plaintiff's claim; (5) whether the balance of private interests of the parties and the public interest of the state predominate in favor of the claim being brought in an alternate forum, which shall include the consideration of the extent to which an injury or death resulted from acts or omissions that occurred in Texas; and (6) whether the stay or dismissal would not result in unreasonable duplication or proliferation of litigation. The law requires the court to state specific findings of fact and conclusions of law.

S.B. 15 The Asbestos/Silica Reform Legislation was the result of a negotiated compromise of several groups.

S.B. 15 is intended to accomplish the following: (1) establish sound medical criteria for determining impairment caused by asbestos or silica and thereby remove unimpaired claimants from litigation; (2) prohibit non-joinder of claims for asbestos and silica injuries so that cases are tried one at a time; (3) make asbestos and silica cases eligible for the Multi-District Litigation ("MDL") court; and (4) apply the legislation to pending and prospective claims.

X-ray readings. S.B. 15 allows a 1/0 x-ray reading on pending claims, but retains the 1/1 requirement on prospective claims. The 1/0 reading is recommended by the American Bar Association. Consulting doctors for reform groups believe that the fail-safe factor in the medical criteria is the pulmonary function test ("PFT"), which is almost impossible to fake by the patient.

Pulmonary Function Test. S.B. 15 allows functionality to be measured by either the 4th Edition or 5th Edition of the AMA guidelines, since there are no significant differences in the functionality requirements of the two editions.

A tightly drawn "discretionary pathway" requires a claimant to file a report by a doctor who has a doctor-patient relationship with the claimant. The report must verify that the physician conducted a PFT on the claimant and "has concluded, to a reasonable degree of medical probability, that the exposed person has radiographic, pathologic or computed technology evidence establishing bilateral pleural or bilateral parenchyma disease

caused by exposure to asbestos or silica". The provision also requires that the claimant have "impairment comparable to the impairment the exposed person would have if the exposed person met" the medical criteria established in other provisions of the bill.

The MDL judge must find that "the report and medical opinions offered by the claimant are reliable and credible" and must make findings that "the unique or extraordinary physical or medical characteristics of the exposed person" justify application of this discretionary pathway. This discretionary pathway is available "only in exceptional and limited circumstances in which the exposed person does not satisfy the medical criteria".

The determination of impairment by the MDL judge using this discretionary pathway is subject to an evidentiary hearing and the decision of the MDL judge is not binding at trial.

This discretionary pathway dulls a potential constitutional challenge to S.B. 15 on the grounds of "retroactivity" - that is, the alleged change of a substantive right held by claimants whose claims are pending as of the effective date of the bill.

Dismissal of Claims. S.B. 15 does not dismiss pending claims that do not meet the medical criteria. Instead, those cases are held in the MDL court and remain pending until such time that they are either voluntarily dismissed or proceed to litigation when they meet the medical criteria established. *Prospective* claims continue to be subject to the dismissal mechanism.

Joinder of Claimants. Absent an agreement by the litigants, claims relating to more than one exposed person cannot be joined for trial. This applies to both pending and prospective claims.

S.B. 15 requires that all prospective malignancy claims go to the MDL. The pre-H.B. 4 malignancy claims are finite, whereas the *prospective* malignancy claims tied to asbestos and silica are continuing.

Bankruptcy Claims. S.B. 15 will not prevent otherwise eligible claimants from filing claims in bankruptcy with trusts established to pay asbestos and silica claims.

S.B. 890 This bill amends the C.P.&R.C. from requiring reductions to a claimant's recovery for amounts received from settling defendants based on *percentage* of responsibility. Now, except cases against a health care provider, a claimant's recovery is reduced by the amounts paid in settlements.

Workers Compensation

H.B. 7 This is the WC reform and sunset bill for TWCC. The following is a broad summary of the bill:

- TWCC is abolished effective 9/1/05.

- H.B. 7 creates an "agency within an agency" the Division of Workers' Compensation (DWC) within TDI. The Governor appoints the Commissioner for the Division to serve a two year term. The DWC will exercise all authority in its purview, allowing for "advice and comment" by the Insurance Commissioner on rulemaking issues. The transition of TWCC's functions to the DWC has begun and is to be completed by 2/28/06.

- The new Office of Injured Employee Counsel (OIEC) is administratively attached to the TDI but independent of TDI and the DWC. The Public Counsel is a Governor-appointed lawyer with rule-making authority to operate the agency. The agency will supervise the ombudsman program. The Public Counsel will not represent individual workers but will speak on behalf of workers within the system.

- TDI will administer and draft rules for Health Care Networks (similar to Chap. 1305, I.C. networks). Networks will be certified by the DWC. Insurers can establish or contract with networks to provide workers com medical benefits. Workers injured before the Act or creation of the network must be treated within the network, if their employer chooses to participate in a network. The bill contains "transition" provisions for such claims. Insurers are liable for out-of-network care for employees who live outside the service area of the network.

- **Network details:**

  -Employees who are in an HMO plan can be treated by their Primary Care Physicians (PCP) from that plan and the PCP will be considered "in-network."

  - A employee with a "chronic, life-threatening injury or chronic pain related to a compensable injury" can apply to the network to use a nonprimary care specialist in the network as PCP.

  -"Hold harmless" clause included for claimants billed for violating provider selection rules.

  - Network doctors cannot serve as Designated Doctor for an in-network claimant.

  - 30 mile urban/60 mile rural access standard for PCPs; 75 mile for specialists; networks can make arrangements with providers outside of area to obtain specialists not available in area.

- Networks must include "sufficient numbers and types of health care providers to ensure choice, access and quality of care" to employees; net works can designate specialties of providers who serve as treating doctors.

- Termination of provider contracts is covered by contract, not statute.

- Networks must have a Quality Improvement Program and a Medical Director.

- Insurers pay for IRO of in-network service; SOAH is eliminated from review process; challenge of an IRO decision is internal at network, then through judicial review process.

- The DWC's research group will produce a report card comparing networks versus out-of-network care.

• **Medical Care details:**

- The DWC and networks must select "evidence-based, scientifically valid and outcome focused" treatment guidelines and return-to-work guidelines. Treatment cannot be denied solely because it is not addressed in the guideline used.

- The DWC may adopt disability management for appropriate out-of- network claims requiring a treatment plan. Parties would work together with DWC to agree on a treatment plan; appeal is to an IRO.

- Fee guidelines follow current statute and only apply to out-of-network services; DWC can adopt "one or more" conversion factors and pay ment can be made under/over the fee guidelines by contract in or out-of- network.

- Prompt pay rules apply to all network claims on a 45 day initial deadline; insurer can pay 85% and conduct audit within 160 days; violations are Class C/$1,000 max penalty; insurers can ask for refunds when appropriate.

- Insurers must notify in-network providers of any denial of compensability and cannot deny services prior to notification; insurer can recover costs from any responsible party if care is later determined to be noncompensable (applies to in or out-of-network care); insurer's liability is limited to $7,000 if compensability is contested successfully; insurers can request medical exam by PCP to "define the compensability" of an injury; PCP is to describe the compensable injury and insurer could require preauthorization for treatment of any other conditions; disputes are considered "extent of injury."

- DWC will adopt rules listing services requiring preauthorization (which must include PT and OT services) for out-of-network care; care that is preauthorized cannot be retrospectively denied.

- The Approved Doctor List is to be abolished 9/1/07; out-of-network employees can use any willing provider but must name a PCP; requirements for IR training, testing and financial disclosure among treating physicians are maintained; doctors previously removed from the ADL cannot return after its elimination.

- DWC must adopt a closed formulary; pharmacies are exempt from inclusion in networks.

- SOAH eliminated from dispute resolution process starting 9/1/05; IROs are available for in and out-of-network medical necessity disputes; in-network disputes go to internal resolution first; IROs are appealed to district court but binding on carrier during appeal on preauthorization disputes; IROs must contain specific elements, consider the adopted treatment guide lines, and must state a basis for ruling counter to them.

- DWC must adopt rules regarding peer review doctors including Texas licensure requirement.

- DWC must adopt e-billing rules by 1/1/06; can adopt e-payment rules for insurers after 12/1/08.

• Maximum weekly indemnity increased to 88% of Texas Workforce Commission's AWW effective 10/1/06; DWC can raise to 100%; retroactive period for indemnity benefits is shortened from four weeks to two; strengthens "good faith effort" definition for SIBs claimants looking for work and requires DWC to adopt rules setting compliance standards.

• Requires insurers to pay injured worker's attorney fees in case where worker prevails and insurer loses in district court.

• Parties are limited to two BRCs prior to a CCH; clarifies BRC's role and allows BRCs only after demonstration of effort by parties to resolve issues.

• Appeals Panel retained but limited to one three-member panel; Appeals Panel is to maintain a precedent manual and will only rule when reversing or remanding.

• Designated Doctor opinions can be used when requested by either party to resolve a dispute on any indemnity-related issue (including extent of injury, disability, and

ability to return to work) requiring medical expertise; DD opinion has presumptive weight but can be overcome by a preponderance of the evidence; DWC will specify DD credential standards, by rule; carrier must pay based on DD's opinion during appeal; DD can communicate with any treating provider; RME only available for out-of-network disputes on medical necessity.

• Adjudication of an injury as non-compensable does not waive exclusive remedy protection for employer.

• Classes of administrative penalties are eliminated; DWC has authority similar to TDI's; specific schedule of penalties not required; oversight and compliance functions will be performance based; DWC will designate high or low performers every two years; allows for a fraud unit; requires reporting of fraud; prohibits misuse of DWC name or seal.

• DWC must produce information on benefits of return to work; target IBs claimants with return to work assistance; and require insurers to determine when to assign skilled case management on lost time claims; DWC and DARS must work closely with workers in need of vocational rehabilitation and report on results; establishes pilot program for small businesses who pay accommodations for injured workers to return to work.

• Political subdivisions must determine that use of networks is not available or practical before opting out; subdivisions may use a group health benefit pool to provide medical care to workers; pool must have access to IRO and report stats.

• HMOs and PPOs can become certified as workers comp networks.

• Employee who tests positive for drugs on the job must overcome a presumption that he was intoxicated and injury is therefore not compensable.

• Non-subscribers cannot use post-injury waivers unless it is knowing and voluntary; signed at least 10 days after injury, and after worker has seen a non-emergency provider.

• Premiums cannot be excessive or inadequate; TDI must report on impact of H.B. 7 reforms on workers comp insurance market and premiums; TDI must hold a workers' comp rate hearing by 12/1/08, and take action if rates are found to be excessive at that time; insurers must file underwriting guidelines with TDI.

• Insurers must designate a single point of contact for an injured employee.

• TDI, DWC and OIEC will undergo Sunset review in 2009.

H.B. 251 This bill adds insurers to the list of entities which can receive information about a workers' comp claim. It applies to certified self-insureds and various forms of health insurers and applies even if the entity has no sub-claim on file. Insurers can obtain information by filing a monthly written request with a list of names for which claim information is requested. Insurers must certify that each person is or was employed by an insured. May also request "full claims data" consisting of an electronic download or tape in an electronic format of all information for all claimants on the list. Insurer must sign a written agreement to comply with Division's rules governing security applicable to the transfer of claim information and electronic data before submitting first request for information.

Division must promptly provide the following information in electronic, un-redacted form if available: full name, SSN, DOB, employer name, DOI, description of type of injury or body part affected including claimant's description of how incurred, treating doctor name, comp insurer's name, address, claim number, adjuster, and Division number; health insurers can file sub-claims based on information obtained; information received is subject to Labor Code confidentiality requirements; the Division can charge a fee not to exceed $.05 per claimant for the information.

Autopsy reports related to workers' comp claims must be released by the 15th business day after the request was received from an authorized person. If no report has been filed, the responding office must respond to the request within 10 business days of receipt and notify the requestor that the report has not been filed and when the requestor will receive the report to the best of its knowledge.

Recodification

H.B. 2017 This bill is the fourth installment of the recodification of the I.C. of 1951. This ongoing project of the Texas Legislative Council is to recodify the laws but make no substantive changes in the law. The following new titles are involved in this bill:

1. Title 4. Regulation of insolvency, including general provisions reserves, investments, delinquent insurers, guaranty associations, requirements of other jurisdictions and reinsurance.

2. Title 10. Property Casualty provisions, including provisions for liability insurance for physicians, auto insurance, fire insurance and allied lines, residential property insurance, coverage for aircraft, self insurance, rate making in general, policy forms in general.

3. Title 12. Other types of coverage such as credit, involuntary unemployment, mortgage guaranty insurance, surety bonds and related instruments.

4. Title 14. Utilization review and independent review organizations.

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