A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,
AND INSURANCE INDUSTRY PROFESSIONALS

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a failure to comply with a "directive . . . or requirement" of the National Association of Insurance Commissioners. The revised law omits the reference to "directive" because "directive" is included in the meaning of "requirement."

TITLE 5. PROTECTION OF CONSUMER INTERESTS

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CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

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CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 501.001. DEFINITION. In this chapter, "office" means the office of public insurance counsel. (New.)

Revisor's Note

The definition of "office" is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 501.002. OFFICE OF PUBLIC INSURANCE COUNSEL. The independent office of public insurance counsel represents the interests of insurance consumers in this state. (V.T.I.C. Art. 1.35A, Sec. 1.)

Source Law

Art. 1.35A
Sec. 1. The independent office of public insurance counsel is created to represent the interests of insurance consumers in Texas.

Revisor's Note

Section 1, V.T.I.C. Article 1.35A, states that "[t]he independent office of public insurance counsel is created." The revised law omits the reference to the creation of the office because that provision is

executed.

Revised Law

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, 2005. (V.T.I.C. Art. 1.35A, Sec. 7.)

Source Law

> Sec. 7. The office of public insurance counsel 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, 2005.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 6(a).)

Source Law

> Sec. 6. (a) The office of public insurance counsel shall prepare information of public interest describing the functions of the office. The office of public insurance counsel shall make the information available to the public and appropriate state agencies.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 6(b).)

Source Law

> (b) The office of public insurance counsel 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 of public insurance counsel's programs. The office of public insurance counsel shall also comply with federal and state laws

for program and facility accessibility.

Revisor's Note
(End of Subchapter)

(1) Section 3(b), V.T.I.C. Article 1.35A, requires the office of public insurance counsel to file an annual report accounting for all funds received and disbursed by the office. The revised law omits that provision because it was impliedly repealed by Section 2101.011, Government Code, which establishes a comprehensive uniform scheme for reporting financial information by all state agencies. The omitted law reads:

> (b) The office of public insurance counsel shall file annually with the governor and the presiding officer of each house of the legislature a complete and detailed written report accounting for all funds received and disbursed by the office of public insurance counsel during the preceding fiscal year. The annual report must be in the form and reported in the time provided by the General Appropriations Act.

(2) Section 3(c), V.T.I.C. Article 1.35A, requires all money paid to the office of public insurance counsel to be deposited in the state treasury. The revised law omits that provision as unnecessary. Section 404.094, Government Code, requires all money collected or received by a state agency to be deposited to the credit of the general revenue fund. It is unnecessary to repeat that requirement in this chapter. The omitted law reads:

> (c) All money paid to the office of public insurance counsel under this article shall be deposited in the state treasury.

[Sections 501.006-501.050 reserved for expansion]

SUBCHAPTER B. PUBLIC COUNSEL

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 2(a), (d), (e), 3(a) (part).)

Source Law

> Sec. 2. (a) The governor with the advice and consent of the senate shall appoint a public counsel who shall serve as the executive director of the office of public insurance counsel.
>
> (d) Appointment of the public counsel shall be made without regard to the race, color, handicap, sex, religion, age, or national origin of the appointee.
>
> (e) The public counsel shall serve for a term of two years expiring on February 1 of each odd-numbered year.
>
> Sec. 3. (a) The public counsel, as executive director of the office of public insurance counsel, ...

Revisor's Note

> Section 2(d), V.T.I.C. Article 1.35A, refers to "handicap." The revised law substitutes "disability" for "handicap" because, in the context of this section, "disability" and "handicap" are synonymous and "disability" is the term used in most other contexts, including the federal Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.).

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 2(b).)

Source Law

(b) To be eligible to serve as public counsel for the office of public insurance counsel, a person must be a resident of Texas and be licensed to practice law in Texas. The public counsel shall be a person who has demonstrated a strong commitment and involvement in efforts to safeguard the rights of the public and who possesses the knowledge and experience necessary to practice effectively in insurance proceedings.

Revisor's Note

Section 2(b), V.T.I.C. Article 1.35A, requires that the public counsel for the office of public insurance counsel be a resident of this state. The provision is omitted from the revised law because the provision is substantively identical to Section 14, Article XVI, Texas Constitution, which requires all civil officers to reside within the state. The policy of the legislative council's statutory revision program is to omit from the revised codes the redundant statutory provisions because a statute that tracks the language of the constitution not only is superfluous but may foster the erroneous belief that a constitutional requirement is merely statutory and subject to amendment through the ordinary legislative process.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 2(c).)

Source Law

> (c) 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 the department 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 the department or receiving funds from the department or the office of public insurance counsel; or
>
> (3) uses or receives a substantial amount of tangible goods, services, or funds from the department or the office of public insurance counsel, other than compensation or reimbursement authorized by law for department or office of public insurance counsel membership, attendance, or expenses.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 4(a).)

Source Law

> Sec. 4. (a) A person may not serve as the public counsel or act as the general counsel for the office of public insurance counsel 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 of public insurance counsel.

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 2(f), (g).)

Source Law

> (f) It is a ground for removal from office if the public counsel:
>
> (1) does not have at the time of appointment the qualifications required by Subsection (b) of this section;
>
> (2) does not maintain during service as public counsel the qualifications required by Subsection (b) of this section;
>
> (3) violates a prohibition established by Subsection (c) of this section or Section 4 of this article; or
>
> (4) cannot discharge the public counsel's duties for a substantial part of the term for which the public counsel is appointed because of illness or disability.
>
> (g) The validity of an action of the office of public insurance counsel is not affected by the fact that it is taken when a ground for removal of the public counsel exists.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 4(b).)

Source Law

> (b) A person serving as the public counsel may not, for a period of two years after the date the person ceases to be public counsel, represent any person in a proceeding before the board or receive compensation for services rendered on behalf of any person regarding a case pending before the rate board, commissioner, or department.

Revisor's Note

Section 4(b), V.T.I.C. Article 1.35A, refers to proceedings "before the board," meaning the State Board of Insurance, and cases pending before "the rate board, commissioner, or department." Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993,

abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. For that reason, the reference to the board has been changed to "department" and "commissioner." The revised law omits the reference to "rate board" because there is no rate board within the Texas Department of Insurance.

[Sections 501.057-501.100 reserved for expansion]

SUBCHAPTER C. PERSONNEL

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Source Law

> Sec. 3. (a) The public counsel, . . . shall be charged with the responsibility of . . . employing all necessary professional, technical, and other employees to carry out the provisions of this article, ... The compensation for employees of the office of public insurance counsel shall be fixed by the legislature as provided by the General Appropriations Act.

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 4(c), (d), (e).)

Source Law

(c) An officer, employee, or paid consultant of a trade association in the field of insurance may not serve as the public counsel or be an employee of the office of public insurance counsel 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 17, of the position classification salary schedule.

(d) A person who is the spouse of an officer, manager, or paid consultant of a trade association in the field of insurance may not serve as the public counsel and may not be an office of public insurance counsel employee 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 17, of the position classification salary schedule.

(e) For purposes of this section, a trade association is 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.

Revisor's Note

Sections 4(c) and (d), V.T.I.C. Article 1.35A, refer to employment in a position "compensated at or above the amount prescribed by the General Appropriations Act for step 1, salary group 17, of the position classification salary schedule." Under the General Appropriations Act for the 1996-1997 and earlier state bienniums, there was a single position classification salary schedule. Under Article IX of the General Appropriations Act for the 2002-2003 state fiscal biennium (Chapter 1515, Acts of the 77th Legislature, Regular Session, 2001), there are three position classification salary schedules. "Salary group 17" under the former schedule corresponds to

"salary group A17" under the current schedule. The revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 3(g), (h).)

Source Law

> (g) The public counsel or the public counsel's designee shall develop an intra-agency career ladder program. The program shall require intra-agency posting of all nonentry level positions concurrently with any public posting.
>
> (h) The public counsel or the public counsel's designee shall develop a system of annual performance evaluations. All merit pay for office of public insurance counsel employees must be based on the system established under this subsection.

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 3(d), (e), (f).)

Source Law

(d) The public counsel or the public counsel'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 the Texas Commission on Human Rights Act (Article 5221k, Vernon's Texas Civil Statutes) and its subsequent amendments;

(2) a comprehensive analysis of the office of public insurance counsel work force that meets federal and state guidelines;

(3) procedures by which a determination can be made of significant underuse in the office of public insurance counsel work force 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.

(e) A policy statement prepared under Subsection (d) of this section must cover an annual period, be updated at least annually and reviewed by the Commission on Human Rights for compliance with Subsection (d)(1) of this section, and be filed with the governor's office.

(f) The governor's office shall deliver a

biennial report to the legislature based on the information received under Subsection (e) of this section. The report may be made separately or as a part of other biennial reports made to the legislature.

Revisor's Note

Section 3(d)(1), V.T.I.C. Article 1.35A, refers to the Texas Commission on Human Rights Act (Article 5221k, Vernon's Texas Civil Statutes) and its subsequent amendments. The relevant portions of that statute were codified in 1993 as Chapter 21, Labor Code, and the revised law is drafted accordingly. The revised law omits the reference to "subsequent amendments" because under Section 311.027, Government Code (Code Construction Act), unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 3(i).)

Source Law

(i) The office of public insurance counsel shall provide to its public counsel and employees, as often as necessary, information regarding their qualification for office or employment under this article and their responsibilities under applicable laws relating to standards of conduct for state officers or employees.

[Sections 501.106-501.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 5(a).)

Source Law

> Sec. 5. (a) The office of public insurance counsel may assess the impact of insurance rates, rules, and forms on insurance consumers in Texas and, in its own name, shall act as an advocate of positions that are most advantageous to a substantial number of insurance consumers as determined by the public counsel for the office.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Source Law

> Sec. 3. (a) The public counsel, . . . shall be charged with the responsibility of administering, enforcing, and carrying out the provisions of this article, including preparation and submission to the legislature of a budget for the office, . . . approval of expenditures for professional services, travel, per diem, and other actual and necessary expenses incurred in administering the office. . . .

Revisor's Note

> Section 3(a), V.T.I.C. Article 1.35A, charges the public counsel with "administering, enforcing, and carrying out" this chapter. The revised law omits the reference to "carrying out" because it is included in the meaning of "administer" and "enforce."

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

(1) may appear or intervene as a matter of right before the commissioner or department as a party or otherwise on behalf of insurance consumers as a class in:

(A) matters involving rates, rules, and forms affecting property and casualty insurance;

(B) matters involving rates, rules, and forms affecting title insurance;

(C) matters involving rules affecting life, health, and accident insurance;

(D) matters involving rates, rules, and forms affecting credit life, and credit accident and health insurance;

(E) matters involving rates, rules, and forms affecting all other lines of insurance for which the commissioner or department promulgates, sets, or approves rates, rules, and/or forms; and

(F) matters involving withdrawal of approval of policy forms in proceedings initiated by the department under Articles 3.42(f) and 3.42(g) of this code or if the public counsel presents persuasive evidence to the department that such forms do not comply with such articles of this code or any valid rule relating thereto duly adopted by the commissioner or are otherwise contrary to law;

(2) may initiate or intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising out of any action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this article;

. . .

(6) may appear or intervene as a matter of right as a party or otherwise on behalf of insurance consumers as a class in all proceedings in which the public counsel determines that insurance consumers need representation, except that the public counsel may not intervene in any enforcement or parens patriae proceeding brought by the attorney general;

(7) 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 matters involving rates, rules, and forms affecting commercial insurance consumers, as a class, in all proceedings where it is deemed by the counsel that small commercial consumers are in need of representation; and

. . .

Revisor's Note

(1) Section 5(b)(1)(E), V.T.I.C. Article 1.35A, refers to rates, rules, and forms promulgated, set, or approved by the department or commissioner. The revised law adds a reference to "adopts" to be

consistent with terminology used in this code.

(2) Section 5(b)(1)(F), V.T.I.C. Article 1.35A, refers to "proceedings initiated by the department under Articles 3.42(f) and 3.42(g) of this code." The revised law substitutes references to Articles 3.42(i), 3.42(k), and 3.42(m), revised in this code as Sections 1701.055 and 1701.057, for "3.42(f) and 3.42(g)" because Section 1, Chapter 176, Acts of the 74th Legislature, Regular Session, 1995, redesignated Article 3.42(f) as 3.42(i) and Article 3.42(g) as Articles 3.42(k) and (m).

(3) Section 5(b)(1)(F), V.T.I.C. Article 1.35A, refers to a "valid rule." The revised law omits "valid" as unnecessary because the word does not add to the clear meaning of the law. A rule that is not valid is no longer a rule.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

. . .

(3) is entitled to access to any records of the department that are available to any party other than the department staff in a proceeding before the commissioner or department under the authority granted public counsel by this article;

(4) is entitled to obtain discovery under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes) 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 article;

. . .

Revisor's Note

Section 5(b)(4), V.T.I.C. Article 1.35A, refers to the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes). Article 6252-13a was codified in 1993 as Chapter 2001, Government Code. The revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

. . .

(5) may recommend legislation to the legislature that, in the judgment of the public counsel, would affect positively the interests of insurance consumers;

. . .

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

Source Law

(b) The public counsel:

. . .

(8) 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 upon the issuance of a policy by insurers to each policyholder under rules adopted by the department.

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 5(c) (part).)

Source Law

> (c) The public counsel may not intervene or appear in any proceedings or hearings before the commissioner or department, or other proceedings, that relate to approval or consideration of individual charters, licenses, acquisitions, mergers, examinations, proceedings concerning the solvency of individual insurers, financial issues, policy forms, advertising, or other regulatory issues affecting individual insurers or agents. . . .

Revisor's Note

Section 5(c), V.T.I.C. Article 1.35A, refers to proceedings or hearings related to the approval or consideration of individual charters or licenses. The revised law adds the term "certificate of authority" because under this code an insurer is issued a certificate of authority by the Texas Department of Insurance to authorize the insurer to engage in business in this state.

Revised Law

Sec. 501.158. CONFIDENTIALITY REQUIREMENTS. Confidentiality requirements applicable to examination reports under Article 1.18 and to the commissioner under Section 3A, Article 21.28-A, apply to the public counsel. (V.T.I.C. Art. 1.35A, Sec. 5(c) (part).)

Source Law

> (c) . . . The confidentiality requirements applicable to examination reports under Article 1.18 of this code and to the commissioner under Section 3A, Article 21.28, of this code shall apply to the public counsel.

Revisor's Note

Section 5(c), V.T.I.C. Article 1.35A, refers to confidentiality requirements under Section 3A, Article 21.28. The revised law corrects the reference by substituting "Article 21.28-A" for "Article 21.28." Section 3A, Article 21.28, does not in any manner address confidentiality requirements, while Section 3A, Article 21.28-A does address such requirements and in context is clearly the correct reference.

[Sections 501.159-501.200 reserved for expansion]

SUBCHAPTER E. ASSESSMENTS

Revised Law

Sec. 501.201. OFFICE EXPENSES. Expenses of the office shall be paid from the assessments collected under this subchapter. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) . . . Expenses for the office shall be paid from the assessment imposed in Article 1.35B of this chapter. . . .

Revised Law

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. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

Art. 1.35B. (a) To defray the costs of creating, administering, and operating the office of public insurance counsel, the comptroller shall collect the following assessments annually in connection with the collection of other taxes imposed on insurers:

. . .

Revisor's Note

Section (a), V.T.I.C. Article 1.35B, refers to the comptroller collecting assessments in order "[t]o defray the costs of creating, administering, and operating the office of public insurance counsel."

The revised law omits the reference to creating the independent office of public insurance counsel as unnecessary because that provision is executed. The revised law omits the reference to "administering" because "administering" is included within the meaning of "operating."

Revised Law

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. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

(a) . . .

(1) each property and casualty insurer authorized to do business in this state shall pay an annual assessment of 5.7 cents for each policy of property and casualty insurance in force at year end in this state;

. . .

Revised Law

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 25;

(2) Chapter 841;

(3) Chapter 842;

(4) Chapter 843;

(5) Chapter 882;

(6) Chapter 884;

(7) Chapter 885;

(8) Chapter 887;

(9) Chapter 888;

(10) Chapter 961;

(11) Chapter 982;

(12) Subchapter B, Chapter 1103;

(13) Subchapter A, Chapter 1104;

(14) Chapter 1201, or a provision listed in Section 1201.005;

(15) Chapter 1551;

(16) Chapter 1578; or

(17) 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. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

(a) . . .

(2) each insurer 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 written for delivery and placed in force with the initial premium thereon paid in full in this state during each calendar year if the insurer is authorized to do business in this state under:

(A) Chapter 3, 10, 11, 14, 20, 22, 23, or 25 of this code;

(B) Chapter 113, Acts of the 53rd Legislature, Regular Session, 1953 (Article 3.49-1, Vernon's Texas Insurance Code);

(C) Section 1, Chapter 417, Acts of the 56th Legislature, Regular Session, 1959 (Article 3.49-2, Vernon's Texas Insurance Code);

(D) the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50-2, Vernon's Texas Insurance Code);

(E) the Texas State College and University Employees Uniform Insurance Benefits Act (Article 3.50-3, Vernon's Texas Insurance Code);

(F) Section 1, Chapter 123, Acts of the 60th Legislature, Regular Session, 1967 (Article 3.51-3, Vernon's Texas Insurance Code);

. . .

(H) Sections 1 to 3A and 4 to 13, Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Articles 3.70-1 to 3.70-3A and 3.70-4 to 3.70-11, Vernon's Texas Insurance Code); or

(I) the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); and

. . .

Revisor's Note

(1) Section (a)(2)(A), V.T.I.C. Article 1.35B,

requires the comptroller to collect an assessment from insurers authorized to engage in business in this state under Chapter 3 of the Insurance Code. The revised law substitutes "Chapter 841" and "Chapter 982" for "Chapter 3" because the relevant provisions of Chapter 3 relating to authorizing an insurer to engage in business in this state have been revised in Chapter 841 and Chapter 982.

(2) Section (a)(2)(G), V.T.I.C. Article 1.35B, requires the comptroller to collect an assessment from an insurer authorized to engage in business under Section 1, Chapter 387, Acts of the 55th Legislature, Regular Session, 1957. The revised law omits the reference because that section was repealed by Section 12.01(3), Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991. The omitted law reads:

> (2) . . .
>
> (G) Section 1, Chapter 387, Acts of the 55th Legislature, Regular Session, 1957 (Article 3.62-1, Vernon's Texas Insurance Code);
>
> . . .

Revised Law

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. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

Source Law

> (a) . . .
>
> (3) each title insurance company authorized to do business in this state shall pay an annual assessment of 5.7 cents for each owner policy and mortgage policy of title insurance written for delivery in this state during each calendar year and for which the full basic premium is charged.

Revisor's Note
(End of Subchapter)

Sections (b), (c), and (d), V.T.I.C. Article

1.35B, create a special account in the state treasury for the office of public insurance counsel, require the comptroller to adopt rules regarding payments to the account, and authorize all amounts in the account to be used for certain purposes. In 1991, the legislature enacted Section 403.094, Government Code, now repealed, under which many funds were merged into the general revenue fund in 1993 and many accounts were abolished on September 1, 1995. The revised law omits Sections (b), (c), and (d), Article 1.35B, because the account ceased to exist as a result of actions taken under the former Government Code provision. The omitted law reads:

> (b) The office of public insurance counsel account is created in the State Treasury, and all assessments collected under this article must be deposited in the State Treasury to the credit of that account as provided by rules of the comptroller of public accounts.
>
> (c) The comptroller of public accounts shall adopt necessary rules to provide for the payment to the office of public insurance counsel account of assessments collected from insurers under this article.
>
> (d) Money deposited in the office of public insurance counsel account may be appropriated for the purpose of paying the costs of creating, administering, and operating the office.

[Sections 501.206-501.250 reserved for expansion]

SUBCHAPTER F. DUTIES RELATING TO HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

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. (V.T.I.C. Art. 1.35A, Sec. 5(e) (part).)

Source Law

> (e) The office of public insurance counsel 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 that are established under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).
>
> (1) In developing the system under this subsection, the office of public insurance counsel may use information or data from any person, agency, organization, or governmental unit that the office deems reliable. . . .

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 5(e)(2), (10), (11).)

Source Law

> (2) The office of public insurance counsel shall develop and issue annually consumer report cards that identify and compare, on an objective basis, health maintenance organizations in this state. The consumer report card may be based on information or data from any person, agency, organization, or governmental unit that the office deems reliable.
>
> (10) The office of public insurance counsel may not endorse or recommend a specific health maintenance organization or plan, or subjectively rate or rank such organizations or plans, other than through comparison and evaluation of objective criteria.
>
> (11) The office of public insurance counsel shall provide a copy of the consumer report to any person on request on payment of a reasonable fee.

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 5(e)(3), (4) (part), (5).)

Source Law

> (3) The department and the health care information council shall provide information or data as requested by the office of public insurance counsel in furtherance of these duties.
>
> (4) The office of public insurance counsel shall use the information collected or received under this subsection for the benefit of the public. . . .
>
> (5) The office of public insurance counsel is entitled to information that is confidential under any law of this state, including Section 27, Texas Health Maintenance Organization Act (Article 20A.27, Vernon's Texas Insurance Code), Chapter 108, Health and Safety Code, and Chapter 552, Government Code.

Revisor's Note

Section 5(e)(3), V.T.I.C. Article 1.35A, refers to the health care information council. The revised law substitutes "Texas Health Care Information Council" for "the health care information council" because under Chapter 108, Health and Safety Code, that is the official name of the agency.

Revised Law

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. (V.T.I.C. Art. 1.35A, Secs. 5(e)(4) (part), (6), (7), (8), (9).)

<u>Source Law</u>

> (4) . . . Except as provided by this subsection, the information is subject to the open records law, Chapter 552, Government Code, and the office of public insurance counsel shall make determinations on requests for information in favor of

access.

(6) The office of public insurance counsel may not make public confidential information provided to the office under this subsection 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 of public insurance counsel may not release, and a person or entity may not gain access to, any information that:

(A) could reasonably be expected to reveal the identity of a patient or physician or that reveals the zip code of a patient's primary residence;

(B) discloses provider discounts or differentials between payments and billed charges; or

(C) relates to actual payments to an identified provider made by a payer.

(7) Information collected or used by the office of public insurance counsel under this subsection is subject to the confidentiality provisions and criminal penalties of:

(A) Section 81.103, Health and Safety Code;

(B) Section 311.037, Health and Safety Code; and

(C) Section 5.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes).

(8) Information that is in the possession of the office of public insurance counsel and that relates to patients and physicians and any compilation, report, or analysis produced from the information that identifies patients and physicians is not:

(A) subject to discovery, subpoena, or other means of legal compulsion for release to any person or entity; or

(B) admissible in any civil, administrative, or criminal proceeding.

(9) Notwithstanding Subdivision (6)(A) of this subsection, the office of public insurance counsel may use zip code information to analyze information on a geographic basis.

Revisor's Note

Section 5(e)(7), V.T.I.C. Article 1.35A, refers to Section 5.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). Section 5.08, Article 4495b, was codified in 1997 as Chapter 159, Occupations Code. The revised law is drafted accordingly.

[Chapters 502-520 reserved for expansion]

SUBTITLE B. CONSUMER SERVICE PROVISIONS

CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

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[Sections 521.057-521.100 reserved for expansion]

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CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

Revised Law

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. (V.T.I.C. Art. 1.37.)

Source Law

> Art. 1.37. The department shall prepare information of public interest describing the functions of the department and describing the department's procedures by which complaints are filed with and resolved by the department. The department shall make the information available to the public and appropriate state agencies.

Revised Law

Sec. 521.002. COMPLAINT RESOLUTION PROGRAM. The department shall establish a program to facilitate resolution of policyholder complaints. (V.T.I.C. Art. 1.04B.)

Source Law

> Art. 1.04B. The department shall establish a program to facilitate resolution of policy holder complaints.

Revised Law

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. (V.T.I.C. Art. 1.10, Sec. 19.)

Source Law

> 19. Notice 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 the parties to the complaint of the status of the complaint unless the notice would jeopardize an undercover investigation.

Revised Law

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. (V.T.I.C. Art. 1.10, Sec. 18.)

Source Law

> 18. Complaint File. The Department shall keep an

information file about each complaint filed with the Department concerning an activity that is regulated by the Department or Commissioner.

Revised Law

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. (V.T.I.C. Art. 1.35.)

Source Law

Art. 1.35. (a) Each insurance policy delivered or issued for delivery in this state shall be accompanied by a brief written notice of suggested procedure to be followed by the policyholder in the event of a dispute concerning a policyholder's claim or premium.

(b) The notice must include the name and address of the department and the toll-free telephone number maintained under Article 1.35D of this code.

(c) The commissioner shall promulgate the proper wording for the written notice.

[Sections 521.006-521.050 reserved for expansion]

SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Revised Law

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. (V.T.I.C. Art. 1.35D, Sec. (a).)

Source Law

Art. 1.35D. (a) The department shall maintain a toll-free telephone number to facilitate distribution

of information to be made available under Subsection (b) of this article and to receive and to aid in resolving complaints against insurers.

Revised Law

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. (V.T.I.C. Art. 1.35D, Sec. (b).)

Source Law

(b) The department, through the toll-free telephone number, shall provide only the following to the public:

(1) information collected or maintained by the department relating to the number of justified, verified as accurate, and documented as valid complaints received against a particular insurer, as a percentage of the number of insurance policies written by the insurer and in force on the preceding December 31, and the disposition of the complaints;

(2) the rating of the insurer, if any, as published by a nationally recognized rating organization;

(3) the types of coverages available to a consumer through any insurer writing insurance in this state;

(4) the insurer's admitted assets-to-liabilities ratio; and

(5) other appropriate information collected and maintained by the department.

Revised Law

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. (V.T.I.C. Art. 1.35D, Sec. (e).)

Source Law

(e) The toll-free telephone number shall be publicized in public service announcements and published in telephone books throughout the state, as the board finds appropriate.

Revisor's Note

Section (e), V.T.I.C. Article 1.35D, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

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. (V.T.I.C. Art. 1.35D, Sec. (c).)

Source Law

(c) The department shall maintain a written record of all inquiries and complaints received through the toll-free telephone number.

Revised Law

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. (V.T.I.C. Art. 1.35D, Sec. (d).)

Source Law

(d) The department shall establish a system for communicating complaints received through the toll-free telephone number to insurers by electronic transmission to a facsimile machine or other appropriate system.

Revised Law

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. (V.T.I.C. Art. 1.35D, Sec. (f).)

Source Law

(f) Each insurer that delivers, issues for delivery, or renews an insurance policy in this state shall include with the policy an information bulletin including the toll-free telephone number and describing the services offered through the number.

[Sections 521.057-521.100 reserved for expansion]

SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

Revised Law

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. (V.T.I.C. Art. 21.71, Secs. (a), (b).)

Source Law

Art. 21.71. (a) Except as provided in Subsection (b) of this article, this article applies to any insurer authorized to do business as an insurance company or to provide insurance in this state, including:

(1) a capital stock company;
(2) a mutual 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 company;
(9) a reciprocal or interinsurance exchange;
(10) a stipulated premium insurance company;
(11) a group hospital service company;
(12) a health maintenance organization; and
(13) a risk retention group.

(b) This article does not apply to an insurer whose gross initial premium receipts collected in this state are less than $2 million a year or to an insurer with regard to fidelity, surety, or guaranty bonds.

Revisor's Note

Section (a), V.T.I.C. Article 21.71, provides that the article applies to an "insurer" authorized to do business or to provide insurance in this state, including certain listed entities. Included among the listed entities is a "health maintenance organization," which is not a traditional insurer. The revised law is drafted to reflect its application to both traditional insurers and health maintenance organizations, and terminology consistent with that application is added throughout this subchapter.

Revised Law

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. (V.T.I.C. Art. 21.71, Sec. (c).)

Source Law

(c) Each insurer in this state shall maintain a toll-free telephone number to provide information concerning policies issued by the insurer and to accept complaints from policyholders.

Revisor's Note

Section (c), V.T.I.C. Article 21.71, requires a health maintenance organization or insurer "in this state" to maintain a toll-free telephone number. The revised law omits the quoted phrase as redundant because Section (a), V.T.I.C. Article 21.71, revised as Section 521.101(a), limits the applicability of Section (c), revised as this section, to a health maintenance organization or insurer authorized to engage in business in this state.

Revised Law

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. (V.T.I.C. Art. 21.71, Sec. (d).)

Source Law

(d) Each insurer that delivers, issues for delivery, or renews an insurance policy in this state shall print on the policy the insurer's toll-free

telephone number. The board may adopt rules governing the manner in which the number appears on the policy.

CHAPTER 522. CONSUMER INFORMATION IN SPANISH

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CHAPTER 522. CONSUMER INFORMATION IN SPANISH

Revised Law

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." (V.T.I.C. Art. 1.35E.)

Source Law

Art. 1.35E. (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 required by this article 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) An informational sheet developed by the commissioner must include a disclaimer, prominently printed in 10-point boldface type at the top of the informational sheet in the Spanish language, 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 insurance company. If you have questions about your insurance, you should consult your insurance agent, the insurance company, or the language of the insurance policy."

CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE

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CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 523.001. DEFINITION. In this chapter, "residential property insurance" means insurance provided by a homeowners policy or residential fire and allied lines policy against loss incurred at a fixed location to real or tangible personal property. The term does not include insurance against loss provided by a farm and ranch owners policy. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

Source Law

> (a) . . . For purposes of this article, residential property insurance means insurance against loss to real or tangible personal property at a fixed location provided in a homeowners policy or a residential fire and allied lines policy, but does not include a farm and ranch owners policy. . . .

Revised Law

Sec. 523.002. RULES. In addition to the plan of operation adopted under Subchapter B, the commissioner may adopt appropriate rules to accomplish the purposes of this chapter. (V.T.I.C. Art. 21.49-12, Sec. 8.)

Source Law

> Sec. 8. The commissioner is authorized to adopt rules in addition to the plan of operation that are appropriate to accomplish the purposes of this article.

Revised Law

Sec. 523.003. IMMUNITY. The market assistance program,

the members of the executive committee, and participating insurers and agents are not personally liable for:

(1) an act performed in good faith in the scope of the person's authority as determined under this chapter; or

(2) damages arising from the person's official acts or omissions, other than a corrupt or malicious act or omission. (V.T.I.C. Art. 21.49-12, Sec. 7.)

Source Law

> Sec. 7. The program, executive committee members, and participating insurers and agents are not personally liable for any act performed in good faith within the scope of the person's authority as determined under this article or for damages occasioned by his or her official acts or omissions except for an act or omission that is corrupt or malicious.

[Sections 523.004-523.050 reserved for expansion]

SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

Revised Law

Sec. 523.051. MARKET ASSISTANCE PROGRAM. (a) The market assistance program is a voluntary program designed to assist applicants for insurance and insureds in this state in obtaining residential property insurance coverage in underserved areas. The commissioner by rule shall designate underserved areas using the standards described by Section 1, Article 5.35-3.

(b) The commissioner shall establish the types of risks for which the market assistance program will provide assistance.

(c) The market assistance program may not provide assistance regarding windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49. (V.T.I.C. Art. 21.49-12, Secs. 1(a) (part), (b).)

Source Law

> Art. 21.49-12
>
> Sec. 1. (a) The commissioner shall establish a voluntary mechanism to be called a market assistance program to assist insureds in Texas in obtaining residential property insurance coverage in underserved areas, which shall be determined and designated by the commissioner by rule using the standards specified in Section 1, Article 5.35-3, of this code. . . . The types of risks to be assisted under the market assistance program will be

established by the commissioner. . . .

(b) The market assistance program established under this article may not provide assistance with respect to windstorm and hail insurance coverage for a risk eligible for that coverage under Article 21.49 of this code.

Revisor's Note

(1) Section 1(a), V.T.I.C. Article 21.49-12, provides that "[t]he commissioner [of insurance] shall establish" a market assistance program. The revised law omits the requirement to establish the program as executed.

(2) Section 1(a), V.T.I.C. Article 21.49-12, states that the purpose of the market assistance program is to assist "insureds" in obtaining certain insurance coverage. The revised law refers to "applicants for insurance" in addition to "insureds" to reflect the clear intent of the legislature that an applicant for insurance who is not currently an insured is also intended to benefit from the program.

(3) Section 1(a), V.T.I.C. Article 21.49-12, refers to underserved areas "determined and designated" by the commissioner of insurance. The revised law omits the reference to "determined" as unnecessary because, in context, the commissioner necessarily determines underserved areas in the process of designating the areas.

Revised Law

Sec. 523.052. MARKET ASSISTANCE PROGRAM DIVISION. The department shall operate a market assistance program division. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

Source Law

(a) . . . A market assistance program division shall be established in and operated by the Texas Department of Insurance.

Revisor's Note

Section 1(a), V.T.I.C. Article 21.49-12, requires that a market assistance program division "be

established" in the Texas Department of Insurance. The revised law omits the requirement to establish the division as executed.

Revised Law

Sec. 523.053. EXECUTIVE COMMITTEE. (a) The market assistance program is administered by an executive committee.

(b) The executive committee consists of 11 members appointed by the commissioner as follows:

(1) five members who represent the interests of insurers;

(2) four public members; and

(3) two members who are general property and casualty agents.

(c) Each member of the executive committee who represents the interests of insurers must be a full-time employee of an authorized insurer.

(d) The commissioner or the commissioner's designated representative serves as an ex officio member of the executive committee and must be present at each executive committee meeting.

(e) The executive committee shall be available to advise and consult with the commissioner regarding the administration of the market assistance program. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), 3.)

Source Law

> Sec. 2. (a) The executive committee . . . shall be available to advise and consult with the commissioner with regard to the administration of the program. . . .
>
> Sec. 3. (a) The program shall be administered by an executive committee composed of 11 members appointed by the commissioner:
>
> (1) five members who represent the interests of insurers;
>
> (2) four public members; and
>
> (3) two members who are licensed local recording agents.
>
> (b) To be eligible to serve on the executive committee as a representative of insurers, a person must be a full-time employee of an authorized insurer.
>
> (c) The commissioner or the commissioner's designated representative shall be an ex officio member of the executive committee and must be present

in every meeting of the executive committee.

Revisor's Note

(1) Section 3(a)(3), V.T.I.C. Article 21.49-12, refers to "licensed" agents. The revised law omits "licensed" as unnecessary in this context because a person may not act as an agent unless the person holds a license. See Section 4001.101 of this code.

(2) Section 3(a)(3), V.T.I.C. Article 21.49-12, refers to "local recording agents." Throughout this chapter, the revised law substitutes "general property and casualty agents" for "local recording agents" because the term "local recording agent" was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a local recording agent in the context of residential property insurance is now regulated as a "general property and casualty agent" under Chapter 4051 of this code.

Revised Law

Sec. 523.054. PLAN OF OPERATION. (a) The operation and management of the market assistance program is governed by a plan of operation adopted by rule by the commissioner.

(b) In addition to the other requirements specified by this chapter, the plan of operation must include provisions regarding types of coverage, policy forms and terms, application forms, eligibility, and the overall operation of the market assistance program.

(c) The plan of operation may provide for subcommittees necessary to administer the market assistance program. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part), (c).)

Source Law

Sec. 2. (a) [The executive committee shall . . . submit] the plan of operation to the commissioner for adoption by rule and . . . . The plan of operation shall indicate types of coverage, policy forms and terms, application forms, eligibility, and overall operation of the

program. . . .

(b) The plan of operation shall include, but is not limited to, the following provisions:

. . .

(c) The plan of operation may provide for subcommittees that are necessary to carry out the functions of a program.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.49-12, as amended by Section 5, Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, requires the executive committee to submit a plan of operation to the commissioner of insurance for approval within 180 days following the effective date of Chapter 415 and provides that if the executive committee fails to do so, the Texas Department of Insurance shall submit a plan to the commissioner for adoption by rule. Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, took effect August 28, 1995. Accordingly, the revised law omits the provision as executed. The omitted law reads:

> Sec. 2. (a) The executive committee shall develop and submit [the plan of operation to the commissioner] . . . . If the executive committee fails to submit a suitable plan of operation within 180 days following the effective date of this article, or . . . [the department shall develop and submit to the commissioner] a plan of operation . . . [and the commissioner shall, after notice and hearing, adopt by rule] the plan of operation developed by the department or . . . .

(2) Section 2(b), V.T.I.C. Article 21.49-12, provides that the plan of operation required by that article shall "include, but is not limited to" the specified provisions. The revised law omits the phrase "but is not limited to" and similar phrases are omitted throughout this chapter as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and

"including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

Sec. 523.055. AMENDMENT OF PLAN OF OPERATION. (a) The executive committee may develop amendments to the plan of operation and submit the amendments to the commissioner for adoption by rule.

(b) If the executive committee fails to submit suitable amendments to the plan of operation, the department shall develop and submit to the commissioner suitable amendments and the commissioner shall, after notice and hearing, adopt the amendments by rule. (V.T.I.C. Art. 21.49-12, Sec. 2(a) (part).)

Source Law

> Sec. 2. (a) [The executive committee shall develop and submit the plan of operation to the commissioner for adoption by rule and] . . . if at any time thereafter the executive committee fails to submit suitable amendments to the plan of operation, the department shall develop and submit to the commissioner [a plan of operation] and thereafter any amendments thereto, and the commissioner shall, after notice and hearing, adopt by rule . . . any amendments to the plan of operation. . . .

Revisor's Note

Section 2(a), V.T.I.C. Article 21.49-12, requires the executive committee to develop the market assistance program plan of operation and requires the Texas Department of Insurance to submit to the commissioner of insurance amendments to the plan if the executive committee fails to submit suitable amendments. For clarity, the revised law makes explicit the authority implied by the section for the executive committee to develop amendments to the plan and submit the amendments to the commissioner for adoption by rule.

[Sections 523.056-523.100 reserved for expansion]

SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE PROGRAM

Revised Law

Sec. 523.101. PARTICIPATION BY INSURERS. (a) An insurer authorized to engage in the business of property or casualty insurance that writes residential property insurance in this state, including a Lloyd's plan or a reciprocal or interinsurance exchange, may voluntarily participate in the market assistance program. The commissioner may not permit an insurer to condition its participation in the program in a manner that is inequitable to the participants.

(b) Notwithstanding Subsection (a), the commissioner may make insurer participation in the market assistance program mandatory. The plan of operation must contain the criteria under which the commissioner may make insurer participation in the market assistance program mandatory.

(c) Each participating insurer is entitled to individually evaluate a risk and apply rates under the market assistance program in accordance with the provisions of this code applicable to the insurer. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part).)

Source Law

> (a) . . . All insurers licensed to write property or casualty insurance and actually writing residential property insurance in this state, including Lloyds, reciprocals, or interinsurance exchanges, may participate in the program unless insurer participation is made mandatory by the commissioner based on criteria provided in the plan of operation, but the commissioner may not permit an insurer to condition its participation in a manner that is inequitable to the participants.
>
> (b) [The plan of operation shall include, but is not limited to, the following provisions:]
>
> . . .
>
> (2) Each insurer has the right to individually evaluate the risk and apply the rates in accordance with the provisions of this code applicable to each insurer.
>
> . . .
>
> (7) The plan of operation shall contain criteria under which the commissioner may make insurer participation in the program mandatory.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.49-12, refers to an insurer "licensed to write" property or casualty

insurance in this state, meaning an insurer that holds a certificate of authority under which the insurer is authorized to engage in the business of writing property or casualty insurance in this state. The revised law substitutes "authorized to engage in the business of" for "licensed to write" for consistent use of terminology within this code.

Revised Law

Sec. 523.102. APPLICATION ASSISTANCE AND REFERRALS. The department may:

(1) assist an applicant for coverage through the market assistance program in completing an initial application; and

(2) refer the applicant to one or more participating insurers. (V.T.I.C. Art. 21.49-12, Sec. 4(a).)

Source Law

Sec. 4. (a) The department may:

(1) assist an applicant for coverage through the market assistance program in completing an initial application; and

(2) refer the applicant to one or more participating companies.

Revised Law

Sec. 523.103. APPLICATION FOR ASSISTANCE. (a) An application for assistance must be addressed to the market assistance program at the department.

(b) An application must be accompanied by a copy of a current notice of nonrenewal or cancellation of coverage and a current declination letter from at least one other insurer that writes the coverage sought, except that an applicant who does not have previous residential property insurance coverage must provide copies of current declination letters from at least two unaffiliated insurers that write the coverage sought. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

Source Law

(b) [The plan of operation shall include, but is not limited to, the following provisions:]

(1) Applications for assistance shall be addressed to the Market Assistance Program at the

Texas Department of Insurance. Each application must be accompanied by a copy of a current nonrenewal or cancellation notice and a current declination letter from at least one other insurer writing the coverage sought. Applicants not having previous residential property insurance coverage must provide copies of current declination letters from at least two unaffiliated insurers writing the coverage sought.

. . .

Revised Law

Sec. 523.104. INSURER ACTION ON APPLICATION. (a) Not later than the 30th day after the date an insurer receives an application, the insurer shall:

(1) quote a premium;

(2) indicate its refusal to quote a premium; or

(3) request additional time to consider a premium quote.

(b) If the insurer quotes a premium, the insurer shall notify the applicant or the applicant's agent, if an agent is used, so that the placement of the insurance may be completed if the applicant accepts the coverage at the quoted premium.

(c) The insurer may provide a premium quote on the same coverage basis for which the insurer normally provides insurance in this state using the insurer's underwriting guidelines and applying rates determined in accordance with the provisions of this code applicable to the insurer. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

Source Law

(b) [The plan of operation shall include, but is not limited to, the following provisions:]

. . .

(3) Each insurer has the option of providing a premium quote on the same coverage basis for which it normally provides insurance in this state using its own underwriting guidelines and the rates determined in accordance with the provisions of this code applicable to each insurer.

(4) An insurer shall make its premium quote, indicate its refusal to quote, or make a request for additional time within 30 days of receiving the application.

(5) If a premium quote is made, the insurer shall notify the applicant or notify the applicant's agent, if an agent is used, so that the placement of the insurance may be completed, if the applicant accepts the coverage at the premium quoted.

. . .

Revised Law

Sec. 523.105. NONPAYMENT OF PREMIUM OR SUBMISSION OF FRAUDULENT CLAIM. If an insurer cancels or does not renew coverage for nonpayment of premium or submission of a fraudulent claim, an applicant is ineligible to subsequently apply to the market assistance program for the same coverage for the same risk. (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

Source Law

(b) [The plan of operation shall include, but is not limited to, the following provisions:]

. . .

(6) An applicant is not eligible to apply to the program again for the same coverage for the same risk if the insurer cancels or nonrenews coverage for nonpayment of premium or submission of a fraudulent claim.

. . .

[Sections 523.106-523.150 reserved for expansion]

SUBCHAPTER D. PROGRAM AGENTS

Revised Law

Sec. 523.151. TYPES OF AGENTS. (a) Notwithstanding other law, the market assistance program may have both originating agents and issuing agents.

(b) An originating agent may complete on behalf of an applicant an application for insurance to submit to the market assistance program. An applicant is not required to submit the application through an originating agent. If an originating agent is used, the originating agent is not required to be appointed to represent the ultimate insurer.

(c) An issuing agent must be appointed to represent the ultimate insurer. The issuing agent shall perform the customary duties of a general property and casualty agent, including:

(1) signing, executing, and delivering insurance policies;

(2) maintaining a record of the business;

(3) examining and inspecting the risk; and

(4) receiving and collecting premiums.

(d) A person may act as both the originating agent and the

issuing agent. If the originating agent and the issuing agent are not the same person, the originating agent may not be held to be the agent of the insurer unless the agent is appointed as provided by Chapter 4051. (V.T.I.C. Art. 21.49-12, Secs. 4(b), (c), (d), (f).)

Source Law

(b) Notwithstanding any other provision of law, a market assistance program may have two categories of agents:

(1) an originating agent; and

(2) an issuing agent.

(c) An originating agent may complete an application for insurance on behalf of an insured for submission to the program, but an applicant is not required to submit the application through an originating agent. If an originating agent is used, the originating agent is not required to be appointed to represent the ultimate insurer.

(d) An issuing agent must be appointed to represent the ultimate insurer and shall perform all of the customary duties of a local recording agent including but not limited to the following:

(1) signing, executing, and delivering policies of insurance;

(2) maintaining a record of the business;

(3) examining and inspecting the risk; and

(4) receiving and collecting premiums.

(f) The originating agent, if any, and the issuing agent may be the same person. If the originating agent and the issuing agent are not the same person, the originating agent may not be held to be the agent of the insurer unless there is an appointment as specified by Article 21.14 of this code.

Revised Law

Sec. 523.152. SHARING OF AGENT COMMISSIONS. (a) An originating agent shall share commissions with an issuing agent as required by the market assistance program plan of operation if the originating agent holds a license as:

(1) a general property and casualty agent; or

(2) a salaried representative for one or more insurers whose plan of operation does not contemplate the use of general property and casualty agents.

(b) The market assistance program may not share in commissions. (V.T.I.C. Art. 21.49-12, Secs. 4(e), (g).)

Source Law

(e) The originating agent, if any, shall share commissions, as required by the market assistance program plan of operation, with the issuing agent if

the originating agent holds a license as either a local recording agent or as a salaried representative for those companies whose plan of operation does not contemplate the use of local recording agents.

(g) The program may not share in commissions.

[Sections 523.153-523.200 reserved for expansion]

SUBCHAPTER E. MARKET ASSISTANCE PROGRAM REVIEW; PROGRAM TERMINATION

Revised Law

Sec. 523.201. COLLECTION OF PROGRAM INFORMATION. Information concerning the number and type of applications received and placed by the market assistance program and other information about the program the executive committee or the commissioner considers appropriate shall be collected. (V.T.I.C. Art. 21.49-12, Sec. 6(a).)

Source Law

Sec. 6. (a) Information concerning the number and type of applications received and placed, and such other information, as deemed appropriate by the executive committee or the commissioner, shall be collected.

Revised Law

Sec. 523.202. PERIODIC REVIEW OF PROGRAM. (a) The executive committee shall review the demand for and performance of the market assistance program at least annually, as necessary.

(b) After each review, the executive committee shall report to the commissioner regarding:

(1) the need to continue operating the voluntary market assistance program;

(2) the need to establish a mandatory market assistance program;

(3) the need to establish a FAIR (Fair Access to Insurance Requirements) Plan under Article 21.49A; or

(4) other recommendations the executive committee considers appropriate. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

Source Law

(b) The executive committee shall review the

demand for and performance of the program six months following the approval of the plan of operation, and at least annually thereafter, as necessary. After each such review the executive committee shall report to the commissioner as to the necessity for continued operation of the voluntary program, need for establishment of a mandatory program, or the need for establishment of a FAIR Plan pursuant to Article 21.49A of this code, or other recommendations the executive committee deems appropriate. . . .

Revisor's Note

(1) Section 6(b), V.T.I.C. Article 21.49-12, refers to a review of the market assistance program to be performed "six months following the approval of the plan of operation." Section 2, V.T.I.C. Article 21.49-12, as amended by Section 5, Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, requires the executive committee to submit a plan of operation to the commissioner of insurance for approval within 180 days following the effective date of the act and requires the Texas Department of Insurance to submit a plan to the commissioner for approval if the executive committee fails to do so. Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, took effect August 28, 1995. Accordingly, the revised law omits the quoted language as executed.

(2) Section 6(b), V.T.I.C. Article 21.49-12, refers to the establishment of a "FAIR Plan" under V.T.I.C. Article 21.49A. Under Article 21.49A, "FAIR" is an acronym for "Fair Access to Insurance Requirements," and the revised law is drafted accordingly.

Revised Law

Sec. 523.203. TERMINATION OF PROGRAM. The department may terminate the market assistance program only on the commissioner's approval. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

Source Law

(b) . . . The program shall be terminated only upon approval of the commissioner, but . . . .

Revisor's Note

Section 6(b), V.T.I.C. Article 21.49-12, provides that the market assistance program may not be terminated until at least 48 months have elapsed following the commencement date of the initial plan of operation. The revised law omits the provision as no longer necessary because, according to information from the Texas Department of Insurance, the initial plan of operation took effect October 1, 1996, and more than 48 months have elapsed since that date. The omitted law reads:

> (b) . . . [The program shall be terminated] . . . in no event earlier than 48 months following the commencement date of the initial plan of operation.

[Chapters 524-540 reserved for expansion]

SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES

CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES

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CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 1(a).)

Source Law

Art. 21.21

Sec. 1. (a) The purpose of this Act is to regulate trade practices in the business of insurance by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Revised Law

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, adjuster, or life and health insurance counselor. (V.T.I.C. Art. 21.21, Secs. 2(a), (c).)

Source Law

Sec. 2. When used in this Article:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and life insurance counselors.

(c) "Knowingly" means actual awareness of the falsity, unfairness, or deception of the act or practice made the basis for a claim for damages under Section 16 of this Article. "Actual awareness" may be inferred where objective manifestations indicate that a person acted with actual awareness.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.21, refers to a "reciprocal exchange" and an "inter-insurer." The revised law substitutes "reciprocal or interinsurance exchange" for "reciprocal exchange" and "inter-insurer" because that is the term used in Chapter 942 of this code to describe that type of insurer.

(2) Section 2(a), V.T.I.C. Article 21.21, refers to "life insurance counselors." The revised law substitutes "life and health insurance counselor" because that is the term used in Chapter 4052 of this code to refer to that type of insurance professional. The term was changed from "life insurance counselor" to "life and health insurance counselor" by Chapter 1530, Acts of the 76th Legislature, Regular Session, 1999.

(3) Section 2(b), V.T.I.C. Article 21.21, defines "board" as the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately. The omitted law reads:

(b) "Board" shall mean the

State Board of Insurance.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 3.)

Source Law

> Sec. 3. No person shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to this Act to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 21.)

Source Law

> Sec. 21. Any action brought under this Article shall be commenced in a district court of Travis County, Texas, if the State Board of Insurance is a party thereto.

Revised Law

Sec. 541.005. APPLICABILITY TO RISK RETENTION OR PURCHASING GROUP. (a) A risk retention group or purchasing group, as those terms are defined by Section 2, Article 21.54, 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. (V.T.I.C. Art. 21.21B.)

Source Law

> Art. 21.21B. (a) A risk retention group or purchasing group, as those terms are defined by Article 21.54 of this code, that is not chartered in this state, may not engage in any trade practice in this state that is declared to be unlawful under Article 21.21 of this code.
>
> (b) A risk retention group or purchasing group

shall be subject to all of the provisions of Article 21.21 of this code and the rules and regulations adopted under Article 21.21 of this code.

Revisor's Note

(1) Section (a), V.T.I.C. Article 21.21B, refers to a trade practice that is "declared" to be unlawful under V.T.I.C. Article 21.21. Throughout this chapter, the revised law substitutes "defined" for "declared" for consistency of terminology within the chapter.

(2) Section (b), V.T.I.C. Article 21.21B, refers to "rules and regulations." Throughout this chapter, the revised law omits references to "regulations" or substitutes references to "rules" for references to "regulations" because in context the terms are synonymous and under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 9(a).)

Source Law

Sec. 9. (a) Notwithstanding any other provision of the Insurance Code (Acts 1951, 52nd Legislature, page 868, Chapter 491) to the contrary, it is hereby declared to be unlawful for any company 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 Board of Insurance Commissioners" or words of a similar import or nature.

Revised Law

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). (V.T.I.C. Art. 21.21, Sec. 12.)

Source Law

Sec. 12. If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence or other documents at any hearing on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture, and shall notwithstanding be directed to give such testimony or produce such evidence, he must nonetheless comply with such direction, but he shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which he may testify or produce evidence pursuant thereto, and no testimony so given or evidence produced shall be received against him upon any criminal action, investigation or proceeding; provided, however, that no such individual so testifying shall be exempt from prosecution or punishment for any perjury committed by him while so testifying and the testimony or evidence so given or produced shall be admissible against him upon any criminal action, investigation or proceeding concerning such perjury, nor shall he be exempt from the refusal, revocation or suspension of any license, permission or authority conferred, or to be conferred, pursuant to the Insurance Code of this state. Any such individual may execute, acknowledge and file in the office of the Board a statement expressly waiving such immunity or privilege in respect to any transaction, matter or thing specified in such statement and thereupon the testimony of such person or such evidence in relation to such transaction, matter or thing may be received or produced before any judge or justice, court, tribunal, grand jury or otherwise, and if so received or produced such individual shall not be entitled to any immunity or privilege on account of any testimony he may so give or evidence so produced.

Revised Law

Sec. 541.008. LIBERAL CONSTRUCTION. This chapter shall be liberally construed and applied to promote the underlying purposes as provided by Section 541.001. (V.T.I.C. Art. 21.21, Sec. 1(b).)

Source Law

(b) This Article shall be liberally construed and applied to promote its underlying purposes as set forth in this section.

[Sections 541.009-541.050 reserved for expansion]

SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES DEFINED

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and False Advertising of Policy Contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation

to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance;

. . .

Revised Law

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; or

(4) in any other manner. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(2) False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading;

. . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

> Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> . . .
>
> (3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure any person engaged in the business of insurance;
>
> . . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

> Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> . . .
>
> (4) Boycott, Coercion and Intimidation.

Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

. . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(5) False Financial Statements. (a) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive;

(b) Making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer;

. . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

> Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> . . .
>
> (6) Stock Operations and Advisory Board Contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, company stock or other capital stock, or benefit certificates or shares in any corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance. Provided, however, that nothing in this subsection shall be construed as prohibiting the issuing or delivery of participating insurance policies otherwise authorized by law.
>
> . . .
>
> (8) Rebates. (a) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract;
>
> . . .

Revisor's Note

Section 4(8), V.T.I.C. Article 21.21, defines certain practices with respect to giving inducements as unfair methods of competition or unfair or deceptive acts or practices in the business of insurance. For clarity and the convenience of the reader, the revised law adds a reference to Section

541.058, which lists certain practices that do not constitute inducements under Section 4(8), V.T.I.C. Article 21.21, revised in part as this section.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

> Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> . . .
>
> (7) Unfair Discrimination. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.
>
> . . .

Revisor's Note

Section 4(7), V.T.I.C. Article 21.21, defines certain discriminatory acts as unfair methods of competition or unfair or deceptive acts or practices in the business of insurance. The revised law adds a reference to Section 541.058 for the reason stated in the revisor's note to Section 541.056.

Revised Law

Sec. 541.058. CERTAIN PRACTICES NOT CONSIDERED DISCRIMINATION OR INDUCEMENT. 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; or

(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 if the waiver and the exchange are fully, fairly, and accurately explained to the contract holder in a manner that is not deceptive or misleading. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. . . .

(8) Rebates. . . .

(b) Nothing in clause 7 or paragraph (a) of clause 8 of this subsection shall be construed as including within the definition of discrimination or rebates any of the following practices:

(i) in the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from non-participating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(ii) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses;

(iii) readjustment of the rate of premium for a group insurance policy based on the

loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year; or

(iv) in the case of a life annuity, waiving surrender charges under an annuity contract when the contract holder exchanges the annuity contract for another annuity contract issued by the same insurer, if the waiver and the exchange are fully, fairly, and accurately explained to the contract holder in a manner that is not deceptive or misleading.

. . .

Revisor's Note

Section 4(8)(b)(iii), V.T.I.C. Article 21.21, refers to "the first or any subsequent policy year of insurance thereunder" of certain insurance policies. The revised law substitutes a reference to "a policy year" for the quoted language because the first or a subsequent policy year necessarily means any policy year.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(9) Deceptive Name, Word, Symbol, Device, or Slogan. Using, displaying, publishing, circulating, distributing, or causing to be used, displayed, published, circulated, or distributed in any letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster, or other document, literature, or public media of:

(a) a name as the corporate or business name of a person or entity engaged in an insurance or 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 company authorized to do business under the laws of this state; or

(b) a word, symbol, device, slogan, or any combination of these items, whether registered or not registered, that is the same as or deceptively similar to one adopted and used by an insurance entity, health maintenance organization, third party administrator, or group hospital service company to distinguish such entities, products, or service from other entities, and includes the title, designation, character names, and distinctive features of broadcast or other advertising.

Where two persons or entities are using a name, word, symbol, device, slogan, or any combination of these items that are the same or deceptively similar and are likely to cause confusion or a mistake, the user who can demonstrate the first continuous actual use of such name, word, symbol, device, slogan, or combination of these items shall not have committed an unfair method of competition or deceptive act or

practice.

. . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

. . .

(10) Unfair Settlement Practices. (a) Engaging in any of the following unfair settlement practices with respect to a claim by an insured or beneficiary:

(i) misrepresenting to a claimant a material fact or policy provision relating to coverage at issue;

(ii) failing to attempt in good faith to effectuate a prompt, fair, and equitable settlement of a claim with respect to which the insurer's liability has become reasonably clear;

(iii) failing to attempt, in good faith, to effectuate a prompt, fair, and equitable settlement under one portion of a policy of a claim with respect to which the insurer's liability has become reasonably clear in order to influence the claimant to settle an additional claim under another portion of the coverage, provided that this prohibition does not apply if payment under one portion of the coverage constitutes evidence of liability under another portion of the policy;

(iv) failing to provide promptly 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 for the offer of a compromise settlement of a claim;

(v) 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;

(vi) refusing, failing, or unreasonably delaying an offer of settlement 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;

(vii) undertaking to enforce a full and final release of a claim from a policyholder when only a partial payment has been made, provided that this prohibition does not apply to a compromise settlement of a doubtful or disputed claim;

(viii) refusing to pay a claim without conducting a reasonable investigation with respect to the claim;

(ix) with respect to a Texas personal auto policy, delaying or refusing settlement of a claim solely because there is other insurance of a different type available to satisfy all or any part of the loss forming the basis of that claim; or

(x) 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) the claimant is ordered to produce those tax returns by a court;

(B) the claim involves a fire loss; or

(C) the claim involves lost profits or income.

(b) Paragraph (a) of this clause 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.

. . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

Source Law

> Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> . . .
>
> (11) Misrepresentation of Insurance Policy. Misrepresenting an insurance policy by:
>
> (a) making an untrue statement of material fact;
>
> (b) failing to state a material fact that is necessary to make other statements made not misleading, considering the circumstances under which the statements were made;
>
> (c) making a statement in such manner as to mislead a reasonably prudent person to a false conclusion of a material fact;
>
> (d) making a material misstatement of law; or
>
> (e) failing to disclose any matter required by law to be disclosed, including a failure to make disclosure in accordance with another provision of this code.

[Sections 541.062-541.100 reserved for expansion]

SUBCHAPTER C. DETERMINATION OF UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE ACTS OR PRACTICES; SANCTIONS AND PENALTIES

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 5.)

Source Law

> Sec. 5. The Board shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 3 of this Act.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 6(a).)

Source Law

> Sec. 6. (a) Whenever the Board shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 4, and that a proceeding by it in respect thereto would be to the interest of the public, it shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than five days after the date of the service thereof;

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 6(b) (part).)

Source Law

> (b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the Board requiring such person to cease and desist from the acts, methods or practices so complained of. . . .

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 6(b) (part), (c).)

Source Law

> (b) . . . Upon good cause shown, the Board shall permit any person to intervene, appear and be heard at such hearing by counsel or in person;
>
> (c) Nothing contained in this Act shall require the observance at any such hearing of formal rules of pleading or evidence;

Revisor's Note

Section 6(d), V.T.I.C. Article 21.21, authorizes the State Board of Insurance, the functions of which were transferred to the commissioner of insurance and the Texas Department of Insurance, to use certain procedures in conducting a hearing, including issuing a subpoena. The revised law omits that provision because it duplicates Section 36.152 of this code. The omitted language reads:

> (d) The Board, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which it deems relevant to the inquiry. . . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 6(d) (part).)

Source Law

> (d) . . . The Board, upon such hearing, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the Board shall prepare a statement of the evidence and proceeding for use on review. . . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 6(d) (part).)

Source Law

> (d) . . . In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the District Court of Travis County or the county where such party resides, on application of the Board, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

Source Law

> Sec. 7. (a) If, after such hearing under the terms of Section 6 of the Act, the Board shall determine that the method of competition or the act or practice in question is defined in Section 4 of this Article, or rules or regulations issued under this Article, or in Section 17.46 of the Business & Commerce Code, as amended, and that the person complained of has engaged in such method of competition, act or practice in violation of this Article or rules and regulations issued under this Article or of the Deceptive Trade Practices--Consumer Protection Act (Sections 17.41 et seq., Business & Commerce Code), as specified in Section 17.46 of the Business & Commerce Code . . . .

Revisor's Note

> Section 7(a), V.T.I.C. Article 21.21, refers to Section 17.46, Business & Commerce Code, "as amended." Throughout this chapter, the revised law omits references to "as amended" and other similar language with respect to a state statute because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to a statute includes reenactments, revisions, or amendments of the statute.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

Source Law

> (a) . . . it shall reduce its findings to writing and issue and cause to be served upon the person charged with the violation an order requiring such person to cease and desist from engaging in such method of competition, act or practice.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 7(b).)

Source Law

> (b) Until a petition appealing from such order shall have been filed in a District Court of Travis County, Texas, in accordance with Subchapter F of Chapter 21 of the Insurance Code of this state, or any amendment thereof, the Board may at any time, upon such notice and in such manner as it shall deem proper, modify or set aside in whole or in part any order issued under this section.

Revisor's Note

(1) Section 7(b), V.T.I.C. Article 21.21, refers to filing an appeal of a cease and desist order "in a District Court of Travis County, Texas." The revised law omits the quoted language because it duplicates the requirement in Section 36.202(b) of this code that a petition for judicial review of an action of the commissioner of insurance be filed in a district court in Travis County.

(2) Section 7(b), V.T.I.C. Article 21.21, refers to the filing of an appeal of a cease and desist order "in accordance with Subchapter F of Chapter 21 of the Insurance Code of this state." That subchapter

consisted of V.T.I.C. Article 21.80, which provided for judicial review of actions of the State Board of Insurance. Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, repealed V.T.I.C. Article 21.80 and amended V.T.I.C. Article 1.04 to include judicial review provisions in that article. V.T.I.C. Article 1.04 was codified in 1999 as Subchapter D, Chapter 36, of this code, and the revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 7(c), (d).)

Source Law

(c) Any person who violates the terms of a cease and desist order under this section is subject to an administrative penalty under Article 1.10E of this code. An administrative penalty assessed under this subsection may not exceed $1,000 for each violation and a total of $5,000 for all violations. In determining whether or not a cease and desist order has been violated, the Board shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the order.

(d) An order of the Board awarding an administrative penalty under Subsection (c) of this section applies only to violations of this order incurred prior to the awarding of the penalty order.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 10.)

Source Law

> Sec. 10. Any person who violates a cease and desist order of the Board under Section 7, while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Texas a sum not to exceed Fifty Dollars ($50.00), which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed Five Hundred Dollars ($500.00).

Revisor's Note

(1) Section 10, V.T.I.C. Article 21.21, refers to a person who violates a cease and desist order "while such order is in effect." The revised law omits the quoted phrase as unnecessary because a person cannot violate an order that is not in effect.

(2) Section 10, V.T.I.C. Article 21.21, refers to a person who violates a cease and desist order and provides that "upon proof thereof to the satisfaction of the court" the person is liable to the state for a penalty. The revised law omits the quoted language because the procedures for establishing proof in a court proceeding are established under other law and it is not necessary to state in this provision that the proof must be satisfactory.

[Sections 541.112-541.150 reserved for expansion]

SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 16(a).)

Source Law

> Sec. 16. (a) Any person who has sustained actual damages caused by another's engaging in an act or practice declared in Section 4 of this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of insurance or in any practice specifically enumerated in a subdivision of Section 17.46(b), Business & Commerce Code, as an unlawful deceptive trade practice may maintain an action against the person or persons engaging in such acts or practices. To maintain an action for a deceptive act or practice enumerated in Section 17.46(b), Business & Commerce Code, a person must show that the person has relied on the act or practice to the person's detriment.

Revised Law

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) 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. (V.T.I.C. Art. 21.21, Sec. 16(b).)

Source Law

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) the amount of actual damages plus court costs and reasonable and necessary attorneys' fees. If the trier of fact finds that the defendant knowingly committed the acts complained of, the trier of fact may award not more than three times the amount of actual damages; or

(2) an order enjoining such acts or failure to act; or

(3) any other relief which the court deems proper.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 16(c).)

Source Law

(c) On a finding by the court that an action under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award to the defendant reasonable and necessary attorneys' fees and court costs.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 16(e), (f).)

Source Law

(e) As a prerequisite to filing a suit seeking damages under this section against any person, the person seeking damages shall give written notice to the other person at least 60 days before filing suit. The notice must advise the person of the specific complaint and the amount of actual damages and expenses, including any attorneys' fees reasonably incurred in asserting the claim against the defendant.

(f) If giving 60 days' written notice is impracticable because the suit must be filed in order to prevent the expiration of the statute of limitations or because the claim is asserted as a counterclaim, the notice provided for in Subsection (e) of this section is not required.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 16(g), (h), (i).)

Source Law

(g) A person against whom a suit is pending who

does not receive written notice, as required by Subsection (e) of this section, 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 suit is pending. This subsection does not apply if Subsection (f) of this section applies.

(h) The court shall abate the suit if the court, after a hearing, finds that the person is entitled to an abatement because notice was not provided as required by this section. A suit is automatically abated without the order of the court beginning on the 11th day after the date a plea in abatement is filed under Subsection (g) if the plea in abatement:

(1) is verified and alleges that the person against whom the suit is pending did not receive the written notice as required by Subsection (e); and

(2) is not controverted by an affidavit filed by the claimant before the 11th day after the date on which the plea in abatement is filed.

(i) An abatement under Subsection (h) continues until the 60th day after the date that written notice is served in compliance with Subsection (e).

Revised Law

Sec. 541.156. SETTLEMENT OFFER. (a) A person who receives notice provided under Section 541.154 may make a settlement offer during a period beginning on the date notice under Section 541.154 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. (V.T.I.C. Art. 21.21, Secs. 16A(a), (b), (c).)

Source Law

Sec. 16A. (a) A person who receives notice under Section 16(e) of this article may tender an offer of settlement at any time during the period beginning on the date notice is received and ending on the 60th day after that date.

(b) If a mediation under Section 16B of this article is not conducted, the person may tender an offer of settlement at any time during the period beginning on the date an original answer is filed and ending on the 90th day after that date.

(c) If a mediation under Section 16B of this article is conducted, a person against whom a claim under Section 16 of this article is pending may tender

an offer of settlement during the period beginning on the day after the date that the mediation ends and ending on the 20th day after that date.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 16A(d).)

Source Law

(d) An offer of settlement tendered by a person against whom a claim under Section 16 of this article is pending must include an offer to pay the following amounts of money, 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 attorneys' fees incurred as of the date of the offer.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 16A(e), (f).)

Source Law

(e) Unless both parts of an offer of settlement required under Subsection (d) of this section are accepted by the claimant not later than the 30th day after the date the offer is made, the offer is rejected.

(f) A settlement offer tendered by a person against whom a claim under Section 16 of this article is pending that complies with this section and that has been rejected by the claimant may be filed with the

court with an affidavit certifying its rejection.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 16A(g), (h), (i), (j).)

Source Law

(g) If the court finds that the amount tendered in the settlement offer for damages under Subsection

(d)(1) of this section is the same as, substantially the same as, or more than the 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 tendered in the settlement offer; or

(2) the amount of damages found by the trier of fact.

(h) If the court makes the finding described by Subsection (g) of this section, the court shall determine reasonable and necessary attorneys' fees to compensate the claimant for attorneys' fees incurred before the date and time of the rejected settlement offer. If the court finds that the amount tendered in the settlement offer to compensate the claimant for attorneys' fees under Subsection (d)(2) of this section is the same as, substantially the same as, or more than the amount of reasonable and necessary attorneys' fees incurred by the claimant as of the date of the offer, the claimant may not recover attorneys' fees greater than the amount of fees tendered in the settlement offer.

(i) If the court finds that the offering party could not perform the offer at the time the offer was made or that the offering party substantially misrepresented the cash value of the offer, Subsections (g) and (h) of this section do not apply.

(j) If Subsection (g) of this section does not apply, the court shall award damages as required by Section 16(b) of this article. If Subsection (h) of this section does not apply, the court shall award attorneys' fees as required by Section 16(b) of this article.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 16A(k).)

Source Law

(k) An offer of settlement is not an admission of engaging in an act or practice declared in Section 4 of this article to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 16B.)

Source Law

Sec. 16B. (a) A party may, not later than the 90th day after the date of service of a pleading in which relief under Section 16 of this article is sought, 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) If the parties do not agree on a mediator, the court shall appoint the mediator.

(d) Mediation shall be held within 30 days after the date the order is signed, unless the parties agree otherwise or the court determines that additional time, not to exceed an additional 30 days, is warranted.

(e) Except as agreed to by all parties who have

appeared in the action, each party who has appeared shall participate in the mediation and, except as provided by Subsection (f), shall 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 in this section, Section 154.023, Civil Practice and Remedies Code, and Subchapters C and D, Chapter 154, Civil Practice and Remedies Code, apply to the appointment of a mediator and to the mediation process provided by this section.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 16(d).)

Source Law

(d) All actions under this Article must be commenced within two years after the date on which the unfair method of competition or unfair or deceptive act or practice occurred or within two years after the person bringing the action discovered or, in the exercise of reasonable diligence, should have discovered the occurrence of the unfair method of competition or unfair or deceptive act or practice. The period of limitation provided in this section may be extended for a period of 180 days if the person bringing the action proves that the failure to timely commence the action was caused by the defendant's engaging in conduct solely calculated to induce the plaintiff to refrain from or postpone the commencement of the action.

[Sections 541.163-541.200 reserved for expansion]

SUBCHAPTER E. ENFORCEMENT BY ATTORNEY GENERAL

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 15(a).)

Source Law

> Sec. 15. (a) If the Attorney General has reason to believe that any person in the insurance business in this state is engaging in, has engaged in, or is about to engage in any act or practice declared to be unlawful by this Article or rules or regulations issued under this Article or by Section 17.46 of the Business & Commerce Code, as amended, and that proceedings would be in the public interest, the Attorney General may bring an action in the name of the state against the person to restrain by temporary or permanent injunction the use of such method, act, or practice.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

Source Law

> (b) An action brought under Subsection (a) of this section may be commenced in the district court of the county in which the person against whom it is brought resides, has his principal place of business, is doing business, or in the district court of the county where the transaction occurred or any substantial portion of the transaction occurred, or in a district court of Travis County. . . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

Source Law

> (b) . . . The court may issue appropriate temporary or permanent injunctions, and the injunctions shall be issued without bond.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 15(c).)

Source Law

> (c) In addition to the request for a temporary or permanent injunction in a proceeding brought under Subsection (a) of this section, the Attorney General, on a finding by the court that the defendant has engaged or is engaging in a practice declared to be unlawful by Article 17.46 of the Business & Commerce Code, as amended, this Article, or rules or regulations issued under this Article, may request a

civil penalty of not more than $10,000 per violation.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 15(d).)

Source Law

> (d) The court may make such additional orders or judgments as are necessary to compensate identifiable persons for actual damages or restoration of money or property, real or personal, which may have been acquired by means of any act or practice restrained.

Revisor's Note

> Section 15(d), V.T.I.C. Article 21.21, refers to "real or personal" property. The revised law omits the reference to "real or personal" because under Section 311.005(4), Government Code (Code Construction Act), applicable to the revised law, "property" includes both real and personal property.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 15(e).)

Source Law

> (e) Any person who violates the terms of an injunction under this section shall forfeit and pay to

the state a civil penalty of not more than $10,000 per violation. In determining whether or not an injunction has been violated the court shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the injunction. For the purposes of this section, the district court issuing the injunction shall retain jurisdiction, and the cause shall be continued, and in such cases, the Attorney General, acting in the name of the state, may petition for recovery of civil penalties under this section.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 15(f).)

Source Law

(f) The remedies in this section are not exclusive and are in addition to any other remedy or procedure provided by any other law or at common law.

[Sections 541.208-541.250 reserved for expansion]

SUBCHAPTER F. CLASS ACTIONS BY ATTORNEY GENERAL OR PRIVATE INDIVIDUAL

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 17(a), (e).)

Source Law

Sec. 17. (a) If a member of the insurance buying public has been damaged by an unlawful method, act, or practice defined in Section 4 of this Article as an unlawful deceptive trade practice, the Board may request the Attorney General to bring a class action, or the individual damaged may bring an action on behalf of himself and others similarly situated, to recover damages and relief as provided in this section.

(e) An action under this section may not be maintained if an administrative class action under Section 14 of this Article has been initiated or has resulted in a final determination regarding the same acts or practices and the same defendant in the action under this section.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 17(b).)

Source Law

(b) A plaintiff who prevails in a class action under this section may recover:

(1) court costs and attorneys' 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;

(3) any other relief which the court deems proper.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 17(c).)

Source Law

(c) On a finding by the court that an action under this section was brought by an individual plaintiff in bad faith or for the purpose of harassment, the court may award to the defendant

reasonable attorneys' fees in relation to the work expended and court costs.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

Source Law

(k) The filing of a suit under this section tolls the statute of limitations for bringing a suit by an individual under Section 16 of this Article. . . .

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 19(a), (b), (c).)

Source Law

Sec. 19. (a) At least 30 days prior to the commencement of a class action suit for damages under Section 17 of this Article, the prospective plaintiff must notify the intended defendant of his complaint and make demand that the defendant provide relief to the prospective plaintiff and others similarly situated. A copy of the notice must also be sent to the commissioner of insurance.

(b) The notice must be in writing and sent by certified or registered mail, return receipt requested, to the place where the transaction occurred, the intended defendant's principal place of business in this state, or if neither will effect notice, to the office of the Secretary of State of Texas.

(c) An action for injunctive relief under Section 17 of this Article may be commenced without compliance with Subsection (a) of this section. Not less than 30 days after the commencement of an action for injunctive relief, and after compliance with the provisions of Subsection (a) of this section, the plaintiff may amend his complaint without leave of court to include a request for damages.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(a).)

Source Law

Sec. 18. (a) 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.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 18(b), (c).)

Source Law

(b) An action may be maintained as a class action if the prerequisites of Subsection (a) of this section 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 which would establish incompatible standards of conduct for the party opposing the class; or

(B) adjudication with respect to individual members of the class which 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; or

(2) the party opposing the class has acted or refused to act on ground generally applicable to the class, thereby 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. The matters pertinent to the findings include:

(A) the interest of members of the class in individually controlling the prosecution or defense of separate actions;

(B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class;

(C) the desirability or undesirability of controversy concentrating the litigation of the claims in the particular forum; and

(D) the difficulties likely to be encountered in the management of a class action.

(c) In construing this section, the courts of Texas shall be guided by the decisions of the federal courts interpreting Rule 23, Federal Rules of Civil Procedure, as amended.

Revisor's Note

Section 18(b)(3)(C), V.T.I.C. Article 21.21, provides that a matter pertinent to a court's determination of whether questions of law or fact

common to class members predominate over questions affecting only individual members, is "the desirability or undesirability of controversy concentrating the litigation of the claims." Except for the use of the word "controversy," the text of Section 18(b)(3)(C) follows the language of Rule 42(b), Texas Rules of Civil Procedure, relating to the maintenance of class actions. The revised law omits "controversy" because the word is nonsensical in context and clearly an error.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(h).)

Source Law

(h) When appropriate, an action may be brought or maintained as a class action 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 section shall be construed and applied accordingly.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(d).)

Source Law

> (d) 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. An order under this subsection may be altered or amended before a decision on the merits. An order determining that the action may or may not be brought as a class action is an interlocutory order which is appealable and the procedures provided in Rule 385, Texas Rules of Civil Procedure, apply.

Revisor's Note

Section 18(d), V.T.I.C. Article 21.21, provides that an order determining whether an action may be brought as a class action is an appealable interlocutory order to which "the procedures provided in Rule 385, Texas Rules of Civil Procedure, apply." The revised law substitutes a reference to procedures applicable to accelerated appeals in the Texas Rules of Appellate Procedure for the quoted phrase. The Texas Supreme Court repealed Rule 385 by order of April 10, 1986, effective September 1, 1986. The main provision of that rule relating to accelerated appeals in civil cases is now contained in Rule 28, Texas Rules of Appellate Procedure, while provisions relating to deadlines for filing items in an accelerated appeal are contained in Rules 26.1, 35.1, and 38.6, Texas Rules of Appellate Procedure. For this reason, the revised law substitutes the reference to the procedures in the Texas Rules of Appellate Procedure.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

Source Law

(k) . . . An order of the court denying the bringing of a suit as a class action does not affect the ability of an individual to bring the same or a similar suit under Section 16 of this Article.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 18(e), (f).)

Source Law

(e) If the action is permitted as a class action, 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.

(f) The notice shall contain a statement that:

(1) the court will exclude the member notified from the class if he so requests by a specified date;

(2) the judgment, whether favorable or not, will include all members who do not request exclusion; and

(3) any member who does not request exclusion, if he desires, may enter an appearance through counsel.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(j).)

Source Law

(j) In the conduct of a class action 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 such manner as the court may direct to some or all of the members or to the Attorney General of any step in the action, or of the proposed extent of the judgment, or of the opportunity of members to signify whether they consider the representation fair and adequate, to intervene and present claims or defenses, or otherwise to come into the action;

(3) imposing conditions on the representative parties or on intervenors;

(4) requiring that the pleadings be amended to eliminate allegations as to representation of absent persons, and that the action proceed accordingly; or

(5) dealing with similar procedural matters.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 19(d), (e).)

Source Law

(d) No damages may be awarded to a class under Section 17 of this Article if within 30 days of receipt of the notice the intended defendant furnished the plaintiff, by certified or registered mail, return receipt requested, a written offer of settlement. The offer of settlement must include a statement that:

(1) all others similarly situated have been adequately identified or a reasonable effort to identify such others has been made, and a description of the class so identified and the method employed to identify them;

(2) all persons so identified have been notified that upon request the intended defendant will provide relief to them and all others similarly situated, and a complete explanation of the relief being afforded and a copy of the notice or communication which the intended defendant is providing to the members of the class;

(3) the relief being afforded the consumer has been, or if said offer is accepted by the consumer, will be given within a stated reasonable time; and

(4) the practice complained of has ceased.

(e) Attempts to comply with the provisions of this section by a person receiving a demand shall be an offer to compromise and shall be inadmissible as evidence. Attempts to comply with a demand shall not be considered an admission of engaging in an unlawful act or practice. Evidence of compliance or attempts to comply with the provisions of this section may be introduced by a defendant for the purpose of establishing good faith or to show compliance with the provisions of this section.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 20.)

Source Law

Sec. 20. No award of damages may be given in any class action filed under Section 17 of this Article 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 any error; and

(2) made restitution of any consideration received from any member of the class.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 17(d).)

Source Law

> (d) In an action under this section, damages may not include any damages incurred beyond a point two years prior to the institution of the action.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(g).)

Source Law

> (g) A class action may not be dismissed, settled, or compromised without the approval of the court, and notice of the proposed dismissal, settlement, or compromise shall be given to all members of the class in such manner as the court directs.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 18(i).)

Source Law

> (i) The judgment in a class action shall describe those to whom the notice was directed and who have not requested exclusion and those the court finds to be members of the class. 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.

[Sections 541.268-541.300 reserved for expansion]

SUBCHAPTER G. DEPARTMENT ACTION FOR REFUND OF PREMIUMS

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

Source Law

Sec. 14. (a) In connection with the issuance of a cease and desist order as provided in Section 7 of this Article or upon application of any aggrieved person, the Board may, after notice and hearing as provided in Section 6 of this Article, in connection with the issuance of a cease and desist order resulting from a finding that a person has engaged in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, or upon finding by the Board that the aggrieved person and persons similarly situated were induced to purchase a policy of insurance as a result of the person engaging in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended, the Board may require the person to account for all premiums collected for policies issued during the immediately preceding two years in connection with such acts in violation of this Article and require: (i) such person to give notice to all persons from whom such premiums were collected, and (ii) to refund the total of all premiums collected from each such person, electing to accept a premium refund in exchange for cancellation of the policy of insurance issued. Premiums so refunded shall be net of policy benefits actually paid by such person while the policy of insurance was in force. . . .

Revisor's Note

Section 14(a), V.T.I.C. Article 21.21, refers to premiums collected for policies issued during "the immediately preceding two years." The revised law omits "immediately" as unnecessary and refers to "the preceding two years" because "the preceding two years" means the immediately preceding two years.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

Source Law

(a) . . . The Board shall specify a reasonable time within which the person shall be required to make such premium refunds.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 14(b).)

Source Law

> (b) If a person fails to comply with the Board's requirement to refund such premiums within the time specified, the Board may, in addition to any other sanctions provided for in the Insurance Code and other applicable laws, report such failure to the Attorney General and request the Attorney General to file a suit to enforce the Board's requirement for refund of premiums. Venue for such suit shall lie in the District Court of Travis County, Texas, and upon finding by the court that such requirement of the Board was lawfully entered and that the person has failed to comply with such requirement, the Court shall enter an appropriate order to enforce such Board order. The Court may enforce its order through contempt proceedings.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 14(c).)

Source Law

(c) Compliance or attempts to comply with the Board's requirement to refund premiums shall be an offer to compromise and shall be inadmissible as evidence. Compliance or attempts to comply with the Board's requirement for refund of premium shall not be considered as admission of engaging in an unlawful act or practice. Evidence of compliance or attempts to comply with the Board's requirements of refund or premium may be introduced by the defendant for the purpose of establishing good faith or to show compliance with the Board's requirement.

[Sections 541.305-541.350 reserved for expansion]

SUBCHAPTER H. ASSURANCE OF VOLUNTARY COMPLIANCE

Revised Law

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). (V.T.I.C. Art. 21.21, Secs. 22(a), (b).)

Source Law

Sec. 22. (a) In the administration of this Article the Board may accept assurance of voluntary compliance with respect to any act or practice which violates this Article or regulations issued under this Article or any act declared to be unlawful in Section 17.46 of the Business & Commerce Code, as amended, from any person who is engaging in, has engaged in, or is

about to engage in the act or practice. The assurance shall be in writing and shall be filed with the Board.

(b) The acceptance of an assurance of voluntary compliance may be conditioned on the stipulation that the person in violation of this Article or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, restore to any person in interest any money which may have been acquired by means of acts or practices which violate this Article or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 22(c).)

Source Law

(c) An assurance of voluntary compliance shall not be considered an admission of prior violation of this Article or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended. However, unless an assurance has been rescinded by agreement, subsequent failure to comply with the terms of an assurance is prima facie evidence of a violation of this Article or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended.

Revised Law

Sec. 541.353. REOPENING. A matter closed by the filing of an assurance of voluntary compliance may be reopened at any time. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

Source Law

(d) Matters closed by the filing of an assurance of voluntary compliance may be reopened at any time. . . .

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

Source Law

> (d) . . . Assurance of voluntary compliance shall in no way affect individual rights of action under this Article, except that the right of individuals with regard to money received pursuant to a stipulation in the voluntary compliance under Subsection (b) of this section are governed by the terms of the voluntary compliance.

[Sections 541.355-541.400 reserved for expansion]

SUBCHAPTER I. RULEMAKING

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 13(a) (part).)

Source Law

> Sec. 13. (a) The State Board of Insurance is authorized to promulgate and may promulgate and enforce reasonable rules and regulations and may order such provision as is necessary in the accomplishment of the purposes of this Article . . . including, but not limited to, such express provision within the purposes of these Articles as it deems necessary or as is required to affect necessary uniformity with the laws of other states or the United States or in conformity with the adopted procedures of the National Association of Insurance Commissioners

notwithstanding any previous definition or interpretation of terms used in these Articles had in or derived from the common law or other statutory law of this state.

Revisor's Note

Section 13(a), V.T.I.C. Article 21.21, refers to "including, but not limited to." The revised law omits "but not limited to" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 13(b).)

Source Law

(b) A petition may be submitted to the Board to adopt, amend, or repeal a regulation. The petition must be signed by 100 interested persons and supported by evidence that a particular act or practice has been or could be false, misleading or deceptive to the insurance buying public, or that an act or practice declared to be false, misleading, or deceptive by a

regulation of the Board is not in fact false, misleading, or deceptive. Within 30 days after receipt of the petition the Board must either deny the petition or initiate hearing proceedings under this section.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 13(c).)

Source Law

(c) On denial of the petition the Board must state the reason or reasons for denial in writing. Denial is expressly authorized if the action sought by the petition would destroy uniformity with the laws of other states or of the United States or would not be in conformity with the adopted procedures of the National Association of Insurance Commissioners.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 13(d).)

Source Law

(d) If in response to the petition the Board determines to hold a hearing, such hearing shall be open to the public and any person may present testimony, data, or other information in writing or orally to the Board regarding the acts or practices under consideration.

Revised Law

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. (V.T.I.C. Art. 21.21, Secs. 13(e), (f).)

Source Law

(e) A person aggrieved by the denial of the hearing under Subsection (b) of this section or by the adoption, amendment, or repeal of a regulation or failure to issue a regulation under this section, may file a petition in a district court of Travis County for a declaratory judgment on the validity or applicability of a regulation adopted, amended, or repealed under this section or on the denial of a hearing under Subsection (b) of this section. The Board shall be made a party to the action. In a suit under this subsection the district court may issue injunctions.

(f) The action of the Board in adopting, amending, repealing, or failing to adopt a regulation or denying a hearing may be invalidated only if it is

found that it:

(1) violates a constitutional or state statutory provision;

(2) exceeds the statutory authority of the Board;

(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 with which conduct can be conformed;

(5) is made on unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.

[Sections 541.406-541.450 reserved for expansion]

SUBCHAPTER J. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 8.)

Source Law

Sec. 8. No order of the Board under this Act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec. 11.)

Source Law

Sec. 11. The powers vested in the Board by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

Revised Law

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. (V.T.I.C. Art. 21.21, Sec.

11A.)

Source Law

Sec. 11A. A person may not recover damages and penalties for the same act or practice under both this Article and under another law.

Revised Law

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) Article 21.28-C or 21.28-D or any other insurance guaranty act; or

(B) Article 21.39-A.

(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. (V.T.I.C. Art. 21.21, Sec. 23.)

Source Law

Sec. 23. Those civil penalties, premium refunds, judgments, compensatory judgments, individual recoveries, orders, class action awards, costs, damages, or attorneys' fees which are assessed or awarded as provided in this Article shall be paid only from the capital or surplus funds of the offending insurance company, and no such payments shall take precedence over, be in priority to, or in any manner be applicable to the provisions of Article 21.28-B, Texas Insurance Code, known as the Loss Claimant's Priorities Act, Article 21.28-C, Texas Insurance Code, known as the Property and Casualty Insurance Guaranty Act, Article 21.28-D, Texas Insurance Code, known as the Life, Accident, Health, and Hospital Service Insurance Guaranty Association Act, Article 21.28-E, Texas Insurance Code, known as the Texas Life, Health and Accident Guaranty Act, any other similar insurance guaranty act hereafter enacted by the Texas Legislature, or Article 21.39-A, Texas Insurance Code, known as the Asset Protection Act, and such special statutes and the priorities of funds created thereby shall be exempt from the provisions of this Article.

Revisor's Note

(1) Section 23, V.T.I.C. Article 21.21, refers to "Article 21.28-B, Texas Insurance Code, known as the Loss Claimant's Priorities Act." That article was repealed by Section 6.21, Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989, and the revised law omits the reference accordingly.

(2) Section 23, V.T.I.C. Article 21.21, refers to "Article 21.28-E, Texas Insurance Code, known as the Texas Life, Health and Accident Guaranty Act." That article was repealed by Section 48, Chapter 1073, Acts of the 70th Legislature, Regular Session, 1987, and the revised law omits the reference accordingly.

Revisor's Note
(End of Chapter)

Section 24, V.T.I.C. Article 21.21, contains a transitional provision relating to acts or omissions before the effective date of the statute. The revised law omits the transitional provision as executed. The omitted law reads:

> Sec. 24. No remedy or civil penalty shall lie or exist by reason of any act or omission occurring prior to the effective date of this Act.

CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

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CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

Revised Law

Sec. 542.001. SHORT TITLE. This subchapter may be cited as the Unfair Claim Settlement Practices Act. (V.T.I.C. Art. 21.21-2, Sec. 1.)

Source Law

Art. 21.21-2

Sec. 1. This Act shall be known as the Unfair Claim Settlement Practices Act.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 7.)

Source Law

Sec. 7. The provisions of this Act are to specifically apply to the following insuring organizations: proprietorships, partnerships, corporations and unincorporated associations, stock and mutual life, health, accident, fire, casualty, fire and casualty, hail, storm, title, and mortgage guarantee companies; mutual assessment companies; local mutual aid associations; local mutual burial associations; statewide mutual assessment companies; stipulated premium companies; fraternal benefit societies; group hospital service organizations; county mutual insurance companies; Lloyds; reciprocal or inter-insurance exchanges and farm mutual insurance companies.

Revisor's Note

Section 7, V.T.I.C. Article 21.21-2, refers to "group hospital service organizations," meaning corporations operating under Chapter 842 of this code. The term most frequently used to refer to such a corporation is "group hospital service corporation." Consequently, the revised law substitutes "group hospital service corporation" for "group hospital service organizations" to provide for consistent use of terminology in this code.

Revised Law

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.

(V.T.I.C. Art. 21.21-2, Secs. 2(a), (b) (part).)

Source Law

Sec. 2. (a) No insurer doing business in this state under the authority, rules and regulations of this code shall engage in unfair claim settlement practices.

(b) Any of the following acts by an insurer shall constitute unfair claim settlement practices:

(1) Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

(2) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(3) Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies;

(4) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear;

(5) Compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) Failure of any insurer [to maintain a complete record of all the complaints which it has received during the preceding three years or since the date of its last examination by the commissioner, whichever time is shorter. . . .]; or

(7) Committing other actions which the State Board of Insurance has defined, by regulations adopted pursuant to the rule-making authority granted

it by this Act, as unfair claim settlement practices.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.21-2, prohibits an "insurer doing business in this state under the authority, rules and regulations of this code" from engaging in unfair claim settlement practices. The revised law omits the reference to "under the authority, rules and regulations of this code" as unnecessary because an insurer may only engage in business in this state in accordance with the provisions of this code.

(2) Section 2(b)(7), V.T.I.C. Article 21.21-2, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 2(c).)

Source Law

> (c) 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 the claimant is ordered to produce those tax returns by a court of competent jurisdiction, the claim involves a fire loss, or the claim involves a loss of profits or income. In addition to committing a prohibited practice under this article, an insurer who violates this subsection commits a deceptive trade practice under Subchapter E, Chapter 17, Business & Commerce Code, and an affected claimant is entitled to remedies under that subchapter.

Revisor's Note

Section 2(c), V.T.I.C. Article 21.21-2, refers to a court "of competent jurisdiction." Throughout this chapter, the revised law omits the quoted language as unnecessary because the general laws of civil jurisdiction determine which courts have jurisdiction over a matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 2(b) (part).)

Source Law

[(b) Any of the following acts by an insurer shall constitute unfair claim settlement practices:

(6) Failure of any insurer] to maintain a complete record of all the complaints which it has received during the preceding three years or since the date of its last examination by the commissioner, whichever time is shorter. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For the purposes of this subsection, "complaint" means any written communication primarily expressing a grievance . . . .

Revised Law

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) The department shall devise a statistical plan for the periodic reports required under Subsection (b). The plan must contain at a minimum:

(1) the following claims information for the preceding 12 months or from the date of the insurer's last periodic report, whichever period is shorter:

(A) the total number of claims filed, including for each individual claim:

(i) the original amount filed for by the insured; and

(ii) the classification by line of insurance;

(B) the total number of claims denied;

(C) the total number of claims settled, including for each individual claim:

(i) the original amount filed for by the insured;

(ii) the amount settled; and

(iii) the classification by line of insurance; and

(D) the total number of claims for which suits have been instituted against the insurer, including for each individual claim:

(i) the original amount filed for by the insured;

(ii) the amount of final adjudication;

(iii) the reason for the suit; and

(iv) the classification by line of insurance; and

(2) the information required to be maintained by the insurer under Section 542.005.

(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. (V.T.I.C. Art. 21.21-2, Sec. 3.)

Source Law

Sec. 3. If it shall be found by the State Board of Insurance, based on complaints of unfair claims settlement practices as defined in Section 2 of this Act, that an insurer should be subjected to closer supervision with respect to such practices, it may require such insurer to file a report at such periodic intervals as the board deems necessary. The board shall also devise a statistical plan for such periodic reports, which is to contain a minimum of the following information:

(a) The total number of written claims filed, including the original amount filed for by the insured and the classification by line of insurance of each individual written claim, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter;

(b) The total number of written claims denied, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter;

(c) The total number of written claims settled, including the original amount filed for by the insured, the settled amount, and the

classification of line of insurance of each individual settled claim, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter;

(d) The total number of written claims for which lawsuits were instituted against the insurer, including the original amount filed for by the insured, the amount of final adjudication, the reason for the lawsuit and the classification by line of insurance of each individual written claim, for the past 12 month period or from the date of the insurer's last periodic report, whichever time is shorter; and

(e) All information required by Subsection (f) of Section 2 of this Act.

For the purposes of this section, "written claim" shall include only those claims reduced to writing and filed by a Texas resident with an insurer as defined in Section 2 of this Act. The board may, at any time, rescind the requirement to file periodic reports if it finds that such requirement is no longer necessary to accomplish the objectives set out in this Act.

Revisor's Note

Section 3(e), V.T.I.C. Article 21.21-2, states that the statistical plan required by that section must contain "[a]ll information required by Subsection (f) of Section 2 of this Act." Section 2(f), V.T.I.C. Article 21.21-2, was redesignated as Section 2(b)(6) by Section 21.01, Chapter 12, Acts of the 72nd Legislature, 2nd Called Session, 1991. The revised law is drafted to reflect that redesignation.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 4(b).)

Source Law

(b) The commissioner shall compile the information received from an insurer pursuant to

Section 3 of this Act in such a manner as to enable him to compare it to a minimum standard of performance which shall be promulgated by the State Board of Insurance. If the commissioner, after such comparison is made, finds that the insurer falls below the minimum standard of performance, he shall cause an investigation to be made of said insurer as to the reason, if any, for said substandard performance.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 4(c).)

Source Law

(c) The commissioner shall also provide for the receiving and processing of individual complaints alleging violations of this Act by both insurers who are required to make periodic reports and those who are not required to make such reports. If the commissioner in his complaint experience determines that the number and type of complaints against an insurer do not meet the board's minimum standard of performance and/or are out of proportion to those against other insurers writing similar lines of insurance, he shall cause an investigation to be made of the respective insurer.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 5(a).)

Source Law

Sec. 5. (a) Upon the receipt of the results of an investigation instituted pursuant to Section 4 of this Act, the commissioner shall review the results and shall determine whether, in the light of the standards set out in Section 2 of this Act, further action is required. If the commissioner deems further action necessary, he shall set a date for a public hearing to review the alleged violations of this Act. At such public hearings, the accused insurer shall be permitted to present his case with the assistance of counsel. Any evidence as to numbers and types of complaints or claims prepared by the commissioner, pursuant to Sections 3 and 4 of this Act, shall be admissible in evidence in such hearings or any judicial proceeding pursuant thereof. Notice as to the date of such hearing and the nature of the charges is to be given the insurer not later than 30 days prior to the date set for the hearing. Such hearings are to be conducted pursuant to the rules and regulations promulgated by the State Board of Insurance and the provisions of the Insurance Code, as amended. Provided, that no insurer shall be deemed in violation of this Act solely by reason of the numbers and types

of such complaints or claims.

Revisor's Note

(1) Section 5(a), V.T.I.C. Article 21.21-2, refers to a "public hearing." The revised law omits "public" as unnecessary. The specific procedures for conducting hearings in this context are established by the law applicable to proceedings before state agencies generally, including Chapter 2001, Government Code.

(2) Section 5(a), V.T.I.C. Article 21.21-2, refers to "rules and regulations." Throughout this chapter, the revised law omits references to "regulations" in this context because under Section 311.005(5), Government Code (Code Construction Act), applicable to the revised law, a rule is defined to include a regulation.

(3) Section 5(a), V.T.I.C. Article 21.21-2, refers to "the provisions of the Insurance Code, as amended." The revised law omits the reference to "as amended" because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, unless expressly provided otherwise, a reference to a statute applies to all reenactments, revisions, or amendments of the statute.

(4) Section 5(b), V.T.I.C. Article 21.21-2, permits review by the State Board of Insurance of any ruling or action of the commissioner of insurance "by making an application to the board as provided for in Article 1.04 of the Insurance Code, as amended." The revised law omits this provision as obsolete and unnecessary. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas

Department of Insurance. In that same act, V.T.I.C. Article 1.04 was amended to provide for judicial review of an order of the commissioner. Article 1.04 was revised in 1999 as Subchapter D, Chapter 36, of this code, and provides sufficient authority for judicial review of a ruling or order of the commissioner under this subchapter. Furthermore, Section 6(b), V.T.I.C. Article 21.21-2, revised in Section 542.011, explicitly refers to the application of Article 1.04. The omitted law reads:

> (b) Any insurer which is affected by any ruling or action of the commissioner shall have the right to have such ruling or action reviewed by the State Board of Insurance by making an application to the board as provided for in Article 1.04 of the Insurance Code, as amended.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 6(a).)

Source Law

> Sec. 6. (a) The State Board of Insurance, upon finding an insurer in violation of the provisions of this Act, shall issue a cease and desist order to said insurer directing it to stop such unlawful practices. If the insurer refuses or fails to comply with said order, the board shall have the authority to revoke or suspend the insurer's certificate of authority as provided for in the Insurance Code, as amended. The board shall also have the authority to limit, regulate, and control the insurer's line of business, the insurer's writing of policy forms or other particular forms, and the insurer's volume of its line of business or its writing of policy forms or other particular forms. The board shall use the above authority to the extent it deems necessary to obtain the insurer's compliance to its order. The attorney general shall offer his assistance if requested by the board to enforce the board's orders.

Revisor's Note

Section 6(a), V.T.I.C. Article 21.21-2, refers to an insurer that "refuses or fails" to comply with an order of the State Board of Insurance. The revised law omits the reference to "refuses" because in context "refuses" is included within the meaning of "fails."

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

Source Law

> (b) Any insurer affected by a ruling or order of the board pursuant to the provisions of this Act may appeal same by filing suit within 20 days from the date of the order of said board. Such appeal shall be governed by Article 1.04 of this code. . . .

Revisor's Note

Section 6(b), V.T.I.C. Article 21.21-2, permits appeal of any ruling or order of the State Board of

Insurance "by filing suit" not later than a certain date and requires that the appeal be governed by V.T.I.C. Article 1.04, revised in 1999 as Subchapter D, Chapter 36, of this code. The revised law refers instead to "filing a petition for judicial review" because that is the procedure provided by Subchapter D, Chapter 36.

Revised Law

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. (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

Source Law

> (b) . . . Reasonable attorneys' fees shall be awarded the board if judicial action is necessary for the enforcement of its orders.

Revised Law

Sec. 542.013. PERSONNEL. The department may hire employees and examiners as needed to enforce this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 4(a).)

Source Law

> Sec. 4. (a) The commissioner is authorized to hire additional employees and examiners as needed for the effective enforcement of the provisions of this Act.

Revised Law

Sec. 542.014. RULES. The commissioner shall adopt reasonable rules as necessary to implement and augment the purposes and provisions of this subchapter. (V.T.I.C. Art. 21.21-2, Sec. 8.)

Source Law

> Sec. 8. The State Board of Insurance is authorized and directed to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this Act, and in augmentation thereof.

Revisor's Note
(End of Subchapter)

Section 9, V.T.I.C. Article 21.21-2, states that

the act does not apply to a person to whom it cannot apply under the Texas or United States Constitution. The revised law omits that provision as unnecessary. Under general principles of constitutional law, a Texas statute could not apply to a person the Texas or United States Constitution does not allow the law to apply to. The omitted law reads:

> Sec. 9. This Act and law does not apply to any insurer or other person to whom, under the Constitution of the United States or the Constitution of the State of Texas, it cannot validly apply.

[Sections 542.015-542.050 reserved for expansion]

SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS

Revised Law

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. (V.T.I.C. Art. 21.55, Secs. 1(1), (2), (3), (5).)

Source Law

> Art. 21.55
> Sec. 1. In this article:
> (1) "Claimant" means a person making a claim.
> (2) "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.
> (3) "Claim" means a first party claim made by an insured or a policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract that must be paid by the insurer directly to the insured or beneficiary.

(5) "Notice of claim" means any notification in writing to an insurer, by a claimant, that reasonably apprises the insurer of the facts relating to the claim.

Revised Law

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 Article 21.28-C or 21.28-D. (V.T.I.C. Art. 21.55, Sec. 1(4).)

Source Law

Sec. 1. In this article:

(4) "Insurer" means any insurer authorized to do business as an insurance company or to provide insurance in this state, including:

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

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

(C) a Mexican casualty company;

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

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

(F) a domestic or foreign fraternal benefit society;

(G) a stipulated premium insurance company;

(H) a nonprofit legal service corporation;

(I) a statewide mutual assessment company;

(J) a local mutual aid association;

(K) a local mutual burial association;

(L) an association exempt under Article 14.17 of this code;

(M) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 20 of this code;

(N) a county mutual insurance company;

(O) a farm mutual insurance company;

(P) a risk retention group;

(Q) a purchase group;

(R) a surplus lines carrier; and

(S) a guaranty association created and operating under Article 21.28-C or 21.28-D of this code.

Revisor's Note

(1) Section 1(4), V.T.I.C. Article 21.55, provides that "insurer" means any insurer authorized to engage in business as an insurance company or to provide insurance in this state, including certain "domestic or foreign" insurers. The revised law omits the reference to "domestic or foreign" as unnecessary. The authority of the Texas Department of Insurance to regulate domestic and foreign insurers is specified in other provisions of the code and, because the revised law applies to all insurers regulated by the department, it is not necessary to distinguish between domestic and foreign insurers in this section.

(2) Section 1(4), V.T.I.C. Article 21.55, refers to an "insurance exchange," "purchase group," and "surplus lines carrier." The revised law substitutes "interinsurance exchange" for "insurance exchange" because that is the term used in Chapter 942 of this code, which governs reciprocal and interinsurance exchanges, substitutes "purchasing group" for "purchase group" because that is the term used in V.T.I.C. Article 21.54, which regulates risk retention groups and purchasing groups, and substitutes "eligible surplus lines insurer" for "surplus lines carrier" because that is the term used in Chapter 981 of this code, which regulates surplus lines insurance.

Revised Law

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 other than inland marine insurance governed by Article 5.53; or

(6) a guaranty association created and operating under Chapter 2602.

(b) A guaranty association operating under Article 21.28-C or 21.28-D 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. (V.T.I.C. Art. 21.55, Secs. 5(a), (b) (part), (c).)

Source Law

Sec. 5. (a) This article does not apply to:

(1) workers' compensation insurance;

(2) mortgage guaranty insurance;

(3) title insurance;

(4) fidelity, surety, or guaranty bonds;

(5) marine insurance other than inland marine insurance governed by Article 5.53 of this code; or

(6) a guaranty association created and operating under Article 9.48 of this code.

(b) A guaranty association created and operating under Article 21.28-C or 21.28-D of this code shall not be subject to the damage provisions contained in Section 6 of this article. . . .

(c) This article does not apply to Chapter 20A of this code except as provided in Section 9 of that chapter. This article does not apply to a claim governed by Section 3A, Article 3.70-3C, of this code.

Revisor's Note

Section 5(c), V.T.I.C. Article 21.55, refers to the inapplicability of the article to "Chapter 20A of this code." For clarity and convenience, the revised law substitutes "health maintenance organization" for "Chapter 20A of this code" because a health maintenance organization is the type of entity regulated under V.T.I.C. Chapter 20A, revised in relevant part as Chapter 843 of this code.

Revised Law

Sec. 542.054. LIBERAL CONSTRUCTION. This subchapter shall be liberally construed to promote the prompt payment of insurance claims. (V.T.I.C. Art. 21.55, Sec. 8.)

Source Law

Sec. 8. This article shall be liberally construed to promote its underlying purpose which is to obtain prompt payment of claims made pursuant to policies of insurance.

Revised Law

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. (V.T.I.C. Art. 21.55, Sec. 2.)

Source Law

> Sec. 2. (a) Except as provided by Subsection (d) of this section, an insurer shall, not later than the 15th day after receipt of notice of a claim or the 30th business day if the insurer is an eligible surplus lines insurer:
>
> (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. Additional requests may be made if during the investigation of the claim such additional requests are necessary.
>
> (b) If the acknowledgment of the claim is not made in writing, the insurer shall make a record of the date, means, and content of the acknowledgment.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.55, provides that "[e]xcept as provided by Subsection (d) of this section," an insurer shall perform certain acts after receiving notice of a claim. Section 2 contains only Subsections (a) and (b), and Subsection (b) does not provide an exception to Subsection (a). Therefore, the revised law omits the reference to an exception as unnecessary.

Revised Law

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. (V.T.I.C. Art. 21.55, Secs. 3(a), (b), (c), (d), (e).)

Source Law

> Sec. 3. (a) Except as provided by Subsections (b) and (d) of this section, an insurer shall notify a claimant in writing of the acceptance or rejection of the claim not later than the 15th business day after the date the insurer receives all items, statements, and forms required by the insurer, in order to secure final proof of loss.
>
> (b) If the insurer has a reasonable basis to believe that the loss results 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 Subsections (a) and (b) of this section 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) of this section, the insurer shall notify the claimant, not later than the date specified under Subsection (a) or (b), as applicable. The notice provided under this subsection must give the reasons the insurer needs additional time.
>
> (e) Not later than the 45th day after the date an insurer notifies a claimant under Subsection (d) of this section, the insurer shall accept or reject the claim.

Revised Law

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. (V.T.I.C. Art. 21.55, Sec. 4.)

Source Law

> Sec. 4. If an insurer notifies a claimant that the insurer will pay a claim or part of a claim under Section 3 of this article, the insurer shall pay the claim not later than the fifth business day after the notice has been made. 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. Surplus lines insurers shall pay the claim not later than the twentieth business day after the notice or date the act is performed.

Revisor's Note

> Section 4, V.T.I.C. Article 21.55, refers to "surplus lines insurers." The revised law substitutes "eligible surplus lines insurer" because that is the term used in Chapter 981 of this code, which regulates surplus lines insurance.

Revised Law

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) This section 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.

(V.T.I.C. Art. 21.55, Secs. 3(f), (g).)

Source Law

> (f) Except as otherwise provided, if an insurer delays payment of a claim following its receipt of all items, statements, and forms reasonably requested and required, as provided under Section 2 of this article, for a period exceeding the period specified in other applicable statutes or, in the absence of any other specified period, for more than 60 days, the insurer shall pay damages and other items as provided for in Section 6 of this article.
>
> (g) If it is determined as a result of arbitration or litigation that a claim received by an insurer is invalid and therefore should not be paid by the insurer, the requirements of Subsection (f) of this section shall not apply in such case.

Revised Law

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. (V.T.I.C. Art. 21.55, Secs. 5(b) (part), (d).)

Source Law

> (b) . . . A guaranty association may receive an extension of the time periods under this article from a court of competent jurisdiction upon good cause shown and after reasonable notice to policyholders.
>
> (d) In the event of a weather-related catastrophe or major natural disaster, as defined by the State Board of Insurance, the claim-handling deadlines imposed under this article are extended for an additional 15 days.

Revised Law

Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER. (a) 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 attorney's fees.

(b) If a suit is filed, the attorney's fees shall be taxed as part of the costs in the case. (V.T.I.C. Art. 21.55, Sec. 6.)

Source Law

> Sec. 6. In all cases where a claim is made pursuant to a policy of insurance and the insurer liable therefor is not in compliance with the requirements of this article, such insurer shall be liable to pay the holder of the policy, or the beneficiary making a claim under the policy, in addition to the amount of the claim, 18 percent per annum of the amount of such claim as damages, together with reasonable attorney fees. If suit is filed, such attorney fees shall be taxed as part of the costs in the case.

Revised Law

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. (V.T.I.C. Art. 21.55, Sec. 7.)

Source Law

> Sec. 7. The provisions of this article are not exclusive. The remedies provided herein are in addition to any other remedy or procedure provided by any other law or at common law.

[Sections 542.062-542.100 reserved for expansion]

SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION ON REQUEST

Revised Law

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. (V.T.I.C. Art. 21.59, Secs. (a), (b), (c), (f).)

Source Law

Art. 21.59. (a) In this article, "liability insurance" means the following types of insurance:

(1) general liability;

(2) medical professional liability;

(3) professional liability other than medical professional liability;

(4) commercial automobile liability; and

(5) the liability portion of commercial multiperil coverage.

(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 request must be transmitted to the insurer within six months from the date of disposition of the claim.

(c) The information supplied to an insured making a request under Subsection (b) of this article must include:

(1) the name of each claimant;

(2) details relating to the amount paid on the claim, settlement of the claim, or 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.

(f) The commissioner, by rule, may require information in addition to that required by Subsection (c) of this article that the commissioner considers necessary to adequately inform an insured with regard to any claim under a liability insurance policy.

Revised Law

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 Article 5.65A. (V.T.I.C. Art. 21.59, Sec. (d).)

Source Law

> (d) Each insurer that writes property and casualty insurance in this state, on written request of the policyholder, shall provide the policyholder with a list of claims charged against the policy and payments made on each claim. This subsection does not apply to a workers' compensation insurance policy subject to Article 5.65A of this code.

Revised Law

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. (V.T.I.C. Art. 21.59, Sec. (e).)

Source Law

> (e) The insurer shall provide the information requested under this article in writing not later than the 30th day after the date on which the written request is received by the insurer. The information is considered to be provided on the date that the information is received by the United States Postal Service or personally delivered.

Revisor's Note

Section (e), V.T.I.C. Article 21.59, refers to a "written request" for information. The revised law omits the reference to "written" as duplicative of

Sections (b) and (d), V.T.I.C. Article 21.59, revised as Sections 542.101(b) and 542.102(a), which require the requests for information to be in writing.

Revised Law

Sec. 542.104. RULES. The commissioner may by rule prescribe forms for requesting information and for providing requested information under this subchapter. (V.T.I.C. Art. 21.59, Sec. (g).)

Source Law

> (g) The commissioner may adopt rules providing the form for requests to an insurer and for information supplied by an insurer under this article.

[Sections 542.105-542.150 reserved for expansion]

SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER CASUALTY INSURANCE POLICY

Revised Law

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. (V.T.I.C. Art. 21.56, Sec. (a) (part).)

Source Law

> Art. 21.56. (a) This article applies only to settlement of a claim under a policy of casualty insurance delivered, issued for delivery, or renewed in this state, including a policy written by a county mutual insurance company, Lloyd's plan company, surplus lines insurer, or a reciprocal or interinsurance exchange. . . .

Revisor's Note

Section (a), V.T.I.C. Article 21.56, refers to a "surplus lines insurer." The revised law substitutes "eligible surplus lines insurer" for "surplus lines insurer" because that is the term used in Chapter 981

of this code, which regulates surplus lines insurance.

Revised Law

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 other than inland marine insurance governed by Article 5.53. (V.T.I.C. Art. 21.56, Secs. (a) (part), (e).)

Source Law

> (a) . . . This article does not apply to a casualty policy that requires the insured's consent to settlement of a claim against the insured or to fidelity, surety, or guaranty bonds.
>
> (e) The provisions of this article shall not apply to marine insurance other than inland marine insurance governed by Article 5.53 of this code.

Revised Law

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. (V.T.I.C. Art. 21.56, Secs. (b), (c).)

Source Law

> (b) An insurer shall notify the named insured in writing of initial offer to compromise or settle a claim against the insured made under a casualty policy issued to the named insured. The notice shall be given not later than the 10th day after the date on which the offer is made.
>
> (c) An insurer shall notify the named insured in writing of any settlement of a claim against the insured made under a casualty policy issued to the named insured. The notice shall be given not later than the 30th day after the date of the settlement.

Revisor's Note

Section (b), V.T.I.C. Article 21.56, refers to an "offer to compromise or settle a claim." The revised law omits the reference to "compromise" because its meaning is included within the meaning of "settle."

Revised Law

Sec. 542.154. RULES. The commissioner may adopt rules to implement this subchapter. (V.T.I.C. Art. 21.56, Sec. (d).)

Source Law

(d) The board may adopt rules to implement this article.

[Sections 542.155-542.200 reserved for expansion]

SUBCHAPTER E. COLLECTION FROM THIRD PARTIES UNDER CERTAIN AUTOMOBILE INSURANCE POLICIES

Revised Law

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. (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

Source Law

(e) This article is intended to encourage insurers to take appropriate and necessary steps to collect from third parties or their insurers. . . .

Revised Law

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. (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

Source Law

(e) . . . As used in this article, the phrase "bring an action" is intended to include various courses of action such as reasonable and diligent collection efforts, mediation, arbitration, or litigation against responsible third parties or their insurers.

Revised Law

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. (V.T.I.C. Art. 21.79G, Sec. (a).)

Source Law

> Art. 21.79G. (a) This article applies to any insurer who delivers, issues for delivery, or renews a private passenger automobile policy of insurance in this state, including an interinsurance exchange, mutual, reciprocal, association, Lloyd's, or other insurer.

Revised Law

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. (V.T.I.C. Art. 21.79G, Secs. (b), (c), (d).)

Source Law

(b) Notwithstanding any other provision of this code, and except as provided by Subsection (c) of this article, if an insurer is liable to an insured for a claim, and such claim 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 bring an action to recover the deductible against the third party not later than 12 months after payment of its insured's claim or pay the amount of the deductible to the insured.

(c) Subsection (b) of this article does not apply if, not later than the earlier of 12 months after the date the insured's claim is paid or 90 days prior to the expiration of the statute of limitations for negligence actions, the insurer notifies the insured in writing that the insurer does not intend to pursue further collection actions against the third party and authorizes the insured to pursue further collection actions.

(d) This article applies whether the third party who may be liable for the amount of the deductible is insured or uninsured.

Revised Law

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. (V.T.I.C. Art. 21.79G, Sec. (f).)

Source Law

(f) The commissioner shall have authority to enforce this article and is authorized to promulgate and enforce reasonable rules and regulations as necessary for the accomplishment of the purposes of this article.

CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE OF MEMBERSHIP

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CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE OF MEMBERSHIP

SUBCHAPTER A. PROHIBITIONS

Revised Law

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. (V.T.I.C. Art. 21.20; Art. 21.21, Sec. 13

(part); Art. 21.21A, Sec. 2.)

Source Law

Art. 21.20. No life insurance company doing business in this State, and no officer, director or agent thereof, shall issue or circulate, or cause or permit to be issued or circulated, any estimate, illustration, circular or statement of any sort misrepresenting the terms of any policy issued by it, or benefits or advantages to be promised thereby, or the dividends or share of surplus to be received thereon.

[Art. 21.21]

Sec. 13. (a) The State Board of Insurance is authorized to promulgate and may promulgate and enforce reasonable rules and regulations and may order such provision as is necessary in the accomplishment of the purposes of [this Article] and Article 21.20[, including, but not limited to, such express provision within the purposes of these Articles as it deems necessary or as is required to affect necessary uniformity with the laws of other states or the United States or in conformity with the adopted procedures of the National Association of Insurance Commissioners notwithstanding any previous definition or interpretation of terms used in these Articles had in or derived from the common law or other statutory law of this state.

(b) A petition may be submitted to the Board to adopt, amend, or repeal a regulation. The petition must be signed by 100 interested persons and supported by evidence that a particular act or practice has been or could be false, misleading or deceptive to the insurance buying public, or that an act or practice declared to be false, misleading, or deceptive by a regulation of the Board is not in fact false, misleading, or deceptive. Within 30 days after receipt of the petition the Board must either deny the petition or initiate hearing proceedings under this section.

(c) On denial of the petition the Board must state the reason or reasons for denial in writing. Denial is expressly authorized if the action sought by the petition would destroy uniformity with the laws of other states or of the United States or would not be in conformity with the adopted procedures of the National Association of Insurance Commissioners.

(d) If in response to the petition the Board determines to hold a hearing, such hearing shall be open to the public and any person may present testimony, data, or other information in writing or orally to the Board regarding the acts or practices under consideration.

(e) A person aggrieved by the denial of the hearing under Subsection (b) of this section or by the adoption, amendment, or repeal of a regulation or failure to issue a regulation under this section, may file a petition in a district court of Travis County for a declaratory judgment on the validity or applicability of a regulation adopted, amended, or repealed under this section or on the denial of a hearing under Subsection (b) of this section. The Board shall be made a party to the action. In a suit under this subsection the district court may issue injunctions.

(f) The action of the Board in adopting, amending, repealing, or failing to adopt a regulation or denying a hearing may be invalidated only if it is found that it:

(1) violates a constitutional or state statutory provision;

(2) exceeds the statutory authority of the Board;

(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 with which conduct can be conformed;

(5) is made on unlawful procedure; or

(6) is clearly erroneous in view of the reliable, probative, and substantial evidence in the whole record as submitted.]

[Art. 21.21A]

Sec. 2. No life, health, or casualty insurance corporation including corporations operating on the cooperative or assessment plan, mutual insurance companies, and fraternal benefit associations or societies, and any other societies or associations authorized to issue insurance policies in this state, and no officer, director, representative, or agent therefor or thereof, or any other person, corporation, or copartnership may issue or circulate or cause or permit to be issued or circulated any illustrated circular or statement of any sort misrepresenting the terms of any policy issued by any such corporation or association or any certificate of membership issued by any such society or corporation, or other benefits or advantages permitted thereby, or any misleading statement of the dividends or share of surplus to be received thereon, or may use any name or title of any policy or class of policy or class of policies, or certificate of membership or class of such certificate misrepresenting the true nature thereof. Nor may any such corporation, society, or association, or officer, director, agent, or representative thereof, or any other person, make any misleading representations or incomplete comparisons of policies or certificates of membership to any person insured in such corporation, association, or society, or member thereof, for the purpose of inducing or tending to induce such person to lapse, forfeit, or surrender said insurance or membership therein.

Revisor's Note

V.T.I.C. Article 21.20 states that certain entities may not "issue or circulate, or cause or permit to be issued or circulated, any [misrepresentative] estimate, illustration, circular or statement of any sort." Section 2, V.T.I.C. Article 21.21A, states that certain entities may not "issue or circulate or cause or permit to be issued or circulated any [misrepresentative] illustrated circular or

statement of any sort." The revised law omits the references to "circular" as redundant with respect to "circulate[,] or cause or permit to be . . . circulated."

Revised Law

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. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Source Law

> Sec. 1. No insurer or agent thereof may make any contract of insurance or agreement as to such contract other than as expressed in the policy issued thereon, ...

Revised Law

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. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Source Law

> Sec. 1. . . . nor may any such insurer or any officer, agent, solicitor or representative thereof, pay, allow or give, or offer to pay, allow or give, directly or indirectly as an inducement to insurance, any rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefits to accrue thereon or any paid employment or contract for service of any kind, or any thing of value or inducement whatever, not specified in the policy; or give, sell or purchase, or offer to give, sell or purchase, as an inducement to insurance or in connection therewith, any stocks, bonds or other securities of any insurer or other corporation, association or partnership, or any dividends or profits to accrue thereon, or anything of value whatsoever not specified in the policy, ...

Revisor's Note

Section 1, V.T.I.C. Article 21.21A, refers to an "officer, agent, solicitor or representative." Throughout this subchapter, the revised law omits the reference to "solicitor" because that term, as it relates to a particular type of person engaged in the business of insurance, was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a solicitor is now regulated as an "agent."

Revised Law

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. (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

Source Law

> Sec. 1. . . . nor may any such insurer or any officer, agent, solicitor or representative thereof . . . or issue any policy containing any special or board contract or similar provision by the

terms of which said policy will share or participate in any special fund derived from a tax or a charge against any portion of the premium on any other policy.

[Sections 543.005-543.050 reserved for expansion]

SUBCHAPTER B. ENFORCEMENT; PENALTY

Revised Law

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. (V.T.I.C. Art. 21.21A, Sec. 4.)

Source Law

Sec. 4. The commissioner, upon giving 10 days' notice of hearing by certified mail, and upon hearing, may suspend or cancel the certificate, charter, permit, or license to engage in the business of insurance of any society, association, corporation, or person violating the provisions of this Article.

Revisor's Note

Section 4, V.T.I.C. Article 21.21A, enables the commissioner of insurance to "cancel" the certificate, charter, permit, or license of certain entities. The revised law substitutes "revoke" for "cancel" because, in context, the terms are synonymous, and "revoke" is more frequently used.

Revised Law

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. (V.T.I.C. Art. 21.21A, Sec. 3.)

Source Law

Sec. 3. If any person violates any of the provisions of this Article, the person shall, in addition to any other penalty specifically provided,

be guilty of a Class A misdemeanor.

CHAPTER 544. PROHIBITED DISCRIMINATION

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CHAPTER 544. PROHIBITED DISCRIMINATION

SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY AN INSURER OR HEALTH MAINTENANCE ORGANIZATION

Revised Law

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, adjuster, or life and health insurance counselor; and

(2) a health maintenance organization. (V.T.I.C. Art.

21.21-6, Sec. 2, as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Sec. 2. This article shall apply to any legal entity engaged in the business of insurance in this state, including:

(a) a capital stock company;
(b) a mutual 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 company;
(i) a reciprocal or interinsurance exchange;
(j) a stipulated premium insurance company;
(k) a group hospital service company;
(l) a health maintenance organization;
(m) a farm mutual insurance company;
(n) a risk retention group;
(o) a surplus lines carrier; and
(p) agents, brokers, adjusters, and life insurance counselors.

Revisor's Note

(1) Section 2, V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, provides that the article applies to a legal entity "engaged in the business of insurance," including certain listed entities. Included among the listed entities is a "health maintenance organization," which is not a traditional insurer. The revised law is drafted accordingly. Similar changes are made throughout this subchapter.

(2) Section 2, V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, refers to "life insurance counselors." The revised law substitutes "life and health insurance counselor" because that is the term used in Chapter 4052 to refer to that type of insurance professional. The term was changed from "life insurance counselor" to "life and health insurance counselor" by Chapter 1530, Acts of the 76th Legislature, Regular Session, 1999.

Revised Law

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. (V.T.I.C. Art. 21.21-6, Secs. 1, 3, 4(e) (part), as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Art. 21.21-6

Sec. 1. No person shall engage in any practice of unfair discrimination which is defined in this article or is determined pursuant to this article to be a practice of unfair discrimination in the business of insurance.

Sec. 3. "Unfair discrimination" means:

(a) Refusing to insure; refusing to continue to insure; limiting the amount, extent, or kind of coverage available; or charging an individual a different rate for the same coverage because of race, color, religion, or national origin;

(b) Refusing to insure; refusing to continue to insure; limiting the amount, extent, or kind of coverage available; or charging an individual a different rate for the same coverage because of the age, gender, marital status, or geographic location of the individual; however, nothing in this paragraph shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(c) Refusing to insure; refusing to continue to insure; limiting the amount, extent, or kind of coverage; or charging an individual a

different rate for the same coverage because of disability or partial disability.

[Sec. 4]

(e) . . . This article shall not prevent requirements to provide title insurance coverage relating to possible community, homestead, or other martial rights in land.

Revisor's Note

(1) Section 1, V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, prohibits any practice of unfair discrimination as defined by that article or an act that "is determined pursuant to this article to be a practice of unfair discrimination in the business of insurance." V.T.I.C. Article 21.21-6 consists of five sections. In addition to Section 1, only Section 4 contains other references to such a determination. Several subsections of Section 4 refer to acts "determined pursuant to Section 3" of that article to be prohibited by the article. Section 3 merely provides a definition of unfair discrimination and does not authorize a determination that an act or practice that does not satisfy the definition is unfair discrimination. Consequently, the revised law omits the quoted language.

(2) Section 4(e), V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, refers to "community, homestead, or other martial rights in land." From the context, it is clear that "martial rights" is a typographical error and that the reference should be to "marital rights." The revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 21.21-6, Secs. 4(a), (b), (c), (d), (e) (part), as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Sec. 4. (a) A legal entity engaged in the business of insurance as specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Sections 3(b) and 3(c) of this article if the refusal to insure; refusal to continue to insure; the limiting of the amount, extent, or kind of coverage; or the charging of an individual a different rate for the same coverage is based upon sound underwriting or actuarial principles reasonably related to actual or anticipated loss experience.

(b) A legal entity engaged in the business of insurance as specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 3 of this article if the entity provides insurance coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization, so long as membership or membership qualifications are uniform requirements of the insurer as a condition of providing insurance, and are applied uniformly throughout this state, and the entity does not engage in any of the prohibited acts defined in or determined pursuant to Section 3 of this article for persons who are qualified members, except as otherwise provided in this section.

(c) A legal entity engaged in the business of insurance as specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 3 of this article if the refusal to insure; refusal to continue to insure; the limiting of the amount, extent, or kind of coverage; or the charging of an individual a different rate for the same coverage is required or authorized by law or regulatory mandate.

(d) A legal entity in the business of insurance specified in Section 2 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 3 of this article because different premiums result for policyholders with like expense factors but different loss exposures under a mass marketing plan. The commissioner shall by rule define selected groups eligible for issuance of policies under mass marketing plan.

(e) In this article, sound actuarial principles for purposes of title insurance means based on an examination of title or closing of the transaction.

. . .

Revisor's Note

Sections 4(a), (b), (c), and (d), V.T.I.C. Article 21.21-6, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995, refer to prohibited acts defined by "or determined pursuant to" one or more provisions of Section 3 of that article. The revised law omits references to the quoted language for the reason stated in Revisor's Note (1) to Section 544.002.

Revised Law

Sec. 544.004. ENFORCEMENT ACTIONS. (a) A legal entity engaged in the business of insurance or a health maintenance organization, 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, including 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. (V.T.I.C. Art. 21.21-6, Sec. 5, as added Acts 74th Leg., R.S., Ch. 415.)

Source Law

Sec. 5. Any legal entity engaged in the business of insurance in this state found to be in violation of or failing to comply with this article is subject to the sanctions authorized in Article 1.10 of this code, including administrative penalties authorized under Article 1.10E of this code. The commissioner may also utilize the cease and desist procedures authorized by Article 1.10A of this code.

[Sections 544.005-544.050 reserved for expansion]

SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY INSURERS

Revised Law

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, adjuster, or life and health insurance counselor. (V.T.I.C. Art. 21.21-8, Sec. 1.)

Source Law

Art. 21.21-8

Sec. 1. This article shall apply to any person engaged in the business of insurance. "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, county mutual, farm mutual, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters, and life insurance counselors.

Revisor's Note

Section 1, V.T.I.C. Article 21.21-8, refers to

"life insurance counselors." The revised law substitutes "life and health insurance counselor" for the reason stated in Revisor's Note (2) to Section 544.001.

Revised Law

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. (V.T.I.C. Art. 21.21-8, Sec. 2.)

Source Law

Sec. 2. No person shall engage in any unfair discrimination by making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

Revised Law

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. (V.T.I.C. Art. 21.21-8, Secs. 4, 5.)

Source Law

Sec. 4. A legal entity engaged in the business of insurance as specified in Section 1 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 2 of this article if the refusal to insure; the refusal to continue to insure; the limiting of the amount, extent, or kind of coverage; or the charging of an individual a different rate for the same coverage is based upon sound actuarial principles.

Sec. 5. A legal entity engaged in the business of insurance as specified in Section 1 of this article is not in violation of the prohibited acts defined in or determined pursuant to Section 2 of this article if the entity provides insurance coverage only to persons who are required to obtain or maintain membership or qualification for membership in a club, group, or organization so long as membership or membership qualifications are uniform requirements of the insurer as a condition of providing insurance, and are applied uniformly throughout this state, and the entity does not engage in any of the prohibited acts defined in or determined pursuant to Section 2 of this article for persons who are qualified members, except as otherwise provided in this section.

Revisor's Note

Sections 4 and 5, V.T.I.C. Article 21.21-8, refer to prohibited acts defined in or "determined pursuant to Section 2 of this article." Section 2 provides a description of unfair discrimination but does not authorize a determination that an act or practice that does not satisfy the description is unfair discrimination. Consequently, the revised law omits the quoted language.

Revised Law

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 before

the first anniversary of the date on which the plaintiff was denied insurance or the unfair act occurred.

(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. (V.T.I.C. Art. 21.21-8, Sec. 3.)

Source Law

Sec. 3. (a) A person who has sustained economic damages as a result of another's engaging in unfair discrimination, as defined in Section 2 of this article, may maintain an action against the person or persons engaging in such acts or practices in a district court in Travis County, Texas, and not elsewhere.

(b) In a suit filed under this article, any plaintiff who prevails may obtain:

(1) the amount of economic damages plus court costs and attorneys' fees. Court costs may include any reasonable and necessary expert witness fees. If the trier of fact finds that the defendant knowingly committed any acts prohibited by this article, the court may award a civil penalty in an amount of not more than $25,000 per claimant; and

(2) an order enjoining such acts or failure to act.

(c) All actions under this article must be commenced within 12 months after the date on which the plaintiff was denied insurance or the unfair act occurred.

(d) On a finding by the court that an action 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 attorneys' fees.

Revisor's Note

Section 3(b)(2), V.T.I.C. Article 21.21-8, provides that a plaintiff in a suit against a person engaging in unfair discrimination described by Section 2, V.T.I.C. Article 21.21-8, may obtain "an order enjoining such acts or failure to act." Section 544.052 codifies Section 2 by prohibiting a person from engaging in or permitting unfair discrimination. A person violates Section 544.052 by acting, or by failing to act (permitting someone else to act), in a prohibited manner. Consequently, a reference to the violation of Section 544.052 is sufficient, and the revised law accordingly omits the reference to a "failure to act."

[Sections 544.055-544.100 reserved for expansion]

SUBCHAPTER C. ENGLISH FLUENCY

Revised Law

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. (V.T.I.C. Art. 21.21-7, Sec. 1.)

Source Law

Art. 21.21-7
Sec. 1. In this article:

(1) "Health insurer" means any 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 insurance agreement, a group hospital service contract, or an evidence of coverage that provides health insurance or health care benefits. Without limiting the foregoing, the definition includes insurance companies, associations, and organizations which come within the purview of the following designated chapters of the Insurance Code: Chapter 3, pertaining to life, health, and accident insurance companies; Chapter 8, pertaining to general casualty companies; Chapter 10, pertaining to fraternal benefit societies; Chapter 11, pertaining to mutual life insurance companies; Chapter 12, pertaining to local mutual aid associations; Chapters 13 and 14, pertaining to statewide mutual assessment companies, mutual assessment companies, and mutual assessment life, health, and accident associations; Chapter 15, pertaining to mutual insurance companies writing other than life insurance; Chapter 18, pertaining to

underwriters making insurance on the Lloyd's plan; Chapter 19, pertaining to reciprocal exchanges; and Chapter 22, pertaining to stipulated premium insurance companies.

(2) "Underwriting guideline" means a rule, standard, marketing decision, or practice, whether written, oral, or electronic, that is used by a health insurer or an agent of a health insurer to examine, bind, accept, reject, renew, nonrenew, cancel, charge a different rate for the same coverage, or limit coverage(s) made available to classes of consumers of insurance.

Revisor's Note

(1) Section 1(1), V.T.I.C. Article 21.21-7, defines "health insurer" to include health maintenance organizations, which are not traditional insurers. "Health benefit plan issuer" is a more accurate term than "insurer," and throughout this subchapter, the revised law substitutes "health benefit plan issuer" for "health insurer."

(2) Section 1(1), V.T.I.C. Article 21.21-7, provides that "[w]ithout limiting the foregoing, the definition [of 'health insurer'] includes" various entities. The revised law omits "[w]ithout limiting the foregoing" as unnecessary because Section 311.005(13), Government Code (Code Construction Act), and Section 312.011(19), Government Code, provide that "includes" and "including" are terms of enlargement and not of limitation and do not create a presumption that components not expressed are excluded.

(3) Section 1(1), V.T.I.C. Article 21.21-7, refers to Chapter 3 of the Insurance Code. The relevant portions of Chapter 3, relating to life, health, or accident insurance companies, are revised in Chapters 841 and 982 of this code. The revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 21.21-7, Sec. 2.)

Source Law

> Sec. 2. This article applies to any health insurance policy, agreement, contract, or evidence of coverage delivered or issued for delivery by a health insurer.

Revised Law

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. (V.T.I.C. Art. 21.21-7, Sec. 3.)

Source Law

> Sec. 3. A health insurer may not use an underwriting guideline that is based on the ability of an insured or an applicant for insurance coverage or health care benefits to speak English fluently or to be literate in the English language. The applicant has the burden of proof to establish a violation of this article.

[Sections 544.104-544.150 reserved for expansion]

SUBCHAPTER D. FAMILY VIOLENCE

Revised Law

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. (V.T.I.C. Art. 21.21-5, Sec. 1.)

Source Law

Art. 21.21-5

Sec. 1. In this article, "family violence" means the occurrence of one or more of the following acts between persons who reside together or who formerly resided together:

(1) wilfully attempting to cause bodily injury, or wilfully or wantonly causing bodily injury;

(2) wilfully placing another, by physical threat, in fear of imminent bodily injury; or

(3) engaging in any of the following acts with a minor under 16 years of age who is not the spouse of the person engaging in the act:

(A) the act of sexual intercourse; or

(B) any lewd fondling or touching of the person of either the minor or the other person, done or submitted to with the intent to arouse or to satisfy the sexual desires of either the minor or the other person or both.

Revised Law

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). (V.T.I.C. Art. 21.21-5, Sec. 2.)

Source Law

Sec. 2. (a) This article applies only to:

(1) a life insurer that delivers, issues for delivery, or renews a life insurance contract or policy in this state, including any 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 20 of this code;

(C) a fraternal benefit society operating under Chapter 10 of this code;

(D) a stipulated premium insurance company operating under Chapter 22 of this code;

(E) a health carrier under Chapter 26 of this code;

(F) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code);

(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 other 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); or

(I) an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

(b) This article 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 issued as part of 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) of this section.

Revisor's Note

(1) Section 2(a)(2)(E), V.T.I.C. Article 21.21-5, refers to a "health carrier under Chapter 26 of this code." The revised law substitutes "health benefit plan issuer" for "health carrier" for consistency with the terminology used in the revision of Chapter 26. See Chapter 1501 of this code.

(2) Section 2(a)(2)(I), V.T.I.C. Article 21.21-5, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The revised law omits the reference to certification under Section 5.01(a), Medical Practice Act, which was codified in 1999 as Section 162.001, Occupations Code, as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under Section 162.001, Occupations Code, as a condition of holding a certificate of authority. The revised law also omits the reference to the commissioner issuing the certificate of authority as unnecessary because Chapter 844 requires the commissioner to issue the certificate of authority.

Revised Law

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. (V.T.I.C. Art. 21.21-5, Sec. 3.)

Source Law

> Sec. 3. (a) A health benefit plan issuer or life insurer, because of an individual's status as a victim of family violence, may not:
>
> (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 different rate 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.

Revised Law

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. (V.T.I.C. Art. 21.21-5, Sec. 8.)

Source Law

Sec. 8. (a) Except as provided by Subsection (b) of this section, 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 phone 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 only release information relating to the status as a victim of family violence of an individual who is clearly a victim of family violence:

(1) to the victim or another individual designated in writing by the victim;

(2) to a physician or health care provider for the provision of health care services;

(3) to a licensed physician designated by the victim;

(4) as required by other law or an order of the commissioner or a court of competent jurisdiction;

(5) when necessary for a valid business purpose if:

(A) the information cannot be segregated from other information about the victim without undue hardship to the health benefit plan issuer or life insurer;

(B) the recipient of the information agrees in writing to be subject to the requirements of this article; and

(C) the recipient of the information is:

(i) a reinsurer that seeks to indemnify or indemnifies all or any part of a health benefit plan or life insurance contract or policy covering the victim of family violence when the reinsurer cannot underwrite or satisfy obligations under the reinsurance agreement without 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 health benefit plan provider or life insurer;

(iii) medical or claims personnel under contract with the health benefit plan provider or life insurer, including parent or affiliate companies under service agreements with the health benefit plan provider or life insurer, when 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 health benefit plan provider transacts business when the information is only the address or telephone number of the victim and the entity cannot transact the business without the address or telephone number;

(6) to an attorney who needs the information to represent effectively the health benefit plan issuer or the life insurer, if the health benefit plan issuer or life insurer notifies the attorney of requirements of this article and requests that the attorney exercise due diligence to protect the information consistent with the attorney's obligation to represent the health benefit plan issuer or life insurer;

(7) to the individual covered under or owner of the health benefit plan or life insurance contract or policy, if the plan, contract, or policy contains information about status as a victim of family violence; or

(8) to any other individual or entity deemed appropriate by the commissioner.

Revisor's Note

Section 8(b)(4), V.T.I.C. Article 21.21-5, refers to an order of "a court of competent jurisdiction." The revised law omits "of competent jurisdiction" as unnecessary because an order of a court that does not have jurisdiction over a matter is not a valid order, and the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

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. (V.T.I.C. Art. 21.21-5, Sec. 6.)

Source Law

> Sec. 6. Notwithstanding any other provision of this article, 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, another insurance law of this state, or a rule adopted under this code or another insurance law of this state, provided that the health benefit plan issuer or life insurer consistently applies the criteria and does not merely use the criteria as a pretext to evade application of Section 3 of this article.

Revised Law

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. (V.T.I.C. Art. 21.21-5, Sec. 5.)

Source Law

> Sec. 5. A health benefit plan provider or life insurer who 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.

Revised Law

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. (V.T.I.C. Art. 21.21-5, Sec. 7.)

Source Law

Sec. 7. This article does not affect the right of an individual to continued coverage under Section 3B, Article 3.51-6, Insurance Code.

Revised Law

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. (V.T.I.C. Art. 21.21-5, Sec. 4.)

Source Law

Sec. 4. A health benefit plan issuer or life insurer who violates this article commits an unfair and deceptive practice as defined by Article 21.21 of this code and is subject to the penalties imposed under that article.

Revisor's Note

Section 4, V.T.I.C. Article 21.21-5, provides that a violation of the article is an "unfair and deceptive practice" under V.T.I.C. Article 21.21. The revised law adds the term "act" so that the phrase reads, "an unfair or deceptive act or practice" to conform to the terminology used in Article 21.21. Section 4, V.T.I.C. Article 21.21-5, also provides that a violation of the article is "subject to the penalties imposed under that article" (meaning Article 21.21). Since a violation of Article 21.21 by its terms subjects the violator to the penalties provided under that article, the revised law omits the quoted language as unnecessary.

[Sections 544.159-544.200 reserved for expansion]

SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

Revised Law

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. (V.T.I.C. Art. 21.21-6, Sec. (a), as added Acts 74th Leg., R.S., Ch. 522.)

Source Law

> Art. 21.21-6. (a) In this article, "insurer" means an insurer who delivers or issues for delivery or renews any health insurance policy or contract in this state, including any group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state. The term includes a group hospital service corporation under Chapter 20 of this code and a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Revisor's Note

Section (a), V.T.I.C. Article 21.21-6, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995, defines "insurer" to include health maintenance organizations. Throughout this subchapter, the revised law substitutes "health benefit plan issuer" for "insurer" for the reason stated in Revisor's Note (1) to Section 544.101.

Revised Law

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. (V.T.I.C. Art. 21.21-6, Sec. (b), as added Acts 74th Leg., R.S., Ch. 522.)

Source Law

> (b) An insurer, solely or in part because an individual has been diagnosed with or has a history of a fibrocystic breast condition, may not:

(1) deny coverage to the individual;

(2) refuse to renew a policy of insurance covering the individual;

(3) cancel a policy of insurance covering the individual;

(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 different rate for the same coverage.

Revisor's Note

Sections (b)(2) and (3), V.T.I.C. Article 21.21-6, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995, provide that under certain circumstances an insurer may not cancel or refuse to renew "a policy of insurance covering the individual." Section (a), Article 21.21-6, revised as Section 544.201, defines "insurer" as an insurer, group hospital service corporation, or health maintenance organization that issues or delivers "any health insurance policy or contract in this state, including any group policy, contract, or certificate of health insurance or evidence of coverage." It is clear that Sections (b)(2) and (3), Article 21.21-6, apply to a health insurance contract, certificate of health insurance, or evidence of coverage as well as to "a policy of insurance." Accordingly, the revised law substitutes "the individual's coverage" for "a policy of insurance covering the individual."

Revised Law

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. (V.T.I.C. Art. 21.21-6, Sec. (c), as added Acts 74th Leg., R.S., Ch. 522.)

Source Law

(c) An insurer who violates this article commits an unfair and deceptive practice as defined by Article 21.21 of this code and is subject to the penalties imposed under that article.

Revisor's Note

Section (c), V.T.I.C. Article 21.21-6, as added by Chapter 522, Acts of the 74th Legislature, Regular Session, 1995, provides that a violation of the article is an "unfair and deceptive practice" under Article 21.21 and "is subject to the penalties imposed under that article." The revised law adds the term "act" and omits the reference to penalties for the reasons stated in the revisor's note to Section 544.158.

Revised Law

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. (V.T.I.C. Art. 21.21-6, Sec. (d), as added Acts 74th Leg., R.S., Ch. 522.)

Source Law

(d) Nothing in this article requires insurers to pay for fibrocystic breast disease.

[Sections 544.205-544.250 reserved for expansion]

SUBCHAPTER F. CHURCH PROPERTY

Revised Law

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. (V.T.I.C. Art. 21.21-9, Sec. 1, as added Acts 75th Leg., R.S., Ch. 1007.)

Source Law

Art. 21.21-9
Sec. 1. In this article:
(1) "Church" means a facility that is owned by a religious organization and that is used primarily for religious services.
(2) "Religious organization" means a church, synagogue, or other organization or association that is organized primarily for religious

purposes.

Revised Law

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. (V.T.I.C. Art. 21.21-9, Sec. 2, as added Acts 75th Leg., R.S., Ch. 1007.)

Source Law

> Sec. 2. This article applies to any insurer admitted to do business 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 company, a reciprocal or interinsurance exchange, or a farm mutual insurance company.

Revised Law

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. (V.T.I.C. Art. 21.21-9, Sec. 3, as added Acts 75th Leg., R.S., Ch. 1007.)

Source Law

> Sec. 3. An insurer writing insurance for a church may not cancel or decline to renew an insurance policy solely because of:
>
> (1) a previous occurrence of arson against the church in which the church has cooperated with police, fire, and other authorities in the investigation of the arson and the prosecution of those responsible; or

(2) a verbal or written statement directed to the religious organization or an official of the religious organization threatening an act of arson against the church when the organization or official within a reasonable amount of time reported the threat to the appropriate law enforcement agency.

Revised Law

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. (V.T.I.C. Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch. 1007.)

Source Law

Sec. 4. A violation of this article is an unfair act or practice in the business of insurance for purposes of Article 21.21 and an insurer that violates this article is subject to the sanctions established by Article 21.21.

Revisor's Note

Section 4, V.T.I.C. Article 21.21-9, as added by Chapter 1007, Acts of the 75th Legislature, Regular Session, 1997, provides that a violation of the article is an "unfair act or practice" under Article 21.21 and that "an insurer that violates this article is subject to the sanctions established by Article 21.21." The revised law adds the term "deceptive" so that the phrase reads, "an unfair or deceptive act or practice" to conform to the terminology used in Article 21.21. The revised law omits the reference to sanctions for the reason stated in the revisor's note to Section 544.158.

CHAPTER 545. HIV TESTING

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CHAPTER 545. HIV TESTING

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (a); New.)

Source Law

Art. 21.21-4. (a) In this article:

(1) "HIV" and "AIDS" have the meanings assigned by Section 81.101, Health and Safety Code.

(2) "Insurer" means an insurer who delivers or issues for delivery or renews any insurance in this state including any group policy, contract, or certificate of health insurance or evidence of coverage delivered, issued for delivery, or renewed in this state by an insurance company, including a group hospital service corporation under Chapter 20 of this code and a health maintenance organization under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(3) "Test result" means any statement or assertion that any identifiable individual is positive, negative, at risk, has or does not have a certain level of antigen or antibody, or any other statement 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.

Revisor's Note

(1) A definition of "applicant" is added to the revised law for drafting convenience and to avoid unnecessary repetition of the substance of the definition.

(2) Section (a)(2), V.T.I.C. Article 21.21-4, provides a definition of "insurer." The revised law substitutes "issuer" for "insurer" because the definition of "insurer" includes persons, such as health maintenance organizations, that issue health coverage but are not insurers. Consequently, "issuer" is a more accurate term.

(3) Section (a)(3), V.T.I.C. Article 21.21-4, refers to "any statement or assertion." The revised law omits "assertion" because, in context, "assertion" is included within the meaning of "statement."

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (p).)

Source Law

(p) The provisions of this article and any rules and regulations adopted pursuant to this article shall exclusively govern all practices of insurers in testing applicants to show or help show whether a person has AIDS or HIV infection, antibodies to HIV, or infection with any other probable causative agent of AIDS.

Revisor's Note

Section (p), V.T.I.C. Article 21.21-4, refers to "rules and regulations." The revised law omits the reference to "regulations" because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (i).)

Source Law

(i) The State Board of Insurance may adopt reasonable rules and forms necessary to implement this article and also may adopt rules relating to HIV-related tests to be followed for tests requested or required by insurers.

Revisor's Note

Section (i), V.T.I.C. Article 21.21-4, refers to the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the

commissioner of insurance and the Texas Department of Insurance. Throughout this chapter, references to the board have been changed appropriately.

[Sections 545.004-545.050 reserved for expansion]

SUBCHAPTER B. ISSUER POWERS AND DUTIES

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (b) (part).)

Source Law

> (b) An insurer may request or require applicants for insurance coverage to take an HIV-related test in connection with an application for insurance coverage. . . .

Revised Law

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. (V.T.I.C. Art. 21.21-4, Secs. (b) (part), (h).)

Source Law

> (b) . . . If an insurer requests or requires applicants for insurance coverage to take an HIV-related test, the insurer must request or require the tests on a nondiscriminatory basis. An HIV-related test may be required of or required to be given to a person only if the test is based on the person's current medical condition or medical history or if underwriting guidelines for the coverage amounts

require all persons within the risk class to be tested.

(h) The marital status, occupation, gender, beneficiary designation, or zip code or other territorial classification of a proposed insured may not be used by an insurer in making a determination as to who will be required or requested to take an HIV-related test.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (c).)

Source Law

(c) If a proposed insured is requested or required to take an HIV-related test in connection with an insurance application, the uses that will be made of the test must be explained to the proposed insured or any other person legally authorized to consent to the test and a written authorization must be obtained from that person by the insurer. The authorization must be on a form adopted by the State Board of Insurance and must be a document separate from any other document presented to the proposed insured or other person legally authorized to consent to the test.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (d).)

Source Law

> (d) An insurer may inquire if an applicant has ever tested positive on an HIV-related test or has been diagnosed as having HIV or AIDS. An insurer may not inquire whether a person has been tested for or has received a negative result from a specific test for exposure to HIV or for a sickness or a medical condition derived from infection with that virus.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (f).)

Source Law

> (f) An applicant must be given written notice of a positive HIV-related test result by a physician designated by the applicant or, in the absence of that designation, by the Texas Department of Health. The Texas Department of Health is authorized to set by rule a fee to cover the costs of providing this service to the insurer. The fee may not exceed $25.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (g).)

Source Law

> (g) An insurer may not make an adverse underwriting decision based on a positive HIV-related test unless test protocol as established by rule of the State Board of Insurance is followed in testing.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Sec. (e).)

Source Law

(e) The result of an HIV-related test is confidential, and an insurer may not release or disclose the test result or allow the test result to

become known except in the following circumstances:

(1) as may be required by law; or

(2) pursuant to the written request or authorization of the proposed insured or other person legally authorized to consent to the test on behalf of the proposed insured, with the release pursuant to written request limited to:

(A) the proposed insured;

(B) the person legally authorized to consent to the test;

(C) a licensed physician, medical practitioner, or other person designated by the proposed insured;

(D) an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also 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 proposed insured;

(E) a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality;

(F) persons within the insurer's organization who have the responsibility to make underwriting decisions on behalf of the insurer; or

(G) outside legal counsel who needs the information to effectively represent the insurer in regard to matters concerning the proposed insured.

[Sections 545.058-545.700 reserved for expansion]

SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

Revised Law

Sec. 545.701. SANCTIONS. The commissioner may impose sanctions under Chapter 82 on an issuer that violates this chapter. (V.T.I.C. Art. 21.21-4, Sec. (q).)

Source Law

(q) An insurer that violates this article is subject to the sanctions provided by Section (7) of Article 1.10 of this code.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Secs. (j), (k), (l), (o).)

Source Law

(j) Any person who is injured by a violation of Subsection (e) of this article may bring a civil action for damages. In addition, any person may bring an action to restrain a violation or threatened violation of Subsection (e) of this article.

(k) If it is found in a civil action that a person or entity has negligently released or disclosed a test result or allowed a test result to become known in violation of Subsection (e) of this article, the person or entity is liable for:

(1) actual damages;

(2) a civil penalty of not more than $1,000; and

(3) court costs and reasonable attorney's fees incurred by the person bringing the action.

(l) If it is found in a civil action that a person or entity has wilfully released or disclosed a test result or allowed a test result to become known in violation of Subsection (e) of this article, the person or entity is liable for:

(1) actual damages;

(2) a civil penalty of not less than $1,000 nor more than $5,000; and

(3) court costs and reasonable attorney's fees incurred by the person bringing the action.

(o) A defendant in a civil action brought under Subsections (j) through (l) of this article is not entitled to claim any privilege as a defense to the action.

Revisor's Note

Section (j), V.T.I.C. Article 21.21-4, states that a person may seek injunctive relief "in addition" to a civil action. The revised law omits the quoted language as unnecessary because an accepted principle of statutory construction requires a statute to be

given cumulative effect with other statutes unless the statute provides otherwise or unless the statutes are in conflict.

Revised Law

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. (V.T.I.C. Art. 21.21-4, Secs. (m), (n).)

Source Law

(m)(1) A person or entity that, with criminal negligence, releases or discloses a test result or other information or that allows a test result or other information to become known in violation of Subsection (e) of this article commits an offense.

(2) An offense under this subsection is a Class A misdemeanor.

(n) Each release or disclosure made or allowance of a test result to become known in violation of this article constitutes a separate offense.

CHAPTER 546. USE OF GENETIC TESTING INFORMATION

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CHAPTER 546. USE OF GENETIC TESTING INFORMATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

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. (V.T.I.C. Art. 21.73, Secs. 1(1), (2), (3), (4), (6).)

Source Law

Art. 21.73

Sec. 1. In this article:

(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 that individual.

(4) "Genetic test" means a presymptomatic laboratory test of an individual's genes, gene products, or chromosomes to identify by analysis of the individual's DNA, RNA, proteins, or chromosomes genetic variations, compositions, or alterations that are associated with a predisposition for a clinically recognized disease, disorder, or syndrome or to be a carrier of such a disease, disorder, or syndrome. The term does not include:

(A) 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;

(B) a routine physical examination or a routine test performed as a part of a physical examination;

(C) a test to determine drug use; or

(D) a test for the presence of the human immunodeficiency virus.

(6) "RNA" means ribonucleic acid.

Revisor's Note

Section 1(5), V.T.I.C. Article 21.73, defines "group health benefit plan." The revised law omits this definition as unnecessary because Section 2, V.T.I.C. Article 21.73, revised as Sections 546.002 and 546.003, specifies the types of group health benefit plans to which the chapter applies, and thus the defined term is not helpful to the reader. The omitted law reads:

> (5) "Group health benefit plan" means a plan described by Section 2 of this article.

Revised Law

Sec. 546.002. APPLICABILITY OF CHAPTER. This chapter applies only to a group 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) 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 group 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. (V.T.I.C. Art. 21.73, Sec. 2(a).)

Source Law

Sec. 2. (a) This article applies to a group 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) 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 20 of this code;

(iii) a fraternal benefit society operating under Chapter 10 of this code;

(iv) a stipulated premium insurance company operating under Chapter 22 of this code; or

(v) a health maintenance organization operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); or

(B) to the extent permitted by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a group health benefit plan that is offered by:

(i) a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(ii) any other entity not licensed under this code or another insurance law of this state that contracts directly for health care services on a risk-sharing basis, including an entity that contracts for health care services on a capitation basis; or

(iii) another analogous benefit arrangement; or

(2) is offered by an approved nonprofit health corporation that is certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and that holds a certificate of authority issued by the commissioner under Article 21.52F of this code.

Revisor's Note

(1) Section 2(a)(1)(B)(ii), V.T.I.C. Article 21.73, refers to a health benefit plan offered by an entity not "licensed" under this code or "another insurance law of this state." The revised law substitutes "authorized" for "licensed" for consistency with terminology used throughout this code.

(2) Section 2(a)(2), V.T.I.C. Article 21.73, refers to an approved nonprofit health corporation that is "certified under Section 5.01(a), Medical Practice Act," and holds a certificate of authority "issued by the commissioner under Article 21.52F." The reference in Article 21.73 to certification under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), which was codified in 1999 in Chapter 162, Occupations Code, is unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844 of this code, requires a nonprofit corporation to be certified under that provision as a condition of holding a certificate of authority. The reference to the commissioner's issuing the certificate of authority is also unnecessary because Article 21.52F, as revised, requires the commissioner to issue the certificate of authority.

Revised Law

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 group health benefit plan as described by Section 546.002. (V.T.I.C. Art. 21.73, Sec. 2(b).)

Source Law

(b) This article 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 issued as part of 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 group health benefit plan as described by Subsection (a) of this section.

[Sections 546.004-546.050 reserved for expansion]

SUBCHAPTER B. GENETIC TESTING AND USE OF TEST RESULTS

Revised Law

Sec. 546.051. CERTAIN TESTING PERMITTED; INDUCEMENT PROHIBITED. (a) A group 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 group 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 group 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. (V.T.I.C. Art. 21.73, Secs. 3(b), (c), (d).)

Source Law

(b) If a group health benefit plan issuer requests that an applicant for coverage under the plan submit to a genetic test in connection with the application for coverage for a purpose other than a purpose prohibited under Subsection (a) of this section, the issuer 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 for the test before the administration of the test.

(c) In the consent form, the applicant shall state whether the applicant elects to be informed of the results of the test. If the applicant does so elect, the person or entity that performs the test shall disclose the results of the test to the applicant, as well as to the group health benefit plan issuer, and the group health benefit plan 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 results of the test.

(d) A group health benefit plan issuer may not use the results of a genetic test conducted in accordance with Subsection (b) of this section as an inducement for the purchase of coverage under the plan.

Revised Law

Sec. 546.052. IMPROPER USE OF TEST RESULTS; REFUSAL TO SUBMIT TO TESTING. A group 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. (V.T.I.C. Art. 21.73, Secs. 3(a), (e).)

Source Law

> Sec. 3. (a) A group health benefit plan issuer may not use genetic information to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect eligibility for or coverage under the group health benefit plan.
>
> (e) A group health benefit plan issuer may not use 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 group health benefit plan.

Revised Law

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 group health benefit plan.

(b) A group 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. (V.T.I.C. Art. 21.73, Sec. 8.)

Source Law

> Sec. 8. (a) No issuer of a group health benefit plan shall require, as a condition of insurance coverage, genetic testing of a child in utero without the consent of the pregnant woman.
>
> (b) No issuer of a group health benefit plan shall use genetic information to coerce or compel a

pregnant woman to have an induced abortion.

(c) "Coercion" for the purposes of this section means the restraining or domination of the free will of a woman by actual or implied force, or by actual or implied threat of rejection, denial, limitation, cancellation, refusal to renew, or otherwise adversely affecting eligibility for coverage under a group health benefit plan.

Revisor's Note

Section 8(a), V.T.I.C. Article 21.73, refers to "insurance coverage." The revised law omits the reference to "insurance" as inaccurate because Section 8 applies to coverage that is not insurance, such as coverage provided by a health maintenance organization.

Revised Law

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. (V.T.I.C. Art. 21.73, Sec. 6.)

Source Law

Sec. 6. A sample of genetic material taken for a genetic test from an individual 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 tested authorizes retention of the sample for purposes of medical treatment or scientific research;

(3) for a sample obtained for research that is cleared by an institutional review board, the sample is retained under the requirements that the institutional review board imposes on a specific research project or as 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 and performed by that department or by a laboratory approved by that department under Section 33.011, Health and Safety Code.

[Sections 546.055-546.100 reserved for expansion]

SUBCHAPTER C. DISCLOSURE OF GENETIC INFORMATION; CONFIDENTIALITY; EXCEPTIONS

Revised Law

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 group 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. (V.T.I.C. Art. 21.73, Sec. 5.)

Source Law

Sec. 5. An individual who submits to a genetic test has the right to know the results of that test. On the written request of the individual, the group health benefit plan issuer or other entity that performed the test shall disclose the test results to the individual or to a physician designated by the individual. The right to information under this section is in addition to any right or requirement established under Section 3 of this article.

Revised Law

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 group 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. (V.T.I.C. Art. 21.73, Secs. 4(a), (d) (part).)

Source Law

> Sec. 4. (a) Except as provided by Subsections (c) and (d) of this section, genetic information is confidential and privileged regardless of the source of the information. A person or entity that holds that information may not disclose or be compelled to disclose, by subpoena or otherwise, genetic information about an individual unless the disclosure is specifically authorized by the individual as provided by Subsection (b) of this section. This subsection applies to a redisclosure of genetic information by a secondary recipient of the information after disclosure of the information by an initial recipient.
>
> (d) Except as provided by this subsection, a group 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 form executed under Subsection (b) of this section. . . .

Revised Law

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 group 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. (V.T.I.C. Art. 21.73, Secs. 4(c), (d) (part), (e).)

Source Law

(c) Subject to Subchapter G, Chapter 411, Government Code, genetic information relating to an individual may be disclosed without the authorization

required under Subsection (b) of this section 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) authorized under a state or federal law to establish paternity;

(4) made to furnish genetic information relating to a decedent to the blood relatives of the decedent for the purpose of medical diagnosis; or

(5) made to identify a decedent.

(d) . . . A group health benefit plan issuer may redisclose genetic information:

(1) for actuarial or research studies if:

(A) a tested individual may 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 purposes of the enforcement of this article; or

(3) for purposes directly related to enabling business decisions to be made about the purchase, transfer, merger, or sale of all or part of an insurance business or about obtaining reinsurance affecting that insurance business.

(e) A redisclosure authorized under Subsection (d) of this section may contain only information reasonably necessary to accomplish the purpose for which the information is disclosed.

Revised Law

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 group 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. (V.T.I.C. Art. 21.73, Sec. 4(b).)

Source Law

(b) An individual or the legal representative of an individual may authorize the disclosure of genetic information relating to that individual through 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 group 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 the legal representative and, if the disclosure is for claiming proceeds of any 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 form.

[Sections 546.105-546.150 reserved for expansion]

SUBCHAPTER D. ENFORCEMENT

Revised Law

Sec. 546.151. CEASE AND DESIST ORDER. (a) On a finding by the commissioner that a group 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 group 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 group health benefit plan in this state. (V.T.I.C. Art. 21.73, Sec.

7(a).)

Source Law

Sec. 7. (a) On a finding by the commissioner that a group health benefit plan issuer is in violation of this article, the commissioner may enter a cease and desist order in the manner provided under Article 1.10A of this code. If the group health benefit plan issuer refuses or fails to comply with the cease and desist order, the commissioner may, in the manner provided by this code and the other insurance laws of this state, revoke or suspend the issuer's certificate of authority or other authorization to engage in the operation of a group health benefit plan in this state.

Revised Law

Sec. 546.152. ADMINISTRATIVE PENALTY. A group health benefit plan issuer that operates a plan in violation of this chapter is subject to an administrative penalty as provided by Chapter 84. (V.T.I.C. Art. 21.73, Sec. 7(b).)

Source Law

(b) A group health benefit plan issuer that operates the plan in violation of this article is subject to an administrative penalty as provided by Article 1.10E of this code.

CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

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CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

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. (V.T.I.C. Art. 21.21-1, Secs. 2(a), (c).)

Source Law

Sec. 2. (a) The term "foreign or alien insurer" shall mean any insurance company organized under the laws of any other state or territory of the United States or any foreign country.

(c) "Residents" shall mean and include person, partnership or corporation, domestic, alien or foreign.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.21-1, refers to a "state or territory of the United States or any foreign country." The revised law omits as unnecessary the reference to "territory" because the term is included in the definition of "state" provided by Section 311.005(7), Government Code (Code Construction Act), applicable to the revised law.

(2) The revised law omits Section 2(b), V.T.I.C. Article 21.21-1, as unnecessary. The subsection defines the term "Unfair Trade Practice Act," used in Sections 3 and 4 of Article 21.21-1, to mean Chapter 198, Acts of the 55th Legislature, Regular Session, 1957 (V.T.I.C. Article 21.21). V.T.I.C. Article 21.21 is revised in Chapter 541 of this code, and this chapter substitutes references to that chapter for references to the Unfair Trade Practice Act. The omitted subsection reads:

(b) "Unfair Trade Practice Act" shall mean the Act of 1957, 55th Legislature, page 401, Chapter 198, also known as Article 21.21 of the Insurance Code.

Revised Law

Sec. 547.002. CONSTRUCTION OF CHAPTER. This chapter shall be construed liberally. (V.T.I.C. Art. 21.21-1, Sec. 1(b).)

Source Law

(b) The provisions of this Act shall be liberally construed.

[Sections 547.003-547.050 reserved for expansion]

SUBCHAPTER B. PROHIBITION; ENFORCEMENT

Revised Law

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. (V.T.I.C. Art. 21.21-1, Sec. 3 (part).)

Source Law

Sec. 3. No unauthorized foreign or alien insurer shall make, issue, circulate or cause to be made, issued or circulated, to residents of this state any advertisement, estimate, illustration, circular, pamphlet, or letter, or cause to be made in any newspaper, magazine or other publication or over any radio or television station, any announcement or statement to such residents misrepresenting its financial condition or the terms of any contracts issued or to be issued or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon in violation of the

Unfair Trade Practice Act, and . . . .

Revised Law

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. (V.T.I.C. Art. 21.21-1, Sec. 3 (part).)

Source Law

> Sec. 3. . . . whenever the State Board of Insurance shall have reason to believe that any such insurer is engaging in such unlawful advertising, it shall be its duty to give notice of such fact by registered mail to such insurer and to the insurance supervisory official of the domiciliary state of such insurer. For the purpose of this Section, the domiciliary state of an alien insurer shall be deemed to be the state of entry or the state of the principal office in the United States.

Revised Law

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. (V.T.I.C. Art. 21.21-1, Sec. 4.)

Source Law

Sec. 4. If after thirty (30) days following the

giving of the notice mentioned in Section 3 such insurer has failed to cease making, issuing, or circulating such false misrepresentations or causing the same to be made, issued or circulated in this state, and if the State Board of Insurance has reason to believe that a proceeding by it in respect to such matters would be to the interest of the public, and that such insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in Section 5, the said Board shall take action against such insurer under the Unfair Trade Practice Act.

Revisor's Note

Section 4, V.T.I.C. Article 21.21-1, provides a duty for the Texas Department of Insurance to take an action against an insurer if the department has reason to believe that the insurer is "doing any of the acts enumerated in Section 5 [of V.T.I.C. Article 21.21-1]." The revised law omits the quoted language as obsolete because Section 5, V.T.I.C. Article 21.21-1, was repealed by Chapter 46, Acts of the 70th Legislature, Regular Session, 1987.

Revisor's Note
(End of Chapter)

(1) V.T.I.C. Article 21.21-1, as enacted by Chapter 122, Acts of the 57th Legislature, Regular Session, 1961, was concerned primarily with substitute service of process on unauthorized insurers. Section 5 of the article, which provided for substitute service of process on unauthorized insurers, was repealed by Chapter 46, Acts of the 70th Legislature, Regular Session, 1987. That repeal made the article's purpose clause (Section 1(a) of the article) and short title (Section 7 of the article) misleading in the context of the remaining text of the article. Consequently, the revised law omits the purpose clause as obsolete and executed and omits the short title as obsolete. The omitted law reads:

Art. 21.21-1
Sec. 1. (a) The purpose of this Act is to subject to the jurisdiction of the

State Board of Insurance of this state and to the jurisdiction of the courts of this state insurers not authorized to transact business in this state which place in or send into this state any false advertising designed to induce residents of this state to purchase insurance from insurers not authorized to transact business in this state. The Legislature declares it is in the interest of the citizens of this state who purchase insurance from insurers which solicit insurance business in this state in the manner set forth in the preceding sentence that such insurers be subject to the provisions of this Act. In furtherance of such state interest, the Legislature herein provides a method of substituted service of process upon such insurers and declares that in so doing, it exercises its powers to protect its residents and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, 1st Session, S. 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states; the authority provided herein to be in addition to any existing powers of this state.

Sec. 7. This Act may be cited as the Unauthorized Insurers False Advertising Process Act.

(2) The revised law omits Section 6, V.T.I.C. Article 21.21-1, regarding the severability of the article's provisions, because the section duplicates Section 311.032, Government Code (Code Construction Act), providing for the severability of statutes. The omitted law reads:

Sec. 6. If any provision of this Act or the application of such provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

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CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

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. (V.T.I.C. Art. 21.48, Sec. 13.)

Source Law

> Sec. 13. It is the purpose of this Article to provide for the protection of the public interest, the investor, and the shareholder of domestic stock insurance companies by regulating proxy solicitation by domestic stock insurance companies and transactions by officers, directors and principal equity security holders of such companies and requiring appropriate reports thereof. To this end the misuse of information by certain insiders of domestic stock insurance companies 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 companies will be promoted and the free exercise of such franchise will be insured. In exercising the authority granted by this Article to make rules and regulations the Board shall promote the purposes of this Article to prevent misuse of information and to encourage good faith dealing and full and fair disclosure.

Revisor's Note

(1) Section 13 and other provisions of V.T.I.C. Article 21.48 refer to "rules and regulations." Throughout this chapter, the revised law omits references to "regulations" in this context because under Section 311.005(5), Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

(2) Section 13, V.T.I.C. Article 21.48, refers to "the Board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the State Board of Insurance and transferred its functions to the commissioner of insurance and the Texas Department of Insurance, as appropriate. Throughout this chapter, references to the State Board of Insurance have been changed

appropriately.

Revised Law

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. (V.T.I.C. Art. 21.48, Secs. 8(3), (4) (part), (6), (7); New.)

Source Law

(3) "Person" shall mean an individual, a corporation, a partnership, an association, a joint-stock company, a business trust, or an unincorporated organization;

(4) "Equity security" shall mean any stock

or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the Board shall deem . . . to treat as an equity security;

(6) "Officer" shall mean a president, vice-president, treasurer, actuary, secretary, controller, and any other person who performs for a domestic stock insurance company functions corresponding to those performed by the foregoing officers.

(7) Without limiting the generality thereof, the term "stock insurance company" shall include domestic title insurance companies, regulated by Chapter 9 of the Texas Insurance Code, and stipulated premium insurance companies, regulated by Chapter 22 of the Texas Insurance Code.

Revisor's Note

(1) Section 8(1), V.T.I.C. Article 21.48, defines "board" as the State Board of Insurance, and Section 8(2), V.T.I.C. Article 21.48, defines "commissioner" as the commissioner of insurance. As explained in Revisor's Note (2) to Section 548.001, the State Board of Insurance has been abolished, and consequently the revised law omits the definition of "board." The revised law also omits the definition of "commissioner" as unnecessary. Section 31.001 of this code defines "commissioner" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance. The omitted law reads:

> Sec. 8. When used in this Article:
>
> (1) "Board" means the State Board of Insurance;
>
> (2) "Commissioner" means the Commissioner of Insurance;
>
> . . .

(2) Section 8(7), V.T.I.C. Article 21.48, states that "[w]ithout limiting the generality thereof," a stock insurance company includes certain insurers. The revised law omits the quoted language as unnecessary because Section 311.005(13), Government Code (Code Construction Act), applicable to the revised law, provides that "includes" and "including" are terms of enlargement and not of limitation and do

not create a presumption that components not expressed are excluded. The revised law substitutes "domestic stock insurer" for "stock insurance company" for consistency with the terminology used in this chapter.

(3) The revised law adds the definition of "federal Securities Exchange Act" for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

Revised Law

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. (V.T.I.C. Art. 21.48, Sec. 10 (part).)

Source Law

> Sec. 10. The State Board of Insurance shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in it by Sections 2 through 9 of this Article, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within its jurisdiction. . . .

Revised Law

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. (V.T.I.C. Art. 21.48, Secs. 8(4) (part), (5).)

Source Law

(4) ["Equity security" shall mean . . . any other security which the Board shall deem] to be of similar nature and consider necessary or appropriate, by such rules and regulations as it may prescribe in the public interest or for the protection of the investors, . . . ;

(5) "Exempted security" or "exempted securities" shall mean such securities as the Board may, by such rules and regulations as it deems necessary or appropriate in the public interest or for the protection of investors, either conditionally or upon specified terms and conditions or for stated periods, exempt from the operation of any one or more provisions of this Article which by their terms do not apply to an "exempted security" or to "exempted securities."

Revisor's Note

Section 8(5), V.T.I.C. Article 21.48, refers to "terms and conditions" determined necessary or appropriate by the (former) State Board of Insurance. The revised law omits "conditions" as unnecessary because, in this context, "conditions" is included within the meaning of "terms."

Revisor's Note
(End of Subchapter)

(1) Section 1, V.T.I.C. Article 21.48, provides a short title for that article. The revised law omits the short title because Article 21.48 is not a statute of wide application that is frequently referred to by its short title, and the heading to this chapter of the revised law is sufficient to describe the revised law to the reader. The omitted law reads:

Art. 21.48
Sec. 1. This Article shall be known as the "Insurance Company Insider Trading and Proxy Regulation Act."

(2) The revised law omits as unnecessary Section 14, V.T.I.C. Article 21.48, which provides a requirement for the effectiveness of a rule adopted under Article 21.48. Chapter 2001, Government Code (the administrative procedure law), prescribes the procedure each agency must follow in adopting rules,

including the filing requirements imposed by the omitted law. The omitted law reads:

> Sec. 14. All rules and regulations promulgated by the State Board of Insurance under authority of this Article shall be filed with the Secretary of State, and no such rules or regulations shall be of any force or effect until so filed.

[Sections 548.005-548.100 reserved for expansion]

SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

Revised Law

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. (V.T.I.C. Art. 21.48, Secs. 2 (part), 3 (part), 4 (part).)

Source Law

> Sec. 2. Every person who is directly or indirectly the beneficial owner of more than ten per cent of any class of any equity security (other than an exempted security) of a domestic stock insurance company, or who is a director or an officer of such a company, ...
>
> Sec. 3. [For the purpose of preventing the unfair use of information which may have been obtained by such] beneficial owner, director, or officer . . . .
>
> Sec. 4. [It shall be unlawful for any such] beneficial owner, director, or officer, ...

Revised Law

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. (V.T.I.C. Art. 21.48, Sec. 2 (part).)

Source Law

> Sec. 2. Every person . . . shall file with the State Board of Insurance on or before the first day of July 1966 and thereafter within ten days after he becomes such beneficial owner, director, or officer, a statement, in such form as such Board may prescribe, of the amount of all equity securities of such company of which he is the beneficial owner, and within ten days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of such Board a statement, in such form as it may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

Revisor's Note

Section 2, V.T.I.C. Article 21.48, requires a person described by that section to file a report with the (former) State Board of Insurance under that section "on or before the first day of July 1966." The revised law omits the quoted language as executed.

Revised Law

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. (V.T.I.C. Art. 21.48, Secs. 3, 6 (part).)

Source Law

> Sec. 3. For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director, or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company (other than an exempted security) within any period of less than six months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director, or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company shall fail or refuse to bring such suit within sixty days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two years after the date such profit was realized. This Section shall not be construed to cover any transaction where such beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the State Board of Insurance by rules and regulations may exempt as not comprehended within the purpose of this Section.

> Sec. 6. The provisions of Section 3 of this Article shall not apply to any purchase and sale, or sale and purchase . . . of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The State Board of Insurance may, by such rules and regulations as it deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

Revisor's Note

Section 3, V.T.I.C. Article 21.48, refers to a suit brought "in any court of competent jurisdiction." Throughout this chapter, the revised law omits the quoted language as unnecessary in that context because a suit may only be brought in a court, and the general laws of civil jurisdiction determine which courts have jurisdiction over the matter. For example, see Sections 24.007-24.011, Government Code, for the general jurisdiction of district courts.

Revised Law

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). (V.T.I.C. Art. 21.48, Secs. 4, 6 (part).)

Source Law

> Sec. 4. It shall be unlawful for any such beneficial owner, director, or officer, directly or indirectly, to sell any equity security of such company (other than an exempted security) if the person selling the security or his principal (i) does not own the security sold, or (ii) if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after such sale deposit it in the mails or other usual channels of transportation; but no person shall be deemed to have violated this Section if he proves that notwithstanding the exercise of good faith he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.
>
> Sec. 6. . . . , and the provisions of Section 4 of this Article shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The State Board of Insurance may[, by such rules and regulations as it deems necessary or appropriate in the public interest,] define and prescribe terms and conditions [with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.]

Revised Law

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. (V.T.I.C. Art. 21.48, Sec. 5.)

Source Law

> Sec. 5. (1) It shall be unlawful for any person, in contravention of such rules and regulations as the State Board of Insurance may prescribe as necessary or appropriate in the public interest or for the protection of investors, to solicit or to permit the use of his name to solicit any proxy or consent or authorization in respect of any equity security (other than an exempted security) of a domestic stock insurance company not listed on a national securities exchange registered as such under the United States Securities Exchange Act of 1934, as amended.
>
> (2) Unless proxies, consents, or authorizations in respect of a security of a domestic stock insurance company subject to subsection (1) of this Section 5 are solicited by or on behalf of the management of such company from the holders of record of stock of such company in accordance with the rules and regulations prescribed under this Section 5 prior to any annual or other meeting, such company shall, in accordance with such rules and regulations prescribed by the Board, file with the Commissioner and transmit to all holders of record of such security, information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

Revised Law

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. (V.T.I.C. Art. 21.48, Secs. 7, 9, 10 (part).)

Source Law

> Sec. 7. The provisions of Sections 2, 3 and 4 of this Article shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the State Board of Insurance may adopt in order to carry out the purposes of this Act.
>
> Sec. 9. The provisions of Sections 2, 3, 4 and 5 of this Article shall not apply to equity securities of a domestic stock insurance company if (a) such securities shall be registered, or shall be required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934, as amended, or if (b) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of Sections 2, 3, 4, and 5 of this Article except for the provisions of this subsection (b).
>
> Sec. 10. . . . No provision of Sections 2, 3, 4, and 5 of this Article imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the said Board, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

Revisor's Note

Section 9, V.T.I.C. Article 21.48, refers to the year "next preceding" a certain year. The revised law

omits "next" as unnecessary. "The preceding" means "the next preceding."

[Sections 548.107-548.200 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT

Revised Law

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. (V.T.I.C. Art. 21.48, Sec. 11.)

Source Law

Sec. 11. Any person who wilfully violates any provision of this Article or any rule or regulation thereunder the violation of which is made unlawful or the observance of which is required under the terms of this Article, or any person who wilfully and knowingly makes, or causes to be made, any statement in any document required to be filed under this Article or any rule or regulation thereunder which statement was false or misleading with respect to any material fact, shall upon conviction be fined not more than ten thousand dollars, or imprisoned not more than two years, or both; but no person shall be subject to imprisonment under this Section 11 for the violation of any rule or regulation if he proves that he has no knowledge of such rule or regulation.

Revisor's Note

Section 11, V.T.I.C. Article 21.48, refers to a person who "wilfully" violates a provision of that

article or certain rules or who "wilfully and knowingly" makes or causes to be made certain false or misleading statements. The revised law substitutes "intentionally" for "wilfully" because the terms are synonymous and "intentional" is the term prescribed by Section 6.02, Penal Code, which classifies culpable mental states in criminal offenses. The revised law omits "knowingly" because under Section 6.02, Penal Code, an "intentional" mental state includes a "knowing" mental state.

Revised Law

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. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

Source Law

Sec. 12. Any person wilfully violating any of the provisions of this Article or wilfully violating any rule or regulation of the Board promulgated hereunder, shall be subject to a civil penalty of not less than one hundred dollars nor more than one thousand dollars for each and every day of such violation, and for each and every act of such violation, to be recovered in any court of competent jurisdiction in Travis County, or in the county of the residence of the defendant or, if there be more than one defendant, in the county of the residence of any of them, or in the county in which the violation is alleged to have occurred, such suit to be instituted at the direction of the Board and conducted in the name of the State of Texas by the Attorney General. . . .

Revisor's Note

The revised law omits as unnecessary the part of Section 12, V.T.I.C. Article 21.48, relating to the cumulative effect of the remedy provided by that section. An accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless it provides otherwise or unless the statutes are in conflict. The general principle applies to this revision. The omitted law reads:

> Sec. 12. . . . This penalty shall be in addition to any forfeiture or penalty that may be provided for by law. . . .

Revised Law

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. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

Source Law

> Sec. 12. . . . Any and all violations, and threatened violations, of this Article may be enjoined by any court of competent jurisdiction in which suit for penalty may be brought, and in such cases the court shall issue such writs or injunctions, prohibitory or mandatory, as the facts justify.

Revisor's Note

Section 12, V.T.I.C. Article 21.48, states that certain violations may be enjoined by any court of competent jurisdiction in which a suit to recover the civil penalty provided by that section may be brought and that "the court shall issue such writs or injunctions, prohibitory or mandatory, as the facts justify." The revised law substitutes a reference to a district court for the reference to a court of competent jurisdiction because the district court is the only trial court with original jurisdiction to

issue a writ or injunction. See Sections 24.007-24.011, Government Code. The revised law omits the quoted language as unnecessary because it does not add to a court's duty or authority to grant appropriate relief according to the facts of the case before the court.

CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

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CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

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. (V.T.I.C. Art. 21.48A, Sec. 1.)

Source Law

Art. 21.48A

Sec. 1. (1) "Lender" means any person, partnership, corporation, association, or other entity, or any agent, loan agent, servicing agent, or any loan or mortgage broker, who lends money and receives or otherwise acquires a mortgage, lien, deed of trust, or any other security interest in or upon any real or personal property as security for such loan.

(2) "Borrower" means any person, partnership, corporation, association, or other entity, who has or acquires a legal or equitable interest in real or personal property which is or becomes subject to a mortgage, lien, security agreement, deed of trust, or other security instrument.

(3) "Insurance binder" means a contract that provides insurance coverage pending the issuance of an original insurance policy which will be issued within 30 days of the issuance of the insurance binder.

Revised Law

Sec. 549.002. INAPPLICABILITY OF CHAPTER TO TITLE INSURANCE. This chapter does not apply to title insurance. (V.T.I.C. Art. 21.48A, Sec. 5.)

Source Law

Sec. 5. Nothing contained herein shall apply to title insurance.

Revised Law

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). (V.T.I.C. Art. 21.48A, Sec. 3A.)

Source Law

> Sec. 3A. In the event of a foreclosure under a deed of trust, the lender may cancel any policy of insurance covering the property foreclosed upon and shall be entitled to any unearned premiums from that policy, provided the lender credits the amount of such unearned premiums against any deficiency owed by the borrower and delivers any excess unearned premiums not so credited to the borrower.

[Sections 549.004-549.050 reserved for expansion]

SUBCHAPTER B. PROHIBITED PRACTICES

Revised Law

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. (V.T.I.C. Art. 21.48A, Secs. 2(a), (e).)

Source Law

> Sec. 2. (a) No Lender shall require a fee of over Ten Dollars ($10.00) for the substitution by the Borrower of an insurance policy for another insurance policy still in effect, or require any fee for the furnishing by the Borrower of an insurance policy for an existing policy upon termination of the existing

policy, when such insurance policy is provided through an insurance company duly licensed to do business in the State of Texas pursuant to the provisions of this Insurance Code.

(e) Upon the sale or transfer of its ownership interest in real or personal property, a lender is subject to the payment of a substitution fee as described in Section 2(a) of this article and the lender may not, directly or indirectly, charge the borrower for such substitution fee.

Revisor's Note

Section 2(a), V.T.I.C. Article 21.48A, refers to an insurer "duly licensed to do business" in this state. The revised law substitutes "authorized" for "duly licensed" for consistency of terminology because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in the business of insurance. Similar changes have been made throughout this chapter.

Revised Law

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. (V.T.I.C. Art. 21.48A, Sec. 2(b).)

Source Law

(b) No Lender shall directly or indirectly impose or require as a condition of any financing or lending of money or the renewal or the extension thereof, that the purchaser or borrower or his successors, shall procure any policy of insurance or the renewal or extension thereof, covering the property involved in the transaction, from or through any particular agent or agents, solicitor or solicitors, insurer or insurers, or any other person or persons, or from or through any particular type or class of any of the foregoing.

Revisor's Note

(1) Section 2(b), V.T.I.C. Article 21.48A, states that a lender may not "impose or require as a condition" that insurance be purchased from certain persons. The revised law omits "impose" as unnecessary because requiring something as a condition is equivalent to imposing the condition.

(2) Section 2(b), V.T.I.C. Article 21.48A, refers to a "solicitor or solicitors." The revised law omits the reference to "solicitor" because that term, as it relates to a particular type of person engaged in the business of insurance, was eliminated by Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, and a person who performs the duties formerly performed by a solicitor is now regulated as an "agent."

Revised Law

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 from selling insurance to a borrower. (V.T.I.C. Art. 21.48A, Sec. 2(c).)

Source Law

(c) No Lender shall use or permit the use of any of the information taken from a policy of insurance insuring the property of a Borrower for the purpose of soliciting insurance business from the Borrower, or make any of such information available to any other person for any purpose, unless such Lender has first been furnished specific written authority from the Borrower permitting or directing such particular use or disclosure; provided, however, this paragraph shall not prevent a Lender who is a licensed local recording agent from selling insurance to a Borrower.

Revisor's Note

Section 2(c), V.T.I.C. Article 21.48A, refers to a person who is licensed as a "local recording agent." Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, consolidated the types of licenses issued to insurance agents and eliminated the license category of "local recording agent." V.T.I.C. Article 21.14, as amended by Article 3, Chapter 703, Acts of the 77th Legislature, Regular Session, 2001, replaced the category of "local recording agent" with a new licensing category, that of "general property and casualty agent." Throughout this chapter, the revised law is drafted accordingly.

Revised Law

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. (V.T.I.C. Art. 21.48A, Sec. 2(d).)

Source Law

(d) No Lender may require a Borrower to furnish evidence of insurance more than fifteen (15) days prior to the termination date of an existing policy.

Revised Law

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 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 general 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). (V.T.I.C. Art. 21.48A, Sec. 2(f).)

Source Law

(f) A Lender that requires a Borrower to secure insurance coverage before the Lender will provide a residential mortgage or commercial real estate loan shall accept an insurance binder as evidence of the required insurance if:

(1) the insurance binder is issued by a licensed local recording agent as that term is defined by Article 21.14 of this code and, if requested to do so, the agent shall furnish appropriate evidence to the Lender;

(2) the local recording agent is appointed to represent the insurance company whose name appears on the binder and is authorized to issue binders and, if requested to do so, the agent shall furnish appropriate evidence to the Lender;

(3) the insurance binder is accompanied by evidence of payment of the required premium; and

(4) the insurance binder will be replaced by an original insurance policy for the required coverage within 30 days of the date of the issuance of the insurance binder.

If the foregoing conditions are met, a Lender may not require a Borrower to provide an original insurance policy in lieu of the insurance binder.

Revised Law

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) 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) 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 by a general property and casualty agent or insurer of an insurance policy to the lender 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. (V.T.I.C. Art. 21.48A, Sec. 3.)

Source Law

Sec. 3. Nothing contained in Section 2 hereof shall be deemed to prevent such Lender from:

(a) requiring evidence, to be produced prior to the commencement or renewal of the risk, that insurance with a fixed termination date providing adequate coverage has been obtained in an amount sufficient to cover the debt or loan and that it will not be cancelled without reasonable notice to the lender;

(b) requiring insurance in an insurer authorized to do business and having a licensed resident agent in this state;

(c) refusing to accept or approve insurance in any particular insurer on reasonable and nondiscriminatory grounds relating to its financial soundness, or its facility to service the policy;

(d) providing adequate insurance coverage to protect the Lender's security interest in any property in accordance with the terms of the mortgage, security agreement, deed of trust, or other security instrument should the Borrower fail to furnish an insurance policy meeting the requirements established by the Lender as authorized by this article within fifteen (15) days prior to the termination date of an existing policy, and in such instance the Lender shall be entitled to use any information contained in the existing policy for the purpose of determining adequate insurance coverage;

(e) requiring at or before the time of delivery of an insurance policy to the Lender by a local recording agent or insurer a statement in writing from the Borrower designating such agent or insurer as his agent for such purpose; provided, however, such statement shall not be required when an agent or insurer is furnishing a renewal of an existing expiring policy provided by such agent or insurer;

(f) furnishing to any person, firm, or corporation who is or becomes the owner or holder of any note or obligation secured by a mortgage, security agreement, deed of trust, or other security instrument the policy of insurance or any information contained therein covering property which is security for such loan; or

(g) processing a claim under the terms of the insurance policy.

[Sections 549.057-549.100 reserved for expansion]

SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

Revised Law

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. (V.T.I.C. Art. 21.48A, Sec. 4(a) (part).)

Source Law

> Sec. 4. (a) The attorney general or the commissioner or board may institute any injunction or other proceeding to enforce the provisions of this article and to enjoin any person, partnership, corporation, association, or other entity from engaging or attempting to engage in any activity in violation of this article or any of its provisions. . . .

Revisor's Note

(1) Section 4(a), V.T.I.C. Article 21.48A, refers to the institution of a proceeding by the attorney general, the commissioner, or the "board," meaning the State Board of Insurance. Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993, abolished the board and transferred its functions to the commissioner of insurance and the Texas Department of Insurance. The revised law accordingly refers to the department instead of the board.

(2) Section 4(a), V.T.I.C. Article 21.48A, provides that the section is cumulative of other penalties or remedies provided by law. The revised law omits that provision as unnecessary because an accepted general principle of statutory construction requires a statute to be given cumulative effect with other statutes unless the statute provides otherwise or the statutes are in conflict. That general principle applies to the revised law. The omitted law

reads:

> (a) . . . The provisions of this section are cumulative of the other penalties or remedies provided for by law.

Revised Law

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. (V.T.I.C. Art. 21.48A, Sec. 4(b).)

Source Law

> (b) A Borrower may recover from any Lender who violates any of the provisions of this article civil damages in an amount equal to three (3) times the annual premium for the policy of insurance in force upon the mortgaged property. In the event that such policy of insurance be for a period of more than one (1) year, the annual premium shall be calculated by dividing the number of years of the duration of such policy into the total premium specified therein for such entire period.

Revisor's Note

Section 4(b), V.T.I.C. Article 21.48A, refers to an insurance policy on "mortgaged property." The revised law substitutes "property that is security for the loan" for consistency with the other provisions of this chapter, including the definition of "borrower," which refers to "property . . . subject to a mortgage, lien, security agreement, deed of trust, or other security instrument," and the definition of "lender," which refers to a "mortgage, a lien, a deed of trust, or any other security interest" in or on property as "security for [a] loan."

CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN

PAYMENTS 394
Sec. 550.002. INCREASE IN CERTAIN PREMIUM PAYMENTS 395

CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

Revised Law

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. (V.T.I.C. Art. 21.35B.)

Source Law

Art. 21.35B. (a) No payment may be solicited or collected by an insurer, its agent, or sponsoring organization in connection with an application for insurance or the issuance of a policy other than:

(1) premiums;

(2) taxes;

(3) finance charges;

(4) policy fees;

(5) agent fees;

(6) service fees, including charges for costs described under Article 21.35A of this code;

(7) inspection fees; or

(8) membership dues in a sponsoring organization.

(b) The commissioner by rule shall permit sponsoring organizations to solicit voluntary contributions with a membership renewal solicitation when 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 violation of this article are as provided for under Section 13, Article 21.49-1 of this code.

Revised Law

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:

(1) 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 and provides the person a postage prepaid form that may be used to object to the increase; and

(2) neither the insurer nor the financial institution

receives written objection to the increase on or before the fifth day before the date on which the increase takes 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. (V.T.I.C. Art. 21.57.)

Source Law

Art. 21.57. (a) Definitions. In this article:

(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 any person or entity transacting the business of insurance in this state, as defined in Article 1.14-1 of this code, including surplus lines insurance.

(4) "Person" means any policyholder, certificateholder, insured, owner of an insurance policy, or owner of a certificate.

(b) Any insurer receiving automatic premium payments through withdrawal of funds from a person's account, including the withdrawal of funds from a person's escrow account, as authorized by such person for purposes of premium payments on any insurance coverage provided through such insurer, shall not increase those premium payments to be withdrawn from such an account for paying premiums on such insurance coverage unless:

(1) the insurer, not later than the 30th day before the effective date of the increase in premium, notifies the person of the increase and provides such person a postage prepaid form that may be used to object to such increase; and

(2) neither the insurer nor the financial institution receives written objection to the increase in premium at least five days before the date on which such increase takes effect.

(c) This article does not require an insurer to

notify the person of an increase in the amount of premium payment if:

(1) the insurance contract or certificate contains a schedule of increasing premiums when issued, expressly specifies the exact amount of each premium, and specifies the period for which each such premium is payable; or

(2) the increase is the result of a change ordered by the insured.

(e) This article does not apply to an increase in premium payment that is less than $10 or ten percent of the previous amount per month.

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