Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(3) the furnishing of or arranging for medical care services only through other health maintenance organizations or physicians or groups of physicians who have independent contracts with the health maintenance organizations; the furnishing of or arranging for the delivery of health care services only through other health maintenance organizations or providers or groups of providers who are under contract with or employed by the health maintenance organization or through other health maintenance organizations or physicians or providers who have contracted for health care services with those other health maintenance organizations or physicians or providers, except for the furnishing of or authorization for emergency services, services by referral, and services to be provided outside of the service area as approved by the commissioner; provided, however, that a health maintenance organization is not authorized to employ or contract with other health maintenance organizations or physicians or providers in any manner which is prohibited by any licensing law of this state under which such health maintenance organizations or physicians or providers are licensed; however . . . .

Revised Law

Sec. 843.102. HEALTH MAINTENANCE ORGANIZATION QUALITY ASSURANCE. (a) A health maintenance organization shall establish procedures to ensure that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice. The procedures must include mechanisms to ensure availability, accessibility, quality, and continuity of care.

(b) A health maintenance organization shall operate a continuing internal quality assurance program to monitor and evaluate its health care services, including primary and

specialist physician services and ancillary and preventive health care services, in all institutional and noninstitutional settings.

(c) The commissioner by rule may establish minimum standards and requirements for the quality assurance programs, including standards for ensuring availability, accessibility, quality, and continuity of care.

(d) A health maintenance organization shall record formal proceedings of quality assurance program activities and maintain documentation in a confidential manner. The health maintenance organization shall make the quality assurance program minutes available to the commissioner.

(e) A health maintenance organization shall establish and maintain a physician review panel to assist in:

(1) reviewing medical guidelines or criteria; and

(2) determining prescription drugs to be covered by the health maintenance organization, if the health maintenance organization offers a prescription drug benefit.

(f) A health maintenance organization shall ensure the use and maintenance of an adequate patient record system to facilitate documentation and retrieval of clinical information for the health maintenance organization's evaluation of continuity and coordination of patient care and assessment of the quality of health and medical care provided to enrollees.

(g) The clinical records of enrollees shall be available to the commissioner for examination and review to determine compliance. The records are confidential and privileged and are not subject to the public information law, Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this section.

(h) A health maintenance organization shall establish a mechanism for the periodic reporting of quality assurance program activities to its governing body, providers, and appropriate health maintenance organization staff. (V.T.I.C. Art. 20A.37.)

Source Law

Art. 20A.37. (a) A health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. Such procedures shall include mechanisms to assure availability, accessibility, quality, and continuity of care.

(b) A health maintenance organization shall have an ongoing internal quality

assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, in all institutional and noninstitutional contexts. The commissioner by rule may establish minimum standards and requirements for ongoing internal quality assurance programs for health maintenance organizations, including but not limited to standards for assuring availability, accessibility, quality, and continuity of care.

(c) A health maintenance organization shall record formal proceedings of quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the commissioner.

(d) A health maintenance organization shall establish and maintain a physician review panel to assist in reviewing medical guidelines or criteria and to assist in determining the prescription drugs to be covered by the health maintenance organization, if the health maintenance organization offers a prescription drug benefit.

(e) A health maintenance organization shall ensure the use and maintenance of an adequate patient record system that will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization's evaluation of continuity and coordination of patient care and assessment of the quality of health and medical care provided to enrollees.

(f) Enrollees' clinical records shall be available to the commissioner for examination and review to determine compliance. Such records are confidential and privileged, and are not subject to the open records law, Chapter 552, Government Code, or to subpoena, except to the extent necessary to enable the commissioner to enforce this article.

(g) A health maintenance organization shall establish a mechanism for the periodic reporting of quality assurance program

activities to its governing body, providers, and appropriate organization staff.

Revised Law

Sec. 843.103. ACQUISITION AND OPERATION OF FACILITIES; CERTAIN LOANS; COMMISSIONER APPROVAL OF AFFILIATE TRANSACTIONS. (a) A health maintenance organization may:

(1) purchase, lease, construct, renovate, operate, or maintain hospitals or medical facilities and ancillary equipment and other property reasonably required for the principal office of the health maintenance organization or for another purpose necessary in engaging in the business of the health maintenance organization; and

(2) make loans to a medical group, under an independent contract with the group to further its program, or corporations under its control, to acquire or construct medical facilities and hospitals, or to further a program providing health care services to enrollees.

(b) If the exercise of a power granted under Subsection (a) involves an affiliate, as described by Section 823.003, the health maintenance organization before exercising that power shall file notice and adequate supporting information with the commissioner for approval.

(c) The commissioner shall disapprove the exercise of a power described by Subsection (a) that would in the commissioner's opinion:

(1) substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations; or

(2) impair the interests of the public or the health maintenance organization's enrollees or creditors in this state.

(d) If the commissioner does not disapprove the exercise of a power described by Subsection (a) before the 31st day after the date notice is filed under this section, the exercise of the power is considered approved. The commissioner may, by official order, delay action as necessary for proper consideration for not more than an additional 30 days.

(e) The commissioner may adopt rules exempting from the filing requirements of Subsection (b) an activity that has a de minimis effect. (V.T.I.C. Art. 20A.06, Secs. (a) (part), (b).)

Source Law

Art. 20A.06. (a) The powers of a health maintenance organization include, but are not limited to, the following:

(1) the purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities,

or both, and ancillary equipment and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the health maintenance organization;

(2) the making of loans to a medical group, under an independent contract with it in furtherance of its program, or corporations under its control, for the purpose of acquiring or constructing medical facilities and hospitals, or in the furtherance of a program providing health care services to enrollees;

. . .

(b)(1) The health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in Subdivision (1) or (2) of Subsection (a) of this section if the exercise of that power involves an affiliate, as that term is defined by Article 21.49-1, Insurance Code. The commissioner shall disapprove such exercise of powers which, in his or her opinion, would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations or would impair the interests of the general public or the organization's enrollees or creditors in this state. If the commissioner does not disapprove within 30 days of filing, it shall be deemed approved; provided that the commissioner may, by official order, postpone action for such further time, not exceeding 30 days, as may be necessary for proper consideration.

(2) The commissioner may promulgate rules and regulations exempting from the filing requirements of this subdivision those activities having a de minimis effect.

Revised Law

Sec. 843.104. CONTRACTS FOR CERTAIN ADMINISTRATIVE FUNCTIONS. A health maintenance organization may contract with any person to perform functions such as marketing, enrollment,

and administration on behalf of the health maintenance organization. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

> (a) The powers of a health maintenance organization include, but are not limited to, the following:
>
> . . .
>
> (4) the contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, and administration;
>
> . . .

Revised Law

Sec. 843.105. MANAGEMENT AND EXCLUSIVE AGENCY CONTRACTS. (a) A health maintenance organization may not enter into a management contract or exclusive agency contract unless the proposed contract is first filed with and approved by the commissioner.

(b) The commissioner must approve or disapprove the contract not later than the 30th day after the date the contract is filed or within a reasonable extended period that the commissioner specifies by notice given within the 30-day period.

(c) The commissioner shall disapprove the proposed contract if the commissioner determines that the contract:

(1) subjects the health maintenance organization to excessive charges;

(2) extends for an unreasonable time;

(3) does not contain fair and adequate standards of performance;

(4) authorizes persons to manage the health maintenance organization who are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the health maintenance organization with due regard for the interests of the health maintenance organization's enrollees or creditors or the public; or

(5) contains provisions that impair the interests of the public in this state or the health maintenance organization's enrollees or creditors.

(d) The commissioner shall disapprove a proposed management contract unless the commissioner determines that the management contractor has in force in its own name a fidelity bond on its officers and employees in the amount of at least $100,000 or another amount prescribed by the commissioner.

(e) The fidelity bond must be issued by an insurer that holds a certificate of authority in this state. If, after notice and hearing, the commissioner determines that a fidelity bond is

not available from an insurer that holds a certificate of authority in this state, the management contractor may obtain a fidelity bond procured by a surplus lines agent resident in this state in compliance with Chapter 981.

(f) The fidelity bond must obligate the surety to pay any loss of money or other property that the health maintenance organization sustains because of an act of fraud or dishonesty by an employee or officer of the management contractor during the period that the management contract is in effect.

(g) Instead of a fidelity bond, the management contractor may deposit with the comptroller cash or securities acceptable to the commissioner. The deposit must be maintained in the amount and is subject to the same conditions required for a fidelity bond under this section. (V.T.I.C. Art. 20A.18.)

Source Law

Art. 20A.18. (a) No health maintenance organization may enter into a management contract or an exclusive agency contract unless the contract is first filed with the commissioner and approved under this section within 30 days after filing or such reasonable extended period as the commissioner may specify by notice given within the 30 days.

(b) The commissioner shall disapprove a contract submitted under Subsection (a) of this section if he finds that:

(1) it subjects the health maintenance organization to excessive charges;

(2) the contract extends for an unreasonable period of time;

(3) the contract does not contain fair and adequate standards of performance;

(4) the persons empowered under the contract to manage the health maintenance organization are not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the health maintenance organization with due regard for the interests of its enrollees, creditors, or the public; or

(5) the contract contains provisions which impair the interests of the organization's enrollees, creditors, or the public in this state.

(c) The commissioner shall disapprove a

management contract submitted under Subsection (a) of this section unless the commissioner finds that the entity with which the health maintenance organization proposes to contract has in force in its own name a fidelity bond on its officers and employees in an amount not less than $100,000 or in any other amount prescribed by the commissioner.

(d) Except as otherwise provided by this subsection, the bond required under Subsection (c) of this section must be issued by an insurance company that holds a certificate of authority in this state. If, after notice and hearing, the commissioner determines that the fidelity bond required by this section is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed Texas surplus lines agent resident in this state in compliance with Article 1.14-2, Insurance Code, satisfies the requirements of this section.

(e) The fidelity bond must obligate the surety to pay any loss of money or other property that the health maintenance organization sustains because of an act of fraud or dishonesty on the part of an employee or officer of the management contractor during the period that the management contract is in effect.

(f) Instead of a bond, the management contractor may deposit with the comptroller cash or securities acceptable to the commissioner. Such a deposit must be maintained in the amount and subject to the same conditions as required for a bond under this section.

Revised Law

Sec. 843.106. INSURANCE, REINSURANCE, INDEMNITY, AND REIMBURSEMENT. A health maintenance organization may contract with an insurer or group hospital service corporation authorized to engage in business in this state to provide insurance, reinsurance, indemnification, or reimbursement against the cost of health care and medical care services provided by the health maintenance organization. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(5) the contracting with an insurance company licensed in this state, or with a group hospital service corporation authorized to do business in the state, for the provision of insurance, reinsurance, indemnity, or reimbursement against the cost of health care and medical care services provided by the health maintenance organization;

. . .

Revised Law

Sec. 843.107. INDEMNITY BENEFITS; POINT-OF-SERVICE PROVISIONS. A health maintenance organization may offer:

(1) indemnity benefits covering out-of-area emergency care;

(2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation;

(3) a point-of-service plan under Article 3.64; or

(4) a point-of-service rider under Section 843.108.

(V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(6) the offering of:

(A) indemnity benefits covering out-of-area emergency services;

(B) indemnity benefits in addition to those relating to out-of-area and emergency services, provided through insurers or group hospital service corporations;

(C) a point-of-service plan under Article 3.64, Insurance Code; or

(D) a point-of-service rider under Subsection (c) of this section;

. . .

Revisor's Note

Subdivision (bb), V.T.I.C. Article 20A.02, defines "point-of-service plan." The revised law revises the portion of the definition that concerns a point-of-service rider as part of Section 843.108. The revised law omits the remainder of the definition as unnecessary. The term is used in the Texas Health Maintenance Organization Act only in Section (a)(6), V.T.I.C. Article 20A.06 (revised as this section), in the context of authorizing a health maintenance organization to offer a point-of-service plan under V.T.I.C. Article 3.64. Article 3.64 has its own definition of the term, which is substantively identical to the portion of the definition omitted from this chapter. The omitted law reads:

[(bb) "Point-of-service plan" means an arrangement under which:]

(1) an enrollee may choose to obtain benefits or services, or both benefits and services, through either a health maintenance organization delivery network, including a limited provider network, or through a non-network delivery system outside the health maintenance organization's health care delivery network, including a limited provider network, and that are administered through an indemnity benefit arrangement for the cost of health care services; or

(2) indemnity benefits for the cost of the health care services may be provided by an insurer or group hospital service corporation in conjunction with corresponding benefits arranged or provided by a health maintenance organization or . . . .

Revised Law

Sec. 843.108. POINT-OF-SERVICE RIDER. (a) In this section, "point-of-service rider" means a rider under which indemnity benefits for the cost of health care services are provided by a health maintenance organization in conjunction with corresponding benefits arranged for or provided by a health maintenance organization.

(b) A health maintenance organization may offer a point-of-service rider for out-of-network coverage without obtaining a separate certificate of authority as an insurer if the expenses incurred under the point-of-service rider do not exceed 10 percent of the total medical and hospital expenses incurred for all health plan products sold by the health maintenance organization. If the expenses exceed that level, the health maintenance organization may not issue new

point-of-service riders until the expenses fall below that level or until the health maintenance organization obtains a certificate of authority as an insurer.

(c) Indemnity benefits for services provided under a point-of-service rider may be limited to those services defined in the evidence of coverage and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For enrollees in a limited provider network, higher cost-sharing may be imposed only when benefits or services are obtained outside the health maintenance organization delivery network.

(d) A health maintenance organization that issues a point-of-service rider under this section must meet additional net worth requirements prescribed by the commissioner. The commissioner shall base the net worth requirements on the actuarial relation of the amount of insurance risk assumed through the point-of-service rider to the amount of solvency and reserve requirements otherwise required of the health maintenance organization. (V.T.I.C. Art. 20A.02, Subdiv. (bb) (part); Art. 20A.06, Sec. (c).)

Source Law

[Art. 20A.02]

(bb) "Point-of-service plan" means an arrangement under which:

. . .

(2) . . . indemnity benefits for the cost of the health care services provided by a health maintenance organization through a point-of-service rider as provided by Section 6(a)(6)(D) of this Act in conjunction with corresponding benefits arranged or provided by a health maintenance organization.

[Art. 20A.06]

(c) A health maintenance organization may offer a point-of-service rider for out-of-network coverage without obtaining a separate insurance carrier license if the expenses incurred under the point-of-service rider do not exceed 10 percent of the total medical and hospital expenses incurred for all health plan products sold. If the expenses incurred by a health maintenance organization under a point-of-service rider exceed 10 percent of the total medical and

hospital expenses incurred for all health plan products sold, the health maintenance organization shall cease issuing new point-of-service riders until those expenses fall below 10 percent or until the health maintenance organization obtains an insurance carrier license under this Act. Indemnity benefits and services provided under a point-of-service rider may be limited to those services defined in the evidence of coverage and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For enrollees in limited provider networks, higher cost sharing may be imposed only when obtaining benefits or services outside the health maintenance organization delivery network. A health maintenance organization that issues a point-of-service rider under this section must meet the net worth requirements promulgated by the commissioner based on the actuarial relation of the amount of insurance risk assumed through the issuance of the point-of-service rider in relation to the amount of solvency and reserve requirements already required of the health maintenance organization.

Revisor's Note

Section (c), V.T.I.C. Article 20A.06, refers to an "insurance carrier license." The revised law substitutes "certificate of authority as an insurer" for consistency with other terminology used throughout this code.

Revised Law

Sec. 843.109. PAYMENT BY GOVERNMENTAL OR PRIVATE ENTITY. A health maintenance organization may accept from a governmental or private entity payments for all or part of the cost of services provided or arranged for by the health maintenance organization. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(7) receiving and accepting from government or private agencies payments covering all or part of the cost of the services provided or arranged for by the organization;

. . .

Revisor's Note

Section (a)(7), V.T.I.C. Article 20A.06, refers to "receiving and accepting . . . payments." The revised law omits "receiving" because, in this context, the meaning of that term is included within the meaning of "accepting."

Revised Law

Sec. 843.110. CORPORATION, PARTNERSHIP, OR ASSOCIATION POWERS. A health maintenance organization has all powers of a partnership, association, or corporation, including a professional association or corporation, as appropriate under the organizational documents of the health maintenance organization, that are not in conflict with this chapter or other applicable law. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

(a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(8) all powers given to corporations (including professional corporations and associations), partnerships, and associations pursuant to their organizational documents which are not in conflict with provisions of this Act, or other applicable law.

Revised Law

Sec. 843.111. GROUP MODEL HEALTH MAINTENANCE ORGANIZATIONS. (a) In this section, "group model health maintenance organization" means a health maintenance organization that provides the majority of its professional services through a single group medical practice that is formally affiliated with the medical school component of a state-supported public college or university in this state.

(b) Unless this section and a power specified in Section 843.101, 843.103, 843.104, 843.106, 843.107, 843.109, or 843.110 are specifically amended by law, a law, without regard to the time of enactment, may not be construed to prohibit or restrict a

group model health maintenance organization from:

(1) selectively contracting with or declining to contract with a provider as the group model health maintenance organization considers necessary;

(2) contracting for or declining to contract for an individual health care service or full range of health care services as the group model health maintenance organization considers necessary, if the service or services may be legally provided by the contracting provider; or

(3) requiring enrolled members of the group model health maintenance organization who wish to obtain the services covered by the group model health maintenance organization to use the providers specified by the group model health maintenance organization. (V.T.I.C. Art. 20A.06A.)

Source Law

Art. 20A.06A. (a) Unless this section and the powers specified in Section 6(a) of this Act are specifically amended by law, a law, whether enacted before or after this enactment of this section, may not be construed to prohibit or restrict a group model health maintenance organization from:

(1) selectively contracting with or declining to contract with any or all providers as the health maintenance organization considers necessary;

(2) contracting for or declining to contract for an individual health care service or full range of health care services as the health maintenance organization considers necessary, if the service or services may be legally provided by the contracting provider; or

(3) requiring enrolled members of the health maintenance organization who wish to obtain the services covered by the health maintenance organization to use the providers specified by the health maintenance organization.

(b) For purposes of this section "group model health maintenance organization" means a health maintenance organization that provides the majority of its professional services through a single group medical practice that is formally affiliated with the medical school component of a Texas, state-supported, public college or

university.

Revised Law

Sec. 843.112. DENTAL POINT-OF-SERVICE OPTION. (a) In this section:

(1) "Point-of-service option" means a plan provided through a contractual arrangement under which:

(A) indemnity benefits for the cost of dental care services, other than emergency care or emergency dental care, are provided by an insurer or group hospital service corporation in conjunction with corresponding benefits arranged or provided by a health maintenance organization; and

(B) an enrollee may choose to obtain benefits or services under the indemnity plan or the health maintenance organization plan in accordance with specific provisions of a point-of-service contract.

(2) "Provider panel" means the providers with whom a health maintenance organization contracts to provide dental services to enrollees covered under a dental benefit plan.

(b) This section applies to a dental health maintenance organization or another single service health maintenance organization that provides dental benefits. This section does not apply to a health maintenance organization that has 10,000 or fewer enrollees in this state who are enrolled in dental benefit plans based on a provider panel.

(c) If an employer, association, or other private group arrangement that employs 25 or more employees or has 25 or more members offers and contributes to the cost of dental benefit plan coverage to employees or individuals only through a provider panel, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another entity to offer, a dental point-of-service option to the employer, association, or other private group arrangement. The employer may offer the dental point-of-service option to the employee or individual to accept or reject.

(d) If a health maintenance organization's dental provider panel is the sole delivery system offered to employees by an employer, the health maintenance organization:

(1) shall offer the employer a dental point-of-service option;

(2) may not impose a minimum participation level on the dental point-of-service option; and

(3) as part of the group enrollment application, shall provide to each employer disclosure statements as required by rules adopted under this code for each dental plan offered.

(e) An employer may require an employee or individual who accepts the point-of-service option to be responsible for the

payment of a premium, over the amount of the premium for the coverage provided to employees or members under the dental benefit plan offered through a provider panel, directly or by payroll deduction in the same manner in which the other premium is paid. The premium for the point-of-service option must be based on the actuarial value of that coverage.

(f) Different cost-sharing provisions may be imposed for the point-of-service option.

(g) An employer may charge an employee or individual who accepts the point-of-service option a reasonable administrative fee for costs associated with the employer's reasonable administration of the point-of-service option. (V.T.I.C. Art. 20A.38.)

Source Law

Art. 20A.38. (a) Each dental health maintenance organization or other single service health maintenance organization that provides dental benefits is subject to this section. This section does not apply to a health maintenance organization with 10,000 or fewer enrollees in this state enrolled in dental benefit plans based on a provider panel.

(b) If an employer, association, or other private group arrangement that employs or has 25 or more employees or members offers and contributes to the cost of dental benefit plan coverage to employees or individuals only through a provider panel, the health maintenance organization with which the employer, association, or other private group arrangement is contracting for the coverage shall offer, or contract with another entity to offer, a dental point-of-service option to the employer, association, or other private group arrangement. The employer may offer the dental point-of-service option to the employee or individual to accept or reject.

(c) If a health maintenance organization's dental provider panel is the sole delivery system offered to employees by an employer, the health maintenance organization:

(1) shall offer the employer a dental point-of-service option;

(2) may not impose a minimum participation level on the dental

point-of-service option; and

(3) as part of the group enrollment application, shall provide to each employer disclosure statements as required by rules adopted under this code for each dental plan offered.

(d) An employer may require an employee or individual who accepts the point-of-service option to be responsible for the payment of a premium over the amount of the premium for the coverage provided to employees or members under the dental benefit plan offered through a provider panel either directly or by payroll deduction in the same manner in which the other premium is paid. The premium for the point-of-service option must be based on the actuarial value of that coverage.

(e) Different cost-sharing provisions may be imposed for the point-of-service option.

(f) An employer may charge an employee or individual who accepts the point-of-service option a reasonable administrative fee for costs associated with the employer's reasonable administration of the point-of-service option.

(g) For purposes of this section:

(1) "Point-of-service option" means a plan provided through a contractual arrangement under which indemnity benefits for the cost of dental care services, other than emergency care or emergency dental care, are provided by an insurer or group hospital service corporation in conjunction with corresponding benefits arranged or provided by a health maintenance organization, and under which an enrollee may choose to obtain benefits or services under either the indemnity plan or the health maintenance organization plan in accordance with specific provisions of a point-of-service contract.

(2) "Provider panel" means those providers with which a health maintenance organization contracts to provide dental services to enrollees covered under the dental benefit plan.

Revised Law

Sec. 843.113. SPECIFIED POWERS NOT EXCLUSIVE. The powers of a health maintenance organization are not limited to the powers specified by this subchapter. (V.T.I.C. Art. 20A.06, Sec. (a) (part).)

Source Law

> Art. 20A.06. (a) The powers of a health maintenance organization include, but are not limited to, the following:
>
> . . .

[Sections 843.114-843.150 reserved for expansion]

SUBCHAPTER E. REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

Sec. 843.151. RULES. The commissioner may adopt reasonable rules as necessary and proper to:

(1) implement this chapter and Chapter 20A, including rules to:

(A) prescribe authorized investments for a health maintenance organization for all investments not otherwise addressed in this chapter;

(B) ensure that enrollees have adequate access to health care services; and

(C) establish minimum physician-to-patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting time for obtaining an appointment; and

(2) meet the requirements of federal law and regulations. (V.T.I.C. Art. 20A.22, Secs. (a), (b) (part), (c).)

Source Law

> Art. 20A.22. (a) The commissioner may promulgate such reasonable rules and regulations as are necessary and proper to carry out the provisions of this Act.
>
> (b) The commissioner is specifically authorized to promulgate rules to prescribe authorized investments for health maintenance organizations for all investments for which provision is not otherwise made in this Act; to ensure that enrollees have adequate access to health care services; and to establish minimum physician/patient ratios, mileage requirements for primary and specialty care, maximum travel time, and maximum waiting times for obtaining appointments. . . .

(c) The commissioner may promulgate such reasonable rules and regulations as are necessary and proper to meet the requirements of federal law and regulations.

Revisor's Note

Section (b), V.T.I.C. Article 20A.22, states that the rulemaking authority provided by that section does not limit the rulemaking authority granted to the commissioner under Section (a) of that article. The revised law omits that provision as unnecessary because nothing in Section (b) acts to limit the authority granted under Section (a). The omitted law reads:

(b) . . . The rulemaking authority provided by this subsection does not limit in any manner the rulemaking authority granted to the commissioner under Subsection (a) of this section.

Revised Law

Sec. 843.152. SUBPOENA AUTHORITY. In implementing this chapter and Chapter 20A, the commissioner may exercise subpoena authority in accordance with Subchapter C, Chapter 36. (V.T.I.C. Art. 20A.03, Sec. (h).)

Source Law

(h) The commissioner may exercise subpoena authority in accordance with Article 1.19-1, Insurance Code, in implementing this Act.

Revised Law

Sec. 843.153. AUTHORITY TO CONTRACT. In performing duties under this chapter and Chapter 20A, the commissioner may contract with a state agency or, after notice and opportunity for hearing, with a qualified person to make recommendations concerning determinations to be made by the commissioner. (V.T.I.C. Art. 20A.28.)

Source Law

Art. 20A.28. The commissioner, in carrying out the commissioner's obligations under this Act, may contract with other state agencies or, after notice and opportunity for hearing, with other qualified persons to make recommendations concerning the determinations

to be made by the commissioner.

Revised Law

Sec. 843.154. FEES. (a) The commissioner shall, within the limits prescribed by this section, prescribe the fees to be charged under this section.

(b) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account.

(c) A health maintenance organization shall pay to the commissioner a fee in an amount not to exceed:

(1) $18,000 for filing and review of its original application for a certificate of authority;

(2) $200 for filing of an evidence of coverage that requires approval; and

(3) $100 for a filing that is required by rule but does not require approval.

(d) A health maintenance organization shall pay to the comptroller a fee in an amount not to exceed $500 for filing of an annual report under Section 843.155.

(e) A health maintenance organization shall pay to the commissioner a fee, in an amount certified by the commissioner to be just and reasonable, for the expenses of all examinations of health maintenance organizations made on behalf of the state by the commissioner or under the commissioner's authority.

(f) A health maintenance organization shall pay to the commissioner a fee in an amount assessed by the commissioner and paid in accordance with rules adopted by the commissioner for the expenses of an examination under Section 843.156(a) that:

(1) are incurred by the commissioner or under the commissioner's authority; and

(2) are directly attributable to that examination, including the actual salaries and expenses of the examiners directly attributable to that examination, as determined under rules adopted by the commissioner. (V.T.I.C. Art. 20A.32, Sec. (a) (part).)

Source Law

Art. 20A.32. (a)(1) Every organization subject to this chapter shall pay to the commissioner the following fees:

(A) for filing and review of its original application for a certificate of authority, a fee in an amount not to exceed $18,000 as determined by the commissioner;

(B) for filing each annual report pursuant to Section 10 of this Act, a fee in an amount not to exceed $500 as

determined by the commissioner;

(C) the expenses of all examinations of health maintenance organizations made on behalf of the State of Texas by the commissioner or under the commissioner's authority in such amounts as the commissioner shall certify to be just and reasonable;

(D) the expenses of an examination under Section 17(a) of this Act incurred by the commissioner or under the commissioner's authority, provided that:

(i) examination expenses are the expenses attributable directly to a specific examination including the actual salaries and expenses of the examiners directly attributable to that examination as determined under rules adopted by the commissioner; and

(ii) the expenses shall be assessed by the commissioner and paid in accordance with rules adopted by the commissioner;

. . .

(F) for filing an evidence of coverage which requires approval, a fee not to exceed $200 as determined by the commissioner; and

(G) for filings required by rule but which do not require approval, a fee not to exceed $100 as determined by the commissioner.

(2) The commissioner shall, within the limits fixed by this subsection, prescribe the fees to be charged under this subsection.

(3) Fees collected under this subsection must be deposited in the State Treasury to the credit of the Texas Department of Insurance operating fund.

(4) Notwithstanding Subdivision (1) of this subsection, the comptroller shall collect the annual report filing fee prescribed by Subdivision (1)(B) of this subsection.

Revisor's Note

Section (a)(1)(E), V.T.I.C. Article 20A.32, refers to "the licensing, appointment, and examination fees pursuant to Section 15 of this Act." The revised law omits that provision because Section 15 of

the Texas Health Maintenance Organization Act (V.T.I.C. Article 20A.15) was repealed effective January 1, 2000, by Section 17(a), Chapter 716, Acts of the 75th Legislature, Regular Session, 1997. The omitted law reads:

[(a)(1) Every organization subject to this chapter shall pay to the commissioner the following fees:]

. . .

(E) the licensing, appointment, and examination fees pursuant to Section 15 of this Act;

. . .

Revised Law

Sec. 843.155. ANNUAL REPORT. (a) Not later than March 1 of each year, a health maintenance organization shall file with the commissioner a report covering the preceding calendar year.

(b) The report shall:

(1) be verified by at least two principal officers;

(2) be in a form prescribed by the commissioner; and

(3) include:

(A) a financial statement of the health maintenance organization, including its balance sheet and receipts and disbursements for the preceding calendar year, certified by an independent public accountant;

(B) the number of individuals enrolled during the preceding calendar year, the number of enrollees as of the end of that year, and the number of enrollments terminated during that year;

(C) updated financial projections for the next calendar year of the type described in Section 843.078(e), until the health maintenance organization has had a net income for 12 consecutive months; and

(D) other information relating to the performance of the health maintenance organization as necessary to enable the commissioner to perform the commissioner's duties under this chapter and Chapter 20A.

(c) Chapter 802 and Article 1.11 apply to the annual report of a health maintenance organization. (V.T.I.C. Art. 20A.10.)

Source Law

Art. 20A.10. (a) Each health maintenance organization shall annually, on or before the 1st day of March, file a report, verified by at least two principal officers, with the commissioner, with a copy to the board, covering the preceding calendar

year.

(b) Such report shall be on forms prescribed by the State Board of Insurance and shall include:

(1) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year, certified by an independent public accountant;

(2) the number of persons enrolled during the year, the number of enrollees as of the end of the year, and the number of enrollments terminated during the year;

(3) updated financial projections for the next calendar year of the type described in Section 4(a)(7) of this Act, until the organization has had a net income for 12 consecutive months; and

(4) such other information relating to the performance of the health maintenance organization as is necessary to enable the commissioner to carry out the duties under this Act.

(c) Article 1.11 of the Insurance Code applies to the annual report of a health maintenance organization.

Revisor's Note

Section (a), V.T.I.C. Article 20A.10, refers to providing a copy of the annual report to "the board," meaning the State Board of Insurance. Section (b), V.T.I.C. Article 20A.10, refers to forms "prescribed by 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. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the State Board of Insurance have been changed appropriately.

Revised Law

Sec. 843.156. EXAMINATIONS. (a) The commissioner may examine the quality of health care services and the affairs of any health maintenance organization or applicant for a certificate of authority under this chapter. The commissioner may conduct an examination as often as the commissioner considers necessary, but shall conduct an examination at least once every three years.

(b) A health maintenance organization shall make its books and records relating to its operations available for an examination and shall facilitate an examination in every way.

(c) Each physician and provider with whom the health maintenance organization has a contract, agreement, or other arrangement is required to make available for an examination only that portion of the physician's or provider's books and records that is relevant to the physician's or provider's relationship with the health maintenance organization.

(d) On request of the commissioner, a health maintenance organization shall provide to the commissioner a copy of any contract, agreement, or other arrangement between the health maintenance organization and a physician or provider. Documentation provided to the commissioner under this subsection is confidential and is not subject to the public information law, Chapter 552, Government Code.

(e) Medical, hospital, and health records of enrollees and records of physicians and providers providing service under an independent contract with a health maintenance organization are subject to an examination only as necessary for a continuing quality of health assurance program concerning health care procedures and outcomes that is established in accordance with an approved plan under this chapter. The plan shall provide for adequate protection of the confidentiality of medical information. Medical information may be disclosed only in accordance with this chapter and other applicable law and is subject to subpoena only on a showing of good cause.

(f) The commissioner may examine and use the records of a health maintenance organization, including records of a quality of care assurance program and records of a medical peer review committee, as necessary to implement the purposes of this chapter and Chapter 20A, including commencement of an enforcement action under Section 843.461 or 843.462. Information obtained under this subsection is confidential and privileged and is not subject to the public information law, Chapter 552, Government Code, or to subpoena except as necessary for the commissioner to enforce this chapter or Chapter 20A. In this subsection, "medical peer review committee" has the meaning assigned by Section 151.002, Occupations Code.

(g) For the purpose of an examination, the commissioner may

administer oaths to and examine the officers and agents of a health maintenance organization and the principals of physicians and providers described by this section concerning their business.

(h) Articles 1.04A, 1.15, 1.16, and 1.19 apply to a health maintenance organization, except to the extent that the commissioner determines that the nature of the examination of a health maintenance organization renders the applicability of those provisions clearly inappropriate.

(i) Section 38.001, Section 81.003, Chapter 82, and Article 1.12 apply to a health maintenance organization. (V.T.I.C. Art. 20A.17.)

Source Law

Art. 20A.17. (a) The commissioner may make an examination concerning the quality of health care services and of the affairs of any applicant for a certificate of authority or any health maintenance organization as often as the commissioner deems necessary, but not less frequently than once every three years.

(b)(1) Every health maintenance organization shall make its books and records relating to its operation available for such examinations and in every way facilitate the examinations. Every physician and provider with whom a health maintenance organization has a contract, agreement, or other arrangement need only make available for examination that portion of its books and records relevant to its relationship with the health maintenance organization.

(2) A copy of any contract, agreement, or other arrangement between a health maintenance organization and a physician or provider shall be provided to the commissioner by the health maintenance organization on the request of the commissioner. Such documentation provided to the commissioner under this subsection shall be deemed confidential and not subject to the open records law, Chapter 552, Government Code.

(3) Medical, hospital, and health records of enrollees and records of physicians and providers providing service under independent contract with a health

maintenance organization shall only be subject to such examination as is necessary for an ongoing quality of health assurance program concerning health care procedures and outcome in accordance with an approved plan as provided for in this Act. Said plan shall provide for adequate protection of confidentiality of medical information and shall only be disclosed in accordance with applicable law and this Act and shall only be subject to subpoena upon a showing of good cause.

(4) The commissioner may examine and use the records of a health maintenance organization, including records of a quality of care assurance program and records of a medical peer review committee as that term is used in Section 1.03, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), as necessary to carry out the purposes of this Act, including an enforcement action under Section 20 of this Act. That information is confidential and privileged and is not subject to the open records law, Chapter 552, Government Code, or to subpoena except as necessary for the commissioner to enforce this Act.

(5) For the purpose of examinations, the commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of such physicians and providers concerning their business.

(c) Articles 1.04A, 1.15, 1.16, and 1.19, as amended, of the Insurance Code shall be construed to apply to health maintenance organizations, except to the extent that the commissioner determines that the nature of the examination of a health maintenance organization renders such clearly inappropriate.

(d) Articles 1.12, 1.24, and 1.30, and Section 7 of Article 1.10, Insurance Code, apply to health maintenance organizations.

Revisor's Note

Section (b)(4), V.T.I.C. Article 20A.17, refers to "a medical peer review committee as

that term is used in Section 1.03, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes)." The relevant part of Section 1.03 was codified in 1999 as a part of Section 151.002, Occupations Code, and the revised law is drafted accordingly.

Revised Law

Sec. 843.157. REHABILITATION, LIQUIDATION, SUPERVISION, OR CONSERVATION OF HEALTH MAINTENANCE ORGANIZATION. (a) The rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be treated as the rehabilitation, liquidation, supervision, or conservation of an insurer and be conducted under the supervision of the commissioner under Article 21.28 or 21.28-A, as appropriate.

(b) The commissioner may also order the rehabilitation, liquidation, supervision, or conservation of a health maintenance organization if in the commissioner's opinion the continued operation of the health maintenance organization would be hazardous to the enrollees or to the people of this state. (V.T.I.C. Art. 20A.21.)

Source Law

Art. 20A.21. All rehabilitation, liquidation, supervision, or conservation of a health maintenance organization shall be considered to be rehabilitation, liquidation, supervision, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to Articles 21.28, as amended, 21.28-A, and 21.28-B of the Insurance Code. The commissioner may also order the supervision, conservation, liquidation, or rehabilitation of a health maintenance organization if the commissioner is of the opinion that the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of the state.

Revisor's Note

V.T.I.C. Article 20A.21 refers to Article 21.28-B, Insurance Code. That provision was repealed by Section 6.21, Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989, and the revised law accordingly omits the reference.

[Sections 843.158-843.200 reserved for expansion]

SUBCHAPTER F. RELATIONS WITH ENROLLEES AND GROUP CONTRACT HOLDERS

Revised Law

Sec. 843.201. DISCLOSURE OF INFORMATION ABOUT HEALTH CARE PLAN TERMS. (a) A health maintenance organization shall provide an accurate written description of health care plan terms, including restrictions or limitations related to a limited provider network or delegated network within a health care plan, to allow a current or prospective group contract holder or current or prospective enrollee to make comparisons and informed decisions before selecting among health care plans. The written description must:

(1) be in a readable and understandable format prescribed by the commissioner; and

(2) include a current list of physicians and providers, including a delineation of any limited provider network or delegated network.

(b) A health maintenance organization may satisfy the requirement imposed under Subsection (a) through the member handbook provided under Section 843.205 if:

(1) the handbook's contents are substantially similar to and provide the same level of disclosure as the written description prescribed by the commissioner; and

(2) the current list of physicians and providers is also provided. (V.T.I.C. Art. 20A.11, Sec. (b).)

Source Law

(b) A health maintenance organization shall provide an accurate written description of health care plan terms and conditions, including restrictions or limitations related to limited provider networks or delegated networks within a health care plan, to allow any current or prospective group contract holder and current or prospective enrollee eligible for enrollment in a health care plan to make comparisons and informed decisions before selecting among health care plans. The written description must be in a readable and understandable format as prescribed by the commissioner and shall include a current list of physicians and providers, including delineation of limited provider networks and delegated networks. The health maintenance organization may provide its handbook to satisfy this requirement provided the handbook's content is substantially similar to and achieves the same level of disclosure

as the written description prescribed by the commissioner and the current list of physicians and providers is also provided.

Revised Law

Sec. 843.202. DISCLOSURE OF INFORMATION TO MEDICARE RECIPIENTS. (a) Before a prospective enrollee is enrolled in a health care plan offered to Medicare recipients by a Medicare-contracting health maintenance organization, the health maintenance organization must provide the prospective enrollee with a disclosure form adopted by the commissioner under Subsection (b).

(b) The commissioner shall adopt a disclosure form informing a prospective enrollee in a Medicare-contracting health maintenance organization of:

(1) the effect of enrollment in the health maintenance organization on the prospective enrollee's opportunity to purchase Medicare supplement insurance; and

(2) any differences in the benefits and costs between the health care plan offered to Medicare recipients and Medicare supplement insurance. (V.T.I.C. Art. 20A.11B.)

Source Law

Art. 20A.11B. (a) Before a prospective enrollee is enrolled in a health care plan offered to Medicare recipients by a Medicare-contracting health maintenance organization, the health maintenance organization must provide the prospective enrollee with a disclosure form promulgated by the commissioner.

(b) The commissioner shall adopt a disclosure form informing prospective enrollees in a Medicare-contracting health maintenance organization of the effect of enrollment in a Medicare-contracting health maintenance organization on the prospective enrollee's opportunity to purchase Medicare supplement insurance and of any differences in the benefits and costs between the health care plan offered to Medicare recipients and Medicare supplement insurance.

Revised Law

Sec. 843.203. SELECTION OF PRIMARY CARE PHYSICIAN OR PROVIDER. (a) Each plan application form shall prominently include a space in which the enrollee at the time of application or enrollment shall select a primary care physician or primary

care provider.

(b) An enrollee shall at all times have the right to select or change a primary care physician or primary care provider within the health maintenance organization network of available primary care physicians and primary care providers, except that a health maintenance organization may limit an enrollee's request to change physicians or providers to not more than four changes in a 12-month period. (V.T.I.C. Art. 20A.11, Sec. (a).)

Source Law

> Art. 20A.11. (a) Each plan application form shall prominently include a space in which the enrollee at the time of application or enrollment shall make a selection of a primary care physician or primary care provider. An enrollee shall at all times have the right to select or change a primary care physician or primary care provider within the health maintenance organization network of available primary care physicians and primary care providers. However, a health maintenance organization may limit an enrollee's request to change physicians or providers to no more than four changes in any 12-month period.

Revised Law

Sec. 843.204. UNTRUE OR MISLEADING INFORMATION. (a) A health maintenance organization or a representative of a health maintenance organization may not:

(1) use or distribute or knowingly permit the use or distribution of prospective enrollee information that is untrue or misleading; or

(2) use or knowingly permit the use of:

(A) advertising that is untrue or misleading;

(B) solicitation that is untrue or misleading; or

(C) any form of evidence of coverage that is deceptive.

(b) In this chapter and Chapter 20A, a statement or item of information is:

(1) considered to be untrue if the statement or item does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a health care plan; and

(2) considered to be misleading, whether or not the statement or item is literally untrue, if, in the total context in which the statement is made or the item is communicated, the statement or item may be reasonably understood by a reasonable

person who does not possess special knowledge regarding health care coverage as indicating:

(A) the inclusion of a benefit or advantage that does not exist and that is of possible significance to an enrollee of, or person considering enrollment in, a health care plan; or

(B) the absence of an exclusion, limitation, or disadvantage that does exist and that is of possible significance to an enrollee of, or person considering enrollment in, a health care plan.

(c) In this chapter and Chapter 20A, an evidence of coverage is considered to be deceptive if the evidence of coverage, taken as a whole and with consideration given to typography and format as well as language, would cause a reasonable person who does not possess special knowledge regarding health care plans and evidences of coverage for health care plans to expect charges or benefits, services, or other advantages that the evidence of coverage does not provide or that the health care plan issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage. (V.T.I.C. Art. 20A.11, Sec. (d); Art. 20A.14, Sec. (a).)

Source Law

[Art. 20A.11]

(d) No health maintenance organization, or representative thereof, may cause or knowingly permit the use or distribution of prospective enrollee information which is untrue or misleading.

Art. 20A.14. (a) No health maintenance organization, or representatives thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For the purposes of this Act:

(1) a statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan;

(2) a statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which said

statement is made or such item of information is communicated, such statement or items of information may be reasonably understood by a reasonable person, not possessing special knowledge, regarding health care coverage, as indicating any benefit or advantage or absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of or person considering enrollment in, a health care plan, if such benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist;

(3) an evidence of coverage shall be deemed to be deceptive if the evidence of coverage, taken as a whole, and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge regarding health care plans, and evidence of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing such evidence of coverage does not regularly make available for enrollees covered under such evidence of coverage.

Revised Law

Sec. 843.205. MEMBER'S HANDBOOK; INFORMATION ABOUT COMPLAINTS AND APPEALS. (a) In this section, "major population" means a group constituting 10 percent or more of the enrolled population of the health maintenance organization.

(b) A health maintenance organization shall establish procedures to:

(1) provide to an enrollee a member handbook and materials relating to the complaint and appeals process in the languages of the major populations of the enrolled population; and

(2) provide access to a member handbook and the complaint and appeals process to an enrollee who has a disability that affects the enrollee's ability to communicate or read. (V.T.I.C. Art. 20A.11A.)

Source Law

Art. 20A.11A. (a) Each health maintenance organization or approved nonprofit health corporation certified under

Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and holding a certificate of authority issued by the commissioner shall establish procedures to provide to an enrollee a member handbook and materials relating to the complaint and appeals process in the languages of the major populations of the enrolled population. A major population is defined as a group comprising 10 percent or more of the health maintenance organization's enrolled population.

(b) Each health maintenance organization and approved nonprofit health corporation certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), and holding a certificate of authority issued by the commissioner shall establish procedures to provide access to a member handbook and the complaint and appeals process to an enrollee who has a disability affecting the enrollee's ability to communicate or to read.

Revisor's Note

V.T.I.C. Article 20A.11A refers to and imposes a duty on an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner. The revised law omits the references as unnecessary because V.T.I.C. Article 21.52F, revised as Chapter 844, provides that an approved nonprofit health corporation has all the powers granted to and duties imposed on a health maintenance organization under the Texas Health Maintenance Organization Act.

Revised Law

Sec. 843.206. NOTICE OF CHANGE IN PAYMENT ARRANGEMENTS. A health maintenance organization shall notify a group contract holder within 30 days of any substantive change to the payment arrangements between the health maintenance organization and physicians or providers. (V.T.I.C. Art. 20A.11, Sec. (c).)

Source Law

(c) A health maintenance organization shall notify a group contract holder within 30 days of any substantive changes to the payment arrangements between the health

maintenance organization and health care physicians or providers.

Revised Law

Sec. 843.207. NOTICE OF CHANGE IN OPERATIONS. A health maintenance organization shall provide to its enrollees reasonable notice of any material adverse change in the operation of the health maintenance organization that will directly affect the enrollees. (V.T.I.C. Art. 20A.11, Sec. (e).)

Source Law

(e) Every health maintenance organization shall provide to its enrollees reasonable notice of any material adverse change in the operation of the organization that will affect them directly.

Revised Law

Sec. 843.208. CANCELLATION OR NONRENEWAL OF COVERAGE. A health maintenance organization may cancel or refuse to renew the coverage of an enrollee only for:

(1) failure to pay the charges for the coverage; or

(2) another reason prescribed by rules adopted by the commissioner. (V.T.I.C. Art. 20A.14, Sec. (c).)

Source Law

(c) An enrollee may not be canceled or not renewed except for the failure to pay the charges for such coverage, or for such other reason as may be promulgated by rule of the commissioner.

[Sections 843.209-843.250 reserved for expansion]

SUBCHAPTER G. DISPUTE RESOLUTION

Revised Law

Sec. 843.251. COMPLAINT SYSTEM REQUIRED; COMMISSIONER RULES AND EXAMINATION. (a) A health maintenance organization shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint initiated by a complainant concerning health care services. The complaint system must include a process for the notice and appeal of a complaint.

(b) The commissioner may adopt reasonable rules as necessary or proper to implement the provisions of this subchapter relating to the complaint system and administer matters relating to the complaint system.

(c) The commissioner may examine a complaint system for

compliance with this subchapter and may require the health maintenance organization to make corrections as the commissioner considers necessary. (V.T.I.C. Art. 20A.12, Secs. (a), (b), (r).)

Source Law

Art. 20A.12. (a) Every health maintenance organization shall implement and maintain a complaint system to provide reasonable procedures for the resolution of oral and written complaints initiated by enrollees or providers concerning health care services, including a process for the notice and appeal of complaints.

(b) The commissioner may adopt reasonable rules as necessary or proper to implement and administer this section.

(r) The commissioner may examine the complaint system for compliance with this Act and may require the health maintenance organization to make corrections as considered necessary by the commissioner.

Revisor's Note

Section (a), V.T.I.C. Article 20A.12, refers to complaints initiated by "enrollees or providers" concerning health care services. The revised law substitutes "complainant" for "enrollees or providers" for consistency of terminology and to reflect the clear intent of the legislature. All similar references in V.T.I.C. Article 20A.12 refer to a complainant, and Subdivision (e), V.T.I.C. Article 20A.02, revised as Section 843.002(4), defines "complainant" to mean an enrollee, or a physician, provider, or other person designated to act on behalf of an enrollee, who files a complaint.

Revised Law

Sec. 843.252. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a health maintenance organization of a complaint, the health maintenance organization, not later than the fifth business day after the date of receiving the complaint, shall send to the complainant a letter acknowledging the date of receipt of the complaint.

(b) The letter required under Subsection (a) must:

(1) include a description of the health maintenance

organization's complaint procedures and time frames; and

(2) if the complaint is made orally, be accompanied by a one-page complaint form that prominently and clearly states that the form must be returned to the health maintenance organization for prompt resolution of the complaint.

(c) A health maintenance organization shall acknowledge, investigate, and resolve a complaint not later than the 30th calendar day after the date the health maintenance organization receives the written complaint or one-page complaint form from the complainant.

(d) Subsections (a)-(c) do not apply to a complaint concerning an emergency or a denial of continued hospitalization. A health maintenance organization shall investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization:

(1) in accordance with the medical or dental immediacy of the case; and

(2) not later than one business day after the health maintenance organization receives the complaint. (V.T.I.C. Art. 20A.12, Secs. (c), (e), (f).)

Source Law

(c) If a complainant notifies the health maintenance organization orally or in writing of a complaint, the health maintenance organization, not later than the fifth business day after the date of the receipt of the complaint, shall send to the complainant a letter acknowledging the date of receipt of the complaint that includes a description of the organization's complaint procedures and time frames. If the complaint is received orally, the health maintenance organization shall also enclose a one-page complaint form. The one-page complaint form must prominently and clearly state that the complaint form must be returned to the health maintenance organization for prompt resolution of the complaint.

(e) The total time for acknowledgment, investigation, and resolution of the complaint by the health maintenance organization may not exceed 30 calendar days after the date the health maintenance organization receives the written complaint or one-page complaint form from the complainant.

(f) Subsections (c) and (e) of this section do not apply to complaints concerning emergencies or denials of continued stays for hospitalization. Investigation and resolution of complaints concerning emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case and may not exceed one business day from receipt of the complaint.

Revisor's Note

Section (c), V.T.I.C. Article 20A.12, refers to notification of a complaint made "orally or in writing." In this section and the following sections of this subchapter, the revised law omits "orally and in writing" and similar references in this context as unnecessary. Subdivision (f), Article 20A.02, revised as Section 843.002(6), defines "complaint" to mean any dissatisfaction expressed orally or in writing. In addition, Section (a), V.T.I.C. Article 20A.12, revised as Section 843.251, makes clear that this subchapter applies to both oral and written complaints.

Revised Law

Sec. 843.253. COMPLAINT INVESTIGATION AND RESOLUTION. (a) A health maintenance organization shall investigate each complaint received in accordance with the health maintenance organization's policies and in compliance with this chapter.

(b) After a health maintenance organization has investigated a complaint, the health maintenance organization shall issue a response letter to the complainant within the time prescribed by Section 843.252(c) that:

(1) explains the health maintenance organization's resolution of the complaint;

(2) states the specific medical and contractual reasons for the resolution;

(3) states the specialization of any physician or other provider consulted; and

(4) contains a complete description of the process for appeal, including the deadlines for the appeals process and the deadlines for the final decision on the appeal. (V.T.I.C. Art. 20A.12, Secs. (d), (g).)

Source Law

(d) The health maintenance organization shall investigate each oral and written complaint received in accordance with its own policies and in compliance with this Act.

(g) After the health maintenance organization has investigated a complaint, the health maintenance organization shall issue a response letter to the complainant explaining the health maintenance organization's resolution of the complaint within the time frame set forth in Subsection (e) of this section. The letter must include a statement of the specific medical and contractual reasons for the resolution and the specialization of any physician or other provider consulted. The response letter must contain a full description of the process for appeal, including the time frames for the appeals process and the time frames for the final decision on the appeal.

Revised Law

Sec. 843.254. APPEAL TO COMPLAINT APPEAL PANEL; DEADLINES. (a) A health maintenance organization shall provide an appeals process for a complainant who is not satisfied with the resolution of the complaint. The appeals process must include the right of the complainant to:

(1) appear in person before a complaint appeal panel at the site at which the enrollee normally receives health care services or at another site agreed to by the complainant; or

(2) address a written appeal to the complaint appeal panel.

(b) The health maintenance organization shall send an acknowledgment letter to the complainant not later than the fifth business day after the date the written request for appeal is received.

(c) The health maintenance organization shall complete the appeals process not later than the 30th calendar day after the date the written request for appeal is received. (V.T.I.C. Art. 20A.12, Secs. (h), (i).)

Source Law

(h) If the complaint is not resolved to the satisfaction of the complainant, the health maintenance organization shall provide

an appeals process that includes the right of the complainant either to appear in person before a complaint appeal panel where the enrollee normally receives health care services, unless another site is agreed to by the complainant, or to address a written appeal to the complaint appeal panel. The health maintenance organization shall complete the appeals process under this section not later than the 30th calendar day after the date of the receipt of the written request for appeal.

(i) The health maintenance organization shall send an acknowledgment letter to the complainant not later than the fifth business day after the date of receipt of the written request for appeal.

Revised Law

Sec. 843.255. COMPOSITION OF COMPLAINT APPEAL PANEL. (a) A health maintenance organization shall appoint members to a complaint appeal panel to advise the health maintenance organization on the resolution of a disputed decision appealed by a complainant.

(b) A complaint appeal panel shall be composed of an equal number of health maintenance organization staff members, physicians or other providers, and enrollees. A member of a complaint appeal panel may not have been previously involved in the disputed decision.

(c) The physicians or other providers on a complaint appeal panel must have experience in the area of care that is in dispute and must be independent of any physician or provider who made any previous determination. If specialty care is in dispute, the complaint appeal panel must include a person who is a specialist in the field of care to which the appeal relates.

(d) The enrollee members of a complaint appeal panel may not be employees of the health maintenance organization. (V.T.I.C. Art. 20A.12, Sec. (j).)

Source Law

(j) The health maintenance organization shall appoint members to the complaint appeal panel, which shall advise the health maintenance organization on the resolution of the dispute. The complaint appeal panel shall be composed of equal numbers of health maintenance organization staff, physicians or other providers, and enrollees. A member of

the complaint appeal panel may not have been previously involved in the disputed decision. The physicians or other providers must have experience in the area of care that is in dispute and must be independent of any physician or provider who made any prior determination. If specialty care is in dispute, the appeal panel must include a person who is a specialist in the field of care to which the appeal relates. The enrollees may not be employees of the health maintenance organization.

Revised Law

Sec. 843.256. INFORMATION PROVIDED TO COMPLAINANT RELATING TO COMPLAINT APPEAL PANEL. Not later than the fifth business day before the date a complaint appeal panel is scheduled to meet, unless the complainant agrees otherwise, the health maintenance organization shall provide to the complainant or the complainant's designated representative:

(1) any documentation to be presented to the complaint appeal panel by the health maintenance organization staff;

(2) the specialization of any physicians or providers consulted during the investigation; and

(3) the name and affiliation of each health maintenance organization representative on the complaint appeal panel. (V.T.I.C. Art. 20A.12, Sec. (k).)

Source Law

(k) Not later than the fifth business day before the scheduled meeting of the panel, unless the complainant agrees otherwise, the health maintenance organization shall provide to the complainant or the complainant's designated representative:

(1) any documentation to be presented to the panel by the health maintenance organization staff;

(2) the specialization of any physicians or providers consulted during the investigation; and

(3) the name and affiliation of each health maintenance organization representative on the panel.

Revised Law

Sec. 843.257. RIGHTS OF COMPLAINANT AT COMPLAINT APPEAL PANEL MEETING. A complainant, or a designated representative if the enrollee is a minor or is disabled, is entitled to:

(1) appear in person before the complaint appeal panel;

(2) present alternative expert testimony; and

(3) request the presence of and question any person responsible for making the disputed decision that resulted in the appeal. (V.T.I.C. Art. 20A.12, Sec. (l).)

Source Law

(l) The complainant, or designated representative if the enrollee is a minor or disabled, is entitled to:

(1) appear in person before the complaint appeal panel;

(2) present alternative expert testimony; and

(3) request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

Revised Law

Sec. 843.258. APPEAL INVOLVING ONGOING EMERGENCY OR CONTINUED HOSPITALIZATION. (a) The investigation and resolution of an appeal of a complaint relating to an ongoing emergency or denial of continued hospitalization shall be concluded:

(1) in accordance with the medical or dental immediacy of the case; and

(2) not later than one business day after the complainant's request for appeal is received.

(b) Because of the ongoing emergency or continued hospitalization and at the request of the complainant, the health maintenance organization shall provide, instead of a complaint appeal panel, a review by a physician or provider who:

(1) has not previously reviewed the case; and

(2) is of the same or a similar specialty as the physician or provider who would typically manage the medical condition, procedure, or treatment under consideration for review in the appeal.

(c) The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide the appeal.

(d) The physician or provider may deliver initial notice of the decision on the appeal orally if the physician or provider subsequently provides written notice of the decision not later

than the third day after the date of the decision.

(e) The investigation and resolution of an appeal after emergency care has been provided shall be conducted in accordance with the procedures otherwise established under this subchapter, including the right to review by a complaint appeal panel. (V.T.I.C. Art. 20A.12, Sec. (m).)

Source Law

> (m) Investigation and resolution of appeals relating to ongoing emergencies or denials of continued stays for hospitalization shall be concluded in accordance with the medical or dental immediacy of the case but in no event to exceed one business day after the complainant's request for appeal. Due to the ongoing emergency or continued hospital stay, and at the request of the complainant, the health maintenance organization shall provide, in lieu of a complaint appeal panel, a review by a physician or provider who has not previously reviewed the case and is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under discussion for review of the appeal. The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall render a decision on the appeal. Initial notice of the decision may be delivered orally if followed by written notice of the determination within three days. Investigation and resolution of appeals after emergency care has been provided shall be conducted in accordance with the process established under this section, including the right to a review by an appeal panel.

Revised Law

Sec. 843.259. NOTICE OF DECISION ON APPEAL. (a) A health maintenance organization shall include in a notice of the final decision on an appeal a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision.

(b) The notice must include the toll-free telephone number and address of the department. (V.T.I.C. Art. 20A.12, Sec. (n).)

Source Law

(n) Notice of the final decision of the health maintenance organization on the appeal must include a statement of the specific medical determination, clinical basis, and contractual criteria used to reach the final decision. The notice must also include the toll-free telephone number and the address of the Texas Department of Insurance.

Revised Law

Sec. 843.260. RECORD OF COMPLAINTS. (a) A health maintenance organization shall maintain a complaint and appeal log regarding each complaint.

(b) A health maintenance organization shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on a complaint until the third anniversary of the date the complaint was received.

(c) A complainant is entitled to a copy of the record of the complainant's complaint and any proceeding relating to that complaint.

(d) The department, during any investigation of a health maintenance organization, may review documentation maintained under Subsection (b) regarding a complaint and action taken on the complaint. (V.T.I.C. Art. 20A.12, Secs. (o), (p), (q).)

Source Law

(o) The health maintenance organization shall maintain a record of each complaint and any complaint proceeding and any actions taken on a complaint for three years from the date of the receipt of the complaint. A complainant is entitled to a copy of the record on the applicable complaint and any complaint proceeding.

(p) Each health maintenance organization shall maintain a complaint and appeal log regarding each complaint.

(q) Each health maintenance organization shall maintain documentation on each complaint received and the action taken on the complaint until the third anniversary of the date of receipt of the complaint. The Texas Department of Insurance may review documentation maintained under this subsection during any investigation of the health maintenance organization.

Revised Law

Sec. 843.261. SPECIAL PROVISIONS FOR APPEALS OF ADVERSE DETERMINATIONS. (a) A health maintenance organization shall implement and maintain an internal appeal system that:

(1) provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination; and

(2) includes procedures for notification, review, and appeal of an adverse determination in accordance with Article 21.58A.

(b) An appeal must be initiated by an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record.

(c) When an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record expresses orally or in writing any dissatisfaction or disagreement with an adverse determination, the health maintenance organization or utilization review agent shall:

(1) consider the expression of dissatisfaction or disagreement as an appeal of the adverse determination; and

(2) review and resolve the appeal in accordance with Article 21.58A.

(d) A health maintenance organization may integrate its appeal procedures related to adverse determinations with the complaint and appeal procedures established by the health maintenance organization under Section 843.251 and otherwise governed by this subchapter only if the procedures related to adverse determinations comply with this section and Article 21.58A. (V.T.I.C. Art. 20A.12A, Secs. (b), (c), (d).)

Source Law

(b) A health maintenance organization shall implement and maintain an internal appeal system that provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination that is initiated by an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record. The appeal system must include procedures for notification, review, and appeal of an adverse determination, as defined by this section, in accordance with Article 21.58A, Insurance Code.

(c) When an enrollee, a person acting on behalf of an enrollee, or an enrollee's provider of record expresses orally or in

writing any dissatisfaction or disagreement with an adverse determination, the health maintenance organization or utilization review agent shall regard the expression of dissatisfaction or disagreement as an appeal of the adverse determination, as defined by this section, and shall review and resolve the appeal in accordance with Article 21.58A, Insurance Code.

(d) A health maintenance organization may integrate its appeal procedures related to adverse determinations with the complaint and appeal procedures established by the health maintenance organization under Section 12 of this Act only if the procedures related to adverse determinations comply with this section and Article 21.58A, Insurance Code.

Revisor's Note

Sections (a)(2) and (3), V.T.I.C. Article 20A.12A, define "independent review organization" and "life-threatening condition." However, the 1999 amendments to V.T.I.C. Article 20A.12A deleted those terms from the text of the article. The revised law omits the definitions as no longer necessary. The omitted law reads:

(2) "Independent review organization" means an organization selected as provided under Article 21.58C, Insurance Code.

(3) "Life-threatening condition" has the meaning assigned by Section 6, Article 21.58A, Insurance Code.

[Sections 843.262-843.280 reserved for expansion]

SUBCHAPTER H. GENERAL PROVISIONS REGARDING COMPLAINTS

Revised Law

Sec. 843.281. RETALIATORY ACTION PROHIBITED. (a) A health maintenance organization may not engage in retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or enrollee because the group or enrollee or a person acting on behalf of the group or enrollee has filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization.

(b) A health maintenance organization may not engage in retaliatory action, including refusal to renew or termination of

a contract, against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization. (V.T.I.C. Art. 20A.14, Sec. (j), as added Acts 75th Leg., R.S., Ch. 1026; Sec. (k).)

Source Law

(j) A health maintenance organization shall not engage in any retaliatory action, including refusal to renew or cancellation of coverage, against a group contract holder or enrollee because the group, enrollee, or person acting on behalf of the group or enrollee has filed a complaint against the health maintenance organization or appealed a decision of the health maintenance organization.

(k) A health maintenance organization shall not engage in any retaliatory action, including termination of or refusal to renew a contract, against a physician or provider because the physician or provider has, on behalf of an enrollee, reasonably filed a complaint against the health maintenance organization or has appealed a decision of the health maintenance organization.

Revised Law

Sec. 843.282. SUBMITTING COMPLAINTS TO DEPARTMENT. (a) Any person, including a person who has attempted to resolve a complaint through a health maintenance organization's complaint system process and is dissatisfied with the resolution, may submit a complaint to the department alleging a violation of this chapter or Chapter 20A.

(b) The commissioner shall complete an investigation of a complaint against a health maintenance organization to determine whether a violation has occurred not later than the 60th day after the date the department receives the complaint and all information necessary for the commissioner to make a determination.

(c) The commissioner may extend the time necessary to complete an investigation if:

(1) additional information is needed;

(2) an on-site review is necessary;

(3) the health maintenance organization, the physician or provider, or the complainant does not provide all documentation necessary to complete the investigation; or

(4) other circumstances beyond the control of the department occur. (V.T.I.C. Art. 20A.12B.)

Source Law

Art. 20A.12B. (a) Any person, including persons who have attempted to resolve complaints through a health maintenance organization's complaint system process who are dissatisfied with the resolution, may report an alleged violation of this Act to the Texas Department of Insurance.

(b) The commissioner shall investigate a complaint against a health maintenance organization to determine compliance with this Act within 60 days after the Texas Department of Insurance's receipt of the complaint and all information necessary for the department to determine compliance. The commissioner may extend the time necessary to complete an investigation in the event any of the following circumstances occur:

(1) additional information is needed;

(2) an on-site review is necessary;

(3) the health maintenance organization, the physician or provider, or the complainant does not provide all documentation necessary to complete the investigation; or

(4) other circumstances beyond the control of the department occur.

Revised Law

Sec. 843.283. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. A contract between a health maintenance organization and a physician or provider must require the physician or provider to post, in the office of the physician or provider, a notice to enrollees on the process for resolving complaints with the health maintenance organization. The notice must include the department's toll-free telephone number for filing a complaint. (V.T.I.C. Art. 20A.18A, Sec. (i), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(i) A contract between a health maintenance organization and a physician or a provider must require the physician or

provider to post, in the office of the physician or provider, a notice to enrollees on the process for resolving complaints with the health maintenance organization. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints.

[Sections 843.284-843.300 reserved for expansion]

SUBCHAPTER I. RELATIONS WITH PHYSICIANS AND PROVIDERS

Revised Law

Sec. 843.301. PRACTICE OF MEDICINE NOT AFFECTED. This chapter and Chapter 20A do not:

(1) authorize any person, other than a licensed physician or practitioner of the healing arts, acting within the scope of the person's license, to engage directly or indirectly in the practice of medicine or a healing art; or

(2) authorize any person to regulate, interfere with, or intervene in any manner in the practice of medicine or a healing art. (V.T.I.C. Art. 20A.29.)

Source Law

Art. 20A.29. This Act shall not be construed to:

(a) authorize any person, other than a duly licensed physician or practitioner of the healing arts, acting within the scope of his or her license, to engage, directly or indirectly, in the practice of medicine or any healing art, or

(b) authorize any person to regulate, interfere, or intervene in any manner in the practice of medicine or any healing art.

Revised Law

Sec. 843.302. DISCLOSURE OF APPLICATION PROCEDURES AND QUALIFICATION REQUIREMENTS TO PHYSICIAN OR PROVIDER. A health maintenance organization shall, on request, make available and disclose to a physician or provider written application procedures and qualification requirements for contracting with the health maintenance organization. (V.T.I.C. Art. 20A.18A, Sec. (a) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

Art. 20A.18A. (a) A health maintenance organization shall, on request, make

available and disclose to physicians and providers written application procedures and qualification requirements for contracting with the health maintenance organization. . . .

Revised Law

Sec. 843.303. DENIAL OF INITIAL CONTRACT TO PHYSICIAN OR PROVIDER. (a) A health maintenance organization that denies a contract to a physician or provider who initially applies to contract with the health maintenance organization to provide health care services on behalf of the health maintenance organization shall provide to the applicant written notice of the reasons the initial application was denied.

(b) Unless otherwise limited by Article 21.52B, this section does not prohibit a health maintenance organization from rejecting an initial application from a physician or provider based on the determination that the plan has sufficient qualified physicians or providers. (V.T.I.C. Art. 20A.18A, Sec. (a) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(a) . . . Each physician and provider who initially applies to contract with a health maintenance organization for the provision of health care services on behalf of the health maintenance organization and who is denied a contract with the health maintenance organization must be provided written notice of the reasons the initial application was denied. Unless otherwise limited by Article 21.52B, Insurance Code, this subsection does not prohibit a health maintenance organization plan from rejecting an application from a physician or provider based on the determination that the plan has sufficient qualified physicians or providers.

Revised Law

Sec. 843.304. EXCLUSION OF PROVIDER BASED ON TYPE OF LICENSE PROHIBITED. (a) A provider licensed or otherwise authorized to practice in this state may not be denied the opportunity to participate in providing health care services that are delivered by a health maintenance organization and that are within the scope of the provider's license or authorization solely because of the type of license or authorization held by the provider.

(b) If a hospital, facility, agency, or supplier is

certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or another national accrediting body, a health maintenance organization shall accept that certification or accreditation.

(c) This section does not require that a health maintenance organization:

(1) use a particular type of provider in its operation;

(2) accept each provider of a category or type, except as provided by Article 21.52B; or

(3) contract directly with providers of a particular category or type.

(d) This section does not limit a health maintenance organization's authority to establish the terms under which health care services are provided by providers.

(e) A provider must comply with the terms established by the health maintenance organization for the provision of health services and for designation as a provider by the health maintenance organization. (V.T.I.C. Art. 20A.06, Sec. (a) (part); Art. 20A.14, Sec. (g).)

Source Law

Art. 20A.06. (a) The powers of a health maintenance organization include, but are not limited to, the following:

. . .

(3) . . . if a hospital, facility, agency, or supplier is certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or another national accrediting body, the health maintenance organization shall be required to accept such certification or accreditation;

. . .

[Art. 20A.14]

(g) No type of provider licensed or otherwise authorized to practice in this state may be denied participation to provide health care services which are delivered by the health maintenance organization and which are within the scope of licensure or authorization of the type of provider on the sole basis of type of license or

authorization. However, if a hospital, facility, agency, or supplier is certified by the Medicare program, Title XVIII of the Social Security Act (42 U.S.C. Section 1395 et seq.), or accredited by the Joint Commission on Accreditation of Healthcare Organizations or another national accrediting body, the health maintenance organization shall be required to accept such certification or accreditation. This section may not be construed to (1) require a health maintenance organization to utilize a particular type of provider in its operation; (2) require, except as provided by Article 21.52B of this code, that a health maintenance organization accept each provider of a category or type; or (3) require that health maintenance organizations contract directly with such providers. Notwithstanding any other provision nothing herein shall be construed to limit the health maintenance organization's authority to set the terms and conditions under which health care services will be rendered by providers. All providers must comply with the terms and conditions established by the health maintenance organization for the provision of health services and for designation as a provider.

Revised Law

Sec. 843.305. ANNUAL APPLICATION PERIOD FOR PHYSICIANS AND PROVIDERS TO CONTRACT. (a) This section applies only to a health maintenance organization that provides coverage for health care services through:

(1) one or more physicians or providers who are not partners or employees of the health maintenance organization; or

(2) one or more physicians or providers who are not owned or operated by the health maintenance organization.

(b) A health maintenance organization shall provide a period of 20 calendar days each calendar year during which any physician or provider in a service area may, under the terms established by the health maintenance organization for the provision of services and the designation of physicians and providers, apply to participate in providing health care services.

(c) A health maintenance organization that denies the application of a physician or provider shall notify the physician

or provider in writing of the reason for the denial.

(d) This section does not require that a health maintenance organization:

(1) use a particular type of physician or provider in its operation;

(2) accept a physician or provider of a category or type that does not meet the practice standards and qualifications established by the health maintenance organization; or

(3) contract directly with physicians or providers of a particular category or type. (V.T.I.C. Art. 20A.14, Sec. (h).)

Source Law

(h) A health maintenance organization that provides coverage for health care services or medical care through one or more providers or physicians who are not partners or employees of the health maintenance organization or one or more providers or physicians that are not owned or operated by the health maintenance organization shall provide a (20) twenty calendar day period each calendar year during which any provider or physician in the geographic service area may apply to participate in providing health care services or medical care under the terms and conditions established by the health maintenance organization for the provision of such services and the designation of such providers and physicians. A health maintenance organization will notify, in writing, such provider or physician of the reason for non-acceptance to participate in providing health care services or medical care. This section may not be construed to (1) require that a health maintenance organization utilize a particular type of provider or physician in its operation; (2) require that a health maintenance organization accept a provider or physician of a category or type that does not meet the practice standards and qualifications established by the health maintenance organizations; or (3) require that a health maintenance organization contract directly with such providers or physicians.

Revisor's Note

Section (h), V.T.I.C. Article 20A.14, refers to "health care services or medical care." The revised law omits the reference to "medical care" in this context as unnecessary because Subdivision (m), V.T.I.C. Article 20A.02, revised as Section 843.002(12), includes medical care within the definition of "health care services." Similar changes are made throughout this chapter, except where helpful for clarity.

Revised Law

Sec. 843.306. TERMINATION OF PARTICIPATION; ADVISORY REVIEW PANEL. (a) Before terminating a contract with a physician or provider, a health maintenance organization shall provide to the physician or provider a written explanation of the reasons for termination.

(b) On request, before the effective date of the termination and within a period not to exceed 60 days, a physician or provider is entitled to a review by an advisory review panel of the health maintenance organization's proposed termination, except in a case involving:

(1) imminent harm to patient health;

(2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession; or

(3) fraud or malfeasance.

(c) An advisory review panel must:

(1) be composed of physicians and providers who are appointed to serve on the standing quality assurance committee or utilization review committee of the health maintenance organization; and

(2) include, if available, at least one representative of the physician's or provider's specialty or a similar specialty.

(d) The health maintenance organization must consider, but is not bound by, the recommendation of the advisory review panel.

(e) The health maintenance organization on request shall provide to the affected physician or provider a copy of the recommendation of the advisory review panel and the health maintenance organization's determination. (V.T.I.C. Art. 20A.18A, Sec. (b), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(b) Before terminating a contract with a physician or provider, the health

maintenance organization shall provide a written explanation to the physician or provider of the reasons for termination. On request and before the effective date of the termination, but within a period not to exceed 60 days, a physician or provider shall be entitled to a review of the health maintenance organization's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health or an action by a state medical or dental board, other medical or dental licensing board, or other licensing board or other government agency, that effectively impairs the physician's or provider's ability to practice medicine, dentistry, or another profession, or in a case of fraud or malfeasance. The advisory review panel shall be composed of physicians and providers, including at least one representative in the physician's or provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of the health maintenance organization. The decision of the advisory review panel must be considered but is not binding on the health maintenance organization. The health maintenance organization shall provide to the affected physician or provider, on request, a copy of the recommendation of the advisory review panel and the health maintenance organization's determination.

Revised Law

Sec. 843.307. EXPEDITED REVIEW PROCESS ON TERMINATION OR DESELECTION. On request by the physician or provider, a physician or provider whose participation in a health care plan is being terminated or who is deselected is entitled to an expedited review process by the health maintenance organization. (V.T.I.C. Art. 20A.18A, Sec. (d) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(d) A physician or provider who is terminated or deselected shall be entitled to an expedited review process by the health

maintenance organization on request by the physician or provider. . . .

Revised Law

Sec. 843.308. NOTIFICATION OF PATIENTS OF DESELECTED PHYSICIAN OR PROVIDER. (a) Except as provided by Subsection (b), if a physician or provider is deselected for a reason other than the request of the physician or provider, a health maintenance organization may not notify patients of the deselection until the effective date of the deselection or the advisory review panel makes a formal recommendation.

(b) If the contract of a physician or provider is deselected for a reason related to imminent harm, a health maintenance organization may notify patients immediately. (V.T.I.C. Art. 20A.18A, Sec. (d) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(d) . . . If the physician or provider is deselected for reasons other than at the physician's or provider's request, the health maintenance organization may not notify patients of the physician's or provider's deselection until the effective date of the termination or the time a review panel makes a formal recommendation. If a physician or provider is deselected for reasons related to imminent harm, the health maintenance organization may notify patients immediately.

Revised Law

Sec. 843.309. CONTRACTS WITH PHYSICIANS OR PROVIDERS: NOTICE TO CERTAIN ENROLLEES OF TERMINATION OF PHYSICIAN OR PROVIDER PARTICIPATION IN PLAN. A contract between a health maintenance organization and a physician or provider must provide that reasonable advance notice shall be given to an enrollee of the impending termination from the plan of a physician or provider who is currently treating the enrollee. (V.T.I.C. Art. 20A.18A, Sec. (c) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(c) Each contract between a health maintenance organization and a physician or provider of health care services must provide that reasonable advance notice be given to an enrollee of the impending termination from the plan of a physician or provider who is

currently treating the enrollee. . . .

Revised Law

Sec. 843.310. CONTRACTS WITH PHYSICIANS OR PROVIDERS: CERTAIN INDEMNITY CLAUSES PROHIBITED. A contract between a health maintenance organization and a physician or provider may not contain a clause purporting to indemnify the health maintenance organization for any liability in tort resulting from an act or omission of the health maintenance organization. (V.T.I.C. Art. 20A.18A, Sec. (f), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(f) A contract between a health maintenance organization and a physician or provider may not contain any clause purporting to indemnify the health maintenance organization for any tort liability resulting from acts or omissions of the health maintenance organization.

Revised Law

Sec. 843.311. CONTRACTS WITH PODIATRISTS. A contract between a health maintenance organization and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request, and the health maintenance organization shall provide not later than the 30th day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the health maintenance organization may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(3) the podiatrist may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the evidence of coverage. (V.T.I.C. Art. 20A.18A, Sec. (j), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(j) A contract between a health maintenance organization and a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners must provide that:

(1) the podiatrist may request, and the insurer shall provide not later than the 30th day after the date of the request, a

copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;

(2) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and

(3) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the evidence of coverage.

Revisor's Note

Section (j), V.T.I.C. Article 20A.18A, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, specifically applies by its terms to contracts between podiatrists and health maintenance organizations but, in Subdivisions (1) and (2) of Section (j), refers to an "insurer" rather than to a "health maintenance organization." The revised law substitutes "health maintenance organization" for "insurer" because it is clear in this context that the legislature intended to refer to health maintenance organizations.

Revised Law

Sec. 843.312. PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. (a) A health maintenance organization may not refuse a request by a physician participating in the health maintenance organization delivery network and a physician assistant or advanced practice nurse who is authorized by the physician to provide care under Subchapter B, Chapter 157, Occupations Code, to identify a physician assistant or advanced practice nurse as a provider in the network.

(b) A health maintenance organization may refuse a request under Subsection (a) if the physician assistant or advanced practice nurse does not meet the quality of care standards previously established by the health maintenance organization for participation in the network by physician assistants and advanced practice nurses. (V.T.I.C. Art. 20A.14, Sec. (i), as added Acts 75th Leg., R.S., Ch. 1260.)

Source Law

(i) If an advanced practice nurse or

physician assistant is authorized to provide care under Section 3.06(d)(5) or (6), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), by a physician participating in a health maintenance organization's provider network, the health maintenance organization may not refuse a request made by the physician and physician assistant or advanced practice nurse to have the physician assistant or advanced practice nurse identified as a provider in the provider network unless the physician assistant or advanced practice nurse fails to meet the quality of care standards previously established by the health maintenance organization for participation in the network by advanced practice nurses and physician assistants.

Revisor's Note

Section (i), V.T.I.C. Article 20A.14, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, refers to Section 3.06(d)(5) or (6), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). Those provisions were codified in 1999 as Subchapter B, Chapter 157, Occupations Code, and the revised law is drafted accordingly.

Revised Law

Sec. 843.313. ECONOMIC PROFILING. (a) A health maintenance organization that conducts or uses economic profiling of physicians or providers participating in the health maintenance organization delivery network shall make available to a network physician or provider on request that physician's or provider's economic profile, including the standards by which the physician or provider is measured.

(b) The use of an economic profile must recognize the characteristics of a physician's or provider's practice that may account for variations from expected costs. (V.T.I.C. Art. 20A.18A, Sec. (h), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(h) A health maintenance organization that conducts or uses economic profiling of physicians or providers within the health maintenance organization shall make available to a network physician or provider on request

the economic profile of that physician or provider, including the standards by which the physician or provider is measured. The use of an economic profile must recognize the characteristics of a physician's or provider's practice that may account for variations from expected costs.

Revised Law

Sec. 843.314. INDUCEMENT TO LIMIT MEDICALLY NECESSARY SERVICES PROHIBITED. (a) A health maintenance organization may not use a financial incentive or make a payment to a physician or provider if the incentive or payment acts directly or indirectly as an inducement to limit medically necessary services.

(b) This section does not prohibit the use of capitation as a method of payment. (V.T.I.C. Art. 20A.14, Sec. (l).)

Source Law

(l) A health maintenance organization may not use any financial incentive or make any payment to a physician or provider that acts directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the use of capitation as a method of payment.

Revised Law

Sec. 843.315. PAYMENT OF CAPITATION; ASSIGNMENT OF PRIMARY CARE PHYSICIAN OR PROVIDER. (a) This section applies to a health maintenance organization that to any extent uses capitation as a method of compensation.

(b) A health maintenance organization shall begin payment of capitated amounts to an enrollee's primary care physician or primary care provider, computed from the date of enrollment, not later than the 60th day after the date the enrollee selects or is assigned a primary care physician or primary care provider.

(c) If selection or assignment of a primary care physician or primary care provider does not occur at enrollment, capitated amounts that would have been paid to a selected or assigned primary care physician or primary care provider if a selection or assignment had been made shall be reserved as a capitated amount payable until the enrollee makes a selection or the health maintenance organization assigns a primary care physician or primary care provider.

(d) If an enrollee does not select a primary care physician or primary care provider at the time of application or enrollment, a health maintenance organization may assign the enrollee to a primary care physician or primary care provider.

(e) A primary care physician or primary care provider assigned under Subsection (d) must be located within the zip code nearest the enrollee's residence or place of employment.

(f) Subject to Subsection (e), the health maintenance organization shall make the assignment in a manner that results in a fair and equal distribution of enrollees among the health maintenance organization delivery network's primary care physicians or primary care providers.

(g) A health maintenance organization shall inform an enrollee of:

(1) the name, address, and telephone number of a primary care physician or primary care provider to whom the enrollee has been assigned under Subsection (d); and

(2) the enrollee's right to select a different primary care physician or primary care provider.

(h) At any time, an enrollee is entitled to reject the primary care physician or primary care provider assigned and select another physician or provider from the list of primary care physicians or primary care providers for the health maintenance organization delivery network. A rejection by an enrollee of an assigned physician or provider is not a change in provider for purposes of the limitation described by Section 843.203.

(i) A health maintenance organization shall notify a physician or provider of an enrollee's selection of that person as the primary care physician or primary care provider, or of the assignment of the enrollee to that physician or provider by the health maintenance organization, not later than the 30th working day after the date of the selection or assignment. (V.T.I.C. Art. 20A.18A, Sec. (e) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) The following applies to any health maintenance organization that to any extent uses capitation as a method of compensation:

(1) The health maintenance organization shall begin payment of capitated amounts to the enrollee's primary care physician or primary care provider, calculated from the date of enrollment, no later than the 60th day following the date an enrollee has selected or has been assigned a primary care physician or primary care provider. If selection or assignment does not occur at the time of enrollment, capitation which would otherwise have been paid to a selected primary care physician or

primary care provider had a selection been made shall be reserved as a capitation payable until such time as an enrollee makes a selection or the plan assigns a primary care physician or primary care provider.

(2) If an enrollee does not select a primary care physician or primary care provider at the time of application or enrollment, a health maintenance organization may assign an enrollee to a primary care physician or primary care provider. If a health maintenance organization elects to assign an enrollee to a primary care physician or primary care provider, the assignment shall be made to a primary care physician or primary care provider located within the zip code nearest the enrollee's residence or place of employment and, to the extent practicable given the zip code limitation, shall be done in a manner that results in a fair and equal distribution of enrollees among the plan's primary care physicians or primary care providers. The health maintenance organization shall inform an enrollee of the name, address, and telephone number of the primary care physician or primary care provider to whom the enrollee has been assigned and of the enrollee's right to select a different primary care physician or primary care provider. An enrollee shall have the right at any time to reject the physician or provider assigned and to select another physician or provider from the list of primary care physicians or primary care providers for the health maintenance organization network. An election by an enrollee to reject an assigned physician or provider shall not be counted as a change in providers for purposes of the limitation described in Section 11(a) of this Act.

(3) A health maintenance organization shall notify a physician or provider of the selection of the physician or provider as a primary care physician or primary care provider by an enrollee within 30 working days of the selection or assignment of an enrollee to that physician

or provider by the health maintenance organization.

. . .

Revised Law

Sec. 843.316. ALTERNATIVE CAPITATION SYSTEM. As an alternative to the procedures prescribed by Section 843.315, a health maintenance organization may request approval from the department of a capitation payment system that ensures:

(1) immediate availability and accessibility of a primary care physician or primary care provider; and

(2) payment to a primary care physician or primary care provider of a capitated amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk assumed. (V.T.I.C. Art. 20A.18A, Sec. (e) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(e) The following applies to any health maintenance organization that to any extent uses capitation as a method of compensation:

. . .

(4) As an alternative to the provisions of Subdivisions (1), (2), and (3) of this subsection, a health maintenance organization may seek approval from the Texas Department of Insurance of a different capitation payment scheme that assures:

(A) immediate availability and accessibility of a primary care physician or primary care provider; and

(B) payment to the primary care physician or primary care provider of a capitation amount certified by a qualified actuary to be actuarially sufficient to compensate the primary care physician or primary care provider for the risk being assumed.

Revised Law

Sec. 843.317. EXCLUSION OF PHYSICIAN OR PROVIDER BASED ON AFFILIATION WITH HEALTH MAINTENANCE ORGANIZATION PROHIBITED. A physician, health care provider, group of physicians or health care providers, or health care facility or institution may not exclude a physician or provider from staff privileges or a facility or institution solely because the physician or provider is associated with a health maintenance organization that holds a

certificate of authority under this chapter. (V.T.I.C. Art. 20A.14, Sec. (e).)

Source Law

(e) No physician or health care provider or group of physicians or providers or health care facility or institution may exclude any other physician or provider from staff privileges, facilities, or institutions solely on the ground that such physician or provider is associated with a health maintenance organization issued a certificate of authority under this Act.

Revised Law

Sec. 843.318. CERTAIN CONTRACTS OF PARTICIPATING PHYSICIAN OR PROVIDER NOT PROHIBITED. (a) This chapter and this code do not prohibit a physician or provider who is participating in a health maintenance organization delivery network, whether by contracting with a health maintenance organization under Section 843.101 or by subcontracting with a physician or provider in the health maintenance organization delivery network, from entering into a contractual arrangement authorized by this section within a health maintenance organization delivery network.

(b) A physician may contract to provide medical care or arrange to provide medical care through subcontracts with other physicians. A physician may contract to provide through another provider any service that is ancillary to the practice of medicine, other than hospital or other institutional or inpatient provider services.

(c) A provider may contract to provide, or arrange to provide through a subcontract with a similarly licensed provider, any health care service that the providers are licensed to provide, other than medical care.

(d) A provider may contract to provide, or arrange to provide through a subcontract with another provider, a health care service that the provider is not licensed to provide, other than medical care, if the contracted or subcontracted services constitute less than 15 percent of the total amount of services the provider is to provide or arrange to provide.

(e) A contract or subcontract authorized under this section may provide for compensation under:

(1) a fee-for-service arrangement;

(2) a risk-sharing arrangement; or

(3) a capitation arrangement under which a fixed predetermined payment is made in exchange for the provision of, or for the arrangement to provide and the guaranty of the provision of, a defined set of covered services to covered

persons for a specified period without regard to the quantity of services actually provided. (V.T.I.C. Art. 20A.26, Secs. (f)(5), (6), (7), (8), (9).)

Source Law

(5) This Act and the Insurance Code may not be construed to prohibit a physician or provider who is participating in a health maintenance organization delivery network, whether contracting with a health maintenance organization under Section 6(a)(3) of this Act or subcontracting with a physician or provider in the health maintenance organization delivery network, from entering into a contractual arrangement within a health maintenance organization delivery network described under Subdivisions (6)-(9) of this subsection.

(6) A physician may contract to provide medical care or arrange to provide medical care through subcontracts with other physicians. A physician may contract to provide through other providers any services that are ancillary to the practice of medicine, other than hospital or other institutional or inpatient provider services.

(7) A provider may contract to provide, or arrange to provide through subcontracts with similarly licensed providers, any health care services that those providers are licensed to provide, other than medical care.

(8) A provider may contract to provide, or arrange to provide through subcontracts with other providers, a health care service that the provider is not licensed to provide, other than medical care, if the contracted or subcontracted services constitute less than 15 percent of the total amount of services to be provided by that provider or arranged to be provided for by that provider.

(9) A contract or subcontract authorized under Subdivision (6), (7), or (8) of this subsection may provide for compensation based on a fee-for-service arrangement, a risk-sharing arrangement, or a capitated risk arrangement under which a

fixed predetermined payment is made in exchange for the provision of, or the arrangement to provide and the guaranty of the provision of, a defined set of covered services to the covered persons for a specified period, regardless of the amount of services actually provided.

Revisor's Note
(End of Subchapter)

Section (j), V.T.I.C. Article 20A.14, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, provides that a health maintenance organization may not take various actions against an advanced practice nurse or physician assistant solely because the advanced practice nurse or physician assistant is not identified under Section 3, V.T.I.C. Article 21.52. The revised law omits Section (j) as unnecessary because Section 3, V.T.I.C. Article 21.52, as amended by Chapter 428, Acts of the 76th Legislature, Regular Session, 1999, includes advanced practice nurses and physician assistants. The omitted law reads:

(j) A health maintenance organization may not refuse to contract with an advanced practice nurse or physician assistant to be included in the organization's provider network, refuse to reimburse the advanced practice nurse or physician assistant for covered services, or otherwise discriminate against the advanced practice nurse or physician assistant solely because the advanced practice nurse or physician assistant is not identified under Section 3, Article 21.52, Insurance Code.

[Sections 843.319-843.335 reserved for expansion]

SUBCHAPTER J. PAYMENT OF CLAIMS TO PHYSICIANS AND PROVIDERS

Revised Law

Sec. 843.336. DEFINITION. In this subchapter, "clean claim" means a completed claim, as determined under department rules, submitted by a physician or provider for health care services under a health care plan. (V.T.I.C. Art. 20A.18B, Sec. (a).)

Source Law

Art. 20A.18B. (a) In this section, "clean claim" means a completed claim, as determined under Texas Department of Insurance rules, submitted by a physician or provider for medical care or health care services under a health care plan.

Revised Law

Sec. 843.337. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A physician or provider for health care services under a health care plan may obtain acknowledgment of receipt of a claim for health care services under a health care plan by submitting the claim by United States mail, return receipt requested.

(b) A health maintenance organization or the contracted clearinghouse of the health maintenance organization that receives a claim electronically shall acknowledge receipt of the claim by an electronic transmission to the physician or provider and is not required to acknowledge receipt of the claim in writing. (V.T.I.C. Art. 20A.18B, Sec. (b).)

Source Law

(b) A physician or provider for medical care or health care services under a health care plan may obtain acknowledgment of receipt of a claim for medical care or health care services under a health care plan by submitting the claim by United States mail, return receipt requested. A health maintenance organization or the contracted clearinghouse of the health maintenance organization that receives a claim electronically shall acknowledge receipt of the claim by an electronic transmission to the physician or provider and is not required to acknowledge receipt of the claim by the health maintenance organization in writing.

Revised Law

Sec. 843.338. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not later than the 45th day after the date on which a health maintenance organization receives a clean claim from a physician or provider, the health maintenance organization shall:

(1) pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) pay the portion of the claim that is not in

dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) notify the physician or provider in writing why the claim will not be paid. (V.T.I.C. Art. 20A.18B, Sec. (c).)

Source Law

(c) Not later than the 45th day after the date that the health maintenance organization receives a clean claim from a physician or provider, the health maintenance organization shall:

(1) pay the total amount of the claim in accordance with the contract between the physician or provider and the health maintenance organization;

(2) pay the portion of the claim that is not in dispute and notify the physician or provider in writing why the remaining portion of the claim will not be paid; or

(3) notify the physician or provider in writing why the claim will not be paid.

Revised Law

Sec. 843.339. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION BENEFIT CLAIMS. If a health maintenance organization or its designated agent authorizes treatment, a prescription benefit claim that is electronically adjudicated and electronically paid shall be paid not later than the 21st day after the date on which the treatment is authorized. (V.T.I.C. Art. 20A.18B, Sec. (d).)

Source Law

(d) If a prescription benefit claim is electronically adjudicated and electronically paid, and the health maintenance organization or its designated agent authorizes treatment, the claim must be paid not later than the 21st day after the treatment is authorized.

Revised Law

Sec. 843.340. AUDITED CLAIMS. A health maintenance organization that acknowledges coverage of an enrollee under a health care plan but intends to audit a claim submitted by a physician or provider shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date on which the health maintenance organization receives the claim from a physician or provider.

Following completion of the audit, any additional payment due a physician or provider or any refund due the health maintenance organization shall be made not later than the 30th day after the later of the date that:

(1) the physician or provider receives notice of the audit results; or

(2) any appeal rights of the enrollee are exhausted. (V.T.I.C. Art. 20A.18B, Sec. (e).)

Source Law

> (e) If the health maintenance organization acknowledges coverage of an enrollee under the health care plan but intends to audit the physician or provider claim, the health maintenance organization shall pay the charges submitted at 85 percent of the contracted rate on the claim not later than the 45th day after the date that the health maintenance organization receives the claim from the physician or provider. Following completion of the audit, any additional payment due a physician or provider or any refund due the health maintenance organization shall be made not later than the 30th day after the later of the date that:
>
> (1) the physician or provider receives notice of the audit results; or
>
> (2) any appeal rights of the enrollee are exhausted.

Revised Law

Sec. 843.341. CLAIMS PROCESSING PROCEDURES. (a) A health maintenance organization shall provide a participating physician or provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(b) A health maintenance organization may, by contract with a participating physician or provider, add or change the data elements that must be submitted with a claim from the physician or provider.

(c) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in a health maintenance organization's claim processing and payment procedures, the health maintenance organization shall provide written notice of the addition or change to each participating physician or provider. (V.T.I.C. Art. 20A.18B, Secs. (i), (j), (k).)

Source Law

(i) The health maintenance organization shall provide a participating physician or provider with copies of all applicable utilization review policies and claim processing policies or procedures, including required data elements and claim formats.

(j) A health maintenance organization may, by contract with a physician or provider, add or change the data elements that must be submitted with the physician or provider claim.

(k) Not later than the 60th day before the date of an addition or change in the data elements that must be submitted with a claim or any other change in a health maintenance organization's claim processing and payment procedures, the health maintenance organization shall provide written notice of the addition or change to each participating physician or provider.

Revised Law

Sec. 843.342. VIOLATION OF CERTAIN CLAIMS PAYMENT PROVISIONS; ADMINISTRATIVE PENALTY. (a) A health maintenance organization that violates Section 843.338 or 843.340 is liable to a physician or provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health care plan.

(b) In addition to any other penalty or remedy authorized by this code, a health maintenance organization that violates Section 843.338 or 843.340 is subject to an administrative penalty under Chapter 84. The administrative penalty imposed under that chapter may not exceed $1,000 for each day the claim remains unpaid in violation of Section 843.338 or 843.340. (V.T.I.C. Art. 20A.18B, Secs. (f), (h).)

Source Law

(f) A health maintenance organization that violates Subsection (c) or (e) of this section is liable to a physician or provider for the full amount of billed charges submitted on the claim or the amount payable under the contracted penalty rate, less any amount previously paid or any charge for a service that is not covered by the health

care plan.

(h) In addition to any other penalty or remedy authorized by the Insurance Code or another insurance law of this state, a health maintenance organization that violates Subsection (c) or (e) of this section is subject to an administrative penalty under Article 1.10E, Insurance Code. The administrative penalty imposed under that article may not exceed $1,000 for each day the claim remains unpaid in violation of Subsection (c) or (e) of this section.

Revisor's Note

Section (h), V.T.I.C. Article 20A.18B, refers to a "penalty or remedy authorized by the Insurance Code or another insurance law of this state." The revised law omits the reference to "another insurance law of this state" as unnecessary because all insurance laws of this state that authorize a penalty or remedy are now included in the Insurance Code.

Revised Law

Sec. 843.343. ATTORNEY'S FEES. A physician or provider may recover reasonable attorney's fees in an action to recover payment under Section 843.342. (V.T.I.C. Art. 20A.18B, Sec. (g).)

Source Law

(g) A physician or provider may recover reasonable attorney's fees in an action to recover payment under this section.

Revised Law

Sec. 843.344. APPLICABILITY TO ENTITIES CONTRACTING WITH HEALTH MAINTENANCE ORGANIZATION. Sections 843.336-843.343 apply to a person with whom a health maintenance organization contracts to:

(1) process claims; or

(2) obtain the services of physicians and providers to provide health care services to enrollees. (V.T.I.C. Art. 20A.18B, Sec. (n).)

Source Law

(n) This section applies to a person with whom a health maintenance organization contracts to process claims or to obtain the

services of physicians and providers to provide health care services to health care plan enrollees.

Revised Law

Sec. 843.345. EXCEPTIONS. Sections 843.336-843.344 do not apply to:

(1) a capitated payment required to be made to a physician or provider under an agreement to provide health care services, including medical care, under a health care plan; or

(2) a claim submitted by a physician or provider who is a member of the legislature. (V.T.I.C. Art. 20A.18B, Secs. (l), (m).)

Source Law

(l) This section does not apply to a claim made by a physician or provider who is a member of the legislature.

(m) This section does not apply to a capitation payment required to be made to a physician or provider under an agreement to provide medical care or health care services under a health care plan.

Revised Law

Sec. 843.346. PAYMENT OF CLAIMS. Subject to Sections 843.336-843.345, a health maintenance organization shall pay a physician or provider for health care services and benefits provided to an enrollee under the evidence of coverage and to which the enrollee is entitled under the terms of the evidence of coverage not later than:

(1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or

(2) if applicable, within the number of calendar days specified by written agreement between the physician or provider and the health maintenance organization. (V.T.I.C. Art. 20A.09, Sec. (j) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

(j) . . . A health maintenance organization shall make payment to a physician or provider for covered services rendered to enrollees of the health maintenance organization not later than the 45th day after the date a claim for payment is received with documentation reasonably necessary for the health maintenance

organization to process the claim or, if applicable, within the number of calendar days specified by written agreement between the physician or provider and the health maintenance organization. For purposes of this subsection, "covered services" means health care services and benefits to which enrollees are entitled under the terms of an applicable evidence of coverage.

Revisor's Note

Section (j), V.T.I.C. Article 20A.09, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, prescribes certain conditions relating to payment for covered services. V.T.I.C. Chapter 20A was amended by the addition of Article 20A.18B by Chapter 1343, Acts of the 76th Legislature, Regular Session, 1999. Article 20A.18B, which is revised as Sections 843.336-843.345, provides for payment of certain "clean claims" submitted by a physician or provider. Section 312.014(a), Government Code, provides that "[i]f statutes enacted at . . . different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails." Thus, as the later enactment, Article 20A.18B prevails over Section (j), Article 20A.09, to the extent of any conflict. Accordingly, the revised law includes a reference to Sections 843.336-843.345.

Revisor's Note

(End of Subchapter)

Section (o), V.T.I.C. Article 20A.18B, authorizes the commissioner of insurance to adopt rules as necessary to implement Article 20A.18B, revised in this subchapter. The revised law omits that provision as unnecessary because V.T.I.C. Article 20A.22, revised as Section 843.151, authorizes the commissioner of insurance to adopt rules to implement the Texas Health Maintenance Organization Act, including Article 20A.18B. The omitted law reads:

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

[Sections 843.347-843.360 reserved for expansion]

SUBCHAPTER K. RELATIONS BETWEEN ENROLLEE AND PHYSICIAN OR PROVIDER

Revised Law

Sec. 843.361. ENROLLEES HELD HARMLESS. A contract or other agreement between a health maintenance organization and a physician or provider must specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services if the health maintenance organization does not pay the physician or provider for those services. (V.T.I.C. Art. 20A.18A, Sec. (g), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (g) All contracts or other agreements between a health maintenance organization and a physician or provider shall specify that the physician or provider will hold an enrollee harmless for payment of the cost of covered health care services in the event the health maintenance organization fails to pay the provider for health care services.

Revised Law

Sec. 843.362. CONTINUITY OF CARE; OBLIGATION OF HEALTH MAINTENANCE ORGANIZATION. (a) In this section, "special circumstance" means a condition regarding which a treating physician or provider reasonably believes that discontinuing care by that physician or provider could cause harm to an enrollee who is a patient. Examples of an enrollee who has a special circumstance include an enrollee with a disability, acute condition, life-threatening illness, or who is past the 24th week of pregnancy.

(b) Each contract between a health maintenance organization and a physician and provider must provide that termination of the contract, except for reason of medical competence or professional behavior, does not release the health maintenance organization from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to an enrollee who has a special circumstance in accordance with the dictates of medical prudence. Subject to Subsections (d) and (e), the health maintenance organization must provide continued reimbursement at not less than the contract rate in exchange for the enrollee's continued receipt of ongoing treatment from the physician or provider.

(c) The treating physician or provider shall identify a special circumstance. The treating physician or provider must:

(1) request that an enrollee be permitted to continue

treatment under the physician's or provider's care; and

(2) agree not to seek payment from the enrollee of any amount for which the enrollee would not be responsible if the physician or provider continued to be included in the health maintenance organization delivery network.

(d) Except as provided by Subsection (e), this section does not extend the obligation of a health maintenance organization to reimburse a terminated physician or provider for ongoing treatment of an enrollee after:

(1) the 90th day after the effective date of the termination; or

(2) if the enrollee has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination.

(e) If an enrollee is past the 24th week of pregnancy at the time of termination, a health maintenance organization's obligation to reimburse a terminated physician or provider or, if applicable, an enrollee extends through delivery of the child and applies to immediate postpartum care and a follow-up checkup within the six-week period after delivery.

(f) A contract between a health maintenance organization and a physician or provider must provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. (V.T.I.C. Art. 20A.18A, Sec. (c) (part), as added Acts 75th Leg., R.S., Ch. 1026.)

Source Law

> (c) . . . Each contract must also provide that the termination of the physician or provider contract, except for reason of medical competence or professional behavior, does not release the health maintenance organization from the obligation to reimburse the physician or provider who is treating an enrollee of special circumstance, such as a person who has a disability, acute condition, or life-threatening illness or is past the twenty-fourth week of pregnancy, at no less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of an enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence. For purposes of this subsection, "special circumstance" means a condition such that the treating physician or provider reasonably believes that discontinuing care by the treating physician or provider could cause

harm to the patient. The special circumstance shall be identified by the treating physician or provider, who must request that the enrollee be permitted to continue treatment under the physician's or provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the physician or provider were still on the health maintenance organization network. Contracts between a health maintenance organization and physicians or providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a physician or provider. This section does not extend the obligation of the health maintenance organization to reimburse the terminated physician or provider for ongoing treatment of an enrollee beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the health maintenance organization to reimburse the terminated physician or provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

Revised Law

Sec. 843.363. PROTECTED PHYSICIAN OR PROVIDER COMMUNICATIONS WITH PATIENTS. (a) A health maintenance organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith with a current, prospective, or former patient, or a person designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(2) information or opinions regarding the terms, requirements, or services of the health care plan as they relate

to the medical needs of the patient; or

(3) the termination of the physician's, dentist's, or provider's contract with the health care plan or the fact that the physician, dentist, or provider will otherwise no longer be providing medical care, dental care, or health care services under the health care plan.

(b) A health maintenance organization may not in any manner penalize, terminate, or refuse to compensate for covered services a physician, dentist, or provider for communicating in a manner protected by this section with a current, prospective, or former patient, or a person designated by a patient.

(c) A contract provision that violates this section is void.

(V.T.I.C. Art. 20A.14, Sec. (i), as added Acts 75th Leg., R.S., Ch. 1026; Art. 20A.18A, as added Acts 75th Leg., R.S., Ch. 735.)

Source Law

[Art. 20A.14]

(i)(1) A health maintenance organization shall not, as a condition of a contract with a physician or provider or in any other manner, prohibit, attempt to prohibit, or discourage a physician or provider from:

(A) discussing with or communicating to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the patient's health care, including but not limited to the patient's medical condition or treatment options; or

(B) discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient.

(2) A health maintenance organization shall not in any way penalize, terminate, or refuse to compensate, for covered services, a physician or provider for discussing or communicating with a current, prospective, or former patient, or a party designated by a patient, pursuant to this section.

Art. 20A.18A. (a) A health maintenance organization may not, as a condition of a contract with a physician, dentist, or provider, or in any other manner, prohibit, attempt to prohibit, or discourage a physician, dentist, or provider from discussing with or communicating in good faith to a current, prospective, or former patient, or a party designated by a patient, with respect to:

(1) information or opinions regarding the patient's health care, including the patient's medical condition or treatment options;

(2) information or opinions regarding the provisions, terms, requirements, or services of the health care plan as they relate to the medical needs of the patient; or

(3) the fact that the physician's, dentist's, or provider's contract with the health care plan has terminated or that the physician, dentist, or provider will otherwise no longer be providing medical care, dental care, or health care services under the health care plan.

(b) A health maintenance organization may not in any way penalize, terminate, or refuse to compensate, for covered services, a physician, dentist, or provider for communicating with a current, prospective, or former patient, or a party designated by a patient, in any manner protected by this section.

(c) A contract provision that violates this section is hereby declared void.

Revisor's Note

(1) Section (i), V.T.I.C. Article 20A.14, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, is substantively identical to Sections (a)(1), (a)(2), and (b), V.T.I.C. Article 20A.18A, as added by Chapter 735, Acts of the 75th Legislature, Regular Session, 1997, except that Section (i)(1)(A), V.T.I.C. Article 20A.14, protects communications regarding a patient's medical condition or treatment

options without explicitly requiring that the communications be made in good faith, while Section (a)(1), V.T.I.C. Article 20A.18A, explicitly requires good faith in order for the communications to be protected. V.T.I.C. Article 20A.18A also provides that a contract provision that violates that article is void. Subchapter C, Chapter 311, Government Code (Code Construction Act), Section 312.014, Government Code, and general rules of statutory construction indicate that different amendments to a statute regarding the same subject should be reconciled whenever possible. The revised law includes the requirement that communications be made in good faith and includes the provision that voids a contract provision in violation of this section because the amendments are reconcilable in this manner. Also, there is no indication that the legislature in enacting Section (i), V.T.I.C. Article 20A.14, intended to override the applicable provisions of V.T.I.C. Article 20A.18A.

(2) Section (i)(1)(B), V.T.I.C. Article 20A.14, as added by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, and Section (a)(2), V.T.I.C. Article 20A.18A, as added by Chapter 735, Acts of the 75th Legislature, Regular Session, 1997, refer to "provisions, terms, requirements, or services." The revised law omits "provisions" as unnecessary because it is included within the meaning of "terms [and] requirements."

[Sections 843.364-843.400 reserved for expansion]

SUBCHAPTER L. FINANCIAL REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

Revised Law

Sec. 843.401. FIDUCIARY RESPONSIBILITY. A director, officer, member, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in a fiduciary relationship to the enrollees. (V.T.I.C. Art. 20A.08.)

Source Law

Art. 20A.08. Any director, officer, member, employee, or partner of a health

maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the enrollees.

Revised Law

Sec. 843.402. OFFICERS' AND EMPLOYEES' BOND. (a) A health maintenance organization shall maintain in force in its own name a fidelity bond on its officers and employees in an amount of at least $100,000 or another amount prescribed by the commissioner.

(b) The fidelity bond must be issued by an insurer that holds a certificate of authority in this state. If, after notice and hearing, the commissioner determines that a fidelity bond is not available from an insurer that holds a certificate of authority in this state, the health maintenance organization may obtain a fidelity bond procured by a surplus lines agent resident in this state in compliance with Chapter 981.

(c) The fidelity bond must obligate the surety to pay any loss of money or other property the health maintenance organization sustains because of an act of fraud or dishonesty by an employee or officer of the health maintenance organization, acting alone or in concert with others, while employed or serving as an officer of the health maintenance organization.

(d) Instead of a fidelity bond, a health maintenance organization may deposit cash with the comptroller. The deposit must be maintained in the amount and is subject to the same conditions required for a fidelity bond under this section. (V.T.I.C. Art. 20A.30.)

Source Law

Art. 20A.30. (a) A health maintenance organization shall maintain in force a fidelity bond in its own name on its officers and employees in an amount not less than $100,000 or in any other amount prescribed by the commissioner. Except as otherwise provided by this subsection, the bond must be issued by an insurance company that holds a certificate of authority in this state. If, after notice and hearing, the State Board of Insurance determines that the fidelity bond required by this section is not available from an insurance company that holds a certificate of authority in this state, a fidelity bond procured by a licensed Texas surplus lines agent resident in this state in

compliance with Article 1.14-2, Insurance Code, satisfies the requirements of this section.

(b) The fidelity bond shall obligate the surety to pay a loss of money or other property the health maintenance organization sustains through acts of fraud or dishonesty on the part of any employee or officer of the health maintenance organization acting either alone or in concert with others, while employed or serving as an officer of a health maintenance organization.

(c) Instead of a bond, a health maintenance organization may deposit cash with the comptroller. Such a deposit must be maintained in the amount and subject to the same conditions required for a bond under this section.

Revised Law

Sec. 843.403. MINIMUM NET WORTH. (a) A health maintenance organization authorized to provide basic health care services shall maintain a minimum net worth of $1.5 million.

(b) A health maintenance organization authorized to provide limited health care services shall maintain a minimum net worth of $1 million.

(c) A health maintenance organization authorized to offer only a single health care service plan shall maintain a minimum net worth of $500,000.

(d) The minimum net worth required by this section may consist only of:

(1) money of the United States;

(2) bonds of this state;

(3) bonds or other evidences of indebtedness of the United States that are guaranteed as to principal and interest by the United States; or

(4) bonds or other interest-bearing evidences of indebtedness of a county or municipality of this state. (V.T.I.C. Art. 20A.13A.)

Source Law

Art. 20A.13A. (a) A health maintenance organization authorized to provide basic health care services shall maintain a minimum net worth of $1.5 million.

(b) A health maintenance organization authorized to provide limited health care services shall maintain a minimum net worth

of $1 million.

(c) A health maintenance organization authorized to offer only a single health care service plan shall maintain a minimum net worth of $500,000.

(d) The minimum net worth required by this section shall consist only of the following:

(1) lawful money of the United States of America;

(2) bonds of this state;

(3) bonds or other evidences of indebtedness of the United States of America or any of its agencies when such obligations are guaranteed as to principal and interest by the United States of America; or

(4) bonds or other interest-bearing evidences of indebtedness of any counties or municipalities of this state.

Revisor's Note

V.T.I.C. Article 20A.13A refers to bonds or other evidences of indebtedness "of the United States of America or any of its agencies." The reference to "its agencies" is omitted from the revised law because under Section 311.005(9), Government Code (Code Construction Act), "United States" includes an agency of the United States.

Revised Law

Sec. 843.4031. PHASE-IN PERIOD FOR MINIMUM NET WORTH. (a) Notwithstanding Section 843.403(a), a health maintenance organization authorized to provide basic health care services that holds a certificate of authority under this chapter issued before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $500,000 not later than December 31, 2000;

(2) $1 million not later than December 31, 2001; and

(3) $1.5 million not later than December 31, 2002.

(b) Notwithstanding Section 843.403(b), a health maintenance organization authorized to provide limited health care services that holds a certificate of authority under this chapter issued before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $300,000 not later than December 31, 2000;

(2) $600,000 not later than December 31, 2001; and

(3) $1 million not later than December 31, 2002.

(c) Notwithstanding Section 843.403(c), a health

maintenance organization authorized to offer only a single health care service plan that holds a certificate of authority under this chapter issued before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $150,000 not later than December 31, 2000;

(2) $300,000 not later than December 31, 2001; and

(3) $500,000 not later than December 31, 2002.

(d) This section expires January 1, 2003. (V.T.I.C. Art. 20A.13B.)

Source Law

Art. 20A.13B. (a) A health maintenance organization authorized to provide basic health care services that was licensed before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $500,000 not later than December 31, 2000;

(2) $1 million not later than December 31, 2001; and

(3) $1.5 million not later than December 31, 2002.

(b) A health maintenance organization authorized to provide limited health care services that was licensed before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $300,000 not later than December 31, 2000;

(2) $600,000 not later than December 31, 2001; and

(3) $1 million not later than December 31, 2002.

(c) A health maintenance organization authorized to offer only a single health care service plan that was licensed before September 1, 1999, shall achieve and maintain a minimum net worth of:

(1) $150,000 not later than December 31, 2000;

(2) $300,000 not later than December 31, 2001; and

(3) $500,000 not later than December 31, 2002.

(d) This section expires January 1, 2003.

Revised Law

Sec. 843.404. ADDITIONAL NET WORTH REQUIREMENTS. (a) The commissioner may adopt rules or by rule establish guidelines requiring a health maintenance organization to maintain a specified net worth based on:

(1) the nature and kind of risks the health maintenance organization underwrites or reinsures;

(2) the premium volume of risks the health maintenance organization underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio;

(4) fluctuations in the market value of securities the health maintenance organization holds;

(5) the adequacy of the health maintenance organization's reserves;

(6) the number of individuals enrolled by the health maintenance organization; or

(7) other business risks.

(b) Rules adopted or guidelines established under this section must be designed to ensure the financial solvency of health maintenance organizations for the protection of enrollees. The rules or guidelines may provide for a health maintenance organization to comply with a risk-based net worth requirement established under this section in stages over a two-year period. (V.T.I.C. Art. 20A.13C.)

Source Law

Art. 20A.13C. (a) The commissioner may adopt rules or by rule establish guidelines requiring any health maintenance organization that holds a certificate of authority under this Act to maintain a specified net worth based on:

(1) the nature and type of risks the health maintenance organization underwrites or reinsures;

(2) the premium volume of risks the health maintenance organization underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the health maintenance organization's investment portfolio;

(4) fluctuations in the market value of securities the health maintenance organization holds;

(5) the adequacy of the health maintenance organization's reserves;

(6) the number of individuals enrolled by the health maintenance organization; or

(7) other business risks.

(b) Rules adopted or guidelines established under Subsection (a) of this section must be designed to ensure the financial solvency of health maintenance organizations for the protection of enrollees. The rules and guidelines may provide for a health maintenance organization to comply with a risk-based net worth requirement established under Subsection (a) of this section in stages over a two-year period.

Revisor's Note

Section (a), V.T.I.C. Article 20A.13C, refers to actions the commissioner of insurance may take in relation to a health maintenance organization "that holds a certificate of authority under this Act." Throughout this chapter, the revised law omits the quoted language and similar language as unnecessary in any context in which it is clear the law refers to health maintenance organizations engaging in business in Texas. All health maintenance organizations engaging in business in Texas are required to hold a certificate of authority under this chapter, and the descriptive phrase referring to the certificate is unnecessary.

Revised Law

Sec. 843.405. DEPOSIT WITH COMPTROLLER. (a) Unless otherwise provided by this section, a health maintenance organization shall deposit with the comptroller cash or securities, or any combination of cash, securities, and other guarantees that are acceptable to the commissioner, in the amount prescribed by this section.

(b) The amount of a health maintenance organization's initial deposit or other guarantee must be $100,000 for a health maintenance organization offering basic health care services, $75,000 for a health maintenance organization offering limited health care services, and $50,000 for a health maintenance organization offering a single health care service plan.

(c) On or before March 15 of the year following the year in which the health maintenance organization receives a certificate

of authority, it shall deposit with the comptroller an amount equal to the difference between the initial deposit and 100 percent of its estimated uncovered health care expenses for the first 12 months of operation.

(d) On or before March 15 of each subsequent year, a health maintenance organization shall deposit the amount of the difference between its total uncovered health care expenses, based on its annual statement from the previous year, and the total amount previously deposited and not withdrawn from the state treasury. For any subsequent year in which the amount of the difference specified by this subsection is zero or less, the commissioner may not require the health maintenance organization to make any additional deposit under this subsection.

(e) If, on application made not more than once in each calendar year by a health maintenance organization, the commissioner determines that the amount previously deposited by the health maintenance organization has exceeded the amount required to be on deposit by more than $50,000 for a continuous 12-month period, the commissioner shall allow the health maintenance organization to withdraw the portion of the deposit that exceeds by more than $50,000 the amount required to be on deposit, unless the commissioner determines that the release of a portion of the deposit could be hazardous to enrollees, creditors, or the public.

(f) If, on application, the commissioner determines that the amount previously deposited by a health maintenance organization continues to exceed the amount required to be on deposit, the commissioner shall allow the health maintenance organization to withdraw the portion of the deposit that exceeds the amount required to be on deposit, unless the commissioner determines that the release of that portion of the deposit could be hazardous to enrollees, creditors, or the public.

(g) On application by a health maintenance organization operating for more than one year under a certificate of authority, the commissioner may waive some or all of the requirements imposed by Subsection (b), (c), or (d) for any period if the commissioner determines that the waiver is justified because:

(1) the total amount of the deposit or other guarantee is equal to at least 25 percent of the health maintenance organization's estimated uncovered expenses for the next calendar year;

(2) the health maintenance organization's net worth is equal to at least 25 percent of its estimated uncovered expenses for the next calendar year;

(3) the health maintenance organization has a net worth of at least $5 million; or

(4) the health maintenance organization's sponsoring

organization has a net worth of at least $5 million for each health maintenance organization whose uncovered expenses the sponsoring organization guarantees.

(h) If one or more of the requirements imposed by Subsection (b), (c), or (d) is waived, any amount previously deposited shall remain on deposit until released in whole or in part by the comptroller on order of the commissioner under Subsection (g).

(i) A health maintenance organization that has made a deposit with the comptroller may, at its option, withdraw the deposit or any part of the deposit after substituting a deposit of cash or securities of equal amount and value to the withdrawn deposit or portion of deposit. The commissioner must first approve any securities being substituted. (V.T.I.C. Art. 20A.13, Secs. (a), (b) (part), (d), (e), (f), (g), (h).)

Source Law

Art. 20A.13. (a) Unless otherwise provided by this section, each health maintenance organization shall deposit with the comptroller cash or securities, or any combination of these or other guarantees that are acceptable to the commissioner, in an amount as set forth in this section.

(b) For a health maintenance organization . . . :

(1) the amount of the initial deposit or other guarantee shall be $100,000 for an organization offering basic health care services, $75,000 for an organization offering limited health care services, and $50,000 for an organization offering a single health care service plan;

(2) on or before March 15 of the year following the year in which the health maintenance organization receives a certificate of authority, it shall deposit with the comptroller an amount equal to the difference between the initial deposit and 100 percent of its estimated uncovered health care expenses for the first 12 months of operation;

(3) on or before March 15 of each subsequent year, it shall deposit the difference between its total uncovered health care expenses based on its annual statement from the previous year and the total amount previously deposited and not withdrawn from

the State Treasury; and

(4) in any year in which the amount determined in accordance with Subdivision (3) of this subsection is zero or less than zero, the commissioner may not require the health maintenance organization to make any additional deposit under this subsection.

(d) If, on application made not more than once in each calendar year by a health maintenance organization under this subsection, the commissioner determines that the amount previously deposited by the organization under this section has exceeded the amount required under this section by more than $50,000 for a continuous 12-month period, the commissioner shall allow the organization to withdraw the portion of the deposit that exceeds by more than $50,000 the amount required to be on deposit for that organization, unless the commissioner considers that the release of a portion of the deposit could be hazardous to enrollees, creditors, or the general public.

(e) On application made not sooner than the 24th month after the effective date of this subsection, if the commissioner determines that the amount previously deposited by an organization under this section continues to exceed the amount required under this section, the commissioner shall allow the organization to withdraw the portion of the deposit that exceeds the amount required to be on deposit for that organization, unless the commissioner considers that the release of the deposit could be hazardous to enrollees, creditors, or the general public.

(f) Upon application by a health maintenance organization operating for more than one year under a certificate of authority issued by the State Board of Insurance or the commissioner, the commissioner may waive some or all of the requirements of Subsection (b) or (c) of this section for any period of time it shall deem proper whenever it finds that one or more of

the following conditions justifies such waiver:

(1) the total amount of the deposit or other guarantee is equal to 25 percent of the health maintenance organization's estimated uncovered expenses for the next calendar year;

(2) the health maintenance organization's net worth is equal to at least 25 percent of its estimated uncovered expenses for the next calendar year; or

(3) either the health maintenance organization has a net worth of $5,000,000 or its sponsoring organization has a net worth of at least $5,000,000 for each health maintenance organization whose uncovered expenses it guarantees.

(g) If one or more of the requirements is waived, any amount previously deposited shall remain on deposit until released in whole or in part by the comptroller upon order of the commissioner pursuant to Subsection (f) of this section.

(h) A health maintenance organization that has made a deposit with the comptroller may, at its option, withdraw the deposit or any part thereof, first having deposited with the comptroller, in lieu thereof, a deposit of cash or securities of equal amount and value to that withdrawn. Any securities shall be approved by the commissioner before being substituted.

Revisor's Note

(1) V.T.I.C. Article 20A.13 distinguishes, for purposes of security deposit requirements, between health maintenance organizations that received certificates of authority before September 1, 1987, and health maintenance organizations that received certificates of authority on or after that date. Health maintenance organizations that received a certificate of authority before that date were required to make initial deposits not later than March 15, 1988. The revised law omits those provisions as executed. The omitted law reads:

(b) [For a health maintenance organization] which has not received a certificate of authority from the State Board of Insurance or the commissioner prior to September 1, 1987:

. . .

(c) For a health maintenance organization which has received a certificate of authority from the State Board of Insurance prior to September 1, 1987:

(1) on or before March 15, 1988, the organization shall deposit an amount equal to the sum of:

(A) $100,000 for an organization offering basic health care services or $50,000 for an organization offering a single health care service plan; and

(B) 100 percent of the uncovered health care expenses for the preceding 12 months of operation;

(2) on or before March 15 of each subsequent year, the organization shall make additional deposits of the difference between its total uncovered health care expenses based on its annual statement from the previous year and the total amount previously deposited and not withdrawn from the State Treasury; and

(3) in any year in which the amount determined in accordance with Subdivision (2) of this subsection is zero or less than zero, the commissioner may not require the health maintenance organization to make any additional deposit under this subsection.

(2) Section (e), V.T.I.C. Article 20A.13, refers to an application "made not sooner than the 24th month after the effective date of this subsection." The relevant version of Section (e) was added by Chapter 567, Acts of the 70th Legislature, Regular Session, 1987, and took effect September 1, 1987. The revised law omits the quoted language as executed.

Revised Law

Sec. 843.406. HAZARDOUS FINANCIAL CONDITION. (a) If the

financial condition of a health maintenance organization indicates that the continued operation of the health maintenance organization could be hazardous to its enrollees or creditors or the public, the commissioner may, after notice and opportunity for hearing:

(1) suspend or revoke the health maintenance organization's certificate of authority; or

(2) order the health maintenance organization to take action reasonably necessary to correct the condition, including by:

(A) reducing by reinsurance the total amount of present and potential liability for benefits;

(B) reducing the volume of new business being accepted;

(C) reducing expenses by specified methods;

(D) suspending or limiting for a period the writing of new business; or

(E) increasing the health maintenance organization's capital and surplus by contribution.

(b) In a manner consistent with the purposes of this section, the commissioner by rule may establish:

(1) uniform standards and criteria for early warning that the continued operation of a health maintenance organization could be hazardous to the health maintenance organization's enrollees or creditors or the public; and

(2) standards for evaluating the financial condition of a health maintenance organization. (V.T.I.C. Art. 20A.19.)

Source Law

Art. 20A.19. (a) Whenever the financial condition of any health maintenance organization indicates a condition such that the continued operation of the health maintenance organization might be hazardous to its enrollees, creditors, or the general public, then the commissioner may, after notice and opportunity for hearing, order the health maintenance organization to take such action as may be reasonably necessary to rectify the existing condition, including but not necessarily limited to one or more of the following steps:

(1) to reduce the total amount of present and potential liability for benefits by reinsurance;

(2) to reduce the volume of new business being accepted;

(3) to reduce expenses by

specified methods;

(4) to suspend or limit the writing of new business for a period of time;

(5) to increase the health maintenance organization's capital and surplus by contribution; or

(6) to suspend or revoke the certificate of authority.

(b) The commissioner is authorized, by rules and regulations, to fix uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public, and to fix standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in Subsection (a) of this section.

Revised Law

Sec. 843.407. RECEIVERSHIP AND DELINQUENCY PROCEEDINGS. (a) In addition to all other remedies available by law, if the commissioner believes that a health maintenance organization or another person is insolvent or does not maintain the net worth required under Sections 843.403, 843.4031, and 843.404, the commissioner may bring an action in a Travis County district court to be named receiver in accordance with Section 843.157 and Article 21.28.

(b) The court may:

(1) find that a receiver should take charge of the assets of the health maintenance organization; and

(2) name the commissioner as the receiver of the health maintenance organization in accordance with Section 843.157 and Article 21.28.

(c) The operations and business of a health maintenance organization represent the business of insurance for purposes of Section 843.157 and Articles 21.28 and 21.28-A.

(d) Exclusive venue of receivership and delinquency proceedings for a health maintenance organization is in Travis County. (V.T.I.C. Art. 20A.31, Secs. (b), (c), (d), (e).)

Source Law

(b) In addition to all other remedies available by law, when it appears to the commissioner that a health maintenance organization or other person is insolvent or does not possess the surplus required by

Section 13 of this Act, the commissioner may bring suit in a district court of Travis County to be named receiver in accordance with Section 21 of this Act and Article 21.28, Insurance Code.

(c) A court of competent jurisdiction may find that a receiver should take charge of the assets of a health maintenance organization and name the commissioner as the receiver of the health maintenance organization in accordance with Section 21 of this Act and Article 21.28, Insurance Code.

(d) The operations and business of a health maintenance organization represent the business of insurance for purposes of Section 21 of this Act and Articles 21.28 and 21.28-A, Insurance Code.

(e) Exclusive venue of receivership and delinquency proceedings for a health maintenance organization shall be in Travis County.

Revisor's Note

(1) Section (b), V.T.I.C. Article 20A.31, refers to a requirement that a health maintenance organization or other person "possess the surplus required by Section 13 of this Act." Section 13 of the Texas Health Maintenance Organization Act (V.T.I.C. Article 20A.13) is revised as Section 843.405. However, in 1999 the legislature substantially revised Article 20A.13. Section 3, Chapter 273, Acts of the 76th Legislature, Regular Session, 1999, repealed the provisions of Article 20A.13 that established surplus requirements for health maintenance organizations. Section 2, Chapter 273, Acts of the 76th Legislature, Regular Session, 1999, added Sections 13A, 13B, and 13C to the Texas Health Maintenance Organization Act. The added sections, revised as Sections 843.403, 843.4031, and 843.404, require health maintenance organizations to maintain a minimum net worth in the form of cash or certain government debt and authorize the commissioner to prescribe additional net worth provisions designed to ensure solvency. It is clear that the legislature intended the

net worth requirements to perform the function of the repealed surplus requirements. Therefore, the revised law references the net worth requirements of Sections 843.403, 843.4031, and 843.404 instead of the repealed surplus requirements.

(2) Section (c), V.T.I.C. Article 20A.31, refers to a court "of competent jurisdiction." The revised law omits the quoted language as unnecessary because 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. 843.408. INSOLVENCY AND ALLOCATION TO OTHER HEALTH MAINTENANCE ORGANIZATIONS. (a) If a health maintenance organization becomes insolvent, the commissioner shall equitably allocate the insolvent health maintenance organization's group contracts and nongroup enrollees among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area. The commissioner shall allocate the group contracts by order. In making allocations, the commissioner shall consider the resources of each health maintenance organization.

(b) A successor health maintenance organization to which one or more groups are allocated shall offer each group the successor health maintenance organization's coverage at rates determined in accordance with the successor health maintenance organization's existing methodology or in accordance with that methodology as adjusted by the commissioner.

(c) A successor health maintenance organization to which nongroup enrollees are allocated shall offer each nongroup enrollee the successor health maintenance organization's existing coverage for individual or conversion coverage, as determined by the nongroup enrollee's type of coverage from the insolvent health maintenance organization, at rates determined in accordance with the successor health maintenance organization's existing methodology or in accordance with that methodology as adjusted by the commissioner. A successor health maintenance organization that does not offer direct nongroup enrollment shall provide coverage at rates that reflect the average group rate of the successor health maintenance organization. (V.T.I.C. Art. 20A.13, Sec. (m).)

Source Law

(m) In the event of the insolvency of a health maintenance organization and on order of the commissioner, the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the resources of each health maintenance organization. Each health maintenance organization to which a group or groups are allocated shall offer such group or groups the health maintenance organization's coverage at rates determined in accordance with the successor health maintenance organization's existing methodology or as adjusted by the commissioner. In addition, the commissioner shall allocate equitably among all health maintenance organizations that operate within a portion of the insolvent health maintenance organization's service area the insolvent health maintenance organization's nongroup enrollees, taking into consideration the resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer each such nongroup enrollee that health maintenance organization's existing coverage for individual or conversion coverage as determined by the nongroup enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology or as adjusted by the commissioner. The successor health maintenance organizations that do not offer direct nongroup enrollment shall provide coverage at rates that reflect the average group rate of the successor health maintenance organization.

[Sections 843.409-843.434 reserved for expansion]

SUBCHAPTER M. HEALTH MAINTENANCE ORGANIZATION SOLVENCY SURVEILLANCE COMMITTEE

Revised Law

Sec. 843.435. DEFINITION. In this subchapter, "committee" means the Health Maintenance Organization Solvency Surveillance Committee. (New.)

Revisor's Note

The revised law adds a definition of "Health Maintenance Organization Solvency Surveillance Committee" for the convenience of the reader and to avoid frequent, unnecessary repetition of the substance of the definition.

Revised Law

Sec. 843.436. COMPOSITION AND ADMINISTRATION. (a) The Health Maintenance Organization Solvency Surveillance Committee exists under the direction of the commissioner.

(b) The committee is composed of nine members appointed by the commissioner. Each member must be a health maintenance organization that holds a certificate of authority under this chapter or a public representative. If a member is a health maintenance organization or its holding company system, the commissioner shall appoint an officer or employee of the member to represent the member on the committee. No two individuals on the committee may be employees or officers of the same health maintenance organization or holding company system.

(c) Five of the members shall represent health maintenance organizations or their holding company systems. Of the health maintenance organization members, one shall represent a limited health care service plan and one shall represent a single health care service plan. The commissioner shall select the remaining health maintenance organization members after considering appropriate factors such as the varying categories of premium income and geographic location.

(d) A public representative may not:

(1) be an officer, director, or employee of a health maintenance organization, a health maintenance organization agent, or any other business entity regulated by the commissioner;

(2) be a person required to register under Chapter 305, Government Code; or

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

(e) Qualifications for membership, terms of office, and reimbursement of expenses shall be governed by the approved plan of operation required under Section 843.437. (V.T.I.C. Art. 20A.36, Sec. (a) (part), as amended Acts 75th Leg., R.S.,

Ch. 1023; Sec. (a) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

Source Law

Art. 20A.36. (a) [as amended Acts 75th Leg., R.S., Ch. 1023] The Health Maintenance Organization Solvency Surveillance Committee is created under the direction of the commissioner. . . . The committee is composed of nine members appointed by the commissioner of insurance. No two members may be employees or officers of the same health maintenance organization or holding company system. The qualifications for membership, terms of office, and reimbursement of expenses shall be as provided by the plan of operation approved by the commissioner. A "member" is a Texas licensed health maintenance organization as defined in Section 2(j) of this Act or a public representative. The commissioner of insurance shall appoint the member along with the officer or employee of the member who shall serve on the committee if the member is a representative of a Texas licensed health maintenance organization or its holding company system. Five of the members shall represent health maintenance organizations or their holding company system. Of the health maintenance organization members, one shall be a limited health care service plan as defined in Section 2(l) of this Act, if one exists at the time of appointment, and one shall be a single health care service plan as defined in Section 2(u) of this Act. The remaining health maintenance organization members shall be selected by the commissioner of insurance with due consideration of factors deemed appropriate including, but not limited to, the varying categories of premium income and geographical location.

A public representative may not be:

(1) an officer, director, or employee of a health maintenance organization, a health maintenance organization agent, or any other business entity regulated by the commissioner;

(2) a person required to register

as a lobbyist under Chapter 305, Government Code; or

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

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] The Health Maintenance Organization Solvency Surveillance Committee is created under the direction of the commissioner. . . . The committee is composed of nine members appointed by the commissioner. No two members may be employees or officers of the same health maintenance organization or holding company system. The qualifications for membership, terms of office, and reimbursement of expenses shall be as provided by the plan of operation approved by the commissioner. A "member" is a Texas licensed health maintenance organization as defined in Section 2(n) of this Act or a public representative. The commissioner of insurance shall appoint the member along with the officer or employee of the member who shall serve on the committee if the member is a representative of a Texas licensed health maintenance organization or its holding company system. Five of the members shall represent health maintenance organizations or their holding company system. Of the health maintenance organization members, one shall be a single health care service plan as defined in Section 2(y) of this Act. The remaining health maintenance organization members shall be selected by the commissioner with due consideration of factors deemed appropriate including, but not limited to, the varying categories of premium income and geographical location.

A public representative may not be:

(1) an officer, director, or employee of a health maintenance organization, a health maintenance organization agent, or any other business entity regulated by the commissioner;

(2) a person required to register with the Texas Ethics Commission under

Chapter 305, Government Code; or

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

Revisor's Note

Section (a), V.T.I.C. Article 20A.36, as amended by Chapter 1023, Acts of the 75th Legislature, Regular Session, 1997, refers to "a person required to register as a lobbyist under Chapter 305, Government Code." Section (a), V.T.I.C. Article 20A.36, as amended by Chapter 1026, Acts of the 75th Legislature, Regular Session, 1997, refers to "a person required to register with the Texas Ethics Commission under Chapter 305, Government Code." The revised law omits the reference to registration as a "lobbyist" because that term is not used in Chapter 305, Government Code. The revised law also omits the reference to registration "with the Texas Ethics Commission" as unnecessary because Chapter 305, Government Code, provides for registration only with that agency.

Revised Law

Sec. 843.437. PLAN OF OPERATION. (a) The committee shall perform its functions under a plan of operation. The plan takes effect on the written approval of the commissioner.

(b) If the committee fails to submit a suitable plan of operation or if, after adoption of a plan, the committee fails to submit suitable amendments to the plan, the commissioner may, after notice and hearing, adopt rules as necessary to implement this subchapter. The rules continue in effect until modified by the commissioner or superseded by a plan submitted by the committee and approved by the commissioner. (V.T.I.C. Art. 20A.36, Sec. (a) (part), as amended Acts 75th Leg., R.S., Ch. 1023; Sec. (a) (part), as amended Acts 75th Leg., R.S., Ch. 1026; Sec. (e).)

Source Law

(a) [as amended Acts 75th Leg., R.S., Ch. 1023] . . . The committee shall perform its functions under a plan of operation approved by the commissioner. . . .

(a) [as amended Acts 75th Leg., R.S., Ch. 1026] . . . The committee shall perform its functions under a plan of operation

approved by the commissioner. . . .

(e) Not later than the 180th day after the date on which the final member of the committee is appointed, the committee shall submit to the commissioner a plan of operation. The plan of operation takes effect on approval in writing by the commissioner. If the committee fails to submit a suitable plan of operation within the period set by this subsection, or if, after the adoption of a plan, the committee fails to submit suitable amendments to the plan, the commissioner may, after notice and hearing, adopt rules as necessary to implement this Act. Those rules continue in effect until modified by the commissioner or superseded by a plan submitted by the committee and approved by the commissioner.

Revisor's Note

Section (e), V.T.I.C. Article 20A.36, refers to an action required to be taken by the Health Maintenance Organization Solvency Surveillance Committee "[n]ot later than the 180th day after the date on which the final member of the committee is appointed" and "within the period set by this subsection." The revised law omits those provisions as executed.

Revised Law

Sec. 843.438. EXAMINATION AND REGULATION. The committee is subject to examination and regulation by the commissioner. Not later than May 1 of each year, the committee shall submit to the commissioner:

(1) a financial report for the preceding calendar year in a form approved by the commissioner; and

(2) a report of its activities during the preceding calendar year. (V.T.I.C. Art. 20A.36, Sec. (f).)

Source Law

(f) The committee is subject to examination and regulation by the commissioner. Not later than May 1 of each year, the committee shall submit to the commissioner a financial report for the preceding calendar year in a form approved by the commissioner and a report of its

activities during the preceding calendar year.

Revised Law

Sec. 843.439. IMMUNITY FROM LIABILITY. A health maintenance organization or its agents or employees, the committee or its agents, employees, or members, or the commissioner or the commissioner's representatives are not liable in a civil action for any act taken or not taken in good faith in the performance of powers and duties under this subchapter. (V.T.I.C. Art. 20A.36, Sec. (g).)

Source Law

(g) A licensed health maintenance organization or its agents or employees, the committee or its agents, employees, or members, or the commissioner or the commissioner's representatives are not liable in a civil action for any act taken or not taken in good faith in the performance of powers and duties under this section.

Revised Law

Sec. 843.440. GENERAL POWERS AND DUTIES. (a) The committee shall assist and advise the commissioner regarding:

(1) the detection and prevention of insolvency problems in health maintenance organizations; and

(2) any health maintenance organization placed in rehabilitation, liquidation, supervision, or conservation.

(b) The method of providing assistance and advice to the commissioner shall be in accordance with the committee's approved plan of operation.

(c) The committee shall file a record of its proceedings with the commissioner.

(d) In performing its duties, the committee may:

(1) enter into contracts as necessary or proper to implement this subchapter;

(2) take legal action as necessary to recover any unpaid assessments owed under Section 843.441;

(3) employ staff as necessary to conduct the financial transactions of the committee;

(4) assess each health maintenance organization for funds necessary to:

(A) enable the committee to perform its duties and other necessary or proper functions; and

(B) reimburse committee members for their actual expenses incurred in performing the functions of the committee; and

(5) perform other functions as necessary or proper under this subchapter.

(e) Reports regarding the financial condition of health maintenance organizations and the financial condition, administration, and status of health maintenance organizations in rehabilitation, liquidation, supervision, or conservation shall be provided to committee members at meetings. With regard to any person examined by the committee, committee members may not reveal:

(1) the condition of the examined person; or

(2) any information obtained in the course of a committee meeting that relates to the examined person. (V.T.I.C. Art. 20A.36, Secs. (b), (d).)

Source Law

(b)(1) The committee shall assist and advise the commissioner relating to the detection and prevention of insolvency problems regarding health maintenance organizations. The committee shall also assist and advise the commissioner regarding any health maintenance organization placed in rehabilitation, liquidation, supervision, or conservation. The method of providing this assistance and advice shall be as contained in the plan of operation approved by the commissioner.

(2) Reports regarding the financial condition of Texas licensed health maintenance organizations and regarding the financial condition, administration, and status of health maintenance organizations in rehabilitation, liquidation, supervision, or conservation shall be provided to the committee members at meetings. Committee members shall not reveal the condition of nor any information secured in the course of any meeting of the Solvency Surveillance Committee with regard to any corporation, form or person examined by the committee. Committee proceedings shall be filed with the commissioner.

(d) In performing its duties under this section, the committee may:

(1) enter into contracts as necessary or proper to implement this section;

(2) take legal action as necessary to recover any unpaid assessments owed under Subsection (c) of this section;

(3) employ staff as necessary to handle the financial transactions of the committee;

(4) assess each health maintenance organization that has a certificate of authority issued under this Act to operate in this state for funds necessary to carry out its duties and perform other functions as necessary or proper under this section and to reimburse committee members for their actual expenses in carrying out the functions of the committee; and

(5) perform other functions as necessary or proper under this section.

Revisor's Note

Section (b)(2), V.T.I.C. Article 20A.36, refers to "any corporation, form or person" examined by the Health Maintenance Organization Solvency Surveillance Committee. The revised law omits the references to "corporation" and "form" as unnecessary. In context, "form" is clearly intended to be "firm," and Subdivision (q), V.T.I.C. Article 20A.02, revised as Section 843.002(20), defines "person" broadly to include corporations and other artificial persons such as firms.

Revised Law

Sec. 843.441. ASSESSMENTS. (a) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, or conservation of an impaired health maintenance organization in this state, the committee, at the commissioner's direction, shall assess each health maintenance organization in the proportion that the gross premiums of the health maintenance organization that were written in this state during the preceding calendar year bear to the aggregate gross premiums that were written in this state by all health maintenance organizations, as provided to the committee by the commissioner after review of annual statements and other reports the commissioner considers necessary.

(b) Assessments to supplement or pay for administrative expenses of rehabilitation, liquidation, supervision, or conservation may be made only after the commissioner determines that:

(1) adequate assets of the impaired health maintenance organization are not immediately available for those administrative expenses; or

(2) use of those assets could be detrimental to rehabilitation, liquidation, supervision, or conservation.

(c) The commissioner may abate or defer an assessment in whole or in part if, in the opinion of the commissioner, payment of the assessment would endanger the ability of a health maintenance organization to fulfill its contractual obligations. If an assessment is abated or deferred in whole or in part, the amount of the abatement or deferral may be assessed against the remaining health maintenance organizations in a manner consistent with the basis for assessments provided by the approved plan of operation.

(d) The total of all assessments on a health maintenance organization may not exceed one-fourth of one percent of the health maintenance organization's gross premiums in any one calendar year.

(e) Notwithstanding any other provision of this subchapter, funds derived from an assessment made under this section may not be used for the expenses of administering the affairs of an impaired health maintenance organization while in supervision, rehabilitation, or conservation for more than 150 days. The committee may extend the period during which it makes assessments for the administrative expenses of an impaired health maintenance organization as it considers appropriate. (V.T.I.C. Art. 20A.36, Secs. (c), (h).)

Source Law

(c) To provide funds for the administrative expenses of the commissioner regarding rehabilitation, liquidation, supervision, or conservation of an impaired health maintenance organization in this state, the committee, at the commissioner's direction, shall assess each health maintenance organization licensed in this state in the proportion that the gross premiums of that health maintenance organization written in this state during the preceding calendar year bear to the aggregate gross premiums written in this state by all health maintenance organizations, as furnished to the committee by the commissioner after review of annual statements and other reports the commissioner considers necessary. Assessments to supplement or pay for administrative expenses

of rehabilitation, liquidation, supervision, or conservation may be made only after the commissioner determines that adequate assets of the health maintenance organization are not immediately available for those purposes or that use of those assets could be detrimental to rehabilitation, liquidation, supervision, or conservation. The commissioner may abate or defer the assessments, either in whole or in part, if, in the opinion of the commissioner, payment of the assessment would endanger the ability of a health maintenance organization to fulfill its contractual obligations. If an assessment is abated or deferred, either in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the remaining licensed health maintenance organizations in a manner consistent with the basis for assessments provided by the plan of operation approved by the commissioner. The total of all assessments on a health maintenance organization may not exceed one-quarter of one percent of the health maintenance organization's gross premiums in any one calendar year.

(h) Notwithstanding any other provision of this section, funds derived from an assessment made under this section may not be used for the expenses of administering the affairs of a health maintenance organization while in supervision, rehabilitation, or conservation for a period longer than 150 days. The committee may extend the period during which it makes assessments for the administrative expenses of an impaired organization as it considers appropriate.

[Sections 843.442-843.460 reserved for expansion]

SUBCHAPTER N. ENFORCEMENT

Revised Law

Sec. 843.461. ENFORCEMENT ACTIONS. (a) After notice and opportunity for a hearing, the commissioner may:

(1) suspend or revoke a certificate of authority issued to a health maintenance organization under this chapter;

(2) impose sanctions under Chapter 82;

(3) issue a cease and desist order under Chapter 83; or

(4) impose administrative penalties under Chapter 84.

(b) The commissioner may take an enforcement action listed in Subsection (a) against a health maintenance organization if the commissioner finds that the health maintenance organization:

(1) is operating in a manner that is:

(A) significantly contrary to its basic organizational documents or health care plan; or

(B) contrary to the manner described in and reasonably inferred from other information submitted under Section 843.078, 843.079, or 843.080;

(2) issues an evidence of coverage or uses a schedule of charges for health care services that does not comply with the requirements of Article 20A.09;

(3) does not meet the requirements of Section 843.082(1);

(4) provides a health care plan that does not provide or arrange for basic health care services, provides a limited health care service plan that does not provide or arrange for the plan's limited health care services, or provides a single health care service plan that does not provide or arrange for a single health care service;

(5) cannot fulfill its obligation to provide:

(A) health care services as required under its health care plan;

(B) limited health care services as required under its limited health care service plan; or

(C) a single health care service as required under its single health care service plan;

(6) is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(7) has not implemented the complaint system required by Section 843.251 in a manner to resolve reasonably valid complaints;

(8) has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner or a person on behalf of the health maintenance organization has advertised or merchandised the health maintenance organization's services in an untrue, misrepresentative, misleading, deceptive, or untrue manner;

(9) would be hazardous to its enrollees if it continued in operation;

(10) has not complied substantially with this chapter or Chapter 20A or a rule adopted under this chapter or Chapter 20A; or

(11) has not taken corrective action the commissioner considers necessary to correct a failure to comply with this chapter, any applicable provision of this code, or any applicable rule or order of the commissioner not later than the 30th day after the date of notice of the failure or within any longer period specified in the notice and determined by the commissioner to be reasonable.

(c) The commissioner may suspend or revoke a certificate of authority only after complying with this section. (V.T.I.C. Art. 20A.20, Secs. (a), (b).)

Source Law

Art. 20A.20. (a) The commissioner may after notice and opportunity for hearing (i) suspend or revoke any certificate of authority issued to a health maintenance organization under this Act; (ii) impose sanctions under Section 7, Article 1.10, Insurance Code; (iii) impose administrative penalties under Article 1.10E, Insurance Code; or (iv) issue a cease and desist order under Article 1.10A, Insurance Code, if the commissioner finds that any of the following conditions exist:

(1) The health maintenance organization is operating significantly in contravention of its basic organizational documents, or its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under Section 4 of this Act.

(2) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which does not comply with the requirements of Section 9 of this Act.

(3) The health care plan does not provide or arrange for basic health care services, the limited health care service plan does not provide or arrange for its limited health care services, or the single health care service plan does not provide or arrange for a single health care service.

(4) The health maintenance organization does not meet the requirements of Section 5(a)(1) of this Act.

(5) The health maintenance

organization is unable to fulfill its obligation to furnish health care services as required under its health care plan, to furnish the limited health care services as required under its limited health care service plan, or to furnish a single health care service as required under its single health care service plan.

(6) The health maintenance organization is no longer financially responsible and may be reasonably expected to be unable to meet its obligations to enrollees or prospective enrollees.

(7) The health maintenance organization has failed to implement the complaint system required by Section 12 of this Act in a manner to resolve reasonably valid complaints.

(8) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(9) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(10) The health maintenance organization has otherwise failed to comply substantially with this Act, and any rule and regulation thereunder.

(11) The health maintenance organization has failed to carry out corrective action the commissioner considers necessary to correct a failure to comply with this Act, any applicable provision of the Insurance Code, or any applicable rule or order of the commissioner within 30 days after the date of notice of a deficiency or within any longer period of time that the commissioner determines to be reasonable and specifies in the notice.

(b) A certificate of authority shall be suspended or revoked only after compliance with this section.

Revised Law

Sec. 843.462. OPERATIONS DURING SUSPENSION OR AFTER REVOCATION OF CERTIFICATE OF AUTHORITY. (a) During the period a

certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not:

(1) enroll additional enrollees except newborn children or other newly acquired dependents of existing enrollees; or

(2) advertise or solicit in any way.

(b) After a certificate of authority of a health maintenance organization is revoked, the health maintenance organization:

(1) shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs;

(2) may not conduct further business except as essential to the orderly conclusion of its affairs; and

(3) may not advertise or solicit in any way.

(c) Notwithstanding Subsection (b), the commissioner may, by written order, permit the further operation of the health maintenance organization to the extent that the commissioner finds necessary to serve the best interest of enrollees and to provide enrollees with the greatest practical opportunity to obtain continuing health care coverage. (V.T.I.C. Art. 20A.20, Secs. (c), (d).)

Source Law

(c) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children, or newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(d) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization, as he may find to be in the best interest of the enrollees, to the end that the enrollees will be afforded the greatest practical opportunity to obtain continuing health care

coverage.

Revised Law

Sec. 843.463. INJUNCTIONS. If the commissioner believes that a health maintenance organization or another person is violating or has violated this chapter or Chapter 20A or a rule adopted under this chapter or Chapter 20A, the commissioner may bring an action in a Travis County district court to enjoin the violation and obtain other relief the court considers appropriate. (V.T.I.C. Art. 20A.31, Sec. (a).)

Source Law

Art. 20A.31. (a) When it appears to the commissioner that a health maintenance organization or other person is violating or has violated this Act or any rule or regulation issued pursuant to this Act, the commissioner may bring suit in a district court of Travis County to enjoin the violation and for such other relief as the court may deem appropriate.

Revised Law

Sec. 843.464. CRIMINAL PENALTY. (a) A person, including an agent or officer of a health maintenance organization, commits an offense if the person:

(1) wilfully violates this chapter or Chapter 20A or a rule adopted under this chapter or Chapter 20A; or

(2) knowingly makes a false statement with respect to a report or statement required under this chapter or Chapter 20A.

(b) An offense under this section is a Class B misdemeanor. (V.T.I.C. Art. 20A.24.)

Source Law

Art. 20A.24. A person or an agent or an officer of a health maintenance organization who wilfully violates this Act or the rules promulgated pursuant to this Act or who knowingly makes a false statement with respect to a report or a statement required by this Act is guilty of a Class B misdemeanor.

Revisor's Note
(End of Chapter)

(1) V.T.I.C. Article 20A.34 states the effective date of the Texas Health

Maintenance Organization Act. The revised law omits the provision as executed. The omitted law reads:

Art. 20A.34. This Act shall take effect on the first day of December, 1975.

(2) V.T.I.C. Article 20A.35 is a severability clause. The revised law omits the provision because it duplicates Section 311.032, Government Code (Code Construction Act), applicable to the revised law, and Section 312.013, Government Code. Those sections state that a provision of a statute is severable from each other provision of the statute that can be given effect. The omitted law reads:

Art. 20A.35. If any provision of this Act or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of this Act which can be given effect without the invalid provisions or application. To this end, all provisions of the Texas Health Maintenance Organization Act are declared to be severable.

CHAPTER 844. CERTIFICATION OF CERTAIN NONPROFIT HEALTH CORPORATIONS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 844.006-844.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

[Sections 844.055-844.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Sec. 844.101. UNFAIR COMPETITION 519

CHAPTER 844. CERTIFICATION OF CERTAIN NONPROFIT HEALTH CORPORATIONS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 844.001. DEFINITIONS. In this chapter:

(1) "Approved nonprofit health corporation" means a nonprofit health corporation certified under Section 162.001, Occupations Code.

(2) "Certificate holder" means an approved nonprofit health corporation that holds a certificate of authority issued under this chapter.

(3) "Health care plan" has the meaning assigned by Section 843.002.

(4) "Health maintenance organization" means a health maintenance organization licensed under Chapter 843. (V.T.I.C. Art. 21.52F, Secs. 1(2), (3), (4), (5).)

Source Law

Art. 21.52F

Sec. 1. In this article:

(2) "Approved nonprofit health corporation" means a nonprofit health corporation certified under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes).

(3) "Certificate holder" means an approved nonprofit health corporation that holds a certificate of authority issued under this article.

(4) "Health care plan" has the meaning assigned by Section 2, Texas Health Maintenance Organization Act (Section 20A.02, Vernon's Texas Insurance Code).

(5) "Health maintenance organization" means a health maintenance organization licensed under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Revisor's Note

(1) Section 1(1), V.T.I.C. Article 21.52F, defines "applicant." The revised law omits that definition because its meaning is clear from the context in which the term appears in the revision. The omitted law

reads:

(1) "Applicant" means an approved nonprofit health corporation that has filed an application with the commissioner for certification under this article.

(2) Section 1(2), V.T.I.C. Article 21.52F, refers to Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). That statute was codified in 1999 as Section 162.001, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 844.002. EXCEPTIONS. This chapter does not apply to:

(1) an approved nonprofit health corporation that contracts to arrange for or provide health care services on a fee-for-service basis;

(2) a contract entered into by a certificate holder to arrange for or provide health care services on a fee-for-service basis; or

(3) an activity exempt from regulation under Section 843.053 or 843.073. (V.T.I.C. Art. 21.52F, Sec. 2(b).)

Source Law

(b) This article does not apply to:

(1) an approved nonprofit health corporation that contracts to arrange for or provide health care services on a fee-for-service basis;

(2) contracts entered into by a certificate holder to arrange for or provide health care services on a fee-for-service basis; or

(3) an activity exempt from regulation under Section 26(f), Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

Revised Law

Sec. 844.003. EXCEPTIONS TO TEXAS HEALTH MAINTENANCE ORGANIZATION ACT. This chapter may not be construed to alter the exceptions stated in Sections 843.053 and 843.073. (V.T.I.C. Art. 21.52F, Sec. 2(d).)

Source Law

(d) This article shall not be construed to alter the exceptions set out in Section 26(f), Texas Health Maintenance Organization

Act (Chapter 20A, Vernon's Texas Insurance Code).

Revised Law

Sec. 844.004. RULES. Except as provided by Section 844.101(b), the commissioner shall adopt rules to implement this chapter. (V.T.I.C. Art. 21.52F, Sec. 7.)

Source Law

Sec. 7. Except as provided by Section 5(b) of this article, the commissioner shall adopt rules to implement this article.

Revised Law

Sec. 844.005. PROVISION OF CERTAIN SERVICES ON BEHALF OF HEALTH MAINTENANCE ORGANIZATIONS. (a) An approved nonprofit health corporation may arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of a health maintenance organization.

(b) An approved nonprofit health corporation is not required to obtain a certificate of authority under this chapter or under Chapter 843 to arrange for or provide health care services as provided by Subsection (a). (V.T.I.C. Art. 21.52F, Sec. 2(c).)

Source Law

(c) An approved nonprofit health corporation may arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of a health maintenance organization. An approved nonprofit health corporation acting under this subsection is not required to obtain a certificate of authority under this article or under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

[Sections 844.006-844.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 844.051. CERTIFICATE OF AUTHORITY REQUIRED. An approved nonprofit health corporation may not arrange for or provide a health care plan to enrollees on a prepaid basis unless the corporation holds a certificate of authority issued under this chapter. (V.T.I.C. Art. 21.52F, Sec. 2(a).)

Source Law

Sec. 2. (a) An approved nonprofit health corporation may arrange for or provide a health care plan to enrollees on a prepaid basis only if the corporation obtains and maintains a certificate of authority issued by the department under this article.

Revisor's Note

(1) Section 2(a), V.T.I.C. Article 21.52F, refers to a certificate of authority issued "by the department" under this chapter. The revised law omits the quoted language as unnecessary because only the Texas Department of Insurance may issue a certificate of authority under this chapter.

(2) Section 2(a), V.T.I.C. Article 21.52F, refers to a corporation that "obtains and maintains" a certificate of authority. The revised law substitutes "holds" for "obtains and maintains" because, in context, "obtains and maintains" and "holds" are synonymous and "holds" is more commonly used in licensing statutes.

Revised Law

Sec. 844.052. CERTIFICATE APPLICATION; ELIGIBILITY REQUIREMENTS. (a) An approved nonprofit health corporation may apply to the department for a certificate of authority under this chapter.

(b) The commissioner may issue a certificate of authority only to an applicant that:

(1) meets the same requirements for the issuance of a certificate of authority that a health maintenance organization is required to meet under Chapter 843; and

(2) establishes accreditation by:

(A) the National Committee on Quality Assurance;

(B) the Joint Commission on Accreditation of Healthcare Organization's accreditation for health care networks; or

(C) an accrediting organization recognized by rule of the commissioner. (V.T.I.C. Art. 21.52F, Secs. 3, 4(a) (part).)

Source Law

Sec. 3. The commissioner may issue a certificate of authority only to an approved nonprofit health corporation that:

(1) meets each requirement for the issuance of a certificate of authority as a health maintenance organization imposed by the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) as if the approved nonprofit health corporation were a health maintenance organization; and

(2) is accredited under Section 4 of this article.

Sec. 4. (a) An applicant must establish . . . accreditation by:

(1) the National Committee on Quality Assurance;

(2) the Joint Commission on Accreditation of Healthcare Organization's accreditation for health care networks; or

(3) an accrediting organization recognized by rule of the commissioner.

Revisor's Note

The revised law clarifies the procedure by which an approved nonprofit health corporation obtains a certificate of authority under this chapter by stating that a corporation may apply to the department for a certificate of authority. Section 3, V.T.I.C. Article 21.52F (revised as this section), requires an approved nonprofit health corporation to meet the same requirements for issuance of a certificate of authority that a health maintenance organization is required to meet under Chapter 20A, revised in this code as Chapter 843. The requirements under that chapter include a requirement that a health maintenance organization file with the commissioner an application for a certificate of authority. See V.T.I.C. Article 20A.04, revised in this code as Section 843.076 and Sections 843.078-843.080. The revised law is drafted to clarify that the procedure for obtaining a certificate of authority under this chapter includes that application requirement.

Revised Law

Sec. 844.053. PROVISIONAL CERTIFICATE OF AUTHORITY. The commissioner shall grant a provisional certificate of authority

to an applicant if:

(1) the applicant has applied for accreditation from an accrediting organization described by Section 844.052(b)(2);

(2) the applicant is diligently pursuing accreditation;

(3) the accrediting organization has not denied the application for accreditation; and

(4) the applicant satisfies each other requirement of this chapter. (V.T.I.C. Art. 21.52F, Sec. 4(b).)

Source Law

(b) The commissioner shall grant a provisional certificate of authority to an applicant if:

(1) the applicant has applied for accreditation;

(2) the applicant is diligently pursuing accreditation;

(3) the accrediting organization has not denied the accreditation; and

(4) all other requirements of this article are satisfied.

Revised Law

Sec. 844.054. POWERS AND DUTIES OF CERTIFICATE HOLDER. (a) A certificate holder has all the powers granted to and duties imposed on a health maintenance organization under the insurance laws of this state, including Chapter 843, and is subject to regulation and regulatory enforcement under those laws in the same manner as a health maintenance organization.

(b) A certificate holder shall maintain accreditation as described by Section 844.052(b)(2). (V.T.I.C. Art. 21.52F, Secs. 4(a) (part), 6.)

Source Law

Sec. 4. (a) . . . a certificate holder must maintain [accreditation by:

(1) the National Committee on Quality Assurance;

(2) the Joint Commission on Accreditation of Healthcare Organization's accreditation for health care networks; or

(3) an accrediting organization recognized by rule of the commissioner.]

Sec. 6. A certificate holder has all the powers granted to and duties imposed on a health maintenance organization under the

Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) and the insurance laws of this state, and is subject to regulation and regulatory enforcement under those laws in the same manner as a health maintenance organization.

[Sections 844.055-844.100 reserved for expansion]

SUBCHAPTER C. PROHIBITED CONDUCT

Revised Law

Sec. 844.101. UNFAIR COMPETITION. (a) A certificate holder may not engage in unfair and disruptive provider hiring or contracting practices for the purpose of limiting competition from traditional community providers.

(b) The Texas State Board of Medical Examiners shall adopt rules to implement this section. (V.T.I.C. Art. 21.52F, Sec. 5.)

Source Law

Sec. 5. (a) A certificate holder may not engage in unfair and disruptive provider hiring or contracting practices, the purpose of which is to limit competition from traditional community providers.

(b) The Texas State Board of Medical Examiners shall adopt rules to implement this section.

CHAPTER 845. STATEWIDE RURAL HEALTH CARE SYSTEM

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 845.005-845.050 reserved for expansion]

SUBCHAPTER B. SYSTEM

[Sections 845.059-845.100 reserved for expansion]

CHAPTER 845. STATEWIDE RURAL HEALTH CARE SYSTEM

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 845.001. SHORT TITLE. This chapter may be cited as the Statewide Rural Health Care System Act. (V.T.I.C. Art. 20C.01.)

Source Law

> Art. 20C.01. This chapter may be cited as the Statewide Rural Health Care System Act.

Revised Law

Sec. 845.002. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the system.

(2) "Enrollee" means an individual entitled to receive health care services through a health care plan arranged for or provided by the system.

(3) "Health care services" has the meaning assigned by Section 843.002.

(4) "Hospital provider" means a county hospital, county hospital authority, hospital district, municipal hospital, or municipal hospital authority.

(5) "Local health care provider" means:

(A) a person licensed, registered, or certified as a health care practitioner in this state who resides or practices in a rural area in which the person provides health

care services; or

(B) a general or specialty hospital that is not a hospital provider under this chapter.

(6) "Participating hospital provider" means a hospital provider that participates in the system.

(7) "Person" means an individual, professional association, professional corporation, partnership, limited liability corporation, limited liability partnership, or nonprofit corporation, including a nonprofit corporation certified under Section 162.001, Occupations Code.

(8) "Rural area" means:

(A) a county with a population of 50,000 or less;

(B) an area that is not delineated as an urbanized area by the United States Bureau of the Census; or

(C) any other area designated as rural by a rule adopted by the commissioner, subject to Section 845.003.

(9) "System" means the statewide rural health care system established under this chapter.

(10) "Territorial jurisdiction" means the geographical area in which a participating hospital provider is obligated by law to provide health care services. (V.T.I.C. Art. 20C.02, Subsec. (a).)

Source Law

Art. 20C.02. (a) In this chapter:

(1) "Board" means the board of directors of the system.

(2) "Enrollee" means an individual entitled to receive health care services through a health care plan arranged for or provided by the system.

(3) "Health care services" has the meaning assigned by Section 2, Texas Health Maintenance Organization Act (Article 20A.02, Vernon's Texas Insurance Code).

(4) "Hospital provider" means a county hospital, county hospital authority, hospital district, municipal hospital, or municipal hospital authority.

(5) "Local health care provider" means:

(A) a person licensed, registered, or certified as a health care practitioner in this state who resides in or practices in a rural area in which the person provides health care services; or

(B) a general or specialty hospital that is not a hospital provider

under this chapter.

(6) "Participating provider" means a hospital provider that participates in the system.

(7) "Person" means an individual, professional association, professional corporation, partnership, limited liability corporation, limited liability partnership, or nonprofit corporation, including a nonprofit corporation created under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes).

(8) "Rural area" means:

(A) a county with a population of 50,000 or less;

(B) an area that is not delineated as an urbanized area by the federal census bureau; or

(C) any other area designated as rural by rules adopted by the commissioner, subject to Subsection (b) of this article.

(9) "System" means the statewide rural health care system established by this chapter.

(10) "Territorial jurisdiction" means the geographical area in which a participating provider is obligated by law to provide health care services.

Revisor's Note

Subsection (a)(7), V.T.I.C. Article 20C.02, refers to a nonprofit corporation created under Section 5.01(a), Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). The revised law refers instead to a nonprofit corporation certified under that statute because that statute provides for the certification of nonprofit organizations already created under the Texas Non-Profit Corporation Act. In addition, Section 5.01(a), V.A.C.S. Article 4495b, was codified in 1999 as Section 162.001, Occupations Code. The revised law is drafted accordingly.

Revised Law

Sec. 845.003. RURAL AREA DESIGNATION. In determining whether to designate an area as a rural area under this chapter,

the commissioner shall consider any area that is delineated as an urbanized area by the United States Bureau of the Census and:

(1) is contiguous with and not more than 10 miles away from a rural area described by Section 845.002(8)(A) or (B);

(2) is sparsely populated, compared to areas within a 10-mile radius that are delineated as urbanized areas by the United States Bureau of the Census;

(3) has not increased in population in any single calendar year in the seven years before the commissioner makes the designation; and

(4) in which emergency or primary care services:

(A) are limited or unavailable in accordance with network access standards imposed by the commissioner under Chapters 20A and 843; and

(B) would be made materially more accessible by allowing access to care in a contiguous area that is otherwise eligible to participate in the system. (V.T.I.C. Art. 20C.02, Subsec. (b).)

Source Law

(b) In designating rural areas under Subsection (a)(8) of this article, the commissioner shall consider any area that is delineated as an urbanized area by the federal census bureau and:

(1) is contiguous with and not more than 10 miles away from a rural area described by Subsection (a)(8)(A) or (B) of this section;

(2) is sparsely populated, compared to areas within a 10-mile radius that are delineated as urbanized areas by the federal census bureau;

(3) has not increased in population in any single calendar year in the seven years before the commissioner makes the designation; and

(4) in which emergency or primary care services are limited or unavailable in accordance with network access standards imposed by the commissioner under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) and in which those services would be made materially more accessible by allowing access to care in a contiguous area that is eligible to participate in the system.

Revised Law

Sec. 845.004. RULES. The commissioner shall adopt rules as necessary to implement this chapter. (V.T.I.C. Art. 20C.15.)

Source Law

Art. 20C.15. The commissioner shall adopt rules as necessary to implement this chapter.

[Sections 845.005-845.050 reserved for expansion]

SUBCHAPTER B. SYSTEM

Revised Law

Sec. 845.051. STATEWIDE RURAL HEALTH CARE SYSTEM. The commissioner shall designate a single organization as the statewide rural health care system to arrange for or provide health care services to enrollees who reside in rural areas. (V.T.I.C. Art. 20C.03; Art. 20C.04, Subsec. (a).)

Source Law

Art. 20C.03. The statewide rural health care system is established to arrange for or provide health care services to enrollees who reside in rural areas.

Art. 20C.04. (a) The commissioner shall designate as the system one organization created under Article 20C.05 of this code.

Revisor's Note

V.T.I.C. Article 20C.03 provides for the establishment of the statewide rural health care system. The revised law omits this provision as executed.

Revised Law

Sec. 845.052. ORGANIZATION REQUIREMENTS. The system must:

(1) be a corporation organized under the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes); and

(2) consist of a combination of two or more hospital providers, each of which:

(A) is a member of the corporation; and

(B) is located in a rural area. (V.T.I.C. Art. 20C.05, Subsec. (a).)

Source Law

Art. 20C.05. (a) The system must be:

(1) a corporation organized under

the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes); and

(2) composed of a combination of two or more hospital providers that are members of the corporation and that are located in a rural area.

Revised Law

Sec. 845.053. APPLICATION OF TEXAS HEALTH MAINTENANCE ORGANIZATION ACT. (a) Except as otherwise provided by this section, if the system arranges for or provides health care services to enrollees in exchange for a predetermined payment per enrollee on a prepaid basis, the system must obtain a certificate of authority under Chapter 843 and meet each requirement imposed by that chapter.

(b) The commissioner by rule may provide exceptions to the application to the system of provisions of Chapter 20A or 843 that relate to mileage, distance, and network adequacy and scope.

(c) The system may fulfill the reserve requirements under Chapter 843 by purchasing reinsurance from insurance companies approved for that purpose by the commissioner. (V.T.I.C. Art. 20C.04, Subsecs. (b), (c), (d).)

Source Law

(b) Except as provided by Subsection (c) of this article, if the system arranges for or provides health care services to enrollees in exchange for a predetermined payment per enrollee on a prepaid basis, the system must obtain a certificate of authority under, and meet each requirement imposed by, the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), as if the organization were a person under the Act.

(c) If the system seeks a certificate of authority under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), the commissioner by rule may provide exceptions to the application of provisions of the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) relating to mileage, distance, and network adequacy and scope.

(d) If the system seeks a certificate of authority under the Texas Health

Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), the system shall meet all reserve requirements required by the commissioner under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code). The system may fulfill the requirements of this subsection through the purchase of reinsurance from insurance companies approved for that purpose by the commissioner.

Revisor's Note

(1) Subsection (b), V.T.I.C. Article 20C.04, requires the statewide rural health care system under certain circumstances to meet each requirement of the Texas Health Maintenance Organization Act "as if the organization were a person under the Act." The revised law omits the quoted language as unnecessary because the term "person" as it is used under the Texas Health Maintenance Organization Act includes any legal entity and specifically includes the system.

(2) Subsection (d), V.T.I.C. Article 20C.04, states that "[i]f the system seeks a certificate of authority under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), the system shall meet all reserve requirements required by the commissioner under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code)." The revised law omits the quoted language because it is redundant of Subsection (b), V.T.I.C. Article 20C.04, which requires the system to meet each requirement of the Texas Health Maintenance Organization Act (revised as Chapter 843 of this code) to obtain a certificate of authority under the Act. These requirements include the reserve requirements under the Act.

Revised Law

Sec. 845.054. LOCAL GOVERNMENT. (a) The system is:

(1) a unit of local government that is a governmental unit for purposes of Chapter 101, Civil Practice and Remedies Code; and

(2) a local government for purposes of Chapter 102, Civil Practice and Remedies Code.

(b) The system may enter into interlocal cooperation contracts under Chapter 791, Government Code, and is a local government for purposes of that chapter. (V.T.I.C. Art. 20C.05, Subsecs. (b), (c).)

Source Law

(b) The system is:

(1) a unit of local government that is a governmental unit for purposes of Chapter 101, Civil Practice and Remedies Code; and

(2) a local government for purposes of Chapter 102, Civil Practice and Remedies Code.

(c) The system may enter into interlocal cooperation contracts under Chapter 791, Government Code, and is a local government for purposes of that chapter.

Revised Law

Sec. 845.055. PROVISION OF ADMINISTRATIVE AND HEALTH CARE SERVICES. (a) The system shall contract with or otherwise arrange for local health care provider networks composed of not more than 19 counties to deliver health care services to enrollees residing in the rural areas of the territorial jurisdiction of the participating hospital providers.

(b) If the local health care provider networks under contract or arrangement with the system as provided by Subsection (a) are unable to provide the type and quality of health care services required by the enrollees, the system may contract with health care practitioners who are not local health care providers.

(c) The system may:

(1) enter into a contract or joint venture to provide administrative services under this chapter;

(2) enter into an intergovernmental or interlocal agreement; or

(3) provide technical assistance and management services to local health care providers as necessary to deliver health care services. (V.T.I.C. Art. 20C.11, Subsecs. (b), (c), (d); Art. 20C.12, Subsecs. (b), (c).)

Source Law

[Art. 20C.11]

(b) The system may enter into contracts or joint ventures to provide administrative services under this chapter.

(c) The system may enter into

intergovernmental and interlocal agreements.

(d) The system may provide technical assistance and management services to local health care providers as necessary to deliver health care services.

[Art. 20C.12]

(b) The system shall contract with or otherwise arrange for local health care providers to deliver health care services to enrollees residing in the rural areas of the territorial jurisdiction of the participants. If those local health care providers are unable to provide the type and quality of services needed by the enrollees, the system may contract with health care practitioners who are not local health care providers.

(c) In contracting with or otherwise arranging for local health care providers to deliver health care services to rural enrollees, the system may contract only with local health care provider networks that are composed of not more than 19 counties.

Revised Law

Sec. 845.056. GIFTS AND GRANTS. The system may accept gifts or grants of money or property to provide programs and services. (V.T.I.C. Art. 20C.13.)

Source Law

Art. 20C.13. The system may accept gifts and grants of money, personal property, and real property to use in the provision of the system's programs and services.

Revisor's Note

V.T.I.C. Article 20C.13 refers to gifts and grants of "personal property" and "real property." The revised law refers to gifts and grants of "property" because under Section 311.005(4), Government Code (Code Construction Act), "property" includes both real and personal property. That definition applies to the revised law.

Revised Law

Sec. 845.057. LIMITATION ON AUTHORITY OF PARTICIPATING HOSPITAL PROVIDERS. The participating hospital providers may exercise only the authority provided by Sections 845.058,

845.101, and 845.103. (V.T.I.C. Art. 20C.10, Subsec. (a) (part).)

Source Law

Art. 20C.10. (a) The powers of the participating providers are limited to:

[(1) the election, by a majority vote of the governing bodies of the participating providers, of the six members of the board of directors of the system to be appointed by the combined participating providers under Article 20C.06(b) of this code;

(2) the authorization by a two-thirds vote of the sale of the system or substantially all of the assets of the system; and

(3) the removal by a two-thirds vote of any member of the board who was appointed by the participating providers.]

Revised Law

Sec. 845.058. SALE OR DISSOLUTION OF SYSTEM. (a) The participating hospital providers may authorize, by a two-thirds vote, the sale of the system or substantially all of the assets of the system.

(b) Except as otherwise provided by law, on the sale or dissolution of the system or the sale of substantially all of the assets of the system, the net revenue shall be distributed equally to the participating hospital providers after payment of any outstanding liabilities incurred by the system. (V.T.I.C. Art. 20C.10, Subsecs. (a) (part), (b).)

Source Law

[(a) The powers of the participating providers are limited to:]

. . .

(2) the authorization by a two-thirds vote of the sale of the system or substantially all of the assets of the system; and

. . . .

(b) Except as otherwise provided by law, in the event of the sale or dissolution of the system or substantially all of the assets of the system, the net revenue shall be redistributed on an equal basis to the participating providers after payment of any outstanding debts, liabilities, or other

obligations incurred by the system.

Revisor's Note

Subsection (b), V.T.I.C. Article 20C.10, refers to "debts, liabilities, or other obligations" of the statewide rural health care system. The references to "debts" and "obligations" are omitted from the revised law because the meaning of each of those terms is included in the meaning of "liabilities."

[Sections 845.059-845.100 reserved for expansion]

SUBCHAPTER C. BOARD OF DIRECTORS

Revised Law

Sec. 845.101. APPOINTMENT OF BOARD. (a) The system is governed by a board of directors that consists of 18 members. Notwithstanding the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), appointments to the board shall be made as provided by this section.

(b) The participating hospital providers shall elect, by a majority vote of the governing bodies of the participating hospital providers, six members who represent the participating hospital providers.

(c) The governor shall appoint:

(1) six members who reside in the territorial jurisdictions of the participating hospital providers, including:

(A) two members who represent employers;

(B) two members who are local government officials; and

(C) two members who are consumers of health care services; and

(2) six members who are licensed physicians who reside and practice in the territorial jurisdictions of the participating hospital providers, including at least three members who perform the general practice of medicine as their professional practice.

(d) The governor shall make appointments to the board under Subsection (c) in a manner that provides representation for the territorial jurisdictions of all participating hospital providers. (V.T.I.C. Art. 20C.06; Art. 20C.10, Subsec. (a) (part).)

Source Law

Art. 20C.06. (a) The system is governed by a board of directors composed of 18 members. Notwithstanding the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), the

board of directors is selected as provided by this chapter.

(b) The participating providers shall appoint as representatives of the participating providers six directors selected in the manner provided by Article 20C.10 of this code.

(c) The governor shall appoint six directors from persons residing in the territorial jurisdictions of the participating providers, including:

(1) two persons who represent employers;

(2) two persons who are local government officials; and

(3) two persons who are consumers of health care services.

(d) In addition to the directors appointed under Subsection (c) of this article, the governor shall appoint six directors from among licensed physicians who reside and practice in the territorial jurisdictions of the participating providers. At least three of the physicians appointed under this subsection must perform as their professional practice the general practice of medicine.

(e) Directors appointed under Subsection (c) or (d) of this article shall be appointed in such a manner as to represent the territorial jurisdictions of all participating providers.

Art. 20C.10. [(a) The powers of the participating providers are limited to:]

(1) the election, by a majority vote of the governing bodies of the participating providers, of the six members of the board of directors of the system to be appointed by the combined participating providers under Article 20C.06(b) of this code;

. . . .

Revised Law

Sec. 845.102. TERMS; VACANCY. (a) Members of the board serve staggered six-year terms. The terms of six members expire December 1 of each even-numbered year.

(b) A person may not be appointed to serve consecutive terms.

(c) A person may be appointed to serve a nonconsecutive term if the person left the board at the expiration of the person's previous term.

(d) If a vacancy occurs during a member's term, the same entity that appointed the member shall appoint a replacement to fill the unexpired term. (V.T.I.C. Art. 20C.07.)

Source Law

> Art. 20C.07. (a) The members of the board serve staggered six-year terms, with the terms of six members expiring December 1 of each even-numbered year.
>
> (b) A member of the board may not serve consecutive terms. A person who has served as a member and has left the board at the expiration of the person's term is eligible for consideration for appointment to the board for a nonconsecutive term.
>
> (c) A vacancy on the board is filled for the remainder of the unexpired term by appointment by the same entity that appointed the director vacating the position.

Revised Law

Sec. 845.103. REMOVAL OF CERTAIN BOARD MEMBERS. The participating hospital providers may remove, by a two-thirds vote, any member of the board elected by the participating hospital providers under Section 845.101(b). (V.T.I.C. Art. 20C.10, Subsec. (a) (part).)

Source Law

> [(a) The powers of the participating providers are limited to:]
>
> . . .
>
> (3) the removal by a two-thirds vote of any member of the board who was appointed by the participating providers.

Revised Law

Sec. 845.104. BOARD DUTIES. The board shall:

(1) administer the system;

(2) adopt policies and procedures for the system that are consistent with the purposes of this chapter; and

(3) adopt rules for the holding of regular and special meetings. (V.T.I.C. Art. 20C.08, Subsec. (a) (part); Art. 20C.09, Subsec. (a).)

Source Law

Art. 20C.08. (a) The board shall administer the system and shall adopt policies and procedures for the system that are consistent with the purposes of this chapter. . . .

Art. 20C.09. (a) The board shall adopt rules for the holding of regular and special meetings.

Revised Law

Sec. 845.105. RULES RELATING TO ADMINISTRATIVE AND HEALTH CARE SERVICES. The board may adopt rules to regulate the provision of administrative services and health care services by the system. (V.T.I.C. Art. 20C.11, Subsec. (a); Art. 20C.12, Subsec. (a).)

Source Law

Art. 20C.11. (a) The board may adopt rules regarding the provision of administrative services by the system.

Art. 20C.12. (a) The board may adopt rules to regulate the provision of health care services by the system.

Revised Law

Sec. 845.106. OFFICERS. The board may elect officers as it considers appropriate. (V.T.I.C. Art. 20C.08, Subsec. (a) (part).)

Source Law

(a) . . . The board may elect officers as it considers appropriate.

Revised Law

Sec. 845.107. EXECUTIVE COMMITTEE. (a) The board may appoint an executive committee as determined by the board to be useful in conducting the business of the board.

(b) The board may delegate to the executive committee any responsibility considered reasonable by the board.

(c) An executive committee appointed under this section must consist of:

(1) two members who represent the participating hospital providers;

(2) two members who are community representatives,

including employers, local government officials, or consumers of health care services; and

(3) two members who meet the requirements of Section 845.101(c)(2). (V.T.I.C. Art. 20C.08, Subsecs. (b), (c).)

Source Law

(b) The board may appoint an executive committee as determined by the board to be useful in conducting the business of the board. The board may delegate to the executive committee any responsibility considered reasonable by the board.

(c) An executive committee appointed under this article must be composed of six members, as follows:

(1) two representatives of the participating providers;

(2) two persons who are community representatives, including employers, local government officials, or consumers of health care services; and

(3) two physicians who meet the requirements adopted under Article 20C.06(d) of this code.

Revised Law

Sec. 845.108. ADMINISTRATIVE SERVICES; PERSONNEL. (a) The board may, by majority vote:

(1) contract for administrative services; or

(2) hire an executive director, a consultant, an attorney or other professional, or other staff as necessary to perform the duties of the system.

(b) If the board hires an executive director for the system, the board shall delegate to the executive director the authority to hire staff for the system and may delegate to the executive director other duties determined by the board to be appropriate. (V.T.I.C. Art. 20C.08, Subsecs. (d), (e).)

Source Law

(d) On a majority vote, the board may:

(1) contract for administrative services; or

(2) hire an executive director, consultants, attorneys and other professionals, and other staff as necessary to implement the duties of the system.

(e) If the board hires an executive director for the system, the board shall

delegate to the executive director the authority to hire staff for the system and may delegate to the executive director other duties determined to be appropriate by the board.

Revised Law

Sec. 845.109. ADVISORY COMMITTEES. (a) The board may appoint a health care services advisory committee. The advisory committee must include members who represent rural, urban, and educational groups and organizations. The advisory committee, as directed by the board, shall meet and advise the board on any matter.

(b) The board may appoint other advisory committees as determined by the board to be appropriate.

(c) A member of an advisory committee appointed under this section is not entitled to compensation for service on the committee. (V.T.I.C. Art. 20C.08, Subsecs. (f), (g), (h).)

Source Law

(f) The board may appoint an advisory committee to represent health care services, including representatives of rural, urban, and educational groups and organizations. The advisory committee shall meet at the will of the board and advise the board on any matters as directed by the board.

(g) In addition to the advisory committee appointed under Subsection (f) of this article, the board may appoint other advisory committees as determined to be appropriate by the board.

(h) A member of an advisory committee appointed under this article is not entitled to compensation for service on the committee.

Revised Law

Sec. 845.110. OPEN MEETINGS AND RECORDS REQUIREMENTS. (a) Meetings of the board are open to the public in accordance with Chapter 551, Government Code. This subsection does not require the board to conduct an open meeting to deliberate:

(1) pricing or financial planning information relating to a bid or negotiation for arranging or providing services or product lines to another person if disclosure of the information would give the advantage to competitors;

(2) information relating to a proposed new service, product line, or marketing strategy;

(3) patient information made confidential under

Chapter 159, Occupations Code, or Subchapter G, Chapter 241, Health and Safety Code; or

(4) information that relates to the credentialing of physicians or to peer review and that is made confidential under Subchapter A, Chapter 160, Occupations Code, or Subchapter G, Chapter 241, Health and Safety Code.

(b) The board shall keep a record of its proceedings in accordance with Chapter 551, Government Code. (V.T.I.C. Art. 20C.09, Subsecs. (b), (c).)

Source Law

(b) Meetings of the board are open to the public in accordance with Chapter 551, Government Code. This subsection does not require the board to conduct an open meeting to deliberate:

(1) pricing or financial planning information relating to a bid or negotiation for arranging or providing services or product lines to another person if disclosure of the information would give the advantage to competitors;

(2) information relating to a proposed new service, product line, or marketing strategy;

(3) patient information made confidential under Section 5.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), or Subchapter G, Chapter 241, Health and Safety Code; or

(4) information relating to the credentialing of physicians or peer review made confidential under Section 5.06, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes), or Subchapter G, Chapter 241, Health and Safety Code.

(c) The board shall keep a record of its proceedings in accordance with Chapter 551, Government Code.

Revisor's Note

Subsection (b), V.T.I.C. Article 20C.09, refers to Sections 5.06 and 5.08, Medical Practice Act (Article 4495b, Vernon's Texas Civil Statutes). Those statutes were codified in 1999 as Subchapter A, Chapter 160, Occupations Code, and Chapter 159, Occupations Code, respectively. The revised

law is drafted accordingly.

[Sections 845.111-845.150 reserved for expansion]

SUBCHAPTER D. STATE MANAGED CARE CONTRACTS

Revised Law

Sec. 845.151. CONTRACT AWARD. To the extent consistent with federal law, the state shall award to the system at least one of the state managed care contracts that are awarded to provide health care services to beneficiaries of the medical assistance program under Chapter 32, Human Resources Code, in the rural areas of the territorial jurisdiction of the participating hospital providers. (V.T.I.C. Art. 20C.14, Subsec. (a).)

Source Law

Art. 20C.14. (a) To the extent consistent with federal law, the state shall award to the system at least one of any state managed care contracts awarded to provide health care services to beneficiaries of the Texas Medical Assistance Program under Chapter 32, Human Resources Code, in the rural areas within the territorial jurisdiction of the participating providers.

Revised Law

Sec. 845.152. PARTICIPATION REQUIREMENT. As a requirement of participation in a state contract awarded under Section 845.151, the system must satisfactorily address the qualifications for arranging to provide health care services to beneficiaries of certain governmental health care programs as delineated in the contractor's request for proposal, including:

(1) readiness reviews and adequacy of credentialing, medical management, quality assurance, claims payment, information management, provider and patient education, and complaint and grievance procedures; and

(2) adequacy of physician and provider networks, including factors such as diversity, geographic accessibility, inclusion of physicians and other providers that have furnished a significant amount of Medicaid or charity care to beneficiaries, and tertiary and subspecialty services. (V.T.I.C. Art. 20C.14, Subsec. (b).)

Source Law

(b) As a requirement of participation in any state contract, the system must satisfactorily address the qualifications for arranging to provide health care services to beneficiaries of certain governmental health care programs as delineated in the

contractor's request for proposal, including:

(1) readiness reviews and adequacy of credentialing, medical management, quality assurance, claims payment, information management, provider and patient education, and complaint and grievance procedures; and

(2) adequacy of physician and provider networks, including such factors as diversity, geographic accessibility, inclusion of physicians and other providers that have furnished a significant amount of Medicaid or charity care to beneficiaries, and tertiary and subspecialty services.

Revised Law

Sec. 845.153. REIMBURSEMENT AT STATE-DEFINED CAPITATION RATE. (a) To the extent the system operates under a certificate of authority issued under Chapter 843, the Medicaid contracting agency shall reimburse the system at the state-defined capitation rate for each service area in which the system operates.

(b) The system is not required as a condition of participation in a state contract awarded under Section 845.151 to accept from the Medicaid contracting agency a capitation rate that is lower than the state-defined capitation rate for each service area in which the system operates. (V.T.I.C. Art. 20C.14, Subsecs. (c), (d).)

Source Law

(c) To the extent the system operates under a certificate of authority issued under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), the system shall be reimbursed by the Medicaid contracting agency at the state-defined capitation rate for each service area in which the system operates.

(d) It is not a condition of participation for the system to accept from the Medicaid contracting agency a capitation rate which is lower than the state-defined capitation rate for each service area in which the system operates.

Revised Law

Sec. 845.154. RIGHT OF STATE TO CANCEL CONTRACT ON SALE OR DISSOLUTION. The state may cancel a contract awarded under this subchapter if the system is sold or dissolved. (V.T.I.C. Art. 20C.14, Subsec. (e).)

Source Law

(e) The state retains the right to cancel a contract awarded under this article if the system is sold or dissolved.

CHAPTER 846. MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 846.008-846.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

[Sections 846.062-846.100 reserved for expansion]

SUBCHAPTER C. BOARD MEMBERS; OTHER OFFICERS AND PERSONNEL

[Sections 846.108-846.150 reserved for expansion]

CHAPTER 846. MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 846.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of trustees or directors, as applicable, of a multiple employer welfare arrangement.

(2) "Employee welfare benefit plan" has the meaning assigned by Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).

(3) "Health benefit plan" includes any plan that provides benefits for health care services. The term does not include:

(A) accident-only or disability income insurance coverage, or a combination of accident-only and disability income insurance coverage;

(B) credit-only insurance coverage;

(C) disability insurance;

(D) coverage for a specified disease or illness;

(E) Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(H) coverage that provides limited-scope dental or vision benefits;

(I) coverage provided by a single service health maintenance organization;

(J) workers' compensation insurance coverage or similar insurance coverage;

(K) coverage provided through a jointly managed trust authorized under 29 U.S.C. Section 141 et seq. that contains a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(L) hospital indemnity or other fixed indemnity insurance coverage;

(M) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(N) short-term major medical contracts;

(O) liability insurance coverage, including general liability insurance coverage and automobile liability insurance coverage;

(P) coverage issued as a supplement to liability insurance coverage;

(Q) automobile medical payment insurance

coverage;

(R) coverage for on-site medical clinics;

(S) coverage that provides other limited benefits specified by federal regulations; or

(T) other coverage that is:

(i) similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other coverage benefits; and

(ii) specified in federal regulations.

(4) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

(5) "Multiple employer welfare arrangement" has the meaning assigned by Section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(40)).

(6) "Organizational document" means the articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to a multiple employer welfare arrangement.

(7) "Participation criteria" means any criteria or rules established by an employer to determine the employees who are eligible for enrollment or continued enrollment under the terms of a health benefit plan.

(8) "Preexisting condition provision" means a provision that excludes or limits coverage for a disease or condition for a specified period after the effective date of coverage.

(9) "Waiting period" means a period established by a multiple employer welfare arrangement that must elapse before an individual who is a potential participating employee in a health benefit plan is eligible to be covered for benefits. (V.T.I.C. Art. 3.95-1, Subdivs. (4), (6), (7), (9) (part), (10) (part), (11), (12); Art. 3.95-1.6; Art. 3.95-2, Subsec. (b) (part); New.)

Source Law

Art. 3.95-1. In this subchapter:

(4) "Employee welfare benefit plan" has the meaning assigned by Section

3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).

(6) "Health benefit plan" means a health benefit plan described by Article 3.95-1.6 of this code.

(7) "Health status related factor" means:

(A) health status;

(B) medical condition, including both physical and mental illness;

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability, including conditions arising out of acts of family violence; and

(H) disability.

(9) "Multiple employer welfare arrangement" has the meaning assigned by Section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(40)) . . . .

(10) "Participation criteria" means any criteria or rules established by an employer to determine the employees who are eligible for enrollment, including continued enrollment, under the terms of a health benefit plan. . . .

(11) "Preexisting condition provision" means a provision that denies, excludes, or limits coverage for a disease or condition for a specified period after the effective date of coverage.

(12) "Waiting period" means a period established by a multiple employer welfare arrangement that must pass before an individual who is a potential participating employee in a health benefit plan is eligible to be covered for benefits.

Art. 3.95-1.6. (a) For purposes of this subchapter, the term "health benefit plan" includes any plan that provides benefits for health care services.

(b) A health benefit plan does not include:

(1) accident-only or disability income insurance or a combination of accident-only and disability income insurance;

(2) credit-only insurance;

(3) disability insurance;

(4) coverage for a specified disease or illness;

(5) Medicare services under a federal contract;

(6) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(7) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(8) coverage that provides limited-scope dental or vision benefits;

(9) coverage provided by a single service health maintenance organization;

(10) coverage issued as a supplement to liability insurance;

(11) workers' compensation or similar insurance;

(12) automobile medical payment insurance coverage;

(13) jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;

(14) hospital indemnity or other fixed indemnity insurance;

(15) reinsurance contracts issued on a stop-loss, quota-share, or similar basis;

(16) short-term major medical contracts;

(17) liability insurance, including general liability insurance and automobile liability insurance;

(18) other insurance coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified in federal regulations;

(19) coverage for on-site medical clinics; or

(20) coverage that provides other limited benefits specified by federal regulations.

[Art. 3.95-2]

(b) . . . [The application shall be completed and submitted along with all information required by the commissioner, including:]

(1) copies of all articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of employers, employees, and beneficiaries with respect to the multiple employer welfare arrangement; . . . .

Revisor's Note

(1) Subdivision (1), V.T.I.C. Article 3.95-1, defines "board" as the Texas Department of Insurance or the commissioner, as appropriate. 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. Chapter 31 of this code defines "department" for purposes of this code and the other insurance laws of this state to mean the Texas Department of Insurance. Throughout this chapter, references to the former board have been changed appropriately. The omitted law reads:

(1) "Board" means the Texas Department of Insurance or the commissioner, as appropriate.

(2) The revised law defines "board" to

mean the board of trustees or board of directors of a multiple employer welfare arrangement for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition.

(3) Subdivision (2), V.T.I.C. Article 3.95-1, defines "commissioner." The revised law omits the definition as unnecessary because Chapter 31 defines "commissioner" for purposes of this code and the other insurance laws of this state to mean "commissioner of insurance." The omitted law reads:

(2) "Commissioner" means the commissioner of insurance.

(4) Subdivision (11), V.T.I.C. Article 3.95-1, refers to a provision that "denies, excludes, or limits" coverage. The reference to "denies" is omitted from the revised law because in context "denies" is included within the meaning of "excludes."

(5) Subdivision (b)(6), V.T.I.C. Article 3.95-1.6, excludes "Medicare supplement and Medicare Select policies" from the definition of "health benefit plan." The revised law substitutes "Medicare supplement and Medicare Select benefit plans" for "Medicare supplement and Medicare Select policies" because federal and state law permit Medicare supplement and Medicare Select benefits to be provided through health maintenance organizations, which are not insurers. Consequently, "benefit plan" is a more accurate term than "policy."

(6) The definition of "organizational document" is derived from V.T.I.C. Article 3.95-2(b) and is added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definition. See also V.T.I.C. Article 3.95-7(c), revised in this chapter in Section 846.101.

Revised Law

Sec. 846.002. APPLICABILITY OF CHAPTER. (a) In this section, "fully insured multiple employer welfare arrangement" means an arrangement that provides to its participating employees and beneficiaries benefits for which 100 percent of the liability has been assumed by an insurance company authorized to do

business in this state.

(b) This chapter applies only to a multiple employer welfare arrangement that meets either or both of the following criteria:

(1) one or more of the employer members in the arrangement:

(A) is domiciled in this state; or

(B) has its principal headquarters or principal administrative office in this state; or

(2) the arrangement solicits an employer that:

(A) is domiciled in this state; or

(B) has its principal headquarters or principal administrative office in this state.

(c) This chapter does not apply to a fully insured multiple employer welfare arrangement during the period in which the arrangement is fully insured. The commissioner periodically may require proof that the arrangement is fully insured. (V.T.I.C. Art. 3.95-1, Subdivs. (5), (9) (part); Art. 3.95-2, Subsec. (a) (part).)

Source Law

[Art. 3.95-1]

(5) "Fully insured multiple employer welfare arrangement" means a multiple employer welfare arrangement that provides benefits to its participating employees and beneficiaries for which 100 percent of the liability has been assumed by an insurance company authorized to do business in this state.

[(9) "Multiple employer welfare arrangement" has the meaning assigned by Section 3(40) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(40))] to describe an entity which meets either or both of the following criteria:

(A) one or more of the employer members in the multiple employer welfare arrangement is either domiciled in this state or has its principal headquarters or principal administrative office in this state; or

(B) the multiple employer welfare arrangement solicits an employer that is domiciled in this state or has its principal headquarters or principal

administrative office in this state.

[Art. 3.95-2]

(a) . . . This subchapter shall not apply to a fully insured multiple employer welfare arrangement for so long as such multiple employer welfare arrangement remains fully insured. The commissioner may, from time to time, require proof that the multiple employer welfare arrangement is fully insured.

Revised Law

Sec. 846.003. LIMITED EXEMPTION FROM INSURANCE LAWS; APPLICABILITY OF CERTAIN LAWS. (a) A multiple employer welfare arrangement is exempt from the operation of all insurance laws of this state, except laws that are made applicable by their specific terms or as specified in this section or chapter.

(b) A multiple employer welfare arrangement is subject to the following laws:

(1) Subchapters C and D, Chapter 36;
(2) Section 38.001;
(3) Section 81.002;
(4) Chapter 82;
(5) Chapter 83;
(6) Chapter 801;
(7) Chapter 803;
(8) Chapter 804;
(9) Subchapter A, Chapter 805;
(10) Sections 841.701-841.702;
(11) Section 841.704;
(12) Section 841.259;
(13) Article 1.10D;
(14) Article 1.12;
(15) Article 1.13;
(16) Article 1.15;
(17) Article 1.16;
(18) Article 1.19;
(19) Article 1.35;
(20) Article 1.31;
(21) Article 3.56;
(22) Article 21.21;
(23) Article 21.28;
(24) Article 21.28A; and
(25) Article 21.28E.

(c) A multiple employer welfare arrangement is only considered an insurer for purposes of the laws described by this section. (V.T.I.C. Art. 3.95-13.)

Source Law

Art. 3.95-13. A multiple employer welfare arrangement shall be exempt from the operation of all insurance laws of this state, except such laws as are made applicable by their specific terms or as specified in this subchapter. Multiple employer welfare arrangements shall be subject to Articles 1.04, 1.10A, 1.10B, 1.10C, 1.10D, 1.12, 1.13, 1.14, 1.14A, 1.15, 1.16, 1.19, 1.19-1, 1.24, 1.28, 1.29, 1.31, 1.35, 1.36, 3.55, 3.56, 3.56-1, 3.67, 21.21, 21.28, 21.28-A, and 21.28-E and Section 7 of Article 1.10 of this code. A multiple employer welfare arrangement will be considered an insurer for purposes of these sections only.

Revised Law

Sec. 846.004. LATE-PARTICIPATING EMPLOYEE OR DEPENDENT. (a) For purposes of this chapter, an employee or dependent eligible for enrollment in a participating employer's health benefit plan is a late-participating employee or dependent if the individual requests enrollment after the expiration of:

(1) the initial enrollment period established under the terms of the first health benefit plan for which that employee or dependent was eligible through the participating employer; or

(2) an open enrollment period under Section 846.257.

(b) An employee or dependent is not a late-participating employee or dependent if the individual:

(1) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;

(2) declined enrollment in writing, at the time of the initial eligibility for enrollment, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(3) has lost coverage under the other health benefit plan or self-funded employer health benefit plan as a result of:

(A) the termination of employment;

(B) a reduction in the number of hours of employment;

(C) the termination of the other plan's coverage;

(D) the termination of contributions toward the premium made by the employer; or

(E) the death of a spouse or divorce; and

(4) requests enrollment not later than the 31st day after the date coverage under the other health benefit plan or self-funded employer health benefit plan terminates.

(c) An employee or dependent is also not a late-participating employee or dependent if the individual is:

(1) employed by an employer that offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period under Section 846.257;

(2) a spouse for whom a court has ordered coverage under a covered employee's plan and the request for enrollment of the spouse is made not later than the 31st day after the date the court order is issued; or

(3) a child for whom a court has ordered coverage under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date the employer receives the court order. (V.T.I.C. Art. 3.95-1, Subdiv. (8); Art. 3.95-1.7.)

Source Law

[Art. 3.95-1]

(8) "Late-participating employee" means an employee described by Article 3.95-1.7 of this code.

Art. 3.95-1.7. (a) An individual is a late-participating employee if the individual:

(1) is an employee or dependent eligible for enrollment; and

(2) requests enrollment in a participating employer's health benefit plan after the expiration of the initial enrollment period established under the terms of the first plan for which that employee or dependent was eligible through the participating employer and after the expiration of an open enrollment period under Article 3.95-4.1 of this code.

(b) An individual is not a late-participating employee if:

(1) the individual:

(A) was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;

(B) declines in writing, at the time of the initial eligibility, stating

that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;

(C) has lost coverage under another health benefit plan or self-funded employer health benefit plan as a result of:

(i) the termination of employment;

(ii) the reduction in the number of hours of employment;

(iii) the termination of the other plan's coverage;

(iv) the termination of contributions toward the premium made by the employer; or

(v) the death of a spouse or divorce; and

(D) requests enrollment not later than the 31st day after the date on which coverage under the other health benefit plan or self-funded employer health benefit plan terminates;

(2) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period;

(3) a court has ordered coverage to be provided for a spouse under a covered employee's plan and request for enrollment is made not later than the 31st day after the date the court order is issued; or

(4) a court has ordered coverage to be provided for a child under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date the employer receives the court order.

Revised Law

Sec. 846.005. RULES; ORDERS. (a) The commissioner may, on notice and opportunity for all interested persons to be heard, adopt rules and issue orders reasonably necessary to augment and implement this chapter.

(b) The commissioner shall adopt rules necessary to meet the minimum requirements of federal law and regulations. (V.T.I.C. Art. 3.95-15, Subsec. (a).)

Source Law

Art. 3.95-15. (a) The commissioner may, on notice and opportunity for all interested persons to be heard, issue such rules, regulations, and orders as are reasonably necessary to augment and carry out the provisions of this subchapter. The commissioner shall adopt rules as necessary to meet the minimum requirements of federal law and regulations.

Revisor's Note

Subsection (a), V.T.I.C. Article 3.95-15, refers to "rules" and "regulations" adopted by the commissioner. 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. 846.006. APPEAL OF ORDERS. A person affected by an order of the commissioner issued under this chapter may appeal that order by filing suit in a district court in Travis County under Subchapter D, Chapter 36. (V.T.I.C. Art. 3.95-15, Subsec. (c).)

Source Law

(c) A person affected by the board's order may appeal that order by filing suit in a district court in Travis County pursuant to Subsection (f) of Article 1.04 of this code.

Revisor's Note

Subsection (b), V.T.I.C. Article 3.95-15, provides that a person affected by a final ruling or action of the commissioner may have that ruling reviewed. This subsection is omitted from the revised law because Subsection (d), V.T.I.C. Article 1.04, was repealed by Chapter 685, Acts of the 73rd Legislature, Regular Session, 1993. The omitted law reads:

(b) A person affected by a final ruling or action of the commissioner under this subchapter is entitled to have that ruling or action reviewed by the board by submitting an

application to the board as provided by Subsection (d) of Article 1.04 of this code. Appeal of the commissioner's ruling or action to the board does not operate as a stay of the ruling or action except as otherwise ordered by the board on application by the appellant.

Revised Law

Sec. 846.007. PREMIUM RATES; ADJUSTMENTS. (a) A multiple employer welfare arrangement may charge premiums in accordance with this section to the group of employees or dependents who meet the participation criteria and who do not decline coverage.

(b) A multiple employer welfare arrangement may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all participating employees and dependents of participating employees of the employer.

(c) Subsection (b) does not restrict the amount that an employer may be charged for coverage.

(d) A multiple employer welfare arrangement may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. A discount, rebate, or reduction established under this subsection does not violate Section 4(8), Article 21.21. (V.T.I.C. Art. 3.95-4.1, Subsec. (b) (part); Art. 3.95-4.6.)

Source Law

[Art. 3.95-4.1]

(b) . . . The multiple employer welfare arrangement may charge premiums in accordance with Article 3.95-4.6 of this code to the group of employees or dependents who meet the participation criteria and who do not decline coverage.

Art. 3.95-4.6. (a) A multiple employer welfare arrangement may not charge an adjustment to premium rates for individual employees or dependents for health status related factors or duration of coverage. Any adjustment must be applied uniformly to the rates charged for all participating employees and dependents of participating employees of the employer. This subsection does not restrict the amount that an employer may be

charged for coverage.

(b) A multiple employer welfare arrangement may establish premium discounts, rebates, or a reduction in otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention. A discount, rebate, or reduction established under this subsection does not violate Section 4(8), Article 21.21, of this code.

Revisor's Note
(End of Subchapter)

Subsection (g), V.T.I.C. Article 3.95-2, provides that certain multiple employer welfare arrangements must file certain notices with the commissioner by December 31, 1993. The revised law omits this subsection as executed. The omitted law reads:

(g) A multiple employer welfare arrangement in existence on June 1, 1993, shall file notice with the commissioner by December 31, 1993, of its intent to apply for an initial certificate of authority and shall file for its initial certificate of authority by June 1, 1994. The multiple employer welfare arrangement may continue to conduct business until the initial certificate of authority is granted or finally denied by the commissioner.

[Sections 846.008-846.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Revised Law

Sec. 846.051. CERTIFICATE OF AUTHORITY REQUIRED. A person may not establish or maintain an employee welfare benefit plan that is a multiple employer welfare arrangement in this state unless the arrangement obtains and maintains a certificate of authority issued under this chapter. (V.T.I.C. Art. 3.95-2, Subsec. (a) (part).)

Source Law

Art. 3.95-2. (a) A person shall not establish or maintain an employee welfare benefit plan which is a multiple employer

welfare arrangement in this state unless the multiple employer welfare arrangement obtains and maintains a certificate of authority pursuant to this subchapter. . . .

Revised Law

Sec. 846.052. APPLICATION FOR INITIAL CERTIFICATE OF AUTHORITY. (a) A person who wants to establish an employee welfare benefit plan that is a multiple employer welfare arrangement must apply for an initial certificate of authority on an application form prescribed by the commissioner.

(b) The application form must be completed and submitted along with all information required by the commissioner, including:

(1) a copy of each organizational document;

(2) current financial statements of the arrangement;

(3) a fully detailed statement indicating the plan under which the arrangement proposes to transact business;

(4) an initial actuarial opinion in compliance with the requirements of Section 846.153(a)(2) and subject to Section 846.157(b); and

(5) a statement by the applicant certifying that the arrangement is in compliance with all applicable provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

(c) The application must be accompanied by proof of a fidelity bond that:

(1) protects against acts of fraud or dishonesty in servicing the multiple employer welfare arrangement;

(2) covers each person responsible for servicing the employee welfare benefit plan; and

(3) is in an amount equal to the greater of 10 percent of the premiums and contributions received by the arrangement or 10 percent of the benefits paid, during the preceding calendar year, with a minimum of $10,000 and a maximum of $500,000.

(d) A third-party administrator licensed to engage in business in this state is not required to submit a fidelity bond under Subsection (c).

(e) The commissioner shall promptly examine the application and documents submitted by the applicant and may:

(1) conduct any investigation that the commissioner considers necessary; and

(2) examine under oath any person interested in or connected with the multiple employer welfare arrangement.

(V.T.I.C. Art. 3.95-2, Subsecs. (b) (part), (c).)

Source Law

(b) A person wishing to establish an employee welfare benefit plan which is a multiple employer welfare arrangement shall apply for an initial certificate of authority on a form prescribed by the commissioner. The application shall be completed and submitted along with all information required by the commissioner, including:

(1) copies of . . . [documents] . . . ;

(2) current financial statements of the multiple employer welfare arrangement;

(3) proof of a fidelity bond which shall protect against acts of fraud or dishonesty in servicing the multiple employer welfare arrangement, covering each person responsible for servicing the employee welfare benefit plan in an amount equal to the greater of 10 percent of the premiums and contributions received by the multiple employer welfare arrangement, or 10 percent of the benefits paid, during the preceding calendar year, with a minimum of $10,000 and a maximum of $500,000; no additional bond shall be required of a third-party administrator licensed to engage in business in this state;

(4) a statement showing in full detail the plan on which the multiple employer welfare arrangement proposes to transact business;

(5) an initial actuarial opinion in compliance with the requirements of Subsection (a)(2), Article 3.95-8, of this code and subject to Subsection (c), Article 3.95-8, of this code; and

(6) a certification by the applicant that the multiple employer welfare arrangement is in compliance with all applicable provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

(c) The commissioner shall promptly examine the application and documents submitted by the applicant and shall have the power to conduct any investigation which the

commissioner may deem necessary and to examine under oath any persons interested in or connected with the multiple employer welfare arrangement.

Revised Law

Sec. 846.053. ELIGIBILITY REQUIREMENTS FOR INITIAL CERTIFICATE OF AUTHORITY. (a) An applicant for an initial certificate of authority as a multiple employer welfare arrangement must meet the requirements of this section.

(b) The employers in the multiple employer welfare arrangement must be members of an association or group of five or more businesses that are in the same trade or industry, including closely related businesses that provide support, services, or supplies primarily to that trade or industry.

(c) If the employers in the multiple employer welfare arrangement are members of an association, the association must:

(1) be engaged in substantial activity for its members other than sponsorship of an employee welfare benefit plan; and

(2) have been in existence for at least two years before engaging in any activities relating to providing employee health benefits to its members.

(d) The employee welfare plan of the association or group in the multiple employer welfare arrangement must be controlled and sponsored directly by participating employers, participating employees, or both.

(e) The association or group of employers in the multiple employer welfare arrangement must be a not-for-profit organization.

(f) The multiple employer welfare arrangement must:

(1) have within its own organization adequate facilities and competent personnel, as determined by the commissioner, to administer the employee benefit plan; or

(2) have contracted with a third-party administrator licensed to engage in business in this state.

(g) The multiple employer welfare arrangement:

(1) must have applications from not fewer than five employers and must provide similar benefits for not fewer than 200 separate participating employees; and

(2) will have annual gross premiums of or contributions to the plan of not less than:

(A) $20,000 for a plan that provides only vision benefits;

(B) $75,000 for a plan that provides only dental benefits; and

(C) $200,000 for all other plans.

(h) The multiple employer welfare arrangement must possess a written commitment, binder, or policy for stop-loss insurance

issued by an insurer authorized to do business in this state that provides:

(1) at least 30 days' notice to the commissioner of any cancellation or nonrenewal of coverage; and

(2) both specific and aggregate coverage with an aggregate retention of not more than 125 percent of the amount of expected claims for the next plan year and a specific retention amount annually determined by the actuarial opinion required by Section 846.153(a)(2).

(i) Both the specific and aggregate coverage required by Subsection (h)(2) must require all claims to be submitted within 90 days after the claim is incurred and provide a 12-month claims incurred period and a 15-month paid claims period for each policy year.

(j) The contributions must be established to fund at least 100 percent of the aggregate retention plus all other costs of the multiple employer welfare arrangements.

(k) The multiple employer welfare arrangement must establish a procedure for handling claims for benefits on dissolution of the arrangement.

(l) The multiple employer welfare arrangement must obtain the required bond. (V.T.I.C. Art. 3.95-2, Subsec. (d) (part).)

Source Law

(d) . . . provided all of the following conditions have been met:

(1) the employers in the multiple employer welfare arrangement are members of an association or group of five or more businesses which are in the same trade or industry, including closely related businesses which provide support, services, or supplies primarily to that trade or industry;

(2) if an association, that the association in the multiple employer welfare arrangement is engaged in substantial activity for its members other than sponsorship of an employee welfare benefit plan;

(3) if an association, that the association in the multiple employer welfare arrangement has been in existence for a period of not less than two years prior to engaging in any activities relating to the provision of employee health benefits to its members;

(4) the employee welfare plan of

the association or group in the multiple employer welfare arrangement is controlled and sponsored directly by participating employers, participating employees, or both;

(5) the association or group of employers in the multiple employer welfare arrangement is a not-for-profit organization;

(6) the multiple employer welfare arrangement has within its own organization adequate facilities and competent personnel, as determined by the commissioner, to service the employee benefit plan or has contracted with a third-party administrator licensed to engage in business in this state;

(7) the multiple employer welfare arrangement has applications from not less than five employers and will provide similar benefits for not less than 200 separate participating employees, and the annual gross premiums of or contributions to the plan will be not less than $20,000 for a plan that provides only vision benefits, $75,000 for a plan that provides only dental benefits, and $200,000 for all other plans;

(8) the multiple employer welfare arrangement possesses a written commitment, binder, or policy for stop-loss insurance issued by an insurer authorized to do business in this state providing not less than 30 days notice to the commissioner of any cancellation or nonrenewal of coverage and which provides both specific and aggregate coverage with an aggregate retention of no more than 125 percent of the amount of expected claims for the next plan year and a specific retention amount annually determined by the actuarial report required by Article 3.95-8 of this code;

(9) both the specific and aggregate coverage will require all claims to be submitted within 90 days after the claim is incurred and provide a 12-month claims incurred period and a 15-month paid claims period for each policy year;

(10) the contributions shall be set to fund at least 100 percent of the aggregate retention plus all other costs of the multiple employer welfare arrangements;

. . .

(13) the multiple employer welfare arrangement has established a procedure for handling claims for benefits in the event of dissolution of the multiple employer welfare arrangement; and

(14) the multiple employer welfare arrangement has obtained the required bond.

Revised Law

Sec. 846.054. ISSUANCE OF INITIAL CERTIFICATE OF AUTHORITY. (a) The commissioner shall issue an initial certificate of authority to a multiple employer welfare arrangement that meets the requirements of Section 846.053 not later than the 60th day after the date on which the application is filed.

(b) An initial certificate of authority is a temporary certificate issued for a one-year term.

(c) On receipt of the initial certificate of authority, the multiple employer welfare arrangement shall begin business. (V.T.I.C. Art. 3.95-2, Subsecs. (d) (part), (e).)

Source Law

(d) Within 60 days of the filing of the application, the commissioner shall issue the initial certificate of authority, which shall be a temporary certificate for a term of one year, to a multiple employer welfare arrangement, ...

(e) On receipt of its initial certificate of authority, the multiple employer welfare arrangement shall commence business.

Revised Law

Sec. 846.055. EXTENSION OF TERM OF INITIAL CERTIFICATE OF AUTHORITY. The commissioner may extend the term of an initial certificate of authority for a period not to exceed one year if the commissioner determines that the multiple employer welfare arrangement is likely to meet the requirements of this chapter for a final certificate of authority within that period. The commissioner may not grant more than one extension of the initial certificate of authority regardless of the length of time for which an extension was granted. (V.T.I.C. Art. 3.95-2, Subsec. (i) (part).)

Source Law

(i) . . . The initial certificate of authority may be extended for up to one year

at the discretion of the commissioner on a determination that the multiple employer welfare arrangement is likely to meet the requirements of this subchapter within one year. No more than one extension of the initial certificate of authority shall be granted regardless of the length of time for which an extension was granted.

Revised Law

Sec. 846.056. FINAL CERTIFICATE OF AUTHORITY. (a) A multiple employer welfare arrangement that holds an initial certificate of authority must apply for a final certificate of authority not later than the first anniversary of the date of issuance of the initial certificate.

(b) The multiple employer welfare arrangement must file an application for a final certificate of authority on a form prescribed by the commissioner and furnish the information required by the commissioner. The application for a final certificate of authority must include only:

(1) the names and addresses of:

(A) the association or group of employers sponsoring the arrangement;

(B) the board members of the arrangement; and

(C) if the employers in the arrangement are not an association, at least five employers;

(2) proof of compliance with the bonding requirements;

(3) a copy of each plan document and each agreement with service providers; and

(4) a funding report containing:

(A) a statement certified by the board and an actuarial opinion that all applicable requirements of Section 846.153 have been met;

(B) an actuarial opinion describing the extent to which contributions or premium rates:

(i) are not excessive;

(ii) are not unfairly discriminatory; and

(iii) are adequate to provide for the payment of all obligations and the maintenance of required cash reserves and surplus by the arrangement;

(C) a statement of the current value of the assets and liabilities accumulated by the arrangement and a projection of the assets, liabilities, income, and expenses of the arrangement for the next 12-month period; and

(D) a statement of the costs to be charged for coverage, including an itemization of amounts for:

(i) administrative expenses;

(ii) reserves; and

(iii) other expenses associated with operation of the arrangement.

(c) The reserves described in Section 846.154(a) must have been established or be established before the final certificate of authority is issued.

(d) If, after examination and investigation, the commissioner is satisfied that the multiple employer welfare arrangement meets the requirements of this chapter, the commissioner shall issue a final certificate of authority to the arrangement.

(e) The commissioner shall maintain the information required under Subsection (b)(1)(C) and Subsection (b)(3) as confidential information. (V.T.I.C. Art. 3.95-2, Subsecs. (d) (part), (h), (i) (part).)

Source Law

(d) . . .

(12) the reserves described in Subsection (a)(2)(B), Article 3.95-8, of this code have been established or will be established before the final certificate of authority is issued; . . . .

(h) A multiple employer welfare arrangement possessing an initial certificate of authority must apply for a final certificate of authority no later than one year after issuance of its initial certificate of authority. The multiple employer welfare arrangement shall file an application on a form prescribed by the commissioner and furnish such information as may be required by the commissioner. The application shall include only:

(1) the names and addresses of:

(A) the association or group of employers sponsoring the multiple employer welfare arrangement;

(B) the members of the board of trustees or directors, as applicable, of the multiple employer welfare arrangement; and

(C) if not an association, at least five employers, which information shall be retained by the commissioner as confidential;

(2) evidence that the bonding requirements have been met;

(3) copies of all plan documents and agreements with service providers, which shall be retained by the commissioner as confidential; and

(4) a funding report containing:

(A) a statement certified by the board of trustees or directors, as applicable, and an actuarial opinion that all applicable requirements of Article 3.95-8 of this code have been met;

(B) an actuarial opinion which sets forth a description of the extent to which contributions or premium rates:

(i) are not excessive;

(ii) are not unfairly discriminatory; and

(iii) are adequate to provide for the payment of all obligations and the maintenance of required cash reserves and surplus by the multiple employer welfare arrangement;

(C) a statement of the current value of the assets and liabilities accumulated by the multiple employer welfare arrangement and a projection of the assets, liabilities, income, and expenses of the multiple employer welfare arrangement for the next 12-month period; and

(D) a statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with operation of the multiple employer welfare arrangement.

(i) After examination and investigation, the commissioner shall issue a final certificate of authority to the multiple employer welfare arrangement if the commissioner is satisfied that the multiple employer welfare arrangement meets the requirements of this subchapter. . . .

Revised Law

Sec. 846.057. DENIAL OF FINAL CERTIFICATE OF AUTHORITY. (a) The commissioner shall deny a final certificate of authority to an applicant that does not comply with this chapter.

(b) If the commissioner denies a final certificate of authority, the commissioner shall issue a written notice of

refusal to the applicant. The notice of refusal must state the basis for the denial. The notice of refusal constitutes 30 days' advance notice of the revocation of the initial certificate of authority.

(c) If the applicant submits a written request for a hearing not later than the 30th day after the date of mailing of the notice of refusal, revocation of the initial certificate of authority is temporarily stayed, and the commissioner shall promptly conduct a hearing at which the applicant is given an opportunity to show compliance with this chapter. (V.T.I.C. Art. 3.95-2, Subsecs. (i) (part), (j).)

Source Law

> (i) . . . The commissioner shall refuse to grant a final certificate of authority to an applicant that fails to meet the requirements of this subchapter. Notice of refusal shall be in writing, shall set forth the basis for the refusal, and shall also be in writing, shall set forth the basis for the refusal, and shall also constitute 30 days' advance notice of revocation of the initial certificate of authority. . . .
>
> (j) If the applicant submits a written request for hearing within 30 days after mailing of the notice of refusal, revocation of the initial certificate of authority shall be temporarily stayed and the commissioner shall promptly conduct a hearing in which the applicant shall be given an opportunity to show compliance with the requirements of this subchapter.

Revised Law

Sec. 846.058. DISQUALIFICATION. (a) A multiple employer welfare arrangement, each board member and officer of the arrangement, and any agent or other person associated with the arrangement shall be subject to disqualification for eligibility for a certificate of authority if the person:

(1) makes a material misstatement or omission in an application for a certificate of authority under this chapter;

(2) obtains or attempts to obtain at any time a certificate of authority or license for an insurance entity through intentional misrepresentation or fraud;

(3) misappropriates or converts to the person's own use or improperly withholds money under an employee welfare benefit plan or multiple employer welfare arrangement;

(4) is prohibited from serving in any capacity with

the arrangement under Section 411, Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1111);

(5) without reasonable cause or excuse, fails to appear in response to a subpoena, examination, warrant, or any other order lawfully issued by the commissioner; or

(6) has previously been subject to a determination by the commissioner resulting in:

(A) suspension or revocation of a certificate of authority or license; or

(B) denial of a certificate of authority or license on grounds that would be sufficient for suspension or revocation.

(b) This section does not apply to a participating employer in its capacity as a participating employer and the employer's participating employees. (V.T.I.C. Art. 3.95-2, Subsec. (f).)

Source Law

(f) The multiple employer welfare arrangement, each of its trustees or directors and officers, and any agent or other person associated with the multiple employer welfare arrangement, other than a participating employer in its capacity as such and its participating employees, shall be subject to disqualification if the person:

(1) made a material misstatement or omission in an application for a certificate of authority under this subchapter;

(2) obtained or attempted to obtain at any time a certificate of authority or license for an insurance entity through intentional misrepresentation or fraud;

(3) misappropriated or converted to the person's own use or improperly withheld money under an employee welfare benefit plan or multiple employer welfare arrangement;

(4) is prohibited from serving in any capacity with the multiple employer welfare arrangement under Section 411 of the Employee Retirement Income Security Act of 1974 (28 U.S.C. Section 1111);

(5) without reasonable cause or excuse failed to appear in response to a subpoena, examination, warrant, or any other order lawfully issued by the commissioner; or

(6) has previously been subject to

a determination by the commissioner resulting in the suspension or revocation of a certificate of authority or license or denial of a certificate of authority or license on grounds that would be sufficient for suspension or revocation.

Revisor's Note

Subsection (f), V.T.I.C. Article 3.95-2, refers to "28 U.S.C. Section 1111." The correct citation to the referenced law is 29 U.S.C. Section 1111, not 28 U.S.C. Section 1111. The revised law is drafted accordingly.

Revised Law

Sec. 846.059. FEES; SERVICE OF PROCESS. (a) Each multiple employer welfare arrangement shall pay to the department in the amount set by the commissioner:

(1) an application fee for an initial certificate of authority;

(2) an application fee for a final certificate of authority; and

(3) a filing fee for submission of the arrangement's annual statement.

(b) The commissioner shall set the fees described by Subsection (a) in amounts reasonable and necessary to defray the costs of administering this chapter.

(c) Each multiple employer welfare arrangement shall appoint the commissioner as its resident agent for purposes of service of process. The fee for that service is $50, payable at the time of appointment.

(d) Fees paid under this section shall be deposited to the credit of the Texas Department of Insurance operating fund. (V.T.I.C. Art. 3.95-3.)

Source Law

Art. 3.95-3. (a) The commissioner shall collect and the multiple employer welfare arrangement shall pay fees to the commissioner as set by the commissioner for:

(1) application for initial certificate of authority;

(2) application for final certificate of authority; and

(3) filing fee for annual statement.

(b) The commissioner shall set the fees established in accordance with Subsection (a)

of this article in amounts reasonable and necessary to defray the cost of administration of this subchapter.

(c) Each multiple employer welfare arrangement shall appoint the commissioner as its resident agent for purposes of service of process. The fee for such service shall be $50, payable at the time of appointment.

(d) Fees paid under this article shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund.

Revisor's Note

V.T.I.C. Article 3.95-3(d) states that fees "shall be deposited in the state treasury to the credit of the State Board of Insurance operating fund." Under Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly.

Revised Law

Sec. 846.060. SUSPENSION, REVOCATION, OR LIMITATION OF CERTIFICATE OF AUTHORITY. In addition to any requirement or remedy under a law cited under Section 846.003, the commissioner may suspend, revoke, or limit the certificate of authority of a multiple employer welfare arrangement if the commissioner determines, after notice and hearing, that the agreement does not comply with this chapter. (V.T.I.C. Art. 3.95-14, Subsec. (a).)

Source Law

Art. 3.95-14. (a) In addition to any requirements or remedies set out in Article 3.95-13 of this code, the commissioner may suspend, revoke, or limit the certificate of authority of a multiple employer welfare arrangement if the commissioner finds, after motion and hearing, that the multiple employer welfare agreement does not meet the requirements of this subchapter.

Revisor's Note

Subsection (a), V.T.I.C. Article 3.95-14, refers to an action by the

commissioner after "motion and hearing." It is clear from the context that "motion and hearing" is a typographical error and that the legislature intended to use the common phrase "notice and hearing." The revised law is drafted accordingly.

Revised Law

Sec. 846.061. ACTION BY ATTORNEY GENERAL. (a) The commissioner may notify the attorney general of a violation of this chapter, and the attorney general may apply to a district court in Travis County for leave to file suit in the nature of quo warranto or for injunctive relief or both.

(b) The attorney general may seek and the court may order:

(1) restitution for victims of an act declared to be unlawful under this chapter;

(2) assessment of a fine under this code; and

(3) recovery of reasonable attorney's fees. (V.T.I.C. Art. 3.95-14, Subsec. (b).)

Source Law

(b) The commissioner may notify the attorney general of a violation of this subchapter, and the attorney general may apply to a district court in Travis County for leave to file suit in the nature of quo warranto or for injunctive relief or both. The attorney general may seek and the court may order restitution for victims of an act declared to be unlawful under this subchapter, a fine under this code, and recovery of reasonable attorney's fees.

[Sections 846.062-846.100 reserved for expansion]

SUBCHAPTER C. BOARD MEMBERS; OTHER OFFICERS AND PERSONNEL

Revised Law

Sec. 846.101. BOARD MEMBERS; NOTICE OF ELECTIONS. (a) Except as otherwise provided, the powers of a multiple employer welfare arrangement shall be exercised by a board elected to carry out the purposes established by the organizational documents of the arrangement.

(b) The member employers shall elect at least 75 percent of the board members. At least 75 percent of the board members must be individuals who are covered under the arrangement.

(c) An owner, officer, or employee of a third-party administrator who provides services to the multiple employer welfare arrangement or any other person who has received compensation from the arrangement may not serve as a board

member.

(d) Each board member shall be elected for a term of at least two years.

(e) Each member employer of a multiple employer welfare arrangement shall be given notice of each election of board members and is entitled to an equal vote, either in person or by a written proxy signed by the member employer. An owner, officer, or employee of a third-party administrator who provides services to the arrangement or any other person who has received compensation from the arrangement may not serve as proxy. (V.T.I.C. Art. 3.95-7, Subsecs. (b), (c).)

Source Law

(b) At least 75 percent of the trustees or directors shall be elected by the member employers of the multiple employer welfare arrangement. Each trustee or director shall be elected for at least a two-year term. Each member employer of a multiple employer welfare arrangement shall be given notice of every election of trustees or directors and shall be entitled to an equal vote either in person or by proxy in writing signed by the member employer. No owner, officer, or employee of a third-party administrator who provides services to the multiple employer welfare arrangement or of any other person who has received compensation from the multiple employer welfare arrangement may serve as proxy.

(c) The powers of a multiple employer welfare arrangement, except as otherwise provided, shall be exercised by the board of trustees or directors chosen to carry out the purposes of the organizational documents. Not less than 75 percent of the trustees or directors shall be persons who are covered under the multiple employer welfare arrangement, and no trustee or director shall be an owner, officer, or employee of a third-party administrator who provides services to the multiple employer welfare arrangement or of any other person who has received compensation from the multiple employer welfare arrangement.

Revised Law

Sec. 846.102. DUTIES OF BOARD MEMBERS. (a) The board

members of a multiple employer welfare arrangement are responsible for all operations of the arrangement and shall take all necessary precautions to safeguard the assets of the arrangement.

(b) A board member shall give the attention and exercise the vigilance, diligence, care, and skill that a prudent person would use in like or similar circumstances. (V.T.I.C. Art. 3.95-10, Subsec. (a) (part).)

Source Law

Art. 3.95-10. (a) The trustees or directors of a multiple employer welfare arrangement shall give the attention and exercise the vigilance, diligence, care, and skill that prudent persons use in like or similar circumstances. Trustees or directors shall be responsible for all operations of the multiple employer welfare arrangement and shall take all necessary precautions to safeguard the assets of the multiple employer welfare arrangement. . . .

Revised Law

Sec. 846.103. LIMITATION ON ACTION AGAINST BOARD MEMBER. A board member may not be held liable in a private cause of action for any delinquency under Section 846.102 after the expiration of the earlier of:

(1) six years from the date of delinquency; or

(2) two years from the time when the delinquency is discovered by a person complaining of the delinquency. (V.T.I.C. Art. 3.95-10, Subsec. (a) (part).)

Source Law

(a) . . . No trustee or director shall be held liable in a private cause of action for any delinquency under this article after six years from the date of delinquency or after two years from the time when the delinquency is discovered by a person complaining of the delinquency, whichever occurs sooner.

Revisor's Note

Subsection (a), V.T.I.C. Article 3.95-10, refers to liability of a trustee or director "under this article," meaning Article 3.95-10. The pertinent provision of that article is revised in this chapter as

Section 846.102, and a cross-reference to that section is included in the revised law for the convenience of the reader.

Revised Law

Sec. 846.104. COMPENSATION OF BOARD MEMBERS. A board member serves without compensation from the multiple employer welfare arrangement except for actual and necessary expenses. (V.T.I.C. Art. 3.95-10, Subsec. (c) (part).)

Source Law

(c) Trustees or directors shall serve without compensation from the multiple employer welfare arrangement except for actual and necessary expenses. . . .

Revised Law

Sec. 846.105. OFFICERS; AGENTS. (a) The board shall select officers for the multiple employer welfare arrangement as designated in the organizational documents and may appoint agents as necessary for the arrangement to engage in business. Each officer and agent may exercise the authority and perform the duties required in the management of the property and affairs of the arrangement as delegated by the board.

(b) The board may remove an officer or agent if the board determines that the business interests of the multiple employer welfare arrangement are served by the removal.

(c) The board shall secure the fidelity of any or all of the officers or agents who handle the funds of the multiple employer welfare arrangement by bond or otherwise. (V.T.I.C. Art. 3.95-10, Subsec. (b).)

Source Law

(b) The board of trustees or directors shall select such officers as designated in the articles or bylaws or trust agreement and may appoint agents as deemed necessary for the transaction of the business of the multiple employer welfare arrangement. All officers and agents shall respectively have such authority and perform such duties in the management of the property and affairs of the multiple employer welfare arrangement as may be delegated by the board of trustees or directors. Any officer or agent may be removed by the board of trustees or directors whenever in their judgment the business interests of the multiple employer welfare arrangement will be served by the removal.

The board of trustees or directors shall secure the fidelity of any or of all such officers or agents who handle the funds of the multiple employer welfare arrangement by bond or otherwise.

Revisor's Note

Subsection (b), V.T.I.C. Article 3.95-10, refers to the "articles or bylaws or trust agreement" of a multiple employer welfare arrangement. The revised law substitutes the defined term "organizational documents" because it is clear from the context that the legislature intended to refer to all of these documents. Similar changes are made throughout this chapter.

Revised Law

Sec. 846.106. COMPENSATION OF OFFICERS, AGENTS, AND EMPLOYEES. (a) A multiple employer welfare arrangement may pay the officers and agents of the arrangement suitable compensation. An officer, employee, or agent of an arrangement may not be compensated unreasonably.

(b) The compensation of any officer or employee of a multiple employer welfare arrangement may not be computed directly or indirectly as a percentage of money or premium collected.

(c) The compensation of an agent may not exceed five percent of the money or premium collected.

(d) A multiple employer welfare arrangement may pay compensation or make an emolument to an officer of the arrangement only if the compensation or emolument is first authorized by a majority vote of the board of the arrangement. (V.T.I.C. Art. 3.95-6 (part); Art. 3.95-10, Subsecs. (c) (part), (d).)

Source Law

[Art. 3.95-6]

. . .

[(4) to appoint such officers and agents as the business of the multiple employer welfare arrangement shall require] and to allow them suitable compensation; . . . .

[Art. 3.95-10]

(c) . . . A multiple employer welfare arrangement shall not pay any salary, compensation, or emolument to any officer of

the multiple employer welfare arrangement unless the payment is first authorized by a majority vote of the board of trustees or directors of the multiple employer welfare arrangement.

(d) An officer, employee, or agent of a multiple employer welfare arrangement shall not be compensated unreasonably. The compensation of any officer or employee of a multiple employer welfare arrangement shall not be calculated directly or indirectly as a percentage of money or premium collected. The compensation of any agent shall not exceed five percent of the money or premium collected.

Revisor's Note

Subsection (c), V.T.I.C. Article 3.95-10, refers to "salary, compensation, or emolument." The revised law omits the reference to "salary" because that concept is included in the meaning of "compensation."

Revised Law

Sec. 846.107. RECEIPT OF THING OF VALUE; CRIMINAL PENALTY. (a) A board member, officer, or employee of a multiple employer welfare arrangement may not, knowingly and intentionally, directly or indirectly:

(1) receive money or another valuable thing for negotiating, procuring, recommending, or aiding in:

(A) a purchase by or sale to the arrangement of property; or

(B) a loan from the arrangement; or

(2) be pecuniarily interested as a principal, coprincipal, agent, or beneficiary in a purchase, sale, or loan described by Subdivision (1).

(b) A person commits an offense if the person violates this section. An offense under this subsection is a felony of the third degree. (V.T.I.C. Art. 3.95-11.)

Source Law

Art. 3.95-11. (a) An officer, trustee, director, or employee of a multiple employer welfare arrangement shall not knowingly and intentionally, directly or indirectly, receive any money or valuable thing for negotiating, procuring, recommending, or aiding in any purchase by or sale to the multiple employer welfare arrangement of any

property or any loan from the multiple employer welfare arrangement or be pecuniarily interested either as principal, coprincipal, agent, or beneficiary in any such purchase, sale, or loan.

(b) A person who violates this article is guilty of an offense. An offense under this section is a felony of the third degree.

[Sections 846.108-846.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

Revised Law

Sec. 846.151. GENERAL POWERS. (a) Unless otherwise provided by or inconsistent with this chapter, each multiple employer welfare arrangement may exercise the powers provided by this section.

(b) A multiple employer welfare arrangement may have succession, by its name, for the term stated in its trust agreement.

(c) A multiple employer welfare arrangement may sue and be sued. An arrangement may:

(1) complain and defend in any court;

(2) be a party to any proceedings before a public body of this state or of any other state or government; and

(3) sue a participating employer, an employee, or a beneficiary for any cause relating to the business of the arrangement.

(d) A multiple employer welfare arrangement may have a seal that may be used by having the seal or a facsimile of the seal impressed, affixed, or otherwise reproduced. The arrangement may alter the seal at will.

(e) A multiple employer welfare arrangement may appoint officers and agents as the business of the arrangement requires.

(f) A multiple employer welfare arrangement may adopt, amend, and repeal bylaws as necessary for the government of its affairs.

(g) A multiple employer welfare arrangement may conduct its business in this state, other states, and foreign countries and their territories and colonies.

(h) A multiple employer welfare arrangement may have offices outside this state.

(i) A multiple employer welfare arrangement may acquire, hold, mortgage, pledge, assign, and transfer real and personal property subject to this chapter. (V.T.I.C. Art. 3.95-6 (part).)

Source Law

Art. 3.95-6. Every multiple employer welfare arrangement, unless otherwise provided in or inconsistent with this subchapter, shall have power:

(1) to have succession, by its name, for the term stated in its trust agreement;

(2) to sue and be sued, to complain and defend in any court of law or equity, or to be a party to any proceedings before any board or commission or other public body of this state or of any other state or government; suits at law may be maintained by the multiple employer welfare arrangement against any of its participating employers, employees, or beneficiaries for any cause relating to the business of the multiple employer welfare arrangement;

(3) to have a seal which may be altered at pleasure and to use the seal by causing it or a facsimile of it to be impressed, affixed, or otherwise reproduced;

(4) to appoint such officers and agents as the business of the multiple employer welfare arrangement shall require . . . ;

(5) to make, alter, amend, and repeal bylaws for the regulation and government of its affairs; and

(6) to conduct its business in this state, other states, the District of Columbia, the territories and colonies of the United States, and foreign countries and their territories and colonies; to have one or more offices out of this state; and to acquire, purchase, hold, mortgage, pledge, assign, transfer, and convey real and personal property subject to the provisions of this subchapter.

Revisor's Note

(1) Subdivision (2), V.T.I.C. Article 3.95-6, provides that a multiple employer welfare arrangement may "complain and defend in any court of law or equity." The revised law omits "of law or equity" as unnecessary

because that term is included within the meaning of "any court."

(2) Subdivision (2), V.T.I.C. Article 3.95-6, refers to "proceedings before any board or commission or other public body." The references to "board" and "commission" are omitted from the revised law because those terms are included within the meaning of "public body."

(3) Subdivision (5), V.T.I.C. Article 3.95-6, grants a multiple employer welfare arrangement the power "to make, alter, amend, and repeal bylaws for the regulation and government of its affairs." The revised law substitutes "adopt" for "make" and "alter" because "make" and "alter" are included within the meaning of "adopt." The revised law omits the reference to "regulation" because, in context, "regulation" is included within the meaning of "government."

(4) Subdivision (6), V.T.I.C. Article 3.95-6, refers to "the District of Columbia, [and] the territories and colonies of the United States." The quoted language is omitted because under Section 311.005(7), Government Code (Code Construction Act), "state," when referring to a part of the United States, includes a district, commonwealth, territory, or insular possession of the United States. The definition applies to the revised law.

(5) Subdivision (6), V.T.I.C. Article 3.95-6, grants a multiple employer welfare arrangement the power "to acquire, purchase, hold, mortgage, pledge, assign, transfer, and convey real and personal property." The revised law omits the reference to "purchase" because that term is included within the meaning of "acquire." The revised law also omits "convey" because that term is included within the meaning of "transfer."

Revised Law

Sec. 846.152. FILING OF ORGANIZATIONAL DOCUMENTS. A multiple employer welfare arrangement shall file with the commissioner its organizational documents and all appurtenant amendments before those documents take effect. (V.T.I.C. Art. 3.95-7, Subsec. (a).)

Source Law

Art. 3.95-7. (a) The articles or bylaws, or trust agreement, as applicable, of the multiple employer welfare arrangement and all appurtenant amendments shall be filed with the commissioner before becoming operative.

Revised Law

Sec. 846.153. REQUIRED FILINGS. (a) A multiple employer welfare arrangement engaging in business in this state shall file the following with the commissioner on forms approved by the commissioner:

(1) a financial statement audited by a certified public accountant;

(2) an actuarial opinion prepared and certified by an actuary who is:

(A) not an employee of the arrangement; and

(B) a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, or an enrolled actuary under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and

(3) any modified terms of a plan document together with a certification from the trustees that the changes are in compliance with the minimum requirements of this chapter.

(b) A multiple employer welfare arrangement shall file the financial statement and the actuarial opinion required by Subsection (a) within 90 days of the end of the fiscal year.

(c) The actuarial opinion required under Subsection (a) must include:

(1) a description of the actuarial soundness of the multiple employer welfare arrangement, including any actions recommended to improve the actuarial soundness of the arrangement;

(2) the amount of cash reserves recommended to be maintained by the arrangement; and

(3) the level of specific and aggregate stop-loss insurance recommended to be maintained by the arrangement.
(V.T.I.C. Art. 3.95-8, Subsec. (a) (part).)

Source Law

Art. 3.95-8. (a) Each multiple employer welfare arrangement transacting business in this state shall file the following with the commissioner on forms approved by the commissioner:

(1) within 90 days of the end of

the fiscal year, financial statements audited by a certified public accountant;

(2) within 90 days of the end of the fiscal year, an actuarial opinion prepared and certified by an actuary who is not an employee of the multiple employer welfare arrangement and who is a fellow of the Society of Actuaries, a member of the American Academy of Actuaries, or an enrolled actuary under the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); and

(3) any modified terms of a plan document along with a certification from the trustees that any changes are in compliance with the minimum requirements of this subchapter. The actuarial opinion shall include:

(A) a description of the actuarial soundness of the multiple employer welfare arrangement, including any recommended actions that the multiple employer welfare arrangement should take to improve its actuarial soundness;

(B) the recommended amount of cash reserves the multiple employer welfare arrangement should maintain . . . and

(C) the recommended level of specific and aggregate stop-loss insurance the multiple employer welfare arrangement should maintain.

Revised Law

Sec. 846.154. CASH RESERVE REQUIREMENTS. (a) The amount of cash reserves recommended under Section 846.153(c)(2) may not be less than the greater of:

(1) 20 percent of the total contributions in the preceding plan year; or

(2) 20 percent of the total estimated contributions for the current plan year.

(b) Cash reserves required by this section must be:

(1) computed with proper actuarial regard for:

(A) known claims, paid and outstanding;

(B) a history of incurred but not reported claims;

(C) claims handling expenses;

(D) unearned premium;

(E) an estimate for bad debts;

(F) a trend factor; and

(G) a margin for error; and

(2) maintained in cash or federally guaranteed obligations of less than five-year maturity that have a fixed or recoverable principal amount or in other investments as the commissioner may authorize by rule. (V.T.I.C. Art. 3.95-8, Subsecs. (a) (part), (b) (part).)

Source Law

Art. 3.95-8. (a) . . .

[(B) the recommended amount of cash reserves the multiple employer welfare arrangement should maintain] which shall not be less than the greater of 20 percent of the total contributions in the preceding plan year or 20 percent of the total estimated contributions for the current plan year; cash reserves shall be calculated with proper actuarial regard for known claims, paid and outstanding, a history of incurred but not reported claims, claims handling expenses, unearned premium, an estimate for bad debts, a trend factor, and a margin for error; cash reserves required by this article shall be maintained in cash or federally guaranteed obligations of less than five-year maturity that have a fixed or recoverable principal amount or such other investments as the commissioner or board may authorize by rule; . . .

(b) . . . The cash reserves required by this article shall be maintained in cash or federally guaranteed obligations of less than five-year maturity that have a fixed or recoverable principal amount or such other investments as the commissioner or board may authorize by rule.

Revised Law

Sec. 846.155. ADJUSTMENT OF CONTRIBUTIONS. If the recommended cash reserves required by Section 846.154(a) exceed the greater of 40 percent of the total contributions for the preceding plan year or 40 percent of the total contributions expected for the current plan year, the contributions may be reduced to fund less than 100 percent of the aggregate retention plus all other costs of the multiple employer welfare arrangement, but not less than the level of contributions necessary to fund the minimum reserves required under Section

846.154(a). (V.T.I.C. Art. 3.95-2, Subsec. (d) (part).)

Source Law

(d) . . .

(11) if the reserves required by Subsection (a)(2)(B), Article 3.95-8, of this code exceed the greater of 40 percent of the total contributions for the preceding plan year or 40 percent of the total contributions expected for the current plan year, the contributions may be reduced to fund less than 100 percent of the aggregate retention plus all other costs of the multiple employer welfare arrangement, but in no event less than the level of contributions necessary to fund the minimum reserves required under Subsection (a)(2)(B), Article 3.95-8, of this code; . . . .

Revised Law

Sec. 846.156. WAIVER OR REDUCTION OF REQUIRED STOP-LOSS INSURANCE OR CASH RESERVES. On the application of a multiple employer welfare arrangement, the commissioner may waive or reduce the requirement for aggregate stop-loss insurance coverage and the amount of recommended cash reserves required by Section 846.154(a) on a determination that the interests of the participating employers and employees are adequately protected. (V.T.I.C. Art. 3.95-8, Subsec. (d).)

Source Law

(d) On application of a multiple employer welfare arrangement, the commissioner may waive or reduce the requirement for aggregate stop-loss coverage and the amount of reserves required by Subsection (a)(2)(B) of this article on a determination that the interests of the participating employers and employees are adequately protected.

Revised Law

Sec. 846.157. RENEWAL OF CERTIFICATE; ADDITIONAL ACTUARIAL REVIEW. (a) The commissioner shall review the forms required by Section 846.153 and shall renew a multiple employer welfare arrangement's certificate of authority unless the commissioner determines that the arrangement does not comply with this chapter.

(b) On a finding of good cause, the commissioner may order

an actuarial review of a multiple employer welfare arrangement in addition to the actuarial opinion required by Section 846.153(a). The arrangement shall pay the cost of the additional actuarial review.

(c) If the commissioner determines that a multiple employer welfare arrangement does not comply with this chapter, the commissioner may order the arrangement to correct the deficiencies. The commissioner may take any action against the multiple employer welfare arrangement authorized by this code if the arrangement does not initiate immediate corrective action. (V.T.I.C. Art. 3.95-8, Subsecs. (b) (part), (c), (e).)

Source Law

> (b) The commissioner shall review the forms required by Subsection (a) of this article. The commissioner shall renew a multiple employer welfare arrangement's certificate of authority unless the commissioner finds that the multiple employer welfare arrangement does not meet the requirements of this subchapter. . . .
>
> (c) On a finding of good cause, the commissioner may order an actuarial review of a multiple employer welfare arrangement in addition to the actuarial opinion required by Subsection (a)(2) of this article. The cost of any such additional actuarial review shall be paid by the multiple employer welfare arrangement.
>
> (e) If the commissioner determines that a multiple employer welfare arrangement does not comply with the requirements established in this subchapter, the commissioner may order the multiple employer welfare arrangement to correct the deficiencies. If the multiple employer welfare arrangement does not initiate immediate corrective action, the commissioner may take any action against the multiple employer welfare arrangement that is authorized by this code.

Revised Law

Sec. 846.158. EXAMINATION OF MULTIPLE EMPLOYER WELFARE ARRANGEMENTS. (a) The commissioner or the commissioner's appointee may examine the affairs of any multiple employer welfare arrangement.

(b) For the purposes of this section the commissioner:

(1) shall have free access to all the books, records, and documents that relate to the business of the plan; and

(2) may examine under oath a board member, officer, agent, or employee of the multiple employer welfare arrangement in relation to the affairs, transactions, and conditions of the arrangement.

(c) Each multiple employer welfare arrangement shall pay the expenses of the examination as provided by Article 1.16. (V.T.I.C. Art. 3.95-9.)

Source Law

Art. 3.95-9. The commissioner or any person appointed by the commissioner shall have the power to examine the affairs of any multiple employer welfare arrangement and for such purposes shall have free access to all the books, records, and documents that relate to the business of the plan and may examine under oath its trustees or directors, officers, agents, and employees in relation to the affairs, transactions, and conditions of the multiple employer welfare arrangement. Expenses of examination shall be paid by each multiple employer welfare arrangement as provided in Article 1.16 of this code.

Revised Law

Sec. 846.159. NAME OF MULTIPLE EMPLOYER WELFARE ARRANGEMENT. (a) A multiple employer welfare arrangement shall transact business under the arrangement's own name and may not adopt any assumed name. An arrangement may not use a name that is the same as or closely resembles the name of any other arrangement that:

(1) possesses a certificate of authority; and

(2) is engaged in business in this state.

(b) A multiple employer welfare arrangement may change its name by:

(1) amending the articles of the arrangement; or

(2) taking a new name with the approval of the commissioner. (V.T.I.C. Art. 3.95-5 (part).)

Source Law

Art. 3.95-5. No multiple employer welfare arrangement authorized under this subchapter shall take any name which is the same as or closely resembles the name of any other multiple employer welfare arrangement possessing a certificate of authority and

doing business in this state. A multiple employer welfare arrangement shall transact its business under its own name and shall not adopt any assumed name, except that a multiple employer welfare arrangement by amending its articles may change its name or take a new name with the approval of the commissioner. . . .

Revised Law

Sec. 846.160. EVIDENCE OF EXISTENCE. A certified copy of the multiple employer welfare arrangement's certificate of authority is prima facie evidence of the existence of the arrangement in a legal proceeding. (V.T.I.C. Art. 3.95-5 (part).)

Source Law

Art. 3.95-5. . . . Whenever it shall be necessary in any legal proceeding to prove the existence of a multiple employer welfare arrangement, a certified copy of the multiple employer welfare arrangement's certificate of authority shall be prima facie evidence of the existence of the multiple employer welfare arrangement.

[Sections 846.161-846.200 reserved for expansion]

SUBCHAPTER E. PROVISION OF COVERAGE

Revised Law

Sec. 846.201. BENEFITS ALLOWED. (a) A multiple employer welfare arrangement may only provide one or more of the following:

(1) medical, dental, vision, surgical, or hospital care;

(2) benefits in the event of sickness, accident, disability, or death;

(3) another benefit authorized to be provided by health insurers in this state; and

(4) prepaid legal services.

(b) Except as otherwise limited by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a multiple employer welfare arrangement may only provide benefits to:

(1) active or retired owners, officers, directors, or employees of or partners in participating employers; and

(2) the beneficiaries of a person described by Subdivision (1). (V.T.I.C. Art. 3.95-4.)

Source Law

Art. 3.95-4. (a) A multiple employer welfare arrangement authorized under this subchapter shall be limited to providing any one or more of the following:

(1) medical, dental, optical, surgical, or hospital care;

(2) benefits in the event of sickness, accident, disability, or death;

(3) any other benefit authorized for health insurers in this state; and

(4) prepaid legal services.

(b) A multiple employer welfare arrangement may only provide benefits to active or retired owners, officers, directors, or employees of or partners in participating employers, or the beneficiaries of such persons, except as may otherwise be limited by provisions of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.).

Revisor's Note

Subsection (a)(1), V.T.I.C. Article 3.95-4, refers to "optical" care. The revised law substitutes the term "vision" for "optical" because that is the more commonly used term in this context.

Revised Law

Sec. 846.202. PREEXISTING CONDITION PROVISION. (a) In this section, "creditable coverage" has the meaning assigned by Section 3, Article 21.52G, as added by Chapter 955, Acts of the 75th Legislature, Regular Session, 1997.

(b) A preexisting condition provision in a multiple employer welfare arrangement's plan document may apply only to coverage for a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(c) A preexisting condition provision in a multiple employer welfare arrangement's plan document may not apply to expenses incurred on or after the expiration of the 12 months following the initial effective date of coverage of the participating employee, dependent, or late-participating employee or dependent.

(d) A preexisting condition provision in a multiple

employer welfare arrangement's plan document may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect until a date not more than 63 days before the effective date of coverage under the health benefit plan, excluding any waiting period.

(e) In determining whether a preexisting condition provision applies to an individual covered by a multiple employer welfare arrangement's plan document, the arrangement shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the arrangement. If the previous coverage was issued under a health benefit plan, any waiting period that applied before that coverage became effective must also be credited against the preexisting condition provision period. (V.T.I.C. Art. 3.95-1, Subdiv. (3); Arts. 3.95-1.5, 3.95-4.8, Subsecs. (a), (b), (e), (f).)

Source Law

[Art. 3.95-1]

(3) "Creditable coverage" means coverage described by Article 3.95-1.5 of this code.

Art. 3.95-1.5. (a) An individual's coverage is creditable for purposes of this subchapter if the coverage is provided under:

(1) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(2) a group health benefit plan provided by a health insurance carrier or health maintenance organization;

(3) an individual health insurance policy or evidence of coverage;

(4) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);

(5) Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);

(6) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);

(7) a medical care program of the Indian Health Service or of a tribal organization;

(8) a state health benefits risk pool;

(9) a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);

(10) a public health plan as defined by federal regulations; or

(11) a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).

(b) Creditable coverage does not include:

(1) accident-only or disability income insurance, or a combination of accident-only and disability income insurance;

(2) coverage issued as a supplement to liability insurance;

(3) liability insurance, including general liability insurance and automobile liability insurance;

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

(8) other coverage that is:

(A) similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and

(B) specified in federal regulations;

(9) coverage that provides limited-scope dental or vision benefits;

(10) long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(11) coverage that provides other limited benefits specified by federal

regulations;

(12) coverage for a specified disease or illness;

(13) hospital indemnity or other fixed indemnity insurance; or

(14) Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan.

Art. 3.95-4.8. (a) A preexisting condition provision in a multiple employer welfare arrangement's plan document may not apply to an expense incurred on or after the expiration of the 12 months following the initial effective date of coverage of the participating employee, dependent, or late-participating employee.

(b) A preexisting condition provision in a multiple employer welfare arrangement's plan document may not apply to coverage for a disease or condition other than a disease or condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of:

(1) the effective date of coverage; or

(2) the first day of the waiting period.

(e) A preexisting condition provision in a multiple employer welfare arrangement's plan document may not apply to an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the health benefit plan, excluding any waiting period.

(f) In determining whether a preexisting condition provision applies to an individual covered by a multiple employer welfare arrangement's plan document, the

multiple employer welfare arrangement shall credit the time the individual was covered under previous creditable coverage if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under the multiple employer welfare arrangement. If the previous coverage was issued under a health benefit plan, any waiting period shall also be credited to the preexisting condition provision period.

Revisor's Note

(1) Subdivision (3), V.T.I.C. Article 3.95-1, defines "creditable coverage" to mean coverage "described by Article 3.95-1.5 of this code." That definition of "creditable coverage" was adopted by Chapter 955, Acts of the 75th Legislature, Regular Session, 1997. A substantially identical definition appeared three times in Chapter 955, in sections amending Chapter 26, Insurance Code, adding Article 21.52G, Insurance Code, and adding Article 3.95-1.5, Insurance Code. The intent of the legislature in enacting Chapter 955 was to implement federal requirements on health insurance portability and availability; the use of the same definition in three different articles was to ensure compliance with the federal requirements.

(2) Subsection (f), V.T.I.C. Article 3.95-4.8, refers to "any waiting period . . . ." The revised law expands the reference to "any waiting period that applied before that coverage became effective" for clarity and to conform to other similar provisions in this code.

Revised Law

Sec. 846.203. TREATMENT OF CERTAIN CONDITIONS AS PREEXISTING PROHIBITED. (a) A multiple employer welfare arrangement may not treat genetic information as a preexisting condition described by Section 846.202 in the absence of a diagnosis of the condition related to the information.

(b) A multiple employer welfare arrangement may not treat pregnancy as a preexisting condition described by Section 846.202. (V.T.I.C. Art. 3.95-4.8, Subsecs. (c), (d).)

Source Law

(c) A multiple employer welfare arrangement shall not treat genetic information as a preexisting condition described by Subsection (b) of this article in the absence of a diagnosis of the condition related to the information.

(d) A multiple employer welfare arrangement shall not treat a pregnancy as a preexisting condition described by Subsection (b) of this article.

Revised Law

Sec. 846.204. WAITING PERIOD PERMITTED. Sections 846.202 and 846.203 do not preclude application of a waiting period that applies to all new participating employees under the health benefit plan in accordance with the terms of the multiple employer welfare arrangement's plan document. (V.T.I.C. Art. 3.95-4.8, Subsec. (g).)

Source Law

(g) This article does not preclude application of any waiting period applicable to all new participating employees under the health benefit plan in accordance with the terms of the multiple employer welfare arrangement's plan document.

Revised Law

Sec. 846.205. CERTAIN LIMITATIONS OR EXCLUSIONS OF COVERAGE PROHIBITED. (a) A multiple employer welfare arrangement's plan document may not limit or exclude, by use of a rider or amendment applicable to a specific individual, coverage by type of illness, treatment, medical condition, or accident.

(b) This section does not preclude a multiple employer welfare arrangement from limiting or excluding coverage for a preexisting condition in accordance with Section 846.202. (V.T.I.C. Art. 3.95-4.1, Subsec. (m).)

Source Law

(m) A multiple employer welfare arrangement's plan document may not, by use of a rider or amendment applicable to a specific individual, limit or exclude coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions as permitted under

Article 3.95-4.8 of this code.

Revised Law

Sec. 846.206. RENEWABILITY OF COVERAGE; CANCELLATION. (a) Except as provided by Section 846.207, a multiple employer welfare arrangement shall renew the health benefit plan, at the employer's option, unless:

(1) a contribution has not been paid as required by the terms of the plan;

(2) the employer has committed fraud or has intentionally misrepresented a material fact;

(3) the employer has not complied with the terms of the health benefit plan document;

(4) the health benefit plan is ceasing to offer any coverage in a geographic area; or

(5) there has been a failure to meet the terms of an applicable collective bargaining agreement or other agreement requiring or authorizing contributions to the health benefit plan, including a failure to renew the agreement or to employ employees covered by the agreement.

(b) A multiple employer welfare arrangement may refuse to renew the coverage of a participating employee or dependent for fraud or intentional misrepresentation of a material fact by that person.

(c) A multiple employer welfare arrangement may not cancel a health benefit plan except for a reason specified for refusal to renew under Subsection (a). An arrangement may not cancel the coverage of a participating employee or dependent except for a reason specified for refusal to renew under Subsection (b). (V.T.I.C. Art. 3.95-4.3.)

Source Law

Art. 3.95-4.3. (a) Except as provided by Article 3.95-4.4 of this code, a multiple employer welfare arrangement shall renew the health benefit plan, at the option of the employer, unless:

(1) a contribution has not been paid as required by the terms of the plan;

(2) the employer has committed fraud or intentional misrepresentation of a material fact;

(3) the employer has not complied with the terms of the health benefit plan document;

(4) the plan is ceasing to offer any coverage in a geographic area; or

(5) there has been a failure to:

(A) meet the terms of an applicable collective bargaining agreement or other agreement requiring or authorizing contributions to the plan;

(B) renew the agreement; or

(C) employ employees covered by the agreement.

(b) A multiple employer welfare arrangement may refuse to renew the coverage of a participating employee or dependent for fraud or intentional misrepresentation of a material fact by that individual.

(c) A multiple employer welfare arrangement may not cancel a health benefit plan except for the reasons specified for refusal to renew under Subsection (a) of this article. A multiple employer welfare arrangement may not cancel the coverage of a participating employee or dependent except for the reasons specified for refusal to renew under Subsection (b) of this article.

Revised Law

Sec. 846.207. REFUSAL TO RENEW. (a) A multiple employer welfare arrangement may elect to refuse to renew all health benefit plans delivered or issued for delivery by the arrangement in this state. The arrangement shall notify:

(1) the commissioner of the election not later than the 180th day before the date coverage under the first health benefit plan terminates under this subsection; and

(2) each affected employer not later than the 180th day before the date on which coverage terminates for that employer.

(b) A multiple employer welfare arrangement that elects under this section to refuse to renew all health benefit plans may not write a health benefit plan in this state before the fifth anniversary of the date notice is delivered to the commissioner under Subsection (a).

(c) A multiple employer welfare arrangement may elect to discontinue a health benefit plan only if the arrangement:

(1) provides notice to each employer of the discontinuation before the 90th day preceding the date of the discontinuation of the plan;

(2) offers to each employer the option to purchase coverage under another health benefit plan offered by the arrangement; and

(3) acts uniformly without regard to the claims experience of the employer or any health status related factor of

participating employees or dependents or new employees or dependents who may become eligible for the coverage. (V.T.I.C. Art. 3.95-4.4.)

Source Law

Art. 3.95-4.4. (a) A multiple employer welfare arrangement may elect to refuse to renew all health benefit plans delivered or issued for delivery by the multiple employer welfare arrangement in this state. The multiple employer welfare arrangement shall notify the commissioner of the election not later than the 180th day before the date coverage under the first health benefit plan terminates under this subsection.

(b) The multiple employer welfare arrangement shall notify each affected employer not later than the 180th day before the date on which coverage terminates for that employer.

(c) A multiple employer welfare arrangement that elects under Subsection (a) of this article to refuse to renew all health benefit plans in this state may not write a health benefit plan in this state before the fifth anniversary of the date on which notice is delivered to the commissioner under Subsection (a) of this article.

(d) A multiple employer welfare arrangement may elect to discontinue a plan only if the multiple employer welfare arrangement:

(1) provides notice to each employer of the discontinuation before the 90th day preceding the date of the discontinuation of the plan;

(2) offers to each employer the option to purchase another plan offered by the multiple employer welfare arrangement; and

(3) acts uniformly without regard to the claims experience of the employer or any health status related factor of participating employees or dependents or new employees or dependents who may become eligible for the coverage.

Revised Law

Sec. 846.208. NOTICE TO COVERED PERSONS. (a) A multiple employer welfare arrangement that cancels or refuses to renew coverage under a health benefit plan under Section 846.206 or Section 846.207 shall notify the employer of the cancellation of or refusal to renew coverage not later than the 30th day before the date termination of coverage is effective. The employer is responsible for notifying participating employees of the cancellation of or refusal to renew coverage.

(b) The notice provided under this section is in addition to any other notice required by Section 846.206 or Section 846.207. (V.T.I.C. Art. 3.95-4.5.)

Source Law

> Art. 3.95-4.5. (a) Not later than the 30th day before the date on which termination of coverage is effective, a multiple employer welfare arrangement that cancels or refuses to renew coverage under a health benefit plan under Article 3.95-4.3 or 3.95-4.4 of this code shall notify the employer of the cancellation or refusal to renew. It is the responsibility of the employer to notify participating employees of the cancellation or refusal to renew the coverage.
>
> (b) The notice provided under this article is in addition to any other notice required by Article 3.95-4.3 or 3.95-4.4 of this code.

Revised Law

Sec. 846.209. WRITTEN STATEMENT OF DENIAL, CANCELLATION, OR REFUSAL TO RENEW. Denial by a multiple employer welfare arrangement of an application for coverage from an employer or cancellation of or refusal to renew must:

(1) be in writing; and

(2) state the reason or reasons for the denial, cancellation, or refusal to renew. (V.T.I.C. Art. 3.95-4.9.)

Source Law

> Art. 3.95-4.9. Denial by a multiple employer welfare arrangement of an application for coverage from an employer or cancellation or refusal to renew must be in writing and must state the reason or reasons for the denial, cancellation, or refusal.

[Sections 846.210-846.250 reserved for expansion]

SUBCHAPTER F. PARTICIPATION IN COVERAGE

Revised Law

Sec. 846.251. PARTICIPATION CRITERIA. Participation criteria may not be based on health status related factors. (V.T.I.C. Art. 3.95-1, Subdiv. (10) (part); Art. 3.95-4.1, Subsec. (a) (part).)

Source Law

[Art. 3.95-1]

(10) . . . Such criteria or rules may not be based on health status related factors.

[Art. 3.95-4.1]

(a) . . . The participation criteria may not be based on health status related factors.

Revised Law

Sec. 846.252. COVERAGE REQUIREMENTS. (a) A multiple employer welfare arrangement:

(1) may refuse to provide coverage to an employer in accordance with the arrangement's underwriting standards and criteria;

(2) shall accept or reject the entire group of individuals who meet the participation criteria and who choose coverage; and

(3) may exclude only those employees or dependents who have declined coverage.

(b) On issuance of coverage to an employer, each multiple employer welfare arrangement shall provide coverage to the employees who meet the participation criteria without regard to an individual's health status related factors. (V.T.I.C. Art. 3.95-4.1, Subsecs. (a) (part), (b) (part).)

Source Law

Art. 3.95-4.1. (a) A multiple employer welfare arrangement may refuse to provide coverage to an employer in accordance with the multiple employer welfare arrangement's underwriting standards and criteria. However, on issuance of coverage to an employer, each multiple employer welfare arrangement shall provide coverage to the employees who meet the participation criteria established by the terms of the plan document without regard to an individual's health

status related factors. . . .

(b) The multiple employer welfare arrangement shall accept or reject the entire group of individuals who meet the participation criteria and who choose coverage and may exclude only those employees or dependents who have declined coverage. . . .

Revised Law

Sec. 846.253. PROHIBITION ON EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT. A multiple employer welfare arrangement may not exclude an employee who meets the participation criteria or an eligible dependent, including a late-participating employee or dependent, who would otherwise be covered. (V.T.I.C. Art. 3.95-4.1, Subsec. (l).)

Source Law

(l) A multiple employer welfare arrangement may not exclude an employee who meets the participation criteria or an eligible dependent, including a late-participating employee, who would otherwise be covered.

Revised Law

Sec. 846.254. WRITTEN NOTICE TO EMPLOYEES COVERED. A multiple employer welfare arrangement, in connection with an employee welfare benefit plan, shall provide to each participating employee covered by the plan a written notice at the time the employee's coverage becomes effective that states that:

(1) individuals covered by the plan are only partially insured; and

(2) if the plan or the arrangement does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the participating employer or its participating employee covered by the plan may be liable for those expenses. (V.T.I.C. Art. 3.95-12.)

Source Law

Art. 395-12. A multiple employer welfare arrangement, in connection with an employee welfare benefit plan, shall provide to each participating employee covered by the plan the following written notice at the time his or her coverage becomes effective:

(1) that individuals covered by

the plan are only partially insured; and

(2) that in the event the plan or the multiple employer welfare arrangement does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, the participating employer or its participating employee covered by the plan may be liable for those expenses.

Revised Law

Sec. 846.255. DECLINING COVERAGE. (a) A multiple employer welfare arrangement shall obtain a written waiver from each employee who meets the participation criteria and declines coverage under a health plan offered to an employer. The waiver must ensure that the employee was not induced or pressured to decline coverage because of the employee's health status related factors.

(b) A multiple employer welfare arrangement may not provide coverage to an employer or the employees of an employer if the arrangement or an agent for the arrangement knows that the employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status related factors. (V.T.I.C. Art. 3.95-4.1, Subsecs. (c), (d).)

Source Law

(c) The multiple employer welfare arrangement shall obtain a written waiver for each employee who meets the participation criteria and who declines coverage under a health plan offered to an employer. The waiver must ensure that the employee was not induced or pressured into declining coverage because of the employee's health status related factors.

(d) A multiple employer welfare arrangement may not provide coverage to an employer or the employees of an employer if the multiple employer welfare arrangement or an agent for the multiple employer welfare arrangement knows that the employer has induced or pressured an employee who meets the participation criteria or a dependent of the employee to decline coverage because of that individual's health status related factors.

Revised Law

Sec. 846.256. MINIMUM CONTRIBUTION OR PARTICIPATION REQUIREMENTS. (a) A multiple employer welfare arrangement may require an employer to meet minimum contribution or participation requirements as a condition of issuance and renewal of coverage in accordance with the terms of the arrangement's plan document.

(b) The minimum contribution and participation requirements must be stated in the plan document and must be applied uniformly to each employer offered or issued coverage by the multiple employer welfare arrangement in this state. (V.T.I.C. Art. 3.95-4.1, Subsec. (e).)

Source Law

(e) A multiple employer welfare arrangement may require an employer to meet minimum contribution or participation requirements as a condition of issuance and renewal in accordance with the terms of the multiple employer welfare arrangement's plan document. Those requirements shall be stated in the plan document and shall be applied uniformly to each employer offered or issued coverage by the multiple employer welfare arrangement in this state.

Revised Law

Sec. 846.257. ENROLLMENT; WAITING PERIOD. (a) The initial enrollment period for employees meeting the participation criteria must be at least 31 days, with a 31-day annual open enrollment period. The enrollment period must consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is February, the period must last through March 2.

(b) A multiple employer welfare arrangement may establish a waiting period.

(c) A new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the multiple employer welfare arrangement not later than the 31st day after the later of:

(1) the date on which the employment begins; or

(2) the date on which the waiting period established under Subsection (b) expires.

(d) If dependent coverage is offered to participating employees under the terms of a multiple employer welfare arrangement's plan document:

(1) the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period; and

(2) a dependent of a new employee meeting the participation criteria established by the arrangement may not be denied coverage if the application for coverage is received by the arrangement not later than the 31st day after the later of:

(A) the date on which the employment begins;

(B) the date on which the waiting period established under Subsection (b) expires; or

(C) the date on which the dependent becomes eligible for enrollment.

(e) A late-participating employee or dependent may be excluded from coverage until the next annual open enrollment period and may be subject to a one-year preexisting condition provision as described by Section 846.202. The period during which a preexisting condition provision applies may not exceed 18 months after the date of the initial application. (V.T.I.C. Art. 3.95-4.1, Subsecs. (f), (g), (h), (i), (j), (k).)

Source Law

(f) The initial enrollment period for employees meeting the participation criteria must be at least 31 days, with a 31-day annual open enrollment period. Such enrollment period shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is February, the period shall last through March 2.

(g) If dependent coverage is offered to participating employees under the terms of a multiple employer welfare arrangement's plan document, the initial enrollment period for the dependents must be at least 31 days, with a 31-day annual open enrollment period.

(h) A multiple employer welfare arrangement may establish a waiting period during which a new employee is not eligible for coverage in accordance with the terms of the plan document.

(i) A new employee who meets the participation criteria may not be denied coverage if the application for coverage is received by the multiple employer welfare arrangement not later than the 31st day after the later of:

(1) the date on which the employment begins; or

(2) the date on which the waiting period established under this article

expires.

(j) If dependent coverage is offered under the terms of a multiple employer welfare arrangement's plan document, a dependent of a new employee meeting the participation criteria established by the multiple employer welfare arrangement may not be denied coverage if the application for coverage is received by the multiple employer welfare arrangement not later than the 31st day after the later of:

(1) the date on which the employment begins;

(2) the date on which the waiting period established under this article expires; or

(3) the date on which the dependent becomes eligible for enrollment.

(k) A late-participating employee may be excluded from coverage until the next annual open enrollment period and may be subject to a 12-month preexisting condition provision as described by Article 3.95-4.8 of this code. The period during which a preexisting condition provision applies may not exceed 18 months from the date of the initial application.

Revisor's Note

Subsection (h), V.T.I.C. Article 3.95-4.1, provides that a multiple employer welfare arrangement may establish a waiting period "during which a new employee is not eligible for coverage in accordance with the terms of the plan document." The revised law omits the quoted language as unnecessary because Subdivision (12), V.T.I.C. Article 3.95-1, revised as Section 846.001(9), defines "waiting period" as a "period established by a multiple employer welfare arrangement that must pass before an individual who is a potential participating employee in a health benefit plan is eligible to be covered for benefits."

Revised Law

Sec. 846.258. COVERAGE FOR NEWBORN CHILDREN. (a) A multiple employer welfare arrangement's plan document may not limit or exclude initial coverage of a newborn child of a

participating employee.

(b) Coverage of a newborn child of a participating employee under this section ends on the 32nd day after the date of the child's birth unless:

(1) dependent children are eligible for coverage under the multiple employer welfare arrangement's plan document; and

(2) not later than the 31st day after the date of birth, the arrangement receives:

(A) notice of the birth; and

(B) any required additional premium. (V.T.I.C. Art. 3.95-4.2, Subsec. (a).)

Source Law

> Art. 3.95-4.2. (a) A multiple employer welfare arrangement's plan document may not limit or exclude initial coverage of a newborn child of a participating employee. Any coverage of a newborn child of a participating employee under this subsection terminates on the 32nd day after the date of the birth of the child unless:
>
> (1) dependent children are eligible for coverage under the multiple employer welfare arrangement's plan document; and
>
> (2) notification of the birth and any required additional premium are received by the multiple employer welfare arrangement not later than the 31st day after the date of birth.

Revised Law

Sec. 846.259. COVERAGE FOR ADOPTED CHILDREN. (a) This section applies only if dependent children are eligible for coverage under the terms of a multiple employer welfare arrangement's plan document.

(b) A multiple employer welfare arrangement plan document may not limit or exclude initial coverage of an adopted child of a participating employee. A child is considered to be the child of a participating employee if the participating employee is a party to a suit in which the employee seeks to adopt the child.

(c) An adopted child of a participating employee may be enrolled, at the employee's option, not later than the 31st day after:

(1) the date the employee becomes a party to a suit in which the employee seeks to adopt the child; or

(2) the date the adoption becomes final.

(d) Coverage of an adopted child of a participating employee under this section ends unless the multiple employer

welfare arrangement receives notice of the adoption and any required additional premiums not later than the 31st day after:

(1) the date the participating employee becomes a party to a suit in which the employee seeks to adopt the child; or

(2) the date the adoption becomes final. (V.T.I.C. Art. 3.95-4.2, Subsecs. (b), (c), (d).)

Source Law

(b) If dependent children are eligible for coverage under the terms of a multiple employer welfare arrangement's plan document, the plan document may not limit or exclude initial coverage of an adopted child of a participating employee. A child is considered to be the child of a participating employee if the participating employee is a party in a suit in which the adoption of the child by the participating employee is sought.

(c) If dependent children are eligible for coverage under the terms of a multiple employer welfare arrangement's plan document, an adopted child of a participating employee may be enrolled, at the option of the participating employee, within either:

(1) 31 days after the participating employee is a party in a suit for adoption; or

(2) 31 days of the date the adoption is final.

(d) Coverage of an adopted child of an employee under this article terminates unless notification of the adoption and any required additional premiums are received by the multiple employer welfare arrangement not later than either:

(1) the 31st day after the participating employee becomes a party in a suit in which the adoption of the child by the participating employee is sought; or

(2) the 31st day after the date of the adoption.

[Sections 846.260-846.300 reserved for expansion]

SUBCHAPTER G. MARKETING

Revised Law

Sec. 846.301. MARKETING REQUIREMENTS. On request, each employer purchasing a health benefit plan shall be given a summary of the plans for which the employer is eligible. (V.T.I.C. Art. 3.95-4.7, Subsec. (a).)

Source Law

> Art. 3.95-4.7. (a) On request, each employer purchasing health benefit plans shall be given a summary of the plans for which the employer is eligible.

Revised Law

Sec. 846.302. ADDITIONAL REPORTING REQUIREMENTS. The department may require periodic reports by multiple employer welfare arrangements and agents regarding the health benefit plans issued by the arrangements. The reporting requirements must comply with federal law and regulations. (V.T.I.C. Art. 3.95-4.7, Subsec. (b).)

Source Law

> (b) The department may require periodic reports by multiple employer welfare arrangements and agents regarding the health benefit plans issued by the multiple employer welfare arrangements. The reporting requirements shall comply with federal law and regulations.

Revised Law

Sec. 846.303. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR. If a multiple employer welfare arrangement enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to offering health benefit plans to employers in this state, the third-party administrator is subject to this chapter. (V.T.I.C. Art. 3.95-4.10.)

Source Law

> Art. 3.95-4.10. If a multiple employer welfare arrangement enters into an agreement with a third-party administrator to provide administrative, marketing, or other services related to the offering of health benefit plans to employers in this state, the third-party administrator is subject to this

CHAPTER 861. GENERAL CASUALTY COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 861.001. DEFINITIONS. In this chapter:

(1) "General casualty company" means an accident or casualty insurance company organized or engaging in the business of insurance under this chapter.

(2) "Incorporators" means those persons who associate by written articles of incorporation to organize a general casualty company. (V.T.I.C. Arts. 8.02 (part), 8.05 (part), 8.06 (part); New.)

Source Law

Art. 8.02. Such persons shall associate themselves together by written articles of incorporation for the purpose of forming an accident or casualty insurance company, ...

Art. 8.05. Only companies organized and doing business under the provisions of this Chapter . . . .

Art. 8.06. A corporation organized or doing business under the provisions of this law . . . .

Revisor's Note

The definitions of "general casualty company" and "incorporators" are derived from V.T.I.C. Articles 8.02, 8.05, and 8.06. Portions of those articles have been revised as definitions for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

Revisor's Note

(End of Subchapter)

V.T.I.C. Article 8.05 provides that only companies organized and doing business under the provisions of this chapter are subject to the provisions of V.T.I.C. Chapter 8, revised as this chapter. The revised law omits this provision as unnecessary. The revised chapter is drafted in such a manner that the chapter applies only to a general casualty company, which is defined by Section 861.001 as a company "organized or engaging in the

business of insurance under this chapter." An additional statement relating to the applicability of the chapter is unnecessary. The omitted law reads:

Art. 8.05. [Only companies organized and doing business under the provisions of this Chapter] shall be subject to its provisions. . . .

[Sections 861.002-861.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF GENERAL CASUALTY COMPANY

Revised Law

Sec. 861.051. FORMATION OF COMPANY AUTHORIZED. Three or more persons, a majority of whom are residents of this state, may form a general casualty company in accordance with this chapter to write insurance described by Subchapter E. (V.T.I.C. Art. 8.01 (part).)

Source Law

Art. 8.01. Any three or more persons, a majority of whom are residents of this State, may associate in accordance with the provisions of this chapter and form an incorporated company for any one or more of the following purposes: . . . .

Revised Law

Sec. 861.052. ARTICLES OF INCORPORATION; FILING AND RECORDING REQUIREMENT. (a) The articles of incorporation for a general casualty company must specify:

(1) the general purpose of the company; and

(2) the proposed duration of the company.

(b) The incorporators shall file with the department:

(1) articles of incorporation for the general casualty company;

(2) a charter fee in the amount determined under Article 4.07; and

(3) an affidavit, made by two or more of the incorporators, that all of the general casualty company's stock is subscribed in good faith and fully paid for.

(c) On receipt of a filing under Subsection (b), the department shall record the articles of incorporation in records maintained for that purpose.

(d) On receipt of a fee in the amount determined under Article 4.07, the department shall provide the incorporators with a certified copy of the articles of incorporation.

(e) On receipt of a certified copy of the articles of incorporation, the general casualty company is a body politic and corporate, and the incorporators may complete organization of the company in accordance with Section 861.055. (V.T.I.C. Arts. 8.02 (part), 8.03 (part).)

Source Law

Art. 8.02. [Such persons shall associate themselves together by written articles of incorporation for the purpose of forming an accident or casualty insurance company,] which articles shall specify the general object of the company, and the proposed duration of the same.

Art. 8.03. When such articles of incorporation are filed with the Board of Insurance Commissioners, together with an affidavit made by two or more of its incorporators, that all the stock has been subscribed in good faith and fully paid for, together with a charter fee of Twenty-five ($25.00) Dollars, the Board shall record the same in a book kept for that purpose, and upon receipt of a fee of One ($1.00) Dollar it shall furnish a certified copy of the same to the corporators, upon which they shall be a body politic and corporate, and may proceed to complete the organization of the company, ...

Revisor's Note

(1) V.T.I.C. Article 8.03 refers to the "Board of Insurance Commissioners." Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to 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. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas

Department of Insurance, respectively. Throughout this chapter, references to the Board of Insurance Commissioners or the State Board of Insurance have been changed appropriately.

(2) V.T.I.C. Article 8.03 refers to a "charter fee of Twenty-five ($25.00) Dollars" and a "fee of One ($1.00) Dollar" for a certified copy of a general casualty company's articles of incorporation. Those specific dollar amounts were impliedly repealed by the amendment of V.T.I.C. Article 4.07 by Chapter 249, Acts of the 70th Legislature, Regular Session, 1987. Article 4.07 is a comprehensive fee provision that authorizes the Texas Department of Insurance to set the amounts of certain fees, including the types of fees referred to in Article 8.03. Chapter 249 expanded the applicability of Article 4.07 to expressly apply to all stock insurance companies, including a general casualty company. Accordingly, the revised law substitutes for the dollar amounts specified by Article 8.03 a general reference to the amounts determined under V.T.I.C. Article 4.07.

Revised Law

Sec. 861.053. PRELIMINARY OFFICERS AND DIRECTORS. The incorporators shall choose from among themselves a president, a secretary, a treasurer, and at least three directors who continue in office until:

(1) the first anniversary of the date the articles of incorporation are filed; and

(2) their successors are chosen and qualify. (V.T.I.C. Art. 8.04 (part).)

Source Law

Art. 8.04. The subscribers to said articles of incorporation shall choose from their number a president, a secretary, a treasurer and such number of directors not less than three who shall continue in office for the period of one year from the date of filing articles of incorporation, and until their successors shall be duly chosen and qualified. . . .

Revised Law

Sec. 861.054. SUBSCRIPTION OF STOCK. The incorporators shall:

(1) open books for the subscription of stock in the general casualty company at the times and places the incorporators consider convenient and proper; and

(2) keep the books open until the full amount specified in the articles of incorporation is subscribed. (V.T.I.C. Art. 8.04 (part).)

Source Law

Art. 8.04. . . . They shall open books for the subscriptions of stock in the company at such times and places as they shall deem convenient and proper, and shall keep them open until the full amount specified in the certificate is subscribed.

Revisor's Note

V.T.I.C. Article 8.04 refers to the amount of stock specified in the "certificate." The revised law substitutes "articles of incorporation" for "certificate" for clarity and consistency with other provisions in this code.

Revised Law

Sec. 861.055. ORGANIZATIONAL MEETING. (a) After receiving a certified copy of the articles of incorporation under Section 861.052, a general casualty company shall promptly call a meeting of the company's shareholders.

(b) At the meeting the shareholders shall:

(1) adopt bylaws to govern the company; and

(2) elect a board of directors composed of shareholders of the company. (V.T.I.C. Art. 8.03 (part).)

Source Law

Art. 8.03. . . . [upon which they shall be a body politic and corporate, and may proceed to complete the organization of the company,] for which purpose they shall forthwith call a meeting of the stockholders who shall adopt by-laws for the government of the company and elect a board of directors composed of stockholders, ...

[Sections 861.056-861.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 861.101. CERTIFICATE OF AUTHORITY REQUIRED. A general casualty company may not engage in the business of insurance in this state without a certificate of authority issued under this chapter. (V.T.I.C. Art. 8.16 (part).)

Source Law

> Art. 8.16. Any such company organized or doing business under this code without a certificate as provided for in this chapter [shall forfeit One Hundred ($100.00) Dollars for every day it continues to write new business in this State without such certificate.]

Revised Law

Sec. 861.102. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) The department shall issue a certificate of authority to a general casualty company authorizing the company to engage in the business of insurance under this chapter if:

(1) the company meets the requirements of this chapter; and

(2) the commissioner has granted a charter to the company in the manner provided by Sections 822.051, 822.052, 822.053, 822.054, 822.057, 822.058, 822.059, 822.060, and 822.210.

(b) A certificate of authority is evidence of a general casualty company's authorization to engage in the business of insurance under this chapter and of the company's solvency and credits. (V.T.I.C. Arts. 8.05 (part), 8.20.)

Source Law

> Art. 8.05. . . . Upon the granting of the charter to said corporation in the mode and manner provided in Article 2.01 and Article 2.02 of this Code, and [upon the deposit of the sum of $50,000.00 of securities of the kind described in Article 2.10 of this Code or in cash with the comptroller,] the Board shall issue to said company a certificate authorizing it to do business.
>
> . . .
>
> Art. 8.20. The Board upon due proof by a company organized under the provisions of

this law, of its possessing the qualifications required, shall issue a certificate setting forth that it has qualified and is authorized for the ensuing year to do business under the law, which certificate or a copy thereof shall be evidence of such qualifications and of such company's authority to transact business authorized by this chapter, and of its solvency and credits.

Revisor's Note

V.T.I.C. Article 8.20 refers to a certificate of authority that authorizes a general casualty company to do business "for the ensuing year." The revised law omits the quoted language as repealed. Section 1, Chapter 194, Acts of the 56th Legislature, Regular Session, 1959, amended Section 1, V.T.I.C. Article 1.14, to require the State Board of Insurance to issue a certificate of authority to transact insurance business to any insurer that fully complies with applicable law. Under Article 1.14, revised in relevant part as Section 801.053, a certificate of authority is valid until it is suspended or revoked. Section 2, Chapter 194, repealed "[a]ll laws and parts of laws in conflict herewith . . . , including [Article] 8.20 . . . to the extent that they require periodic renewal of certificates of authority."

[Sections 861.103-861.150 reserved for expansion]

SUBCHAPTER D. POWERS AND DUTIES OF GENERAL CASUALTY COMPANY

Revised Law

Sec. 861.151. AUTHORITY OF BOARD OF DIRECTORS. Subject to the bylaws of the company as adopted or amended by the shareholders or directors, the board of directors of a general casualty company has full control and management of the company. (V.T.I.C. Art. 8.03 (part).)

Source Law

Art. 8.03. . . . which board shall have full control and management of the affairs of the corporation, subject to the by-laws thereof as adopted or amended from time to time by the stockholders or directors, and to

the laws of this State.

Revisor's Note

V.T.I.C. Article 8.03 provides that the board of directors of a general casualty company has full control and management of the company, subject to "the laws of this State." The revised law omits the quoted language as unnecessary because the provisions of state law require compliance without an express statement to that effect.

Revised Law

Sec. 861.152. GENERAL POWERS OF COMPANY. A general casualty company may:

(1) sue or be sued in the name of the company;

(2) make or enforce contracts in relation to the business of the company;

(3) have and use a common seal;

(4) in its own name, or through a trustee chosen by the board of directors, acquire, purchase, hold, and dispose of real and personal property to further the purposes of the company; and

(5) through its board of directors, trustees, or managers, adopt and amend bylaws that include provisions establishing the qualifications, duties, and terms of office of and the manner of electing directors, trustees, or managers and officers of the company. (V.T.I.C. Art. 8.06.)

Source Law

Art. 8.06. A corporation organized or doing business under the provisions of this law shall, by the name adopted by such corporation, in law, be capable of suing or being sued, and may make or enforce contracts in relation to the business of such corporation; may have and use a common seal, and in the name of the corporation or by a trustee chosen by the board of directors, shall, in law, be capable of taking, purchasing, holding and disposing of real and personal property for carrying into effect the purposes of their organization; and may by their board of directors, trustees, or managers, make by-laws and amendments thereto not inconsistent with the laws or the Constitution of this State or of the United States, which by-laws shall define the manner of electing directors, trustees or managers

and officers of such corporation, together with the qualifications and duties of the same and fixing the term of office.

Revisor's Note

V.T.I.C. Article 8.06 authorizes a general casualty company to make bylaws and amendments "not inconsistent with the laws or the Constitution of this State or of the United States." The revised law omits the quoted language as unnecessary because the provisions of the laws and constitutions of this state and the United States require compliance without an express statement to that effect.

Revised Law

Sec. 861.153. AUTHORIZED SHARES. (a) A general casualty company may increase or decrease its capital stock after:

(1) the intent to increase the stock is ratified by a two-thirds vote of the shareholders or the intent to decrease the stock is ratified by a majority vote of the shareholders; and

(2) notice of the intent to increase or decrease the stock is published in a newspaper of general circulation for five consecutive days.

(b) An increase in capital stock must be equal to an amount of at least $50,000. (V.T.I.C. Arts. 8.13; 8.23.)

Source Law

Art. 8.13. Any such company may increase its capital stock at any time after the intention to so increase the capital stock shall have been ratified by a two-thirds vote of the stockholders, and after notice of the purpose to so increase the capital stock has been given by publication in some newspaper of general circulation for five consecutive days. No increase of capital stock in less amount than Fifty Thousand ($50,000.00) Dollars is hereby authorized.

Art. 8.23. Any such company may decrease its capital stock at any time after the intention to so decrease the capital stock shall have been ratified by a majority vote of the stockholders, and after notice of such purpose has been published in some newspaper of general circulation for a period of five consecutive days.

Revised Law

Sec. 861.154. DIVIDENDS. Except as authorized by Article 21.31, the directors of a general casualty company may not issue dividends. (V.T.I.C. Art. 8.14.)

Source Law

> Art. 8.14. The directors of any such company shall not make any dividends except in compliance with Article 21.31 of this Code.

Revised Law

Sec. 861.155. INTERFERENCE WITH CONDUCT OF BUSINESS PROHIBITED; EXCEPTIONS. A person, including the department and the commissioner, may not restrain or interfere with the conduct of business of a general casualty company, except in:

(1) a revocation of the company's certificate of authority and appointment of a receiver under Section 861.701;

(2) an action by a judgment creditor; or

(3) a proceeding supplementary to execution. (V.T.I.C. Art. 8.11 (part).)

Source Law

> Art. 8.11. . . . [Board shall revoke its certificate of authority . . . and shall refer the facts to the Attorney General, who shall proceed to ask the proper court to appoint a receiver] . . . . In no other way can the Board or any other person restrain or interfere with the prosecution of business of any company doing business under the provisions of this chapter, except in actions by judgment creditor or in proceedings supplementary to execution.

[Sections 861.156-861.200 reserved for expansion]

SUBCHAPTER E. INSURANCE COVERAGE PROVIDED BY GENERAL CASUALTY COMPANIES

Revised Law

Sec. 861.201. KINDS OF INSURANCE AUTHORIZED. (a) A general casualty company may:

(1) insure a person against:

(A) bodily injury, disability, or death that results from an accident; or

(B) disability that results from disease;

(2) insure against loss or damage that results from an accident or injury sustained by an employee or other person, for

which accident or injury the insured is liable;

(3) insure against loss or damage that results from an accident to or injury sustained by a person, for which loss the insured is liable, other than employers liability insurance under Subdivision (2);

(4) insure against loss or damage by burglary, theft, or housebreaking;

(5) insure glass against breakage;

(6) insure a steam boiler, elevator, electrical device, or engine and any machinery or appliance used or operated in connection with a steam boiler, elevator, electrical device, or engine;

(7) insure against loss or damage from injury to a person or property that results accidentally from an item described by Subdivision (6);

(8) insure against loss or damage by water to goods or premises that arises from the breakage or leakage of a sprinkler or water pipe;

(9) insure against loss that:

(A) results from accidental damage to an automobile; or

(B) is caused accidentally by an automobile;

(10) insure a person, association, or corporation against loss or damage that results from giving or extending credit;

(11) insure against loss that results from the nonpayment of the principal of or interest on a bond, mortgage, or other evidence of indebtedness;

(12) write marine insurance, which may include insurance against the hazards and perils incident to war; or

(13) insure against any other casualty or insurance risk, other than fire or life insurance, specified in the company's articles of incorporation that:

(A) may be lawfully made the subject of insurance; and

(B) is not otherwise provided for by this chapter.

(b) A general casualty company may engage in one or more of the activities specified by Subsection (a). (V.T.I.C. Arts. 8.01 (part); 8.05 (part).)

Source Law

> Art. 8.01. [Any three or more persons, a majority of whom are residents of this State, may associate in accordance with the provisions of this chapter and form an incorporated company for any one or more of the following purposes:]

1. To insure any person against bodily injury, disablement or death resulting from accident and against disablement resulting from disease.

2. To insure against loss or damage resulting from accident to or injury sustained by an employee or other person for which accident or injury the assured is liable.

3. To insure against loss or damage by burglary, theft or housebreaking.

4. To insure glass against breakage.

5. To insure against loss from injury to person or property which results accidentally from steam boilers, elevators, electrical devices, engines and all machinery and appliances used in connection therewith or operated thereby; and to insure boilers, elevators, electrical devices, engines, machinery and appliances.

6. To insure against loss or damage by water to any goods or premises arising from the breakage or leakage of sprinklers and water pipes.

7. To insure against loss resulting from accidental damage to automobiles or caused accidentally by automobiles.

8. To insure against loss or damages resulting from accident to or injury suffered by any person for which loss and damage the insured is liable; excepting employers liability insurance as authorized under Subdivision 2 of this article.

9. To insure persons, associations or corporations against loss or damage by reason of giving or extending of credit.

10. To insure against loss or damage on account of circumstances upon, or defects in the title to, real estate, and against loss by reason of the nonpayment of the principal or interest of bonds, mortgages or other evidences of indebtedness.

11. To write marine insurance in which may be included the hazards and perils incident to war.

12. To insure against any other

casualty or insurance risk specified in the articles of incorporation which may be lawfully made the subject of insurance, and the formation of a corporation for issuing against which is not otherwise provided for by this article, excepting fire and life insurance.

Art. 8.05. . . . Such a company shall be authorized to transact all and every kind of insurance specified in the first Article of this chapter. . . .

[Sections 861.202-861.250 reserved for expansion]

SUBCHAPTER F. REGULATION OF GENERAL CASUALTY COMPANY

Revised Law

Sec. 861.251. MINIMUM CAPITAL AND SURPLUS. (a) A general casualty company must have at least the minimum capital and surplus applicable to casualty, fidelity, guaranty, surety, and trust companies under Sections 822.054, 822.210, and 822.211. At the time of incorporation, the required capital and surplus must be in cash.

(b) After incorporation and issuance of a certificate of authority, a general casualty company shall invest the minimum capital and surplus as provided by Section 822.204. The company shall invest all other funds of the company in excess of the minimum capital and surplus as provided by Article 2.10 and Section 862.002.

(c) A general casualty company may not loan any part of the company's capital or paid in surplus to an officer of the company. (V.T.I.C. Art. 8.05 (part).)

Source Law

Art. 8.05. . . . Such companies shall have not less than the minimum capital and the minimum surplus applicable to casualty, fidelity, guaranty, surety and trust companies as set out in Article 2.02 of this Code. . . . At the time of incorporation all of said capital and surplus shall be in cash. The capital and minimum surplus required of said company as provided in Article 2.02 of this Code shall, following incorporation and the issuance by the Board to said company of a certificate authorizing it to do business, be invested as provided in Article 2.08 of this Code. All other funds of said

corporation in excess of its capital and minimum surplus shall be invested by such company as provided in Article 2.10 and in Article 6.08 of this Code. . . .

No part of the capital or surplus paid in shall be loaned to any officer of said company.

. . .

Revised Law

Sec. 861.252. SECURITY DEPOSIT. (a) On granting of the charter to a general casualty company, the company shall deposit with the comptroller $50,000 in:

(1) cash; or

(2) securities of the kind described by Article 2.10.

(b) If, as a prerequisite to engaging in the business of insurance in another state, country, or province, a general casualty company is required to deposit with the appropriate officer of that state, country, or province, or with the comptroller, securities or cash in excess of the deposit made under Subsection (a), the company may deposit with the comptroller any authorized securities or cash sufficient to meet the requirement. The comptroller shall receive and hold the deposit exclusively for the protection of policyholders of the company.

(c) A general casualty company may withdraw a deposit made under Subsection (b) if the company files with the department satisfactory evidence, as determined by the commissioner, that the company:

(1) has withdrawn from business in the other state, country, or province; and

(2) has no unsecured liabilities outstanding in the other state, country, or province.

(d) A general casualty company may change the company's securities on deposit with the comptroller by withdrawing those securities and substituting an equal amount of other securities authorized by Subsection (a). (V.T.I.C. Arts. 8.05 (part), 8.12.)

Source Law

Art. 8.05. . . . [Upon the granting of the charter to said corporation in the mode and manner provided in Article 2.01 and Article 2.02 of this Code,] and upon the deposit of the sum of $50,000.00 of securities of the kind described in Article 2.10 of this Code or in cash with the comptroller, [the Board shall issue to said company a certificate authorizing it to do

business.]

. . .

In the event any such company shall be required by the law of any other State, country or province as a requirement prior to doing an insurance business therein to deposit with the duly appointed officer of such other State, country or province, or with the comptroller, any securities or cash in excess of the said deposit of $50,000.00 hereinbefore mentioned, such company, at its discretion, may deposit with the comptroller securities of the character authorized by law, or cash sufficient to enable it to meet such requirements. The comptroller is hereby authorized and directed to receive such deposit and to hold it exclusively for the protection of policyholders of the company. Any deposit so made to meet the requirements of any other State, country or province shall not be withdrawn by the company except upon filing with the Board evidence satisfactory to it that the company has withdrawn from business, and has no unsecured liabilities outstanding in any such other State, country or province by which such additional deposit was required, and upon the filing of such evidence the company may withdraw such additional deposit at any time.

Art. 8.12. Such companies shall have the right at any time to change their securities on deposit with the comptroller by substituting for those withdrawn a like amount in other securities of the character provided for in this law.

Revised Law

Sec. 861.253. INTEREST ON SECURITY DEPOSITS. (a) A general casualty company with securities on deposit under this chapter is entitled to collect the interest on the deposits as the interest becomes due. The comptroller shall deliver to the company the coupons or other evidence of interest pertaining to the deposits.

(b) The comptroller shall collect a general casualty company's interest described by Subsection (a) as the interest becomes due and hold that interest as additional security if:

(1) the company fails to deposit additional security as required by the commissioner; or

(2) proceedings are pending to wind up or enjoin the company. (V.T.I.C. Art. 8.15.)

Source Law

> Art. 8.15. The comptroller shall permit companies having securities on deposit with him under the provisions of this law to collect the interest as the same may become due, and shall deliver to such companies, respectively, the coupons or other evidences of interest pertaining to such deposits. Upon failure of any company to deposit additional security as called for by the Board, or pending any proceedings to close up or enjoin it, the comptroller shall collect the interest as it becomes due and hold the same as additional security in his hands belonging to such company.

Revised Law

Sec. 861.254. ANNUAL STATEMENT; FILING FEE. (a) The president, vice president, and secretary of a general casualty company, or a majority of the directors or trustees of the company, shall, not later than the 60th day after January 1 of each year, deliver to the department a verified statement of the condition of the company as of December 31 of the preceding year.

(b) The statement must include:

(1) the name and location of the company;

(2) the names of the company's officers;

(3) the amount of the company's capital stock;

(4) the amount of the company's capital stock paid in;

(5) the assets of the company;

(6) the liabilities of the company;

(7) the income of the company during the year;

(8) the expenditures of the company during the year;

(9) the amount paid by the company in fees during the year;

(10) the amount paid by the company for losses during the year; and

(11) the total amount of insurance issued by the company and in force.

(c) A general casualty company's assets under Subsection (b)(5) consist of:

(1) the value of real property owned by the company;

(2) the amount of cash on hand;

(3) the amount of cash deposited with a bank or trust company;

(4) the names, amounts, and par and market values of

United States bonds and all other bonds;

(5) the amount of loans secured by first mortgage on real estate;

(6) the amount of all other bonds and loans and how secured, with rate of interest;

(7) the amount of notes given for unpaid stock and how secured;

(8) the amount of interest due and unpaid;

(9) if the total value of the equipment exceeds $2,000, the value of all electronic machines that comprise a data processing system and of all other office equipment, furniture, machines, and labor-saving devices purchased for and used in connection with the business of an insurance company to the extent that the total actual cash market value of those assets is less than five percent of the other admitted assets of the company; and

(10) all other credits or assets.

(d) A general casualty company's liabilities under Subsection (b)(6) consist of:

(1) the amount of losses due and unpaid;

(2) the amount of claims for losses unadjusted; and

(3) the amount of claims for losses resisted.

(e) A general casualty company's income under Subsection (b)(7) consists of:

(1) the amount of fees received;

(2) the amount of interest received from all sources; and

(3) the amount of receipts from all other sources.

(f) A general casualty company's expenditures under Subsection (b)(8) consist of:

(1) the amount paid for losses;

(2) the amount of dividends paid to shareholders;

(3) the amount of commissions and salaries paid to agents;

(4) the amount paid to officers for salaries;

(5) the amount paid for taxes; and

(6) the amount of all other payments or expenditures.

(g) The commissioner may amend the form of the annual statement and require additional information as considered necessary to determine the standing of a general casualty company.

(h) Except as provided by Article 4.07, the department shall charge a fee of $20 for filing the annual statement required by this section. The comptroller shall collect the fee. (V.T.I.C. Arts. 8.07 (part), 8.08, 8.21.)

Source Law

Art. 8.07. The president, vice president

and secretary or a majority of directors or trustees of any such company shall annually, on the first day of January or within sixty (60) days thereafter, prepare and deposit in the office of the Board a verified statement of the condition of such company on the 31st day of December of the preceding year, showing:

1. Name and where located, (a) names of officers, (b) the amount of capital stock, (c) the amount of capital stock paid in.

2. Assets, (a) the value of real estate owned by said company, (b) the amount of cash on hand, (c) the amount of cash deposited in bank or trust company, (d) the amount of bonds of the United States, and all other bonds, giving names and amounts with par and market values of each kind, (e) the amount of loans secured by first mortgage on real estate, (f) the amount of all other bonds, loans and how secured, with rate of interest, (g) the amount of notes given for unpaid stock and how secured, (h) the amount of interest due and unpaid, (i) the value of all electronic machines, constituting a data processing system or systems, and all other office equipment, furniture, machines and labor-saving devices heretofore or hereafter purchased for and used in connection with the business of an insurance company to the extent that the total actual cash market value of all of such systems, equipment, furniture, machines and devices constitute less than five per cent (5%) of the otherwise admitted assets of such company; and provided further, that the total value of all such property of a company must exceed Two Thousand Dollars ($2,000), to qualify hereunder, (j) all other credits or assets. . . .

3. Liabilities, (a) the amount of losses due and unpaid, (b) the amount of claims for losses unadjusted, (c) the amount of claims for losses resisted.

4. Income during the year, (a) the amount of fees received during the year, (b) the amount of interest received from all

sources, (c) the amount of receipts from all other sources.

5. Expenditures during the year, (a) the amount paid for losses, (b) the amount of dividends paid to stockholders, (c) the amount of commissions and salaries paid to agents, (d) the amount paid to officers for salaries, (e) the amount paid for taxes, (f) the amount of all other payments or expenditures.

6. Miscellaneous, (a) the amount paid in fees during the year, (b) the amount paid for losses during the year, (c) the whole amount of insurance issued and in force on the 31st day of December of the previous year.

Art. 8.08. The Board is authorized to amend the form of statement and to exact such additional information as it may think necessary in order that a full exhibit of the standing of such companies may be shown.

Art. 8.21. The department shall charge for filing the annual statement required by this chapter, a fee of Twenty ($20.00) Dollars. The comptroller shall collect the fee.

Revisor's Note

(1) Paragraph 6, V.T.I.C. Article 8.07, refers to insurance issued and in force "on the 31st day of December of the previous year." The revised law omits the quoted language as unnecessary because the introductory language to Article 8.07 provides that the annual statement required by that article must contain information regarding the condition of the company "on the 31st day of December of the preceding year."

(2) V.T.I.C. Article 8.21 refers to a "fee of Twenty ($20.00) Dollars" for filing an annual statement of a general casualty company. As explained in Revisor's Note (2) to Section 861.052, V.T.I.C. Article 4.07 applies to a general casualty company. Under Article 4.07, a general casualty company that writes certain classes of insurance is

required to pay an annual statement filing fee in an amount that could exceed the amount specified by Article 8.21. Therefore, the revised law adds language clarifying that the filing fee amount specified by Article 8.21 is subject to any different amount authorized by Article 4.07.

Revised Law

Sec. 861.255. RULES REGARDING CERTAIN ASSETS. (a) The value of the electronic machines and systems, office equipment, furniture, other machines, and labor-saving devices specified in Section 861.254(c)(9), as determined under this section and in accordance with rules adopted by the commissioner, is an admitted asset of the company.

(b) The commissioner may adopt rules defining electronic machines and systems, office equipment, furniture, other machines, and labor-saving devices as specified in Section 861.254(c)(9) and stating the maximum period for which each class of equipment may be amortized. (V.T.I.C. Art. 8.07 (part).)

Source Law

[Art. 8.07]

2. . . . The Commissioner of Insurance may adopt regulations defining electronic machines and systems, office equipment, furniture, machines and labor-saving devices as used in (i) above, and provide for the maximum period for which each such class of equipment may be amortized; the value of all such property as determined hereunder and under the regulations herein provided for shall be deemed to be an admitted asset for all purposes. . . .

Revisor's Note

Paragraph 2, V.T.I.C. Article 8.07, refers to the authority of the commissioner of insurance to adopt "regulations" defining certain equipment. The revised law substitutes "rules" for "regulations" because, in this context, the terms are synonymous and because under Section 311.005, Government Code (Code Construction Act), a rule is defined to include a regulation. That definition applies to the revised law.

Revised Law

Sec. 861.256. FAILURE TO MAKE DEPOSIT OR DELIVER ANNUAL STATEMENT. (a) If a general casualty company fails to make a deposit under Section 861.252 or to deliver an annual statement under Section 861.254 in a timely manner, the department shall notify the company that the company may not issue new insurance until the deposit is made or the statement is delivered to the department.

(b) A general casualty company may not issue an insurance policy in violation of this section. (V.T.I.C. Art. 8.09.)

Source Law

> Art. 8.09. Upon the failure of any company to make such deposit or to file the statement in time, the Board shall notify such company to issue no new insurance until the law is complied with, and it shall be unlawful for any such company to thereafter issue any policy of insurance until such requirements shall be complied with.

Revised Law

Sec. 861.257. EXAMINATION OF COMPANY. A general casualty company is subject to Articles 1.15 and 1.16. (V.T.I.C. Art. 8.10.)

Source Law

> Art. 8.10. All of the provisions of Article 1.15 and Article 1.16 relative to the examination of companies shall apply to companies formed under this Chapter.

Revised Law

Sec. 861.258. REAL PROPERTY. (a) A general casualty company is subject to Section 862.002 and may not purchase, hold, or convey real property except as authorized by that section.

(b) A general casualty company shall sell real property acquired in compliance with Subsection (a) not later than the 10th anniversary of the date the real property was acquired.

(c) A general casualty company may retain real property after the date specified by Subsection (b) if the commissioner issues a certificate stating:

(1) that sale of the real property in compliance with Subsection (b) would cause the company to incur a material loss; and

(2) a later date by which the real property must be sold.

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

(1) real property occupied by buildings used in whole or in part by a general casualty company in the transaction of business;

(2) an interest in minerals or royalty reserved on the sale of real property acquired under Sections 862.002(c)(1)-(3); and

(3) investment real property acquired under Article 2.10(e)(11). (V.T.I.C. Arts. 8.18, 8.19.)

Source Law

Art. 8.18. Such company shall be subject to the provisions of Article 6.08 of this Code; and no such company shall be permitted to purchase, hold or convey real estate, except for the purposes and in the manner set forth in said Article.

Art. 8.19. All real estate so acquired, except as is occupied by buildings used in whole or in part for the accommodation of such companies in the transaction of their business, interests in minerals and royalty reserved upon the sale of land acquired under Subdivisions 2, 3, and 4 of Article 6.08 of this Code, and the other investment real estate acquired under Paragraph 8 of Article 2.10 of this Code, shall, except as hereinafter provided, be sold and disposed of within ten (10) years after such company shall have acquired title to the same. No such company shall have such real estate for a longer period than that above mentioned, unless the said company shall procure a certificate from the Board that the interests of the company will suffer materially by a forced sale of such real estate, in which event the time for the sale may be extended to such time as the Board shall direct in said certificate.

[Sections 861.259-861.700 reserved for expansion]

SUBCHAPTER O. DISCIPLINARY PROCEDURES AND PENALTY

Revised Law

Sec. 861.701. REVOCATION OF CERTIFICATE. (a) If, as a result of an examination under Section 861.257, the commissioner determines that a general casualty company has not complied with this chapter, the commissioner shall:

(1) revoke the company's certificate of authority; and

(2) notify the attorney general of the revocation.

(b) On receipt of notification under Subsection (a)(2), the attorney general shall request court appointment of a receiver for the general casualty company. Under the direction of the court, the receiver shall wind up the affairs of the company. (V.T.I.C. Art. 8.11 (part).)

Source Law

> Art. 8.11. If the Board shall at any time from the report of examination determine that such company has not complied with any provision of this law, said Board shall revoke its certificate of authority to do business in this State, and shall refer the facts to the Attorney General, who shall proceed to ask the proper court to appoint a receiver for said company, who shall, under the direction of the court, wind up the affairs of said company. . . .

Revised Law

Sec. 861.702. PENALTY. A general casualty company that violates Section 861.101 is subject to a penalty of $100 for each day the company writes new business in this state without the certificate of authority required by that section. (V.T.I.C. Art. 8.16 (part).)

Source Law

> Art. 8.16. [Any such company organized or doing business under this code without a certificate as provided for in this chapter] shall forfeit One Hundred ($100.00) Dollars for every day it continues to write new business in this State without such certificate.

Revised Law

Sec. 861.703. COLLECTION OF PENALTY. (a) The attorney general or a district or county attorney under the direction of the attorney general may file an action in the name of the state to collect a penalty under this chapter.

(b) An action filed under this section must be filed in Travis County or in the county in which the general casualty company's principal office is located. (V.T.I.C. Art. 8.17 (part).)

Source Law

Art. 8.17. Suits to recover any penalty provided for in this chapter shall be instituted in the name of the State of Texas, by the Attorney General or by a district or county attorney under his direction, either in the county where the principal office is situated, or in Travis County, Texas. . . .

Revisor's Note

V.T.I.C. Article 8.17 provides that a penalty recovered under V.T.I.C. Chapter 8, revised as this chapter, "shall be paid into the State Treasury for the use of the school fund." The revised law omits the portion of this provision that dedicates revenue for the use of the school fund because former Section 403.094(h), Government Code, enacted by Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, abolished all statutory dedications of revenue in existence on August 31, 1995, subject to certain exceptions that are not applicable. The revised law omits the portion of the provision that requires the revenue to be paid into the state treasury because Section 404.094, Government Code (State Funds Reform Act), requires all money collected or received by a state agency to be deposited in the treasury. The omitted law reads:

Art. 8.17. . . . Such penalties, when recovered, shall be paid into the State Treasury for the use of the school fund.

CHAPTER 862. FIRE AND MARINE INSURANCE COMPANIES

SUBCHAPTER A. REGULATION OF FIRE AND MARINE INSURANCE COMPANIES

[Sections 862.004-862.050 reserved for expansion]

CHAPTER 862. FIRE AND MARINE INSURANCE COMPANIES

SUBCHAPTER A. REGULATION OF FIRE AND MARINE INSURANCE COMPANIES

Revised Law

Sec. 862.001. ANNUAL STATEMENT. (a) Each year the president or vice president and the secretary of a fire, marine, or inland marine insurance company shall:

(1) prepare under oath a complete and accurate statement of the condition of the company as of December 31 of the preceding year; and

(2) file the statement with the department before the 62nd day of the year in which it is prepared.

(b) The annual statement must show:

(1) the name and location of the company;

(2) the names and residences of the company's officers;

(3) the amount of the capital stock of the company;

(4) the amount of capital stock paid up;

(5) the property and assets held by the company, specifying:

(A) the location, description, and value, as near

as may be, of real property owned by the company and, if the company is organized under the laws of this state, the annual statement must include an abstract of the title to that real property;

(B) the amount of cash on hand and on deposit in banks to the credit of the company and the names of those banks;

(C) the amount of cash held by agents of the company and the names of those agents;

(D) the amount of cash in the course of transmission;

(E) the amount of loans secured by a first mortgage on real property, the rate of interest on each loan, the location and value of each property, and the name of each mortgagor;

(F) the amount of all other bonds and loans, the rate of interest on each bond or loan, and a description of the security given for each bond or loan;

(G) the amount due the company from judgments that have been obtained and a description of each judgment;

(H) the amount of all stock owned by the company, including a description of the stock, the amount and number of shares, and the par and market values of each kind of stock;

(I) the amount of stock held by the company as collateral security for loans, including the amount loaned on the stock and the par and market values of the stock;

(J) the amount of interest due and unpaid to the company;

(K) a description and value of all other securities; and

(L) if the total value of the equipment exceeds $2,000, the value of all electronic machines that comprise a data processing system or systems and of all other office equipment, furniture, machines, and labor-saving devices purchased for and used in connection with the business of the insurance company to the extent that the total actual cash market value of those assets is less than five percent of the other admitted assets shown on the statement;

(6) the liabilities of the company, specifying:

(A) losses adjusted and due;

(B) losses adjusted and not due;

(C) losses unadjusted;

(D) losses in suspense and the cause for suspension;

(E) losses resisted and in litigation;

(F) dividends, in scrip or cash, specifying the amount of each declared but not due;

(G) dividends declared and due;

(H) the amount required by law as reserve on all

unexpired risks, computed as required by this code;

(I) the amount due banks or other creditors, the name of each bank or creditor, and the amount due each bank or creditor;

(J) the amount of money borrowed by the company, the name of each lender, a description of the security given for each loan, and the rate of any interest; and

(K) all other claims against the company and a description of each claim;

(7) the income of the company during the preceding year, specifying:

(A) separately the amount received, after deducting reinsurance, as fire, marine, and inland marine transportation premiums;

(B) the amount received as interest; and

(C) the amount received from all other sources;

(8) the expenditures of the company during the preceding year, specifying:

(A) the amount of losses paid, showing losses that accrued before and that accrued after the date of the preceding statement, and the amount at which losses were estimated in that statement;

(B) the amount paid as dividends;

(C) the amount paid for return premiums, commissions, salaries, expenses, and other charges of officers, agents, and employees;

(D) the amount paid for federal, state, and local taxes and duties; and

(E) the amount paid for all other expenses;

(9) the largest amount insured by the company in a single risk, naming that risk;

(10) the amount of risks written during the preceding year;

(11) the amount of risks in force that have less than one year to run;

(12) the amount of risks in force that have more than one year but less than three years to run;

(13) the amount of risks that have more than three years to run; and

(14) a statement of whether dividends are declared on premiums received for risks not terminated.

(c) The commissioner may adopt rules defining electronic machines and systems, office equipment, furniture, machines, and labor-saving devices as specified in Subsection (b)(5)(L) and stating the maximum period for which each class of equipment may be amortized. (V.T.I.C. Arts. 6.11, 6.12 (part).)

Source Law

Art. 6.11. The president or vice-president and secretary of each fire, marine or inland insurance company doing business in this State, annually, on the first day of each year, or within sixty days thereafter, shall prepare under oath and deposit with the Board a full, true and complete statement of the condition of such company on the last day of the month of December preceding.

Art. 6.12. Such annual statement shall exhibit the following items and facts:

1. The name of the company and where located.

2. The names and residence of the officers.

3. The amount of the capital stock of the company.

4. The amount of capital stock paid up.

5. The property or assets held by the company, viz: the real estate owned by such company, its location, description and value as near as may be, and if said company be one organized under the laws of this State, shall accompany such statement with an abstract of the title to the same; the amount of cash on hand and deposited in banks to the credit of the company, and in what bank or banks the same is deposited; the amount of cash in the hands of agents, naming such agents; the amount of cash in course of transmission; the amount of loans secured by first mortgages on real estate, with the rate of interest thereon, specifying the location of such real estate, its value and the name of the mortgagor; the amount of all bonds and other loans, with the rate of interest thereon and how secured; the amount due the company in which judgments have been obtained, describing such judgments; the amount of any stock owned by the company, describing the same and specifying the amount and number of shares, and the par and market value of each kind of stock; the amount of stock held by such company as collateral

security for loans, with amount loaned on each kind of stock, its par and market value; the amount of interest actually due to the company and unpaid; all other securities, their description and value; the value of all electronic machines, constituting a data processing system or systems, and all other office equipment, furniture, machines and labor-saving devices heretofore or hereafter purchased for and used in connection with the business of an insurance company to the extent that the total actual cash market value of all of such systems, equipment, furniture, machines and devices constitute less than five per cent (5%) of the otherwise admitted assets of such company; and provided further, that the total value of all such property of a company must exceed Two Thousand Dollars ($2,000), to qualify hereunder. The Commissioner of Insurance may adopt regulations defining electronic machines and systems, office equipment, furniture, machines and labor-saving devices as used herein, and provide for the maximum period for which each such class of equipment may be amortized; . . . .

6. The liabilities of such company, specifying the losses adjusted and due; losses adjusted and not due; losses unadjusted; losses in suspense and the cause thereof; losses resisted and in litigation; dividends, either in scrip or cash, specifying the amount of each declared but not due; dividends declared and due; the amount required as the lawful reserve on all unexpired risks computed in the manner provided elsewhere in this Code; the amount due banks or other creditors, naming such banks or other creditors and the amount due to each; the amount of money borrowed by the company, of whom borrowed, the rate of interest thereon and how secured; all other claims against the company, describing the same.

7. The income of the company during the preceding year, stating the amount received for premiums, specifying separately fire, marine and inland transportation

premiums, deducting reinsurance; the amount received for interest, and from all other sources.

8. The expenditures during the preceding year, specifying the amount of losses paid during said term, stating how much of the same accrued prior, and how much subsequent, to the date of the preceding statement, and the amount at which losses were estimated in such preceding statement; the amount paid for dividends; the amount paid for return premiums, commissions, salaries, expenses, and other charges of officers, agents, clerks, and other employees; the amount paid for local, state, national, internal revenue and other taxes and duties; the amount paid for all other expenses, such as fees, printing, stationery, rents, furniture, etc.

9. The largest amount insured in any one (1) risk, naming the risk.

10. The amount of risks written during the preceding year.

11. The amount of risks in force having less than one (1) year to run.

12. The amount of risks in force having more than one (1) and not over three (3) years to run.

13. The amount of risks having more than three (3) years to run.

14. Whether or not dividends are declared on premiums received for risks not terminated.

Revisor's Note

(1) V.T.I.C. Articles 6.11 and 6.12 refer to an "inland insurance company" and to "inland transportation premiums." The revised law substitutes "inland marine insurance company" and "inland marine transportation premiums" because "inland marine insurance" is the phrase more commonly used in the insurance industry. Similar changes are made throughout this chapter.

(2) V.T.I.C. Article 6.11 refers to "the Board," meaning the Board of Insurance Commissioners. Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957,

administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to 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. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the Board of Insurance Commissioners and the State Board of Insurance have been changed appropriately.

(3) V.T.I.C. Article 6.12 refers to "clerks, and other employees." The reference to "clerks" is omitted from the revised law because "clerks" is included in the meaning of "employees."

(4) V.T.I.C. Article 6.12 refers to "all other expenses, such as fees, printing, stationery, rents, furniture, etc." The phrase "such as fees, printing, stationery, rents, furniture, etc." is omitted from the revised law as included in the meaning of "all other expenses."

Revised Law

Sec. 862.002. PROHIBITIONS RELATING TO HOLDING REAL PROPERTY; EXCEPTIONS. (a) A fire, marine, or inland marine insurance company may not purchase, hold, or convey real property, except as provided by Subsections (b) and (c).

(b) The company may erect and maintain buildings ample and adequate for the transaction of the company's business.

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

(1) real property mortgaged to the company in good faith as security for a loan previously contracted or for money due;

(2) real property conveyed to the company in satisfaction of a debt previously contracted in the legitimate business of the company or for money due;

(3) real property purchased under a judgment, decree, or mortgage obtained or made for a debt under Subdivision (2); or

(4) a mineral or royalty interest reserved on the sale of real property acquired under Subdivision (1), (2), or (3)

before January 1, 1942.

(d) A fire, marine, or inland marine insurance company may not invest more than 33-1/3 percent of the company's admitted assets in real property. A fire, marine, or inland marine insurance company may not invest any of its capital or minimum surplus in real property, other than real property described by Subsection (c).

(e) Section 861.258 applies to real property acquired under Subsection (c)(1), (2), or (3).

(f) The commissioner shall appoint at least two competent and disinterested residents of this state to appraise real property described by Subsection (b) when the property is acquired or when the company applies for amendment to its charter. The company shall pay to the commissioner the reasonable cost of the appraisal. (V.T.I.C. Art. 6.08.)

Source Law

> Art. 6.08. No such company shall be permitted to purchase, hold or convey real estate, except for the purpose and in the manner herein set forth:
>
> 1. For the erection and maintenance of buildings at least ample and adequate for the transaction of its own business;
>
> 2. Such as shall have been mortgaged to it in good faith by way of security of loans previously contracted or for money due;
>
> 3. Such as shall have been conveyed to it in satisfaction of debts previously contracted in the legitimate business of the company or for money due;
>
> 4. Such as shall have been purchased at sales under judgments, decrees or mortgages obtained or made for such debts;
>
> 5. Mineral and royalty interests reserved upon the sale of land acquired under Subdivisions 2, 3, and 4 of this Article 6.08 of this Code before January 1, 1942.
>
> All real estate acquired under authority of the above paragraphs of this Article numbered 2, 3, and 4, or either of them, shall be subject to the provisions of Article 8.19 of this Code.
>
> No more than thirty-three and one-third per cent (33 1/3) of its admitted assets shall be invested by such company in real

estate, and none of its capital and minimum surplus may be so invested, except to the extent that the foregoing limitation shall not apply to real estate held under authority of the above paragraphs of this Article numbered 2, 3, 4, and 5, or either of them.

The value of real estate mentioned in paragraph numbered 1 above shall be appraised by two (2) or more competent and disinterested citizens of Texas appointed by the Board of Insurance Commissioners of Texas, when such real estate is hereafter acquired or when amendment to charter is applied for, the reasonable cost and expense of such appraisal to be paid by the insurance company to the Board.

Revisor's Note

V.T.I.C. Article 6.08 refers to "citizens." The revised law substitutes "residents" for "citizens" because, in the context of this section, "citizens" and "residents" are synonymous and "residents" is more commonly used.

Revised Law

Sec. 862.003. ADMITTED ASSETS. The value of the property of the company shown on the report as determined under Section 862.001 and the rules adopted by the commissioner adopted under that section is considered to be an admitted asset of the company for all purposes. (V.T.I.C. Art. 6.12 (part).)

Source Law

Art. 6.12. . . .

5. . . . the value of all such property as determined hereunder and under the regulations herein provided for shall be deemed to be an admitted asset for all purposes.

. . .

[Sections 862.004-862.050 reserved for expansion]

SUBCHAPTER B. INSURANCE COVERAGE PROVIDED BY FIRE AND MARINE INSURANCE COMPANIES

Revised Law

Sec. 862.051. KINDS OF INSURANCE AUTHORIZED. On filing notice of its intent with the department, an insurance company engaged in the business of insurance in this state under an

appropriate certificate of authority may:

(1) insure houses, buildings, and other property against loss or damage by fire;

(2) insure goods, merchandise, and other property in the course of transportation by land or water, or vessels afloat, regardless of their location;

(3) insure motor vehicles, whether stationary or being operated under the motor vehicle's own power, against loss or damage by fire, lightning, windstorm, hail storm, tornado, cyclone, explosion, transportation by land or water, theft, and collision;

(4) lend money on bottomry or respondentia;

(5) obtain insurance against:

(A) any loss or risk the company has incurred in the course of its business; and

(B) any loss or risk on an interest that the company has in property because of a loan it has made on bottomry or respondentia; and

(6) take any action proper to promote an activity described by this section. (V.T.I.C. Art. 6.03 (part).)

Source Law

> Art. 6.03. It shall be lawful for any insurance company doing business in this State under the proper certificate of authority, . . . to insure houses, buildings and all other kinds of property against loss or damage by fire; to take all kinds of insurance on goods, merchandise, or other property in the course of transportation, whether on land or water, or any vessel afloat, wherever the same may be; to lend money on bottomry or respondentia; to cause itself to be insured against any loss or risk it may have incurred in the course of its business and upon the interest which it may have in any property by means of any loan or loans which it may have on bottomry or respondentia; and generally to do and perform all other matters and things proper to promote these objects; to insure automobiles or other motor vehicles, whether stationary or being operated under their own power, against all or any of the risks of fire, lightning, windstorms, hail storms, tornadoes, cyclones, explosions, transportation by land or water, theft and collisions, upon filing with the Board

notification of their purpose to do so.

Revised Law

Sec. 862.052. PROHIBITIONS RELATING TO LIFE INSURANCE AND LIFE INSURANCE COMPANIES. (a) An insurance company authorized by its charter to write fire, marine, lightning, tornado, or inland marine insurance in this state may not write life insurance.

(b) An insurance company authorized to write life insurance in this state may not write fire, marine, or inland marine insurance or any other insurance described by Section 862.051.

(c) The commissioner shall enforce this section. (V.T.I.C. Art. 1.10, Sec. 15; Art. 6.03 (part).)

Source Law

[Art. 1.10]

15. See That No Company Does Business. The Commissioner shall see that no company is permitted to transact the business of life insurance in this State whose charter authorizes it to do a fire, marine, lightning, tornado, or inland insurance business, and that no company authorized to do a life insurance business in this State be permitted to take fire, marine or inland risks.

Art. 6.03. [It shall be lawful for any insurance company doing business in this State under the proper certificate of authority,] except a life insurance company, [to] . . . .

Revised Law

Sec. 862.053. FIRE INSURANCE: TOTAL LOSS OF REAL PROPERTY. (a) A fire insurance policy, in case of a total loss by fire of property insured, shall be held and considered to be a liquidated demand against the company for the full amount of the policy. This subsection does not apply to personal property.

(b) An insurance company shall incorporate verbatim the provisions of Subsection (a) in each fire insurance policy issued as coverage on real property in this state.

(c) The commissioner shall require compliance with this section. (V.T.I.C. Art. 6.13.)

Source Law

Art. 6.13. A fire insurance policy, in case of a total loss by fire of property insured, shall be held and considered to be a

liquidated demand against the company for the full amount of such policy. The provisions of this article shall not apply to personal property.

On and after January 1, 1951, the provisions of the preceding paragraph of this article shall be incorporated verbatim in each and every fire insurance policy hereafter issued as coverage on any real property in this State; and it shall be the duty of the Board of Insurance Commissioners, by proper order and procedure, to compel compliance with this statute.

Revisor's Note

V.T.I.C. Article 6.13 refers to fire insurance policies issued on or after "January 1, 1951." Any fire insurance policy issued before that date would no longer be in force. Accordingly, the revised law omits the reference to the date as executed.

Revised Law

Sec. 862.054. FIRE INSURANCE: BREACH BY INSURED; PERSONAL PROPERTY COVERAGE. Unless the breach or violation contributed to cause the destruction of the property, a breach or violation by the insured of a warranty, condition, or provision of a fire insurance policy or contract of insurance on personal property, or of an application for the policy or contract:

(1) does not render the policy or contract void; and

(2) is not a defense to a suit for loss. (V.T.I.C. Art. 6.14.)

Source Law

Art. 6.14. No breach or violation by the insured of any warranty, condition or provision of any fire insurance policy, contract of insurance, or applications therefor, upon personal property, shall render void the policy or contract, or constitute a defense to a suit for loss thereon, unless such breach or violation contributed to bring about the destruction of the property.

Revised Law

Sec. 862.055. FIRE INSURANCE: INTEREST OF MORTGAGEE OR TRUSTEE. (a) The interest of a mortgagee or trustee under a fire insurance contract covering property located in this state may

not be invalidated by:

(1) an act or neglect of the mortgagor or owner of the property; or

(2) the occurrence of a condition beyond the mortgagor's or owner's control.

(b) A provision of a contract that conflicts with Subsection (a) is void. (V.T.I.C. Art. 6.15.)

Source Law

> Art. 6.15. The interest of a mortgagee or trustee under any fire insurance contract hereafter issued covering any property situated in this State shall not be invalidated by any act or neglect of the mortgagor or owner of said described property or the happening of any condition beyond his control, and any stipulation in any contract in conflict herewith shall be null and void.

[Sections 862.056-862.100 reserved for expansion]

SUBCHAPTER C. REINSURANCE AND RESERVES

Revised Law

Sec. 862.101. FIRE AND ALLIED LINES OF INSURANCE: AUTHORIZED AND REQUIRED REINSURANCE. (a) In this section, "fire and allied lines of insurance" has the meaning assigned by statute, rules adopted by the commissioner, or lawful custom.

(b) An insurance or reinsurance company that is authorized to write or reinsure fire and allied lines of insurance in this state may reinsure all or any part of a single risk in one or more other solvent insurers.

(c) An insurance company that is incorporated under the laws of the United States or a state of the United States and authorized to write fire and allied lines of insurance in this state may not, unless the excess is reinsured by the company in another solvent insurer, expose itself to any loss or hazard on a single risk in an amount that exceeds 10 percent of the company's paid-up capital stock and surplus.

(d) An insurance company that is incorporated under the laws of a jurisdiction other than the United States or a state of the United States and authorized to write fire and allied lines of insurance in this state may not, unless the excess is reinsured by the company in another solvent insurer, expose itself to any loss or hazard on a single risk in an amount that exceeds the sum of:

(1) 10 percent of the company's deposit with the statutory officer in the state through which the company is authorized to do business in the United States; and

(2) 10 percent of the other policyholders' surplus of the company's United States branch.

(e) Subsections (c) and (d) do not apply in connection with the writing of insurance for cotton in bales or for grain.

(f) Reinsurance that is required or permitted by this section must comply with Articles 5.75-1 and 21.72. (V.T.I.C. Art. 6.16.)

Source Law

Art. 6.16

1. No insurance company incorporated under the laws of the United States or of any State thereof and authorized to do business in this State in the writing of fire and allied lines of insurance as those terms may be defined by statue, by ruling of the State Board of Insurance, hereinafter called the "Board," or by lawful custom, shall expose itself to any loss or hazard on any one (1) risk, except when insuring cotton in bales, and grain, to an amount exceeding ten (10%) per cent of its paid-up capital stock and surplus, unless the excess shall be reinsured by such company in another solvent insurer. Similarly, no insurance company incorporated under a jurisdiction other than that of the United States or a state thereof and authorized to do business in this State in the writing of said lines of insurance shall expose itself to any loss or hazard on any one (1) risk, except when insuring cotton in bales, and grain, to an amount exceeding ten (10%) per cent of the company's deposit with the statutory officer in the state through which the company gains admission to the United States, together with ten (10%) per cent of the other surplus to policyholders of the company's United States Branch, unless the excess shall be reinsured by such company in another solvent insurer.

2. Any insurance or reinsurance company authorized to transact insurance or reinsurance within this State as to lines of insurance defined in Section 1 hereof, may reinsure the whole or any part of an individual risk in another solvent insurer.

3. Any reinsurance required or permitted by this article must comply with

Article 5.75-1 or Article 5.75-2 of this code.

Revisor's Note

(1) Section 1, V.T.I.C. Article 6.16, refers to the "surplus to policyholders." The term most commonly used in the insurance industry to refer to that type of surplus is "policyholders' surplus." The revised law substitutes "policyholders' surplus" for "surplus to policyholders."

(2) V.T.I.C. Article 6.16 states that certain reinsurance must comply with V.T.I.C. Article 5.75-1 or 5.75-2. Article 5.75-2 was repealed by Chapter 1082, Acts of the 71st Legislature, Regular Session, 1989. The revised law is drafted accordingly. For the convenience of the reader, the revised law also adds a reference to V.T.I.C. Article 21.72, enacted in 1995, which also governs the reinsurance subject to this section.

Revised Law

Sec. 862.102. REINSURANCE OR RESERVES REQUIRED FOR FIRE INSURANCE. (a) An insurance company writing fire insurance in this state shall maintain reinsurance or unearned premium reserves on its policies in force.

(b) The commissioner may require that reserves required by Subsection (a) equal the unearned portions of the gross premiums in force after deducting reinsurance under Section 862.101, as computed on each respective risk from the policy's date of issue.

(c) If the commissioner does not impose a requirement under Subsection (b), the portions of the gross premium in force held as reinsurance or unearned premium reserves after deducting reinsurance under Section 862.101 shall be computed as follows:

Term for Which Policy Was Written	Reserve for Unearned Premium
1 year or less	1/2
2 years	1st year 3/4
	2nd year 1/4
3 years	1st year 5/6
	2nd year 1/2
	3rd year 1/6
4 years	1st year 7/8
	2nd year 5/8

	3rd year 3/8
	4th year 1/8
5 years	
	1st year 9/10
	2nd year 7/10
	3rd year 1/2
	4th year 3/10
	5th year 1/10
More than 5 years	
	pro rata

(d) Notwithstanding Subsection (c), an insurance company may compute, or the commissioner may require an insurance company to compute, the reserves on a quarterly, monthly, or more frequent pro rata basis.

(e) An insurance company that adopts a method for computing the reserve may not adopt another method without commissioner approval. (V.T.I.C. Art. 6.01.)

Source Law

Art. 6.01. (1) Every company doing fire insurance business in this state shall maintain a re-insurance or unearned premium reserve on all policies in force.

(2) The Board may require that such reserves shall be equal to the unearned portions of the gross premiums in force after deducting re-insurance in accordance with the provisions of Article 6.16 of the Texas Insurance Code as computed on each respective risk from the policy's date of issue. If the Board does not so require, the portions of the gross premium in force, less re-insurance in accordance with the provisions of Article 6.16 of the Texas Insurance Code, to be held as a re-insurance or unearned premium reserve, shall be computed according to the following table:

Term for Which Policy Was Written	Reserve for Unearned Premium
1 year or less	1/2
2 years	1st year 3/4
	2nd year 1/4
3 years	1st year 5/6
	2nd year 1/2
	3rd year 1/6

4 years	1st year	7/8
	2nd year	5/8
	3rd year	3/8
	4th year	1/8
5 years	1st year	9/10
	2nd year	7/10
	3rd year	1/2
	4th year	3/10
	5th year	1/10
Over 5 years		pro-rata

(3) In lieu of computation according to the foregoing table, the Board may require or the insurer at its option may compute all of such reserves on a quarterly, monthly or more frequent pro-rata basis.

(4) After adopting a method for computing such reserve, an insurer shall not change methods without approval of the Board.

Revised Law

Sec. 862.103. REINSURANCE OR RESERVES REQUIRED FOR HOME WARRANTY INSURANCE COMPANIES. (a) An insurance company writing home warranty insurance in this state shall maintain reinsurance or unearned premium reserves on its policies in force.

(b) Reserves required by Subsection (a) shall be computed in the same manner and to the same extent as is fire insurance under Section 862.102. (V.T.I.C. Art. 6.01-A.)

Source Law

Art. 6.01-A

Sec. 1. Every company writing home warranty insurance in Texas shall maintain reinsurance or unearned premium reserves on all policies in force.

Sec. 2. The reserves on home warranty insurance shall be computed in the same manner and to the same extent as fire insurance is reserved in accordance with Article 6.01 of this Code.

Revised Law

Sec. 862.104. RESERVES REQUIRED FOR OCEAN AND INLAND MARINE TRIP INSURANCE COMPANIES. The total of the premiums on ocean and inland marine trip insurance risks not terminated is considered to be unearned, and the insurance company shall maintain a reserve equal to the total of the premiums for those policies. (V.T.I.C. Art. 6.02.)

Source Law

Art. 6.02. The entire amount of premiums

on ocean and inland marine trip risks not terminated shall be deemed unearned, and the insurer shall carry a reserve equal to one hundred percent of such premiums.

[Sections 862.105-862.150 reserved for expansion]

SUBCHAPTER D. IMPAIRMENT OF SURPLUS

Revised Law

Sec. 862.151. REDUCTION OF CAPITAL STOCK AND PAR VALUE OF SHARES. (a) If the minimum surplus of a fire, marine, or inland marine insurance company is impaired in excess of the amount permitted under Section 5, Article 1.10, the commissioner may allow the company to amend its charter as provided by Sections 822.157 and 822.158 to reduce the amount of the company's capital stock and the par value of its shares in proportion to the extent of the permitted amount of impairment.

(b) A company acting under Subsection (a):

(1) may not reduce the par value of its shares below the sum computed under Section 822.055;

(2) may not deduct from the assets and property on hand more than $125,000;

(3) shall retain the remainder of the assets and property on hand as surplus assets;

(4) may not distribute any of the assets or property to the shareholders; and

(5) may not reduce the capital stock or surplus of the company to an amount less than the minimum capital and the minimum surplus required by Sections 822.202, 822.210, and 822.211, subject to Section 5, Article 1.10. (V.T.I.C. Art. 6.04.)

Source Law

Art. 6.04. Whenever the minimum surplus of any fire, fire and marine, or marine insurance company of this State becomes impaired to a greater extent than that provided by Section 5 of Article 1.10, the Board may, in its discretion, permit the said company by amendment to charter as provided by Article 2.03, to reduce its capital stock and par value of its shares in proportion to the extent of permitted impairment; provided that the par value of said shares shall not be reduced below the sum provided by Section 1 of Article 2.07. In fixing such reduced capital, no sum exceeding $125,000.00 shall be deducted from the assets and property on

hand, which shall be retained as surplus assets. No part of such assets and property shall be distributed to the stockholders, nor shall the capital stock of a company or its surplus in any case be reduced to an amount less than the minimum capital and the minimum surplus provided by Article 2.02 of this Code, subject to the provisions of Section 5 of Article 1.10 of this Code.

Revisor's Note

V.T.I.C. Article 6.04 uses the phrase "fire, fire and marine, or marine insurance company." The revised law substitutes "fire, marine, or inland marine insurance company" because, in this context, the phrases are synonymous and "fire, marine, or inland marine insurance company" is the phrase used throughout this chapter.

Revised Law

Sec. 862.152. MAKING GOOD ON IMPAIRMENT. (a) This section applies to a fire, marine, or inland marine insurance company that receives notice from the commissioner under Section 5, Article 1.10, to make good within 60 days:

(1) any impairment of the company's required capital; or

(2) the company's surplus.

(b) The company shall promptly call on its shareholders for an amount necessary to make the company's capital and surplus equal to the amount required by Sections 822.054 and 822.210, subject to Section 5, Article 1.10.

(c) The shareholders of the company shall be informed of a call under Subsection (b):

(1) by personal notice; or

(2) by advertisement for the time and in the manner approved by the commissioner. (V.T.I.C. Arts. 6.05, 6.06 (part).)

Source Law

Art. 6.05. Any fire, marine or inland insurance company having received notice from the Board to make good any impairment of its required capital or to make good its surplus within 60 days as provided by Section 5 of Article 1.10 shall forthwith call upon its stockholders for such amounts as shall make its capital and its surplus equal to the amount required by Article 2.02, subject to

the provisions of said Section 5 of Article 1.10 of this Code.

Art. 6.06. . . . after notice personally given, or by advertisement for such time and in such manner as said Board shall approve . . . .

Revised Law

Sec. 862.153. FAILURE OF SHAREHOLDER TO PAY. (a) If a shareholder of the insurance company who is given notice under Section 862.152 does not pay the amount called for by the company under that section, the company may:

(1) require the return of the original certificate of stock held by the shareholder; and

(2) issue a new certificate for a number of shares that the shareholder may be entitled to in the proportion that the value of the funds of the company, computed without inclusion of any money or other property paid by shareholders in response to the notice under Section 862.152, bears to the total amount of the original capital and the minimum surplus of the company required by Section 822.054 or 822.210, subject to Section 5, Article 1.10.

(b) The value of any shares for which new certificates are issued under Subsection (a)(2) shall be computed under the direction of the commissioner. The insurance company shall pay for the fractional parts of shares.

(c) Any interested person may pay all or any part of the amount of the deficit resulting from a shareholder default under Subsection (a). The company shall issue to each person who makes a payment a stock certificate that is representative of the number of shares to which the person is entitled. The certificate must be for the number of shares in proportion to the total number of forfeited shares that the payment made by the person bears to the deficit that resulted from the forfeited shares. (V.T.I.C. Art. 6.06 (part).)

Source Law

Art. 6.06. If any stockholder of such company shall neglect or fail to pay the amount so called for, after notice . . . it shall be lawful for said company to require the return of the original certificate of stock held by such stockholder, and in lieu thereof to issue a new certificate for such number of shares as such defaulting stockholder may be entitled to in the proportion that the ascertained value of the funds of said company, calculated without

inclusion of any money or property paid by stockholders in response to such call, may be found to bear to the total of the original capital and the minimum surplus of said company as required by Article 2.02; as qualified by the provisions of Section 5 of Article 1.10 of this Code, the value of such shares for which new certificates are issued shall be ascertained under the direction of said Board and the company shall pay for the fractional parts of shares.

Any interested person may pay part or all of the amount of the deficit resulting from such default and the company shall issue to each such person a stock certificate for the number of shares to which he is entitled, such certificate to be for the number of shares in proportion to the whole number of forfeited shares which the payment made by the recipient of the new stock certificate bears to the deficit which resulted from such forfeited shares.

Revised Law

Sec. 862.154. CREATION AND DISPOSAL OF NEW STOCK. (a) A fire, marine, or inland marine insurance company that complies with Sections 822.155, 822.157, and 822.158 may:

(1) create new stock;

(2) dispose of the new stock according to applicable law; and

(3) issue new certificates for the new stock.

(b) The insurance company shall sell any new stock created under Subsection (a) for an amount sufficient to make up any impairment of the company's required minimum capital and to make up the surplus of the company as required by Section 822.054 or 822.210, subject to Section 5, Article 1.10, but may not impair the capital of the company. (V.T.I.C. Art. 6.07.)

Source Law

Art. 6.07. It shall be lawful for such company upon compliance with Article 2.03 of this Code to create new stock and dispose of the same according to law and to issue new certificates therefor. Said new stock shall be sold for an amount sufficient to make up any impairments of its required minimum capital and to make up the surplus of the company as provided in Article 2.02 of this

Code as qualified by Section 5 of Article 1.10, without impairment of the capital of the company.

[Chapters 863-880 reserved for expansion]

SUBTITLE E. MUTUAL AND FRATERNAL COMPANIES AND RELATED ENTITIES

CHAPTER 881. STATEWIDE MUTUAL ASSESSMENT COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 881.007-881.050 reserved for expansion]

SUBCHAPTER B. STRUCTURE AND OPERATION OF STATEWIDE MUTUAL ASSESSMENT COMPANIES

[Sections 881.059-881.100 reserved for expansion]

SUBCHAPTER C. BENEFITS PROVIDED BY STATEWIDE MUTUAL ASSESSMENT COMPANIES

[Sections 881.105-881.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT; CRIMINAL PENALTY

CHAPTER 881. STATEWIDE MUTUAL ASSESSMENT COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 881.001. DEFINITION. In this chapter, "statewide mutual assessment company" means a corporation engaged in the statewide business of mutually protecting or insuring members' lives with money provided by assessments on those members. (V.T.I.C. Art. 13.01 (part); New.)

Source Law

> Art. 13.01. Any corporation . . . carrying on in this State . . . the statewide business of mutually protecting or insuring the lives of its members by assessments made upon its members . . . shall be known as statewide mutual assessment corporations.

Revised Law

Sec. 881.002. LIMITED EXEMPTION FROM INSURANCE LAWS. (a) Except as provided by this chapter and Chapter 887, the insurance laws of this state do not apply to a statewide mutual assessment company.

(b) A law enacted after June 20, 1933, does not apply to statewide mutual assessment companies unless statewide mutual assessment companies are expressly designated in the law. (V.T.I.C. Art. 13.09, Subsec. (a) (part).)

Source Law

> (a) . . . Except as expressly provided in this chapter and in Chapter 14 of this code, no insurance law of this State shall apply to any corporation operating under this chapter, and no law hereafter enacted shall apply to them unless they be expressly designated therein.

Revisor's Note

> (1) Subsection (a), V.T.I.C. Article 13.09, refers to "Chapter 14 of this code." The pertinent part of Chapter 14 is revised as Chapter 887. The revised law is drafted accordingly.
>
> (2) Subsection (a), V.T.I.C. Article 13.09, refers to laws "hereafter enacted." Article 13.09 was enacted by Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951. Section 2 of that act provided that "[n]othing contained in this Act shall

be held or construed to effect any substantive change in the laws existing prior to the passage of this Act, ..." Article 13.09 was derived from Article 4859f, Revised Statutes, which was enacted by Chapter 245, General Laws, Acts of the 43rd Legislature, Regular Session, 1933. That act was approved June 20, 1933. Accordingly, the revised law substitutes a reference to that effective date for "hereafter."

(3) Subsection (b), V.T.I.C. Article 13.09, provides that "Articles 1.15 and 1.16 of this code apply to corporations and associations regulated under this chapter." The revised law omits this provision as duplicative of V.T.I.C. Article 14.16, revised as Section 887.062, applicable to a statewide mutual assessment company by virtue of V.T.I.C. Articles 13.01 and 13.06, revised in relevant part as Section 881.003 of this chapter. The omitted law reads:

(b) Articles 1.15 and 1.16 of this code apply to corporations and associations regulated under this chapter.

Revised Law

Sec. 881.003. COMPLIANCE WITH INSURANCE LAWS. An individual, firm, unincorporated association, or corporation may not engage in business as a statewide mutual assessment company in this state unless the entity complies with this chapter and Chapter 887. (V.T.I.C. Arts. 13.01 (part); 13.06 (part).)

Source Law

Art. 13.01. [Any corporation . . . actually carrying on . . . the statewide business of mutually protecting or insuring the lives of its members by assessments made upon its members] shall comply with the terms of this chapter and Chapter 14 of this code, be subject to the subsequent provisions hereof and . . . .

Art. 13.06. No person, firm, unincorporated association, or corporation shall carry on in this State the statewide business of mutually protecting or insuring the lives of its members by assessments made upon its members except under the terms of

and by complying with the provisions of this chapter and Chapter 14 of this code. . . .

Revisor's Note

(1) V.T.I.C. Articles 13.01 and 13.06 refer to "Chapter 14 of this code." The pertinent part of Chapter 14 is revised as Chapter 887. The revised law is drafted accordingly.

(2) V.T.I.C. Article 13.01 provides that a statewide mutual assessment company shall comply with V.T.I.C. Chapter 13, revised as this chapter, and "be subject to the subsequent provisions hereof." The revised law omits the quoted language as redundant of the requirement that a corporation comply with V.T.I.C. Chapter 13.

Revised Law

Sec. 881.004. EXEMPTION FROM CHAPTER. This chapter applies only to a statewide mutual assessment company. This chapter does not apply to a company operating as a local mutual aid association, fraternal benefit society, or reciprocal exchange or to a foreign assessment company operating under any other law in this state. (V.T.I.C. Art. 13.09, Subsec. (a) (part).)

Source Law

Art. 13.09. (a) This chapter shall in no wise affect or apply to companies operating as local mutual aids, as fraternal benefit societies, reciprocal exchanges, or to foreign assessment companies operating under any other law in this State, or any other form of insurance other than those corporations carrying on in this State the statewide business of mutually protecting or insuring the lives of their members by assessments made upon their members. . . .

Revisor's Note

Subsection (a), V.T.I.C. Article 13.09, provides that the chapter does not "affect or apply to" certain companies. The revised law omits the reference to "affect" because in context "affect" is included within the meaning of "apply to."

Revised Law

Sec. 881.005. ORGANIZATION OF NEW COMPANY PROHIBITED. A new statewide mutual assessment company may not be organized under

this chapter. (New.)

Revisor's Note

Section 881.005 is added to the revised law because it is clear from V.T.I.C. Article 13.01, revised as Section 881.051, Article 13.02, omitted as obsolete at the end of this subchapter, and the portion of Article 13.06 that is omitted as executed at the end of this chapter that no new company may be formed under this chapter.

Revised Law

Sec. 881.006. ANNUAL STATEMENT. (a) For the filing of each annual statement, the department shall charge the appropriate fee. The fee must be deposited in the Texas Department of Insurance operating account.

(b) Article 1.31A applies to the fee. (V.T.I.C. Art. 13.08.)

Source Law

Art. 13.08. For the filing of each annual statement, the Board shall charge the filing fee prescribed by law. The fee shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund, and Article 1.31A of this code applies to that fee.

Revisor's Note

(1) V.T.I.C. Article 13.08 refers to the "Board," meaning the "Board of Insurance Commissioners." Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to 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. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the Board of Insurance

Commissioners have been changed appropriately.

(2) V.T.I.C. Article 13.08 requires filing fees to be deposited in the state treasury to the credit of the State Board of Insurance operating fund. Under the authority of Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly.

Revisor's Note

(End of Subchapter)

V.T.I.C. Article 13.02 in part provides that each "mutual assessment life, health and accident insurance company chartered by authority of Chapter 6, Title 78, Revised Civil Statutes of Texas, and licensed by the Insurance Department of Texas under said Act and Section 18a of Senate Bill No. 37, Acts of the First Called Session of the 41st Legislature, and which has qualified under this chapter may transact the business of life, health and accident insurance under the provisions of its charter and this chapter." The revised law omits Article 13.02 because under Chapter 197, Acts of the 50th Legislature, Regular Session, 1947, from which Article 13.02 is derived, each company had to qualify under that article not later than six months after the act's effective date, which was September 4, 1947. Currently, only one company is governed by V.T.I.C. Chapter 13, and that company qualified under V.T.I.C. Article 13.01, revised in pertinent part as Section 881.051 of this chapter. Thus, since no company is currently governed by Article 13.02 and no company may qualify under that article, Article 13.02 is obsolete. The omitted law reads:

Art. 13.02. Every mutual assessment life, health and accident insurance company chartered by authority of Chapter 6, Title 78, Revised Civil Statutes of Texas, and

licensed by the Insurance Department of Texas under said Act and Section 18a of Senate Bill No. 37, Acts of the First Called Session of the 41st Legislature, and which has qualified under this chapter may transact the business of life, health and accident insurance under the provisions of its charter and this chapter. Provided, further, that any such company may amend or extend its charter by compliance with the same requirements provided in the general corporation laws of Texas.

[Sections 881.007-881.050 reserved for expansion]

SUBCHAPTER B. STRUCTURE AND OPERATION OF STATEWIDE MUTUAL ASSESSMENT COMPANIES

Revised Law

Sec. 881.051. AUTHORITY TO ACT AS STATEWIDE MUTUAL ASSESSMENT COMPANY. A corporation may engage in business as a statewide mutual assessment company only if the corporation:

(1) was incorporated in this state under a law that was amended, repealed, or reenacted before June 20, 1933;

(2) was engaged in business as a statewide mutual assessment company in this state on December 31, 1932;

(3) does not have capital stock; and

(4) is not for profit. (V.T.I.C. Art. 13.01 (part).)

Source Law

Art. 13.01. Any corporation organized and incorporated under a preexisting law in this State without capital stock and not for profit, which law has been amended or repealed or reenacted, prior to the effective date of this code and which was operating and actually carrying on in this State immediately prior to January 1, 1933, the statewide business of mutually protecting or insuring the lives of its members by assessments made upon its members . . . shall be known as statewide mutual assessment corporations.

Revisor's Note

(1) V.T.I.C. Article 13.01 refers to a corporation organized and incorporated under a "preexisting law" in this state, "prior to the effective date of this code." The reference to a "preexisting law" was added by

Chapter 245, General Laws, Acts of the 43rd Legislature, Regular Session, 1933, which took effect June 20, 1933. Subsequently, Chapter 491, Acts of the 52nd Legislature, Regular Session, 1951, amended Article 13.01 and added the language "prior to the effective date of this code." However, Section 2 of that act provided that "[n]othing contained in this Act shall be held or construed to effect any substantive change in the laws existing prior to the passage of this Act, ..." Thus, the revised law substitutes a reference to "June 20, 1933" for "preexisting law" and for "prior to the effective date of this code."

(2) V.T.I.C. Article 13.01 refers to a corporation "operating and actually carrying on" a certain type of business in this state. The revised law refers instead to a statewide mutual assessment company "engaged in" a certain type of business because the phrases are synonymous in context and the latter is more consistent with the terminology used in this code.

Revised Law

Sec. 881.052. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION ACT. (a) Except to the extent of any conflict with this code, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a statewide mutual assessment company. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to statewide mutual assessment companies.

(b) On advance approval of the commissioner, a statewide mutual assessment company may pay dividends to its members. (V.A.C.S. Art. 1396-10.04, Sec. B (part).)

Source Law

[Art. 1396-10.04]

B. In so far as the same are not inconsistent with or contrary to any applicable provision of the Insurance Code of Texas, or any amendment thereto, the provisions of this Act shall apply to and govern . . . statewide mutual assessment corporations, . . . ; provided however, (a) that any such mutual insurance associations . . . may, upon advance approval of the

Commissioner of Insurance, pay dividends to its members, and (b) that wherever in this Act some duty, responsibility, power, authority, or act is vested in, required of, or to be performed by the Secretary of State, such is to be vested in, required of, or performed by the Commissioner of Insurance in so far as such mutual insurance . . . associations are concerned.

Revisor's Note

(1) Section B, V.A.C.S. Article 1396-10.04, states that the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) shall "apply to and govern" statewide mutual assessment corporations. The revised law omits the reference to "govern" because, in context, "govern" is included within the meaning of "apply to."

(2) Section B, V.A.C.S. Article 1396-10.04, refers to the Insurance Code "or any amendment thereto." The revised law omits the reference to "any amendment thereto" 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.

(3) Section B, V.A.C.S. Article 1396-10.04, refers to a "duty, responsibility, power, authority . . ." of the secretary of state and commissioner of insurance. The revised law substitutes "power and duty" for the quoted phrase because "responsibility" is included within the meaning of "duty" and "authority" is included within the meaning of "power."

(4) Section B, V.A.C.S. Article 1396-10.04, refers to an act "vested in, required of, or to be performed by" the secretary of state and commissioner of insurance. The revised law omits the references to "vested in" and "required of" because, in context, these phrases are included within the meaning of the phrase "to be performed by."

Revised Law

Sec. 881.053. SEPARATE GROUPS, CLUBS, OR CLASSES. A statewide mutual assessment company may provide in its by-laws for the creation of separate groups, clubs, or classes based on reasonable classifications specified in the by-laws. (V.T.I.C. Art. 13.03 (part).)

Source Law

> Art. 13.03. . . . Nothing herein shall be construed, however, as to prohibit any corporation hereunder from providing by its by-laws for the creation of separate groups, clubs, or classes, based upon such a reasonable classification as specified in the by-laws, ...

Revised Law

Sec. 881.054. MINIMUM MEMBERSHIP REQUIRED. A statewide mutual assessment company may not issue a certificate or policy unless the membership of the company or the group, class, or club of the company that is liable for assessments on the certificate or policy is sufficient in number at the assessment rate charged the company, group, class, or club to pay 50 percent of the maximum benefit in the certificate or policy. (V.T.I.C. Art. 13.05 (part).)

Source Law

> Art. 13.05. [No corporation operating under this chapter shall write] . . . nor any policy or certificate of insurance unless the membership of said corporation, liable for assessments on said policy or certificate or group or class or club liable therefor shall be sufficient in number at the assessment rate charged said class to pay fifty (50%) per cent of the maximum benefit set forth in said policy or certificate. . . .

Revised Law

Sec. 881.055. USE OF COMPANY NAME. A statewide mutual assessment company may not operate an independent branch office or a separate group, club, or class under a name different from the name of the company. (V.T.I.C. Art. 13.03 (part).)

Source Law

> Art. 13.03. No corporation operating under this chapter shall be permitted to operate any independent branch office,

separate group, club, or class, under any other name than that of said corporation, ...

Revised Law

Sec. 881.056. ISSUANCE OF CERTIFICATE OR POLICY TO SEPARATE GROUPS, CLUBS, OR CLASSES. (a) A certificate or policy issued by the company to members of a group, club, or class may limit benefits under the certificate or policy to the assessments made, levied, and collected from the group, club, or class.

(b) The assets or benefits of a group, club, or class may not be pledged or transferred without the consent of at least three-fourths of the members of the group, club, or class. (V.T.I.C. Art. 13.03 (part).)

Source Law

Art. 13.03. . . . and providing in the policies issued to the members of such groups, clubs, or classes that the benefits under said policies shall be limited to the assessments made, levied, and collected from any such particular group, club, or class, respectively. It is further provided that no stock or assets or benefits of any such particular group, club or class, shall be pledged, sold, or transferred without the consent of three-fourths (3/4) of the members of such particular group, club, or class.

Revisor's Note

(1) V.T.I.C. Article 13.03 refers to "policies." The revised law substitutes "certificate or policy" for "policies" in this section and for "policy" throughout this chapter to maintain consistency throughout the chapter. It is clear from other provisions of Chapter 13, revised as this chapter, that the types of documents issued by a statewide mutual assessment company may be called a "certificate" or a "policy."

(2) V.T.I.C. Article 13.03 refers to "stock or assets or benefits" of a group, club, or class being "pledged, sold, or transferred." The revised law omits "stock" because its meaning is included within the meaning of "assets." The revised law also omits "sold" because its meaning is included within the meaning of "transferred."

Revised Law

Sec. 881.057. INSUFFICIENT MEMBERSHIP: CONSOLIDATION OR DISCONTINUATION OF GROUP, CLUB, OR CLASS OR LIQUIDATION OF COMPANY. (a) If membership of a group, club, or class of a statewide mutual assessment company is less than the number required by Section 881.054, the company shall immediately notify:

(1) the members of the group, club, or class; or

(2) if the company has only one group, club, or class, the members of the company.

(b) Not later than six months after a statewide mutual assessment company notifies the members of a group, club, or class under Subsection (a)(1), the company shall:

(1) increase the membership of the group, club, or class to at least the number required by Section 881.054;

(2) consolidate the group, club, or class with another group, club, or class; or

(3) discontinue the group, club, or class.

(c) Not later than six months after a statewide mutual assessment company notifies the members of the company under Subsection (a)(2), the company shall increase the membership to at least the number required by Section 881.054. If the membership is not increased to at least that number, the commissioner shall take steps to liquidate the company under Subchapter L, Chapter 887. (V.T.I.C. Art. 13.05 (part).)

Source Law

> Art. 13.05. . . . In the event the membership in any group, class, or club of said corporation shall fall below such number, then the corporation shall immediately notify the members of such group, class, or club, and if said membership is not increased to said number within six (6) months thereafter, said group, class, or club, shall be consolidated with some other group, class, or club, or discontinued. In the event any corporation hereunder has only one class, group, or club, then in the event the membership of said corporation shall at any time fall below fifty (50%) per cent of the number required at the assessment rate charged to pay the maximum benefit provided by any one of its policies or certificate, the corporation shall immediately notify the members of the corporation, and unless the membership is increased to said number within six (6) months thereafter, the Board of

Insurance Commissioners shall take steps under Article 14.33 of Chapter 14 to bring about the liquidation of said corporation.

Revised Law

Sec. 881.058. AGENT. (a) A person who solicits an application for a certificate or policy providing insurance on the life of another is considered to be an agent of the statewide mutual assessment company that issues the certificate or policy in a controversy between the company and the insured or the insured's beneficiary.

(b) An agent described by Subsection (a) may not waive or alter the terms of an application, certificate, or policy. (V.T.I.C. Art. 13.04 (part).)

Source Law

Art. 13.04. . . . any person who shall solicit an application for insurance upon the life of another shall in any controversy between the insured and his beneficiary and the company issuing any policy upon such application, be regarded as the agent of the company, and not the agent of the insured, but such agent shall not have power to waive, change or alter any of the terms or conditions of the application or policy.

Revisor's Note

(1) V.T.I.C. Article 13.04 provides that an agent does not have the authority to "waive, change or alter" the terms of an application or policy. The revised law omits the reference to "change" as unnecessary because the meaning of "change" is included within the meaning of "alter."

(2) V.T.I.C. Article 13.04 refers to the "terms or conditions" of an application or policy. The revised law omits the reference to "conditions" because its meaning is included within the meaning of "terms."

[Sections 881.059-881.100 reserved for expansion]

SUBCHAPTER C. BENEFITS PROVIDED BY STATEWIDE MUTUAL ASSESSMENT COMPANIES

Revised Law

Sec. 881.101. TYPES OF CERTIFICATES OR POLICIES AUTHORIZED. (a) A statewide mutual assessment company may issue only a certificate or policy that provides for the continuous payment of premiums or assessments during the policyholder's life.

(b) A statewide mutual assessment company may not:

(1) issue a certificate or policy on a limited payment plan; or

(2) promise to pay an endowment or annuity benefit. (V.T.I.C. Art. 13.04 (part).)

Source Law

Art. 13.04. No corporation hereunder shall issue any certificate or policy upon a limited payment plan, nor guarantee or promise to pay any type of endowment or annuity benefits, but shall confine its operation to the issuance of certificates looking to continuous payment of premiums or assessments during the life time of the policyholder.

. . .

Revisor's Note

(1) V.T.I.C. Article 13.04 refers to a "guarantee or promise to pay." The revised law omits "guarantee" because in context its meaning is included within the meaning of "promise to pay."

(2) V.T.I.C. Article 13.04 authorizes a statewide mutual assessment company to issue only certain types of "certificates" and prohibits companies from issuing a "certificate or policy" of another type. Throughout this subchapter, the revised law substitutes "certificate or policy" for the reference to "certificates."

Revised Law

Sec. 881.102. MAXIMUM BENEFIT UNDER CERTIFICATE OR POLICY. A statewide mutual assessment company may not issue a certificate or policy that provides a benefit that exceeds $5,000. (V.T.I.C. Art. 13.05 (part).)

Source Law

Art. 13.05. No corporation operating under this chapter shall write any policy or certificate of insurance calling for a maximum benefit in excess of Five Thousand ($5,000.00) Dollars, ...

Revised Law

Sec. 881.103. LOCATION OF ISSUANCE OF CERTIFICATES OR POLICIES. A statewide mutual assessment company may issue

certificates or policies only in the home office of the company. (V.T.I.C. Art. 13.03 (part).)

Source Law

> Art. 13.03. . . . [corporation operating under this chapter] . . . but all of its policies shall be issued in the home office of said corporation. . . .

Revised Law

Sec. 881.104. CERTIFICATE OR POLICY AND APPLICATION; REPRESENTATIONS IN APPLICATION. (a) An application for a certificate or policy may not be used as a defense against a claim or loss under the certificate or policy unless a copy of the application is attached to the certificate or policy.

(b) A misrepresentation in an application for a certificate or policy may not be used as a defense against a claim or loss under the certificate or policy unless it is shown that the misrepresentation is material to the risk assumed. (V.T.I.C. Art. 13.04 (part).)

Source Law

> Art. 13.04. . . .
>
> Nothing in any application for the policy shall constitute a defense against any claim or loss under the policy unless a copy of said application is attached to the policy, and no misrepresentation therein shall constitute a defense unless same shall be shown to be material to the risk assumed, and . . . .

[Sections 881.105-881.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT; CRIMINAL PENALTY

Revised Law

Sec. 881.701. GENERAL CRIMINAL PENALTY. (a) A person commits an offense if:

(1) the person violates this chapter; or

(2) the person:

(A) is a corporation or a responsible officer of a corporation; and

(B) permits or participates in a violation of this chapter by a corporation.

(b) An offense under this section is a misdemeanor punishable by a fine not to exceed $500. (V.T.I.C. Art. 13.07 (part).)

Source Law

Art. 13.07. Any person or persons violating any of the provisions of this chapter shall be deemed guilty of a misdemeanor and upon conviction shall be fined in any sum not more than Five Hundred ($500.00) Dollars. Any responsible officer or any corporation permitting or participating in the violation of this law by any corporation shall be deemed guilty of a violation of this chapter and subject to the penalties herein.

. . .

Revised Law

Sec. 881.702. ENFORCEMENT BY ATTORNEY GENERAL. (a) The attorney general may enforce the penalty provided under Section 881.701 and Section 887.705 against a corporation or unincorporated association.

(b) Notwithstanding Section 887.209, venue of a prosecution under this section may be in Travis County. (V.T.I.C. Art. 13.07 (part).)

Source Law

Art. 13.07. . . .

The Attorney General shall be authorized to enforce in addition to the rights of forfeiture provided herein the penalty provided in this article and Article 14.59 of Chapter 14 against any corporation or unincorporated association which shall be guilty of the violation of any of the provisions of this chapter and Chapter 14. The venue of any suit or prosecution under this article may be in Travis County, Texas.

Revisor's Note

(1) V.T.I.C. Article 13.07 refers to the attorney general's enforcement powers under V.T.I.C. Chapter 13, revised as this chapter, as being "in addition to the rights of forfeiture provided herein." The revised law omits the quoted language because it refers to that part of V.T.I.C. Article 13.06 that is omitted from the revised law for the reason stated in the revisor's note at the end of this chapter.

(2) V.T.I.C. Article 13.07 refers to a "suit or prosecution" under that article. The revised law omits "suit" because that term is not commonly used to refer to the type of proceeding used to enforce a criminal penalty.

(3) V.T.I.C. Article 13.07 in part provides that venue of a prosecution under that article against a corporation may be in Travis County, Texas. V.T.I.C. Article 14.35, revised as Section 887.209 of this code, is a general venue provision that applies to an action brought against a statewide mutual assessment company and provides that venue shall be in the county in which the policyholder or beneficiary resides or in which the principal office of the corporation is located. The revised law adds a reference to Section 887.209 to clarify that the venue provided by Article 13.07 is in addition to the venue provided by Article 14.35.

Revisor's Note

(End of Chapter)

V.T.I.C. Article 13.06 in part provides that the attorney general shall "immediately upon the effective date of this code . . . take necessary action . . . to enforce the forfeiture of charters" of certain corporations and that such corporations are "forever prohibited from carrying on any business in this State." The article also provides that the charters of certain other corporations are "expressly continued in force subject to the provisions of law." The revised law omits that part of Article 13.06 relating to the forfeiture and continuation of charters as executed. The omitted law reads:

Art. 13.06. . . . Each and every charter of every corporation and mutual relief or benefit association granted by the State of Texas under the authority of the Secretary of State of this State, which was or is exempt from the provisions of the insurance laws of this State by the terms of Article 2971a, R.S. 1879, (Article 3096, Revised Statutes 1895) and Article 3096w,

Revised Statutes, 1895, which corporations heretofore have failed or refused to comply with the terms of Chapter 8A, Title 78, Revised Civil Statutes of Texas is hereby expressly repealed and revoked and said corporations are hereafter forever prohibited from carrying on any business in this State. It is the expressed intent of this article and this chapter to revoke, repeal and cancel the charter of every corporation, dormant, or otherwise, exempt from the insurance laws of this State by Article 2971a, Revised Statutes 1879, and Article 3096 and 3096w, Revised Statutes of 1895, which failed to comply with the terms of Chapter 8A, Title 78, Revised Civil Statutes of Texas. The charters of all corporations complying with said Chapter 8A, Title 78, are expressly continued in force subject to the provisions of law. It shall be the duty of the Attorney General of this State immediately upon the effective date of this code to take necessary action by quo warranto, application for receiver, or otherwise to enforce the forfeiture of charters as provided herein and to liquidate and close the affairs of any corporation herein referred to which has heretofore failed to comply with the terms of this chapter and Chapter 14 of this code.

CHAPTER 882. MUTUAL LIFE INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 882.004-882.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF MUTUAL LIFE INSURANCE COMPANY

CHAPTER 882. MUTUAL LIFE INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 882.001. APPLICABILITY OF THIS CHAPTER AND OTHER LAW. Except to the extent of any conflict with this chapter, a law governing a company organized under Chapter 841 applies to a mutual life insurance company organized under this chapter. (V.T.I.C. Art. 11.19 (part).)

Source Law

> Art. 11.19. The provisions of Chapter 3 of this Code, when not in conflict with the Articles of this Chapter, shall apply to and govern mutual life insurance companies organized under the provisions of this Chapter, [provided, however, that when any mutual life insurance company organized under the provisions of this Chapter has a surplus equal to or greater than the minimum of capital and surplus required of capital stock companies under the provisions of Article 3.02 of Chapter 3, Insurance Code of the

State of Texas, Revised Civil Statutes of Texas of 1925, the following provisions of Chapter 11 only shall apply to such mutual companies: 11.01, 11.02, 11.03, 11.04, 11.05, 11.06, 11.07, 11.10, 11.11, 11.12, 11.14, 11.16, 11.17, 11.18, 11.19, 11.20, and 11.21.] On all other matters the provisions of said Chapter 3 shall apply to and govern such mutual life insurance companies.

Revisor's Note

(1) V.T.I.C. Article 11.19 refers to Chapter 3 of the Insurance Code. To accurately reflect the intent of the legislature, the revised law refers to the law governing a company organized under Chapter 841. Chapter 841 revises the provisions of Chapter 3 relating to the organization of domestic life, health, and accident insurance companies.

(2) V.T.I.C. Article 11.19 states that certain laws shall "apply to and govern" mutual life insurance companies. The revised law omits "govern" as unnecessary because its meaning is included in the meaning of "apply to."

(3) V.T.I.C. Article 11.19 lists those provisions of Chapter 11 that apply to a mutual life insurance company organized under the chapter that has a surplus of at least the minimum amount of capital and surplus required of a capital stock company under V.T.I.C. Article 3.02. Because most of Chapter 11 applies to those companies, the revised law instead includes a specific statement in each part of the revision that does not apply to such a company. The omitted law reads:

Art. 11.19. . . . provided, however, that when any mutual life insurance company organized under the provisions of this Chapter has a surplus equal to or greater than the minimum of capital and surplus required of capital stock companies under the provisions of Article 3.02 of Chapter 3, Insurance Code of the State of Texas, Revised Civil Statutes of Texas of 1925, the following provisions of Chapter 11 only shall

apply to such mutual companies: 11.01, 11.02, 11.03, 11.04, 11.05, 11.06, 11.07, 11.10, 11.11, 11.12, 11.14, 11.16, 11.17, 11.18, 11.19, 11.20, and 11.21. . . .

Revised Law

Sec. 882.002. EXAMINATION OF COMPANY. Articles 1.15 and 1.16 apply to a mutual life insurance company organized under this chapter. (V.T.I.C. Art. 11.07.)

Source Law

Art. 11.07. All of the provisions of Article 1.15 and Article 1.16 relative to the examination of companies shall apply to companies formed under this Chapter.

Revised Law

Sec. 882.003. ANNUAL STATEMENT. A mutual life insurance company shall file an annual statement with the department. (V.T.I.C. Art. 11.06 (part).)

Source Law

Art. 11.06. Such mutual life insurance companies shall file their annual statements with the Board of Insurance Commissioners, and . . . .

Revisor's Note

V.T.I.C. Article 11.06 refers to the "Board of Insurance Commissioners." Under Chapter 499, Acts of the 55th Legislature, Regular Session, 1957, administration of the insurance laws of this state was reorganized and the powers and duties of the Board of Insurance Commissioners were transferred to 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. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the Board of Insurance Commissioners and the

State Board of Insurance have been changed appropriately.

[Sections 882.004-882.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF MUTUAL LIFE INSURANCE COMPANY

Revised Law

Sec. 882.051. AUTHORITY TO FORM COMPANY; PURPOSE. A mutual life insurance company may be formed under this chapter to insure the lives of individuals on the mutual level premium and legal reserve plan. (V.T.I.C. Art. 11.01, Sec. 1 (part).)

Source Law

Sec. 1. . . . may form a mutual life insurance company for the purposes of insuring the lives of individuals on the mutual level premium, legal reserve plan, and . . . .

Revised Law

Sec. 882.052. FORMATION OF COMPANY; ARTICLES OF INCORPORATION. (a) Nine or more persons who are residents of this state may form a mutual life insurance company by executing and acknowledging articles of incorporation for that purpose.

(b) The articles of incorporation of the proposed company must state:

(1) the name and residence of each incorporator;

(2) the name of the company;

(3) the location of the company's principal office at which company business is to be transacted;

(4) the number of directors;

(5) the name and residence of each initial director; and

(6) the amount of the company's unencumbered surplus. (V.T.I.C. Art. 11.01, Sec. 1 (part).)

Source Law

Art. 11.01

Sec. 1. Nine or more persons, residents of this State, [may form a mutual life insurance company] . . . by executing and acknowledging articles of incorporation for that purpose. Such articles of incorporation shall set forth:

1. The name and residence of each incorporator;

2. The name of the proposed company, . . .

3. The location of the principal

office from which the business of the company is to be transacted;

4. The number of directors and the name and residence of each one [who is to serve until the first regular election of directors];

5. The amount of its free surplus

. . . .

Revisor's Note

Section 1, V.T.I.C. Article 11.01, refers to a mutual life insurance company's "free surplus." Throughout this chapter, the revised law substitutes "unencumbered surplus" for "free surplus" because, in context, the phrases are synonymous and the phrase "unencumbered surplus" is more consistent with modern usage.

Revised Law

Sec. 882.053. COMPANY'S NAME. (a) The name of a mutual life insurance company must contain the words "Mutual Life Insurance Company."

(b) A mutual life insurance company's name may not be so similar to the name of another insurance company as to likely mislead the public. (V.T.I.C. Art. 11.01, Sec. 1 (part).)

Source Law

Sec. 1. . . .

2. [The name of the proposed company,] which shall contain the words "Mutual Life Insurance Company" as a part thereof; and the name selected shall not be so similar to that of any other insurance company as to be likely to mislead the public;

. . .

Revised Law

Sec. 882.054. INITIAL BOARD OF DIRECTORS; TERM. An initial director named as provided in Section 882.052 serves until:

(1) the first annual election of directors;

(2) the initial director's successor qualifies for office; or

(3) the initial director is removed from the board for improper practices. (V.T.I.C. Art. 11.01, Sec. 1 (part); Art. 11.03 (part).)

Source Law

Art. 11.01

Sec. 1. . . .

4. [The . . . directors and the name . . . of each one] who is to serve until the first regular election of directors;

. . .

Art. 11.03. . . . The directors who are to serve until the first annual election [shall be named in the charter, and] they shall hold office until their successors shall be elected and qualified, or until they shall be removed for improper practices. . . .

Revisor's Note

Section 1, V.T.I.C. Article 11.01, refers to the first "regular" election of directors. The revised law substitutes "annual" for "regular" to provide for consistent use of terminology in this chapter.

Revised Law

Sec. 882.055. UNENCUMBERED SURPLUS REQUIREMENTS. A mutual life insurance company must possess at the time of incorporation unencumbered surplus in an amount of at least $200,000. The unencumbered surplus may consist only of:

(1) United States currency;

(2) bonds of the United States, this state, or a county or municipality of this state; or

(3) government insured mortgage loans that are authorized by this chapter, with not more than 25 percent of the unencumbered surplus invested in first mortgage real estate loans. (V.T.I.C. Art. 11.01, Sec. 1 (part).)

Source Law

Sec. 1. . . .

5. [The amount of its free surplus] which shall, at the time of incorporation, be not less than Two Hundred Thousand ($200,000.00) Dollars. Such free surplus shall, at the time of incorporation, consist only of lawful money of the United States or bonds of the United States or of this State or of any county or incorporated municipality thereof, or government insured

mortgage loans which are otherwise authorized by this chapter, and shall not include any real estate as a part of its free surplus; provided, however, that twenty-five (25%) per cent of the minimum free surplus may be invested in first mortgage real estate loans. . . .

Revisor's Note

(1) Section 1, V.T.I.C. Article 11.01, refers to an "incorporated municipality." The revised law omits "incorporated" because under the Local Government Code all municipalities must be incorporated.

(2) Section 1, V.T.I.C. Article 11.01, provides that the minimum surplus "shall not include any real estate." The revised law omits the quoted phrase as unnecessary because the revised law expressly sets out all of the forms that surplus may take, which do not include real property.

Revised Law

Sec. 882.056. APPLICATION FOR CHARTER. (a) To obtain a charter for a mutual life insurance company under this chapter, the incorporators must pay the charter fee in the amount determined under Article 4.07 and file with the department:

(1) an application for charter on the form and including the information prescribed by the commissioner;

(2) the company's articles of incorporation; and

(3) an affidavit made by two or more of the incorporators that states that:

(A) the unencumbered surplus requirements of Section 882.055 are satisfied;

(B) the unencumbered surplus is the bona fide property of the company; and

(C) the information in the application and articles of incorporation is true and correct.

(b) The commissioner may require that the incorporators provide at their expense additional evidence of a matter required in the affidavit before the commissioner takes further action on the application for the charter.

(c) The charter must state the name of each director who is to serve until the first annual election. (V.T.I.C. Art. 11.02, Sec. 1 (part); Art. 11.03 (part).)

Source Law

Art. 11.02

Sec. 1. As a condition precedent to the

granting of a charter of any such insurance company, the incorporators shall file with the State Board of Insurance the following:

1. An application for charter on such form and include therein such information as may be prescribed by the Board;

2. The articles of incorporation as provided in this Code;

3. An affidavit made by two (2) or more of its incorporators that such company is possessed of at least Two Hundred Thousand ($200,000.00) Dollars free surplus, as required by law, which affidavit shall state that the facts set forth in the application and articles of incorporation are true and correct and that the free surplus is the bona fide property of such company. The State Board of Insurance may, in its discretion, at the expense of the incorporators, require other and additional satisfactory evidence of the matters required to be set forth in said affidavit before it shall be required to file the articles of incorporation, application for charter, or follow the procedure hereinafter set forth;

4. A charter fee prescribed by law.

. . .

Art. 11.03. . . . The directors who are to serve until the first annual election shall be named in the charter, and . . .

Revisor's Note

Section 1, V.T.I.C. Article 11.02, refers to the charter fee "prescribed by law." V.T.I.C. Article 4.07 is a comprehensive fee provision applicable by its terms to "any and all . . . mutual insurance companies." That article authorizes the Texas Department of Insurance to set the amounts of various fees, including a fee for filing a charter. Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

Revised Law

Sec. 882.057. APPLICATION PROCESS. (a) After the charter fee is paid and all items required for a charter under Section 882.056 are filed with the department, the commissioner may set a date for a hearing on the application.

(b) The date for a hearing on an application may not be before the 11th or later than the 60th day after the date notice is provided under Subsection (c).

(c) The commissioner shall:

(1) provide written notice of the date of the hearing to:

(A) the person or persons who filed the application; and

(B) any interested party, including any other party who had previously requested a copy of the notice; and

(2) publish, at the expense of the incorporators, a copy of the notice in a newspaper of general circulation in the county in which the mutual life insurance company's home office is proposed to be located.

(d) The department shall make a record of the proceedings of a hearing under this section.

(e) An interested party is entitled to oppose or support the granting or denial of the application and may intervene and participate fully and in all respects in any hearing or other proceeding on the application. An intervenor has the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel. (V.T.I.C. Art. 11.02, Sec. 1 (part).)

Source Law

Sec. 1. . . .

When such application for charter, articles of incorporation, affidavit and charter fee are filed with the State Board of Insurance, the Board may set a date for a public hearing of the same, which date shall be not less than ten (10) nor more than sixty (60) days after the date of notice thereof. The Board shall notify in writing the person or persons submitting such application of the date for such hearing, and shall furnish a copy of such notice to all interested parties, including any other parties who have theretofore requested a copy of such notice. The Board shall, at the expense of the incorporators, publish a copy of such notice in any newspaper of general circulation in the county of the proposed home office of

said company. In all such public hearings on such applications, a record shall be made of such proceedings and . . . . Any interested party shall have the right to oppose or support the granting or denial of such application and may intervene and participate fully and in all respects in any hearing or other proceeding had on any such application. Any such intervenor shall have and enjoy all the rights and privileges of a proper or necessary party in a civil suit in the courts of this State, including the right to be represented by counsel.

. . .

Revisor's Note

Section 1, V.T.I.C. Article 11.02, refers to a "public hearing" of the former State Board of Insurance. Throughout this chapter, the revised law omits "public" as unnecessary. In context, "hearing" means a hearing open to the public.

Revised Law

Sec. 882.058. ACTION ON APPLICATION. (a) In considering the application, the commissioner, not later than the 30th day after the date a hearing under Section 882.057 is completed, shall determine if:

(1) the minimum unencumbered surplus required by Section 882.055 is the bona fide property of the mutual life insurance company;

(2) the proposed officers, directors, and managing executives of the company have sufficient insurance experience, ability, and standing to make success of the proposed company probable; and

(3) the applicants are acting in good faith.

(b) If the commissioner determines by an affirmative finding any of the issues under Subsection (a) adversely to the applicants, the commissioner shall reject the application in writing, giving the reason for the rejection. An application may not be granted unless it is adequately supported by competent evidence.

(c) If the commissioner does not reject the application under Subsection (b), the commissioner shall approve the application. (V.T.I.C. Art. 11.02, Sec. 1 (part).)

Source Law

Sec. 1. . . . no such application shall be granted except when same is adequately

supported by competent evidence. . . .

In considering any such application, the Board shall within thirty (30) days after public hearing, determine whether:

(a) The minimum free surplus, as required by law, is the bona fide property of the company;

(b) The proposed officers, directors and managing executive have sufficient insurance experience, ability and standing to render success of the proposed company probable;

(c) The applicants are acting in good faith;

If the Board shall determine by an affirmative finding any of the above issues adversely to the applicants, it shall reject the application in writing, giving the reason therefor. Otherwise, the Board shall approve the application, whereupon all such documents shall be deposited with the Board.

Revisor's Note

Section 1, V.T.I.C. Article 11.02, provides that on the board's approval of an application for a charter, "all such documents shall be deposited with the Board." The revised law omits the quoted language as unnecessary because it duplicates the requirement under that section, revised as Section 882.056, that the incorporators of a mutual life insurance company file with the board the charter application, the company's articles of incorporation, and an affidavit.

Revised Law

Sec. 882.059. EXAMINATION AFTER DETERMINATION. After making a determination on an application under Section 882.058, the commissioner shall immediately make or cause to be made a full and thorough examination of the mutual life insurance company. The company shall pay for the examination. (V.T.I.C. Art. 11.02, Sec. 2 (part).)

Source Law

Sec. 2. The Board shall thereupon immediately make, or cause to be made, at the expense of the company, a full and thorough examination thereof. . . .

[Sections 882.060-882.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 882.101. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a) After the examination of a mutual life insurance company under Section 882.059, the commissioner shall issue a certificate of authority to the company if the commissioner finds that:

(1) the company has complied with all applicable laws;

(2) the company satisfies the unencumbered surplus requirements of Section 882.055; and

(3) the company's unencumbered surplus is in the custody of the company's officers.

(b) A certificate of authority issued under this section authorizes the company to engage in the business of life, health, or accident insurance in this state as may be specified in the company's charter or charter application. (V.T.I.C. Art. 11.02, Sec. 2 (part).)

Source Law

Sec. 2. [The Board shall thereupon immediately make, or cause to be made, . . . a full and thorough examination thereof.] If it finds that the company has complied with all applicable laws and is possessed of a free surplus of not less than Two Hundred Thousand ($200,000.00) Dollars and that such surplus is in the custody of the officers either in cash or classes of investments as provided in Paragraph 5 of Article 11.01 of this Code, as amended, it shall issue to such company a certificate of authority to transact a life, health or accident insurance business within this State as such officers may apply for and as may be authorized by its charter issued pursuant to Article 11.01 of this chapter; . . . . No original or first certificate of authority shall be granted, except in conformity herewith.

Revisor's Note

(1) Section 2, V.T.I.C. Article 11.02, refers to "Paragraph 5 of Article 11.01 of this Code, as amended." Throughout this chapter, the revised law omits references to "as amended" because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to

a statute applies to all reenactments, revisions, or amendments of the statute.

(2) Section 2, V.T.I.C. Article 11.02, refers to a finding by the commissioner of insurance that a mutual life insurance company possesses unencumbered surplus in an amount of at least $200,000 in cash or classes of investments as provided by Paragraph 5 of Article 11.01 of the Insurance Code. Paragraph 5 of Article 11.01 is revised in relevant part as Section 882.055 of this chapter and included within that section is the requirement that a mutual life insurance company possess unencumbered surplus in an amount of at least $200,000. Accordingly, the revised law refers to a finding by the commissioner that a company satisfies the unencumbered surplus requirements of Section 882.055.

(3) Section 2, V.T.I.C. Article 11.02, refers to an "original or first" certificate of authority and to the term of a certificate of authority issued under that article, implying that a certificate of authority is subject to renewal. In addition, V.T.I.C. Article 11.06 requires mutual life insurance companies to file an annual statement with the Texas Department of Insurance "and receive from the [department] their certificates of authority to transact the business of life, health, and accident insurance," implying a requirement that a certificate of authority must be renewed. Under Section 1, Article 1.14, revised in relevant part as Section 801.053, a certificate of authority is valid until it is suspended or revoked. Section 2, Chapter 194, Acts of the 56th Legislature, Regular Session, 1959, amending Article 1.14, repealed "[a]ll laws and parts of laws in conflict herewith . . ., including [Article] 11.02 . . . to the extent that they require periodic renewal of certificates of authority." The omitted law reads:

[Art. 11.02]

Sec. 2. . . . which certificate shall be issued for a period of not more than fifteen (15) months and not extending more than

ninety (90) days beyond the last day of February next after the date of its issuance, on which date such certificate shall expire by its terms unless revoked or suspended according to law. . . .

Art. 11.06. [Such mutual life insurance companies shall file their annual statements with the Board of Insurance Commissioners, and] receive from the Board their certificates of authority to transact the business of life, health, and accident insurance.

(4) Section 1, V.T.I.C. Article 11.01, states that a mutual life insurance company may issue a life, health, or accident insurance policy subject to the provisions of this chapter. The revised law omits the provision as unnecessary. V.T.I.C. Article 11.02, revised in relevant part as this section, provides for the issuance of a certificate of authority to a mutual life insurance company that authorizes the company to engage in the business of life, health, or accident insurance. Included within that authority is the authority to issue a life, health, or accident insurance policy. The omitted law reads:

Sec. 1. . . . any such company heretofore or hereafter created may issue, combined or separately, life, health and accident insurance policies, subject to the provisions of this chapter, ...

[Sections 882.102-882.150 reserved for expansion]

SUBCHAPTER D. MANAGEMENT OF MUTUAL LIFE INSURANCE COMPANY

Revised Law

Sec. 882.151. BOARD OF DIRECTORS. (a) The board of directors of a mutual life insurance company controls the business of the company.

(b) The board of directors consists of at least five directors as stated in the company's articles of incorporation. (V.T.I.C. Art. 11.03 (part).)

Source Law

Art. 11.03. The business of a mutual

life insurance company shall be controlled and directed by a board of directors consisting of not less than five (5) members, ...

Revisor's Note

V.T.I.C. Article 11.03 states that the business of a mutual life insurance company is "controlled and directed" by a board of directors. The revised law omits "directed" because its meaning is included in the meaning of "controlled."

Revised Law

Sec. 882.152. ADOPTION OF INITIAL BYLAWS. (a) At the first meeting of the initial board of directors of a mutual life insurance company after the department issues a certificate of authority to the company, the board shall adopt the initial bylaws of the company.

(b) The bylaws adopted under Subsection (a) shall govern the company until the first annual meeting of the board of directors. (V.T.I.C. Art. 11.03 (part).)

Source Law

Art. 11.03. . . . The by-laws governing the company until the date of its first annual meeting shall be adopted by the board of directors at their first meeting after the certificate of authority shall be issued authorizing the company to transact the business of a mutual life insurance company.

Revised Law

Sec. 882.153. ANNUAL MEETING. (a) Except as provided by Subsection (b), after a mutual life insurance company is issued a certificate of authority under Section 882.101, the company shall hold an annual meeting of the policyholders on the fourth Tuesday in April at the home office of the company or another location properly announced to each policyholder.

(b) The bylaws of a mutual life insurance company may establish an annual meeting date different than the date under Subsection (a). A meeting date established under this subsection must be before April 30 of each year.

(c) At each annual meeting, the policyholders:

(1) shall elect the company's board of directors to serve until the next annual meeting, except as provided by Section 882.154; and

(2) may adopt, amend, or repeal the bylaws of the

company. (V.T.I.C. Arts. 11.03 (part), 11.04 (part).)

Source Law

> Art. 11.03. . . . [a board of directors] . . . who shall be elected annually as provided in this chapter. . . .
>
> Art. 11.04. There shall be an annual meeting of all the policyholders of each mutual life insurance company at the home office of such company or at such other place as may be properly announced to the policyholders, on the fourth Tuesday in April after it shall have received a certificate of authority to transact the business of life insurance, and annually thereafter, at which the directors shall be elected for the succeeding year, and at which bylaws for the government of the company, . . . may be adopted, and at which the existing bylaws may be repealed or amended. Provided, however, the bylaws of the company may set an annual meeting date on any day prior to April 30 in each year; and . . . .

Revised Law

Sec. 882.154. STAGGERED TERMS FOR LARGE BOARD OF DIRECTORS. (a) This section applies only to a mutual life insurance company whose board of directors consists of at least nine members.

(b) The bylaws of a mutual life insurance company may provide that the company's directors, other than initial directors, may be elected to serve staggered terms as provided by this section.

(c) The company's directors shall be divided into two or three classes, with each class consisting of an equal number of directors to the extent possible. After the directors are divided into classes:

(1) the terms of the directors in the first class expire on the first annual meeting date after their initial election;

(2) the terms of the directors in the second class expire on the second annual meeting date after their initial election; and

(3) the terms of the directors in the third class, if any, expire on the third annual meeting date after their initial election.

(d) At each annual meeting after the directors are first elected, the policyholders shall elect the number of directors whose terms expire on that date. Directors are elected for:

(1) staggered two-year terms, if the board is divided into two classes; or

(2) staggered three-year terms, if the board is divided into three classes. (V.T.I.C. Art. 11.04 (part).)

Source Law

> Art. 11.04. . . . provided further, that when the Board of Directors shall consist of nine or more members, in lieu of electing the whole number of directors annually, the bylaws may provide that the directors be divided into either two or three classes, each class to be as nearly equal in number as possible, the terms of office of directors of the first class to expire at the first annual meeting of policyholders after their election, that of the second class to expire at the second annual meeting after their election, and that of the third class, if any, to expire at the third annual meeting after their election. At each annual meeting after such classification the number of directors equal to the number of the class whose term expires at the time of such meeting shall be elected to hold office until the second succeeding annual meeting, if there be two classes, or until the third succeeding annual meeting, if there be three classes. No classification of directors shall be effective prior to the first annual meeting of policyholders. . . .

Revised Law

Sec. 882.155. VOTING BY POLICYHOLDERS. (a) At an annual or special meeting of a mutual life insurance company, each policyholder is entitled to one vote for each $500 of insurance held by the policyholder in the company.

(b) A policyholder may vote at an annual or special meeting by proxy, unless the proxy is revoked before the meeting. (V.T.I.C. Art. 11.04 (part).)

Source Law

> Art. 11.04. . . . At an annual or special meeting, each policyholder shall be entitled to one vote for each Five Hundred Dollars ($500.00) of insurance held by him. Any policyholder may execute his proxy authorizing and entitling the holder to

exercise his voting powers, unless such proxy shall be revoked previous to such annual or special meeting.

Revised Law

Sec. 882.156. OFFICERS. (a) The board of directors of a mutual life insurance company shall elect the following officers for the company:

(1) a president;

(2) the number of vice presidents as required by the company's bylaws;

(3) a secretary;

(4) a treasurer;

(5) a medical director; and

(6) other officers as required by the company's bylaws.

(b) The board shall establish the compensation of each officer.

(c) The duties of each officer shall be prescribed by the company's bylaws. (V.T.I.C. Art. 11.03 (part).)

Source Law

Art. 11.03. . . . The board of directors shall elect the officers of the company, which shall be a president, and such number of vice presidents as the by-laws may provide; a secretary, a treasurer, a medical director and such other officers as the by-laws may provide for; and shall fix the compensation of all such officers. The duties of all officers shall be prescribed by the by-laws. . . .

Revised Law

Sec. 882.157. OFFICER BONDS. The president, secretary, and treasurer of a mutual life insurance company shall each provide a bond for the protection of the company's policyholders:

(1) in an amount and with sureties approved by the commissioner; and

(2) conditioned on the faithful performance of the officer's duties. (V.T.I.C. Art. 11.05.)

Source Law

Art. 11.05. The president, secretary and treasurer shall each give bond for the protection of the policyholders in amount and with securities to be approved by the Board of Insurance Commissioners, conditioned for

the faithful performance of their respective duties.

Revisor's Note

V.T.I.C. Article 11.05 refers to a bond with "securities" approved by the commissioner of insurance. The reference to "securities" is clearly a typographical error. To reflect the clear intention of the legislature, and consistent with other provisions of this code, the revised law substitutes "sureties" for "securities."

Revised Law

Sec. 882.158. BYLAWS MUST COMPLY WITH LAW. The bylaws of a mutual life insurance company may not be inconsistent with this chapter or other laws of this state. (V.T.I.C. Art. 11.04 (part).)

Source Law

Art. 11.04. . . . and at which bylaws for the government of the company, not inconsistent with the provisions of this Chapter or with the laws of this state . . . .

[Sections 882.159-882.200 reserved for expansion]

SUBCHAPTER E. AGENTS

Revised Law

Sec. 882.201. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a mutual life insurance company organized under this chapter that has a surplus of at least the minimum amount of capital and surplus required of a capital stock company under Sections 841.054, 841.204, 841.205, 841.301, and 841.302. (New.)

Revisor's Note

Section 882.201 is added to the revised law to clarify the applicability of this subchapter. See Revisor's Note (3) to Section 882.001.

Revised Law

Sec. 882.202. ISSUANCE OF LICENSE TO AGENT. On written request of a mutual life insurance company to which a certificate of authority has been issued under this chapter, the department shall issue a license to each agent of the company. (V.T.I.C. Art. 11.08 (part).)

Source Law

Art. 11.08. Any such mutual life

insurance company which has received authority from the Board of Insurance Commissioners to transact business in this State shall receive from such Board, upon written request therefor, a certificate of authority for each of its agents in this State. . . .

Revisor's Note

V.T.I.C. Article 11.08 refers to the issuance of a "certificate of authority" to an agent of a mutual life insurance company. The revised law substitutes "license" for "certificate of authority" for consistency throughout this code when referring to an agent's authority to engage in business on behalf of an insurance company.

Revised Law

Sec. 882.203. LIMITATION ON AGENT COMPENSATION. A contract between a mutual life insurance company and an agent of the company to which a license has been issued under Section 882.202 may not provide a commission or other compensation to the agent that exceeds the expense loading in the premiums on policies that are issued on applications obtained by the agent and for which the premiums are collected and paid to the company in cash. (V.T.I.C. Art. 11.08 (part).)

Source Law

Art. 11.08. . . . Contracts between such companies and such agents shall not provide for commissions or other compensation to such agents in excess of the expense loading in the premiums of policies issued upon the applications procured by such agents, collected therefor, and paid to the company in cash.

[Sections 882.204-882.250 reserved for expansion]

SUBCHAPTER F. GENERAL FINANCIAL REQUIREMENTS

Revised Law

Sec. 882.251. LIMITED AUTHORITY TO BORROW MONEY. (a) Except as provided by this subchapter, a mutual life insurance company may not borrow money for any purpose other than to pay a death loss.

(b) A company may not incur a debt on an account for which any part of the company's assets that exceeds the assets represented by or derived from the expense loading in the

premiums collected by the company is subject to execution on a judgment.

(c) Subsection (b) does not prohibit a company from incurring a debt on an account:

(1) under a policy issued by the company; or

(2) to borrow money to pay a death loss. (V.T.I.C. Art. 11.15.)

Source Law

Art. 11.15. No mutual life insurance company shall have the power except as provided in this chapter, to borrow money for any purpose other than the payment of death losses. No such company shall have the power to incur any debt on any account except under policies issued by it or for money borrowed to pay death losses, for which any portion of its assets over and above that which may represent or be derived from the expense loading of the premiums collected by it, shall, in any event be subject to execution upon a judgment therefor.

Revisor's Note

V.T.I.C. Article 11.15 refers to a company's power to borrow money "except as provided in this chapter." The relevant portion of V.T.I.C. Chapter 11 relating to borrowing is revised in this subchapter. The revised law is drafted accordingly.

Revised Law

Sec. 882.252. INVESTMENT OF MONEY. (a) A mutual life insurance company shall invest the company's money in accordance with the law governing investments of life, health, and accident insurance companies organized under Chapter 841.

(b) An officer of a mutual life insurance company who does not invest the money of the company as required by Subsection (a) shall deposit the money in the name of the company in a bank that:

(1) is subject to state or federal regulation; and

(2) has been approved by the commissioner as a depository for that purpose. (V.T.I.C. Arts. 11.18, 11.18-1 (part).)

Source Law

Art. 11.18. Mutual life insurance companies shall invest their funds in accordance with the provisions of the third

chapter of this code, concerning investments of life, health and accident insurance companies in this State; all moneys of mutual life insurance companies, coming into the hands of any officer thereof, when not invested as prescribed, shall be deposited in the name of such company in some bank which is subject to either state or national regulation and supervision, and which has been approved by the Board of Insurance Commissioners as a depository therefor.

Art. 11.18-1. Mutual life insurance companies shall invest their funds in accordance with the provisions of the statutes concerning investments of life insurance companies in this State; all moneys of mutual life companies, coming into the hands of any officer or officers thereof, when not invested as prescribed by said laws, shall be deposited in the name of such company or companies in some bank or banks which are subject to either State or national regulation and supervision, and which have been approved by the Commissioner of Insurance as depositories therefor. . . .

Revisor's Note

(1) V.T.I.C. Article 11.18 refers to "the provisions of the third chapter of this code, concerning investments of life, health and accident insurance companies . . . ." V.T.I.C. Article 11.18-1 refers to "the provisions of the statutes concerning investments of life insurance companies . . . ." The revised law refers to the law governing the investments of companies organized under Chapter 841. Chapter 841 revises the provisions of Chapter 3 relating to the organization of domestic life, health, and accident insurance companies.

(2) V.T.I.C. Articles 11.18 and 11.18-1 refer to a bank under state or federal "regulation and supervision." The revised law omits "supervision" because in context its meaning is included in the meaning of "regulation."

Revised Law

Sec. 882.253. LOANS TO COMPANY. (a) An officer or director of a mutual life insurance company, or a person authorized under Chapter 825, may loan to the company money to:

(1) promote or conserve the company's business; or

(2) enable the company to comply with a legal requirement.

(b) The company may repay a loan and agreed interest, at an annual rate not to exceed 10 percent, from the surplus remaining after the company provides for the company's reserves and other liabilities.

(c) A loan under this section or interest on a loan is not otherwise a liability or claim against the company or any of its assets.

(d) A mutual life insurance company may not pay a commission or promotion expense in connection with a loan made to the company.

(e) A mutual life insurance company shall report in its annual statement the amount of each loan. (V.T.I.C. Art. 11.16.)

Source Law

> Art. 11.16. Any officer or director of a mutual life insurance company or any person so authorized in Article 21.27 of this code, may advance to such company any sum of money for the purpose of promoting or conserving its business, or to enable it to comply with any requirement of the law; and such money, together with such interest thereon as may have been agreed upon, not exceeding ten (10%) per cent per annum, shall be payable only out of the surplus remaining after providing for all reserves and other liabilities, and shall not otherwise be a liability or claim against the company or any of its assets. No commission or promotion expenses shall be paid in connection with the advance of any such money to the company, and the amount of such advance shall be reported in each annual statement.

[Sections 882.254-882.300 reserved for expansion]

SUBCHAPTER G. UNENCUMBERED SURPLUS REQUIREMENTS

Revised Law

Sec. 882.301. AMOUNT OF UNENCUMBERED SURPLUS. (a) A mutual life insurance company that engages in the business of insurance in this state shall maintain an unencumbered surplus of at least

$100,000 that consists of cash or classes of investment as provided by Section 882.055.

(b) Except as otherwise authorized by this code, a company that does not maintain an unencumbered surplus as required by this section may not write new insurance. (V.T.I.C. Art. 11.01, Sec. 1 (part); Art. 11.17 (part).)

Source Law

[Art. 11.01]

Sec. 1. . . .

5. . . . Notwithstanding any other provision of this Code, a minimum of One Hundred Thousand ($100,000.00) Dollars of such free surplus shall at all times be maintained in cash or in the classes of investments described in this article. . . .

Art. 11.17. Any such insurance company transacting business within this State shall at all times have and maintain a minimum free surplus of not less than One Hundred Thousand ($100,000.00) Dollars and . . . . No company shall write new business unless it is possessed of the minimum free surplus required by this article, except to the extent it may be otherwise expressly authorized by this Code to do so.

Revised Law

Sec. 882.302. EXEMPTION FOR CERTAIN COMPANIES. A mutual life insurance company that was authorized and engaged in the business of insurance in this state before May 1, 1955, is not required to increase the amount or convert the class or form of the company's existing unencumbered surplus to comply with Section 882.301 and may not be prohibited from writing new insurance because the company does not maintain an unencumbered surplus as required by that section if the company complies with all other laws. (V.T.I.C. Art. 11.01, Sec. 2(a) (part).)

Source Law

Sec. 2. (a) . . . provided, however, that no such company which was licensed and doing business in this State prior to May 1, 1955 shall be required to increase the amount or convert the class or form of its existing surplus to comply with the surplus requirement of said Paragraph 5 of Section 1 of Article 11.01 of this Code as amended, nor

shall any such company be denied the right of writing new business if such company does not maintain the surplus stated in Article 11.17 of this Code, so long as all other laws are complied with.

Revisor's Note

Section 2, V.T.I.C. Article 11.01, refers to a mutual life insurance company that is "licensed," meaning a company that is authorized to engage in the business of insurance in this state. The revised law substitutes "authorized" for "licensed" for consistent use of terminology within this code.

Revised Law

Sec. 882.303. UNENCUMBERED SURPLUS LESS THAN $25,000. A mutual life insurance company whose unencumbered surplus is less than $25,000 shall allocate at least 25 percent of the company's net earned surplus for the preceding calendar year to the company's unencumbered surplus until the company has obtained an unencumbered surplus of at least $25,000. (V.T.I.C. Art. 11.12 (part).)

Source Law

Art. 11.12. . . . it being the intent and purpose of this clause that each company whose free surplus is less than Twenty-five Thousand ($25,000.00) Dollars shall be obligated to apportion a minimum of twenty-five (25%) per cent of the net earned surplus for the preceding calendar year to the free surplus of such company until such company shall have acquired or accumulated a free surplus of at least Twenty-five Thousand ($25,000.00) Dollars.

. . .

Revised Law

Sec. 882.304. INVESTMENT OF EXCESS UNENCUMBERED SURPLUS. A mutual life insurance company that is granted a charter under this chapter may invest that part of the company's unencumbered surplus that exceeds $100,000 as provided by this code for companies operating under Chapter 841. (V.T.I.C. Art. 11.01, Sec. 1 (part).)

Source Law

Sec. 1. . . .

5. . . . After the granting of charter the free surplus in excess of such One Hundred Thousand ($100,000.00) Dollars may be invested as otherwise provided in this Code for stock companies.

Revisor's Note

Section 1, V.T.I.C. Article 11.01, provides that certain excess unencumbered surplus may be invested "as otherwise provided in this Code for stock companies." For the convenience of the reader, the revised law substitutes a reference to "companies operating under Chapter 841" for the reference to "stock companies." Chapter 841 is the chapter governing the operation of stock life insurance companies.

Revised Law

Sec. 882.305. IMPAIRMENT OF UNENCUMBERED SURPLUS. (a) If one-third or more of a mutual life insurance company's unencumbered surplus as required by Section 882.301 is impaired, the company shall correct the impairment not later than the 60th day after the date the surplus is impaired.

(b) A company that does not correct an impairment of surplus as required by Subsection (a) may not write insurance in this state until the company corrects the impairment.

(c) In determining whether a company's surplus is impaired, the company shall compute its liabilities in the manner provided by state law. (V.T.I.C. Art. 11.17 (part).)

Source Law

Art. 11.17. . . . if such minimum free surplus shall become impaired to the extent of thirty-three and one-third (33 1/3%) per cent thereof, computing its liabilities in the manner provided by the laws of this State, it shall make good such impairment within sixty (60) days; and failing to make good such impairment within said time shall forfeit its right to write any business in this State until said impairment shall have been made good. . . .

Revised Law

Sec. 882.306. IMPAIRMENT OF UNENCUMBERED SURPLUS; APPOINTMENT OF RECEIVER. (a) If one-half or more of a mutual life insurance company's unencumbered surplus as required by Section 882.301 is impaired, the commissioner may apply to a

court for the appointment of a receiver to wind up the affairs of the company.

(b) In determining whether a company's surplus is impaired, the company shall compute its reserve liability in the manner provided by state law. (V.T.I.C. Art. 11.17 (part).)

Source Law

> Art. 11.17. . . . The Board of Insurance Commissioners may apply to any court of competent jurisdiction for the appointment of a receiver to wind up the affairs of such company when its above mentioned minimum free surplus shall become impaired to the extent of fifty (50%) per cent thereof, computing its reserve liability in the manner provided by the laws of this State for the computation of such reserve liability. . . .

Revisor's Note

V.T.I.C. Article 11.17 refers to an application to a court of "competent jurisdiction." 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.

Revisor's Note

(End of Subchapter)

Section 2(a), V.T.I.C. Article 11.01, in part provides that the surplus requirements under that article apply to a mutual life insurance company "[f]rom and after the effective date of this Act." The revised law omits that part of Article 11.01 as executed. The omitted law reads:

> Sec. 2. (a) From and after the effective date of this Act the surplus requirement of Paragraph 5 of Section 1 of Article 11.01 of this Code shall be the minimum surplus requirement for any company which is subject to the provisions of Chapter 11 of this Code as amended; . . . .

[Sections 882.307-882.350 reserved for expansion]

SUBCHAPTER H. DIVIDENDS

Revised Law

Sec. 882.351. POLICYHOLDER'S ENTITLEMENT TO DIVIDEND. A policyholder of a mutual life insurance company is entitled to a credit or payment of a dividend from that part of the company's divisible surplus that may be fairly allocated to the policyholder's policy. (V.T.I.C. Art. 11.12 (part).)

Source Law

> Art. 11.12. . . . each such policyholder shall be entitled to and credited with or paid such portion of the entire divisible surplus as may be equitably apportioned to his policy. . . .

Revisor's Note

> V.T.I.C. Article 11.12 refers to the part of a mutual life insurance company's divisible surplus that may be "equitably" allocated to a policyholder's policy. The revised law substitutes "fairly" for "equitably" and, throughout this subchapter, substitutes "fair" for "equitable" and "just" because in context the terms are synonymous and "fair" is the more modern and commonly used term.

Revised Law

Sec. 882.352. ACCOUNTING AND PROCEDURE FOR ALLOCATION OF DIVISIBLE SURPLUS; REPORT TO COMMISSIONER. (a) On December 31 of each year, or as soon after as practicable, each mutual life insurance company shall determine the amount of surplus earned by the company during that year.

(b) Not later than the end of the second year in which a policy issued by the company is in effect, the company shall provide to the policyholder:

(1) an annual accounting of the company's divisible surplus; and

(2) if all premiums due on the policy have been paid for at least two years, a fair allocation of the company's divisible surplus that remains after deducting:

(A) any amount approved by the commissioner for retirement of any unpaid loans made under Section 882.253;

(B) the company's contingency reserve; and

(C) any earned surplus the company allocated to unencumbered surplus as provided by this chapter.

(c) The company shall immediately submit to the commissioner a detailed report of an allocation of divisible

surplus made under this section. The president or secretary of the company shall sign the report under oath. (V.T.I.C. Art. 11.12 (part).)

Source Law

> Art. 11.12. Each such company shall make an annual accounting and apportionment of divisible surplus to each policyholder, beginning not later than the end of the second policy year on all policies issued; and . . . . Upon the 31st day of December of each year, or as soon thereafter as may be practicable, each such company shall truly ascertain the surplus earned by it during such year; and after setting aside from such surplus such portion thereof as the Board of Insurance Commissioners may approve for retirement of any unpaid advances theretofore made pursuant to Article 11.16 of this chapter, and after deducting the contingency reserve and the amount of earned surplus, if any, apportioned to free surplus as provided for in this chapter, it shall apportion to each of its policies upon which all premiums due and payable for at least two (2) years have been paid, an equitable proportion of the remainder of such surplus, and shall immediately submit a detailed report of such apportionment under oath of its president or secretary to the Board of Insurance Commissioners. . . .

Revised Law

Sec. 882.353. DEPARTMENT APPROVAL OF ALLOCATION; REVISIONS. (a) The department shall approve a mutual life insurance company's allocation of divisible surplus under Section 882.352 if the department finds that the allocation is fair to the policyholders and complies with this chapter.

(b) If the department does not approve a company's allocation of surplus, the department shall revise the allocation in a manner that the department determines is fair to the policyholders and necessary to comply with this chapter. The department shall certify the revisions to the company.

(c) An allocation of surplus approved under Subsection (a) takes effect on the date of approval. An allocation of surplus revised by the department under Subsection (b) takes effect on the date the department certifies the revisions to the company. (V.T.I.C. Art. 11.12 (part).)

Source Law

> Art. 11.12. . . . If such Board shall find such apportionment to be equitable and just to the policyholders and in accordance with the provisions of this chapter, it shall approve the same, and it shall become effective. If it shall not approve such apportionment, it shall make such changes therein as it shall deem equitable and just and necessary to make the same comply with the provisions of this chapter, and shall certify such changes to such company, whereupon such apportionment as changed by such Board shall become effective. . . .

Revised Law

Sec. 882.354. DIVIDEND PAYMENT METHOD. (a) A dividend declared by a mutual life insurance company under this subchapter shall be paid in:

(1) cash; or

(2) the equivalent of the dividend's cash value as provided by an option stated in the policy and selected by the policyholder.

(b) A policyholder shall notify the company in writing of an option selected by the policyholder under Subsection (a)(2). (V.T.I.C. Art. 11.12 (part).)

Source Law

> Art. 11.12. . . . Each dividend declared as aforesaid shall be paid in cash, or in the equivalent of its cash value in any option stated in the policy and selected by the policyholder, notice of which selection by the policyholder shall be given to the company in writing.
>
> . . .

Revised Law

Sec. 882.355. LIMITATIONS ON DIVISIBLE SURPLUS. A mutual life insurance company's divisible surplus available for payment of dividends to the company's policyholders may not include:

(1) any part of the company's unencumbered surplus that has been:

(A) allocated from the company's earned surplus;

(B) transferred from the company's contingency reserve; or

(C) otherwise acquired by the company;

(2) if the company was organized after September 5, 1955, any part of the company's unencumbered surplus required to comply with Section 882.301; or

(3) if the company's unencumbered surplus is less than $25,000, the part of the company's earned surplus for the preceding calendar year in excess of 75 percent of the earned surplus. (V.T.I.C. Art. 11.12 (part).)

Source Law

> Art. 11.12. . . . The divisible surplus available for payment of dividends shall not include:
>
> (a) Any portion of the free surplus, required by Article 11.01 as amended, of companies organized after the effective date of this amendment;
>
> (b) Any portion of the free surplus of any company theretofore apportioned from earned surplus, transferred from contingency reserves or otherwise accumulated or acquired by such company as a part of its free surplus;
>
> (c) That portion of the earned surplus for the preceding calendar year in excess of seventy-five (75%) per cent thereof whenever the free surplus of any company shall be less than Twenty-five Thousand ($25,000.00) Dollars; . . . .

Revisor's Note

V.T.I.C. Article 11.12 refers to mutual life insurance companies "organized after the effective date of this amendment." That amendment was enacted by Chapter 363, Acts of the 54th Legislature, Regular Session, 1955, which took effect on September 5, 1955. The revised law substitutes that date for the quoted language.

Revised Law

Sec. 882.356. PAYMENT OF DIVIDENDS NOT REQUIRED. This subchapter does not require a mutual life insurance company to pay a dividend to a policyholder if the unencumbered surplus acquired by the company is impaired. (V.T.I.C. Art. 11.12 (part).)

Source Law

> Art. 11.12. . . .
>
> No such company shall ever be required

by the provisions of this article to pay dividends to policyholders at any time when the free surplus theretofore accumulated or acquired by said company shall be impaired.

Revisor's Note
(End of Subchapter)

V.T.I.C. Article 11.12 provides an exemption from the dividend requirements of that article. Mutual life insurance companies that do not maintain as of the "effective date of this amendment" the minimum amount of unencumbered surplus as required by V.T.I.C. Article 11.01, revised in relevant part as Section 882.301, are exempt from the dividend requirements of V.T.I.C. Article 11.12 until the company acquires the required minimum amount of unencumbered surplus. The amendment that added the quoted language was enacted by Chapter 363, Acts of the 54th Legislature, Regular Session, 1955, which took effect September 5, 1955. It is the understanding of the Texas Department of Insurance that any company that qualified for the exemption on September 5, 1955, has acquired the required minimum amount of unencumbered surplus and therefore is no longer eligible for the exemption. In addition, according to the terms of the exemption, no company may become eligible in the future. The revised law omits the provision as executed. The omitted law reads:

Art. 11.12. . . .

It is further provided that each such company heretofore organized or converted and operating under the provisions of Chapter 11 of this Code which does not at the effective date of this amendment to this Code maintain the minimum free surplus specified in Article 11.01 as amended shall have the right, subject to the limitations herein set forth, to pay dividends but shall not be obligated by the provisions of this article to pay dividends to the policyholders until the minimum free surplus specified in Article 11.01 as amended has been acquired or

accumulated by such company. . . .

[Sections 882.357-882.400 reserved for expansion]

SUBCHAPTER I. CONTINGENCY RESERVE

Revised Law

Sec. 882.401. AMOUNT OF CONTINGENCY RESERVE. (a) A mutual life insurance company organized under this chapter may maintain a contingency reserve that exceeds the reserves and liabilities provided by this chapter. The amount of the contingency reserve may not exceed the greater of:

(1) $10,000;

(2) an amount that:

(A) equals 20 percent of the company's policy reserves and policy liabilities plus one percent of the amount of the company's life insurance in force; and

(B) does not exceed $750,000; or

(3) an amount that equals 20 percent of the company's policy reserves and policy liabilities.

(b) In determining the amount of a company's policy reserves and policy liabilities for purposes of this section, the company may only include the following, after deducting the net value of the company's risks reinsured by other solvent assuming insurers:

(1) the company's reserves on outstanding life insurance policies and annuity contracts, contracts issued as supplemental to the policies or contracts or in connection with the policies or contracts or provisions included in policies or contracts that insure against disability or accidental death; and

(2) the company's liabilities for:

(A) optional modes of settlement; or

(B) dividends left on deposit at interest.

(V.T.I.C. Art. 11.11 (part).)

Source Law

> Art. 11.11. Any mutual, level premium, legal reserve life insurance company organized and doing business under the provisions of this Chapter may accumulate and maintain a contingency reserve, over and above all of its reserves and liabilities required or specifically permitted by the provisions of this Chapter, in an amount not exceeding Ten Thousand Dollars ($10,000), or an amount equal to the sum of twenty per cent (20%) of all of its policy reserves and policy liabilities, plus one per cent (1%) of the amount of its life insurance then in

force, if such sum be greater than Ten Thousand Dollars ($10,000), but in no event to exceed Seven Hundred and Fifty Thousand Dollars ($750,000), or twenty per cent (20%) of all of its policy reserves and policy liabilities, whichever shall be greater. The term "policy reserves and policy liabilities" as used in this Section of this Act shall include only its reserves on outstanding life insurance policies and annuity contracts, contracts issued as supplemental thereto or in connection therewith or provisions included therein insuring against disability or against death by accident or accidental means, and including liabilities required under optional modes of settlement, and for dividends left on deposit at interest, after deducting the net value of its risks reinsured by other solvent assuming insurers, but . . . .

Revisor's Note

(1) V.T.I.C. Article 11.11 refers to any "mutual, level premium, legal reserve life insurance company organized and doing business under the provisions of this Chapter." Section 1, V.T.I.C. Article 11.01, revised in relevant part as Section 882.051, refers to the formation of a "mutual life insurance company . . . [to insure] the lives of individuals on the mutual level premium, legal reserve plan." For consistency with that section and because a mutual life insurance company may only be formed for that purpose under this chapter, the revised law substitutes "mutual life insurance company" for "mutual, level premium, legal reserve life insurance company."

(2) V.T.I.C. Article 11.11 authorizes a mutual life insurance company to "accumulate and maintain" a contingency reserve. Throughout this chapter, the revised law omits references to "accumulate" in this context because its meaning is included in the meaning of "maintain."

(3) V.T.I.C. Article 11.11 provides an exemption from the contingency reserve requirements of that article for any

contingency reserve held by a company "on the effective date of this Act." That provision was added by Chapter 98, Acts of the 52nd Legislature, Regular Session, 1951, which took effect April 30, 1951. According to the Texas Department of Insurance, no contingency reserves still qualify for this exemption. The revised law therefore omits the provision as executed. The omitted law reads:

Art. 11.11. . . . this shall not affect any existing contingency reserve held by any such company on the effective date of this Act, save that whenever and as long as such existing contingency reserve shall exceed the limit above-mentioned, it shall not be entitled to maintain any additional contingency reserve.

. . .

Revised Law

Sec. 882.402. EXCESS CONTINGENCY RESERVE. (a) The commissioner, for good cause shown, may issue an order authorizing a mutual life insurance company to maintain a contingency reserve that exceeds the amount of the reserve authorized by Section 882.401.

(b) The order must state:

(1) a period not exceeding one year during which the company may maintain the excess contingency reserve; and

(2) each reason for authorizing the excess contingency reserve. (V.T.I.C. Art. 11.11 (part).)

Source Law

Art. 11.11. . . .

The State Board of Insurance may, for good cause shown by an official order, permit any such company to accumulate and maintain a contingency reserve in excess of the maximum amount hereinbefore prescribed, for a period, not exceeding one (1) year under any one order, which shall be specified in such order. The State Board of Insurance shall state in such order its reasons therefor.

. . .

Revised Law

Sec. 882.403. CONTINGENCY RESERVE REQUIREMENTS. (a) A mutual life insurance company's contingency reserve as authorized by this subchapter must be:

(1) invested as provided by law; and

(2) used only to pay death claims and dividends to policyholders.

(b) If the interest and earnings from the investment of a company's contingency reserve exceed the amount of reserve authorized by Section 882.401 or 882.402, the company shall pay the excess amount to the policyholders of the company in the form of dividends as provided by law. (V.T.I.C. Art. 11.11 (part).)

Source Law

Art. 11.11. . . .

All such contingency reserves as provided for by this Act shall be invested according to law under the supervision of the State Board of Insurance and shall be used exclusively for the payment of death claims and dividends to policyholders. All interests and earnings from such investments in excess of the maximum contingency reserves as provided for in this Act shall be paid in dividends to policyholders according to present laws.

. . .

Revisor's Note

Section 1, V.T.I.C. Article 11.11 provides that contingency reserves must be invested "according to law under the supervision of the State Board of Insurance." The revised law omits as unnecessary the reference to "under the supervision of the State Board of Insurance." Under V.T.I.C. Articles 11.18 and 11.18-1, revised as Section 882.252, the investments of a mutual life insurance company are regulated in the same manner as the investments of life, health, and accident insurance companies organized under Chapter 841. V.T.I.C. Article 3.33 establishes extensive requirements for those investments and specifies the applicable powers of the Texas Department of Insurance.

Revised Law

Sec. 882.404. ALLOCATION OF CONTINGENCY RESERVE TO UNENCUMBERED SURPLUS. If a mutual life insurance company's unencumbered surplus is less than $100,000, the company may allocate any part of the company's contingency reserve to the company's unencumbered surplus. (V.T.I.C. Art. 11.01, Sec. 2(b).)

Source Law

(b) Each such mutual life insurance company shall have the right to apportion to its free surplus all or any portion of the contingency reserves provided for in Article 11.11 of the Insurance Code while and whenever the free surplus of such company shall be less than One Hundred Thousand ($100,000.00) Dollars.

Revised Law

Sec. 882.405. DESIGNATION OF CONTINGENCY RESERVE AS UNASSIGNED SURPLUS. The contingency reserve described by this subchapter is and may be treated as unassigned surplus, including designating the contingency reserve as unassigned surplus in financial statements. (V.T.I.C. Art. 11.11 (part).)

Source Law

Art. 11.11. . . .

The contingency reserve described in this Article shall be deemed to be unassigned surplus, and in addition to any free surplus elsewhere required or allowed, may be so designated in all financial statements and reports and treated as such.

Revisor's Note

V.T.I.C. Article 11.11 states that a mutual life insurance company's contingency reserve may be treated as unassigned surplus "in addition to any free surplus elsewhere required or allowed." The revised law omits the quoted language as unnecessary because the revision does not purport to limit the treatment of unencumbered surplus as unassigned surplus.

[Sections 882.406-882.450 reserved for expansion]

SUBCHAPTER J. POLICY REQUIREMENTS

Revised Law

Sec. 882.451. APPLICABILITY OF CERTAIN PROVISIONS. Sections 882.452, 882.453, and 882.454 do not apply to a mutual life insurance company organized under this chapter that has a surplus of at least the minimum amount of capital and surplus required of a capital stock company under Sections 841.054, 841.204, 841.205, 841.301, and 841.302. (New.)

Revisor's Note

Section 882.451 is added to the revised law to clarify the applicability of certain provisions of this subchapter. See Revisor's Note (3) to Section 882.001.

Revised Law

Sec. 882.452. TYPE OF POLICY AUTHORIZED. A mutual life insurance company may issue a policy only on the participating plan with dividends payable annually as provided by Subchapter H. (V.T.I.C. Art. 11.13 (part).)

Source Law

Art. 11.13. . . . they shall issue no policies except upon the participating plan with dividends payable annually as provided in this chapter; . . . .

Revisor's Note

V.T.I.C. Article 11.13 refers to the payment of dividends "as provided in this chapter." The relevant portions of this chapter that relate to the payment of dividends are revised in Subchapter H. The revised law is drafted accordingly.

Revised Law

Sec. 882.453. POLICY FORM. An insurance policy issued by a mutual life insurance company must:

(1) be on a form approved by the department; and

(2) contain the following statement on both the front and reverse sides of the policy: "The form of this policy is approved by the Texas Department of Insurance." (V.T.I.C. Art. 11.13 (part).)

Source Law

Art. 11.13. . . . the form of all policies issued by any such company shall be approved by the Board of Insurance Commissioners, and all such policies shall have plainly printed on both the face and the reverse sides thereof the words, "The form of this policy is approved by the Board of Insurance Commissioners of the State of Texas," and . . . .

Revised Law

Sec. 882.454. LIMITATION ON AMOUNT OF POLICY VALUE FOR CERTAIN COMPANIES. If the total amount of a mutual life insurance company's insurance in force is less than $10 million, the

company may not issue a policy that, after deducting any reinsurance, binds the company for more than $5,000 on a single life. (V.T.I.C. Art. 11.13 (part).)

Source Law

> Art. 11.13. . . . No such company shall issue any policy or policies by which, after deducting reinsurance, if any, it shall be bound for more than Five Thousand ($5,000.00) Dollars upon any one life at any time when the total amount of its insurance in force is less than Ten Million ($10,000,000.00) Dollars.

Revised Law

Sec. 882.455. TABLE OF GUARANTEED VALUES. (a) Each insurance policy issued by a mutual life insurance company must contain a table of guaranteed values. The guaranteed values become nonforfeitable not later than the date of payment of the third full annual premium.

(b) The table of guaranteed values shall be drawn in accordance with the law governing life, health, and accident insurance companies. (V.T.I.C. Art. 11.14.)

Source Law

> Art. 11.14. Each policy issued by such company shall contain a table of guaranteed values, which shall become non-forfeitable not later than upon the payment of the third full annual premium; such tables of values shall be drawn in accordance with the law governing life, health and accident insurance companies.

[Sections 882.456-882.500 reserved for expansion]

SUBCHAPTER K. TOTAL ASSUMPTION REINSURANCE AGREEMENTS

Revised Law

Sec. 882.501. TOTAL ASSUMPTION REINSURANCE AGREEMENTS BETWEEN LIFE INSURANCE COMPANIES. (a) A domestic mutual life insurance company and any other domestic or foreign life insurance company may enter into a total assumption reinsurance agreement if the company assuming the policies under the agreement is authorized to engage in the kinds of insurance provided by those policies.

(b) Before a total assumption reinsurance agreement may be entered into:

(1) the agreement must be submitted to the department;

and

(2) the commissioner must approve the agreement as fully protecting the interests of each domestic company's policyholders.

(c) After an assumption reinsurance agreement in which the ceding company is a domestic mutual insurance company is approved by the commissioner as required by Subsection (b), the agreement must be approved by the policyholders of the ceding domestic company in the same manner as required for a merger or consolidation under Subchapter L.

(d) When the reinsurance agreement described by Subsection (c) is effective, the assuming company is entitled to the same rights, privileges, and benefits granted a company that assumes a company by merger or consolidation as provided by Subchapter L. (V.T.I.C. Art. 11.21.)

Source Law

Art. 11.21

Sec. 1. Total direct reinsurance agreements may be made and entered into between any domestic mutual life insurance company and any other life insurance company, domestic or foreign, provided: (a) the assuming company is authorized to transact the kinds of insurance provided by the policies assumed; and (b) no total direct reinsurance agreement shall be made until the contract therefor has been submitted to and approved by the Commissioner of Insurance as protecting fully the interests of the policyholders of any domestic insurer.

Sec. 2. Total direct reinsurance agreements, whereby all policies of any ceding domestic mutual life insurance company, are totally assumed by another company, must first be so approved by the Commissioner of Insurance and thereafter by such affected policyholders of the domestic company in like mode and manner as is required under the provisions of Article 11.20 of this Chapter of this Code for policyholder approval of a merger or consolidation agreement. Upon consummation of any such total direct reinsurance agreement, the assuming company shall be entitled to all the rights, privileges and benefits accorded under Section 7, of Article 11.20 of this Chapter of this Code, the same

as though such business had been assumed by merger or consolidation.

Revisor's Note

V.T.I.C. Article 11.21 refers to "total direct reinsurance." The revised law substitutes the phrase "total assumption reinsurance" for "total direct reinsurance" because, in context, the terms are synonymous and "total assumption reinsurance" is more commonly used.

[Sections 882.502-882.550 reserved for expansion]

SUBCHAPTER L. MERGERS AND CONSOLIDATIONS

Revised Law

Sec. 882.551. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a merger or consolidation in which at least one of the parties to the transaction is a mutual life insurance company. (V.T.I.C. Art. 11.20, Sec. 9 (part).)

Source Law

Sec. 9. The provisions of this Article shall only apply to mergers and consolidations in which at least one of the parties thereto is a mutual life insurance company. . . .

Revisor's Note

Section 9, V.T.I.C. Article 11.20, in part provides that a merger or consolidation between at least two stock insurance corporations is governed by V.T.I.C. Article 21.25. The revised law omits the provision as unnecessary because V.T.I.C. Article 21.25, revised as Chapter 824 of this code, provides sufficient authority as to the applicability of that law to mergers and consolidations between stock insurance corporations. The omitted law reads:

Sec. 9. . . . Mergers and consolidations between two or more stock insurance corporations in which no mutual life insurance company is a party thereto shall be governed by Article 21.25 of this Code.

Revised Law

Sec. 882.552. AUTHORITY TO MERGE OR CONSOLIDATE. A domestic or foreign mutual life insurance company may merge with a

domestic or foreign mutual or stock legal reserve life insurance company or consolidate into a new domestic or foreign mutual or stock life insurance company as provided by this subchapter. (V.T.I.C. Art. 11.20, Sec. 1.)

Source Law

Art. 11.20

Sec. 1. Any domestic or foreign mutual life insurance company may merge with any mutual or stock legal reserve life insurance company, domestic or foreign, or consolidate into either a new mutual or stock life insurance company, domestic or foreign, by compliance with the procedures provided in this Article.

Revised Law

Sec. 882.553. PROPOSED PLAN OF MERGER OR CONSOLIDATION; FILING WITH COMMISSIONER. (a) If the boards of directors of at least two life insurance companies determine by majority vote to merge or consolidate, the boards of directors shall prepare a proposed plan of merger or consolidation. The plan may contain:

(1) a future allocation of divisible surplus; or

(2) any other fair arrangement by which any equitable interests of the mutual life insurance company's policyholders may be adjusted.

(b) The boards of directors shall file the proposed plan with the commissioner for approval. (V.T.I.C. Art. 11.20, Sec. 2.)

Source Law

Sec. 2. When it shall be determined by a majority vote of the Board of Directors, respectively, of two or more of such life insurance companies, at least one of which must be a mutual life insurance company, to either merge or consolidate, said Boards of Directors shall prepare a plan of merger or consolidation, as the case may be, and file such plan with the Commissioner of Insurance for approval. Such plan may contain provisions for future apportionment of then existing or prospective accumulations, or both, of divisible surplus, or any other equitable arrangement, whereby the equitable interests, if any, of affected policyholders of the mutual life insurance company may be adjusted.

Revisor's Note

Section 2, V.T.I.C. Article 11.20, states that at least one of the merging or consolidating companies must be a mutual life insurance company. The revised law omits this statement as unnecessary because under Section 9, V.T.I.C. Article 11.20, revised in part as Section 882.551, this subchapter only applies when at least one of the merging or consolidating companies is a mutual life insurance company.

Revised Law

Sec. 882.554. HEARING ON PLAN. As soon as practicable after a proposed plan is filed with the commissioner, the commissioner shall hold a hearing to determine whether to approve the plan. (V.T.I.C. Art. 11.20, Sec. 3 (part).)

Source Law

Sec. 3. As soon as practicable after such filing, the Commissioner of Insurance shall hold a hearing on the question of whether he should approve such plan. . . .

Revised Law

Sec. 882.555. COMMISSIONER DETERMINATION ON PLAN. (a) As soon as practicable after the commissioner holds a hearing on a proposed plan under Section 882.554, the commissioner shall approve the plan unless the commissioner determines that:

(1) the plan is contrary to law; or

(2) implementation of the plan:

(A) would not be in the best interests of the policyholders of any mutual life insurance company that is a party to the plan; or

(B) would substantially reduce the security of or service to be rendered to policyholders of any mutual insurance company that is a party to the plan, regardless of whether the policyholders reside in this state or elsewhere.

(b) In determining whether to approve a proposed plan, the commissioner may consider all relevant financial or other information, including past, present, and future operations and accumulations of each company that is a party to the plan.

(c) If the commissioner approves the proposed plan, the commissioner shall notify each party to the plan of the approval.

(d) If the commissioner disapproves the proposed plan, the commissioner shall, within a reasonable time after holding a hearing under Section 882.554:

(1) specify in detail each reason for the disapproval; and

(2) notify each party to the plan. (V.T.I.C. Art. 11.20, Sec. 3 (part).)

Source Law

Sec. 3. . . . As soon as practicable after such hearing, said Commissioner shall approve such plan unless he finds that such plan:

(1) is contrary to law, or

(2) effectuation of such plan would not be in the best interest of the policyholders of any mutual life insurance company which is a party to such plan, or

(3) effectuation of such plan would substantially reduce the security of or service to be rendered to policyholders, whether residents of this state or elsewhere, of any mutual insurance company which is a party to such plan.

In making such decision, the Commissioner of Insurance may consider all facts, elements, matters and financial conditions relating thereto, including but not limited to past, present and prospective operations and accumulations of said companies desiring to merge or consolidate.

If the Commissioner of Insurance disapproves such plan, he shall within a reasonable time after such hearing specify in detail his reasons therefor and so notify all of the parties to such plan. If the Commissioner of Insurance approves such plan, he shall so notify all of the parties thereto, ...

Revisor's Note

Section 3, V.T.I.C. Article 11.20, refers to information relating to certain insurance companies, including but not limited to past, present, and prospective operations and accumulations of the companies. The revised law omits "but not limited to" 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.

Revised Law

Sec. 882.556. APPROVAL OF PLAN BY POLICYHOLDERS. (a) As soon as practicable after receiving from the commissioner notice of approval of a proposed plan under Section 882.555, the board of directors of each mutual life insurance company that is a party to the plan shall submit the plan to the policyholders for a vote at an annual or special meeting.

(b) Not later than the 15th day before the date of the meeting, the company shall provide written notice of the meeting to the policyholders as provided by the company's bylaws. The notice must:

(1) be sent to the policyholder's last known address;

(2) state that one of the purposes of the meeting is to vote on the proposed plan; and

(3) be accompanied by a copy of the proposed plan.

(c) At a meeting under Subsection (a), each policyholder:

(1) is entitled to the number of votes as provided by Section 882.155; and

(2) may vote:

(A) in person;

(B) by written proxy; or

(C) by mailed ballot.

(d) A proposed plan is approved by the policyholders on the affirmative vote of at least two-thirds of the votes cast at the meeting. (V.T.I.C. Art. 11.20, Secs. 3 (part), 4, 5 (part).)

Source Law

Sec. 3. . . . [If the Commissioner of Insurance approves such plan, he shall so notify all of the parties thereto,] whereupon each board of directors of each company party thereto shall proceed to submit such plan for adoption or rejection to its respective policyholders or . . . as hereinafter provided.

Sec. 4. As soon as practicable after receipt of notice of approval of a plan of merger or consolidation to which a company is a party, each mutual life insurance company which is a party thereto shall cause such plan to be submitted to a vote of its policyholders at a meeting thereof, which meeting may be either an annual or a special meeting. Written or printed notice shall be given to each policyholder, addressed to his last known address, in accordance with the applicable bylaws, but not less than fifteen

(15) days before such meeting. And each such notice shall specifically state that at least one of the purposes of such meeting is to vote upon such plan, a copy of which shall accompany such notice. At each such meeting of policyholders of a domestic mutual life insurance company which is a party to such plan, each policyholder shall (i) be entitled to a number of votes determined as provided in Article 11.04 of this Chapter of this Code, and (ii) may vote in person, by proxy to whomever the policyholder may designate in writing, or by mailed ballot. The plan of merger or consolidation shall be considered approved by the policyholders of such company upon receiving the affirmative vote of at least two-thirds (2/3) of the votes cast at such meeting on such question.

Sec. 5. (a) . . . [the required approval of such plan] (i) by the policyholders of each domestic mutual life insurance company which is a party to such plan, ...

Revised Law

Sec. 882.557. DOMESTIC STOCK LIFE INSURANCE COMPANY; APPROVAL OF PLAN BY SHAREHOLDERS. On notice of approval of a proposed plan under Section 882.555, the board of directors of each domestic stock life insurance company that is a party to the plan shall submit the plan for approval to the company's shareholders in the manner provided by Section 824.003. (V.T.I.C. Art. 11.20, Secs. 3 (part), 5(a) (part).)

Source Law

Sec. 3. . . . [If the Commissioner of Insurance approves such plan, he shall so notify all of the parties thereto,] whereupon each board of directors of each company party thereto shall proceed to submit such plan for adoption or rejection to its . . . shareholders, . . . as hereinafter provided.

Sec. 5. (a) . . . [the required approval of such plan] . . . (ii) by the shareholders of each domestic stock life insurance company which is a party to such plan in like mode and manner as is required under Section 2 of Article 21.25 of this

Code, and . . . .

Revised Law

Sec. 882.558. FOREIGN LIFE INSURANCE COMPANY; APPROVAL OF PLAN BY POLICYHOLDERS OR SHAREHOLDERS. On notice of approval of a proposed plan under Section 882.555, the board of directors of each foreign life insurance company that is a party to the plan shall submit the plan for approval to the company's policyholders or shareholders as provided by the law of the appropriate jurisdiction. (V.T.I.C. Art. 11.20, Secs. 3 (part), 5(a) (part).)

Source Law

> Sec. 3. . . . [If the Commissioner of Insurance approves such plan, he shall so notify all of the parties thereto,] whereupon each board of directors of each company party thereto shall proceed to submit such plan for adoption or rejection to its respective policyholders or shareholders, as the case may be, as hereinafter provided.
>
> Sec. 5. (a) . . . [the required approval of such plan] . . . (iii) if one or more foreign life insurance companies is a party thereto, upon the approval thereof by its policyholders or shareholders, as the case may be, in compliance with such foreign law or laws as may be applicable thereto, ...

Revised Law

Sec. 882.559. FILING OF AFFIDAVIT OF PLAN APPROVAL; ISSUANCE OF CERTIFICATE OF MERGER OR CONSOLIDATION. (a) On the approval of a proposed plan under Section 882.556, 882.557, or 882.558, the president or a vice president and the secretary or an assistant secretary of each company that is a party to the plan shall execute and file with the department an affidavit stating that the plan has been approved by the policyholders or shareholders of the company as required by this subchapter.

(b) If the department finds that the affidavit complies with law, the department shall:

(1) endorse the affidavit with:

(A) the word "filed"; and

(B) the date of filing;

(2) if the plan is a plan of merger, issue a certificate of merger to the surviving company or the company's representative; and

(3) if the plan is a plan of consolidation, issue a

certificate of consolidation to the new company on the issuance of a charter and a certificate of authority to the new company after:

(A) submission of proper articles of incorporation to the department;

(B) approval by the department in accordance with procedures required for the issuance of a new charter; and

(C) submission of proof that the new company has policyholder surplus at least equal to that of the mutual life insurance company that is a party to the consolidation and has the largest surplus. (V.T.I.C. Art. 11.20, Secs. 5(a) (part), (b).)

Source Law

Sec. 5. (a) Upon the required approval of such plan . . . the president or a vice-president and the secretary or an assistant secretary of each company which is a party to such plan shall execute and file with the Commissioner of Insurance an affidavit that such plan has been approved as herein required.

(b) If the Commissioner of Insurance finds that such affidavit conforms to law, he shall endorse thereon the word "Filed," and the date of filing thereof; and

(1) if the plan be a plan of merger, the Commissioner shall then execute and deliver a Certificate of Merger to the surviving company or its representative; or

(2) if the plan be a plan of consolidation, the Commissioner shall execute and deliver a Certificate of Consolidation to the new company when such new company shall be issued a charter and license upon submission of proper articles of incorporation to the Commissioner of Insurance, and upon his approval in accordance with the procedure required for the issuance of a new charter, and proof that the new company has surplus as regards policyholders of not less than the surplus as regards policyholders of the mutual life insurance company involved in such merger or consolidation having the largest surplus.

Revisor's Note

(1) Section 5(b), V.T.I.C. Article

11.20, refers to the execution and delivery of a certificate of merger. Throughout this subchapter, the revised law substitutes "issue" for "execute and deliver" to provide for consistent use of terminology throughout the Insurance Code.

(2) Section 5(b), V.T.I.C. Article 11.20, refers to the issuance of a "charter and license." The revised law substitutes "certificate of authority" for "license" because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

Revised Law

Sec. 882.560. EFFECTIVE DATE OF MERGER OR CONSOLIDATION. A merger or consolidation takes effect on the later of:

(1) the date of issuance of the certificate of merger or consolidation; or

(2) a date specified in the plan of merger or consolidation. (V.T.I.C. Art. 11.20, Sec. 6.)

Source Law

Sec. 6. Upon the issuance by the Commissioner of a Certificate of Merger or Consolidation, as the case may be, the merger or consolidation referred to in such certificate shall thereupon be deemed effective unless some subsequent date be specifically stated as the effective date thereof in the plan therefor.

Revised Law

Sec. 882.561. ASSUMPTION OF OUTSTANDING INSURANCE POLICIES. (a) On the effective date of a merger or consolidation under this subchapter, a new or surviving life insurance company resulting from the merger or consolidation assumes each insurance policy outstanding against each company that merges or consolidates on the same terms and under the same conditions as if the policy had continued in force through the original company.

(b) The new or surviving insurance company shall implement the terms of the policy.

(c) The new or surviving insurance company is entitled to:

(1) all rights and privileges under the policy; and

(2) all reserves and surplus that accumulated on the policy before the merger or consolidation.

(d) A policyholder of a mutual life insurance company that is a party to a merger or consolidation resulting in a new or

surviving stock life insurance company is not entitled to any voting rights in the new or surviving company. (V.T.I.C. Art. 11.20, Sec. 7 (part).)

Source Law

Sec. 7. As of the time that such merger or consolidation is deemed effective:

(1) All policies of insurance outstanding against any company so merged or consolidated shall be deemed to be assumed by the new or surviving life insurance company on the same terms and under the same conditions as if such policies had continued in force against the original issuer thereof and the new or surviving company shall carry out the terms of such policies and be entitled to all the rights and privileges thereof and the reserves and surplus accumulating on such policy prior to such merger or consolidation, with the exception that policies in a mutual life insurance company shall not be entitled to any voting privileges or rights in a new or surviving stock life insurance company, if that is the circumstance.

. . .

Revised Law

Sec. 882.562. ASSUMPTION OF LIABILITIES. On the effective date of a merger or consolidation under this subchapter, a new or surviving life insurance company resulting from the merger or consolidation assumes all liabilities of the original companies. (V.T.I.C. Art. 11.20, Sec. 7 (part).)

Source Law

Sec. 7. As of the time that such merger or consolidation is deemed effective:

. . .

(2) . . . simultaneously therewith the surviving or new life insurance company shall be deemed to have assumed all of the liabilities of the merged or consolidated companies;

. . .

Revised Law

Sec. 882.563. EFFECT OF MERGER OR CONSOLIDATION ON PROPERTY. On the effective date of a merger or consolidation

under this subchapter, the property rights, including any right of recovery, of each company that is a party to the merger or consolidation are transferred to the new or surviving life insurance company resulting from the merger or consolidation without a deed or other transfer. (V.T.I.C. Art. 11.20, Sec. 7 (part).)

Source Law

Sec. 7. As of the time that such merger or consolidation is deemed effective:

. . .

(2) All the rights, franchises and interests of the companies so merged or consolidated, in and to every species of property, real, personal and mixed, and the things in action thereunto belonging, shall be deemed as transferred to and vested in the surviving or new life insurance company, without any other deed or transfer, and

. . . .

Revisor's Note

(1) Section 7, V.T.I.C. Article 11.20, refers to the "rights, franchises and interests" of companies "in and to every species of property, real, personal and mixed." The revised law omits "franchises" and "interests" because in context the meaning of each term is included in the meaning of "rights." The revised law also omits "real, personal and mixed" because under Section 311.005(4), Government Code (Code Construction Act), applicable to the revised law, the term "property" includes real and personal property.

(2) Section 7, V.T.I.C. Article 11.20, refers to "things in action" in relation to property rights. The revised law substitutes "right of recovery" for "things in action" because the phrases are synonymous in context and the former is more modern and more commonly used.

Revised Law

Sec. 882.564. EFFECT OF MERGER OR CONSOLIDATION ON CERTAIN INVESTMENTS. (a) This section applies to each investment of an affected life insurance company, including an investment in real property, that:

(1) was authorized as a proper asset, as of the date

on which the investment was made and under the laws of the state in which the company was organized, for investment of funds of a life insurance company; and

(2) is taken over by the new or surviving company under the terms of the merger or consolidation.

(b) On the effective date of a merger or consolidation of two or more life insurance companies under this subchapter, an investment of the affected companies described by Subsection (a) is a proper asset under the laws of this state of the new or surviving company if the investment is:

(1) approved by the commissioner; and

(2) taken over on terms satisfactory to the commissioner.

(c) A new or surviving company that acquires, under the terms of the merger or consolidation, real property that exceeds the amount of real property permitted by the applicable sections of this code relating to owning or holding real property shall sell or dispose of the excess real property:

(1) within the period specified by those sections; or

(2) within a longer period if the company obtains a certificate from the commissioner:

(A) stating that the interests of the company will materially suffer by the forced sale or other disposition of the real property; and

(B) specifying the longer period for the sale or other disposition of the real property.

(d) This section does not preclude the designation and use of the excess real property as branch offices of the company in accordance with this code. (V.T.I.C. Art. 11.20, Sec. 7 (part).)

Source Law

> Sec. 7. As of the time that such merger or consolidation is deemed effective:
>
> . . .
>
> (3) All investments of each life insurance company which was a party to such merger or consolidation that were authorized when made by the laws of the state in which such life insurance company was organized, as proper securities or assets, including real property, for investment of the funds of such life insurance company and which investments are taken over by the surviving or new company by virtue of such merger or consolidation under the provisions of this Article, shall be, under the laws of this state, considered as valid securities or assets, including real property, of such new

or surviving company, provided such investments are approved by the Commissioner of Insurance in this state, and the same are taken over on terms satisfactory to said Commissioner; provided, however, that in the event the new or surviving company acquires by virtue of such merger or consolidation real estate or property beyond or in excess of that permitted by the applicable Articles pertaining to owning or holding real estate, such company shall sell or dispose of all such excess real estate within the time specified in such applicable Articles unless it shall procure a certificate from said Commissioner that the interest of such company will materially suffer from the forced sale or disposition thereof, in which event the time for the sale or disposition thereof may be extended to such time as the Commissioner of Insurance shall direct in such certificate. Provided further, that this Section will not preclude the designation and use of such acquired excess real estate as branch offices in accordance with the applicable provisions of this Code.

. . .

Revisor's Note

Section 7, V.T.I.C. Article 11.20, refers to "securities or assets" of a life insurance company. The revised law omits "securities" because in context its meaning is included in the meaning of "assets."

Revised Law

Sec. 882.565. EFFECT OF MERGER OR CONSOLIDATION ON DIVISIBLE SURPLUS. (a) This section applies only to a mutual life insurance company that is a new company or the surviving company resulting from a merger or consolidation under this subchapter.

(b) If the divisible surplus of each domestic mutual life insurance company that is a party to a merger or consolidation under this subchapter was available for allocation to policyholders as provided by Subchapter H immediately before the effective date of the merger or consolidation, the divisible surplus remains available to the policyholders of the new or surviving mutual life insurance company resulting from the merger or consolidation as provided by Subchapter H. (V.T.I.C. Art. 11.20, Sec. 7 (part).)

Source Law

Sec. 7. As of the time that such merger or consolidation is deemed effective:

. . .

(4) In those cases where the surviving or new company following a merger or consolidation is a mutual life insurance company, the divisible surplus of each domestic mutual life insurance company which is a party to such merger or consolidation which was available for apportionment to policyholders in accordance with the provisions of Article 11.12 of this Chapter of this Code immediately prior to the effectiveness of such merger or consolidation shall continue to be available to the policyholders of the surviving or new mutual life insurance company in accordance with the provisions of such Article.

Revised Law

Sec. 882.566. EFFECT ON ANTITRUST LAWS. This subchapter does not affect in any manner the antitrust laws of this state. (V.T.I.C. Art. 11.20, Sec. 8.)

Source Law

Sec. 8. Nothing herein shall be construed as affecting, modifying, amending, or repealing in any manner the Anti-Trust Statutes of this state.

Revisor's Note

Section 8, V.T.I.C. Article 11.20, states that the article may not be "construed as affecting, modifying, amending, or repealing" Texas antitrust laws. The revised law omits "modifying," "amending," and "repealing" because the meaning of each of those terms is included in the meaning of "affecting."

[Sections 882.567-882.600 reserved for expansion]

SUBCHAPTER M. CONVERSION OF MUTUAL LIFE INSURANCE COMPANY TO STOCK LEGAL RESERVE LIFE INSURANCE COMPANY

Revised Law

Sec. 882.601. AUTHORITY TO CONVERT TO STOCK LEGAL RESERVE LIFE INSURANCE COMPANY; POLICYHOLDER AUTHORIZATION REQUIRED. A mutual life insurance company organized under this chapter may

convert to a stock legal reserve life insurance company as provided by this subchapter only if the conversion is approved by the policyholders by a vote of at least two-thirds of the votes cast by the policyholders in person or by proxy at a meeting called for that purpose. (V.T.I.C. Art. 11.01, Sec. 2(c) (part).)

Source Law

(c) Any mutual life insurance company organized or operating under the provisions of Chapter 11 of this Code may convert into a stock legal reserve life insurance company subject to the following conditions:

. . .

2. Such conversion shall only be made upon receiving the affirmative vote of at least two-thirds (2/3) of the votes cast in person or by proxy by the policy holders of such company at a meeting called for such purpose. . . .

Revised Law

Sec. 882.602. AMENDMENT TO CHARTER OR ARTICLES OF INCORPORATION REQUIRED. If the policyholders of a mutual life insurance company authorize a conversion under Section 882.601, the board of directors and officers of the company shall amend the company's charter or articles of incorporation to comply with the requirements applicable to a stock legal reserve life insurance company under Chapter 841. (V.T.I.C. Art. 11.01, Sec. 2(c) (part).)

Source Law

(c) . . .

2. . . . Pursuant to such policy holder authorization, the Board of Directors and officers of such mutual legal reserve life insurance company shall amend its existing charter or articles of incorporation so as to comply with the requirements of Article 3.02 of this Code, as amended; . . . .

Revisor's Note

Section 2(c), V.T.I.C. Article 11.01, provides that on policyholder authorization for a conversion to a stock legal reserve life insurance company, the charter or articles of incorporation of a mutual life

insurance company must be amended to satisfy the requirements of V.T.I.C. Article 3.02. Article 3.02, revised as part of Chapter 841, establishes some of the requirements applicable to a stock legal reserve life insurance company. Under the portion of Section 2(c) revised as Section 882.606, the converted company is generally subject to the same provisions as a company organized under Chapter 841. The revised law is drafted accordingly.

Revised Law

Sec. 882.603. CAPITAL AND SURPLUS REQUIREMENTS. (a) The capital and surplus of the converted stock legal reserve life insurance company must be at least equal to the minimum capital and surplus required for the organization of a stock legal reserve life insurance company under Chapter 841.

(b) If a contribution of United States currency is necessary to meet the capital and surplus requirements of this section, the contribution must be made before the effective date of the conversion. (V.T.I.C. Art. 11.01, Sec. 2(c) (part).)

Source Law

(c) . . .

1. The capital and surplus of such converted stock legal reserve life insurance company shall be not less than the minimum capital and surplus required for the organization of a stock legal reserve life insurance company under the provisions of Chapter 3 of this Code, as amended, and if necessary in order to meet such minimum capital and surplus requirements, contributions of cash of the United States shall be made prior to the effective date of such conversion.

. . .

Revisor's Note

Section 2(c), V.T.I.C. Article 11.01, refers to Chapter 3 of the Insurance Code. The pertinent portions of Chapter 3, relating to the minimum capital and surplus required for stock legal reserve life insurance companies, are revised in Chapter 841. The revised law is drafted accordingly.

Revised Law

Sec. 882.604. HEARING. (a) After public notice, the

commissioner shall hold a hearing on a conversion authorized under Section 882.601.

(b) Any policyholder of the mutual life insurance company that is the subject of the conversion is entitled to appear and be heard at the hearing. (V.T.I.C. Art. 11.01, Sec. 2(c) (part).)

Source Law

(c) . . .

3. . . . following public notice and hearing at which any policy holder shall have the right to appear and be heard, ...

Revised Law

Sec. 882.605. CONVERSION ON COMMISSIONER APPROVAL. A mutual life insurance company is converted to a stock legal reserve life insurance company if:

(1) the company complies with this subchapter; and

(2) after hearing, the conversion is approved by the commissioner. (V.T.I.C. Art. 11.01, Sec. 2(c) (part).)

Source Law

(c) . . .

3. Upon compliance with the provisions hereof and approval of the proposed conversion by the Commissioner of Insurance, . . . such mutual life insurance company shall be and become a legal reserve stock life insurance company;

. . .

Revised Law

Sec. 882.606. APPLICABLE LAW AFTER CONVERSION. After a mutual life insurance company is converted to a stock legal reserve life insurance company, the converted company is governed in the same manner as a company organized under Chapter 841. (V.T.I.C. Art. 11.01, Sec. 2(c) (part).)

Source Law

(c) . . .

4. From and after the date of such conversion such stock legal reserve life insurance company shall be governed by the provisions of Chapter 3 of this Code, as amended, except as otherwise herein provided.

Revisor's Note

Section 2(c), V.T.I.C. Article 11.01,

states that a mutual life insurance company that converts to a stock legal reserve life insurance company is governed by V.T.I.C. Chapter 3 "except as otherwise herein provided." To accurately reflect the intent of the legislature, the revised law refers to the law governing a company organized under Chapter 841. Chapter 841 revises the provisions of Chapter 3 relating to the organization of a stock legal reserve life insurance company. The revised law also omits the quoted language as unnecessary because the law revised as this chapter does not provide for any exceptions.

Revised Law

Sec. 882.607. OTHER TYPES OF CONVERSION NOT PROHIBITED. This subchapter does not prohibit a mutual life insurance company from converting to a stock legal reserve life insurance company by:

(1) merger or consolidation;

(2) a total direct or assumption reinsurance agreement; or

(3) any other plan or procedure approved by the company's policyholders and the commissioner. (V.T.I.C. Art. 11.01, Sec. 2(c) (part).)

Source Law

(c) . . .

2. . . . provided that nothing contained herein shall be deemed to prohibit such company from converting to a stock legal reserve life insurance company by merger or consolidation, by a total direct or assumption reinsurance agreement or by such other plan or procedure as may be approved by the policy holders and the Commissioner of Insurance;

. . .

[Sections 882.608-882.650 reserved for expansion]

SUBCHAPTER N. CONVERSION OF CERTAIN MUTUAL ASSESSMENT COMPANIES OR ASSOCIATIONS TO MUTUAL LIFE INSURANCE COMPANIES

Revised Law

Sec. 882.651. AUTHORITY TO CONVERT. A mutual assessment company or association organized and operating under the laws of this state on May 17, 1943, may convert to a mutual life insurance company as provided by this subchapter. (V.T.I.C.

Art. 11.10, Sec. 1 (part).)

Source Law

Sec. 1. . . . mutual assessment companies and associations organized and operating under the laws of this State on May 17, 1943 which desire to convert to a mutual legal reserve company, and . . . .

Revisor's Note

Section 1, V.T.I.C. Article 11.10, refers to the conversion of a mutual assessment company that complies with the requirements of V.T.I.C. Chapter 11, revised as this chapter, to a "mutual legal reserve company." V.T.I.C. Chapter 11 governs mutual life insurance companies. Throughout this subchapter, the revised law substitutes "mutual life insurance company" for "mutual legal reserve company" to provide for consistent use of terminology throughout this chapter.

Revised Law

Sec. 882.652. VOLUNTARY CONVERSION. The department may not require a mutual assessment company or association to convert to a mutual life insurance company under this subchapter. (V.T.I.C. Art. 11.10, Sec. 2 (part).)

Source Law

Sec. 2. Nothing in this article or in the provisions of this chapter or Chapter 3 of this Code shall ever be construed to mean that any of the associations or similar concerns, by whatsoever name or class designated, whether specifically named herein or not, shall be required by the State Board of Insurance to convert to mutual legal reserve companies as herein authorized unless they voluntarily decide to do so; and . . . .

Revisor's Note

Section 2, V.T.I.C. Article 11.10, states that the article does not apply to a mutual assessment company or association unless the company or association voluntarily decides to convert to a mutual life insurance company. The revised law omits this statement as unnecessary because it is clear

from Section 1, V.T.I.C. Article 11.10, revised in relevant part as Section 882.651, that conversion to a mutual life insurance company under this subchapter is voluntary and that this subchapter applies only to a company or association that decides to convert to a mutual life insurance company. The omitted law reads:

Sec. 2. . . . if such associations have not heretofore voluntarily decided to come under this chapter, and if such associations do not hereafter so voluntarily decide to come under this chapter, then this chapter shall not in any way apply to any such associations.

Revised Law

Sec. 882.653. CONVERSION REQUIREMENTS. Except as provided by Section 882.654, a mutual assessment company or association may convert to a mutual life insurance company only if the company or association:

(1) possesses an unencumbered surplus of at least $1.4 million; and

(2) complies with the requirements of this chapter, including the requirements that the company or association execute articles of incorporation and obtain a charter and a certificate of authority. (V.T.I.C. Art. 11.10, Sec. 1 (part).)

Source Law

Sec. 1. Except as provided by Section 3 of this article, [mutual assessment companies and associations . . . which desire to convert to a mutual legal reserve company, and] qualify under Chapter 11 of the Insurance Code, shall be required at the time of conversion to be possessed of free surplus of not less than One Million Four Hundred Thousand ($1,400,000.00) Dollars. In order to convert, such company shall comply with the provisions of Articles 11.01 and 11.02 of the Insurance Code, as amended, and . . . .

Revisor's Note

Section 1, V.T.I.C. Article 11.10, states that a company or association must "comply with the provisions of Articles 11.01 and 11.02" of the Insurance Code. For the convenience of the reader, the revised law

specifically states the applicable requirements in those articles, which are the requirements that the company or association execute articles of incorporation and obtain a charter and a certificate of authority.

Revised Law

Sec. 882.654. EXEMPTION FROM SURPLUS REQUIREMENTS. (a) A mutual assessment company or association is exempt from the surplus requirements of Section 882.653 if the company or association:

(1) possesses an unencumbered surplus of at least $200,000; and

(2) converted to a mutual life insurance company before September 1, 1999.

(b) A mutual assessment company or association that is exempt under Subsection (a) and that was converted on or after September 1, 1989, shall immediately increase its surplus to an amount that satisfies Section 882.653 on:

(1) a change of control of at least 50 percent of the voting securities of the converted company or association; or

(2) if the converted company or association or the holding company that controls the converted company or association, if any, is not controlled by voting securities, a change of at least 50 percent of the ownership of the converted company or association or its holding company.

(c) For purposes of Subsection (b), a transfer of ownership because of death, regardless of whether the decedent died testate or intestate, is not considered a change of control of a converted mutual assessment company or association or its holding company, if ownership is transferred only to one or more individuals, each of whom would have been an heir of the decedent if the decedent had died intestate. (V.T.I.C. Art. 11.10, Sec. 3.)

Source Law

Sec. 3. (a) The requirement under Section 1 of this article that a mutual assessment company or association have a surplus of at least One Million Four Hundred Thousand ($1,400,000.00) Dollars does not apply to a mutual assessment company or association that converts to a Chapter 11 company if:

(1) the mutual assessment company or association shall be possessed of free and unencumbered surplus of at least Two Hundred Thousand ($200,000.00) Dollars; and

(2) the conversion takes effect

before September 1, 1999.

(b) A mutual assessment company or association that is converted on or after September 1, 1989, and that has less than One Million Four Hundred Thousand ($1,400,000.00) Dollars surplus may continue to transact the kind or kinds of insurance business for which it has been issued a Texas certificate of authority. However, a mutual assessment company or association that is converted on or after September 1, 1989, must increase its surplus to at least One Million Four Hundred Thousand ($1,400,000.00) Dollars immediately after any change of control of the converted mutual assessment company or association or any holding company controlling the converted mutual assessment company or association if, after August 31, 1989:

(1) there is a change of control of at least 50 percent of the voting securities of the converted company or association; or

(2) if the converted mutual assessment company or association or holding company is not controlled by voting securities, there is a change of at least 50 percent of the ownership of the converted mutual assessment company or association or holding company.

(c) For the purpose of Subsection (b) of this section, a transfer of ownership that occurs because of death, irrespective of whether the decedent died testate or intestate, may not be considered a change of control of a converted mutual assessment company or association or change of control of a holding company, if ownership is transferred solely to one or more natural persons, each of whom would be an heir of the decedent if the decedent had died intestate.

Revisor's Note

Section 3(b), V.T.I.C. Article 11.10, provides that a mutual assessment company that converts to a mutual life insurance company "may continue to transact the kind or kinds of insurance business for which it has been issued a Texas certificate of

authority." The revised law omits the quoted language because the company's certificate of authority is unchanged by the conversion and permits the company to transact only those kinds of business.

Revised Law

Sec. 882.655. APPLICABLE LAW AFTER CONVERSION. After a mutual assessment company or association is converted to a mutual life insurance company, the converted company is governed by this chapter. (V.T.I.C. Art. 11.02, Sec. 2 (part); Art. 11.10, Sec. 1 (part).)

Source Law

[Art. 11.02]

Sec. 2. . . . [the company . . . is possessed of a free surplus of not less than Two Hundred Thousand ($200,000.00) Dollars and that such surplus is in the custody of the officers either in cash or classes of investments as provided in Paragraph 5 of Article 11.01 of this Code] . . . . The foregoing requirement as to free surplus shall apply to mutual assessment companies or associations which may convert to mutual legal reserve companies under the provisions of Article 11.10 of the Insurance Code as amended. . . .

[Art. 11.10]

Sec. 1. . . . upon such conversion shall be subject to all of the provisions of Chapter 11 of this Code.

[Sections 882.656-882.700 reserved for expansion]

SUBCHAPTER O. ENFORCEMENT PROVISIONS

Revised Law

Sec. 882.701. APPLICABILITY OF SUBCHAPTER. This subchapter does not apply to a mutual life insurance company organized under this chapter that has a surplus of at least the minimum amount of capital and surplus required of a capital stock company under Sections 841.054, 841.204, 841.205, 841.301, and 841.302. (New.)

Revisor's Note

Section 882.701 is added to the revised law to clarify the applicability of this subchapter. See Revisor's Note (3) to Section 882.001.

Revised Law

Sec. 882.702. INVESTMENT AND DEPOSIT OF FUNDS; CRIMINAL PENALTY. (a) A person commits an offense if the person is an officer or director of a mutual life insurance company and the person knowingly or wilfully violates or assents to the violation of Section 882.252.

(b) An offense under this section is punishable by imprisonment in the institutional division of the Texas Department of Criminal Justice for a term of not more than five years or less than one year. (V.T.I.C. Art. 11.18-1 (part).)

Source Law

> Art. 11.18-1. [Mutual life insurance companies shall invest their funds in accordance with the provisions of the statutes concerning investments of life insurance companies in this State; all moneys of mutual life companies, coming into the hands of any officer or officers thereof, when not invested as prescribed by said laws, shall be deposited in the name of such company or companies in some bank or banks which are subject to either State or national regulation and supervision, and which have been approved by the Commissioner of Insurance as depositories therefor.] Any officer or director of any such company who shall knowingly and wilfully violate or assent to the violation of the provisions of this article shall be imprisoned in the penitentiary not less than one nor more than five years.

Revised Law

Sec. 882.703. POLICY FORM; REVOCATION OF CERTIFICATE. The department shall revoke the certificate of authority of a mutual life insurance company that issues a policy on a form that has not been approved by the department as required by Section 882.453. (V.T.I.C. Art. 11.13 (part).)

Source Law

> Art. 11.13. . . . [the form of all policies issued by any such company shall be approved by the Board of Insurance Commissioners] . . . the Board shall revoke the certificate of authority of any such company which shall issue any policy except upon such form so approved. . . .

Revisor's Note

(End of Chapter)

V.T.I.C. Article 11.13 provides that "[m]utual life insurance companies are authorized to transact business throughout this State and in other states to which they may be admitted." The revised law omits the quoted language as unnecessary because a company's certificate of authority issued by the Texas Department of Insurance provides sufficient authority for the company to engage in the business of insurance in this state. Similarly, an authorization from another state provides sufficient authority in that state. The omitted law reads:

Art. 11.13. Mutual life insurance companies are authorized to transact business throughout this State and in other states to which they may be admitted; . . . .

CHAPTER 883. MUTUAL INSURANCE COMPANIES OTHER THAN MUTUAL LIFE INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 883.004-883.050 reserved for expansion]

SUBCHAPTER B. FORMATION, STRUCTURE, AND MANAGEMENT OF COMPANY

[Sections 883.059-883.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS IN THIS STATE

[Sections 883.104-883.150 reserved for expansion]

CHAPTER 883. MUTUAL INSURANCE COMPANIES OTHER THAN MUTUAL LIFE INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 883.001. DEFINITIONS. In this chapter:

(1) "Domestic mutual insurance company" means a mutual insurance company organized under this chapter.

(2) "Foreign mutual insurance company" means a mutual insurance company organized under the laws of a jurisdiction other than this state and authorized to engage in the business of insurance on a mutual plan in any state, district, or territory. (V.T.I.C. Arts. 15.14 (part); 15.15 (part); New.)

Source Law

Art. 15.14. Any such mutual insurance company organized outside of this State and

authorized to transact the business of insurance on the mutual plan in any state, district or territory, ...

Art.15.15. Every such mutual insurance company . . . organized within . . . the state . . . .

Revisor's Note

The definitions of "domestic mutual insurance company" and "foreign mutual insurance company" are added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

Revised Law

Sec. 883.002. APPLICABILITY OF CERTAIN GENERAL LAWS. (a) Except as otherwise provided by law, domestic and foreign mutual insurance companies organized or operating under this chapter are subject to the laws applicable to:

(1) a stock insurance company engaging in the same kind of insurance;

(2) investments;

(3) valued policies;

(4) policy forms and rates;

(5) reciprocal or retaliatory laws;

(6) insolvency and liquidation; and

(7) publication and defamatory statements.

(b) This chapter does not exempt a domestic mutual insurance company from being subject to other laws of this state governing the incorporation, organization, regulation, and operation of a company or organization writing insurance in this state. (V.T.I.C. Arts. 15.15 (part), 15.16.)

Source Law

Art. 15.15. Every such mutual insurance company, whether organized within or without the state, shall be subject, except as otherwise provided by law, to all general provisions of law applicable to stock insurance companies transacting the same kinds of insurance, investments, valued policies, policy forms and rates, reciprocal or retaliatory laws, insolvency and liquidation, publication and defamatory statements, and . . . .

Art. 15.16. Nothing in this chapter shall be construed to mean that any company or association incorporated or organized

hereunder shall be exempt from the provisions of the General Laws of this State, heretofore or hereafter enacted governing the incorporation, organization, regulation and operation of companies or organizations writing insurance in this State.

Revised Law

Sec. 883.003. APPLICABILITY OF TEXAS NON-PROFIT CORPORATION ACT. Except to the extent of any conflict with this code, the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) applies to a domestic mutual insurance company. The commissioner has each power and duty of, and shall perform each act to be performed by, the secretary of state under that Act with respect to mutual insurance companies. (V.T.I.C. Art. 15.05-A (part).)

Source Law

Art. 15.05-A. Insofar as the provisions of the Texas Non-Profit Corporation Act, as amended (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), are not inconsistent with or contrary to any applicable provisions of the Insurance Code, as amended, the provisions of the Texas Non-Profit Corporation Act as amended (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), shall apply to and govern mutual insurance companies as defined in Article 15.01 of this chapter. Provided however, . . . wherever in the Texas Non-Profit Corporation Act, as amended (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes), some duty, responsibility, power, authority, or act is vested in, required of, or to be performed by the secretary of state, such is to be vested in, required of, or performed by the Commissioner of Insurance insofar as such mutual insurance companies are concerned.

Revisor's Note

(1) V.T.I.C. Article 15.05-A states that the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes) shall "apply to and govern" mutual insurance companies. The revised law omits the reference to "govern" because, in context, "govern" is included within the

meaning of "apply to."

(2) V.T.I.C. Article 15.05-A refers to the Insurance Code "as amended" and to the provisions of the Texas Non-Profit Corporation Act "as amended." The revised law omits these quoted references 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.

(3) V.T.I.C. Article 15.05-A refers to a "duty, responsibility, power, [or] authority" of the secretary of state and commissioner of insurance. The revised law substitutes "power and duty" for the quoted phrase because "responsibility" is included within the meaning of "duty" and "authority" is included within the meaning of "power."

(4) V.T.I.C. Article 15.05-A refers to acts "vested in, required of, or to be performed by" the secretary of state and commissioner of insurance. The revised law omits the references to "vested in" and "required of" because, in context, these phrases are included within the meaning of the phrase "to be performed by."

[Sections 883.004-883.050 reserved for expansion]

SUBCHAPTER B. FORMATION, STRUCTURE, AND MANAGEMENT OF COMPANY

Revised Law

Sec. 883.051. FORMATION OF COMPANY. (a) Twenty or more persons, a majority of whom are residents of this state, may incorporate in accordance with this chapter to engage in the business of mutual insurance as provided by this chapter.

(b) To form a mutual insurance company, each incorporator must sign and acknowledge the articles of incorporation of the company.

(c) The incorporators of a proposed mutual insurance company are subject to Sections 822.001, 822.051, 822.057(a)(1)-(3), (b), and (c), 822.058(a), 822.059, 822.060, and 822.201, except that:

(1) the minimum number of persons required to adopt and sign the proposed company's articles of incorporation under Section 822.051 is equal to the number of the proposed company's incorporators as provided by Subsection (a); and

(2) the unencumbered surplus of the mutual insurance company is capital structure for purposes of Section 822.201.

(V.T.I.C. Arts. 15.01, 15.02 (part), 15.04.)

Source Law

Art. 15.01. Any number of persons not less than twenty (20), a majority of whom shall be bona fide residents of this State, by complying with the provisions of this chapter, may become, together with others who may hereafter be associated with them or their successors, a body corporate for the purpose of carrying on the business of mutual insurance as herein provided.

Art. 15.02. Any person proposing to form any such company shall subscribe and acknowledge articles of incorporation . . . .

Art. 15.04. Applicants for such Articles of Incorporation shall comply with and be subject to the provisions of Article 2.01 of this Code except:

1. The minimum number of persons adopting and signing such Articles of Incorporation shall be governed by Article 15.01 of this Chapter; and

2. Free surplus shall constitute capital structure within the meaning of Article 2.01.

Revisor's Note

V.T.I.C. Article 15.01 refers to the formation of a mutual insurance company by the incorporators of those companies and to "others who may hereafter be associated with them or their successors." The revised law omits the quoted language as unnecessary because, in context, it does not add to the clear meaning of the law. "Incorporators" is the term used to describe the individuals who form a company. The individuals referred to in the quoted language are not involved with the formation of the company but become members of a mutual insurance company together with the incorporation after the company has been incorporated under this chapter.

Revised Law

Sec. 883.052. ARTICLES OF INCORPORATION. Articles of incorporation of a proposed mutual insurance company must

specify:

(1) the name of the company;

(2) the purpose for which the company is being formed;

(3) the location of the company's principal or home office;

(4) the name and place of residence of each incorporator; and

(5) the name and address of each member of the initial board of directors. (V.T.I.C. Art. 15.02 (part).)

Source Law

Art. 15.02. [Any person proposing to form any such company shall subscribe and acknowledge articles of incorporation] specifying:

(a) The name, the purpose for which formed, and the location of its principal or home office, . . .;

(b) The names and addresses of those composing the board of directors . . .;

(c) The names of places of residence of the incorporators.

Revisor's Note

V.T.I.C. Article 15.02 refers to the "names of places of residence of the incorporators." Names "of" places of residence, in context, is clearly a typographical error. Accordingly, the revised law substitutes "name and place of residence" for "names of places of residence."

Revised Law

Sec. 883.053. COMPANY'S NAME. (a) The name of a mutual insurance company must contain the word "mutual."

(b) A mutual insurance company's name may not be so similar to the name of any other mutual insurance company organized or engaging in business in the United States, that it is confusing or misleading. (V.T.I.C. Art. 15.03.)

Source Law

Art. 15.03. No name shall be adopted by such company which does not contain the word "mutual," or which is so similar to any name already in use by any such existing corporation, company or association, organized or doing business in the United States, as to be confusing or misleading.

Revised Law

Sec. 883.054. LOCATION OF PRINCIPAL OR HOME OFFICE. The principal or home office of a mutual insurance company must be located in this state. (V.T.I.C. Art. 15.02 (part).)

Source Law

> Art. 15.02. . . .
>
> (a) . . . the location of its principal or home office which shall be within this State . . . .

Revised Law

Sec. 883.055. BEGINNING OF CORPORATE EXISTENCE. The corporate existence of a mutual insurance company begins on the date on which the commissioner issues a certificate of authority to the company. (V.T.I.C. Art. 15.05 (part).)

Source Law

> Art. 15.05. The company shall have legal existence from and after the date of issuance of said certificate. . . .

Revised Law

Sec. 883.056. BOARD OF DIRECTORS. (a) The board of directors named in a mutual insurance company's articles of incorporation shall manage the company until the initial meeting of the members of the company.

(b) After a mutual insurance company is issued a certificate of authority, the company's board of directors may:

(1) adopt bylaws;

(2) accept applications for insurance; and

(3) transact the business of the company. (V.T.I.C. Arts. 15.02 (part), 15.05 (part).)

Source Law

> Art. 15.02. . . .
>
> . . .
>
> (b) [The names and addresses of those composing the board of directors] in which management shall be vested until the first meeting of members . . . .
>
> Art. 15.05. [The company shall have legal existence from and after the date of issuance of said certificate.] . . . The Board of Directors named in such articles may thereupon adopt by-laws, accept applications for insurance, and proceed to transact the

business of such company; provided, that . . . .

Revised Law

Sec. 883.057. MEMBERSHIP OF PUBLIC OR PRIVATE ENTITIES IN COMPANY AUTHORIZED. (a) Any public or private corporation, board, association, or estate may make an application for, enter into an agreement for, or hold a policy in a mutual insurance company. An officer, shareholder, trustee, or legal representative may act on behalf of the entity for that participation.

(b) An officer, shareholder, trustee, or legal representative of a public or private entity described by Subsection (a) may not be held personally liable on a contract of insurance executed by the person in the person's capacity as a representative of the entity under Subsection (a).

(c) The right of a corporation organized under the laws of this state to participate as a member of a mutual insurance company is:

(1) incidental to the purpose for which the corporation was organized; and

(2) in addition to the corporate rights or powers expressly conferred in the corporation's articles of incorporation. (V.T.I.C. Art. 15.09.)

Source Law

Art. 15.09. Any public or private corporation, board or association in this State or elsewhere may make application, enter into agreements for and hold policies in any such mutual insurance company. Any officer, stockholder, trustee or legal representative of any such corporation, board, association or estate may be recognized as acting for or on its behalf for the purpose of such membership, but shall not be personally liable upon such contract of insurance by reason of acting in such representative capacity. The right of any corporation organized under the laws of this State to participate as a member of any such mutual insurance company is hereby declared to be incidental to the purpose for which such corporation is organized and as much granted as the rights and powers expressly conferred.

Revised Law

Sec. 883.058. MEMBERSHIP VOTES. Each member of a mutual insurance company is entitled to one vote on each matter submitted to a vote unless a different number of votes is authorized by the company's bylaws based on:

(1) the insurance in force;

(2) the number of policies held by the member; or

(3) the amount of the premium paid by the member.

(V.T.I.C. Art. 15.10.)

Source Law

Art. 15.10. Every member of the company shall be entitled to one vote, or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premium paid, as may be provided in the by-laws.

Revisor's Note

(End of Subchapter)

V.T.I.C. Article 15.08, as amended by Chapter 117, Acts of the 54th Legislature, Regular Session, 1955, refers to renewal of a certificate of authority under V.T.I.C. Article 2.20. The revised law omits this provision as repealed. Under Section 1, V.T.I.C. Article 1.14, revised in pertinent part as Section 801.053, a certificate of authority is valid until it is suspended or revoked. Section 2, Chapter 194, Acts of the 56th Legislature, Regular Session, 1959, amending Article 1.14, repealed "[a]ll laws and parts of laws in conflict herewith . . . to the extent that they require periodic renewal of certificates of authority." Article 2.20 was amended to remove all references to renewal of certificates of authority by Chapter 585, Acts of the 68th Legislature, Regular Session, 1983. The omitted law reads:

Art. 15.08. . . . The provisions of Article 2.20 of this Code shall apply to all renewal Certificates of Authority.

[Sections 883.059-883.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS IN THIS STATE

Revised Law

Sec. 883.101. MUTUAL INSURANCE BUSINESS. Mutual insurance of any kind may not be written in this state except as authorized by this chapter or any other law. (V.T.I.C. Art. 15.20.)

Source Law

Art. 15.20. No sort of mutual insurance, other than life insurance, may be conducted in this State, except under the provisions of this law, or under some law remaining on the statutes authorizing the same.

Revisor's Note

V.T.I.C. Article 15.20 states that "[n]o sort of mutual insurance, other than life insurance" may be conducted in this state except as provided by specified law. The revised law omits the reference to "other than life insurance" as misleading because it implies that mutual life insurance may be written without complying with law. V.T.I.C. Chapter 11, revised in this code as Chapter 882, as well as other provisions of this code, apply to the writing of mutual life insurance.

Revised Law

Sec. 883.102. CHARTER AND CERTIFICATE OF AUTHORITY REQUIRED. A domestic mutual insurance company may not engage in the business of insurance until:

(1) the company obtains a charter as provided by Chapter 822; and

(2) the commissioner issues to the company a certificate of authority for that purpose. (V.T.I.C. Arts. 15.05 (part), 15.08 (part).)

Source Law

Art. 15.05. . . . no insurance shall be put into force until the company has been licensed to transact insurance as provided by this chapter.

Art. 15.08. No company organized under this Chapter shall issue policies or transact any business of insurance unless and until its charter is granted as provided in this

Code and unless and until the Board has, by issuance of Certificate of Authority, authorized it to do so. . . .

Revisor's Note

(1) V.T.I.C. Article 15.05 provides that "no insurance shall be put into force until the company has been licensed to transact insurance as provided by this chapter." The revised law omits the reference to "no insurance shall be put into force" because it is included within the meaning of "engaging in the business of insurance." Also, the revised law substitutes "authorized" for "licensed" and "certificate of authority" for "license" throughout this chapter because "certificate of authority" is the term used throughout this code in relation to an entity's authority to engage in business.

(2) V.T.I.C. Article 15.08 refers to a charter that is granted to a mutual insurance company "as provided in this code." The revised law substitutes a reference to Chapter 2, Insurance Code, revised as Chapter 822, because that is the provision of this code that contains the requirements a mutual insurance company must satisfy to obtain a charter.

(3) V.T.I.C. Article 15.08 provides that the authority of a mutual insurance company to engage in business in this state is contingent on the issuance of a charter and a certificate of authority by 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. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the "State Board of Insurance" have been changed to "commissioner" and "department,"

appropriately.

Revised Law

Sec. 883.103. AUTHORIZATION OF FOREIGN MUTUAL INSURANCE COMPANY TO ENGAGE IN BUSINESS. (a) The department shall authorize a foreign mutual insurance company to write the kinds of insurance authorized by the company's charter or articles of incorporation in this state if the company:

(1) is solvent as determined under this chapter;

(2) files with the department:

(A) a copy of the company's bylaws certified by the company's secretary; and

(B) a certified copy of the company's charter or articles of incorporation;

(3) appoints the commissioner as the company's agent for service of process as provided by Chapter 804;

(4) files a financial statement under oath in a form as required by the department; and

(5) complies with legal requirements applicable to the filing of documents and the furnishing of information by a stock insurance company that files an application with the department for authority to transact the same kind of insurance as the company.

(b) A foreign mutual insurance company's name may not be so similar to a name of a mutual insurance company or foreign mutual insurance company organized or authorized to engage in business in this state that it is confusing or misleading.

(c) A foreign mutual insurance company authorized to engage in the business of insurance under this section has, to the same extent, all of the powers granted to and privileges of a mutual insurance company organized and operating under this chapter. (V.T.I.C. Art. 15.14 (part).)

Source Law

Art. 15.14. [Any such mutual insurance company organized outside of this State and authorized to transact the business of insurance on the mutual plan in any state, district or territory,] shall be admitted and licensed to transact the kinds of insurance authorized by its charter or articles to the extent and with the powers and privileges specified in this chapter when it shall be solvent under this chapter, and shall have complied with the following requirements:

(a) Filed with the State Board of Insurance a copy of its by-laws certified to by its secretary;

(b) Filed with the said Board a

certified copy of its charter or articles of incorporation;

(c) Appointed the Commissioner of Insurance its agent for the service of process as provided by Article 1.36 of this code;

(d) Filed a financial statement under oath, in such form as the Board may require, and have complied with the other provisions of law applicable to the filing of papers and furnishing information by stock companies on application for authority to transact the same kind of insurance;

(e) Its name shall not be so similar to any name already in use by any such existing corporation, company or association organized or licensed in this State as to be confusing or misleading.

[Sections 883.104-883.150 reserved for expansion]

SUBCHAPTER D. POWERS, DUTIES, AND OPERATION OF COMPANY

Revised Law

Sec. 883.151. AUTHORITY TO WRITE CERTAIN INSURANCE. A domestic mutual insurance company may write any kind of insurance that may be lawfully written in this state, other than life insurance. (V.T.I.C. Art. 15.06 (part).)

Source Law

Art. 15.06. Any company organized under the provisions of this Chapter is empowered and authorized to write any kinds of insurance, which may lawfully be written in Texas, except life insurance. . . .

Revised Law

Sec. 883.152. PRIOR AUTHORITY NOT AFFECTED. This chapter does not affect any authority that existed before September 6, 1955, that allowed mutual insurance companies to write non-assessable policies in this state, subject to any prerequisite imposed by law on that authority. (V.T.I.C. Art. 15.11 (part).)

Source Law

Art. 15.11. . . . If up to the time of the effectiveness of this Act a mutual insurance company was authorized to write non-assessable policies in Texas under the

provisions of this Code, such mutual company shall not be denied such authority by reason of provisions which are contained herein that were not contained in this Insurance Code immediately prior to the effective date of this Act, so long as such company is complying with Article 2.20 of this Code as added by this Act.

Revisor's Note

V.T.I.C. Article 15.11 provides in relevant part that mutual insurance companies authorized to write non-assessable policies "up to the time of the effectiveness of this Act" are not denied that authority "by reason of provisions which are contained herein" that were not part of the Insurance Code "immediately prior to the effective date of this Act" if the companies are in compliance with Article 2.20 "as added by this Act."

The "Act" to which Article 15.11 refers is Chapter 117, Acts of the 54th Legislature, Regular Session, 1955, effective September 6, 1955. The reference to provisions "contained herein" refers to the requirements adopted under Article 15.11, as added by Chapter 117. Therefore, the companies are authorized to continue to write non-assessable policies, notwithstanding any conflicting requirements under Article 15.11, if the companies are in compliance with Article 2.20, as added by Chapter 117.

V.T.I.C. Article 2.20, as added by Chapter 117, imposed renewal requirements for a certificate of authority, based in part on compliance with certain minimum capital and surplus requirements. The requirement that a certificate of authority be renewed was repealed by Section 2, Chapter 194, Acts of the 56th Legislature, Regular Session, 1959. The minimum capital and surplus requirements imposed under Article 2.20 have been amended significantly several times since 1955.

It is unclear whether any mutual insurance company that was writing non-assessable policies in 1955 still exists. To the extent that V.T.I.C. Article 15.11 authorizes the continued writing of

non-assessable policies by those companies, the revised law preserves that authority.

Revised Law

Sec. 883.153. POLICY RATES. A mutual insurance company operating under this chapter shall charge the insurance rates prescribed by the commissioner and is subject to the same rate requirements as a domestic insurance company. (V.T.I.C. Art. 15.06 (part).)

Source Law

Art. 15.06. . . . Mutual insurance companies operating under the provisions of this Chapter shall be required to charge the rates prescribed by the Board of Insurance Commissioners and be subject to the same rates and [reserve] supervision that domestic insurance companies are subject to by law.

Revised Law

Sec. 883.154. MAXIMUM PREMIUMS. (a) The maximum premium of an insurance policy issued by a domestic mutual insurance company must be stated in the policy.

(b) A policy's maximum premium may consist only of:

(1) a cash premium; or

(2) a cash premium and a contingent premium in an amount equal to one additional cash premium. (V.T.I.C. Art. 15.11 (part).)

Source Law

Art. 15.11. The maximum premium shall be expressed in the policy of a mutual company organized under this Chapter, and it may be solely a cash premium or a cash premium and an additional contingent premium, which contingent premium shall be equal in amount to one (1) additional cash premium, but . . . .

Revised Law

Sec. 883.155. ISSUANCE OF POLICY FOR CASH PREMIUM ONLY. (a) A domestic mutual insurance company may not issue an insurance policy for a cash premium only unless:

(1) the company possesses surplus above all liabilities in an amount at least equal to the minimum capital and surplus required of a stock insurance company engaging in the same kinds of insurance;

(2) the company files with the department:

(A) an application for the issuance of this type of policy; and

(B) a certified copy of the resolution of the company's board of directors authorizing the issuance; and

(3) the commissioner approves the documents filed under Subdivision (2).

(b) A mutual insurance company that issues a policy for a cash premium only may waive all contingent premiums in any outstanding policies.

(c) A foreign mutual insurance company authorized to engage in the business of insurance in this state may issue an insurance policy for a cash premium only and may waive contingent premiums on any of its outstanding policies in the same manner and subject to the same requirements as a mutual insurance company under this section that is engaged in the same kinds of insurance.
(V.T.I.C. Art. 15.11 (part).)

Source Law

> Art. 15.11. . . . no such company shall issue an insurance policy for a cash premium and without an additional contingent premium until and unless it possesses a surplus above all liabilities of a sum at least equal to the minimum capital and surplus required of a stock insurance company transacting the same kinds of business.
>
> When any company shall issue policies for cash premiums only, in pursuance of the authority of this Article, it may waive all contingent premiums set forth in policies then outstanding. The issuance of policies for cash premiums only in pursuance of this Article may not be exercised by any such company until written notice of its intention so to do accompanied by a certified copy of the resolution of the Board of Directors providing for the issuance of such policies shall have been filed with and approved by the Board. . . .
>
> A foreign mutual insurance company authorized to do business in Texas may issue an insurance policy for a cash premium and without an additional contingent premium and may waive contingent premiums on outstanding policies under the same conditions and subject to the same restrictions and provisions as a mutual insurance company organized under this Code and doing the same

kinds of business. . . .

Revised Law

Sec. 883.156. ASSESSMENT ON POLICYHOLDERS. (a) A policyholder is not liable for an assessment imposed on a policy issued by a mutual insurance company with approval of the commissioner under Section 883.155(a).

(b) An assessment may not be imposed on the holder of a policy described by Section 883.155(a) by:

(1) the officers or directors of a mutual insurance company;

(2) the department;

(3) a receiver; or

(4) a liquidator. (V.T.I.C. Art. 15.11 (part).)

Source Law

> Art. 15.11. . . . Policyholders of a mutual insurer shall at no time be liable for assessment on policies issued at a time when such approval by the Board is in effect. Neither the officers nor directors of any such mutual insurer, the Board of Insurance Commissioners, nor any receiver or liquidator shall have authority to levy assessments upon the holders of such policies. . . .

Revised Law

Sec. 883.157. REINSURANCE OF POLICY. (a) Subject to Subsection (c), a mutual insurance company authorized to engage in the business of insurance in this state may enter into an agreement with an insurer to cede to or accept from the insurer all or part of an insurance risk.

(b) A reinsurance agreement under this section does not create or confer contingent liability, participation, or membership unless otherwise provided by the agreement.

(c) A mutual insurance company may not enter into an agreement with a reinsurer that has been disapproved for that purpose by written order of the commissioner filed in the department's offices. (V.T.I.C. Art. 15.17.)

Source Law

> Art. 15.17. Any such mutual insurance company organized or admitted to transact insurance in this State may by policy, treaty or other agreement cede to or accept from any insurance company or insurer reinsurance upon the whole or any part of any risk which reinsurance shall be without contingent

liability or participation or membership unless the contract provides otherwise and shall not be effected with any company or insurer disapproved therefor by written order of the Board of Insurance Commissioners filed in its office.

Revisor's Note

(1) V.T.I.C. Article 15.17 refers to a "policy, treaty or other agreement" and a "contract." The revised law substitutes "agreement" for the quoted term and language because a "policy," "treaty," and "contract" are all types of agreements.

(2) V.T.I.C. Article 15.17 refers to an "insurance company or insurer." The revised law omits the reference to "insurance company" because "insurance company" is included within the meaning of "insurer."

Revised Law

Sec. 883.158. REQUIREMENTS FOR COMPANIES WRITING BONDS. A mutual insurance company qualifying to write bonds under this chapter is subject to the same legal requirements as any other insurance company writing bonds under this chapter. (V.T.I.C. Art. 15.07.)

Source Law

Art. 15.07. Any mutual insurance company qualifying to write bonds under this chapter shall meet the same legal requirements as all other insurance companies who are writing bonds under this chapter.

Revisor's Note

V.T.I.C. Article 15.07 provides that a mutual insurance company qualifying to write bonds under this chapter must meet the same legal requirements as "other insurance companies" who are writing bonds under this "chapter." Because Chapter 15, Insurance Code, only applies to mutual insurance companies other than life, the legislature probably intended to refer to the legal requirements of other insurance companies writing bonds under this "code" or another specific provision of this code. A review of the legislative history of V.T.I.C. Article 15.07 offers no insight in clarifying the

legislature's intent. Consequently, the revised law is drafted in a manner that preserves the ambiguity of the source law.

Revised Law

Sec. 883.159. NECESSARY OR INCIDENTAL POWERS. A domestic mutual insurance company has such powers as are necessary or incidental to the transaction of its business. (V.T.I.C. Art. 15.05 (part).)

Source Law

Art. 15.05. . . . The company shall have such powers as are necessary or incident to the transaction of its business. . . .

Revised Law

Sec. 883.160. RIGHTS AND PRIVILEGES OF CERTAIN COMPANIES RETAINED. A mutual insurance company engaged in business under Chapters 5, 9, 12, 13, 14, and 15, Title 78, Revised Statutes, before their repeal by Section 18, Chapter 40, Acts of the 41st Legislature, 1st Called Session, 1929, as amended by Section 1, Chapter 60, Acts of the 41st Legislature, 2nd Called Session, 1929, retains the rights and privileges under the repealed law to the extent provided by those sections. (V.T.I.C. Art. 15.19.)

Source Law

Art. 15.19. Rights and privileges of companies affected by the repeal of Chapters 5, 9, 12, 13, 14 and 15 of Title 78 of the Revised Civil Statutes of 1925, shall remain in effect to the extent set out in the Acts 1929, 41st Legislature, 1st Called Session, page 90, Chapter 40, Section 18 as amended Acts 1929, 41st Legislature, 2nd Called Session, page 99, Chapter 60, Section 1.

Revised Law

Sec. 883.161. DIVIDENDS. On advance approval of the commissioner, a mutual insurance company may pay dividends to its members. (V.T.I.C. Art. 15.05-A (part).)

Source Law

Art. 15.05-A. . . . any such mutual insurance company may upon advance approval of the Commissioner of Insurance pay dividends to its members, and . . . .

Revised Law

Sec. 883.162. LOANS TO COMPANY. (a) A person, including a

director, officer, or member of a mutual insurance company, may loan to the company money necessary:

(1) for the company to engage in the company's business; or

(2) to enable the company to comply with a legal requirement.

(b) The mutual insurance company may repay a loan and agreed interest, at an annual rate not to exceed 20 percent, only from the surplus remaining after the company provides for the company's reserves, other liabilities, and required surplus.

(c) A loan under this section or interest on a loan is not otherwise a liability or claim against the company or any of its assets.

(d) A mutual insurance company may not pay a commission or promotion expense in connection with a loan made to the company.

(e) A mutual insurance company shall report in its annual statement the amount of each loan made to the company. (V.T.I.C. Art. 15.12.)

Source Law

> Art. 15.12. Any director, officer or member of such company, or any other person, may advance to such company, any sum or sums of money necessary for the purpose of its business or to enable it to comply with any requirements of the law and such moneys and interest thereon as may have been agreed upon, not exceeding twenty (20%) per cent per annum shall be payable only out of the surplus remaining after providing for all reserve, other liabilities and lawful surplus, and shall not otherwise be a liability or claim against the company or any of its assets. No commission or promotion expenses shall be paid in connection with the advance of any such money to the company, and the amount of such advances shall be reported in each annual statement.

Revised Law

Sec. 883.163. IMMEDIATE NOTIFICATION WHEN ASSETS ARE INSUFFICIENT; EXAMINATION. The president and the secretary of a mutual insurance company operating under the law providing for the incorporation of mutual fire, lightning, hail, and storm insurance companies shall immediately notify the commissioner any time the admitted assets of the company are less than the largest single risk for which the company is liable. The commissioner may make an examination into the affairs of the company as the

commissioner considers best. (V.T.I.C. Art. 15.19-1 (part).)

Source Law

> Art. 15.19-1. If at any time the admitted assets of any mutual company operating under the law providing for the incorporation of mutual fire, lightning, hail and storm insurance companies, shall come to be less than the largest single risk for which the company is liable, then the president and the secretary of the company shall at once notify the Commissioner of Insurance, and he may make an examination into the company's affairs if he deems best, and . . . .

[Sections 883.164-883.200 reserved for expansion]

SUBCHAPTER E. REGULATION OF COMPANY

Revised Law

Sec. 883.201. SURPLUS REQUIREMENTS. A domestic mutual insurance company must possess a surplus over and above all liabilities in an amount equal to the minimum capital stock and surplus required of a stock insurance company engaged in the same kinds of insurance. (V.T.I.C. Art. 15.06 (part).)

Source Law

> Art. 15.06. . . . Any such company shall be possessed of a surplus over and above all of its liabilities equal to the minimum capital stock and surplus required of a stock insurance company transacting the same kinds of business. . . .

Revised Law

Sec. 883.202. REQUIRED DEPOSIT FOR COMPANIES WRITING BONDS. (a) A domestic mutual insurance company that writes fidelity and surety bond coverage shall maintain on deposit with the comptroller cash or securities of the kind described by Article 2.10 in an amount equal to the amount of cash or securities required of a domestic stock insurance company.

(b) The commissioner must approve for deposit the cash or securities required by this section. (V.T.I.C. Art. 15.06 (part).)

Source Law

> Art. 15.06. . . . Any such company writing fidelity and surety bonds shall keep

on deposit with the comptroller cash or securities as provided in Article 2.10 approved by the Board equal in amount to that required of domestic stock companies. . . .

Revised Law

Sec. 883.203. RESERVES. (a) A domestic mutual insurance company shall maintain unearned premiums and other reserves separately for each kind of insurance. The reserves must be maintained on the same basis as those reserves are required to be maintained by a domestic stock insurance company engaging in the same kinds of insurance.

(b) A mutual insurance company operating under this chapter is subject to the same reserve requirements as a domestic insurance company under law. (V.T.I.C. Arts. 15.06 (part), 15.13.)

Source Law

Art. 15.06. . . . Mutual insurance companies operating under the provisions of this Chapter shall . . . be subject to the same . . . reserve supervision that domestic insurance companies are subject to by law.

Art. 15.13. Such company shall maintain unearned premium and other reserves separately for each kind of insurance, upon the same basis as that required of domestic stock insurance companies transacting the same kind of insurance.

Revised Law

Sec. 883.204. ANNUAL REPORT. (a) Domestic and foreign mutual insurance companies organized or operating under this chapter shall submit to the commissioner an annual report in the form required by the commissioner.

(b) To the extent practicable, the commissioner shall adopt a form that is similar to a form that is generally used for submission of the annual report throughout the United States. (V.T.I.C. Art. 15.15 (part).)

Source Law

Art. 15.15. Every such mutual insurance company, whether organized within or without the state . . . shall make its annual report in such form and . . . as may be required by the Board. As far as practicable . . . the forms of annual report shall be such as are

in general use throughout the United States.

Revised Law

Sec. 883.205. EXAMINATION OF FOREIGN MUTUAL INSURANCE COMPANY. To the extent practicable, an examination of a foreign mutual insurance company must be conducted in cooperation with the insurance departments of other states in which the foreign company is authorized to transact business. (V.T.I.C. Art. 15.15 (part).)

Source Law

Art. 15.15. . . . As far as practicable such examinations of mutual insurance companies organized outside of this State shall be made in cooperation with the insurance departments of other states and . . . .

Revisor's Note

V.T.I.C. Article 15.15 permits the commissioner of insurance to examine domestic and foreign mutual insurance companies. The revised law omits this provision for the reason stated in the revisor's note to Section 883.163. The omitted law reads:

Art. 15.15. Every such mutual insurance company, whether organized within or without the state . . . shall . . . submit to such examination and furnish such information as may be required by the Board. . . .

Revised Law

Sec. 883.206. FEES. Each domestic or foreign mutual insurance company organized or operating under this chapter is subject to a fee imposed by law on a stock insurance company engaging in the same kinds of insurance. (V.T.I.C. Art. 15.18 (part).)

Source Law

Art. 15.18. Every such company, whether organized within or without this State shall be subject to such fees as are now provided by law for stock companies doing the same kind of business and . . . .

Revised Law

Sec. 883.207. PREMIUM TAX. Each domestic or foreign mutual insurance company organized or operating under this chapter is

subject to taxes imposed by law on that company. The company shall pay the tax on the gross premiums received for direct insurance written on property or risks located in this state. The tax payable must be computed on the portion of the gross premiums remaining after deducting:

(1) premiums charged on policies not taken;

(2) premiums returned on canceled policies; and

(3) any refund or other return made to the policyholders other than for the incurrence of a loss. (V.T.I.C. Art. 15.18 (part).)

Source Law

> Art. 15.18. [Every such company, whether organized within or without this State shall be subject] . . . to such taxes as may be provided by law for such mutual companies. The tax shall be paid upon the gross premiums received for direct insurance upon property or risks located in this State, deducting premiums upon policies not taken, premiums returned on cancelled policies and any refund or return made to the policyholders other than for losses.

[Sections 883.208-883.700 reserved for expansion]

SUBCHAPTER O. CRIMINAL PENALTIES

Revised Law

Sec. 883.701. VIOLATION OF CHAPTER. (a) Except as otherwise provided by this subchapter, a person or corporation commits an offense if the person or corporation violates this chapter.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than $50 or more than $500. (V.T.I.C. Art. 15.21.)

Source Law

> Art. 15.21. Any person or corporation violating the provisions of this Act shall be guilty of a misdemeanor, and upon conviction shall be punished by a fine of not less than Fifty ($50.00) Dollars nor more than Five Hundred ($500.00) Dollars.

Revised Law

Sec. 883.702. FAILURE TO REPORT CONDITION. (a) A person commits an offense if the person is a president or secretary described by Section 883.163 and the person fails to make the

report required by that section.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than $100 or more than $500. (V.T.I.C. Art. 15.19-1 (part).)

Source Law

> Art. 15.19-1. . . . if such president and secretary shall fail to report the company's condition as so required, they shall each be fined not less than one hundred nor more than five hundred dollars.

Revisor's Note

> V.T.I.C. Article 15.19-1 states that a person who violates that article is punishable by a fine not to exceed $500. The revised law adds a statement that the punishment imposed under that article is an "offense" because the article was transferred from Vernon's Annotated Penal Code Article 601 by authority of Chapter 399, Acts of the 63rd Legislature, Regular Session, 1973, which enacted the Texas Penal Code. A criminal penalty is described as an "offense" by the Penal Code. The revised law also adds that the offense is a "misdemeanor" to conform to the way offenses punishable by a fine are described by the Penal Code.

Revised Law

Sec. 883.703. FALSE STATEMENT OR MISAPPROPRIATION. (a) A person commits an offense if the person intentionally submits a false statement or misappropriates the funds of a mutual insurance company organized under the laws providing for the incorporation of mutual fire, lightning, hail, and storm insurance companies.

(b) An offense under this section is a felony punishable by confinement in the institutional division of the Texas Department of Criminal Justice for not less than 5 years or more than 10 years. (V.T.I.C. Art. 15.19-2.)

Source Law

> Art. 15.19-2. Whoever shall intentionally submit a false statement, or intentionally misappropriate the funds of mutual companies organized under the laws providing for the incorporation of mutual fire, lightning, hail and storm insurance companies, shall be confined in the

penitentiary not less than five nor more than ten years.

Revisor's Note

(1) V.T.I.C. Article 15.19-2 refers to a "penitentiary." The revised law substitutes "institutional division of the Texas Department of Criminal Justice" for "penitentiary" to conform to the changes in law made by Chapter 785, Acts of the 71st Legislature, Regular Session, 1989, which transferred to that division the powers and duties that were previously those of the Texas Department of Corrections, the state agency with jurisdiction over penitentiaries in this state.

(2) V.T.I.C. Article 15.19-2 states that a person who violates that article is punishable by confinement. The revised law adds a statement that the punishment imposed under that article is an "offense" and that the offense is a "felony" to conform to the way offenses punishable by confinement are described by the Penal Code.

Revised Law

Sec. 883.704. UNAUTHORIZED MUTUAL FIRE INSURANCE. (a) A person commits an offense if the person engages in the business of mutual fire insurance in this state in violation of the laws regulating mutual fire insurance.

(b) An offense under this section is a misdemeanor punishable by a fine of not less than $50 or more than $500. (V.T.I.C. Art. 15.20-1.)

Source Law

Art. 15.20-1. Any person who shall transact the business of mutual fire insurance in this State without complying with the laws regulating such business shall be fined not less than fifty nor more than five hundred dollars.

Revisor's Note

V.T.I.C. Article 15.20-1 states that a person who violates that article is punishable by a fine not to exceed $500. The revised law adds a statement that the punishment imposed under that article is an "offense" and adds a reference to

"misdemeanor" for the reasons stated in the revisor's note to Section 883.702.

CHAPTER 884. STIPULATED PREMIUM INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

[Sections 884.004-884.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF STIPULATED PREMIUM INSURANCE COMPANY

[Sections 884.062-884.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

[Sections 884.104-884.150 reserved for expansion]

SUBCHAPTER D. MANAGEMENT OF STIPULATED PREMIUM COMPANY

[Sections 884.156-884.200 reserved for expansion]

SUBCHAPTER E. CAPITAL AND SURPLUS

[Sections 884.208-884.250 reserved for expansion]

CHAPTER 884. STIPULATED PREMIUM INSURANCE COMPANIES

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 884.001. DEFINITION. In this chapter, "stipulated premium company" means a:

(1) stipulated premium life insurance company;

(2) stipulated premium accident insurance company;

(3) stipulated premium life and accident insurance company;

(4) stipulated premium accident and health insurance company; or

(5) stipulated premium life, accident, and health insurance company. (V.T.I.C. Art. 22.01, Sec. 1 (part).)

Source Law

Art. 22.01

Sec. 1. . . . [citizens of this state may associate themselves for the purpose of forming] a stipulated premium life insurance company or a stipulated premium accident insurance company or a stipulated premium life and accident, health and accident, or life, health and accident insurance company.

Revised Law

Sec. 884.002. APPLICABILITY OF OTHER LAW TO COMPANY. (a) Except as expressly provided by this code, a provision of this code, other than this chapter, does not apply to a stipulated premium company organized under this chapter.

(b) A law enacted after August 28, 1961, does not apply to a stipulated premium company unless stipulated premium companies are expressly designated in the law.

(c) The following provisions of this code apply to a stipulated premium company:

(1) Article 1.15;

(2) Article 1.15A;

(3) Article 1.16;

(4) Article 1.19;

(5) Article 1.32;

(6) Article 3.10;

(7) Article 3.39;

(8) Article 3.40;

(9) Article 21.07-7;

(10) Article 21.21;

(11) Article 21.28;

(12) Article 21.32;
(13) Article 21.39;
(14) Article 21.47;
(15) Section 38.001;
(16) Sections 801.001-801.002;
(17) Sections 801.051-801.055;
(18) Section 801.057;
(19) Sections 801.101-801.102;
(20) Subchapter A, Chapter 821;
(21) Chapter 824;
(22) Chapter 828;
(23) Section 841.251;
(24) Section 841.259;
(25) Section 841.261; and
(26) Section 841.703.

(d) The Securities Act (Article 581-1 et seq., Vernon's Texas Civil Statutes) applies to a stipulated premium company.

(e) The Texas Business Corporation Act applies to a stipulated premium company to the extent that law is not inconsistent with an insurance law applicable to a stipulated premium company. The department shall perform a duty imposed by the Texas Business Corporation Act on the office of the secretary of state that is applicable to a stipulated premium company. (V.T.I.C. Art. 22.01, Sec. 2 (part); Art. 22.16; Art. 22.18, Secs. 1, 2.)

Source Law

[Art. 22.01]

Sec. 2. . . . no other insurance law of this state shall apply to any corporation chartered under this Chapter and no law hereafter enacted shall apply to stipulated premium companies unless they be expressly designated therein.

Art. 22.16. The Texas Business Corporation Act applies to and governs stipulated premium companies to the extent that that Act is not inconsistent with or contrary to this chapter or any other insurance law applicable to stipulated premium companies. A duty imposed by the Texas Business Corporation Act on the office of the secretary of state shall be performed by the department for the purposes of this chapter.

Art. 22.18

Sec. 1. The following Articles of this Code: Article 1.14, Article 1.15, Article 1.15A, Article 1.16, Article 1.19, Article 1.24, Article 1.32, Article 3.10, Article 3.13, Article 3.39, Article 3.40, Article 3.61, Article 3.63, Article 3.67, Article 21.07-7, Article 21.21, Article 21.25, Article 21.26, Article 21.28, Article 21.32, Article 21.39, Article 21.45, and Article 21.47, shall apply to and govern stipulated premium companies and each company shall comply with the provisions thereof.

Sec. 2. Stipulated premium companies shall be regulated by the Texas Securities Act, same being Acts 1957, 55th Legislature, pages 575 et seq., Chapter 269, and shall pay premium taxes in like manner, as a company chartered and doing business under the provisions of Chapter 3 of this Code.

Revisor's Note

(1) Section 2, V.T.I.C. Article 22.01, refers to a law "hereafter enacted." That provision of Section 2 was a part of the original enactment of Chapter 22, enacted by Chapter 180, Acts of the 57th Legislature, Regular Session, 1961, which took effect August 28, 1961. The revised law substitutes that date for the quoted language.

(2) Section 2, V.T.I.C. Article 22.18, provides that a stipulated premium company "shall pay premium taxes in like manner, as a company chartered and doing business under the provisions of Chapter 3 of this Code." Premium taxes for life, health, and accident carriers are governed by V.T.I.C. Article 4.11. Article 4.11 applies to a stipulated premium company by its terms, so the quoted phrase is omitted from the revised law as unnecessary.

Revised Law

Sec. 884.003. ADMITTED ASSETS. A stipulated premium insurer may include among its admitted assets a net asset under Section 841.004. (V.T.I.C. Art. 3.01, Sec. 10(d) (part).)

Source Law

(d) . . . stipulated premium companies, may include among their admitted

assets any asset herein designated as "net assets" . . . .

Revisor's Note

Section 10(d), V.T.I.C. Article 3.01, provides that a stipulated premium company may include certain net assets as an admitted asset. For the convenience of the reader, the revised law includes a reference to Section 841.004, which revises the portion of Section 10 that describes the net assets.

Revisor's Note

(End of Subchapter)

Section 2, V.T.I.C. Article 22.01, provides that Chapter 22, Insurance Code, applies to a stipulated premium company unless otherwise expressly provided by the Insurance Code. The revised law omits the provision because this chapter clearly applies by its own terms and the provision adds nothing. Currently, an exception to the application of Chapter 22 to a stipulated premium company does not exist. If the legislature enacts such an exception in the future, it will control by its own terms even without an expressed provision in this chapter of the revised law. The omitted provision reads:

Sec. 2. Every stipulated premium company incorporated or transacting business in this state shall be subject to the provisions of this Chapter 22, unless otherwise expressly provided by this Code and . . . .

[Sections 884.004-884.050 reserved for expansion]

SUBCHAPTER B. FORMATION AND STRUCTURE OF STIPULATED PREMIUM INSURANCE COMPANY

Revised Law

Sec. 884.051. FORMATION OF COMPANY. (a) Five or more, but not more than 35, residents of this state may form a stipulated premium company.

(b) To form a stipulated premium company:

(1) each incorporator must sign and acknowledge the articles of incorporation of the company; and

(2) the incorporators must file the articles of incorporation with the department. (V.T.I.C. Art. 22.01, Sec. 1

(part).)

Source Law

Art. 22.01

Sec. 1. Any five (5) or more, but not to exceed thirty-five (35), citizens of this state may associate themselves for the purpose of forming a stipulated premium life insurance company or a stipulated premium accident insurance company or a stipulated premium life and accident, health and accident, or life, health and accident insurance company. In order to form such a company, the corporators shall sign and acknowledge its articles of incorporation and file the same in the office of the State Board of Insurance. . . .

Revisor's Note

(1) Section 1, V.T.I.C. Article 22.01, refers to "citizens of this state." The revised law substitutes "resident" for "citizen" because, in the context of this section, "citizen" and "resident" are synonymous and "resident" is more commonly used.

(2) Section 1, V.T.I.C. Article 22.01, 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. Chapter 31 of this code defines "commissioner" and "department" for purposes of this code and the other insurance laws of this state to mean the commissioner of insurance and the Texas Department of Insurance, respectively. Throughout this chapter, references to the State Board of Insurance have been changed appropriately.

Revised Law

Sec. 884.052. ARTICLES OF INCORPORATION. (a) Articles of incorporation of a stipulated premium company must specify:

(1) the name and place of residence of each incorporator;

(2) the name of the proposed stipulated premium company;

(3) the location of the proposed company's home office;

(4) the kinds of insurance business the proposed company will transact;

(5) the amount of the proposed company's capital stock;

(6) the number of shares of the proposed company's capital stock; and

(7) the period of the proposed company's duration, which may not exceed 500 years.

(b) The incorporators of a stipulated premium company may include other provisions in the articles of incorporation. (V.T.I.C. Art. 22.01, Sec. 1 (part).)

Source Law

Sec. 1. . . . Such articles shall specify:

1. The name and place of residence of each of the incorporators;

2. The name of the proposed company, . . .

3. The location of its home office;

4. The kind or kinds of insurance business it proposes to transact;

5. The amount of its capital stock, . . .

6. The period of time it is to exist, which shall not exceed five hundred (500) years;

7. The number of shares of such capital stock;

8. Such other provisions not inconsistent with the law as the corporators may deem proper to insert therein.

Revisor's Note

Section 1(8), V.T.I.C. Article 22.01, states that the articles shall specify "other provisions not inconsistent with the law . . . ." The revised law omits "not inconsistent with the law" as unnecessary. The incorporators of a stipulated premium company may not include provisions that violate law in the articles of incorporation of the company.

Revised Law

Sec. 884.053. COMPANY'S NAME. (a) The name of a stipulated

premium company must contain the words "Insurance Company."

(b) A stipulated premium company's name may not be so similar to the name of another insurance company as to likely mislead the public. (V.T.I.C. Art. 22.01, Sec. 1 (part).)

Source Law

> Sec. 1. . . . Such articles shall specify:
>
> . . .
>
> 2. The name of the proposed company, which shall contain the words "Insurance Company" as a part thereof, and the name selected shall not be so similar to the name of any other insurance company as to be likely to mislead the public;
>
> . . .

Revised Law

Sec. 884.054. CAPITAL STOCK AND SURPLUS REQUIREMENTS. (a) A proposed stipulated premium company's capital stock must be in an amount of at least $15,000.

(b) All of the capital stock required by Subsection (a) must be fully subscribed and paid up and delivered to the incorporators before the articles of incorporation are filed.

(c) To be incorporated, a stipulated premium company must possess at the time of incorporation, in addition to its capital, surplus in an amount of at least $7,500. The amount of the surplus is not required to be stated in the company's articles of incorporation.

(d) At the time of incorporation the minimum capital and surplus shall consist only of:

(1) United States currency;

(2) bonds of the United States, this state, or a county or municipality of this state; or

(3) government insured mortgage loans that are authorized by this chapter, with not more than 50 percent of the minimum capital invested in first mortgage real property loans. (V.T.I.C. Art. 22.01, Sec. 1 (part).)

Source Law

> Sec. 1. . . . Such articles shall specify:
>
> . . .
>
> 5. The amount of its capital stock, not less than Fifteen Thousand Dollars ($15,000.00); all of which capital stock must be fully subscribed and paid up and in the hands of the corporators before said

articles of incorporation are filed. Such stipulated premium insurance company shall not be incorporated unless at the time of incorporation such company is possessed of at least Seven Thousand Five Hundred Dollars ($7,500.00) surplus, in addition to its capital; provided the amount of such surplus need not be stated in its articles of incorporation. Such minimum capital and surplus shall, at the time of incorporation, consist only of lawful money of the United States or bonds of the United States or of this state or of any county or incorporated municipality thereof, or government insured mortgage loans which are otherwise authorized by this chapter; and shall not include any real estate; provided, however, fifty per cent (50%) of the minimum capital may be invested in first mortgage real estate loans. . . .

Revisor's Note

(1) Section 1, V.T.I.C. Article 22.01, refers to an "incorporated municipality" of this state. The revised law omits "incorporated" because under the Local Government Code all municipalities must be incorporated.

(2) Section 1, V.T.I.C. Article 22.01, provides that the minimum capital and surplus "shall not include any real estate." The revised law omits the quoted phrase as unnecessary because the revised law expressly sets out all of the forms that capital and surplus may take, which does not include real property.

Revised Law

Sec. 884.055. SHARES OF STOCK. (a) The shares of stock of a stipulated premium company must have a par value of not less than $1 or more than $100.

(b) A stipulated premium company may issue and dispose of authorized shares for money or an instrument authorized for minimum capital under Section 884.054(d). After the company receives payment for a share of stock, the share is nonassessable.

(c) If all of the shares of stock authorized by the charter or an amendment to the charter are not subscribed and paid for when the charter is granted or the amendment is filed,

respectively, the stipulated premium company shall file with the department a certificate authenticated by a majority of the directors stating the number of shares issued and the consideration received for those shares. The company shall file the certificate not later than the 90th day after the date of issuance of any of those remaining shares. (V.T.I.C. Art. 22.02.)

Source Law

Art. 22.02. The stock of any stipulated premium company shall be of par value. Each share shall be for not less than One Dollar ($1.00) nor more than One Hundred Dollars ($100.00). Such stipulated premium companies may issue and dispose of their authorized shares having a par value for money or those notes, bonds and mortgages, of which Art. 22.01 of this Chapter authorizes for minimum capital and such shares shall thereafter be nonassessable. In the event all of the shares of stock, authorized by the original charter or any amendment, are not subscribed and paid for at the time the original charter is granted, or the amendment is filed, then when such remaining shares of stock are sold and issued, the company shall file with the State Board of Insurance, within ninety (90) days after the issuance of such shares, a certificate authenticated by a majority of the directors setting forth the number of shares so issued and the actual consideration received by the company for such shares.

Revisor's Note

(1) V.T.I.C. Article 22.02 refers to "those notes, bonds and mortgages, of which Art. 22.01 of this Chapter authorizes for minimum capital." The relevant portion of Article 22.01 is revised as Section 884.054. Subsection (d) of that section lists the authorized forms that capital may take. The revised law refers to that provision.

(2) V.T.I.C. Article 22.02 refers to "actual" consideration. The revised law omits "actual" because it is unnecessary. While consideration may take many forms, to be consideration a thing must be "actual"

consideration.

Revised Law

Sec. 884.056. APPLICATION FOR CHARTER. (a) To obtain a charter for a stipulated premium company under this chapter, the incorporators must pay a charter fee in an amount determined under Article 4.07 and file with the department:

(1) an application for charter on the form and containing the information prescribed by the department;

(2) the company's articles of incorporation; and

(3) an affidavit made by two or more of the incorporators that states that:

(A) the minimum capital and surplus requirements of Section 884.054 are satisfied;

(B) the capital and surplus is the bona fide property of the company; and

(C) the information in the application and articles of incorporation is true and correct.

(b) The department may require that the incorporators provide at their expense additional evidence of a matter required in the affidavit before the department takes further action on the application for the charter. (V.T.I.C. Art. 22.03, Sec. 1.)

Source Law

Art. 22.03

Sec. 1. As a condition precedent to the granting of a charter of any such company, the incorporators shall file with the State Board of Insurance the following:

1. An application for charter on such form and including therein such information as may be prescribed by the Board;

2. The articles of incorporation as provided in this Code;

3. An affidavit made by two (2) or more of its incorporators that all of the stock has been subscribed in good faith and fully paid for, as required by law, in the amount of not less than Fifteen Thousand Dollars ($15,000.00) capital and that such company is possessed of at least Seven Thousand Five Hundred Dollars ($7,500.00) surplus, as required by law, in addition to its capital, which affidavit shall state that the facts set forth in the application and the articles of incorporation are true and correct and that the capital and surplus is the bona fide property of such company. The State Board of Insurance may, in its discretion, at the expense of the incorporators, require other and additional satisfactory evidence of the matters required to be set forth in said affidavit before it shall be required to file the articles of incorporation, application for charter or follow the procedure hereinafter set forth;

4. A charter fee as prescribed by law.

Revisor's Note

Section 1, V.T.I.C. Article 22.03, provides that a stipulated premium company must deposit with the Texas Department of Insurance "[a] charter fee as prescribed by law" when it files an application to obtain a charter. V.T.I.C. Article 4.07 is a comprehensive fee provision that authorizes the Texas Department of Insurance to set the amounts of various fees, including a charter fee. Section D, Article 4.07, provides that Article 4.07 applies to stipulated premium companies. Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

Revised Law

Sec. 884.057. ACTION BY COMMISSIONER AND DEPARTMENT AFTER FILING. (a) After the charter fee is paid and all items required for a charter under Section 884.056 are filed with the department:

(1) the commissioner may set a date for a hearing on the application; and

(2) the department shall make or cause to be made a full and thorough examination of the company before a hearing.

(b) The stipulated premium company shall pay for the examination required under Subsection (a)(2). (V.T.I.C. Art. 22.03, Sec. 2 (part); Art. 22.05 (part).)

Source Law

[Art. 22.03]

Sec. 2. When such application for charter, articles of incorporation, affidavit, and charter fee are filed with the State Board of Insurance, the Board may set a date for a public hearing of the same, ...

Art. 22.05. When the application for charter, articles of incorporation, affidavit, and charter fee are filed with the State Board of Insurance and before the hearing required by Article 22.03 of this Code, the Board shall make or cause to be made at the expense of the company a full and thorough examination thereof. . . .

Revisor's Note

Section 2, V.T.I.C. Article 22.03, refers to a "public hearing" of the former State Board of Insurance. Throughout this chapter, the revised law omits "public" as unnecessary. In context, "hearing" means a hearing open to the public.

Revised Law

Sec. 884.058. APPLICATION PROCESS. (a) The date for a hearing on an application may not be before the 11th or later

than the 30th day after the date notice is provided under Subsection (b).

(b) The commissioner shall:

(1) provide written notice of the date of a hearing to:

(A) the person or persons who filed the application; and

(B) any interested party, including any other party who had previously requested a copy of the notice; and

(2) publish, at the expense of the incorporators, a copy of the notice in a newspaper of general circulation in the county in which the stipulated premium company's home office is proposed to be located.

(c) The department shall make a record of the proceedings of a hearing under this section.

(d) An interested party is entitled to oppose or support the granting or denial of the application and may intervene and participate fully and in all respects in any hearing or other proceeding on the application. An intervenor has the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel. (V.T.I.C. Art. 22.03, Sec. 2 (part).)

Source Law

Sec. 2. . . . [the Board may set a date for a public hearing of the same,] which date shall be not less than ten (10) nor more than thirty (30) days after the date of notice thereof. The Board shall notify in writing the person or persons submitting such application of the date for such hearing and shall furnish a copy of such notice to all interested parties, including any parties who have theretofore requested a copy of such notice. The Board shall, at the expense of the incorporators, publish a copy of such notice in any newspaper of general circulation in the county of the proposed home office of said company. In all such public hearings on such applications, a record shall be made of such proceedings, ... Any interested party shall have the right to oppose or support the granting or denial of such application and may intervene and participate fully and in all respects in any hearing or other proceeding had on any such application. Any such intervener shall have and enjoy all the rights and privileges of a proper or necessary party in a civil suit in the courts of this state, including the right to be represented by counsel.

Revised Law

Sec. 884.059. ACTION ON APPLICATION. (a) In considering the application, the commissioner, not later than the 30th day after the date on which a hearing under Section 884.058 is

completed, shall determine if:

(1) the minimum capital and surplus required by Section 884.054 are the bona fide property of the stipulated premium company;

(2) the proposed officers, directors, and managing executives of the company have sufficient insurance experience, ability, and standing to make success of the proposed company probable; and

(3) the applicants are acting in good faith.

(b) If the commissioner determines by an affirmative finding any of the issues under Subsection (a) adversely to the applicants, the commissioner shall reject the application in writing, giving the reason for the rejection. An application may not be granted unless it is adequately supported by competent evidence.

(c) If the commissioner does not reject the application under Subsection (b), the commissioner shall approve the application and on receipt of a fee in the amount determined under Article 4.07 shall provide to the incorporators a certified copy of the application, articles of incorporation, and submitted affidavit. (V.T.I.C. Art. 22.03, Secs. 2 (part), 3, 4(a) (part).)

Source Law

Sec. 2. . . . and no such application shall be granted except when same is adequately supported by competent evidence. . . .

Sec. 3. In considering any such application the Board shall, within thirty (30) days after public hearing, determine whether or not:

(a) The minimum capital and surplus as required by law is the bona fide property of the company;

(b) The proposed officers, directors and managing executives have sufficient insurance experience ability and standing to render success of the proposed company probable;

(c) The applicants are acting in good faith.

Sec. 4. (a) If the Board shall determine by an affirmative finding any of the above issues adversely to the applicants, it shall reject the application in writing, giving the reason therefor. Otherwise, the Board shall approve the application. On receipt of a fee of One Dollar ($1.00), the Board shall furnish a certified copy of the application, articles of incorporation, and affidavit to the incorporators, ...

Revisor's Note

Section 4(a), V.T.I.C. Article 22.03, refers to a "fee of One Dollar ($1.00)" for a certified copy of the application, articles of incorporation, and affidavit. That specific dollar

amount was impliedly repealed by V.T.I.C. Article 4.07, which is a comprehensive fee provision that authorizes the Texas Department of Insurance to set the amounts of various fees, including a fee "for making copies of any paper of record in the Texas Department of Insurance." Section D, Article 4.07, provides that Article 4.07 applies to stipulated premium companies. Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

Revised Law

Sec. 884.060. BEGINNING OF CORPORATE EXISTENCE. On receipt of the certified copy of documents under Section 884.059(c), the stipulated premium company becomes a body politic and corporate and the incorporators may complete organization of the company under Section 884.061. (V.T.I.C. Art. 22.03, Sec. 4(a) (part).)

Source Law

(a) . . . [the Board shall furnish a certified copy of the application, articles of incorporation, and affidavit to the incorporators,] upon which they shall become a body politic and corporate and may proceed to complete the organization of the company, ...

Revised Law

Sec. 884.061. ORGANIZATIONAL MEETING. (a) After receipt of the certified copy of documents under Section 884.059(c), the incorporators shall promptly call a meeting of the stipulated premium company's shareholders. The shareholders shall:

(1) adopt bylaws to govern the company; and

(2) elect the company's initial board of directors.

(b) The directors elected under this section serve until directors are first elected under Section 884.153. (V.T.I.C. Art. 22.03, Sec. 4(a) (part).)

Source Law

(a) [. . . the incorporators . . . may proceed to complete the organization of the company,] for which purpose they shall forthwith call a meeting of the stockholders who shall adopt by-laws for the government of the company, and elect a Board of Directors, ... The Board of Directors so elected shall serve until the second Tuesday in April thereafter, ...

[Sections 884.062-884.100 reserved for expansion]

SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

Revised Law

Sec. 884.101. SCHEDULE OF ASSETS. Two or more officers of the stipulated premium company shall execute and file with the

department:

(1) a sworn schedule of each of the assets of the company exhibited to the department during the examination under Section 884.057 showing the value of the assets; and

(2) a sworn statement that the assets are bona fide, are the unconditional and unencumbered property of the company, and are worth the amount stated in the schedule. (V.T.I.C. Art. 22.05 (part).)

Source Law

Art. 22.05. . . . not less than two (2) officers of such company shall execute and file with the State Board of Insurance a sworn schedule of all the assets of the company exhibited to the Board upon such examination showing the value thereof, together with a sworn statement that the same are bona fide, the unconditional and unencumbered property of the company, and are worth the amount stated in such schedule. . . .

Revised Law

Sec. 884.102. TEMPORARY CERTIFICATE OF AUTHORITY. (a) If the commissioner makes a determination favorable to the applicants on all issues under Section 884.059(a), the department, on compliance with the requirements of Section 884.101, shall promptly issue to the company a temporary certificate of authority. The temporary certificate must limit the activities of the company solely to negotiating and obtaining a direct reinsurance agreement, as described by Subchapter L, with a company that on August 28, 1961, was chartered and doing business under former Chapter 14 of this code.

(b) A temporary certificate of authority expires on the first anniversary of its date of issuance unless the department renews it for an additional one-year period.

(c) On the expiration of a temporary certificate of authority the incorporators of the stipulated premium company to which the certificate was issued shall promptly surrender the company's charter to the department for cancellation. (V.T.I.C. Art. 22.05 (part).)

Source Law

Art. 22.05. . . . [After the hearing under Article 22.03 of this Code,] if the Board finds that all of the capital stock of the company amounting to not less than the minimum amount required by law has been fully paid up and is in the custody of the officers either in cash or securities of the class such companies are authorized by this Chapter to invest or loan their funds, and if the State Board of Insurance makes the other findings required by Section 3 of Article 22.03 of this Code favorably to the applicant, on compliance with the other

requirements of this article and Article 22.03 of this Code, it shall issue forthwith to such stipulated premium company a temporary certificate of authority limiting the activities of such stipulated premium company solely to the negotiating and obtaining of a direct reinsurance agreement with a company chartered and doing business under the provisions of Chapter 14 of this code on the effective date of this Act. Such certificate of authority shall terminate twelve (12) months from its date, unless renewed by the State Board of Insurance for an additional period of twelve (12) months, provided that such stipulated premium company has not theretofore consummated a direct reinsurance agreement with such a company doing business under the provisions of Chapter 14 of the Insurance Code.

Before such temporary certificate of authority is issued, . . . [officers of such company shall . . . file with the State Board of Insurance a sworn schedule of . . . assets of the company . . . together with a sworn statement . . . .]

In the event a direct reinsurance agreement be not so consummated within such twelve (12) months period, unless renewed by the State Board of Insurance for an additional period of twelve (12) months, the certificate of authority shall automatically terminate and the incorporators of such stipulated premium company shall forthwith surrender its charter to the State Board of Insurance for cancellation.

. . .

Revisor's Note

(1) V.T.I.C. Article 22.05 refers to "the effective date of this Act." The revised law substitutes "August 28, 1961," for "the effective date of this Act" for the reason stated in Revisor's Note (1) to Section 884.002.

(2) The revised law adds for the reader's convenience a reference to Subchapter L, which relates to direct reinsurance agreements with Chapter 14 companies (mutual assessment companies).

Revised Law

Sec. 884.103. REGULAR CERTIFICATE OF AUTHORITY. (a) If a direct reinsurance agreement described by Section 884.102(a) is entered into while the temporary certificate of authority is valid, the department shall promptly issue to the stipulated premium company a regular certificate of authority to transact the business of insurance in this state in accordance with Subchapter L.

(b) The regular certificate of authority shall provide for the kind of insurance business that the stipulated premium company may conduct. If the other party to the agreement conducts the business of life insurance or is a burial association, the stipulated premium company is entitled to write

life insurance policies under this chapter. If the other party is permitted under its charter to write accident insurance, health and accident insurance, or life, health, and accident insurance, the stipulated premium company is entitled to write that kind of insurance.

(c) If a stipulated premium company that holds a regular certificate of authority enters into a direct reinsurance agreement with another company engaged in business under Chapter 887 or 888, the stipulated premium company's certificate of authority shall be amended to authorize the writing of any kind of insurance authorized for the other company. (V.T.I.C. Art. 22.05 (part).)

Source Law

Art. 22.05. . . . In the event a direct reinsurance agreement as provided in this Chapter is consummated with such a company doing business under the provisions of Chapter 14 of this code, the State Board of Insurance shall forthwith and in accordance with the provisions of Article 22.15 of this Code issue to such a company a regular certificate of authority to transact business in the State of Texas. Likewise, such certificate of authority shall provide for the type of insurance business which may be written by the stipulated premium company; if the Chapter 14 company was engaged in the life business or was a burial association, the stipulated premium company shall be entitled and authorized to write life insurance policies as regulated by the provisions of this Chapter, and if the Chapter 14 company was permitted by its charter to write accident insurance, or health and accident insurance, or life, health and accident insurance, then the stipulated premium company shall be so permitted.

As such stipulated premium company thereafter directly reinsures additional Chapter 14 companies chartered and doing business under the provisions of Chapter 14 of this Code, its regular certificate of authority shall be amended to write any type of such insurance coverage as those authorized for any such Chapter 14 company whose policies are so assumed by the stipulated premium company.

. . .

Revisor's Note
(End of Subchapter)

V.T.I.C. Article 22.05 contains a provision for the expansion of authority of a company that held a regular certificate of authority to operate as a stipulated premium company on the effective date of the Act that added the provision to Article 22.05, June 17, 1967, that limited the company's

authority to an area smaller than the entire state. The Texas Department of Insurance records show that all stipulated premium companies now have statewide authority and, therefore, the revised law omits this provision as executed. The omitted law reads:

Any stipulated premium company holding a permanent certificate of authority on the effective date of this Act, and which permanent certificate of authority limits the territory of operation or writing of business of such company to an area or territory less than the entire State of Texas may, at any time thereafter, make application for, and thereafter be entitled to receive a permanent certificate of authority to operate and issue policies of insurance as so previously authorized (or as may thereafter be authorized by compliance with the provisions of this Chapter 22), anywhere within the State of Texas.

[Sections 884.104-884.150 reserved for expansion]

SUBCHAPTER D. MANAGEMENT OF STIPULATED PREMIUM COMPANY

Revised Law

Sec. 884.151. CONDUCTING SHAREHOLDERS' MEETING. (a) At a meeting of a stipulated premium company's shareholders, each shareholder is entitled to one vote for each fully paid share of stock appearing in the shareholder's name on the company's books.

(b) A shareholder may vote in person or by written proxy.

(c) At a shareholders' meeting, a quorum is any number of shareholders whose cumulative stock ownership in the stipulated premium company represents a majority of the company's paid up capital stock. (V.T.I.C. Art. 22.03, Sec. 4(a) (part).)

Source Law

Sec. 4. (a) . . . At all meetings of the stockholders, each stockholder shall be entitled to one vote for each share of stock fully paid up appearing in his name on the books of the company, which vote may be given in person or by written proxy. The majority of the paid up capital stock at any meeting of the stockholders shall be a quorum.

Revised Law

Sec. 884.152. BOARD OF DIRECTORS. (a) Subject to the bylaws of the stipulated premium company, as adopted or amended by the shareholders or directors, the board of directors has full management and control of the company.

(b) The board consists of not fewer than five directors.

(c) The directors shall keep a full and correct record of the board's transactions. The shareholders may inspect those records during business hours.

(d) The directors shall fill a vacancy that occurs on the

board or in any office of the company.

(e) A majority of the board is a quorum. (V.T.I.C. Art. 22.03, Sec. 4(a) (part).)

Source Law

(a) . . . [elect a Board of Directors,] not less than five (5) persons; which Board shall have full control and management of the affairs of the corporation, subject to the by-laws thereof as adopted or amended from time to time by the stockholders or directors, and to the laws of this state. . . . The directors shall keep a full and correct record of their transactions to be open during business hours to the inspection of stockholders. The directors shall fill any vacancy which occurs in the Board or in any office of such company. A majority of the Board shall be a quorum for the transaction of such business. . . .

Revisor's Note

(1) Section 4(a), V.T.I.C. Article 22.03, provides that the board's control of a company is subject "to the laws of this state." The revised law omits that provision as unnecessary because the provisions of state law require compliance without an express statement to that effect.

(2) Section 4(a), V.T.I.C. Article 22.03, provides that a majority of the board is a quorum "for the transaction of such business." The revised law omits the quoted phrase as unnecessary. "Quorum" means the number of persons or votes necessary for a body to act.

Revised Law

Sec. 884.153. ELECTION OF DIRECTORS. (a) On the second Tuesday of April of each year the shareholders of a stipulated premium company shall meet at the company's home office and shall elect the company's board of directors to serve one-year terms beginning immediately after the election.

(b) If the shareholders do not elect directors at that meeting, the shareholders may elect the directors at a special shareholders' meeting called for that purpose. (V.T.I.C. Art. 22.03, Sec. 4(a) (part).)

Source Law

(a) . . . [The Board of Directors so elected shall serve until the second Tuesday in April thereafter,] on which date, annually thereafter, there shall be held a meeting of the stockholders at the home office, and a Board of Directors elected for the ensuing year. If the stockholders fail to elect directors at any such annual meeting, directors may be elected at a special meeting of the stockholders called for that purpose. . . .

Revised Law

Sec. 884.154. OFFICERS. (a) A stipulated premium company's directors shall choose one of the directors to serve as the company's president.

(b) Other officers of the stipulated premium company shall be chosen in accordance with the bylaws of the company. An officer other than the president is not required to be a director or a shareholder unless such a qualification is required by the company's bylaws.

(c) The duties and compensation of a stipulated premium company's officers are as stated in the company's bylaws. If the bylaws do not state the duties or compensation of the officers, the directors shall establish the duties or compensation. (V.T.I.C. Art. 22.03, Sec. 4(a) (part).)

Source Law

(a) . . . The directors shall choose a President from their own number, and all other officers shall be chosen in accordance with the by-laws of the company, and none of such officers need be either a director or a stockholder except as required by the by-laws of such company. The duties and compensation of officers of such company shall be in accordance with the by-laws of the company, or, to the extent of the absence of provisions governing the same in the by-laws, then the duties and compensation of officers shall be defined and fixed by the directors. . . .

Revised Law

Sec. 884.155. AMENDMENT OF CHARTER OR ARTICLES. (a) The shareholders of a stipulated premium company by resolution may amend the company's charter or articles of incorporation at any shareholders' meeting.

(b) The amendment and a copy of the resolution certified by the president and secretary of the stipulated premium company shall be filed and recorded in the same manner as the charter.

(c) An amendment of the charter or articles takes effect when it is recorded. (V.T.I.C. Art. 22.03, Sec. 4(b) (part); Art. 22.04, Sec. 1 (part).)

Source Law

[Art. 22.03]

Sec. 4. . . .

(b) At any regular or called meeting of the stockholders, they may, by resolution, provide for any lawful amendment to the charter or articles of incorporation; and such amendment, accompanied by a copy of such resolution duly certified by the President and Secretary of the company, shall be filed and recorded in the same manner as the original charter, and shall

thereupon become effective. . . .

Art. 22.04

Sec. 1. At any regular or called meeting of the stockholders, they may, by resolution, provide for any lawful amendment to the charter or articles of incorporation; and such amendment, accompanied by a copy of such resolution duly certified by the President and Secretary of the company, shall be filed and recorded in the same manner as the original charter, and shall thereupon become effective. . . .

Revisor's Note

Section 4(b), V.T.I.C. Article 22.03, provides for the amendment of a company's charter or articles at "any regular or called meeting of the stockholders." The revised law omits "regular or called" as unnecessary because a meeting of the shareholders is either "regular" or "called."

[Sections 884.156-884.200 reserved for expansion]

SUBCHAPTER E. CAPITAL AND SURPLUS

Revised Law

Sec. 884.201. FORM OF CAPITAL AND SURPLUS. After a charter is granted under this chapter, the stipulated premium company:

(1) shall maintain the company's minimum capital at all times in a form described by Section 884.054(d); and

(2) may invest the company's surplus as provided by Article 3.39. (V.T.I.C. Art. 22.01, Sec. 1 (part).)

Source Law

Sec. 1. . . . After the granting of charter, the surplus may be invested as otherwise provided in this Chapter. Notwithstanding any other provisions of this Chapter, such minimum capital shall at all times be maintained in cash or in the classes of investments described in this article; . . . .

Revisor's Note

Section 1, V.T.I.C. Article 22.01, provides that "the surplus may be invested as otherwise provided in this Chapter." While there is no provision in Chapter 22 that expressly relates to the investment of surplus, V.T.I.C. Article 3.39, which regulates the authorized investments for certain types of insurers, is made applicable to stipulated premium companies by Section 1, V.T.I.C. Article 22.18, revised as Section 884.002. Article 3.39 is the only statutory provision that provides specific authority relating to a stipulated premium company's investment of its surplus. To provide more explicit guidance for the reader of the revised statute, the revised law contains a reference to that article.

Revised Law

Sec. 884.202. INCREASE OR DECREASE OF CAPITAL STOCK. (a) At any shareholders' meeting, shareholders of a stipulated premium company whose cumulative stock ownership represents a majority of the capital stock of the company by resolution may increase or decrease the amount of the company's capital stock subject to this section.

(b) Capital stock may be decreased to an amount that is less than $100,000 only to avoid insolvency as provided by Section 884.205 and may never be decreased to an amount that is less than the minimum amount of paid-up stock required by Section 884.054.

(c) Two officers of the stipulated premium company must sign and acknowledge a statement of the increase or decrease. The acknowledged statement and a certified copy of the resolution shall be filed and recorded in the same manner as the charter.

(d) For an increase or decrease of capital stock, the stipulated premium company may require the return of the original certificates evidencing the stock in exchange for new certificates. An issuance of new certificates that results in a transfer of stock is subject to Section 884.254. (V.T.I.C. Art. 22.03, Sec. 4(b) (part); Art. 22.04, Sec. 1 (part).)

Source Law

[Art. 22.03]

Sec. 4

(b) . . . Stockholders representing a majority of the capital stock of any such company may in such manner also increase or reduce the amount of its capital stock. The capital stock shall in no case be reduced to less than the minimum amount of fully paid up capital stock required by applicable provisions of law. A statement of any such increase or reduction shall be signed and acknowledged by two officers of the company and filed and recorded along with the certified copy of the resolution of the stockholders provided therefor in the same manner as the charter or amendment thereto. For any such increase or reduction, the company may require the return of the original certificates as other evidence of stock in exchange for new certificates issued in lieu thereof. . . .

[Art. 22.04]

Sec. 1. . . . Stockholders representing a majority of the capital stock of any such company may in such manner also increase or reduce the amount of its capital stock. The capital stock may in no case be reduced to less than One Hundred Thousand Dollars ($100,000.00) except for the purpose of avoiding insolvency as provided in Article 22.12 of this Chapter, but in such event never less than Fifteen Thousand Dollars ($15,000.00).

A statement of any such increase or reduction shall be signed and acknowledged by two officers of the company and filed and recorded along with the certified copy of the resolution of the stockholders provided therefor in the same manner as the charter amendment thereto. For any such increase or reduction, the company may require the return of the original certificates as evidence of stock in exchange for new certificates . . . .

Revisor's Note

The parts of Section 4(b), V.T.I.C. Article 22.03, and Section 1, V.T.I.C. Article 22.04, that follow the parts of the law revised in this section are revised as Section 884.254 of this code. The revised law adds a cross-reference to Section 884.254 for the reader's convenience.

Revised Law

Sec. 884.203. PUBLIC OFFERING OF CAPITAL STOCK. A stipulated premium company may not make to the public an offering that is subject to The Securities Act (Article 581-1 et seq., Vernon's Texas Civil Statutes), of any of its capital stock before the company possesses:

(1) capital in an amount of at least $100,000; and

(2) unencumbered surplus in an amount of at least $100,000. (V.T.I.C. Art. 22.18, Sec. 3.)

Source Law

Sec. 3. Until such time as a stipulated premium company shall have and be possessed of capital of at least One Hundred Thousand Dollars ($100,000.00) and free and unencumbered surplus in at least the amount of One Hundred Thousand Dollars ($100,000.00), it shall be unlawful for any stipulated premium company to make a public offering, as defined in the Texas Securities Act, of any of its capital stock.

Revisor's Note

(1) Section 3, V.T.I.C. Article 22.18, refers to the "free and unencumbered surplus" of a stipulated premium insurance company. Throughout this chapter, the revised law substitutes "unencumbered surplus" for "free and unencumbered surplus" because, in context, the phrases are synonymous and the phrase "unencumbered surplus" is more consistent with modern usage.

(2) Section 3, V.T.I.C. Article 22.18, refers to a public offering "defined in the Texas Securities Act." The Securities Act does not define the term "public offering." The revised law refers to an offering that is subject to The Securities Act.

Revised Law

Sec. 884.204. COMPANY'S REPURCHASE OF STOCK. (a) Subject to Section 884.202, a stipulated premium company may purchase in the name of the company outstanding shares of the company's

capital stock as provided by the Texas Business Corporation Act.

(b) A purchase of stock under this section is not considered an investment and does not violate the provisions of this code relating to eligible investments for a stipulated premium company.

(c) A stipulated premium company that purchases stock under this section shall file with the department not later than the 10th day after the date of the purchase a statement that contains the name of each shareholder from whom the shares were purchased and the sum of money paid for those shares. (V.T.I.C. Art. 22.04, Sec. 2.)

Source Law

Sec. 2. Subject to Section 1 of this article, any stipulated premium company may purchase issued and outstanding shares of the capital stock of that company in the name of the company as provided by the Texas Business Corporation Act. A purchase of stock made under this section shall not be considered an investment and does not constitute a violation of the provisions of this code relating to eligible investments for such a company. A company that makes such a purchase shall file a statement with the Commissioner of Insurance that sets forth the name of each shareholder from whom the shares have been purchased and the sum of money paid for those shares. The statement must be filed not later than the tenth (10th) day after the date of the purchase.

Revisor's Note

Section 2, V.T.I.C. Article 22.04, refers to "issued and outstanding shares" of stock. The revised law omits the reference to "issued" as unnecessary because a share of a company may not be outstanding unless it has been issued by the company.

Revised Law

Sec. 884.205. IMPAIRMENT OF CAPITAL STOCK. (a) If, when computing the liabilities of a stipulated premium company under this chapter, one-third or more of the company's capital stock becomes impaired, the company shall correct the impairment not later than the 60th day after the date the company becomes subject to this subsection by:

(1) reducing the company's capital stock subject to the limitation provided by Section 884.202(b);

(2) adjusting the premium rate if permitted by policy contract; or

(3) both reducing capital stock and adjusting the premium rate.

(b) If, when computing a stipulated premium company's reserve liability under this chapter, 50 percent or more of the company's capital stock becomes impaired, the commissioner may apply to a court for the appointment of a receiver to wind up the

affairs of the company. (V.T.I.C. Art. 22.12 (part).)

Source Law

Art. 22.12. Any stipulated premium company transacting business within this state, whose capital stock shall become impaired to the extent of thirty-three and one-third per cent (33 1/3%) thereof, computing its liabilities in the manner provided for in this Chapter of this Code, shall make good such impairment within sixty (60) days by: (a) a reduction of its capital stock (provided such capital stock shall in no case be less than the minimum amount required of a stipulated premium company by this Chapter); or (b) by rate adjustment where permitted by policy contract; or (c) by both such methods; . . . .

The State Board of Insurance may apply to any court of competent jurisdiction for the appointment of a receiver to wind up the affairs of such company when its capital stock shall become impaired to the extent of fifty per cent (50%) thereof; computing its reserve liability in the manner provided by this Chapter for the computation of such reserve liability. . . .

Revisor's Note

V.T.I.C. Article 22.12 refers to a suit brought "in a court of competent jurisdiction." The revised law omits the quoted language as unnecessary 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. 884.206. COMMISSIONER MAY REQUIRE LARGER CAPITAL AND SURPLUS AMOUNTS. (a) The commissioner by rule may require a stipulated premium company that writes or assumes life insurance, annuity contracts, or accident and health insurance for a risk to one person in an amount that exceeds $10,000 to maintain capital and surplus in amounts that exceed the minimum amounts required by this chapter because of:

(1) the nature and kind of risks the company underwrites or reinsures;

(2) the premium volume of risks the company underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of the company's investment portfolio;

(4) fluctuations in the market value of securities the company holds; or

(5) the adequacy of the company's reserves.

(b) A rule adopted under Subsection (a) must be designed to ensure the financial solvency of a stipulated premium company for the protection of policyholders and may not require that the

total admitted assets of a company exceed 106 percent of its total liabilities. (V.T.I.C. Art. 22.13, Secs. 2(e), (f).)

Source Law

(e) In addition to the capital requirements under Subsection (d) of this section, the board may adopt rules and regulations requiring a stipulated premium company that writes or assumes life insurance, annuity contracts or health, accident, sickness or hospitalization insurance for any risk in excess of $10,000 to any one person to maintain capital and surplus levels in excess of the statutory minimum capital levels required by Chapter 22 of this Code based upon any of the following factors:

(1) the nature and type of risks a company underwrites or reinsures;

(2) the premium volume of risks a company underwrites or reinsures;

(3) the composition, quality, duration, or liquidity of a company's investment portfolio;

(4) fluctuations in the market value of securities a company holds; or

(5) the adequacy of a company's reserves.

(f) The rules adopted under Subsection (e) of this section shall be designed to assure the financial solvency of companies for the protection of policyholders and may not, according to the dates specified, require that the total admitted assets of a company exceed the following percentages of its total liabilities:

(1) as of December 31, 1992, 103 percent;

(2) as of December 31, 1993, 103 percent;

(3) as of December 31, 1994, 103 percent;

(4) as of December 31, 1995, 104 percent;

(5) as of December 31, 1996, 105 percent; and

(6) as of December 31, 1997, 106 percent.

Revisor's Note

(1) Section 2(e), V.T.I.C. Article 22.13, refers to "rules and regulations." The reference to "regulations" is omitted from the revised law 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 2(e), V.T.I.C. Article 22.13, refers to "health, accident, sickness or hospitalization" insurance. Section 2(a), V.T.I.C. Article 22.13, revised in Chapter 1302, provides that "Chapter 397, Acts of the 54th Legislature, Regular Session, 1955 (Article 3.70-1 et seq., Insurance Code)" applies to the issuance of health, accident, sickness, and hospitalization policies by a stipulated premium company. Chapter 1302 of this code, the revision of Article 3.70-1 et

seq., uses the term "accident and health insurance policy" when referring to those types of policies and that term has been substituted for "health, accident, sickness or hospitalization policy" throughout this chapter.

(3) Section 2(f), V.T.I.C. Article 22.13, provides a series of limits for admitted assets based on percentages of liabilities for years 1992 to 1997. The revised law omits the series as executed.

Revised Law

Sec. 884.207. NEW BUSINESS PROHIBITED WHEN CAPITAL REQUIREMENTS NOT SATISFIED. (a) A stipulated premium company may not write new business in this state unless the company possesses the minimum capital required under this chapter.

(b) A stipulated premium company subject to Section 884.205(a) that does not correct the impairment on or before the date provided by that subsection may not write new business in this state after that date until the impairment is corrected. (V.T.I.C. Art. 22.12 (part).)

Source Law

Art. 22.12. . . . and failing to make good such impairment within said time shall forfeit its right to write new business in this state until said impairment shall have been made good.

. . . No stipulated premium company shall write new business unless it is possessed of the minimum capital required by this Chapter 22, except to the extent it may be otherwise expressly authorized by this Chapter of this Code.

Revisor's Note

V.T.I.C. Article 22.12 provides that a stipulated premium company that does not meet the minimum capital requirement may not write new business, "except to the extent it may be otherwise expressly authorized by this Chapter of this Code." The revised law omits the quoted phrase because Chapter 22, Insurance Code, revised as this chapter, does not authorize a stipulated premium company to write business without maintaining the minimum capital.

[Sections 884.208-884.250 reserved for expansion]

SUBCHAPTER F. GENERAL POWERS AND DUTIES OF STIPULATED PREMIUM COMPANY

Revised Law

Sec. 884.251. DEPOSIT OF COMPANY'S FUNDS. (a) A director, member of a committee, officer, or clerk of a stipulated premium company who has the duty of handling or investing the company's funds shall deposit or invest those funds in the corporate name of the company.

(b) An individual described by Subsection (a) may not:

(1) borrow the funds of the stipulated premium

company;

(2) have an interest in any way in a loan, pledge, security, or property of the company, except as shareholder; or

(3) take or receive for the individual's use a fee, brokerage, commission, gift, or other consideration for, or on account of, a loan made by or on behalf of the company. (V.T.I.C. Art. 22.10.)

Source Law

Art. 22.10. Any director, member of a committee, or officer, or any clerk of a stipulated premium company, who is charged with the duty of handling or investing its funds, shall not deposit or invest such funds, except in the corporate name of such company; shall not borrow the funds of such company; shall not be interested in any way in any loan, pledge, security or property of such company, except as stockholder; shall not take or receive to his own use any fee, brokerage, commission, gift or other consideration for, or on account of, a loan made by or on behalf of such company.

Revised Law

Sec. 884.252. PAYMENTS TO OFFICERS, DIRECTORS, AND EMPLOYEES. (a) Unless first authorized by a vote of a stipulated premium company's board of directors or a committee of the board that has the duty of authorizing the payment, the company may not pay:

(1) any compensation or emolument to an officer or director of the company; or

(2) compensation or emolument in an amount that exceeds $50,000 in any year to an individual, firm, or corporation that is not an officer or director of the company.

(b) This section does not prevent a stipulated premium company from contracting with its agents for the payment of renewal commissions.

(c) The shareholders of a stipulated premium company may authorize the creation of one or more plans for the payment of pensions, retirement benefits, or group insurance for its officers and employees. The shareholders may delegate to the company's board of directors the power and duty to prepare, effect, finally approve, administer, and amend a plan. (V.T.I.C. Art. 22.09.)

Source Law

Art. 22.09. (a) No stipulated premium company shall pay any salary, compensation or emolument to any officer, trustee, or director thereof, nor any salary, compensation or emolument amounting in any year to more than Fifty Thousand Dollars ($50,000.00) to any person, firm or corporation, unless such

payment be first authorized by a vote of the Board of Directors of such company, or by a committee of such Board charged with the duty of authorizing such payments. The limitation as to time contained herein shall not be construed as preventing any stipulated premium company from entering into contracts with its agents for the payment of renewal commissions.

(b) The stockholders of any such stipulated premium company may authorize the inauguration of a plan or plans for the payment of pensions, retirement benefits or group insurance to its officers and employees. The stockholders may delegate to the Board of Directors authority and responsibility for the preparation, inauguration, putting into effect, final approval and administration of any such plan or plans or any amendments thereof.

Revisor's Note

(1) Subsection (a), V.T.I.C. Article 22.09, refers to "salary, compensation or emolument." The reference to "salary" is omitted from the revised law because "salary" is included within the meaning of "compensation."

(2) Subsection (a), V.T.I.C. Article 22.09, refers to a company's "trustee." This is the only reference in Chapter 22 to that term. A company is governed by directors rather than trustees. The revised law omits the reference as unnecessary.

(3) Subsection (b), V.T.I.C. Article 22.09, refers to "the preparation, inauguration, putting into effect, final approval and administration of any such plan or plans." The revised law omits the reference to "inauguration" because in this context it is included in the action of "putting into effect."

Revised Law

Sec. 884.253. DIVIDENDS. (a) A stipulated premium company may declare or pay a dividend to its shareholders only from the profits made by the company, not including surplus from the sale of stock.

(b) A stipulated premium company may not pay a dividend, other than a stock dividend, unless:

(1) any deficiency reserve under Section 884.453 has been eliminated; and

(2) the capital of the company is maintained in an amount of at least $100,000.

(c) A stipulated premium company that complies with Subsection (b) may pay cash dividends in accordance with Article 21.32. (V.T.I.C. Art. 22.08.)

Source Law

Art. 22.08. No stipulated premium company shall declare or pay any dividends to its stockholders except from the profits made by said company not including surplus arising from the sale

of stock, and shall pay no dividends except stock dividends until: (a) the capital of said stipulated premium company shall be at least One Hundred Thousand Dollars ($100,000.00); (b) the deficiency reserve as permitted by this Chapter has been retired; and (c) capital of said stipulated premium company is maintained at not less than One Hundred Thousand Dollars ($100,000.00). Thereafter cash dividends may be paid in accordance with this Chapter.

Revisor's Note

V.T.I.C. Article 22.08 provides that "cash dividends may be paid in accordance with this Chapter." While there is no provision in Chapter 22 that expressly relates to the payment of dividends, V.T.I.C. Article 21.32, which regulates the payment of dividends for certain types of insurers, is made applicable to stipulated premium companies by Section 1, V.T.I.C. Article 22.18, revised as Section 884.002. Article 21.32 is the only statutory provision that provides specific requirements relating to a stipulated premium company's payment of dividends. To provide more explicit guidance for the reader of the revised statute, the revised law contains a reference to that article.

Revised Law

Sec. 884.254. TRANSFER OF STOCK. (a) A stipulated premium company's shares of stock are transferable on the company's books, in accordance with law and the bylaws of the company, by the owner or the owner's authorized agent.

(b) Each person who becomes a shareholder by a transfer of shares succeeds to all rights of the former holder of those shares, by reason of that ownership. (V.T.I.C. Art. 22.03, Sec. 4(b) (part); Art. 22.04, Sec. 1 (part).)

Source Law

[Art. 22.03]

Sec. 4

(b) . . . The shares of stock of such company shall be transferable on its books, in accordance with law and the by-laws of the company, by the owner in person or his authorized agent. Every person becoming a stockholder by such transfer shall succeed to all rights of the former holder of the stock transferred, by reason of such ownership.

Art. 22.04

Sec. 1. . . . [For any such increase or reduction, the company may require the return of the original certificates as evidence of stock in exchange for new certificates] transferable on its books, in accordance with this Chapter and the by-laws of the company, by the owner in person or his authorized agent. Every person becoming a stockholder by such transfer shall succeed to all rights of the former holder of the stock

transferred, by reason of such ownership.

Revised Law

Sec. 884.255. USE OF CERTAIN TERMS IN ADVERTISING. A stipulated premium company may not use in its advertising or representation of a policy the words "legal reserve company," "stock company," "old line legal reserve company," or words of similar meaning that might lead the public to believe that a policy provides nonforfeiture values. (V.T.I.C. Art. 22.17 (part).)

Source Law

Art. 22.17. No stipulated premium company may ever use in its advertising or representation of its policies the words: "legal reserve company," "stock company," "old line legal reserve company," or any other words of like import whereby the public might be led to believe that policies of stipulated premium companies provide non-forfeiture values. . . .

Revised Law

Sec. 884.256. ANNUAL STATEMENT; FILING FEE. (a) Except as provided by Section 884.406, not later than March 31 of each year a stipulated premium company shall:

(1) prepare a statement showing the condition of the company on December 31 of the preceding year; and

(2) deliver the statement to the department accompanied by a filing fee in the amount determined under Article 4.07.

(b) The statement must be under the oath of two of the stipulated premium company's officers and must show in detail:

(1) the character of the company's assets and liabilities on December 31 of the preceding year;

(2) the amount and character of business transacted and money received during the year and how money was spent during the year;

(3) the number and amount of the company's policies in force on that date; and

(4) the total amount of the company's policies in force on that date.

(c) For purposes of Subsection (b), an insured under a family group policy to which Section 884.451(b) applies is accounted for only if a reserve is required for that insured under that section.

(d) The department shall prescribe the form of the statement.

(e) Fees collected under this section shall be deposited to the credit of the Texas Department of Insurance operating account. Article 1.31A applies to fees collected under this

section. (V.T.I.C. Art. 22.06.)

Source Law

Art. 22.06. Each stipulated premium company shall after the first day of January of each year and before the first day of April prepare under oath of two (2) of its officers and deposit in the office of the State Board of Insurance a statement accompanied with the fee for filing annual statements of Twenty Dollars ($20.00) showing the condition of the stipulated premium company on the 31st day of December next preceding, which shall include a statement in detail showing the character of its assets and liabilities on that date, the amount and character of business transacted, monies received, and how expended during the year, and the number and amount of its policies in force on that date and the total amount of its policies in force, except that insureds under family group policies as defined in Art. 22.11, Section 1(b) of this Code will be accounted for only if a reserve is required as to such insured under said Art. 22.11, Section 1(b). The form of such annual statement shall be prepared and determined by the State Board of Insurance. Filing fees collected by the State Board of Insurance under this article shall be deposited in the State Treasury to the credit of the State Board of Insurance operating fund. Article 1.31A of this code applies to filing fees under this article.

Revisor's Note

(1) V.T.I.C. Article 22.06 refers to "the fee for filing annual statements of Twenty Dollars ($20.00)." That specific dollar amount was impliedly repealed by V.T.I.C. Article 4.07, which is a comprehensive fee provision that authorizes the Texas Department of Insurance to set the amounts of various fees, including fees for annual statements. Section D, Article 4.07, provides that Article 4.07 applies to stipulated premium companies, and under 28 Tex. Admin. Code Sec. 7.1301, the fee for an annual statement by a company subject to V.T.I.C. Chapter 22 is $250. Accordingly, the revised law substitutes a general reference to a fee in the amount determined under V.T.I.C. Article 4.07.

(2) V.T.I.C. Article 22.06 refers to December 31 of the "next preceding" year. The revised law omits "next" as unnecessary. "[T]he preceding" means "the next preceding."

(3) V.T.I.C. Article 22.06 requires fees to be deposited in the state treasury to the credit of the State Board of Insurance operating fund. Under the authority of Chapter 4, Acts of the 72nd Legislature, 1st Called Session, 1991, the Texas Department of Insurance operating fund (the later name of the State Board of Insurance operating fund) was converted to an account in the general revenue fund. The revised law is drafted accordingly.

[Sections 884.257-884.300 reserved for expansion]

SUBCHAPTER G. POWERS AND DUTIES RELATING TO COVERAGES

Revised Law

Sec. 884.301. REINSURANCE OF POLICY. (a) A stipulated premium company may reinsure on an individual indemnity policy basis any risk or part of a risk that the company underwrites or assumes.

(b) The reinsurer must be a legal reserve company that:

(1) is authorized to write life, health, and accident insurance in this state; and

(2) has capital and surplus in an amount of at least $200,000.

(c) After reinsuring under Subsection (a), a stipulated premium company may take a credit for the reinsurance against the aggregate reserves required by Subchapter J. (V.T.I.C. Art. 22.07, Sec. 1.)

Source Law

Art. 22.07

Sec. 1. Any stipulated premium company may reinsure on an individual indemnity policy basis with any legal reserve company authorized to write life, health and accident insurance in this state having a capital and surplus or surplus of at least Two Hundred Thousand Dollars ($200,000.00) any risk or part of a risk which the stipulated premium company may issue or assume, and upon such reinsurance proper credit therefor may be taken against the aggregate reserves required by Art. 22.11 of this Chapter.

Revisor's Note

Section 1, V.T.I.C. Article 22.07, refers to "capital and surplus or surplus of at least" $200,000. The revised law omits the phrase "or surplus" because if a company has a surplus of at least $200,000 the combined amount of its capital and surplus is at least $200,000.

Revised Law

Sec. 884.302. LIMITS ON LIFE INSURANCE. (a) Until the amount of the surplus of a stipulated premium company is at least $50,000, the company may not insure one life for more than $1,000 in the event of death from natural causes or more than $2,000 in the event of death from accidental causes, unless the company reinsures the amount of coverage greater than that applicable amount under Section 884.301.

(b) Subsection (a) does not apply to a policy of insurance assumed by a stipulated premium company under Subchapter L.

(c) If the amount of the surplus of a stipulated premium company is at least $50,000 but less than $200,000, the company shall reinsure the insurance amount that exceeds $15,000 on a life insurance risk on one life. (V.T.I.C. Art. 22.07, Secs. 2,

3.)

Source Law

Sec. 2. Until the surplus of any stipulated premium company is at least Fifty Thousand Dollars ($50,000.00), no such stipulated premium company shall insure any life for more than One Thousand Dollars ($1,000.00) in the event of death from natural causes nor more than Two Thousand Dollars ($2,000.00) in the event of death from accidental causes, unless such stipulated premium company reinsures the amount of coverage above One Thousand Dollars ($1,000.00) in the event of natural death and the amount of coverage above Two Thousand Dollars ($2,000.00) in the event of accidental death with a legal reserve company authorized to write life, health and accident insurance in this state having a capital and surplus or surplus of at least Two Hundred Thousand Dollars ($200,000.00); provided, however, the provisions of this Section of this Art. 22.07 shall not apply to policies of insurance assumed by a stipulated premium company pursuant to the provisions of Art. 22.15 of this Chapter.

Sec. 3. If the surplus of a stipulated premium company is at least Fifty Thousand Dollars ($50,000.00) but less than Two Hundred Thousand Dollars ($200,000.00), the stipulated premium company shall reinsure the insurance amount that exceeds Fifteen Thousand Dollars ($15,000) on a life insurance risk on any one life.

Revisor's Note

Section 2, V.T.I.C. Article 22.07, requires certain stipulated premium companies to reinsure certain life insurance policies with "a legal reserve company authorized to write life, health and accident insurance in this state having a capital and surplus or surplus of at least Two Hundred Thousand Dollars ($200,000.00)." The requirements prescribed by Section 2 are identical to those prescribed by Section 1, V.T.I.C. Article 22.07, revised as Section 884.301, which applies to reinsurance of any policy issued by a stipulated premium company. The revised law substitutes a reference to Section 884.301 for the quoted language.

Revised Law

Sec. 884.303. ISSUANCE OF LIFE INSURANCE POLICIES BY CERTAIN COMPANIES. (a) A stipulated premium company that possesses capital and unencumbered surplus in a combined amount of at least $100,000 may issue life insurance policies as authorized for a company operating under Chapter 841.

(b) A stipulated premium company may not insure one life under this section for more than $15,000, except as provided by Section 884.304 or Subchapter I.

(c) A stipulated premium company may issue a policy under

this section only on an endowment or limited pay basis.

(d) A stipulated premium company must reserve and reinsure a policy issued under this section as required for a company operating under Chapter 841. (V.T.I.C. Art. 22.23(a).)

Source Law

Art. 22.23. (a) Each stipulated premium company possessing capital and unencumbered surplus of at least the combined total sum of $100,000.00 may issue policies of life insurance as authorized and permitted under the provisions of Chapter Three of this Insurance Code provided that:

(1) no individual life shall be insured for more than $15,000, except as provided by Section 1(b), Article 22.13, of this code or Article 22.23A of this code;

(2) each such policy shall be reserved and reinsured as required under the provisions of Chapter Three of this Insurance Code; and

(3) each such life policy shall be issued only upon an endowment or limited pay basis.

Revisor's Note

V.T.I.C. Article 22.23(a) refers to policies of life insurance authorized under V.T.I.C. Chapter 3 and to the reservation and reinsurance of a life insurance policy as required under that chapter. The portions of Chapter 3 that relate to the organization of companies that are authorized to write that type of life insurance and that are subject to the appropriate reserve and reinsurance requirements are revised as Chapter 841. The revised law is drafted accordingly.

Revised Law

Sec. 884.304. LIFE INSURANCE OF MORE THAN $15,000. (a) Except as provided by this section, a stipulated premium company may not assume liability on a life insurance risk on one life in an amount that exceeds $15,000.

(b) If a stipulated premium company assumes a life insurance risk under a life insurance policy, the initial death benefit of $15,000 or less may increase to an amount greater than $15,000 subject to this section.

(c) For each policy year of a policy for which, after issuance, the death benefit exceeds $15,000, the amount of the increase of the death benefit at the end of that policy year from the end of the preceding policy year may not exceed the greater of:

(1) the amount computed using the maximum rate of increase provided by the policy, which rate may not exceed five percent a year, compounded annually; or

(2) the amount computed using the consumer price index for all urban consumers for all items and for all regions of the

United States combined, as determined by the United States Department of Labor, Bureau of Labor Statistics, on September 30 of the year preceding the year in which the policy year ends, compounded annually. (V.T.I.C. Art. 22.13, Sec. 1(b).)

Source Law

(b) Except as otherwise provided by this subsection, it shall be unlawful for any stipulated premium company to assume liability on a life insurance risk on any one life in an amount in excess of Fifteen Thousand Dollars ($15,000). If a stipulated premium company assumes a life insurance risk under a life insurance policy, the initial death benefit of Fifteen Thousand Dollars ($15,000) or less may increase to an amount greater than Fifteen Thousand Dollars ($15,000). For a policy in which the death benefit subsequent to issuance exceeds Fifteen Thousand Dollars ($15,000), the death benefit at the end of each policy year may not exceed the greater of the maximum increase as specified in the policy, compounded annually, or the CPI-U, compounded annually. The maximum increase that may be specified in a life insurance policy subject to this article is five percent, compounded annually. For purposes of this subsection, the CPI-U for a given calendar year is the consumer price index for all urban consumers for all items and for all regions of the United States, combined as determined by the United States Department of Labor, Bureau of Labor Statistics, on September 30 of the prior calendar year.

Revised Law

Sec. 884.305. PREMIUMS ON LIFE INSURANCE POLICIES. The premiums charged on a life insurance policy issued by a stipulated premium company may not be less than the renewal net premium computed under the reserve standard adopted by the stipulated premium company and approved by the department. (V.T.I.C. Art. 22.11, Sec. 7.)

Source Law

Sec. 7. Premiums charged on all life policies issued by stipulated premium companies shall be at least equal to the renewal net premium calculated in accordance with the reserve standard adopted by the stipulated premium company and approved by the State Board of Insurance.

Revised Law

Sec. 884.306. LIFE INSURANCE CONTRACT. A life insurance policy issued by a stipulated premium company constitutes the entire contract, except that if a copy of the application for the policy is attached to the policy, the policy and application constitute the entire contract. (V.T.I.C. Art. 22.13, Sec. 1(a)

(part).)

Source Law

(a) . . . The policy, or the policy and the application if a copy of the application is attached to the policy, shall constitute the entire contract. . . .

Revised Law

Sec. 884.307. ISSUANCE OF ANNUITY CONTRACT. (a) A stipulated premium company that possesses capital and unencumbered surplus in a combined amount of at least $100,000 more than all of its liabilities, including contingent liabilities, may issue annuity contracts as authorized by Chapter 3 and Title 7.

(b) The stipulated premium company shall maintain reserves on the contracts in accordance with the statutes governing reserves on equivalent contracts issued by a legal reserve company.

(c) A stipulated premium company that writes annuity contracts under this section shall maintain capital and unencumbered surplus in at least the combined amount required by Subsection (a).

(d) A stipulated premium company that does not comply with Subsection (c) is considered to be insolvent. (V.T.I.C. Art. 22.23(b).)

Source Law

(b) Each stipulated premium company possessing capital and unencumbered surplus of at least the combined total sum of $100,000.00, over and above all liabilities, including contingent liabilities, may issue annuity contracts as authorized and permitted under the provisions of Chapter Three of this Insurance Code. Reserves on such contracts shall be maintained in accordance with the statutes governing reserves on equivalent contracts issued by legal reserve companies, as such laws now exist or as they may hereafter be amended. Any insurer which elects to write annuity contracts under authority of this Article shall thereafter be required to maintain capital and unencumbered surplus of at least the combined total sum of $100,000.00, over and above all liabilities, including contingent liabilities, and any such company shall be regarded as insolvent which fails to maintain capital and unencumbered surplus of at least a combined total sum of $100,000.00, over and above all liabilities, including contingent liabilities.

Revisor's Note

(1) V.T.I.C. Article 22.23(b) refers to the issuance of annuity contracts as authorized by "Chapter Three of this

Insurance Code." Some of the pertinent provisions of Chapter 3 are revised in Title 7 of this code. The revised law is drafted accordingly.

(2) V.T.I.C. Article 22.23(b) requires a stipulated premium company to maintain reserves on annuity contracts it issues "in accordance with the statutes governing reserves on equivalent contracts issued by legal reserve companies, as such laws now exist or as they may hereafter be amended." The revised law omits the phrase "as such laws now exist or as they may hereafter be amended" because under Section 311.027, Government Code (Code Construction Act), applicable to the revised law, a reference to a statute applies to all reenactments, revisions, and amendments of the statute.

Revised Law

Sec. 884.308. LIMITS ON AMOUNT OF ACCIDENT AND HEALTH INSURANCE POLICIES. (a) A stipulated premium company may not assume liability on or indemnify one person for any risk under one or more accident, health, or hospitalization insurance policies, or any combination of those policies in an amount that exceeds $10,000, unless the amount of the issued, outstanding, and stated capital of the company is at least $700,000.

(b) A stipulated premium company that before January 1, 2002, ceases to assume liability on, or indemnify any risk under a policy described by Subsection (a) in the amount specified by Subsection (a), and notifies the commissioner of that action is exempt from the requirements of Subsection (a) until the date the company resumes writing those policies. A company that resumes assuming liability on or indemnifying risks under these policies shall comply with Subsections (a) and (c). For purposes of this subsection, renewal of a policy is not considered to be writing a policy.

(c) A stipulated premium company that is exempt under Subsection (b) shall maintain its issued, outstanding, and stated capital in an amount that is at least:

(1) $100,000, if the last date that the company writes a policy described by Subsection (a) is before January 1, 1993;

(2) $160,000, if the last date that the company writes a policy described by Subsection (a) is during 1993;

(3) $220,000, if the last date that the company writes a policy described by Subsection (a) is during 1994;

(4) $280,000, if the last date that the company writes a policy described by Subsection (a) is during 1995;

(5) $340,000, if the last date that the company writes a policy described by Subsection (a) is during 1996;

(6) $400,000, if the last date that the company writes a policy described by Subsection (a) is during 1997;

(7) $460,000, if the last date that the company writes a policy described by Subsection (a) is during 1998;

(8) $520,000, if the last date that the company writes a policy described by Subsection (a) is during 1999;

(9) $580,000, if the last date that the company writes a policy described by Subsection (a) is during 2000; and

(10) $640,000, if the last date that the company writes a policy described by Subsection (a) is during 2001.

(V.T.I.C. Art. 22.13, Secs. 2(d), (g).)

Source Law

(d) A stipulated premium company may not assume liability on, or indemnify any one person for, any risk under any health, accident, sickness, or hospitalization policy, or any combination of those policies, in an amount in excess of $10,000, unless the issued, outstanding, and stated capital of the company is:

(1) at least $100,000 as of December 31, 1991;

(2) at least $160,000 as of December 31, 1992;

(3) at least $220,000 as of December 31, 1993;

(4) at least $280,000 as of December 31, 1994;

(5) at least $340,000 as of December 31, 1995;

(6) at least $400,000 as of December 31, 1996;

(7) at least $460,000 as of December 31, 1997;

(8) at least $520,000 as of December 31, 1998;

(9) at least $580,000 as of December 31, 1999;

(10) at least $640,000 as of December 31, 2000; and

(11) at least $700,000 as of December 31, 2001.

(g) If a stipulated premium company ceases to write new health, accident, sickness, or hospitalization policies, or any combination of those policies, in an amount in excess of $10,000 for any one risk, and so notifies the commissioner, the requirements imposed under Subsection (d) of this section relating to increase of minimum capital shall be suspended until the date on which the stipulated premium company resumes writing those health, accident, sickness, or hospitalization policies, and upon such resumption of writing of such policies, the stipulated premium company shall be required to increase its capital to the amount required by Subsection (d) as of the date of such resumption of such policy writings. For purposes of this subsection, renewal of a policy is not the writing of a new health, accident, sickness, or hospitalization policy.

Revised Law

Sec. 884.309. ADJUSTMENT OF PREMIUMS. (a) The board of directors of a stipulated premium company by resolution may, subject to this chapter, increase or otherwise adjust a rate of premium on any insurance policy it issues, reinsures, or assumes when, in the board's discretion, the adjustment is necessary.

(b) In making a comprehensive adjustment of one or more

classes of the stipulated premium company's policies, the board of directors may provide that an insured who is required to pay an increased premium may choose to pay a part or none of the amount of the increase and receive a reduction of the corresponding insurance benefits proportionate to the value of the unpaid part of the increase.

(c) This section does not apply to a policy:

(1) issued by a stipulated premium company that on the date the policy is issued possesses an unencumbered surplus in an amount of at least $50,000;

(2) on which the stipulated premium company has relinquished the right to adjust rates; and

(3) under which the premium for life insurance requires the payment of a premium for life insurance that alone is sufficient to maintain reserves at least equal to those computed on the basis of the 1958 Commissioners Standard Ordinary Table of Mortality with interest not to exceed 3-1/2 percent a year. (V.T.I.C. Art. 22.13, Sec. 3 (part).)

Source Law

Sec. 3. [Each stipulated premium company shall provide in all policies of insurance issued, reinsured, or assumed by it for an increase or readjustment,] not inconsistent with the provisions of this Chapter, of the rates of premium on any such insurance contracts, to be effectuated by resolution of its Board of Directors, whenever in their discretion such action becomes necessary. The Board of Directors shall have power in making any comprehensive readjustment of any class or classes of its policies, that any insured required to pay an increased premium may, at his option, in lieu thereof, or in combination therewith, consent to a reduction of the corresponding insurance benefits proportionate to the value of the increased premiums. Such requirement as to such policy provisions shall not apply to policy forms under which the premium for life insurance requires the payment of a premium for life insurance alone sufficient to maintain reserves at least equal to those computed on the basis of the 1958 Commissioners Standard Ordinary Table of Mortality with interest not to exceed three and one-half per cent (3 1/2%) per annum and upon which the right to adjust rates has been relinquished by the stipulated premium company, provided that the stipulated premium company is possessed of free and unencumbered surplus in at least the amount of Fifty Thousand Dollars ($50,000.00) at the date of issuance of each such policy.

Revised Law

Sec. 884.310. AGENT. Each agent of a stipulated premium company must be licensed under Article 21.07. (V.T.I.C. Art. 22.14.)

Source Law

Art. 22.14. All agents of stipulated premium companies shall be licensed in accordance with the provisions of Art. 21.07 of Chapter 21 of this Code.

[Sections 884.311-884.350 reserved for expansion]

SUBCHAPTER H. CONTENTS OF APPLICATIONS AND POLICIES

Revised Law

Sec. 884.351. GENERAL REQUIREMENTS FOR POLICY AND APPLICATION FORMS. (a) Each stipulated premium company policy or application form must contain on its face immediately after the name of the company "A Stipulated Premium Company."

(b) A stipulated premium company shall provide for an adjustment of the premium rate on the insurance contract in each insurance policy it issues, reinsures, or assumes that is subject to a premium adjustment under Section 884.309. Each policy subject to a premium adjustment under that section must contain on the front of the policy a statement that the premium is subject to readjustment.

(c) A stipulated premium company's policy of insurance may not contain "Approved by the Commissioner of Insurance" or words of a similar meaning.

(d) A life insurance policy issued by a stipulated premium company or an application for the policy may not contain language or be in a form that misleads the policyholder or applicant about the kind of insurance offered or the rights or benefits of the policyholder or applicant. (V.T.I.C. Art. 22.13, Secs. 1(a) (part), 3 (part), 6; Art. 22.17 (part).)

Source Law

[Art. 22.13]

Sec. 1. (a) . . . No policy nor the application therefor shall contain language or be in such form as to mislead the applicant or policyholder as to the type of insurance afforded nor as to his rights or benefits.

Sec. 3. Each stipulated premium company shall provide in all policies of insurance issued, reinsured, or assumed by it for an increase or readjustment, . . . of the rates of premium on any such insurance contracts, ...

Sec. 6. No policy of insurance shall be approved for issuance of a stipulated premium company which shall contain thereon the words, "Approved by the State Board of Insurance," or words of a similar import or nature, and it shall be unlawful for any stipulated premium company to ever issue a policy containing

such words or words of a similar import or nature.

Art. 22.17. . . . All stipulated premium company policies and application forms must contain on the face thereof and immediately after the name of the company, the following language: "A Stipulated Premium Company." Each stipulated premium company policy shall provide on the front thereof that the premium is subject to readjustment, unless such policy is not subject to a premium readjustment under the provisions of Section 3 of Art. 22.13 of this Chapter.

Revised Law

Sec. 884.352. REQUIREMENTS FOR ACCIDENT, HEALTH, AND HOSPITALIZATION INSURANCE POLICIES. An accident, health, or hospitalization insurance policy issued, reinsured, or assumed by a stipulated premium company must contain a premium redetermination clause that permits the company's board of directors to adjust the premium rate. (V.T.I.C. Art. 22.13, Sec. 2(b).)

Source Law

(b) All health, accident, sickness and hospitalization policies issued, reinsured or assumed by a stipulated premium company shall contain therein a premium redetermination clause so as to permit a rate readjustment by action of the Board of Directors of the stipulated premium company.

Revised Law

Sec. 884.353. LIFE INSURANCE APPLICATION FORMS. (a) An application for a life insurance policy issued by a stipulated premium company must be signed by the applicant. If the applicant is a minor, the application may be signed by a parent or guardian.

(b) The application for a policy that provides that a misstatement relating to the applicant's health or physical condition may void the policy within the contestable period must state that provision in language approved by the department. The statement must be in not less than 10-point type.

(c) In the absence of fraud each statement in an application is regarded as a representation and not a warranty. (V.T.I.C. Art. 22.13, Sec. 1(a) (part).)