BIENNIAL REPORT OF THE TEXAS DEPARTMENT OF INSURANCE TO THE 76TH LEGISLATURE

DECEMBER 1998

TEXAS DEPARTMENT OF INSURANCE

ELTON BOMER
COMMISSIONER OF INSURANCE

INTRODUCTION

Articles 1.25(a) and 1.25A of the Texas Insurance Code require that the Commissioner of Insurance submit to the appropriate committees of each House of the Legislature and to the Governor, a written report that indicates needed changes in laws relating to regulation of the insurance industry or any other industry or occupation under the department's jurisdiction and that states the reasons for those needed changes.

This report summarizes the changes in the laws that the Commissioner believes are needed for the Texas Department of Insurance (TDI) to continue to effectively regulate the industry. The report also provides the reasons for the needed changes.

Many of the issues included in the report address Health Maintenance Organizations (HMOs) and employer health benefit plans. For example: the solvency of HMOs, HMO complaint and appeal procedures, and withdrawal from the market by an HMO. Other issues relate to technical corrections and streamlining reporting requirements for small and large employer carriers. Also, there are issues involving the Residential Property Market Assistance Program, including the mandatory use of agents and the removal of farm and ranch owners' policies, which are now included under commercial lines. Lastly there are issues involving title insurance audits, the definition of unauthorized insurance, and fire alarm buttons.

The needed changes contained in this report are currently being developed into bill draft form to assist in preparing legislation, should the Legislature choose to do so.

TABLE OF CONTENTS

Issue 1 – Net Worth Requirement for Health Maintenance Organizations (HMOs)

PROBLEM:

Texas laws, unlike the laws of other states, do not establish a net worth requirement for HMOs. Stated differently, Texas does not require HMOs to set aside assets to support all of their liabilities when determining compliance with minimum statutory requirements. This allows a Texas HMO to legally operate in an insolvent position.

BACKGROUND:

Texas does not require HMOs to set aside assets to support certain liabilities to the extent that they are covered by a guaranty or transferred to providers (i.e. doctors) pursuant to certain contractual agreements. In these instances, no party is required to set aside assets to fund these liabilities. Other states do not permit this.

The Texas HMO industry has been and continues to suffer losses, in large part due to intense price competition. On an aggregate basis, the HMOs operating in Texas have been losing money since the second quarter of 1996; and, they lost $322 million in 1997.

Allowing HMOs to operate without a net worth requirement, that requires assets to support all liabilities, greatly increases the risks that an HMO will be operating in a hazardous financial condition and/or at the risk of receivership. No Guaranty Fund protection exists to pay the claims of an HMO that goes into receivership.

SOLUTION:

Amend Article 20A.13 to establish a net worth requirement for HMO's that includes all liabilities; include a phase in period for compliance with the new requirements.

Issue 2 – Risk Based Capital Requirements for HMOs

PROBLEM (Reason Change Needed):

The current required capitalization for HMOs is very low in relation to the risks assumed.

BACKGROUND:

The Texas HMO industry is currently suffering losses, in part, due to the intense price competition. On an aggregate basis, the HMOs operating in Texas have been losing money since the second quarter of 1996; and these HMOs lost $322 million in 1997. No Guaranty Fund protection exists to pay the claims of an HMO that goes into receivership

SOLUTION (Recommended Change):

Amend Article 20A.13 to authorize TDI to adopt rules requiring HMOs to maintain capital and surplus levels in excess of minimum levels required by this article for that HMO based on any of the following:

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;
5. The adequacy of a company's reserves;
6. Number of HMOs enrollees; or
7. Other business risks.

These criteria are similar to the criteria already in place for companies that sell life and health insurance.

Issue 3 – HMO Withdrawal From the Market

PROBLEM (Reason Change Needed):
Currently, there is no statutory provision to address an HMO discontinuing operations in the state or in a region of the state, similar to Article 21.49-2C, Texas Insurance Code. There is also no provision to allow return of an HMOs' statutory deposit if the HMO withdraws from the state.

BACKGROUND:

Article 21.49-2C does not include HMOs. This appears to have been an oversight when the statute was initially enacted.

SOLUTION (Recommended Change):

Repeal Article 20A.13(f) as it now reads and enact a new Article 20A.13(f) to provide the following: "An HMO that is discontinuing operations in this state or in any one service area within this state shall file a withdrawal plan evidencing how the HMO shall: (A) meet its contractual obligations, (B) provide continuity of service to its enrollees and claimants, and (C) provide necessary documents that must be included in such withdrawal plan. An HMO that files a withdrawal plan may request a return of part or all of its deposit with the State Treasurer, and the commissioner may direct the return of such portion that he deems appropriate."

Issue 4 – Complaints and Appeals Procedures of HMOs, URAs and IROs

PROBLEM (Reason Change Needed):

Inconsistencies exist in the complaints and appeals procedures established for HMOs, Utilization Review Agents (URAs) and Independent Review (IROs). Organizations.

BACKGROUND:

Over the years, these statutes have been amended a number of times, however, when one statute has been amended, other are not necessarily amended to ensure consistency among the statutes.

SOLUTION (Recommended Change):
Amend Articles 20A.12, 21.58A, and 21.58C to achieve consistency and harmony in the complaint and appeals procedures for HMOs, URAs and IROs.

Issue 5 – Texas Health Insurance Risk Pool (Health Pool)

PROBLEM:

The current statute, Article 3.77, Section 7 (f), provides for the Health Pool to pay an administering insurer or third party administrator for expenses incurred in performing the duties and functions contracted for by the Health Pool. The statute caps the administrative costs and fees paid by the Health Pool to the administering insurer or third party administrator at 12.5% of the gross premium receipts of the Health Pool for the preceding calendar year. Because the maximum is based on premiums for the preceding year, the fee needed to pay the administering insurer or third party administrator may be greater than 12.5% of the premiums for the preceding year. If the fees exceed the maximum and the Health Pool cannot pay the fees, this would jeopardize the ability for the Health Pool to continue operating. Continued operation of the Health Pool is necessary in order for Texas to remain in compliance with the federal law (Health Insurance Portability and Accountability Act.)

BACKGROUND:

Federal law requires states to comply with HIPAA in one of several ways. The 75th Legislature chose to use a health insurance risk pool in order for Texas to comply and amended Article 3.77 in accordance with HIPAA. The amendments to Article 3.77 were based on the NAIC Model Law for health risk pools as required by federal law. Texas law differs from the model due to the cap on fees paid by the Health Pool to a third party administrator or administering insurer. A cap on the fee that is not sufficient for the Health Pool to remain operational could cause problems with our compliance with HIPAA.

SOLUTION:

Amend Article 3.77, Section 7 (f), to base the 12.5% cap on current year premiums and provide authority for the Commissioner to approve a higher cap not to exceed 15%, only in the event that it is necessary to pay fees and cover claims.

Issue 6 – Texas Property and Casualty Guaranty Association (TPCIGA)

PROBLEM: The statute is not clear that the Texas Property & Casualty Insurance Guaranty Association (TPCIGA) is responsible for paying valid claims which have been deemed by Receivership Court as timely filed.

BACKGROUND: In 1991, Article 21.28, §3(i) was amended to provide that the Receiver refer all "covered" claims to the appropriate guaranty association, notwithstanding any other provision of Article 21.28, §3. Consequently, the filing of a proof of claim ("POC") under Article 21.28, §3(a) was no longer required for covered claims. At the same time, Article 21.28-C was amended to require TPCIGA to pay claims directly. TPCIGA was also given the duty to discharge the insurer's policy obligations, including the defense of insureds. The net result of these changes was that a third party claimant preserved his claim by filing suit within the statute of limitations instead of filing a POC.

In 1993, Article 21.28-C, §8(d) was amended to provide that a covered claim would not include a claim filed with TPCIGA after the later of: 1) the final date for filing claims against the receiver; or, 2) 18 months after the order of liquidation. Thus, under this amendment, claimants were not only required to sue insureds within the statute of limitation, but also file a claim within the claims filing period.

The "final date for filing claims against the receiver" under the Texas Insurance Code is the claims filing deadline set by the Receivership Court under Article 21.28, §3(a). The deadline established under Article 21.28, §3(a) is subject to Article 21.28, §3(b), which authorizes the Receivership Court to accept claims after the filing deadline at its discretion. Under this provision, the Receivership Court will deem a claim as timely filed if no POC was mailed to the claimant, and the claim was known before the claims filing deadline. TPCIGA interprets the law interprets differently and this interpretation can result in a complete loss of benefits to an insured or third party whose claim otherwise qualifies as a covered claim.

SOLUTION: Amend Article 21.28-C, §8(d) by specifically referencing Article 21.28, Section 3(b), which authorizes the receivership court, at its discretion, to accept claims after the claim filing deadline. This would harmonize these sections and give them their intended effect of providing guaranty association coverage to policyholders whose claims have been accepted by the court. This would also clarify that the claim filing deadline under Article 21.28-C, Section 8(d) specifically includes any filing deadlines established under Article 21.28, Section 3(b).

Issue 7 – Yearly Certifications by Small Employer Carriers

PROBLEM (Reason Change Needed):

Article 26.07 currently requires carriers to certify and list **each year** the plans that they are selling to small employers and to identify which ones are and are not subject to the Chapter 26. These annual listings of plans submitted to TDI are unnecessary and serve no real purpose.

BACKGROUND:

Yearly certifications were first included in the statute in 1993 when the first small employer health benefit plan law was enacted. Such certifications have proven to serve no real purpose.

SOLUTION (Recommended Change):

Streamline the reporting process by deleting this requirement of yearly certifications.

Issue 8 – Annual Elections by Carriers Writing Employer Health Plans

PROBLEM (Reason Change Needed):

Currently, Articles 26.07 and 26.82 requires carriers to certify **each year** if they are offering small employer and/or large employer health benefit plans. An annual certification of this type is not necessary since the information can otherwise be obtained.

BACKGROUND:

The original statute Article 26.07 included this requirement for annual certification, which was based on NAIC Model. The information can be obtained in a more cost effective manner.

SOLUTION (Recommended Change):

Streamline the reporting process by amending Articles 26.07 and 26.82 to require carriers to submit an initial notification of whether carriers are offering these plans, with subsequent notification only if a carrier changes its election.

Issue 9 – Participation Requirement

PROBLEM (Reason Change Needed):

Article 26.83 is not clear regarding whether or not companies can require minimum dependent participation in a group health benefit plan. The department's position is that the wording of the statute does not allow a carrier to impose a minimum dependent participation requirement on a group health benefit plan.

BACKGROUND:

Article 26.83 is based on Subchapter C of Chapter 26 which relates to small employer health benefit plans. Since 1993, when Chapter 26 was first enacted, the department has required that small employer carrier offer dependent coverage to for small employer health benefit plans with no minimum dependent participation requirements.

SOLUTION (Recommended Change):

Amend the statute to clarify that a minimum dependent participation requirement is prohibited in large employer health benefit plans. This would be consistent with requirements for small employer health benefit plans.

Issue 10 – Notification to Employers on Discontinuation of Health Benefit Plans

PROBLEM (Reason Change Needed):

Article 26.24(d) (small employer plans) and Article 26. 87(d) (large employer plans) require carriers to give employers at least 90 days' notice before discontinuing coverage under a particular plan. While carriers generally observe this deadline, the carriers often wait until much later to comply with the law requiring them to offer other plans that they are currently selling. As a result, many employers and their employees seek new coverage without knowing that the discontinuing carrier must offer them whatever type of health coverage the carrier is currently selling.

BACKGROUND:

It is the department's understanding that the statute always intended that the offer of other health benefit plans (that a carrier currently sells) should be made within 90 days of discontinuance when the notification of discontinuance of a plan is made.

SOLUTION (Recommended Change):

Amend the statutes to clarify that a carrier must provide 90 days notice, prior to discontinuance, of the availability of other health benefit plans offered by the carrier.

Issue 11 – Texas Residential Market Assistance Program (MAP)

PROBLEM (Reason Change Needed):

Article 21.49-12, Section 2(b)(1) requires the department to accept applications only from agents duly licensed by the department. Consumers therefore can not apply directly for coverage through the MAP. If an applicant contacts the department directly, the department must refer the applicant to an originating agent. Some agents to whom the department refers applications are offering surplus lines policies for immediate coverage. The average time taken for the agents to return an application for coverage through the MAP is approximately thirty days. By the time the participating company receives the application and ultimately offers a quote the applicant is not interested or has obtained alternative coverage, such as surplus lines coverage.

BACKGROUND:

The requirement for accepting applications only through agents was included in the original statute creating the MAP. Since the MAP has been in place for several years, the department has determined that a more streamlined approach would likely help MAP applicants to expedite their applications for MAP coverage and possibly allow the applicants to obtain coverage sooner.

SOLUTION (Recommended Change):

Delete the requirement that an applicant must go through an originating agent when applying for MAP coverage. This would then allow department staff to assist the applicant in partially completing the application, then the department could directly refer the applicant to the participating companies.

Issue 12 – Texas Residential Market Assistance Program (MAP)

PROBLEM:

Farm and ranch owners policies and farm and ranch policies are now a line of commercial property insurance and should no longer be included in the definition of residential property insurance contained in Article 21.49-12, regarding the Texas Residential Property Market Assistance Program.

BACKGROUND:

Last session the 75th Texas Legislature enacted SB1499. One component of the bill amended Article 5.13-2, Insurance Code to include farm and ranch owners and farm and ranch policies as a line of commercial property insurance. This change requires a corresponding change in the definition of residential property insurance contained in Article 21.49-12, regarding the Texas Residential Property Market Assistance Program.

SOLUTION:

Amend the definition of residential property insurance contained in Article 21.49-12, Section 1(a) by deleting the words “farm and ranch owners policy”.

Issue 13 – Audit of Agent and Insurer Escrow and Trust Accounts

PROBLEM (Reason Change Needed):

Article 9.48, Section 14(c)(13), does not specifically extend authority for title auditors to audit insurer escrow and trust accounts. The department auditors should be able to access such records pertaining to title insurance agents on an as-needed basis; such as investigating possible rebating violations.

BACKGROUND:

When House Bill 2960, effective 6/17/95, amended Article 9.48, Section 14(c)(13) of the Texas Title Insurance Guaranty Act to extend specific authority for additional responsibilities for the title auditors, the words "and insurer", which had been part of the Act from its inception, were omitted. The exact phrase previously was "…a person or persons who will audit and review agent *and insurer* escrow and trust accounts. Although the title insurance auditors do not normally audit records of title insurance companies, a number of these companies maintain accounting records pertaining to Texas title insurance agents and direct operations in their corporate offices.

SOLUTION (Recommended Change):

Amend the statute and include the phrase "and insurer" into the paragraph so that it reads: "(13) shall, on the request of the commissioner, authorize the expenditure of funds from the guaranty fee account to retain, compensate, and reimburse for reasonable and necessary expenses, a person or persons who will audit and review agent *and insurer* escrow and trust accounts, financial condition, and compliance with applicable statutes and rules and make reports relating to the accounts, agent financial condition, and compliance to the commissioner, solely under the direction or and as assigned by the commissioner;

Issue 14 – Annual Audit (Title)

PROBLEM (Reason Change Needed):

Art. 9.39 requires an annual audit by an independent CPA of the escrow and trust accounts of each licensed title agent.

This statute also requires every title insurance company (underwriter) to examine and analyze the audit report furnished by each of its agents and direct operations and submit a report to the Board within three months. To implement this requirement, the department adopted Form T-19.

These requirements are obsolete. Department staff reviews each audit report received, therefore, the company analysis is no longer needed.

In addition, some questions have been raised regarding the deadline for title insurance companies to report to TDI when escrow audit reports are not received from title agents or direct operations. Current language says "…shall forthwith report such omission…" "Forthwith" is not defined.

BACKGROUND:

There are currently 556 licensed title agents, many with multiple licenses. In all, there are 1456 licenses for which underwriters must submit Forms T-19 every year.

The information contained on these forms is no longer useful. The information was useful - even critical - at one time when the staff allocated to Title functions was very limited. Sufficient staff was allocated to the Title Division several years ago; therefore, staff is able to review in detail all audit reports received. Currently, our Title staff reviews audit reports (on an average) within two weeks of receipt.

SOLUTION (Recommended Change):

Amend the statutes to provide that title companies have 30 days to notify TDI when their agents or direct operations fail to submit audit reports to the underwriters on time. Also amend the statutes to allow agents and direct operations 90 days from the close of their fiscal years to submit the audit reports.

Issue 15 – State Fire Marshal's Office
Fire Alarm Licensing and Alarm Panic Buttons

PROBLEM (Reason Change Needed):

A licensed security firm that installs residential burglar alarm systems is required to obtain a fire alarm license if the firm activates a fire alarm button on a residential burglar alarm system. The firms generally disable the fire button so that they do not have to obtain the required license. A homeowner who is unaware of this fact could encounter a delay in summoning firefighters in the event of a fire.

BACKGROUND:

Licensed security firms generally install one or two family residential burglar alarm systems. These systems always have a three button (police, fire, medical) key pad (panic button). Since the "fire" button initiates a fire alarm, installers have been required to obtain a fire alarm license. To avoid the fire alarm licensing requirements, security firms simply disable the fire button.

SOLUTION (Recommended Change):
Amend Article 5.43-2, Section 3(b) to exempt firms (installers), that are licensed for security under the Private Investigators and Private Security Agencies Act, from the fire alarm licensing requirements when installing a fire alarm panic button in a one or two family dwelling. The installation of smoke detectors and other fire detection devices would still require a license.

Issue 16 – Unauthorized Insurance

PROBLEM (Reason Change Needed):

The current statutory definition of engaging in the business of insurance sometimes makes it difficult to determine whether a particular act is unauthorized insurance. As a result, district attorneys are reluctant to prosecute a person who is operating as an agent without the required license or whose agent's license has been revoked. Consequently, the sale of insurance by unlicensed and revoked agents is not being adequately prosecuted

BACKGROUND:

To interpret what is considered unauthorized insurance, several different section of Article 1.14-1 must be reviewed. This creates difficulty in prosecuting acts of persons involved in unauthorized insurance.

SOLUTION (Recommended Change):

Amend Article 1.14-1, Sections 2, 3, and 13, to clarify the definition and to specify that it is an offense to engage in the business of insurance:

1. Without a valid certificate of authority, license, authorization or exemption from the department, or
2. After the Commissioner has revoked or suspended one's certificate of authority, license or other authorization.