August 2001

Texas Insurance News

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TDI Issues Emergency Rules On Privacy of Financial Info

COMMISSIONER JOSE MONTEMAYOR has adopted emergency rules for the protection of non-public personal financial information in the hands of insurance companies, agents and other entities regulated by TDI.

At the heart of the rules are disclosure requirements and an opportunity for consumers to instruct regulated entities not to share non-public financial information obtained from or about them.

The emergency rules took effect on July 12, 2001, and were published in the July 27, 2001, *Texas Register*. The rules are codified as 28 TAC §§ 22.1–22.26.

To give insurers and other regulated entities time to establish their own policies and systems, Montemayor extended the date for compliance to September 11, 2001.

Simultaneously with issuance of the emergency rules, the Department proposed adoption of the same rules on a permanent basis.

Senate Bill 712 of the 77th Legislature authorized the Commissioner to adopt emergency rules based on the NAIC model to bring Texas insurers into compliance with the Gramm-Leach-Bliley Act's requirements for the protection of non-public personal financial information.

Most other financial services institutions fall under federal regulation and already have issued the disclosures and opt-out information required by the Office of the Comptroller of the Currency (OCC) and other federal agencies.

The 77th Legislature also passed Senate Bill 11, which calls for protection of non-public personal health information in the hands of insurance companies, utilization review agents, HMOs and other entities regulated by TDI. The Department hopes to propose rules patterned after the NAIC's model for health information as early as this fall.

Montemayor issued Commissioner's Bulletin B-0030-01 on June 26, 2001, explaining TDI's plans for compliance with GLBA, Senate Bill 712 and Senate Bill 11.

TDI staff developed an explanation of the emergency rules on financial information in a simple Q-and-A format. The explanation is available on TDI's Web site, **www.tdi.state.tx.us**, and is paraphrased below.

Q Why is TDI adopting these rules?

A Title V of GLBA requires states to adopt standards relating to the disclosure of non-public personal financial information applicable to the insurance industry.

Q Who must comply with the financial privacy rules?

A All "covered entities" that issue or provide products or services primarily for personal, family or household purposes. A covered entity is any individual or entity subject to regulation by the Commissioner of Insurance and authorized to do business in Texas as provided by *Texas Insurance Code* Section 82.002. However, the rules exempt covered entities from certain requirements under certain circumstances. Some of these exceptions are explained later in this article.

Q What is non-public personal financial information?

A Any information, other than health information, that a covered entity collects about an individual and which falls under the definition of "personally identifiable financial information." This can be information obtained from an individual's insurance application, as well as information collected as a result of claims submissions and other transactions. It also includes information obtained from consumer reporting agencies and by tracking people who have used the entity's Web site. It can include such things as income information, credit history and premium payment history. Even phone numbers and addresses may fall under this definition. However, the rules provide exceptions for information that is publicly available from sources such as phone books and non-confidential government records.

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INSIDE

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By necessity, summaries of proposed and adopted rules cannot explain their full complexity. Readers interested in complete information about administrative rules should consult the versions published in the Texas Register.

To the best of the staff's ability, information presented in this newsletter is correct as of the publication date, but scheduled dates and proposed rules and amendments may change as the adoption process goes forward.

Agents'Corner

By **Matt Ray,** *Deputy Commissioner, Licensing Division*

SENATE BILL 414 reduced the number of agent licensing authorities from 44 to 23. TDI plans to issue a Commissioner's bulletin in the near future providing additional information on implementation of this bill. Meanwhile, the conversion table below summarizes the "roll-up" of the old license types into the new, broader authorities.

Adjuster licenses and the Managing General Agent (08-00), Suplus Lines Agent (09-00) and Life and Health Insurance Counselor (11-00) licenses were left unchanged.

Company-Administered Examinations

Senate Bill 414, the sweeping agent licensing reform bill that takes effect on September 1, authorizes insurance companies to administer examinations for three limited licenses:

- Life insurance under $15,000, sold mainly by stipulated premium companies, statewide mutual assessment companies, local mutual aid associations and local mutual burial associations,
- Pre-need- funeral prearrangement, and
- County mutual agent.

TDI will draft the life insurance under $15,000 and county mutual examinations, which should be available for distribution around August 15, 2001. The pre-need funeral examination is already in use and will not change.

Applicants for these license types must complete a five-hour training course and pass the company-administered examination before they apply for licensing. Companies must submit the outlines and contents of their training courses for TDI's approval.

On-Line Exam Scheduling

Starting in October, candidates for agent licenses in Texas will be able to schedule their examinations quickly and easily at the Web site of TDI's testing contractor, Experior Assessments LLC.

Experior's Web site is **www.experioronline.com**. Candidates will be able to register, pay for the exam, select an appointment time and place and print an immediate confirmation report. The Web site is a secure environment. Candidates will be able to pay exam fees securely by credit card. T he entire process can be completed in one step with no extra fees.

Experior tests for most agent licenses, including the general life/health and property and casualty licenses. However, not all licenses require an examination by TDI or its contractor. ★

Life, Accident and Health License Article 21.07-1

RETAINED OR NEW LICENSE	LICENSE TO BE ROLLED UP
General Lines–Life, Accident, Health and HMO (01-01)	01-02–Agent for Legal Reserve Combination or Industrial 01-03–Agent for Legal Reserve Selling Accident and Health-only and HMO 02-92–Stipulated Premium—Life-only Over $15,000 02-93–Stipulated Premium–Accident and Health 02-94–Stipulated Premium–Life Insurance Over $15,000 and Accident and Health 02-08–Casualty Selling Accident and Health 02-09–Agent for United States Military Personnel in Foreign Country 04-00–Variable Contract Agent 04-01–Bank Selling Annuities (Fraternal benefit society agents will become licensed under the 01-01 license authority)
Preneed-Funeral Prearrangement (01-04)	None
Life Under $15,000	02-91–Stipulated Premium—Life-only Under $15,000 02-02–Statewide Mutual 02-03–Local Mutual 02-04–Burial

Property and Casualty License Article 21.14

General Lines–Property and Casualty (05-01)	05-10–Local Recording Agent-Temporary 06-00–Solicitor for Local Recording Agent 10-00–Non-Resident Property and Casualty Agent
Insurance Service Representative for Local Recording Agent (06-01)	None
Full Time Home Office Employees (07-01)	None
County Mutual Agent (02-06)	None

Limited Lines License

Limited Lines–Multiple Lines (02-00)	02-05–Credit Insurance Agent 02-07–Ticket Agent Selling Accident and Health 02-10–Job Protection 03-00–Agricultural Agent 05-02–Local Recording Agent—Motor Vehicle-only 15-00–Prepaid Legal Services Agent

Specialty Licenses Article 21.09

Specialty–Credit (02-95)	None
Specialty–Travel (02-96)	None
Specialty–Rental Car Company (02-97)	None
Specialty–Self Storage Facility (02-98)	None
Specialty–License–Telecommunications	New License

TDI update

Corpus Christi Hearing On Mold Coverage Set

COMMISSIONER JOSE MONTEMAYOR will hold a public hearing on the mold coverage provided by Texas residential property insurance policies on Tuesday, August 21, 2001, in Corpus Christi.

The hearing will begin at 10 a.m. in the Warren Theatre at Texas A&M University-Corpus Christi, 6300 Ocean Drive. It will last as long as people are signed up to testify, but no later than 5 p.m. People may sign up at the hearing.

This is the second in a series of three hearings on mold coverage. About 500 people attended the first one, in Austin, on June 26, 2001. The third hearing will be in Houston on a date yet to be determined.

TDI scheduled the Corpus Christi hearing at the request of State Senator Carlos Truan and State Representatives Vilma Luna and Gene Seaman, all of Corpus Christi.

Testimony and comments can be e-mailed to **CommercialPC@tdi.state.tx.us**, faxed to **512-463-6607** or mailed to

Texas Department of Insurance
Homeowners Division (MC 104-1F)
P.O. Box 149104
Austin, Texas 78714-9104.

Shortly after the Corpus Christi hearing, an audio recording of testimony will be available on TDI's Web site at **www.tdi.state.tx.us/comish/audio.html**. An audio recording of the Austin hearing currently is available at that Web address.

The hearings are designed to gather information and comments on mold coverage, the causes of mold and health consequences of mold exposure. ★

PersonalNotes

Brady Named to Head HMO Division

KEVIN BRADY, deputy commissioner of TDI's Financial Program for the past five years, has become acting head of the Department's HMO Division.

Kim Stokes, senior associate commissioner of the Life, Health and Licensing Program, announced Brady's appointment as acting deputy commissioner in charge of HMO.

Brady replaces Blake Brodersen, who left TDI to take a position in the private sector.

Brady joined TDI's Financial Program in 1984, shortly after receiving his bachelor's degree in finance from Southwest Texas State University in San Marcos.

He began his career as a financial examiner and holds the certified financial examiner (CFE) designation. Brady later served as a senior analyst/team leader in the Financial Monitoring Division, director of reinsurance and director of the Surplus Lines Section.

For the past five years, Brady has been deputy commissioner of the Financial Program, serving most recently as back-up to Senior Associate Commissioner Betty Patterson. He has testified before the Texas Legislature on a number of matters, including HMO solvency issues.

Brady is active in the NAIC and serves as the Department's NAIC liaison. ★

EnforcementActions

Chiropractor Pleads Guilty in Fraud Case

MARK ALLEN DARNER, an Arlington, Texas, chiropractor, has pleaded guilty in federal court to charges of conspiracy to commit mail fraud in connection with fraudulent medical claims that cost insurance companies approximately $3.2 million over a five-year period.

Darner entered his plea in U. S. District Court in Fort Worth. Judge John McBryde received the plea and scheduled sentencing for October 12, 2001.

The indictment against Darner accused him of using the U. S. mail to submit false claims for medical services and to receive checks from insurance companies. It also alleged that his activities involved medical doctors and other individuals.

The scheme involved claims totaling approximately $5.7 million that were submitted to 84 insurance companies during the period 1996-2000. Insurers actually paid about $3.2 million of these claims.

TDI's Insurance Fraud Unit began investigating Darner's activities in March 1997 and cooperated with several federal agencies including the Internal Revenue Service, the FBI, U. S. Postal Service and the Department of Labor. Assistant U. S. Attorney Ronald C. H. Eddins was the prosecuting attorney.

According to the federal prosecution, the scheme involved:

- Creation of "shell" entities to make it appear that services were provided by legitimate clinics or other health service businesses.
- Billing for physician encounters that never took place, at rates of $60 to $120 per visit. Claims were filed naming particular medical doctors as treating physicians when the doctors neither saw the patients nor supervised their treatment.
- False billings for MRI and X-ray examinations.
- Falsification of patient charts to show CPT code designations for medical procedures that either did not occur at all or were different from, and more expensive than, the services actually received by patients.

Prosecutors said "patients" in many cases were people who merely had gone to a gym owned by Darner to work out.

Another aspect of the case involved TDI complaint forms signed in blank by "patients." If an insurer refused to pay a fraudulent claim, Darner or a fellow conspirator would fill out a pre-signed complaint form without the patient's knowledge and send it to TDI. ★

Privacy... from page 1

Q What about health information?

A Later this year, TDI will propose health information privacy rules consistent with federal privacy regulations under the Health Insurance Portability and Accessibility Act (HIPAA). TDI's rules will apply to health care plans and other TDI-regulated entities that conduct business relating to health care plans and will employ an "opt-in" standard..

Q What do the financial privacy rules require a covered entity to do?

A Covered entities must provide notices explaining their privacy policies. They must also give **consumers** and **customers** of products or services that are primarily for personal, family or household purposes an opportunity to opt out of the sharing of protected information to non-affiliated third parties.

Consumers. A consumer is an individual who seeks to obtain, is in the process of obtaining or has obtained a product or service from a covered entity. For example, an individual who has submitted an insurance application is a consumer of the company to which he or she has applied, even if a policy is never issued. The following also are considered consumers for purposes of the financial privacy rules:

- a beneficiary of a life insurance policy underwritten by the covered entity;
- a claimant under an insurance policy issued by the covered entity;
- an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the covered entity;
- a mortgagor of a mortgage covered under a mortgage insurance policy.

Notice must be given to a consumer only if the covered entity intends to disclose or share protected information to or with a non-affiliated third party. The notice must indicate the kind of information the covered entity collects and its policy for maintaining and sharing information. The notice also must explain how the consumer can opt out of any planned disclosure to a non-affiliated party.

Customers. A customer is a consumer with whom a covered entity has an ongoing or "customer" relationship. Once an insurer issues a policy to a consumer, for example, an ongoing relationship is established and the consumer becomes a customer of the insurer.

A covered entity must provide its customers an initial privacy notice explaining the kind of information it collects about them and its policies for maintaining and sharing that information. In addition, a covered entity must provide an annual notice as long as any customer relationship continues. If a covered entity changes its privacy policy after issuing initial or annual notices, it must send revised notices to its customers.

If a covered entity plans to share protected financial information with any non-affiliated third party, it must tell its customers how to opt out of the planned disclosure. If an entity later adds information items to those it intends to disclose, it must provide an opportunity to opt out as to that information as well.

Q What's does "opt out" mean? How is it different from "opting in"?

A Under an opt out standard, information about individuals generally may be shared unless they notify the holder of the information that they do not want the information shared.

Under an opt in standard, the general rule is that a covered entity will not share protected information unless the subject of the information signs an authorization or consent that expressly allows sharing. No initial or annual notices are required. The federal HIPAA privacy rules employ an opt-in standard, as will the health information privacy rules that TDI intends to propose later this year.

Q How long does an opt out last?

A An opt out remains in effect until the customer or consumer revokes it in writing. A person may cancel an opt-out electronically if he or she has agreed to conduct business with a company through the Internet or by e-mail.

Q What does a notice look like?

A Notices must be written so that they are conspicuous and can be read clearly. For example, they cannot be in difficult-to-read type or hidden on the back of a page in the middle of a large mailing. They must contain particular information, including:

- the types of information the covered entity collects about an individual;
- how the covered entity protects the confidentiality and security of the collected information
- the types of information that the covered entity discloses;
- the types of entities to which the covered entity intends to give an individual's information (including affiliates and third parties);
- the types of information and the entities to which the covered entity intends to give information for joint marketing purposes; and
- an explanation of the individual's right to opt out and instructions for notifying the covered entity not to share information with unaffiliated third parties.

The rules contain sample notice forms that a covered entity may use if a form accurately reflects the covered entity's actual privacy policy.

Q What must a covered entity do to comply with these rules if it does not share protected financial information?

A In the case of a consumer, no action must be taken. In the case of a customer, simplified initial and annual notices are permitted. See also the question below pertaining to covered entities that do not have a consumer/customer relationship.

Q Do I have to send an initial notice to everyone I've ever had contact with?

A No. A covered entity has 60 days from the effective date of the rules to send notices to every customer with whom it has a continuing relationship. After that, however, an initial notice must be given to each new customer and, if information about consumers is to be shared with non-affiliates, to each new consumer.

Q What happens if an insurance company or other covered entity fails to send the required notices?

A Failure to provide a required notice is a violation of TDI rules and is subject to enforcement action by the Department. In addition, an enforcement action for unfair trade practices under *Texas Insurance Code* Article 21.21 may be taken. An individual whose information has been shared in violation of the rules may bring a civil action against a covered entity, regardless of any action taken by TDI.

Q How can my company conduct business if it is required to get permission for everything it does?

A The rules do not require a company to get permission to share information that must be shared in order to conduct its ordinary business or to comply with another law. The purpose of privacy requirements is to prevent the unauthorized sharing of personal information for purposes other than the purpose for which an individual originally provided the information.

Protected information may be shared with third parties, without regard to an opt out, for ordinary activities such as servicing an account, claims administration and policy issuance. It may also be shared without permission whenever the company or other entity has a legal

Privacy... page 8

HEALTH CARE

APA Adoptions

Point-of-Service Contracts

■ Commissioner Jose Montemayor has adopted new and amended rules under the TAC chapters on HMOs, trade practices, and large and small employer health plans concerning point-of-service plans. The proposals implement House Bill 1498 of the 76th Legislature, which added Articles 26.09 and 3.64 to the *Texas Insurance Code* and amended Articles 20A.02 and 20A.06.

Point-of-service (POS) plans combine managed care and indemnity coverage. An enrollee may choose to obtain health care through the managed care delivery system or from a physician or provider outside the delivery system on a fee-for-service basis.

HMOs

The adopted rules for HMOs wishing to issue POS riders are codified as new 28 TAC 11.2501–11.2503 (Subchapter Z).

HMOs must meet certain solvency requirements before they may issue a POS rider.

An HMO licensed for a year or longer must maintain the greater of the minimum net worth required by the *Texas Insurance Code* or the sum of 100 percent of the HMO's authorized control level of risk-based capital and 25 percent of total gross POS premium revenue reported in the preceding year.

An HMO licensed for less than a year must maintain a net worth of at least the sum of the minimum net worth required by the insurance code for that HMO and 50 percent of the yearly average of the two-year annual gross POS premium revenue projected in its application for a certificate of authority.

Admitted assets of the HMO must be sufficient to cover reserve liabilities for POS riders.

If an HMO's net worth or assets fall below the required amounts, it must stop issuing new POS rider plans (with some exceptions) until it complies with the prescribed solvency requirements. Exceptions are new members of a plan to which an HMO has already committed to furnish POS riders unless the HMO divests itself of the group's business or stops writing a particular individual plan.

An HMO's POS rider expenses may not exceed 10 percent of the total annual medical and hospital expenses for all health plan products sold by the HMO. If POS rider expenses exceed the 10 percent limit, the HMO must immediately stop issuing new POS rider plans, with certain exceptions. An HMO may resume selling POS rider plans if it satisfies the Commissioner that its POS expenses in the coming year will stay within the 10 percent cap.

POS rider plans are guaranteed renewable for small and large employer plans, individual plans and association plans. If an HMO discontinues a POS rider plan because it exceeds the 10 percent cap, the HMO must offer small and large employers, individuals and associations the option to buy any other coverage offered to such customers.

HMOs may not require enrollees to use either the POS rider benefits or in-plan covered services first. Nor may they consider an in-plan covered service to be a benefit provided under the POS rider. HMOs using POS riders are subject to the applicable provisions of *Texas Insurance Code* Chapter 20A and Articles 21.21, 21.21-A, 21.21-1, 21.21-2, 21.21-5 and 21.21-6.

An HMO that has limited provider networks may not restrict an enrollee's access under a POS rider to either network or non-network physicians and providers. The HMO also may not impose different cost-sharing arrangements when a POS enrollee in a limited provider network uses a participating physician or provider outside that limited provider network. An HMO may, however, impose a different cost-sharing arrangement when such an enrollee uses physicians and providers outside the HMO network. Coinsurance required under a POS rider may not exceed 50 percent of the total amount to be covered.

Among other things, a POS rider must:

- Provide coverage corresponding to all in-plan covered services provided in the evidence of coverage and through any separate riders attached to it.
- Disclose, if applicable, how POS rider cost-sharing arrangements differ from those in the evidence of coverage. This disclosure must include any reduction in benefits and any deductible to be met by the enrollee. The disclosure also must state whether co-payments for in-plan covered services apply toward the POS rider deductible.
- Provide coverage for services obtained from a participating physician or provider without the HMO's authorization. The enrollee, however, must comply with any applicable cost containment requirements.
- Describe how an enrollee may access out-of-plan covered benefits under the POS rider, including coverage contained in other riders attached to the evidence of coverage.
- Disclose all cost-containment requirements for coverage under the POS rider, including penalties for failure to comply with any cost containment provisions. Such penalties may not reduce benefits by more than 50 percent in the aggregate.

The rules prohibit POS riders from:

- Reducing or limiting in-plan covered services in any way by coverage for benefits an enrollee obtained under the POS rider.
- Limiting (with certain exceptions) coverage for benefits that correspond to in-plan covered services.

A POS rider may (but is not required to):

- Include benefits in addition to in-plan covered services.
- Limit or exclude coverage for benefits not corresponding to in-plan covered services.
- Include reasonable out-of-pocket limits and annual and lifetime benefit allowances that differ from the limits or allowances for in-plan covered services provided under other riders. Any such limits and allowances must comply with applicable state and federal laws.
- Provide for cost-sharing arrangements that differ from those for in-plan covered services. However, coinsurance under a POS rider may never exceed 50 percent of the total amount to be covered.

Benefits under a POS rider may be reduced by benefits obtained as in-plan covered services.

POS rider plans must include an evidence of coverage that adequately notifies prospective or current enrollees that the plan provides the option of accessing either participating or non-participating physicians and providers for out-of-plan covered benefits but that using the POS rider may cost more than accessing in-plan covered services.

A POS rider plan also must contain a side-by-side comparison of coverages for services, benefits and supplies available under the POS rider with those shown in the evidence of coverage.

Continued on page 6

RuleMaking

Publication: 26TexReg5007, July 6, 2001
Effective date: July 10, 2001
Further information: 512 463-6327

POS Arrangements Between Indemnity Carriers and HMOs

The new rules governing these arrangements are codified as 28 TAC §§ 21.2901–21.2902 (Subchapter U). They define terms and set forth requirements for blended contract POS plans and dual contract POS plans.

A blended contract plan is a POS plan, evidenced by a single contract, policy, certificate or evidence of coverage, that provides a combination of indemnity benefits for which an indemnity carrier is at risk and services are provided by an HMO.

A dual contracts plan is a POS plan providing a combination of indemnity benefits and HMO services through separate contracts. One of these is the contract, policy or certificate offered by an indemnity carrier for which that carrier would be at risk. The other contract is the evidence of coverage offered by the HMO.

Point-of-service indemnity coverage is that for which an indemnity carrier is at risk under a POS plan for health care services, benefits and supplies (other than emergency services), selected at the enrollee's option, from non-participating physicians or providers. POS indemnity coverage also includes services, benefits and supplies obtained from participating physicians or providers under circumstances in which the enrollee fails to comply with the requirements of the HMO.

A POS plan established under the new rules must be evidenced by a written agreement between the HMO and the indemnity carrier. The agreement must be filed with TDI as a plan document. Each such agreement must provide:

- The identity of each entity - the HMO, the indemnity carrier or any third-party administrator (TPA) that will administer the coverages offered under the POS plan.
- All duties of the HMO and the indemnity carrier to each other.
- All POS plan costs allocable to the HMO or the indemnity carrier.
- The HMO's network of providers and, if the indemnity coverage includes preferred provider benefits, the indemnity carrier's preferred provider list. The preferred provider list may not be identical to the HMO's provider network.
- Separately derived and identified premium rates for both the HMO coverage and the indemnity coverage. The HMO, the indemnity carrier or a TPA may collect the premiums for both coverages. The purchaser of the POS plan may make a single payment for both coverages. The entity delegated to collect the premium is required to disburse the appropriate premium to the other party or parties.

Premium rates charged by an HMO must be based on the actuarial value of the POS HMO coverage and may differ from the premium rates charged by the indemnity carrier. The indemnity carrier must base its rates on the actuarial value of the POS indemnity coverage offered by that carrier.

An agreement between an HMO and an indemnity carrier must require that each party keep separate books and records for the POS plan.

Neither entity may use the other to perform functions or duties that are its own responsibility by law or rule. However, the entities may delegate functions and duties that state laws or rules allow to be delegated, including contracting with providers and administering claims.

A POS agreement between an indemnity carrier and an HMO may not be canceled or terminated until the coverage for each affected enrollee is terminated or cancelled as provided by the adopted rules.

An agreement must spell out the arrangements to be made if insolvency or other circumstance affects the ability of either party to comply with TDI rules.

Contracts creating blended contract or dual contract POS plans must provide that:

- Enrollees may not be required to first use either the indemnity coverage or the HMO coverage.
- If premiums necessary to maintain both the HMO and the indemnity coverage are not paid, both coverages will be cancelled simultaneously.
- The POS HMO evidence of coverage must include all mandatory HMO coverages, and the POS indemnity coverage must contain all mandatory indemnity coverages.
- Mandatory benefit offers must be accepted or rejected by the purchaser in the same manner with respect to both the POS HMO and the POS indemnity coverage.
- Benefits under the HMO coverage may not be reduced by benefits received under the indemnity coverage. However, benefits for POS indemnity coverage may be reduced by benefits received under the POS HMO coverage.
- If medically necessary covered services, benefits and supplies are not available through the HMO's participating physicians and providers, the availability of such services through POS indemnity coverage does not relieve the HMO of its obligation under *Texas Insurance Code* Article 20A.09 to provide out-of-network services.

Each POS contract must identify the respective premium rates for the HMO coverage and the indemnity coverage. It also must give the name and address of the entity to which the premiums must be paid.

In addition to these general requirements, contracts for POS **blended contract** plans are required to list all POS HMO and indemnity coverages; specify how services, benefits and supplies under the POS HMO coverage are assessed; specify how indemnity claims are to be made, disclose all required deductibles and co-payments; and disclose all coinsurance required for POS indemnity coverage. Coinsurance may not exceed 50 percent of the total amount to be covered. These contracts also must disclose all cost-containment requirements for POS indemnity coverage, including penalties for failing to comply with cost containment provisions. Such penalties may not reduce benefits by more than 50 percent in the aggregate.

When a POS **dual contract** plan is issued, there must be separate requirements for the contracts issued by the indemnity carrier and the HMO. The contract issued by the indemnity carrier must meet all applicable requirements for such carriers and list all indemnity coverages, specify how claims are made, disclose applicable copayments and coinsurance (not to exceed 50 percent of total amount covered), and disclose all cost-containment requirements, including any penalties for failing to comply with those requirements. Penalties may not reduce benefits by more than 50 percent. The HMO's contract must comply with all requirements for an HMO evidence of coverage and also must list all covered services, benefits and supplies; specify how the enrollee may access them and disclose all applicable copayments.

Publication: 26TexReg5014, July 6, 2001
Effective date: July 10, 2001
Further information: 512 463-6327

Small and Large Employer Plans

Adopted rule changes governing such plans are codified as amendments to 28 TAC §§ 26.4 and 26.14 and as new 26.312.

The amendments do the following:

- Update the definition of point-of-service contract to reflect the types of POS plans authorized by House Bill 1498 for issuance by large and small employer carriers.
- Clarify that small and large employer carriers may issue POS plans if they comply with the new rules summarized in the preceding two sections.
- Create standards for the POS coverage options that large employer carriers issuing HMO coverage must offer to eligible employees when the only coverage available to those employees is one or more HMOs.

When two or more HMOs provide coverage to the employees of a large employer that offers only network-based delivery systems to its employees, the HMOs may enter into a written agreement designating which one will offer the required POS option. Each participating HMO must retain a copy of the agreement and make it available to TDI upon request. If one HMO stops offering coverage to the large employer, the remaining HMOs must enter into a new agreement. If, for some reason, there is no written agreement, each HMO serving the large employer is required to offer eligible employees the option of selecting out-of-plan coverage.

Employees who select a POS option are responsible for paying all cost-sharing amounts, including premiums, coinsurance, copayments and deductibles, plus any administrative cost imposed by the employer under *Texas Insurance Code* Article 26.09(e). Premiums must be based on the actuarial value of the POS coverage and could differ from the premium for in-plan coverage provided by the HMO.

Publication: 26TexReg5017, July 6, 2001
Effective date: July 10, 2001
Further information: 512 463-6327

RuleMaking

PROPERTY

Exempt Proposal

New Public Protection Classification

■ Commissioner Jose Montemayor will hold a public hearing August 22, 2001, under Docket No. 2489 on a staff petition proposing Fire Suppression Rating Schedule amendments that would establish a new public protection classification, 8B, and set forth criteria for eligibility for the new classification. The petition also proposes conforming amendments to the *Texas Personal Lines Manual* and the Texas Statistical Plan for Residential Risks if the new classification is established.

The hearing will be at 9:30 a.m., in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe, Austin.

The proposed revision to the Fire Suppression Rating Schedule (FSRS) would provide lower property insurance rates in recognition of an improved level of fire protection in some areas that now have a Class 9 public protection classification. The proposed Class 8B would represent a fire protection delivery system that has improved fire fighting capability through equipment, training and management techniques but which lacks a water supply system capable of the minimum FSRS fire flow criterion of 250 gallons per minute for two hours. The water supply standard for Class 8B would be an uninterrupted fire flow of 200 gallons per minute for 20 minutes, beginning within five minutes of the first arriving engine company.

In addition to the new classification and conforming amendments, the staff petition also proposes to:

- Update the Fire Suppression Rating Schedule in its references to the new classification and re-number the rules referencing Class 9.
- Delete outdated rate capping and previous key rate references in the *Texas Personal Lines Manual* since the public protection classification system has been in effect long enough that rate capping factors no longer are needed.
- Correct a typographical error.

Publication: 26TexReg5447, July 20, 2001
Reference No. P-0701-07-I
Further information and copies: 512 463-6326 ★

Data Call Reminders

(Failure to comply with TDI's reporting requirements may result in disciplinary action)

Quarterly Closed Claim Reports

Reports (Long/Short Forms) for claims closed during the second quarter of 2001 were due by July 10, 2001. Reports for claims closed during the third quarter of 2001 are due by October 10, 2001.

The call for the 2000 Annual Aggregate Closed Claim Report and Closed Claim Reconciliation was mailed July 20, 2001, as Commissioner's Bulletin No. B-0032-01. The acknowledgment is due on August 10, 2001. The data call is due September 10, 2001. The bulletin and forms may be downloaded from TDI's Web site at **http://www.tdi.state.tx.us/company/indexcmp.html#datacalls_ind** TDI contact is Vicky Knox, 512 475-1879. E-mail address: **vicky.knox@tdi.state.tx.us**

Call for Quarterly Experience

The Call for Second Quarter 2001 Experience was mailed July 2, 2001, as Commissioner's Bulletin No. B-0031-01 and is due August 15, 2001. The bulletin and forms may be downloaded from TDI's Web site at **http://www.tdi.state.tx.us/company/indexcmp.html#datacalls_ind**. TDI contact is Julie Jones, 512 475-3030. E-mail address: **julie.jones@tdi.state.tx.us**

Call for Quarterly Experience, Workers' Compensation Deductible Plans

The Call for Second Quarter 2001 Experience was mailed July 2, 2001, as Commissioner's Bulletin No. B-0031-01 and is due August 15, 2001. The bulletin and forms may be downloaded from TDI's Web site at **http://www.tdi.state.tx.us/company/indexcmp.html#datacalls_ind**. TDI contact is Julie Jones, 512 475-3027. E-mail address: **julie.jones@tdi.state.tx.us**

2001 Texas Title Insurance Company Call For Experience For The Calendar Year Ended December 31, 2000,

was mailed June 7, 2001, and was due July 30, 2001. The bulletin and forms may be downloaded from TDI's Web site at: **http://www.tdi.state.tx.us/commish/b-0026-1.html**. TDI contact is Julie Jones, 512 475-3030. E-mail address: **julie. jones@tdi.state.tx.us** ★

Privacy... *from page 4*

obligation to do so, such as reporting of suspected fraud or in response to a TDI information request. It also may be shared with affiliated companies as well.

The privacy requirements kick in only when a covered entity wants to share information for a purpose that is not an integral part of conducting the business of insurance. Under the rules, the use of such information by a company marketing on its own behalf is permissible. However, if a consumer has opted out, this information cannot be shared for marketing on behalf of some other entity.

Q Do the rules about financial privacy apply to HMOs?

A Yes. Any information that an HMO collects about a consumer that fits the definition of non-public personal information that does not constitute health information is subject to the financial privacy rules. This can include such things as income information, credit history, and premium payment history. However, if a company does not share this information for non-insurance related business, nothing is required beyond a simplified annual notice.

Q Do HMOs have to comply with both the HIPAA privacy rules and TDI's privacy rules?

A No. A covered entity that is in compliance with the HIPAA rules is exempt from compliance with TDI's privacy rules. As stated earlier, the HIPAA rules use an opt in standard. They require that a health care payor, which would include an HMO, obtain consent from an individual before releasing information protected under the rules for any reason other than a business reason exempted under the rules or pursuant to state or federal law. An HMO that has not yet come into compliance with the HIPAA privacy rules would need to comply with TDI's financial privacy rules. Once an HMO comes into compliance with the HIPAA rules, it would not need to comply with the financial privacy rules.

Q How about utilization review agents (URAs), third party administrators (TPAs) and independent review organizations (IROs)? Are they required to send out notices about financial information?

A All entities that hold a license or authorization from TDI are covered entities that are subject to the financial privacy rules. However, the financial privacy rule requires that notices be provided only to consumers or customers. A URA or a TPA that only provides services to another covered entity, such as an insurer or an HMO, is not considered to have established a customer or consumer relationship with a consumer or customer of the insurer or HMO so long as the URA or TPA does not share any information that it receives from the insurer or the HMO. This should not affect URAs because 28 TAC Chapter 19 requires URAs to maintain the confidentiality of patient information.

If a covered entity, relying on this exception, does not provide notices but later shares protected financial information received from a covered entity about an individual, that individual is immediately deemed to be a consumer of the covered entity and the release is deemed to violate the notice requirements for consumers under the rule.

IROs do not provide services to customers or consumers nor are they acting on behalf of a covered entity. In addition, they are prohibited by law from disclosing any personal financial information received about an individual whose care is subject to review. Therefore, they are not required to provide notice under the financial privacy rules.

Q Do the privacy rules apply to agents and adjusters?

A Yes. However, an agent or adjuster who discloses protected financial information only to the insurer on whose behalf the information was collected does not have to comply with the notice and opt out requirements if the company itself is in compliance.

However, if the agent or adjuster intends to shares the information with anyone other than the insurance company, the agent or adjuster must provide separate notices and opt out opportunities as required by the rules.

In addition, if an agent, for a fee, provides other services to an individual such as financial, investment or economic advisory services relating to an insurance product, that individual becomes the agent's customer and must receive all required notices about the agent's privacy policy and, if the agent plans to share information with any third party, the opportunity to opt out.

Q How will an agent know which companies have complied with the notice requirements so the agent doesn't have to?

A It is up to the company and the agent to determine who will provide the notice on behalf of the company. The initial notice required by the rules must be given as soon as a person becomes a customer. Some companies may require the agent to provide the initial notice. In that case, it will be the company's responsibility to provide the agent with the notice form to be used. After that, however, TDI anticipates that most companies will take responsibility for providing the follow up and annual notices required by the rule.

Q What about independent agents that share information with several insurers in order to get offers for clients?

A An independent agent who shares information with multiple insurance companies to obtain the best price quote for a client does not need to provide notices to the client. It is the responsibility of each insurance company to comply with the notice requirements as to that client. Under the rules, the client is considered a consumer of each company to whom the client's information is provided, and if the client purchases coverage from one of the companies, the client becomes the customer of that company.

However, if the agent discloses or plans to disclose that information to anyone other than the companies, the agent must send that client all required notices and provide the client with the opportunity to opt out.

Q What about beneficiaries and claimants against a policy issued by an insurer?

A If a covered entity wishes to disclose protected financial information about a named beneficiary or claimant to third parties, the insurer must provide the beneficiary or claimant with its privacy policy and the opportunity to opt out. No annual notices are required. The covered entity may disclose financial information to its affiliates.

Q Do the financial privacy rules apply to farm and ranch policies?

A No. Farm and ranch policies are classified as commercial insurance products. The rules do not apply to information about companies or about individuals who obtain products or services for business, commercial or agricultural purposes. ★

DisciplinaryActions

Editor's Note: *Copies of individual orders may be obtained by calling TDI's Public Information Office, 512 463-6425.*

AGENTS & AGENCIES NAME	CITY	ACTION TAKEN	VIOLATION	ORDER	DATE
Corpus Christi Security Title Services	Corpus Christi	$1,000 Fine	Late Filing of Annual Audit Report	01-0561	6/18/01
Kennell, David Maddox	Houston	Property and Casualty Agent's License Revoked	Misappropriation or Conversion	01-0541	6/13/01
Lutes, Judy A.	Scottsdale, AZ	Non-Resident Property & Casualty Agent's License Revoked	Felony Conviction	01-0504	6/4/01
Medina, Victor S.	Corpus Christi	$5,000 Fine and Cancellation of Qualified Inspector Appointment	Failure to Substantiate Building Certifications; Signing Certifications After Engineer's License Expired	01-0513	6/5/01
Metropolitan Title Co.	Dallas	$900 Fine	Late Filing of Annual Audit Report	01-0563	6/18/01
Miller, Jerome	Houston	Adjuster's License Revoked	Fraudulent and Dishonest Practices; Felony Conviction	01-0427	5/9/01
Montemayor, Manuel J.	Brownsville, TX	$7,500 Fine and One-Year Probated Suspension of Qualified Inspector's Appointment	Failure to Provide Substantiating Information for Building Certifications	01-0569	6/18/01
Russell-Surles Title Inc.	Baird	$1,100 Fine	Late Filing of Annual Audit Report	01-0562	6/18/01
Udomfu, Isaiah Joseph	Houston	County Mutual Agent's License Revoked; Payment of $715 in Restitution	Misappropriation and/or Conversion	01-0521	6/6/01
Were, Francis R.	Houston	Property and Casualty Agent's License Revoked	Misappropriation or Conversion; Fraudulent and Dishonest Acts	01-0540	6/13/01

COMPANIES NAME	CITY	ACTION TAKEN	VIOLATION	ORDER	DATE
Allianz Insurance Co.	Burbank, CA	$7,500 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0605	6/25/01
American Idea Life Insurance Co.	Stamford, CT	$2,500 Fine	Failure to Respond to TDI Information Request	01-0565	6/18/01
Americom Life & Annuity Insurance Co.	Houston	$15,000 Fine	Consent Order; Alleged Unapproved Affiliate Transaction and Failure To Notify TDI of Three Transactions Involving Company Assets	01-0601	6/21/01
Atlas Assurance Company of America	Keene, NH	$3,000 Fine	Failure to Respond to TDI Information Request	01-0498	6/4/01
Cedar Hill Assurance Co.	Scottsdale, AZ	$500 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0536	6/13/01
Commercial Indemnity Insurance Co.	Austin	$500 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0535	6/13/01
The Connecticut Indemnity Co.	Hartford, CT	$3,000 fine	Failure to Respond to TDI Information Request	01-0503	6/4/01
Cumis Insurance Society Inc.	Madison, WI	$7,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0512	6/5/01
Directors Life Assurance Co.	Oklahoma City	$3,000 Fine	Consent Order; Alleged Failure to Respond to TDI Information Request	01-0567	6/18/01
First National Insurance Company of America	Seattle, WA	$10,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0594	6/21/01

Continued on page 10

DisciplinaryActions

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COMPANIES NAME	CITY	ACTION TAKEN	VIOLATION	ORDER	DATE
Gallant Insurance Co.	Bedford Park, IL	$500 Fine	Failure to Respond to TDI Information Request	01-0510	6/5/01
GAN National Insurance Co. (Now known as Rampart Insurance Co.)	New York, NY	$9,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0559	6/18/01
General Insurance Company of America	Seattle, WA	$13,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0593	6/21/01
Hanover Insurance Co.	Worchester, MA	$17,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0501	6/4/01
Hanover Lloyds Insurance Co.	Worchester, MA	$1,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0500	6/4/01
Lewis Life Insurance Co.	Marshall	$3,000 Fine	Failure to Respond to TDI Information Request	01-0499	6/4/01
Liberty Insurance Underwriters Inc.	Boston, MA	$3,000 Fine	Failure to Respond to TDI Information Request	01-0511	6/5/01
Massachusetts Bay Insurance Co.	Worchester, MA	$5,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0502	6/4/01
Mountain Valley Indemnity Co.	Manchester, NH	$2,500 Fine	Failure to Respond to TDI Information Request	01-0564	6/18/01
National American Insurance Company of California	Rancho Dominguez, CA	$500 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0537	6/13/01
National Continental Insurance Co.	Mayfield Village, OH	$1,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0566	6/18/01
National Foundation Life Insurance Co.	Fort Worth	Order Prohibiting Extra-Contractual Incentives and Requiring Payment at Preferred Provider Rate for Emergency Care and Certain Specialist Care	Consent Order; Alleged Extra-Contractual Incentives and Under-Payment of Certain Claims	01-0520	6/6/01
Progressive Casualty Insurance Co.	Mayfield Village, OH	$1,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0568	6/18/01
Safeco Insurance Company of America	Seattle, WA	$17,000 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0592	6/21/01
Southern United Fire Insurance Co.	Mobile, AL	$3,000 Fine	Failure to Respond to TDI Information Request	01-0533	6/13/01
Standard Insurance Co.	Portland, OR	$2,500 Fine	Failure to Respond to TDI Information Request	01-0534	6/13/01
Unicare Life and Health Insurance Co.	Thousand Oaks, CA	$1,500 Fine	Failure to Respond to TDI Information Request	01-0545	6/14/01
Valley Forge Life Insurance Co.	Reading, PA	$7,500 Fine	Consent Order; Alleged Failure to File Internet Ad for Long-Term Care Insurance with TDI Prior to Use	01-0538	6/13/01
Western Continental Insurance Co.	Scottsdale, AZ	$500 Fine	Failure to Make Required Refunds of Workers' Compensation Maintenance Tax Surcharges	01-0560	6/18/01

DisciplinaryActions

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HMOS	NAME	CITY	ACTION TAKEN	VIOLATION	ORDER	DATE
	Driscoll Children's Health Plan	Corpus Christi	$5,000 Fine	Failure to Employ a Full-time Medical Director and Other Violations of HMO Act and TDI HMO Rules	01-0546	6/14/01

URAS	NAME	CITY	ACTION TAKEN	VIOLATION	ORDER	DATE
	Heritage Southwest Medical Group, PA	Dallas	$10,000 Fine	Consent Order; Alleged Violations of Utilization Review Agent Requirements	01-0570	6/18/01

CompanyLicensing

Applications Pending

For admission to do business in Texas

COMPANY NAME	LINE	HOME OFFICE
Ace Guaranty Re Inc.	Fire & Casualty	New York, NY
American Physicians Network Inc. (doing business under the assumed name of Oregon American Physicians Network Inc.)	TPA	Portland, OR
American Summit Insurance Co.	Fire & Casualty	Scottsdale, AZ
National Benefit Resources Inc.	TPA	Minneapolis, MN
Senior Life Insurance Co.	Life	Thomasville, GA
Spectera Inc.	TPA	Baltimore, MD
Technology Insurance Co.	Fire & Casualty	Nashua, NH

For incorporation

Allied Claims Solutions, LLC	TPA	Dallas, TX
National Administrators Inc.	TPA	Houston, TX
Pacific Specialty Lloyd's	Fire & Casualty	Austin, TX

For name change in Texas

FROM	TO	LINE	LOCATION
Chrysler Insurance Company	DaimlerChrysler Insurance Co.	Fire & Casualty	Southfield, MI
Memorial Hermann Affiliated Services Inc.	University Place	CCRC	Houston, TX
The Nippon Fire & Marine Insurance Co. Ltd., U.S. Branch	Nipponkoa Insurance Company, Limited (U.S. Branch)	Fire & Casualty	New York, NY
Nobel Insurance Co.	Stonington Insurance Co.	Fire & Casualty	Dallas, TX
The Ohio Life Insurance Co.	Chase Life and Annuity Co.	Fire & Casualty	Columbus, OH
Unified Life Insurance Company of Texas	Unified Life Insurance Co.	Life	Austin, TX
The Yasuda Fire & Marine Insurance Company of America	Sompo Japan Insurance Company of America	Fire & Casualty	New York, NY

Applications Approved

For admission to do business in Texas

COMPANY NAME	LINE	HOME OFFICE
Camico Mutual Insurance Co.	Fire and/or Casualty	Redwood City, CA
CBCA Inc.	TPA	Wilmington, DE
R.V.I. America Insurance Co.	Casualty	Stamford, CT

For incorporation

COMPANY NAME	LINE	HOME OFFICE
Cimarron Administrators Inc.	TPA	Dallas, TX
Highlander Financial Services Inc.	TPA	Spring, TX
Texscripts, L.P.	TPA	Fort Worth, TX

For name change in Texas

FROM	TO	LINE	LOCATION
AG. Workers Life Insurance Co.	American Farm Life Insurance Co.	Life	Fort Worth, TX
AXA Nordstern Art Insurance Corp.	AXA Art Insurance Corp.	Fire & Casualty	New York, NY

Continued on page 12

CompanyLicensing

Applications Approved

For name change in Texas

FROM	TO	LINE	LOCATION
Baltica-Skandinavia Reinsurance of America Inc.	ICM Insurance Co.	Fire & Casualty	New York, NY
Florida Physicians Insurance Company Inc.	First Professionals Insurance Company Inc.	Casualty	Jacksonville, FL
NAC Reinsurance Corp.	XL Reinsurance America Inc.	Fire & Casualty	New York, NY
Sunamerica National Life Insurance Co.	SBLI USA Financial Services Life Insurance Company Inc.	Life	Phoenix, AZ

Fraud Unit Prosecutions

Indictments

Lark, Nedra Dale, indicted in Dallas on charges of insurance fraud, a state jail felony.

Cavaluzzi, Anthony. indicted in Austin on charges of making a false statement in a written instrument, a third-degree felony.

Cleveland, Eric R., indicted in Austin on charges of making a false statement in a written instrument, a third-degree felony.

McLeod, Joann, indicted in Dallas on charges of theft, a third-degree felony.

Villanueva, Angie Lee, indicted in Austin on charges of making a false statement in a written instrument, a third-degree felony.

Convictions

Beck, Cathleen Mathis, pleaded guilty in Bell County to theft, a state jail felony. Sentenced to five years' deferred adjudication, 90 days in jail, 220 hours of community service, $9,795.59 restitution and a $500 fine.

Fernandez, Victor, pleaded guilty in Austin to attempted false statement, a Class A misdemeanor. Sentenced to 12 months' deferred adjudication, 80 hours of community service and a requirement that he not work in the business of insurance.

Kearns, Thomas, pleaded guilty in Dallas federal court to mail fraud and investment advisor fraud. Sentenced to 90 months in jail, 60 months' probation upon release from prison and $2,693,146 in restitution.

Fluder, Swakina Kiyotna, pleaded guilty in Dallas to insurance fraud, a state jail felony. Sentenced to five years' deferred adjudication, a $1,000 fine and $1,318.74 in restitution.

Hernandez, Cecillia, pleaded *nolo contendere* in San Antonio, convicted of insurance fraud, and sentenced to 24 months in a state jail. ★

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