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Texas InsuranceNews

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Turning Bills into Regulatory Reality Takes Major Implementation Effort

WHEN THE 78th Legislature ended its regular session on June 2, TDI followed up on the lawmakers' work by shifting immediately into the "implementation" phase that will be a major preoccupation of the Department for months to come.

Implementation fleshes out the general provisions of newly enacted statutes into regulatory reality and can have a major effect on the way insurers, HMOs and other regulated entities do business in Texas.

The 78th Legislature enacted more than 60 bills amending the *Texas Insurance Code* or otherwise affecting the insurance industry, TDI and various entities regulated by the Department. Major subjects of the new legislation were health care coverage (28 bills) and property insurance (12 bills).

Lawmakers rightly expect TDI to promptly and diligently carry out each of the new insurance laws they have passed.

Government Relations

Getting it all done promptly and assuring that implementation accurately reflects legislative intent requires much coordination. At TDI, the Government Relations Division, headed by Associate Commissioner David Durden, is responsible for this effort. When the Legislature is in session, Government Relations reviews and tracks bills, coordinates TDI testimony before legislative committees and assists legislators who need input from the Department. During the 78th Legislature, Government Relations tracked 645 bills.

Each of TDI's operating programs appoints legislative liaisons to work with Government Relations in reviewing and commenting on bills during the session. When the session ends, the legislative liaisons assist Government Relations in developing TDI's implementation plan by identifying the actions necessary to carry out each provision of every bill that was enacted. The liaisons track their programs' progress in following the plan and work to assure that each bill is fully implemented.

Implementation Plan

The implementation plan for the 78th Legislature calls for several hundred distinct actions that TDI must take.

Some implementation measures are big enough to command newspaper headlines. These include review and possible modification of homeowners rate filings made by companies previously exempt from rate regulation. TDI's Property and Casualty Program has an August 10, 2003, deadline to approve or modify homeowners rates filed by companies with $10 million or more in annual homeowners premium.

Rulemaking is a major implementation requirement. Other actions that may be needed include issuing interpretive bulletins, updating manuals, producing or revising forms, establishing or changing internal procedures, appointing advisory committees and rewriting consumer publications to reflect new rights and realities. These actions are spelled out in the implementation plan, which is updated at least quarterly.

The implementation plan is available on TDI's Web site at **www.tdi.state.tx.us/commish/78bills/legindex.html**. Besides listing required actions and pinpointing responsibilities, the plan is a check list that shows at a glance what has been done and what still needs to happen. Bulletins, proposed rules and adopted rules also are available on the Web site.

Short Deadlines and New Duties

A unique characteristic of the 78th Legislature was the enactment of several bills containing very specific—and sometimes very short—deadlines for TDI to implement various features.

For example, Senate Bill 418, which tightened the state's "clean claim"laws, gave the Commissioner

Please see **Implementation** *on page 9*

INSIDE

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The staff that prepares this newsletter has no role in proposing, drafting, editing, or approving TDI rules or policies or interpreting statutes. **TexasInsurance News** *should not be construed to represent the policy, endorsement or opinion of the Commissioner of Insurance or the Texas Department of Insurance.*

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.

NewsBriefs

Texas Insurance News To Become TDInsight

AFTER MORE THAN 10 years, **Texas InsuranceNews** is being redesigned. The transformation begins next month, when ***TDInSight,*** a new, expanded, comprehensive bi-monthly publication, is unveiled.

With much of TDI's technical information now available on the agency's website **www.tdi.state.tx.us,** ***InSight*** will focus on the latest insurance news, as well as on actions taken by the agency to promote a healthy industry and a fair market for Texas consumers.

Many popular features of **TIN** will continue in the new publication. ***InSight*** will still include insurance news briefs, information on company licensing and the latest disciplinary actions. However, ***InSight*** also will include rotating features from divisions within TDI, a calendar of upcoming events and a message from the Commissioner.

We are excited about the upcoming premiere of ***InSight*** and hope that you will continue to turn to TDI for the latest information about insurance and industry regulation.

Note: *Current subscribers of* **TIN** *will receive the same number of issues they originally contracted for.* ★

WPI-1 Apps Must Show Coastal Barrier Locations

TDI HAS NOTIFIED the coastal home building industry and Texas P&C carriers that applications for windstorm inspections (WPI-1) must clearly show if a structure is in the Coastal Barrier Resources Area designated by federal law.

The area in question consists of territory located seaward of the Intracoastal Canal in a first-tier coastal county and portions of Galveston, Brazoria, Matagorda and Kleberg Counties located in the Inland I area defined by TDI in 28 TAC § 5.4008.

Senate Bill 14 of the 78th Legislature amended the Texas Windstorm Insurance Association law to provide that single-family dwellings in the Coastal Barrier Resources Area (CBRA) are "insurable property" if the building permits or plats were filed before the bill's effective date, June 11, 2003.

In Commissioner's Bulletin B-0024-03, Deputy Commissioner Alexis Dick of TDI's Inspections Division advised the coastal construction industry as well as insurers that a complete application for a windstorm inspection must include **1)** a statement indicating if the structure is in the CBRA as defined by the Flood Insurance Rate Map and if so, **2)** a copy of the file-stamped building permit or plat showing a file date before June 11, 2003. ★

TDI Receives Tech Award from NAIC

THE NATIONAL Association of Insurance Commissioners has recognized TDI for successfully implementing all 12 technology-based initiatives that make up the NAIC's Uniform Regulation Through Technology program.

The URTT award was presented to the Department during the NAIC's summer meeting in New York City on June 22, 2003. ★

Fraud Unit Prosecutions

Indictments

Evans, Jan, was indicted in San Antonio on charges of insurance fraud, a third-degree felony.

George, Reginald, was indicted in Houston on charges of securing the execution of a document by deception, a state jail felony.

Johnson, David Glenn, was indicted in Dallas on charges of insurance fraud, a state jail felony.

Miller, Frederick Charles, was indicted in the U.S. District Court for the Northern District of Texas in Fort Worth on charges of one count of wire fraud; five counts of theft from a health care benefit program; and five counts of conducting monetary transaction with criminally derived funds.

Powell, Kathy, was indicted in San Antonio on charges of insurance fraud, a state jail felony.

Roberts, Matthew, was indicted in Houston on charges of insurance fraud, a state jail felony.

Vallier, Craig, was indicted in Houston on charges of insurance fraud, a state jail felony.

Case Dispositions

Davos, Rose Mary, was sentenced in Houston to three years' deferred adjudication, 200 hours of community service and restitution of $4,906 for theft, a state jail felony.

Hanson, Craig S., was sentenced in Austin to 120 months' deferred adjudication, 180 hours of community service and restitution of $40,000 for misapplication of fiduciary property, a second-degree felony.

Howard, Charles F., was sentenced in the U.S. District Court for the Northern District of Texas (Fort Worth) to 80 months' confinement, a $100 fine and restitution of $2,814,364 for conducting a monetary transaction with criminally derived funds.

Martinez, Evelyn, was sentenced in San Antonio to four years' deferred adjudication, a $500 fine and restitution of $12,155 for securing the execution of a document by deception, a state jail felony.

McMillin, David, paid $117,038 in restitution in Giddings for theft, a second-degree felony.

Stanfield, Darrell, was sentenced in Gatesville to 10 years' deferred adjudication and restitution of $20,265 for arson, a second-degree felony. ★

Data Call Reminders

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

Quarterly Closed Claim Reports

Reports (Long/Short Forms) of claims closed during the second quarter of 2003 were due July 10, 2003. The forms may be downloaded from TDI's Web site located at **http://www.tdi.state.tx.us/company/indexpc.html** TDI contact is **Vicky Knox, 512 475-1879.** E-mail address: **vicky.knox@tdi.state.tx.us**

Closed Claim Reconciliation Report

The 2002 Annual Aggregate Closed Claim Report and 2002 Closed Claim Reconciliation Form were mailed mid-July. The forms may be downloaded from TDI's Web site located at **http://www.tdi.state.tx.us/company/indexpc.html** 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 2003 Experience is due August 15, 2003. The bulletin and forms may be downloaded from TDI's Web site located at **http://www.tdi.state.tx.us/general/download/b-0027-3.exe** 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 2003 Experience is due August 15, 2003. The bulletin and forms may be downloaded from TDI's Web site located at **http://www.tdi.state.tx.us/general/download/b-0027-3.exe** TDI contact is **Julie Jones, 512 475-3030.** E-mail address: **julie.jones@tdi.state.tx.us** ★

TDI update

Health Risk Pool Rates to Increase

COMMISSIONER Jose Montemayor has granted the request of the Texas Health Insurance Risk Pool to increase its rates by an average of 16.6 percent.

The pool's new rates and rate schedules will take effect on September 1, 2003.

Pool rates are determined by applying a multiplier to the "standard rate," which averages the rates charged by the five largest issuers of individual A&H policies. The *Texas Insurance Code* limits the multiplier to 200 percent.

The increase taking effect in September is due entirely to trend. The multiplier will remain at its present 180 percent. The trend increase is attributable to higher rates charged by the five largest writers of individual A&H policies and to a change in the five largest writers. Because of changes in their total in-force policies, one carrier dropped off and one (with higher rates) was added to the list of the five largest individual A&H writers.

The pool, activated by the Legislature in 1997, now has an enrollment of 22,320 lives. ★

EnforcementActions

Federal Judge Assesses Prison Terms in $2.8 Million Fraud Against Allstate

A **PAROLED MURDERER** has been sentenced to federal prison for carrying out an elaborate scheme to get an insurance adjuster's license and then bilk Allstate out of more than $2.8 million in fraudulent claim payments. His alleged accomplice also drew a federal prison sentence.

Charles Francis Howard, 56, of Irving, and Andrew Krumm, 60, of Dallas were convicted in federal court of conducting monetary transactions with criminally derived funds ("money laundering")

Howard entered a guilty plea and was sentenced by Judge John McBryde of the U.S. District Court for the Northern District of Texas to 80 months in federal prison and $2.8 million in restitution to Allstate.

A federal court jury in Fort Worth convicted Krumm, who subsequently was sentenced by Judge McBryde to 46 months in federal prison, plus a $75,000 fine. .

TDI's Insurance Fraud Unit investigated the activities of Howard and Krumm and referred the case for prosecution by federal authorities. The FBI, Internal Revenue Service and U. S. Postal Inspection Service also took part in the investigation. The case was prosecuted by Assistant U. S. Attorney Ronald C. H. Eddins.

Howard had been convicted of homicide in San Antonio in 1976 in connection with the death of Richard C. Forestello. Howard was sentenced to 75 years in a Texas state prison but was paroled in December 1987 after serving 10 years of his sentence.

In 1995, Howard applied for an insurance adjuster's license, using a fictitious birth date and Social Security number and changing his middle initial to conceal his true identify and his criminal history. Howard also concealed his criminal record when he applied for a job with Allstate after receiving his adjuster's license.

Allstate hired Howard as a claim adjuster and gave him authority to write checks to settle auto and homeowners claims.

Evidence in the case showed that between February 1995 and April 2002, Howard falsified computerized loss reports to document Allstate claim checks he issued to carpet cleaners and other businesses, supposedly on behalf of policyholders. However, the checks written to further the claim fraud scheme went into bank accounts opened by Howard in the name of two businesses, ARC and Amigos Carpet Cleaning, without their knowledge.

Among other things, Howard and Krumm used the money obtained through the fraudulent claims to buy and operate bars in the Dallas area.

After Howard completes his federal prison sentence, he will be returned to the Texas Department of Criminal Justice as a parole violator to serve out the rest of his sentence for the San Antonio murder. ★

Mid-Continent Casualty Agrees to $70,000 Fine for Use of Unapproved Mold Rider

COMMISSIONER Jose Montemayor has fined Mid-Continent Casualty Co. of Tulsa, Oklahoma, $70,000 for misleading more than 1,500 Texas business customers into thinking their commercial liability policies did not cover mold.

Mid-Continent consented to the fine, which also punished the company for attaching mold exclusion endorsements to commercial general liability and umbrella policies without the required approval from the Texas Department of Insurance.

According to the Commissioner's order, Mid-Continent attached the unapproved endorsements to policies as they were renewed by customers between July 1, 2001, and January 18, 2002. Mid-Continent previously had filed the endorsements for approval but withdrew them after learning that TDI intended to hold hearings on mold before considering any new policy language excluding mold coverage.

Without TDI's approval, the endorsements were not valid and did not modify the policies to which they applied. The policies thus continued to provide the businesses with coverage for losses arising from fungi, allergens, mildew or mold.

Please see **Mold** *on page 9*

RuleMaking

ADMINISTRATION

APA Adoption

TDI Employee Training

■ Commissioner Jose Montemayor has adopted amendments to 28 TAC §§ 1.2702 and 1.2703 regarding training for TDI employees. The amendments reflect current policy and procedures and also address requirements of the General Appropriation Act enacted by the 77th Legislature in 2001.

The adopted amendments include, but are not limited to, these changes from previous rules:

- Include Internet-based training as a component of TDI's employee training program, including new employee orientation.
- Clarify that incomplete courses are not eligible for tuition reimbursement or education leave.
- Provide that reimbursement is not available for federal income taxes incurred because of education assistance paid by the Department.
- Require that employees take classes scheduled during the lunch hour or outside of business hours when classes are available at such times rather than request education leave to take classes during the working day.
- Authorize managers to require employees who have completed training programs to assume additional job duties for which the training prepared them and to share with other employees the information acquired through the training.

Publication: 28TexReg5186, July 4, 2003
Effective date: July 8, 2003
Further information: 512 463-6327

AUTOMOBILE

Exempt Proposal

Disclosures by Rental Car Company Employees

■ The Department has proposed amendments to Rule 141, Rental Car Companies, of the *Texas Automobile Rules and Rating Manual* concerning mandatory disclosures to automobile renters.

TDI staff recommends repeal of the requirement that a rental car company employee verbally inform prospective renters that they may already have an insurance policy that duplicates the auto rental liability insurance offered by the company. Staff also recommends repeal of the requirement that prospective renters be told verbally that purchase of automobile rental liability insurance is not required as a condition for renting an automobile.

Certain car rental companies petitioned for the repeal of the verbal disclosure requirements, saying they slowed rental transactions, have no consumer benefit and are imposed by Texas alone among the states. TDI staff agreed with the request, saying that the statute underlying the underlying statute had been amended since the rules were adopted and was subject to an interpretation that written disclosures would suffice.

Publication: 28TexReg4933, June 27, 2003
Reference No. A-0603-13-I
Further information: 512 463-6327

HEALTH CARE

APA Proposals

Rules Implementing Senate Bill 418, Concerning Payment of Providers

■ The Department has proposed new and amended rules to implement Senate Bill 418 of the 78th Legislature. The rules were developed in consultation with the Clean Claims Working Group and the Senate Bill 418 Technical Advisory Committee. A public hearing on the proposed rules will be held on August 7, 2003, at 9:30 a.m. in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe, Austin.

Senate Bill 418 made significant changes in the laws requiring HMOs and preferred provider insurance carriers to pay promptly the clean claims submitted by their contracted physicians and providers. Some of the proposed rules also would apply to non-contracted physicians and providers who give emergency care or who provide services not reasonably available on the network of an HMO or preferred provider carrier. For brevity, the following summary of the proposed rules refers to physicians and providers as "providers" and to HMOs and preferred provider carriers as "carriers." The rule proposals are summarized in TAC order.

TDI simultaneously proposes the repeal of 21.2804–21.2806 and 21.2818–21.2820 concerning the submission of clean claims. Repeal is necessary for the adoption of new clean claim rules consistent with the provisions of Senate Bill 418.

The rules are proposed to take effect on September 4, 2003. However, because Senate Bill 418 applies to provider contracts entered into or renewed on or after August 16, TDI staff may recommend a separate proceeding to adopt emergency rules to cover the period between August 16 and the date these proposed rules go into effect.

Claim Payment Processing Information *(Amendments to 28 TAC 3.3703 for preferred provider plans and 28 TAC 11.901 for HMOs)*

As under existing rules, carriers would have to furnish information on their claim payment procedures, including bundling processes and downcoding policies, within 30 days after receiving a request from a provider. Bundling processes would have to be consistent with nationally recognized and generally accepted bundling edits and logic. The information provided about a carrier's bundling software must include the publisher's name, product name and the version currently in use by the carrier.

A carrier would have to give 90 days' notice (instead of the present 60 days) before changing its claim payment procedures. Carriers could not make retroactive changes to these procedures or to the information they must furnish to providers.

A provider's permissible uses of claim payment information received from a carrier would be enlarged to include "other business operations" and communications with government agencies that regulate health care and insurance.

Providers that receive claim payment procedure information from a carrier could terminate their contracts, without penalty, within 30 days after receiving the information. Provider contracts would be required to include reasonable advance notice for patients before such a termination could occur.

Carriers would be allowed to require providers to keep updated information about a patient's other health benefit plan coverage in their records.

Publication: 28TexReg5087 (Preferred Providers) and 5089 (HMOs), July 4, 2003
Earliest possible adoption: August 4, 2003
Further information: 512 463-6327

Preauthorization and Verification *(28 TAC §§ 19.1703, 19.1723 and 19.1724)*

Definitions

A **preauthorization** is a determination by a carrier that proposed medical care or health care services are medically necessary and appropriate.

RuleMaking

Verification is a guarantee that a carrier will pay for medical care or health care services if the services are rendered within the required time frame to the patient for whom the services are proposed. A verification may include a preauthorization.

Declination is a response to a request for verification in which the carrier declines to guarantee payment for proposed medical or health care services before receiving a claim for those services. A declination is not a determination that a claim for the proposed services will not ultimately be paid.

Preauthorization

Within 10 business days after receiving a request from a provider, a carrier would have to provide information about the carrier's preauthorization process along with a list of services that would enable the provider to determine which services require preauthorization.

After receiving a request for preauthorization, a carrier would have to meet response deadlines as outlined below:

- A time appropriate to the circumstances and to the condition of the patient, but not to exceed one hour, for post-stabilization treatment and life-threatening conditions.
- Within 24 hours for concurrent hospitalization care.
- No later than three days for all other services.

After preauthorizing treatment, a carrier could not deny or reduce payment for reasons of medical necessity or appropriateness unless the provider materially misrepresented the proposed services or substantially failed to perform the preauthorized services.

A carrier approving a preauthorization would be required also to issue a "length of stay" for admitting the patient into a health care facility based on the provider's recommendation and the carrier's written screening criteria and review procedures.

When issuing an adverse determination in response to a request for preauthorization, a carrier would have to provide notice to the plan member, a person acting on the member's behalf or the member's provider of record. The plan member or a person acting on the member's behalf would have the right to appeal an adverse determination.

Verification

The proposed rules specify 18 items of information that a request for verification must contain. These include the patient's relationship to the enrollee or subscriber; initial diagnosis; procedure code(s); name and address of hospital or facility, if applicable; proposed date of service; name of employer, if applicable; group number, if applicable; and name and contact information of any other carrier, if known.

A provider could request verification by telephone, in writing or by any other means agreed to by the provider and carrier.

If a provider requests verification, a carrier could make one request for additional information. Such a request would have to be made within three days after the carrier receives the request for verification.

Under normal circumstances, a carrier would be required to issue either a verification or a declination without delay, but not later than 15 days after receiving the request. However, when a verification request deals with concurrent hospitalization, post-stabilization care or a life-threatening condition, the carrier would have to respond without delay, but not later than 72 hours. A declination is not the equivalent of a denial of the claim. A carrier that issues a verification could not deny or otherwise reduce payment for those services, if provided on or before the expiration date of the verification, unless the provider has materially misrepresented or substantially failed to perform the services.

A carrier could deliver a determination in writing or by telephone followed by a written response within three days. In both cases, a written response would have to include, among other things:

- A specific description, including relevant procedure codes, of the services that are verified or declined.
- If the services are verified, the effective period for the verification, which may not be less than 30 days.
- If the services are verified, any applicable deductibles, copayments or coinsurance for which the enrollee is responsible.
- If the verification is declined, the specific reason for the declination.
- If the request involved services for which preauthorization is required, a decision as to whether the proposed services are medically necessary and appropriate.
- A statement that the proposed services are being verified or declined pursuant to 28 TAC §19.1724.

Carriers would be required to maintain call centers with qualified staff during specified hours to receive requests for preauthorization and verification. During off-hours, carriers would have to maintain a recording/answering system for these calls. A carrier would be required to return calls within 24 hours for preauthorization and two days for verification.

Publication: 28TexReg5091, July 4, 2003
Earliest possible adoption: August 4, 2003
Further information: 512 463-6327

Submission of Clean Claims

(28 TAC §§ 21.2801–21.2809, 21.2811–21.2819 and 21.2821–21.2825)

Claims Submission Deadline

Providers would have to file claims within 95 days after performing a covered health care service. A provider that misses the 95-day deadline would forfeit the right to payment unless the delay resulted from a catastrophic event. Carriers and providers could agree by contract to a longer (but not shorter) time frame for providers to file their claims.

What is a Clean Claim?

For non-electronic submissions (mail, fax or hand delivery), a claim would be considered "clean" if it contained all the required data elements set forth in the rules and, if applicable, the amount paid by the primary plan or other valid coverages. Claims submitted electronically would be considered clean if they are submitted in the ASC X12N 837 format and comply with requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) for electronic health care claims.

Clean Claim Elements

As with the current rules, the proposed clean claim elements primarily rely on data elements shown on Centers for Medicare and Medicaid Services (CMS) forms. These forms are CMS 1500 for physicians and other individual providers and UB-92 for institutional providers. Required data elements are listed in Section 21.2803 of the proposed rule.

Carriers could not require providers to submit data elements other than those stipulated in the rule. Nor could a carrier require attachments to establish a clean claim. Claims

Continued on page 6

RuleMaking

submitted electronically must be HIPAA-compliant.

Payment Deadlines

By law, carriers must take action on a claim within 45 days after receiving a non-electronically submitted claim, within 30 days after receiving a claim submitted electronically and within 21 days after affirmative adjudication of an electronically submitted pharmacy claim.

Within those deadlines, a carrier must:

- Pay the entire contracted amount of a clean claim;
- Notify the provider that the claim is deficient;
- Deny the entire claim and notify the physician or provider why the claim will not be paid;
- Notify the provider it intends to audit the claim and pay the statutorily required 100 percent (formerly 85 percent) of the applicable contracted rate pending the conclusion of the audit; or
- Pay part of the claim and deny or audit the remainder. The provider must pay 100 percent of the applicable contracted rate for the audited portion pending the outcome of the audit.

Requests for Additional Information

A carrier could make only one request to a provider for additional information needed to process a claim. The request would have to be made within 30 days after receiving the claim. The carrier would have to be specific about the additional information it needs and could request only information from the patient's medical or billing records that is relevant to the resolution of the claim. A request for additional information would suspend the deadline for the carrier to act on the claim until the provider sends the information or responds that the provider does not have it. Once the carrier receives the requested information, it must act within 15 days or by the statutory deadline, whichever is later.

A carrier could request additional information from a third party but only if it notifies the provider of the request. The carrier's deadline to act on a claim would not be suspended for requests for information from third parties.

Audits

A carrier would be required to notify a provider in writing within the statutory (21-, 30-, or 45-day) deadline if it intends to audit a claim. The explanation of payment would have to clearly indicate that the claim is being audited. A carrier that audits a claim would be allowed to request additional information within the audit period. The carrier would have to notify the provider that the additional information must be furnished within 45 days. The carrier could recover the amount paid if the provider fails to respond within that time limit. A carrier would have to complete its audit within 180 days of the date it received the claim. Providers would have 30 days to appeal the results of an audit. A carrier could not recover a refund resulting from an audit until the later of **1)** the 30th day after the provider has been notified of the audit results or **2)** the exhaustion of the provider's appeal rights.

Coordination of Benefits

Carriers would be prohibited from requiring providers to investigate coordination of benefits with other coverages. However, providers must maintain information about a patient's other coverages. In instances where multiple coverages apply, the provider would have to file a claim with the secondary payor within 95 days after receiving the primary payor's determination. If a secondary payor overpays a claim, it would have to recover the overpayment from the primary payor. However, if the primary payor already has paid the claim, the secondary payor could recover the overpayment directly from the provider.

Submitting Duplicate Claims

A duplicate claim would be defined as any claim for payment for the same health care service provided to a particular individual on a particular date of service that was included in a previously submitted claim. Providers could not submit duplicate claims before the expiration of the statutory (21-, 30-, or 45-day) payment deadline. A duplicate claim would not include corrected claims or additional information provided to satisfy a carrier's request. Providers would have to indicate on claim forms whether a claim is a duplicate claim or a corrected claim.

Overpayments

As provided by Senate Bill 418, carriers would have 180 days to request refunds of overpayments made to providers. A carrier that misses the 180-day deadline would forfeit the refund. A provider would have 45 days to appeal an overpayment notice. A carrier could not recover an overpayment from a provider that has not already arranged to make a refund until the later of **1)** the 45th day after the provider has received the overpayment notice or **2)** the date when the provider has exhausted all appeal rights.

Late Payment Penalties

Carriers would be subject to the following statutory penalties for late payment of contracted providers' claims:

- A carrier that pays a clean claim between one and 45 days late would have to pay the full contracted rate for the services provided, plus either 50 percent of the difference between the billed charges and the applicable contracted rate or $100,000, whichever is less.
- If payment is 46 days to 90 days late, the carrier would have to pay the full contracted rate for the services provided, plus either 100 percent of the difference between the billed charges and the applicable contracted rate or $200,000, whichever is less
- If a clean claim is paid 91 or more days late, the carrier must pay the full contracted rate for the services provided, plus either 100 percent of the difference between the billed charges and the applicable contracted rate or $200,000, whichever is less. In addition, the carrier would have to pay 18 percent annual interest on the penalty amount, accruing from the date payment was originally due and through the date of actual payment.

Carriers are also would be subject to the new statutory penalties for late underpayment of clean claims:

- If the carrier underpays a clean claim between one and 45 days late, it must pay the full contracted rate for the services provided, plus either 50 percent of the underpaid amount or $100,000, whichever is less
- If the carrier underpays a clean claim between 46 and 90 days late, it must pay the full contracted rate for the services provided, plus either 100 percent of the underpaid amount or $200,000, whichever is less
- If the carrier underpays a clean claim 91 or more days late, it must pay the full contracted rate for the services provided plus either 100 percent of the underpaid amount or $200,000, whichever is less. In addition, the carrier would have to pay 18 percent annual interest on the penalty amount, accruing from the date payment was originally due and through the date of actual payment.

RuleMaking

The underpaid amount, for the purposes of determining penalties, is calculated on the ratio of the amount underpaid on the contracted rate to the contracted rate as applied to the billed charges.

To obtain a penalty payment, a provider would be required to notify a carrier within 180 days of receipt of an underpayment. If the notice is given after the 180th day and the carrier pays the balance within 45 days of receipt of the underpayment notice, no penalty accrues.

A carrier would be required to furnish a provider with an explanation of payment that clearly notes any penalties paid.

Penalties would not be assessed if a late payment or underpayment resulted from a catastrophic event that interrupted the carrier's operations for more than two consecutive business days and the carrier filed proper notice with TDI. In such a case, the statutory claims payment period would be suspended for the period during which the carrier's operations were interrupted.

Extension of Deadlines Because of Catastrophic Events

The statutory claims submission and payment deadlines would be suspended because of catastrophic events under the following conditions:

- Within five days of the event, the carrier or provider must notify TDI that it is unable to meet its statutory deadlines because of a catastrophic event that interrupted its normal business operations for at least two consecutive business days.
- Within 10 days of returning to normal operations, the carrier or provider must provide TDI with a sworn affidavit specifying the nature of the event and the length of time normal operations were suspended.

The statutory claims payment period would be suspended only for the period of time that the carrier's operations were interrupted.

Administrative Penalties

Senate Bill 418 and the proposed rules authorize TDI to assess administrative penalties against carriers that fail to comply with the statutory payment deadlines on more than 2 percent of the clean claims submitted to the carriers. Compliance would be determined on a quarterly basis and would be calculated separately for claims submitted by institutional and non-institutional providers. Carriers with a noncompliance rate greater than 2 percent on either type of claim could be assessed penalties of up to $1,000 per day for each claim not in full compliance with the prompt pay law and rules.

Reporting Requirements

Carriers would be required to submit quarterly and annual reports to TDI on their claims processing activities, catastrophic events and verifications.

Publication: 28TexReg5099, July 4, 2003
Earliest possible adoption: August 4, 2003
Further information: 512 463-6327

Diabetes Coverage by Local Risk Pools

■ The Department has proposed amendments to 28 TAC §§ 21.2602 and 21.2604 to clarify that all requirements of 28 TAC Chapter 21, Subchapter R, relating to diabetes, apply to health plans provided by local government (city and county) risk pools.

The rules in question, adopted in 1999 to implement *Texas Insurance Code* Articles 21.53D and 21.53G, require health benefit plans that cover treatment of diabetes and associated conditions to include diabetes equipment, supplies and self-management training programs in that coverage. An exhaustive study of the legislative history of Articles 21.53D and 21.53G, both enacted by the 76th Texas Legislature, led to TDI's determination that lawmakers intended to provide persons covered by local government risk pools with the same benefits as everyone else covered by health plans subject to Article 21.53D. The preamble to TDI's filing of the proposed rule amendment concludes: "Excluding risk pools from providing these coverages does not conform to the applicable statutory mandate and is inconsistent with legislative intent."

The proposed amendments continue the present coverage requirements for all other plans while deleting all provisions that exempted risk pools created under Chapter 172, *Local Government Code.*

Publication: 28TexReg5625, July 18, 2003
Earliest possible adoption: August 18, 2003
Further information: 512 463-6327

Exclusive Provider Benefit Plans

■ The Department has proposed new 28 TAC §§ 3.9201–3.9212 concerning exclusive provider benefit plans. An exclusive provider benefit plan (EPP) is authorized for use in only three circumstances: **1)** by issuers that contract with the Texas Health and Human Services Commission to provide health services under the Children's Health Insurance Program (CHIP); **2)** to provide Medicaid managed care; or **3)** to sponsor, arrange for or provide health care services under the Statewide Rural Health Care System. An EPP is a managed care plan that requires covered persons to receive services only from a network of exclusive providers and limits or excludes benefits for services provided by other providers, except in cases of emergency or approved referral. Specific rules are needed for EPPs because an EPP blends characteristics found in both indemnity and HMO plans.

Highlights of the proposed rules follows.

Policy and Premium Rates

If medically necessary covered services are unavailable through exclusive providers, the issuer, upon request from an exclusive provider, would be required to allow referral to a non-network provider. The non-network provider would be reimbursed at the usual and customary or agreed rate.

Issuers would be required to file their rates and rating methodology with TDI prior to use. The methodology would have to be based on accepted actuarial principles. Rates resulting from such a methodology could not be altered for individual insureds based on their health status. Filings would have to include an actuarial certification that the rates are reasonable, adequate, not excessive and not unfairly discriminatory. When rates are predetermined by an entity contracted with the insured, the issuer must show that it can provide the services at the contracted rates.

Provider Contracts

Issuers would have to give all providers in the service area an opportunity, including notice, to participate in their EPP plans. Applicants could not be rejected solely because of the type of licenses held but could be rejected on the ground that the plan has enough qualified providers. Terminated providers would be entitled to a written explanation of the reasons and would have the right to a review by an advisory review panel except in cases of imminent harm to patients, action by a state licensing board or fraud or malfeasance. Each exclusive provider contract would be required

Continued on page 8

RuleMaking

to include language holding insureds harmless in the event the issuer failed to pay the provider for health care services.

Quality Improvement and Utilization Management

Issuers would be required to have procedures to assure that services are rendered under reasonable standards of quality of care. This would include an ongoing internal quality improvement program to monitor and evaluate health care services rendered by contract providers. The quality improvement program would be required to include an adequate patient record system and a mechanism for making clinical records of insureds available for review by TDI.

Credentialing and Network Accessibility and Availability

Issuers would be subject to the same criteria as HMOs for credentialing of providers and for network accessibility and availability.

Mandatory Disclosure Requirements

Issuers would be required to provide current and prospective insureds, upon request, with readable and accurate written descriptions of policy terms and conditions that would enable them to make comparisons and informed decisions before choosing a plan. Each issuer would have to furnish all insureds a current list of exclusive providers at least once a year.

Complaints System

Each issuer would be required to have a system for resolving oral and written complaints from insureds and providers. Complaints generally would have to be acknowledged within five business days and resolved within 30 days after receiving a written complaint or one-page complaint form. However, complaints about emergencies or denials of continued hospitalization would have to be investigated and resolved within one business day. Notice of a final decision on a complaint would have to include a statement of the specific contractual and clinical criteria used to reach that decision.

Appeal of Non-Medicaid Adverse Determinations

Issuers would be required to perform utilization review in compliance with *Texas Insurance Code* Article 21.58A and to have procedures for notification, review and appeal of an adverse determination.

Publication: 28TexReg5483, July 11, 2003
Earliest possible adoption: August 11, 2003
Further information: 512 463-6327

APA Adoption

Diabetes Coverage

■ Commissioner Jose Montemayor has adopted amendments to 28 TAC §§ 21.2601 and 21.2606, concerning standards for benefits provided to health plan members with diabetes. He also repealed 28 TAC § 21.2607, whose statutory authority has expired.

The adopted amendments do the following:

- Define "nutrition counseling" in conformity with Section 701.002 of the *Texas Occupations Code*, which governs dietitians. "Nutrition counseling" means advising and assisting an individual or group on appropriate nutritional intake by integrating information from a nutrition assessment with information on food and other sources of nutrients and meal preparation consistent with cultural background and socioeconomic status.
- Establish that a person may not provide a component of diabetes self-management training unless the subject matter of the component is within the scope of the person's practice and he or she meets the education requirements of his or her licensing agency in consultation with the Texas Commissioner of Health.

Publication: 28TexReg5657, July 18, 2003
Effective date: July 27, 2003
Further information: 512 463-6327

PROPERTY

APA Adoptions

TWIA Inspections

■ Commissioner Jose Montemayor has adopted new 28 TAC § 5.4605, which exempts 18 types of repairs from the general requirement that repairs be inspected in order for a building to remain eligible for coverage by the Texas Windstorm Insurance Association. The TWIA is the residual market for wind and hail coverage in the 14 coastal counties and portions of Harris County on Galveston Bay.

The exemption from inspections applies only if repairs are made with materials, fasteners and craftsmanship of like kind and quality to those in the building before repair and as compared to the parts of the building that were not repaired. In addition, the initial installation or replacement of the listed items may be made without an inspection if it does not involve any structural change.

The items are

- roof repairs of less than 100 square feet (one square),
- gutter repairs or replacement,
- replacement of decorative shutters,
- repairs to breakaway walls,
- fascia repairs,
- repairs to porch and balcony railings,
- repairs to stairways/steps and wheelchair ramps,
- protective measures before a storm,
- temporary repairs after a storm,
- leveling and repairs to an existing slab on grade foundation, unless wall and/or foundation anchorage is altered or repaired,
- fence repair,
- painting, carpeting and refinishing,
- plumbing and electrical repairs,
- repairs to slabs poured on the ground for patios (including slabs under homes on pilings),
- repairs or replacement of soffits less than 24 inches in width,
- repairs or replacement of non-structural interior fixtures, cabinets, partitions (non-loadbearing), surfaces, trims or equipment,
- replacement of glass in windows or glass doors or replacement of exterior doors not involving the frames provided that the area is less than 10 percent of the surface area of the affected side (elevation) of the structure, and
- replacement of exterior siding provided that the area is less than 10 percent of the surface area of the affected side (elevation) of the structure.

Publication: 28TexReg5535, July 11, 2003
Effective date: July 31, 2003
Further information: 512 463-6327

TWIA Premium Discounts

■ Commissioner Jose Montemayor has adopted amendments to 28 TAC §§ 5.4501 and 5.4700 concerning Texas Windstorm Insurance Association premium discounts for homes built to specified codes. Discounts have been in effect since 1999 for homes built to the TWIA *Building Code for Windstorm-Resistant Construction.* The newly adopted amendments add discounts for homes built to the 2000 International Residential Code (IRC) and the 2000 International Building Code (IBC) with Texas revisions.

RuleMaking

The IRC and IBC, with Texas revisions, replaced the TWIA *Building Code for Windstorm-Resistant Construction* effective February 1, 2003, as the standard that new construction must meet to qualify for TWIA coverage. TWIA is the residual market for wind and hail insurance in the 14 coastal counties and part of Harris County on Galveston Bay.

Code requirements are most stringent for homes seaward of the Intracoastal Canal. They are somewhat less stringent in the **"Inland I"** area between the Intracoastal Canal and 25 miles inland. Code requirements are least stringent in the **Inland II** area more than 25 miles west of the canal.

The adopted credits, requested by the TWIA, are slightly greater than those currently in place for homes built to the TWIA *Building Code for Windstorm-Resistant Construction.* Credits are mandatory. There are additional credits when a house is built to a higher standard than required for its area, e.g., a home in the Inland I area built to the Seaward standard.

The table below compares the newly adopted discounts for homes built to the IRC and IBC codes with those in place for homes build to the TWIA *Building Code for Windstorm-Resistant Construction.*

The annual average saving from the discount is estimated at $158 per policy.

As with the TWIA *Building Code for Windstorm-Resistant Construction,* a 10 percent rate reduction is available for older homes retro-fitted with exterior opening protections that meet the IRC/IBC requirements.

		TWIA BUILDING CODE FOR WINDSTORM-RESISTANT CONSTRUCTION		INTERNATIONAL RESIDENTIAL CODE AND INTERNATIONAL BUILDING CODE	
LOCATION OF RISK	BUILDING CODE STANDARD MET	DWELLING DISCOUNT	PERSONAL PROPERTY DISCOUNT	DWELLING DISCOUNT	PERSONAL PROPERTY DISCOUNT
Seaward	Seaward	26%	20%	28%	23%
Inland I	Inland I	24%	19%	26%	21%
Inland I	Seaward	29%	23%	31%	25%
Inland II	Inland II	0%	0%	26%	20%
Inland II	Inland I	27%	21%	28%	23%
Inland II	Seaward	32%	25%	33%	28%

Publication: 28TexReg5533, July 11, 2003
Effective date: July 31, 2003
Further information: 512 463-6327

SURPLUS LINES

APA Adoption

Surplus Lines Stamping Office Fee

- Commissioner Jose Montemayor has adopted an amendment to 28 TAC § 15.101 concerning the procedure for calculating the stamping fee that provides the funds that finance operations of the Surplus Lines Stamping Office of Texas.

  The fee previously was based on the one-year projection method for estimating the necessary revenue. The newly adopted method changes this to a method using the previous five-year period.

  Projected reserves may not exceed twice the average of audited operating expenses for the five years immediately before the budget year. If the reserve balance is projected to exceed this limit in an upcoming year, the SLSOT board will give TDI a written plan for reducing actual reserves within a reasonable period, given the market conditions existing at the time.

  In proposing the rule change, TDI said it would provide for more flexibility and stability in the setting of the stamping fee, resulting in less disruption and more efficiency in the surplus lines market.

Publication: 28TexReg5536, July 11, 2003
Effective date: July 17, 2003
Further information: 512 463-6327 ★

Implementations...*from page 1*

of Insurance 90 days—or until September 1, 2003—to issue the necessary implementation rules. Rule drafting began even before the session adjourned. The proposed rules, totaling 130 pages, were sent to the *Texas Register* for publication on June 23—just 21 days after the lawmakers went home.

Occasionally, the Legislature gives TDI an entirely new set of entities to regulate. The 78th Legislature passed a law requiring licensure of public adjusters. Not only will TDI need to add new rules, it also will need to create a license application form, adopt a licensing examination for would-be public adjusters to take and issue a code of ethics for public adjusters. The bill gives the Commissioner until September 1, 2004, to adopt a code of ethics for public adjusters.

Role of Legislators

Making sure that implementation squares with legislative intent is a central concern. To make sure they get it right, Government Relations staff members sometimes listen to tapes of floor debates and committee meetings.

In addition, Government Relations stays in close touch with legislative sponsors of the bills to be implemented. Lawmakers receive the implementation plan and subsequent updates. Sponsors are notified when an implementing rule is proposed and are routinely consulted during the rule drafting process.

"If there are issues where we are not clear on intent, we consult the sponsors… We want to be in accord with the purposes and intent of the legislation,"Durden said. ★

Mold...*from page 3*

By sending the unapproved endorsements to policyholders, Mid-Continent "created the false impression that losses arising from , resulting from, caused by, contributed to, attributed to, or in any way related to any fungus, mildew, mold or resulting allergens were not covered, when such was not the fact," the Commissioner's order said.

Montemayor noted that Mid-Continent had represented to TDI that the company had not used the unapproved endorsements to deny any claims under the liability policies. However, his order said if such claims exist, then Mid-Continent must reconsider them without applying the unapproved endorsements.

TDI eventually approved Mid-Continent's endorsements effective January 18, 2002. ★

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
Alvarez, Marivel	Dallas	$750 Fine	Material Misrepresentation on License Application	03-0497	6/16/03
Barnett, Danny Wayne	Arlington	$5,000 Fine plus Restitution to Insureds and Revocation of General Life, Accident, Health and HMO Agent's Licenses	Acted as Agent for Unauthorized Insurer	03-0459	6/6/03
Brower, M. Seth	Austin	Revocation of General Life, Accident, Health and HMO License and General Property and Casualty License	Misappropriation and Conversion	03-0538	6/26/03
Erfurth, Justin	San Antonio	Probated Suspension of General Life, Accident Health and HMO Agent's License	Deferred Adjudication Probation for Felony Offense	03-0456	6/5/03
Foley, Clifford E.	Plano	$1,000 Fine, Plus Restitution to Claimants	Acted as Agent for Unauthorized Insurer	03-0452	6/3/03
Galindo, Arturo	San Antonio	$750 Fine	Material Misrepresentation on License Application	03-0499	6/16/03
Goree, Leslie	DeSoto	General Life, Accident, Health and HMO Agent's License Denied	Conviction of Misdemeanor Directly Related to Duties of Licensed Occupation	03-0405	5/21/03
Gulledge, Jo Ann Charron	Dallas	$2,500 Fine, Plus Restitution to Insureds	Acted as Agent for Unauthorized Insurer	03-0453	6/3/03
Hammond, Ryan Michael	Kemah	$2,500 Fine, Plus Restitution to Insureds	Acted as Agent for Unauthorized Insurer	03-0445	6/2/03
Hardy, Cereta	Spring	Probated Suspension of General Life, Accident, Health and HMO License	Misdemeanor Convictions	03-0500	6/16/03
Hill, Michael Earl	Seagoville	General Life, Accident, Health and HMO Agent's License Revoked	Imprisonment for Felony Conviction	03-0467	6/11/03
Hover, David Lee Hover, Brian Lee Seacoast Brokers of Texas, LLC	Hilton Head Island, SC	$45,000 Fine	Acted as Agency without a License; Placed Risks in Surplus Lines Market in Violation of Surplus Lines Statute Surplus Lines	03-0550	6/27/03
Marcontell, Donald Van	Flower Mound	$1,500 Fine, Plus Restitution to Claimants	Acted as Agent for Unauthorized Insurer	03-0444	6/2/03
Marino, Jaimie Robert	Irving	$7,000 Fine, Subject to Dollar-for-Dollar Reduction by Restitution to Insureds Down to a Minimum Fine of $5,000	Acted as Agent for Unauthorized Insurer	03-0470	6/11/03
Morales, Daniel A.	Lubbock	General Property and Casualty Agent's License Revoked	Misappropriation or Conversion; Conviction of Misdemeanor Directly Related to Duties of Licensed Occupation	03-0406	5/21/03
Murphy, Jerry II	Conroe	Probated Suspension of General Life, Accident Health and HMO Agent's License	Deferred Adjudication Probation for Misdemeanor Offenses	03-0454	6/3/03
Pearson, Casey Louis	Kingwood	General Life, Accident, Health and HMO Agent's License Denied	Material Misstatement on License Application	03-0408	5/21/03
Radford, Angela Denise	Houston	General Property and Casualty Agent's License Denied	Material Misstatement on License Application	03-0407	5/21/03
Shackelford, Duwane Charles	Houston	$1,000 Fine; Probated Suspension of General Life, Accident, Health and HMO Agent's License	Material Misrepresentation on License Application; Felony Conviction	03-0501	6/16/03

DisciplinaryActions

AGENTS & AGENCIES NAME	CITY	ACTION TAKEN	VIOLATION	ORDER	DATE
Traylor, Wilson Charles	Dallas	Adjuster's License Denied	Felony Conviction; Fraudulent or Dishonest Acts or Practices	03-0446	6/2/03
Westall, Eric Dillon	El Lago	$3,000 Fine, Plus Restitution to Insureds	Acted as Agent for Unauthorized Insurer	03-0471	6/11/03
Younkers, Terry Wayne	Cedar Hill	Revocation of General Life, Accident, Health and HMO License and General Property and Casualty License, Plus Restitution to Claimants	Acted as Agent for Unauthorized Insurer; Use of Unregistered Assumed Names; Failure to Report Change of Address	03-0476	6/12/03
INSURANCE COMPANIES					
ABBA Indemnity Co.	Houston	$8,000 Fine	Pledged Certificates of Deposit Owned by Company for an Officer/Director's Personal Loans; Failed to Adopt Privacy Policy Required by Texas Law	03-0451	6/3/03
American Motorists Insurance Co.	Long Grove, IL	$5,000 Fine	Failure to Provide Commercial Auto Experience Rating Data	03-0498	6/16/03
Beacon National Insurance Co.	Wichita Falls	$7,000 Fine, Plus Restitution Including 10 Percent Interest	Denial of Portions of Valid Claims for Roof Damage; Failure to Maintain Complete Complaint Record	03-0548	6/27/03
Federated Mutual Insurance Co.	Owatonna, MN	$3,000 Fine	Failure to Provide Commercial Auto Experience Rating Data	03-0469	6/11/03
First Preferred Insurance Co.	Wichita Falls	$7,000 Fine, plus Restitution Including 10 Percent Interest	Denial of Portions of Valid Claims for Roof Damage; Failure to Maintain Complete Complaint Record	03-0549	6/27/03
IMBI Ltd. (U.S. Branch)	Garland	$60,000 Fine	Consent Order; Alleged Filing of Misleading Financial Statements, Commingling of Books and Records and Failure to Respond Promptly to TDI Inquiries	03-0490	6/13/03
Petrolia Insurance Co.	Wichita Falls	$7,000 Fine, Plus Restitution Including 10 Percent Interest	Denial of Portions of Valid Claims for Roof Damage; Failure to Maintain Complete Complaint Record	03-0551	6/27/03
Royal Indemnity Co.	Charlotte, NC	$3,000 Fine	Late Filing of Commercial Auto Experience Rating Data	03-0537	6/26/03
Voyager Life Insurance Co.	Atlanta, GA	$5,000 Fine, Plus Refund of Premium Overcharges, with Interest	Consent Order; Alleged Credit Accident and Health Insurance Overcharges	03-0502	6/16/03

CompanyLicensing

Applications Pending

For admission to do business in Texas

COMPANY NAME	LINE	HOME OFFICE
The Bar Plan Mutual Insurance Co.	Fire and/or Casualty	St. Louis, MO
Diversified Title Insurance Co.	Title	Long Beach, CA
Healthscope Benefits Inc. *dba* Health Benefits of Arkansas Inc	TPA	Wilmington, DE

For incorporation

COMPANY NAME	LINE	HOME OFFICE
Bay Bridge Administrators, LLC	TPA	Austin, TX

Continued on back page...

CompanyLicensing

Applications Pending

For name change in Texas

FROM	TO	LINE	LOCATION
American Agri-Business Insurance Co.	Ameritech Insurance Co.	Fire and/or Casualty	Lubbock, TX
Mitsui Marine and Fire Insurance Company of America	Mitsui Sumitomo Insurance USA Inc.	Fire and/or Casualty	Warren, NJ

Applications Approved

For admission to do business in Texas

COMPANY NAME	LINE	HOME OFFICE
AFIC Administrators Inc.	TPA	Jackson, MS
Delta Dental Plan of California	TPA	San Francisco, CA
Group Management Services Inc.	TPA	Omaha, NE
Ingenium Benefits Inc.	TPA	Omaha, NE
Medpayexpress, L.L.C.	TPA	Lake Charles, LA
Midlands Claim Administrators Inc.	TPA	Oklahoma City, OK
Total Administrative Services Corporation	TPA	Madison, WI

For incorporation

COMPANY NAME	LINE	HOME OFFICE
Abercrombie, Simmons & Gillette Inc.	TPA	Houston, TX
Kazdon Inc.	TPA	Austin, TX

For name change in Texas

FROM	TO	LINE	LOCATION
Mid-Continent Life Insurance Co.	Mid-Continent Preferred Life Insurance Co.	Life	Oklahoma City, OK
Northbrook Property and Casualty Insurance Co.	St. Paul Protective Insurance Co.	Fire & Casualty	Chicago, IL
Worldwide Direct Auto Insurance Co.	Response Worldwide Direct Auto Insurance Co.	Fire & Casualty	Columbus, OH

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