BIENNIAL REPORT OF THE TEXAS DEPARTMENT OF INSURANCE TO THE 79TH LEGISLATURE

DECEMBER 2004

TEXAS DEPARTMENT OF INSURANCE
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COMMISSIONER OF INSURANCE

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December 31, 2004

The Honorable Rick Perry
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The Honorable David Dewhurst
Lieutenant Governor of Texas
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The Honorable Tom Craddick
Speaker, Texas House of Representatives
P.O. Box 2910
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The Honorable Robert Duncan
Texas Senate
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The Honorable John Smithee
Texas House of Representatives
P.O. Box 2910
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Dear Governors, Mr. Speaker, and Chairmen:

In accordance with Section 32.022, Texas Insurance Code, I am pleased to submit the biennial report of the Texas Department of Insurance. The report summarizes needed changes in the laws relating to regulation of the insurance industry. The report also states the reasons for the needed changes.

My staff and I are available to discuss any of the issues contained in the report and to provide technical assistance. Please contact me or David Durden, Director of Government Relations, at 463-6651 with any questions or if you need additional information.

Thank you for your consideration.

Sincerely,

Jose Montemayor
Commissioner of Insurance

INTRODUCTION

Texas Insurance Code Section 32.022 requires the Texas Department of Insurance to submit to the appropriate committees of each house of the Legislature, a written report that indicates needed changes in laws relating to regulation of the insurance industry or any other industry or occupation under the Department's jurisdiction and that states the reasons for those needed changes.

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

Several of the recommendations included in this report are a result of the Department's role in a national effort to improve the financial solvency monitoring of insurer groups. Included in this section are issues such as updating the company licensing statutes, removing automatic exemptions from the Holding Company Act and specifying that HMOs are subject to the Holding Company Act and Merger Statute. Another significant issue involves updating the statutes related to the Life Health Guaranty Association and the consolidation, liquidation, rehabilitation, reorganization or conservation of insurers.

The report also contains several recommendations designed to increase the Department's ability to receive timely and complete reports of activities suspected to constitute insurance fraud and to clarify the standard of proof in criminal prosecutions of unauthorized insurance. These recommendations were developed in conjunction with the Department's participation on the Texas Committee on Insurance Fraud.

The report also contains recommendations to streamline the review process for certain life products, to enable insurers to get insurance products to market faster and provide consumers with more choices faster. Interstate compacts are an important part of the modernization of the insurance regulatory framework across the country and are designed to foster competitive and stable markets, while maintaining adequate consumer protections.

Senate Bill 14 from the 78th Session significantly changed the method of rate and form regulation of property casualty insurance. The implementation of this extensive reform identified areas where further clarification and consistency in regulation are needed. These areas include recommendations regarding the application of surcharges, expanding the applicability of the "right to choose repair shop" statute, clarifying that Lloyds and reciprocal exchanges are subject to Department inquiries (Section 38.001), and amending 5.13-2 to apply to multi-peril policies.

Florida's four hurricanes during 2004 have underscored the need to review our exposure, management, and financing of hurricane catastrophes in Texas. To make certain Texas is prepared for major windstorms, a recommendation is included regarding the mitigation of the Texas Windstorm Insurance Association (TWIA) potential

for loss and resulting impact on the General Revenue Fund and new approaches needed to protect the State against these losses.

The remaining issues discussed in this report include recommendations to expand the eligibility and change the assessment methodology of the Texas Health Insurance Risk Pool and the gradual phase out of the Texas Health Reinsurance System.

The recommendations contained in this report are currently being developed into bill draft form to assist the Legislature in preparing legislation, should the Legislature choose to formally consider the recommendations summarized above. The final drafts can be obtained by contacting the Government Relations Division of the Department at 463-6651.

OVERVIEW OF THE TEXAS INSURANCE MARKET

The Texas insurance market generated $76.6 billion dollars in premium in 2003 making Texas one of the largest insurance market in the United States. Insurers writing in Texas paid approximately $132 million in maintenance taxes and $1.045 billion in premium taxes in 2003. For 2004, the year-end estimate will likely maintain Texas' standing in the insurance marketplace. Starting in 2001, however, the Texas insurance market suffered several disruptions. Homeowners, medical malpractice and health insurance experienced steep price increases, limited availability, or both.

The 78th Texas Legislature enacted several major pieces of legislation designed to address these issues. Those enactments have attracted new insurance companies to the Texas market and resulted in new products and lower rates being offered to insurance consumers in Texas.

The most significant change was in homeowners insurance. Senate Bill 14, 78th Regular Session, required insurers to charge rates that are just, fair, reasonable, adequate, not confiscatory, not excessive and not unfairly discriminatory. For the first time in Texas history, all companies writing homeowners insurance are subject to the same rate standards. Prior to SB 14, 95 percent of homeowners insurers were exempted from rate regulation.

In August 2003, 32 companies were ordered to reduce their homeowners rates by an average reduction of 12.5 percent, for a total of $511 million in rate reductions. All but one company have complied with the rate reductions providing for the return of approximately $350 million to policyholders. Since the enactment of SB 14 Texas has had 13 new insurers enter the residential property market and 3 new companies enter the personal auto market. The Department has also approved 18 new residential property policy form filings and 19 personal auto policy form filings. These new companies and new forms mean more choices and increased competition for Texas insurance consumers.

House Bill 4 and Proposition 12 limited non-economic damages in medical malpractice lawsuits, and have had a positive impact on the Texas medical malpractice market. As of September 2004, a total of 12 new medical malpractice carriers had entered the Texas market. This is triple the number of companies reported to be writing medical professional liability insurance in 2002. Many companies rescinded rates increases planned for 2003 and the largest medical malpractice insurance carrier in Texas, the Texas Medical Liability Trust, reduced its medical malpractice insurance rates by 12 percent across the board on January 1, 2004 and then an additional 5 percent effective January 2005.

Senate Bill 418 established requirements regarding insurers issuing PPO plans and HMOs and their relationships with contracted providers, such as requiring carriers to make a determination as to whether to pay within 45 days of the claim being submitted or, if the claim is filed electronically, within 30 days. Information provided to the

Department indicates that insurers are paying 98% of claims within 45 days of receipt of the claims. In 2004, the number of complaints from health care providers was approximately half that of the previous year.

Senate Bill 541, authorized insurers and health maintenance organizations to issue “standard health benefit plans” that do not include state-mandated benefits or offer of coverage mandates. Insurers began offering these plans, also known as “Consumer Choice Plans” (CCPs), soon after the bill became effective. To date, the Department has approved 43 CCPs filed by indemnity carriers and 31 CCPs filed by HMOs. Insurers have provided estimates to the Department indicating that the cost savings associated with the CCPs for indemnity insurers are from 5% to as high as 38%. The indicated savings for HMOs range up to 26.5%.

During 2004, the Texas workers’ compensation system was carefully scrutinized by several legislative committees. The Department reported to the Legislature that loss ratios were improving in the workers compensation market; however, Texas continues to be a relatively high cost state. With additional reforms, Texas will move toward a more stable pricing environment.

These developments indicate that the Texas insurance market is improving and expanding. Consumers are benefiting from increased choices, increased consumer protections and increased competition.

The additional flexibility given to insurers to develop forms and rates requires the Department to modernize the statutes relied upon to monitor the financial solvency of insurers. The legislative changes recommended in this report will enhance the Department’s ability to protect public interest and provide for the consistent application of the significant reforms enacted during the 78th Legislature.

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SURCHARGES

BACKGROUND:

Article 21.49-2B, Insurance Code, governs the imposition of claims surcharges for personal automobile insurance and various property and casualty policies. Articles 5.43 and 5.35-4, Insurance Code enacted by the 78th Legislature, have been implemented in conjunction with Article 21.49-2B. Article 5.43, Optional Premium Discount for Certain Residential Property Insurance Policies, allows an insurer to provide a claims-free discount to residential property insureds under certain circumstances. Article 5.35-4, Restrictions on Use of Claims History for Water Damage, provides that a properly remediated appliance-related water damage claim may not be used as the basis for rating a policy. Generally, claims experience is an actuarially accepted measure of risk and is a basis for collecting additional premium to cover the risk. There are several issues, however, involving the implementation of the various claim-related laws that warrant legislative clarification.

PROBLEM:

Article 21.49-2B, Section 7 fails to provide an express definition of surcharge. The Department has interpreted a surcharge under 21.49-2B to mean any increase in an insured's premium due to the insured's claim history, whether accomplished by surcharging, the loss of all or part of a discount, reassigning a consumer from one rating tier to another, re-underwriting or otherwise.

Some insurers have imposed a surcharge for a single claim on the basis that Article 21.49-2B only refers to two or more claims. The Department and the State Office of Administrative Hearings (SOAH) have held that the law prohibits any renewal surcharge based on a single claim.

Another issue is the claims-based "discount" plan, where a discount is reduced in whole or in part, although the statute refers to a "premium surcharge". Mathematically, the outcome of a surcharge or a reduced discount (e.g., a 10% discount is reduced to a 5% discount) is the same, in that the premium is increased upon renewal. The difference occurs because some insurers elect to set a higher base rate and then offer discounts, while other insurers set a lower base rate and then impose surcharges.

Within the course of implementing Articles 5.43 and 5.35-4, in conjunction with Article 21.49-2B, several issues arose regarding the harmonization of these statutes. The statutes, read in concert with one another, could be interpreted to mean optional discounts offered under 5.43 are eliminated on the basis of a single claim, causing premiums to increase. This interpretation could be contrary to prohibitions under Art. 21.49-2B, Section 7 as it would have the same effect as an excessive claims surcharge.

Article 5.35-4, provides that a properly remediated appliance-related water damage claim may not be used as the basis for rating a policy. Article 21.49-2B currently

provides no exception for such claims nor do the statutes address how this prohibition affects discounts offered under Article 5.43.

SOLUTION:

Clarify the application of Article 21.49-2B by requiring that any increase in renewal premium based on an insured's claim history must be actuarially justified.

Clarify that the statute applies to surcharges, discounts, rating, underwriting using multiple affiliates, and tiering. Clarify that any action or classification, such as tiering, that does not lend itself to actuarial analysis be reasonably objective and have supporting information filed with the Department.

Harmonize Articles 5.35-4, 5.43 and 21.49-2B to provide clear guidance regarding the types of claims that may be considered if a policyholder is claims free or incurs an appliance related water damage claim. The proposed change would incorporate the effect of Articles 5.43 and 5.35-4.

*If limits on the actuarially derived amounts that an insurer can increase premium are considered, such limits should be applied on a per claim basis (e.g., 10% per claim), with variances allowed where there is a demonstrated lack of availability of insurance due to inadequate rating.

ADDITIONAL CLARIFICATIONS

GUARANTY BONDS

PROBLEM: Article 5.13, Insurance Code states that Subchapter B of Chapter 5 applies to the writing of fidelity, surety and guaranty bonds. When Article 5.13-2 was amended regarding the regulation of rates and forms for bonds, guaranty bonds was omitted.

SOLUTION: Add guaranty bonds to the lines of insurance subject to Article 5.13-2.

COUNTY MUTUAL RATE FILINGS

PROBLEM: On and after December 1, 2004, Article 5.13-2 applies to county mutual insurers, which means the county mutual's rates for personal auto (and certain other coverages) are subject to rate regulation. Prior to December 1, 2004, county mutuals' rates were not subject to rate regulation. The rating requirements of Article 5.13-2 require that rates may not be excessive, inadequate, unreasonable, or unfairly discriminatory for the risks to which they apply.

County mutuals often write business through managing general agents (MGAs). These MGAs often have individual insurance programs that they market to consumers. The statutes are currently unclear as to whether the rates used by county mutuals should be evaluated at the company level or at the individual program (MGA) level. In many cases, there can be more than one MGA writing for the same county mutual company and the rates between them may vary due to different limits or coverages offered or due to differences in operational expenses and reinsurance support. As a practical matter, the different MGAs operate as separate insurance companies today.

SOLUTION: Clarify the current statutes to specify whether the county mutuals' rates should be evaluated and the rating standards should be applied at the company level or the program level. The amendment should also address multiple rating plans for county mutuals.

RATING TERRITORIES

PROBLEM: Article 5.171, Insurance Code provides that an insurer may not use rating territories that subdivide a county unless the rate for any subdivisions within that county is not greater than 15% higher than the rate used in any other subdivisions in the county by that insurer. An exception is provided to allow the commissioner by rule, to allow a rate difference greater than 15%. By rule (TAC 5.9960), the Commissioner may allow insurers writing residential property and personal auto to have differences greater than 15% as long as the rates are actuarially supported.

Article 5.171 seems to apply to all lines of business but the ability to file rates that exceed the 15% cap is only permitted for residential property and personal auto insurance. The exception, along with the background which led to the development of Article 5.171, has caused uncertainty regarding whether the statute is intended to only apply to residential property and personal automobile insurance.

SOLUTION: Amend Article 5.171, Insurance Code to clarify that the 15% cap applies to residential and personal automobile insurance.

ARTICLE 21.48A

PROBLEM: Article 21.48A, Insurance Code, governs practices relating to insurance of real estate or personal property. The article was amended during the Regular Session of the 78th Texas Legislature, by House Bill 1338, which added Section 2(g). Section 2(g) prohibits a lender from requiring an amount of insurance greater than the replacement value of the dwelling. However, Section 3(a) of Article 21.48A provides that a lender may require evidence that insurance has been obtained in an amount sufficient to cover the debt or loan. Section 3(a) might possibly be construed to conflict with Section 2(g).

SOLUTION: Amend Article 21.48A, Section 3(a) to remove the potential conflict with Section 2(g).

TWIA RATE ROLLBACK

PROBLEM: Article 21.49, Insurance Code, Section 8E calls for a rate rollback for insurance policies issued by the Texas Windstorm Insurance Association (TWIA) covering new residential construction that is built to the standards of a new building code. The rollback requirement was in response to a specific and comprehensive change in building codes applicable to structures built in designated catastrophe areas that might seek wind and hail insurance coverage through the TWIA. The enactment of this section by the 75th Legislature was coordinated with the implementation of comprehensive and substantive changes in building code specifications in 1997 and the adoption of the TWIA Building Code for Windstorm Resistant Construction. The Department believes it was not intended for application to all future building code changes. However, as is, the rollback requirement applies to all future building code changes regardless of the appropriateness of a reduction in insurance risk relative to the building code change.

SOLUTION: Repeal Section 8E of Article 21.49.

PROMPT PAYMENT OF CLAIMS

Problem: Article 21.55 Insurance Code, Prompt Payment of Claims sets forth specific time lines and requirements that an insurer must comply with upon receiving notice of a first party claim. The Department has experienced difficulty with the enforcement of this Article by entities who argue that 21.55 does not apply to all entities regulated by the Department.

Solution: Clarify Article 21.55, Insurance Code to make it clear that the article applies to any entity that the Department regulates. This will ensure that claims payment protections in Article 21.55 are extended to all first party claims made by insureds, policyholders or their beneficiaries.

MOTOR VEHICLE THEFT AND MOTOR VEHICLE INSURANCE FRAUD REPORTING

Problem: Article 21.78, Insurance Code (recodified as Chapter 702, Insurance Code) provides that upon written request of a governmental entity, an insurer must provide any relevant information the insurer has that relates to a specific motor vehicle theft or motor vehicle insurance fraud. Research on Article 21.78 indicates that this article was the first insurance fraud statute enacted and it was not amended or repealed when art. 1.10D was enacted in 1991. Article 1.10D creates the Insurance Fraud Unit in the Texas Department of Insurance and provides for the comprehensive investigation and reporting of insurance fraud.

There are some provisions in Article 21.78 that are in conflict with Article 1.10D, Insurance Code and differing definitions of the same terms exist within the two statutes. The Department is concerned that these differences could create problems with enforcement and could create a defense challenge to our authority to discipline or prosecute persons committing insurance fraud.

Solution: Repeal Article 21.78 (recodified Chapter 702), Insurance Code

INSURANCE REQUIREMENTS FOR AMUSEMENT RIDES

Problem: Section 2151.101 of the Occupations Code law requires an insurance policy covering an amusement ride to insure the owner or operator against liability for injury to persons in specified minimum limits. The minimum amounts of insurance required are specified as a single, per occurrence limit. In practice the policies issued by insurers includes both bodily injury and property damage in the same limit. The Department requires the insurer to modify policy language so that in the event of an accident the insurer pays bodily injury claims before property damage claims are paid, to comply with the "injury to persons" language of the statute. Based on the way the statute is written, insurers are reluctant to write coverage for amusement ride operators. A clarification in

the statute would alleviate the problem that amusement ride owners and operators are experiencing in obtaining the required liability insurance.

SOLUTION: Amend the Occupations Code Section 2151.101(a)(3) (A) and (B) to clarify that an insurer may write either a combined single limit policy or a split limit policy in amounts that will comply with the statutory language of "injury to persons". The amended language would provide separate limits for bodily injury and property damage.

CONSISTENT REGULATION

PREMIUM RATING PLANS

PROBLEM: Article 5.01-1, Insurance Code prohibits an insurer from assigning any rate consequence to a charge or conviction for a violation of the Uniform Act Regulating Traffic on Highways. County mutual companies are not subject to this statute. This means that insurers are not subject to the same requirements with regard to their ability to surcharge for traffic violations. This difference in treatment appears to be contrary to one of the major goals of Senate Bill 14, (i.e. to put all insurers on the same regulatory standard). This restriction has also hampered new entries into the market by companies that want to write standard and non-standard risks. Further, use of traffic violations in rating has an actuarial basis.

SOLUTION: Delete Article 5.01-1, Insurance Code. Deletion of this provision would put all insurers on the same footing and allow all companies to impose a surcharge for traffic violations. Any surcharge imposed by an insurer would have to be actuarially sound and subject to review by the Department as part of the insurer's rate filing.

MULTI-PERIL POLICIES

PROBLEM: Article 5.81 provides the commissioner with the authority to regulate multi-peril policies of insurance under any of the subchapters of Chapter 5. A multi-peril policy is a policy that combines two or more coverages under a single policy form. Lloyds Plans and reciprocal exchanges are not specifically mentioned in Article 5.81.

SB 14, which applies to Lloyds Plans and reciprocal exchanges for most lines of insurance, amended Article 5.13-2 to apply to the regulation of rates and policy forms for essentially all property and casualty lines of insurance regulated under Chapter 5 that may be included in a multi-peril policy. This article is the primary Insurance Code provision regulating rates and policy forms for property and casualty insurance. Therefore, Article 5.13-2 should be the only statutory provision which applies to the regulation of rates and policy forms for these lines of insurance when included in multi-peril policies. To avoid conflicting provisions in the Insurance Code and provide more efficient regulation, specific reference to multi-peril should be included in Article 5.13-2 and Article 5.81 should be repealed.

SOLUTION: Amend Article 5.13-2 to specifically include multi-peril as a line of insurance subject to regulation under the article and repeal Article 5.81.

COMMERCIAL PROPERTY RATE REGULATION

PROBLEM: SB 14 enacted by the 78th Legislature, subjected Lloyd's Plan insurers and reciprocals or interinsurance exchanges to rate regulation for residential property insurance. SB 14 also subjected county mutual insurers to rate regulation for automobile insurance, residential and commercial property insurance and inland marine insurance. However, the definition of insurer contained in Article 5.13-2 provides an exception for Lloyd's Plan insurers and reciprocals or interinsurance exchanges that specifies that the rate provisions contained in Article 5.13-2 do not apply to these insurers for commercial property insurance and that the rate and form provisions do not apply to these insurers for inland marine insurance, rain insurance or hail insurance on farm crops. These exceptions do not provide for regulatory consistency among certain insurers and lines of insurance.

SOLUTION: Amend Article 5.13-2 to remove the exception for Lloyd's Plan insurers and reciprocals or interinsurance exchanges regarding commercial property insurance, inland marine insurance, rain insurance and hail insurance on farm crops. This change would make all insurance companies writing the lines of property and casualty insurance regulated under 5.13-2, Insurance Code subject to the same regulatory system.

STEERING

PROBLEM: The Department has received complaints that county mutuals are improperly "steering" insureds to a particular body shop for repairs in violation of Article 5.07-1, Insurance Code. Steering, unlike common referral practices, can impose on consumers' ability to choose. County mutuals are exempt from statutes that do not specifically mention them or are not mentioned under Section 912.002, Insurance Code. Many Texans have private passenger auto insurance through county mutuals; however, these Texans are not guaranteed the right to independently choose an automobile repair person or facility.

SOLUTION: Amend the Insurance Code to make county mutuals and all other insurers writing automobile insurance in Texas expressly subject to the requirements and prohibitions of that article. This change will afford claimants the right to choose an automobile repair person or facility and the type of parts or products they want to use to repair their vehicles.

REBATING

PROBLEM: Article 5.20 which prohibits an insurer, agent and broker from giving or allowing rebates does not apply to county mutuals. The Department has encountered an agent that is offering inducements to consumers with every auto policy or quote.

The Department believes this practice violates article 5.20 Insurance Code and any other type of insurer engaging in this practice would be subject to disciplinary action by the Department.

SOLUTION: Amend the Insurance Code to make county mutuals and all other insurers writing under Chapter 5, Subchapter B expressly subject to the requirements of Article 5.20 Insurance Code.

DEPARTMENT INQUIRIES

PROBLEM: Section 38.001, Insurance Code requires insurers to respond to reasonable Department inquiries within 10 days of receipt. The Department's authority to obtain information has been challenged by a reciprocal exchange that refused to respond to the Department's inquiries due to its exemption from this requirement under Section 942.003, Insurance Code. Lloyds companies are also exempt pursuant to Section 941.003, Insurance Code. Reciprocal exchanges and Lloyds companies write a significant volume of business in the automobile and homeowners lines of business. The inability to require these companies to respond to the Department's requests for information could severely impair the Department's ability to provide proper oversight of the companies' operations.

SOLUTION: Amend Sections 942.003 and 941.003 of the Insurance Code to make reciprocal exchanges and Lloyds expressly subject to the requirements of Section 38.001.

CPA AUDITS

BACKGROUND:

One of the essential responsibilities of the Texas Department of Insurance (Department) is the examination of insurers. The Department examines insurers to ensure they are financially solvent, able to meet their liabilities and are complying with Texas' laws affecting the conduct of its business. In the normal course of business, an insurer is examined every 3 to 5 years. An insurer will be examined more frequently if the Department determines that the insurer's financial condition or business practices warrant increased review. However, the normal exam schedule allows for a period of years in between insurer exams.

Insurers are required to submit annual financial audits conducted by a Certified Public Accountant (CPA). During the period between Department exams, the CPA audits serve as an annual review of the insurer's financial condition. It is important to the Department to ensure that the CPA performs all of the appropriate auditing steps and that the CPA is completely independent of the insurer being audited.

PROBLEM:

CPAs auditing insurance companies are provided guidance through the Examiners Handbook. The handbook applies uniformly throughout the country and was developed by insurance regulators through the National Association of Insurance Commissioners (NAIC). Current law provides that the CPA's examination of the insurer's financial report should be conducted in accordance with generally accepted auditing standards and consideration should be given to procedures illustrated in the NAIC Examiners Handbook. The Department relies heavily on the CPA audits and believes that CPAs should be required to follow the standards set forth in the Examiners Handbook. This will ensure consistency among audit reports and strengthen the Department's ability to detect problems in an insurer's financial condition or business conduct.

It is also important to avoid conflicts-of-interest among the insurer and its auditor. In some cases an insurance company agrees to indemnify the CPA for litigation or other matters that may arise as a result of the audit. The Department is concerned that the indemnification agreements could influence a CPA to be more willing to give a clean audit opinion (on a company that does not deserve one) because the CPA knows they will be indemnified if they are sued by someone who relied on the audit report. Conversely, a CPA who is not insulated by an indemnification agreement will have more incentive to fully disclose the results of an audit to minimize the potential for adverse litigation.

SOLUTION:

Give the Department greater ability to rely on CPA audits of insurers by amending the Insurance Code to require CPAs to consider the procedures illustrated in the NAIC Examiners Handbook while performing insurer audits.

Ensure the independence of an auditor who is examining an insurer's financial reports and guard against conflicts of interest by amending the Insurance Code to specifically prohibit indemnification agreements between the auditor and the insurer for matters arising from the audit.

HOLDING COMPANY ACT

BACKGROUND:

The Insurance Holding Company System Regulatory Act (Act), Chapter 823, Texas Insurance Code, was enacted to protect the public interest and the interest of policyholders. This protection is accomplished by requiring the Department to review changes in the control and ownership of insurance companies as well as certain transactions and relationships between insurers and their affiliates. Among the many provisions, the Act gives the Department the responsibility of ensuring that persons seeking to control an insurance holding company do not harm the policyholders or any one of the affiliated companies through the powers of ownership. Essentially, the Act contemplates a level playing field in transactions and relationships among *related* companies within a holding company structure, similar to what would occur between two *independent* companies that have separate interests to protect. Otherwise, one affiliate could cause financial harm to another for its own gain – and ultimately bring harm to the policyholders - due simply to the exercise of poor judgment by the controlling owner(s). For example, an insurer that was financially troubled would not be permitted to dividend out all of its reserves that secure obligations owed to policyholders.

PROBLEM:

Although the stated goal of the Holding Company Act is to protect the public interest and the interest of policyholders, the protections of the Act do not currently extend to an insurance company holding system if each affiliate in the system is privately owned by five or fewer individuals. This broad exemption can lessen the Department’s ability to accomplish the purposes of the Holding Company Act because affiliates owned by five or fewer people are also capable of causing harm to the public interest and policyholders. This is evident in a number of regulatory interventions, including four significant receivership actions that have involved exempt insurers in the past four years. Receivership actions typically result in unpaid obligations owed to consumers which trigger guaranty funds benefits. Further, there is a negative impact to the State’s General Revenue Fund because companies that pay assessments to the guaranty funds can take credits against their premium taxes owed to the state, dollar for dollar. Additionally, exempt insurers are also typically exempt from oversight by the Securities and Exchange Commission. Although most if not all states have enacted similar laws governing insurance holding company systems, this exemption is unique to Texas.

SOLUTION:

Amend Section 823.015, Insurance Code, to remove the exemption for insurance holding company systems owned by five or fewer individuals.

HMO ACT

BACKGROUND:

Chapter 843 of the Insurance Code governs the establishment, operation and dissolution of Health Maintenance Organizations (HMOs). HMO's are regulated pursuant to this essentially stand alone statute and are not subject to certain provisions that provide guidance to other types of insurers regarding the operation of their business. For example, most insurers are subject to various laws of general application such as statutes relating to examinations and regulatory interventions. In contrast HMOs are subject to unique laws contained in Chapter 843 including statutes relating to interventions in troubled company scenarios.

PROBLEM:

Section 843.441 of the Insurance Code authorizes the commissioner of insurance to assess HMOs to obtain funds needed to cover the administrative expenses of the commissioner when conducting the rehabilitation, liquidation, supervision or conservation of an impaired HMO. Current law also provides that such assessment may be made only after the commissioner determines that adequate assets of the impaired HMO are not immediately available or use of those assets could be detrimental to the rehabilitation, liquidation, supervision or conservation. Because of ambiguities in the statute, the Department has not used Section 843.441 in practice despite the failure in recent years of several HMOs. The Department is not clear whether this statute effectively allows for assessments in the case of an insolvent HMO or requires the commissioner to spend all of the money in the estate before the commissioner can assess for administrative costs. A related concern is whether the statute requires that the commissioner make certain determinations that would be subject to potential challenges.

SOLUTION:

Clarify Section 843.441 to specifically provide that the commissioner has discretionary authority to assess HMOs to provide funding for administrative expenses associated with regulatory interventions, including funds needed to finance the costs of Special Deputy Receivers.

PROBLEM:

Currently HMO's are not subject to the Holding Company Act (Chapter 823, Insurance Code). The Holding Company Act was enacted to protect the interests of policyholders and contains certain solvency provisions that are not addressed in the HMO act. The Department believes making HMOs subject to the Holding Company Act will provide additional protections to enrollees and increase the Department's ability to monitor the financial condition of HMOs.

SOLUTION:

Amend the HMO Act, Chapter 843, Insurance Code to specify that HMOs are subject to the Holding Company Act.

PROBLEM:

Texas law does not provide a specific statutory framework for two HMO's to merge. The absence of a specific framework means that the Department must utilize the more general provisions of the Texas Business Corporation Act, which does not provide the Department with specific statutory authority to protect the interests of the public, including the ability for the commissioner to deny a merger that is contrary to law or that would not be in the best interests of the HMO's enrollees. In contrast, the Department reviews mergers of traditional insurers under Chapter 824 of the Insurance Code. Chapter 824 is a specific statute that governs mergers and provides the Department with specific powers and authority to protect the public and policyholders of the merging insurers.

SOLUTION:

Amend the HMO Act, Chapter 843, Insurance Code, to specify that the procedures for governing mergers contained in Chapter 824 shall govern mergers of HMOs.

VOLUNTARY DEPOSITS

BACKGROUND:

Article 1.10, Section 17 permits an insurance company to make a voluntary deposit with the Comptroller when another state or jurisdiction requires the insurer to maintain a deposit as a condition of doing business in that state. The deposit is held for the protection of policyholders or creditors of the insurer, either in a specific state or jurisdiction or for all policyholders and creditors of the insurer wherever they may be located. Once deposited, the money can only be withdrawn after the insurer satisfies the commissioner that the company does not have any unsecured liabilities or potential policy liabilities or obligations in the state or jurisdiction for which the deposit was made.

PROBLEM:

Often, the Department is involved with insurers whose financial condition merits special attention but who are not at the stage of needing to be formally designated as being in hazardous financial condition. In such cases, to supplement the Department's monitoring of the insurer and address the Department's concerns about the insurer's financial condition, it is often appropriate for the commissioner to require the insurer to make a special deposit to be held by the commissioner. Current law does not clearly state that the commissioner has the authority to request and hold this type of special deposit. Clarifying the current law would ensure that a certain amount of funds will be available to pay claims owed consumers in the event of an insurer's failure. Ultimately, this would also help protect the State's General Revenue since certain costs of an insurer's receivership may be recouped via credits (deductions) against premium taxes that would otherwise be paid to the State of Texas.

SOLUTION:

The Department believes that the current law regarding voluntary deposits under Article 1.10 Section 17 should be clarified to specify that the commissioner may require and hold special deposits to address case specific instances of an insurer's potentially hazardous financial condition.

TEXAS HEALTH INSURANCE RISK POOL

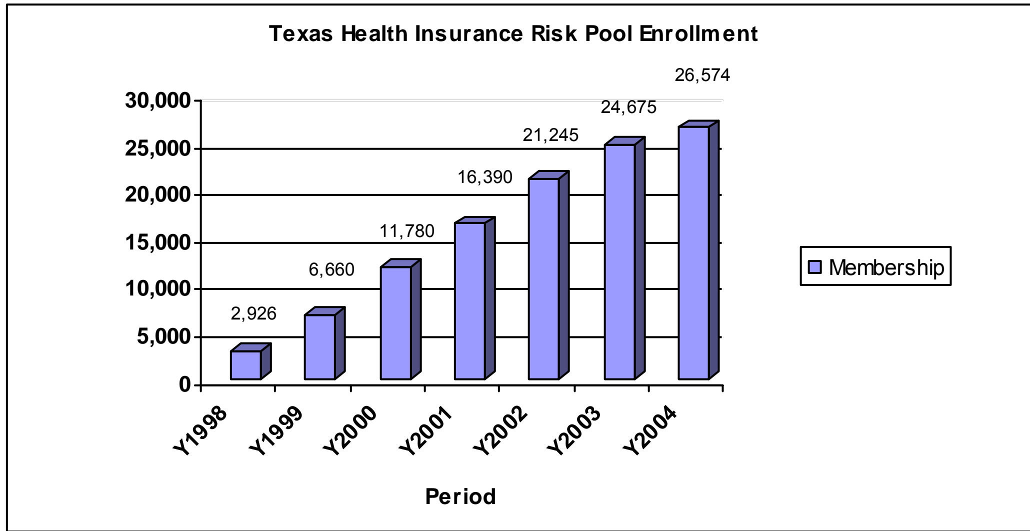
BACKGROUND:

The Texas Health Insurance Risk Pool (Risk Pool) was established pursuant to Article 3.77, Insurance Code. The Risk Pool provides health insurance to Texas residents who either (i) cannot obtain adequate health insurance coverage as a result of their medical conditions, or (ii) are considered "Federally Eligible Individuals," as defined by the Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA. The Risk Pool's rates are determined by an analysis of the average rates charged by major Texas health insurers for individual health coverage. This average rate is called the "Standard Rate". The Risk Pool's premium rate is 200 percent of the standard rate (the maximum rate permitted by law), although at inception the Risk Pool only charged 125% of the standard rate. The average premium for coverage through the Risk Pool is $478 per member, per month or $5,736 annually.

If the members' premium is not sufficient to cover the Risk Pool's claims and expenses of operation, the Risk Pool may assess insurers to obtain the additional funds needed to cover claims and expenses. The assessment is based on the carrier's percentage share of the gross premiums collected for health insurance in Texas.

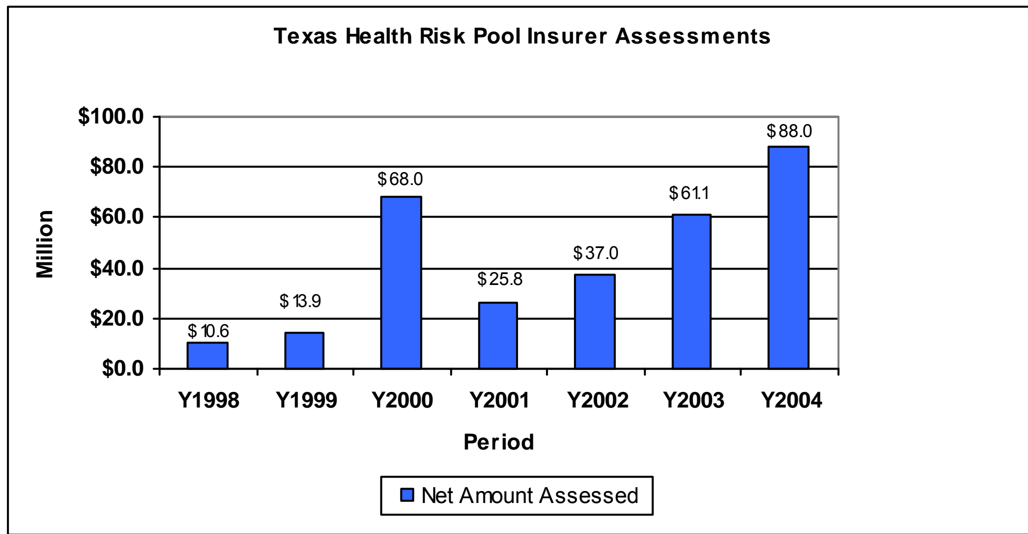
Even with rates climbing to the current position of 200 percent of the standard rate, the Risk Pool's number of insureds has increased steadily over the years (Table 1).

Table 1



The increase in membership, coupled with the fact that premium paid by the members is not sufficient to cover the Risk Pool's costs of claims and expenses of operation, has resulted in increased assessments for carriers (Table 2).

Table 2



The Department believes that it is important to balance the goals of keeping the Risk Pool as affordable as possible with the goal of minimizing the burden of assessments on insurers. Reducing the statutory maximum allowable rate will make the Risk Pool's rates more affordable. Reducing the rate to 150 percent of the standard rate could also help qualify the Risk Pool to receive supplemental federal monies under the Trade Adjustment Act of 2002 (TAA), contingent on whether Congress enacts a bill to extend funding for state risk pools the TAA initiated, as well as the terms of that bill. One bill Congress is currently considering, S2283, passed the Senate on November 16, 2004, and is currently in committee in the House. S2283 maintains the requirement that a qualifying risk pool restrict premiums charged to no more than 150% of the premium for the applicable standard risk rate. Should federal funds become available and the risk pool qualify for them, they would compensate in part for the reduced premium and the lower premium would allow for increased access to coverage for more uninsured Texans.

While the reduction in the maximum premium rate would likely have the effect of increasing carrier assessments, changing the Risk Pool's assessment methodology to distribute the burden more equitably among carriers could mitigate that increase. This more equitable approach assesses based on the number of lives each carrier covers, commonly referred to as the "covered lives approach". At least three other states with high risk pools have adopted this assessment method. More particularly, the method assesses based on the number of policyholders for individual coverage and the number of employees for group coverage. Carriers providing stop loss and excess loss

coverage, as well as reinsurance, are subject to assessment based on the number of employees in a group the carrier insures or reinsures.

SOLUTION:

Amend Article 3.77, Section 9(d), Insurance Code to reduce the maximum rate for Risk pool coverage from 200 percent to 150 percent of the rates applicable to individual standard risks.

Amend Section 13 of Article 3.77 to change the assessment methodology to a covered lives approach instead of the current market share/written premium approach.

PROBLEM:

The Risk Pool is increasingly encountering situations in which the Risk Pool has paid large sums of money for medical treatment on behalf of a Risk Pool member who receives a settlement from a third party, often including past and future medical expenses. The Risk Pool member is then unwilling to pay any part of the sometimes large settlements to reimburse the Pool for the benefits paid or in recognition of the Risk Pool's responsibility for future medical costs to the member.

Article 3.77, Insurance Code, gives the Risk Pool the authority to exercise any of the authority that a health insurance company may exercise under Texas law. Nevertheless, the Risk Pool has had difficulty obtaining subrogation/reimbursement from these members, even when the member collects from a third party for medical expenses already paid by the Risk Pool. The arguments which have presented the most difficulty to the Risk Pool's successful assertion of a subrogation right are that Article 3.77 does not give the Risk Pool the right of subrogation, or that the "made whole" doctrine limits the right. It is important to maximize the resources of the Risk Pool to recoup the cost of paid claims to which it has a legal right. Amending Article 3,77 to establish a clear right of subrogation would accomplish this goal.

SOLUTION:

Amend Article 3.77, Section 6 to specifically provide the Risk Pool with the right of subrogation.

PROBLEM:

Section 12 of Article 3.77, Insurance Code, provides that the Risk Pool's coverage excludes charges or expenses incurred during the first 12 months for any condition for which medical advice, care, or treatment was recommended or received during the six-month period preceding the effective date of coverage.

The Risk Pool has frequently encountered situations where a person with no creditable coverage applying for coverage through the Pool avoids application of the Risk Pool's

preexisting condition limitation by not seeing a doctor or taking medication for 6 months before the effective date of Pool coverage. Under the current statutory provision, the Pool cannot consider a condition of many years duration "preexisting" if there is no doctor visit or medication taken for that condition in the 6 months prior to the effective date of coverage. Allowing the presence of symptoms to prove the existence of a preexisting condition would limit the extent of this problem. An applicant who has creditable coverage in the 12 months prior to the effective date of Pool coverage would still receive a credit toward the Pool's limitation period for the number of months of that prior creditable coverage.

SOLUTION:

Amend Article 3.77, Section 12, Insurance Code, to add a provision that defines a preexisting condition to include a condition for which the member experiences symptoms that would cause a reasonably prudent person to seek diagnosis, care or treatment.

The solutions described above were also recommended by the Board of Directors of the Texas Health Insurance Risk Pool.

TEXAS HEALTH REINSURANCE SYSTEM

BACKGROUND:

Subchapter F of Chapter 26, Insurance Code establishes the Texas Health Reinsurance System (System), which is a mechanism for small employer carriers to reinsure risks covered under small employer health benefit plans. The System operates like a reinsurer and spreads its aggregate loss among its member carriers. The System was initially established to address the concern that one small employer carrier could suffer financial problems if the carrier happened to insure a disproportionate share of sick persons since they are subject to guaranteed issue and renewability of small employer health benefit plans. A related initial objective was to ensure that reinsurance was available to small employer carriers, thereby decreasing the risk of financial harm and encouraging participation in the small employer marketplace. A small employer carrier may reinsure a small employer group, an eligible employer of a small employer or the employee dependent. A reinsured carrier's liability to any insured individual may not exceed a maximum of $10,000 in any calendar year.

Each small employer carrier must elect to participate in the System as a reinsured carrier or seek approval to become a risk assuming carrier. A carrier seeking to be a risk assuming carrier must be financially able to support the assumption of risk and meet other conditions required by statute. The System's nine member board of directors establishes the methodology for determining the premium to be charged small employer carriers for reinsuring small employer groups and individuals.

If the System incurs a net loss in a calendar year, the loss is recouped by assessments on reinsured carriers. A reinsured carrier's assessment is in proportion to the carrier's earned premiums from small employer health benefit plans issued in Texas.

There are approximately 60 small employer insurers writing in Texas. Of those, 39 carriers are risk assuming carriers and 21 insurers are "participating insurers" meaning they can cede risks to the System. Of the 21 insurers, eleven insurers actually cede lives to the system. There are currently 342 lives covered by the Reinsurance System.

PROBLEM:

Over the years, the number of carriers participating in the System has declined. This is due to the withdrawal of carriers from the small employer health plan market and other carriers obtaining approval to become risk assuming carriers. However the amount of claims associated with the lives ceded to the System has increased.

Under current law, a reinsured carrier may stop writing small employer health benefit plans on a guaranteed issue basis if the assessment amount payable for the previous calendar year is greater than or equal to five percent of the total premiums earned in that calendar year from all small employer health benefit plans delivered or issued for delivery by reinsured carriers in this state. Last year the System's experience came close to reaching this trigger. The Department believes this provision of state law conflicts with the Health Insurance Portability and Availability Act (HIPAA).

The current premium base in the System is approximately $197 million. This is small compared to the overall small employer market. The System is not credible due to the small premium base and the small number of participating insurers. The system is not large enough to meet its purpose of spreading the risk over a large base. The small employer health insurance market in Texas is robust and many carriers are currently able to find reinsurance in the traditional market to cover their exposure. The Department believes that given the condition of the small employer health insurance market and the small numbers of carriers participating in the System indicates that the System has served its purpose. The Department recommends that the System be phased out.

SOLUTION:

Amend Subchapter F of Chapter 26 to provide for the phasing out of the Texas Health Reinsurance System. The legislation should provide for a gradual phasing out of the System in a manner that limits market disruptions and protects persons and carriers currently insured through the system, including making provisions for final cessions to the System and provisions for final assessments to recoup deficits.

INSURANCE FRAUD REPORTING

BACKGROUND:

Article 1.10D, Insurance Code establishes the Insurance Fraud Unit within the Department. The Fraud Unit investigates and refers for prosecution persons engaged in, or suspected of being engaged in, fraudulent insurance activities. The Fraud Unit also assists in the prosecution of laws relating to fraudulent insurance acts or insurance fraud. National statistics suggest that fraud adds several hundred dollars to the typical insurance consumer yearly expenditure.

During Fiscal Year 2004, the Fraud Unit:

- Received 5,738 reports of suspected insurance fraud;
- Opened 265 cases for investigation;
- Referred 181 persons for criminal prosecution;
- Obtained 102 criminal indictments;
- Obtained 66 criminal convictions, and
- Obtained orders for $2,015,960 in restitution to victims of insurance fraud.

The results indicate that the Fraud Unit depends heavily on reports regarding actual or suspected fraudulent activity.

In January 2004 the Department began meeting with the Texas Committee on Insurance Fraud (TCIF). The TCIF is a coalition comprised of representatives of insurers, law enforcement, the Office of Public Insurance Counsel (OPIC), antifraud organizations, other state and federal government agencies and the public. One of the purposes of the meetings was to develop suggestions for changes to enhance fraud fighting efforts in Texas. Several recommendations were developed from those meetings.

PROBLEM:

The prompt reporting of suspected insurance fraud is an essential element of the Fraud Unit's ability to conduct a thorough investigation of insurance fraud cases. Certain provisions of Article 1.10D could be strengthened to avoid delays in reporting.

Section 2(e) of Article 1.10D provides that before an insurer may request the commissioner to conduct an investigation of suspected claim fraud, the insurer must have *completed* its investigation and drafted a report of its findings. Similarly, Section 4(a) provides that if a person *determines* that a fraudulent insurance act has been committed, the person shall report the information to the commissioner. This subsection also requires that the report must be made not later than the 30th day after the date of the *determination*.

Requiring insurers to delay reporting suspected fraud until their investigation is complete can impede the Fraud Unit's ability to identify and terminate a fraudulent insurance scheme earlier. The Fraud Unit investigates a broad scope of fraudulent activity and receives reports from a myriad of sources other than insurance companies; therefore, an insurer's report of suspected fraud can be valuable in corroborating whether a pattern or scheme of fraud is occurring.

Article 1.10D provides that a report to one authorized governmental agency or the Department, constitutes notice to all governmental agencies or the Department. This provision creates a decentralized and inefficient method for comprehensive reporting of insurance fraud. The importance of timely investigating, prosecuting and curtailing insurance fraud requires increased accountability for those responsible for reporting insurance fraud as well as those responsible for acting on those reports. The Department believes that requiring suspected insurance fraud to be reported to one agency will make the process more efficient and facilitate the coordinated investigation of insurance fraud across governmental agencies. Having a central agency to receive reports will also increase our understanding of the overall scope of the problem.

Insurers and other persons required or requested to provide information to the Department regarding suspected fraudulent activity often express concerns that the immunity protections in Article 1.10D are insufficient to provide them with protection. Often, the Fraud Unit requests information from persons acting on behalf of insurance companies. These persons are reluctant to furnish the information directly to the Fraud Unit because of concerns that the protections of immunity available to companies do not extend to them. This results in unnecessary delays in the Fraud Unit's access to needed information and slows the investigation of suspected insurance fraud.

Insurers are concerned by language in Section 6(e) of Article 1.10D that requires an insurer to "exercise reasonable care concerning the accuracy of the information conveyed to the insurance fraud unit…" this language is contrasted with the language in Section 6(a) of Article 1.10D which states that, "A person acting without malice, fraudulent intent, or bad faith is not subject to liability based on filing reports or furnishing…other information concerning suspected, anticipated or completed fraudulent insurance acts…" Insurers have expressed concern that the language in subsection (a) provides the appropriate level of immunity protection, while subsection (e) weakens their immunity defenses when reporting fraud to the Fraud Unit. Stronger immunity provisions would encourage the prompt and thorough reporting of suspected insurance fraud and enable the Fraud Unit to be more effective in its campaign against insurance fraud.

The last area of concern regarding fraud involves the prosecution of unauthorized insurance. Section 101.102(a), Insurance Code, Unauthorized Insurance Prohibited, provides that "A person, including an insurer may not directly or indirectly do an act that constitutes the business of insurance under this chapter except as authorized by statute." The Fraud Unit has found difficulty when trying to convince some district attorneys to pursue criminal prosecution in cases involving unauthorized insurance

activity because those district attorneys believe this language requires them to prove that the conduct was knowing and intentional. The Department strongly disagrees with this assessment and believes it would be beneficial to clarify the statute and specify the standard of proof that a prosecutor has to meet. This will improve the Department's ability to obtain criminal prosecution in more unauthorized insurance cases.

SOLUTION:

Amend Section 2(e) of Article 1.10D to allow insurers to report fraud to TDI and request an investigation of suspected fraud while the insurer completes its investigation. This change will expedite the investigation of insurance fraud by the TDI.

Amend Section 4(a) of Article 1.10D to require a person to report acts that the person suspects are fraudulent. Also require the reports to be submitted to the TDI Fraud Unit.

Amend Section 4(c) of Article 1.10D to require that any person authorized to act on behalf of an insurer shall furnish to an authorized governmental agency, upon written request, any information or material relevant to a matter under investigation.

Amend Section 5(a) of Article 1.10D to enhance the confidentiality provisions.

Amend Section 6 (e) of Article 1.10D to ensure that insurers have the appropriate level of immunity to encourage the prompt reporting of insurance fraud.

Amend Section 101.102 Insurance Code to clarify the standard of proof in the prosecution of unauthorized insurance cases.

LIFE, ACCIDENT AND HEALTH
GUARANTY ASSOCIATION

BACKGROUND:

Article 21.28-D, Insurance Code is known as the Life, Accident, Health, and Hospital Service Insurance Guaranty Association Act (Guaranty Act). The Guaranty Act protects Texas policyholders against the insolvency of an insurance carrier and its inability to perform its contractual obligations under life, accident, health and annuity contracts. The legislature established this protection in 1973 by creating a mandatory association of all licensed insurers that write these lines of business in Texas. There are 745 companies writing Life, Accident and Health Insurance and annuity contracts in Texas and premium written in Texas in 2003 was over $38 billion.

PROBLEM:

Texas' last comprehensive update of the Guaranty Act was conducted in 1991 by the 72nd Texas Legislature. The current law was based on a prior version of a model law developed by the National Association of Insurance Commissioners (NAIC). The NAIC has revised and updated the model Act on at least five different occasions since 1991, including an increase of the coverage limits to provide greater consumer protections in the event of an insurer's failure. Also since that time, new insurance products have been introduced and innovations have been made in the marketing and sale of insurance products. Updating the Guaranty Act to reflect these changes will provide greater protection to policyholders and ease of administration, as well as clarify certain ambiguities within the Texas' Guaranty Act. Updating the Guaranty Act would also help ensure uniform treatment of policyholders among the states because it would more closely align Texas laws with the guaranty acts of other states. Uniformity among the states produces a variety of desirable results, including decreasing the risk of litigation.

SOLUTION:

Amend Article 21.28-D, Insurance Code so that Texas' Guaranty Act provides greater consumer protections, is more uniform with the laws of other states, and is better attuned to handle the types of claims, products and business practices that are occurring in the market today. The changes should include creating separate categories of coverage limits for life insurance, health insurance and annuities and making those limits subject to an aggregate limit; implementing a $5 million cap on corporate owned life insurance; increasing the maximum assessment from 1% to 2%; allowing for better management of resources by permitting "authorized" and "called" assessments; shortening the period for recouping tax credits from 10 years to 5 years; and conditioning the initiation of coverage on a finding of financial insolvency rather than requiring a special commissioner's order.

The solution summarized above was also recommended by the Board of Directors of the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association.

REHABILITATION-RECEIVERSHIP OF INSURERS

BACKGROUND:

Article 21.28, Insurance Code exists for the orderly liquidation, rehabilitation, reorganization and conservation of insurers that have been deemed by a court to require such action. The statute provides for the appointment of a person (receiver) to take charge of and conserve an insurer's assets, administer the insurer's estate, pay properly filed claims and distribute any assets that remain after all of the insurer's obligations have been met. The underlying goal of Article 21.28 is to ensure that the insurer's assets are handled in manner that protects the rights of policyholders.

Article 21.28 is largely based on a model law developed many years ago and is in need of a general updating to reflect current business practices and to provide clearer and more complete guidance for handling a failed insurer. The model law was recently updated on a national level and the improvements contained in the latest revised model would provide greater protection to a failed insurer's policyholders in Texas.

PROBLEM:

Article 21.28 has not been comprehensively updated since 1991 when the statute was revised to authorize the appointment of special deputy receivers. As a result, Texas may not be considered a reciprocal state and other states may not enforce receivership court orders issued in Texas. This has the potential effect of giving preferences to non-Texas claimants over Texas claimants or giving preferences to parties who sue Texas insurers in another state. In addition, the claim filing procedures in 21.28 can be burdensome and expensive. This increases costs to the estate and increases the time for distribution of assets to claimants. Finally, the lack of specific guidelines may increase the risk of litigation to resolve disputes impacting the amount and timing of ultimate distributions.

SOLUTION:

Enact the revised Receivership Model Act developed by the National Association of Insurance Commissioners. Updating the current law in Texas with the new model will provide many new protections to policyholders that are not currently available. The new law gives the commissioner of insurance the authority to act sooner to take control of a failed insurer and would streamline multi-state receiverships. Enactment of the model should reduce the amount of litigation associated with receiverships and expedite the distribution of assets to claimants. Enactment of the model would also put Texas claimants on par with claimants of others states and would make Texas receivership orders enforceable in other states adopting the model law.

INTERSTATE COMPACT

BACKGROUND:

The financial services industry has undergone significant changes since the passage of the Gramm-Leach-Bliley Act (GLBA) by the 106th Congress in November 1999. GLBA removed the federal and state provisions that required the insurance, banking and securities to operate independently of each other. GLBA allows banks, insurers and securities dealers to operate under common ownership and preempts state agent licensing laws that prevent or significantly interfere with a depository institution's ability to engage in the sale, solicitation or cross marketing of insurance. GLBA also codified the 1945 McCarren-Ferguson Act and affirmatively stated that the states have the responsibility and authority to regulate insurance activities.

The financial services industry has not experienced the amount of mergers initially predicted since GLBA's enactment; however, banking and security products are competing more directly with insurance products today than ever before. Many insurers, life insurers in particular, believe that they are competitively disadvantaged because of the different systems of regulation that insurers are subject to versus other types of financial services institutions.

Insurers point to the fact that much of the activities of banking institutions are conducted through national banks which are regulated by the federal government, primarily the Office of Comptroller of the Currency. Banking institutions are able to introduce new products to the market faster than insurers because banking institutions need only satisfy one regulator while insurers must obtain separate approval of contractual forms in each jurisdiction in which the insurer desires to offer the product. This can be a time consuming and lengthy process. To address this concern many insurers have begun to push for the federal regulation of life insurance products and repeal of the McCarren-Ferguson Act. While a variety of proposals have been offered, the common goal of the proposals is to streamline the regulation of insurance and create a mechanism that eliminates the need for insurers to obtain 50 approvals before they can begin to offer new products countrywide.

The states are attuned to the insurers' concerns, in part because of concern that a federal regulatory system could threaten the premium tax revenue that comes into the states. In 2003 the premium tax revenue for Texas was approximately $1.045 Billion. States also realize that there are many aspects of state regulation which are inefficient and could be improved. Finally, state regulators are concerned that the states' policyholders are best protected by a regulator who is familiar with all of the nuances of the insurance market of that state and who is not far removed from the policyholders.

PROBLEM:

To address these issues the National Association of Insurance Commissioners set out to develop a system that would provide for uniform product filings standards for insurers and efficient and expeditious approval of filings submitted in accordance with those standards. The result was the development of the Interstate Insurance Product Regulation Compact (Compact) which modernizes the regulatory process among the states.

The Compact establishes the Interstate Insurance Product Regulation Commission (Commission). The Commission is a not-for-profit, multi state organization that is an instrumentality of the compacting states. Each compacting state has a representative on the Commission. The Commission serves as a single point of filing for designated insurance products: life insurance, annuities, long term care and disability insurance; and the Commission is responsible for developing uniform product standards.

The Compact would become effective when 26 states/jurisdictions or states/jurisdictions representing 40% of the premium volume for the designated products enter into the Compact. Currently nine states have enacted the Compact into law and 12 additional states are planning to introduce the Compact legislation in 2005. The Compact has been endorsed by the National Conference of State Legislatures and the National Conference of Insurance Legislators.

SOLUTION:

Enact the Interstate Insurance Product Regulation Compact. The Texas Insurance Commissioner should serve as the Texas representative on the Commission. The Compact will streamline and modernize the regulation of insurance in Texas and countrywide. Having a uniform set of standards and an efficient approval process will help insurers compete with other sectors of the financial services industry. The Compact will streamline the insurance regulatory system and preserve the consumer protections that currently exist in the states.

TEXAS WINDSTORM COVERAGE

BACKGROUND:

Insurance companies are not required to write windstorm insurance along the Texas coast. Individuals who cannot obtain windstorm insurance through the voluntary market may obtain coverage through the Texas Windstorm Insurance Association (Association), created by the Legislature in 1971. Structures complying with building specifications or falling within the grandfather provisions qualify for coverage through the Association. The Association, consisting of all property insurers authorized to write property insurance in Texas, administers day-to-day operations, including policy issuance and claims processing. In the event the Association is unable to cover losses from collected premiums, the following funding mechanism applies (in order):

1. $100 million assessed to member insurers,
2. Catastrophe Reserve Trust Fund (CRTF) and reinsurance (approximately $1 billion),
3. $200 million assessed to member insurers,
4. Unlimited assessment to member insurers (subject to premium tax credits for 5 or more successive years).

PROBLEM:

The current capacity that is not subject to future premium tax credits for the Association is approximately $1.3 billion for residential and commercial property combined. The $1.3 billion is a combination of the CRTF, reinsurance, and member assessments not subject to premium tax credit, and is estimated to cover the probable maximum loss of a storm that would occur every 100 - 125 years (e.g., a Category III storm striking Galveston). Florida's 2004 Hurricane season demonstrated that multiple hurricanes are possible in a single storm season. Additionally, those storms could easily exceed the Category III level. Texas' General Revenue stream would be at a significant risk should storm severity or occurrence go beyond the single Category III scenario.

The combined voluntary exposure of private insurers covering coastal property is estimated at $55 billion for both residential and commercial risks (projections based on 2003 and 2002 data; actual amount is most likely higher). This $55 billion is separate from the amounts that would be payable by the Association which currently has over $20 billion in exposure. In addition, the threat of future assessments stifles the full development of a competitive homeowners market since insurers must weigh expanding their market share against the potential for future assessments also based on marketshare. As an additional consideration, insurers are precluded by IRS regulations to accumulate reserves for future catastrophe events on a tax deferred basis.

SOLUTION:

- Evaluate and enhance risk management,
- Provide incentives for carriers to directly assume more risk along the Texas coast,
- Restructure the financing of storm damage by transferring risk to reinsurance markets and special facilities capable of accumulating catastrophe reserves on a tax exempt basis,
- Provide for the issuance of bonds within the insurance structure to pay for future losses with repayment of bonds to be funded by policyholders rather than General Revenue Tax offsets, and
- Establish stand-by financing capacity as a tool for short-term cash needs.

Future changes should contemplate the combination of reinsurance, financial instruments, and bonding, as well as restructuring the public-private system of coastal insurance. The state can, over time, begin moving toward a system that does not expose general revenue to hurricane losses while at the same time allowing for strong, sustainable economic growth along the coast by being able to provide insurance coverage.