# BIENNIAL REPORT OF THE TEXAS DEPARTMENT OF INSURANCE TO THE 78TH LEGISLATURE

## DECEMBER 2002


TEXAS DEPARTMENT OF INSURANCE
JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

**Texas Department of Insurance**
***Commissioner of Insurance,*** *Mail Code 113-1C* ***Jose Montemayor***
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-463-6464 telephone • 512-475-2005 fax • www.tdi.state.tx.us

December 31, 2002

The Honorable Rick Perry
Governor of Texas
P.O. Box 12428
Austin, Texas 78711

The Honorable Bill Ratliff
Lieutenant Governor of Texas
The Capitol
Austin, Texas 78711

The Honorable Troy Fraser
Texas Senate
P. O. Box 12068
Austin, Texas 78711

The Honorable James E. "Pete" Laney
Speaker, Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768

The Honorable John Smithee
Texas House of Representatives
P.O. Box 2910
Austin, Texas 78768

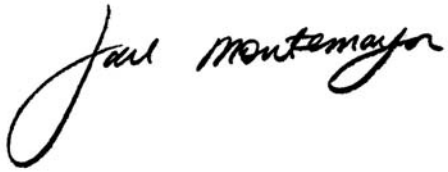
Dear Governors, Mr. Speaker, and Chairmen:

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 463-6410 with any questions or if you need additional information.

Thank you for your consideration.

Sincerely,



Jose Montemayor
Commissioner of Insurance

# INTRODUCTION

Section 32.022, Insurance Code, 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 and provides an overview of the insurance industry. The recommendations are based on extensive study afforded these issues during the interim by the Department and various interim committees of the Texas Legislature.

Several of the recommendations included in this report pertain to changes needed to address problems brought to light by the mold crisis experienced since the last session of the Texas Legislature. Those changes include revising the system for regulating rates charged by insurers writing personal lines, licensing of persons involved in handling mold claims, establishing specific time frames for insurers to respond to water claims and broadening the applicability of laws governing insurers' withdrawal from a line of business such as homeowners insurance.

The report also contains recommendations for changing the method of rate and form regulation in other casualty lines such as commercial automobile, inland marine insurance and fidelity and surety bonds, and requiring that the rates filed by the Texas Medical Liability Trust, the largest Texas writer of medical professional liability insurance, comply with commonly used rate standards. These recommendations provide flexibility for insurers to respond to market conditions while preserving the Commissioner's and Department's authority to ensure that rates charged to Texas insurance consumers are just, reasonable, adequate, and neither excessive nor unfairly discriminatory for the risks to which they apply.

The remaining issues discussed in this report include recommendations: to facilitate the prompt payment of physicians and other health care providers; pertaining to the operation of the Texas Health Insurance Risk Pool; to standardize the Department's current rulemaking authority; to provide guidance to insurers and protections to consumers regarding the use of credit scoring and credit reports in underwriting and rating; to expand eligibility for the JUA; and to improve the Commissioner's ability to establish a residual market facility for homeowners insurance. The report also contains a recommendation regarding the minimum non-forfeiture rate of interest for individual deferred annuities.

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.

# INSURANCE INDUSTRY OVERVIEW

In 2001 there were 7,065 domestic insurers in the U.S., and the total premium volume in the U.S. insurance market exceeded $1 trillion. Of those insurers, 2,041 were licensed to do business in Texas. Texas' premium volume of $70 billion ranked third among all states, behind California and New York, making Texas one of the top insurance markets in the world, roughly equal in size to the whole Canadian insurance market.

Texas premium was written by Life/Health insurers (approximately $36.2 billion), Property/Casualty insurers (approximately $24.2 billion), Health Maintenance Organizations (HMOs) (approximately $8.3 billion), Title insurers (approximately $1.1 billion), and miscellaneous other insurers (less than $300 million). With the exception of Title and miscellaneous insurers, each segment has had unique challenges affecting its continued operations and financial viability.

With rising medical costs and a very competitive market for rates, the HMO industry experienced six years of net losses in Texas through 2001, for a cumulative total net loss of $2.5 billion. This long-running trend appears to have turned in 2002 with rising premium rates and efforts toward better medical expense management, resulting in a modest net income of $39 million industry wide for the nine months ending September 30, 2002. Historically the fourth quarter has produced less favorable results than the first three quarters of the year, but 2002 to date gives good indications of being a turn-around year for the HMO industry in Texas.

The Life/Health industry was heavily impacted by low interest rates and the significant downturn in the investment markets. In 2001 the Federal Reserve Board cut interest rates several times, from 6.5 percent at the beginning of the year to 1.75 percent at the end of 2001. Interest rates have since been cut further and currently are set at 1.25 percent. Life/Health insurers will continue to be challenged as they struggle to meet contractual or statutorily guaranteed rates on the insurance products they have sold or are marketing.

The Property/Casualty industry has been heavily impacted by claim losses such as mold, malpractice lawsuits, weather catastrophes, and the terrorist attacks of September 11, 2001. The Industry's combined ratio (a measure of incurred claim losses and underwriting expenses per dollar of premium) was 116 percent nationwide in 2001. This performance was the industry's third worst on record, exceeded only by combined ratios of 116.5 percent in 1985 and 118 percent in 1984. These underwriting results, combined with lower investment returns and gains, caused a combined net loss after taxes of $7.9 billion in 2001, the first net loss ever recorded by the Property/Casualty industry.

The terrorist attacks on the World Trade Center and other locations on September 11, 2001, was the largest insured catastrophe in world history. Insurance losses for those events are estimated to be as high as $70 billion. Following the attacks, demand for insurance outstripped supply, pushing prices up and reducing the amount of coverage

available as insurers became more selective in the risks they were willing to insure. The cost of reinsurance increased dramatically, affecting virtually all insurers and insurance consumers.

In November 2002, Congress enacted and President Bush signed the Terrorism Risk Insurance Act of 2002. The Act establishes a temporary Federal program that provides a system of shared public and private compensation for insured losses resulting from acts of terrorism. Insurers included under the program must make coverage available to their policyholders, and must disclose the premium charged for terrorism insurance and the Federal government's share of compensation provided under the law.

Insurance is indeed the lubricant of the world's economy. The recommendations presented in this report are intended to help assure the availability and affordability of insurance products that are vital to the Texas economy, while continuing to encourage competition in the marketplace.

# TABLE OF CONTENTS

# WATER DAMAGE CLAIMS

**PROBLEM:**

Article 21.55, Insurance Code, sets forth standards and time frames with which insurers must comply in responding to first party claims made by an insured or a policyholder. Article 21.55 requires that insurers must acknowledge and begin the investigation of a claim not later than the 15th day after receipt of written notice of the claim. The statute also requires an insurer to notify the claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date the insurer receives all information needed for proof of loss unless the insurer has a reasonable basis to believe the loss resulted from arson or the insurer notifies the claimant that it is unable to accept or reject the claim.

Molds require a water source to grow and can begin growing within 24 to 48 hours of a water event. To minimize the cost and property damage that can result from a water damage claim and potential mold loss, insurers should be required to respond to a water damage claim in a shorter time frame than for non-water damage claims. Prompt handling of water damage claims will minimize the cost of the claims for insureds and insurers.

**BACKGROUND:**

In 2001, Commissioner Montemayor held public hearings in Austin, Corpus Christi and Houston to gather information and comments relating to mold coverage in residential property insurance forms, the effect of increased mold claims on those forms, the continuing availability of insurance coverage for losses caused by mold, the causes of mold and the health consequences of mold exposure. Testimony was received from state and national health officials, mold claimants, consumer groups, insurers, mold and water remediators, representatives of various building trades and others. Many of the witnesses testified that delays in responding to water-related claims allowed mold to develop and increased the severity of the damage.

The failure to respond promptly to a water damage claim greatly increases the potential cost of the loss resulting from a water damage claim. The information received by the Department also indicated that water damage claims that include active mold growth result in significantly higher costs than water damage claims that do not include mold.

In January 2002, the Commissioner appointed a 19-member Advisory Task Force for Mold-Related Claims (task force) to develop recommendations on how insurers should respond to claims for water and mold damage. Members of the task force included indoor air quality experts, consumers, bankers, realtors, builders, contractors, adjusters and insurers.

In April 2002 the Department, with input from the task force, issued a brochure of suggested practices to help insurers and consumers effectively handle water damage claims. Those suggested practices urge insurers to acknowledge water damage claims within 24 hours. The suggested practices also state that it is appropriate for an insurer to send a company representative to the claimant's home within 24 to 72 hours of notice of the claim.

Because Article 21.55 allows longer time frames for acknowledging claims, insurers cannot be required to respond to water claims in the shorter time frames suggested by the Department and the task force, without changes to the current statute. In addition to water claims, there may be other types of claims that necessitate shorter response times.

**SOLUTION:**

Amend Article 21.55, Insurance Code, to require specific time frames for acknowledging and responding to water damage claims. The law should require, at a minimum, that insurers acknowledge water damage claims within 24 hours of notice of the claim and that insurers send a representative to the claimant's home within 72 hours of notice of the claim. The statute should also be amended to grant the Commissioner rulemaking authority to establish response times for other types of claims as market conditions dictate to effectuate prompt and fair handling of claims.

# LICENSING OF PUBLIC ADJUSTERS AND MOLD REMEDIATORS

**PROBLEM:**

Since January 2000 the number of claims and the dollar amount of losses paid for mold damage claims under residential property policies have increased dramatically. During the period of January 2000 through December 2001 insurers' estimated incurred losses and allocated loss adjustment expenses associated with mold damage claims exceeded $1 billion dollars.

One recurring concern of claimants, insurers and other interested persons is the absence of standards to ensure that persons involved in important aspects of handling a mold claim are knowledgeable and qualified to perform the tasks they are performing. The absence of standards, coupled with the heightened concerns about the dangers of mold and the large amount of claim dollars being spent to repair mold damage, make this area ripe for abuse by unscrupulous persons seeking to make a quick profit without regard to the best interest of the consumer. This problem has resulted in improperly adjusted and remediated water damage claims, to the detriment of consumers with legitimate claims. This situation has also led to fraudulent claims activity, which ultimately increases the costs that all insureds pay for insurance coverage.

**BACKGROUND:**

During the 2001 mold coverage hearings (see Section A – Issue 1: Background), many witnesses expressed concern about the lack of standards, accountability, licensing or certification of public adjusters and persons in the mold testing and remediation industry.

Another source of information regarding mold claims was based on data calls issued to the five largest insurer groups writing residential property insurance. These groups write approximately 75 percent of the residential property insurance market in Texas. The initial data call was sent 07/30/01 and a second data call for updated information was sent 12/31/01.

One important issue the data calls revealed was the unusually high number of multiple claims (i.e., from multiple individual water leaks or discharges) alleged to be associated with a single mold infestation under a policy, which led insurers to ultimately pay more than the stated policy limits for a dwelling damage claim. This practice was referred to as "stacking" and in some cases was exacerbated by the involvement of public adjusters.

Persons who adjust losses on behalf of an insurer generally are required to hold a license from the Department. To become licensed, insurance company adjusters must meet qualifying criteria, which include being trustworthy, having experience or training in the handling of loss claims and successfully passing an examination required by the

Commissioner. Licensed adjusters must also take continuing education courses to maintain their licenses. These requirements do not apply to public adjusters. Public adjusters are persons who adjust losses on behalf of an insured claimant. Public adjusters are not required to hold a license as a condition for conducting business, i.e. adjusting losses, in Texas. Public adjusters are paid a percentage of the claim payment received by the policyholder.

Similarly, there are no state licensing or certification requirements and no standards or guidelines for persons engaged in the testing and remediation of mold. Because of the lack of standards, many operators enter the field with little or no preparation or qualifications.

**SOLUTION:**

Add a chapter to the Insurance Code requiring persons acting as public adjusters to first obtain a license. The law should establish qualifying criteria and continuing education requirements, and should contain consumer protection requirements such as, disclosure of fees to be paid by the consumer.

In addition, the Department believes that persons engaged in mold testing and remediation should be required to hold a license and that standards should be established for proper mold remediation. This latter recommendation is admittedly outside of the Department's regulatory purview; however, the information obtained through the Department's public hearings, complaints and discussions with parties involved in the mold claim process have clearly shown that these issues directly affect residential property insurance losses for mold claims and point to the pressing need for legislation to address these issues.

# WITHDRAWAL PLANS

**PROBLEM:**

Article 21.49-2C, Insurance Code, which requires the filing of withdrawal plans by insurers, does not specifically include Lloyd's insurers, reciprocal and interinsurance exchanges and county mutuals. Therefore, if these insurers choose to withdraw from a line of insurance, they are not required to file a plan of orderly withdrawal, and the other provisions of the Article are not applicable. Lloyd's insurers and reciprocal exchanges currently write approximately 95 percent of the residential property insurance market, and county mutual insurers write approximately 28 percent of the automobile market. A withdrawal by one or more of these insurers can potentially cause severe market disruptions. A corollary problem exists because the requirement to file a withdrawal plan is not triggered if an insurer stops writing a single type of policy form or coverage. In the residential property market severe disruptions occurred when insurers stopped writing the Homeowners Form B (HO-B), yet the insurers could not be required to file a plan to ensure that the people of Texas were protected. In both of these situations, insurers should be required to file a withdrawal plan. In addition, the Commissioner needs to be able to assure that the insurer's withdrawal will be orderly and will not result in severe market disruptions or the displacement of insureds.

**BACKGROUND:**

Article 21.49-2C, Insurance Code, requires an authorized insurer to file with the Commissioner a plan of orderly withdrawal if the insurer proposes to: withdraw from writing a line of insurance in this state; reduce its total annual premium volume by 75 percent or more; or reduce its total annual premium volume in a rating territory by 50 percent or more in a personal line of motor vehicle comprehensive or residential property insurance. Article 21.49-2C requires the insurer's plan to be designed to protect the interests of the people of Texas and to indicate the dates it intends to begin and complete its withdrawal.

Article 21.49-2C contains several important protections for consumers, and two are especially worth noting for this discussion. The first is that the Commissioner may require a deposit of securities if the Commissioner determines that such action is in the best interest of the people of Texas. The second protection is that the Commissioner may impose a moratorium on the approval of certain withdrawal plans filed after a catastrophic event of natural origin, if the relevant line of insurance is not reasonably expected to be available to a substantial number of policyholders or potential policyholders.

While Article 21.49-2C seems to impose a duty on all authorized insurers, it does not specifically reference Lloyd's plan insurers, reciprocal and interinsurance exchanges or county mutuals. Similarly, the chapters governing the operation of Lloyd's insurers, reciprocal and interinsurance exchanges and county mutuals do not stipulate that Article 21.49-2C is applicable.

The chapters of the Insurance Code that govern these insurers stipulate that these insurers are exempt from the operation of all insurance laws unless specifically provided in the governing chapter or unless a law outside of the governing chapter specifically states that it is applicable to such insurers; therefore Article 21.49-2C has been held to be inapplicable and the Commissioner has limited authority to ensure that interests of the people of Texas are protected when one of these types of insurers withdraws from a line of insurance.

**SOLUTION:**

Amend Article 21.49-2C, Insurance Code, to make it applicable to Lloyd's insurers, reciprocal and interinsurance exchanges and county mutuals. In addition make the insurers' withdrawal plan statute applicable to an insurer's withdrawal from a type of coverage, such as the discontinuance of HO-B coverage. Finally, authorize the Commissioner to disapprove or modify a withdrawal plan (including establishing later dates for the insurer to begin or end its withdrawal) if the Commissioner determines that the insurer's withdrawal will displace or make the line of insurance unavailable to a substantial number of policyholders or have other adverse effects on the competitiveness of insurance markets in Texas.

# PERSONAL LINES

**PROBLEM:**

The Insurance Code currently provides for a dual system of rate regulation for automobile and residential property insurance. Some insurers are subject to the benchmark rate system, which is a file and use/prior approval form of rate regulation, while other insurers are exempt from rate regulation. This dual system of rate regulation has led to the development of the current insurance market in which a substantial number of Texas insureds obtain their automobile and residential property insurance from insurers that are not subject to rate regulation. The Department is continuing to see insurers writing an increasing percentage of personal lines insurance through companies that are not subject to rate regulation.

The exemption of insurers from rate regulation severely limits the Commissioner's ability to ensure that the rates charged by all insurers writing automobile and residential property insurance are just, adequate, reasonable, not excessive and not unfairly discriminatory. The rates charged by all insurers writing automobile and residential property insurance in Texas should be required to meet these basic rate standards. Additionally, the Commissioner needs to have authority to examine the rates charged by all insurers writing automobile and residential property insurance in Texas to ensure that these standards are met. The authority granted to the Commissioner should include the ability to disapprove rates that do not meet the basic rate standards in order to ensure a stable, competitive and affordable market.

Under current law the Commissioner approves or adopts policy forms for residential property insurance. Only the largest insurers and national organizations of insurance companies are allowed to submit their forms used in other states, unnecessarily restricting the homeowners market from additional choices.

**BACKGROUND:**

Pursuant to Article 5.101, Insurance Code, the Commissioner establishes benchmark rates for commercial automobile, personal automobile and residential property insurance. Insurers subject to the benchmark rating system must file their rates with the Commissioner. Such insurers may use rates within a range of 30 percent below to 30 percent above the benchmark rate (referred to as the flexibility band) once the rates are filed with the Commissioner (file and use). Rates outside the flexibility band, i.e. greater than 30 percent above or below the benchmark rate, may not be used until approved by the Commissioner (prior approval). All rates filed by insurers under Article 5.101 are required to meet specified rate standards which include that the rates must be just, reasonable, adequate, and not excessive for the risks to which they apply. In addition insurers subject to the benchmark rating system must use the rating manual of classifications, territories and rating rules promulgated by the Commissioner unless they obtain approval to use a different rating manual.

Insurance companies writing residential property insurance that are organized as reciprocal and interinsurance exchanges and Lloyd's plan insurers are not subject to the benchmark rate system. Articles 19.12 and 18.23, Insurance Code, exempt reciprocal and interinsurance exchanges and Lloyd's plan insurers, respectively, from the operation of all insurance laws unless the law is specifically made applicable to those insurers, while Article 5.101 does not specifically state that the Article applies to such insurers. The result is that these companies do not have to file their rates with the Department and there is no requirement that the rates charged by these insurers meet commonly used rate standards.

Similarly, companies organized as county mutual insurers and writing automobile insurance are not subject to the benchmark rate system. Article 17.22, Insurance Code, exempts county mutual insurers from the operation of all insurance laws unless the law is specifically made applicable to the insurers; Article 5.101 does not specifically state that the Article applies to county mutuals. Article 17.25, Section 6, Insurance Code, requires a county mutual to file "a schedule of its rates, the amount of policy fee, inspection fee, membership fee, or initial charge by whatever name called, to be charged its policyholders or those applying for policies;" however, there is no requirement that the rates filed by county mutual insurers meet commonly used rate standards.

Over the past 10 years, the percentage of residential property insurance direct premium written by non-rate regulated insurers increased from 57.8 percent to 95 percent. During this same period, the percentage of personal automobile insurance direct premium written by non-rate regulated insurers increased from 20.8 percent to 28.2 percent.

During 2001 and 2002, residential property insureds have experienced dramatic increases in their rates. Complaints to the Department regarding rate increases for residential property insurance increased from 283 in calendar year 2001 to 2,415 through November 2002.

Similar trends are occurring in personal automobile. Insurers are writing an ever-increasing amount of business in their non-rate-regulated affiliates. Complaints to the Department regarding automobile insurance excessive rates increased from 168 in calendar year 2001 to 352 through November 2002.

Another issue in the homeowners market that requires attention is the use of alternate policy forms. Currently only residential property insurers that operate in at least 26 states and have a national premium volume of at least $750 million, and national organizations of insurers may submit their forms. National forms for Nationwide, State Farm and USAA in addition to forms for the Insurance Services Office, Inc. (a national organization of insurance companies) have been approved or adopted for use in Texas. There may be other companies desiring to compete in the Texas market that wish to use their forms used in other states that do not meet the current threshold for consideration, unnecessarily restricting competition.

**SOLUTION:**

Amend the Insurance Code to establish a rate oversight system that ensures competitive markets for personal automobile and residential property insurance. Such a system should, at a minimum, include a file and use rating system. Rate oversight should be applicable to reciprocal and interinsurance exchanges, Lloyd's plan insurers and county mutual insurers. The rates charged by all insurers should be required to meet the commonly used rate standards of being just, adequate, reasonable, not excessive and not unfairly discriminatory. The rate oversight process should provide for timely review of rate filings to enable insurers to quickly respond to changing market conditions. The rating system should give the Commissioner the authority to review and disapprove rates that do not meet the rate standards. Texas law should also enable the Commissioner to initiate alternative forms of rate regulation, such as prior approval, when necessary to address problems occurring in the market.

Implementing this type of rate oversight system would eliminate the exemption from rate regulation for certain insurers. This system also allows for a great degree of competition by allowing insurers to develop their own rating manuals and classification systems. Lastly, this system would give the Commissioner sufficient authority to monitor the rates charged by all insurers to ensure that the rates are fair and not unfairly discriminatory and to initiate regulatory action when the rates being charged do not meet the required standards.

Amend Article 5.35 to allow any insurer to file residential property policy forms for approval.

# MEDICAL MALPRACTICE

**PROBLEM:**

Physicians and health care providers are facing severe problems with the availability and affordability of medical liability insurance coverage. This is due, in part, to high loss ratios incurred by insurers writing this line of coverage, the withdrawal of several insurers from the marketplace because of solvency and other concerns and the implementation of substantial rate increases by the remaining medical liability insurers writing in Texas.

Many physicians and health care providers have complained that medical liability insurance premiums are becoming so high that it is no longer profitable for them to continue practicing medicine in Texas. Physicians are limiting their practices by eliminating certain services, such as obstetrics. In addition, some physicians are retiring early and others are moving their practices to other states. Physicians of all specialties have also advised the Department that the high cost of medical malpractice insurance has a detrimental effect on the ability of communities to recruit physicians to Texas. The net effect of this problem is that some communities in Texas do not have ready access to the health care providers needed to provide care to the injured and sick persons in their areas.

Because medical liability insurance coverage is so critical to the wellbeing of the state, the Commissioner should have full visibility over the rates charged by all insurers. The Texas Medical Liability Trust (TMLT) is the dominant writer of medical liability insurance in Texas, accounting for 34 percent of the medical liability insurance market (approximately 10,000 physicians) as of December 31, 2001. However, TMLT is governed by Article 21.49-4, Insurance Code, which stipulates that TMLT is not engaged in the business of insurance. Therefore, the rates and forms used by TMLT are not subject to regulation by the Department. Although the TMLT is required to file rates and forms with the Department for informational purposes only, the rate filing does not include actuarial justification. Additionally, TMLT is not subject to the statutory financial reporting requirements with which licensed insurers must comply.

**BACKGROUND:**

While the causes of the medical malpractice coverage availability and affordability problems are multifaceted, the Department believes that subjecting TMLT to certain insurance laws will greatly increase the Commissioner's ability to ensure that doctors and health care providers obtaining liability insurance are adequately protected by increasing visibility over the market.

Given the TMLT's dominant role in the Texas medical liability market, the Department believes it is critical that the rates charged by TMLT be required to meet commonly used rate standards. The TMLT should also be subject to the same reporting requirements as other licensed insurers writing medical liability insurance. TMLT should

be required to submit financial reports in accordance with statutory accounting principles, and the Commissioner should have specific authority to examine the financial condition of TMLT. This framework would preserve the status of TMLT as a trust yet would provide a basis for comparability with other insurers and significantly increase the Commissioner's visibility over the entire market.

Article 21.49-4, Insurance Code, requires TMLT to file an independently audited annual financial statement with the Department but does not specify a date by which the statement must be submitted. The Department must verify that TMLT satisfies reasonable minimum requirements to ensure TMLT's capability to meet its contractual obligations. Under the current framework, it is unclear what standards the Department must apply in fulfilling this obligation.

**SOLUTION:**

Amend Article 21.49-4, Insurance Code, to require that the rates charged by the TMLT meet commonly used rate standards. The Commissioner should have the authority to examine TMLT's rates and actuarial justification to ensure that the rate standards are met. The Commissioner also needs the authority to require financial statements and to conduct financial examinations under Article 1.15, Insurance Code, to ensure the solvency of the TMLT.

# COMMERCIAL AUTO

**PROBLEM:**

Commercial automobile insurance is regulated differently than most other lines of commercial insurance. This difference in regulation prevents commercial automobile policies from being integrated with other forms and packages of coverage commonly sold to businesses. Additionally, commercial auto forms are subject to an equivalency requirement, which limits the ability of insurers to quickly introduce new coverage forms to address changes occurring in the marketplace. These limitations tend to reduce market competition and increase costs to the consumer.

**BACKGROUND:**

Commercial automobile insurance rates are established pursuant to Article 5.101, Insurance Code, which provides for the annual establishment of benchmark rates. The Commissioner also promulgates the insuring forms for commercial automobile insurance, although insurers may file endorsements to enhance the coverage provided in the promulgated forms. Most other commercial lines sold to businesses (e.g. general liability, commercial property and excess liability coverage) are subject to a file and use rating system, and insuring forms are subject to prior approval. Commercial coverages often are “packaged”, or integrated, with the rating modified based on the package purchased by the business. The inability of commercial automobile insurance to be integrated with other commercial coverages adds unnecessary costs to the insurance system. Texas differs from standard countrywide practices because it precludes insurers from passing on the savings related to packaging. Also, because insuring forms must provide coverage that is equivalent to forms promulgated by the Commissioner, individual insurance companies cannot quickly introduce forms that are responsive to changes in coverage desired or needed in the market. Changing the form of regulation of commercial automobile insurance should enable insurers to be more responsive to changing conditions in the market, allow business consumers to select the coverage that best meets their needs, permit the integration of commercial automobile with other coverages, enhance competition and pass the savings to consumers, while retaining the Commissioner’s authority to monitor insurers’ rates and intervene where necessary to ensure that consumers are treated fairly.

**SOLUTION**:

Amend Articles 5.06, 5.13-2 and 5.101, Insurance Code, to remove commercial automobile from the requirements of promulgated forms and endorsements and the benchmark rating system and place the regulation of commercial automobile insurance under the provisions governing the writing of general liability, commercial property, commercial casualty and medical professional liability insurance. Rates would be subject to a file and use requirement and forms would be subject to prior approval.

# MISCELLANEOUS LINES

**PROBLEM:**

The Insurance Code provides for a variety of methods to regulate the rates used by insurers writing property and casualty insurance in Texas. The Department believes that a single system for regulating rates would be more efficient for the Department and insurers and would ease the administrative burden now associated with the use of differing regulatory systems.

**BACKGROUND:**

Rates for numerous lines of insurance, including fidelity and surety bonds, personal umbrella, personal liability and financial guaranty insurance are subject to Article 5.15, Insurance Code. This statute requires insurers to file their rates with the Department for approval prior to use. Rate filings submitted to the Department are deemed approved if not disapproved within 60 days of the date of filing. The Commissioner may grant a 60-day extension to complete the review of the filing.

Inland marine insurance is governed by Article 5.53, Insurance Code. This statute also requires insurers to file their rates with the Department for approval prior to use. Rate filings submitted to the Department are deemed approved if not disapproved within 30 days of the date of filing. The Commissioner may grant a 30-day extension to complete the review of the filing.

Meanwhile, most other commercial property and casualty lines fall under Article 5.13-2, Insurance Code, a file and use statute. Under Article 5.13-2, rates must be filed before an insurer can use them. File and use gives insurers ample flexibility in developing rates while preserving the Commissioner's ability to ensure that the rates charged are fair and not unfairly discriminatory.

The Department believes a common system of regulation for property and casualty lines will assist insurers by establishing a single set of regulations for insurers to use in developing and submitting filings. Further, the Department believes that the most effective and efficient form of regulation is the file and use system for rates and the prior approval system for policy forms.

**SOLUTION:**

Amend the Insurance Code to place the lines of insurance currently regulated under Articles 5.15 and 5.53 under the provisions of Article 5.13-2 of the Insurance Code.

# PROMPT PAYMENT OF PHYSICIANS AND PROVIDERS

**PROBLEM:**

Prompt payment of physicians and health care providers is one of the major issues that the Department studied in great detail immediately after the close of the Regular Session of the 77th Texas Legislature.

The Commissioner undertook several measures to address this problem, including the appointment of an ombudsman, numerous enforcement actions and the further amendment of rules to facilitate the prompt and accurate payment of physicians and providers. However, legislation is needed to further clarify the relationship and responsibilities of carriers, physicians and providers. The fact that insurers and HMOs may, by contract, establish clean claim data elements in addition to those required by the Commissioner has created confusion.

The statutory language regarding the Commissioner's authority to adopt rules concerning disclosure of fee schedules and coding procedures that affect payment for services should be further clarified.

The Department has also identified areas where the claims payment process could be streamlined for physicians and providers and carriers. Those areas include the lack of specific deadlines for the filing of claims by physicians and providers, the inability of carriers to identify resubmitted claims and the lack of specific deadlines for physicians and providers to comply with a request for repayment when a claim is overpaid.

A final issue that arose in the Department's investigation and enforcement actions regarding untimely claim payments was the need to set a reasonable expectation for prompt payment of claims instead of subjecting carriers to penalties and administrative fines for every claim that is not paid promptly and correctly.

**BACKGROUND:**

Shortly after adoption of amendments to the clean claims rules to provide greater clarity and more specificity regarding prompt payment procedures in September 2001, the Commissioner established the Clean Claims Working Group (CCWG), which consists of representatives of physician groups, hospitals, health plans, health insurers, preferred provider organizations and claims administrators. The CCWG was formed by the Commissioner to serve as an advisory body and to consider additional revisions to the clean claims rules.

The CCWG, held its first meeting in November 2001 and convened six additional times. The topics discussed by the CCWG included ERISA claims, downcoding, bundling, duplicate filings, graduated penalties and the elements of a clean claim. The discussions of the CCWG were instrumental in identifying problem areas and impediments to the prompt payment of claims. Department staff used information

obtained through the CCWG's discussions to develop and recommend rule amendments concerning the disclosure of certain information concerning fee schedules and coding procedures that affect the payment for services provided by contracted physicians and other health care providers.

In addition to the work of the CCWG, in February 2001 the Department began an aggressive campaign to enforce the rules and statutes governing prompt payment of claims. The results of these efforts were $45 million in restitution to physicians and providers and $14 million in fines paid by insurance carriers for claims that were not paid timely and correctly. The enforcement effort was coupled with educational seminars and workshops conducted by the Department to instruct physicians, providers and carriers on their responsibilities under the laws and rules governing the prompt payment of claims.

The combined work of the CCWG, enforcement actions and educational seminars identified several areas in which specific legislation could alleviate problems incurred in the oversight of prompt payment of claims. In short, the responsibilities of carriers, physicians and providers need to be standardized and clearly stated at each step in the claim process.

Standardization would simplify the claim process by enabling physicians and providers to operate by a single set of rules. Physicians and providers should not have to know numerous sets of claim elements or a myriad of time frames for submitting or resubmitting claims that vary among insurers. Standardization would increase the efficiency of the claims payment process by eliminating the duplication of efforts. Carriers, physicians and providers need to know what to expect and when to expect certain actions to be taken.

In addition, as mentioned above, the Commissioner adopted rules regarding the disclosure of certain information concerning fee schedules and coding procedures used by carriers. The rule was adopted after the Attorney General issued an interpretation that the statute's rulemaking authority permits the Commissioner to adopt rules on this subject. Current law should be amended to clearly authorize the Commissioner to adopt rules regarding fee schedules and coding procedures. This could forestall potential challenges to future rules and amendments.

The final issue concerns a problem that was characterized as the "100%" requirement regarding payment of claims. Carriers assert that it is unreasonable for carriers to face stiff penalties and fines for failure to pay less than 100% of all claims timely and correctly. Currently, any level of performance less than 100% subjects the carrier to administrative penalties. Some have proposed that carriers be required to meet the same 95% payment performance standard as in the Medicare system or a 98% performance standard as suggested by some members of the CCWG. When considering the volume of claims processed daily by carriers, the Department believes it is reasonable to recognize that a carrier that consistently pays the overwhelming majority of claims promptly should not be subject to the full administrative penalties and

fines for the small percentage of claims that are not paid promptly. Additionally, the statutes should specify a method for determining the reasonable penalty that must be paid to physicians and providers when all of their clean claims are not paid promptly.

**SOLUTION:**

Amend Articles 3.70-3C and 20A.18B to:

- authorize the Commissioner to develop an exclusive set of clean claim data elements;
- repeal the statutory provisions that allow carriers to add or amend clean claim data elements by contract;
- authorize the Commissioner to enact rules regarding fee schedules and coding procedures (the requirements should also be included in the statutory provisions governing provider contracts);
- establish deadlines for filing of claims;
- establish requirements for filing of duplicate claims and authorize the Commissioner to adopt rules regarding identification of resubmissions;
- establish time periods for requesting repayment of amounts improperly paid to physicians and providers and for the repayment of the amounts requested; and
- amend the penalty provisions to require substantial compliance such as a 98% performance standard and to establish a method for determining a reasonable penalty for claims that are not paid promptly.

Amend the Texas Insurance Code to establish an advisory committee to advise the Commissioner and recommend additional rules to ensure the prompt payment of physicians and health care providers. This advisory committee's recommendations would be in addition to the Commissioner's statutory rulemaking authority.

# THE TEXAS HEALTH INSURANCE RISK POOL

**PROBLEM:**

The Texas Health Risk Pool (Risk Pool) provides health insurance to Texas residents who meet certain eligibility requirements, such as: (1) rejection or refusal by an insurance company to issue similar health benefits, (2) agent or insurer representative certification of uninsurability based on medical conditions, (3) an offer of coverage that excludes specific medical condition(s), (4) an offer of similar coverage at a greater premium rate than the Risk Pool's, (5) qualifying medical condition(s) or (6) "Federally Eligible Individuals," as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Since January 1998, when the rates for the Risk Pool were initially established, the affordability of coverage for the Risk Pool's members has been an important and continuing concern. The Risk Pool's rates are determined by factoring the average rate charged by major Texas health insurers for individual health coverage. This average rate is called the "Standard Rate." Currently the rates charged by the Risk Pool are 180 percent of the standard rate. Under current law, the rates may go up to 200 percent of the standard rate. The maximum rate that can be charged by the Risk Pool should be capped at an amount that will make coverage more affordable for persons needing to obtain coverage from the Risk Pool.

A recent development that affects this issue is the Trade Adjustment Act (Act) signed by President Bush on August 6, 2002. The Act includes a number of initiatives, one of which amended the Public Health Service Act to promote the creation of a high risk pool by each state. Another is an appropriation of money to be made available to the states which already have "qualified" high risk pools. Congress provided $40 million for years 2003 and 2004 to be used to pay for losses incurred by high risk pools. The money would be provided to states in the form of grants of up to 50% of the losses incurred in connection with operation of the pool. The exact amount of each state's grant would be determined on the basis of the number of uninsured individuals in each state.

For a high risk pool to be qualified under the Act, it must: (1) restrict premiums charged to no more than 150% of the premium for applicable standard risk rates, (2) offer a choice of two or more coverage options through the pool, and (3) have in effect a mechanism reasonably designed to ensure continued funding of losses incurred by the pool.

Texas currently meets the second and third requirements; however, as stated earlier, current law allows Risk Pool premiums to be set as high as 200% of the standard rate.

**BACKGROUND:**

Section 9(d) of Article 3.77, Insurance Code, provides "Initial pool rates may not be less than 125 percent and may not exceed 150 percent of rates established as applicable for individual standard rates. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation,

investment income of claim reserves, and any other cost factors subject to the limitations described in this subsection. In no event shall pool rates exceed 200 percent of rates applicable to individual standard risks."

Currently the Risk Pool provides coverage to more than 21,000 enrollees. During 2002, the total enrollment increased by more than 400 enrollees per month. Effective January 1, 2002, the Commissioner approved the Risk Pool Board of Directors' request for a 15 percent average increase in rates. That increase brought the Risk Pool's rates up to 180 percent of rates applicable to individual standard risks. Effective July 1, 2002, another 5 percent average increase was necessary to maintain the standard rate multiplier of 180 percent. Effective January 1, 2003, Risk Pool members will incur an average rate increase of 7 percent that reflects market trend and maintains the 180 percent multiplier. At 180 percent of the standard rate, the Risk Pool's premiums are still insufficient to cover the health claims of members and expenses of operation of the Risk Pool. This means that current and new members of the Risk Pool can expect to incur significant rate increases in the future.

The Risk Pool is authorized to assess insurers to fund claims and expenses not covered by member premiums. The assessment is based on an insurer's percentage share of the gross premiums collected for health insurance in Texas. Lowering the cap directly increases the insurer assessments; however, the Legislature should consider the policy implications of keeping the cap at 200% considering the new federal legislation and the cost to consumers. The Department is concerned that additional rate increases may make the health care coverage provided by the Risk Pool unaffordable for many current and potential Risk Pool members.

**SOLUTION:**

To lessen the effect of future rate increases on current and potential members, the Department recommends the Legislature consider amending Article 3.77, Section 9(d) to provide for a lower maximum cap on rates that can be charged by the Risk Pool and possibly enabling Texas to qualify for the federal funding available to risk pools under the Trade Adjustment Act.

# STANDARDIZE RULEMAKING AUTHORITY

**PROBLEM:**

Existing statutes unreasonably limit the Department's ability to propose rules and the Commissioner's ability to adopt rules. The provision that rules may be adopted "only as authorized by statute" has led contentions that unless a statute specifically states that the Commissioner may adopt rules within the statute itself, the Commissioner is acting outside his statutory authority.

In addition, limitations are placed on the Commissioner that are not placed on any other state agency in that rules proposed by the Department must state the reasonable actual costs required and if the reasonable actual costs exceed the stated costs by at least 25 percent, the rule is void as of the date the rule is adopted. The Commissioner needs greater flexibility to amend or adopt rules as needed to address, in the most cost efficient and expeditious manner, the rapid changes occurring in the technology field and in federal law and rules affecting the insurance industry to maintain a competitive market.

Examples of recent changes include increased use of electronic filings and electronic signatures; HIPAA laws and regulations that affect health care coverage and privacy issues; and uniform licensing and regulatory standards. There are several provisions in the Insurance Code pertaining to rulemaking which may impede or inhibit the Commissioner's and Department's ability to effectively respond to emerging issues in the rapidly evolving insurance and financial services industry.

**BACKGROUND:**

The Commissioner's general rulemaking authority (Section 36.001, Insurance Code) provides that "the Commissioner may adopt rules for the conduct and execution of the powers and duties of the Department only as authorized by statute." The law also provides that "rules adopted under this section must have general and uniform application." This language has required interpretation by the Department because questions have arisen as to whether this authority is sufficient to enable the Commissioner to develop and adapt the Department's regulatory processes to address the many changes and developments that are occurring with respect to the writing of insurance. Thus, it is necessary to clarify that Section 36.001 is the Commissioner's general rulemaking authority and that each specific Article of the Insurance Code need not expressly authorize rules.

In addition, Section 36.004, Insurance Code, limits the Commissioner's authority to adopt model rules or standards developed by the National Association of Insurance Commissioners. In some cases, however, the Department's most effective response to an emerging issue will be the adoption of NAIC model rules, which reflect a national consensus among insurance regulators.

With respect to rules governing the approval of life, accident and health forms, pursuant to Article 3.42, Insurance Code, the Commissioner is prohibited from repealing or amending a rule adopted under the Article until the first anniversary of the adoption of the rule. The only exception to this law requires the Commissioner to have a public hearing and find that there is a compelling public need for the amendment or repeal of the rule. This provision could impair the Commissioner's ability to regulate the rapidly changing insurance industry.

When adopting rules, the Commissioner is unreasonably constrained by the statutory provision that a rule is void *ab initio* if the fiscal note or public cost note accompanying the proposed rule does not accurately state the reasonable actual costs, and the reasonable actual costs exceed the stated costs by 25 percent. (Section 36.002, Insurance Code). This limitation is not placed on any other state agency. Moreover, the Department, like other state agencies, has to comply with the requirements of the Administrative Procedure Act (APA) regarding providing a Fiscal Note and Cost Note. The Department continually makes a diligent effort to comply with this requirement of the APA but also has to contend with the 25 percent limitation placed on it in Section 36.002. This restriction could jeopardize the Department's rulemaking ability since it is very difficult to accurately anticipate the actual costs of compliance. In addition, making a rule void from the date of adoption could have devastating effects on the insurance industry and consumers who relied on the Department's rule.

Regulatory discretion and flexibility to respond to unforeseen changes are increasingly important to effective regulation of the insurance industry. The Department must also be able to respond to sudden developments in technology, business practices and new or amended federal law and regulations in a way that does not jeopardize consumer protection and company solvency, safety, and soundness. This change would enable Texas insurers to be more competitive and Texas consumers to receive the best possible array of services.

**SOLUTION:**

Amend Sections 36.001, 36.004 and Article 3.42, Insurance Code; add a new section providing for the adoption of interim rules to comply with federal requirements and repeal Section 36.002. This will ensure that the Commissioner has adequate rulemaking authority to promptly address developing market practices resulting from changes in federal statutes and rules, technology, and information availability in the financial services industry. Additionally, these changes would standardize the Department's rulemaking authority by making it consistent with every other state agency.

# USE OF CREDIT SCORING OR INSURANCE SCORING

**PROBLEM:**

Texas law currently does not specifically prohibit insurers from using credit scoring or insurance scoring when determining whether to write, or the rate to be charged, an insurance consumer. Insurers have increasingly begun to use a person's credit/insurance score in underwriting. Insurers subject to the benchmark rating system are not permitted to use credit scoring in rating. However, approximately 95 percent of the residential property insurance market and 28 percent of the automobile insurance market is written by insurers that are not subject to the benchmark rating system, and these insurers therefore can use credit/insurance scoring with very little limitation. The use of credit/insurance scoring in rating and underwriting can significantly affect the rate a consumer pays for insurance.

The Department is concerned that because there are no statutory limitations specifically governing the use of credit scoring, insurers' use of credit/insurance scores may unfairly limit or deny access to personal lines coverage for consumers. Statutes should be enacted governing the use of credit/insurance scoring in the underwriting and rating of risk and giving the Commissioner the authority to take action against insurers using credit/insurance scoring in violation of those statutes. Such laws would ensure that consumers are being treated fairly and that access to coverage is not being unfairly restricted.

**BACKGROUND:**

The Department has conducted an extensive study into the use of credit/insurance scoring in Texas. The use of credit/insurance scoring varies significantly within the personal lines market. Not all insurers use credit scoring. Some companies use credit/insurance scoring only for underwriting; some only for rating; others use credit scoring for both underwriting and rating and some insurers use credit scoring for the underwriting and rating of renewals as well as new policies. In the case of residential property coverage, 75 percent of insurers writing this coverage use credit history/scoring in underwriting and/or rating. In the case of private passenger automobile insurance, nine of the ten largest groups writing this coverage use credit history/scoring in underwriting.

Moreover, the treatment assigned to a particular credit score varies among insurers. For example, an insured with a credit score in a certain range may not be able to obtain coverage from one insurer, while another insurer may provide coverage with a 25 percent surcharge.

Proponents of the use of credit/insurance scoring assert a person's credit/insurance score strongly correlates with that person's future likelihood of filing insurance claims. They advise that credit/insurance scores developed for use by insurers are not designed to predict the likelihood of default or creditworthiness, but whether an

individual will file an insurance claim. However the Department has received no information that independently verifies the reliability and accuracy of the models. The Department believes it is noteworthy that correlation does not necessarily mean causation.

The Department has received complaints and numerous inquiries from insureds questioning the fairness of credit scoring. Some complained of being treated adversely because they operated on a cash basis and thus did not have a credit history. Others complained that a catastrophic event, such as a medical bankruptcy, resulted in a credit problem that should not be used as a basis for determining that person's risk as a driver or homeowner.

**SOLUTION:**

Amend the Insurance Code to authorize the Commissioner to define how and when an insurer may use credit/insurance scoring in the underwriting and rating of consumers for personal insurance lines. The Department further recommends that the law: 1) require insurers to file their credit/insurance scoring models along with actuarial justification prior to use; 2) prohibit insurers from using credit/insurance scoring in a manner that adversely affects persons with no credit history or persons whose history reflects a decline due solely to a catastrophic event; 3) prohibit insurers from using credit/insurance scoring as the sole factor in determining a consumer's rate; 4) provide a means for consumers to appeal an adverse determination based on a credit score; and 5) require insurers to re-rate a policy in the event of an erroneous credit score/report.

# JUA ELIGIBILITY

**PROBLEM:**

Article 21.49-3, Insurance Code, creates and establishes the regulatory framework for the operation of the Texas Medical Liability Insurance Underwriting Association (JUA). The JUA was created to provide a means for physicians and health care providers to obtain medical liability insurance when such coverage is not available in the admitted market. The Article sets out the categories of physicians and health care providers that are eligible for coverage through the JUA.

Two categories of health care providers that are not currently permitted to obtain coverage through the JUA are assisted living facilities and ambulatory surgical centers (surgical centers). The Department has heard from associations representing assisted living facilities and surgical centers that they are experiencing problems with the availability and affordability of medical liability coverage in the admitted market similar to those recently experienced by nursing homes. Assisted living facilities and surgical centers should be eligible for coverage from the JUA when the coverage is not available through the admitted market.

**BACKGROUND:**

The Texas Medical Liability Insurance Underwriting Association was created by the Texas Legislature in 1975. Current law defines the terms “physician” and “health care provider” and provides that the Commissioner by order shall establish the categories of physicians and health care providers who are eligible to obtain coverage from the JUA. Assisted living facilities and surgical centers are not included as categories of health care providers potentially eligible for coverage from the JUA.

Assisted living facilities house residents who may require assistance with personal care services such as meals, dressing and bathing, etc. Assistance with medication may also be provided to residents. These facilities are defined and licensed in Chapter 247, Health and Safety Code.

Surgical centers developed as an alternative to overnight hospitalization for surgical services. A surgical center is a freestanding, ambulatory surgery treatment center that may have operating rooms, recovery areas, radiology and other diagnostic imaging equipment, laboratory services, and patient and family waiting areas. Surgical centers were defined and licensed in 1989 under Chapter 243, Health and Safety Code, approximately 14 years after the establishment of the JUA.

The 77$^{th}$ Texas Legislature enacted HB 415 and SB 1839, which amended the definition of “health care provider” in Article 21.49-3 to include ‘for-profit’ nursing homes. The change was requested by the Department in response to evidence obtained in a public hearing that coverage for ‘for-profit’ nursing homes was not reasonably available in the admitted market. Subsequently, the Department began to receive reports that some

assisted living facilities and surgical centers were unable to obtain liability coverage. One association representing assisted living facilities reported recent premium increases of 400% and of an increased tendency to “go bare.” The association also stated a growing concern that a decrease in availability of assisted living facilities could overburden nursing homes.

The Department believes assisted living facilities and surgical centers should be added to the definition of Health Care Provider, thus making them eligible for coverage through the JUA if the Commissioner determines that coverage is not reasonably available in the admitted market.

**SOLUTION:**

The optimal solution to this problem is to amend Articles 21.49-3 and 5.15-1, Insurance Code, to permit the Commissioner to add categories of health care providers to the list of eligible providers after notice and opportunity for hearing and the Commissioner finding that medical liability insurance for such providers is not reasonably available in the admitted market. This approach would give the Commissioner flexibility to address restrictions in coverage availability that may occur for any unlisted category of health care provider while the Legislature is not in session.

In the alternative, Articles 21.49-3 and 5.15-1 should be amended to include assisted living facilities and surgical centers as categories of health care providers that may be deemed eligible to obtain coverage from the JUA.

# STREAMLINE STATUTORY FRAMEWORK REGARDING HOMEOWNERS RESIDUAL MARKET FACILITY

**PROBLEM:**

The Insurance Code authorizes the Commissioner to establish a residual market mechanism for residential property insurance, known as a FAIR Plan (Fair Access to Insurance Requirements). The FAIR Plan can be established after the Commissioner determines, among other things, that residential property insurance is not reasonably available in the voluntary market. Recent restrictions by insurers in the residential property insurance market created the need to enact a FAIR Plan at the end of 2002. The process of implementing the FAIR Plan revealed two areas where clarifying amendments to the governing statute would be beneficial to future changes in the program. The criteria for establishing a FAIR Plan should be independent of the Market Assistance Program (MAP) or any other programs operated by the Department to assist consumers in obtaining residential property coverage. Also a funding mechanism needs to be available, such as the issuance of revenue bonds, to fund the FAIR Plan, if needed.

**BACKGROUND:**

Article 21.49A authorizes the Commissioner to establish a FAIR (Fair Access to Insurance Requirements) Plan upon finding that "in all or any part of the state residential property insurance is not reasonably available in the voluntary market to a substantial number of insurable risks and that at least 50 percent of the applicants to the residential property market assistance program who are qualified under the plan of operation, after the Commissioner has made insurer participation mandatory under the plan of operation, have not been placed with an insurer in the previous 12-month period."

Conditioning the operation of the FAIR Plan on the experience of the MAP creates barriers that could inadvertently delay implementation of the FAIR Plan even though the need for such a program is indisputable.

In addition, in establishing the FAIR Plan, the Department and FAIR Plan governing committee relied on the resources and infrastructure of the Texas Windstorm Insurance Association. Establishing the program required the FAIR Plan governing committee to contract with a servicing carrier to administer the program. Administration includes policy issuance, premium collection, claims adjustment, etc.

The Texas Public Finance Authority, on behalf of the Department and the FAIR Plan, should be required to issue revenue bonds if needed. This funding mechanism was successfully used for the Texas Workers' Compensation Insurance Fund (72nd Texas Legislature) and is available for use by the Texas Medical Liability Insurance Underwriting Association (JUA) to fund the stabilization reserve fund for for-profit and not-for-profit nursing homes (77th Texas Legislature). A similar approach could be used as a standby funding mechanism if it is ever needed.

**SOLUTION:**

Amend Article 21.49A, Insurance Code, to remove the provisions that make establishment of the FAIR Plan contingent on activity in the Market Assistance Program and that require the Commissioner to consider factors specified in Section 1, Article 5.35-3, Insurance Code. If amended in this manner, establishment of the FAIR Plan would require the Commissioner to find that residential property insurance is not reasonably available in the voluntary market to a substantial number of insurable risks.

Second, amend the Insurance Code to add a provision that authorizes the issuance of revenue bonds. This provision should be modeled after Article 21.49-3d, Insurance Code.

# MINIMUM NON-FORFEITURE INTEREST RATES FOR ANNUITIES

**PROBLEM:**

Article 3.44b, Insurance Code, establishes the minimum non-forfeiture amount for individual deferred annuities. The minimum non-forfeiture amount may be provided in a lump sum or in installments at surrender or death. The minimum rate of interest to be used in calculating the minimum non-forfeiture amount outlined in Article 3.44b is currently 3 percent per annum. However, for competitive reasons insurers frequently contract to pay a higher amount than the guaranteed minimum. Given the decline in interest rates, insurers may be challenged to meet this 3 percent requirement, unnecessarily restricting sales of new individual deferred annuities.

**BACKGROUND:**

The non-forfeiture provision of an annuity contract provides for a minimum benefit in either lump sum or installments when the annuity contract is surrendered or upon death or annuitization. Article 3.44b sets forth the criteria for determining the minimum non-forfeiture amount. Several factors are considered in determining the minimum values that an insurer must meet. Those factors include mortality and the minimum rate of interest to be used in accumulating the minimum non-forfeiture amount.

Given the decline in interest rates over the past few years some insurers are unable to find an adequate spread between minimum non-forfeiture interest rates and market rates. This could lead to solvency problems and the unavailability of deferred annuity products in the market. Similar problems have been cited by industry experts and scholars as causes of the decline of the insurance market in Japan. The minimum non-forfeiture interest rate should be revised to better reflect current market conditions. Ideally, it should be indexed to some easily recognizable benchmark such as prevailing rates on U. S. Treasury securities.

**SOLUTION:**

Amend Article 3.44b, Insurance Code to change the minimum non-forfeiture rate of interest, from 3 percent to 1.5 percent per annum. In addition, authorize the Commissioner to develop by rule, a permanent solution based on an appropriate index that reflects prevailing market rates. The statute should also provide that in the event the commissioner's rules are not effective on or before September 2005 the minimum non-forfeiture interest rate will revert to 3 percent per annum. This change provides short and long-term solutions that better reflect changing market conditions while promoting solvency and market availability.