CHAPTER 12

H.B. No. 62

AN ACT

relating to insurance, including the regulation of insurance, the powers and duties of the Texas Department of Insurance, motor vehicle financial responsibility, and benefits for state employees; making an appropriation.

Be it enacted by the Legislature of the State of Texas:

ARTICLE 1. GUARANTY FUNDS AND LIQUIDATION OF INSURERS

SECTION 1.01. Section 1, Article 21.28, Insurance Code, is amended by amending Subsection (d) and adding Subsection (g) to read as follows:

(d) "Liquidator" means *"receiver." The term includes the commissioner of insurance or* the person designated by the *commissioner of insurance to act as special deputy receiver* [~~State Board of Insurance as liquidator~~].

(g) "Person" means an individual, association, corporation, partnership, or other private legal entity.

SECTION 1.02. Sections 2(a), (d), and (h), Article 21.28, Insurance Code, are amended to read as follows:

(a) Receiver Taking Charge*; Commissioner and Powers and Duties.* Whenever under the law of this State a court of competent jurisdiction finds that a receiver should take charge of the assets of an insurer domiciled in this State, the *commissioner of insurance or a person designated by the commissioner under contract* [~~liquidator designated by the State Board of Insurance as hereinafter provided for~~] shall *act as* [~~be such~~] receiver. The [~~liquidator so appointed~~] receiver shall forthwith take possession of the assets of such insurer and deal with the same in *the person's* [~~his~~] own name as receiver or in the name of the insurer as the court may direct. *The receiver has the powers specified in this code. A person designated by the commissioner to act as special deputy receiver under contract is subject to the performance standards imposed by this subsection. It is the intent of the legislature that continuous oversight of the special deputy receivers and guaranty associations shall be conducted by the commissioner. The commissioner shall use a competitive bidding process in the selection of special deputy receivers and shall establish specifications for the position of special deputy receiver. The special deputy receiver shall submit monthly written reports to the court and commissioner that state the special deputy receiver's business plan for the receivership, including expenses incurred in administering the receivership during the preceding month and an estimate of those expenses for the succeeding month. The report must include a cost-benefit analysis on the expenditure of funds other than funds spent for the payment of claims. The business plan report must include a budget of monthly expenses that explains any variation from the original projection. The business plan report must include a list of any lawyers or law firms that offered to or did represent the special deputy receiver in relation to*

its duties under this article, and any hours billed or fees paid to a lawyer or law firm that represented the special deputy receiver. The special deputy receiver shall submit the business plan report to the attorney general on a quarterly basis, and the attorney general may make recommendations to the commissioner based on the report. In addition to the business plan report, the special deputy receiver shall submit a monthly report to the commissioner relating to the special deputy receiver's activities in administering the receivership.

(d) Bonds. The receiver shall be responsible[~~, on his official bond hereinafter provided for,~~] for all assets coming into his possession. The court may require *a* [~~an additional~~] bond, or bonds, from the said receiver, and, if deemed desirable for the protection of the assets, may require a bond, or bonds, of any special deputy *receiver* [~~liquidator~~], or other assistant or employee appointed by or under the authority of this Article.

(h) Depositories. *Except as provided by this subsection, all* [~~All~~] money collected by the receiver shall be forthwith deposited *into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the state treasurer. The receiver may deposit the money* in any bank, banks, or savings and loan association or associations in this State *insured by a federal agency that provides for deposit insurance if the receiver, in the exercise of sound financial judgment, determines that it would be advantageous to do so* [~~which are members of the Federal Deposit Insurance Corporation or Federal Savings and Loan Insurance Corporation~~]. The funds collected or realized from the assets of each insurer *for which the receiver has been appointed* shall be *accounted for by the receiver separately* [~~kept separate and apart~~] from all other funds. Whenever any account in *a* [~~any such~~] bank or savings and loan association exceeds the maximum amount insured by *the appropriate federal agency* [~~said Federal Deposit Insurance Corporation or Federal Savings and Loan Insurance Corporation~~], the receiver is hereby authorized and directed to make such contracts and require such security as it may deem proper for the safeguarding of such deposit *without* [~~upon~~] approval of the court.

SECTION 1.03. Section 3, Article 21.28, Insurance Code, is amended by adding Subsection (i) to read as follows:

(i) Notwithstanding any other provision of this article, if a claim is covered by a guaranty fund created under Article 9.48, 21.28–C, or 21.28–D of this code, the receiver shall refer the claim to the appropriate guaranty association for processing.

SECTION 1.04. Section 8A, Article 21.28, Insurance Code, is amended to read as follows:

Sec. 8A. SETTLEMENT OF CLAIMS; ABANDONED FUNDS; RE–OPENING OF RECEIVERSHIPS. Any and all assets other than cash remaining in the receiver's hands after payment of the final dividend may be conveyed, transferred or assigned to the *commissioner* [~~State Insurance Liquidator and his successors in office,~~] to be handled as a trust. The *commissioner* [~~State Insurance Liquidator~~] shall have authority to convey, transfer, and assign any assets, including causes of action, judgments, and claims, and to settle or release causes of action, judgments, claims, and liens on such terms and for such amounts as he deems for the best interest of such trust, whether such assets have heretofore or may hereafter come into his hands. From proceeds derived from any such assets the *commissioner or the special deputy receiver* [~~Liquidator~~] shall defray the costs incident to the sale, settlement, release or other transaction whereby such proceeds are obtained, and deliver the remainder to the Board to be deposited by it in trust in a special account to be maintained with the State Treasurer to be handled, disposed of and used as follows:

An order directing disposition of such funds may be made by a court of competent jurisdiction of Travis County, Texas, upon application of the *commissioner* [~~Liquidator~~], after notice and hearing. Notice shall be posted on the courthouse door of said court for at least twenty (20) days before a hearing is had on the *commissioner's* [~~Liquidator's~~] application, and notice shall be published at least once, and at least ten (10) days prior to the date set for such hearing, in a newspaper of general circulation in Travis County. Such notice shall state the amount of the funds and the receivership from which they were derived. It shall be addressed to all persons having an interest, as claimant or

otherwise, in the assets of the particular receivership involved in the application, and shall state generally that a hearing shall be had on the date specified for the purpose of determining the disposition to be made of such funds, including a declaration that such funds are abandoned and the property of the State Board of Insurance.

If the court finds that funds derived from any receivership are sufficient to justify re-opening of the receivership and payment of a dividend, then such may be ordered, but otherwise, if such funds are insufficient for that purpose, the court may declare such funds abandoned and a certified copy of such judgment will be authority for the Comptroller of Public Accounts to issue a Warrant therefor to the State Board of Insurance. The Board shall forthwith deposit such funds in accordance with the provisions of Section 2(h) of this Article, except that funds derived from one insurer need not be kept separate from funds derived through any other insurer.

Such funds may be used as provided in Section 8(j) of this Article.

SECTION 1.05. Section 9(c), Article 21.28, Insurance Code, is amended to read as follows:

(c) [~~No~~] Limitation. *Except as otherwise provided by this subsection, each* [~~Each~~] receivership or other delinquency proceeding prescribed by this Article shall be administered *in accordance with Section 64.072, Civil Practice and Remedies Code. To the extent a receivership or delinquency proceeding initiated against an insurer applies to claims against a workers' compensation insurance policy or a title insurance policy, the receivership or delinquency proceeding shall be administered* continuously [~~hereunder~~] for whatever length of time is necessary to effectuate its purposes, *and no*[~~, No~~] arbitrary period prescribed elsewhere by the laws of Texas limiting the time for the administration of receiverships or of corporate affairs generally shall be applicable thereto. *Instead of the winding up and distribution of a receivership estate of an insurer without capital stock, the court shall order revival and reinstatement of the charter, permits, licenses, franchises, and management contracts or other control instruments of the insurer if the insurer's remaining cash on hand and on deposit, less any outstanding valid and enforceable liabilities, exceeds the minimum amount of capital and surplus prescribed for that insurer under Article 2.02 or Section 1 of Article 3.02 of this code.*

SECTION 1.06. Sections 11(a) and (b), Article 21.28, Insurance Code, are amended to read as follows:

(a) Records Admitted. All books, records, documents and papers of any delinquent insurer received by the *receiver* [~~liquidator~~] and held [~~by him~~] in the course of the delinquency proceedings, or certified copies thereof, under the hand and official seal of the Board and/or *receiver* [~~liquidator~~], shall be received in evidence in all cases without proof of the correctness of the same and without other proof, except the certificate of the Board and/or *receiver* [~~liquidator~~] that the same was received from the custody of the delinquent insurer or found among its effects.

(b) Certificates. The *receiver* [~~liquidator~~] shall have the authority to certify to the correctness of any paper, document or record of *the receiver's* [~~his~~] office, including those described in (a) of this section, and to make certificates under seal of the Board and certified by the *receiver* [~~liquidator~~] certifying to any fact contained in the papers, documents or records of the *Texas Department* [~~Liquidation Division of the State Board~~] of Insurance; and the same shall be received in evidence in all cases in which the originals would be evidence.

SECTION 1.07. Section 12, Article 21.28, Insurance Code, as amended by Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended by amending Subsections (a), (b), (c), (d), and (e) and adding Subsections (h)–(k) to read as follows:

(a) *Special Deputy Receiver* [~~Liquidator~~], Bond. *A special deputy receiver appointed by the commissioner under this article shall file with the commissioner a bond in an amount established by the commissioner, payable to the commissioner for the benefit of injured parties, and conditioned on the faithful performance of the special deputy receiver's duties and the proper accounting for all moneys and properties received or administered by the special deputy receiver.* [~~The liquidator herein named shall be~~

~~appointed by the State Board of Insurance, and shall be subject to removal by said Board, and before entering upon the duties of said office, shall file with the Board a bond in the sum of Ten Thousand Dollars ($10,000), payable to the Board for the benefit of injured parties, and conditioned upon the faithful performance of his duties and the proper accounting for all moneys and properties received or administered by him.~~]

(b) Appointments, Expenses. *The commissioner may appoint, set the compensation of, and contract with one or more qualified special deputy receivers to act for the commissioner under this code. In making an appointment under this section, the commissioner shall attempt to reflect the ethnic, racial, and geographic diversity of the state. A special deputy receiver has all the powers of the receiver granted by this code, unless limited by the commissioner.* [~~The Board shall have the power to appoint and fix the compensation of the liquidator and of such special deputy liquidators, counsel, clerks, or assistants, as it may deem necessary.~~] The payment of such compensation and all expenses of liquidation shall be made by the *commissioner or special deputy receiver* [~~liquidator~~] out of funds or assets of the insurer [~~on approval of the Board~~]. An itemized report of such expenses, sworn to by the *commissioner or a special deputy receiver* [~~liquidator and approved by the Board~~], shall be presented *on a monthly basis* to the court [~~from time to time~~], which account shall be approved by the court unless objection is filed thereto within ten (10) days after the presentation of the account. The objection, if any, must be made by a party at interest and shall specify the item or items objected to and the ground of such objection. The court shall set the objection down for hearing, notifying the parties of the setting. The burden of proof shall be upon the party objecting to show that the items objected to are improper, unnecessary or excessive.

(c) Filing Reports. *The receiver* [~~Said liquidator~~] shall file reports with the Board upon its request showing the operation, receipts, expenditures, and general condition of any organization of which *the receiver* [~~he~~] may have charge at that time, and, upon request, shall file a copy of said report with the court in which said receivership proceeding is pending. *The receiver* [~~He~~] shall also file a final report of each organization which [~~he~~] has *been* liquidated or handled showing all receipts and expenditures, and giving a full explanation of the same and a true statement of the disposition of all of the assets of each organization.

(d) Audit. The state auditor shall conduct an annual audit of the liquidator *in accordance with the audit plan reviewed and approved by the legislative audit committee.* [~~The audit must include a financial audit and an economy and efficiency audit. The auditor shall also conduct a compliance audit or an effectiveness audit.~~] The audits authorized or required by this subsection shall be conducted in the manner provided by Chapter 321, Government Code.

(e) Contents of Auditor's Report. The state auditor's report of the audit required by Subsection (d) of this section *may* [~~must~~] include:

(1) an analysis of the overall performance of the liquidator;

(2) an analysis of the liquidator's financial operations and condition;

(3) an analysis of receipts and expenditures made in connection with each *audited* receivership and an analysis of the adequacy of the receiver's bond in relation to assets, receipts, and expenditures;

(4) the amount of funds made available to the liquidator by a guaranty association in connection with each *audited* receivership and a detail of the purpose and manner of expenditure of such funds;

(5) the ratio of the total amount of claims paid to the total costs incurred in connection with each *audited* receivership;

(6) the ratio of the liquidator's administrative expenses to the total costs incurred in connection with each *audited* receivership; or

(7) an analysis of the feasibility of using attorneys who are employees of the liquidator in all litigation.

(h) Authority of Special Deputy Receiver. A special deputy receiver appointed by the commissioner serves at the pleasure of the commissioner. Unless restricted by the

commissioner, a special deputy receiver may perform any act on behalf of the commissioner. If expressly authorized by the commissioner, a special deputy receiver may employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants, and other personnel as the special deputy receiver considers necessary to assist in the performance of the receiver's duties. The expenses of employing those persons are expenses of the receivership payable out of funds or assets of the insurer.

(i) Reports of Fraudulent Activities. The special deputy receiver shall report to the insurance fraud unit any information relating to possible fraudulent, deceptive, or unlawful conduct by an insurer discovered in administration of the receivership.

(j) The Board shall adopt rules prescribing the audit coverage required for the receiver, each special deputy receiver appointed under this section, and each guaranty association established under Article 9.48, 21.28-C, or 21.28-D of this code. Such rules shall include, but not be limited to, provisions relating to the scope, frequency, reporting requirements, and cost of audits, and shall be submitted to the state auditor for review and comment prior to adoption.

(k) The state auditor is authorized to conduct audits, as defined by Sections 321.0131 through 321.0136, Government Code, of the receiver, each special deputy receiver appointed under this section, and each guaranty association established under Article 9.48, 21.28-C, or 21.28-D of this code, as the commissioner or the state auditor determines to be necessary to supplement audits conducted under Subsection (j) of this section. Costs associated with any such audit shall be reimbursed to the state auditor by the audited entity.

SECTION 1.08. Section 12A(a), Article 21.28, Insurance Code, as amended by Section 23, Chapter 641, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(a) It is the sense of the Legislature, as necessary to state policy, that facilities be immediately and continually available to meet any or all of the requirements of preparing for, placing in, continuing or completing any liquidation, rehabilitation, reorganization or conservation of insurers, and in order to make such provision and to provide that the Liquidator and employees be used for other Insurance Department duties when not involved in liquidation or conservation matters, the Legislature may make provisions for the Liquidator and employees and their expenses, in whole or in part, by making appropriations therefor, or by appropriating or permitting use of funds, other than funds or assets of insurers being liquidated, rehabilitated, reorganized or conserved, which are received by or made available to the Board, or by establishing disappearing or partially or wholly reimbursable revolving funds in the Appropriation Acts, notwithstanding any other provision of Article 21.28 of Chapter 21 of the Insurance Code. *This subsection expires January 1, 1994.*

(a-1) The provisions of this Act are cumulative of existing law and in the event of conflict the provisions of this Act shall govern.

SECTION 1.09. Section 5(2)A, Article 9.48, Insurance Code, is amended to read as follows:

A. "Covered claim" is an unpaid claim:

(i) of an insured which arises out of and is within the coverage and not in excess of the applicable limits of a title insurance policy to which this article applies, issued or assumed (whereby an assumption certificate is issued) by an insurer licensed to do business in this state and covered by this article, if such insurer becomes an "impaired insurer" after the effective date of this article and the insured real property (or lien thereon) is located within this state;

(ii) against trust funds or an escrow account of an impaired insurer which arises due to a shortage of those funds or in that account;

(iii) for which an impaired insurer is liable in connection with the fidelity of any agent of that insurer as authorized by Article 9.49 of this code; or

(iv) against trust funds or an escrow account of an impaired agent which arises due to a shortage of those funds or in that account and which shall be paid only from funds derived from guaranty fees and not from assessments.

A "covered claim" [~~Individual "covered claims"~~] under Subparagraphs (i) and (iii) of this paragraph shall be limited to *the lesser of* $250,000 per claimant *or $250,000 per policy* [~~and shall not include any amount in excess of $250,000 per claimant~~]. The amount of a "covered claim" under Subparagraph (ii) *and* [~~or~~] (iv) of this paragraph is the amount of the unpaid claim up to and not to exceed, the lesser of[~~:~~

[~~(i)~~] the amount of funds *actually* delivered to the impaired insurer or agent as trust funds or an escrow account for each claimant in a transaction from which the claim arises[~~;~~] or

[~~(ii)~~] $250,000 per claimant, *provided that the cumulative amount of covered claims arising from one transaction may not exceed $250,000.*

SECTION 1.10. Article 9.48, Insurance Code, is amended by adding Section 6A to read as follows:

Sec. 6A. DEPOSIT OF ASSESSMENTS. All assessments and fees collected by the association may be deposited into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the state treasurer. The funds deposited shall be accounted for separately from all other funds by the state treasurer to the association.

SECTION 1.11. Section 7, Article 9.48, Insurance Code, is amended to read as follows:

Sec. 7. *ASSESSMENTS* [~~ADMINISTRATION~~]. *(a)* Whenever the commissioner determines that an insurer or agent has become impaired, the *association* [~~receiver appointed in accordance with Article 21.28 of the Insurance Code or the conservator appointed under the authority of Article 21.28-A or Article 9.29 of the Insurance Code~~] shall promptly estimate the amount of additional funds needed to supplement the assets of the impaired insurer or agent [~~immediately available to the receiver or the conservator~~] for the purpose of making payment of all covered claims and administrative expenses.

(b) The association shall assess insurers amounts necessary to pay the obligations of the association under this article subsequent to an impairment, the expenses of handling covered claims subsequent to an impairment, and other expenses authorized by this article. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers and for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than the 30th day before the date on which the assessment is due. A member insurer may not be assessed in any year an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available.

(c) The association may defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. During the period of deferment, no dividends may be paid to shareholders or policyholders. Deferred assessments shall be paid when that payment will not reduce capital or surplus below required minimums. These payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of such a company, credited against future assessments [~~The receiver or conservator shall advise the board of those estimates and the board shall make available from the appropriate account maintained by the association funds sufficient to enable the receiver or conservator to carry out an efficient program of paying the covered claims and administrative expenses of the impaired insurer or agent. The board shall~~

~~make additional funds available as the actual need for those funds arises for each impaired insurer or agent.~~

[~~If the board has determined that additional funds are needed in the administrative or title account it shall advise the commissioner who shall make such assessments as may be needed to produce the necessary funds. The commissioner may make partial assessments as the actual need for additional funds arises for each impaired insurer~~]. No assessment shall be made to produce funds for the guaranty fee account but such funds shall be derived solely from guaranty fees as provided by Section 6 of this article.

(d) Each insurer shall pay the amount of its assessment to the association not later than the 30th day after the date on which the assessment is made. The commissioner may collect the assessments on behalf of the association through suits brought for that purpose.

[~~The commissioner shall assess individual insurers in proportion to the ratio that the total net direct written premium collected in the State of Texas by the insurer bears to the total net direct written premium collected by all insurers (except impaired insurers) in the State of Texas. The commissioner shall determine the total net direct written premiums of an individual insurer and for all insurers in the state from the insurers' annual statements for the year preceding the assessment. Assessments during a calendar year may be made up to, but not in excess of, two percent of each insurer's net direct written premium for the preceding calendar year. If the maximum assessment in any calendar year does not provide an amount sufficient for payment of covered claims of impaired insurers, assessments may be made in the next successive calendar years.~~

[~~Insurers designated as impaired insurers by the commissioner shall be exempt from assessment from and after the date of such designation and until the commissioner determines that such insurer is no longer an impaired insurer.~~

[~~The commissioner shall designate the impaired insurer for which each assessment or partial assessment is made and it shall be the duty of each insurer to pay the amount of its assessment to the association within 30 days after the commissioner gives notice of the assessment, and assessments may be collected on behalf of the association by the conservator or receiver through suits brought for that purpose. Venue for such suits shall lie in Travis County, Texas. Either party to said action may appeal to the appellate court having jurisdiction over said cause, and said appeal shall be at once returnable to said appellate court having jurisdiction over said cause and said action so appealed shall have precedence in said appellate court over all causes of a different character therein pending. Neither the receiver nor the conservator shall be required to give an appeal bond in any cause arising hereunder.~~

[~~Funds derived from assessments or from guaranty fees under the provisions of this article shall not become assets of the impaired insurer or agent but shall be deemed a special fund loaned to the receiver or the conservator for payment of covered claims or administrative expenses, which loan shall be repayable to the extent available from the funds of such impaired insurer or agent, as herein provided.~~]

(e) Income from the investment of any of the funds of the association may be transferred to the administrative account authorized in Section 14(a)(1) of this article. The funds in this account may be used by the association for the purpose of meeting administrative costs and other general expenses of the association. *If* [~~Upon notification by the association of the amount of any~~] additional funds *are* needed for the administrative account, the *association* [~~commissioner~~] shall assess insurers to attain the needed funds in the same manner provided by this section.

(f) No insurer shall be deemed or considered to have or incur any liability, real or contingent, under the provisions of this Article 9.48 of this Chapter 9 until any such assessment shall have been actually made in writing by the *association* [~~commissioner~~] under the provisions of this Article 9.48.

SECTION 1.12. Section 9, Article 9.48, Insurance Code, is amended to read as follows:

Sec. 9. ACCOUNTING FOR AND REPAYMENT OF ASSESSMENTS. *(a)* Upon receipt from an insurer of payment of an assessment or partial assessment, the association shall provide the insurer with a participation receipt which shall create a liability

against the impaired insurer, and the holder of such participation receipt shall be regarded as a general creditor of the impaired insurer; provided, however, that with reference to the remaining balance of any portions of assessments received by the *association* [~~receiver or conservator~~] and not expended in payment of "covered claims," the holders of such participation receipts shall have preference over other general creditors and shall share pro rata with other holders of participation receipts. The *association* [~~receiver or conservator of any impaired insurer~~] shall adopt accounting procedures reflecting the expenditure and use of all funds received from assessments or partial assessments and shall make a final report of the expenditure and use of such funds to the commissioner, which final report shall set forth the remaining balance, if any, from the funds collected by assessment. The *association* [~~receiver or conservator~~] shall also make any interim reports concerning such accounting as may be required by the commissioner [~~or requested by the association~~]. Upon completion of the final report, the *association* [~~receiver or conservator~~] shall, as soon thereafter as is practicable, refund pro rata the remaining balance of such assessments to the holders of the participation receipts.

(b) Should the association at any time determine that money exists in the administrative account or the title account in excess of the amount reasonably necessary for efficient future operation under the terms of this article, it shall cause the excess money to be returned pro rata to the holders of any participation receipts on which there is a balance outstanding after deducting any credits taken against premium taxes as authorized by Section 15 of this article. The amount deducted for those credits shall be deposited with the state treasurer for credit to the general fund of this state. Any excess money remaining after the distribution shall be retained by the association in the guaranty fee account and held pursuant to this article.

SECTION 1.13. Section 10, Article 9.48, Insurance Code, is amended to read as follows:

Sec. 10. *ADMINISTRATION AND* PAYMENT OF COVERED CLAIMS. *(a) The association shall pay covered claims existing before the determination of the impairment or arising on or before the date of cancellation of the policies of the impaired insurer or of the claim deadline for covered claims against an impaired agent. The court in which the receivership proceedings are pending shall set the date of cancellation of the policies and that date may not be later than the date five years after the determination of impairment. The court shall set the claim deadline and that deadline may not be later than one year after the determination of impairment.*

(b) The association may not pay a claimant an amount in excess of the amount of the covered claim.

(c) Notwithstanding any other provisions of this article, a covered claim does not include a claim filed with the association after the final date set by the court for the filing of claims against the receiver of an impaired insurer or agent.

(d) The association stands in the place of the impaired insurer or agent to the extent of its obligation on the covered claims and, to that extent, has all rights, duties, and obligations of the impaired insurer or agent as if the insurer or agent had not become impaired.

(e) The association shall investigate claims brought against the association, adjust, compromise, settle, and pay covered claims to the extent of the association's obligation, and deny all other claims. The association may review settlements, releases, and judgments to which the impaired insurer or agent or its insureds were parties to determine the extent to which the settlements, releases, and judgments are contested.

(f) The association shall pay claims in any order it considers reasonable, including the payment of claims as those claims are received from the claimants or in groups or categories of claims.

(g) Subject to the approval of the commissioner, the association shall establish procedures by which claims may be filed with the association and acceptable forms of proof of covered claims. Notice of claims to the receiver of the impaired insurer or agent shall constitute notice to the association or its agent and a list of claims

periodically shall be submitted to the association or similar organization in another state by the receiver.

(h) The association may handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner. Designation as a servicing facility may be declined by a member insurer. The association shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association. [~~When an insurer or agent has been designated by the commissioner as impaired, the receiver or conservator, as the case may be, shall marshal all assets of the impaired insurer or agent, including but not limited to those which are designated as or that constitute reserve assets offsetting reserve liabilities for all liabilities falling within the definition of "covered claim" as defined in this article. The receiver or conservator shall apply all of such assets to the payment of covered claims, but may utilize funds received from assessments in the payment of covered claims as provided by Section 7 of this article, pending orderly liquidation or disposition of such assets. When all covered claims have been paid or satisfied by the receiver or conservator, any balance remaining from the liquidation or disposition of such assets shall first be applied in repayment of funds expended from assessments and second in repayment of funds derived from guaranty fees. Such repayments of funds expended from assessments shall be credited as remaining balances and be refunded as provided in Section 9 of this article.~~]

(i) In addition to authorization to make actual payment of covered claims, the *association may use* [~~receiver or conservator is specifically authorized to utilize such marshalled assets and~~] funds derived from assessments for the purpose of negotiating and consummating contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for outstanding liabilities of covered claims. *There is no liability on the part of, and no cause of action of any nature arises against, any insurer that reinsures or assumes the policies of an impaired insurer for any act or failure to act by the impaired insurer or its officers, directors, employees, attorneys, or agents or by subrogation or under any type of indemnity agreement.* [~~The commissioner shall not require the insurer that reinsures or assumes the policies of the impaired insurer or enters into an agreement to substitute itself in the place of the impaired insurer, to issue assumption certificates or other written evidence of such agreement to the policyholders of the impaired insurer, except to policyholders that have made a claim for loss arising under their policy (issued by the impaired insurer) before the date of such reinsurance, assumption or substitution agreement. The commissioner shall require that the reinsurance, assumption, or substitution agreement be filed as a public record with the State Board of Insurance. The commissioner shall approve such agreement unless, after public hearing held within 30 days following such filing, he determines that such agreement does not effectively protect the policyholders of the insurers to give notice of such hearing to its policyholders. Such notice shall be by publication, not less than seven days in advance of the hearing, in a newspaper of general circulation printed in the State of Texas. No cause of action shall lie against the impaired insurer for breach of contract or refund of premium after the agreement has been approved by the commissioner and the notice of hearing before the commissioner shall so advise the policyholders of the impaired insurer.~~

[~~This article shall not be construed to impose restriction or limitation upon the authority granted or authorized the commissioner, the conservator, or the receiver elsewhere in the Insurance Code and other statutes of this state but shall be construed and authorized for use in conjunction with other portions of the Insurance Code dealing with delinquency proceedings or threatened insolvencies or supervisions or conservatorships.~~]

SECTION 1.14. Section 12(b), Article 9.48, Insurance Code, is amended to read as follows:

(b) Notwithstanding any provision to the contrary, the *association* [~~receiver or conservator~~], for the purpose of avoiding undue hardship to a claimant, subject to the approval of the receivership court or the commissioner, as the case may be, may authorize payment of covered claims against an impaired agent without regard to the liability of any insurer

or to coverage under any insurance policy. On payment, the *association* [~~receiver or conservator~~] is in all respects subrogated to the rights and claims of the claimant.

SECTION 1.15. Section 14, Article 9.48, Insurance Code, is amended by adding Subsection (f) to read as follows:

(f) Delegation of powers and duties. The plan of operation may provide that any or all powers and duties of the association, except those under Sections 7 and 14(c)(3) of this article, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association or its equivalent in two or more states. The corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this subsection may take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this article.

SECTION 1.16. Sections 14(e)(3) and (4), Article 9.48, Insurance Code, are amended to read as follows:

(3) The board shall advise and counsel with the commissioner upon matters relating to the solvency of insurers and agents. The commissioner shall call a meeting of the board when he determines that an insurer or agent is insolvent or impaired and may call a meeting of the board when he determines that a danger of insolvency or impairment of an insurer or agent exists. Such a meeting is not open to the public and only members of the board of directors, members of the State Board of Insurance, the commissioner, and persons authorized by the commissioner shall attend such meetings. The board shall notify the commissioner of any information indicating that an insurer or agent may be unable or potentially unable to fulfill its contractual obligations and request a meeting with the commissioner. At such meetings the commissioner may divulge to the board any information in his possession and any records of the State Board of Insurance, including examination reports or preliminary reports from examiners relating to such insurer or agent. The commissioner may summon officers, directors, and employees of an insolvent or impaired insurer or agent, or an insurer or agent the commissioner considers to be in danger of insolvency or impairment, to appear before the board for conference or for the taking of testimony. Members of the board shall not reveal information received in such meetings to anyone unless authorized by the commissioner or the State Board of Insurance or when required as witness in court. Board members and all of these meetings shall be subject to the same standard of confidentiality as is imposed upon examiners under Article 1.18 of the Insurance Code, except that no bond shall be required of a board member.

The board shall, upon request by the commissioner, attend hearings before the commissioner and meet with and advise the commissioner, the *receiver* [~~liquidator~~] or *the* conservator appointed by the commissioner, on matters relating to the affairs of an impaired insurer or agent and relating to action that may be taken by the commissioner, liquidator, or conservator to best protect the interests of persons holding covered claims against an impaired insurer or agent and relating to the [~~amount and timing of partial assessments and the~~] marshalling of assets [~~and the processing and handling of covered claims~~].

(4) The board may make reports and recommendations to the commissioner relating to any matter germane to the solvency, liquidation, rehabilitation, or conservation of any insurer or agent. Those reports and recommendations shall not be considered public documents *until such time as an insurer is declared to be impaired*[~~, and there shall be no liability on the part of and no cause of action against a member of the board or the board for any report, individual report, recommendation, or individual recommendation by the board or members to the commissioner, liquidator, or conservator~~].

SECTION 1.17. Article 9.48, Insurance Code, is amended by amending Sections 17 and 20 and adding Sections 20A and 20B to read as follows:

Sec. 17. IMMUNITY; *ATTORNEY GENERAL REPRESENTATION. (a)* There shall be no liability on the part of and no cause of action of any nature shall arise against

any member insurer of the association or its agents or employees, the association or its agents or employees, members of the association's board of directors, *a special deputy receiver or its agents or employees,* or the commissioner or his representatives for any *good faith* action [~~taken~~] or *omission* [~~not taken by them~~] in the performance of their powers and duties under this article.

(b) The attorney general shall defend any action to which Subsection (a) applies that is brought against a member insurer or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver or its agents or employees, or the commissioner or the commissioner's representatives. This subsection continues to apply to an action instituted after the defendant's service with the guaranty association, commissioner, or department has terminated. This subsection does not require the attorney general to defend any person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend any member insurer of the association or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver or its agents or employees with respect to any actions filed regarding the disposition of a claim filed with the guaranty association under this Act or to an issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under the Interagency Cooperation Act (Article 4413(32), Vernon's Texas Civil Statutes) to provide legal services not covered under this subsection.

Sec. 20. APPEALS. *(a) A member insurer may appeal any action or ruling of the association relating to an assessment made under this article to the commissioner.*

(b) Any action or ruling of the commissioner under this article may be appealed as provided in Article 1.04 of the Insurance Code, as amended.

(c) The liability of the appealing insurer for an assessment shall be suspended pending appeal by such insurer contesting the amount or legality of such assessment.

(d) Venue in a suit against the association relating to any action or ruling of the association made under this article is in Travis County. The association is not required to give an appeal bond in an appeal of a cause of action arising under this article.

Sec. 20A. TAX EXEMPTION. The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Sec. 20B. STAY OF PROCEEDINGS. All proceedings in which an impaired insurer is a party or is obligated to defend a party in any court in this state, except proceedings directly related to the receivership or instituted by the receiver, shall be stayed for six months and any additional time thereafter as may be determined by the court from the date of the designation of impairment or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the receiver or the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the impaired insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and shall be permitted to defend the claim on the merits. The receiver or statutory successor of an impaired insurer covered by this article shall permit access by the board or its authorized representative to records of the impaired insurer as are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the receiver or statutory successor shall provide the board or its representative with copies of the records on request of the board and at the expense of the board.

SECTION 1.18. Section 5(2)C, Article 9.48, Insurance Code, is repealed.

SECTION 1.19. Section 11, Article 9.48, Insurance Code, is amended to read as follows:

Sec. 11. APPROVAL OF COVERED CLAIMS. *Funds* [~~Covered claims against an impaired insurer or agent placed in temporary or permanent receivership under an order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction shall be processed and acted upon by the receiver or ancillary receiver in the same manner as other claims as provided in Article 21.28 of the Insurance Code and as ordered by the court in which such receivership is pending; provided, however, that funds~~] received from assessments or from guaranty fees shall be liable only for the difference between the amount of the covered claims [~~approved by the receiver~~] and the amount of the assets marshalled by the receiver for payment to holders of covered claims. *In*[~~; and provided further that in~~] ancillary receiverships in this state, funds received from assessments shall be liable only for the difference between the amount of the covered claims [~~approved by the ancillary receiver~~] and the amount of assets marshalled by the receivers in other states for application to payment of covered claims within this state.

If a conservator is appointed to handle the affairs of an impaired insurer or agent, the conservator shall determine whether or not covered claims should or can be provided for in whole or in part by reinsurance, assumption, or substitution. Upon determination by the conservator that actual payment of covered claims should be made, the conservator shall give notice of such determination to claimants falling within the class of "covered claims." The conservator shall mail such notice to the latest address reflected in the records of the impaired insurer or agent. If the records of the impaired insurer or agent do not reflect the address of a claimant, the conservator may give notice by publication in a newspaper of general circulation. Such notice shall state the time within which the claimant must file his claim with the conservator, which time shall in no event be less than 90 days from the date of the mailing or publication of such notice. The conservator may require, in whole or in part, that sworn claim forms be filed and may require that additional information or evidence be filed as may be reasonably necessary for the conservator to determine the legality or the amount due under a covered claim. When an impaired insurer or agent has been placed in conservatorship, the funds received from assessments or from guaranty fees shall be liable only for the difference between the amount of the covered claim approved by the conservator and the amount of assets marshalled by the conservator for payment to holders of covered claims.

Upon determination by the conservator that actual payment of covered claims should be made or upon order of the court to the receiver to give notice for the filing of claims, any person who has a cause of action against an insured of the impaired insurer under a title insurance policy issued or assumed by such insurer shall, if such cause of action meets the definition of "covered claim," have the right to file a claim with the receiver or the conservator, regardless of the fact that such claim may be unliquidated or undetermined, and such claim may be approved as a "covered claim" (1) if it may be reasonably inferred from the proof presented upon such claim that such person would be able to obtain a judgment upon such cause of action against such insured; and (2) if such person shall furnish suitable proof that no further valid claims against such insurer arising out of his cause of action other than those already presented can be made; and (3) if the total liability of such insurer to all claimants arising from the same title insurance policy shall be no greater than its total liability would be were it not in liquidation, rehabilitation, or conservation. In the proceedings of considering "covered claims," no judgment against an insured taken after the date of the commencement of the delinquency proceedings or the appointment of a conservator shall be considered as evidence of liability, or of the amount of damages, and no judgment against an insured taken by default or by collusion prior to the commencement of the delinquency proceedings or the appointment of a conservator shall be considered as conclusive evidence either (1) of the liability of such insured to such person upon such cause of action, or (2) of the amount of damages to which such person is therein entitled.

The acceptance of payment from the *association* [~~receiver or conservator~~] by the holder of a covered claim or the acceptance of the benefits of contracts [~~negotiated~~] by the *association* [~~receiver or conservator~~] providing for reinsurance or assumption of liabilities or for substitution shall constitute an assignment to the *association* [~~impaired insurer or agent~~] of any cause of action or right of the holder of such covered claim arising from the occurrence upon which the covered claim is based. Such assignment shall be to the

extent of the amount accepted or the value of the benefits provided by such contracts of reinsurance or assumption of liabilities or substitution. Such assignment to the *association* [~~impaired insurer or agent~~] may be assigned to the insurer executing such reinsurance, assumption or substitution agreement.

SECTION 1.20. Article 21.28–C, Insurance Code, is amended to read as follows:

Art. 21.28–C. PROPERTY AND CASUALTY INSURANCE GUARANTY ACT

Sec. 1. SHORT TITLE. This article shall be known as the Texas Property and Casualty Insurance Guaranty Act.

Sec. 2. PURPOSE. The purpose of this Act is to:

(1) provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment;

(2) avoid financial loss to claimants or policyholders because of the impairment of an insurer;

(3) assist in the detection and prevention of insurer insolvencies; and

(4) provide an association to assess the cost of that protection among insurers.

Sec. 3. SCOPE. This Act applies to all kinds of direct insurance, but is not applicable to the following:

(1) life, annuity, health, or disability insurance;

(2) mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;

(3) fidelity or surety bonds, or any other bonding obligations;

(4) credit insurance, vendors' single-interest insurance, collateral protection insurance, or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

(5) insurance of warranties or service contracts;

(6) title insurance;

(7) ocean marine insurance;

(8) any transaction or combination of transactions between a person, including an affiliate of such a person, and an insurer, including an affiliate of such an insurer, that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; or

(9) any insurance provided by or guaranteed by government.

Sec. 4. CONSTRUCTION. This Act shall be liberally construed to effect the purposes under Section 2 of this Act, which will constitute an aid and guide to interpretation.

Sec. 5. DEFINITIONS. In this Act:

(1) "Account" means any one of the three accounts created under Section 6 of this Act.

(2) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an impaired insurer on December 31 of the year next preceding the date the insurer becomes an impaired insurer.

(3) "Association" means the Texas Property and Casualty Insurance Guaranty Association.

(4) "Board" means the board of directors of the association.

(5) "Claimant" means any insured making a first-party claim or any person instituting a liability claim. A person who is an affiliate of the impaired insurer may not be a claimant.

(6) "Commissioner" means the commissioner of insurance.

(7) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through

the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

(8) "Covered claim" means an unpaid claim of an insured or third-party liability claimant that arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this Act applies, issued or assumed (whereby an assumption certificate is issued to the insured) by an insurer licensed to do business in this state, if that insurer becomes an impaired insurer and the third-party claimant or liability claimant or insured is a resident of this state at the time of the insured event, or the property from which the claim arises is permanently located in this state. "Covered claim" shall also include 75 percent of unearned premiums, but in no event shall a covered claim for unearned premiums exceed $1,000. Individual covered claims shall be limited to $100,000, except that the association shall pay the full amount of any covered claim arising out of a workers' compensation policy. "Covered claim" shall not include any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. "Covered claim" shall not include supplementary payment obligations, including adjustment fees and expenses, attorney's fees and expenses, court costs, interest and penalties, and interest and bond premiums incurred prior to the determination that an insurer is an impaired insurer under this Act. "Covered claim" shall not include any punitive, exemplary, extracontractual, or bad-faith damages awarded in a court judgment against an insured or insurer. With respect to a covered claim for unearned premiums, both persons who were residents of this state at the time the policy was issued and persons who are residents of this state at the time the company is found to be an impaired insurer shall be considered to have covered claims under this Act. If the impaired insurer has insufficient assets to pay the expenses of administering the receivership or conservatorship estate, that portion of the expenses of administration incurred in the processing and payment of claims against the estate shall also be a covered claim under this Act.

(9) "Impaired insurer" means:

(A) a member insurer that is placed in temporary or permanent receivership under an order of a court of competent jurisdiction based on a finding of insolvency and that has been designated an impaired insurer by the commissioner; or

(B) a member insurer placed in conservatorship after it has been determined by the commissioner to be insolvent and that has been designated an impaired insurer by the commissioner.

(10) "Member insurer" means any person who:

(A) writes any kind of insurance to which this Act applies under Section 3 of this Act, including the exchange of reciprocal or inter-insurance contracts; and

(B) is licensed to transact insurance in this state.

(11) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this Act applies, less return premiums on those policies and dividends paid or credited to policyholders on that direct business. The term does not include premiums on contracts between insurers or reinsurers.

(12) "Person" means any individual, corporation, partnership, association, or voluntary organization.

Sec. 6. ASSOCIATION. The Texas Property and Casualty Insurance Guaranty Association is a nonprofit, unincorporated legal entity composed of all member insurers, who must be members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a

plan of operation approved under Section 9 of this Act and shall exercise its powers through the board of directors. For purposes of administration and assessment, the association is divided into the workers' compensation insurance account, the automobile insurance account, and the account for all other lines of insurance to which this Act applies.

Sec. 7. BOARD OF DIRECTORS. (a) The board of directors of the association is composed of nine persons who serve terms as established in the plan of operation. Five members shall be selected by member insurers, subject to the approval of the commissioner. The remaining members shall be representatives of the general public appointed by the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(b) In approving selections to the board, the commissioner shall consider whether all member insurers are fairly represented.

(c) Members of the board of directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

(d) A public representative may not be:

(1) an officer, director, or employee of an insurance company, insurance agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the Texas Department of Insurance;

(2) a person required to register with the secretary of state under Chapter 305, Government Code; or

(3) related to a person described by Subdivision (1) or (2) of this subsection within the second degree of affinity or consanguinity.

(e) Each member of the board of directors shall file a financial statement with the secretary of state in accordance with Sections 3 and 4, Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-9b, Vernon's Texas Civil Statutes).

Sec. 8. POWERS AND DUTIES OF ASSOCIATION. (a) The association shall pay covered claims that exist before the designation of impairment or that arise within 30 days after the date of the designation of impairment, before the policy expiration date if the policy expiration date is within 30 days after the date of the designation of impairment, or before the insured replaces the policy or causes its cancellation if the insured does so within 30 days after the date of the designation. The obligation is satisfied by paying to the claimant the full amount of a covered claim for benefits.

(b) The association is considered the insurer to the extent of its obligation on the covered claims and to that extent has all rights, duties, and obligations of the impaired insurer as if the insurer had not become impaired.

(c) The association shall assess insurers amounts necessary to pay the obligations of the association under Subsection (a) of this section after an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment. Each member insurer shall be notified of the assessment not later than the 30th day before the date on which the assessment is due. A member insurer may not be assessed in any year an amount greater than two percent of that member insurer's net direct written premiums for the calendar year preceding the assessment. If the maximum assessment, with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated, and the unpaid portion shall be paid as soon thereafter as funds become available. The association shall pay claims in any order it considers reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association may defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a

certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, dividends may not be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. The payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of such a company, credited against future assessments.

(d) The association shall investigate claims brought against the association and shall adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims. The association may review settlements, releases, and judgments to which the impaired insurer or its insureds were parties to determine the extent to which those settlements, releases, and judgments may be properly contested.

(e) The association shall give notice as the commissioner directs under Section 10(c) of this Act.

(f) The association shall handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such a designation may be declined by a member insurer.

(g) The association shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this Act.

(h) The association may:

(1) employ or retain persons as necessary to handle claims and perform other duties of the association;

(2) borrow funds necessary to implement this Act in accordance with the plan of operation;

(3) sue or be sued;

(4) negotiate and become a party to contracts as necessary to implement this Act;

(5) perform other acts as necessary or proper to implement this Act; or

(6) refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities, if at the end of any calendar year the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

(i) If a member insurer is insolvent, the association shall provide the money, pledges, guarantees, or other means as are reasonably necessary to discharge the duties of that insurer and:

(1) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of that insurer; or

(2) assure payment of the contractual obligations of that insurer.

(j) The board of directors may deposit all money collected by the association into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the state treasurer. The funds deposited shall be accounted for separately from all other funds by the state treasurer to the association.

Sec. 9. PLAN OF OPERATION. (a) The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments take effect on approval in writing by the commissioner.

(b) If the association fails to submit suitable amendments to the plan, the commissioner, after notice and hearing, shall adopt reasonable rules as necessary or advisable to implement this Act. Those rules shall continue in force until modified by the

commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) All member insurers shall comply with the plan of operation.

(d) The plan of operation must:

(1) establish the procedures under which the powers and duties of the association are performed;

(2) establish procedures for handling assets of the association;

(3) establish the amount and method of reimbursing members of the board of directors;

(4) establish procedures by which claims may be filed with the association; and

(5) establish acceptable forms of proof of covered claims.

(e) Notice of claims to the receiver of the impaired insurer constitutes notice to the association or its agent. A list of claims shall be submitted periodically to the association or similar organization in another state by the receiver.

(f) The plan of operation must:

(1) establish regular places and times for meetings of the board of directors;

(2) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(3) provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner not later than the 30th day after the date of the action or decision;

(4) establish the procedures under which selections for the board of directors are submitted to the commissioner; and

(5) contain additional provisions as necessary or proper for the execution of the powers and duties of the association.

(g) The plan of operation may provide that any or all powers and duties of the association, except those under Section 8(c) and 8(h)(2) of this Act, are delegated by contract to a corporation, association, or other organization that performs or will perform functions similar to those of the association or its equivalent in two or more states. The corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for the performance of any other functions of the association. A delegation under this subsection takes effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this Act. A contract entered into under this subsection is subject to the performance standards imposed under Section 2(a), Article 21.28, of this code.

Sec. 10. DUTIES AND POWERS OF COMMISSIONER. (a) The commissioner shall notify the association of the existence of an impaired insurer not later than three days after the commissioner gives notice of the designation of impairment. The association is entitled to a copy of any complaint seeking an order of receivership with a finding of insolvency against a member company at the same time that the complaint is filed with a court of competent jurisdiction.

(b) On request of the board of directors, the commissioner shall provide the association with a statement of the net direct written premiums of each member insurer.

(c) The commissioner may require that the association notify the insureds of the impaired insurer and any other interested parties of the designation of impairment and of their rights under this Act. The notification shall be by mail at the last known address, if available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation is sufficient.

(d) The commissioner shall suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or otherwise fails to comply with the plan of

operation. As an alternative, the commissioner may assess a fine on any member insurer that fails to pay an assessment when due. The fine may not exceed the lesser of five percent of the unpaid assessment per month or $100 per month.

(e) The commissioner may revoke the designation of any servicing facility if the commissioner finds that claims are being handled unsatisfactorily.

(f) Any final action or order of the commissioner under this Act is subject to judicial review by a court of competent jurisdiction.

(g) Venue in a suit against the association or commissioner relating to any action or ruling of the association or commissioner made under this Act is in Travis County. The association or commissioner is not required to give an appeal bond in an appeal of a cause of action arising under this Act.

Sec. 11. EFFECT OF PAID CLAIMS. (a) A person recovering under this Act is considered to have assigned the person's rights under the policy to the association to the extent of the person's recovery from the association. Each insured or claimant seeking the protection of this Act shall cooperate with the association to the same extent as that person would have been required to cooperate with the impaired insurer. The association does not have a cause of action against the insured of the impaired insurer for any sums it has paid out except those causes of action the impaired insurer would have had if the sums had been paid by the impaired insurer and except as provided in Subsection (b) of this section. In the case of an impaired insurer operating on a plan with assessment liability, payments of claims of the association do not reduce the liability of the insureds to the receiver or statutory successor for unpaid assessments.

(b) The association is entitled to recover from the following persons the amount of any covered claim paid on behalf of that person under this Act:

(1) any insured whose net worth on December 31 of the year next preceding the date the insurer becomes an impaired insurer exceeds $50 million and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act; and

(2) any person who is an affiliate of the impaired insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this Act.

(c) The receiver or statutory successor of an impaired insurer is bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant those claims priority equal to that which the claimant would have been entitled to in the absence of this Act against the assets of the impaired insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the receiver's expenses.

(d) The association shall file periodically with the receiver of the impaired insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association that shall preserve the rights of the association against the assets of the impaired insurer.

Sec. 12. NONDUPLICATION OF RECOVERY. (a) A person who has a claim against an insurer under any provision in an insurance policy other than a policy of an impaired insurer that is also a covered claim shall exhaust first the person's rights under the policy. Any amount payable on a covered claim under this Act shall be reduced by the amount of any recovery under the insurance policy.

(b) A person who has a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first-party claim for damage to property with a permanent location, the person shall seek recovery first from the association of the location of the property, and if it is a workers' compensation claim the person shall seek recovery first from the association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

Sec. 13. PREVENTION OF INSOLVENCIES. (a) To aid in the detection and prevention of insurer insolvencies, the board of directors, on majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies and respond to requests by the commissioner to discuss and make recommendations regarding the status of any member insurer whose financial condition may be hazardous to policyholders or the public. Those recommendations are not public documents and are not subject to the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-17a, Vernon's Texas Civil Statutes), until such time as an insurer is declared to be impaired.

(b) At the conclusion of any domestic insurer insolvency in which the association was obligated to pay covered claims, the board of directors may prepare a report on the history and causes of the insolvency, based on the information available to the association, and may submit the report to the commissioner.

Sec. 14. EXAMINATION OF THE ASSOCIATION. The association shall be subject to examination and regulation by the commissioner in the same manner as other insurers under this code. Not later than March 30 of each year, the board of directors shall submit a financial report for the preceding calendar year in a form approved by the commissioner.

Sec. 15. TAX EXEMPTION. The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Sec. 16. IMMUNITY; ATTORNEY GENERAL REPRESENTATION. (a) There is no liability on the part of, and no cause of action of any nature arises against, any member insurer, the association or its agents or employees, the board of directors, special deputy receiver or its agents or employees, or the commissioner or the commissioner's representatives for any good faith action or failure to act in the performance of powers and duties under this Act.

(b) The attorney general shall defend any action to which Subsection (a) applies that is brought against a member insurer or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver to its agents or employees, or the commissioner or the commissioner's representatives. This subsection continues to apply to an action instituted after the defendant's service with the guaranty association, commissioner, or department has terminated. This subsection does not require the attorney general to defend any person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend any member insurer of the association or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver or its agents or employees with respect to any actions filed regarding the disposition of a claim filed with the guaranty association under this Act or to an issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under the Interagency Cooperation Act (Article 4413(32), Vernon's Texas Civil Statutes) to provide legal services not covered under this subsection.

Sec. 17. STAY OF PROCEEDINGS. All proceedings in which an impaired insurer is a party or is obligated to defend a party in any court in this state, except proceedings directly related to the receivership or instituted by the receiver, shall be stayed for six months and any additional time thereafter as may be determined by the court from the date of the designation of impairment or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the receiver or the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the impaired insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and shall be permitted to defend the claim on the merits. The receiver or statutory successor of an impaired insurer

covered by this Act shall permit access by the board or its authorized representative to records of the impaired insurer as are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the receiver or statutory successor shall provide the board or its representative with copies of the records on request of the board and at the expense of the board.

Sec. 18. ASSESSMENTS. (a) If the commissioner determines that an insurer has become an impaired insurer, the association shall promptly estimate the amount of additional funds, by lines of business, needed to supplement the assets of the impaired insurer immediately available to pay covered claims. The board shall make additional funds available as the actual need arises for each impaired insurer.

(b) If the board of directors determines that additional funds are needed in any of the three accounts, it shall make assessments as necessary to produce the necessary funds. The association, in determining the proportionate amount to be paid by individual insurers under an assessment, shall take into consideration the lines of business written by the impaired insurer and shall assess individual insurers in proportion to the ratio that the total net direct written premium collected in this state by the insurer for those lines of business bears to the total net direct written premium collected by all insurers, other than impaired insurers, in this state for those lines of business. The association shall determine the total net direct written premium of an individual insurer and for all insurers in the state from the insurers' annual statements for the year preceding assessment. Assessments under this subsection during a calendar year may be made up to, but not in excess of, two percent of each insurer's net direct written premium for the preceding calendar year in the lines of business for which the assessments are being made. If the maximum assessment in any calendar year does not provide an amount sufficient for payment of covered claims of impaired insurers, assessments may be made in the next and successive calendar years.

(c) It shall be the duty of each insurer to pay the amount of an assessment under Subsection (b) of this section to the association not later than the 30th day after the commissioner gives notice of the assessment.

(d) Assessments may be collected on behalf of the association by the commissioner through suits brought for that purpose. Venue for those suits is in Travis County. Either party to the action may appeal to the appellate court having jurisdiction over the cause, the appeal shall be at once returnable to the appellate court having jurisdiction over the cause, and the action so appealed shall have precedence in the appellate court over all causes of a different character pending before the court. The commissioner is not required to give an appeal bond in any cause arising under this subsection.

(e) An insurer designated as an impaired insurer by the commissioner is exempt from assessment from and after the date of the designation and until the commissioner determines that the insurer is no longer an impaired insurer.

(f) Funds advanced by the association under this Act shall not become assets of the impaired insurer but are considered a special fund loaned to the impaired insurer for payment of covered claims. That loan is repayable to the extent available from the funds of the insurer.

(g) Income from the investment of any of the funds of the association may be transferred to the administrative account authorized under this Act. The funds in the account may be used by the association for the purpose of meeting administrative costs and other general expenses of the association. On notification by the association of the amount of any additional funds needed for the administrative account, the association shall assess member insurers to obtain the needed funds in the manner set out in this section. The commissioner shall consider the net direct written premium collected in this state for all lines of business covered by this Act. An assessment for administrative expenses incurred by a supervisor or conservator appointed by the commissioner or a receiver appointed by a court of competent jurisdiction for a nonmember of the association or unauthorized insurer operating in this state may not exceed $1,000,000 each calendar year.

Sec. 19. PURPOSE OF ASSESSMENT. (a) The amounts provided under assessments made under this Act are in addition to the marshaling of assets by the receiver under Article 21.28 of this code for the purpose of making payments on behalf of an impaired insurer.

(b) This section does not require the receiver to exhaust the assets of the impaired insurer before an assessment is made or before funds derived from an assessment may be used to pay covered claims.

Sec. 20. ACCOUNTING FOR AND REPAYMENT OF ASSESSMENTS. (a) On receipt from an insurer of payment of an assessment or partial assessment required by the association under Section 18(b) of this Act, the association shall provide the insurer with a participation receipt, which shall create a liability against the account for the line or lines of business for which the assessment was made.

(b) The account from which an advance is made to an impaired insurer for the payment of covered claims shall be regarded as a general creditor of the impaired insurer for the amount of funds so advanced; provided, however, that with reference to the remaining balance of any advances not expended in payment of covered claims, the claim of the account has preference over other general creditors. The association of any impaired insurer shall adopt accounting procedures reflecting the expenditure and use of all funds and shall make a final report of the expenditure and use of the funds to the commissioner, which final report shall set forth the remaining balance, if any, from the moneys advanced. The association shall also make any interim reports concerning such accounting as may be required by the commissioner or requested by the conservator. On completion of the final report, the association shall, as soon thereafter as is practicable, refund by line of business the remaining balance of those advances to the accounts maintained by the association.

(c) If the association at any time determines that there exist moneys in the account for any line of business in excess of those reasonably necessary for efficient future operation under the terms of this Act, it shall cause those excess moneys to be returned pro rata to the holders of any participation receipts on which there is a balance outstanding after deducting any credits taken against premium taxes as authorized in Section 21 of this Act, which receipts were issued for an assessment on the same line of business as that for which the excess moneys are found to exist. If after such a distribution the association finds that an excess amount still exists in the fund, or if there are no such participation receipts on which there is an outstanding balance, it shall cause the excess amount to be deposited with the state treasurer to the credit of the general revenue fund.

Sec. 21. RECOGNITION OF ASSESSMENTS IN PREMIUM TAX OFFSET. One hundred percent of any assessment paid by an insurer under this Act shall be allowed to that insurer as a credit against its premium tax under Article 4.10 of this code. The tax credit referred to in this section shall be allowed at a rate of 10 percent per year for 10 successive years following the date of assessment and, at the option of the insurer, may be taken over an additional number of years. The balance of any tax credit not claimed in a particular year may be reflected in the books and records of the insurer as an admitted asset of the insurer for all purposes, including exhibition in annual statements under Article 6.12 of this code.

Sec. 22. RELEASE FROM RECEIVERSHIP. An impaired insurer placed in receivership for which advances have been made under this Act may not be authorized, on release from receivership, to issue new or renewal insurance policies until the impaired insurer has repaid in full to the association the funds advanced by it. However, the commissioner may, on application of the association and after hearing, permit the issuance of new policies in accordance with a plan of operations by the released insurer for repayment of advances. The commissioner, in approving the plan, may place restrictions on the issuance of new or renewal policies as the commissioner considers necessary to the implementation of the plan.

Sec. 23. RULES AND REGULATIONS. The State Board of Insurance is authorized and directed to issue such reasonable rules and regulations as may be necessary

to carry out the various purposes and provisions of this article, and in augmentation thereof.

[~~Sec. 1. TITLE. This article shall be known and may be cited as the "Texas Property and Casualty Insurance Guaranty Act."~~

[~~Sec. 2. PURPOSE. This Act is for the purposes and findings set forth in Section 1 of Article 21.28-A of the Insurance Code and in supplementation thereto by providing funds in addition to assets of impaired insurers for the protection of the holders of "covered claims" as defined herein through payment and through contracts of reinsurance or assumption of liabilities or of substitution or otherwise.~~

[~~Sec. 3. SCOPE. This Act shall apply to all kinds of insurance, including workers' compensation insurance, written by stock and mutual fire insurance companies, casualty insurance companies and fire and casualty insurance companies licensed to do business in this State; and shall also include all kinds of insurance written by county mutual insurance companies, Lloyd's and reciprocal exchanges licensed to do business in this State; but shall not apply to insurance written by title insurance companies or title insurance written by any insurer; and shall not apply to mortgage guaranty insurance companies or mortgage guaranty insurance, nor to ocean marine insurance, nor to credit insurance that insures a lender against loss due to default by a borrower in the repayment of a loan secured by a second or junior lien mortgage, nor to insurance that insures a municipal bond holder against loss due to default of a political subdivision in the repayment of a municipal bond, nor to fidelity, surety, and guaranty bonds, nor to home warranty insurance; and shall not apply to Mexican casualty insurance companies or to policies of insurance issued by Mexican casualty insurance companies; and shall not apply to crop insurance reinsured by the Federal Crop Insurance Corporation, to flood insurance reinsured, guaranteed or conditionally assumed by the Federal Insurance Administration, to coverages issued by risk retention groups, to financial guaranty or other forms of insurance offering protection against investment risks.~~

[~~Sec. 4. CONSTRUCTION. This Act shall be liberally construed to effect the purpose under Section 2 which shall constitute an aid and guide to interpretation.~~

[~~Sec. 5. DEFINITIONS. As used in this Act~~

[~~(1) A. "State Board of Insurance" is the state board of insurance of this state.~~

[~~B. "Commissioner" is the Commissioner of Insurance of this State.~~

[~~(2) "Covered claim" is an unpaid claim of an insured or third party liability claimant which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this Act applies, issued or assumed (whereby an assumption certificate is issued to the insured) by an insurer licensed to do business in this State, if such insurer becomes an "impaired insurer" after the effective date of this Act and (a) the third party claimant or liability claimant or insured is a resident of this State at the time of the insured event; or (b) the property from which the claim arises is permanently located in this State. "Covered claim" shall also include seventy-five percent (75%) of unearned premiums but in no event shall a "covered claim" for unearned premiums exceed One Thousand Dollars ($1,000). Individual "covered claims" shall be limited to One Hundred Thousand Dollars ($100,000), except that the association shall pay the full amount of any "covered claim" arising out of a workers' compensation policy. "Covered claim" shall not include any amount due any reinsurer, insurer, insurance pool or underwriting association, as subrogation recoveries or otherwise. "Covered claim" shall not include supplementary payment obligations, including but not limited to adjustment fees and expenses, attorneys fees and expenses, court costs, interest and penalties, and interest and bond premiums, incurred prior to the determination that an insurer is an "impaired insurer" under this Act. "Covered claim" shall not include any punitive, exemplary, extracontractual, or bad faith damages awarded in a court judgment against an insured or insurer. With respect to a "covered claim" for unearned premiums, both persons who were residents of this State at the time the policy was issued and persons who are residents of this State at the time the company is found to be an "impaired insurer" shall be considered to have "covered claims" under this Act. Where the impaired insurer has insufficient assets to pay the expenses of administering the receivership or conservatorship estate, that portion of the~~

expenses of administration incurred in the processing and payment of claims against the estate shall also be a "covered claim" under this Act.

[(3) "Insurer" and "member insurer" includes all stock and mutual fire insurance companies, casualty insurance companies and fire and casualty insurance companies licensed to do business in this State; and also includes all county mutual insurance companies, Lloyd's and reciprocal exchanges licensed to do business in this State; but shall not include title insurance companies, mortgage guaranty insurance companies or Mexican casualty insurance companies.

[(4) "Impaired insurer" is (a) a member insurer which, after the effective date of this Act, is placed in temporary or permanent receivership under an order of a court of competent jurisdiction based on a finding of insolvency, and which has been designated an "impaired insurer" by the Commissioner; or (b) after the effective date of this Act, a member insurer placed in conservatorship after it has been deemed by the Commissioner to be insolvent and which has been designated an "impaired insurer" by the Commissioner.

[(5) "Payment of covered claims" is actual payment and also is utilization of funds derived from assessments for consummation of contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for liabilities for covered claims.

[(6) "Net direct written premiums" is the gross amount of premiums received from policies of insurance issued in this State to which this Act applies, less return premiums and dividends paid or credited to policyholders. The term does not include premiums for indemnity reinsurance accepted from other licensed insurers, and there shall be no deductions for premiums for indemnity reinsurance ceded to other insurers.

[(7) "Lines of business" is policies of insurance falling within one of the three following categories:

[1. Workers' Compensation insurance.

[2. Automobile insurance.

[3. All other insurance to which this Act applies.

[(8) "Association" means the Texas Property and Casualty Insurance Guaranty Association created under Section 14 of this article.

[(9) "Account" means one of the four accounts created under Section 14 of this article.

[(10) "Board" or "board of directors" means the board of directors of the Texas Property and Casualty Insurance Guaranty Association created under Section 14 of this article.

[(11) "Unauthorized insurer" means a person or insurer that has engaged in activities prohibited by Section 3, Article 1.14-1 of this code.

[(12) "Nonmember of the association" includes mortgage guaranty insurance companies, Mexican casualty insurance companies, risk retention groups, and all persons and entities authorized to act as agents under this code including without limitation managing general agents, local recording agents, surplus lines agents, and agents subject to Article 21.07 of this code who participated in transactions involving lines of insurance within the scope of this Act.

[Sec. 6. TERMINATION OF POLICIES. This Act shall apply to covered claims existing prior to the determination that an insurer is an impaired insurer and to covered claims arising within thirty (30) days after the determination of impairment, or before the policy expiration date if less than thirty (30) days after the determination of impairment, or before the insured replaces the policy or effects its cancellation, if he does so within thirty (30) days of the determination of impairment.

[Upon the determination by the Commissioner that an insurer is an impaired insurer, the conservator or receiver appointed under Article 21.28 or Article 21.28-A of this code shall notify the insureds of the impaired insurer of the determination and of their rights under this Act. Such notification shall be by mail at each insured's address as disclosed by the books and records of the insurer but, if sufficient information for notification by

~~mail is not available, notice by publication in a newspaper of general circulation printed in this State shall be sufficient. Such notification may be combined with notice provided under Subsection (a) of Section 3 of Article 21.28 of this code.~~

[~~Sec. 7. ASSESSMENTS. (a) Whenever the Commissioner determines that an insurer has become an impaired insurer the receiver appointed in accordance with Article 21.28 of the Insurance Code or the conservator appointed under the authority of Article 21.28-A of the Insurance Code shall promptly estimate the amount of additional funds, by lines of business, needed to supplement the assets of the impaired insurer immediately available to the receiver or the conservator for the purpose of making payment of all covered claims. The receiver or conservator shall advise the board of directors of the association of such estimates, and the board shall make available from the account maintained by the association for each line of business funds sufficient to enable the receiver or conservator to carry out an efficient program of paying the covered claims of the impaired insurer. The board shall make additional funds available as the actual need therefor arises for each impaired insurer.~~

[~~(b) When the board of directors shall determine that additional funds are needed in any of the three accounts, they shall advise the Commissioner who shall make such assessments as may be needed to produce the necessary funds. The Commissioner in determining the proportionate amount to be paid by individual insurers under an assessment shall take into consideration the lines of business written by the impaired insurer and shall assess individual insurers in proportion to the ratio that the total net direct written premium collected in the State of Texas by the insurer for such or lines of business bears to the total net direct written premium collected by all insurers (except impaired insurers) in the State of Texas for such lines of business. The Commissioner shall determine the total net direct written premium of an individual insurer and for all insurers in the state from the insurers' annual statements for the year preceding the assessment. Assessments under this subsection during a calendar year may be made up to, but not in excess of, two percent (2%) of each insurer's net direct written premium for the preceding calendar year in the lines of business for which the assessments are being made. If the maximum assessment in any calendar year does not provide an amount sufficient for payment of covered claims of impaired insurers, assessments may be made in the next and successive calendar years.~~

[~~(c) It shall be the duty of each insurer to pay the amount of an assessment under Subsection (b) of this section to the association within thirty (30) days after the Commissioner gives notice of the assessment.~~

[~~(d) Assessments may be collected on behalf of the association by the conservator or receiver through suits brought for that purpose. Venue for such suits shall lie in Travis County, Texas. Either party to said action may appeal to the appellate court having jurisdiction over said cause and said appeal shall be at once returnable to said appellate court having jurisdiction over said cause and said action so appealed shall have precedence in said appellate court over all causes of a different character therein pending. Neither the receiver, the conservator, nor the association shall be required to give an appeal bond in any cause arising hereunder.~~

[~~(e) Insurers designated as impaired insurers by the Commissioner shall be exempt from assessment from and after the date of the designation and until the Commissioner determines that the insurer is no longer an impaired insurer.~~

[~~(f) Funds advanced by the association under the provisions of this Act shall not become assets of the impaired insurer but shall be deemed a special fund loaned to the receiver or the conservator for payment of covered claims, which loan shall be repayable to the extent available from the funds of such impaired insurer, as herein provided.~~

[~~(g) Income from the investment of any of the funds of the association may be transferred to the administrative account authorized in Section 14A(1) of this article. The funds in this account may be used by the association for the purpose of meeting administrative costs and other general expenses of the association. Upon notification by the association of the amount of any additional funds needed for the administrative account the Commissioner shall assess member insurers to obtain the needed funds in the same manner as hereinbefore set out, provided, that he shall take into consideration the~~

~~net direct written premium collected in the State of Texas for all lines of business covered by this article, and provided further that no assessment for administrative expenses incurred by a supervisor or conservator appointed by the Commissioner or a receiver appointed by a court of competent jurisdiction for a nonmember of the association or unauthorized insurer operating in this state shall exceed $1,000,000 each calendar year.~~

[~~Sec. 7A. PURPOSE OF ASSESSMENT. (a) The amounts provided pursuant to assessments made under this article are in addition to the marshaling of assets by the receiver under Article 21.28 of this code for the purpose of making payments on behalf of an impaired insurer.~~

[~~(b) This section does not require the receiver to exhaust the assets of the impaired insurer before an assessment is made or before funds derived from an assessment may be used to pay covered claims.~~

[~~Sec. 7B. EMERGENCY CLAIMS. (a) In this section, "emergency claims" means those claims:~~

[~~(1) that would be covered claims if the insurer was declared an impaired insurer;~~

[~~(2) for which no bona fide dispute exists as to the liability of the insurer on the claim or for which payments were begun on liability accepted before the finding of insolvency;~~

[~~(3) for which a bona fide hardship exists or will exist with certain policyholders or claimants if their claims are not handled forthwith; and~~

[~~(4) for which the insurer under conservation or receivership does not have sufficient funds to pay the emergency claims.~~

[~~(b) If before a determination by the Commissioner that the insurer has become an impaired insurer, an insurer has been placed in conservation under an order of the Commissioner based on a finding of insolvency or temporary or permanent receivership under a court order based upon a finding of insolvency, the Commissioner may request from the board of directors of the association the advancement of funds to enable the conservator or receiver to have sufficient funds to pay emergency claims.~~

[~~(c) The Commissioner shall certify to the board of directors of the association a list of active claims that are emergency claims and shall certify the amount of additional funds needed to supplement the assets of the insurer to make payment of those emergency claims.~~

[~~(d) The Commissioner, in his request, shall state the reason or reasons that a bona fide hardship exists or will exist, that the insurer has not been declared an impaired insurer, and when the Commissioner reasonably anticipates that it will be declared an impaired insurer or released from conservation or receivership.~~

[~~(e) Upon receipt of the required certifications, the board of directors may advance the funds necessary to pay the additional claims.~~

[~~(f) In order to avoid undue delay in the payment of emergency claims, the conservator or receiver may contract with an insurer licensed to do business in this State or any other qualified organization for the handling and adjustment of those emergency claims.~~

[~~(g) If an insolvent insurer is subsequently rehabilitated, any amounts advanced by the association shall be repaid to the association by the insurer or pursuant to any plan of rehabilitation. If an insolvent insurer is subsequently declared an impaired insurer, amounts advanced pursuant to this section shall be considered assessments for covered claims under Section 7 and subject to the provisions of this article.~~

[~~Sec. 8. PENALTY FOR FAILURE TO PAY ASSESSMENTS. A. The Commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this State of any member insurer who fails to pay an assessment when due, and the association shall promptly report to the Commissioner any such failure. Any insurer whose certificate of authority to do business in this State is cancelled or surrendered shall be liable for any unpaid assessments made prior to the date of such cancellation or surrender.~~

[~~B. As an alternative to the penalty provided by Subsection A of this section, the Commissioner may levy a monetary penalty on a member insurer who fails to pay an assessment when due. The monetary penalty may not exceed five percent of the unpaid assessment a month and may not be less than $100 a month.~~

[~~Sec. 9. ACCOUNTING FOR AND REPAYMENT OF ASSESSMENTS. (a) Upon receipt from an insurer of payment of an assessment or partial assessment required by the Commissioner under Section 7(b) of this article, the association shall provide the insurer with a participation receipt which shall create a liability against the account for the line or lines of business for which the assessment was made.~~

[~~(b) The account from which an advance is made to an impaired insurer for the payment of covered claims shall be regarded as a general creditor of the impaired insurer for the amount of funds so advanced; provided, however, that with reference to the remaining balance of any advances received by the receiver or conservator and not expended in payment of "covered claims" the claim of such account shall have preference over other general creditors. The receiver or conservator of any impaired insurer shall adopt accounting procedures reflecting the expenditure and use of all funds received from the association and shall make a final report of the expenditure and use of such funds to the Commissioner and to the association, which final report shall set forth the remaining balance, if any, from the moneys advanced. The receiver or conservator shall also make any interim reports concerning such accounting as may be required by the Commissioner or requested by the association. Upon completion of the final report, the receiver or conservator shall, as soon thereafter as is practicable, refund by line of business the remaining balance of such advances to the accounts maintained by the association.~~

[~~(c) Should the association at any time determine that there exist moneys in the account for any line of business in excess of those reasonably necessary for efficient future operation under the terms of this Act, it shall cause such excess moneys to be returned pro rata to the holders of any participation receipts on which there is a balance outstanding after deducting any credits taken against premium taxes as authorized in Section 15 of this article, which receipts were issued for an assessment on the same line of business as that for which the excess moneys are found to exist. If after such a distribution the association finds that an excess amount still exists in any such fund, or if there are no such participation receipts on which there is an outstanding balance, it shall cause such excess amount to be deposited with the State Treasurer for credit to the general fund of this State.~~

[~~Sec. 10. PAYMENT OF COVERED CLAIMS. When an insurer has been designated by the Commissioner as an impaired insurer, the receiver or conservator, as the case may be, shall marshal all assets of the impaired insurer, including but not limited to those which are designated as or that constitute reserve assets offsetting reserve liabilities for all liabilities falling within the definition of "covered claim" as defined in this Act. The receiver or conservator shall apply all of such assets to the payment of covered claims, but may utilize funds received from the association in the payment of claims, pending orderly liquidation or disposition of such assets. When all covered claims have been paid or satisfied by the receiver or conservator, any balance remaining from the liquidation or disposition of such assets shall first be applied in repayment of funds expended from those advanced by the association. Such repayments shall be credited as remaining balances and be refunded as provided in Section 9 of this Act.~~

[~~In addition to authorization to make actual payment of covered claims, the receiver or conservator is specifically authorized to utilize such marshalled assets and funds derived from the association for the purpose of negotiating and consummating contracts of reinsurance or assumption of liabilities or contracts of substitution to provide for outstanding liabilities of covered claims. This Act shall not be construed to impose restrictions or limitations upon the authority granted or authorized the Commissioner, the conservator or the receiver elsewhere in the Insurance Code and other statutes of this State but shall be construed and authorized for use in conjunction with other portions of the Insurance Code dealing with delinquency proceedings or threatened insolvencies or supervisions or conservatorships.~~

[~~Sec. 11. APPROVAL OF COVERED CLAIMS. Covered claims against an impaired insurer placed in temporary or permanent receivership under an order of liquidation, rehabilitation or conservation by a court of competent jurisdiction shall be processed and acted upon by the receiver or ancillary receiver in the same manner as other claims as provided in Article 21.28 of the Insurance Code and as ordered by the court in which such receivership is pending; provided, however, that funds received from the association shall be liable only for the difference between the amount of the covered claims approved by the receiver and the amount of the assets marshalled by the receiver for payment to holders of covered claims; and provided further, that in ancillary receiverships in this State, funds received from the association shall be liable only for the difference between the amount of the covered claims approved by the ancillary receiver and the amount of assets marshalled by the receivers in other states for application to payment of covered claims within this State. Such funds received from the association shall not be liable for any amount over and above that approved by the receiver for a covered claim, and any action brought by the holder of such covered claim appealing from the receiver's action shall not increase the liability of such funds; provided, however, that the receiver may, in the discretion of the receiver, modify a rejection or approval of a covered claim for just cause at any time during the pendency of the receivership. The receiver may use funds received from the association to pay a particular covered claim before the receiver has processed all claims to determine which are covered claims.~~

[~~If a conservator is appointed to handle the affairs of an impaired insurer the conservator shall determine whether or not covered claims should or can be provided for in whole or in part by reinsurance, assumption or substitution. Upon determination by the conservator that actual payment of covered claims should be made the conservator shall give notice of such determination to claimants falling within the class of "covered claims." The conservator shall mail such notice to the latest address reflected in the records of the impaired insurer. If the records of the impaired insurer do not reflect the address of a claimant, the conservator may give notice by publication in a newspaper of general circulation. Such notice shall state the time within which the claimant must file his claim with the conservator, which time shall in no event be less than ninety (90) days from the date of the mailing or publication of such notice. The conservator may require, in whole or in part, that sworn claim forms be filed and may require that additional information or evidence be filed as may be reasonably necessary for the conservator to determine the legality or the amount due under a covered claim. When an impaired insurer has been placed in conservatorship, the funds received from the association shall be liable only for the difference between the amount of the covered claim approved by the conservator and the amount of assets marshalled by the conservator for payment to holders of covered claims. Any action brought by the holder of such covered claim against the impaired insurer shall not increase the liability of such funds; provided, however, that the conservator may review his action in approving a covered claim and may for just cause modify such approval at any time during the pendency of the conservatorship.~~

[~~Upon determination by the conservator that actual payment of covered claims should be made or upon order of the court to the receiver to give notice for the filing of claims, any person who has a cause of action against an insured of the impaired insurer under a liability insurance policy issued or assumed by such insurer shall (if such cause of action meets the definition of "covered claim") have the right to file a claim with the receiver or the conservator, regardless of the fact that such claim may be contingent, and such claim may be approved as a "covered claim" (1) if it may be reasonably inferred from the proof presented upon such claim that such person would be able to obtain a judgment upon such cause of action against such insured; and (2) if such person shall furnish suitable proof that no further valid claims against such insurer arising out of his cause of action other than those already presented can be made; and (3) if the total liability of such insurer to all claimants arising out of the same act of its insured shall be no greater than its total liability would be were it not in liquidation, rehabilitation or conservation. In the proceedings of considering "covered claims" no judgment against an insured taken after the date of the commencement of the delinquency proceedings or the appointment of a conservator shall be considered as evidence of liability, or of the amount of damages, and~~

~~no judgment against an insured taken by default or by collusion prior to the commencement of the delinquency proceedings or the appointment of a conservator shall be considered as conclusive evidence either (1) of the liability of such insured to such person upon such cause of action, or (2) of the amount of damages to which such person is therein entitled.~~

[~~The acceptance of payment from the receiver or conservator by the holder of a covered claim or the acceptance of the benefits of contracts negotiated by the receiver or conservator providing for reinsurance or assumption of liabilities or for substitution shall constitute an assignment to the impaired insurer of any cause of action or right of the holder of such covered claim arising from the occurrence upon which the covered claim is based. Such assignment shall be to the extent of the amount accepted or the value of the benefits provided by such contracts of reinsurance or assumption of liabilities or substitution.~~

[~~Sec. 12. NONDUPLICATION OF RECOVERY. Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an impaired insurer, which is also a covered claim, shall be required to exhaust first his right under such policy. The amount of an approved claim under this Act shall be reduced by the policy limits of or amount paid under such insurance policy, whichever amount is greater. When a claimant exhausts his right under a policy other than a policy of an impaired insurer, the insurer issuing that policy is not entitled to sue or continue a suit against the insured of the impaired insurer to recover any amount paid the claimant under that policy.~~

[~~Any recovery under this Act shall be reduced by the amount of recovery under any other insurance guaranty act, or its equivalent, in any other state. Any person having a covered claim who is a resident of another state shall not be entitled to payment under this Act unless and until he furnishes adequate sworn proof that he has exhausted any and all rights of recovery that he has in his state of residence and the state of residence of the insured under any insurance guaranty act or its equivalent; provided, however, that any nonresident holder of a covered claim for damage to property with a permanent location in this State shall be entitled to payment of the covered claim without first having exhausted his right of recovery in his state of residence.~~

[~~Sec. 13. RELEASE FROM CONSERVATORSHIP OR RECEIVERSHIP. An impaired insurer placed in conservatorship or receivership for which advances have been made under the provisions of this Act shall not be authorized, upon release from conservatorship or receivership, to issue new or renewal insurance policies until such time as the impaired insurer has repaid in full to the association the funds advanced by it; provided, however, the Commissioner may, upon application of the association and after hearing, permit the issuance of new policies in accordance with a plan of operations by the released insurer for repayment of advances. The Commissioner may, in approving such plan, place such restrictions upon the issuance of new or renewal policies as he deems necessary to the implementation of the plan.~~

[~~Sec. 14. ADVISORY ASSOCIATION. A. Creation of the Association. (1) There is hereby created a nonprofit legal entity to be known as the Texas Property and Casualty Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition precedent to their authority to transact insurance in this State. The association shall perform its functions under the plan of operation established and approved as set out below and shall exercise its powers through a board of directors established as set out below. For the purposes of administration and assessment, the board shall establish four accounts:~~

[~~(a) the administrative account;~~

[~~(b) the workers' compensation account;~~

[~~(c) the automobile account; and~~

[~~(d) the other lines of insurance account.~~

[~~(2) The association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this State.~~

[~~B. Board of Directors. (1) The association shall exercise its powers through a board of directors consisting of nine (9) persons, five (5) of whom shall be appointed from~~

employees or officers of the member insurers and who shall be chosen to give fair representation to all member insurers giving due consideration to the various categories of premium income, geographical location, and segments of the industry represented in Texas. The remaining members shall be representatives of the general public. Members of the board shall be appointed by the State Board of Insurance to serve overlapping three-year terms, with the terms of three of the members expiring each year. All directors shall serve until their successors are appointed, except that in the case of any vacancy, the unexpired term of office shall be filled by the appointment of a director by the State Board of Insurance. If any director ceases to be an officer or employee of a member insurer during the term of office, that office becomes vacant until a successor is appointed. All directors shall be eligible to succeed themselves in office. A public representative may not be:

[(1) an officer, director, or employee of an insurance company, insurance agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the State Board of Insurance;

[(2) a person required to register with the secretary of state under Chapter 305, Government Code; or

[(3) related to a person described by Subdivision (1) or (2) of this subsection within the second degree of affinity or consanguinity.

[(2) Directors shall not receive any remuneration or emolument of office, but they shall be entitled to reimbursement for their actual expenses incurred in performing their duties as directors.

[(3) Each director of the association shall file a financial statement with the secretary of state in accordance with Sections 3 and 4, Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-9b, Vernon's Texas Civil Statutes).

[C. Powers and Duties of Association. In addition to the powers and duties enumerated in other sections of this article, the association:

[(1) May render assistance and advice to the Commissioner, upon his request, concerning rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired insurer;

[(2) Shall have the standing to appear before any court in this State with jurisdiction over an impaired insurer concerning which the association is or may become obligated under this Act;

[(3) May enter into such contracts as are necessary or proper, including the power to borrow money, to carry out the provisions and purposes of this article;

[(4) May sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments;

[(5) May employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this Act;

[(6) May negotiate and contract with any liquidator, rehabilitator, conservator, receiver, or ancillary receiver to carry out the powers and duties of the association; and

[(7) May take such legal action as may be necessary to avoid the payment of improper claims.

[D. Plan of Operation. (1)(a) The association shall submit to the Commissioner a plan of operation and any amendment thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

[(b) If the association fails to submit a suitable plan of operation within one hundred and eighty (180) days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the Commissioner may, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such

~~rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the association and approved by the Commissioner.~~

[~~(2) All member insurers shall comply with the plan of operation.~~

[~~(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:~~

[~~(a) establish procedures for handling the assets of the association;~~

[~~(b) establish the amount and method of reimbursing members of the board of directors under this section;~~

[~~(c) establish regular places and times for meetings of the board of directors;~~

[~~(d) establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;~~

[~~(e) establish any additional procedures for assessments under Section 7 of this article; and~~

[~~(f) contain additional provisions necessary or proper for the execution of the powers and duties of the association.~~

[~~E. Prevention of Insolvencies and Impairments and Administration of Estates. To aid in the detection and prevention of insurer insolvencies and impairments and in the administration of receivership and conservatorship estates:~~

[~~(1) The board of directors shall notify the Commissioner of any information indicating any member, unauthorized insurer, or nonmember of the association may be unable or potentially unable to fulfill its contracts, policies, or contractual obligations and may request appropriate investigation and action by the Commissioner who may, in his discretion, make such investigation and take such action as he deems appropriate. In carrying out its duties under this Act and on written request by the Commissioner, the board of directors shall authorize expenditure of funds from the administrative account for reasonable and necessary administrative expenses incurred by a supervisor or conservator appointed by the Commissioner or a receiver appointed by a court of competent jurisdiction for a nonmember of the association or unauthorized insurer operating in this state in those instances in which the Commissioner has notified the board of directors or the board of directors has otherwise become aware that:~~

[~~(a) the nonmember of the association or unauthorized insurer has insufficient liquid assets to pay the expenses of administering the receivership or conservatorship of the nonmember of the association or unauthorized insurer;~~

[~~(b) insufficient funds are available from abandoned funds as provided by Section 8 of Article 21.28 of the Insurance Code; and~~

[~~(c) insufficient funds are available to the State Board of Insurance from appropriations for use in meeting those administrative expenses.~~

[~~Funds spent by the association under this provision shall not become assets of the nonmember of the association or unauthorized insurer but are considered a special fund loaned to the receiver or the conservator for payment of administrative expenses, which loan is repayable to the extent available from the funds of the nonmember of the association or unauthorized insurer.~~

[~~(2) The board of directors shall advise and counsel with the Commissioner upon matters relating to the solvency of insurers. The Commissioner shall call a meeting of the board of directors when he determines that an insurer is insolvent or impaired and may call a meeting of the board of directors when he determines that a danger of insolvency or impairment of an insurer exists. Such meetings shall not be open to the public and only members of the board of directors, members of the State Board of Insurance, the Commissioner, and persons authorized by the Commissioner shall attend such meetings. The board of directors shall notify the Commissioner of any information indicating that an insurer may be unable or potentially unable to fulfill its contractual obligations and request a meeting with the Commissioner. At such meetings the Commissioner may divulge to the board of directors any information in his possession and any records of the State Board of Insurance, including examination~~

~~reports or preliminary reports from examiners relating to such insurer. The Commissioner may summon officers, directors, and employees of an insolvent or impaired insurer (or an insurer the Commissioner considers to be in danger of insolvency or impairment) to appear before the board of directors for conference or for the taking of testimony. Members of the board of directors shall not reveal information received in such meetings to anyone unless authorized by the Commissioner or the State Board of Insurance or when required as witness in court. Board members and all of such meetings and proceedings under this section shall be subject to the same standard of confidentiality as is imposed upon examiners under Article 1.18 of the Insurance Code, as amended, except that no bond shall be required of a board member.~~

[~~The board of directors shall, upon request by the Commissioner, attend hearings before the Commissioner and meet with and advise the Commissioner, liquidator, or conservator appointed by the Commissioner, on matters relating to the affairs of an impaired insurer and relating to action that may be taken by the Commissioner, liquidator, or conservator appointed by the Commissioner to best protect the interests of persons holding covered contractual obligations against an impaired insurer and relating to the amount and timing of partial assessments and the marshalling of assets and the processing and handling of contractual obligations.~~

[~~(3) The board of directors may make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer. Such reports and recommendations shall not be considered public documents. Reports or recommendations made by the board of directors to the Commissioner, liquidator, or conservator shall not be considered public documents, and there shall be no liability on the part of and no cause of action against a member of the board of directors or the board of directors for any report, individual report, recommendation, or individual recommendation by the board of directors or members to the Commissioner, liquidator, or conservator.~~

[~~(4) The board of directors may make recommendations to the Commissioner for the detection and prevention of member insurer impairments.~~

[~~(5) The board of directors shall, at the conclusion of any member insurer impairment in which the association carried out its duties under this article or exercised any of its powers under this article, prepare a report on the history and causes of such impairment, based on the information available to the association, and submit a report on same to the Commissioner.~~

[~~(6) Any insurer that has an officer, director, or employee serving as a member of the board of directors shall not lose the right to negotiate for and enter into contracts of reinsurance or assumption of liability or contracts of substitution to provide for liabilities for contractual obligations with the receiver or conservator of an impaired insurer. The entering into any such contract shall not be deemed a conflict of interest.~~

[~~(7) The association or any insurer assessed under this article shall be an interested party under Section 3(h) of Article 21.28 of the Insurance Code, as amended.~~

[~~Sec. 15. RECOGNITION OF ASSESSMENTS IN PREMIUM TAX OFFSET. One hundred percent (100%) of any assessment paid by an insurer under this Act shall be allowed to such insurer as a credit against its premium tax under Article 4.10 of this code. The tax credit referred to herein shall be allowed at a rate of ten percent (10%) per year for ten (10) successive years following the date of assessment and at the option of the insurer may be taken over an additional number of years, and the balance of any tax credit not claimed in a particular year may be reflected in the books and records of the insurer as an admitted asset of the insurer for all purposes, including exhibition in annual statements pursuant to Article 6.12 of this Code.~~

[~~Sec. 16. IMMUNITY. There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer of the association or its agents or employees, the association or its agents or employees, members of the board of directors, or the Commissioner or his representatives for any action taken or not taken by them in the performance of their powers and duties under this Act.~~

[~~Sec. 17. RULES AND REGULATIONS. The State Board of Insurance is authorized and directed to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this Act, and in augmentation thereof.~~

[~~Sec. 17a. ADVERTISING PROHIBITED. It shall be unlawful for any insurer required to participate in the association to advertise or use in any manner for promotional purposes the fact that its policies are protected under this Act, and such acts of advertisement or promotion shall constitute unfair methods of competition or unfair or deceptive acts or practices under Article 21.21, Insurance Code, and shall be subject to the provisions thereof.~~

[~~Sec. 18. APPEALS. Any action or ruling of the Commissioner under this Act may be appealed as provided in Article 1.04 of the Insurance Code. The liability of the appealing insurer for an assessment shall be suspended pending appeal by such insurer contesting the amount or legality of such assessment.~~

[~~Sec. 19. CERTAIN EVIDENCE NOT ADMISSIBLE; UNFAIR PRACTICES. (1) In any lawsuit brought by a conservator or receiver of an impaired insurer for the purpose of recovering assets of the impaired insurer, the fact that claims against the impaired insurer have been or will be paid under the provisions of this article shall not be admissible for any purposes and shall not be placed before any jury either by evidence or argument.~~

[~~(2) The use in any manner of the protection afforded by this article by any person in the sale of insurance shall constitute unfair competition and unfair practices under Article 21.21 of the Insurance Code, as amended, and shall be subject to the provisions thereof.~~

[~~Sec. 20. CONTROL OVER CONFLICTS. The provisions of this Act and the powers and functions authorized by this Act are to be exercised to the end that its purposes are accomplished. This Act is cumulative of existing laws, but in the event of conflict between this Act and other law relating to the subject matter of this Act or its application, the provisions of this Act shall control, except Articles 21.28 and 21.28-A of this code always prevail over the provisions of this Act.~~

[~~Sec. 21. UNCONSTITUTIONAL APPLICATION PROHIBITED. This Act and law does not apply to any insurer or other person to whom, under the Constitution of the United States or the Constitution of the State of Texas, it cannot validly apply.~~

[~~Sec. 22. SEVERANCE CLAUSE. If any provision of this Act or the application thereof to any person or circumstance is held invalid by any court of competent jurisdiction, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are declared to be severable.~~]

SECTION 1.21. Article 21.28–D, Insurance Code, is amended to read as follows:

Art. 21.28–D. LIFE, ACCIDENT, HEALTH, AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Sec. 1. SHORT TITLE. This Act shall be known and may be cited as the Life, Accident, Health, and Hospital Service Insurance Guaranty Association Act.

Sec. 2. PURPOSE. The purpose of this Act is to protect, subject to certain limitations, the persons specified in Section 3(a) of this Act against failure in the performance of contractual obligations, under life, accident, and health insurance policies and annuity contracts specified in Section 3(b) of this Act, because of the impairment or insolvency of the member insurer that issued the policies or contracts. To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited in this Act, and members of the association are subject to assessment to provide funds to carry out the purpose of this Act.

Sec. 3. COVERAGE AND LIMITATIONS. (a) This Act provides coverage for a policy or contract specified in Subsection (b) of this section to:

(1) a person, other than a nonresident certificate holder under a group policy or contract, who is the beneficiary, assignee, or payee of a person covered under Paragraph (2) of this subsection; and

(2) a person who is an owner of or certificate holder under the policy or contract; or, in the case of an unallocated annuity contract, to the person who is the contract holder, and who:

(A) is a resident; or

(B) is not a resident, but only if:

(i) the insurers that issued the policies or contracts are domiciled in this state;

(ii) the insurers never held a license or certificate of authority in the states in which the persons reside;

(iii) the states have associations similar to the association created by this Act; and

(iv) the person is not eligible for coverage by the associations.

(b) This Act provides coverage to the persons specified in Subsection (a) of this section for direct, non-group life, health, accident, annuity, and supplemental policies or contracts, for certificates under direct group policies and contracts, group hospital service contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Act. This Act also provides coverage for all other insurance coverages written by mutual assessment corporations, local mutual aid associations, statewide mutual assessment companies, and stipulated premium companies licensed to do business in this state. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(c) This Act does not provide coverage for:

(1) a portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;

(2) a policy or contract of reinsurance, unless assumption certificates have been issued;

(3) a portion of a policy or contract to the extent that the rate of interest on which it is based:

(A) averaged over the period of four years before the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the association became obligated; and

(B) on and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) a plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

(A) a multiple employer welfare arrangement as defined by the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002);

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services-only contract;

(5) a portion of a policy or contract, to the extent that it provides dividends or experience rating credits, or provides that fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;

(6) a policy or contract issued in this state by a member insurer at a time when it was not licensed to issue the policy or contract in this state;

(7) an unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

(8) a portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, benefit plan for a union or association of natural persons, or a government lottery; and

(9) any portion of a financial guarantee, funding agreement, or guaranteed investment contract which (1) contains no mortality guarantees and (2) is not issued to or in connection with a specific employee, benefit plan, or a governmental lottery.

(d) The benefits for which the association may become liable may not exceed the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer.

Sec. 4. CONSTRUCTION. This Act shall be liberally construed to effect the purpose under Section 2 of this Act. Section 2 of this Act shall be used as an aid and guide to interpretation.

Sec. 5. DEFINITIONS. As used in this Act:

(1) "Account" means the four accounts created under Section 6 of this Act.

(2) "Association" means the Life, Accident, Health, and Hospital Service Insurance Guaranty Association created under Section 6 of this Act.

(3) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 3 of this Act. A contractual obligation does not include:

(A) death benefits in an amount in excess of $300,000 or a net cash surrender or net cash withdrawal value in an amount in excess of $100,000 in the aggregate under one or more covered policies on any one life;

(B) an amount in excess of $100,000 in the aggregate under one or more annuity contracts within the scope of this Act issued to the same holder of individual annuity policies or to the same annuitant or participant under group annuity policies or an amount in excess of $5,000,000 in unallocated annuity contract benefits with respect to any one contract holder irrespective of the number of such contracts;

(C) an amount in excess of $200,000 in the aggregate under one or more accident and health, accident, or health insurance policies on any one life; or

(D) punitive, exemplary, extracontractual, or bad faith damages, whether agreed to or assumed by an insurer or insured or imposed by a court of competent jurisdiction.

(4) "Covered policy" means any policy or contract within the scope of this Act under Section 3 of this Act.

(5) "Impaired insurer" means:

(A) a member insurer that is placed by the commissioner under an order of supervision, liquidation, rehabilitation, or conservation under the provisions of Article 21.28 or 21.28-A, Insurance Code, and that has been designated an "impaired insurer" by the commissioner; or

(B) a member insurer determined in good faith by the commissioner to be unable or potentially unable to fulfill its contractual obligations.

(6) "Insolvent insurer" means a member insurer whose minimum free surplus, if a mutual company, or whose required capital, if a stock company, becomes impaired to the extent prohibited by law and that has been designated an "insolvent insurer" by the commissioner.

(7) "Member insurer" means any insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is

provided under Section 3 of this Act, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, including a mutual assessment corporation, a local mutual association, a statewide mutual assessment company, and a stipulated premium company licensed to do business in this state, but does not include:

(A) a health maintenance organization;

(B) a fraternal benefit society;

(C) a mandatory state pooling plan;

(D) an insurance exchange; or

(E) any entity similar to any of those described by Paragraphs (A)-(D) of this subdivision.

(8) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor to that entity.

(9) "Person" means any individual, corporation, partnership, association, or voluntary organization.

(10) "Premiums" means amounts received on covered policies or contracts less premiums, considerations, and deposits returned on those policies or contracts, and less dividends and experience credits on those policies or contracts. "Premiums" does not include amounts received for policies or contracts or for the portions of any policies or contracts for which coverage is not provided under Section 3(b) of this Act, except that assessable premiums shall not be reduced on account of Section 3(c)(3) of this Act relating to interest limitations and Section 5(3) of this Act relating to limitations with respect to any one individual, any one participant, any one annuitant, and any one contract holder. "Premiums" does not include premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457 of the United States Internal Revenue Code (26 U.S.C. Sections 401, 403(b) and 457). "Premiums" also does not include premiums received from the Treasury of the State of Texas or from the Treasury of the United States for insurance contracted for by the state or federal government for the purpose of providing welfare benefits to designated welfare recipients or for insurance contracted for by the state or federal government in accordance with or in furtherance of the provisions of Title 2, Human Resources Code, or the Federal Social Security Act.

(11) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person is its principal place of business.

(12) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(13) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Sec. 6. CREATION OF ASSOCIATION. (a) The Life, Accident, Health, and Hospital Service Insurance Guaranty Association is a nonprofit legal entity. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under Section 10 of this Act and shall exercise its powers through a board of directors established under Section 7 of this Act. For purposes of administration and assessment, the association shall maintain four accounts:

(1) the accident, health, and hospital services insurance account;

(2) the life insurance account;

(3) the annuity account; and

(4) the administrative account.

(b) The association is under the immediate supervision of the commissioner and is subject to the applicable provisions of this code and any other law governing insurance in this state.

Sec. 7. BOARD OF DIRECTORS. (a) The State Board of Insurance shall appoint a board of directors of the association consisting of nine members, three of whom shall be chosen from employees or officers chosen from the ten member companies having the largest total direct premium income based on the latest financial statement on file at date of appointment, two of whom shall be chosen from the other companies to give fair representation to member insurers based on due consideration of their varying categories of premium income and geographical location, and four of whom shall be representatives of the general public. Members serve for six-year staggered terms, with the terms of three members expiring each odd-numbered year. All directors shall serve until their successors are appointed, except that in the case of any vacancy, the unexpired term of office shall be filled by the appointment of a director by the State Board of Insurance. If a director ceases to be an officer or employee of a member insurer during the director's term of office, that office becomes vacant until the director's successor is appointed. All directors are eligible to succeed themselves in office. A public representative may not be:

(1) an officer, director, or employee of an insurance company, insurance agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the State Board of Insurance;

(2) a person required to register with the secretary of state under Chapter 305, Government Code; or

(3) related to a person described by Subparagraph (1) or (2) of this paragraph within the second degree of affinity or consanguinity.

(b) Each director of the association shall file a financial statement with the secretary of state in accordance with Sections 3 and 4, Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252–9b, Vernon's Texas Civil Statutes).

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board may not otherwise be compensated by the association for their services.

Sec. 8. POWERS AND DUTIES OF THE ASSOCIATION. (a) If a member insurer is an impaired domestic insurer, the association may, subject to the approval of the commissioner, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer that are approved by the commissioner, and that are, except in cases of court-ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer;

(2) provide the moneys, pledges, notes, guarantees, or other means as are proper to effectuate Subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under Subdivision (1) of this subsection; or

(3) loan money to the impaired insurer.

(b) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, subject to the conditions specified in Subsection (c) of this section, the association shall:

(1) take any of the actions specified in Subsection (a) of this section, subject to the conditions in that subsection; or

(2) provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners

who petition for substitute benefits under claims of emergency or hardship under standards proposed by the association and approved by the commissioner.

(c) The association is subject to Subsection (b) of this section only if:

(1) the laws of the impaired insurer's state of domicile provided that, until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses of the associations and interest on all those payments and expenses have been repaid to the guaranty associations or a plan of repayment by the impaired insurer has been approved by the guaranty associations:

(A) the delinquency proceeding may not be dismissed;

(B) the impaired insurer and its assets may not be returned to the control of its shareholders or private management; and

(C) the impaired insurer may not solicit or accept new business or have any suspended or revoked license restored; and

(2) the impaired insurer is a domestic insurer, and has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

(3) the impaired insurer is a foreign or alien insurer and:

(A) it has been prohibited from soliciting or accepting new business in this state;

(B) its certificate of authority has been suspended or revoked in this state; and

(C) a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.

(d) Except as provided by Subsection (e) of this section, if a member insurer is an insolvent insurer, the association shall provide the moneys, pledges, guarantees, or other means as are reasonably necessary to discharge the duties of the insolvent insurer and:

(1) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(2) assure payment of the contractual obligations of the insolvent insurer.

(e) When proceeding under Subsections (b)(2) or (d) of this section, with respect to only life and health insurance policies the association shall:

(1) assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability that would have been payable under the policies of the insolvent insurer, for claims incurred:

(A) with respect to a group policy or contract, the later of:

(i) the earlier of the next renewal date under the policy or contract or the 45th day after the date the association becomes obligated with respect to the policy; or

(ii) the 30th day after the date the association becomes obligated with respect to the policy; or

(B) with respect to an individual policy, the later of:

(i) the earlier of the next renewal date under the policy, if any, or the date one year after the date the association becomes obligated with respect to the policy; or

(ii) the 30th day after the date the association becomes obligated with respect to the policy;

(2) make diligent efforts to provide all known insureds or group policyholders notice before the 30th day before the benefits provided are terminated; and

(3) with respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, substitute coverage on an individual basis in accordance with the provisions of Subsection (f)

of this section, if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(f) In providing the substitute coverage required under Subsection (e)(3) of this section, the association may offer either to reissue the terminated coverage or to issue an alternative policy. Alternative or reissued policies shall be offered without requiring evidence of insurability, and may not provide for any waiting period or exclusion that would not have applied under the terminated policy. The association may reinsure any alternative or reissued policy.

(g) An alternative policy adopted by the association is subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(h) An alternative policy issued by the association must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates adopted by the association. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy was last underwritten.

(i) An alternative policy issued by the association must provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(j) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

(k) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy cease on the date the coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(l) When proceeding under Subsection (b)(2) or (d) of this section with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Section 3(c)(3) of this Act.

(m) Failure to pay premiums before the 32nd day after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy or coverage under this Act with respect to that policy or coverage, except with respect to any claims incurred or any net cash surrender value due in accordance with the provisions of this Act.

(n) Premiums due for coverage after entry of an order of receivership of an insolvent insurer belong to and are payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(o) The protection provided by this Act does not apply if any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(p) In carrying out its duties under this section, the association may, subject to approval by the court:

(1) impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement if the association finds that the amounts that can be assessed under this Act are less than the amounts needed to assure full

and prompt performance of the association's duties under this Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to make the imposition of the permanent policy or contract liens in the public interest; or

(2) impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

(q) If the association fails to act within a reasonable period of time as provided in Subsections (b)(2), (d), and (e) of this section, the commissioner may assume the powers and duties of the association under this Act with respect to impaired or insolvent insurers.

(r) The association may render assistance and advice to the commissioner, on request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(s) The association may appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this Act. This right extends to all matters germane to the powers and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association may appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

(t) A person receiving benefits under this Act is considered to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received under this Act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of the rights and cause of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition to the receipt of a right or benefit under this Act. The subrogation rights of the association under this subsection have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Act.

(u) The association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such a policy or contract.

(v) The association may:

(1) enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act;

(2) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 9 of this Act and to settle claims or potential claims against it;

(3) borrow money to effect the purposes of this Act, and any notes or other evidence of indebtedness of the association not in default are legal investments for domestic insurers and may be carried as admitted assets;

(4) employ or retain employees or contractors to handle the financial transactions of the association and to perform other functions under this Act;

(5) take legal action as may be necessary to avoid payment of improper claims; and

(6) exercise, for the purposes of this Act and to the extent approved by the commissioner, the powers of a domestic life, accident, health, or hospital service insurer, but the association may not issue insurance policies or annuity contracts other than those issued to perform its obligations under this Act.

(w) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

Sec. 9. ASSESSMENTS. (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall determine the amount necessary and the association shall assess the member insurers, separately for each account established by Section 6(a) of this Act, at such times and for such amounts as the board of directors finds necessary. All assessments are due on a date specified by the association that may not be earlier than the 30th day after the date on which prior written notice is given to the member insurers. Interest accrues on the unpaid amount at a rate of 10 percent beginning on the due date.

(b) There are two classes of assessments, as follows:

(1) Class A assessments are made to meet administrative costs of the association, administrative expenses properly incurred under this Act relating to any unauthorized insurer or nonmember of the association, and other general expenses not related to a particular insolvent or impaired insurer; and

(2) Class B assessments are made to the extent necessary to carry out the powers and duties of the association under Section 8 with regard to an insolvent or impaired insurer.

(c) The amount of a Class A assessment for each account is determined by the board of directors taking into consideration one or more of the following: annual premium receipts, admitted assets, or insurance in force, as reflected in the annual statements for the year preceding the assessment.

(d) The amount of a Class B assessment shall be divided among the separate accounts as reflected in the annual statements for the year preceding the assessment in the same proportion that the premiums from the policies covered by each account were received by the insolvent or impaired insurer from all covered policies during the year preceding impairment.

(e) Class A assessments shall be allowed as a credit on the amount of premium taxes in the manner provided by Article 1.16 of this code.

(f) Class B assessments against member insurers for each account shall be in the proportion that premiums received on all business by each assessed member insurer on policies covered by each account bear to the premiums received on all business by all assessed member insurers.

(g) Assessments for funds to meet the requirements of the association with respect to an insolvent or impaired insurer may not be made until necessary to implement the purposes of this Act. Classification of assessments under Subsection (b) of this section and computation of assessments under this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(h) The association may defer, in whole or in part, the assessment of a member insurer if, in the opinion of the association, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. The total of all assessments on a member insurer for each account may not exceed one percent of the insurer's premiums on the policies covered by the account in any one calendar year.

(i) If an assessment against a member insurer is deferred under Subsection (h) of this section, in whole or in part, the amount by which the assessment is deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this subsection. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.

(j) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each

member insurer, the amount by which the assets exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that amount, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.

(k) The association shall issue to each insurer paying a Class B assessment under this Act a certificate of contribution, in a form prescribed by the commissioner, for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or date of issue.

(l) Any insurer whose certificate of authority to do business in this state is canceled or surrendered shall be liable for any unpaid assessments made prior to the date of such cancellation or surrender.

(m) The amounts provided according to assessments made under this section are supplemental to the marshaling of assets for the purpose of making payments on behalf of an impaired insurer.

(n) All assessments collected by the association may be deposited into the Texas Treasury Safekeeping Trust Company in accordance with procedures established by the state treasurer. The funds deposited shall be accounted for separately from all other funds by the state treasurer to the association.

Sec. 10. PLAN OF OPERATION. (a) The association operates under a plan of operation approved by the commissioner. The association may amend the plan, subject to the approval of the commissioner. An amendment to the plan becomes effective on the date on which the commissioner approves the amendment, or on the 30th day after the date the amendment is submitted to the commissioner for approval, if the commissioner does not approve or disapprove the amendment before that date.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation must, in addition to requirements of this Act:

(1) establish procedures for handling the assets of the association;

(2) establish the amount and method of reimbursing members of the board of directors under Section 7 of this Act;

(3) establish regular places and times for meetings, including telephone conference calls, of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish any additional procedures for assessments under Section 9 of this Act; and

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(d) The plan of operation may provide that any or all powers and duties of the association, except those under Sections 8(u) and 9 of this Act, are delegated to a corporation, association, or other organization that performs functions similar to those of this association, or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection may take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this Act.

Sec. 11. DUTIES AND POWERS OF THE COMMISSIONER. (a) In addition to the duties and powers enumerated elsewhere in this Act, the commissioner shall provide the association, on request, with a statement of the premiums in this and any other appropriate states for each member insurer.

(b) When an impairment is declared and the amount of the impairment is determined, the commissioner shall serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with the demand does not excuse the association from the performance of its powers and duties under this Act.

(c) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent of the unpaid assessment per month and may not be less than $100 per month.

(d) An action of the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken before the 61st day after the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company.

(e) The commissioner, as receiver of an impaired insurer, may notify all interested persons of the effect of this Act.

Sec. 12. PREVENTION OF INSOLVENCIES. (a) The commissioner shall:

(1) notify the commissioners of all the other states, territories of the United States, and the District of Columbia by mail not later than the 30th day after the commissioner takes any of the following actions against a member insurer:

(A) revokes a license;

(B) suspends a license; or

(C) makes any formal order that the insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors;

(2) report to the board of directors when the commissioner has taken any of the actions set forth in Subdivision (1) of this subsection or has received a report from any other commissioner indicating that a similar action has been taken in another state; the report to the board of directors must contain all significant details of the action taken or the report received from the other commissioner;

(3) report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer; and

(4) furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners.

(b) The board may use the information described by Subsection (a) of this section in carrying out its duties and responsibilities under this Act. The board shall keep the report and the information contained in the report confidential until it is made public by the commissioner or other lawful authority.

(c) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(d) The board of directors, on majority vote, may make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. These reports and recommendations are not public documents and are not subject to the open records

law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252–17a, Vernon's Texas Civil Statutes), until such time as an insurer is declared to be impaired.

(e) The board of directors, on majority vote, shall notify the commissioner of information indicating a member insurer may be an impaired or insolvent insurer.

(f) The board of directors, on majority vote, may request that the commissioner order an examination of any member insurer that the board in good faith believes may be an impaired or insolvent insurer. Not later than the 30th day after the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by persons designated by the commissioner. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors before its release to the public, but this does not preclude the commissioner from complying with Subsection (a) of this section. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it is open to public inspection before the release of the examination report to the public.

(g) The board of directors, on majority vote, may make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(h) The board of directors, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, shall prepare a report to the commissioner containing any information as it has in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by the other associations.

Sec. 13. CREDITS FOR ASSESSMENTS PAID. (a) Unless a longer period of time has been required by the commissioner, a member insurer shall at its option have the right to show a certificate of contribution as an admitted asset in the form approved by the commissioner under Section 9(k) of this Act at percentages of the original face amount approved by the commissioner, for calendar years as follows:

100 percent for the calendar year of issuance, which shall be reduced 10 percent a year for each year thereafter for a period of 10 years.

(b) The insurer may offset the amount written off by it in a calendar year under Subsection (a) of this section against its premium tax liability to this state accrued with respect to business transacted in that year. An insurer may not be required to write off in any one year, an amount in excess of its premium tax liability to this state accruing within the year.

(c) Any sums acquired by refund, pursuant to Section 9(j) of this Act, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in Subsection (b) of this section, and are not then needed for purposes of this Act, shall be paid by the association to the commissioner and by him deposited with the state treasurer for credit to the general fund of this state.

Sec. 14. MISCELLANEOUS PROVISIONS. (a) This Act does not reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) The association shall maintain records of all negotiations and meetings in which the association or its representatives discuss the activities of the association in carrying out its powers and duties under Section 8 of this Act. Records of the negotiations or meetings may be made public only on the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, on the termination of the impairment or insolvency of the insurer, or on the

order of a court of competent jurisdiction. This subsection does not limit the duty of the association to report on its activities under Section 15 of this Act.

(c) To carry out its obligations under this Act, the association is considered a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee under Sections 8(t) and (u) of this Act. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Act. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets that the reserves that should have been established for the policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) Before the termination of any receivership, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policyholders of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In making this determination, the court shall consider the welfare of the policyholders of the continuing or successor insurer.

(e) A distribution to stockholders of an impaired or insolvent insurer may not be made until the total amount of valid claims of the association for funds expended in carrying out its powers and duties under Section 8 of this Act with respect to the insurer have been recovered with interest by the association.

(f) If an order of receivership of an insurer domiciled in this state has been entered, the receiver appointed under the order may recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of Subsections (g), (h), and (i) of this section.

(g) A distribution to stockholders is not recoverable under Subsection (f) of this section if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(h) A person that was an affiliate that controlled the insurer at the time distributions subject to Subsection (f) of this section were paid is liable for the amount of distributions received. A person that was an affiliate that controlled the insurer at the time the distributions were declared is liable for the amount of distributions the person would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

(i) The maximum amount recoverable under Subsections (f) and (h) of this section is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(j) If a person liable under Subsection (h) of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(k) An impaired insurer placed in conservatorship or receivership for which assessments have been made under the provisions of this article, or for which guaranty fees have been provided, may not, on release from conservatorship or receivership, issue new or renewal insurance policies until the insurer has repaid in full the amount of guaranty fees furnished by the association. The commissioner may, on application of the association and after hearing, permit the issuance of new policies in accordance with a plan of operation by the released insurer for repayment. The commissioner may, in approving such plan, place restrictions on the issuance of new or renewal policies as necessary to the implementation of the plan. The commissioner shall give

10 days' notice of a hearing under this subsection to the association, and the association and member insurers that paid assessments in relation to the impaired insurer are entitled to appear at and participate in the hearing. Money recovered by the association under this subsection shall be repaid to the member insurers that paid assessments in relation to the impaired insurer on return of the appropriate certificate of contribution.

Sec. 15. EXAMINATION OF THE ASSOCIATION; ANNUAL REPORT. The association shall be subject to examination and regulation by the commissioner in the same manner as other insurers under this code. The board of directors shall submit to the commissioner each year, not later than the 120th day after the last day of the association's fiscal year, a financial report in a form approved by the commissioner and a report of the association's activities during the preceding fiscal year.

Sec. 16. TAX EXEMPTIONS. The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real or personal property.

Sec. 17. IMMUNITY; ATTORNEY GENERAL REPRESENTATION. (a) There is no liability on the part of and no cause of action of any nature arises against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, the special deputy or its agents or employees, or the commissioner or the commissioner's representatives, for any good faith action or omission in the performance of powers and duties under this Act. This immunity extends to the participation in any organization of one or more other state associations of similar purposes and to any similar organization and its agents or employees.

(b) The attorney general shall defend any action to which Subsection (a) applies that is brought against a member insurer or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver to its agents or employees, or the commissioner or the commissioner's representatives. This subsection continues to apply to an action instituted after the defendant's service with the guaranty association, commissioner, or department has terminated. This subsection does not require the attorney general to defend any person or entity with respect to an issue other than the applicability or effect of the immunity created by Subsection (a). The attorney general is not required to defend any member insurer of the association or its agents or employees, the association or its agents or employees, members of the association's board of directors, a special deputy receiver or its agents or employees with respect to any actions filed regarding the disposition of a claim filed with the guaranty association under this Act or to an issue other than the applicability or effect of the immunity created by Subsection (a). The association may contract with the attorney general under the Interagency Cooperation Act (Article 4413(32), Vernon's Texas Civil Statutes) to provide legal services not covered under this subsection.

Sec. 18. STAY OF PROCEEDINGS. All proceedings in which an impaired insurer is a party or is obligated to defend a party in any court in this state, except proceedings directly related to the receivership or instituted by the receiver, shall be stayed for six months and any additional time thereafter as may be determined by the court from the date of the designation of impairment or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the receiver or the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the impaired insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that made the judgment, order, decision, verdict, or finding and shall be permitted to defend the claim on the merits. The receiver or statutory successor of an impaired insurer covered by this Act shall permit access by the board or its authorized representative to records of the impaired insurer as are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the receiver or

statutory successor shall provide the board or its representative with copies of the records on request of the board and at the expense of the board.

Sec. 19. PROHIBITED ADVERTISEMENT OF INSURANCE GUARANTY ASSOCIATION ACT IN INSURANCE SALES; NOTICE TO POLICYHOLDERS. (a) A person may not make, publish, disseminate, circulate, or place before the public or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, that uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this Act. This section does not apply to the association or any other entity which does not sell or solicit insurance. The use of the protection afforded by this Act, other than as provided by this section, by any person in the sale of insurance constitutes unfair competition and unfair practices under Article 21.21 of this code, and is subject to the sanctions imposed under that article.

(b) The association shall prepare a summary document describing the general purposes and current limitations of the Act and complying with Subsection (c) of this section. This document shall be submitted to the commissioner for approval. Unless Subsection (d) of this section applies, at the expiration of the 60th day after the date on which the commissioner approves the document, an insurer may not deliver a policy or contract described in Section 3 of this Act to a policy or contract holder unless the summary document is delivered to the policy or contract holder before or at the time of delivery of the policy or contract. The document shall be available on request by a policyholder. The distribution, delivery, or contents or interpretation of this document does not guarantee that the policy or the contract or the holder of the contract or policy is covered in the event of the impairment or insolvency of a member insurer. The document shall be revised by the association as amendments to the Act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this Act.

(c) The document prepared under Subsection (b) of this section must contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) state the name and address of the association and insurance department;

(2) warn the policy or contract holder that the association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(3) state that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(4) state that the policy or contract holder should not rely on coverage under the association when selecting an insurer; and

(5) provide other information as directed by the commissioner.

(d) An insurer or agent may not deliver a policy or contract described in Section 3(b) of this Act and excluded under Section 3(c) of this Act from coverage under this Act unless the insurer or agent, before or at the time of delivery, gives the policy or contract holder a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall by rule specify the form and content of the notice.

Sec. 20. SUITS AGAINST ASSOCIATION. (a) Venue in a suit against the association arising under this article is in Travis County.

(b) The association is not required to give an appeal bond in an appeal of a cause of action under this article.

Sec. 21. RULES AND REGULATIONS. The State Board of Insurance is authorized and directed to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this article, and in augmentation thereof.

[~~Sec. 2. PURPOSE. The purpose of this Act is to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies; accident insurance policies; health insurance policies, annuity contracts, and supplemental contracts, and the holders of group hospital service contracts, subject to certain limitations, against failure in the performance of contractual obligation due to the impairment of the insurer issuing such policies or contracts. To provide this protection, (1) an association of insurers is created to enable the guaranty of payment of benefits and of continuation of coverages, (2) members of the association are subject to assessment to provide funds to carry out the purpose of this Act, and (3) the association is authorized to proceed in the prescribed manner, in the detection and prevention of insurer impairments.~~

[~~Sec. 3. SCOPE. (1) This Act shall apply:~~

[~~(a) to direct life insurance policies, accident insurance policies, health insurance policies, annuity contracts including unallocated annuity contracts except those specifically excluded in this Act, and contracts supplemental to life, accident or health insurance policies, group hospital service contracts and annuity contracts issued by any domestic member insurer and all such policies and contracts issued by a foreign or alien member insurer and all of those insurance policies and annuity contracts and all other insurance coverages written by mutual assessment corporations, local mutual aid associations, local mutual burial associations, statewide mutual assessment companies, and stipulated premium insurance companies licensed to do business in this state; and~~

[~~(b) with respect to such policies and contracts:~~

[~~(i) to those persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under Paragraph (ii) or (iii); and~~

[~~(ii) to those persons who are owners of or certificate holders under those policies or contracts and who are residents of this state at the time such insurer becomes an impaired insurer as defined in this Act; or~~

[~~(iii) to those persons who are not residents of this state at that time but who meet all of the following conditions:~~

[~~(A) the policies or contracts are issued by insurers domiciled in this state;~~

[~~(B) at the time the policies or contracts were issued, the persons were residents of this state;~~

[~~(C) the insurers did not hold a license or certificate of authority in the states in which the persons reside at the time a delinquency proceeding as defined by Article 21.28 of this code is commenced against those insurers;~~

[~~(D) the other states have associations similar to the association created by this Act; and~~

[~~(E) the persons are not eligible for coverage by those associations in the other state.~~

[~~(2) This Act shall not apply to:~~

[~~(a) Any such policies or contracts, or any part of such policies or contracts, under which the risk is borne by the policyholder;~~

[~~(b) Any kind of reinsurance contract or agreement between insurers, the terms of which do not create a direct liability of the assuming insurer, or the terms of which do not require the creation of a direct liability to the policyholder through issuance of an assumption certificate, or other written instrument;~~

[~~(c) Any kind of insurance or annuities, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy to be maintained by the insurer or by a separate entity;~~

[(d) Any such policies or contracts issued by a foreign or alien insurer on nonresidents of this state at the time such insurer becomes an impaired insurer as defined in this Act;

[(e) Any such policy or contracts of a foreign or alien insurer whose domiciliary jurisdiction or state of entry provides by statutes or regulations for residents of this state protection substantially similar to that provided by this Act for residents of other states;

[(f) Any such policies or contracts issued by fraternal benefit societies and assessment-as-needed companies, nor to such policies or contracts issued by insurers subject to the provisions of Chapter 360, Acts of the 62nd Legislature, Regular Session, 1971 (Article 21.28-C, Vernon's Texas Insurance Code);

[(g) Subject to Section 12 of this Act pertaining to the payment of expenses of administration, any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under:

[(i) a multiple employer welfare arrangement as defined by Section 514 of the Employee Retirement Income Security Act of 1974;

[(ii) a minimum premium group insurance plan;

[(iii) a stop-loss group insurance plan; or

[(iv) an administrative services only contract;

[(h) Any policy or contract issued in this state by a member, nonmember, or unauthorized insurer when the insurer was not licensed or did not have a certificate of authority to do insurance business in this state subject to Section 12 of this Act pertaining to the payment of expenses of administration;

[(i) Any portion of a policy or contract to the extent that the rate of interest on which it is based:

[(i) averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

[(ii) on and after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

[(j) Any portion of a policy or contract that constitutes an unallocated annuity contract issued to an employee pension benefit plan which provides fixed benefits and which is not an individual account plan;

[(k) Any portion of a financial guarantee, funding agreement, or guaranteed investment contract which (1) contains no mortality guarantees and (2) is not issued to or in connection with a specific employee benefit plan or a governmental lottery.

[Sec. 4. CONSTRUCTION. This Act shall be liberally construed to effect the purpose under Section 2 which shall constitute an aid and guide to interpretation.

[Sec. 5. DEFINITIONS. As used in this Act:

[(1) "Account" means any of the four accounts created under Section 6 of this Act.

[(2) "Association" means the Life, Accident, Health and Hospital Service Insurance Guaranty Association created under Section 6 of this Act.

[(3) "Commissioner" means the Commissioner of Insurance of this state.

[(4) "Contractual obligation" means any policy or contract benefit (including but not limited to death, disability, hospitalization, medical, premium deposits, advance premiums, supplemental contracts, cash surrender, loan, nonforfeiture, extended coverage,

~~annuities, and coupon and dividend accumulations to the owner, beneficiary, assignee, certificate holder, or third-party beneficiary), arising from an insurance policy or annuity contract to which this Act applies, issued or assumed by an insurer who becomes an impaired insurer. A contractual obligation shall not include:~~

[~~(a) death benefits in an amount in excess of $300,000 or a net cash surrender or net cash withdrawal value in an amount in excess of $100,000 in the aggregate under one or more covered policies on any one life;~~

[~~(b) an amount in excess of $100,000 in the aggregate under one or more annuity contracts within the scope of this Act issued to the same holder of individual annuity policies or to the same annuitant or participant under group annuity policies or an amount in excess of $5,000,000 in unallocated annuity contract benefits with respect to any one contract holder irrespective of the number of such contracts;~~

[~~(c) an amount in excess of $200,000 in the aggregate under one or more accident and health, accident, or health insurance policies on any one life;~~

[~~(d) any benefits that would have been payable under any group life, accident, or health policies or contracts of the impaired insurer for claims incurred after the next renewal date under those policies or contracts or 90 days, but in no event less than 60 days, after the date that a permanent receiver has been appointed for the insurer by a court of competent jurisdiction, whichever occurs first; or~~

[~~(e) punitive, exemplary, extracontractual, or bad faith damages, whether agreed to or assumed by an insurer or insured or imposed by a court of competent jurisdiction.~~

[~~If the impaired insurer has no assets within the State of Texas, or has insufficient assets to pay the expenses of administering the receivership or conservatorship of the impaired insurer, that portion of the expenses of administration incurred in the processing and payment of claims against the impaired insurer shall also be a contractual obligation under this Act.~~

[~~(5) "Covered policy" means any policy or contract within the scope of this Act under Section 3.~~

[~~(6) "Member insurer" means any insurance company authorized to transact in this state any kind of insurance to which this Act applies under Section 3.~~

[~~(7) "Insolvent insurer" means a member insurer whose minimum free surplus, if a mutual company, or whose required capital, if a stock company, becomes, after the effective date of this Act, impaired to the extent prohibited by law.~~

[~~(8) "Impaired insurer" means:~~

[~~(a) A member insurer which, after the effective date of this Act, is placed by the commissioner under an order of supervision, liquidation, rehabilitation, or conservation under the provisions of Article 21.28, Insurance Code, as amended, and Chapter 281, Acts of the 60th Legislature, Regular Session, 1967 (Article 21.28-A, Vernon's Texas Insurance Code); and that has been designated an "Impaired Insurer" by the commissioner, or~~

[~~(b) A member insurer determined in good faith by the commissioner after the effective date of this Act to be unable or potentially unable to fulfill its contractual obligations.~~

[~~(9) "Premiums" means direct gross insurance premiums and annuity considerations collected from persons residing or domiciled in the State of Texas on covered contracts and policies, less return premiums and considerations thereon and dividends paid or credited to policyholders on such direct business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers nor do "premiums" include any premiums in excess of $5,000,000 on any covered unallocated annuity contract. "Premiums" also do not include premiums received from the Treasury of the State of Texas or from the Treasury of the United States for insurance contracted for by the state or federal government for the purpose of providing welfare benefits to designated welfare recipients or for insurance contracted for by the state or federal government in accordance with or in furtherance of the provisions of Title 2, Human Resources Code, or the Federal Social Security Act. As used in Section 9, "premiums"~~

are those for the calendar year preceding the determination of insolvency or impairment.

[(10) "State Board of Insurance" means the State Board of Insurance created under Article 1.02, Insurance Code, as amended.

[(11) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

[(12) "Unauthorized insurer" means a person or insurer that has engaged in activities prohibited by Section 3, Article 1.14-1 of this code.

[(13) "Nonmember of the association" includes, for the purposes of Section 12 of this Act, fraternal benefit societies, assessment-as-needed companies, and all persons and entities authorized to act as agents under this code who solicit policies and contracts to which this Act applies including, without limitation, legal reserve life insurance agents, and agents subject to Article 21.07 of this code and who participated in transactions involving types of insurance within the scope of this Act.

[(14) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual person including guaranteed interest contracts and deposit administration contracts, except to the extent any annuity benefits under that contract or certificate are guaranteed to an individual person by an insurer.

[Sec. 6. CREATION OF THE ASSOCIATION. (1) There is created hereby a nonprofit legal entity to be known as the Life, Accident, Health and Hospital Service Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition precedent to their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under Section 10 below, and shall exercise its powers through a board of directors established under Section 7 below. For purposes of administration and assessment, the association shall establish four accounts:

[(a) The accident, health and hospital services account;

[(b) The life insurance account;

[(c) The annuity account; and

[(d) The administrative account.

[(2) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

[Sec. 7. BOARD OF DIRECTORS. (1) The State Board of Insurance shall appoint a board of directors of the association consisting of nine members, three of whom shall be chosen from employees or officers chosen from the ten member companies having the largest total direct premium income based on the latest financial statement on file at date of appointment, two of whom shall be chosen from the other companies to give fair representation to all such member insurers based on due consideration of their varying categories of premium income and geographical location, and four of whom shall be representatives of the general public. Members serve for six-year staggered terms, with the terms of three members expiring each odd-numbered year. All directors shall serve until their successors are appointed, except that in the case of any vacancy, the unexpired term of office shall be filled by the appointment of a director by the State Board of Insurance. Should any director cease to be an officer or employee of a member insurer during his term of office, such office shall become vacant until his successor shall have been appointed. All directors shall be eligible to succeed themselves in office. A public representative may not be:

[(A) an officer, director, or employee of an insurance company, insurance agency, agent, broker, solicitor, adjuster, or any other business entity regulated by the State Board of Insurance;

[(B) a person required to register with the secretary of state under Chapter 305, Government Code; or

[(C) related to a person described by Subparagraph (A) or (B) of this paragraph within the second degree of affinity or consanguinity.

[(2) Directors shall not receive any remuneration or emolument of office, but they shall be entitled to reimbursement for their actual expenses incurred in performing their duties as directors.

[(3) Each director of the association shall file a financial statement with the secretary of state in accordance with Sections 3 and 4, Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-9b, Vernon's Texas Civil Statutes).

[Sec. 8. POWERS AND DUTIES OF THE ASSOCIATION. In addition to the powers and duties enumerated in other sections of this Act,

[(1) If a member insurer becomes an insolvent insurer, as that term is herein defined, and has been designated an "Impaired Insurer" by the commissioner, the association shall, upon entry by a court of competent jurisdiction after the effective date of this Act of an order appointing a receiver, either temporary or permanent, to take charge of the assets of such insolvent insurer, subject to any reasonable conditions imposed by the association and approved by the commissioner, guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of such insolvent insurer, and shall make or cause to be made prompt payment of the contractual obligations of such insolvent insurer.

[(2) If a member insurer becomes an impaired insurer, as that term is herein defined, the association may, subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the commissioner:

[(a) guarantee or reinsure, or cause to be guaranteed or reinsured, the impaired insurer's covered policies; or

[(b) provide such moneys, pledges, notes, guarantees or other means as are proper to effectuate Subparagraph (a) above, and assure payment of the impaired insurer's contractual obligations pending action under Subparagraph (a) above, or

[(c) loan money to the impaired insurer.

[(3) In carrying out its duties under Paragraphs (1) and (2), above, the association may impose moratoriums or policy liens against the nonforfeiture values of any contractual obligation under a covered policy; and

[(4) The association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired insurer.

[(5) The association shall have standing to appear before any court in this state with jurisdiction over an insolvent insurer or an impaired insurer concerning which the association is or may become obligated under this Act. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the insolvent insurer or the impaired insurer and the termination of the covered policies and contractual obligations.

[(6) (a) Any person receiving benefits under this Act shall be deemed to have assigned his rights under the covered policy to the association to the extent of the benefits received because of this Act whether the benefits are payments of contractual obligations or continuation of coverage. The association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this Act upon such person. The association shall be subrogated to these rights against the assets of any impaired insurer.

[(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the insolvent insurer or the impaired insurer as that possessed by the person entitled to receive benefits under this Act.

[(7) The contractual obligations of the insolvent insurer or impaired insurer for which the association becomes or may become liable shall be as great as but no greater than

the contractual obligations of the insolvent insurer or impaired insurer would have been in the absence of an impairment unless such obligations are reduced as permitted by Paragraph (3).

[(8) The association may:

[(a) enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act;

[(b) sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under Section 9;

[(c) borrow money to effect the purposes of this Act. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

[(d) employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this Act;

[(e) negotiate and contract with any liquidator, rehabilitator, conservator, receiver, or ancillary receiver to carry out the powers and duties of the association;

[(f) take such legal action as may be necessary to avoid payment of improper claims;

[(g) exercise, for the purposes of this Act and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired insurer.

[Sec. 9. ASSESSMENTS. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall determine the amount necessary and the commissioner shall assess the member insurers, separately for each account established by Section 6 of this Act, at such times and for such amounts as the board of directors finds necessary. All assessments ordered by the commissioner shall be payable to the association and are due on a date specified by the commissioner which may not be earlier than the 30th day after the date on which prior written notice is given to the member insurers. Interest accrues on the unpaid amount at a rate of 10 percent beginning on the due date.

[(2) There shall be two classes of assessments, as follows:

[(a) Class A assessments shall be made for the purpose of meeting administrative costs of the association, the administrative expenses properly incurred under Subsection (1) of Section 12 of this Act relating to any unauthorized insurer or nonmember of the association, and other general expenses not related to a particular insolvent or impaired insurer;

[(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under Section 8 with regard to an insolvent or impaired insurer.

[(3)(a) The amount of any Class A assessment for each account shall be determined by the board of directors taking into consideration one or more of the following: annual premium receipts, admitted assets, or insurance in force, as reflected in the annual statements for the year preceding the assessment. The amount of any Class B assessment shall be divided among the separate accounts as reflected in the annual statements for the year preceding the assessment in the same proportion that the premiums from the policies covered by each account were received by such insolvent or impaired insurer from all covered policies during the year preceding impairment;

[(b) Class A assessments shall be allowed as a credit on the amount of premium taxes in the manner provided by Article 1.16 of this code. Class B assessments against member insurers for each account shall be in the proportion that premiums received on all business by each assessed member insurer on policies covered by each account bears to such premiums received on all business by all assessed member insurers;

[~~(c) Assessments for funds to meet the requirements of the association with respect to an insolvent or impaired insurer shall not be made until necessary to implement the purposes of this Act. Classification of assessments under Paragraph (2), above, and computation of assessments under this paragraph shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.~~

[~~(4) The commissioner may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed one percent of such insurer's premiums on the policies covered by the account.~~

[~~(5) In the event an assessment against a member insurer is abated or deferred, in whole or in part, because of the limitations set forth in Paragraph (4), above, the amount by which such assessment is abated or deferred, may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this paragraph. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.~~

[~~(6) The board of directors may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer, the amount by which the assets exceed the amount the board of directors finds is necessary to carry out during the coming year the obligations of the association with regard to that amount, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained to provide funds for the continuing expenses of the association and for future losses if refunds are impractical.~~

[~~(7) The association shall issue to each insurer paying a Class B assessment under this Act a certificate of contribution, in a form prescribed by the commissioner, for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or date of issue.~~

[~~(8) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any insurer who fails to pay an assessment when due. Any insurer whose certificate of authority to do business in this state is cancelled or surrendered shall be liable for any unpaid assessments made prior to the date of such cancellation or surrender.~~

[~~(9) The provisions of this section shall be valid and enforceable so long as the provisions of Section 19 remain in full force and effect.~~

[~~(10) The amounts provided pursuant to assessments made under this section are considered to be supplemental to the marshaling of assets for the purpose of making payments on behalf of an impaired insurer.~~

[~~Sec. 10. PLAN OF OPERATION. (1)(a) The association shall submit to the commissioner a plan of operation and any amendment thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the State Board of Insurance;~~

[~~(b) If the association fails to submit a suitable plan of operation within 180 days following the effective date of this Act, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner may, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.~~

[~~(2) All member insurers shall comply with the plan of operation.~~

[~~(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:~~

[(a) establish procedures for handling the assets of the association;

[(b) establish the amount and method of reimbursing members of the board of directors under Section 7;

[(c) establish regular places and times for meetings of the board of directors;

[(d) establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

[(e) establish any additional procedures for assessments under Section 9;

[(f) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

[(4) The plan of operation may provide that any or all powers and duties of the association, except those under Paragraph (8)(c) of Section 8 and Section 9, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this paragraph shall take effect only with the approval of the board of directors, the commissioner, and the court in which the delinquency proceeding, if any, is pending and may be made only to a corporation, association, or organization which extends protection not less favorably and effectively than that provided by this Act.

[Sec. 11. DUTIES AND POWERS OF THE COMMISSIONER. In addition to the duties and powers enumerated elsewhere in this Act,

[(1) The commissioner shall:

[(a) notify the board of directors of the existence of an insolvent or an impaired insurer not later than three days after a determination of impairment is made or after receipt of notice of impairment, whichever is earlier. The commissioner shall within three days notify the association of a member insurer placed under supervision pursuant to Article 21.28, Insurance Code, as amended, and Chapter 281, Acts of the 60th Legislature, Regular Session, 1967 (Article 21.28–A, Vernon's Texas Insurance Code);

[(b) upon request of the board of directors provide the association with a statement of the premiums for each member insurer.

[(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture upon any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month. Any forfeiture paid under this section shall be paid by the member insurer to the commissioner and by him deposited with the state treasurer for credit to the general fund of this state.

[(3) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within 30 days of the action being appealed. Any final action or order of the commissioner shall be subject to appeal to the State Board of Insurance and to judicial review as provided in Sections (d) and (f), Article 1.04, Insurance Code, as amended.

[Sec. 12. PREVENTION OF INSOLVENCIES AND IMPAIRMENTS; ADMINISTRATION OF ESTATES. To aid in the detection and prevention of insurer insolvencies and impairments and in the administration of receivership and conservatorship estates:

[(1) The board of directors shall notify the commissioner of any information indicating any member or unauthorized insurer or nonmember of the association may be unable or potentially unable to fulfill its contracts, policies, or contractual obligations and may request appropriate investigation and action by the commissioner who may, in his discretion, make such investigation and take such action as he deems appropriate. In carrying out its duties under this Act, upon written request by the commissioner, the board of directors shall authorize expenditure of funds from the administrative account

~~for reasonable and necessary administrative expenses incurred by a supervisor or conservator appointed by the commissioner or a receiver appointed by a court of competent jurisdiction for a nonmember of the association or unauthorized insurer operating in this state in those instances in which the commissioner has notified the board of directors or the board of directors has otherwise become aware that:~~

[~~(A) the nonmember of the association or unauthorized insurer has insufficient liquid assets to pay the expenses of administering the receivership or conservatorship of the nonmember of the association or unauthorized insurer;~~

[~~(B) insufficient funds are available from abandoned funds as provided by Section 8, Article 21.28, of this code; and~~

[~~(C) insufficient funds are available to the State Board of Insurance from appropriations for use in meeting the administrative expenses.~~

[~~Funds spent by the association pursuant to this subsection do not become assets of the nonmember of the association or unauthorized insurer but are a special fund loaned to the receiver or the conservator for payment of administrative expenses, which loan shall be repayable to the extent available from the funds of such nonmember of the association or unauthorized insurer.~~

[~~(2) The board of directors shall advise and counsel with the commissioner upon matters relating to the solvency of insurers. The commissioner shall call a meeting of the board of directors when he determines that an insurer is insolvent or impaired and may call a meeting of the board of directors when he determines that a danger of insolvency or impairment of an insurer exists. The board of directors shall notify the commissioner of any information indicating that an insurer may be unable or potentially unable to fulfill its contractual obligations and request a meeting with the commissioner. At such meetings the commissioner may divulge to the board of directors any information in his possession and any records of the State Board of Insurance, including examination reports or preliminary reports from examiners relating to such insurer. The commissioner may summon officers, directors and employees of an insolvent or impaired insurer (or an insurer the commissioner considers to be in danger of insolvency or impairment) to appear before the board of directors for conference or for the taking of testimony. Members of the board of directors shall not reveal information received in such meetings to anyone unless authorized by the commissioner or the State Board of Insurance or when required as witness in court. Board members and all of such meetings and proceedings under this section shall be subject to the same standard of confidentiality as is imposed upon examiners under Article 1.18 of the Insurance Code, as amended, except that no bond shall be required of a board member.~~

[~~The board of directors shall, upon request by the commissioner, attend hearings before the commissioner and meet with and advise the commissioner, liquidator or conservator appointed by the commissioner, on matters relating to the affairs of an impaired insurer and relating to action that may be taken by the commissioner, liquidator or conservator appointed by the commissioner to best protect the interests of persons holding covered contractual obligations against an impaired insurer and relating to the amount and timing of partial assessments and the marshalling of assets and the processing and handling of contractual obligations.~~

[~~(3) The board of directors may make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer. Such reports and recommendations shall not be considered public documents. Reports or recommendations made by the board of directors to the commissioner, liquidator or conservator shall not be considered public documents and there shall be no liability on the part of and no cause of action against a member of the board of directors or the board of directors for any report, individual report, recommendation or individual recommendation by the board of directors or members to the commissioner, liquidator or conservator.~~

[~~(4) The board of directors may make recommendations to the commissioner for the detection and prevention of member insurer impairments.~~

[~~(5) The board of directors shall, at the conclusion of any member insurer impairment in which the association carried out its duties under this Act or exercised any of its powers under this Act, prepare a report on the history and causes of such impairment, based on the information available to the association, and submit a report on same to the commissioner.~~

[~~(6) Any insurer that has an officer, director or employee serving as a member of the board of directors shall not lose the right to negotiate for and enter into contracts of reinsurance or assumption of liability or contracts of substitution to provide for liabilities for contractual obligations with the receiver or conservator of an impaired insurer. The entering into any such contract shall not be deemed a conflict of interest.~~

[~~(7) The association or any insurer assessed under this Act shall be an interested party under Section 3(h) of Article 21.28 of the Insurance Code, as amended.~~

[~~Sec. 13. MISCELLANEOUS PROVISIONS. (1) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under Section 8. Records of all such negotiations or meetings shall be made public only upon the termination of a receivership, liquidation, rehabilitation, conservatorship proceeding involving the insolvent insurer or impaired insurer, or upon the order of a court of competent jurisdiction. Nothing in this paragraph shall limit the duty of the association to render a report of its activities under Section 14.~~

[~~(2) For the purpose of carrying out its obligations under this Act, the association shall be deemed to be a creditor of the insolvent insurer or impaired insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to Paragraph (6) of Section 8.~~

[~~(3) No distribution to stockholders, if any, of an insolvent or impaired insurer shall be made until and unless the total amount of assessments levied by the commissioner with respect to such insurer has been fully recovered by the association.~~

[~~(4) The use in any manner of the protection afforded by this Act by any person in the sale of insurance shall constitute unfair competition and unfair practices under Article 21.21 of the Texas Insurance Code, as amended, and shall be subject to the provisions thereof.~~

[~~(5)(a) If an order for receivership, liquidation, rehabilitation, or conservatorship of a member insurer has been entered, the receiver appointed under such order shall have the right to recover on behalf of such insurer from any affiliate as defined in Section 1, Chapter 356, Acts of the 62nd Legislature, Regular Session, 1971 (Article 21.49-1, Vernon's Texas Insurance Code), that controlled it the amount of distributions, other than stock dividends paid by such insurer on its capital stock, at any time during the five years preceding the petition for receivership, liquidation, rehabilitation, or conservatorship, subject to the limitations of Subparagraphs (b) to (d), below:~~

[~~(b) No such dividend shall be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.~~

[~~(c) Any person who was an affiliate as defined in Section 1, Chapter 356, Acts of the 62nd Legislature, Regular Session, 1971 (Article 21.49-1, Vernon's Texas Insurance Code), that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received. If two persons are liable with respect to the same distributions, they shall be jointly and severally liable.~~

[~~(d) The maximum amount recoverable under this paragraph shall be the amount needed in excess of all other available assets of the insolvent insurer or impaired insurer to pay the contractual obligations of such insurer.~~

[~~(e) If any person liable under Subparagraph (c) is insolvent, all its affiliates as defined in Section 1, Chapter 356, Acts of the 62nd Legislature, Regular Session, 1971 (Article 21.49-1, Vernon's Texas Insurance Code), that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate as defined in Section 1, Chapter~~

~~356, Acts of the 62nd Legislature, Regular Session, 1971 (Article 21.49-1, Vernon's Texas Insurance Code).~~

[~~(f) Claims against an impaired insurer placed under an order of liquidation, rehabilitation, or conservation shall be processed and acted on by the receiver in the same manner as other claims under Article 21.28 of this code.~~

[~~(g) A person who has a claim against an insurer under a provision in an insurance policy, other than a policy of an impaired insurer, that also is a contractual obligation under this Act must first exhaust his right under that policy. The amount of an approved claim under this Act shall be reduced by the policy limits of or amount paid under that insurance policy, whichever amount is greater. If a claimant exhausts his right under a policy other than a policy of an impaired insurer, the insurer issuing that policy is not entitled to sue or continue a suit against the insured of the impaired insurer to recover an amount paid the claimant under that policy. Notwithstanding the foregoing, a person having a contractual obligation as defined by this Act under a life insurance policy or annuity contract issued by an impaired insurer is not required to exhaust other coverage for that claim, and the amount of an approved claim under a life insurance policy or annuity contract issued by an impaired insurer may not be reduced because of that duplicate coverage.~~

[~~Sec. 14. EXAMINATION OF THE ASSOCIATION; ANNUAL REPORT. The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of its activities during the preceding calendar year.~~

[~~Sec. 15. TAX EXEMPTIONS. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.~~

[~~Sec. 16. IMMUNITY. There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents, or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his representatives, for any action taken or not taken by them in the performance of their powers and duties under this Act.~~

[~~Sec. 17. CONTINUING TO WRITE INSURANCE POLICIES. Companies subject to the provisions of this Act shall not be liable for assessments for contractual obligations arising from insurance policies issued or renewed after the effective date of and while an impaired insurer is subject to an order by the commissioner of insurance placing an impaired insurer in conservatorship unless the commissioner, in his order appointing the conservator, directs the conservator to continue the issuance or renewal of insurance policies, under such terms and conditions as the commissioner may prescribe. The commissioner shall furnish a copy of such order to the board of directors of the association. In the event that the commissioner, in his original order appointing the conservator, directs the conservator to continue the issuance or renewal of insurance policies in the impaired insurer, companies subject to the provisions of this Act shall not be liable for assessments for claims arising from insurance policies issued or renewed more than 90 days after the date of the commissioner's order appointing the conservator unless the commissioner, prior to the expiration of such 90 day period, determines, after public hearing, that it is in the best interests of the policyholders of the impaired insurer or in the public interest for the impaired insurer to continue the issuance or renewal of insurance policies. At least 10 days notice of such hearing shall be given to the board of directors of the association. The board of directors shall have the right to appear at and participate in the hearing. The conservator or his representative shall appear at such hearing and present evidence why it would be in the best interest of the policyholders of the impaired insurer to continue the issuance or renewal of policies. Nothing in this section limits the liability of companies subject to this Act for assessments for claims presented after an impaired insurer is placed in receivership.~~

[~~Sec. 18. RELEASE FROM CONSERVATORSHIP OR RECEIVERSHIP. An impaired insurer placed in conservatorship or receivership for which assessments have been made under the provisions of this Act shall not be authorized, upon release from conservator-~~

~~ship or receivership, to issue new or renewal insurance policies until such time as the impaired insurer has repaid in full to the association the amount of Class B assessments paid to the association to carry out the duties of the association under Section 8 in relation to such insurer the amount paid; provided, however, the commissioner may, upon application of the board of directors of the association and after hearing, permit the issuance of new policies in accordance with a plan of operations by the released insurer for repayment of assessments. The commissioner may, in approving such plan, place such restrictions upon the issuance of new or renewal policies as he deems necessary to the implementation of the plan.~~

[~~Sec. 19. TAX WRITE-OFFS OF CERTIFICATE OF CONTRIBUTION. (1) Unless a longer period of time has been required by the commissioner, a member insurer shall at its option have the right to show a certificate of contribution as an admitted asset in the form approved by the commissioner pursuant to Section 9, Paragraph (7), at percentages of the original face amount approved by the commissioner, for calendar years as follows:~~

[~~100 percent for the calendar year of issuance, which shall be reduced 10 percent a year for each year thereafter for a period of 10 years;~~

[~~(2) The insurer may offset the amount written off by it in a calendar year under Paragraph (1), above, against its premium tax liability to this state accrued with respect to business transacted in such year. Provided, however, an insurer may not be required to write off in any one year, an amount in excess of its premium tax liability to this state accruing within such year.~~

[~~(3) Any sums acquired by refund, pursuant to Paragraph (6) of Section 9, from the association which have theretofore been written off by contributing insurers and offset against premium taxes as provided in Paragraph (2), above, and are not then needed for purposes of this Act, shall be paid by the association to the commissioner and by him deposited with the state treasurer for credit to the general fund of this state.~~

[~~Sec. 20. RULES AND REGULATIONS. The State Board of Insurance is authorized and directed to issue such reasonable rules and regulations as may be necessary to carry out the various purposes and provisions of this Act, and in augmentation thereof.~~

[~~Sec. 20A. CONFLICTS OF LAW. In the event of conflict between this Act and other law relating to the subject matter of this Act or its application, this Act controls, except that Articles 21.28 and 21.28-A of this code always prevail over this Act.~~]

SECTION 1.22. Section 4A, Article 21.28-A, Insurance Code, is amended by adding Subsection (e) to read as follows:

(e) This section does not apply to:

(1) any life, accident, or health insurance policy or contract delivered or issued for delivery by an insurer that is subject to any provision of Chapter 3, 11, 14, or 22 of this code;

(2) any contract or certificate that is delivered or issued for delivery by a group hospital service corporation organized under Chapter 20 of this code; or

(3) any contract or evidence of coverage delivered or issued for delivery by a health maintenance organization operating under a certificate of authority issued under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

SECTION 1.23. Section 11(b), Article 21.54, Insurance Code, is amended to read as follows:

(b) No claim against a purchasing group or its members shall be entitled to payment from any insurance insolvency guaranty fund or similar mechanism in this state, nor shall a purchasing group or its members or claimants against the group or its members receive any benefit from such fund for claims arising under the insurance policies procured through the purchasing group *unless the policies are underwritten by insurance companies that are licensed in this state and have capital and surplus of at least $25 million at the time of policy issuance.*

SECTION 1.24. Section 404.102(a), Government Code, is amended to read as follows:

(a) The treasurer may incorporate a special-purpose trust company called the Texas Treasury Safekeeping Trust Company. The purposes of the trust company are to provide a means for the treasurer to obtain direct access to services provided by the Federal Reserve System and to enable the treasurer to manage, disburse, transfer, safekeep, and invest [~~public~~] funds and securities more efficiently and economically. The treasurer may deposit [~~public~~] funds and securities with the trust company to achieve its purpose.

SECTION 1.25. Section 404.103(a), Government Code, is amended to read as follows:

(a) The trust company may receive, transfer, and disburse money and securities *as provided by statute or* belonging to the state, agencies and local political subdivisions of the state, and nonprofit corporations, foundations, and other charitable organizations created on behalf of the state or an agency or local political subdivision of the state in a manner that qualifies the trust company as a "depository institution" as defined by Section 19, Federal Reserve Act (12 U.S.C. Section 461).

SECTION 1.26. Article 1.10, Insurance Code, is amended by adding Subdivision 20 to read as follows:

20. Electronic Transfer of Funds. The Board shall adopt rules for the electronic transfer of any taxes, fees, guarantee funds, or other money owed to or held for the benefit of the state. The Board shall require the electronic transfer of any amounts held or owed in an amount exceeding $500,000.

SECTION 1.27. (a) Except as provided by Subsection (b), (c), or (d) of this section, this article takes effect January 1, 1992, and applies only to liquidation proceedings initiated against an insurer or agent declared insolvent or impaired on or after that date and to assessments made in relation to those proceedings, and a proceeding initiated against an insurer or agent that is declared insolvent or impaired before that date is governed by the law in effect on the date that the declaration was made and the former law is continued in effect for that purpose.

(b) A guaranty association established under Article 9.48, 21.28–C, or 21.28–D, Insurance Code, may elect to assume its responsibilities under this Act in proceedings initiated before January 1, 1992. A proceeding covered by such an election is subject to Article 9.48, 21.28–C, or 21.28–D, as appropriate, as amended by this article. On and after September 1, 1994, the appropriate guaranty association shall assume its responsibilities under Article 9.48, 21.28–C, or 21.28–D, Insurance Code, as amended by this article, in any proceeding pending on that date that was initiated under Article 9.48, 21.28–C, or 21.28–D, Insurance Code.

(c) The commissioner of insurance may elect to assume the commissioner's responsibilities under Article 21.28, Insurance Code, as amended by this article, in proceedings initiated before January 1, 1992. Except as provided by Subsection (d) of this section, a proceeding covered by the election is subject to Article 21.28, Insurance Code, as amended by this article. On and after January 1, 1993, the commissioner shall assume the commissioner's responsibilities under Article 21.28, Insurance Code, as amended by this article, in any proceeding pending on that date that was initiated under Article 21.28, Insurance Code.

(d) Section 1.05 of this article takes effect January 1, 1992, and applies to liquidations proceedings initiated against an insurer or agent declared insolvent or impaired before, on, or after that date.

ARTICLE 2. CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE

SECTION 2.01. Section 2A, Article 3.51–9, Insurance Code, is amended to read as follows:

Sec. 2A. AVAILABILITY OF COVERAGE FOR CHEMICAL DEPENDENCY. *(a)* Insurers, nonprofit hospital and medical service plan corporations subject to Chapter 20 of this code, health maintenance organizations providing group health coverage, and all employer, trustee, or other self-funded or self-insured plans or arrangements transacting health insurance or providing other health coverage or services in this state shall provide, *directly or by contract with other entities, including a single service health maintenance organization,* under such group insurance policies or contracts and such plans or

arrangements providing hospital and medical coverage or services on an expense incurred, service, or prepaid basis, benefits for the necessary care and treatment of chemical dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and coinsurance factors. *An entity under this section may set dollar or durational limits in a policy, contract, plan, or arrangement providing benefits under this article which are less favorable than for physical illness generally if such limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under Subsection (d) of this section.*

This section shall not be construed to require that a usual, customary, and reasonable rate be paid when a negotiated rate is established by a health maintenance organization or preferred provider organization for the locality in which the covered individual customarily receives care.

If no guidelines or standards are in effect under Subsection (d), such limits shall be no less favorable than for physical illness generally.

(b) Notwithstanding Subsection (a) of this section, coverage for chemical dependency is limited to a lifetime maximum of three separate series of treatments for each covered individual.

A series of treatments is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the covered individual is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days.

(c) This section does not apply to any employer, trustee, or any other self-funded or self-insured plans or arrangements with 250 or fewer employees or members, or any individual insurance policies regardless of the method of solicitation or sale, or any individual H.M.O. policies, or to any health insurance policies that only provide cash indemnity for hospital or other confinement benefits, or supplemental or limited benefit coverage, or coverage for specified diseases or accidents, or disability income coverage, or any combination thereof.

(d) Any benefits so provided shall be determined as if necessary care and treatment in a chemical dependency treatment center were care and treatment in a hospital. The *Texas Department* [~~State Board~~] of Insurance and the Texas Commission on Alcohol and Drug Abuse shall formulate standards for use by insurers, other third party reimbursement sources, and chemical dependency treatment centers for the reasonable control of costs necessary for inpatient and outpatient treatment of chemical dependency, including guidelines for treatment periods. The standards shall provide for appropriate utilization review of treatment as well as necessary extensions of treatment. The *department* [~~State Board of Insurance~~] by rule shall adopt the standards as approved by both the *department* [~~State Board of Insurance~~] and the Texas Commission on Alcohol and Drug Abuse, and those standards are applicable to the provision of all services under this section. On adoption of standards or rules by the *department* [~~State Board of Insurance~~] under this section, benefits provided herein shall be subject to those standards or rules.

(e) For purposes of this *section* [~~article~~], the term "chemical dependency treatment center" means a facility which provides a program for the treatment of chemical dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

(1) affiliated with a hospital under a contractual agreement with an established system for patient referral; or

(2) accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

(3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

(4) licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

SECTION 2.02. Subdivision (2), Subsection A, Section 2, Article 3.53, Insurance Code, is amended to read as follows:

(2) All life insurance and all accident and health insurance sold in connection with loans or other credit transactions [~~of less than five (5) years duration~~], the premium for which is charged to or paid for in whole or in part either directly or indirectly by the debtor, shall be subject to the provisions of this Act, regardless of the nature, type or plan of the credit insurance coverage or premium payment system, except*:*

(a) insurance issued or sold in connection with a loan or other credit transaction of more than 10 years' duration;

(b) insurance issued or sold in connection with a credit transaction that is:

(i) secured by a first mortgage or deed of trust; and

(ii) made to finance the purchase of commercial real property or the construction of or improvement to a building other than a single family dwelling on the real property if the purchase, construction, or improvement is secured by a lien on the real property, or to refinance a credit transaction made for those purposes; or

(c) insurance issued or sold as [~~where the issuance of such insurance is~~] an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

SECTION 2.03. Section 7, Article 3.53, Insurance Code, is amended by adding Subsection H to read as follows:

H. The department shall charge a fee, in an amount to be determined by the department but not to exceed $200, for a form or schedule filed under this article. Fees collected shall be deposited in the state treasury to the credit of the department operating fund.

SECTION 2.04. Sections 8(A)(1), (2), and (3), Article 3.53, Insurance Code, are amended to read as follows:

(1) Any insurer may revise its schedules of premium rates *for various classes of business* from time to time, and shall file such revised schedules *and classes of business* with the Commissioner. No insurer shall issue any credit life insurance policy or credit accident and health insurance policy for which the premium rate exceeds that determined by the schedules *and classes of business* of such insurer as then on file with the Commissioner.

(2) The State Board of Insurance may, after notice and hearing, adopt and promulgate a presumptive premium rate *for various classes of business and terms of coverage* which shall be presumed, subject to a rebuttal of such presumption, to be just, reasonable, adequate, and not excessive. Any hearing conducted pursuant to this section shall be held in accordance with the contested case provisions of the Administrative Procedure and Texas Register Act (Article 6252–13a, Vernon's Texas Civil Statutes).

(3) In determining the presumptive premium rate, the board shall *consider* [~~determine~~] reasonable acquisition costs, loss *ratios, and* [~~ratio,~~] administrative expenses, *reserves,* loss settlement expenses, *the type or class of business, the duration of various credit transactions, reasonable and adequate profits to the insurers,* and other relevant data. The board may not set a presumptive premium rate that is unjust, unreasonable, inadequate, confiscatory, or excessive to the insurers, the insureds, or agents. The board may not fix or limit the amount of compensation actually paid by a company to an agent. The board may request information from any insurer or agent with respect to compensation paid for the sale of credit insurance, *expenses, losses, profits, and any other relevant data relating to the presumptive premium rate* and it is the duty of each insurer or agent to provide such information to the board in a timely manner.

SECTION 2.05. Section 2.02 of this article, amending Subdivision (2), Subsection A, Section 2, Article 3.53, Insurance Code, applies only to policies delivered, issued for delivery, or renewed on or after June 30, 1992. Policies delivered, issued for delivery, or renewed before June 30, 1992, are governed by the law that existed immediately before the effective date of this article, and that law is continued in effect for that purpose.

SECTION 2.06. Section 2.03 of this article, amending Section 7, Article 3.53, Insurance Code, applies only to fees charged for forms or schedules filed under Article 3.53, Insurance Code, on or after the effective date of this article.

SECTION 2.07. Section 2.04 of this article, amending Section 8(A), Article 3.53, Insurance Code, applies only to board determinations of the presumptive premium rate made on or after the effective date of this article, including any adjustment in the presumptive premium rate made under Section 2.08 of this article. Determinations of the presumptive premium rate made before the effective date of this article are governed by the law as it existed immediately before that effective date, and that law is continued in effect for that purpose.

SECTION 2.08. Not later than June 30, 1992, the Texas Department of Insurance shall conduct a hearing on the presumptive premium rate for credit insurance policies covering transactions of five through 10 years' duration and may adjust the presumptive credit rate for all policies.

ARTICLE 3. LICENSING OF INSURANCE AGENTS

SECTION 3.01. Section 8, Article 21.07, Insurance Code, is amended to read as follows:

Sec. 8. TEMPORARY LICENSE. The *department* [~~State Board of Insurance~~], if it is satisfied with the honesty and trustworthiness of any applicant who desires to write health and accident insurance, may issue a temporary agent's license, authorizing the applicant to write health and accident insurance, as well as all other insurance authorized to be written by the appointing insurance carrier, effective for ninety (90) days, without requiring the applicant to pass a written examination, as follows:

To any applicant who has been appointed or who is being considered for appointment as an agent by an insurance carrier authorized to write health and accident insurance immediately upon receipt by the *department* [~~State Board of Insurance~~] of an application executed by such person in the form required by this Article, together with a *nonrefundable filing fee of $100 and a* certificate signed by an officer or properly authorized representative of such insurance carrier certifying:

(a) that such insurance carrier has investigated the character and background of such person and is satisfied that he is trustworthy and of good character;

(b) that such person has been appointed or is being considered for appointment by such insurance carrier as its agent; and

(c) that such insurance carrier desires that such person be issued a temporary license; provided that if such temporary license shall not have been received from the *department* [~~Board~~] within seven days from the date on which the application and certificate were delivered to or mailed to the *department* [~~Board~~], the insurance carrier may assume that such temporary license will be issued in due course and the applicant may proceed to act as an agent; provided, however, that no temporary license shall be renewable or issued more than once in a consecutive six months period to the same applicant; and provided further, that no temporary license shall be granted to any person who does not intend to actively sell health and accident insurance to the public generally and it is intended to prohibit the use of a temporary license to obtain commissions from sales to persons of family employment or business relationships to the temporary licensee, to accomplish which purposes an insurance carrier is hereby prohibited from knowingly paying directly or indirectly to the holder of a temporary license under this Section any commissions on the sale of a contract of health and accident insurance to any person related to temporary licensee by blood or marriage, and the holder of a temporary license is hereby prohibited from receiving or accepting commissions on the sale of a contract of health and accident insurance to any person included in the foregoing classes of relationship.

SECTION 3.02. Section 2(b), Article 1.36, Insurance Code, is amended to read as follows:

(b) *As a condition of being authorized to conduct the business of insurance in this state, a* [~~A~~] domestic carrier and the controlling person of the affiliated insurance holding company system that has moved its principal offices and any portion of its books, records, and accounts outside this state under Article 1.28 of this code must *appoint and maintain a person in this state as attorney for service of process on whom* [~~have appointed the commissioner as their attorney for service for~~] all judicial and administrative processes, notices, or demands *may be served. The commissioner is authorized to accept service and notify the carrier, in the manner provided by Section 3 of this article, if the carrier does not appoint or maintain an attorney for acceptance of service who cannot with reasonable diligence be found.*

SECTION 3.03. Section 4(c), Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07–1, Vernon's Texas Insurance Code), as amended by Section 11.63, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(c) The application, when filed, shall be accompanied by a nonrefundable filing fee in an amount not to exceed $50 as determined by the State Board of Insurance and, in the case of applicants required to take an examination administered by the Commissioner, *by a certification that the required examination has been successfully completed and passed by the applicant,* as hereafter prescribed, unless the State Board of Insurance accepts a qualifying examination administered by a testing service, as provided under Article 21.01–1, Insurance Code, as amended[~~, by an examination fee in an amount not to exceed $20 as determined by the State Board of Insurance. The examination fee shall not be returned for any reason other than for failure to appear and take the examination after the applicant has given at least 24 hours' notice of an emergency situation to the Commissioner and received the Commissioner's approval. A new examination fee shall be paid for each and every examination~~].

SECTION 3.04. Section 5(a), Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07–1, Vernon's Texas Insurance Code), as amended by Section 11.64, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(a) Each *prospective* applicant for a license to act as a life insurance agent within this State shall submit to a personal written examination administered in the English or Spanish language, as prescribed by the State Board of Insurance, to determine the applicant's competence with respect to insurance and annuity contracts, including medicare supplement contracts, and the applicant's familiarity with the pertinent provisions of the laws of this State and the obligations and duties of a life insurance agent, and shall pass the same to the satisfaction of the State Board of Insurance. *A nonrefundable examination fee, in an amount determined by the Board but not more than $20, must accompany the application to take the examination. The department shall charge the fee each time the examination is taken. The department shall give certifications of a passing score to those applicants that obtain such a score. No*[~~; except that no such~~] written examination shall be required of:

(1) An applicant for the renewal of a license issued by the State Board of Insurance pursuant to Article 21.07, Texas Insurance Code, 1951, which is currently in force at the time of the effective date of this Act;

(2) An applicant whose license as a life insurance agent expired less than one year prior to the date of application may, in the discretion of the State Board of Insurance, be issued a license without written examination;

(3) A person who holds the designation Chartered Life Underwriter (CLU);

(4) An applicant that is a partnership or corporation.

SECTION 3.05. Section 10, Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07–1, Vernon's Texas Insurance Code), is amended to read as follows:

Sec. 10. TEMPORARY LICENSE. The *department* [~~Life Insurance Commissioner~~], if *it* [~~he~~] is satisfied with the honesty and trustworthiness of the applicant, may issue a temporary life insurance agent's license, effective for ninety days, without requiring the applicant to pass a written examination, as follows:

(a) To an applicant who has fulfilled the provisions of Section 4 of this Act where such applicant will actually collect the premiums on industrial life insurance contracts during the period of such temporary license; provided, however, that if such temporary license is not received from the *department* [~~Commissioner~~] within seven days from the date the application was sent to the *department* [~~Commissioner~~], the company may assume that the temporary license will be issued in due course and the applicant may proceed to act as an agent. For the purpose of this subsection an industrial life insurance contract shall mean a contract for which the premiums are payable at monthly or more frequent intervals directly by the owner thereof, or by a person representing the owner, to a representative of the company;

(b) To any person who [~~has been appointed or who~~] is being considered for appointment as an agent by an insurer immediately upon receipt by the *department* [~~Commissioner~~] of an application executed by such person in the form required by Section 4 of this Act, together with a *nonrefundable filing fee of $100 and a* certificate signed by an officer or properly authorized representative of such insurer stating:

(1) that such insurer has investigated the character and background of such person and is satisfied that he is trustworthy;

(2) that such person [~~has been appointed or~~] is being considered for appointment by such insurer as its full-time agent; and

(3) that such insurer desires that such person be issued a temporary license; provided that if such temporary license shall not have been received from the *department* [~~Commissioner~~] within seven days from the date on which the application and certificate were delivered to or mailed to the *department* [~~Commissioner~~], the insurer may assume that such temporary license will be issued in due course and the applicant may proceed to act as an agent; provided, however, that no temporary license shall be renewable nor issued more than once in a consecutive six months period to the same applicant; and provided further, that no temporary license shall be granted to any person who does not intend to *apply for a license to* [~~actively~~] sell life insurance to the public generally and it is intended to prohibit the use of a temporary license to obtain commissions from sales to persons of family employment or business relationships to the temporary licensee, to accomplish which purposes an insurer is hereby prohibited from knowingly paying directly or indirectly to the holder of a temporary license under this subsection any commissions on the sale of a contract of insurance on the life of the temporary licensee, or on the life of any person related to him by blood or marriage, or on the life of any person who is or has been during the past six months his employer either as an individual or as a member of a partnership, association, firm or corporation, or on the life of any person who is or who has been during the past six months his employee, and the holder of a temporary license is hereby prohibited from receiving or accepting commissions on the sale of a contract of insurance to any person included in the foregoing classes of relationship;

(4) that a person who has been issued a temporary license under this subsection and is acting under the authority of the temporary license may not engage in any insurance solicitation, sale, or other agency transaction that results in or is intended to result in the replacement of any existing individual life insurance policy form or annuity contract that is in force or receive, directly or indirectly, any commission or other compensation that may or does result from such solicitation, sale, or other agency transaction; and that any person holding a permanent license may not circumvent or attempt to circumvent the intent of this subdivision by acting for or with a person holding such a temporary license. As used in this subdivision, "replacement" means any transaction in which a new life insurance or annuity contract is to be purchased, and it is known or should be known to the temporary agent that by reason of the solicitation, sale, or other transaction the existing life insurance or annuity contract has been or is to be:

(A) lapsed, forfeited, surrendered, or otherwise terminated;

(B) converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(C) amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(D) reissued with any reduction in cash value; or

(E) pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy;

(5) that such person will complete, under such insurer's supervision, at least forty hours of training as prescribed by Subsection (c) of this Section within fourteen days from the date on which the application and certificate were delivered or mailed to the *department* [Commissioner].

(6) The *department* [Commissioner] shall have the authority to cancel, suspend, or revoke the temporary appointment powers of any life insurance company, if, after notice and hearing, he finds that such company has abused such temporary appointment powers. In considering such abuse, the *department* [Commissioner] may consider, but is not limited to, the number of temporary appointments made by a company as provided by Subsection (e) of this Section, the percentage of appointees sitting for the examination as life insurance agents under this Article as it may be in violation of Subsection (d) of this Section, and the number of appointees successfully passing said examination in accordance with Subsection (d). Appeals from the *department's* [Commissioner's] decision shall be made in accordance with Section 13 hereof.

(c) At least forty hours of training must be administered to any applicant for a temporary license as herein defined within fourteen days from the date on which the application and certificate were delivered or mailed to the *department* [Commissioner]. Of this forty-hour requirement, ten hours must be taught in a classroom setting, including but not limited to an accredited college, university, junior or community college, business school, or private institute or classes sponsored by the insurer and especially established for this purpose. Such training program shall be constructed so as to provide an applicant with the basic knowledge of:

(1) the broad principles of insurance, licensing, and regulatory laws of this State; and

(2) the obligations and duties of a life insurance agent.

The Commissioner of Insurance may, in his discretion, require that such training program shall be filed with the *department* [State Board of Insurance] for approval in the event he finds an abuse of temporary appointment powers under Subsection (b)(6) of this Section.

(d) Each insurer is responsible for requiring that not less than 70 percent of such insurer's applicants for temporary licenses sit for an examination during any two consecutive calendar quarters. At least 50 percent of those applicants sitting for the examination must pass during such a period.

(e) Each insurer may make no more than two hundred and fifty temporary licensee appointments during a calendar year under Subsection (b) of this Section.

SECTION 3.06. Section 3A, Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07-1, Vernon's Texas Insurance Code), as amended by Section 11.63, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 3A. CONTINUING EDUCATION. *(a)* The State Board of Insurance shall adopt a procedure for certifying and shall certify continuing education programs for agents. Participation in the programs is mandatory for all agents licensed under this article. The State Board of Insurance shall exempt agents who have been licensed for 15 years or

more beginning September 1, 1987; 16 years or more beginning September 1, 1988; 17 years or more beginning September 1, 1989; 18 years or more beginning September 1, 1990; 19 years or more beginning September 1, 1991; and 20 years or more on or after September 1, 1992, and shall have the rulemaking authority to provide for other reasonable exemptions. No agent shall be required to complete more than 15 hours of continuing education per year. An agent licensed under both Articles 21.07-1 and 21.14 may elect to satisfy the continuing education requirements of either article and shall not be required to complete a total of more than 15 hours of continuing education per year.

(b) Notwithstanding the rules or regulations of any other state agency, the board has sole jurisdiction for all matters relating to the continuing education of insurance agents who are licensed under this article.

SECTION 3.07. Section 5d, Article 21.14, Insurance Code, as added by Section 11.84, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 5d. *Notwithstanding the rules or regulations of any other state agency, the board has* [~~The State Board of Insurance shall have~~] sole jurisdiction for all matters relating to the continuing education of insurance agents who are licensed under this Article.

SECTION 3.08. The requirements adopted under this article apply only to an application filed under Article 21.07, Insurance Code, or Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07-1, Vernon's Texas Insurance Code), as amended under this article, on or after January 1, 1992. An application filed before January 1, 1992, is governed by the law in effect on the date that the application is filed, and the prior law is continued in effect for that purpose.

ARTICLE 4. SUBPOENA AUTHORITY

SECTION 4.01. Section 3, Article 1.10D, Insurance Code, as added by Section 4.01, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 3. SUBPOENA AUTHORITY; EXAMINATION OF MATERIAL IN OTHER STATES. (a) The commissioner *and at least one member of the*[~~,~~] board[~~, or any officer designated by the commissioner or board~~] may issue a subpoena and compel the attendance and testimony of witnesses and the production of materials relevant to an inquiry under this article, except that a witness is not required to produce any item that can be identified only through the writing and execution of a special computer program.

(b) A person with materials located outside this state that are requested by the commissioner *and at least one member of the* [~~or~~] board may make the materials available to the commissioner *and the* [~~or~~] board *member* or a representative of the commissioner *and the* [~~or~~] board *member* for examination at the place where the materials are located. The commissioner *and the* [~~or~~] board *member* may designate representatives, including officials of the state in which the materials are located, to examine the materials and may respond to similar requests from an official of another state or of the United States.

SECTION 4.02. Sections 1(a), (b), (d), and (e), Article 1.19-1, Insurance Code, as added by Section 4.03, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, are amended to read as follows:

(a) The commissioner and *at least one member of the board* [~~the State Board of Insurance~~] may require, by subpoena issued by the commissioner *and at least one member of the* [~~or~~] board, the attendance and testimony of witnesses and the production of any books, accounts, records, papers, correspondence, or other records relating to any matter that the commissioner or board has authority to consider or investigate. To accomplish this purpose, the commissioner *and the* [~~or a~~] board member shall *both* personally sign and issue *any subpoena* [~~subpoenas~~]. In this connection, the commissioner *and the* [~~or~~] board *member have* [~~has~~] statewide subpoena power and may compel attendance and production of records before the commissioner or board *member* or a designated person at the board's offices in Austin, Texas, or at any other places as the

commissioner *and the* [~~or~~] board *member* shall designate, including the offices of any person, to administer oaths and affirmations, examine witnesses, and receive evidence.

(b) A person with materials located outside this state that are requested by the commissioner *and at least one member of the* [~~or~~] board may make the materials available to the commissioner or board *member* or a representative of the commissioner or board *member* for examination at the place where the materials are located. The commissioner *and the* [~~or~~] board *member* may designate representatives, including officials of the state in which the materials are located, to examine the materials, and may respond to similar requests from an official of another state or of the United States.

(d) Any information or material acquired *under this article* [~~by the department, the board, or the commissioner~~] under a subpoena is not a public record for as long as the board or commissioner considers reasonably necessary to complete the investigation, protect the person being investigated from unwarranted injury, or serve the public interest. The information or material is not subject to a subpoena, except a valid grand jury subpoena, until released for public inspection by *at least one member of* the board *and the* [~~or~~] commissioner or, after notice and a hearing, a district court determines that the public interest and any investigation by the board *member and the* [~~or~~] commissioner would not be jeopardized by obeying the subpoena. Except for good cause, an order issued by a district court may not extend to a record or communication received from other law enforcement or regulatory agencies or to the internal notes, memoranda, reports, or communications made in connection with a matter that the commissioner or board has the authority to consider or investigate.

(e) On request, the commissioner *and at least one member of the* [~~or~~] board may furnish all materials, documents, reports, complaints, or other evidence obtained by subpoena to any law enforcement agency of this state, of another state, or of the United States, or any prosecuting attorney of any municipality, county, or judicial district of this state, of another state, or of the United States.

SECTION 4.03. Section 2, Article 1.19–1, Insurance Code, as added by Section 4.03, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 2. This section applies to materials and testimony resulting in cases involving allegations of engaging in the business of insurance without a license. On *joint* certification by the commissioner *and at least one member of the board* [~~of insurance or the State Board of Insurance~~] under official seal, any books, records, papers, and documents produced or testimony taken pursuant to this article and held by the Texas Department of Insurance are admissible in evidence in all cases without prior proof of their correctness and without other proof except the certificate of the *board member and* [~~State Board of Insurance or~~] the commissioner that the books, records, papers, documents, and testimony were received from the person producing the material or testifying. The certified books, records, documents, and papers, or certified copies of them, are prima facie evidence of the facts disclosed thereby. This section may not be construed to limit any other provision of this article or any law that makes provision for the admission of certain evidence or for its evidentiary value.

SECTION 4.04. Section 4(b), Article 1.19–1, Insurance Code, as added by Section 4.03, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) The sheriff's or constable's fee for serving a subpoena shall be the same as those paid the sheriff or constable for similar services. Any subpoena issued by the commissioner *and a* [~~or~~] board *member* may be served, at the [~~commissioner's or board's~~] discretion *of the commissioner and the board member*, by the commissioner *and the* [~~or~~] board *member*, an authorized agent of the commissioner *and the* [~~or~~] board *member*, a sheriff, or a constable.

SECTION 4.05. Articles 1.10D and 1.19–1, Insurance Code, as amended by Sections 4.01–4.04 of this article, apply only to subpoenas issued on or after January 1, 1992. A subpoena issued under those articles before January 1, 1992, is governed by the law in effect on the date that the subpoena was issued, and the former law is continued in effect for that purpose.

ARTICLE 5. SURETY BONDS

SECTION 5.01. Section 1(b), Chapter 87, Acts of the 56th Legislature, Regular Session, 1959 (Article 7.19–1, Vernon's Texas Insurance Code), as added by Section 11.28, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) If any bond, undertaking, recognizance, or other obligation described in Subsection (a) of this section is in an amount in excess of 10 percent of the surety company's capital and surplus, the municipality, board, body, organization, court, judge, or public officer may require, as a condition to accepting the bond, undertaking, obligation, recognizance, or other obligation, written certification that the surety company has reinsured the portion of the risk that exceeds 10 percent of the surety company's capital and surplus with one or more reinsurers who are duly authorized, *accredited, or trusteed* to do business in this state. For the purposes of this subsection, the amount reinsured by any reinsurer may not exceed 10 percent of the reinsurer's capital and surplus. The State Board of Insurance shall furnish, on request, the amount of the allowed capital and surplus as of the date of the last annual statutory financial statement for a surety company or reinsurer authorized and admitted to do business in this state.

ARTICLE 6. LLOYD'S PLAN INSURERS AND RECIPROCAL AND INTERINSURANCE EXCHANGES

SECTION 6.01. Subsection (a), Article 18.23A, Insurance Code, as added by Section 2.48, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(a) An insurer subject to Article 5.26 of this code may not directly or indirectly assume all or a substantial part of any risk covered by a policy written by a Lloyd's that is an affiliate of that insurer if the risk is written at a rate *less* [~~different~~] than the rate that may be lawfully charged by the insurer subject to Article 5.26 of this code, or any affiliate of the insurer that is subject to Article 5.26 of this code.

SECTION 6.02. Subchapter A, Chapter 5, Insurance Code, is amended by adding Article 5.01–2 to read as follows:

Art. 5.01–2. LLOYD'S PLAN INSURERS AND RECIPROCAL AND INTERINSURANCE EXCHANGES. (a) Lloyd's plan insurers and reciprocal and interinsurance exchanges are subject to this subchapter.

(b) On and after March 1, 1992, rates for motor vehicle insurance written by a Lloyd's plan insurer or a reciprocal or interinsurance exchange are determined as provided by the flexible rating program adopted under Subchapter M of this chapter. This subsection expires December 31, 1995.

SECTION 6.03. Article 19.12A, Insurance Code, as added by Section 2.47, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, applies only to an insurance policy issued or renewed on or after October 1, 1992.

SECTION 6.04. (a) Except as provided by Subsection (b) of this section, this article takes effect October 1, 1991.

(b) Section 6.03 of this article takes effect September 1, 1991.

(c) Section 6.01 of this article, amending Article 18.23A, Insurance Code, applies only to a policy issued or renewed on or after October 1, 1992.

ARTICLE 7. EXEMPTION

SECTION 7.01. Section 1, Article 21.55, Insurance Code, as added by Section 11.03, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 1. DEFINITIONS. In this article:

(1) "Claimant" means a person making a claim.

(2) "Business day" means a day other than a Saturday, Sunday, or holiday recognized by this state.

(3) "Claim" means a first party claim made by an insured or a policyholder under an insurance policy or contract or by a beneficiary named in the policy or contract that must be paid by the insurer directly to the insured or beneficiary.

(4) "Insurer" means any insurer authorized to do business as an insurance company or to provide insurance in this state, including:

(A) a domestic or foreign, stock and mutual, life, health, or accident insurance company;

(B) a domestic or foreign, stock or mutual, fire and casualty insurance company;

(C) a Mexican casualty company;

(D) a domestic or foreign Lloyd's plan insurer;

(E) a domestic or foreign reciprocal or insurance exchange;

(F) a domestic or foreign fraternal benefit society;

(G) a stipulated premium insurance company;

(H) a nonprofit legal service corporation;

(I) a statewide mutual assessment company;

(J) a local mutual aid association;

(K) a local mutual burial association;

(L) an association exempt under Article 14.17 of this code;

(M) a nonprofit hospital, medical, or dental service corporation, including a company subject to Chapter 20 of this code;

(N) a county mutual insurance company;

(O) a farm mutual insurance company;

(P) a risk retention group;

(Q) a purchase group; [~~and~~]

(R) a surplus lines carrier*; and*

(S) a guaranty association created and operating under Article 21.28–C or 21.28–D of this code.

(5) "Notice of claim" means any notification in writing to an insurer, by a claimant, that reasonably apprises the insurer of the facts relating to the claim.

SECTION 7.02. Section 4, Article 21.55, Insurance Code, as added by Section 11.03, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 4. PAYMENT OF CLAIMS. If an insurer notifies a claimant that the insurer will pay a claim or part of a claim under Section 3 of this article, the insurer shall pay the claim not later than the fifth business day after the notice has been made. If payment of the claim or part of the claim is conditioned on the performance of an act by the claimant, the insurer shall pay the claim not later than the fifth business day after the date the act is performed. *Surplus lines insurers shall pay the claim not later than the twentieth business day after the notice or date the act is performed.*

SECTION 7.03. Section 5, Article 21.55, Insurance Code, as added by Section 11.03, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 5. *EXEMPTIONS* [~~EXEMPTION~~]. *(a)* This article does not apply to:

(1) workers' compensation insurance;

(2) mortgage guaranty insurance;

(3) title insurance*;*

(4) [~~,~~] fidelity, surety, or guaranty bonds*;*

(5) [~~, or~~] marine insurance other than inland marine insurance governed by Article 5.53 of this code*;* or

(6) [~~to~~] a guaranty association created and operating under Article 9.48[~~, 21.28-C, or 21.28-D~~] of this code.

(b) A guaranty association created and operating under Article 21.28–C or 21.28–D of this code shall not be subject to the damage provisions contained in Section 6 of this article. A guaranty association may receive an extension of the time periods under this article from a court of competent jurisdiction upon good cause shown and after reasonable notice to policyholders.

(c) This article does not apply to Chapter 20A of this code except as provided in Section 9 of that chapter.

(d) In the event of a weather-related catastrophe or major natural disaster, as defined by the State Board of Insurance, the claim-handling deadlines imposed under this article are extended for an additional 15 days.

SECTION 7.04. (a) This article takes effect October 1, 1991.

(b) Section 5, Article 21.55, Insurance Code, as amended by this article, applies to each claim filed with an insurer on or after October 1, 1991. A claim filed before that date is governed by the law in effect on the date that the claim is filed, and the former law is continued in effect for that purpose.

ARTICLE 8. RATES FOR CERTAIN LINES OF INSURANCE

SECTION 8.01. Section 8(e), Article 5.13–2, Insurance Code, as added by Section 2.15, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(e) The board may promulgate standard insurance policy forms, endorsements, and other related forms that may be used, *at the discretion of the insurer*, by *an insurer* [~~insurers~~] instead of the insurer's own forms in writing insurance subject to this article. Forms submitted by insurers for approval under this section must provide coverage equivalent to that provided in the policy forms used for these lines of coverage on the effective date of this article. An endorsement may not reduce coverage provided under the approved policy form.

SECTION 8.02. Article 5.14(b), Insurance Code, as added by Section 2.16, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *October* [~~September~~] 1, *1991* [~~1992~~], rates *and forms* for general liability and commercial property insurance coverage subject to this subchapter are determined as provided by Article 5.13–2 of this code. This subsection expires December 31, 1995.

SECTION 8.03. Section 3(c), Article 5.101, Insurance Code, as added by Section 2.01, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(c) Each initial flexibility band is based on a benchmark rate promulgated by the board. On or before *January* [~~July~~] 1, 1992, and annually thereafter, the board shall conduct hearings to determine the benchmark rates and flexibility bands by line. The determination of the rate shall not include disallowed expenses under Subsection (h) of this section. An insurer, the public insurance counsel, and any other interested person may present testimony at the hearing and may file information for consideration by the board. An advisory organization which collects ratemaking data shall not be a party to the hearing. An insurer shall use that benchmark rate and the flexibility band to develop rates used for the line for the year following the setting of the benchmark rate and the flexibility band.

SECTION 8.04. Article 5.01(f), Insurance Code, as added by Section 2.02, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(f) Notwithstanding Subsections (a) through (d) of this article, on and after *March* [~~September~~] 1, 1992, rates for motor vehicle insurance in this state are determined as provided by the flexible rating program adopted under Subchapter M of this chapter. This subsection expires December 31, 1995.

SECTION 8.05. Article 5.03(g), Insurance Code, as added by Section 2.04, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(g) Notwithstanding Sections (a) through (e) of this article, on and after *March* [~~September~~] 1, 1992, rates for motor vehicles are determined as provided by Subchapter M of this chapter. This subsection expires December 31, 1995.

SECTION 8.06. Article 5.04(c), Insurance Code, as added by Section 2.05, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(c) Notwithstanding Subsections (a) and (b) of this article, on and after *March* [~~September~~] 1, 1992, rates for motor vehicles are determined as provided by Subchapter M of this chapter. This subsection expires December 31, 1995.

SECTION 8.07. Article 5.09(b), Insurance Code, as added by Section 2.12, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for motor vehicles are determined as provided by Subchapter M of this chapter. This subsection expires December 31, 1995.

SECTION 8.08. Article 5.11(c), Insurance Code, as added by Section 2.14, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(c) Notwithstanding Subsections (a) and (b) of this article, on and after *March* [~~September~~] 1, 1992, rates for motor vehicles are determined as provided by Subchapter M of this chapter. This subsection expires December 31, 1995.

SECTION 8.09. Article 5.15(h), Insurance Code, as added by Section 2.17, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(h) Notwithstanding Subsections (a)-(g) of this article, on and after *October* [~~September~~] 1, *1991* [~~1992~~], rates for general liability and commercial property insurance coverage under this article are determined, and hearings related to those rates are conducted, as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.10. Article 5.25(b), Insurance Code, as added by Section 2.23, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection does not affect the requirement for the Board to conduct inspections of commercial property and prescribe a manual of rules and rating schedules for commercial property under this subchapter. This subsection expires December 31, 1995.

SECTION 8.11. Article 5.25A(b), Insurance Code, as added by Section 2.24, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.12. Article 5.26(i), Insurance Code, as added by Section 2.26, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(i) Notwithstanding Subsections (a)—(h) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.13. Article 5.28(d), Insurance Code, as added by Section 2.27, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(d) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.14. Article 5.29(b), Insurance Code, as added by Section 2.28, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.15. Article 5.30(b), Insurance Code, as added by Section 2.29, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.16. Article 5.31(b), Insurance Code, as added by Section 2.30, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.17. Article 5.32(b), Insurance Code, as added by Section 2.31, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.18. Article 5.34(b), Insurance Code, as added by Section 2.32, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.19. Article 5.39(b), Insurance Code, as added by Section 2.34, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined, and hearings related to those rates are conducted, as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.20. Article 5.40(d), Insurance Code, as added by Section 2.35, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(d) Notwithstanding Subsections (a)—(c) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined, and hearings related to those rates are conducted, as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.21. Article 5.41(b), Insurance Code, as added by Section 2.36, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) Notwithstanding Subsection (a) of this article, on and after *March* [~~September~~] 1, 1992, rates for homeowners and farm and ranch owner's residential fire and residential allied lines insurance coverage under this subchapter are determined as provided by Subchapter M of this chapter, and rates for other lines of insurance subject to this subchapter are determined as provided by Article 5.13-2 of this code. This subsection expires December 31, 1995.

SECTION 8.22. Section 8.02 of this article, amending Article 5.14(b), Insurance Code, and Section 8.09 of this article, amending Article 5.15(h), Insurance Code, take effect October 1, 1991.

SECTION 8.23. The changes made by Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, to the application of the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes) and to the participation of State Board of Insurance staff members in rate proceedings apply to proceedings before the State Board of Insurance commenced on or after October 1, 1991.

ARTICLE 9. WITHDRAWALS FOR PREMIUM PAYMENTS

SECTION 9.01. Article 21.57(c), Insurance Code, as added by Section 11.03, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(c) This article does not require an insurer to notify the person of an increase in the amount of premium payment if*:*

(1) the insurance contract or certificate contains a schedule of increasing premiums when issued, expressly specifies the exact amount of each premium, and specifies the period for which each such premium is payable*; or*

(2) the increase is the result of a change ordered by the insured.

SECTION 9.02. Section 9.01 of this article, amending Section 21.57(c), Insurance Code, takes effect October 1, 1991.

ARTICLE 10. THIRD-PARTY ADMINISTRATORS

SECTION 10.01. Section 1(1), Article 21.07-6, Insurance Code, is amended to read as follows:

(1) "Administrator" means a person who collects premiums or contributions from or who adjusts or settles claims in connection with life, health, and accident benefits or annuities for residents of this state but does not include:

(A) an employer on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer;

(B) a union on behalf of its members;

(C) an insurance company or a group hospital service corporation subject to Chapter 20 of this code with respect to a policy lawfully issued and delivered by it in and under the law of a state in which the insurer was authorized to do an insurance business;

(D) a health maintenance organization that is authorized to operate in this state under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), with respect to any activity that is specifically regulated under that Act;

(E) an agent licensed under Article 21.07 or Chapter 213, Acts of the 54th Legislature, Regular Session, 1955 (Article 21.07–1, Vernon's Texas Insurance Code), who is acting under appointment on behalf of an insurance company authorized to do business in this state and within the customary scope and duties of the insurance agent's authority as an agent and who receives commissions as an agent;

(F) a creditor who is acting on behalf of its debtors with respect to insurance that covers a debt between the creditor and its debtor so long as only the functions of a group policyholder or creditor are performed;

(G) a trust established in conformity with 29 U.S.C. Section 186 and the trustees and employees who are acting under the trust;

(H) a trust that is exempt from taxation under Section 501(a) of the Internal Revenue Code of 1986 and the trustees and employees acting under the trust, or a custodian and the custodian's agents and employees who are acting pursuant to a custodian account that complies with Section 401(f), Internal Revenue Code of 1986;

(I) a bank, credit union, savings and loan association, or other financial institution that is subject to supervision or examination under federal or state law by federal or state regulatory authorities so long as that institution is performing only those functions for which it holds a license under federal or state law;

(J) a company that advances and collects a premium or charge from its credit card holders on their authorization, if the company does not adjust or settle claims and acts only in the company's debtor-creditor relationship with its credit card holders;

(K) a person who adjusts or settles claims in the normal course of his practice or employment as a licensed attorney and who does not collect any premium or charge in connection with life, health, or accident benefits or annuities;

(L) an adjuster licensed by the commissioner, if the adjuster is engaged in the performance of his powers and duties as an adjuster within the scope of his license;

(M) a person who provides technical, advisory, utilization review, precertification, or consulting services to an insurer, plan, or plan sponsor and who does not make any management or discretionary decisions on behalf of an insurer, plan, or plan sponsor;

(N) an attorney in fact for a Lloyd's operating under Chapter 18 of this code or a reciprocal or interinsurance exchange operating under Chapter 19 of this code if acting in the capacity of attorney in fact under the applicable chapter;

(O) a municipality that is self-insured or a joint fund, risk management pool, or a self-insurance pool composed of political subdivisions of this state that participate in a fund or pool through interlocal agreements and any nonprofit administrative agency or governing body or any nonprofit entity that acts solely on behalf of a fund, pool, agency, or body or any other funds, pools, agencies, or bodies that are established pursuant to or for the purpose of implementing an interlocal governmental agreement;

(P) a self-insured political subdivision; [~~or~~]

(Q) a plan under which insurance benefits are provided exclusively by a carrier licensed to do business in this state and the administrator of the plan is either:

(i) a full-time employee of the plan's organizing or sponsoring association, trust, or other entity; or

(ii) the trustee or trustees of the organizing or sponsoring trust; *or*

(R) a parent of a wholly owned direct or indirect subsidiary insurer licensed to do business in this state or a wholly owned direct or indirect subsidiary insurer that is a part of the parent's holding company system that, only on behalf of itself or its affiliated insurers:

(i) collects premiums or contributions, if the parent or subsidiary insurer prepares only billing statements, places those statements in the United States mail, and causes all collected premiums to be deposited directly in a depository account of the particular affiliated insurer, and the services rendered by the parent or subsidiary are performed under an agreement regulated and ap-

proved under Article 21.49-1 of this code or a similar statute of the domiciliary state if the parent or subsidiary is a foreign insurer doing business in this state; or

(ii) furnishes proof-of-loss forms, reviews claims, determines the amount of the liability for those claims, and negotiates settlements, but pays claims only from the funds of the particular subsidiary by checks or drafts of that subsidiary and the services rendered by the parent or subsidiary are performed under an agreement regulated and approved under Article 21.49-1 of this code or a similar statute of the domiciliary state if the parent or subsidiary is a foreign insurer doing business in this state.

ARTICLE 11. STIPULATED PREMIUM COMPANIES

SECTION 11.01. Chapter 22, Insurance Code, is amended by adding Article 22.16 to read as follows:

Art. 22.16. APPLICABILITY OF TEXAS BUSINESS CORPORATION ACT. The Texas Business Corporation Act applies to and governs stipulated premium companies to the extent that that Act is not inconsistent with or contrary to this chapter or any other insurance law applicable to stipulated premium companies. A duty imposed by the Texas Business Corporation Act on the office of the secretary of state shall be performed by the department for the purposes of this chapter.

ARTICLE 12. MEDICARE SUPPLEMENT INSURANCE

SECTION 12.01. Section 1(a), Article 3.74, Insurance Code, is amended to read as follows:

(a) Scope of Article. Notwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs group and individual medicare supplement policies delivered or issued for delivery in this state and certificates issued under group medicare supplement policies that have been delivered or issued for delivery in this state if those policies or certificates are issued by capital stock companies, including but not limited to life, health and accident, and general casualty companies; mutual life insurance companies; mutual assessment life insurance companies, including but not limited to statewide mutual assessment corporations, local mutual aids, and burial associations; mutual and mutual assessment associations of all kinds and types, including but not limited to associations subject to Article 14.17 of this code; mutual insurance companies other than life; mutual or natural premium life or casualty insurance companies; fraternal benefit societies; Lloyds; reciprocal or inter-insurance exchanges; nonprofit hospital, medical, or dental service corporations, including but not limited to companies subject to Chapter 20 of this code; stipulated premium insurance companies; or any other insurer which by law is required to be licensed by the State Board of Insurance; and, *to the extent required by federal law,* health maintenance organizations subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code); provided, that this article shall not be construed to enlarge the powers of any of the enumerated companies.

SECTION 12.02. Section 1(b)(3), Article 3.74, Insurance Code, is amended to read as follows:

(3) "Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of a hospital service corporation subject to Chapter 20 of this code or, *to the extent required by federal law, an* evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, as amended (Chapter 20A, Vernon's Texas Insurance Code), which policy, subscriber contract, or *such* evidence of coverage is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare; provided that the State Board of Insurance may by rule modify the definition of medicare supplement policy to the extent necessary for the State of Texas to qualify as a state with an approved regulatory program under the provisions of Public Law 96-265,

Section 507(a), 94 Stat. 476 (42 U.S.C.A. Section 1395ss (1980)). Such term does not include:

(A) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations; [~~or~~]

(B) a policy or health care benefit plan including a policy or contract of group insurance or group contract of a hospital service corporation subject to Chapter 20 of this code or group evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), when such policy or plan is not marketed or held to be a medicare supplement policy or benefit plan*;* *or*

(C) an individual or group evidence of coverage issued pursuant to a contract under Section 1876 or Section 1833 of the Federal Social Security Act (42 U.S.C.A. Section 1395, et seq.) by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

SECTION 12.03. Sections 2(b) and (c), Article 3.74, Insurance Code, are amended to read as follows:

(b) Any insurer or other entity designated in Section 1(a) of this article that offers for sale in this state a medicare supplement insurance policy must offer a basic medicare supplement policy that *provides only those benefits common to all medicare supplement policies, and that meets, but does not exceed* [~~meets~~] the minimum standards of benefits for medicare supplement policies *authorized by 42 U.S.C. Section 1395ss and* adopted by the board. [~~Each such basic medicare supplement policy shall provide all or none of the Medicare Part A inpatient hospital deductible amount.~~] In addition to this basic medicare supplement insurance policy, any such insurer or other entity may offer for sale in this state [~~a maximum of two~~] additional medicare supplement policies. *The combination of benefits provided by the additional policies must conform to one of the benefit packages authorized by 42 U.S.C. Section 1395ss and adopted by the board. The board by rule shall provide for the approval of new or innovative benefits that may be provided in a policy other than the basic policy and that otherwise comply with this section. The new or innovative benefits shall be offered in a manner consistent with the goal of medicare supplement policy simplification and shall meet the requirements set forth in 42 U.S.C. Section 1395ss* [~~However, any entity established and operating under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), shall provide benefit coverage comparable to and no less favorable than the minimum standards of benefits adopted by the board and mandated by state and federal law~~].

(c) The State Board of Insurance shall issue reasonable rules to establish specific standards for provisions of medicare supplement policies and standards for facilitating comparison among the medicare supplement products of the insurer or entity offering such medicare supplement products. Such standards shall be in addition to and in accordance with applicable laws of this state, including but not limited to Subchapter G of Chapter 3, [~~and~~] Chapter 20 of this Code [~~and the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code)~~], and applicable federal law, rules, regulations, and standards and any model rules and regulations required by *42 U.S.C. Section 1395ss and other* federal law and may cover but shall not be limited to:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) probationary periods;

(5) benefit limitations, exceptions, and reductions;

(6) elimination periods;

(7) requirements for replacement;

(8) recurrent conditions;

(9) definitions of terms; and

(10) exclusions required by state or federal law.

SECTION 12.04. Section 3(b), Article 3.74, Insurance Code, is amended to read as follows:

(b) Minimum standards for *benefits and* claim payments shall include the requirements for certification of medicare supplement policies as provided by 42 U.S.C. Section 1395ss.

SECTION 12.05. Section 4, Article 3.74, Insurance Code, is amended to read as follows:

Sec. 4. LOSS RATIO STANDARDS. (a) Medicare supplement policies shall return to holders of a medicare supplement policy benefits which are reasonable in relation to the premium charged. The State Board of Insurance shall issue reasonable rules to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience[~~, or incurred health care expenses if coverage is provided by a health maintenance organization on a service rather than a reimbursement basis,~~] and earned premiums for the entire period for which rates are computed to provide coverage and in accordance with accepted actuarial principles and practices.

(b) Every entity providing medicare supplement policies *or benefits* in this state shall file annually its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state. *The supporting documentation must include a report of the ratio of incurred losses to covered premiums for the preceding calendar year, illustrated by calendar year of issue. The board may adopt rules relating to filing requirements for rates, rating schedules, and loss ratios.*

(c) All filings of rates, [~~and~~] rating schedules, *and loss ratios* must demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this section and rules adopted by the board.

(d) The State Board of Insurance *shall* [~~may~~] issue reasonable rules providing loss ratio standards applicable to rates charged for medicare supplement policies[~~. The rules adopted may be in accordance with any model rules and regulations adopted by the National Association of Insurance Commissioners~~] to the extent *necessary for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss* [~~determined by the board~~].

(e) Before the effective date of any medicare benefit changes required by federal law as applicable to existing policies, every insurer, health care service plan, or other entity providing medicare supplement insurance or contracts in this state[~~, except employers subject to the requirements of Section 421 of the Medicare Catastrophic Coverage Act of 1988,~~] shall file with the commissioner, in accordance with Article 3.42 of this code [~~or Section 9, Texas Health Maintenance Organization Act (Article 20A.09, Vernon's Texas Insurance Code)~~]:

(1) appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts, and such supporting documents as necessary to justify the adjustment shall accompany the filing; and

(2) appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefit duplications with medicare.

Those riders, endorsements, or policy forms shall provide a clear description of the medicare supplement benefits provided by the policy or contract.

(f) The board by rule shall provide a process for review and approval or disapproval of proposed premium increases with respect to medicare supplement policies or benefits. Any rules adopted by the board under this subsection must comply with 42 U.S.C. Section 1395ss and other federal law.

(g) The board shall comply with federal requirements relating to periodical reporting on loss ratio information to the Secretary of Health and Human Services, based on uniform methodology for reporting loss ratios, as authorized by federal law to the extent necessary for this state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

SECTION 12.06. Section 5, Article 3.74, Insurance Code, is amended by amending Subsections (a), (b), (d), and (e) and by adding Subsection (f) to read as follows:

(a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered or issued for delivery in this state unless an outline of coverage *complying with the requirements of this section* is delivered to the applicant at the time application is made.

(b) The State Board of Insurance *by rule* shall prescribe the format and content of the outline of coverage required by Subsection (a) of this section. For purposes of this section, "format" means style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. *The rules adopted by the board governing the* [~~Such~~] outline of coverage *must* [~~shall, at a minimum,~~] include *provisions at least equal to those required by rules, regulations, and standards adopted under 42 U.S.C. Section 1395ss or required by other federal law*[~~:~~

[~~(1) a description of the principal benefits and coverage provided in the medicare supplement policy;~~

[~~(2) a statement of the exceptions, reductions, and limitations contained in the medicare supplement policy;~~

[~~(3) a statement of the renewal provisions, including any reservation by the insurer, group hospital service corporation, or health maintenance organization of a right to change the premiums;~~

[~~(4) a statement that the outline of coverage is a summary of the medicare supplement policy issued or applied for and that the medicare supplement policy should be consulted to determine governing contractual provisions~~].

(d) The State Board of Insurance may promulgate reasonable rules for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds, subscribers, or enrollees that particular coverages are not medicare supplement coverages for all accident and sickness insurance policies or subscriber contracts or evidences of coverage sold to persons eligible for medicare, other than:

(1) medicare supplement policies;

(2) disability income policies;

(3) basic, catastrophic, or major medical expense policies;

(4) single premium nonrenewable policies; or

(5) other policies, contracts, *or* subscriber contracts[~~, or evidences of coverage~~] as specified in Paragraphs (A) *and*[~~,~~] (B)[~~, and (C)~~] of Subsection (b) of Section 1 of this article.

(e) The State Board of Insurance may further promulgate reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, *or* certificates[~~, or evidences of coverage~~] by persons eligible for medicare.

(f) Any rules adopted by the board under this section must include requirements that are at least equal to those required by rules, regulations, and standards adopted under 42 U.S.C. Section 1395ss or required by other federal law.

SECTION 12.07. Sections 6 and 8, Article 3.74, Insurance Code, are amended to read as follows:

Sec. 6. NOTICE OF FREE EXAMINATION. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of such policy or certificate or attached thereto stating in substance that the applicant shall have the right to return such policy or certificate within 30 days of its delivery and to have the premium refunded

if, after examination of such policy or certificate, the applicant is not satisfied for any reason. [~~However, the costs of benefits that are provided pursuant to a medicare supplement contract by an entity subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code) and that are provided not later than the 30th day after the date of issuance of the contract may be offset against any refund of premium mandated by this section.~~] A refund made pursuant to this section must be paid directly to the applicant in a timely manner by the entity issuing the policy or certificate.

Sec. 8. *WAIVER OF CERTAIN WAITING PERIODS ON* REPLACEMENT [~~OF MEDICARE SUPPLEMENT POLICIES~~]. *An* [~~(a) Except as specifically provided by this subsection, the State Board of Insurance shall issue reasonable rules to require that an entity designated in Section 1(a) of this article and that provides medicare supplement insurance or coverage to a resident of this state shall not provide compensation to its agents or other producers that is greater than the renewal compensation that would have been paid on an existing policy or coverage if that existing policy or coverage is replaced by another policy or coverage with the same entity and if the new policy benefits or coverage benefits are substantially similar to the benefits under the old policy or coverage and the old policy was issued by the same insurer, insurer group, or entity. For a policy replaced within the first policy year, an agent is entitled to receive the pro rata unpaid portion of commission attributable to that original policy year and a commission not greater than renewable compensation thereafter.~~

[~~(b) If an~~] insurer or other entity *that* delivers or issues for delivery a medicare supplement policy *or certificate in this state* that replaces an existing medicare supplement policy *or certificate* [~~within the 24-month period following the date that the existing policy is issued, the succeeding insurer or other entity~~] shall give credit for the satisfaction or partial satisfaction of any waiting periods, *elimination periods, and probationary periods that are applicable to preexisting conditions and that have* already *been* satisfied *under the policy being replaced.* Any new or additional benefits that are *clearly set forth* [~~included~~] in the *replacement* [~~succeeding insurer's~~] policy may include appropriate *clearly stated time* [~~waiting~~] periods as a condition of payment for such new or additional benefits.

SECTION 12.08. Article 3.74, Insurance Code, is amended by adding Section 9B to read as follows:

Sec. 9B. PERMITTED COMPENSATION ARRANGEMENTS. The board shall adopt rules limiting the commission or other compensation that may be paid to an agent for the sale of a medicare supplement policy or certificate, including replacement policies or certificates. Rules adopted by the board under this section must conform to, but may not be more restrictive than, the requirements of federal law that must be met for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss.

SECTION 12.09. Section 10, Article 3.74, Insurance Code, is amended to read as follows:

Sec. 10. RULES. In addition to other rules required or authorized by this article, the State Board of Insurance *shall* [~~may~~] adopt rules in accordance with federal law *applicable to the regulation of medicare supplement insurance coverage that are necessary for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. Section 1395ss* [~~regulating medicare supplement policies~~] and any other reasonable rules that are necessary and proper to carry out this article.

SECTION 12.10. This article takes effect October 1, 1991. Article 3.74, Insurance Code, as amended by this article, applies only to medicare supplement policies and certificates delivered or issued for delivery on and after March 1, 1992. Policies and certificates delivered or issued for delivery before March 1, 1992, or renewed before, on, or after March 1, 1992, are governed by the law as it existed immediately before October 1, 1991, and that law is continued in effect for that purpose.

ARTICLE 13. LONG-TERM CARE INSURANCE

SECTION 13.01. Chapter 3, Insurance Code, is amended by adding Article 3.70-12 to read as follows:

Art. 3.70-12. MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE POLICIES

Sec. 1. SCOPE. (a) Notwithstanding Section 2(b)(5) of Article 1.14-1 of this code, this article applies to and governs individual and group long-term care insurance policies delivered or issued for delivery in this state and certificates issued under group long-term care insurance policies that have been delivered or issued for delivery in this state, if those policies or certificates are issued by:

(1) capital stock companies, including but not limited to life, health and accident, and general casualty companies;

(2) mutual life insurance companies;

(3) mutual assessment life insurance companies, including statewide mutual assessment corporations, local mutual aids, and burial associations;

(4) mutual and mutual assessment associations of all kinds and types, including associations subject to Article 14.17 of this code;

(5) mutual insurance companies other than life companies;

(6) mutual or natural premium life or casualty insurance companies;

(7) fraternal benefit societies;

(8) Lloyd's plan insurers;

(9) reciprocal or inter-insurance exchanges;

(10) nonprofit hospital, medical or dental service corporations, including companies subject to Chapter 20 of this code;

(11) stipulated premium insurance companies; or

(12) any other insurer which by law is required to be licensed by the Texas Department of Insurance.

(b) This article shall apply to evidences of coverage delivered or issued for delivery for long-term care in this state by health maintenance organizations under the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code).

(c) This article may not be construed to enlarge the powers of any of the enumerated companies.

(d) This article does not apply to certificates that are delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state.

(e) This article does not apply to a policy that is not advertised, marketed, or offered as long-term care insurance or nursing home insurance.

Sec. 2. DEFINITIONS. In this article:

(1) "Applicant" means:

(A) in the case of an individual long-term care insurance policy, the person who seeks to contract for insurance or other health benefits; and

(B) in the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long-term insurance policy, which certificate has been delivered or issued for delivery in this state, regardless of the place where the policy was delivered or issued for delivery.

(3) "Group long-term care insurance" means any long-term care insurance policy or certificate of group long-term care insurance which is delivered or issued for delivery in this state and issued to an eligible group as defined by Section 1(a), Article 3.51-6 of this code.

(4) "Long-term care insurance policy" means any insurance policy, group certificate, or rider to such policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Chapter 20A, Vernon's Texas Insurance Code), which policy, certificate, rider or evidence of coverage is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term also includes a policy or rider, other than a group or individual annuity or life insurance policy, that provides for payment of benefits based on cognitive impairment or the loss of functional capacity. The term "long-term care insurance" shall not include any insurance policy or group certificate which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, or basic or single health care services.

Sec. 3. MINIMUM STANDARDS FOR LONG-TERM CARE INSURANCE. (a) The State Board of Insurance by rule shall establish specific standards for provisions of long-term care insurance policies and standards for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of long-term care insurance policies. Those standards are in addition to and in accordance with applicable laws of this state, including Subchapter G of Chapter 3 of this code, applicable federal law, and any rules, regulations, and standards required by federal law. The standards shall cover the following:

(1) terms of renewability;

(2) initial and subsequent conditions of eligibility;

(3) nonduplication of coverage;

(4) coverage of dependents;

(5) preexisting conditions;

(6) termination of insurance;

(7) continuation or conversion;

(8) probationary periods;

(9) benefit limitations, exceptions, and reductions;

(10) elimination periods;

(11) requirements for replacement;

(12) recurrent conditions;

(13) definitions of terms; and

(14) inflation protection.

(b) Any rules issued by the State Board of Insurance under this section shall include requirements no less favorable than the minimum standards of benefits for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and mandated by federal law.

(c) In addition to other provisions of this section, a long-term care insurance policy or certificate subject to this article may not contain a provision which denies a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. A policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. The State Board of Insurance by rule may provide for additional reasonable regulation of preexisting conditions consistent with this section. That authority

includes the authority to extend the limitations periods set forth in this section as to specific age group categories in specific policy forms, based on the board's first finding that such an extension is in the best interest of the public.

Sec. 4. LOSS RATIO STANDARDS. (a) Long-term care insurance policies shall return to holders of the policies benefits that are reasonable in relation to the premium charged. The State Board of Insurance shall adopt reasonable rules to establish minimum standards for loss ratios of long-term care insurance policies on the basis of incurred claims experience, earned premiums, the period for which rates are computed to provide coverage, experienced and projected trends, concentration of experience within early policy duration, expected claim fluctuation, experience refunds, adjustments, dividends, renewability features, all relevant expense factors, interest, policy reserves, mix of business by risk classification, and product features otherwise affecting claims experience.

(b) Each entity providing long-term care insurance in this state annually shall file its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state, as well as any other filing requirements relating to loss ratios promulgated under rules adopted by the State Board of Insurance.

(c) The State Board of Insurance shall adopt reasonable rules providing loss ratio standards applicable to rates charged for long-term care insurance policies. The rules adopted shall be no less favorable to the holders of those policies than any model laws, rules, and regulations adopted in connection with minimum standards for benefits for long-term care insurance.

Sec. 5. NOTICE OF FREE EXAMINATION. Each long-term care insurance policy or certificate must have a notice prominently printed on the first page of or attached to the policy or certificate stating in substance that the applicant has the right to return the policy or certificate within 30 days of the date of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. The entity issuing the policy or certificate shall pay in a timely manner a refund made under this section directly to the person or entity that remitted the premium.

Sec. 6. CONSTRUCTION WITH OTHER LAWS. This article is cumulative of all other law, but in the event of any conflict between a provision of this article and any other provisions of this code, the provision of this article controls to the extent of the conflict. If any provision of this article or the application of any provision of this article to any person or circumstance is for any reason held to be invalid, the remainder of this article and the application of that provision to other persons or circumstances shall not be affected by the invalidity.

Sec. 7. RULES. In addition to other rules required or authorized by this article, the State Board of Insurance may adopt reasonable rules that are necessary and proper to carry out this article. Any rules so adopted shall include requirements no less favorable than minimum standards for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and in accordance with all applicable federal law.

SECTION 13.02. This article takes effect October 1, 1991. The provisions of this article apply only to long-term care insurance policies and certificates delivered or issued for delivery on and after March 1, 1992. Policies and certificates delivered or issued for delivery before March 1, 1992, or renewed before, on, or after March 1, 1992, are governed by the law that existed at the time the policy was delivered, issued for delivery, or renewed, respectively, and that law is continued in effect for that purpose.

ARTICLE 14. SUBORDINATED INDEBTEDNESS

SECTION 14.01. Chapter 1, Insurance Code, is amended by adding Article 1.39 to read as follows:

Art. 1.39. SUBORDINATED INDEBTEDNESS. (a) This article applies to an insurer as that term is defined by Article 1.15A of this code.

(b) An insurer may obtain a loan or an advance with interest and may assume a subordinated liability for repayment and payment of interest if the insurer and creditor execute a written agreement stating that the creditor may be paid only out of the portion of the insurer's surplus that exceeds a minimum surplus stated in the agreement.

(c) Before an insurer may assume a subordinated liability under Subsection (a) of this article, the agreement must be approved by the commissioner.

(d) An insurer may not repay principal or pay interest on a subordinate liability assumed under this article unless the repayment or payment is approved by the commissioner. The commissioner may approve the repayment or payment only if satisfied that the repayment or payment is appropriate, considering the financial condition of the insurer. The commissioner may not deny approval of the repayment or payment if the insurer submits evidence, satisfactory to the commissioner, that the insurer has at least the minimum surplus stated in the agreement.

(e) A loan or advance made under this article, and any interest accruing on the loan or advance, is not a legal or financial liability of the insurer until the commissioner authorizes repayment or payment under Subsection (d) of this article. Until the commissioner authorizes the repayment or payment, all financial statements published by the insurer or filed with the commissioner must show as a liability that portion of the insurer's surplus that exceeds the minimum surplus as defined in the subordinated agreement to the extent of the unpaid balance thereon, and must show the amount of that minimum surplus as a special surplus account.

SECTION 14.02. Article 1.39, Insurance Code, as added by this article, applies only to a subordinated indebtedness created on or after the effective date of this Act.

ARTICLE 15. MOTOR VEHICLE SAFETY-RESPONSIBILITY

SECTION 15.01. Section 1B, Texas Motor Vehicle Safety-Responsibility Act (Article 6701h, Vernon's Texas Civil Statutes), as amended by Section 10.04, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Sec. 1B. FURNISHING EVIDENCE OF FINANCIAL RESPONSIBILITY. (a) *As a condition of operating a motor vehicle in this state, the operator of the motor vehicle shall furnish, on request of a peace officer or a person involved in an accident with the operator:*

(1) a liability insurance policy in at least the minimum amounts required by this Act, or a photocopy of that policy, that covers the vehicle;

(2) a standard proof of liability insurance form promulgated by the Texas Department of Insurance and issued by a liability insurer that:

(A) includes the name of the insurer;

(B) includes the insurance policy number;

(C) includes the policy period;

(D) includes the name and address of each insured;

(E) includes the policy limits or a statement that the coverage of the policy complies with at least the minimum amounts of liability insurance required by this Act; and

(F) includes the make and model of each covered vehicle;

(3) an insurance binder that confirms that the operator is in compliance with this Act;

(4) a certificate or copy of a certificate issued by the department that shows the vehicle is covered by self-insurance;

(5) a certificate issued by the state treasurer that shows that the owner of the vehicle has on deposit with the treasurer money or securities in at least the amount required by Section 25 of this Act;

(6) a certificate issued by the department that shows that the vehicle is a vehicle for which a bond is on file with the department as provided by Section 24 of this Act; or

(7) a copy of a certificate issued by the county judge of a county in which the vehicle is registered that shows that the owner of the vehicle has on deposit with the county judge cash or a cashier's check in at least the amount required by Section 1A(b)(6) of this Act. [~~On and after January 1, 1982, every owner and/or operator in the State of Texas shall be required, as a condition of driving, to furnish, upon request, evidence of financial responsibility to a law enforcement officer of the State of Texas or any subdivision thereof, or agent of the Department, or to another person involved in an accident.~~]

(b) *An operator of a motor vehicle who fails or refuses to furnish, on request of a peace officer or a person involved in an accident with the operator, one of the documents listed in Subsection (a) of this section is presumed to have operated the vehicle in violation of Section 1A of this Act.* [~~The following evidence of financial responsibility satisfies the requirement of Subsection (a) of this section:~~

[~~(1) a liability insurance policy in at least the minimum amounts required by this Act or a photocopy of that policy;~~

[~~(2) a standard proof of liability insurance form promulgated by the Texas Department of Insurance and issued by a liability insurer that includes:~~

[~~(A) the name of the insurer;~~

[~~(B) the insurance policy number;~~

[~~(C) the policy period;~~

[~~(D) the name and address of each insured;~~

[~~(E) the policy limits or a statement that the coverage of the policy complies with at least the minimum amounts of liability insurance required by this Act; and~~

[~~(F) the make and model of each covered vehicle;~~

[~~(3) an insurance binder that confirms to the satisfaction of a law enforcement officer or an agent of the Department that the owner and/or operator is in compliance with this Act; or~~

[~~(4) a copy of a certificate issued by the Department showing that the vehicle is covered by self-insurance;~~

[~~(5) a certificate or copy of a certificate issued by the state treasurer that shows that the owner of the vehicle has on deposit with the treasurer money or securities in at least the amount required by Section 25 of this Act;~~

[~~(6) a certificate or copy of a certificate issued by the Department that shows that the vehicle is a vehicle for which a bond is on file with the Department as provided by Section 24 of this Act; or~~

[~~(7) a copy of a certificate issued by the county judge of a county in which the vehicle is registered that shows that the owner of the vehicle has on deposit with the county judge cash or a cashier's check in at least the amount required by Section 1A(b)(6) of this Act.~~]

(c) In this section, "peace officer" has the meaning assigned by Article 2.12, Code of Criminal Procedure.

SECTION 15.02. Section 1F(a), Texas Motor Vehicle Safety-Responsibility Act (Article 6701h, Vernon's Texas Civil Statutes), as amended by Section 10.09, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(a) *The department shall suspend the* [~~A second or subsequent conviction of an offense under Section 1C(a)(1) of this Act shall also carry a suspension of~~] driver's license and motor vehicle registration *of a person convicted of an offense under Section 1C(a) of this Act, if a prior conviction of the person under Section 1C(a) of this Act has been previously reported to the department by a magistrate or the judge or clerk of a court,* unless the *person* [~~defendant~~] establishes and maintains proof of financial responsibility for two years from the date of *the second or subsequent* conviction. The requirement for

filing proof of financial responsibility may be waived if satisfactory evidence is filed with the Department that the party convicted was at the time of arrest covered by a policy of liability insurance or was otherwise exempt as provided in Sec. 1A(b) of this Act.

SECTION 15.03. Chapter 88, General Laws, Acts of the 41st Legislature, 2nd Called Session, 1929 (Article 6675a–1 et seq., Vernon's Texas Civil Statutes), is amended by adding Section 2b to read as follows:

Sec. 2b. (a) The first time a person applies for registration of a vehicle, the person may demonstrate compliance with Section 2a(a) of this Act as to that vehicle by showing proof of financial responsibility under any of the methods set forth in Section 2a(d) of this Act as to any vehicle the person owns, or as to a vehicle, if any, used as part of the consideration for the purchase of the vehicle for which the person seeks registration.

(b) For purposes of Section 2a(a) of this Act, the term "owner" includes a person who represents the owner for purposes of obtaining registration to a vehicle.

SECTION 15.04. This article takes effect October 1, 1991.

ARTICLE 16. EXEMPTION FROM PROHIBITED REPRESENTATION REQUIREMENTS

SECTION 16.01. Article 1.06C, Insurance Code, as added by Section 1.05, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended by adding Subsection (e) to read as follows:

(e) This section does not apply to an employee of the Texas Department of Insurance whose employment is terminated based on the elimination of the employee's position of employment that is a direct result of a reduction in the agency's workforce.

ARTICLE 17. DISCRIMINATION IN RATES OR RENEWAL

SECTION 17.01. Article 21.21–5, Insurance Code, as added by Section 11.30, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

Art. 21.21–5. DISCRIMINATION IN RATES OR RENEWAL. (a) *This article applies to any insurer authorized to do business as an insurance company or to provide insurance in this state, including:*

(1) a capital stock company;

(2) a mutual company;

(3) a title insurance company;

(4) a fraternal benefit society;

(5) a local mutual aid association;

(6) a statewide mutual assessment company;

(7) a county mutual insurance company;

(8) a Lloyd's plan company;

(9) a reciprocal or interinsurance exchange;

(10) a stipulated premium insurance company;

(11) a group hospital service company;

(12) a health maintenance organization;

(13) a farm mutual insurance company;

(14) a risk retention group; and

(15) a surplus lines carrier.

[~~The department shall conduct an ongoing study of discrimination on the basis of race, color, disability, geographical location, religion, sex, national origin, or age in the setting or use of rates or rating manuals and in the nonrenewal of policies.~~]

(b) *An insurer may not discriminate* [~~The board may, on the basis of the department study, adopt rules to end discrimination~~] on the basis of race, color, religion, [~~geographical location,~~] or national origin, and, to the extent not justified by sound actuarial principles, on the basis of *geographical location,* disability, sex, or age, in the setting or use of rates or rating manuals and in the nonrenewal of policies.

SECTION 17.02. This article takes effect October 1, 1991.

ARTICLE 18. WORKERS' COMPENSATION

SECTION 18.01. Article 5.55, Insurance Code, is amended to read as follows:

Art. 5.55. WORKERS' COMPENSATION RATES

Sec. 1. DEFINITIONS. In this article:

(1) "Filer" means an insurer that files rates, prospective loss costs, or supplementary rating information under this article.

(2) "Insurer" means a person authorized and admitted by the Texas Department of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance. The term includes the Texas Workers' Compensation Insurance Fund.

(3) "Prospective loss cost" means that portion of a rate that does not include provisions for expenses or profit, other than loss adjustment expenses, and that is based on historical aggregate losses and loss adjustment expenses projected by development to their ultimate value and through trending to a future point in time.

(4) "Rate" means the cost of workers' compensation insurance per exposure unit, whether expressed as a single number or as a prospective loss cost, with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, before any application of individual risk variations based on loss or expense considerations. The term does not include a minimum premium.

(5) "Rate change date" means the later of March 1, 1992, or the 60th day after the date of issuance of the first insurance policy by the Texas Workers' Compensation Insurance Fund under Article 5.76-3 of this code. The department shall publish notice of the rate change date in the Texas Register.

(6) "Supplementary rating information" means any manual, rating schedule, plan of rules, rating rules, classification systems, territory codes and descriptions, rating plans, and other similar information required to determine the applicable premium for an insured. The term includes factors and relativities, such as increased limits factors, classification relativities, deductible relativities, or other similar factors.

(7) "Supporting information" means:

(A) the experience and judgment of the filer and the experience or information of other insurers;

(B) the interpretation of any other information relied on by the filer;

(C) descriptions of methods used in making the rates; and

(D) any other information required by the department to be filed.

Sec. 2. RATE STANDARDS. (a) Rates under this article shall be made in accordance with the provisions of this section.

(b) In setting rates, an insurer shall consider:

(1) past and prospective loss cost experience;

(2) operation expenses;

(3) investment income;

(4) a reasonable margin for profit and contingencies; and

(5) any other relevant factors.

(c) The insurer may group risks by classifications for the establishment of rates and minimum premiums and may modify classification rates to produce rates for individual risks in accordance with rating plans that establish standards for measuring variations in those risks on the basis of any factor listed in Subsection (b) of this section.

(d) Rates may not be excessive, inadequate, or unfairly discriminatory.

(e) In setting rates applicable solely to policyholders in this state, an insurer shall use available premium, loss, claim, and exposure information from this state to the full extent of the actuarial credibility of that information. The insurer may use experience from outside this state as necessary to supplement information from this state that is not actuarially credible.

(f) Premium rates promulgated by the State Board of Insurance for 1991 continue to apply to all workers' compensation insurance policies issued before the rate change date.

(g) For policies written on or after the rate change date, each insurer's rating plan shall provide that premium rates for policies with an estimated premium less than $100,000 may not be more than 15 percent greater than the premium rates promulgated by the State Board of Insurance for 1991. This subsection expires July 1, 1993.

(h) For policies written on or after July 1, 1993, each insurer's rating plan shall provide that premium rates for policies with an estimated premium less than $100,000 may not be more than 30 percent greater than the premium rates for 1991. This subsection expires January 1, 1994.

Sec. 3. RATE FILINGS. (a) Each insurer shall file with the Texas Department of Insurance all rates, supplementary rating information, and reasonable and pertinent supporting information for risks written in this state. An insurer may not make such filing more frequently than every six months. Subject to Subsection (b) of this section, a rate proposed in a filing made under this subsection does not take effect until all necessary information required for the filing is received by the department.

(b) A filer shall designate the date on which the filing is to take effect. The filing takes effect on the designated date unless the board, not later than the 30th day after the date of the receipt of the filing, advises the filer of what specific information that is required for the filing has not been included in the filing. The filer must provide the missing information not later than the 30th day after the date on which the filer is notified by the board of the missing information. If the filer in good faith believes that the requested information has already been provided, the filer may request a hearing. The board shall hold the hearing not later than the 30th day after the receipt of the hearing request from the filer. The board shall issue a decision not later than the 30th day after the date of the hearing. If the board determines that necessary information is still missing, the board shall specify in the decision the information that was not included in the filing.

(c) An insured that is aggrieved with respect to any filing in effect or the office of public insurance counsel may make a written application to the board for a hearing on the filing. The application must specify the grounds on which the applicant bases the grievance. If the board finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds in the application are established, and that those grounds otherwise justify holding the hearing, the board shall hold a hearing not later than the 30th day after the date of receipt of the application. The board must give at least 10 days' written notice to the applicant and to each insurer that made the filing in question. The notice must specify which of the grounds in the application are in question and whether the hearing is limited to consideration of the specific application of the aggrieved insured or to the entire filing.

(d) If, after the hearing, the board finds that the filing does not meet the requirements of this article, the board shall issue an order specifying how the filing fails to meet the requirements of this article and stating the date on which, within a reasonable period of not less than 60 days after the order date, the filing is no longer in effect. The board order must specify whether the order applies only to the

applicant or to all insureds affected by the filing. The board shall send copies of the order to the applicant and to each affected insurer. An order issued under this subsection does not affect a contract or policy made or issued before the expiration of the period established in the order.

Sec. 4. PUBLIC INFORMATION. Each filing and any supporting information filed under this article is open to public inspection as of the date of the filing.

Sec. 5. DISAPPROVAL OF FILING. (a) The State Board of Insurance shall disapprove a rate filing if the board determines that the rate filing made under Section 3 of this article does not meet the standards established under this article.

(b) If the board disapproves a rate filing, the board shall issue an order specifying in what respects the rate filing fails to meet the requirements of this article. The filer is entitled to a hearing on written request made to the board not later than the 30th day after the effective date of the disapproval order.

Sec. 6. DISAPPROVAL OF RATE. (a) The State Board of Insurance may issue a disapproval order only after notice and hearing. The board must provide at least 10 days' written notice to the insurer that made the rate filing.

(b) The disapproval order must be issued not later than the 15th day after the close of a hearing and must specify how the rate fails to meet the requirements of this article. The disapproval order must state the date on which the further use of that rate is prohibited. A disapproval order does not affect a policy made or issued in accordance with this code before the expiration of the period established in the order.

Sec. 7. EFFECT OF DISAPPROVAL; PENALTY. (a) If a policy is issued and the board subsequently disapproves the rate or filing that governs the premium charged on the policy:

(1) the policyholder may continue the policy at the original rate;

(2) the policyholder may cancel the policy without penalty; or

(3) the policyholder and the insurer may agree to amend the policy to reflect the premium that would have been charged based on the insurer's most recently approved rate; the amendment may not take effect before the date on which further use of the rate is prohibited under the disapproval order.

(b) If the board determines, based on a pattern of charges for premiums, that an insurer is consistently overcharging or undercharging, the board may assess an administrative penalty. The penalty shall be assessed in accordance with Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes), and set by the board in an amount reasonable and necessary to deter the overcharging or undercharging of policyholders. [~~The Board shall make, establish and promulgate all classifications of hazards, rates of premiums and rating plans respectively applicable to each, contemplated and provided for by the Texas Workers' Compensation Act or by the "Longshoremen's and Harbor Workers' Compensation Act" as enacted by the Congress of the United States. The Board shall publish all rates and rating plans promulgated by it as affecting compensation insurance in this State, which shall be published fifteen (15) days before they become effective.~~]

SECTION 18.02. Subsections (a), (e), (f), (g), and (i), Article 5.58, Insurance Code, are amended to read as follows:

(a) Recording and Reporting of Loss Experience and Other Data. The Board shall *develop*[~~, after due consideration, promulgate~~] reasonable [~~rules and~~] statistical plans, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss experience and such other data as may be required, in order that the total loss and expense experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid in determining whether rates *meet the standards imposed under Section 2, Article 5.55 of this code. If the Board determines that any insurer's rates do not meet those standards, the Board may order the insurer to adjust its rates to meet those standards. A Board order under this article may be appealed under Article 1.04 of this code* [~~comply with the standards set forth in Article 5.60. In promulgating such~~

~~rules and plans, the Board shall have due regard for the rates approved by it, and in order that such rules and plans may be as uniform as is practicable, to the rules and to the form of the plans used in other states~~]. *The Board may not contract with or designate an insurer or advisory organization to gather or compile data for statistical plans; however, an insurer may provide to one or more advisory organizations the information provided by the insurer to the Board under this article.* [~~The Board may designate one or more agencies to gather and compile such experience.~~]

(e) Payments Excluded From Rates. In any statistical plan *developed* [~~promulgated~~] by the Board, direct expenditures by an insurer to influence public policy and any amounts paid by an insurer as damages in a suit against the insurer for malice or bad faith or as fines or penalties shall be reported separately, and the expenditures and payments shall not be considered as a loss or expense for [~~rate-making purposes under this subchapter or for~~] the calculation of any premium rate modifier or surcharge of an insured.

(f) Transmission of Statistical Reports. The statistical reports filed under Subsection (c) of this article shall be updated by each insurer and transmitted to the Board in accordance with the filing requirements of the Board's [~~promulgated~~] statistical plan. Each insurer writing at least one-half of one percent of the workers' compensation insurance in this state shall report its data in a compatible electronic format prescribed by the Board. The Board shall take necessary measures to ensure the accuracy of the data and the adequacy of the format for data reported in an electronic format.

(g) Reports of Aggregate Data. The Board [~~by rule~~] may permit the information required by Subsection (c) of this article to be reported in the aggregate for each risk for claims in which benefit payments are less than $5,000. The Board may [~~by rule~~] adjust the dollar threshold for aggregate reporting to account for inflationary changes.

(i) Consultation with Other States. In order to further uniform administration of rating laws, the Board and every insurer [~~and advisory organization~~] may exchange information and experience data with the National Association of Insurance Commissioners, insurance supervisory officials, insurers, and advisory organizations in other states and may consult and cooperate with them with respect to rate-making and the application of rating systems.

SECTION 18.03. Subsections (c), (f), and (g), Article 5.58A, Insurance Code, are amended to read as follows:

(c) The Board shall *develop confidential procedures for conducting computer audits to verify the information filed by insurers under this article. The Board shall verify the information as part of the Board's on-site financial examinations* [~~adopt procedures for the verification of the information filed by insurers under this article. The Board may be assisted by a licensed advisory organization and the Office of Public Insurance Counsel~~].

(f) The Board shall aggregate all of the information filed under this article[~~, to be used for rate-making purposes by the Board~~]. The Board shall provide the information on request to *any person, including an advisory organization, at a reasonable fee* [~~all parties to rate hearings free of charge~~].

(g) The Board shall promulgate [~~rules and~~] forms necessary to implement this article.

SECTION 18.04. Article 5.59, Insurance Code, is amended to read as follows:

Art. 5.59. MAY REQUIRE *SWORN* STATEMENTS. The Board may require sworn statements from any insurance company or *the Texas Workers' Compensation Insurance Fund* [~~association affected by this law~~] showing the *payroll* [~~pay roll~~] reported to it and incurred losses by classifications and such other information which in the judgment of the Board may be necessary *to carry out its duties* [~~in determining proper classifications, rates and forms~~]. The Board shall prescribe the necessary forms for such statements and reports, having due regard to the methods and forms in use in other states for similar purpose in order that uniformity of statistics may not be disturbed.

SECTION 18.05. Article 5.60, Insurance Code, is amended to read as follows:

Art. 5.60. RATING. (a) *For workers' compensation insurance, the* [~~The~~] Board shall determine hazards by classes and fix *classification relativities* [~~rates of premium~~] applicable to the payroll in each of *the* [~~such~~] classes as shall be adequate to the risks to which they apply. *The relativities:*

(1) shall be designed to encourage safety;

(2) may be territorially based; and

(3) may reflect differences in losses between employers of high and low wage earners within the same class [~~and consistent with the maintenance of solvency and the creation of adequate reserves and a reasonable surplus. Those rates shall be fair and reasonable and not confiscatory as to any class of insurance carriers authorized by law to write workers' compensation insurance in this State. To ensure the adequacy and reasonableness of rates, the Board shall take into consideration the premium, loss, claim, and payroll experience, past and prospective, within the State, and all other relevant factors, within and outside the State, gathered from a territory sufficiently broad to include the varying conditions of the industries in which the classifications are involved, and over a period sufficiently long to ensure that the rates determined shall be just, reasonable, adequate, and not excessive~~].

(b) [~~In making its rate determination under this subchapter, the Board shall consider the probable investment income to be earned by insurers writing workers' compensation insurance in this state.~~

[~~(c) Under Subsection (a) of this article, the Board shall establish for each hazard classification a manual rate, based on the average expected experience of risks in the classification and subject to the actuarial credibility of the class. In addition to any other modifications, the Board may adopt rules to modify the manual rate to provide for equity among employers of high and low wage earners.~~

[~~(d)~~] The Board shall adopt *a uniform experience* rating *plan. The rating plan shall* [~~plans designed to~~] encourage the prevention of accidents *and*[~~. The rating plans shall~~] consider the peculiar hazard and experience of individual risks, past and prospective, within and outside this state, and all other relevant factors.

(c) [~~(e)~~] This subchapter may not be construed to prohibit any stock company, mutual company, reciprocal or interinsurance exchange, *the Texas Workers' Compensation Insurance Fund,* or Lloyd's association from issuing participating policies; however, a dividend to policyholders under the Texas Workers' Compensation Act *(Article 8308–1.01 et seq., Vernon's Texas Civil Statutes)* [~~(S.B. No. 1, Acts of the 71st Legislature, 2nd Called Session, 1989)~~] may not take effect until approved by the Board. Such a dividend may not be approved until adequate reserves have been provided, those reserves to be computed on the same basis for all classes of companies operating under this subchapter.

(d) [~~(f)~~] The Board shall *revise the classification system and rating plans not later than March 1, 1993, and subsequently shall revise the system and plans at least once every five years* [~~conduct a study to determine the feasibility of establishing a system of rate deviations to account for differences in the hazard levels of different geographical regions of this state. The Board shall report the findings of the study to the 72nd Legislature not later than January 15, 1991.~~

[~~(g) The Board shall conduct a study to determine the feasibility, effectiveness, and efficiency of establishing a revised classification system. The Board shall report the findings of the study to the 72nd Legislature not later than January 15, 1991.~~

[~~(h) An insurer that desires to write workers' compensation insurance at a rate lower than the rate promulgated by the Board shall file a written application with the Board for permission to write workers' compensation insurance using a uniform percentage deviation by class for a lesser rate on a statewide basis. The deviated rate must be equal to at least 75 percent of the promulgated statewide rate. The application must specify the basis of the deviation and must be accompanied by the supporting information on which the applicant relies. An application filed under this subsection is considered approved by the Board unless the Board finds that the filing does not meet the requirements of this subchapter. The application is considered approved unless disapproved on or before the 60th day after the date it is received by the Board. On and after the date on which an~~

(5) is an officer, employee, or consultant of an association in the field of insurance; or

(6) is required to register as a lobbyist under Chapter 305, Government Code.

(d) Subsection (c) of this section does not prohibit a person who is only a consumer of insurance or insurance products from serving as a member of the governing committee.

(e) A person who is ineligible to serve on the governing committee under Subsection (c) of this section may not serve as a member of the governing committee for one year after the date on which the condition making the person ineligible ends [~~nine voting members will be appointed by the board as follows:~~

[~~(1) six voting members shall represent workers' compensation insurance companies, of which no more than two are servicing companies, initially appointed by the board as follows: two members for a two-year term; two members for a four-year term; and two members for a six-year term. At the expiration of the appointed terms, two members shall be appointed every two years by the board for six-year terms. No member shall serve more than one six-year term; and~~

[~~(2) three voting members shall include one representative of labor, one representative of business, and one representative of the public, initially appointed by the board as follows: the labor representative for a two-year term; the business representative for a four-year term; and the public representative for a six-year term. At the expiration of the initial terms of appointment, one representative shall be appointed every two years for a six-year term. No representative shall serve more than one six-year term~~].

(f) [~~(c)~~](1) The nonvoting, ex officio members shall be the representative of the Texas Workers' Compensation Commission and the public counsel *appointed under Article 1.35A of this code* [~~of the State Board of Insurance~~].

(2) The ex officio, nonvoting members shall not be considered in determining a quorum of the governing committee.

(g) [~~(3)~~] The duties and responsibilities of the members shall be provided in the bylaws, rules, and regulations of the facility adopted by the membership of the facility and approved by the board as provided by Section 2.04 of this article.

SECTION 18.09. Section 2.05, Article 5.76–2, Insurance Code, is amended by adding Subsections (c) through (*l*) to read as follows:

(c) The facility shall develop and implement a program to identify and investigate fraud and violations of this code relating to workers' compensation insurance by an applicant, policyholder, claimant, agent, or insurer. The facility shall contract with the commission to:

(1) compile and maintain data to detect practices or patterns of conduct that violate this code relating to workers' compensation insurance or the Texas Workers' Compensation Act (Article 8308–1.01 et seq., Vernon's Texas Civil Statutes); and

(2) conduct semiannual performance reviews of its servicing carriers.

(d) The facility shall refer all cases of suspected fraud and violations of this code relating to workers' compensation insurance to the commission to:

(1) perform investigations;

(2) conduct administrative violation proceedings; and

(3) assess and collect penalties and restitution.

(e) The facility may enter into interdepartmental funding agreements with local prosecutors for the prosecution of offenses against the facility.

(f) Restitution collected under Subsection (d) of this section shall be deposited in the rejected risk fund.

(g) Penalties collected under Subsection (d) of this section shall be deposited in the general revenue fund to the credit of the commission and shall be appropriated to the commission to offset the costs of this program.

(h) The governing committee, facility, and employees of the facility are not liable in a civil action for any action made in good faith in the execution of duties under this section, including the identification and referral of a person for investigation and prosecution for a possible administrative violation or criminal offense.

(i) The facility may not indemnify the servicing companies.

(j) Unless the attorney general provides prior approval for the facility to obtain outside counsel, the attorney general shall:

(1) represent the facility in actions to collect debts or assessments;

(2) review and advise the facility on contracts and approve contracts between the facility and servicing companies; and

(3) provide other legal assistance to the facility.

(k) Subsection (j) of this section does not prohibit the servicing companies from obtaining legal counsel in relation to claims handling.

(l) The facility shall pay the attorney general for the reasonable costs of providing legal assistance under Subsection (j) of this section.

SECTION 18.10. Section 2.07, Article 5.76–2, Insurance Code, is amended to read as follows:

Sec. 2.07. INVESTMENTS. *(a) Funds in the facility are outside the state treasury.*

(b) The facility shall invest its funds only in *investments authorized by law for the investment of state funds as provided in Chapter 404, Government Code. The governing committee shall develop an investment policy and submit the policy to the state treasurer for review and approval* [~~interest-bearing time deposits or certificates of deposit in any bank or banks doing business in the State of Texas which are members of the Federal Deposit Insurance Corporation, treasury bills, notes, or any other treasury obligations of the United States of America or in any other investments as may be proposed by the governing committee and approved by the board~~].

SECTION 18.11. Article 5.76–2, Insurance Code, is amended by adding Section 3.07 to read as follows:

Sec. 3.07. TRANSITION. The Texas Workers' Compensation Insurance Fund may write any risk before January 1, 1994, but is not required to accept all risks under Article 5.76–4 of this code until January 1, 1994.

SECTION 18.12. Section 4.02, Article 5.76–2, Insurance Code, is amended by adding Subsections (c), (d), and (e) to read as follows:

(c) The facility may permit a premium to be paid in installments as provided in rules adopted by the board. The facility shall charge interest at eight percent per year on premiums paid in installments.

(d) The facility may refuse to write insurance coverage on an applicant that is a credit risk if the applicant does not:

(1) pay the total estimated premium and other charges before the policy is issued; or

(2) provide security for payment of the total estimated premium and other charges before the policy is issued.

(e) The facility may not issue a policy to a debtor in possession unless the applicant pays the total estimated premium and other charges before the policy is issued.

SECTION 18.13. Section 4.04, Article 5.76–2, Insurance Code, is amended to read as follows:

Sec. 4.04. FACILITY DEFICITS. (a) *Not later than June 1 of each year, the facility shall report its operating results to the board on a calendar year premium and an accident year loss basis.*

(b) For claims with an accident date before January 1, 1992, the facility shall calculate at least annually its results for incurred losses, including incurred but not reported losses, by accident year. If there is a deficit or surplus from operations, the amount of the deficit or surplus shall be assessed or rebated to the insurance carriers

licensed in this state who were members of the facility during the calendar year. Each insurance carrier shall pay a proportion of the total assessment or receive a proportion of the total rebate based on its proportion of the total voluntary workers' compensation insurance writings during the calendar year. The board may provide by rule for the redistribution of all or part of an assessment that would otherwise be levied on an insurance carrier if the insurance carrier is unable to pay the full assessment because the carrier is in liquidation at the time of the assessment. The state fund is not liable for any deficits incurred on policies with an effective date before January 1, 1992.

(c) For claims with an accident date on or after January 1, 1992, the facility shall calculate at least annually its results for incurred losses, including incurred but not reported losses, by accident year. If there is a deficit or surplus from operations, the amount of the deficit or surplus shall be assessed or rebated to the insurance carriers licensed in this state who were members of the facility during the calendar year and to the state fund. Each insurance carrier and the state fund shall pay a proportion of the total assessment or receive a proportion of the total rebate based on its proportion of the total voluntary workers' compensation insurance writings during the calendar year. The board may provide by rule for the redistribution of all or part of an assessment that would otherwise be levied on an insurance carrier if the insurance carrier is unable to pay the full assessment because the carrier is in liquidation at the time of the assessment.

(d) For assessments or rebates made under Subsection (b) of this section, the board shall establish an appropriate pass-through allowance so that each retrospectively rated risk written during the calendar year shall pay a proportion of the assessment or receive a proportion of the rebate. The pass-through allowance shall be based on the premium paid by the retrospectively rated risk as a proportion of the total voluntary writings by the insurance carrier in the calendar year. A pass-through allowance may not be permitted under this subsection after January 1, 1994.

(e) For assessments or rebates made under Subsection (c) of this section, the board shall establish an appropriate pass-through allowance so that each retrospectively rated risk written during the calendar year shall pay a proportion of the assessment or receive a proportion of the rebate. The pass-through allowance shall be based on the premium paid by the retrospectively rated risk as a proportion of the total voluntary writings by the insurance carrier or the state fund in the calendar year.

(f) By rule, the board may authorize the deferment of the payment of an assessment made under Subsection (b) or (c) of this section. Deferments may only be allowed if the cash flow of the facility is adequate to meet all needs.

(g) A deferment of an assessment under Subsection (b) of this section does not earn interest.

(h) A deferment of an assessment under Subsection (c) of this section shall earn interest payable to the facility at a rate annually determined by the board based on the auction rate quoted on a discount basis for the 52-week treasury bills issued by the United States government, as published by the Federal Reserve Board on the date nearest to the date on which the interest rate is determined [~~The facility shall annually report its operating results to the board. In the event there is a deficit from operations, the amount of such deficit shall be assessed on the members based on the proportion to the amount that a member company's voluntary workers' compensation insurance writings bear to the total voluntary workers' compensation insurance writings in this state for the preceding calendar year.~~

[~~(b) The board may by rule provide for a maximum annual assessment for the facility deficit assessed against a member company under Subsection (a) of this section and may provide that the payment of any portion of the assessment not met because of such maximum is deferred from year to year.~~

[~~(c) The rules shall require consideration of the financial stability of the fund and the member company when setting a maximum and allowing deferments under Subsection (b) of this section~~].

(i) [~~(d)~~] A designated insurer may not cede more than 50 percent of its total writings of premium from risks eligible for a small premium policy. One-half of that portion of written premiums from risks eligible for small premium policies which is not ceded to the reinsurance account shall be removed from a member company's voluntary writings when calculating the assessment ratio of that member company as set out in *Subsections (b) and (c)* [~~Subsection (a)~~] of this section.

(j) A member of the facility or the state fund shall receive a credit against the amount of its voluntary market writings if the insurer provides coverage for at least two years to a rejected risk that was most recently insured through the employers' rejected risk fund.

(k) In order to receive the credit under Subsection (j) of this section, each insurer shall file its current underwriting guidelines by classification with the board no later than April 1 of each year.

(l) A credit authorized under Subsection (j) of this section shall be calculated as follows:

(1) 100 percent of the premium received from the rejected risk may be deducted from the insurer's voluntary market writings for the first calendar year in which the insurer provides coverage to the rejected risk; and

(2) 80 percent of the premium received from the rejected risk may be deducted from the insurer's voluntary market writings for the second calendar year the insurer provides coverage to the rejected risk.

(m) An insurer may not receive a credit for any risk rejected by that insurer within the preceding 12 months.

(n) A policy written under Subsection (j) of this section may be written at a rate not greater than rates applicable to the risk in the facility if the insurer writes the risk for a second year at rates applicable to the risk in the voluntary market.

(o) A credit calculated under Subsection (l) of this section shall be applied to the assessment for the calendar year in which the policy is written. The credit shall be granted to the insurer only if coverage is provided for the complete year without cancellation. An insurer that fails to provide coverage for at least two years shall pay the facility the difference between the assessment calculated without the credit and the assessment calculated with the credit for each year that a credit has been granted.

(p) [~~(e)~~] Commencing January 1, 1992, *if a* [~~every~~] member insurer *or the state fund* [~~which~~] elects to defer any portion of an assessed deficit as provided herein, [~~must show~~] the entire unpaid, assessed portion thereof *and accrued interest, if any, must be shown* as a liability on all of its financial and annual statements.

SECTION 18.14. Section 4.05, Article 5.76–2, Insurance Code, is amended to read as follows:

Sec. 4.05. FUND RATES. (a) The board, in addition to the provisions prescribed by Subchapter D, Chapter 5, Insurance Code, is authorized and directed to determine, fix, prescribe, promulgate, change, or amend endorsements, rates, rating plans, or minimum premiums normally applicable to a risk so as to apply to any and every rejected risk assigned by the facility such endorsements, rates, rating plans, and minimum premiums as are commensurate with the greater hazard of the rejected risk, considering in connection therewith the experience and physical, financial, and other conditions of such risk.

(b) *Not later than the 30th day after the effective date of this subsection and annually thereafter, the governing committee shall engage the services of an independent actuary who is a member in good standing with the Casualty Actuarial Society or the American Academy of Actuaries to estimate the deficit for the next accident year. The governing committee shall adopt rating plans to reduce the facility deficit. The rating plans must be predicated on individual risk characteristics, including but not limited to the use of tabular surcharges. The governing committee shall submit*

the rating plans to the board for review and approval not later than November 30 of each year. The facility may not write a policy below manual rates set by the board.

(c) In developing and implementing a rating plan under Subsection (b) of this section, the board shall consider as an extraordinary risk an employer whose actual incurred losses exceed the employer's expected losses in two of the three most recent policy years for which information is available and shall give due consideration to an appropriate allowance for the greater risk. In this subsection:

(1) "actual incurred losses" are those shown in column 5 of the employer's experience rating form as prepared by the board according to the Texas Experience Rating Plan for Workers' Compensation Insurance; and

(2) "expected losses" are those shown in column 11 of the employer's experience rating form as prepared by the board according to the Texas Experience Rating Plan for Workers' Compensation Insurance.

(d) The facility shall create a procedure to review, on request of an employer, the application of the rating plan to an employer identified as an extraordinary risk under Subsection (c) of this section. The facility may exclude the employer from the extraordinary risk provisions of the rating plan if:

(1) the facility determines that the employer's actual incurred losses exceeded expected losses due to injuries resulting from acts of God or actions of third parties unrelated to the workplace; or

(2) the employer has:

(A) had a material change in ownership of the employer's business;

(B) had a substantial change in the type of business enterprise in which the employer is engaged;

(C) implemented a safety and accident prevention program approved by the health and safety division; or

(D) had excess losses resulting from a single incident involving multiple claims.

(e) In promulgating a rate or rates for rejected risks assigned by the facility, the board shall give due consideration to an appropriate allowance for the greater hazard of the risks' losses, claims expense, audit expenses, premium taxes, maintenance taxes, general administration expense, agent's commissions, other acquisition expense, inspection expense, an allowance for profit or contingencies, and any other relevant facts in connection with insuring and servicing such rejected risks.

(f) Not later than January 1, 1992, the board shall develop and publish classification relativities specifically designed for the risks insured through the facility and designed so that no payroll classification is expected to have a combined loss ratio of greater than 1.0.

(g) [~~(c)~~] The board shall establish a surcharge program for risks insured by the *employers' rejected risk* fund for the purposes of encouraging safety and funding any deficit caused by excessive losses. The surcharge program shall include provisions that if an individual insured's actual losses are equal to or less than the insured's modified expected losses, as determined under the Texas workers' compensation experience rating plan, then there is to be no surcharge. The maximum surcharge shall be 100 percent of standard premiums and shall be related to the difference between each insured's actual losses and its modified expected losses.

(h) [~~(d)~~] The board shall promulgate a special form of all states endorsement, in keeping with the purposes of this article, which may be used in connection with any risk insured by the *employers' rejected risk* fund, and shall establish premiums for the use of such endorsement.

[~~(e) The board may establish a separate rating plan for those employers who apply for workers' compensation insurance in the facility and are either certified self-insurers or members of a certified self-insurer group.~~]

SECTION 18.15. Section 4.06, Article 5.76–2, Insurance Code, is amended to read as follows:

Sec. 4.06. INJURY PREVENTION REQUIREMENTS. (a) The facility or any of its *servicing companies* [~~members~~] may make and enforce [~~reasonable~~] rules for the prevention of injuries to employees of its policyholders or applicants for insurance under this article. For this purpose, representatives of the facility, any of its members, *representatives of the commission,* or representatives of the board *on reasonable notice* shall be granted free access to the premises of each such policyholder or applicant during regular working hours.

(b) Failure or refusal by any such policyholder or applicant to comply with any [~~reasonable~~] rule prescribed by the facility for the prevention of injuries or failure or refusal to make full disclosure of all information pertinent to the insuring or servicing of the policyholder or applicant shall be sufficient grounds for the facility to cancel a policy or deny an application for insurance.

(c) The health and safety division shall develop a program targeting a policyholder in the facility under the employers' rejected risk fund.

(d) A policyholder in the facility who is insured under the rejected risk fund shall obtain a safety consultation if the employer:

(1) has an experience modifier greater than 1.25;

(2) does not have an experience modifier but has had a loss ratio greater than 0.70 in at least two of the three most recent policy years for which information is available; or

(3) has not been in business three years and meets criteria established by the commission, which may include the number and classification of employees, the policyholder's industry, and previous workers' compensation experience in this state or another jurisdiction.

(e) The employer shall obtain the safety consultation not later than the 30th day after the effective date of the policy and shall obtain the consultation from the health and safety division of the commission, the policyholder's servicing company, or another professional source approved for that purpose by the health and safety division of the commission. The safety consultant shall file a written report with the commission and the policyholder that sets out any hazardous conditions or practices identified by the safety consultation.

(f) The policyholder and the consultant shall develop a specific accident prevention plan that addresses the hazards identified by the consultant. The policyholder shall comply with the accident prevention plan.

(g) The health and safety division may investigate accidents occurring at the work sites of a policyholder for whom a plan has been developed under Subsection (f) of this section, and the division otherwise may monitor the implementation of the accident prevention plan as it finds necessary.

(h) In accordance with rules adopted by the commission, not earlier than 90 days or later than six months after the development of an accident prevention plan under Subsection (f) of this section, the health and safety division shall conduct a follow-up inspection of the policyholder's premises. The commission may require the participation of the safety consultant who performed the initial consultation and developed the safety plan. If the division determines that the policyholder has complied with the terms of the accident prevention plan or has implemented other acceptable corrective measures, the division shall so certify. If a policyholder fails or refuses to implement the accident prevention plan or other suitable hazard abatement measures, the policyholder may elect to cancel coverage not later than the 30th day after the date of the division determination. If the policyholder does not elect to cancel, the facility may cancel the coverage or the commission may assess an administrative penalty not to exceed $5,000. Each day of noncompliance constitutes a separate violation. Penalties collected under this section shall be deposited in the General Revenue Fund to the credit of the commission or reappropriated to the commission to offset the costs of implementing and administering this section.

(i) In assessing an administrative penalty, the commission may consider any matter that justice may require and shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) any economic benefit resulting from the prohibited act; and

(5) the penalty necessary to deter future violations.

(j) The procedures established in this section must be followed each year the policyholder meets the qualifications established in Subsection (d) of this section and is insured through the facility under the employers' rejected risk fund.

(k) The commission shall charge the policyholder for the reasonable cost of services provided under Subsections (c) through (f) of this section. The fees for those services shall be set at a cost-reimbursement level, including a reasonable allocation of the commission's administrative costs.

(l) The compliance and practices division shall enforce compliance with this section through the administrative violation proceedings established under Article 10, Texas Workers' Compensation Act (Article 8308–10.01 et seq., Vernon's Texas Civil Statutes).

SECTION 18.16. Section 5.01, Article 5.76–2, Insurance Code, is amended to read as follows:

Sec. 5.01. MARKET ASSISTANCE PROGRAM. *(a)* The board shall establish a voluntary market assistance program to *reduce* [~~monitor the operation of the fund with the object of reducing~~] the number of risks insured by the *employers' rejected risk* fund. Pursuant to such program each rejected risk [~~meeting qualifications set forth by the board and making a request~~] shall be reviewed before [~~or after~~] its assignment under Section 4.02 of this article. The market assistance program shall attempt to find an insurer to voluntarily insure the risk before its initial assignment to the *employers' rejected risk* fund, assignment to a specific company under Section 4.02 of this article, or renewal of the risk's assignment to the *employers' rejected risk* fund. The board shall adopt rules as necessary to implement this section. A licensed local recording agent need not be appointed by an insurer willing to accept business offered by the agent for review by the market assistance program. The market assistance program may establish reasonable fees for market assistance review, and those fees are dedicated to the *facility* [~~board~~] for the administration of this section.

(b) Each member of the facility shall file all information prescribed by the board with the market assistance program.

(c) A member of the facility that fails or refuses to file the information required in Subsection (b) of this section commits an administrative violation punishable by an administrative penalty not to exceed $5,000 assessed under Section 7, Article 1.10 of this code.

SECTION 18.17. Subchapter G, Chapter 5, Insurance Code, is amended by adding Article 5.76–3 to read as follows:

Art. 5.76–3. TEXAS WORKERS' COMPENSATION INSURANCE FUND

Sec. 1. DEFINITIONS. In this article:

(1) "Board" means the board of directors of the fund.

(2) "Commission" means the Texas Workers' Compensation Commission.

(3) "Fund" means the Texas Workers' Compensation Insurance Fund.

(4) "Workers' compensation insurance" means the insurance for any risk under the Texas Workers' Compensation Act (Article 8308–1.01 et seq., Vernon's Texas Civil Statutes), the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Section 901), the Federal Mine Safety and Health Act of 1977 (33 U.S.C. Section 801 et seq.), or Article 8309h, Revised Statutes.

Sec. 2. CREATION; OPERATION. (a) The Texas Workers' Compensation Insurance Fund is created as a corporate body with the powers provided in this article and with all general corporate powers incident to its operation as a corporate body.

(b) Except as otherwise provided by this subsection, the fund is subject to the open meetings law, Chapter 271, Acts of the 60th Legislature, Regular Session, 1967 (Article 6252–17, Vernon's Texas Civil Statutes), and the open records law, Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252–17a, Vernon's Texas Civil Statutes). The board may hold closed meetings to consider and refuse to release information relating to claims, rates, the fund's underwriting guidelines, and other information that would give advantage to competitors or bidders.

(c) A decision by the fund to deny, cancel, or refuse to renew a policy or risk insured under Article 5.76–4 of this code is appealable to the board not later than the 30th day after the date on which the affected party received actual notice that the act occurred or that the decision was made. The board shall hear the appeal not later than the 30th day after the date on which the request for hearing is made and shall notify the fund and the appellant in writing of the time and place of the hearing not later than the 10th day before the date of the hearing. Not later than the 30th day after the last day of the hearing, the board shall affirm, reverse, or modify the act appealed to the board. A hearing under this subsection does not suspend the operation of any act, ruling, decision, or order of the fund, unless the board specifically so orders. A decision of the board under this subsection is subject to review in the manner provided by the Administrative Procedure and Texas Register Act (Article 6252–13a, Vernon's Texas Civil Statutes).

(d) The fund is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in effect as provided by that chapter, the fund is abolished September 1, 1995.

Sec. 3. BOARD OF DIRECTORS. (a) The fund is governed by a board of directors composed of nine members, all of whom shall be citizens of this state. The members shall be appointed by the governor with the advice and consent of the senate, and vacancies shall be filled in the same manner. The members of the board of directors serve staggered six-year terms, with the terms of three members expiring February 1 of each odd-numbered year.

(b) Except as provided by Subsection (c) of this section, to be eligible for appointment as a member of the board a person must be a policyholder of the fund or an officer or employee of a policyholder and must maintain that status during the period of service on the board. Failure to maintain that status disqualifies the board member and creates a vacancy on the board.

(c) The initial appointees to the board must be employers in this state.

(d) In making appointments to the board, the governor shall attempt to reflect the social, geographic, and economic diversity of the state. To ensure balanced representation, the governor may consider the geographic location of a prospective appointee's domicile and the prospective appointee's experience in business and insurance matters and shall consider those factors in appointing members to fill vacancies on the board.

(e) A person may not serve as a member of the board if the person, an individual related to the person within the second degree by consanguinity or affinity, or an individual residing in the same household with the person:

(1) is required to be registered or licensed under this code;

(2) is employed by or acts as a consultant to a person required to be registered or licensed under this code;

(3) owns, controls, has a financial interest in, or participates in the management of an organization required to be registered or licensed under this code;

(4) receives a substantial tangible benefit from the fund or the Texas Department of Insurance;

(5) is an officer, employee, or consultant of an association in the field of insurance; or

(6) is required to register as a lobbyist under Chapter 305, Government Code.

(f) Subsection (e) of this section does not prohibit a person who is only a consumer of insurance or insurance products from serving as a member of the board.

(g) A person who is ineligible to serve on the board under Subsection (e) of this section may not serve as a member of the board for one year after the date on which the condition that makes the person ineligible ends.

(h) Each member shall receive actual and necessary travel expenses and expenses incurred in the performance of the member's duties as a member.

(i) The members of the board shall elect annually from their number a chairman, a vice-chairman, and a secretary.

(j) The board shall hold meetings at least once each month and at other times at the call of the chairman and at times established by board rule. Special meetings may be called by any two members of the board on two days notice.

(k) A majority of the board members constitutes a quorum.

(l) The board shall maintain the principal office of the fund in Austin, Texas.

(m) For cost control purposes and as is determined to be cost-effective, as many functions as possible shall be performed by the fund.

Sec. 4. AUTHORITY AND PURPOSE. (a) According to this article and the plan of operation, the board shall, on behalf of the fund:

(1) provide for the acceptance of applications and delivery or issuance for delivery in this state of workers' compensation insurance and for the transaction of workers' compensation insurance business to the same extent as any other insurance carrier transacting workers' compensation insurance business in this state;

(2) enter into and approve contracts;

(3) propose rates for workers' compensation insurance issued by the fund;

(4) appoint and supervise the activities of the president of the fund and other officers and employees;

(5) adopt necessary bylaws and rules for the operation of the fund;

(6) delegate specific responsibilities to the president of the fund;

(7) develop a general plan of operation, in accordance with Section 5 of this article, to assure the orderly management and operation of the fund; and

(8) exercise any other authority necessary to conduct a workers' compensation insurance business for the fund.

(b) The fund may not have affiliates, interlocking boards of directors, spinoffs, or subsidiaries that write lines of insurance other than workers' compensation insurance.

Sec. 5. PLAN OF OPERATION. (a) The initial board of directors shall prepare and adopt a plan of operation that is consistent with this article. The plan must provide for the:

(1) economic, fair, and nondiscriminatory administration of the fund and its duties;

(2) prompt and efficient provision of workers' compensation insurance;

(3) establishment of necessary facilities;

(4) management of the fund;

(5) reasonable and objective underwriting standards; and

(6) obtainment of reinsurance.

(b) The initial plan of operation is subject to approval by the State Board of Insurance.

(c) With consent of the State Board of Insurance, the board may amend the plan of operation to provide for operation of the fund in a manner consistent with this article.

Sec. 6. PRESIDENT AND CHIEF EXECUTIVE OFFICER. (a) The board shall appoint a person to serve as president and chief executive officer who serves at the pleasure of the board. The board shall appoint other officers as necessary to manage the fund prudently.

(b) To be eligible for appointment as president, an individual must have had at least 10 years of administrative or professional experience and training and experience in the field of insurance.

(c) The president shall manage and conduct the affairs of the fund under the general supervision of the board and shall perform duties as provided by this article and as directed by the board.

(d) In addition to any other duties provided by this article or by the board, the president shall:

(1) hire employees as necessary to conduct the business and carry out the provisions of this article or to perform the duties imposed on the president by this article;

(2) receive and approve applications for workers' compensation insurance and issue policies to applicants who are eligible for workers' compensation insurance provided by the fund;

(3) negotiate contracts on behalf of the fund;

(4) issue renewals of workers' compensation insurance for those who qualify for renewal;

(5) process and pay valid claims according to the rules of the board and the appropriate workers' compensation insurance laws;

(6) collect premiums for workers' compensation insurance issued or renewed by the fund; and

(7) collect and compile statistical information relating to the fund and provide this information to the board.

(e) In addition to any other authority provided by this article or by the board, the president shall have full power and authority, in the name of the fund, to:

(1) sue and be sued in all of the courts of the state in all actions arising out of any act, deed, matter, or things made, omitted, entered into, done, or suffered in connection with the fund and its administration, management, or conduct of its business and affairs;

(2) delegate to any officer of the fund, subject to any conditions prescribed by the president, any of the powers, functions, or duties conferred or imposed on the president under this article in connection with the fund, its administration, management, and conduct of business or related affairs; an officer to whom such a delegation is made may exercise the delegated powers with the same force and effect as the president, subject to approval by the president;

(3) inspect and audit employers who apply to the fund for issuance of workers' compensation insurance or who seek renewal of that insurance;

(4) purchase reinsurance from insurance carriers admitted or accredited to reinsure risks in this state;

(5) cancel or refuse to renew workers' compensation insurance if a risk does not comply with a board-approved plan or any provision of this article;

(6) with the approval of the board, enter into contracts on behalf of the fund;

(7) draft guidelines for approval of the board relating to the settlement of claims against the fund; and

(8) perform any other acts authorized by the board to carry out this article and the rules of the board.

Sec. 7. APPLICATIONS. (a) Applications to the fund shall be submitted on forms prescribed by the board and shall be made:

(1) directly by the applicant; or

(2) on behalf of the applicant by a local recording agent.

(b) The fund shall adopt such rules as required to provide for the financing of all or part of the premiums by the fund or a person licensed under Chapter 24 of this code. Those rules shall require that the fund receive a minimum initial premium sufficient to cover the administrative costs of issuing and booking the policy in the event of cancellation.

(c) If the premium is financed by the fund as provided by Subsection (b) of this section, the payment deferred earns interest payable to the fund at a rate annually determined by the board based on the auction rate quoted on a discount basis for 52–week treasury bills issued by the United States government, as published by the Federal Reserve Board on the date nearest to the date on which the interest rate is determined.

(d) If an applicant is identified as a credit risk, the fund may refuse to write insurance coverage if the applicant does not:

(1) pay the total estimated premium and related charges before the policy is issued; or

(2) provide security for payment of the total estimated premium and related charges before the policy is issued.

(e) If the policy is written through a licensed agent, the fund shall pay the agent a reasonable commission. The commission shall be paid at the time of the initial deposit, based on the annual estimated premium, and shall be adjusted at the final audit.

Sec. 8. LIABILITY. Neither a member of the board nor the president or any officer or employee of the fund is personally liable in the person's private capacity for any act performed or for any contract or other obligation entered into or undertaken in an official capacity in good faith and without intent to defraud, in connection with the administration, management, or conduct of the fund, its business, or other related affairs.

Sec. 9. RATES. (a) Except as otherwise provided by this subsection, the board shall have full power and authority to propose rates to be charged by the fund for insurance. The board shall engage the services of an independent actuary who is a member in good standing with the Casualty Actuarial Society or the American Academy of Actuaries to develop and recommend actuarially sound rates. The fund is subject to the requirements of Article 5.55 of this code and shall include the recommendations of its independent actuary as part of its filing under that article.

(b) Rates shall be set in amounts sufficient, when invested, to:

(1) carry all claims to maturity;

(2) meet the reasonable expenses of conducting the business of the fund; and

(3) maintain a reasonable surplus.

(c) Notwithstanding any other provision of this article, the fund may establish multitiered premium systems to provide workers' compensation insurance to insureds who would not otherwise meet the fund's underwriting standards. Those multitiered systems shall be filed in accordance with Article 5.55 of this code. The systems may provide for higher premium payments by insureds who present higher than normal risks within a class.

Sec. 10. ACCIDENT PREVENTION. (a) The fund may make and enforce rules for the prevention of injuries to employees of its policyholders or applicants for insurance under this article. For this purpose, representatives of the fund, representatives of the commission, or representatives of the Texas Department of Insurance on reasonable notice shall be granted free access to the premises of each policyholder or applicant during regular working hours.

(b) Failure or refusal by any such policyholder or applicant to comply with any rule prescribed by the fund for the prevention of injuries, or failure or refusal to make full disclosure of all information pertinent to the insuring or servicing of the policyholder or applicant, constitutes sufficient grounds for the fund to cancel a policy or deny an application for insurance.

(c) A policyholder in the fund who is insured under Article 5.76-4 of this code shall obtain a safety consultation if the policyholder:

(1) has an experience modifier greater than 1.25; or

(2) does not have an experience modifier but has had a loss ratio greater than 0.70 in at least two of the three most recent policy years for which information is available.

(d) A policyholder in the fund who is insured under Article 5.76-4 of this code shall obtain a safety consultation as required by the fund if the policyholder:

(1) has been in business for less than three years; and

(2) meets criteria for a safety consultation established by the fund, which may include the number and classification of employees, the policyholder's industry, and the policyholder's previous workers' compensation experience in this state or another jurisdiction.

(e) The policyholder shall obtain the safety consultation not later than the 30th day after the effective date of the policy and shall obtain the safety consultation from the health and safety division of the commission, the fund, or another professional source approved for that purpose by the health and safety division. The safety consultant shall file a written report with the commission and the policyholder setting out any hazardous conditions or practices identified by the safety consultation.

(f) The policyholder and the consultant shall develop a specific accident prevention plan that addresses the hazards identified by the consultant. The safety consultant may approve an existing accident prevention plan. The policyholder shall comply with the accident prevention plan.

(g) The health and safety division may investigate accidents occurring at the work sites of a policyholder for whom a plan has been developed under Subsection (f) of this section, and the division may otherwise monitor the implementation of the accident prevention plan as it finds necessary.

(h) In accordance with rules adopted by the commission, not earlier than 90 days or later than six months after the development of an accident prevention plan under Subsection (f) of this section, the health and safety division of the commission shall conduct a follow-up inspection of the policyholder's premises. The commission may require the participation of the safety consultant who performed the initial consultation and developed the safety plan. If the health and safety division of the commission determines that the policyholder has complied with the terms of the accident prevention plan or has implemented other accepted corrective measures, the health and safety division shall so certify. If a policyholder fails or refuses to implement the accident prevention plan or other suitable hazard abatement measures, the policyholder may elect to cancel coverage not later than the 30th day after the date of the division determination. If the policyholder does not elect to cancel, the fund may cancel the coverage or the commission may assess an administrative penalty not to exceed $5,000. Each day of noncompliance constitutes a separate violation. Penalties collected under this section shall be deposited in the general revenue fund to the credit of the commission or reappropriated to the commission to offset the costs of implementing and administering this section.

(i) In assessing an administrative penalty, the commission may consider any matter that justice may require and shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) any economic benefit resulting from the prohibited act; and

(5) the penalty necessary to deter future violations.

(j) The procedures established under this section must be followed each year the policyholder meets the qualifications established under Subsection (c) of this section and is insured through Article 5.76-4 of this code.

(k) The commission shall charge the policyholder for the reasonable cost of services provided under Subsections (e) and (f) of this section. The fees for those services shall be set at a cost-reimbursement level including a reasonable allocation of the commission's administrative costs.

(l) The compliance and practices division of the commission shall enforce compliance with this section through the administrative violation proceedings under Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes).

Sec. 11. CONTROL OF FRAUD. (a) The fund shall develop and implement a program to identify and investigate fraud and violations of this code relating to workers' compensation insurance by an applicant, policyholder, claimant, agent, or insurer. The fund shall contract with the commission to compile and maintain information necessary to detect practices or patterns of conduct that violate this code relating to workers' compensation insurance or the Texas Workers' Compensation Act (Article 8308-1.01 et seq., Vernon's Texas Civil Statutes).

(b) The fund shall refer all cases of suspected fraud and violations of this code relating to workers' compensation insurance to the commission to:

(1) perform investigations;

(2) conduct administrative violation proceedings; and

(3) assess and collect penalties and restitution.

(c) The fund may enter into interdepartmental funding agreements with local prosecutors for the prosecution of offenses against the fund.

(d) Restitution collected under Subsection (b) of this section shall be deposited to the fund.

(e) Penalties collected under Subsection (b) of this section shall be deposited in the general revenue fund to the credit of the commission and shall be appropriated to the commission to offset the costs of this program.

(f) The board, fund, and employees of the fund are not liable in a civil action for any action made in good faith in the execution of duties under this section including the identification and referral of a person for investigation and prosecution for a possible administrative violation or criminal offense.

Sec. 12. PAYMENT OF TAXES AND FEES; GUARANTY ASSOCIATION. (a) Except as provided in Subsection (b) of this section, the fund shall pay premium taxes, maintenance taxes, and the maintenance tax surcharge established under Article 5.76-5 of this code in the same manner as an insurance carrier authorized by the Texas Department of Insurance to write workers' compensation insurance in this state.

(b) The fund is granted a tax credit equal to two percent of the gross workers' compensation premiums written by the fund during the period for which taxes are assessed. The credit may be applied only against the taxes and surcharge established in Subsection (a) of this section and shall be applied against the taxes and surcharge in the following order:

(1) maintenance tax surcharge;

(2) maintenance taxes assessed to support the Texas Department of Insurance;

(3) maintenance tax assessed to support the commission; and

(4) premium taxes.

(c) The fund shall pay all other taxes and fees or any payments due in lieu of taxes in the same manner as an insurance carrier authorized and admitted by the Texas Department of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance.

(d) The fund may not be a member of nor be protected by the Texas Property and Casualty Insurance Guaranty Association and is not subject to assessment under the Texas Property and Casualty Insurance Guaranty Act (Article 21.28–C, Insurance Code).

Sec. 13. FINANCIAL ADMINISTRATION. (a) Revenues of the fund consist of:

(1) premiums paid by employers for workers' compensation insurance from the fund;

(2) investments and money earned from investments of the fund;

(3) money received from the issuance and sale of bonds under Article 5.76–5 of this code; and

(4) any other money received by the fund.

(b) Administrative expenses of the fund shall be paid from the fund at the direction of the board.

(c) Money in the fund shall be paid from the fund, without legislative appropriation, on vouchers approved by the board. That money shall be held exclusively for the purposes stated in this article and may not be used or appropriated for any other purpose.

(d) Money in the fund shall be invested, subject to a policy approved by the state treasurer, in the types of investments authorized by law for investment of state funds as provided by Chapter 404, Government Code.

(e) The fund shall establish and maintain reserves for losses on an actuarially sound basis in accordance with Article 5.61 of this code.

(f) The fund must maintain a ratio of premiums on policies written to surplus of not more than three to one.

(g) The fund may pay cash dividends or allow a credit on renewal premium for each policyholder insured with the fund other than a policyholder insured under Article 5.76–4 of this code. A dividend or credit requires prior approval of the Texas Department of Insurance.

(h) The fund shall file annual statements with the Texas Department of Insurance and the commission in the same manner as required of other workers' compensation insurance carriers, and the State Board of Insurance shall include a report on the fund's condition in that board's annual report under Article 1.25 of this code.

(i) If the fund incurs a deficit for any reason, no other insurer is liable for or subject to an assessment for that deficit.

Sec. 14. REPORT TO BOARD. The president shall make periodic reports to the board with regard to the status of the fund and its investments.

Sec. 15. POLICY FORMS. The fund shall use the uniform policy and standard policy forms prescribed by the State Board of Insurance under Articles 5.56 and 5.57 of this code.

Sec. 16. CANCELLATION AND NONRENEWAL. The fund may cancel or refuse to renew coverage on a policyholder as provided in Section 3.28, Texas Workers' Compensation Act (Article 8308–3.28, Vernon's Texas Civil Statutes).

Sec. 17. ANNUAL REPORT; OTHER REPORTS. (a) Not later than the 30th day after the date on which the fund's fiscal year ends, the board shall publish a report analyzing the fund's activities and fiscal condition during the preceding fiscal year. The board shall have an independent audit made of each such report.

(b) The fund shall file with the State Board of Insurance and the commission all reports required of other workers' compensation insurers.

Sec. 18. EXAMINATION OF FUND. (a) The State Board of Insurance shall conduct an examination of the fund in the manner and under the conditions provided by Articles 1.15 through 1.19 of this code for the examination of insurance carriers.

(b) The board shall pay the costs of the examination from the fund.

(c) The fund is subject to all provisions of this code and to the jurisdiction of the commissioner of insurance and the State Board of Insurance in the same manner as private insurance carriers.

Sec. 19. ASSISTANCE FROM INSURANCE DEPARTMENT. On the request of the board, the Texas Department of Insurance shall provide technical assistance to the board and the president as reasonably necessary to implement this article.

Sec. 20. FUND SOLVENCY. (a) In addition to other regulatory authority granted the commissioner of insurance, if the commissioner finds that the fund does not own assets at least equal to all liabilities and required reserves, together with the minimum basic surplus required under this article, or that the condition of the fund is such that continuing operation of the fund is hazardous to the public or to the policyholders of the fund, the commissioner shall:

(1) notify the president and board of the finding; and

(2) furnish the fund with a written list of the commissioner's recommendations to abate the problems.

(b) If the fund fails to comply with the recommendations of the commissioner not later than the 60th day after the date of the recommendations, the commissioner shall notify the governor, the lieutenant governor, and the speaker of the house of representatives of the recommendations with which the fund is not in compliance, together with solutions and estimations of all fiscal implications.

Sec. 21. APPLICABILITY OF OTHER STATUTES. (a) The fund is an insurance company for purposes of the Texas Workers' Compensation Act (Article 8308-1.01 et seq., Vernon's Texas Civil Statutes).

(b) All regulatory authority granted the commissioner of insurance relating to a stock or mutual insurance company is applicable to the fund.

(c) Unless specifically defined as a state agency in a specific statute, the fund is not a state agency.

SECTION 18.18. Subchapter G, Chapter 5, Insurance Code, is amended by adding Article 5.76-4 to read as follows:

Art. 5.76-4. FUND AS INSURER OF LAST RESORT. (a) The Texas Workers' Compensation Insurance Fund may not, except as otherwise provided by this article and by Section 16, Article 5.76-3 of this code, refuse to insure any risk that tenders the necessary premium and any applicable accident prevention service fees.

(b) If an applicant to the fund would be rejected for workers' compensation insurance under the fund's underwriting standards, the risk may not be rejected, but shall be insured at a higher premium as provided by the fund's rules. The risk may be required to meet other conditions considered necessary to protect the fund's interests.

(c) The fund shall develop statistical and other information as necessary to allow the fund to distinguish between its writings in the voluntary market and its writings as the insurer of last resort.

(d) The fund shall decline to insure any risk if insuring that risk would cause the fund to exceed the premium-to-surplus ratios established by Article 5.76-3 of this code.

(e) The Texas Department of Insurance shall develop and publish classification relativities specifically designed for the risks insured under this article.

SECTION 18.19. Subchapter G, Chapter 5, Insurance Code, is amended by adding Article 5.76-5 to read as follows:

Art. 5.76-5. REVENUE BOND PROGRAM AND PROCEDURES

Sec. 1. LEGISLATIVE FINDING; PURPOSE. The legislature finds that the issuance of bonds for the purposes of providing a method to raise funds to provide workers' compensation insurance coverage through the Texas Workers' Compensation Insurance Fund and workers' compensation insurance coverage for employers in this state is for the benefit of the public and in furtherance of a public purpose.

Sec. 2. DEFINITIONS. In this article:

(1) "Bond resolution" means the resolution or order authorizing the bonds to be issued under this article.

(2) "Board" means the board of directors of the Texas Public Finance Authority.

(3) "Fund" means the Texas Workers' Compensation Insurance Fund.

Sec. 3. BONDS AUTHORIZED; APPLICATION OF TEXAS PUBLIC FINANCE AUTHORITY ACT. (a) On behalf of the fund, the Texas Public Finance Authority shall issue revenue bonds to:

(1) establish the initial surplus of the fund;

(2) establish and maintain reserves;

(3) pay initial operating costs;

(4) pay costs related to issuance of the bonds; and

(5) pay other costs related to the bonds as may be determined by the board.

(b) To the extent not inconsistent with this article, the Texas Public Finance Authority Act (Article 601d, Vernon's Texas Civil Statutes) applies to bonds issued under this article. In the event of a conflict, this article controls.

Sec. 4. APPLICABILITY OF OTHER STATUTES. The following Acts apply to bonds issued under this article to the extent consistent with this article:

(1) Chapter 656, Acts of the 68th Legislature, Regular Session, 1983 (Article 717q, Vernon's Texas Civil Statutes);

(2) Chapter 3, Acts of the 61st Legislature, Regular Session, 1969 (Article 717k-2, Vernon's Texas Civil Statutes);

(3) the Bond Procedures Act of 1981 (Article 717k-6, Vernon's Texas Civil Statutes);

(4) Chapter 1078, Acts of the 70th Legislature, Regular Session, 1987 (Article 717k-7, Vernon's Texas Civil Statutes);

(5) Article 3, Chapter 53, Acts of the 70th Legislature, 2nd Called Session, 1987 (Article 717k-8, Vernon's Texas Civil Statutes);

(6) Article 717k-9, Revised Statutes; and

(7) Chapter 400, Acts of the 66th Legislature, 1979 (Article 717m-1, Vernon's Texas Civil Statutes).

Sec. 5. LIMITS. The Texas Public Finance Authority may issue, on behalf of the fund, bonds in a total amount not to exceed $300 million.

Sec. 6. CONDITIONS. (a) Bonds may be issued at public or private sale.

(b) Bonds may mature not more than 20 years after the date issued.

(c) Bonds must be issued in the name of the fund.

Sec. 7. ADDITIONAL COVENANTS. In a bond resolution, the board may make additional covenants with respect to the bonds and the designated income and receipts of the fund pledged to their payment and may provide for the flow of funds and the establishment, maintenance, and investment of funds and accounts with respect to the bonds.

Sec. 8. SPECIAL ACCOUNTS. (a) A bond resolution may establish special accounts including an interest and sinking fund account, reserve account, and other accounts.

(b) The president of the fund or the president's designee shall administer the accounts in accordance with Article 5.76-3 of this code.

Sec. 9. SECURITY. (a) Bonds are payable only from the maintenance tax surcharge established in Section 10 of this article or other sources the fund is authorized to levy, charge, and collect in connection with paying any portion of the bonds.

(b) Bonds are obligations solely of the fund. Bonds do not create a pledging, giving, or lending of the faith, credit, or taxing authority of this state.

(c) Each bond must include a statement that the state is not obligated to pay any amount on the bond and that the faith, credit, and taxing authority of this state are not pledged, given, or lent to those payments.

(d) Each bond issued under this article must state on its face that the bond is payable solely from the revenues pledged for that purpose and that the bond does not and may not constitute a legal or moral obligation of the state.

Sec. 10. MAINTENANCE TAX SURCHARGE. (a) A maintenance tax surcharge is assessed against:

(1) each insurance company writing workers' compensation insurance in this state;

(2) each certified self-insurer as provided in Chapter D, Article 3, Texas Workers' Compensation Act (Article 8308–3.51 et seq., Vernon's Texas Civil Statutes); and

(3) the fund.

(b) The maintenance tax surcharge shall be set in an amount sufficient to pay all debt service on the bonds. The maintenance tax surcharge is set by the State Board of Insurance in the same time and shall be collected on behalf of the fund in the same manner as provided under Article 5.68 of this code.

(c) On receiving notice of the rate of assessment set by the Texas Workers' Compensation Commission under Section 2.23, Texas Workers' Compensation Act (Article 8308–2.23, Vernon's Texas Civil Statutes), the State Board of Insurance shall increase the tax rate to a rate sufficient to pay all debt service on the bonds subject to the maximum tax rate established by Section 2.22, Texas Workers' Compensation Act (Article 8308–2.22, Vernon's Texas Civil Statutes). If the resulting tax rate is insufficient to pay all costs for the Texas Workers' Compensation Commission and all debt service on the bonds, the State Board of Insurance may assess an additional surcharge not to exceed one percent of gross workers' compensation premiums to cover all debt service on the bonds. In this code, the maintenance tax surcharge includes the additional maintenance tax assessed under this subsection and the surcharge assessed under this subsection to pay all debt service of the bonds.

(d) The fund and each insurance company may pass through the maintenance tax surcharge to each of its policyholders.

(e) As a condition of engaging in the business of insurance in this state, an insurance company writing workers' compensation insurance in this state agrees that if the company leaves the workers' compensation insurance market in this state it remains obligated to pay, until the bonds are retired, the company's share of the maintenance tax surcharge assessed under this section in an amount proportionate to that company's share of the workers' compensation insurance market in this state as of the last complete reporting period before the date on which the company ceases to engage in the insurance business in this state. The proportion assessed against the company shall be based on the company's workers' compensation insurance gross premiums for the company's last reporting period. However, a company is not required to pay the proportionate amount in any year in which the surcharge assessed against insurance companies continuing to write workers' compensation insurance in this state is sufficient to service the bond obligation. The abolition of the fund under Section 2(d), Article 5.76–3, Insurance Code, does not affect the liability of an insurance company for a maintenance tax surcharge assessed under this section.

Sec. 11. TAX EXEMPT. The bonds issued under this article, and any interest from the bonds, and all assets pledged to secure the payment of the bonds are free from taxation by the state or a political subdivision of this state.

Sec. 12. AUTHORIZED INVESTMENTS. The bonds issued under this article constitute authorized investments under Article 2.10 and Subpart A, Part I, Article 3.39 of this code.

Sec. 13. STATE PLEDGE. The state pledges to and agrees with the owners of any bonds issued in accordance with this article that the state will not limit or alter the rights vested in the fund to fulfill the terms of any agreements made with the owners of the bonds or in any way impair the rights and remedies of those owners until the bonds, any premium or interest, and all costs and expenses in connection with any action or proceeding by or on behalf of those owners are fully met and discharged. The fund may include this pledge and agreement of the state in any agreement with the owners of the bonds.

Sec. 14. ENFORCEMENT BY MANDAMUS. A writ of mandamus and all other legal and equitable remedies are available to any party at interest to require the fund and any other party to carry out agreements and to perform functions and duties under this article, the Texas Constitution, or a bond resolution.

SECTION 18.20. Subchapter D, Chapter 32, Penal Code, is amended by adding Section 32.54 to read as follows:

Sec. 32.54. PENALTY FOR FRAUDULENTLY OBTAINING WORKERS' COMPENSATION INSURANCE COVERAGE. (a) A person commits an offense if the person, with intent to obtain workers' compensation insurance coverage for himself or another under the workers' compensation insurance laws of this state, knowingly or intentionally:

(1) makes a false statement;

(2) misrepresents or conceals a material fact; or

(3) makes a false entry in, fabricates, alters, conceals, or destroys a document other than a governmental record.

(b) An offense under Subsection (a) of this section is a felony of the third degree.

(c) The court may order a person to pay restitution to an insurance company, the Texas workers' compensation insurance facility, or the Texas Workers' Compensation Insurance Fund if the person commits an offense under this section.

SECTION 18.21. Sections 2 and 6, Article 5.73, Insurance Code, as amended by Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, are amended to read as follows:

Sec. 2. [~~(a)~~] No advisory organization shall compile or distribute, and no insurer may accept from an advisory organization, recommendations for rates or for profit and expenses other than loss adjustment expenses.

[~~(b) This section does not apply to workers' compensation insurance. This subsection does not apply if H.B. 2898, Acts of the 72nd Legislature, Regular Session, 1991, becomes law.~~]

Sec. 6. To the extent that this article conflicts with the provisions of *Articles 5.55, 5.58, and 5.58A of this code* [~~Chapter 1, Acts of the 71st Legislature, 2nd Called Session, 1989,~~] with respect to the setting of rates for workers' compensation insurance, the provisions of *those articles* [~~Chapter 1, Acts of the 71st Legislature, 2nd Called Session, 1989, shall~~] control.

SECTION 18.22. Section 21.69, Insurance Code, as added by Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, is amended and redesignated to read as follows:

Art. [~~Sec.~~] 21.69. BOARD MAY CONTRACT FOR PREMIUM AND LOSS DATA. *Except as provided in Article 5.58 of this code, the* [~~The~~] board may contract with any qualified entity to collect historical premium and loss data as defined by the board and pursuant to statistical plans promulgated or approved by the board.

SECTION 18.23. REPEALER. (a) Article 5.65, Insurance Code, is repealed.

(b) Part 3, Article 5.76–2, Insurance Code, is repealed effective January 1, 1994.

(c) Subsection (j), Article 5.58, Insurance Code, is repealed.

(d) Subsection (h), Article 5.58A, Insurance Code, is repealed.

SECTION 18.24. TRANSITION. (a) Workers' compensation insurance may not be written through the Texas workers' compensation insurance facility under the employers' rejected risk fund on or after January 1, 1994.

(b) The Texas workers' compensation insurance facility shall contract with the Texas Workers' Compensation Insurance Fund to assume all claim liabilities of the facility no later than January 1, 1999.

(c) The governing committee of the Texas workers' compensation insurance facility, as that committee existed on December 31, 1991, is abolished January 1, 1992. In making appointments to the committee as created under Section 2.03, Article 5.76–2, Insurance Code, as amended by this article:

(1) the State Board of Insurance shall appoint:

(A) two members for terms expiring February 1, 1993;

(B) two members for terms expiring February 1, 1995; and

(C) one member for a term expiring February 1, 1997; and

(2) the governor shall appoint:

(A) one member for a term expiring February 1, 1993;

(B) one member for a term expiring February 1, 1995; and

(C) two members for terms expiring February 1, 1997.

(d) In making appointments to the board of directors of the Texas Workers' Compensation Insurance Fund, the governor shall designate:

(1) three members for terms expiring February 1, 1993;

(2) three members for terms expiring February 1, 1995; and

(3) three members for terms expiring February 1, 1997.

(e) Notwithstanding Subsection (a), Section 5.58, Insurance Code, as amended by Section 18.02 of this article, until January 1, 1993, the State Board of Insurance may contract with or designate an insurer or advisory organization to gather or compile data for statistical plans. Such a contract must require that the contracting advisory organization maintain an office in Austin, Texas, and that the board have access to the experience data compiled and held by the advisory organization relating to workers' compensation insurance losses in this state.

SECTION 18.25. INITIAL APPROPRIATION TO THE TEXAS WORKERS' COMPENSATION INSURANCE FUND. (a) The comptroller of public accounts shall transfer from the State Board of Insurance operating fund to the general revenue fund an amount equal to $5 million. The amount transferred is appropriated to the Texas Workers' Compensation Insurance Fund.

(b) Out of proceeds of bonds issued under Article 5.76–5, Insurance Code, the Texas Workers' Compensation Insurance Fund shall pay to the State Board of Insurance $5 million plus interest calculated at eight percent per year. The money shall be deposited in the State Board of Insurance operating fund and shall not be considered reappropriated to the State Board of Insurance.

(c) Penalties collected under Subsection (g) of Section 2.05 of Article 5.76–2 and Subsection (e) of Section 11 of Article 5.76–3, Insurance Code, are appropriated for the biennium ending August 31, 1993, to the Texas Workers' Compensation Commission for the purposes provided by those provisions.

SECTION 18.26. INITIAL CONTRACTS BETWEEN THE TEXAS WORKERS' COMPENSATION INSURANCE FACILITY AND THE TEXAS WORKERS' COMPENSATION COMMISSION. (a) The initial contract between the Texas workers' compensation insurance facility and the Texas Workers' Compensation Commission required under Subsection (c), Section 2.05, Article 5.76–2, Insurance Code, as amended by this article, shall be in an amount that is at least:

(1) $114,357 for calendar year 1992; and

(2) $114,357 for calendar year 1993.

(b) The Legislative Budget Board shall review the continuing need for the Texas workers' compensation insurance facility's contracts with the Texas Workers' Compensation Commission under Subsection (a) of this section and may make reasonable adjustments to the amounts established in this section.

SECTION 18.27. CLASSIFICATION RELATIVITIES FOR TEXAS WORKERS' COMPENSATION INSURANCE FUND. Before January 1, 1993, the Texas Department of Insurance shall develop and publish classification relativities specifically designed for the risks insured under Article 5.76–4, Insurance Code, as added by Section 14.18 of this article.

SECTION 18.28. EFFECTIVE DATE. (a) Except as otherwise provided by this section, this article takes effect January 1, 1992.

(b) Sections 18.01, 18.02, 18.03, 18.04, and 18.05 of this article take effect on the later of April 1, 1992, or the 60th day after the date of issuance of the first insurance policy by the Texas Workers' Compensation Insurance Fund under Article 5.76–3, Insurance Code, as added by this article. Section 18.18 of this article takes effect January 1, 1994.

(c) Sections 18.17 and 18.19 of this article, adding Articles 5.76–3 and 5.76–5, Insurance Code, respectively, Section 18.25(a) of this article, and this section take effect immediately. To the extent necessary for the prompt issuance of revenue bonds under Article 5.76–5, Insurance Code, the Texas Workers' Compensation Insurance Fund may exercise any powers granted by other provisions of this article, and for that purpose those provisions also take effect immediately.

ARTICLE 19. SUNSET ACT

SECTION 19.01. Article 1.02(d), Insurance Code, as amended by H.B. 222, Acts of the 72nd Legislature, 1st Called Session, 1991, is amended to read as follows:

(d) The Texas Department of Insurance is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the department is abolished September 1, *1993* [~~1995~~].

SECTION 19.02. Section (k), Article 1.35A, Insurance Code, as added by Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, and amended by H.B. No. 222, Acts of the 72nd Legislature, 1st Called Session, 1991, is amended to read as follows:

(k) The office of public insurance counsel is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the office is abolished September 1, *1993* [~~1995~~].

ARTICLE 20. LIABILITY INSURANCE COVERAGE FOR MEMBERS OF THE BOARD OF TRUSTEES OF A COUNTY EDUCATION DISTRICT

SECTION 20.01. Subchapter G, Chapter 20, Education Code, is amended by adding Section 20.9441 to read as follows:

Sec. 20.9441. LIABILITY INSURANCE COVERAGE. A member of the board of trustees of a component school district who is designated to serve as a member of the board of trustees of a county education district and who is covered by a liability insurance policy obtained by the school district covering the member's acts and omissions in the member's capacity as a school board member is entitled to analogous liability insurance coverage of the member's acts and omissions in the member's capacity as a member of the board of trustees of the county education district. An insurance company may not sell liability insurance coverage to a school district covering the acts and omissions of school board members in their capacity as board members unless the policy also provides coverage for acts and omissions of a school board member in the member's capacity as a member of the board of trustees of a county education district.

SECTION 20.02. (a) This article takes effect October 1, 1991.

(b) This article applies only to an insurance policy or contract for liability insurance coverage for school board members that is delivered, issued for delivery, or renewed on or after January 1, 1992.

(c) A policy or contract for liability insurance coverage for school board members that is not covered by Subsection (b) of this section is subject to the law as it existed immediately before the effective date of this article, and that law is continued in effect for that purpose.

ARTICLE 21. CERTAIN CLAIM SETTLEMENT PRACTICES

SECTION 21.01. Section 2, Article 21.21-2, Insurance Code, is amended to read as follows:

Sec. 2. PROHIBITED PRACTICES. *(a)* No insurer doing business in this state under the authority, rules and regulations of this code shall engage in unfair claim settlement practices.

(b) Any of the following acts by an insurer shall constitute unfair claim settlement practices:

(1) [(a)] Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;

(2) [(b)] Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

(3) [(c)] Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies;

(4) [(d)] Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear;

(5) [(e)] Compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

(6) [(f)] Failure of any insurer to maintain a complete record of all the complaints which it has received during the preceding three years or since the date of its last examination by the commissioner, whichever time is shorter. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For the purposes of this subsection, "complaint" means any written communication primarily expressing a grievance; or

(7) [(g)] Committing other actions which the State Board of Insurance has defined, by regulations adopted pursuant to the rule-making authority granted it by this Act, as unfair claim settlement practices.

(c) An insurer regulated under this code may not require a claimant, as a condition of settling a claim, to produce the claimant's federal income tax returns for examination or investigation by the insurer unless the claimant is ordered to produce those tax returns by a court of competent jurisdiction, the claim involves a fire loss, or the claim involves a loss of profits or income. In addition to committing a prohibited practice under this article, an insurer who violates this subsection commits a deceptive trade practice under Subchapter E, Chapter 17, Business & Commerce Code, and an affected claimant is entitled to remedies under that subchapter.

SECTION 21.02. Section 2(c), Article 21.21-2, Insurance Code, as added by this article, applies only to an act done on or after the effective date of this Act.

ARTICLE 22. WINDSTORM AND HAIL INSURANCE

SECTION 22.01. Section 8D, Article 21.49, Insurance Code, is amended by adding Subsection (e) to read as follows:

(e) A policyholder who is insured on September 1, 1991, for an amount higher than the liability limits prescribed by Subsection (a) of this section may not be required to

reduce the insurance coverage to an amount lower than the amount in effect on September 1, 1991.

ARTICLE 23. RATES FOR INSURANCE ISSUED BY TEXAS CATASTROPHE PROPERTY INSURANCE POOL

SECTION 23.01. Notwithstanding the date specified in Section 3(c), Article 5.101, Insurance Code, as added by Section 2.01, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, not later than December 31, 1991, the State Board of Insurance shall promulgate a benchmark rate applicable only to the setting of rates for insurance issued by the Texas Catastrophe Property Insurance Pool under Section 8, Article 21.49, Insurance Code. The benchmark rate shall be otherwise set in the manner provided by Article 5.101, Insurance Code, as added by Section 2.01, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991. The benchmark rate promulgated under this provision is applicable to rates for insurance issued by the Texas Catastrophe Property Insurance Association in accordance with Section 8(h), Article 21.49, Insurance Code, as amended by Section 11.43, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991, on and after January 1, 1992. The benchmark rate promulgated under this provision expires effective the date a benchmark rate is promulgated by the board in accordance with Section 3(c), Article 5.101, Insurance Code, as added by Section 2.01, Chapter 242, Acts of the 72nd Legislature, Regular Session, 1991.

SECTION 23.02. This article takes effect October 1, 1991.

ARTICLE 24. DEDUCTIONS FOR SUPPLEMENTAL BENEFITS FOR STATE EMPLOYEES

SECTION 24.01. Title 117, Revised Statutes, is amended by adding Article 6813g to read as follows:

Art. 6813g. DEDUCTIONS FOR SUPPLEMENTAL BENEFITS FOR STATE EMPLOYEES

Sec. 1. DEFINITIONS. In this article "state agency" means a department, commission, board, office, or other agency of any branch of state government, including an institution of higher education as defined by Section 61.003, Education Code.

Sec. 2. DEDUCTION AUTHORIZED. In addition to deductions for coverage under the Texas Employees Uniform Group Insurance Benefits Act (Article 3.50–2, Vernon's Texas Insurance Code) or other law, an employee of a state agency may authorize in writing a deduction each pay period from the employee's salary or wage payment for coverage of the employee under a supplemental optional benefits program, including a program of permanent life insurance, catastrophic illness insurance, disability insurance, or prepaid legal services, that may be made if the program has been approved by the Employees Retirement System of Texas under Section 3 of this article. The written authorization must direct the comptroller or, if applicable, the appropriate financial officer of an institution of higher education to transfer the withheld funds to the program designated by the employee. The comptroller or financial officer shall comply with the direction.

Sec. 3. ELIGIBLE PROGRAM. The Employees Retirement System of Texas shall designate supplemental benefit programs that are eligible to receive deductions under Section 2 of this article and that promote the interests of the state and state agency employees.

Sec. 4. FORM; DURATION. (a) The payroll deduction must be accomplished in a form and manner prescribed by the comptroller or the appropriate financial officer of an institution of higher education.

(b) The employee or the employee's designee may change or revoke the deduction authorization by delivering written notice of the change or revocation to the comptroller or financial officer, as appropriate. The authorization is effective until the date the comptroller or financial officer receives the notice. The notice must be given in a form and manner prescribed by the comptroller or financial officer.

Sec. 5. VOLUNTARY PARTICIPATION. Participation by employees in the program authorized by this article is voluntary.

Sec. 6. ADMINISTRATIVE FEE. The state may withhold from the employee's salary or wage payment an administrative fee for making the deduction under this article. The fee may not exceed the actual administrative cost of making the deduction or the highest fee charged by the state for making a similar deduction, whichever amount is less.

ARTICLE 25. EFFECTIVE DATE; EMERGENCY

SECTION 25.01. Except as otherwise provided by this Act, this Act takes effect January 1, 1992.

SECTION 25.02. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended, and that this Act take effect and be in force according to its terms, and it is so enacted.

Passed by the House on August 22, 1991: Yeas 128, Nays 0, 1 present, not voting; the House concurred in Senate amendments to H.B. No. 62 on August 25, 1991: Yeas 132, Nays 1; passed subject to the provisions of Article III, Section 49a, of the Constitution of the State of Texas; passed by the Senate, with amendments, on August 25, 1991: Yeas 29, Nays 2; passed subject to the provisions of Article III, Section 49a, of the Constitution of the State of Texas.

Approved August 30, 1991.

Effective January 1, 1992, and as otherwise provided in this Act.