



Biennial Report of the Texas Department of Insurance to the 82nd Legislature

December 2010

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Mike Geeslin

Commissioner of Insurance



Texas Department of Insurance
Commissioner of Insurance

333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-463-6464 telephone • 512-475-2005 fax • www.tdi.state.tx.us

December 31, 2010

The Honorable Rick Perry, Governor
The Honorable David Dewhurst, Lieutenant Governor
The Honorable Joe Straus, III, Speaker

Dear Governors and Speaker:

In accordance with Section 32.022, Texas Insurance Code, I am pleased to submit the biennial report of the Texas Department of Insurance (Department or TDI). The report summarizes needed changes in the laws relating to regulation of the insurance industry, provides information on market conditions, and includes reviews required by Senate Bill 1 (81st Legislature, Regular Session).

The Department is available to discuss any of the issues contained in the report and to provide technical assistance. Please contact me or Carol Cates, Associate Commissioner of Government Relations, at 463-6123 with any questions or if you need additional information. Thank you for your consideration.

Respectfully Submitted,

A handwritten signature in black ink that reads "Mike Geeslin". The signature is written in a cursive style and is positioned above a horizontal line.

Mike Geeslin
Commissioner of Insurance

Mission Values

Texas Department of Insurance *Securing the Future for Texas*

Mission

- To protect insurance consumers by
- regulating the industry fairly and diligently
 - promoting a stable and competitive market
 - providing information that makes a difference

Values

We have a passionate commitment to service in the public interest. We are:

Responsible Stewards
accountable, efficient, effective
“Using resources wisely”

Professional
knowledgeable and fair
“Adhering to the highest ethical standards”

Collaborative
cooperative, inclusive, diverse
“Respecting others’ opinions and expertise”

Resilient and Creative
open-minded and proactive
“Learning from the past to enhance the future”

Balanced
fulfilled and well-rounded
“Celebrating personal and professional successes”

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Market Overview

Effect of the Economy on the Insurance Industry

Although the insurance industry has been buffeted by severe economic winds, the total amount of policyholder surplus held by insurers operating in Texas increased more than \$50 billion during the first 9 months of 2010, growing from \$874 billion to \$925 billion. (“Policyholder surplus” represents the amount of assets held over and above reserves and other liabilities.) Unlike the banking industry, which has experienced recent record failure rates, there have been relatively few recent failures of insurance companies. However, there is no doubt that the insurance industry has been negatively impacted by the economy; and certain sub-industries have been impacted more than others. The length of time it takes for the economy to return to strength, including the time it takes the nation’s employment levels to return to normal, will largely determine how well insurers respond to their current challenges. This section describes:

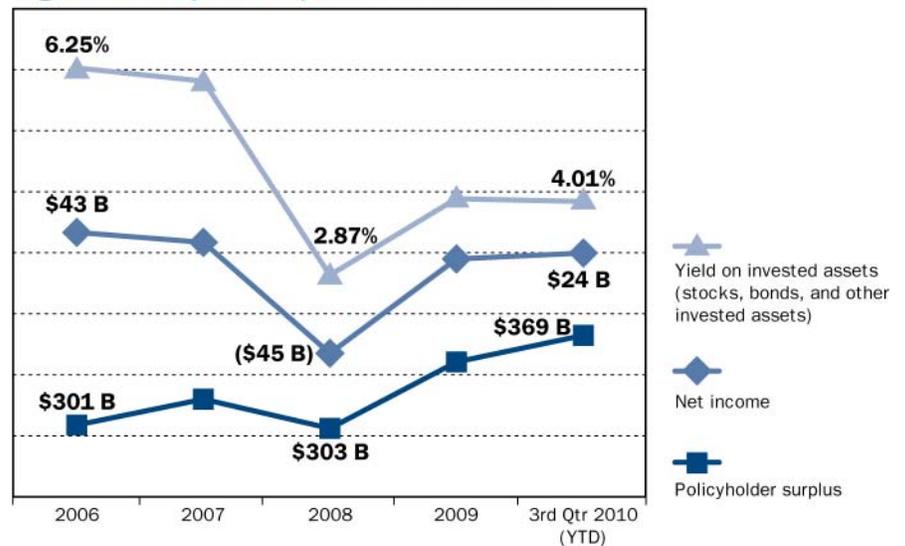
- economic pressures impacting insurance companies, including why certain types of insurers have been impacted more than others;
- a summary of pertinent regulatory protections for consumers; and
- actions being taken by the Department to protect the public.

Life, Health and Annuity Insurers

The declines in the investment markets that occurred in 2008 often had a larger effect on life and annuity insurers compared to property and casualty insurers because of the types of assets that they hold. Conversely, life and annuity insurers often benefited more from the recent improvements in the investment markets. The recent investment results, however, have been partially offset by declines in earned premium revenue.

- Life and annuity insurers typically hold a greater percentage of their assets in stocks and other assets whose value increased along with recent improvements in the investment markets.
- However, normal operating earnings have been depressed due to a decline in earned premium revenue, which is believed to relate to the nation’s unemployment levels and reductions in discretionary income.
- Certain annuity insurers have been challenged by a combination of reduced premium volume and low investment yields on short-term

Figure 1: Life/Health/Annuities Market



securities. Early reports indicate that life and annuity insurers have recently increased their holdings in long-term bonds.

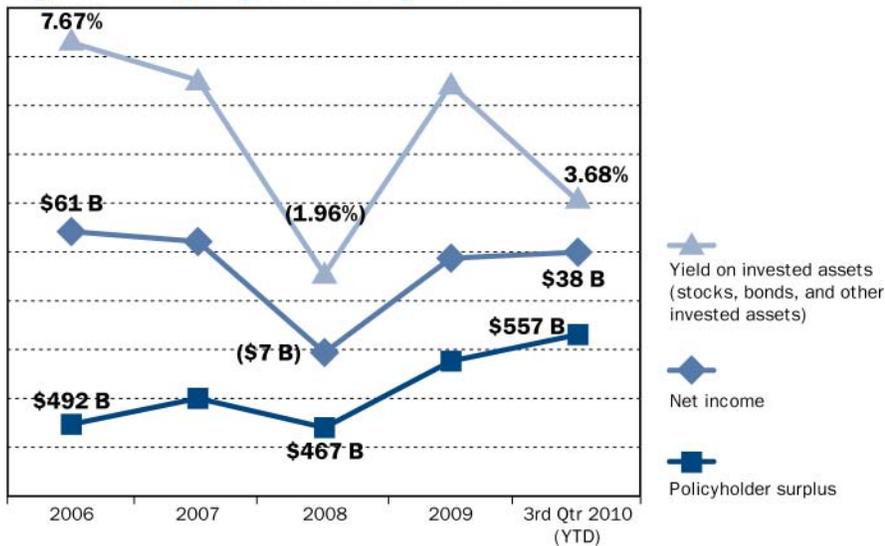
- Certain health insurers are being challenged by declines in commercial enrollment related to unemployment rates and uncertainties relating to federal health care reform.
- Certain insurers that offer long term care insurance are being challenged by depressed demand from consumers and historical pricing inadequacies.
- Despite these challenges, life, health and annuity insurers operating in Texas reported that their policyholder surplus increased \$20.8 billion in the first 9 months of 2010 to \$369 billion, a 6% increase, largely due to a decrease in capital losses on their investments.

Property and Casualty Insurers

The property and casualty industry generally fared better than the life and annuity industry when the investment markets declined in 2008. Nevertheless, the property and casualty industry has been confronted by a number of adversities related to economic conditions, including reduced demand from consumers, as well as losses from flooding and winter storms in other states. Certain types of property and casualty insurers, such as mortgage insurers and financial guaranty insurers, were impacted more from the economy than others. On balance, however, the industry has shown resilience in terms of income and growth in policyholder surplus.

- Because property and casualty insurers generally hold relatively smaller percentages of their investments in stocks, real estate and mortgage-related securities, declines in those markets generally did not impact them to the same degree as life and annuity insurers.
- Property and casualty insurers tend to invest fairly conservatively. Excluding investments in affiliates, investments in bonds comprise the majority of the industry's invested assets.

Figure 2: Property & Casualty Market



- Depressed demand led to decreases in premiums for certain types of insurance sold in other states, with the declines typically in states with higher unemployment and foreclosure rates.
- Early indications are that underwriting results from a pure insurance function weakened somewhat in the first part of 2010.
- Mortgage and financial guaranty insurers experienced more significant losses. Although these insurers comprise a small percentage of the industry in terms of premiums, their losses have had a disproportionate impact on the industry's overall results.
- Title insurance companies and title agencies were also impacted more from the economy than other types of entities. Revenues have been negatively impacted by weaknesses in the housing markets, and may continue to be impacted in the future by recent foreclosure processing issues.
- Despite these challenges, property and casualty insurers operating in Texas increased their policyholder surplus by \$31 billion in the first 9 months of 2010 to \$557 billion, a 6% increase. Title insurers, however, reported a decrease in their policyholder surplus of \$329 million to \$2.5 billion through the 3rd quarter of 2010.

Consumer Protections

The following is a non-exhaustive summary of certain protections for the insurance-buying public:

- Authorized investment statutes limit the types of investments that can be made by insurers. These laws are designed to ensure that insurers invest conservatively, limit or prohibit risky investments, and diversify their investment portfolios.
- Risk Based Capital (RBC) requirements index the amount of capital that insurers are required to maintain to the unique risks they assume. For example, larger insurers and those that make riskier investments are required to maintain more capital than smaller insurers and those that invest conservatively.
- The Holding Company Systems Act is designed to protect insurance companies and their policyholders from potential abuses of insider control positions. This report includes a recommendation that the Texas Legislature update the Texas Holding Company Systems Act to enhance existing consumer protections.
- Insurance companies must undergo annual audits by independent certified public accountants and have their reserves reviewed by actuaries.
- Guaranty Associations exist to pay certain insured claims for insurers that have been declared insolvent. These associations are comprised of other insurers in the insurance industry who pay the outstanding insured claims of a failed insurer in the event a company becomes insolvent.

Protecting the Public—Informal Actions

The Department routinely takes a number of regulatory actions in order to protect the interests of the public. While the Department stands ready, if necessary, to formally intervene in troubled company scenarios, it typically views formal interventions as a last resort when other informal options have been exhausted. The Department's pre-intervention actions include, but are not limited to:

- on-going financial monitoring of certain insurers and specific types of assets held in investment portfolios;
- coordinating efforts with insurance regulators from other states and other types of regulatory agencies, such as the Federal Reserve, the State Department of Banking, etc.;
- policing insurers' compliance with solvency requirements such as authorized investment statutes and RBC requirements;
- assisting the public by providing consumers with additional sources of information regarding specific insurers and situations; and,
- complaints resolution.

Protecting the Public—Regulatory Interventions

The Department strives to address regulatory concerns informally when possible, such as by hosting conferences with company management to discuss regulatory concerns. However, the Department can and will implement formal interventions in troubled insurance company scenarios when necessary to protect consumers. The Department's intervention authority, which is used judiciously, includes:

- issuing emergency cease and desist orders;
- issuing hazardous financial condition orders that require insurers to take corrective action;
- issuing orders that place insurers under supervision or conservation; and
- petitioning the Travis County District Court to place insurers into receivership, either for rehabilitation or liquidation.

Market Overview

Life and Health

Competition in the Market

Over the past several years, Texas has had a stable health insurance industry, with the number of companies in the market staying fairly consistent. As of October 2010, there were almost 500 companies authorized to write health coverage in Texas. This includes not only ‘traditional’ health insurance companies, but also health maintenance organizations (HMOs), property and casualty companies writing health insurance, and companies writing only through Medicaid or Medicare programs.

Carriers in Texas may choose which health insurance markets they participate in, and some carriers that are authorized to write health insurance do not actively offer health coverage. Of the carriers actively writing coverage:

- 31 carriers write coverage for small employers,
- 49 carriers write coverage for large employers,
- 37 carriers write non-employer coverage for members of associations, and
- 96 carriers write coverage for individuals and families.

Six new companies became authorized to write health insurance in Texas in 2009 and one in 2010. Three companies filed withdrawal plans in 2009 and 2010 to stop writing health insurance, and one more is expected to file a withdrawal plan in early 2011.

- Unicare Life and Health Insurance Company and Unicare Health Plans of Texas, Inc., an HMO, withdrew from writing large and small employer, association, and (in the case of Unicare Life) individual health insurance coverage, impacting approximately 187,000 lives. Arrangements were made for another carrier to offer coverage to Unicare’s insureds on a guaranteed issue basis.
- National Health Insurance Company withdrew from writing individual health insurance, affecting approximately 1,800 lives.
- Principal Life Insurance Company has filed a proposed withdrawal that is currently pending and affecting approximately 70,000 lives.

Growing Premium Volume

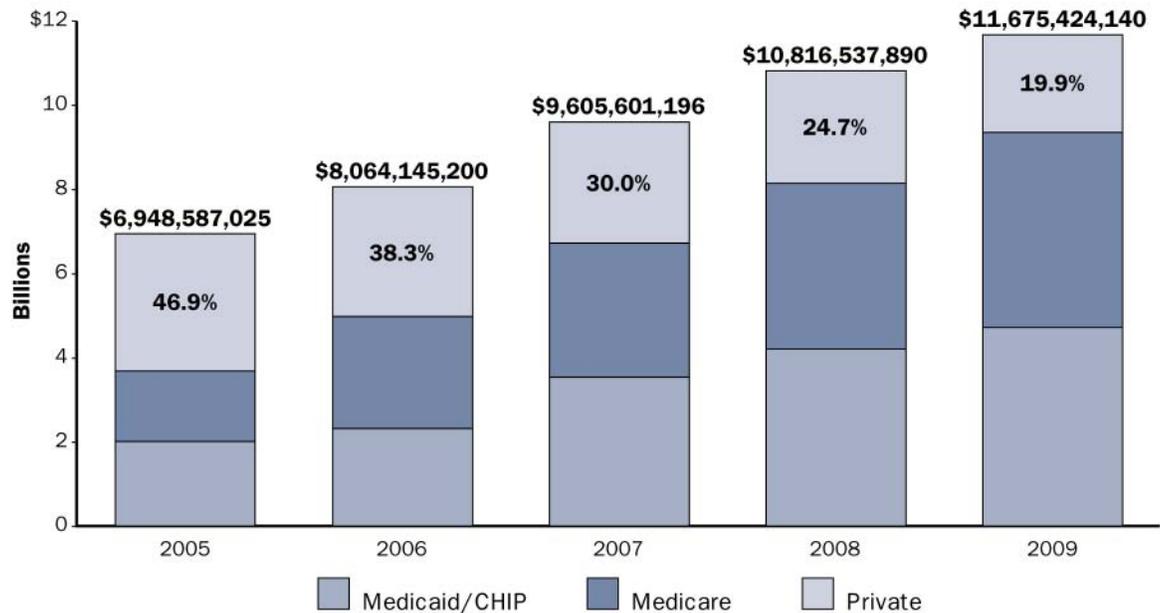
Total reported premium for all health insurance lines maintained a long standing trend of steady increases, rising from \$32.6 billion in 2008 to \$34.8 billion in 2009.

Consumer Choice Plans continue to increase in popularity. Legislation permitting these plans was passed in 2003. The plans are exempt from many state mandates and provide less-costly insurance options for businesses and individuals. In 2008, insurers reported that 362,655 Texans were insured under such plans, and this increased to 408,361 in 2009.

Over the last two years, carriers have reported notable increases in premiums received in certain product lines, particularly Medicare, Medicaid, and CHIP products. Overall reported premium for all carriers for those three lines increased from \$10.6 billion in

2008 to \$12.1 billion in 2009. Figure 1 below shows the increases specific to HMOs participating in the Medicare, Medicaid, and CHIP markets, but note that HMO premiums in the private commercial market have declined.

Figure 1: Texas HMO Premium Growth



Source: 2009 Annual Financial Data for Basic Service HMOs, Texas Department of Insurance

Types of Coverage in Texas

(see *Primer* on page 9 for descriptions of private health plans)

The next series of charts (Figures 2-9)¹ analyze the Texas population in 2009 by coverage status, funding source, and type of coverage. Figure 2 shows the 2009 population statistics on healthcare coverage in Texas. The Department only regulates the private insurance market, sometimes referred to as “fully insured coverage,” the source of about 21% of the health coverage in Texas. Figures 3-9 further analyze the insured populations.

1 The information for Figures 2-9 was compiled from numerous sources, including the following:

- March 2010 Current Population Survey (Texas Sample), United States Census Bureau.
- 2009 Medical Expenditure Panel Survey – Insurance Component, Agency for Healthcare Research and Quality.
- Texas Medicaid and CHIP in Perspective - Seventh Edition, Texas Health and Human Services Commission.
- Final Count — Medicaid Enrollment by Month, Texas Health and Human Services Commission.
- CHIP Enrollment, Renewal and Disenrollment by Month, Texas Health and Human Services Commission.
- 2009 Annual Financial Data for Basic Service HMOs, Texas Department of Insurance.
- 2009 Preferred Provider Benefit Plan Survey, Texas Department of Insurance.
- Employer Health Benefits – 2009 Annual Survey, Kaiser Family Foundation
- Medicare Advantage Fact Sheet, Kaiser Family Foundation
- Teacher Retirement System of Texas- 2009 Comprehensive Annual Financial Report
- Employees Retirement System of Texas - 2009 Comprehensive Annual Financial Report
- State-by-State FEHBP Enrollment Analysis, RUPRI Center for Rural Health Policy Analysis, University of Nebraska Medical Center

Since no single data source contained all of the information needed to conduct a thorough analysis, and most statewide surveys inherently contain a margin of error, TDI reconciled available information with industry experience to derive the data for this analysis.

Figure 3 details the private (fully insured) coverage (21.3% in Figure 2) and shows how the Texas population purchases its private health insurance. Figure 3 reflects that almost three quarters of privately purchased insurance coverage in Texas is employer-based. The rest is purchased directly from carriers by individuals. Figure 4 reflects the fully insured population by type of coverage, with the “Other” category including such coverages as indemnity, fee-for-service, and limited benefit plans.

Figure 2: 2009 Total Texas Population by Coverage Source

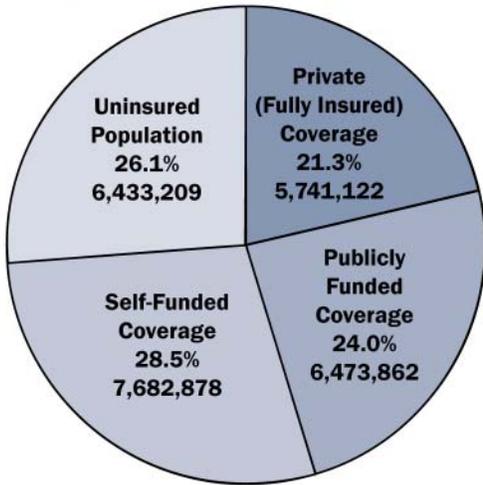


Figure 3: Private (Fully Insured) Population by Funding Source

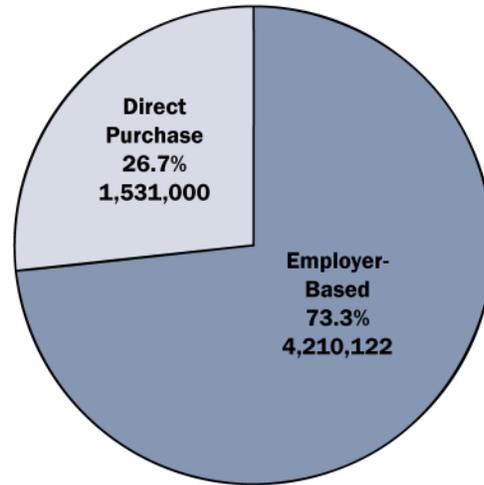


Figure 4: Private (Fully Insured) Population by Type of Coverage

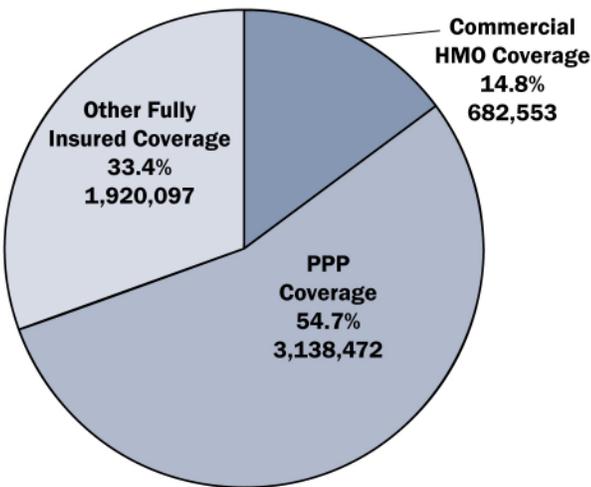
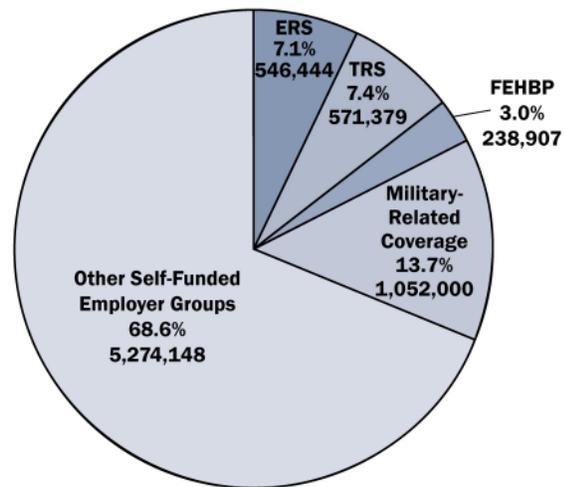


Figure 5: Self-Funded Population by Funding Source



By way of comparison to the private market, Figure 5 breaks down the self-funded insurance market (28.5% in Figure 2), reflecting the Texas population that is covered by self-funded health insurance plans in which the employers take on the risk themselves rather than insurance companies. Such employers include larger private employers, the Texas Employee Retirement System, the Texas Teacher Retirement System, the Federal Employees Health Benefit Plan, and military health coverage.

Figure 6 breaks down the self-funded insurance market by type of coverage, reflecting that the vast majority of self-funded plans consist of Preferred Provider Plan (PPP) coverage.

Again, by way of comparison, Figure 7 breaks down publicly funded coverage in Texas (24.0% in Figure 2), reflecting Medicare, Medicaid, and CHIP percentages.

Figure 6: Self-Funded Population by Type of Coverage

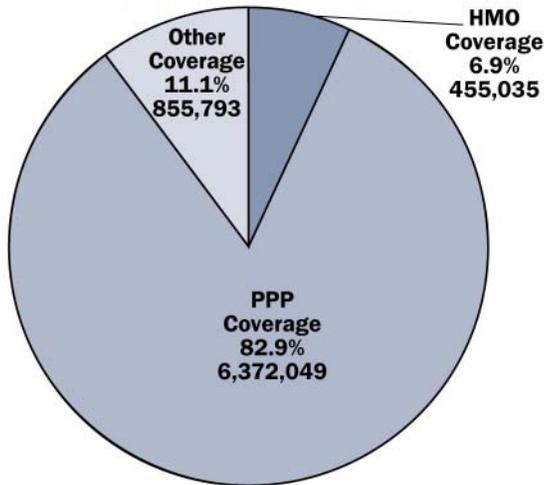


Figure 7: Publicly Funded Population by Funding Source

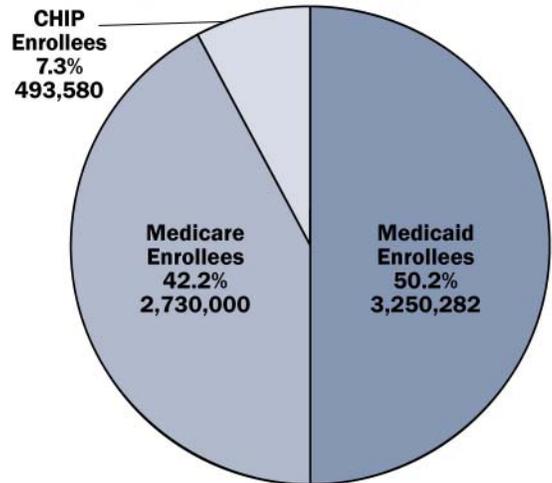


Figure 8: Publicly Funded Population by Type of Coverage

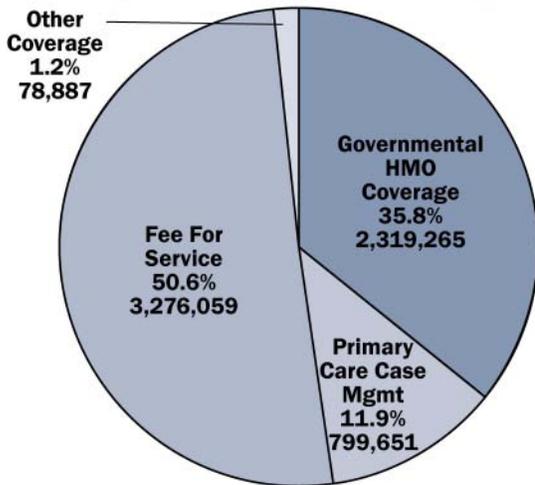


Figure 9: Texas Insured Population by Type of Coverage

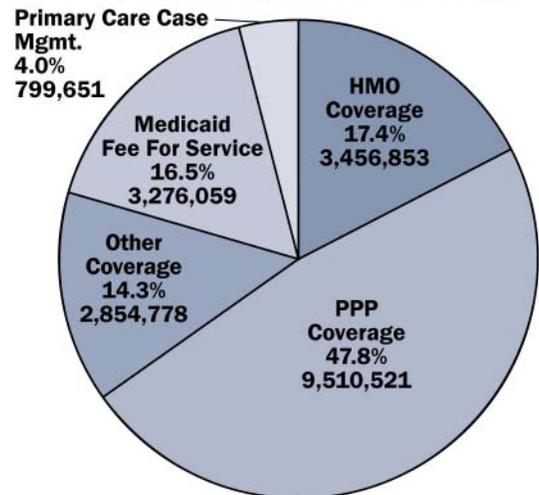


Figure 8 breaks down the publicly funded coverage by type of coverage, reflecting that PPP coverage is uncommon for this type of coverage.

Figure 9 combines the insured charts above (private, self-funded, and public coverages) to show the distribution of insureds by publicly funded plan type, including PPP plans, HMO plans, and other coverage (such as fee for service, indemnity and primary care case management).

Primer on the Types of Private Health Insurance Coverage in Texas

- **Health maintenance organizations (HMOs)** usually require the use of providers within the HMO's network. There are exceptions for medical emergencies and for when medically necessary covered services are not available within the network.

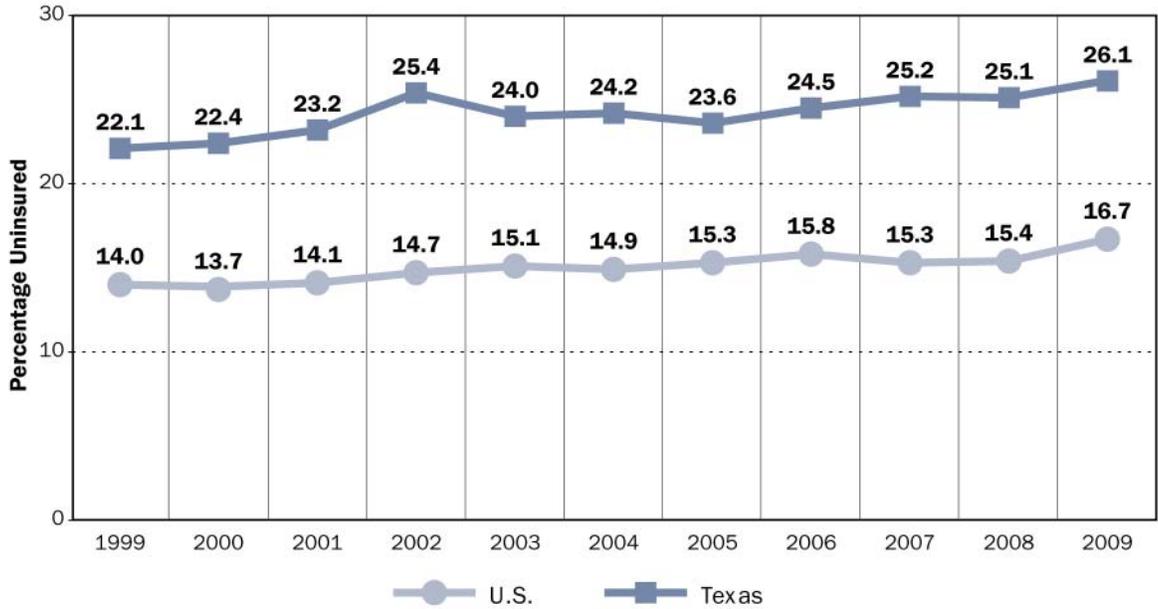
With an HMO, a primary care physician is selected to oversee all medical care and provide referrals to specialists and other providers. HMOs may pay primary care physicians a set monthly fee for each member, regardless of how many covered services they perform.

- **Preferred provider plans (PPPs)** are more flexible than HMOs, with networks of doctors and financial incentives in the form of higher coinsurance and lower copayments to use them. Insureds don't have to go to providers in the PPP's network, but costs will be lower if they do. PPPs don't require that insureds select a primary care physician, and insureds don't have to get a referral to see an out-of-network doctor or specialist.
- **Point-of-service (POS)** plans are a combination of HMOs and PPPs. Insureds are required to choose a primary care physician but can go to out-of-network doctors without a referral. If insureds use providers outside the network, they have to pay more. A POS plan may exclude the option for out-of-network care for certain medical conditions. POS coverage is usually offered as an add-on to the plan—known as a rider—for an additional fee.
- **Hospital surgical policies** cover only expenses directly related to hospital and surgical services, such as daily room, surgery, and doctor charges.
- **Hospital indemnity policies** pay up to a maximum fixed amount for each day in the hospital.
- **Specified or dread disease policies** only cover specific illnesses listed in the policy, such as cancer or AIDS. This coverage may also be offered as a rider to extend other types of individual coverage.
- **Short-term policies** are generally used to avoid a gap in coverage and protect from the expense of a sudden serious medical condition when between traditional health insurance plans. Short term coverage is less expensive than traditional coverage and usually does not limit which hospitals or providers may be used, but usually excludes preexisting conditions.

The Uninsured

While the health insurance market in Texas continues to grow, so, too, does the number of uninsured. As an update to the Department's report to the Legislature in December 2008 regarding the uninsured, Figure 10 illustrates the percentage of uninsured in Texas and in the U.S.

Figure 10: Uninsured in Texas and the U.S.



Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, Health Insurance Historical Table HIA-4.

Figure 11: Texas Uninsured Population by Labor Force Status
(Non-retired persons 18 and older for whom labor force status could be determined)

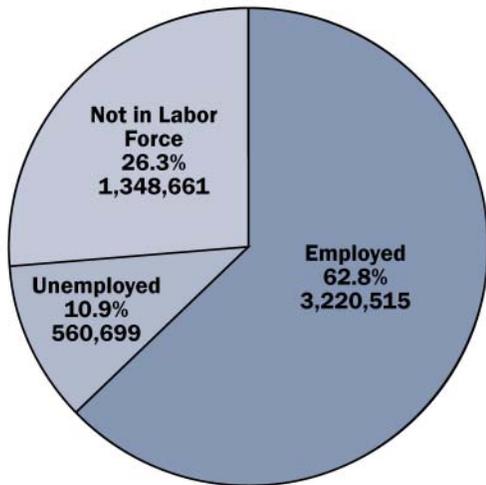


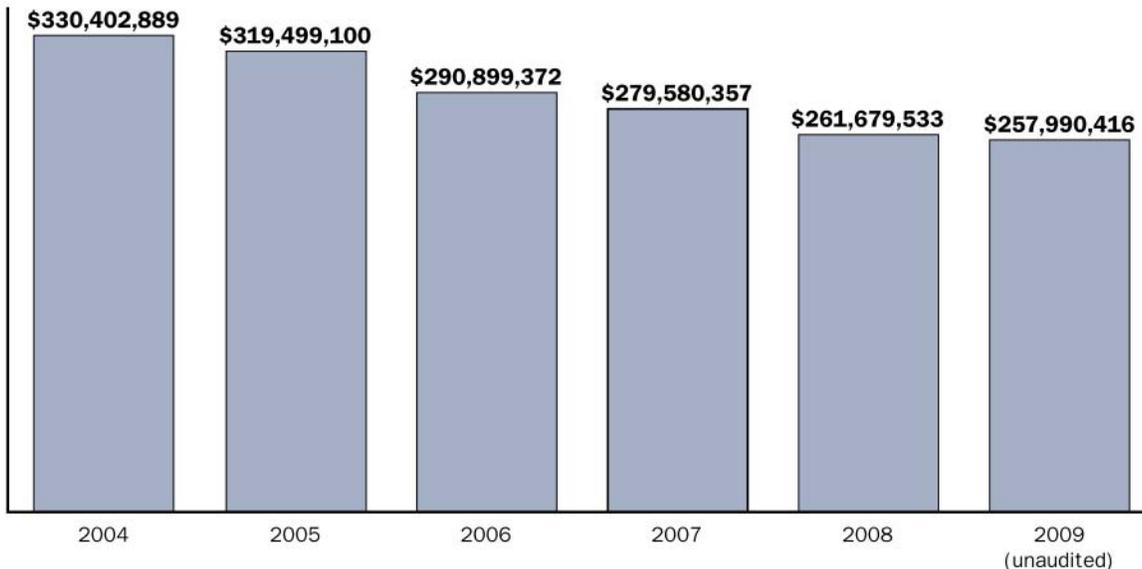
Figure 11 illustrates the percentage of the uninsured that are currently in the workforce in Texas.

Credit Life and Accident Insurance

Credit life and credit accident and health rates are regulated. Effective with House Bill 2159, passed by the 77th Legislature, presumptively appropriate rates are set through a rulemaking process instead of a contested hearing rate process. Issuers have the opportunity to use rates that are +/- 30% of the presumptive rates and request approval for a greater deviation if the request is actuarially justifiable.

Senate Bill 1429, passed by the 78th Legislature, permits lenders governed by Chapter 342 Finance Code “to offer to the borrower a debt suspension agreement or debt cancellation agreement under similar terms and conditions as such an agreement may be offered by a bank or savings association.” The decrease in actual earned premium for credit insurance, as reflected in Figure 12, may be due to the use of these agreements. Banking and credit union entities providing such agreements are not regulated by the Texas Department of Insurance.

Figure 12: Credit Insurance Actual Earned Premium



Discount Health Care Programs

As a result of HB 4341 (81st Legislature), TDI assumed regulation of 37 Discount Health Care Program Operators on April 1, 2010 from the Texas Department of Licensing and Regulation. As of November 30, 2010, there are 39 registered Discount Health Care Program Operators in Texas.

Agent Licensing

Electronic Application Filing: Six years ago, the Department began accepting via the National Insurance Producer Registry electronic applications from nonresident individuals for agent licenses, specifically those qualifying for a license by reciprocity. In July 2010, the Licensing Division added electronic nonresident entity application filings and resident individual application filings. By increasing the number of applications filed electronically, the Licensing Division is able to save time, paper, postage, and decrease

the number of applications rejected as incomplete by providing the applicant guidance through the electronic fields of the application.

Licensing now accepts electronic filings for all major lines licenses: General Lines - Life, Accident and Health, General Lines - Property & Casualty, Life Agent, and Personal Lines Property & Casualty. Figure 13 represents for the month of November 2010 the proportion of electronic applications processed in comparison to paper and Prometric applications. Prometric applications are those applications received via the Licensing Division's examination vendor, Prometric, and partially processed by Prometric.

**Figure 13: November 2010
Application Processing:
Paper and Electronic Applications**

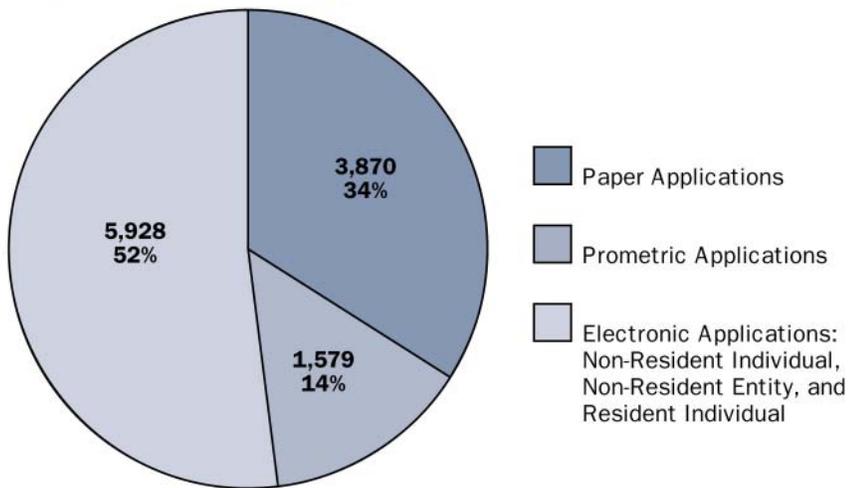


Figure 13 reflects that, of the 5,928 electronically filed applications in November 2010, 623 were filed utilizing the newly available electronic filing options for non-resident entities and resident individuals. The Licensing Division anticipates this number to grow rapidly as additional license lines are added and applicants become more familiar with the electronic application process.

Life and Annuity Insurance

Unlike the health insurance market, the economic downturn impacted the life insurance and annuity markets. Of the two, sales of annuities fell by a much higher degree. Figure 14 reflects the gross life and annuity premium volumes for the years 1999 through 2009.

Viatical and Life Settlements

Texas laws allow life insurance policy owners to access their policy's death benefit or convert the policies to cash before death. A life insurance policy is considered personal property and can be sold for cash, similar to other property, although some special rules apply. Life insurance policies can be sold to authorized viatical and life settlement providers for a percentage of the policy's death benefit. Viatical and life settlement providers, provider representatives, and brokers (agents who represent policyholders to negotiate settlement transactions) must register with TDI.

Settlement providers pay a percentage of the policy's face value. The price paid takes into consideration the life expectancy of the insured, current interest rates, and policy premium rates, among other factors.

Figure 14: 1999-2009 Life Annuity Premium Volume

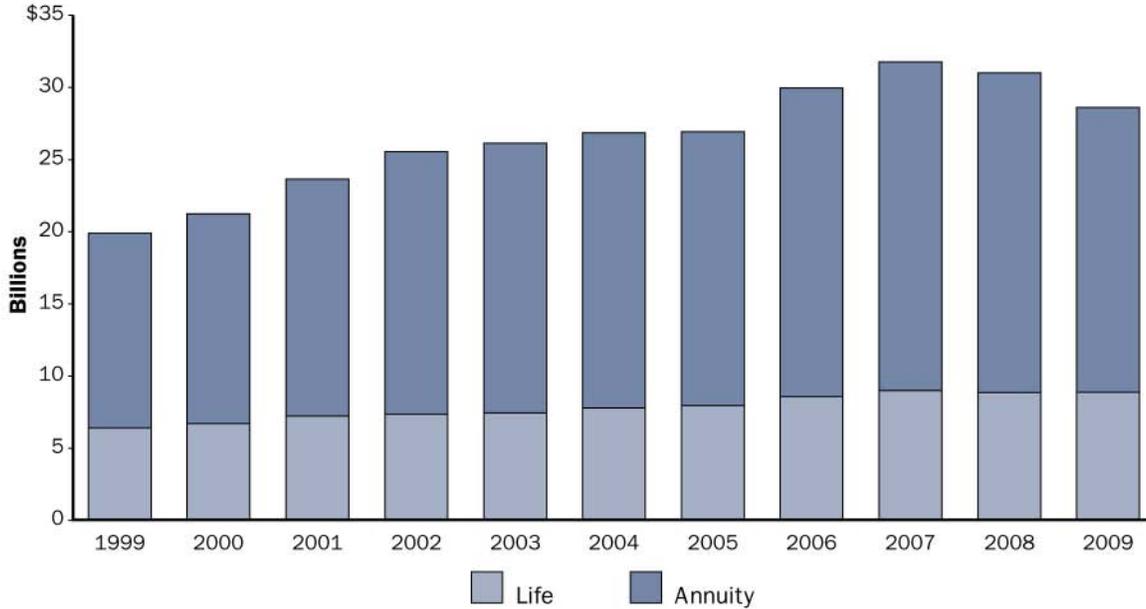
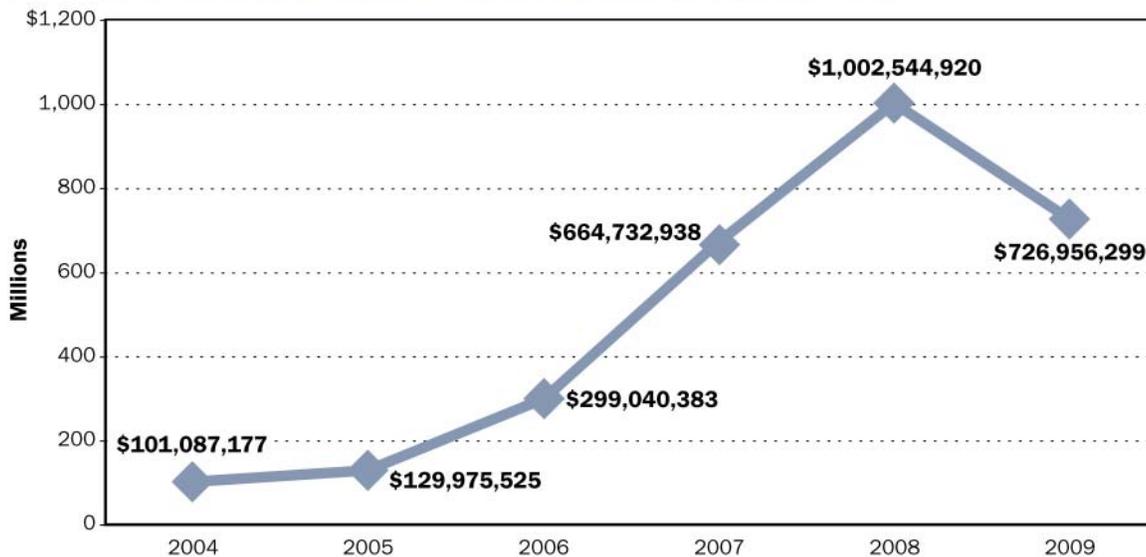


Figure 15 shows Texas data collected by TDI from viatical and life settlement providers on the face amount of life insurance policies purchased through viatical and life settlements. With the financial downturn, the number of policies purchased declined sharply.

Figure 15: Total Face Amount of Texas Viatical/Life Settlements



Market Overview

Property and Casualty

In general, the Texas property and casualty insurance market remains healthy; however, the threat of hurricanes affects the residential and commercial property market along the coast, while severe spring storms in recent years resulted in property losses further inland. In addition, increases in non-weather loss costs put an upward pressure on property rates. For the other major lines of insurance, insurers continue to see favorable results largely due to stabilizing loss trends and reforms enacted by the Texas Legislature that helped mitigate losses and create competition.

Homeowners Market

Fiscal Year 2010 was a mild year in terms of Texas weather, a stark contrast to the previous fiscal year that saw Hurricane Ike make landfall on Galveston Island. The National Association of Insurance Commissioners (NAIC) releases yearly comparison data reflecting statewide average premiums from two years previous. Data released in December 2009, reflecting average premiums in 2007, showed Texas overtaken by Florida and Louisiana in highest average premium (all policy forms combined). Data released in December 2010, reflecting average premiums in 2008, shows that Texas' average premium (all policy forms combined) is still less than Florida's, and about 10 percent higher than Louisiana's average premium. These results are despite the fact that Texas data includes its wind risk, while neither Florida nor Louisiana include premiums and policies from their wind insurers of last resort. Nevertheless, Texas along with the other Gulf Coast states continues to experience an upward pressure on homeowners rates, a result of the unusual hurricane activity of 2004-2005 and exacerbated by Hurricanes Dolly and Ike in 2008, severe storm seasons, and general increases in non-weather loss costs. Direct written premium in Texas' admitted market for 2009 was \$5.6 billion, compared with \$5.3 billion in 2008.

The active hurricane seasons of 2004 and 2005, coupled with predictions of continued increased hurricane activity, led to affordability and availability problems for properties along the Texas Gulf Coast. The 2008 hurricane season was an active one with hurricanes Gustav, Dolly and Ike, and tropical storm Edouard affecting the Texas coast. Hurricane Ike hit Texas on September 13, 2008; as of June 30, 2010, insurers had reported over 800,000 claims for all personal and commercial lines of insurance in those counties that were declared disasters, totaling \$11.9 billion in claims payments and an estimated total gross loss of \$13.7 billion from this single weather event. Residential property losses are a significant portion of the total loss.

The Texas Windstorm Insurance Association (TWIA) continues to grow due to decreased availability of insurance along the Texas Gulf Coast. The number of policies written in TWIA has more than tripled since 2001. As of October 31, 2010, the policy count for TWIA was 242,271, with direct liability in force of \$67.6 billion. This does not include indirect liability such as additional living expense and business income, which is

estimated at \$6.5 billion. TWIA's rates for residential property have increased by more than 37 percent since 2006. The most recent rate change of 5 percent is effective January 1, 2011. In 2008, TWIA member insurers were assessed a total of \$100 million for Hurricane Dolly and \$430 million for Hurricane Ike, with \$230 million of the assessments subject to premium tax credits. In addition, the \$470 million catastrophe reserve trust fund was used to pay losses and TWIA estimates that its \$1.5 billion in reinsurance will be exhausted. Current estimates are that Hurricane Ike will result in an estimated \$2.3 billion in insured losses for TWIA. As of December 2, 2010, the catastrophe reserve trust fund has an approximate balance of \$76.3 million.

The Texas Fair Access to Insurance Requirements (FAIR) Plan Association (the insurer of last resort for residential property) has also been affected by concerns for hurricane exposed areas of the state. In November 2004, the policy count for the FAIR Plan peaked at more than 134,000 policies. As of October 31, 2010, the policy count was 85,482. The overall decline in policy count is normally an indicator of a healthy market. However, the policy count in Harris County is concerning. In December 2008, the policies in force in Harris County were 51,604, or 61.1 percent of the FAIR Plan's policies. In December 2009, the policies in force in Harris County fell to 45,945 which represented 63.0% of the FAIR Plan's policies. Since then it has increased to 56,014 policies in force as of September 30, 2010 which is 66.4 percent of the FAIR Plan's policies. Despite the fluctuation in the actual policy counts, they are at their highest level to date in Harris County, and the ratio of policies in Harris County to statewide has increased over time and represents two-thirds of the policies written in the FAIR Plan as of September 30, 2010. While the FAIR Plan is prohibited from providing windstorm and hail coverage in the first tier coastal counties and those areas designated as a catastrophe area in Harris County, it does provide this coverage in the remainder of Harris County and all other counties in the state. The growth seen in the FAIR Plan in the second tier coastal counties indicates potential availability and affordability problems for residents in those areas.

Effective November 1, 2008, the FAIR Plan revised its rates upward by 20 percent in the second tier coastal counties and downward by 20 percent in the first tier coastal counties. The remainder of the state also received rate decreases ranging from 8 percent to 20 percent. Subsequently, effective September 1, 2010, the FAIR Plan increased its homeowners rates another 5 percent in the second tier coastal counties and upwards of only 1.4 percent in the first tier coastal counties. The remainder of the state also received rate increases of 5 percent.

Based on the top ten insurers in the market, overall rates decreased 13.5 percent between June 2003 and September 2006. Currently, homeowners rates in Texas are 5.1 percent higher than they were at the time of the 2003 market reforms, though it bears noting that rate increases in Texas are far below the pace of increases in other states (and other Gulf coast states in particular). These changes were due in large part to major weather events, including hurricanes and severe spring storms, changes in reinsurance, and other market forces. During 2009, just over half the rate filings received were revenue neutral changes; 40 percent were for rate increases. For the annual period ending June 30, 2010,

rate increases for the first and second tier coastal counties are estimated at under 8 percent. Non-coastal average rate increases are estimated at 6 percent and vary by county. Non-coastal rates were constant or declining in 2008.

Despite expected catastrophic losses, Texas continues to attract new entrants and new products to the homeowners market, providing more choices and increased competition for Texas insurance consumers. Between January 1, 2009 and December 17, 2010, eight new insurers filed homeowners insurance products and seven existing insurers filed new homeowners products. While these new products generally include variations of the traditional coverages, the migration toward more “all risks” type of coverage continues.

Personal Auto Market

The personal auto market appears competitive with new entrants, new products, moderate rate increases and a continued decline in the volume of drivers in the assigned risk plan. Direct written premium in the admitted market for 2009 was \$13.2 billion, slightly higher than the \$12.7 billion for 2008.

The Texas Automobile Insurance Plan Association (TAIPA), the market of last resort for commercial and private passenger auto, continues to experience substantial decreases in total assignment counts. In 2005 the assignment counts were 31,517; assignment counts for 2009 were 10,299 and assignment counts for 2010 (through November) are 8,193.

The Department continues to lead the multi-agency TexasSure Vehicle Insurance Verification project, the financial responsibility verification program mandated by SB 1670 (79th Legislature, 2005)(TexasSure). TexasSure was implemented in late 2008 to verify insurance during traffic stops by law enforcement and at vehicle registration renewal. In June 2010, TexasSure began sending Uninsured Notices to the owners of registered vehicles that appear to be uninsured. While these notices have no fines or penalties associated with them, the Department anticipates they will have some impact on the uninsured rate. TexasSure data shows the number of vehicles not matched to an insurance policy dropped from 24.28% in December 2008 to 22.88% in December of 2010, with a program low of 19.71% in August 2010. The Department monitors TexasSure data for possible seasonal and economy-related trends. Additionally, the Department continues to monitor industry preparedness for additional customers and claim volume as a result of TexasSure.

Between January 1, 2010 and September 30, 2010, 136 companies made a total of 471 rate filings. Even though about 14 percent of these filings represented rate decreases, close to 30 percent represented rate increases, and the remaining filings represented no overall rate change. The industry statewide rate change was about zero percent. This is down from the average industry rate change of three percent in 2009, and influenced by some rate decreases taken by larger insurers.

Texas continues to attract new entrants to the personal automobile market. Between January 1, 2009 and December 17, 2010, 9 new insurers filed personal automobile insurance products and 22 existing insurers filed new personal auto products. These new products and new entrants mean more choices and increased competition for Texas insurance

consumers. In recent years, a number of companies began writing personal automobile policies that require household residents to be specifically named on the policy in order for coverage to apply (named driver policies). These policies have generated some public policy discussion and legislative review may be warranted.

Medical Professional Liability Market

In 2003, the Legislature enacted legislation that reformed the tort system, significantly impacting medical liability insurance losses. These reforms continue to have a positive impact on the physicians' medical malpractice market, which is more competitive compared to prior years.

Direct written premium in the admitted market for 2009 was \$234 million, compared with \$242 million in 2008. Direct written premium has been declining over the last several years, down from a high of \$539.9 million in 2003. This reduction in written premium is due in large part to rate reductions implemented by insurers.

Physicians' medical malpractice rates have dropped with all of the top five writers announcing significant rate reductions over the past several years. As of December 17, 2010, the cumulative rate change since September 2003 for 17 major physician medical malpractice insurers is -28.7%.

The policy count in the Texas Medical Liability Insurance Underwriting Association (JUA), which is the market of last resort for medical providers, continues to decline. The number of policyholders started to decline in December 2004, from approximately 2,600 to 175 as of September 30, 2010.

Between December 1, 2008 and December 1, 2010, there have been two new entrants into the admitted market for physicians. In addition, several new risk retention groups have been registered to write medical liability insurance. Risk retention groups are formed under the provisions of the federal Liability Risk Retention Act for the purpose of providing insurance. The rates and policy forms of risk retention groups are not regulated, and risk retention groups are not covered by the Guaranty Fund.

Title Market

After 10 years of unprecedented growth in the Texas title insurance industry, the effects of the current economic downturn are becoming apparent. Ten agents were placed in conservatorship or receivership in calendar year 2008, as opposed to an average of one per year for 2005 through 2007. In calendar year 2009, two agents were placed in receivership or supervision. In calendar year 2010, one agent was placed in supervision. The Commissioner proposed rules to implement HB 4338 (81st Legislature, 2009) which include provisions for minimum capitalization for title agents. A hearing is scheduled for January, 2011.

Written premiums for Title also reflect the market downturn:

2006 - \$1,646,214,607

2007 - \$1,621,647,087

2008 - \$1,233,649,075

2009 - \$1,017,604,499

The rules phase of the 2008 Biennial Title Hearing concluded with 47 new or revised rules and forms adopted. An order was issued in the rate phase of the 2008 Biennial Title Hearing with no change to the basic premium, but with a two percent credit when minerals coverage and minerals searches are reduced by use of a general exception.

During fiscal year 2009, 598 licensed title agents held a total of 1,631 licenses. In fiscal year 2010, 582 licensed title agents held a total of 1,631 licenses.

There were 5,961 escrow officers holding 6,921 escrow officer licenses in fiscal year 2009, and 5,667 escrow officers holding 6,680 escrow officer licenses during fiscal year 2010.

There were 14 licensed direct operations in fiscal year 2009 and 11 licensed direct operations in fiscal year 2010.

During fiscal year 2007 there was \$243 billion in title escrow accounts. This number increased to \$251 billion in fiscal year 2008. The amount of escrow funds flowing through title agency escrow accounts decreased to \$240 billion in fiscal year 2009 and decreased to \$146 billion in fiscal year 2010.

Workers' Compensation Market – Rates

Since 2002, the workers' compensation insurance industry has experienced underwriting profits after numerous years of substantial underwriting losses. This allowed insurers to file more rate reductions and increase the use of competitive pricing tools to further reduce employers' premiums.

Direct written premium in the admitted market for 2009 was \$2.2 billion, compared with \$2.6 billion for 2008 – a 16 percent drop.

In 2005, the Legislature enacted House Bill (HB) 7, which represents the most comprehensive organizational and policy reforms to the Texas workers' compensation system since 1989. One aspect of these reforms is the requirement for the Department to hold a hearing before December 1 of even numbered years to determine the impact of the HB 7 reforms on workers' compensation rates and premiums. Following these biennial hearings, the Department issues a report that includes information regarding the impact of HB 7 on the availability and affordability of workers' compensation insurance. While it is still early to fully evaluate the impact of HB 7 on rates, it is clear that losses have come down significantly since the late 1990's and, while rates and premiums have followed suit, there continues to be room for further reductions in rates and premiums.

Between January 1, 2009 and November 1, 2010, average rate levels were reduced by approximately 14 percent. This does not include the network credits filed by insurers. There were minimal rate increases effective in 2009 and 2010; 7 and 4 percent respectively. Furthermore, there were 40 rate decreases effective in 2010 compared with 69 rate decreases effective in 2009. Most filings were revenue neutral in each year, primarily due to insurers adopting the Department's promulgated classification relativities. These relativities are used by insurers in determining the rates charged for each classification.

In addition, the use of competitive pricing tools, along with rate reductions, brought the 2009 average premium per \$100 of payroll by policy year down to \$1.47; an approximately 23 percent decrease from the 2007 level of \$1.91 per \$100 of payroll. An example of a competitive pricing tool is schedule rating, which reflects characteristics of the policyholder (i.e., the employer) that may not be fully reflected in the employer's actual past experience. (Data is not yet available for 2010.)

Between January 1, 2009 and December 1, 2010, three newly licensed companies began writing workers' compensation coverage; and a total of 444 endorsements/form filings were submitted to the Department for prior approval. The majority of these filings are terrorism endorsements (due to changes and extension of the Federal law), negotiated deductible endorsement filings, dividend endorsements and filings adding various schedules to the Information Page.

Market Reform

Overview of the Patient Protection and Affordable Care Act

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) became law, which reformed not only how health insurance is sought and delivered, but also the nature of benefits provided. It is designed to be implemented over several years, with certain provisions already in effect. Health insurance plans that were in effect as of its effective date may be grandfathered for a period of time.

Under PPACA reform, pre-existing condition exclusions will no longer exist. Health insurance policies will no longer have annual limits. Insurers will no longer be able to rescind coverage, except in instances of fraud or material misrepresentation. Benefits for dependants must be made available through age 26, instead of Texas' earlier provisions for up to age 25.

PPACA requires the creation of health insurance exchanges, designed to connect individuals and small businesses with insurers offering coverage. Through the exchange, low-income individuals can apply for subsidies and employers can access tax incentives through a one-stop shop. Coverage offered through an exchange will consist of graduated levels of coverage, based on the amount of benefits offered as a percentage of the health plan's actuarial value.

Texas isn't required to establish and run an exchange, but enacting the legislation for the exchange will prevent policy decisions from being ceded to the federal government. If Texas does not establish and run an exchange, the federal government will establish and run the exchange. Exchanges are required to be operational by January 1, 2014, but by January 1, 2013, the Secretary of the U.S. Department of Health and Human Services will determine whether a state electing to develop an exchange has taken sufficient action necessary to implement an exchange.

Federal grants are available for use in planning, establishing and operating an exchange, but an exchange must be self-sustaining by January 1, 2015. An exchange may charge assessments or user fees to participating health insurers to generate funding or support its operations.

PPACA also requires the establishment of a tax-exempt reinsurance program for payments made by all health insurers to be equitably allocated to health insurers covering high-risk individuals in the individual market. PPACA also requires the sharing of risk by high actuarial risk health plans with low actuarial risk plans, but only in the individual and small group markets.

Implementing all of these reforms will require changes to the Texas Insurance Code to be consistent with and to reflect the new federal law. Texas will also need to make state-level policy decisions to determine what is best for Texas consumers. Failing to do so could generate consumer confusion in getting assistance, as well as confusion for health plan providers regarding jurisdictional issues.

Market Reform

Overview of the Dodd-Frank Wall Street Reform and Consumer Protection Act

An economic crisis, widely reported to be the worst since the “Great Depression,” began in the Fall of 2007, and resulted in the near collapse of the global financial system by the Fall of 2008. Economic policy makers around the world scrambled to find ways to prevent a similar future financial crisis. In June 2009, the Obama Administration released a comprehensive plan for financial regulatory reform to shore up consumer protection, enhance transparency in financial markets, and address the proper resolution, or dissolution, of those companies deemed “too big to fail.” On July 1, 2010, after a long and arduous political process, the president signed the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the Act). It represents the most significant legislative changes to financial supervision since the 1930s. The sweeping new federal laws impact a wide-range of U.S. financial industries, including banking, securities, derivatives, and other commercial enterprises. A number of the provisions also directly impact the insurance industry and insurance regulation. Although the new Act largely leaves state regulation of insurance intact, it may potentially pre-empt state insurance laws in several areas as discussed below.

While some of the provisions are immediately effective, the majority of the Act becomes effective in stages. The Act is complex, and many of its provisions are ambiguous. More clarity will only come when various federal agencies adopt numerous required regulations. By some accounts, the Act requires over 200 federal rulemakings and more than 60 studies. To conform to the Act, the Texas Insurance Code will require many revisions – now, and as future federal regulations are adopted. The summary below highlights those areas of the Act that clearly impact insurance.

Financial Stability Oversight Council

Title I of the Act creates the Financial Stability Oversight Council (the Council). It serves as an early warning mechanism to identify risks to the stability of the U.S. financial system that may arise from the material financial distress, failure, or market activities of large interconnected bank holding companies and nonbank financial companies. Nonbank financial companies include insurance companies although they have not historically posed the type of systemic risk envisioned. The Council is intended to enhance oversight of the U.S. financial system as a whole and to harmonize prudential standards across agencies. The new Office of Financial Research will serve as the information-gathering arm of the Council and will coordinate with state regulators, among others, to perform that function.

The Act empowers the Council to identify “systemically important” nonbank financial companies, and to bring them under federal authority by recommending heightened prudential standards for the Federal Reserve to impose on these companies. Once the Federal Reserve is authorized to regulate a nonbank financial company, it may issue increasingly strict rules for capital, leverage, liquidity and risk management and it may even

break up those companies that it deems to pose a threat to the U.S. financial system. The Council also has the power to recommend heightened prudential standards to primary financial regulators to apply to any activity that the Council identifies as contributing to systemic risk. The fifteen-member Council includes a presidentially appointed, independent voting member with insurance experience and a non-voting member selected by and representing state insurance regulators.

Orderly Liquidation Authority

Title II of the Act creates a new liquidation authority that replaces the Bankruptcy Code and other insolvency laws for liquidating financial companies and certain subsidiaries under certain circumstances. The orderly liquidation authority is unlimited and applies to any financial company in extreme cases upon certain findings, including that the failure of the financial company would have serious adverse effects on the financial stability of the United States. The Treasury Secretary has the authority to appoint the Federal Deposit Insurance Corporation (FDIC) as receiver of any financial company if certain conditions are met. The FDIC may also serve as receiver over the subsidiary of the financial company. The new statute, however, contains a presumption against applicability, and instead creates a presumption that favors applying the Bankruptcy Code or other insolvency laws to liquidate or reorganize an insolvent financial company.

A 2/3 vote of the Federal Reserve Board of Governors and the affirmative approval of the Director of the newly created Federal Insurance Office is required for an insurance company to be deemed a systemic risk to the economy and in need of winding down. Although the new federal financial reform is a broad brush effort to protect the public from financial disaster, it goes far to preserve state insurance laws and the state-based insurance regulatory system. If an insurance company or subsidiary is deemed systemically risky, it will be rehabilitated or liquidated pursuant to state receivership laws. However, if a state does not take action within 60 days after the determination of risk, the FDIC has the authority to step in and take the matter over from the state insurance commissioner.

To pay for the orderly liquidation of a systemically risky company, the FDIC may, under certain circumstances, assess financial companies that fall under one of two categories: they must have total consolidated assets of at least \$50 billion, or they must be non-bank financial companies supervised by the FDIC at the request of the Federal Stability Oversight Council. These funds would be assessed only if a systemically risky company became unstable and in need of resolution. The FDIC must take into consideration other assessments required of companies under state law, such as state insurance guaranty fund assessments, as it determines what kind of assessment it will require of an insurance company.

Federal Insurance Office

Title V of the Act established the Federal Insurance Office (FIO) within the Department of the Treasury, to be led by a Director appointed by the United States Treasury Secretary. The FIO is charged with monitoring, not regulating, all aspects of the insur-

ance industry, identifying gaps in the process that could contribute to a systemic crisis, and providing information and expertise to Congress and the Administration, including submitting a number of reports to Congress, the first of which is due within 18 months after enactment. FIO has limited subpoena power to obtain non-public records from insurers. Small insurers may be exempted from the FIO authority based on standards to be established by the United States Treasury. This gathering of insurance information within Treasury could facilitate more federal involvement in the regulation of the insurance industry. The FIO has authority with respect to all lines of insurance except health insurance, long-term care insurance (aside from those LTC policies included with life or annuity components), and crop insurance.

For some time, the European Union and other countries have sought to interact with a singular regulatory authority that represents the United States on insurance matters instead of individual states under the long-standing state based regulatory system. Recognizing this need, the Nonadmitted and Reinsurance Reform Act empowered the FIO to coordinate and negotiate international compacts and agreements involving insurance and could preempt state laws and regulations that conflict with those compacts and agreements if the FIO determines that the state provisions impose a “less favorable” treatment of a foreign carrier or conflicts with an existing international agreement. The Act also requires that any preemption achieve a level of protection that is substantially equivalent to that provided by the state laws and regulation. However, international agreements could potentially be used to decrease the collateral requirements of the state reinsurance laws that apply when a U.S. insurance company obtains reinsurance from a non-U.S. reinsurer.

Nonadmitted and Reinsurance Reform Act

The national nonadmitted insurance market generates approximately \$32 billion annually. Representing a little more than 1/8 of the United States market, Texas is the second largest market in the United States with approximately \$4.3 billion in nonadmitted insurance premium written in 2009. Nonadmitted agents and brokers have for some time found multistate premium tax payment and form filing procedures and processes among the states very inconsistent, complicated, and costly.

Drawing upon these difficulties, the Nonadmitted and Reinsurance Reform Act (NRRA) has a long history and has passed the House in previous Congressional sessions, but never passed the Senate until 2010. Recognizing a need for consistency and simplification in state regulatory measures, Congress included the NRRA in Title V of the Act and streamlined the market for nonadmitted insurance and reinsurance by limiting interstate application of regulation and encouraging implementation of uniform standards. The NRRA prohibits any state, other than the insured’s “home state”, from requiring a license or requiring premium tax payments. It also encourages the development of an agreement or interstate compact to provide for payment, collection and allocation of the premium taxes. Presently, state law allows Texas to join such a compact or arrangement. Under the NRRA, if the states have not entered into an agreement or interstate compact within a year after enactment, the “home state” is entitled to collect and retain 100% of

all premium taxes attributable to policies covering insureds with their residence or principal place of business in that state. If 100% of the risk is located outside of the state of the insured's residence or principal place of business, the state to which the majority of the insured's taxable premium is allocated is entitled to the premium taxes. Through the National Association of Insurance Commissioners (NAIC), state insurance regulators are striving to come to an agreement regarding how best to implement an allocation and collection system. However, the task is proving to be a challenge.

Reinsurance

Reinsurance has been described as “insurance for insurance companies.” That description, however, does not adequately convey the importance of reinsurance in providing capital and capacity to the primary insurance markets, which impacts whether insurance bought by consumers is available and affordable. Virtually all insurance companies purchase reinsurance. Insurance companies licensed in Texas reported ceding more than \$500 billion in reinsurance premiums nationwide in 2009. A year after enactment, the NRRRA is not only prospectively effective, but also applies to all business in force. The new federal law prohibits a state from denying credit for reinsurance if the state of domicile of the ceding insurer recognizes the credit and is NAIC accredited or has similar requirements. The state of domicile is solely responsible for regulating a reinsurer's financial solvency. Under current credit for reinsurance laws, to receive credit for reinsurance, the reinsurance must be ceded to a reinsurer that is 1) licensed in the cedent's state, 2) accredited, or 3) domiciled in a state that has adopted credit for reinsurance standards substantially similar to the NAIC Credit for Insurance Model Law. The NRRRA does not appear to preempt these requirements and seems to require a reinsurer to post collateral if it does not meet these requirements.

Although the NRRRA requires the single-state regulation of reinsurers, it does not require single-state licensure. Many reinsurers in the United States are currently licensed in all states in which they do business, and may additionally write direct business. As a result, these reinsurers may not meet the definition of “reinsurer” in the NRRRA and may create subsidiaries that do in order to take advantage of the single-state regulation. Accordingly, there will be a need for the states to continue to work toward adopting consistent reinsurance regulatory measures. Through the NAIC, state insurance regulators are striving to come to an agreement regarding how best to modernize the collateral requirements for reinsurance purchased from reinsurers located outside of the United States, which may forestall future federal preemptive action in this area.

Senior Investment Protection

Title X of the Act creates the Bureau of Consumer Financial Protection (BCFP) under the jurisdiction of the Federal Reserve Board of Governors to regulate the provision of consumer financial products and services under federal consumer financial laws; however, Title X excludes the business of insurance. Furthermore, any consumer protection authority delegated to state regulators of insurance under the Gramm-Leach-Bliley Act remains with state regulators under the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010. Numerous provisions in the Act acknowledge the role of state

insurance and securities regulators and, in many instances, enhance and strengthen state authority. More specifically, section 989A of the Act provides the opportunity for states to access additional resources to enhance the protection of elderly investors.

Protection of senior citizen investing in annuities in Texas falls upon the State Securities Board and the Department of Insurance through their respective statutory authority or the ability to adopt standards. Title IX of the Act establishes a grant program for states to hire staff, fund technology, and develop educational and training materials to help reduce misleading annuity sales practices that target seniors. The Act charges the Office of Financial Literacy, within the BCFP, to administer the grant program. Under the grant program, states or certain eligible state entities may apply for up to \$500,000 for three consecutive years if they adopt rules that: 1) meet or exceed the minimum requirements of the North American Securities Administrators Association Model Rule on the Use of Senior-Specific Certifications and Professional Designations; 2) conform to the minimum requirements of the NAIC Model Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities; and 3) meet or exceed the minimum requirements of the NAIC Suitability in Annuity Transactions Model Regulation. Although the Act did not provide a time frame, once the Office of Financial Literacy is operational, it will issue the specific grant forms and requirements.

Senior Investment Protection

- **The Dodd-Frank Wall Street Reform and Consumer Protection Act (the Act) establishes a grant program for states to hire staff, fund technology, and develop educational and training materials to help reduce misleading annuity sales practices that target seniors.**
- **The Act charges the Office of Financial Literacy, within the Bureau of Consumer Financial Protection, to administer the grant program.**
- **Under the grant program, states or certain eligible state entities may apply for up to \$500,000 for three consecutive years if they adopt rules that:**
 - **meet or exceed the minimum requirements of the North American Securities Administrators Association Model Rule on the Use of Senior-Specific Certifications and Professional Designations;**
 - **conform to the minimum requirements of the NAIC Model Regulation on the Use of Senior-Specific Certifications and Professional Designations in the Sale of Life Insurance and Annuities; and**
 - **meet or exceed the minimum requirements of the NAIC Suitability in Annuity Transactions Model Regulation.**

CURRENT TEXAS LAW does not include the current version of the NAIC Suitability in Annuity Transactions Model Regulation named in the Act and as such Texas may not qualify to receive the maximum available grant to be offered.

82nd Legislative Session **RECOMMENDATIONS**

Amend the Texas Insurance Code to:

- Incorporate provisions that meet or exceed the minimum requirements of the NAIC Suitability in Annuity Transactions Model Regulation.

Surplus Lines Insurance

- **The Nonadmitted and Reinsurance Reform Act (NRRA), part of federal financial reform, will go into effect on July 21, 2011.**
- **Nonadmitted insurance is more commonly known as Surplus Lines insurance.**
- **Surplus lines insurers do not hold a TDI certificate of authority, nor are their rates and forms approved by TDI.**
- **Surplus lines policies are not backed by the protection of any state guaranty association.**
- **The NRRA contains provisions that contemplate states voluntarily entering into an interstate agreement relating to the reporting, payment, collection, and allocation of premium taxes for nonadmitted insurance.**
- **The NRRA contains several provisions that conflict with Chapter 981 of Texas Insurance Code (Chapter 981).**

THE PROVISIONS of Insurance Code Chapter 981 that conflict with NRRA and may be unenforceable, depending on applicability of the Federal Preemption Doctrine, include:

- Provisions concerning when a state can charge premium taxes or impose statutory requirements for placing surplus lines insurance.
- Certain provisions that apply when Texas is not the “home state” of the insured.
- Any eligibility requirements for surplus lines insurers domiciled in another state that exceed the greater of the minimum capital and surplus requirements under the law of that state or \$15,000,000.
- Any eligibility requirements that apply to surplus lines insurers domiciled outside of the United States who are listed on the National Association of Insurance Commissioners Quarterly Listing of Alien Insurers.

The NRRA also provides a limited exemption to the Texas requirement that agents attempt to obtain insurance from an insurer authorized to write, and actually

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RECOMMENDATIONS

If preempted, the following amendments to the Insurance Code Chapter 981 will be needed to comply with the Nonadmitted and Reinsurance Reform Act (NRRA):

- add and/or amend certain definitions;
- limit certain provisions to instances where Texas is the home state of the insured;
- reduce the eligibility requirements for surplus lines insurers where state law is preempted;
- allow certain commercial risks to be placed directly into the surplus lines market;
- clarify that an insurer engages in the unauthorized business of insurance if a surplus lines policy is issued when the insurer owes the State either penalties or premium taxes; and
- repeal §§981.060, 981.061 and 981.062 of the Insurance Code.

writing, the type of insurance sought in the state. Current Texas law does not provide for this exemption, nor provide any way to monitor the exemption’s use.

Texas Insurer Receivership Act

- **One of the over-arching purposes of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (the Act) was to provide for the resolution, or dissolution, of companies deemed “too big to fail.”**
- **The Act provides a new liquidation authority that will replace the Bankruptcy Code and other laws for liquidating financial companies under certain circumstances, including insurance companies.**
- **If an insurance company or subsidiary is determined to be systemically risky to the United States economy, it would be rehabilitated or liquidated pursuant to state law. However, if state insurance regulators do not file the appropriate judicial action within 60 days, the Federal Deposit Insurance Corporation (FDIC) has the authority to stand in the place of the state insurance regulator and initiate an appropriate action under state laws.**

UNDER CURRENT TEXAS LAW:

- An insurance company may be placed into receivership only if certain conditions are found to exist. Those conditions, however, do not include a situation where the FDIC has taken steps to trigger liquidation under the new federal Act. In effect, the commissioner of insurance may be precluded from filing the appropriate judicial action within 60 days as contemplated by the federal Act, in which case the FDIC would step in and take the matter over from the commissioner. This is problematic because the FDIC does not have experience liquidating insurance companies, which are fundamentally different from the liquidations of banks and other depository institutions.
- Only the commissioner of insurance may initiate action to place an insurance company into receivership. Thus, various conforming amendments are necessary to the Texas law to recognize that the FDIC may now also initiate these actions under certain instances.
- The commissioner may appoint a special deputy receiver to liquidate an insurance company after a competitive bidding process, which at times may take up to 3 months or even longer to complete. The current Texas law does not contemplate emergency exceptions, such as a

82nd Legislative Session RECOMMENDATIONS

Amend the Texas Insurer Receivership Act to:

- allow the Commissioner of Insurance to initiate the liquidation or rehabilitation of an insurer if the FDIC has taken action that could result in liquidation.
- make certain conforming amendments to conform Texas law to the new federal law.
- provide for an emergency exception for certain special deputy receiver contracting requirements (e.g., allow expedited action to address companies that are “too big to fail” and are systemically risky to the U.S. economy.)

determination that an insurance company is “too big to fail” and systemically risky to the U.S. economy. Moreover, the current pool of special deputy receiver candidates may not include individuals of the caliber needed to liquidate an insurer that is so large that it poses a threat to the U.S. economy.

Financial Program: Self Directed Budget

- **The number of insurance companies and other entities in receivership has essentially doubled from 2005 to present, with most of the increase occurring after the down-turn in the nation’s economy.**
- **Qualified examiners are either retiring or leaving for higher salaries making it difficult to attract and retain qualified examiners**
- **Insurers receive premium tax credits for guaranty fund assessments thus reducing the premium taxes collected by the State.**
- **Reduction in travel funds limits examiners’ and actuaries’ ability to travel to insurers and conduct on-site examinations.**
- **The current situation increases the risk TDI may fail to detect and/or take action against a troubled insurer in a timely manner,**

SELF DIRECTED BUDGETING would align the TDI Financial Program with several other state agencies that regulate financial services, including the Texas Department of Banking, the Texas Savings and Loan Department, the Office of the Consumer Credit Commissioner, and the State Board of Public Accountancy.

TDI believes that all of the public policy reasons for changing these other state agencies to a self-directed budget equally apply to changing TDI’s Financial Program to a self-directed budget, and in particular the examinations function.

This change would result in an immediate decrease in TDI’s need for legislative appropriations and a savings to the State’s general revenue.

82nd Legislative Session RECOMMENDATIONS

- Amend Texas law to provide that TDI’s examination function (salaries and travel expenses only) is funded by a self-directed budget.
- The amendments could provide for a transition period for implementation (e.g., Sept. 2011 to March 2012) and if the program can be implemented before then (e.g., January 2012) provide for the option of an earlier effective date conditioned upon TDI returning any un-spent funds to the State to fund other needs. The transition period would involve using funds appropriated by a conventional budget and a self-directed budget.
- The amendments could provide for a subsequent expansion, with a phased in approach to TDI’s Financial Analysis Division, which conducts in-house examinations of company filings, subject to review by the legislature in the next legislative cycle.

Insurance Holding Company Systems Act

The Insurance Holding Company Systems Act (the Act):

- **Addresses potential abuses that may occur if an insurer is caused to enter into transactions or relationships with affiliated companies on terms that are not fair and reasonable;**
- **Prevents persons that control an insurer from using that control to adversely impact the interests of policyholders; and**
- **Protects the solvency of insurance companies against the spread of financial contagion and systemic risks that exist in other companies within a holding company system.**

THE ACT REGULATES relationships between insurance companies and their affiliates or subsidiaries and is a foundational component in the Department's oversight of insurance company solvency.

A holding company system, or “group”, may include insurance companies and firms engaged in banking, securities, real estate development, and other commercial enterprises.

The Insurance Holding Company Systems Act should be enhanced to provide greater breadth and scope to solvency regulation and increase the level of policyholder protections that currently exist. Insurance regulators need to be able to evaluate the enterprise risk within a holding company system and its impact on an insurer within that group to ensure the protection of insurance policyholders. Under current law, holding company groups are not required to report on enterprise risk to insurance regulators. As a result, insurance regulators are challenged by not having the regulatory tools to evaluate contagion risk developing within the holding company. This risk can ulti-

82nd Legislative Session RECOMMENDATIONS

Amend Texas law to:

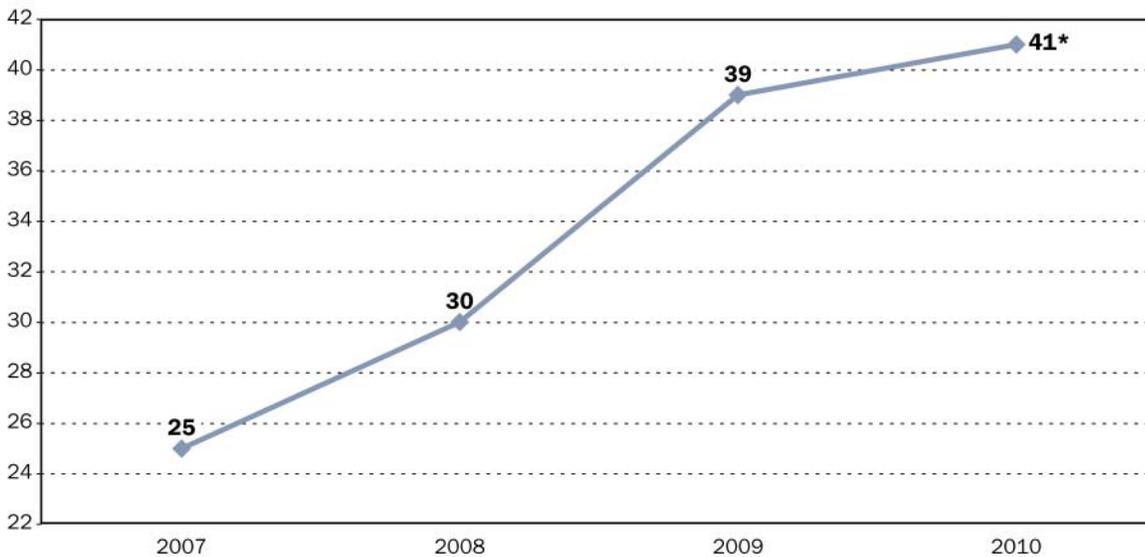
- enhance access to information related to enterprise and systemic risks that could impact the financial condition and/or reputation of insurance companies;
- require holding company system/groups to provide the Texas Department of Insurance with additional information about the financial condition of holding company systems;
- enhance communication between regulators; and
- enhance examination authority.

mately threaten the financial solvency of the insurance company subsidiaries. The NAIC has updated the Holding Company Model Act to provide transparency into group operations, while building upon the existing fire-walls that provide insurance company solvency protection. The recent national financial crisis demonstrated the need for enhanced protections for policyholders.

Insurer Receivership Act

- **HB 2157, 79th Legislature, enacted the Insurer Receivership Act (the Act) – a comprehensive update to a 50-year old receivership statute.**
- **The possibility of a clean-up bill was contemplated based on the complexity of the legislation.**
- **Corrections to the Act are needed to amend unintended variances and erroneous cross-references.**

Figure 1: Texas Receiverships



* TDI is overseeing 53 open receivership estates through 41 legal receivership proceedings. It is not unusual to consolidate actions against several affiliated entities into one receivership proceeding for ease of administration.

THE INSURER RECEIVERSHIP ACT
Chapter 443 of the Insurance Code, provides for receiverships of insurers and other entities in the business of insurance.

The Insurer Receivership Act was enacted in 2005 in HB 2157 by the 79th Legislature, and was based on a draft NAIC model (the Model).

A number of changes were made to the final version of HB 2157 that resulted in unintended drafting mistakes such as incorrect cross-references.

82nd Legislative Session RECOMMENDATIONS

Amend the Insurer Receivership Act to incorporate technical corrections and to eliminate unintended variances from the Model.

There are inadvertent variances from the Model, misplaced provisions, and other items that should be clarified. These errors can cause confusion and potentially result in unnecessary litigation.

Public Insurance Adjusters

- In 2003, the Texas Legislature enacted SB 127 that provided for the licensing of public insurance adjusters.
- The statute limits the amount of total commission that a public insurance adjuster may receive to 10% of the amount of the insurance settlement on the claim.
- Interpretations have differed over the calculation of the 10% based on the service provided by the public insurance adjuster.
- Local jurisdictions have raised concerns about being unable to identify or require performance of out-of-state public insurance adjusters operating in the area after an emergency or disaster event.

A PUBLIC INSURANCE ADJUSTER, by statute, is defined as a person who, for direct, indirect or any other compensation: acts on behalf of an insured in negotiating for or effecting the settlement of a claim or claims for loss or damage under any policy of insurance covering real or personal property; or on behalf of any other Public Insurance Adjuster, investigates, settles, or adjusts or advises or assists an insured with a claim or claims for loss or damage under any policy of insurance covering real or personal property; or a person who advertises, solicits business, or holds himself or herself out to the public as an adjuster of claims for loss or damage under any policy of insurance covering real or personal property.

As of December 21, 2010, there were 743 public insurance adjusters licensed by TDI.

In the aftermath of Hurricane Ike, TDI received complaints involving insurance companies, agents, and public insurance adjusters. TDI currently has twenty-one open Enforcement cases concerning public insurance adjusters. Many of the public insurance adjuster cases are related to fee disputes or nonresident adjuster issues.

82nd Legislative Session RECOMMENDATIONS

Amend the laws governing public insurance adjusters to:

- Clarify that the public insurance adjuster commission should be limited to 10% of the claim proceeds that are directly facilitated by the public insurance adjuster.
- Define “service provided” and define “insurance settlement” in a manner that directly relates to the public insurance adjuster’s activities.
- In addition to TDI licensing requirements and in emergency situations, allow local jurisdictions to register and require financial security from out-of-state public adjusters.

Third Party Automobile Claims

- **Third party automobile claims continue to comprise a significant percentage of complaints received by TDI – one-sixth of the total complaints received in the Consumer Protection Division for 2010 year-to-date and over 50% of the auto complaints.**
- **Primary reasons for justified complaints include unsatisfactory settlement/offer and claim handling delays, such as involving uncooperative insureds.**
- **Policyholders who fail to respond to their insurer’s request for information are referred to as “uncooperative insureds.”**
- **Automobile insurance policies direct an insured to cooperate with the insurer, otherwise a claim may be denied.**
- **TDI tries to facilitate contact with the uncooperative insured by locating the address or telephone number of the insured.**
- **TDI also suggests possible documentation the insurer may want to consider in determining the liability of its insured, such as police reports and witness statements.**
- **There is no current Texas statute establishing timeframes for handling third party claims.**

TDI FREQUENTLY RECEIVES complaints regarding delays in the processing of third party claims. Insurers often state that they were unsuccessful in contacting their insured in order to obtain more information relating to the accident. There is no specific Insurance Code provision relating to situations where the insured is uncooperative and delays the processing of a third party claim. Another reason often cited for delays is the insurer’s failure to promptly negotiate with third party claimants.

82nd *Legislative Session* **RECOMMENDATIONS**

- Amend Insurance Code, Chapter 541 and/or 542 to address this issue to reduce delays in processing third party claims, particularly in regard to property damage claims.

Life, Accident, Health, and Hospital Service Insurance Guaranty Association

- **The Life, Accident, Health, and Hospital Service Insurance Guaranty Association (Guaranty Association) was created by statute in 1973, and is currently enabled by Chapter 463 of the Insurance Code.**
- **The Guaranty Association provides protection to insurance policyholders and third party beneficiaries in the event of an insolvency of a member insurer.**
- **Participation in the Guaranty Association is mandatory for insurers licensed to write life, accident, health and annuity contracts in Texas.**
- **The other states' laws provide for similar entities and consumer protections.**

THE THE LIFE, Accident, Health and Hospital Service Insurance Guaranty Association was established in 1973 and the legislation was based on a Model Act adopted by the NAIC. The coverage limit for annuity benefits provided by the Guaranty Association has not changed since the law was enacted. The current limit is lower than the \$250,000 in protection that the FDIC provides to bank deposits, and bank products often compete with products offered by annuity insurers. The NAIC has revised the Model to increase the limit to \$250,000.

The current law needs to be updated to address issues that commonly arise today when handling insolvencies of life, accident and health insurers such as

- the treatment of statutory deposits,
- the Guaranty Association's rights with respect to reinsurance, and
- the treatment of Medicare parts C and D benefits.

82nd Legislative Session RECOMMENDATIONS

Amend Texas law as follows:

- Amend Chapter 463, Insurance Code to update the Guaranty Association statute.
- Increase the coverage limit for annuities to \$250,000. This will provide greater protection for consumers in the event their insurer becomes insolvent.
- Clarify certain ambiguities in the current law.
- Change the name of the Guaranty Association to the "Texas Life and Health Insurance Guaranty Association", which more accurately reflects its purpose.

Updating the Guaranty Act will help ensure uniform treatment of policyholders among the states, ease the administration of the Guaranty Association and decrease the risk of litigation.

Texas Windstorm Insurance Association

- When Hurricane Celia struck the Texas coast in 1970, many insurance companies ceased selling property insurance in the gulf coast region.
- In 1971, the Texas legislature created a mandatory association of all property and casualty insurance companies, now known as the Texas Windstorm Insurance Association (TWIA), for the benefit of coastal consumers.
- TWIA provides wind and hail insurance in the 14 Texas coastal counties and certain parts of Harris County to those who are unable to obtain such insurance in the voluntary (or private) market. TWIA functions similar to other insurers in that it sells policies, collects premiums, and pays claims.
- TWIA experienced significant growth over the last 5 years; total insured direct exposures exceeded \$67.5 billion as of September 30, 2010. TWIA's largest risk exposure is catastrophic losses from hurricanes. For Hurricane Ike (Galveston, 2008), TWIA incurred an estimated \$2.3 billion in losses.
- In 2009, the Texas legislature enacted major changes to TWIA operations with the passage of HB 4409. In part, HB 4409 changed TWIA's funding mechanism in the event of catastrophic losses, which are spread among property and casualty insurance companies through assessments, TWIA's policyholders, and other property and casualty insurance policyholders located throughout the seacoast area and, indirectly, the entire state.
- HB 4409 also changed the purpose of TWIA to a residual insurer of last resort for windstorm and hail insurance in the seacoast territory.
- HB 4409 further provided that TDI may develop programs to improve the efficient operation of TWIA including a program designed to create incentives for insurers to write windstorm and hail insurance voluntarily to cover property located in a catastrophe area, especially property located on barrier islands.

AFTER HURRICANE IKE STRUCK, TDI increased its level of oversight of TWIA due to a variety of concerns, including (i) consumer complaints, (ii) a desire to ascertain the impact of Ike-related losses on various constituencies, including the insurance industry and the public generally, and (iii) a desire to obtain an indication of the negative impact of Ike-related losses on the general revenue of the State of Texas.¹

During the course of a comprehensive financial examination that encompassed the period impacted by Hurricane Ike, TDI was significantly hampered in its at-

tempt to evaluate TWIA's financial condition because, unlike other insurance carriers, TWIA is not required to obtain an actuarial opinion on the reasonableness of its reserves, nor produce supporting work papers that form the basis for that opinion.

An actuarial opinion and supporting work papers are critical for TDI because they provide the technical analysis and conclusions of a qualified actuary on one of the most significant items on an insurer's balance sheet. Because this information was not available for TWIA, TDI's examination report was qualified and limited in

¹ Prior to the passage of HB 4409, TWIA's funding mechanism included certain assessments levied on the insurance industry that resulted in premium tax credits that reduced the State's general revenue.

82nd Legislative Session

RECOMMENDATIONS

Amend Texas law as follows:

- Amend Insurance Code §2210.054 to include a cross-reference to §802.002, which requires insurance carriers to include the statement of a qualified actuary as part of their annual financial statement that is filed with TDI. This recommendation would subject TWIA's loss reserves to the same level of transparency that applies to other property and casualty carriers. Among other benefits, this would enhance TDI's ability to exercise its required oversight of TWIA and respond to legislative inquiries.
- TWIA's purpose, as stated in statute, is a residual provider of last resort. The term "residual" was added in the 81st Session. Currently, TWIA may not exercise all available underwriting tools, through its plan of operation, to ensure its place as a residual provider. First, the Legislature needs to address the question: Should TWIA's exposure mitigation practices mirror the statutory purpose? Depending on how the Legislature decides this question, then there are some underwriting criteria relating to condition of property, especially roof condition, and acceptance of an offer to write wind coverage from the primary carrier that could be required by law. There are other practices that could be part of the deliberation, though it is recommended to not make abrupt changes in underwriting practices with which the average TWIA policyholder could not reasonably comply.
- Provide assessment credits based on risk-based capital, where the Commissioner may establish a multi-year plan to enhance assessment credits in favor of those not only increasing market share in concentrated areas, but also while maintaining robust capital strength. The goal would be to encourage more voluntary writing in concert with changes in capital strength.
- Provide for dedicated surcharges to the Catastrophe Reserve Trust Fund, not to exceed five percent, that would be levied in addition to contributions made from the provisions included in the rates. The surcharge would enable faster growth of the CRTF and not be subject to reduction as a result of non-claim liabilities. Dedicated surcharges can be separate nonrefundable charges in addition to the premiums collected and not subject to premium tax or commissions.
- Require TWIA's participation in TDI's mediation program.

scope because TDI was unable to form an opinion on TWIA's Hurricane Ike-related reserves.

In addition, given the legislative changes to the purpose of TWIA, there are other tools that TWIA could use that will enable it to align with its new stated purpose. The focus on these organizational issues is designed to improve TWIA and incent the private market to grow smartly.

The primary incentive for insurers to voluntarily write wind coverage along the Texas Coast is the credit which is applied for voluntary writings in the desig-

nated catastrophe area when calculating member insurer assessments. This credit alone does not appear to generate enough incentive for insurers to continue or increase coastal writings.

TDI will continue to solicit direct feedback from insurers as to what would prompt them to write wind coverage along the coast. While past efforts have been primarily with bringing new insurers (and capital) to Texas, TDI will be surveying insurers currently writing in Texas and will share the results of this survey with legislators.

Title Insurance Rates

- Texas is one of only three states (along with New Mexico and Florida) in which the Commissioner of Insurance promulgates title insurance rates, including the agent/underwriter premium split. All title underwriters and agents must use these.
- This regulatory system contrasts with other lines, where greater rate freedom is permitted. For instance, at present, rates for virtually all property and casualty coverage in Texas, other than Title, are subject to a file-and-use regulatory system. Most states regulate title insurance through a file-and-use system, although some use a prior-approval system. Iowa has state title insurance.
- Rates in Texas are relatively high, although accurate comparisons to other jurisdictions are difficult because the scope of the services covered can vary significantly.
- Texas rates are considered “all-inclusive” in that the fees for title search and examination are included in the basic rate. The term “all-inclusive” should be qualified, however, in that title agents charge a number of additional fees, such as an escrow fee of several hundred dollars or more per party, which are not currently regulated by the state.

UNDER OUR CURRENT SYSTEM, rates are set at biennial rate and rule hearings, which are long and costly processes. Given that the resulting rates are mandatory, consumers do not have the ability to shop for coverage on the basis of price or policy form, as they can in most other states or lines of insurance.

Lack of price competition results in inefficiencies in the marketplace. For instance, instead of competing on the basis of price, many, though not all, agents compete for market share by expending their marketing efforts on the real estate agents, lenders, builders and other “producers” who can direct the ultimate consumers, property buyers, to their agency. These marketing efforts may result in higher costs which are passed through to consumers in the form of expenses which are factored into the rate base.

82nd Legislative Session RECOMMENDATIONS

Amend Texas law as follows:

- Require the Commissioner of Insurance to complete a study and report to the Legislature the market impact of alternative rating structures.
- Provide the Commissioner of Insurance the explicit flexibility to develop and implement alternative rating structures that introduce some measure of price competition into the market.
- Alternative rating structures could take several forms, such as initially permitting the filing of independent rates on a prior-approval basis for a period of time to allow the analysis of its effects on the market. This could then be followed by a file-and-use system. Another approach could be to allow downward rate deviations from the promulgated rate.
- Another alternative rating structure might permit rating distinctions based on geographic region or the size of the underwriter or agency. Rating distinctions could include variations in the monetary split between underwriters and agents to account for the cost-shifting cited by many rural agents. Any such changes should be developed in such a way as to prevent or minimize predatory pricing practices that may adversely impact title agencies, particularly those in certain rural and mid-sized counties.

Some small, rural and/or independent agents contend that large, metropolitan, and/or underwriter-owned agents put them at a competitive disadvantage by their arrangements with large property developers which control the title transaction, and then use their market clout to pay the smaller agents only a fraction of what is necessary to cover their costs. This can put a real strain on the profitability of such agencies, and if a rural agent, who may be the only agent in a particular county, is put out of business, the local population loses the local title expertise needed to evaluate and minimize local title issues.

The recommended changes may result in downward pressure on rates. If some level of price competition is allowed, insurers will have incentive to be more efficient and, consequently, reflect these savings in lower rates. The shift in regulatory platform discussed in these recommendations is a major change in public policy. Any change should be incremental and conducted under the close scrutiny of the Legislature. As reforms are implemented gradually, data on outcomes should be gathered and analyzed, allowing the market to evolve at a measured pace, ensuring an orderly transition.

Direct Repair Facilities

- TDI conducted a survey in May, 2010 of the top five personal automobile insurers in Texas to obtain current information relating to automobile claim payments.
- Of the insurers surveyed, all had some sort of contract/agreement with direct repair facilities or had selected repair facilities to be on a preferred list (preferred shops).
- Based upon the survey responses, for calendar year 2009 the percentage of initial automobile claims with repairs made at direct repair facilities ranged from approximately 18% to 50%.
- The Insurance Code specifically addresses prohibited acts in connection with the repair of motor vehicles.
- The Texas Administrative Code addresses notice requirements and claimants' rights regarding motor vehicle repairs.

TDI HAS RECEIVED COMPLAINTS that insurers improperly “steer” claimants to particular repair shops (direct repair facilities/preferred shops). Such action can restrict consumer choice. TDI has also received complaints that insurers are informing claimants that they may be responsible to pay for certain repair costs if the claimant selects a repair facility that is not on the insurer’s list of direct repair facilities.

Current law does not provide consistent regulation among insurers. For example, county mutual insurers, which represent approximately 45% of the Texas personal automobile insurance market, are not required to comply with the statutes and rules regarding the repair of motor vehicles.

Additionally, there may not be a clear understanding among the participants of the requirements to become a contracted direct repair facility with an automobile insurer.

82nd Legislative Session RECOMMENDATIONS

Amend Texas law as follows:

- Require insurers to provide written notice to claimants outlining its policies and procedures for claims and repair processes performed at direct repair facilities and non-direct repair facilities, including how those procedures, processes and claims payments may differ. This should provide claimants with a better understanding regarding the repair/claim process under an automobile insurance policy.
- Make county mutual insurers subject to Insurance Code §§1952.301-307. This would allow all claimants the right to select an automobile repair person or facility and the type of parts or products used to repair their vehicles.
- Require insurers to provide a written disclosure upon request to automobile repair facilities outlining the requirements to become a contracted direct repair facility. This would allow all automobile repair facilities an equal opportunity to understand the requirements of becoming a contracted direct repair facility.

Retained Asset Accounts

- Life insurers frequently deposit proceeds of a life insurance policy into a checking or draft account, known as a retained asset account.
- Retained asset accounts are not regular checking accounts, and some media have reported instances where third parties were reluctant to accept drafts drawn on these accounts.
- Insurers often use retained asset accounts as their default method of paying proceeds.
- Insurers maintain that a retained asset account enables the beneficiary to earn interest on the funds until the beneficiary determines what to do with the funds.
- Insurers have historically invested retained asset account funds and have earned more on these investments than they have paid in interest to policyholders.

THE FOLLOWING POLICY issues have arisen in the debate over retained asset accounts:

- Should insurers or policyholders have the option to place their funds in retained asset accounts?
- Is there adequate disclosure in the insurance policies?
- Should the retained asset account be the default option for claim settlement?
- Does a life insurance beneficiary understand what he has received when he receives settlement proceeds in the form of a retained asset account?
- How long should retained asset accounts remain with insurers?

82nd *Legislative Session* **RECOMMENDATIONS**

Amend Texas law as follows:

- Require insurers to provide clear disclosure that the retained asset account is a form of settlement provided by the insurance company.
- Require insurers to disclose the details regarding retained assets accounts such as:
 - the interest rate earned by the beneficiary,
 - the fact that the beneficiary can cash the entire amount,
 - where the checks may be cashed and any fees charged, and
 - the number of withdrawals permitted each year or month.
- Require insurers to get an affirmative election for a settlement to be provided in a retained asset account.

Workers' Compensation

Align the Statutory Authority for the Commissioner of Workers' Compensation to Designate a Statistical Agent for the Collection of Data with Similar Authority Currently Utilized by the Commissioner of Insurance

IN 1999, the Texas Legislature passed HB 2511 (76th Legislature, Regular Session), which added a provision to Section 401.024, Labor Code, allowing the Texas Workers' Compensation Commission to contract with a data collection agent to fulfill the data collection requirements of the Workers' Compensation Act if deemed cost-effective. The Workers' Compensation Act requires the collection of a variety of data, including: claims information; income benefit payments; the types of medical treatment rendered on individual claims, including diagnoses, treatments, billed charges and actual payments; and workers' compensation insurance coverage information. This data is vital to the Texas Department of Insurance-Division of Workers' Compensation's (TDI-DWC) ability to effectively monitor the system; complete its statutorily required Performance Based Oversight activities; conduct objective research; produce agency performance measures and legislatively required reports; and select health care providers or other system participants for quality of care audits by the Medical Quality Review Panel.

Since 1999, TDI-DWC and its predecessor have not fully explored the possibility under Section 401.024, Labor Code to designate a data collection agent/statistical agent, partly because the Labor Code does not clarify the payment of fees to data collection agents and does not lay out minimum qualifications for these agents. Given stakeholders' interests in aligning workers' compensation data col-

82nd Legislative Session RECOMMENDATIONS

- Amend Section 401.024, Labor Code to incorporate the requirements relating to the qualifications of statistical agents and the payment of statistical agent fees with similar provisions found in Sections 38.203, 38.206 and 38.207, Insurance Code.

lection requirements across states and the creation of national standards for the reporting of claim, income benefit, proof of coverage, and medical billing and payment data, TDI-DWC is interested in having the flexibility to determine whether it is more cost-effective to collect data in house or utilize a data collection/statistical agent to collect needed data. Before TDI-DWC would engage in the designation of data collection/statistical agent, it would obtain input from system participants to ensure that the designation of a data collection/statistical agent is indeed cost-effective and meets the needs of system participants who are responsible for reporting data to TDI-DWC.

For further information, see the Division of Workers' Compensation Biennial Report to the 82nd Legislature located at www.tdi.state.tx.us/reports/dwc/documents/dwcbiennial2010.pdf

Issue Update

Life Settlements

- Texas law permits owners of life insurance policies to sell their policies through a process called viatical settlements (for those insureds with terminal illnesses) or life settlements (for those with no life threatening illness). TDI regulates those involved with the initial viatical or life settlement.
- Current protections include requirements that persons involved in the purchase of policies in or from Texas pass background checks and become registered, use approved applications and contracts, submit annual reports and be subject to sanctions.
- Settlement providers, registered by TDI, have traditionally purchased life insurance policies from those who were insured and then sold interests in the death benefits in the policies to institutional and individual investors.
- It has been a growth business nationwide. In 2008, the settlement industry reached a peak, with over \$1 billion in policies being purchased in Texas.
- TDI's role in regulating the investment side of the industry is limited.
- In recent years, TDI has received consumer complaints relating to the investment side of the industry, assisted the State Securities Board (SSB), and taken regulatory actions in a number of cases.
- Due to numerous factors, including the general increased awareness of the availability of life insurance settlements, many policies are available for sale on the market. Policies that traditional purchasers turn down are sometimes acquired by fraudulent operations. Further, due to the duration of the investment, fraud can occur before it can easily be detected by investors.
- Additionally, in recent years, a secondary market for previously settled life insurance policies has developed and sometimes results in an unregulated party selling more death benefit than actually exists in the policy. Due to confidentiality issues that limit the ability of investors to verify that the life insurance policies, and the sale, are bona-fide, some investors have provided funds for policies not yet owned by the operator.
- Even though the settlement industry is relatively young, it has produced a substantial amount of harm to Texas investors, resulting in at least five receiverships and bankruptcies involving several hundred million dollars in investor funds. Recently, life settlement-based insolvencies have occurred for various reasons, including operators misappropriating money and securing investment funds based on incorrect life expectancy estimates.
- The Waco Court of Appeals has ruled that sales of interests in life insurance policies are not securities under the current Texas definition of a security in the Texas Securities Act.¹ This raises confusion about the ability of the SSB to regulate the sale of investments in life insurance policies, and this confusion has made enforcement cumbersome and costly and the fraud easier to perpetrate.
- Given the harm to consumers to date, the legislature may consider clarification of authority over the investment side of the life settlement industry.

1 *Griffitts v. Life Partners, Inc.*, 10-01-00271-CV (Tex.App.-Waco [10th Dist.] 2004).

Issue Update

Long-Term Care

- Long-Term Care (LTC) insurance in Texas is based on two distinct pricing models:
 1. Policies issued up to July 1, 2002 were priced to meet certain loss ratios.
 2. Policies issued on and after July 1, 2002, must be priced to sustain rates for the life of the policy under moderately adverse conditions.
- Policies issued in 2002 and later, include nonforfeiture and contingent nonforfeiture benefits.
- The 81st Legislature enacted Senate Bill 963 to give TDI rate approval authority for LTC premium rate increases and gave insureds facing rate increases a contingent nonforfeiture benefit.
- Rate approval gives TDI an essential tool to ensure Texas consumers are not subsidizing insureds in other states, and that the increases are actuarially justified.
- Despite these efforts, the work on LTC is not complete. Policyholders continue to experience significant rate increases.
- Recognizing LTC rate increases are a national concern; TDI introduced a resolution at the Interstate Insurance Product Regulation Commission (IIPRC) and the NAIC, to engage in the development of a national solution for all consumers. The resolution was adopted by both organizations.
- A copy of the resolution is provided on the following page.

Interstate Insurance Product Regulation Commission Resolution to Address National Long-Term Care Insurance Rating Problems

WHEREAS:

- The Interstate Insurance Product Regulation Commission (IIPRC) is currently considering standards for rates for the issuance of long-term care (LTC) products to be filed for its review and action;
- Consumers in existing pre-rate stabilized blocks of LTC insurance products are subject to significant rate increases;
- The LTC standards under consideration will only impact new consumers;
- The IIPRC seeks to encourage the NAIC to take action to begin the process of protecting all consumers including those consumers who own existing, pre-rate stabilized LTC insurance products; and
- The development of LTC rate review standard, with features that encourage carriers to provide pre-rate stabilized LTC consumers the option to obtain a rate-stabilized policy, is beneficial to the consumer and could provide carriers greater flexibility for rate changes.

IT IS RESOLVED THAT:

The IIPRC formally recommends that the NAIC National Standards Working Group and the Long-Term Care Executive Task Force determine the feasibility of a national program that protects all LTC consumers, including consumers who own existing, pre-rate stabilized LTC insurance products. The national program will be created using existing regulatory authority or a model law, whichever is most inclusive and expeditious.

IT IS FURTHER RESOLVED THAT:

The IIPRC formally recommends that such analysis of a national program include, but not be limited to the following:

- Combining pre-rate stabilized and rate stabilized and rate increases;
- Granting companies that combine rating practices under the national program greater flexibility in rate increases;
- Establishing gradual implementation to ensure stability in the market; and
- Preserving states' authority.

IT IS FURTHER RESOLVED THAT:

The NAIC Life and Health Actuarial Task Force will make necessary recommendations to accommodate the national program.

IT IS FURTHER RESOLVED THAT:

The IIPRC will develop standards for policies offered pursuant to the national program which will replace pre-rate stabilization policies.

Issue Update

Network Adequacy

- Preferred provider plans (PPPs) are not currently subject to any network requirements in Texas—health maintenance organizations (HMOs) are.
- PPPs have increased to almost 58% of the fully insured health insurance market, while the HMO market share has fallen to about 15%.
- Pursuant to SB 1731, 80th Legislature, TDI issued a report regarding facility-based network adequacy. The Health Network Adequacy Advisory Committee report may be found at: www.tdi.state.tx.us/reports/life/documents/hlthnetwork09.doc.
- The 81st Legislature enacted HB 2256, which requires that the Commissioner adopt network adequacy standards that are adapted to local markets, ensure availability of a full range of physicians and providers, and allow for departure from the standards on good cause shown.
- TDI has met with many stakeholders, circulated two informal working drafts of the proposed rules, and held two comprehensive stakeholder meetings.
- Because TDI regulates insurance carriers and not facilities, e.g. hospitals, or providers, the proposed rules focus on the requirements for carriers in the market.
- The rules address many issues which have been the subject of complaints over the years, and generally attempt to increase transparency for consumers, set minimum standards for availability, and consequences for inadequacy.

TDI anticipates that the formal rule proposal will be published in early 2011. Some of the issues that may be addressed in the proposed rules include:

- Network adequacy requirements adapted to local markets
- Waivers of network adequacy and alternative access plan requirements
- Annual network reporting requirements
- Network credentialing requirements
- Enhanced requirements for accurate network directories
- Notice requirements to consumers
- Out of network physicians providing services at network facilities
- Out of network referrals by network physicians
- Out of network claims payment standards, especially in cases of emergency or network inadequacy

The latest informal draft of the rules may be viewed at:

www.tdi.state.tx.us/rules/life/netwrkadeqinfrm.html.

Issue Update

Public Inspection of Rate Filings

- Insurance Code Section 2251.107 specifies that rate filings are open to public inspection as of the date of filing. This applies to virtually all lines of property and casualty business such as residential property, private passenger auto, commercial property, general liability and more. No similar provision exists for health insurance rate filings.
- TDI has found that in practice, many companies claim that information included in their rate filings is confidential, proprietary or trade-secret in an attempt to avoid public inspection of their rate filings. Companies also claim a copyright in their rate filings, another method of asserting a recognized privilege to prevent TDI from furnishing copies to requestors.
- What is confidential, proprietary and/or a trade secret varies with each company. Therefore, there is no single element common to all companies to identify what would actually be a trade secret, proprietary or confidential information.
- Rate filings have become increasingly complex as companies develop or use third party models or algorithms to determine rates based on an amalgamation of numerous risk characteristics such as:
 - territory assignments based on loss experience and environmental influences;
 - tier placement based on prior coverage, financial relationship with insurer, and telematic data, and;
 - ratemaking provisions for various catastrophes, such as for hurricanes and terrorism.
- The Texas Attorney General has consistently ruled that information relating to an insurer's rate filing is an open record under the Public Information Act and there are no exceptions to disclosure.
- TDI is currently in litigation on whether or not information in a company's rate filing or response to a Department request for additional supporting information is open to public inspection when the company has asserted that some information is confidential, trade secret, or proprietary.
- It is conceivable that based upon a company's filings, TDI will need and ask for information that is trade secret, given the complexity of insurer's rating models.
- Ultimately, TDI should not be restrained from requesting necessary information to evaluate a rate filing for reasonableness, adequacy and appropriateness to the risk.
- Barring legislative guidance concerning the right of the public to inspect additional supporting information, the outcome will be determined by the courts, and TDI's ability to obtain information needed to review a filing could be impaired.

Senate Bill 1 – Rider 18

Review of Health Insurance Availability and Affordability

The 81st Legislature included in Senate Bill 1 a directive to the Texas Department of Insurance to conduct a review of “the accessibility of health benefit plan coverage for and the affordability of health benefit plan premiums for low-income families and families not eligible for employer-sponsored insurance.” Following is a summary of the results of the review.

Like many states, Texas has struggled with increasing healthcare costs and insurance premiums that have prohibited many individuals from obtaining affordable health insurance. The rising cost of insurance affects individuals at all income levels and employers of all sizes but is particularly challenging for low income workers and small business owners. In 2009, the U.S. Census Bureau Current Population Survey (CPS) reports that 6.4 million Texans were uninsured for the entire year (Table One). Of the Texans who have health insurance, slightly more than half (53.8 percent) have private coverage, down from 56.9 percent in 2007 and lower than the national average of 63.9 percent. Texas workers are less likely to have employer-sponsored coverage with 48.2 percent of Texans enrolled in employment-based plans compared to a national average of 55.8 percent.

Table 1: Sources of Health Insurance – 2009

SOURCE OF INSURANCE	NUMBER	TEXAS PERCENTAGE	NATIONAL AVERAGE
Private Insurance	13,257,000	53.8%	63.9%
Employment	11,893,000	48.2%	55.8%
Individual	1,531,000	6.2%	8.9%
Government Insurance	6,925,000	28.1%	30.6%
Medicaid	3,951,000	16.0%	15.7%
Medicare	2,730,000	11.1%	14.3%
Military	1,052,000	4.3%	4.1%
Total Insured	18,224,000	73.9%	83.3%
Total Uninsured	6,433,000	26.1%	16.7%

Source: U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic Supplement.
(Note: Numbers may not add up to totals as some people have more than one type of insurance.)

Like other states, the majority of uninsured in Texas live in families with low to moderate incomes (Table 2). Detailed analysis of 2008 CPS data shows that 59 percent of the uninsured (3.5 million people) reported family incomes below 200 percent of the federal poverty level (FPL). Another 12 percent had incomes between 200 and 249 percent FPL. The data also confirms that individuals with lower incomes were much more likely to

be uninsured than those with higher incomes. Forty-five percent of individuals under 50 percent of FPL were uninsured compared to only 14 percent of individuals at 250 percent or higher.

Table 2: Uninsured Rates by Poverty Level – 2008

INCOME AS A PERCENTAGE OF POVERTY LEVEL	NUMBER UNINSURED	PERCENT OF TOTAL UNINSURED	PERCENT UNINSURED WITHIN INCOME CATEGORY
Under 50%	817,821	13.5%	45.5%
51% to 99%	793,071	13.1%	39.0%
100% to 149%	1,064,129	17.5%	37.0%
150% to 199%	897,803	14.8%	33.7%
200% to 249%	703,379	11.61%	31.9%
250% or Higher	1,800,667	29.7%	14.3%
Total	6,076,870	100%	25.1%

Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.

While most states have experienced declining rates of employer-sponsored coverage in recent years, the decline in Texas is more pronounced. Since 2001, the percentage of Texans with employer coverage has dropped from 58.5 percent to the current rate of 48.2 percent, an 18 percent decrease in eight years. Additional data from the annual Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) indicates that even when firms offer insurance, many employees are ineligible or choose not to purchase coverage. The MEPS-IC survey, administered by the federal Health Resources and Services Administration (HRSA) collects detailed information on employer-sponsored insurance, including data for both large firms (defined as 50 or more employees) and small businesses (2-49 employees). Table 3 summarizes information on both insurance offer rates and participation rates for large and small businesses and clearly indicates important differences based on firm size. Some of the more significant findings are:

- Most large firms (94 percent) offer health insurance compared to only 34.2 percent of small firms.
- Nearly half (49.1 percent) of employees in small firms work for an employer offering coverage, compared to 95.7 percent of employees in large firms.
- Of those employees with employer-sponsored health coverage, more than 3.8 million work in large firms compared to 653,162 workers in small firms.
- More than 1.3 million workers have access to coverage in a large or small firm but are not enrolled. Not all are uninsured; some have other coverage, such as a spouse’s employer-sponsored plan. However, a large number of these eligible workers are uninsured and have not enrolled due primarily to costs.
- Although most large employers offer coverage, many workers are not eligible. More than one million workers in large firms do not qualify for their employer-sponsored plan because they work part time, are temporary or contract workers, or have not

worked long enough to meet the required waiting period. Again, however, not all of these workers are uninsured.

- More than one million employees in small firms also do not have access to coverage. Most of these workers (1,038,936) are employed in firms that do not offer coverage. Another 169,415 workers are not eligible for coverage offered by their employer.

Table 3: Employer Sponsored Insurance: Offer and Participation Data - 2009

TEXAS INSURANCE ENROLLMENT DATA	SMALL FIRMS	LARGE FIRMS
1 Total number of firms	324,554	125,685
2 Total number of employees	2,041,132	6,375,152
3 Percentage of firms that offer insurance	34.2%	94.0%
4 Number of firms that do offer insurance	110,997	118,144
5 Number of firms that do not offer insurance	213,557	7,541
6 Number of employees working in firms that offer insurance	1,002,196	6,101,020
7 Percentage of employees working in firms that offer insurance	49.1%	95.7%
8 Number of employees working in firms that do not offer insurance	1,038,936	274,132
9 Number of employees eligible for coverage	832,781	4,947,118
10 Number of employees who are enrolled	653,162	3,818,716
11 Percentage of all employees that have employer-sponsored coverage	32%	60%
12 Number of employees who have access to coverage but are not enrolled	179,619	1,128,402
13 Number of employees who do not have access to coverage	1,208,351	1,428,034

Source: Agency for Healthcare Research and Quality, 2009 Medical Expenditure Panel Survey-Insurance Component.

Of those employers that do not offer coverage, extensive research shows the most common reason cited is the increasing cost of insurance. Consistent with national trends, Texas employers and employees have experienced significant premium rate increases over the past ten years, despite a number of programs and industry efforts to hold down costs. As Table 4 below indicates, average premium costs across all firms (including both fully insured and self-funded) have more than doubled in the past ten years.

Table 4: Average Employer-Sponsored Insurance Premium Costs

YEAR	AVERAGE ANNUAL PREMIUM FOR SINGLE COVERAGE	AVERAGE ANNUAL PREMIUM FOR FAMILY COVERAGE
1999	\$2,336	\$6,208
2000	\$2,627	\$6,638
2001	\$2,924	\$7,486
2002	\$3,268	\$8,837
2003	\$3,400	\$9,575
2004	\$3,781	\$10,110
2005	\$4,108	\$11,680
2006	\$4,133	\$11,680
2008	\$4,205	\$11,967
2009	\$4,499	\$13,221

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component 1997-2006, 2008-2009 (No survey available for 2007).

Though most employers are challenged by significant premium increases, higher rates are usually more difficult for small firms (those with 2-50 employees) to absorb. Because a small employer's rates are based on the age, gender and health status of the employer's workers and their dependent enrollees, rates can vary significantly from the average cost based on a group's specific demographics. Generally, groups with younger, healthier employees will pay lower premiums while groups with older, less healthy workers will pay higher rates. An employer with even one worker with a pre-existing condition may see their group rates increase by up to 67 percent based on health status underwriting factors. TDI data shows groups that are subject to a combination of the highest allowed rating factors may see premium rates for individual employees in excess of \$20,000 a year, a cost that is higher than maximum rates charged for coverage in the Texas Health Insurance Pool for individuals who are uninsurable in the individual market.

Over the last 10 years, the Department of Insurance has conducted significant research to collect information on uninsured Texans and uninsured small businesses, why they have no coverage, how much they can afford, and options to assist them with purchasing coverage. Through a federal State Planning Grant administered by HRSA, TDI conducted multiple focus groups, surveys, and community events across the state. Though some of the study findings are somewhat dated, many of the conclusions are likely still applicable given the high cost of insurance and continued high uninsured rate.

Beginning in 2002 and continuing through 2006, TDI hosted more than 60 focus group sessions with individuals, small business owners and their employees in 20 different cities across Texas representing all of the major geographical areas of the state. Focus group sessions were attended by uninsured individuals or small employers who were unable to provide insurance for their employees. The personal stories expressed at these focus group sessions underscored the challenges many consumers face when trying to

find affordable health coverage. (For additional information on the research findings, please see TDI reports at: <http://www.tdi.state.tx.us/health/spg.html>.)

The primary conclusion from these discussion sessions was that health insurance remains unaffordable for many of these individuals and employers. The vast majority of participants expressed willingness to pay for insurance, and most had attempted to buy coverage within the past year but could not find a benefit plan that was affordable. More than 90 percent of the attendees were employed or owned their own business, and many participants expressed frustration with the fact that “average, working, responsible citizens” could not afford coverage.

Even when employer coverage is offered, many employees decline to enroll due to employee premium payments and cost sharing requirements. While the majority of employers pay at least half the cost of the premium for employee-only coverage, employer contributions for both employee and dependent coverage have declined as more employers struggle to keep up with increasing premium costs and other economic pressures. Employees increasingly are asked to share more of the cost of coverage through increased premium contributions and higher cost-sharing policy provisions, particularly in the small group market. In 2009, the MEPS-IC data show small employers in Texas reported the third highest individual deductible levels in the country at \$1,634, compared to a national average of \$1,283. Large employers had the sixth highest individual deductible at \$990 compared to a national average of \$882. For family deductibles, small employers reported the sixth highest average (\$3,210 compared to \$2,652 nationally), and large firms were at the second highest level (\$1,883 in Texas compared to \$1,610 nationally).¹

In addition to premium contributions and deductibles, enrollees in group health plans face other out-of-pocket expenses, including co-payments and coinsurance, which vary depending on the type of service provided (i.e., primary care visits, specialist visits, emergency room services, hospital admissions, etc.). The data included in Table 5 illustrates average costs for some of the most common cost-sharing provisions in 2009 but is not inclusive of all expenses an enrollee pays under a typical health plan.

These data underscore the relatively high cost low income families incur to enroll their families in employer-sponsored benefit plans. While some workers may find employee-only coverage affordable depending on the employer’s actual contribution rate and the employee’s overall financial circumstances, adding family coverage would likely be cost-prohibitive for most low-income workers up to 200 percent of poverty, and for many even above those income levels. Add these premium contribution requirements to high family deductibles and other coinsurance expenses, and most low income families are likely unable to afford employer sponsored coverage. Table 6 shows the cost of the average employee contribution for individual and family coverage as a percentage of the 2010 income levels for each poverty level listed (100, 150, and 200 percent of federal

1 Agency for Healthcare Research and Quality, 2009 Medical Expenditure Panel Survey—Insurance Component

poverty level, FPL). For workers with health plans that require higher employee premium payments than the average, the cost of coverage as a percentage of income will be even higher.

Table 5: Average Cost Sharing Requirements for Employer-Sponsored Insurance, 2009

	SMALL FIRMS	LARGE FIRMS
Average Total Employee-Only Premium	\$4,391	\$4,523
Average Total Family Total Premium	\$12,674	\$13,288
Average Individual Deductible	\$1,634	\$990
Average Family Deductible	\$3,210	\$1,883
Average Co-payment for an Office Visit	\$26.03	\$23.44
Average Percentage Coinsurance for an Office Visit	19.08%	18.0%
Average Employee Payment for Employee-Only Coverage	\$588	\$1079
Average Employee Payment for Family Coverage	\$3,924	\$4036

Source: Agency for Healthcare Research and Quality, 2009 Medical Expenditure Panel Survey-Insurance Component

Table 6: Average Employee Premium Contributions as a Percentage of Income by Federal Poverty Level (FPL) – 2009

SMALL FIRMS						
	Avg. Employee Contribution for Employee-Only Coverage (\$588) as a Percentage of Family Income by FPL			Avg. Employee Contribution for Family Coverage (\$3,924) as a Percentage of Family Income by FPL		
FAMILY SIZE	POVERTY LEVEL					
	100% FPL	150% FPL	200% FPL	100% FPL	150% FPL	200% FPL
Family of 1	5.4%	3.6%	2.7%	–	–	–
Family of 2	4.0%	2.7%	2.0%	26.9%	18.0%	13.4%
Family of 3	3.2%	2.1%	1.6%	21.4%	14.3%	10.7%
Family of 4	2.7%	1.8%	1.3%	17.8%	11.9%	8.9%
LARGE FIRMS						
	Avg. Employee Contribution for Employee-Only Coverage (\$1,079) as a Percentage of Family Income by FPL			Avg. Employee Contribution for Family Coverage (\$4,036) as a Percentage of Family Income by FPL		
FAMILY SIZE	POVERTY LEVEL					
	100% FPL	150% FPL	200% FPL	100% FPL	150% FPL	200% FPL
Family of 1	10.0%	6.6%	5.0%	–	–	–
Family of 2	7.4%	4.9%	3.7%	27.7%	18.5%	13.8%
Family of 3	5.9%	3.9%	2.9%	22.0%	14.7%	11.0%
Family of 4	4.9%	3.3%	2.4%	18.3%	12.2%	9.2%

While premium amounts alone exceed the budgets of many Texas families, out-of-pocket expenses (co-pays, co-insurance, and deductibles) add to the burden. Using 2007 MEPS-IC data for average costs of out-of-pocket expenses for non-elderly enrollees adjusted for private coverage in Texas, Texans pay an average of \$631 annually per person in out-of-pocket expenses. Table 7 illustrates this with examples.

Table 7: Impact of Health Costs on Texas Families

EXAMPLE A: FAMILY OF FOUR WITH A HOUSEHOLD INCOME OF 200% FPL	
Annual income	\$44,100
Average annual premium	\$13,221
Average annual employer premium contribution	(\$9,197)
Average annual employee premium responsibility	\$4,024
Average annual cost of out-of-pocket expenses	\$2,524
Average annual cost to family (% of income)	\$6,548 (14.8%)
EXAMPLE B: INDIVIDUAL WITH AN INCOME OF 200% FPL	
Annual income	\$21,660
Average annual premium	\$4,499
Average annual employer premium contribution	(\$3,508)
Average annual employee premium responsibility	\$991
Average annual cost of out-of-pocket expenses	\$631
Average annual cost to individual (% of income)	\$1,622 (7.5%)

While the vast majority of Texans with private insurance coverage are enrolled in an employer-sponsored benefit plan, an estimated 1.5 million residents have purchased some type of individual medical insurance. The individual market offers a wide variety of options designed to meet varying healthcare needs. Some policies provide comprehensive coverage similar to benefits included in an employer-sponsored plan while others provide more limited benefits. Other plans provide supplemental coverage to Medicare or only cover certain diseases, such as cancer. People shopping in the individual market have the opportunity to choose the plan that best fits their needs and financial situation, which vary widely among consumers.

Unlike the group market, it is important to note that individual health insurance is subject to strict medical underwriting requirements that determine whether or not a person is eligible to purchase coverage. People with pre-existing health conditions or a past history of health problems are often declined coverage or may receive plans that exclude coverage for certain services related to their pre-existing condition. Premiums are based on the applicant's medical status, age, gender, and area of residency, and are usually significantly higher for older applicants or people with health conditions.

Although TDI does not collect detailed enrollment or premium cost data on the individual market and is unable to determine the number of enrollees by type of plan, the insurance association America's Health Insurance Plans (AHIP) conducted a survey in 2009 of insurers participating in the individual health insurance market.² Limited data on state-specific results show that average annual premiums in Texas for a comprehensive health insurance policy were \$3,208 for single coverage (i.e., one person) and \$6,459 for family coverage. Single policies had an average annual out-of-pocket maximum limit (the maximum amount a person would pay for eligible healthcare services) of \$5,000, while family policies had an annual limit of \$10,000.

Because the individual market allows carriers to medically underwrite applicants and select only those individuals that meet the carrier's specific requirements, some applicants will be unable to purchase individual coverage at any price from any carrier. Though the federal Patient Protection and Affordable Care Act (PPACA) of 2010 prohibits carriers from denying coverage of dependents based on health conditions beginning with new policies issued on or after September 23, 2010, this provision does not extend to adults until 2014. Individuals who cannot obtain coverage in the individual market and have no access to group coverage may obtain insurance from the Texas Health Insurance Pool (THIP, formerly Texas Health Insurance Risk Pool) or the newly created federal Pre-Existing Condition Insurance Plan (PCIP).

THIP was created by the Texas Legislature to provide insurance for individuals who are unable to obtain coverage from the commercial market. It also serves as the Texas alternative for individual health insurance coverage under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), guaranteeing insurance to qualified individuals who lose coverage under an employer-based plan. Eligibility and premium rating requirements are established by law.

The federally operated PCIP was created under the recently enacted federal healthcare reform legislation, PPACA. Beginning in 2014, PPACA requires insurers to accept all applicants regardless of health status. To assist individuals with health conditions who cannot obtain commercial coverage prior to 2014, PPACA includes provisions for federally or state run insurance programs. Texas opted for the federally operated insurance pool, PCIP. The PCIP functions in many ways like the THIP, but there are some critical distinctions which significantly affect cost, eligibility and covered benefits.

Both THIP and PCIP provide comprehensive health coverage for individuals with previous health conditions. To enroll, individuals must be legal U.S. citizens and a resident of the state, and must provide evidence that they were declined coverage for insurance or have a current or previous medical condition that makes them uninsurable. However, PCIP requires an individual be uninsured for at least six months before they are eligible to enroll. This provision precludes enrollees in the THIP from enrolling in the PCIP.

2 America's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits* (October 2009), www.ahipresearch.org.

Premium rates for coverage in THIP and PCIP vary dramatically. Rates for THIP are set at twice the average rate (200 percent) for standard coverage offered in the commercial market and are adjusted semi-annually to reflect changes in the market rates. Rates also are adjusted based on the age, gender, and geographic location of the enrollee, which reflects variations in local healthcare costs and expected healthcare utilization. Rates are higher for individuals with a history of tobacco use. Enrollees may choose from a range of deductible options and plan cost-sharing limits, with annual deductibles from \$1,000 up to \$7,500. Higher deductibles will lower the premium rate for the enrollee. Due to the variability of rating factors, monthly premium costs vary widely from a low of \$160 a month for an individual age 18 or lower with a deductible of \$7,500 to a high of \$2,207 a month for a male age 60-64 with a deductible of \$1,000. In 2009, 13 percent of THIP enrollees selected a \$1,000 deductible, 38 percent a \$2,500 deductible, 37 percent a \$5,000 deductible and 10 percent a \$7,500 deductible. The average monthly premium was \$620.

Premium rates for PCIP are set at the average standard rate in the commercial market and vary based on the age of the applicant and the plan they select. Monthly premiums for Texas enrollees beginning January 1, 2011 are as follows:

PLAN TYPE	AGE 0-18	AGE 19-34	AGE 35-44	AGE 45-54	AGE 55+
Standard	\$174	\$261	\$313	\$400	\$567
Extended	\$234	\$351	\$422	\$539	\$749
HSA	\$181	\$271	\$325	\$416	\$578

Note: Plan descriptions available at www.pcip.gov/PCIP_%20pamphlet_benefits_summary.pdf.

While both programs (PCIP and THIP) provide comprehensive coverage, PCIP has no waiting period for treatment of pre-existing conditions, an important benefit for this population since all enrollees have some pre-existing medical condition as a condition of eligibility. By contrast, the THIP includes a 12 month pre-existing condition exclusion waiting period for most new enrollees (with exceptions for enrollees with creditable coverage and some enrollees with continued coverage under a previous employer plan). This means that, while individuals in PCIP are immediately eligible for benefits for their pre-existing condition, enrollees in THIP must wait 12 months before pre-existing conditions are covered.

Impact of Federal Health Reform

The federal health reform Patient Protection and Affordable Care Act includes significant private insurance market provisions that will dramatically alter the insurance market in Texas and other states. The law includes a series of reform requirements that begin in 2010, with the most dramatic changes occurring in 2014. With a few exceptions, most of the initial reforms effective in 2010 through 2013 will primarily affect individuals who already have insurance coverage and will have little impact effect on individuals who are uninsured or who are enrolled in public plans. However, beginning in 2014, several fed-

eral requirements should significantly assist lower income families and employees obtain affordable health insurance, including the following:

- Advanceable tax credits will be available to families earning up to 400 percent of federal poverty level to purchase affordable health insurance;
- Insurance plans must meet certain benefit requirements and cost-sharing provisions designed to ensure benefit plans provide comprehensive services with limited out-of-pocket costs to enrollees;
- Most large employers will be required to offer health insurance benefits that meet minimum requirements or may face penalty payments;
- Insurance plans are prohibited from denying coverage based on an individual's health status;
- Insurance plans will not be able to increase premiums based on an individual's health status or gender, and premium rates for older individuals are limited; and
- Insurance Exchanges will provide access to health insurance plans that meet standard benefit requirements and provide simplified application and enrollment procedures for individuals, small businesses and Medicaid/CHIP enrollees.

The provisions listed above will require federal regulations and, in some cases, state legislative and/or regulatory action to fully implement. Until the details of these requirements are finalized, it is impossible to predict the long-term impact on the affordability of insurance coverage. However, the removal of underwriting restrictions, new premium rating reforms, availability of subsidies and limitations on out of pocket expenses for low and middle income families should make it easier for many low-income Texans to obtain private insurance.

Senate Bill 1 – Rider 19

Review of Insurance Industry Practices Regarding Data Mining and Pattern Recognition Practices and Technologies

From the 1960s until the present, the manner in which information is stored, shared, and manipulated has shaped the way insurers – and other industries – do business. Data mining is not only about discovering new information hidden in large data sets; it also encompasses pattern recognition, prediction, and analysis. Data mining has been embraced by the insurance industry and insurers use data mining and pattern recognition for rating, underwriting, fraud detection, analyzing losses, and enhancing the customer experience.

Senate Bill 1 of the 81st Legislative Session (2009) required the Department to conduct a review of insurance industry practices regarding the use of data mining and pattern recognition practices and technologies that are used to predict differences in expected losses for personal automobile or residential property insurance coverage or health benefit plan coverage; and the manner in which insurers use these technologies in underwriting and setting rates.

Since a number of definitions for the term “data mining” exist, the Department used the following definition in its review:

Data mining involves the use of sophisticated data analysis tools to discover previously unknown, valid patterns and relationships in large data sets. Data mining consists of more than collecting and managing data; it also includes analysis and prediction.

In March 2010, the Department surveyed more than 140 insurers and one property and casualty advisory organization to gather information required by SB 1. The survey sample included 25 property and casualty groups representing 103 different insurers writing personal auto, residential property, or both. These groups represent a wide spectrum of insurers, both in terms of size and type of market (standard and nonstandard). While most write both personal automobile and homeowners policies, a few write only one line of business.

For life and health, 43 insurers that write individual, small employer, and large employer major medical health insurance plans were included in the survey. Some insurers write all these plans while others only write certain types. Of the sample, 27 insurers write individual major medical policies, 15 write large group policies, and 23 write small group policies.

Altogether, the insurers participating in the survey represent 85 percent of the personal automobile market, 90 percent of the homeowner market, and 84 percent of the health insurance market in Texas.

Data mining reflects the evolution of the technology revolution.

Data mining in insurance has evolved significantly over the past several years. Today, insurers use data mining for underwriting, rating, fraud detection, claims management, marketing, distribution strategies, consumer research, and customer experience. Through data mining technology, insurance companies tailor rates and services to meet both theirs and customers’ needs and over time, more accurately correlate rates to risk.

A summary of the usage of data mining for rating, underwriting, and predicting differences in expected losses is shown in Table 1. The numbers reflect the percentage of respondents that reported using data mining for these purposes. All respondent groups reported using data mining more often for rating than in underwriting. For the property and casualty markets, more than two thirds of the respondents also used data mining for predicting differences in expected losses, which is then often parlayed into the development of rating plans. For the health market, the use of data mining in predicting differences in expected losses varied by plan type.

Table 1: Uses of Data Mining by the Texas Insurance Industry

PURPOSE AUTO	PROPERTY AND CASUALTY		HEALTH BENEFIT PLANS*		
	PERSONAL PROPERTY	RESIDENTIAL EMPLOYER	LARGE EMPLOYER	SMALL MARKET	INDIVIDUAL
Rating	73%	64%	20%	57%	11%
Underwriting	38%	32%	27%	30%	11%
Predicting differences in expected losses	73%	71%	13%	57%	15%

* Some have since abandoned data mining for these purposes.

Source: 2010 TDI Data Mining Survey

Personal Auto & Residential Property Survey Findings

Personal automobile respondents use data mining slightly more so than the residential property respondents. Following is a brief summary of the survey findings.

Use of Data Mining – Rating

Seventy-three percent of personal auto and 64 percent of residential property respondents use data mining in creating or modifying rating practices. While most insurers use data mining to identify and implement new rating variables, some respondents use data mining to identify or refine multivariate tiering methods for classifying risks within a single underwriting company.

While some insurers have been using data mining for more than 10 years, most began using some form of data mining between 3 and 10 years ago.

Use of Data Mining – Underwriting

A large percentage, though not a majority, of insurers use data mining in their underwriting: 38 percent of personal auto respondents use data mining to identify or implement new risk characteristics, but only 32 percent of residential property insurers do so. A small number of respondents use data mining to introduce or modify risk classification methods for the placement of risks among multiple companies. A similar subset of respondents also use data mining for evaluating expansions into new markets or offering coverage to previously rejected insureds.

Data Mining Techniques Used to Predict Differences in Expected Losses

The survey requested that insurers report the data mining and pattern recognition practices and technologies they use to predict differences in expected losses. Seventy-three

percent of personal auto and 71 percent of residential property respondents use data mining to predict differences in expected losses.

Generalized linear models (GLM) are the most common technique used for predicting differences in expected losses. While only one property insurer and one auto insurer used this technique 10 years ago, about three-quarters of personal auto respondents and two-thirds of the residential property respondents currently use GLM.

The next most common technique is cluster analysis. Approximately 40 percent of both personal auto and residential property respondents currently use this technique, most of which began using this technique more than two years ago.

Factor analysis is used by just over 30 percent of both personal auto and residential property respondents. Other techniques such as classification and regression trees, multivariate adaptive regression splines, regression, decision trees, and neural networks are used by a few groups.

Best practices dictate that the raw results of data mining should never be used without validation, including human intervention to check for reasonable results. These checks are necessary to avoid results garnered from a subset of data that ultimately are not representative of the whole.

Databases Utilized

Insurers typically use well-established sources of data for a wide range of uses including data mining. The most common databases or sources used by insurers in the survey were Comprehensive Claim Underwriting Exchange reports to verify claim history, motor vehicle records to verify driving records, and credit reporting agencies for credit scores or other credit-related information. Beyond these common sources of data, insurers also use information such as county tax records and census information.

Health Benefit Plan Survey Findings

While some insurers have since abandoned the use of data mining, just over half of those surveyed have used data mining for at least one purpose. Of the three major markets for health benefit plans, respondents that write large employer plans tend to use data mining the least. Following is a brief summary of the survey findings.

Use of Data Mining – Rating

For those insurers that use data mining in rating, the primary approach is to introduce or refine multivariate tiering methods for classifying risks within a single underwriting company. This practice is used primarily in rating within the small employer market (i.e., groups of 2-50 employees). While several insurers utilized data mining beginning 6-10 years ago, two that write both small and large employer plans have since abandoned data mining for use in rating.

Use of Data Mining – Underwriting

Most insurers responded that they do not use data mining and pattern recognition practices for their underwriting practices. Less than 22 percent of the respondents (20 percent of the large employer market, 22 percent of small insurer market, and 7 percent of the individual market) reported using data mining to identify and implement new risk characteristics. All of the respondents reported that data mining is not used to restrict the availability of coverage, and less than 13 percent (0 percent of the large employer

market, 13 percent of small insurer market, and 7 percent of the individual market) use data mining to expand into new markets.

Data Mining Techniques Used to Predict Differences in Expected Losses

Most insurers stated that they do not use data mining technologies to predict differences in expected losses. Insurers that do use these technologies prefer to use linear regression or simulation practices, and these insurers often use two or more different pattern recognition practices together. Some large carriers have been employing loss-related data mining practices for more than 10 years. Other insurers have been using data mining methodologies for more than five years.

Data mining is a concept and a process, rather than an executable program; and despite advances in technology, too much dependence on the automation process can mislead people “into believing that data mining is a product that can be bought rather than a discipline that must be mastered.”¹ In other words, regardless of how data mining technologies and techniques develop, the essential value will always lie in the ability to extract meaningful information from patterns uncovered in the data mining process.

In the large group market, only two companies use data mining for predicting differences in expected losses. The small group market reports using data mining more extensively—perhaps because these policies are guaranteed issue and represent increased risk due to the smaller size of the groups. Large group and individual coverage policies are not guaranteed issue and pose less risk to insurers since they can choose to decline coverage to applicants that do not meet their underwriting requirements.

Databases Utilized

The majority of respondents, both large and small, use information from outside sources. The three sources most often cited in the survey responses were the Medical Information Bureau (MIB), Milliman IntelliScript, and ImpactPro/Ingenix, all of which are used primarily for underwriting purposes. These databases provide prior prescription and limited diagnosis history on individuals. Other database sources used include Acxiom, credit bureaus, Dunn and

Bradstreet, and InfoUSA. It does not appear that any of the insurers use medical information services companies solely for data mining outside the underwriting process.

¹ Michael J. A. Berry, Gordon S. Linoff, *Mastering Data Mining: The Art and Science of Customer Relationship Management* 7-8 (Robert M. Elliott ed., Robert Ipsen 2000).



In 2006, the following article on Data Mining and Pattern Recognition was published in the *TDInsight*, an insurance information resource from the Texas Department of Insurance. This article highlighted issues relating to emerging pattern recognition technology and is reprinted for your information.

Data Mining and Pattern Recognition – The Next Generation of Risk Classification

What is Data Mining and Pattern Recognition?

Data mining is the collection of non-traditional data for correlation with characteristics found in risk events to create risk classifications for insurance rating purposes. The combined processes of data mining and pattern recognition, or the search for previously unknown correlations, has received more attention lately, especially as its use has become more widespread in insurance. Insurers deploy the process to detect fraudulent claims, identify subrogation opportunities, and improve marketing effectiveness. It is the coupling of data mining - the search for data - and the emerging pattern recognition technology - using data to detect future losses - that is generating a number of policy issues.

Risk Classification

Insurers classify customers into groups whose members share common characteristics. Different risk classes are accordingly charged different rates depending on their predicted losses. Risk classification ensures compliance with state rating laws that require rates to be fair and commensurate with risk.

Prior to the advent of information technology, these groupings were broad and few in number because the administrative costs of implementing more precise risk-predicting categories exceeded the potential gains from increased sales and decreased claims.

As the data-related technology has evolved and become more cost-effective, greater refinement in risk classification is not only economically viable, but inevitable, because companies cannot afford to be adversely selected against.

As recently as the late 1990’s, most auto insurers restricted their basic classifications to age, gender, marital status, location and type and use of vehicle.

Adverse Selection and Technological Arms Race

Adverse selection occurs when the forces of competition move risk so that an insurance company finds itself insuring only the highest and most unpredictable risks, though not intentionally. More simply, market forces “select” who will insure the most adverse risks by allowing the better risks to flow to the companies that have the better prices. This situation is analogous to a professional sports team paying higher salaries to attract the best athletes with proven abilities, leaving the other teams with players whose skill and performance levels are unknown.

While consumers consider many factors when purchasing insurance, price is a dominant factor. Moreover, change in price can be a dominant factor, too. For instance, a person might be content with the amount they are currently paying, but when the rate is increased significantly at renewal, the amount of change pressures many

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consumers to shop for a better rate. Hence, when one company changes prices, other companies begin taking defensive positions to protect against adverse selection and keep their best customers, usually by adopting similar rating structures. This cycle is nearly endless, since insurers will be forced to pursue more refined classifications as long as the benefits of doing so exceed the costs. However, as previously noted, the marginal costs of technology are decreasing, thus spawning a cycle of exponential refinement. Dr. Robert P. Hartwig, then serving as chief economist for the Insurance Information Institute, once observed, "...the industry is engaged in what amounts to a technological arms race."

Future Impact

What is currently under development is the next generation technology for risk prediction. There

At the end point, rating systems will become so refined that each individual is effectively self-insuring, and "insurance" will have morphed into a form of self-financing.

are two impacts likely to arise in the next few years.

As mega-data and hyper-tiering of risks are tested and imple-

mented in markets, the risk transfer mechanism may be reduced. Many individuals will effectively be self-insuring. The result is that insurance will morph into a form of self-financing. In this instance, premiums for some may become prohibitively expensive, further exacerbating any disproportionate impact among many groups of risks. In these instances, an analysis of the classifications must be taken to make sure the risk classifications are appropriate and accurately represent true risk classifications. After all, insurance is still a business of sharing risk.

Another issue is the availability of property insurance in emerging urban markets. In such markets, the risks are so varied that the broad, homogeneous rating and tier placement methods better suited to the suburbs do not always work. To address this issue, The Urban Insurance Partners Institute is undertaking a study to identify data from non-traditional sources that may serve as an antidote to broad, non-traditional risk rating variables, such as credit scoring. By gathering and tracking data generated from utility and rental payments, check cashing transactions and other non-traditional sources, it is hoped by the Institute that patterns can be detected that neutralize the adverse effects of credit scoring and allow lower rates.

What Should Be Done?

Accurate classification of risks is both efficient and fair in that it improves loss prevention incentives and makes the right people bear the cost of the risks they voluntarily choose to take. Further, it could create markets for risks that were previously under served. However, caution needs to be exercised that any new factors considered have a direct causal connection to the risks represented.

While the development of data mining and pattern-recognition may be cause for concern, these phenomena should not be condemned out of hand simply because we do not fully understand the results they will produce. A key message is that the industry must be mindful of the possible adverse legal and social implications of this process, and must be prepared to demonstrate that its use of technologies and new rating classifications are accurate and accurately portray direct causal connections.

Society's reaction is usually manifested through its legislative bodies. There is a need for industry visionaries to open a dialogue with legislators and the public over how these tools are to be used, as well as the beneficial effect of their proper use. Industry should be open to acknowledging the possibly harmful results of improper use as well. The regulatory challenge is to avoid any sudden or extreme changes that could have potential extreme economic implications. As benefits to previously underserved areas are explored, care is required to observe and properly measure the application of the various tools to assure proper and accurate application. Such measured steps will permit a gradual and reasonable application of risk at levels to minimize policyholder shock. With time to understand and react, policymakers will be better able to set the law on a course that is right for the times that lie ahead, while allowing the markets to address problems of importance to the public.

