February 2001

Texas Insurance News

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Agent License Renewals Go On-Line

THE APPROXIMATELY 80,000 agents who renew their licenses each year can save time and trouble by using the Internet and their credit cards instead of the U. S. Postal Service and their checkbooks.

On-line license renewal is now available as part of the state's "Portal Project." The project is an initiative mandated by the Legislature to bring the benefits of electronic commerce to state agency customers. TDI volunteered to participate.

"Electronic commerce is the wave of the future for state licensing agencies. It offers huge benefits in convenience for our licensees and potential labor cost savings for taxpayers. The Texas Department of Insurance is pleased, therefore, to be among the first state agencies offering direct service on-line to our licensees," said Commissioner Jose Montemayor.

Agents can renew on-line if they have received their renewal notices and are within 90 days of their license expiration dates.

How to Renew On-Line

The steps for on-line renewal are:

- Access TDI's Web site, **www.tdi.state.tx.us**, and click on "Agent License Data."
- Enter the necessary information to look up your own agent profile. If you are eligible to renew, the first page of your profile will include a "Renew" button.
- Click on the "Renew" button to bring up your renewal form.
- Enter the required information, including a VISA, Master Card, Discover Card or American Express card number.

Your credit card company will bill you for your renewal fee and a $3 convenience fee. The state Comptroller of Public Accounts will process your credit card license renewal fee payment and transmit the data to TDI electronically.

Credit card transactions are encrypted so that no unauthorized person—including employees of TDI and the Comptroller—has access to your credit card number.

Agents can submit address changes at the same time they renew their licenses. This is the only time, however, when they can file address changes electronically. On other occasions an agent needs to send address changes in writing to TDI's Agents Licensing Division.

Documentation

A legitimate question about the new system is, "What do I get in writing to prove I renewed and have a current license?" Agents renewing on-line receive ample documentation:

- When they complete the on-line transaction, they receive immediate confirmation, with a transaction number, which they can print out.
- Their on-line agent profiles are updated within three to five days to show their new license expiration dates.
- They receive their paper licenses within five to seven business days after renewing on-line, a big time saving compared to the 15 to 20 days it takes to receive a new license after mailing in a renewal application.

In addition, TDI's internal agent query system is updated within three to five days after an on-line transaction to show the agent's new license expiration date. That is important because the system provides the information to callers who connect to Agent Licensing's interactive voice response (IVR) system for answering telephone calls.

How Many Will Use It?

The state's Portal Project contractor, KPMG, estimates that 5 percent of the licenses up for renewal in the first year—or about 4,000 licenses—will be renewed on-line. TDI expects more than that. States that already offer on-line renewal report that as many as 50 percent of their agents renew their licenses electronically.

The new system will be especially useful to agents who wait until just before their expiration dates to renew their licenses. An agent who renews on-line will be recorded as having accomplished his or her renewal on the date of the on-line transaction. The $3 convenience charge for renewing on-line is a bargain when compared with the $25 late fee for renewals that arrive at TDI after the expiration date. ★

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NewsBriefs

Montemayor Approves WC Class for Domestics

COMMISSIONER JOSE MONTEMAYOR has established a new workers' compensation classification for residential domestic workers whose premiums are based on payroll.

Montemayor amended Rule XV of the *Texas Basic Manual of Rules, Classifications and Experience Rating Plan for Workers' Compensation and Employers Liability Insurance.*

The manual previously allowed calculation of the premium for residential domestic workers on either a per capita basis or a payroll basis. However, there was no separate classification to use if the premium was calculated on a payroll basis rather than a per capita basis.

The Commissioner's action added Code 0923 Domestic Workers—Residences: Payroll Basis to both the alphabetic and numeric classification sections of the manual. He revised Rule XV—Domestic Workers—Residences by adding a reference to Code 0923 to clarify that both Codes 0913 and 0923 are "a" rated classifications. ★

Auto Benchmark Rate Hearing Set for March

COMMISSIONER JOSE MONTEMAYOR has scheduled this year's private passenger and commercial auto benchmark rate hearing to start March 6, 2001.

The hearing before an administrative law judge will begin at 9 a.m. in the State Office of Administrative Hearings (SOAH), Stephen F. Austin State Office Building, 1700 N. Congress Avenue, Austin.

Parties are the Office of Public Insurance Counsel, the Insurance Council of Texas, Farmers (Texas Farmers Insurance Co. and Mid-Century Insurance Company of Texas), State Farm and TDI staff. The parties have until 5 p.m., February 12, 2001, to submit their pre-filed testimony. ★

SAI Plus Hearing Reset for March 26

AN ADMINISTRATIVE LAW JUDGE has rescheduled the public hearing on TDI's unauthorized insurance allegations against SAI Plus, LLC, of Rockville, Maryland, to begin on March 26, 2001.

Judge Cassandra J. Church of the State Office of Administrative Hearings (SOAH) granted SAI's request for a continuance on December 20, 2000, the day before the hearing was originally scheduled to begin.

TDI staff attorneys seek a cease-and-desist order, a $1 million fine and reimbursement to health plan members for unpaid medical bills. ★

Policy Count Data Due February 15

INSURERS AND HMOS have until February 15, 2001, to submit policy count data that TDI will use to calculate complaint ratios and indexes. The call for the 2000 policy count exhibit was issued January 8, 2001.

Companies can find the bulletin (B-0001-01) on TDI's Web site, **www.tdi.state.tx.us**, and may file their data on-line, by fax or by mail.

The call asks insurers and HMOs to report the number of policies of various types that they had in force as of December 31, 2000. Each company in a group must submit its own policy count filings.

TDI is required to provide consumers with complaint ratio information. Ratios are computed as "the number of justified, verified as accurate and documented as valid complaints" received against a company as a percentage of the number of policies the company had in force on the preceding December 31. ★

TDI Calls for Price Data For New LTC Rate Guide

THE DEPARTMENT has issued a call for long-term-care premium information that will be used in a new rate guide. The call went to companies licensed to sell LTC insurance in Texas as of January 1, 2001.

The guide will enable consumers to compare annual premiums for companies actively marketing LTC insurance in Texas. TDI plans to update the rate guide annually.

Companies had a deadline of January 26, 2001, to submit their rate information on forms provided by TDI.

The forms were set up to capture rates in effect on January 1, 2001, for 18 sample policies, nine of them tax qualified and nine non-tax qualified. The samples consist of various combinations of benefits.

The call also seeks information on each specific LTC policy form offered by a company in Texas, including benefits, features and discounts. ★

Medicare HMOs Urged To Send Rights Reminder

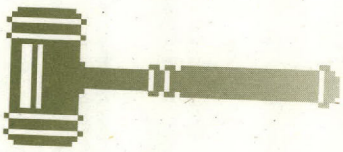
COMMISSIONER JOSE MONTEMAYOR has urged Texas HMOs that withdrew from Medicare on January 1, 2001, to remind the affected enrollees of their special—but temporary—right to guaranteed issue of certain Medicare supplement policies.

He issued letters in December asking each of the 11 HMOs withdrawing totally or partially from Medicare in Texas to send written reminders to the approximately 200,000 Texans affected by the withdrawals.

The right to guaranteed issue expires on March 4, 2001.

Montemayor also directed the HMOs to make sure they have complied with state and federal laws requiring them to inform their members of their rights and options. He said TDI will closely monitor the HMOs' compliance and will take enforcement action where appropriate.

Montemayor noted that this was the second consecutive year of Medicare HMO withdrawals and that many members lacked the option of joining another HMO because no Medicare HMOs remained in some counties. In some other areas, the remaining Medicare HMOs stopped accepting new members after their health care provider networks reached capacity. ★



Fraud Unit Prosecutions

Indictments

Tennant, Charles, J., indicted in Austin on charges of theft, a first-degree felony.

Simmons, Joyce, indicted in Fort Worth on charges of insurance fraud, a state jail felony.

Convictions

Jones, Elisa, pleaded guilty in Houston to theft. Sentenced to six months' probation.

Ashbrook, Joel, pleaded guilty in Dallas to securing the execution of documents by deception. Sentenced to 60 months' deferred adjudication and a $500 fine.

Guiterrez, Vincent, pleaded guilty in Austin to making a false statement in a written instrument. Sentenced to 36 months' probation and 160 hours of community service. ★

RuleMaking

AUTOMOBILE

Exempt Adoption

Commercial Auto Experience Rating

■ Commissioner Jose Montemayor has amended the *Texas Automobile Rules and Rating Manual,* Rule 48, and the Automobile Liability Experience Rating Plan.

As a result of the amendments, insurers, rather than TDI, will perform all routine experience rating functions, subject to information requests by the Department. The amendments delete the requirements for regular reporting to TDI and set forth other duties of insurers such as maintaining experience data for availability to the Department. The revised rules require insurers to maintain experience data for five years and to supply any requesting company, agent or insured with experience rating information upon request. TDI will no longer maintain experience rating information but will maintain oversight of the function.

Publication: 26TexReg689, January 12, 2001
Effective date: January 27, 2001
Further information: 512 463-6327

FINANCIAL

APA Proposals

2000 Annual Statements

■ The Department has proposed new 28 TAC § 7.70, which would establish requirements for filing 2000 annual statements. The instructions and forms would be the same as those for the 1999 annual statement filings. The 2001 quarterly filing information is set out in 28 TAC § 7.71, which is simultaneously proposed with this section.

Publication: 26TexReg 59, January 5, 2001
Earliest possible adoption: February 4, 2001
Further information: 512 463-6327

2001 Annual and Quarterly Statements

■ The Department has proposed new 28 TAC § 7.71, which would set out filing requirements for the 2001 annual and quarterly statements. This rule is intended to conform to the new *Accounting Practices and Procedures Manual,* adopted under 28 TAC § 7.18 and effective January 1, 2001.

Significant changes from the previous year's requirements are:

- HMOs would file on the new NAIC health blank beginning with the first quarter of 2001.
- HMOs would file quarterly health blanks with the NAIC.
- Texas life companies that wrote only accident and health business in 2000 would be allowed to use the new NAIC health blank. Foreign life companies that write health premiums would be permitted to file on the health blank in Texas if permitted by their domiciliary states.
- Texas-only supplemental forms to be filed with the 2001 annual statement are not included in this rule. The Department intends to have these Texas forms updated later in 2001 and will propose an amendment to the rule by December 31, 2001.
- The NAIC instructions provide that certain annual statement schedules need only be filed with the insurers' domiciliary state. Some foreign companies may not file paper copies of these schedules with Texas, but copies will be available from the insurers' domiciliary states.
- Schedule DC information is now in Schedule DB, relating to options and futures information.
- Companies filing electronically with the NAIC would be required to include PDF format filings.

Publication: 26TexReg 59, January 5, 2001
Earliest possible adoption: February 4, 2001
Further information: 512 463-6327

HEALTH CARE

APA Proposals

Point-of-Service Contracts

■ The Department has proposed new or amended rules under the TAC chapters on HMOs, trade practices, and large and small employer health plans concerning point-of-service plans. The proposals would implement House Bill 1498 of the 76th Legislature, which added Articles 26.09 and 3.64 to the *Texas Insurance Code* and amended Articles 20A.02 and 20A.06.

Point-of-service (POS) plans combine managed care and indemnity coverage. An enrollee may choose to obtain health care through the managed care delivery system or from a physician or provider outside the delivery system on a fee-for-service basis.

HMOs

The proposed rules for HMOs wishing to issue POS riders would be codified as new 28 TAC 11.2501–11.2503 (Subchapter Z).

HMOs would have to meet certain solvency requirements before they could issue a POS rider. An HMO licensed for a year or longer would have to maintain a net worth at least equal to the sum of 25 percent of total gross POS premium revenue reported in the preceding year plus the greater of 1) $1.5 million or 2) 100 percent of the HMO's authorized control level of risk-based capital. An HMO licensed for less than a year would have to maintain a net worth of at least $1.5 million plus 50 percent of the yearly average of the two-year annual gross POS premium revenue projected in its application for a certificate of authority.

An HMO's admitted assets would have to be sufficient to cover reserve liabilities for POS riders.

If an HMO's net worth or assets fall below the required amounts, it would have to stop issuing new POS rider plans (with some exceptions) until it complies with solvency requirements. Exceptions would be new members of plans to which an HMO had already committed to furnish POS riders unless the HMO divests itself of a group's business or stops writing a particular individual plan.

An HMO's POS rider expenses could not exceed 10 percent of the total annual medical and hospital expenses for all health plan products sold by the HMO. If POS rider expenses exceed the 10 percent limit, the HMO would have to immediately stop issuing new POS rider plans, with certain exceptions. An HMO could resume selling POS rider plans if it satisfied the Commissioner that its POS expenses in the coming year would stay within the 10 percent cap.

POS rider plans would be guaranteed renewable for small and large employer plans, individual plans and association plans. If an HMO discontinued a POS rider plan because it exceeded the 10 percent cap, the HMO would have to offer small and large employers, individuals and associations the option to buy any other coverage offered to such customers.

HMOs could not require enrollees to use either the POS rider benefits or in-plan covered services first. Nor could they consider an in-plan covered service to be a benefit provided under the POS rider.

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An HMO that has limited provider networks could not restrict an enrollee's access under a POS rider to either network or non-network physicians and providers. The HMO also could not impose different cost-sharing arrangements when a POS enrollee in a limited provider network uses a participating physician or provider outside that limited provider network. An HMO could, however, impose a different cost-sharing arrangement when such an enrollee uses physicians and providers outside the HMO network. Coinsurance required under a POS rider could not exceed 50 percent of the total amount to be covered.

Among other things, a POS rider would be required to:

- Provide coverage corresponding to all in-plan covered services provided in the evidence of coverage and through any separate riders attached to it.
- Disclose, if applicable, how POS rider cost-sharing arrangements differ from those in the evidence of coverage. This disclosure would have to include any reduction in benefits, any deductible to be met by the enrollee and whether co-payments for in-plan covered services apply toward the POS rider deductible.
- Provide coverage for services obtained from a participating physician or provider without the HMO's authorization. The enrollee, however, would have to comply with any applicable precertification requirements.
- Describe how an enrollee may access out-of-plan covered benefits under the POS rider, including coverage contained in other riders attached to the evidence of coverage.
- Disclose all precertification requirements for coverage under the POS rider, including penalties for failure to comply with any precertification or cost containment provisions. Such penalties could not reduce benefits by more than 50 percent in the aggregate.

A POS rider would be prohibited from:

- Reducing or limiting in-plan covered services in any way by coverage for benefits an enrollee obtained under the POS rider.
- Limiting (with certain exceptions) coverage for benefits that correspond to in-plan covered services.

A POS rider could (but would not be required to):

- Include benefits in addition to in-plan covered services.
- Limit or exclude coverage for benefits not corresponding to in-plan covered services.
- Include reasonable out-of-pocket limits and annual and lifetime benefit allowances that differ from the limits or allowances for in-plan covered services provided under other riders. Any such limits and allowances would have to comply with applicable state and federal laws.
- Provide for cost-sharing arrangements that differ from those for in-plan covered services. However, coinsurance under a POS rider could never exceed 50 percent of the total amount to be covered.

Benefits under a POS rider could be reduced by benefits obtained as in-plan covered services.

POS rider plans would have to contain an evidence of coverage that adequately notifies prospective or current enrollees that the plan provides the option of accessing either participating or non-participating physicians and providers for out-of-plan covered benefits but that using the POS rider may cost more than accessing in-plan covered services.

A POS rider plan also would have to contain a side-by-side comparison of coverages for services, benefits and supplies available under the POS rider with those shown in the evidence of coverage.

Publication: 26TexReg73, January 5, 2001
Earliest possible adoption: February 4, 2001
Further information: 512 463-6327

POS Arrangements Between Indemnity Carriers and HMOs

■ The proposed rules governing these arrangements would be codified as 28 TAC §§ 21.2901–21.2902 (Subchapter U). They set forth requirements for blended contract POS plans and dual contract POS plans.

A blended contract plan is a POS plan, evidenced by a single contract, policy, certificate or evidence of coverage, that provides a combination of indemnity benefits for which an indemnity carrier is at risk and services are provided by an HMO.

A dual contracts plan is a POS plan providing a combination of indemnity benefits and HMO services through separate contracts. One of these would be the contract, policy or certificate offered by an indemnity carrier for which that carrier would be at risk. The other contract would be the evidence of coverage offered by the HMO.

Point-of-service indemnity coverage would be that for which an indemnity carrier is at risk under a POS plan for health care services, benefits and supplies (other than emergency services), selected at the enrollee's option, from non-participating physicians or providers. POS indemnity coverage also would include services, benefits and supplies obtained from participating physicians or providers under circumstances in which the enrollee fails to comply with the requirements of the HMO.

A POS plan would have to be evidenced by a written agreement between the HMO and the indemnity carrier, filed with TDI and providing:

- The identity of each entity, including the HMO, the indemnity carrier or any third-party administrator (TPA), that will administer the coverages offered under the POS plan.
- All duties of the HMO and the indemnity carrier to each other.
- All POS plan costs allocable to the HMO or the indemnity carrier.
- The HMO's network of providers and, if the indemnity coverage includes preferred provider benefits, the indemnity carrier's preferred provider list. The preferred provider list could not be identical to the HMO's provider network.
- Separately derived and identified premium rates for both the HMO coverage and the indemnity coverage. The HMO, the indemnity carrier or a TPA could collect the premiums for both coverages. The purchaser of the POS plan could make a single payment for both coverages. The entity delegated to collect the premium would be required to disburse the appropriate premium to the other party or parties.

Premium rates charged by an HMO would have to be based on the actuarial value of the POS HMO coverage and could be different from the premium rates charged by the indemnity carrier. The indemnity carrier would be required to base its rates on the actuarial value of the POS indemnity coverage offered by that carrier.

Neither entity could use the other to perform functions or duties that are its own responsi-

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bility by law or rule. However, the entities could delegate functions and duties that state laws or rules allow to be delegated, including contracting with providers and administering claims.

A POS agreement between an indemnity carrier and an HMO could not be canceled or terminated until the coverage for each affected enrollee is terminated or cancelled as provided by the proposed rules.

An agreement would have to spell out the arrangements to be made if insolvency or other circumstance affects the ability of either party to comply with TDI rules.

Contracts creating blended contract or dual contract POS plans would have to provide that:

- Enrollees could not be required to first use either the indemnity coverage or the HMO coverage.
- If premiums necessary to maintain both the HMO and the indemnity coverage are not paid, both coverages would be cancelled simultaneously.
- The POS HMO evidence of coverage must include all mandatory HMO coverages, and the POS indemnity coverage must contain all mandatory indemnity coverages.
- Mandatory benefit offers must be accepted or rejected by the purchaser in the same manner with respect to both the POS HMO and the POS indemnity coverage.
- Benefits under the HMO coverage could not be reduced by benefits received under the indemnity coverage. However, benefits for POS indemnity coverage could be reduced by benefits received under the POS HMO coverage.
- If medically necessary covered services, benefits and supplies are not available through the HMO's participating physicians and providers, the availability of such services through POS indemnity coverage does not relieve the HMO of its obligation to provide out-of-network services.

Each POS contract would have to identify the respective premium rates for the HMO coverage and the indemnity coverage. It also would have to give the name and address of the entity to which the premiums must be paid.

In addition to these general requirements, contracts for POS blended contract plans would be required to list all POS HMO and indemnity coverages; specify how services, benefits and supplies under the POS HMO coverage are accessed; specify how indemnity claims are to be made; disclose all required deductibles and co-payments; and disclose all coinsurance required for POS indemnity coverage. Coinsurance could not exceed 50 percent of the total amount to be covered. These contracts also would have to disclose all precertification requirements for POS indemnity coverage, including penalties for failing to comply with precertification and cost containment provisions. Such penalties could not reduce benefits by more than 50 percent in the aggregate.

When a POS dual contract plan is issued, there would be separate requirements for the contracts issued by the indemnity carrier and the HMO. The contract issued by the indemnity carrier would have to meet all applicable requirements for such carriers and list all indemnity coverages, specify how claims are made, disclose applicable copayments and coinsurance (not to exceed 50 percent of total amount covered), and disclose all precertification requirements, including any penalties for failing to comply with those requirements. Penalties could not reduce benefits by more than 50 percent. The HMO's contract would be required to comply with all requirements for an HMO evidence of coverage and also would have to list all covered services, benefits and supplies, specify how the enrollee may access them and disclose all applicable copayments.

Publication: 26TexReg77, January 5, 2001
Earliest possible adoption: February 4, 2001
Further information: 512 463-6327

Small and Large Employer Plans

■ Proposed rule changes governing such plans would be codified as amendments to 28 TAC §§ 26.4 and 26.14 and as new 26.312.

The proposed amendments would:

- Update the definition of point-of-service contract to reflect the types of POS plans authorized by House Bill 1498 for issuance by large and small employer carriers.
- Clarify that small and large employer carriers may issue POS plans if they comply with the proposed new rules summarized in the preceding two sections.
- Create standards for the POS coverage options that large employer carriers issuing HMO coverage must offer to eligible employees when the only coverage available to those employees is one or more HMOs.

When two or more HMOs provide coverage to the employees of a large employer that offers only network-based delivery systems to its employees, the HMOs could enter into a written agreement designating which one will offer the required POS option. If one HMO stops offering coverage to the large employer, the remaining HMOs would have to enter into a new agreement. If, for some reason, there is no written agreement, each HMO serving the large employer would be required to offer eligible employees the option of selecting out-of-plan coverage.

Employees who select a POS option would be responsible for paying all cost-sharing amounts, including premiums, coinsurance, copayments and deductibles, plus any administrative cost imposed by the employer.

Publication: 26TexReg80, January 5, 2001
Earliest possible adoption: February 4, 2001
Further information: 512 463-6327

APA Adoptions

Utilization Review of Mental Health Treatment

■ Commissioner Jose Montemayor has amended 28 TAC §§ 19.1703, 19.1708 and 19.1715 concerning requirements for prospective, concurrent and retrospective reviews of mental health treatment provided under health insurance policies or health benefit plans.

The amendments implement Senate Bill 569 of the 76th Legislature, regarding observation of mental health therapy and review of a mental health therapist's notes. The changes also address numerous inquiries to TDI concerning the permissible scope and contents of mental health medical record summaries and concerning the term "mental health therapist." Finally, the amendments are necessary to clarify that patients whose mental health treatments are reviewed retrospectively are entitled to the same confidentiality protections as patients whose treatments are reviewed prospectively or concurrently.

The new rules define "mental health medical record summary" as a summary of process or progress notes that are relevant to understanding the patient's need for treatment of a mental or emotional condition or disorder. A summary contains information such as identifying information and a treatment plan, which includes diagnosis, treatment intervention, general characterization of patient behaviors or thought processes affecting the level of care needed and a discharge plan.

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"Mental or emotional condition or disorder" is defined as a mental or emotional illness as detailed in the most current revision of the *Diagnostic and Statistical Manual of Mental Disorders.*

"Retrospective review" is defined in the new rules as a system in which review of the medical necessity and appropriateness of health care services provided to an enrollee is performed for the first time after the completion of those services. It does not include a subsequent post-service review of a service upon which prospective or concurrent review already had been performed.

The rules expand on the present rule prohibiting utilization review agents from requiring the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes. The new rules specify that the protected notes are those that relate to the therapist's treatment of the patient's condition or disorder. The protection now extends to oral, electronic and facsimile renditions of the therapist's notes.

Under the rules, a utilization review agent may require submission of medical records and/or process or progress notes about conditions other than mental or emotional problems.

The newly adopted rules add a subsection to the retrospective review provisions. In a retrospective review situation, the utilization review agent may not require the submission of a mental health therapist's process or progress notes about treatment of a patient's condition or disorder. However, this does not preclude:

- Requiring submission of the patient's medical record summary or
- Requiring submission of medical records and/or process or progress notes about the treatment of problems other than mental or emotional conditions or disorders.

Publication: 25TexReg12981, December 29, 2000
Effective date: January 7, 2001
Further information: 512 463-6327

Benefit Notice Requirement

■ Commissioner Jose Montemayor has amended 28 TAC §§ 21.2101–21.2103, 21.2105 and 21.2106, concerning mandatory benefit notice requirements. The changes implement House Bill 1764 of the 76th Legislature and provisions of the federal Women's Health and Cancer Rights Act of 1998.

Health benefit plans that cover or provide benefits for mastectomies must provide notice to enrollees that their coverage includes benefits for reconstructive surgery after a mastectomy. The notice must be given upon enrollment in a health benefit plan and annually thereafter by all carriers that were issuing, delivering or renewing health benefit plans as of June 18, 1999.

The required enrollment notice must describe the coverage and/or benefits and disclose that the coverage and/or benefits will be provided in a manner determined to be appropriate in consultation with the attending physician and the patient. The notice also must state the specific deductibles, copayments and/or coinsurance for breast reconstruction, which may be no greater than those for other benefits provided by the plan.

The required annual notice must spell out that the health benefit plan provides coverage and/or benefits for reconstructive surgery after mastectomy, surgery and reconstruction of the other breast for symmetry, prostheses and treatment of complications resulting from a mastectomy (including lymphedema).

The notice requirement does not apply to specified disease or other limited benefit plans, other than cancer insurance; to hospital indemnity policies; to credit insurance; or to dental or vision plans.

Publication: 26TexReg202, January 5, 2001
Effective date: January 8, 2001
Further information: 512 463-6327

LIFE INSURANCE

APA Adoption

Variable Life Insurance Advertising

■ Commissioner Jose Montemayor has amended 28 TAC § 3.803, repealing the requirement that insurers file all variable life insurance sales material, advertisements and descriptive material with TDI before using or distributing them to prospective applicants. The amendment also eliminates the requirement that revised versions of these materials be filed with the Department prior to use. The materials remain subject to all other TDI advertising standards and applicable requirements of *Texas Insurance Code* Chapters 3 and 21.

Publication: 25TexReg12981, December 29, 2000
Effective date: January 4, 2001
Further information: 512 463-6327

TAXES, ASSESSMENTS AND FEES

APA Adoptions

2001 Examination Expenses

■ Commissioner Jose Montemayor has amended 28 TAC § 7.1012, revising domestic insurance company assessments to cover TDI administrative expenses attributable to the examination of insurers during 2001.

Each company undergoing an examination will continue paying examiners' actual salaries and expenses allocable to the examination.

All domestic companies will pay a 2001 overhead assessment computed as follows. The 2000 rates are shown in brackets.

- .00458 [.00503] of 1 percent of the company's admitted assets as of Dec. 31, 2000, taking into consideration the annual admitted assets that are not attributable to 90 percent of pension plan contracts and
- .01406 [.01271] of 1 percent of the company's gross premium receipts for 2000, taking into consideration the annual premium receipts that are not attributable to 90 percent of pension plan contracts.

In addition to paying examiners' direct salaries and expenses, foreign companies undergoing examination will pay an assessment of 32 percent of the gross salary of each examiner for each month or partial month, the same as in 2000.

Publication: 26TexReg202,January 5, 2001
Effective date: January 10, 2001
Further information: 512 463-6327

2000 Maintenance Taxes and Fees

■ Commissioner Jose Montemayor has adopted amendments to 28 TAC §1.414 that establish maintenance taxes and fees for 2001. The new maintenance tax and fee rates are assessed on gross premiums for 2000.

The new rates, with 2000 rates shown in brackets, are:

- .057 [.055] of 1 percent for motor vehicle insurance.
- .186 [.200] of 1 percent for casualty insurance and fidelity, guaranty and surety bonds.
- .352 [.358] of 1 percent for fire insurance and allied lines, including inland marine.
- .060 [.055] of 1 percent for workers' compensation insurance.

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- .086 [.144] of 1 percent for title insurance.
- .040 [.040] of 1 percent for life, health and accident insurance.
- $.37 [$.36] per enrollee for single service HMOs.
- $1.11 [$1.08] per enrollee for multi-service HMOs.
- $.37 [$.36] per enrollee for limited service HMOs.
- .237 [.218] of 1 percent of the correctly reported gross amount of administrative or service fees for TPAs.
- .02 [.03] of 1 percent for corporations issuing prepaid legal service contracts.

Publication: 26TexReg201,January 5, 2001
Effective date: January 10, 2001
Further information: 512 463-6327

Premium Finance Assessment

■ Commissioner Jose Montemayor has adopted an amendment to 28 TAC § 25.88, setting the general administrative expense assessment of premium finance companies for 2001. The assessment will be .01684 [0.0] of 1 percent of a company's total loan dollar volume for 2000, with a minimum assessment of $250.

Publication: 26TexReg204, January 5. 2001
Effective date: January 10, 2001
Further information: 512 463-6327 ★

CompanyLicensing

Applications Pending

For admission to do business in Texas

COMPANY NAME	LINE	HOME OFFICE
Benefit Management Inc. (using the assumed name of BMI-Health Plans Inc.)	TPA	Bartlesville, OK
Dealers Assurance Co.	Fire & Casualty	Upper Arlington, OH
Omni Indemnity Co.	Fire & Casualty	Chicago, IL

For incorporation

COMPANY NAME	LINE	HOME OFFICE
Steven Goldstein, M.D. & Associates, P.A. (using the assumed name of Medirect)	TPA	Houston, TX

For name change in Texas

FROM	TO	LINE	LOCATION
AFBA Life Insurance Co.	5 Star Life Insurance Co.	Life	Alexandria, VA
Agricultural Insurance Co.	Great American Assurance Co.	Fire & Casualty	Cincinnati, OH
American Alliance Insurance Co.	Great American Alliance Insurance Co.	Fire & Casualty	Cincinnati, OH
AXA Reinsurance Co.	AXA Corporate Solutions Reinsurance Co.	Life	Wilmington, DE
AXARE Life Insurance Co.	AXA Corporate Solutions Life Reinsurance Co.	Life	Wilmington, DE
Greentree Insurance Co. Inc.	The Aries Insurance Co.	Fire & Casualty	Miami, FL
Guaranty National Insurance Company of California	Guaranty National Insurance Company of Connecticut	Fire & Casualty	Farmington, CT
Mission American Life Insurance Co.	Guaranty Insurance and Annuities Co.	Life	Houston, TX
Mutual Insurance Corporation of America	American Physicians Assurance Corp.	Fire & Casualty	East Lansing MI
Signet Star Reinsurance Co.	Berkley Insurance Co.	Fire & Casualty	Wilmington, DE
Spectera Dental Inc.	National Pacific Dental	HMO	Houston, TX

Applications Approved

For admission to do business in Texas

COMPANY NAME	LINE	HOME OFFICE
Amerisure Partners Insurance Co.	Fire & Casualty	Farmington Hills, MI
Arag Insurance Co.	Casualty	Des Moines, IA
Great River Insurance Co.	Fire & Casualty	Meridian, MS
John Hewitt & Associates Inc.	TPA	Portland, ME
Mayflower Insurance Co., Ltd., The	Fire & Casualty	Carmel, IN
Member Protection Insurance Plans Inc.	TPA	Wallingford, CT
MSaver Resources, L.L.C.	TPA	Wilmington, DE

Continued on page 8

CompanyLicensing

Applications Approved *(continued)*

For incorporation

COMPANY	LINE	HOME OFFICE
Grayhawk Financial and Benefits Services Inc.	TPA	Addison, TX
MediCa$h.com Inc.	TPA	Odessa, TX

For name change in Texas

FROM	TO	LINE	LOCATION
Comercial America, U.S. Branch a/n for the U.S. Branch of Seguros Comercial America, S.A. DE C.V.	Seguros Comercial America, S.A. DE C.V., converted from stock P&C back to a Mexican casualty company	Fire & Casualty	Houston, TX
Willis Corroon Administrative Services Corp.	Willis Administrative Services Corp.	TPA	Nashville, TN
Humana Workers' Compensation Services Inc.	Protegrity Services Inc.	TPA	Longwood, FL
Jardine Group Services Corp., Schenectady, NY	JLT Services Corp.	TPA	Albany, NY
Massachusetts Casualty Insurance Co.	Centre Life Insurance Co.	Life	Boston, MA
Reliance Reinsurance Co.	Overseas Partners US Reinsurance Co.	Fire & Casualty	Wilmington, DE
Reserv Corp.	Cambridge Integrated Services Group Inc.	TPA	Horsham, PA
Royal Special Risks Insurance Co., Glastonbury, CT	Homesite Insurance Co.	Fire & Casualty	Hartford, CT
Virginia Insurance Reciprocal, The	Reciprocal of America	Fire & Casualty	Glen Allen, VA

DisciplinaryActions

Editor's Note: *Copies of individual orders may be obtained by calling TDI's Public Information Office, 512 463-6425.*

AGENTS & AGENCIES NAME	CITY	ACTION TAKEN	VIOLATION	ORDER	DATE
Chivers, George Brent	Dallas	Life, Accident, Health and HMO Agent's License Revoked	Material Misstatement on License Application	00-1326	12/13/00
Garcia, Dario Mena	Falfurrias	Agent's License Denied	Material Misstatement on License Application	00-1304	12/6/00
Kaufman County Title & Abstract Co.	Kaufman	$800 Fine	Late Filing of Annual Escrow Audit Report	00-1342	12/15/00
Robertson, James Henry	Austin	Life, Accident, Health and HMO and Variable Contract Agent's Licenses Revoked	Misappropriation or Conversion of Money Belonging to an Insurer	00-1303	12/6/00
HMOS NAME	**CITY**	**ACTION TAKEN**	**VIOLATION**	**ORDER**	**DATE**
Safeguard Health Plans Inc.	Aliso Viejo, CA	$17,000 Fine	Acting as Third Party Administrator Without a License; Advertising Violations; Late Filing of Quarterly Financial Statement	00-1358	12/20/00
COMPANIES NAME	**CITY**	**ACTION TAKEN**	**VIOLATION**	**ORDER**	**DATE**
American Life & Accident Insurance Co.	Dallas	$2,500 Fine	Advertising Violations	00-1302	12/6/00
Amerus Life Insurance Co.	Des Moines, IA	$500 Fine	Late Response to TDI Inquiry	00-1286	11/29/00

Texas Department of Insurance
P. O. Box 149104
Austin, Texas 78714-9104

Bulk Rate
U. S. Postage
P A I D
Austin, Texas
Permit No. 1613