

VII. Guide to Agency Programs

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Life, Health, and Licensing – General Management
Location/Division	William P. Hobby Building, Tower I, 7th Floor
Contact Name	Jennifer Ahrens, Senior Associate Commissioner
Actual Expenditures, FY 2006	\$677,078.23
Number of FTEs as of August 31, 2006	9

B. What is the objective of this program or function? Describe the major activities performed under this program.

General Management provides operational direction for the Life, Health, and Licensing (LHL) Program. LHL performs the following major activities:

- licenses agents, adjusters, and third-party administrators
- processes and reviews rate and form filings
- reviews accident and health, life, annuities, and credit insurance products
- regulates health maintenance organizations, utilization review agents, independent review organizations, and workers' compensation health care networks, including resolving complaints against these entities.

The Senior Associate Commissioner (SAC) for Life, Health, and Licensing leads the program. The SAC chairs the Technical Advisory Committee on Claims Processing and is the agency's Provider Ombudsman. The SAC or a designee represents the Commissioner of Insurance on various boards and councils. Additionally, the SAC is TDI's liaison for the boards of the Texas Health Insurance Risk Pool (THIRP), the Children's Health Insurance Program (CHIP), and the Texas Health Care Policy Council, and attends board meetings of the Texas Health Reinsurance System (THRS).

General Management provides technical assistance to the Texas Health and Human Services Commission (HHSC), the Texas Department of State Health Services, the Office of the Attorney General, THIRP, THRS, and the federal Centers for Medicare and Medicaid Services (CMS). The SAC and division deputies serve on various National Association of Insurance Commissioners (NAIC) working groups. General Management staff collect and analyze data to monitor the Texas health insurance market.

In addition, General Management staff:

- report on industry data and provide technical assistance to legislative committees and task forces
- direct the federal State Planning Grant study of options to expand health insurance in Texas
- monitor electronic claim submission requirements mandated by the Health Insurance Portability and Availability Act (HIPAA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
- assist the SAC in developing regulatory policies for LHL divisions
- communicate with consumers and the regulated community
- provide technical assistance to other state and federal agencies
- track, analyze, and coordinate TDI's comments on proposed legislation pertaining to LHL

- inform industry and other interested parties of legislative and rule changes through bulletins or other means
- draft rules to implement state and federal legislation.

General Management develops the program's business plan and the program's portion of the agency's strategic plan, annual report, appropriations request and budget, and handles ad hoc special projects.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

Performance measure charts are in VII.C of each division's description. In addition to formal performance measures, LHL uses input from staff surveys, such as the Survey of Organizational Excellence conducted by the University of Texas School of Social Work, and from consumer surveys to monitor effectiveness.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

History is in each Life, Health and Licensing division's VII.D response.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

This information is in each Life, Health and Licensing division's VII.E response.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The Senior Associate Commissioner leads the program. The program has four divisions, each led by a Deputy Commissioner:

- Licensing
- Filings and Operations
- Life/Health
- Health and Workers' Compensation Network Certification and Quality Assurance.

The program regulates health maintenance organizations (HMOs), workers' compensation health care networks, and life, annuity, accident and health insurance, and related coverages. LHL also licenses insurance agents, adjusters, public insurance adjusters, third-party administrators, viatical and life settlement providers, provider representatives and brokers, premium finance companies, utilization review agents, and independent review organizations. LHL resolves HMO complaints and conducts quality of care examinations of HMOs. The Health and Workers' Compensation Network Certification and Quality Assurance Division certifies workers' compensation health care networks. While the LHL Program affects the entire state, no regional staff operate in this program.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The primary funding sources are general revenue and dedicated general revenue funds, which finance over 96 percent of the agency's operations. Maintenance taxes and fees are the two main revenues that fund the agency's appropriations to regulate the insurance and workers' compensation industries.

H. Identify any programs, internal or external to your agency, that provide identical or similar services or functions. Describe the similarities and differences.

No other programs perform the oversight functions or support functions of LHL's General Management. However, several sections within the agency, including Human Resources, Administrative Services, and Information Technology Services, provide business and resource planning and technology support services similar to or in conjunction with LHL General Management.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

While no other program in the agency provides the same services that LHL provides, General Management works with other programs in the agency to ensure coordination and consistency of regulatory efforts.

J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.

General Management works with CMS to ensure that the State's High Risk Pool remains a federally qualified alternative to guaranteed individual health insurance coverage. General Management's Director of Special Projects recently worked with the federal Health Resources and Services Administration (HRSA) to develop a pilot project in Harris County to provide group insurance for small employers.

K. If contracted expenditures are made through this program please provide:

- the amount of those expenditures in fiscal year 2006;
- the number of contracts accounting for those expenditures;
- a short summary of the general purpose of those contracts overall;
- the methods used to ensure accountability for funding and performance; and
- a short description of any current contracting problems.

An attachment to TDI's Self-Evaluation Report provides agency contract expenditures by program.

L. What statutory changes could be made to assist this program in performing its functions? Explain.

Not applicable.

M. Provide any additional information needed to gain a preliminary understanding of the program or function.

Not applicable.

- N. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:**
- why the regulation is needed;
 - the scope of, and procedures for, inspections or audits of regulated entities;
 - follow-up activities conducted when non-compliance is identified;
 - sanctions available to the agency to ensure compliance; and
 - procedures for handling consumer/public complaints against regulated entities.

This information is in each Life, Health and Licensing division's VII.N response.

O. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

Complaint information is in each Life, Health and Licensing division's VII.O response.

VII. Guide to Agency Programs

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Life, Health, and Licensing Program – Licensing Division
Location/Division	William P. Hobby Building, Tower I, 7th Floor
Contact Name	Matt Ray, Deputy Commissioner
Actual Expenditures, FY 2006	\$1,802,281.17
Number of FTEs as of August 31, 2006	42.5

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Licensing Division licenses and regulates insurance agents, adjusters, risk managers, life insurance counselors, insurance service representatives, reinsurance intermediaries, third-party administrators (TPAs), premium finance companies, and persons involved in selling insurance products in travel agencies, self-service storage facilities, retail establishments, telecommunications outlets, and rental car companies.

The Licensing division has five sections:

- **Applications Section** reviews and processes applications for new licenses for agents and adjusters, oversees the criminal history review process, registers additional trade names and trade locations, and records sponsors of subagents and insurance service representatives.
- **Customer Service Section** responds to inquiries and telephone calls from agents, companies, and the public, including questions regarding licenses, appointment status, and the licensing process.
- **Renewals, Appointments, and Continuing Education Section** reviews and processes renewals, records and cancels agent and sub-agent appointments, approves continuing education providers and courses, and oversees the training courses for agents and adjusters.
- **Administrative Review and Data Management Section** researches and reviews applications with a criminal history, makes recommendations on the issuance or denial of a license, and recommends appropriate action on nonroutine agent applications, renewals, and cancellations for cause. This section also produces certificates and other records regarding license status, cancels licenses when requested by the licensee, records address and name changes, processes open records requests, and maintains the division's files.
- **Third-Party Administrator and Premium Finance Section** licenses, regulates, and examines TPAs, which administer plans under contracts with insurance companies, HMOs, or self-funded plans; and licenses premium finance companies.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

As evidence of its effectiveness and efficiency, the Licensing Division:

- Exceeded the performance measure target for completing 98 percent of licenses within 60 days in fiscal year FY 2006 and FY 2007.
- Exceeded the performance measure target for completing 95 percent of agent license filings within 15 days in FY 2006 and FY 2007.
- Lowered the average processing time for the more than 700,000 filings received each year. Average processing time has fallen from 5.2 days in FY 2002 to 3.0 days in FY 2003, and to 2.2 days in FY 2004, FY 2005, and FY 2006.

In addition, the division adopted the Criminal History Fingerprint Rule. The rule transfers the \$39 cost of processing fingerprints to the license applicant. It also establishes a process by which TDI can submit fingerprints and obtain a state and national fingerprint criminal history on applicants.

The division expanded electronic processing capabilities in 2006 by accepting nonresident renewals processed electronically through the National Insurance Producer Registry (NIPR).

The Licensing Deputy Commissioner was a member of the NAIC Producer Licensing Working Group, which developed the Fingerprint Model Act, the Public Adjuster Model Act, and the Producer Licensing Fiduciary Model Act.

Other evidence of the division's effectiveness includes:

- The Securities and Insurance Licensing Association (SILA) honored the Licensing Division as the Regulatory Unit of the Year in 2005. The division was the first licensing division to be awarded this recognition.
- SILA selected the Licensing Deputy Commissioner as an advisory board member of SILA. The organization serves more than 800 members from the insurance industry.
- SILA honored the Licensing Deputy Commissioner as the 2006 Warren E. Spruill outstanding regulator of the year award.

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

Not applicable.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Licensing Division affects individuals contracted with or employed by insurance companies to sell, solicit, or market insurance products to the public. Most applicants must pass a licensing examination, complete an application, and pay a licensing fee. The following table illustrates the breakdown of persons or entities affected.

TEXAS DEPARTMENT OF INSURANCE FY 2005 and FY 2006 ACTIVE LICENSES AT FISCAL YEAR ENDS						
License Description	8/31/2005			8/31/2006		
	Agents	Agencies	Total Active Licenses	Agents	Agencies	Total Active Licenses
Adjuster - All Lines	16,316	0	16,316	21,591	0	21,591
Adjuster - Property and Casualty	33,461	0	33,461	39,351	0	39,351
Adjuster - Workers' Compensation	3,886	0	3,886	3,828	0	3,828
Adjuster – Trainee	1,131	0	1,131	1,399	0	1,399
Adjuster – Emergency	16	0	16	75	0	75
County Mutual	3,432	30	3,462	3,453	28	3,481
Emergency MGA	0	0	0	0	0	0
General Lines - Life, Accident, Health and HMO	145,054	4,784	149,838	152,406	5,217	157,623
General Lines - Property and Casualty	82,578	5,093	87,671	89,610	5,678	95,288
Home Office Salaried Employees	1,292	0	1,292	1,259	0	1,259
Insurance Service Representative	2,069	0	2,069	1,832	0	1,832
Life and Health Insurance Counselor	232	3	235	266	7	273
Life Insurance not to Exceed \$15,000	1,020	6	1,026	967	6	973
Limited Lines	7,539	81	7,620	5,797	77	5,874
Managing General Agent	1,154	489	1,643	1,120	476	1,596
Pre-Need (funeral pre-arrangement)	2,487	4	2,491	2,360	6	2,366
Public Insurance Adjuster	114	1	115	161	3	164
Public Insurance Adjuster Trainee	0	0	0	3	0	3
Reinsurance Broker	1,232	57	1,289	1,287	61	1,348
Reinsurance Managers	139	13	152	141	14	155
Risk Manager	1,096	4	1,100	1,089	9	1,098
Surplus Lines	2,761	624	3,385	2,972	725	3,697
Specialty – Credit	194	2,694	2,888	171	2,737	2,908
Specialty - Rental Car Company	3	69	72	4	64	68
Specialty – Self-Service Storage Facility	5	69	74	4	70	74
Specialty - Telecommunications	0	11	11	0	13	13
Specialty – Travel	264	435	699	277	444	721
Temp. County Mutual	0	0	0	0	0	0
Temp. General Lines – LAH	510	0	510	750	0	750
Temp. General Lines - P&C	13	0	13	9	0	9
Temp. General Lines - Emerg. P&C	0	0	0	1	0	1
Temp. Life Insurance not to Exceed \$15,000	0	0	0	0	0	0
Temp. Limited Lines	2	0	2	2	0	2
Temp. Pre-Need	13	0	13	10	0	10
TOTAL	308,013	14,467	322,480	332,195	15,635	347,830

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

A Deputy Commissioner oversees the activities of the Licensing Division. The division's primary functions include:

Applications

Staff receive applications and enter basic information (name, address, Social Security number, date of birth, and type of license sought) into the tracking system. As processors review applications, they can generate licenses if the applicant has met all licensing requirements. If a processor rejects an application, the system retains the agent information and the reasons for the rejection.

The Licensing Division processes approximately 1,800 license applications each week. Each morning, staff print the licenses issued the previous day and deliver them to Mail Services for mailing.

The licensing tracking system:

- generates a list showing the names, birth dates, and Social Security numbers of applicants for which the division requested a criminal history from the Texas Department of Public Safety
- shows an applicant's sponsors or a sponsor-type relationship, which is required for some licenses
- captures the date that staff entered new information, such as additional locations or trade names
- generates a unique identification number for each new licensee.

Fees

Licensing fee payments are handled through a lockbox agreement with the Comptroller of Public Accounts. Staff indicate the fee paid on the source documents and deposit the money. Fee transactions are recorded in the Administrative Services Division's cash receipts system and in the licensing system.

Some licensing processes are automated electronic filings. The Comptroller of Public Accounts receives these fees electronically.

Renewals

The system identifies licenses due for renewal and prints renewal notices 90 days prior to the expiration of the existing license. The system administrator can change the 90-day period, if needed, and set other criteria to generate renewal notices. If the licensee holds multiple general lines licenses, the renewal notice includes all qualifications with the same expiration date.

The system accommodates license types with different renewal periods and sorts renewals in a specified order (for example, by name or ZIP code). It also generates rejection letters for renewals that cannot be processed.

Appointments

Appointments may be entered into the system electronically through the NIPR or an NIPR-authorized business partner. Electronically transmitted appointments that contain incomplete or erroneous data are rejected and transmitted back to the sender with a reason for the rejection.

The system generates daily listings to each company with appointment or cancellation activity. The listings show all appointments and cancellations for that company.

Continuing Education

The Continuing Education (CE) Section registers CE providers and courses and oversees the training courses for agents and adjusters.

Staff review CE provider applications and CE and licensing course submissions to determine whether the filing is complete and in compliance with the Texas Insurance Code and rules. Staff enter all filings into the CE database and notify the applicant whether the application was approved or rejected. Approved filings display on the agency's website.

The CE Section randomly audits approximately one percent of all licensees to determine compliance with their continuing education requirement. Licensees must provide evidence of completion of their continuing education requirements. The CE Compliance Specialist refers any licensees deficient in their CE requirements to TDI's Enforcement Program.

Administrative Review

The Administrative Review Section recommends whether the agency should issue or deny a license if an applicant has a criminal history. The section also recommends appropriate action on all nonroutine agent applications, renewals, and cancellations for cause. The section relies on applicable state laws and agency rules to determine whether the specific criminal history justifies denial of an application. Staff use the following decision matrix to guide their recommendations.

Significance of 28 TAC 1.502(b) Factors

1.502 (b) Rule Provision	Less Significant	Most Significant
(1)(A) nature and seriousness of crime	Misdemeanors, crimes that do not involve fraud, dishonesty or deceit	Felonies, any offense for which fraud, dishonesty or deceit is an essential element
(1)(B) relationship of crime to purposes for requiring a license	Crime does not involve an element of trust	Crime shows evidence of lack of trustworthiness
(1)(C) extent to which a license might offer opportunity to engage in criminal activity of the same type	Crime does not involve an element of trust, dishonesty, or fraud	Crime shows evidence of lack of trustworthiness, dishonesty or fraud
(1)(D) relationship of crime to ability, capacity, or fitness required to perform duties and responsibilities of occupation	Crime does not involve an element of trust, dishonesty, or fraud and did not involve a fiduciary relationship or handling of money	Crime shows evidence of lack of trustworthiness, dishonesty or fraud and involved a fiduciary relationship or handling of money
(2)(A) extent and nature of past criminal activity	Single offense	Multiple offenses
(2)(B) age of person at the time of commission of crime	Youthful offense	Adult offense
(2)(C) amount of time elapsed since last criminal activity	Felony offense - > 10 years Misdemeanor - > 7 years	Felony offense ≤ 10 years Misdemeanor ≤ 7 years
Mitigating Factors:		
(2)(D) conduct and work activity prior to and following criminal activity	No work history or sporadic work	Steady employment, extensive work history
(2)(E)	No rehabilitative effort, failure to	Educational degrees, completion

1.502 (b) Rule Provision	Less Significant	Most Significant
evidence of person's rehabilitation or rehabilitative effort	pay fines or restitution, no evidence of remorse	of rehab programs (i.e. drug), payment of fines or restitution, expression of remorse
(2)(F) other evidence of present fitness including letters of recommendation	No letters of recommendation	Multiple letters of recommendation from individuals aware of criminal history

A flow chart detailing the administrative review process is available for review.

Letter of Clearance or Certification

Staff enter information about requests for clearance or certification. The system generates letters of clearance and certification in the order entered. If the status of the license does not allow the issuance of a letter of clearance or certification, the agent receives an acknowledgement letter.

Address Changes

Staff enter address change requests into the system, which automatically updates the agent/adjuster database on TexasOnline. TexasOnline is accessible from TDI's website, www.tdi.state.tx.us.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The primary funding sources are general revenue and dedicated general revenue funds, which finance over 96 percent of the agency's operations. Maintenance taxes and fees are the two main revenues that fund the agency's appropriations to regulate the insurance and workers' compensation industries.

H. Identify any programs, internal or external to your agency that provide identical or similar services or functions. Describe the similarities and differences.

TDI's Title Division licenses escrow officers, title agents, and title agencies. Title insurance is a unique product and there is very little, if any, dual licensing of title agents, escrow officers, and title agencies with the individuals licensed by the Licensing Division.

The Life/Health Division registers individuals engaged in the viatical/life settlement business. The main difference between the Life/Health Division's process and the Licensing Division's is the lack of an examination requirement for viatical/life settlement registrants. Plans are under way to transfer viatical/life settlement registration to the Licensing Division. A majority of viatical/life settlement brokers also have a life, accident, and health license. For this reason, consolidating the functions would improve efficiency.

The HWCN Division's utilization review agent certification process is similar. The main difference is the lack of an examination requirement for URAs. There is very little, if any, crossover between URAs and individuals licensed by the Licensing Division.

The State Fire Marshal issues registrations, licenses, and permits to individuals and companies in the fire alarm, extinguisher, sprinkler, and fireworks industries. There is very little, if any, crossover between SFMO licensees and individuals licensed by the Licensing Division.

The Financial Program's Company Licensing and Registration Division (CL&R) licenses and issues certificates of authority to insurance companies.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Consolidation of Criminal History Background Checks

The Licensing Division performs criminal history reviews for the agency as a whole to avoid duplication of effort. The division submits fingerprint cards to the Texas Department of Public Safety (DPS) and the Federal Bureau of Investigation (FBI) on behalf of the Title Division and the Company Licensing and Registration (CL&R) Division.

Coordination with Fraud Unit on Applicant's Failure to Disclose a Criminal History

TDI's CL&R Division submits a daily copy of the list of applicants who failed to disclose a criminal history. The Fraud Unit determines whether to refer the applicant to the Travis County District Attorney for making a false filing with a governmental entity. Making a false filing is a felony offense.

J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.

Not applicable.

K. If contracted expenditures are made through this program please provide:

- the amount of those expenditures in fiscal year 2006;
- the number of contracts accounting for those expenditures;
- a short summary of the general purpose of those contracts overall;
- the methods used to ensure accountability for funding and performance; and
- a short description of any current contracting problems.

An attachment to TDI's Self-Evaluation Report provides agency contract expenditures by program.

L. What statutory changes could be made to assist this program in performing its functions? Explain.

Not applicable.

M. Provide any additional information needed to gain a preliminary understanding of the program or function.

The Licensing Division has focused on the automation of licensing functions due to:

- large volumes of transactions
- receptive nature of the transactions to automation
- increased opportunity for minimizing clerical mistakes
- ability to minimize processing time
- improved convenience, service, and satisfaction of our customers.

Electronic Processes and Program's use of Internet and Databases

Applications Section

A TDI contract testing vendor installed digital fingerprinting machines in the 16 contracted testing sites in July 2003. The result is faster submission of fingerprints to DPS and fewer rejections for poor quality fingerprints.

Applicants required to pass an examination for licensing submit an application to the testing vendor, who then enters the application into the vendor's database, screens the application per TDI business rules, and submits information electronically to TDI.

Texas accepts and processes electronic nonresident applications via the NIPR automated system, which is available 24 hours a day, seven days a week. Average TDI processing time for electronic nonresident licensing is three days, starting from the time the applicant completes the online application. (Average time for nonresident nonelectronic license processing is nine days).

Nonresidents may submit general lines agent license applications to TDI via NIPR's website, www.licenseregistry.com.

Customer Service Section

The Licensing Division uses an interactive voice response (IVR) telephone system to answer calls to its Customer Assistance section. During normal business hours, callers can press "0" to speak to a customer service representative.

Callers can access license status and additional information from the IVR system. They can also request duplicate renewal applications and license certificates and obtain instructions for ordering forms. This automated feature handles 30 percent of the 14,000 calls the division receives on average each month.

The Dictaphone Freedom call recording system records calls received and made on designated phone lines. This includes calls made to and transferred by Customer Service Representatives to other agency staff. Recorded calls are archived for six months. Customer Service management can listen to "live" calls and retrieve archived calls within 10 minutes after the call ends. The system allows management to monitor the quality of responses provided to customers and helps identify topics for additional training.

Renewals, Appointments and Continuing Education

The Licensing Division utilizes TexasOnline, a state web portal, to allow electronic renewal of agent/adjuster licenses. The average processing time for online transactions is slightly shorter than the processing time for offline transactions. The average turn-around time for both processes is the same – two days. More than 50 percent of renewals are submitted and processed electronically.

The biggest advantage of the online process is customer convenience, since customers can renew licenses 24 hours a day, 7 days a week. The process provides an online database of licensed agents and adjusters in Texas. The Agent Lookup/Renewal feature on TexasOnline receives a monthly average of 400,000 hits.

Offline renewal forms contain optical character recognition coding that allows the Texas Comptroller of Public Accounts to electronically read the form and transmit the information to TDI for automated processing.

Appointments/terminations are processed via a form that can be scanned and entered into the system. They also may be entered electronically through NIPR or an NIPR-authorized business partner. Approximately 90 percent of the 470,000 appointments and terminations processed each year are processed electronically through NIPR or an NIPR-authorized business partner.

Administrative Review and Data Management Section

Approximately 50 percent of the letters of certification requests are handled in an automated process when licensees make their requests through an outside vendor, SIRCON.

Third-Party Administrator (TPA) and Premium Finance Section

The TPA section revised the TPA Annual Report Form to include collection of additional data from TPAs about the plans administered and the average claim adjudication and payment time periods per plan. The forms are available on the website for download.

The annual report forms are mailed using a mail merge program. The spreadsheets that serve as exhibits are posted on TDI's website for download so that TPAs can fill them out and submit them electronically to TDI as e-mail attachments.

N. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

Regulation and licensing of insurance agents and adjusters protects the public. The complex and varied nature of insurance and related products makes it crucial that the public be able to trust and rely on such persons. License and authorization holders and applicants must be knowledgeable, honest, and reliable.

Applicants for agent and adjuster licenses must demonstrate a basic knowledge of the specific line of insurance they will be selling by passing an entry-level examination. Once licensed, the licensee must complete continuing education courses during every two-year licensing period (30 hours for most license types and 10 hours for a limited license).

Applicants must submit fingerprint cards for criminal background checks with DPS and FBI. This check determines whether the applicant has a criminal history that should preclude licensure. TDI reviews the criminal history using the guidelines in Texas Insurance Code, Chapter 4005, Texas Occupations Code, Section 53.025, and 28 Texas Administrative Code, Section 1.502.

The agency may take disciplinary action, including fines, suspension, or license revocations, against agents or adjusters who do not comply with state or federal insurance laws, as well as those found to have engaged in fraudulent or dishonest practices or convicted of a felony. The Enforcement Program investigates and handles disciplinary proceedings against agents and adjusters before the State Office of Administrative Hearings.

O. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

Not applicable.

VII. Guide to Agency Programs

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Life, Health and Licensing Program – Filing and Operations Division
Location/Division	William P. Hobby Building, Tower I, 4th Floor
Contact Name	Angelia Johnson, Deputy Commissioner
Actual Expenditures, FY 2006	\$580,569.89
Number of FTEs as of August 31, 2006	14.5

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Filing and Operations (F&O) Division encourages fair competition in the insurance industry by initially screening rate and form filings for compliance with minimum requirements. The division consists of the following sections:

- **Property and Casualty (P&C) Intake Section** receives rule, rate, and policy form filings for personal and commercial automobile, general liability, workers' compensation, professional liability, personal and commercial property, bond and miscellaneous casualty, inland marine, identity theft, and interline and multiperil lines of insurance. In addition, the section receives filings related to credit scoring and underwriting guidelines. Intake staff screen the filings for compliance with basic requirements. Most filings are paper; however, the section receives electronic filings via the National Association of Insurance Commissioner (NAIC) System for Electronic Rate and Form Filing (SERFF). Staff enter filing data into the Oracle tracking system and forward the filings to the appropriate divisions for review and final action. Intake staff manage the P&C tracking database. Staff prepare various management and NAIC reports and assist Information Technology Services (ITS) with SERFF and tracking system issues and enhancements.
- **Life/Health and HMO Intake Section** receives rate and policy form filings for life, annuity, group and individual accident and health, credit life, credit accident and health, HMO, nonprofit prepaid legal, viatical and life settlements, and related products. The section screens filings for compliance with basic requirements. Most filings are paper; however, the section also receives electronic filings via SERFF and the Multi-State Review (MSR) I-File system. The MSR allows a company to submit a single filing to the states of California, Florida, Texas, Georgia, and Nevada for approval. Intake staff enter filing data into the Oracle tracking system and forward the filings to the appropriate divisions for review and final action. Staff prepare NAIC reports and assist ITS staff with SERFF issues and enhancements.
- **Micrographics Section** produces electronic images of closed files for the Life, Health, and Licensing (LHL) Program, Division of Workers' Compensation, and the Property and Casualty Program. Micrographics arranges to destroy program files according to their retention schedules and assists with agency imaging projects.
- **Operations Section** performs LHL program activities, including project management, forms management, disaster recovery planning, business planning, strategic planning, performance measure tracking, and records retention. The section is the liaison between LHL divisions and Administrative Services on operations matters and represents LHL on the Agency Planning and

Technology Team. The Deputy Commissioner is the TDI Compliance Conference Coordinator and Outreach and Education Coordinator for LHL's Health and Workers' Compensation Network Division.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

To address issues regarding receipt of checks attached to filings and large refunds, F&O implemented a billing system and associated administrative rules. The new billing system has allowed staff to redirect time spent processing checks to reviewing filings and handling billing inquiries. Another evidence of efficiency is the increased number of electronic filings submitted to the agency. SERFF filings are more efficient and, when appropriate, allow automatic invoicing of applicable fees. Customer feedback has been positive. Insurance companies using SERFF report cost savings from electronic filing. Additionally, F&O implemented back-end scanning in 1998. The public may now view imaged closed files on dedicated personal computers. Electronic filing has reduced the amount of time spent processing open records requests and substantially decreased the amount of space required for file storage.

Following is a comparison of fiscal year (FY) 2006 output levels to FY 2005 levels:

- \$429,150 in life and health rate and form filing fees, compared with \$379,911 in FY 2005
- \$99,822 in HMO rate and form filing fees, compared with \$58,100 in FY 2005
- \$57,650 in viatical settlement regulatory fees, compared with \$36,850 in FY 2005
- 7,559 exempt life/health rate and form filings processed, compared with 6,324 in FY 2005
- 27,184 life/health rates and forms received, compared with 30,945 in FY 2005
- 1,541 HMO rate and form filings received, compared with 1,557 in FY 2005
- 16,734 P&C rate and form filings received, compared with 18,665 in FY 2005
- 189 P&C rate and form filings processed, compared with 468 in FY 2005
- 372,164 images scanned for LHL, compared with 341,294 in FY 2005
- 673,276 images scanned for the P&C Program, compared with 577,997 in FY 2005
- 11,724 images scanned for DWC (scanning for DWC files began in FY 2006).

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

1991 -- Implementation of insurance reform legislation changed the way property and casualty insurance was regulated. The P&C Program implemented a file-and-use system for commercial property and general liability rate filings, a flex rating system for personal lines (property and automobile), and a prior approval system for individual company filings of policy forms and endorsements.

1992 -- The P&C Intake Section was created to receive, process, and assign filings. To handle the large numbers of filings, the section developed a tracking system.

1993 -- The Life, Health, and HMO Intake Section was created to handle, sort, and distribute Life/Health group mail, including filings.

1994 -- The division overhauled the tracking system and installed it on the network. The system automatically assigns a unique number to each filing, calculates the "deemer" date where applicable, and

maintains status and location of each filing. The system also generates management reports. Currently, the tracking system is available to all personnel in all applicable divisions.

2003 – The Life/Health division implemented SERFF and began accepting annuity forms electronically.

2005 – The section implemented a billing system for rate and form filing fees. The billing system accommodates paper filing fees as well as electronic filing fees. With the implementation of the billing system, the agency no longer requires the regulated entity to submit the fee with the filing; instead, the agency invoices the regulated entity submitting the filing by monthly itemized invoice.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

F&O affects insurers and advisory organizations filing rate and form filings in Texas.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

A Deputy Commissioner leads F&O. The division has two sections, the Life/Health and HMO Section and the P&C Intake Section.

Life/Health staff track filings using an Oracle system called PATK. The section processes and completes “exempt” filings. Exempt forms include life, accident, and sickness policy forms and annuity forms. The Texas Insurance Code exempts these forms from prior approval requirements, but stipulates that they must be filed before use in the state. All other filings are forwarded to the Life/Health and HWCN divisions for review and final action.

Regulated entities are billed for filing fees through a monthly invoice.

The P&C Intake Section screens P&C rate and form filings. P&C filings do not have a statutory requirement for filing fees. The form and rate filings are entered into an Oracle tracking system called TRACK. Staff process and complete “reference filings.” These are filings that reference a previously approved and accepted policy form, endorsement, or manual rule of another company/advisory organization, or that reference other filings with an assigned TDI number. All other filings are processed within one to two days and forwarded to the P&C Division for review and final action.

Filings Intake staff use the Internet to educate the industry. Staff often refer industry representatives to TDI’s website for various forms, checklists, and other documents.

Both the PATK and TRACK databases track rate and form filings, produce management reports, performance measure reports, and capture closed rate and form filings via VisiFLOW imaging software.

Both sections have documented procedures. The procedure manuals are updated as necessary.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The primary funding sources are general revenue and dedicated general revenue funds, which finance over 96 percent of the agency's operations. Maintenance taxes and fees are the two main revenues that fund the agency's appropriations to regulate the insurance and workers' compensation industries.

H. Identify any programs, internal or external to your agency that provide identical or similar services or functions. Describe the similarities and differences.

The Financial Program processes some HMO filings and associated filing fees that are similar to Life/Health and HMO Intake services. These include change in control of an HMO, dividend filings, and lists of officers and directors, biographical data, and reinsurance agreements.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Intake staff met with the Financial Program to discuss how to identify the fees processed by the LHL Program and the Financial Program. Administrative rules were amended to identify the filings subject to the agency's billing system.

J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.

Not applicable.

K. If contracted expenditures are made through this program please provide:

- the amount of those expenditures in fiscal year 2006;
- the number of contracts accounting for those expenditures;
- a short summary of the general purpose of those contracts overall;
- the methods used to ensure accountability for funding and performance; and
- a short description of any current contracting problems.

An attachment to TDI's Self-Evaluation Report provides agency contract expenditures by program.

L. What statutory changes could be made to assist this program in performing its functions? Explain.

Not applicable.

M. Provide any additional information needed to gain a preliminary understanding of the program or function.

Not applicable.

N. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

Not applicable.

O. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

Not applicable.

VII. Guide to Agency Programs

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Life, Health, and Licensing – Life/Health Division
Location/Division	William P. Hobby Building, Tower I, 6 th Floor
Contact Name	Ana M. Smith-Daley, Deputy Commissioner
Actual Expenditures, FY 2006	\$1,830,125.94
Number of FTEs as of August 31, 2006	44

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Life/Health (L/H) Division reviews accident and health, life, and annuity forms and rates filed with TDI. During reviews, staff ensure that policies, contracts, certificates, and related insurance forms comply with Texas laws. Certain rates for accident and health insurance are also reviewed to ensure rates are reasonable in relation to the benefit provided. The division also reviews viatical and life settlement contracts and registers persons in the viatical and life settlement business.

The L/H Division's activities require detailed knowledge of Texas laws, which vary depending on the insurance product and the market in which it is being offered.

The review function requires staff to perform a comprehensive and detailed reading and understanding of the documents submitted by the various insurers. Over the past 10 years, more than 2,000 insurers have filed forms with the L/H Division. There are 344 persons registered as viatical/life settlement entities.

The L/H Division also performs the following activities:

- Assists the Financial Program in regard to companies having financial difficulties. This includes providing form and rate filings information and product expertise, assisting with complaints or concerns about specific companies under examination, withdrawing from a market, changing name, demutualizing, or involved in mergers or assumptions.
- Assists Legal Services' Policy Development Counsel in drafting preliminary rules to implement legislation and provides product expertise.
- Assists Enforcement by making referrals for noncompliance with form filing requirements, mandates, or state laws.
- Assists the Consumer Protection Program by providing actuarial reviews and opinions to resolve complaints on Medicare supplement, long-term care, and individual major medical policies; providing product knowledge on complaints pertaining to life, annuities, and other accident and health products or issues related to advertising; reviewing consumer publications; and making presentations to the public.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The L/H Division has consistently met or exceeded the target for the percent of forms completed in 90 days. The division has generally met the target for number of forms completed.

1.1.2. Outcome 3 – Percent of statutory rate and form filings completed within 90 days					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	91%	90%	87%	88%	88%
Annual Target	80%	80%	91%	91%	87%
Percentage of Target	113.93%	112.82%	95.60%	96.70%	101.15%

1.1.2. Output 1 – Number of Life/Health insurance filings completed					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	31,149	33,620	29,132	28,339	30,353
Annual Target	24,500	24,500	31,149	31,149	29,800
Percentage of Target	127.14%	137.22%	93.52%	90.98%	101.86%

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

Not applicable.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

This function affects insurers that issue, use, or deliver accident and/or health, life, annuity, credit life, and credit accident and health, and nonprofit prepaid legal services in Texas, as well as consumers who purchase such products. The function also affects persons who sell their policies in the viatical/life settlement industry and persons who seek registration in that industry.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

A Deputy Commissioner leads the L/H Division. Following is a description of the division's form review process:

- The F&O Division and enters received forms into the agency's tracking system, PATK, and performs an initial screening of forms.
- F&O hand-delivers the filing to the L/H Division.
- L/H assigns forms to reviewers based on experience and product knowledge.
- L/H reviews forms in date-received order. On average, L/H has about 2,000 forms pending review.

- Currently, 31 specialists review and complete forms, actuarial memorandums and calculations, and rates.
- Final action occurs within 60 days of receipt, unless the company agrees to extend or waive the 60-day “deemer” date. The deemer date refers to the statutory provision that forms are “deemed” approved if TDI has not affirmatively approved or disapproved the form within 60 days of its received date.
- If a form under review has fewer than 10 noncompliant issues, staff contact the filer for corrections. If the form contains 10 or more noncompliant issues, staff will disapprove the form and send a letter to the filer explaining the reason for the disapproval.
- The Texas Insurance Code allows the commissioner to “exempt” certain forms from review, but not from filing or compliance. L/H specialists performs a random five percent audit of the forms filed as exempt to identify compliance with the law.

Filing Opportunities

Texas law provides the following filing opportunities for life, health, and annuity forms:

- **Review prior to use:** This provision requires industry to receive an affirmative approval before issuing, using, or delivering a form in the state. Final action occurs within 60 days of receipt, unless the company agrees to extend or waive the 60-day deemer date.
- **File-and-use:** This provision allows industry to issue, use, or deliver a form in the state upon filing with the agency. L/H staff by the 60th day must disapprove the form if it is found not to be compliant with the laws. Industry is required to file corrected forms for approval, and, once approved, issue corrected forms to consumers. If the forms are compliant, they are approved. If the form has fewer than the 10 noncompliant issues, the filer is contacted for corrections. If the form has 10 or more noncompliant issues, the form is disapproved. The company is required to correct noncompliant issued forms and cease issuing such forms until amendments addressing corrections are approved.
- **Exempt forms:** This provision requires industry to file certain forms, even though they do not require prior approval. Exempt forms completed within a day or two from receipt. Five percent of the exempted forms are audited. If found to be noncompliant, a noncompliant letter is issued requesting corrections to the form and the issued forms.
- **Exact copy of previously approved form:** Generally this option is used for sister company filings in which the only change is the name of the company.
- **Substantially similar to previously approved form:** These reviews are based on the certification that the only changes made to the form are underlined or noted with stricken text. Only the changed text is reviewed.
- **Matrix filings:** Paragraphs are assigned unique form numbers. Once approved, the company can use the filed paragraphs to create policies. The company has the responsibility to combine the paragraphs properly to create compliant policies.
- **Corrections to pending form:** This allows a company to make corrections to a pending policy based on objections raised in oral or written communication.
- **Resubmission of previously disapproved form:** This allows a company to make corrections to the policy based on the objections made on the disapproval letter.

Opportunities for Companies to Develop Compliant Products. The L/H Division continues to identify opportunities to assist industry in the development of compliant forms. Compliant forms do not require the extensive staff time required to note objections to filers and to process and review resubmitted forms.

L/H efforts to assist the industry include the following:

- making product checklists available on TDI's website
- conducting compliance conferences to assist the industry
- discussing filings with companies
- including details in corrections and disapproval letters explaining the noncompliant issues to help companies make corrections.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The primary funding sources are general revenue and dedicated general revenue funds, which finance over 96 percent of the agency's operations. Maintenance taxes and fees are the two main revenues that fund the agency's appropriations to regulate the insurance and workers' compensation industries.

H. Identify any programs, internal or external to your agency that provide identical or similar services or functions. Describe the similarities and differences.

The Interstate Insurance Compact (IIC) law is a model representing an agreement among member states to create, implement, and refine a streamlined system of insurance product regulation through the employment of national uniform product standards. It creates a multistate commission to receive, review, and make decisions on insurance product filings according to national uniform standards. The goal is to reduce the number of form variations a company must produce to meet each state's specific product standards and to permit insurers to market approved products in all compacting states. IIC review of life, annuity, long-term care (LTC) and disability, and LTC and disability rates is a function similar to that performed by the L/H Division. The insurer has the option to decide where to file its forms. A description of the functions follows.

Both HWCN and the L/H Division review documents submitted by carriers pertaining to the issuance of health coverage in Texas. F&O receives and initially tracks filings for both divisions. HWCN and L/H review the forms to ensure compliance with Texas laws and regulations. However, the legal and regulatory requirements differ depending on whether the carrier issuing the product is a health maintenance organization (HMO) or an indemnity company. The HWCN division reviews filings pertaining to HMOs, and the L/H reviews filings pertaining to indemnity companies.

The Licensing Division and L/H both process applications submitted by individuals and companies in connection with their request to do business in Texas. Licensing performs this service for agents doing business in Texas. L/H performs this service for persons engaged in the viatical/life settlement business. Viatical/life settlement registrations require fingerprinting and a criminal background check. L/H forwards fingerprint cards to the Department of Public Safety and to the Federal Bureau of Investigation through the Licensing Division. Any issues with a criminal history are based on Licensing Division rules and its historical handling of specific issues.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

While the functions are similar, they are not duplicative. There have been discussions between the divisions to transfer the processing of viatical/life settlement brokers to the Licensing Division. Licensing is developing a work plan to enable the transfer. The transfer of this function will increase efficiency. It will also ensure consistency as some viatical/life settlement brokers also hold an agents license.

J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.

L/H occasionally works with the Centers for Medicare and Medicaid Services (CMS) as the Medicare supplement product reviewed by the L/H Division is based on federal laws. L/H has been working recently with the Health and Human Services Commission (HHSC) and CMS on LTC awareness campaigns and the implementation of the LTC Partnership in Texas.

K. If contracted expenditures are made through this program please provide:

- the amount of those expenditures in fiscal year 2006;
- the number of contracts accounting for those expenditures;
- a short summary of the general purpose of those contracts overall;
- the methods used to ensure accountability for funding and performance; and
- a short description of any current contracting problems.

An attachment to TDI's Self-Evaluation Report provides agency contract expenditures by program.

L. What statutory changes could be made to assist this program in performing its functions? Explain.

Statutory issues highlighted in the TDI's Biennial Report to the 80th Texas Legislature will assist L/H by providing direction on issues that have arisen in the form review process. These issues included eligible children, group policy amendments, noninsurance benefits, and arbitration.

M. Provide any additional information needed to gain a preliminary understanding of the program or function.

Not applicable.

N. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

The purpose of viatical/life settlement registration is to protect consumers who sell their life insurance policies in that market. Prior to issuing registration, L/H performs a background check of the applicant. If the result is favorable, a two-year certificate of registration is issued. Regulated entities are required to file annual reports summarizing their activities. Staff review the reports to determine if the registered entity is complying with the law. Staff investigate noncompliance issues and, if appropriate, refer the entity to TDI's Enforcement Program or the Fraud Unit.

O. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

The Consumer Protection (CP) Program handles most complaints. The L/H Division is only involved in the process when called on to respond to legislative complaints or when called on for product or actuarial assistance from CP.

VII. Guide to Agency Programs

A. Provide the following information at the beginning of each program description.

Name of Program or Function	Life, Health, and Licensing – Health and Workers’ Compensation Network Certification and Quality Assurance (HWCN) Division
Location/Division	William P. Hobby Building, Tower I, 3rd Floor
Contact Name	Margaret Lazaretti, Deputy Commissioner
Actual Expenditures, FY 2006	\$1,039,784.71
Number of FTEs as of August 31, 2006	29

B. What is the objective of this program or function? Describe the major activities performed under this program.

The Health and Workers’ Compensation Network Certification and Quality Assurance Division (HWCN) regulates HMOs, certifies and regulates utilization review agents (URAs), certifies independent review organizations (IROs), assigns IRO requests, and certifies and regulates workers’ compensation health care networks. The division investigates complaints against these entities, conducts quality of care examinations, and reviews HMO and URA form filings. In 2006, the division began accepting applications from workers’ compensation health care networks (WC networks) and processing complaints relating to these networks. In 2007, the division will begin conducting examinations of the networks. The division has four core functions. The core functions are:

- **Compliance and Certification** – staff review and analyze forms and filings for HMOs, insurers offering exclusive provider plan (EPP) coverage, URAs, IROs, and WC networks; certify URAs, IROs, and WC networks; and register insurers and HMOs to conduct utilization reviews.
- **Complaints** – staff investigate complaints related to HMOs, URAs, IROs, and WC networks; and track complaints to identify issues that may require attention during routine examinations or a need for a bulletin, website announcement, or other educational tool.
- **Examinations** – staff examine HMOs, URAs, IROs, and WC networks. The division routinely examines HMOs based on their licensure date. The division may examine an HMO any time in the first three years of operation and no less than every three years thereafter. Staff conduct a desk review when an HMO requests a certificate of authority and may conduct an onsite examination before approving the certificate to ensure that the HMO has the appropriate infrastructure to start and sustain a health plan. Staff conduct another examination once the HMO has had members for one year. This allows staff to identify operational issues and allows the HMO to make corrections before there is a detrimental effect on the HMO’s members. If staff find problems or issues during the complaint process, the division may conduct an examination. The division may examine workers’ compensation health care networks in a similar manner, although the statute does not require specific timeframes. Initial examinations of WC networks will begin in 2007. URAs and IROs are also subject to examination as required by the Commissioner of Insurance.
- **IRO Assignment** – staff assign cases to certified IROs within one day of receipt of a request. The division assigns reviews to the 26 currently certified IROs on a rotating basis. This prevents “forum shopping” by insurance carriers and URAs to find an IRO that may be perceived to be

more favorable. In 2006, the division began assigning requests related to WC networks in addition to those regarding health carriers and HMOs. In 2007, the division began assigning requests related to non-network workers' compensation.

In addition, HWCN:

- assists in the development of rules
- responds to open records requests
- educates industry, provider, and consumer groups through bulletins, compliance workshops, manuals, checklists, and speaking engagements
- provides technical assistance to TDI staff regarding complaints, consumer publications, enforcement actions, and withdrawals from HMO and WC network markets
- provides technical assistance to external entities such as the Employees Retirement System, the Texas Department of State Health Services, the Texas Health and Human Services Commission, the Office of the Attorney General, the Texas Department of Mental Health and Mental Retardation, the Texas Commission on Alcohol and Drug Abuse, the Texas Department of Criminal Justice, the National Association of Insurance Commissioners, and the federal Centers for Medicare and Medicaid Services.

C. What evidence can you provide that shows the effectiveness and efficiency of this program or function? Provide a summary of key statistics and performance measures that best convey the effectiveness and efficiency of this function or program.

The division is converting its paper-intensive processes to electronic processes. Currently, most of the division's major functions are paperless, and others are pending conversion by TDI's Information Technology Services Division. Electronic processing improves efficiency and customer service. Stakeholders may submit URA annual reports IRO assignment requests online. Multiple agency programs, including Consumer Protection, Enforcement, and the Financial Program, can now view supporting documents. Staff can access electronic documents to provide information instantly to customers rather than first having to retrieve paper files.

HWCN has actively solicited stakeholder input. Staff participate in the Technical Advisory Committee on Claims Processing. The division has used input from stakeholders to develop rules, including prompt pay rules and a reporting process for carriers. HWCN solicits input on WC networks from a stakeholder group formed shortly after the Legislature authorized the networks. The scope of the group was expanded to include non-network issues after the network certification process was well under way. Stakeholder input was invaluable in the development of the rules and implementation of the network certification process. The group has also helped manage expectations during implementation by allowing the exchange of information and ideas about ways to streamline and improve the processes.

WC network outreach has expanded beyond the working group. The division publishes a network newsletter and distributes it electronically to several thousand stakeholders and via the agency website. Hits on the web version have steadily increased with each new issue. Other outreach activities include workshops, seminars, and conference calls. DWC staff, the Texas Medical Association, and the University of North Texas Small Business Development Program assist with many outreach activities. The division holds conference calls for system providers and certification applicants. Plans include development of another newsletter for HMOs and conference calls with other regulated entities.

The following performance measure data and other key statistics demonstrate the division's effectiveness:

Activity: Health Maintenance Organization Filings

1.1.2. Outcome 3 – Percent of statutory rate and form filings completed within 90 days					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	100%	100%	98%	97%	98%
Annual Target	80%	80%	91%	91%	87%
Percentage of Target	125.00%	124.94%	107.96%	106.59%	112.64%
Analysis/Variance Explanation	The HWCN Division has historically completed the majority of filings received in less than 90 days and typically completes form filings within 30 days in order to meet deemer dates.				

1.1.2. Output 2 – Number of HMO form and rate filings completed					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	2,446	2,026	1,596	1,538	1,577
Annual Target	2,900	2,900	2,446	2,446	1,300
Percentage of Target	84.34%	69.86%	65.25%	62.88%	121.31%
Analysis/Variance Explanation	The number of HMOs has declined significantly in Texas as a result of acquisitions, mergers, and financial issues. The decline in the number of HMOs has resulted in fewer filings. Compounding the situation is the fact that these acquisitions, mergers, and financial issues have occurred primarily in the basic service HMO realm. Basic service HMOs tend to submit more filings than single service HMOs. Thus, the impact of fewer HMOs is even greater because there are fewer basic service HMOs.				

1.2.1. Output 4 – Number of complaints against HMOs resolved					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	8,464	6,280	3,620	2,422	1,329
Annual Target	6,000	6,000	7,000	7,000	2,240
Percentage of Target	141.07%	104.67%	51.71%	34.60%	59.33%
Analysis/Variance Explanation	The HWCN Division resolved fewer complaints than targeted because it received fewer complaints. This may be attributable to a number of factors which include a shrinking market share for HMOs resulting in fewer enrollees. Additionally, increased knowledge about prompt pay requirements by HMOs and providers has resulted in fewer complaints.				

1.2.1. Efficiency 2 – Average time for HMO complaint resolution					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	13	10	9	6	9
Annual Target	20	20	18	18	10
Percentage of Target	64.40%	47.98%	48.01%	33.11%	90.00%
Analysis/Variance Explanation	The average time to resolve complaints is below target due to a lower number of complaints received. A shrinking market share may be contributable to fewer complaints. Additionally, increased knowledge about prompt pay requirements by HMOs and providers has resulted in fewer complaints. An efficient system and well trained staff have resulted in a timely resolution of complaints, resulting in performance that is lower than the target.				

1.2.2. Output 5 – Number of HMO quality assurance examinations conducted					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	23	28	22	16	22
Annual Target	21	21	12	12	12
Percentage of Target	109.52%	133.33%	183.33%	133.33%	183.33%
Analysis/Variance Explanation	The HWCN Division exceeded the annual target. A significant number of triennial examinations are conducted, which are statutorily required every three years. At times, triennials may be started in one fiscal year and completed in the next fiscal year.				

1.2.2. Efficiency 1 – Average cost per HMO quality assurance examination conducted					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Actual Performance	\$3,608	\$5,042.61	\$3,619.41	\$4,178	\$2,400
Annual Target	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000
Percentage of Target	51.54%	72.04%	51.71%	59.69%	34.29%
Analysis/Variance Explanation	The average cost of conducting on-site exams was below the annual target. A large portion of the exam process is performed in-house resulting in lower travel costs. Additionally, more efficient processes and well-trained staff, reduces overall costs.				

Activity: Utilization Review Filings

	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Applications Received	17	15	15	16	12
Registered Utilization Review Agents Approved	1	1	1	2	1
Certified Utilization Review Agents Approved	21	15	12	17	11
Certified URAs Renewed	76	97	103	81	78

Activity: IRO Applications

	FY 2003	FY 2004	FY 2005	FY2006
IRO Applications Received	1	4	4	8
IRO Applications Approved	1	3	3	6
IRO Renewals Approved	3	6	10	10

Activity: HMO Projects/Inquiries

	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Projects/Inquiries Received	248	197	124	119	169
Projects/Inquiries Completed	248	197	124	117	171

D. Describe any important history regarding this program not included in the general agency history section, including how the services or functions have changed from the original intent.

Regulation of HMOs

Originally, the functions that make up regulation of HMOs were separated into several functional areas in TDI, including Consumer Protection and the Life/Health Division. When the HMO division was created, the functions were centralized into that division, along with URA and IRO regulation. The consolidation has allowed HMOs to be regulated so that all aspects of the company except for the financial aspects are overseen by a relatively small group of staff who are able to share information readily. For instance, when a team goes onsite to examine an HMO, the team members have already been briefed about the status of form filings and complaints against the HMO. The team also receives input from the Financial

Program. This gives the team a well-rounded picture of the overall status of the company.

Regulation of IROs

TDI's original statutory duties (certification, assignment, and oversight) have not changed since the creation of IROs and will be needed as long as the Legislature desires to have an independent review process available.

Regulation of URAs

TDI's original statutory duties (certification and oversight) have not changed since the creation of URAs. They were regulated in Consumer Protection until 1993, when the function was moved to HWCN. As long as carriers and URAs make medical necessity determinations, certification and oversight will be needed.

Regulation of Certified Workers' Compensation Health Care Networks

The name of the HMO Division was changed in 2006 to reflect the new functions related to WC networks, and it became the Health and Workers' Compensation Network Certification and Quality Assurance Division. In January 2006, the division began receiving applications for certified workers' compensation health care networks. The first network was certified in April 2006. As of July 2007, there are 29 certified workers' compensation health care networks in Texas.

IRO Assignments for Health Insurance

The Legislature created the independent review process for Texas in 1997. The purpose of the process was to provide an independent review of medical necessity decisions that are adverse to enrollees. The functions regarding assignment of IRO reviews have not changed since inception.

IRO Assignments for Workers' Compensation Claims

The division began assigning IRO requests related to networks in 2006. Previously, the Division of Workers' Compensation (formerly the Texas Workers' Compensation Commission) assigned requests for non-network workers' compensation cases. TDI evaluated the IRO assignment process and determined that it would be more efficient and consistent if it were centralized in HWCN.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Compliance and Certification function affects any and all Texans covered under HMOs, health insurers that perform utilization review, workers' compensation carriers, and certified WC networks.

The Complaints function affects HMOs, URAs, IROs and WC networks in that complaints against these entities are addressed by HWCN staff. This function also affects insured Texans and Texans covered by a certified WC network.

The Examination function affects HMOs and certified WC networks and Texans covered by HMOs and certified WC networks.

The IRO Assignment function affects anyone covered by an HMO or certified WC network in Texas, as well as the HMOs and certified WC networks themselves.

F. Describe how your program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

Visio Flowcharts are available for review.

G. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The primary funding sources are general revenue and dedicated general revenue funds, which finance over 96 percent of the agency's operations. Maintenance taxes and fees are the two main revenues that fund the agency's appropriations to regulate the insurance and workers' compensation industries.

HMOs are billed for certifications and examinations, as well as for each form filed with TDI. Each application for certification of a WC network must include the fee specified by statute. URAs and IROs must pay certification and renewal fees. WC networks will be billed for examination costs.

H. Identify any programs, internal or external to your agency that provide identical or similar services or functions. Describe the similarities and differences.

HMO and WC network examinations are coordinated with the Financial Program. The Financial Program routinely examines HMOs regarding their financial status. Financial also performs market conduct examinations of carriers, which are similar to the examinations performed by HWCN, but they do not examine HMOs or WC networks.

The L/H Division reviews forms filed by insurance companies other than HMOs which, at times are identical or very similar to those filed by an HMO, resulting in a coordinated review between the two divisions. However, the statutory timelines for reviews of forms completed in Life/Health are different from those completed by HWCN.

Complaint Resolution and Customer Service (CRCS) at DWC handle complaints related to non-network workers' compensation. All complaints related to certified workers' compensation health care networks and HMOs, URAs, and IROs are handled by HWCN. Consumer Protection also handles complaints related to a variety of insurance products in Texas. There is no overlap among the areas regarding the type of complaints handled.

I. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question H and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The exams conducted by HWCN and Financial are separated by specific area of responsibility to avoid duplication.

While HWCN and Life/Health may review the same or similar forms submitted by a company, the statutes and rules that the forms are reviewed against are not the same. The divisions coordinate review of identical documents. Therefore, there is no duplication of effort.

Staff follow written procedures and receive training to assure that complaints are handled by the appropriate program area. Two charts, "SORT for Success" and "Overview of Complaints Processing," that include information about TDI program areas and the types of complaints they handle are available for review. All areas handling complaints follow a consistent process, which was established by an agencywide complaint workgroup. The *High Level Complaint Process Framework* and supporting complaint procedures are available for review.

HWCN coordinates its examinations of HMOs that contract for Medicaid and CHIP products with HHSC, and the agency has recently entered into an MOU with HHSC regarding the examination function.

J. If the program or function works with local, regional, or federal units of government include a brief description of these entities and their relationship to the agency.

The division shares complaints against HMOs contracted by Medicaid and CHIP with HHSC. If issues arise regarding the HMOs with either agency, the other agency is contacted.

Employee Retirement System (ERS) complaints about HMOs are reported to ERS.

Medicare complaints that reach the agency are referred to the contracting HMOs at the request of CMS. No investigation is performed by HWCN. HWCN does not perform examinations of HMOs that are Medicare contractors because CMS has authority.

K. If contracted expenditures are made through this program please provide:

- the amount of those expenditures in fiscal year 2006;
- the number of contracts accounting for those expenditures;
- a short summary of the general purpose of those contracts overall;
- the methods used to ensure accountability for funding and performance; and
- a short description of any current contracting problems.

An attachment to TDI's Self-Evaluation Report provides agency contract expenditures by program.

L. What statutory changes could be made to assist this program in performing its functions? Explain.

Not applicable.

M. Provide any additional information needed to gain a preliminary understanding of the program or function.

Not applicable.

N. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. For each regulatory program, if applicable, describe:

- **why the regulation is needed;**
- **the scope of, and procedures for, inspections or audits of regulated entities;**
- **follow-up activities conducted when non-compliance is identified;**
- **sanctions available to the agency to ensure compliance; and**
- **procedures for handling consumer/public complaints against regulated entities.**

HMO Regulation

HMOs apply for a certificate of authority through the TDI's Financial Program. The HWCN Division participates in the review of the HMO's form filings, network adequacy, quality improvement program, and utilization review program. After TDI issues the certificate of authority, HWCN monitors the HMO's operations, investigates complaints against the HMO, and performs quality of care examinations at statutorily mandated intervals. Staff refer the HMO to Enforcement for noncompliance with statutory requirements. Enforcement investigates the referral and can take actions that range from a letter of reprimand to administrative fines and ultimately to revoking the HMO's certificate of authority.

URA Regulation

Utilization review agents determine the medical necessity and reasonableness of services requested by physicians or other providers. If the URA determines the requested service is not medically necessary or reasonable, the carrier will not pay for it, and the patient must then pay for the service out of pocket. The decision to deny requested services based on medical necessity or reasonableness is known as an adverse determination. To protect the patient (or injured employee), statute includes consumer protections that URAs must follow.

TDI evaluates URAs at the time of certification and upon renewal to ensure URAs have procedures that meet statutory requirements. If the URA changes procedures in the interim between certification and renewals, it is required to file the changes with TDI. URAs must submit an annual report to TDI that includes aggregate information about adverse determinations and complaints. Staff review the annual reports and monitor complaints submitted to TDI to determine whether a URA needs more in-depth review. Such review may be a desk review of files or an onsite examination, generally in conjunction with contracting carriers of the URA.

If staff identify noncompliance as a result of the monitoring or review of a URA, they refer the URA to the Enforcement Program. Enforcement investigates the referral and can take actions that range from a letter of reprimand to administrative fines and ultimately to revoking the URA's certification.

Complaints against URAs are handled through the agency complaint process. Since a URA must either be a licensed carrier, an HMO, or be contracted with one of those entities, complaints are typically entered against both entities. Complaints are tracked for patterns of behavior, and results are used to determine further regulatory action.

IRO Regulation

The Legislature created the IRO process in 1997. IROs review appeals of adverse determinations regarding medical necessity or reasonableness. IROS are independent of carriers and URAs making medical necessity determinations. In addition to regulation of the certification process, HWCN assigns requests to IROs on a rotating basis. This prevents insurance carriers and URAs from attempting to have an appeal reviewed by an IRO that may be perceived to be more favorable.

IROs are evaluated at the time of certification and renewal to ensure that they meet statutory requirements. If an IRO changes procedures in the interim between certification and renewals, it must file the changes with the division. Division staff review the decision reports and monitor complaints to determine whether an IRO needs more in-depth review. The review may be a desk review of files or an onsite examination.

If staff identify noncompliance during the monitoring or review of an IRO, they refer the IRO to TDI's Enforcement Program. Enforcement investigates the referral and can take actions that range from a letter of reprimand to administrative fines and ultimately to revoking the IRO's certification.

Complaints against IROs are handled through the agency complaint process. Complaints are tracked for patterns of behavior. Results are used to help determine further regulatory action.

WC Network Regulation

HWCN began accepting applications for WC network certification in 2006. During the certification process, the applicant is evaluated for network adequacy, financial solvency, compliant contracting processes with providers and carriers, quality improvement program, and credentialing program for providers. The requirements are similar to those for HMOs and contain similar consumer protections. It is critical that the networks be monitored closely for compliance with the requirements.

In addition to the evaluation during the certification process, HWCN staff evaluate additional filings by certified networks and monitor complaints received about them. The division will begin routine examinations of networks in 2007 to ensure that they are in compliance with the statutory requirements. The division is currently evaluating annual quality improvement reports submitted by certified networks. Division staff coordinate with the Research and Evaluation Group to receive information about studies that are being done in preparation for the report cards, which will be published in September 2007.

If staff identify noncompliance during the monitoring or review of a WC network, they refer the network to the Enforcement Program. Enforcement investigates the referral and can take actions that range from a letter of reprimand to administrative fines and ultimately to revoking the network's certification.

Complaints against WC networks are handled through the agency complaint process. Complaints are tracked for patterns of behavior. Results are used to help determine further regulatory action.

O. For each regulatory program, if applicable, provide the following complaint information. The chart headings may be changed if needed to better reflect your agency's practices.

The chart below includes information for IROs, URAs and HMOs.

Texas Department of Insurance, HWCN Division		
Exhibit 12: Information on Complaints Against Regulated Persons or Entities, FY 2005 and 2006		
	FY 2005	FY 2006
Total number of regulated entities	268	300
Total number of entities inspected	16	23
Total number of complaints received from the public	3,028	2,095
Number of complaints pending from prior years	0	3
Number of complaints found to be non-jurisdictional	137	277
Number of jurisdictional complaints found to be without merit	1,683	972
Number of complaints resolved	3,298	1,446
Average number of days for complaint resolution	6	9

