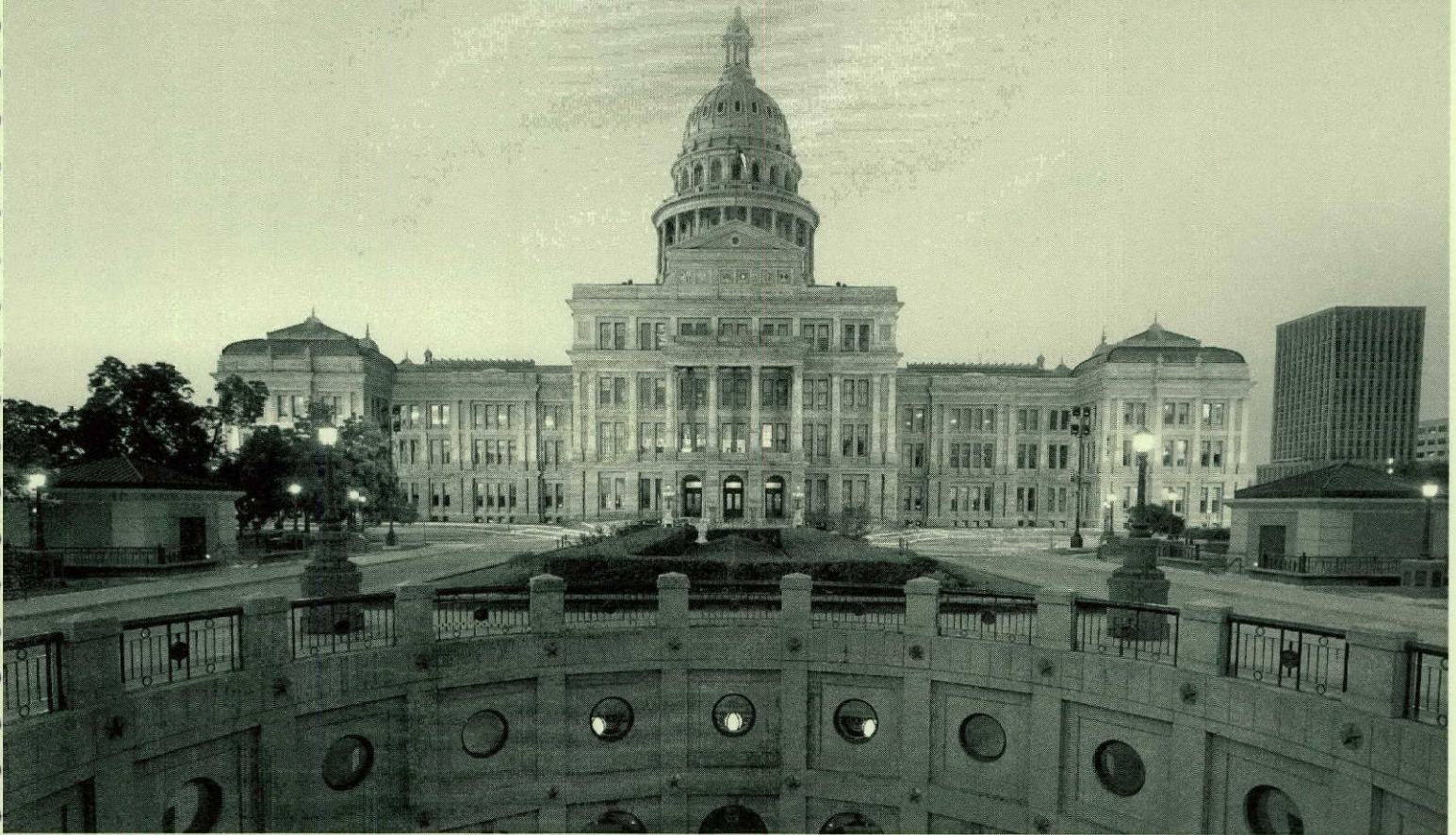


INTERIM REPORT

to the 85th Texas Legislature



HOUSE COMMITTEE ON
INSURANCE



JANUARY 2017



**HOUSE COMMITTEE ON INSURANCE
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2016**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
85TH TEXAS LEGISLATURE**

**JOHN FRULLO
CHAIRMAN**

**COMMITTEE CLERK
JESSE SIFUENTEZ**





Committee On
Insurance

January 4, 2017

John Frullo
Chairman

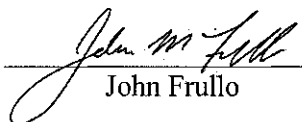
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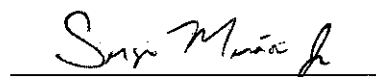
The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

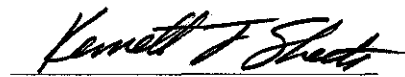
The Committee on Insurance of the Eighty-fourth Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-fifth Legislature.

Respectfully submitted,


John Frullo


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Kenneth Sheets


Paul Workman


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CHARGE #1. HAILSTORM CLAIMS

Examine available data on the cost of weather-related property insurance claims and the incidence of litigation of these claims. Study whether these data reveal trends or patterns over time and what the drivers of these trends might be. Identify impacts on the property insurance market and on consumers from claims litigation.

Introduction

The Texas Department of Insurance reported the following to the Committee:

On February 24, 2016, and March 14, 2016, Commissioner Mattax received requests from the Chairs of the Senate Business and Commerce Committee and the House Insurance Committee, respectively, to collect data on hailstorm claims litigation in Texas to assist the committees with their interim charges on the topic. Accordingly, in March 2016, the Texas Department of Insurance (TDI) developed a draft data call to gather information about the cost of weather-related residential property claims and the incidence of litigation of these claims. The data call was designed to collect information TDI did not already have from its residential property statistical plan. TDI published the draft data call on its website, inviting written comments and announcing an April 21, 2016, public meeting to discuss the data call, which was led by Commissioner Mattax. TDI received written comments from eight interested parties, and six people commented at the April 21, 2016, meeting. TDI made several changes to the data call in response to comments and issued the data call on May 20, 2016. TDI gave insurers 90 days to complete the data call, with responses due on August 19, 2016. Insurers comprising about 140 separate insurance companies submitted responses to the data call.

Section I asked for a 5 percent random sample of all wind and hail claims for events in 2010-2015. All admitted companies except farm mutual insurers were required to report Section I data. TDI did not require farm mutual insurers to report because they are exempt from reporting data under TDI's Statistical Plan for Residential Risks.

Section II asked for a 100 percent sample of all wind and hail claims for nine specified events (only the top 15 companies with paid claims for the nine specified events were required to respond; it was optional for other companies including farm mutual insurers).

Both Sections I and II requested

- basic information about the policy
- significant dates in each claim's history
- insurer costs associated with the claim
- whether an attorney or public adjuster (PA) represents the claimant
- attorney, PA, and suit-related information, and
- information on pre-suit settlement efforts.

Section III required companies to complete an underwriting survey, which asked companies about actions such as nonrenewals, reductions in coverage, more restrictive underwriting guidelines, and rate changes, either statewide or in particular regions, in response to increased weather-related litigation (all admitted insurers except farm mutual insurers were required to respond to the survey).

February 2017 Deadline for Report

In TDI testimony, the department reported to the Committee that they will have the Residential Property Hail Litigation Data Call report completed by the end of February 2017. Due to the complex nature of data call, in lieu of an independent analysis of the data, the Committee refers readers to TDI's report on the matter.

CHARGE #2: BALANCE BILLING

Examine the effectiveness of previous legislative efforts to encourage transparency and adequacy of health care networks, and of legislation to protect consumers from the negative impacts of disputes over out-of-network services. Study whether enhancements in transparency or regulation are necessary.

Introduction

The major focus of this charge is balance billing and how to protect consumers from unexpected high bills. For this reason, the following report examines only preferred provider benefit plan (PPO¹) laws and regulations in the state of Texas. The language of Charge #2 is not limited to PPO laws but much of the concerns stated by Committee members and testimony from stakeholders focused solely on this insurance product. The reason being is that PPOs are where a substantial amount of balance billing occurs both because of the out-of-network options and wide popularity of the product. Furthermore, HMOs² and EPOs³—which are also technically under the charge's purview—do not have out-of-network options and are required by Texas law to hold harmless their enrollees when emergency care is rendered.⁴

TDI provided a helpful definition for a PPO which will be used throughout the report. A PPO is:

a type of health plan that contracts with doctors and hospitals to create a **network of [in-network providers]**⁵ that can provide care to enrollees at a **discounted cost**. PPOs will cover some out-of-network costs, but you will pay more and may be **balance billed**.⁶

The major cost-containing feature of this insurance product are networks which achieve the discounted costs that are determined through contracts between insurers and providers. However, achieving the largest discounted costs is not absolute. Insurers are expected to provide sufficient PPO products for Texas consumers. So Texas law prescribes an overarching governing principle

¹ Technically, PPOs are the preferred provider organizations that insurers contract with to create the preferred provider network for the preferred provider benefit plan. However, in common nomenclature, PPOs have come to refer to preferred provider benefit plans. For the sake of avoiding confusion for non-experts the acronym PPO will be used to refer to preferred provider benefit plans in this report.

² **Health maintenance organization (HMO)** A type of health plan that usually limits coverage to care from preferred providers. Out-of-network care is only covered in an emergency, or if you can't access the care you need in-network. In an HMO plan, your care is managed by your primary care provider and you need a referral in order to see a specialist. HMO plans are similar to EPO plans, but HMOs are regulated differently than insurance companies. TDI, *Balance Billing: Glossary of Terms*, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016060110001/1fb95d28-b607-47bd-8003-c4e3dcf62f41.PDF>. [hereinafter *Glossary of Terms*].

³ **Exclusive provider organization (EPO)** A type of health plan where services are covered only if you go to preferred providers. Out-of-network care is only covered in an emergency, or if you can't access the care you need in-network. EPO plans are similar to HMO plans, but EPOs are offered by insurance companies, which are regulated differently than HMOs. *Id.*

⁴ 28 T.A.C. §11.204(20)(HMO); 28 T.A.C. §3.3725(d)(EPO).

⁵ Also referred to in statute and healthcare literature as "preferred providers." The terms are synonymous.

⁶ *Glossary of Terms*, at 2.

that provides that PPOs must “ensure that both [in-network] benefits and [out-of-network] benefits are reasonably available to all consumers within a designated service area.”⁷ Essentially, this overarching principle aims to ensure that PPO consumers have “access” to the healthcare promised in their health plans. The contractual requirement is crucial because in Texas it is illegal to reimburse a physician on a discounted fee basis without a contractual agreement.⁸ An insurer who violates this provision is liable for sanctions, administrative penalties, and unfair settlement practices.⁹ On the other hand, doctors who contractually agree to the discounted fee cannot balance bill for the remainder of their billed charge.¹⁰

Balance billing occurs when a consumer is charged the difference between an insurer's allowed amount¹¹ and the provider's bill charges for out-of-network services. There are several scenarios in which balance billing can occur. Here are three that will be referred to in the report.

- **Lack of In-network Provider Scenario** - The consumer needs specialty care but the necessary specialist is not reasonably close to the consumer. The consumer is required to go out-of-network to receive care. This scenario is common to rural areas.
- **Surprise Billing Scenario** - The consumer makes a voluntary, informed decision to go to an in-network facility for a scheduled service. However, the consumer is treated by an out-of-network provider during the consumer's treatment at the in network facility.
- **Emergency Scenario** - The consumer has a medical emergency and makes sure to be taken to an in-network hospital. However during the emergency treatment the consumer receives services from a non-network provider.

Furthermore, according to TDI testimony, the department approaches the balance billing issue in four basic ways.

- **Network Adequacy** - TDI requires carriers to have an adequate network of providers so that receiving services outside of the network occurs less frequently.
- **Transparency Requirements** - TDI ensures that consumers have access to information relevant to their decision making.
- **Payment Standards** - TDI ensures that carriers' payment methodologies are appropriate.
- **Mediation** - TDI provides a mediation process for services provided by an out-of-network facility-based physician¹² at an in-network facility.¹³

⁷ TEX. INS. CODE §1301.005; see also, 28 T.A.C. §3.3704(h). According to 28 T.A.C. §3.3704(h), a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but any service areas that are smaller than statewide must be defined in terms of one of the following: one or more of the 11 Texas geographic regions designated in 28 T.A.C. §3.3711 (relating to Geographic Regions), one or more Texas counties, or the first three digits of ZIP Codes in Texas.

⁸ TEX. INS. CODE §1301.056(a).

⁹ TEX. INS. CODE §1301.056(c).

¹⁰ TEX. INS. CODE §1301.060.

¹¹ **Allowed amount** The maximum amount on which payment is based for covered health care services. From the health plan's perspective, this is the fair price for a health care service. This may be called “eligible expense,” “payment allowance,” “contracted rate,” or “negotiated rate.” If your doctor or hospital charges more than the allowed amount, you may have to pay the difference. This is called balance billing. *Glossary of Terms*, at 1.

The following sections are divided in this order.

I. Adequacy of Health Care Networks

Insurers contract with providers to create a network of preferred providers (in-network providers) to provide care to their enrollees at a discounted cost and in exchange for giving the discount, physicians receive a reliable source of patient volume via the insurer's enrollees. An inherent task that insurers must undertake when creating a network is achieving an acceptable balance between costs and quality of care. In other words, insurers attempt to provide an insurance product that reliably meets their enrollees' healthcare needs without being too expensive. Now, what is an "acceptable balance" is in the eye of the beholder. Some populations tolerate higher premiums for a wider range of provider options, while others prefer lower premiums with more limited provider options—commonly referred to as "narrow networks." However, consumers are not always aware of what they are really purchasing when weighing their choices, so states—like Texas—provide laws that regulate network formations in order to protect consumers from deficient or inadequate networks.

In 2013 TDI released the network adequacy standards which at the time were one of the first in the nation.¹⁴ The network adequacy standards are governed by an overarching provision which requires an insurer marketing a preferred provider benefit plan to:

contract with physicians and health care providers to ensure that all medical and health care services and items contained in the package of benefits in a manner ensuring the *availability* of and *accessibility* to adequate personnel, specialty care, and facilities.¹⁵

Texas law adds detail to the overarching provision by requiring TDI to promulgate local market network adequacy standards for PPOs which must be designed to ensure the availability of a full range of contracted physicians and health care providers to provide health care services to consumers.¹⁶ What's more, Texas law also recognizes certain scenarios in which the insurer is unable to meet those standards based upon good cause, so TDI regulations—in accordance with legislative mandate¹⁷—provide waiver options for these cases.

However, a waiver is in effect a declaration to enrollees and TDI that the insurer cannot provide certain necessary services without going outside the cost containing network. This—in effect—exposes the enrollee to more costs since the risk of being balance billed increases when services are provided outside the network. Due to this, some stakeholders argue that Texas regulations

¹² Radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon. TEX. INS. CODE §1467.051(a) (cross referencing TEX. INS. CODE §1467.001(4) defining "facility-based physician"). *see also* Section IV Out-of-Network Claims Disputes—Mediation.

¹³ June 1st Hearing at 5:25, available at: http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=12002.

¹⁴ June 1st Hearing at 5:05.

¹⁵ TEX. INS. CODE §1301.006.

¹⁶ TEX. INS. CODE §1301.0055 (1-2).

¹⁷ TEX. INS. CODE §1301.0055(3).

fail to achieve the overarching goal of availability and accessibility—especially in light of the increase in the market of health plans with narrow networks. The following sections address these issues respectively.

A. Creating the Networks—Contracting with Providers

In order to ensure that insurers make honest attempts to contract with providers and create adequate networks, the Insurance Code prescribes mandatory procedures that facilitate engagement between the insurer and providers. They are:

- **Notification Requirements** - The insurer must notify providers in the plan's service area that the insurer intends to form a PPO.¹⁸
- **Application Review Procedures** - Insurers must approve or make a reasonable denial for provider PPO applications.¹⁹ If denied, a provider has a right to appeal to an advisory only review panel made up of practitioners chosen by the insurer.²⁰ However, an insurer is not bound by the panel's decision but if their decision is contrary to the panel's they must provide a written explanation.²¹
- **Contract Requirements** - Contracts are required to have a complaint resolution system that incorporates a review panel made up of practitioners chosen by the insurer.²² Among the subjects of complaints include interfering with the physician patient relationship.²³
- **Expelling a Provider** - A written notice must be provided to the provider with an opportunity to appeal to an advisory panel if the provider is a physician.²⁴ However, the review mechanism is not required if the case involves either imminent harm to a patient's health, licensure suspension, or fraud or malfeasance.²⁵
- **Continuity of Care** - The Insurance Code imposes certain continuity of care obligations to protect consumers from the financial impact of network terminations occurring while the consumer has a "special circumstance."²⁶ The physician is required to agree not to

¹⁸ TEX. INS. CODE §1301.054(c).

¹⁹ TEX. INS. CODE §1301.051(b). Insurer is allowed to deny based on economic profile but must provide reasons. §1301.058.

²⁰ TEX. INS. CODE §1301.053(a-b).

²¹ TEX. INS. CODE §1301.051(c).

²² TEX. INS. CODE §1301.055. Furthermore, the statute prohibits insurers from engaging in quality assessments unless performed by a review panel made up of three physicians chosen by the insurer. §1301.059(b).

²³ TEX. INS. CODE §1301.067.

²⁴ TEX. INS. CODE §1301.057 (2). The insurer must provide the practitioner the panel's recommendation and, if the insurer's decision is contrary to the panel's, they must provide a written explanation. §1301.057(c). Also, if the insurer used an economic profile in their determination, they must make it available to the physician. §1301.058. Moreover, the insurer must provide an expedited review for the physician if the physician requests. §1301.057(d).

²⁵ TEX. INS. CODE §1301.057(2)(A-C).

²⁶ TEX. INS. CODE §1301.153. A 'special circumstance' exists when the consumer has a condition that requires ongoing treatment and the treating physician reasonably believes that discontinuing care by the treating provider could cause harm to the consumer. §1301.153(a)(2). Additionally, the in-network provider contract must provide that the provider's network termination does not release the insurer from the obligation to reimburse the provider at the same in-network provider rate if, at the time a provider is terminated, the consumer (whom the provider is currently treating) has a 'special circumstance. §1301.153(b)(2). The insurer's obligation under this section ends, however, based upon specific timeframes set forth in the statute (e.g. the 90th day after the effective date of termination, in some circumstances). §1301.154.

seek payment from the consumer of any amount for which the consumer would not be responsible, if the provider were still an in-network provider.²⁷

There are, however, certain limitations to these requirements. For example, the requirements apply only if the provider complies with the terms established by the insurer for designation as an in-network provider.²⁸ Also, the Insurance Code does not prohibit an insurer from rejecting a provider's application based on a determination that the PPO has a sufficient number of qualified providers.²⁹

According to TDI testimony, the department received only six complaints from January 1, 2013, through December 31, 2015, regarding failure to provide an opportunity to apply to be an in-network provider.³⁰ Of these complaints, only one was confirmed.³¹ TDI has issued two consent orders since 2013, when two providers, both optometrists, could not join a plan's medical panel without their assistance. Furthermore, the Texas Medical Association (TMA) reported to the Committee that they conducted an internal survey of their physician members to determine the success rate for physicians who attempted to join a PPO network that was already established. From 2015–2016 30% of their members reported that they attempted to join a network.³² Of that 30%, only 33% received a contract and another 33% received an offer but it was unacceptable.³³ The remaining 34% received no reply at all.³⁴

B. Network Requirements & Network Adequacy Reports

Texas law lays out two general policy objectives that insurers must strive for when creating their networks.³⁵ One section lists the services that networks must have to be deemed fair while the second section specifically lays out the requirements that networks must meet to become adequate networks.³⁶ Adequate PPO networks must comply with specific regulatory requirements which includes but not limited to:

- sufficient in number, size, and geographic distribution capable of furnishing covered health care services;

²⁷ TEX. INS. CODE §1301.153(c)(2).

²⁸ TEX. INS. CODE §1301.051(a)(2).

²⁹ TEX. INS. CODE, §1301.051(d).

³⁰ TDI, *Questions for the Texas Department of Insurance (TDI) from the Chair of the House Insurance Committee*, at 1, available at:

<http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016060110001/102dfbda-028f-4125-a220-c302bd353a24.PDF>. [hereinafter *Response to Questions*].

³¹ A complaint is confirmed if there is an apparent violation of an insurance policy provision, contract provision, rule or statute, or there is a valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice. *Id.*

³² Texas Medical Association, *Texas Medical Association Testimony: House Insurance Committee Charge 2*, at 3, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016060110001/ea79ec46-0091-4462-86ce-cdf026a10305.PDF>. [hereinafter *TMA Written Testimony*].

³³ *Id.* at 4.

³⁴ *Id.*

³⁵ 28 T.A.C. §3.3704.

³⁶ 28 T.A.C. §3.3704(a)(f).

- include an adequate number of accessible in-network providers and emergency care that are available 24/7;
- include a sufficient number of classes of in-network providers to ensure choice, access, and quality of care across the insurer's designated service area;
- provide preferred benefit services within certain distances.³⁷

Additionally, the regulations require PPOs to make a good faith effort to have a mix of for-profit, non-profit, and tax supported institutional providers in their networks and give special consideration to those that provide indigent care.³⁸

1. Self-Reporting

To facilitate the regulatory process, TDI requires insurers to "self-report" and file annual network adequacy reports. These reports require the insurer to tell the department whether their networks meet the regulatory requirements.³⁹ The reports require insurers to provide information such as but not limited to:

- demographic data to aid TDI staff in their review of the adequacy of the network,
- complaints by out-of-network providers, and
- consumer complaints related to balance billing and availability of in-network providers.⁴⁰

According to testimony given to the Committee by TDI, in the first year of reporting TDI received reports from only 40% of plans by the reporting deadline. However, TDI attributes these failures to common mistakes associated with learning a new process. Since then, reporting deadlines have been met most likely because the industry has a better understanding of the new reporting requirements.⁴¹

2. Review Process—Flexible and Complaint Driven

The regulatory review process does not operate according to fixed formulas—such as a provider patient ratio—but is flexible and subjective. However, Texas regulations do provide some concrete distance and time requirements that serve as a basis for TDI's review process. For example, preferred benefit services are required to be provided at a distance from any point in the insurer's designated service area to a point of service that is not greater than:

- 30 miles in non-rural areas and 60 miles in rural areas for primary care and general hospital care; and
- 75 miles for specialty care and specialty hospitals.⁴²

³⁷ 28 T.A.C. §3.3704 (f).

³⁸ 28 T.A.C. §3.3704(e).

³⁹ 28 T.A.C. §3.3709(a).

⁴⁰ 28 T.A.C. §3.3709(c).

⁴¹ *Response to Questions*, at 4; *See also* June 1st Hearing at 1:12:30.

⁴² 28 T.A.C. §3.3704(f)(8); *see also* TDI Written Testimony, *TDI Power Point*, at 13, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016060110001/a7f342f8-ddc7-4d9c-902b->

Also, routine care must be available and accessible from an in-network provider within:

- three weeks for medical conditions; and
- two weeks for behavioral health conditions.⁴³

In accordance with these requirements, when TDI reviews a network adequacy report, regulators ascertain the number of providers that are available in the designated service area, the number of complaints reported to TDI, and time frame for appointments.⁴⁴ If the regulator is satisfied with the reported information, the regulator will approve the report, but the regulator's determination is not based on hard numbers and they admit that the process is based on "touchy feely" numbers.⁴⁵

TDI testified that for the most part they accept the insurer's determination of adequacy. In order to manage resources, they only verify information from plans that they have reason to believe are problematic. The factor that triggers a review are the number of complaints TDI receives from plan participants. For instance, TDI testified that regulators accept the insurer's adequacy determination in the report approximately 80% of the time. They are not inclined to question the plan's determination unless they already know of a problem—which they learn of through complaints.⁴⁶ What's more, once a plan is approved by TDI, the department rarely conducts follow up reviews unless a complaint is filed.⁴⁷ TDI testified this process is a product of circumstance because they lack the resources and staff to verify the information in all of the reports. At the time of the hearing, the Managed Care Quality Assurance Office of TDI was staffed with only three people.⁴⁸ So TDI streamlines their resources to target plans they know have problems. TDI testified that there is a process in place to verify the information in reports, such as random sampling and verifying directory information, but would need more staff.⁴⁹ Until TDI can rectify this problem, the department must rely on complaints to trigger reviews. Unfortunately this means TDI must wait for a problem to happen instead of preventing the problem from occurring—a dilemma not lost upon the Committee.⁵⁰

C. Waiver & Local Market Access Plan

In the event that an insurer is unable to meet the network adequacy requirements, all is not lost. The statute provides the Commissioner of Insurance (Commissioner) the authority to provide waivers to some of the network adequacy requirements so long as the Commissioner posts on the Department's website the name of the preferred provider plan, the insurer offering the plan, and

6cb136e0be0a.PDF.

⁴³ 28 T.A.C. §3.3704(f)(9).

⁴⁴ June 1st Hearing at 48:30.

⁴⁵ June 1st Hearing at 48:30, 55:20.

⁴⁶ June 1st Hearing at 56:35.

⁴⁷ June 1st Hearing at 57:10.

⁴⁸ June 1st Hearing at 1:15:00.

⁴⁹ June 1st Hearing at 1:00:40.

⁵⁰ June 1st Hearing at 59:26.

the affected local market.⁵¹ Furthermore, TDI testimony stressed the point that a waiver and access plan do not waive the insurer's requirement to provide services nor does it mean the department ceases monitoring the plan. It simply notifies consumers and TDI that there is a gap in the network and explains how the plan is going to rectify that problem.⁵²

1. Waiver

According to TDI regulations, the Commissioner will grant a waiver to one or more of the network adequacy standards if the insurer demonstrates good cause. An insurer can demonstrate good cause to TDI if they can meet one of two criteria. They are:

- **Criteria One** - Show that the providers necessary for an adequate network are not available to contract. This waiver is disproportionately used for rural networks.
- **Criteria Two** - Show that providers were available but refused to contract to reasonable terms. This waiver is disproportionately used for urban networks.⁵³

If there are no providers available to contract for the necessary service, the insurer must simply state that in their waiver request.⁵⁴ However, if the insurer claims that providers refused to contract with them, the regulations are designed to compel the insurer to provide proof of that refusal and allow the providers an opportunity to respond. An insurer that claims providers refused to contract must provide the following:

- List of Providers
- Explanation for Why Provider Refused to Contract
- Costs for Using a Waiver
- Explanation of How the Network Will Improve⁵⁵

Once the waiver request is filed, the physicians listed in the request have 30 days from that date to respond to the information.⁵⁶ Furthermore, waivers expire in one year unless the insurer chooses to renew.⁵⁷ Also, all the plans that reported to the Committee as having waivers have renewed their waivers each of the three years that the reporting requirements were in effect.⁵⁸

2. Local Market Access Plan

At the same time an insurer files a waiver request, they must also file a "local market access plan."⁵⁹ A local market access plan must:

⁵¹ TEX. INS. CODE §1301.0055(3).

⁵² June 1st Hearing at 50:05.

⁵³ 28 T.A.C. §3.3707(a); *See also Response to Questions*, at 2.

⁵⁴ 28 T.A.C. §3.3707(b)(2).

⁵⁵ 28 T.A.C. §3.3707(b)(1).

⁵⁶ 28 T.A.C. §3.3707(e).

⁵⁷ 28 T.A.C. §3.3707(g).

⁵⁸ *Response to Questions*, at 2.

⁵⁹ 28 T.A.C. §3.3707(c). The plans are also required within 30 days after a network becomes inadequate. 28 T.A.C.

- specify the affected geographic area, including a map, for each service area that does not meet the network adequacy standards including a specification of the class of provider that is not sufficiently available.
- specify the reasons why the PPO does not meet the adequacy standards.
- state procedures that will ensure that consumers obtain medically necessary care including procedures to coordinate care to limit the likelihood of balance billing and how they will handle out-of-network billing.⁶⁰

Additionally, the insurer must establish procedures in areas that are under a local market access plan that identify requests for preauthorization of services for consumers that are likely to be rendered by an out-of-network provider.⁶¹ Regulations also require them to keep track of the out-of-network claims where a provider was not reasonably available.⁶² TDI reported that most local market access plans are similar because all of them tend to refer to the same types of specialists, such as hospital-based providers or specialists, that are not available in particular Texas counties or areas.⁶³

3. Rural and Urban Waiver Distinctions

TDI reported that due to shortages of particular provider types in Texas, it currently appears impossible for any insurer to have an adequate statewide network under TDI rules. For instance, TDI reported to the Committee that 25% of PPOs were operating under a waiver and access plan which totaled 34 waivers.⁶⁴ Furthermore, the insurer with the largest statewide network has waivers of various types in 155 counties.⁶⁵ This pattern can be attributed to the vast rural demographic of the state.

It is important to emphasize the distinct differences between the Criteria 1 and Criteria 2 waivers. As stated above, Criteria 1 waivers tend to be rural and according to TDI testimony correspond to the "lack of in-network providers scenario" for balance billing described in the Introduction section of this report.⁶⁶ For instance, 24 of the waivers granted by TDI were granted because no providers of a particular type were available to contract.⁶⁷ TDI reported to the Committee that numerous rural counties have few or no available specialists with whom to contract.⁶⁸ To illustrate this point, TDI explained that in some rural areas in Texas primary care providers regularly send their patients to Dallas or San Antonio for specialized care because specialists are

§3.3707(i); Insurers must also file a local market access plan when they submit their annual network adequacy report if their network is out of compliance. 28 T.A.C. §3.3707(m).

⁶⁰ 28 T.A.C. §3.3707(j).

⁶¹ 28 T.A.C. §3.3707(k)(1)(A).

⁶² 28 T.A.C. §3.3707(k)(2).

⁶³ *Response to Questions*, at 3.

⁶⁴ *Id.* at 1.

⁶⁵ *Id.* at 3.

⁶⁶ *Id.* at 2.

⁶⁷ *Id.* at 1.

⁶⁸ *Response to Questions*, at 2.

not available locally. This pattern of travel to obtain health care services occurs regardless of whether insurers file waivers and access plans.⁶⁹

On the other hand, waivers granted in urban areas follow a different pattern. For instance, the remaining 10 waivers from the 34 referenced above were granted because available providers refused to contract.⁷⁰ A trend cited by TDI in requests for Criteria 2—urban waivers—is the refusal of facility-based providers to contract.⁷¹ Insurers cite TDI's adoption of the "usual and customary" rule which provides an automatic payment for emergency situations—discussed at length in Section III of this report—as the cause.⁷² Facility-based providers are incentivized to stay out of network since they are guaranteed payment at the high usual and customary charge level which insurers recognize as the most rational economic choice.⁷³ Furthermore, this assertion is supported by TDI's conclusion that facility-based providers often refuse to contract with health plans.⁷⁴ What's more, of the providers that insurers reported to TDI as refusing to contract, in each instance, none of those providers replied to TDI regarding the failure to contract.⁷⁵

D. Penalties for Failure to Provide an Adequate Network

TDI regulations state that if the Commissioner determines—after notice and an opportunity for hearing—that the insurer's network and any local market access plan are inadequate⁷⁶, the Commissioner may order one or more of the following sanctions:

- reduction of service area
- cessation of marketing in parts of the state; and/or
- cessation of marketing entirely and withdrawal from the PPO market.
- any other appropriate corrective action, sanction, or penalty.⁷⁷

As of the date of the hearing, the Commissioner had not exercised his sanction authority.⁷⁸ Furthermore, plans that were reviewed and were subjected to further scrutiny by being asked to prove their network's adequacy, decided not to prove that. Instead the plans chose to voluntarily reduce their service areas.⁷⁹ Also, an inadequate network is one of the three circumstances that

⁶⁹ *Id.* at 3.

⁷⁰ *Id.* at 1.

⁷¹ *Id.* at 2.

⁷² June 1st Hearing at: 2:12:11.

⁷³ June 1st Hearing at 2:12:45.

⁷⁴ *Response to Questions*, at 2.

⁷⁵ *Id.* at 1.

⁷⁶ 28 T.A.C. §3.3710. A network is inadequate if the health plan is unable to ensure that preferred provider benefits are reasonably available to all consumers or are unable to ensure that all health care services and items covered pursuant to the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities. *Id.*

⁷⁷ 28 T.A.C. §3.3710.

⁷⁸ *Response to Questions*, at 5.

⁷⁹ *Id.* see also June 1st Hearing at 1:07:10.

entitles an out-of-network physician to an in-network reimbursement described in detail in Section III of this charge.

E. Narrow Networks

Network adequacy is cited as a major cause for balance billing because networks have become so narrow that it becomes more common for patients to go out-of-network for services which increases the probability of being balance billed. Furthermore, the Committee heard testimony from stakeholders that balance billing can occur even in so called adequate networks.⁸⁰ This assertion is supported by TDI testimony that reported that waiver requests for facility-based physicians are minimal because TDI generally requires insurers to have at least one hospital in each area that has contracted hospital based providers.⁸¹ As eluded to above, a general definition of narrow networks are networks that have a more limited number of providers in comparison to more robust adequate networks. However, as the Committee learned in testimony, there is not a clear definition for what constitutes a "narrow network" and what's more there is not a clear definition for "adequate network" either.⁸² Moreover, consumer groups noted that network size is used as a proxy for access, but may not always be a good one.⁸³ Nevertheless, it is clear in the media⁸⁴ and healthcare literature⁸⁵ that there is a broader health system trend towards narrow networks that some argue is problematic while others see as evidence of a paradigm shift brought about by the Patient Protection and Affordable Care Act (ACA).

1. Paradigm Shift

Some commentators explain that the increase in narrow networks is due to reforms enacted in the ACA which suggests a paradigm shift in the U.S. health insurance market caused by the ACA from which the Texas health insurance market is not exempt. Specifically at fault, are the ACA's removal of the common methods of constraining costs used by insurers such as underwriting to exclude consumers with pre-existing conditions, benefit exclusions, and annual or lifetime dollar limits on benefits. So with these cost cutting methods no longer at their disposal, insurers have turned to narrowing networks since it is one of the few cost cutting methods left.⁸⁶ This assertion is supported by TDI testimony that blamed the increase in narrow networks on market changes

⁸⁰ June 1st Hearing at 2:09:40.

⁸¹ *Response to Questions*, at 2.

⁸² June 1st Hearing at 2:41:00, 3:45:35.

⁸³ Centers for Public Policy Priorities, *Charge #2: Surprise medical billing and network adequacy*, at 13, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016060110001/b3a8ef14-5279-42c7-9191-b24f7fd2fcf1.PDF>. [hereinafter *CPPP Written Testimony*].

⁸⁴ O'Hare, San Antonio News Express, *Health plans' narrow networks a struggle for consumers*, Jan. 21, 2016; Harrington, Austin American Statesman, *Narrow marketplace plans in Texas are a problem for some autistic children*, Feb. 21, 2016; Schnurman, Dallas Morning News, *HCA, Blue Cross reach new deal*, Apr. 23, 2016.

⁸⁵ Corlette & Volk, *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, Georgetown University Center on Health Insurance Reforms; University of Pennsylvania Leonard Davis Institute of Health Economics, *State Variation in Narrow Networks on the ACA Marketplace*.

⁸⁶ Corlette & Volk, *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, Georgetown University Center on Health Insurance Reforms at 2.

and not by state regulation.⁸⁷ TDI stressed to the Committee, that even narrow networks must still meet the network adequacy requirements.⁸⁸

2. Consumers Prefer Lower Premiums but Do They Know the Tradeoffs?

According to consumer groups and insurers, consumers are willing to trade broader networks for a lower premium.⁸⁹ Recent reports by the Kaiser Foundation⁹⁰ and Georgetown University Center on Health Insurance Reforms⁹¹ support this assertion. However, insurers also testified to the Committee that the debate over narrow networks has intensified because there are more consumers purchasing HMO products in the individual market because they are cheaper.⁹² HMOs are cheaper for several reasons but one of the major cost savers is that they do not have out-of-network benefits. However this also means the consumer trades the breadth of choices that PPOs offer and is stuck with in-network providers. Furthermore, in order to avoid higher costs, brand name institutions such as academic teaching hospitals and children's hospitals are left out of these narrow networks which consumers do not realize until they need them.⁹³ This begs the question, do the consumers know what they are trading when they choose a lower premium.⁹⁴ This is discussed in Section II on Transparency.

II. Transparency

In 2007, the Texas Legislature passed SB 1731 by Senator Duncan which expanded agency oversight and directed state agencies to collect and publish information in a manner useful for Texas consumers. Moreover, the bill established transparency requirements for insurers, facilities, and physicians, and requires disclosures to warn consumers of the possibility of being balance billed. Furthermore, an integral piece to transparency is the education of the consumer. In order to realize the benefits of transparency, the consumer must understand the information provided to them.

The following addresses these issues respectively.

A. Agency Information Resources

The Department of State Health Services and the Texas Medical Board must maintain a website with a consumer guide intended to educate Texas consumers on the complex topic of medical billing.⁹⁵ The requirement for the guide touches on several components of medical billing that

⁸⁷ June 1st Hearing at 46:15.

⁸⁸ June 1st Hearing at 1:01:40.

⁸⁹ *CPPP Written Testimony*, at 13; Texas Association of Health Plans Written Testimony, at 16, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016060110001/a28707e1-c557-4da9-baf6-253cc5c41163.PDF>; June 1st Hearing at 2:34:55. [hereinafter *TAHP Written Testimony*].

⁹⁰ Kaiser Family Foundation, Kaiser Health Tracking Poll: June 2015, available at: <http://kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-june-2015/>.

⁹¹ Corlette & Volk at 2.

⁹² June 1st Hearing at 2:34:14.

⁹³ June 1st Hearing at 2:38:37, 3:37:03.

⁹⁴ June 1st Hearing at 2:32:48.

⁹⁵ HEALTH & SAFETY CODE §324.051(c). TDI maintains www.TexasHealthOptions.com in order to educate

are continuously a source of great confusion among consumers. TDI must also collect reimbursement rate information and organize it in a manner that allows Texas consumers to make comparisons.⁹⁶ Furthermore, Texas law requires insurers to file PPO reports that contain financial statements and enrollment data, which are made publicly available.⁹⁷

B. Insurer Transparency

The Insurance Code contains an overarching requirement that PPO policies and related documents are written in plain language⁹⁸, and in a format that is both readable and understandable.⁹⁹ Furthermore, Texas statute provides that the insurer must inform the consumer what their personal responsibility will be for copayments, deductibles¹⁰⁰, and coinsurance¹⁰¹ amounts.¹⁰² Also, the insurer must explain whether a proposed healthcare service is covered by the plan.¹⁰³ If the consumer requests, the insurer must inform them whether a physician is in-network.¹⁰⁴

1. Provider Directories

Insurers must provide a directory of in-network providers to each consumer at least annually¹⁰⁵ and the insurer must notify consumers how to access the directory on a cost-free basis.¹⁰⁶ The insurer must also make the provider directory available on the insurer's website, update it at least monthly, and provide a method for individuals to report any inaccuracy in the provider information listed.¹⁰⁷ To encourage and enforce timely updates to an insurer's directory, TDI

consumers about health insurance. This website illustrates how different types of health plans function, explains how to compare health plans, and describes the rights and protections that exist for Texas insurance consumers.

⁹⁶ TEX. INS. CODE §38.356–357.

⁹⁷ TEX. INS. CODE §1301.009(d). Larger PPOs must include information to enable the consumers to compare plans (range of benefits provided, premium and plan costs, copayments and deductibles, coverage areas, number of in-network providers) and companies (customer satisfaction, quality of care, in-network provider credentials, accuracy and speed of claims). TEX. INS. CODE §1301.009(b)(3).

⁹⁸ In order to meet the plain language requirement a health plan form must achieve a minimum score of 40 on the Flesch reading ease text, provide the text in a font no smaller than 10 point, give no undue prominence to any portion of the plan text, provide a table of contents, write the text in a clear and coherent manner with words of common and everyday meaning, and provide policy on 8 1/2 by 11 inch paper. TEX. INS. CODE §1301.157(1-2).

⁹⁹ TEX. INS. CODE §1301.157(1-2).

¹⁰⁰ **Deductible** The amount you must pay out-of-pocket for covered services before your plan begins to pay its portion of your medical expenses. You usually must meet a deductible each year. For example, if your deductible is \$1,000, your plan won't pay anything until you've paid \$1,000 out-of-pocket for covered health care services subject to the deductible. If you have a family plan that covers your spouse or dependents, you may have one deductible for the entire family, or you may have to meet a separate deductible for each family member. *Glossary of Terms*, at 1.

¹⁰¹ **Coinsurance** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. In most plans, after meeting your deductible you must pay coinsurance until you reach your out-of-pocket limit. For example, if your plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20 percent would be \$20. The health plan pays the rest of the allowed amount. Coinsurance usually does not apply to HMOs. *Glossary of Terms*, at 1.

¹⁰² TEX. INS. CODE §1301.158(d)(3-4), §1456.007, §1661.002(b).

¹⁰³ TEX. INS. CODE §1301.158(d)(2).

¹⁰⁴ TEX. INS. CODE §1301.158(d)(1).

¹⁰⁵ TEX. INS. CODE §1301.159.

¹⁰⁶ 28 T.A.C. §3.3705(h).

¹⁰⁷ TEX. INS. CODE §1451.505.

regulations provide that if a consumer reasonably relied on a directory that was not up to date, the insurer must pay the physician the usual and customary billed charge for that service.¹⁰⁸ By statute, directories must include the contract information of each in-network provider and indicate whether they are accepting new patients.¹⁰⁹ Moreover, TDI regulations require directories to contain certain disclosures that help the consumer identify facility-based physicians that are out-of-network to protect them from balance billing.¹¹⁰

2. Plan Disclosure Informing Consumers of Out-of-Network Services & Network Adequacy

Texas statute requires insurers to inform consumers of their obligations if they use out-of-network services. Upon request, an insurer must inform the consumer of the amount of cost-sharing they will owe for a given service based on the insurer's reimbursement rates for out-of-network services.¹¹¹

i. Out-of-Network Services Disclosure

More broadly, TDI regulations require insurers issuing a PPO to disclose how the insurer reimburses for out-of-network services.¹¹² These disclosures must explain how those reimbursements will be determined and provide consumers a method to obtain a real time estimate of the amount the insurer will pay for these services. If they use usual and customary charges, the insurer must disclose the source of the data, how the data is used in making that determination.¹¹³ If the insurer uses anything other than the full billed charge, they must disclose to the consumer that may be balanced billed and describe the reimbursement methodology the insurer uses to determine payment.¹¹⁴

Moreover, insurers must disclose to the consumer—in writing—that facility-based physicians may be out-of-network and therefore may balance bill.¹¹⁵ Furthermore, the insurer must clearly identify within provider directories any in-network healthcare facilities that have no in-network facility-based physicians.¹¹⁶ Upon request, a PPO must disclose to the consumer within 10 business days an estimate of what payments will be made and shall also specify any deductibles, copayments, coinsurance, or other amounts that the consumer is responsible for and must advise the consumer that they may be personally liable for payment of services.¹¹⁷ In the event the consumer is not satisfied with the payment to the facility-based physician for out-of-network

¹⁰⁸ 28 T.A.C. §3.3705(k). The consumer must demonstrate they reasonably relied upon a directory information that stated the provider was an in-network; was obtained from the insurer or a third party designated by the insurer; was obtained not more than 30 days prior to the date of service; and that indicated that the provider is an in-network provider within the insurer's network. *Id.*

¹⁰⁹ TEX. INS. CODE §1451.504.

¹¹⁰ 28 T.A.C. §3.3705(l).

¹¹¹ TEX. INS. CODE §1301.158(d)(3-4).

¹¹² 28 T.A.C. §3.3705(o).

¹¹³ 28 T.A.C. §3.3705(o)(2).

¹¹⁴ 28 T.A.C. §3.3705(o)(3).

¹¹⁵ TEX. INS. CODE §1456.003(a-b).

¹¹⁶ TEX. INS. CODE §1456.003(c).

¹¹⁷ TEX. INS. CODE §1456.007.

services, the insurer must provide the phone number for TDI's consumer protection division.¹¹⁸ The Commissioner may take disciplinary action against a licensee who violates these provisions.¹¹⁹

ii. Network Adequacy Disclosure

Furthermore, TDI regulations require insurers to make certain disclosures informing consumers of network adequacy. For example, regulations require insurers to send annual notices to consumers whose network is operating under a waiver and must provide the consumer information on how to obtain the local market access plan.¹²⁰ Moreover, if a consumer's in-network hospital suffers a substantial decrease in the availability of in-network facility-based providers¹²¹, the insurer must notify the consumer of the substantial decrease.¹²² Furthermore, they must update their in-network directory within 2 days of the termination of the contract.¹²³ However, the notice is not required if the insurer is able to contract with an alternative physician group at the same percentage level.¹²⁴

Moreover, according to Texas regulations, insurers must designate whether their plans have an Approved Hospital Care Network (AHCN) or a Limited Hospital Care Network (LHCN). If a plan meets the network adequacy requirements for hospitals without reliance on an access plan, then it should be designated as an AHCN.¹²⁵ If the plan does not meet the requirements, then the plan must disclose that the plan has a LHCN.¹²⁶ Furthermore, if a plan that is designated as an AHCN falls out of compliance, they have 30 days to correct the inadequacy.¹²⁷ If they do not correct, they must report the status to TDI, cease marketing the plan as AHCN, and inform consumers at the time of renewal.¹²⁸ At the time of the hearing, TDI reported to the Committee that health plans are not designating their plans as Limited Hospital Care Networks.¹²⁹

C. Facility Transparency

1. Billing Policies & Itemized Statements

Healthcare facilities must develop written billing policies that elucidate the organization's billing process and direct consumers on how to dispute their bills. Facility billing policies must:

¹¹⁸ TEX. INS. CODE §1456.003(d).

¹¹⁹ TEX. INS. CODE §1456.005(a).

¹²⁰ 28 T.A.C. §3.3705(m).

¹²¹ A decrease is substantial if the contract between the insurer and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates; or the contract between the facility and any facility-based physician group that comprises 75 percent or more of the preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) (relating to Contracting Requirements). 28 T.A.C. §3.3705(n).

¹²² 28 T.A.C. §3.3705(n).

¹²³ 28 T.A.C. §3.3705(n)(5).

¹²⁴ 28 T.A.C. §3.3705(n)(2)(A).

¹²⁵ 28 T.A.C. §3.3705(p).

¹²⁶ *Id.*

¹²⁷ 28 T.A.C. §3.3705(q).

¹²⁸ 28 T.A.C. §3.3705(q)(1-3).

¹²⁹ *Response to Questions*, at 5.

- stipulate any discounts for the financially or medically indigent,
- state whether interest will be charged,
- describe complaint procedures, and
- address the consumer's right to request an itemized statement.¹³⁰

Furthermore, facilities must post in their waiting areas a notice of the availability of the written billing policy.¹³¹

Upon request, facilities are required to provide an estimate of the facility's charges for an elective inpatient or outpatient treatment before scheduling the procedure and within 10 business days of the estimate request.¹³² Additionally, facilities are required to advise the consumer that the estimate may cause a scheduling delay, and that the actual charges will vary based on the patient's medical condition, and therefore may not match what the consumer pays. Furthermore, facilities must advise the consumer that they may be balanced billed based on their plan and should contact their plan for accurate information.¹³³ Moreover, for services that have already been charged, the consumer has within a year from the date of the discharge to request an itemized statement from the facility.¹³⁴ The itemized statement must be provided within 10 days of the request.¹³⁵ If a consumer overpays a facility, the provider must return the overpayment within 30 days.¹³⁶

2. Out-of-Network Warning

Furthermore, healthcare facilities have billing requirements in addition to the ones described above. Healthcare facilities must provide, upon admittance of a patient, a conspicuous written disclosure that confirms whether the facility is in-network and disclose that one of the treating physicians may be out-of-network.¹³⁷ However—for emergencies—disclosures may be postponed until after treatment and given before discharge.¹³⁸ If a third party payor requests an itemized statement within 1 year of a procedure, the facility has 30 days to provide the itemized statement.¹³⁹ Violations of the billing requirements can lead to adverse action against the facility's license.¹⁴⁰ Moreover, a facility must implement a complaint procedure that makes a good faith effort to resolve disputes in an informal manner.¹⁴¹ Texas statute prohibits these provisions from being waived or nullified by contract.¹⁴²

¹³⁰ TEX. HEALTH & SAFETY CODE §324.101(a)(6)(B).

¹³¹ TEX. HEALTH & SAFETY CODE §324.101(c).

¹³² TEX. HEALTH & SAFETY CODE §324.101(d).

¹³³ TEX. HEALTH & SAFETY CODE §324.101(d)(1-5).

¹³⁴ TEX. HEALTH & SAFETY CODE §324.101(e).

¹³⁵ TEX. HEALTH & SAFETY CODE §324.101(e).

¹³⁶ TEX. HEALTH & SAFETY CODE §324.101(i).

¹³⁷ TEX. HEALTH & SAFETY CODE §324.101(a).

¹³⁸ TEX. HEALTH & SAFETY CODE §324.101(b).

¹³⁹ TEX. HEALTH & SAFETY CODE §324.101(f).

¹⁴⁰ TEX. HEALTH & SAFETY CODE §324.101(g).

¹⁴¹ TEX. HEALTH & SAFETY CODE §324.102.

¹⁴² TEX. HEALTH & SAFETY CODE §324.103.

D. Physician Transparency

1. Billing Policies & Itemized Statements

Physicians must make many of the same and similar disclosures to consumers as facilities. Physicians must also:

- develop written billing policies that stipulate any discounts for the uninsured or the indigent,
- provide itemized statements,
- state in their policies whether interest will be charged, and
- describe in their policies complaint procedures.¹⁴³

Physicians who have a waiting area must post a notice in the waiting area of policy requirements described in the written billing policy.¹⁴⁴

If requested, physicians must provide an estimate for patients seeking services that are provided on an out-of-network basis or who does not have coverage for that service within 10 business days of a request.¹⁴⁵ However, if the charges were for emergency services, the physician may either provide the estimate either within the 10 days of a request or before discharging the patient—whichever is later.¹⁴⁶ Additionally, facilities and physicians are required to advise the consumer that the estimate may cause a scheduling delay.¹⁴⁷ Furthermore, providers are required to inform the patient that the actual charges will vary based on the patient's medical condition and therefore may not match what the consumer pays.¹⁴⁸ Also, providers must notify patients that they may be personally liable for charges based on their plan.¹⁴⁹ Moreover, for services that have already been charged, the consumer has within a year of when the physician provided the service to request an itemized statement.¹⁵⁰ The itemized statement must be provided within 10 business days of the request.¹⁵¹ If a consumer overpays a physician, the provider must return the overpayment within 30 days.¹⁵² An additional requirement for physicians is that on the request of a patient, a physician shall provide—in plain language—a written explanation of the charges for services or supplies previously made on a bill or statement for the patient.¹⁵³

¹⁴³ TEX. OCC. CODE §101.352(a).

¹⁴⁴ TEX. OCC. CODE §101.352(b).

¹⁴⁵ TEX. OCC. CODE §101.352(c).

¹⁴⁶ TEX. OCC. CODE §101.352(d).

¹⁴⁷ TEX. OCC. CODE §101.352(c)(1).

¹⁴⁸ TEX. OCC. CODE §101.352(c)(2).

¹⁴⁹ TEX. OCC. CODE §101.352(c).

¹⁵⁰ TEX. OCC. CODE §101.352(e).

¹⁵¹ TEX. OCC. CODE §101.352(e).

¹⁵² TEX. OCC. CODE §101.352(h).

¹⁵³ TEX. OCC. CODE §101.352(g).

2. Facility-Based Physician Disclosures

Facility-based physicians that bill a patient on an out-of-network basis must also give the patient an itemized statement that contains "conspicuous" language that informs the patient that the physician is out-of-network and the insurer paid a rate below the physician's bill charge.¹⁵⁴ The statement must also provide a number which the patient can call to discuss that statement and work out any payment issues.¹⁵⁵ Additionally, the billing statement must include a statement that the patient may call to discuss alternative payment arrangements.¹⁵⁶ For billing statements that total an amount greater than \$200 the billing statement is required to inform the consumer—in plain language—that if they finalize a payment plan agreement within 45 days of receiving the first billing statement and substantially complies with it then the physician may not furnish adverse information to a consumer reporting agency.¹⁵⁷ The statement must also provide notice that the patient may file a complaint with the Texas Medical Board.¹⁵⁸

E. Educating the Consumer

Despite all of these disclosure requirements, the Committee heard testimony that an education gap persists. TMA provided excerpts from a Rice University study that found 25% of Texans surveyed did not understand basic insurance terms.¹⁵⁹ What's more, 35% did not understand maximum out-of-pocket expenses, 45% did not understand coinsurance, and 30% did not know what provider networks or covered services are. This sentiment was not lost upon the Committee and on repeated occasions throughout the hearing Committee members expressed concerns that not enough was being done to adequately educate consumers on the insurance product they were purchasing. On two separate occasions members asked who is educating consumers about the terms of their plans?¹⁶⁰ Specifically, members expressed concerns that consumers were not aware of the tradeoffs from switching to a cheaper plan which would entail purchasing a narrower network with a more limited number of providers.¹⁶¹

III. Payment Standards for Out-of-Network Care

Texas statute provides two situations when an insurer is required to pay an out-of-network physician at the *same percentage level of reimbursement as an in-network provider*, which corresponds to coverage levels. One, an insurer must reimburse at the *same percentage level of reimbursement as an in-network provider* when services are not available through an in-network physician within a designated service area—Lack of In-Network Provider Scenario.¹⁶² Two, insurers must pay an out-of-network physician at the *same percentage level of reimbursement as*

¹⁵⁴ TEX. INS. CODE §1456.004(a)(1-2).

¹⁵⁵ TEX. INS. CODE §1456.004(a)(3-4)

¹⁵⁶ TEX. INS. CODE §1456.004(a)(4).

¹⁵⁷ TEX. INS. CODE §1456.004(a)(6).

¹⁵⁸ TEX. INS. CODE §1456.004(a)(5)

¹⁵⁹ *TMA Written Testimony*, at 2.

¹⁶⁰ June 1st Hearing at 2:32:10 & 2:39:30.

¹⁶¹ June 1st Hearing at 2:33:48.

¹⁶² TEX. INS. CODE §1301.005(b).

an in-network provider for circumstances where a consumer cannot reasonably reach an in-network physician in an emergency—Emergency Scenario.¹⁶³ TDI supplements these statutory requirements in Title 28, §3.3708 of the Texas Administrative Code.

TDI cited these statute sections when they adopted the usual and customary payment rule.¹⁶⁴ The Committee learned from testimony that TDI's adoption of the usual or customary rule was controversial for several reasons. One, insurers argue that TDI overstepped their authority when drafting the rule because the sections they cite do not give them that authority so therefore the Legislature did not direct the department to adopt a usual or customary charge payment standard.¹⁶⁵ Furthermore, the Committee and insurers complain that TDI failed to adequately define usual and customary thus leaving it too vague which leads to a lack of uniformity in application of the rule.¹⁶⁶ What's more, insurers argue that the rule incentivizes facility-based physicians to stay out-of-network since they are guaranteed payment even if they stay out.¹⁶⁷ As far as TDI overstepping its authority, that is a controversy for the courts and outside the scope of this charge. So the Committee focuses on the problems that arise from lack of a concise definition for usual or customary.

A. Mandatory Payment for Out-of-Network Care

In that section, TDI requires insurers to pay an out-of-network physician—at a minimum—at the *usual or customary charge* for a service (less any coinsurance, copayment, or deductible) if one of three circumstances occur.¹⁶⁸ (emphasis added) Those circumstances are when:

- emergency care is required;
- no in-network provider is reasonably available within the designated service area for which the policy is issued (e.g., if there is an inadequate network); and
- an out-of-network provider's services were pre-approved or preauthorized based upon the unavailability of an in-network provider.¹⁶⁹

The regulations also include additional consumer protections to reduce the financial hardships consumers may experience from paying out-of-network costs for services received under these three circumstances. The insurer must also pay the claim at the in-network benefit coinsurance level and credit any out-of-pocket amounts paid to the out-of-network provider above the allowed amount toward the consumer's deductible and annual out-of-pocket maximum; so that the consumer reaches his or her in-network deductible and out-of-pocket maximum quicker.¹⁷⁰

¹⁶³ TEX. INS. CODE §1301.155(b).

¹⁶⁴ TDI, Proposed and Adopted Rules for 2012, available at: <http://www.tdi.texas.gov/rules/2012/index.html>.

¹⁶⁵ June 1st Hearing at 2:11:46.

¹⁶⁶ June 1st Hearing at 28:30.

¹⁶⁷ *TAHP Written Testimony*, at 3.

¹⁶⁸ 28 T.A.C. §3.3708(b)(1).

¹⁶⁹ 28 T.A.C. §3.3708(a).

¹⁷⁰ 28 T.A.C. §3.3708(b) (2-3).

B. Usual or Customary Bill Charge—TDI Vagueness

TDI rules state that the reimbursements are required to be calculated based upon an *appropriate methodology* that is updated no less than once per year, does not use data that is more than three years old, and is consistent with nationally recognized and generally accepted bundling edits and logic.¹⁷¹ The rules provide further requirements based on whether the "appropriate methodology" requirement is based on usual or customary charges, or claims data. They are the following:

- **Usual or Customary** - If the methodology is based on usual, reasonable, or customary charges, it must be based on *generally accepted industry standards and practices* for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs.¹⁷²
- **Claims Data** - If the payment is based upon claims data, it must be based on sufficient data to constitute a representative and statistically valid sample.¹⁷³

Application of the "generally accepted industry standards and practices" requirement is vague and leaves the details to insurers to interpret. TDI testified that leaving the definition vague was intentional.¹⁷⁴ TDI characterized the vagueness of the definition as "guardrails."¹⁷⁵ In effect, this definition places broad limits on what insurers can use to meet the statutory *same percentage level of reimbursement as an in-network provider* requirement to *generally accepted industry standards and practices*. The "specific" methodology used to meet the *generally accepted industry standards requirement*, however, is left to the insurer to decide.

1. TDI Usual and Customary Survey September 2016

At the time of the hearing, TDI testified that the department was surveying insurers to ascertain how insurers are determining usual and customary.¹⁷⁶ TDI surveyed insurers with historical annual health premiums of more than \$1 million and received submissions from 25 insurers making up about 90 percent of the total comprehensive health market.¹⁷⁷ In September of 2016, the department released the results of that survey and found that common reimbursement methodologies that insurers use are based off of:

- FAIR Health¹⁷⁸,

¹⁷¹ 28 T.A.C. §3.3708(c)(3-5).

¹⁷² 28 T.A.C. §3.3708(c)(1).

¹⁷³ 28 T.A.C. §3.3708(c)(2).

¹⁷⁴ June 1st Hearing at 29:10.

¹⁷⁵ June 1st Hearing at 28:42.

¹⁷⁶ June 1st Hearing at 14:57.

¹⁷⁷ TDI, *Usual and Customary Survey (Revised January 2017)* at 5, available at:

<http://www.tdi.texas.gov/reports/life/documents/ucreport.pdf> [hereinafter *Usual and Customary Survey*].

¹⁷⁸ **FAIR Health, Inc.** is a non-profit entity formed to create a conflict-free, trusted, and transparent source of data to support the adjudication of healthcare claims and to promote sound decision-making by all participants in the healthcare industry. FAIR Health reimbursement rates are developed from a comprehensive database comprising data from more than 60 contributors, covering over 150 million individuals; and non-discounted fees-for-service as reported on claims submitted by providers to insurers and administrators. *Id.* at 29.

- Medicare reimbursement schedules, or
- their own internal data.¹⁷⁹

TDI reported that the vast majority of insurers use a third-party data source, that is regularly updated, to determine usual and customary. Furthermore, of those insurers that use third-party data most do not use Medicare reimbursement schedules to determine the charge.¹⁸⁰ To be exact, TDI survey results show that 17 of the insurers surveyed reimbursed out-of-network physicians for emergency department visits in and around the FAIR Health average while 7 insurers were closer to the Medicare average.¹⁸¹ 1 insurer's reimbursement average reimbursement rate fell in between the FAIR Health and Medicare averages. Insurers that use Medicare reimbursement schedules pay far less—one could say dramatically less—than those who use another methodology. To illustrate the range of differences between the two averages on the low end the difference is a \$28.23 difference while on the high end it is \$1,274.14 difference.¹⁸²

To further illustrate the degree of difference, TDI aggregated data by region and compared the reimbursement amounts of those who use primarily Medicare reimbursement schedules to those who primarily use FAIR Health. TDI found insurers that use Medicare in:

- **El Paso** - reimburse 13.2% of what insurers that use FAIR Health reimburse.
- **Houston** - reimburse 19.4% of what insurers that use FAIR Health reimburse.
- **Austin** - reimburse 22.5% of what insurers that use FAIR Health reimburse.
- **Brownsville** - reimburse 15.0% of what insurers that use FAIR Health reimburse.
- **Dallas / Ft. Worth** - reimburse 19.5% of what insurers that use FAIR Health reimburse.¹⁸³

This degree of difference was also reflected in the number of complaints the insurers surveyed reported to TDI. The survey found that 12 insurers reported complaints, 7 reported no complaints, and 6 did not have complaint data.¹⁸⁴ Insurers that reimbursed close to the Medicare average reported having a dramatically higher number of complaints compared to those who reimbursed close to FAIR health.¹⁸⁵ Also—an important note—TDI found that most insurers reported holding consumers harmless in balance billing situations although they are not required by law.¹⁸⁶

¹⁷⁹ June 1st Hearing at 29:19; *Usual and Customary Survey*, at 10-11.

¹⁸⁰ *Usual and Customary Survey*, at 6.

¹⁸¹ *Id.* at 16-21.

¹⁸² *Id.*

¹⁸³ *Id.* at 8.

¹⁸⁴ *Id.* at 22.

¹⁸⁵ *Id.*

¹⁸⁶ *Id.* at 6.

2. Reasons for Vagueness—No Authority and Not Enough Resources

One reason given to the Committee for the vagueness is TDI believes they would exceed their authority if the department were to specifically define usual or customary.¹⁸⁷ Another reason given is that the department does not have the resources to determine usual or customary by geographical region. TDI representatives stated that to take on that task would be a "heavy lift" because it would require the creation of an all-payer database.¹⁸⁸ All-payer databases are pretty complex which would overwhelm current TDI resources so additional funds would be needed to accomplish the task.¹⁸⁹

C. ER Physician Group Exodus

Insurers reported to the Committee that after six months of the usual and customary rule going into effect, 12 large ER provider groups left Blue Cross Blue Shield citing the exodus as a business decision.¹⁹⁰ TMA counters this assertion that physicians left only because of the new payment standard by explaining that they personally like the protection of being in-network and it is part of their Hippocratic oath to obtain a fair negotiated rate.¹⁹¹ Furthermore, TMA cites the physician survey explained above which found that 30% attempted to join networks and of that 30% only 33% received a contract. TMA also reported great disparity between what reimbursement amounts among insurers.¹⁹² Also, as an added incentive to join provider networks, Texas statute provides that only in-network providers enjoy the prompt payment protections studied by the Committee in Charge #3.

IV Out-of-Network Claims Disputes—Mediation

In Texas, a consumer may request mediation if the consumer receives bill for treatment that is over \$500 (after copayments, deductibles, and coinsurance)¹⁹³ and the medical treatment was provided by a physician that is based in an in-network facility that is either a:

- radiologist,
- anesthesiologist,
- pathologist,
- emergency department physician,
- neonatologist, or
- assistant surgeon. (collectively facility-based physician).¹⁹⁴

¹⁸⁷ June 1st Hearing at 30:10.

¹⁸⁸ June 1st Hearing at 30:35.

¹⁸⁹ June 1st Hearing at 30:40.

¹⁹⁰ June 1st Hearing at 2:12:11, *TAHP Written Testimony*, at 3.

¹⁹¹ June 1st Hearing at 2:58:11.

¹⁹² June 1st Hearing at 3:03:00-3:08:00.

¹⁹³ TEX. INS. CODE §1467.051(a).

¹⁹⁴ TEX. INS. CODE §1467.051(a) (cross referencing TEX. INS. CODE, §1467.001(4) defining 'facility-based physician').

However, if the facility-based physician gives a balance bill disclosure to the patient before treatment and obtains the patient's written acknowledgment of that disclosure, and the amount billed is less than or equal to the amount projected in the disclosure, then that physician is exempt from mandatory mediation unless the treatment was for emergency services.¹⁹⁵

A. Emergency Scenario Divergence

Here, it is important to recognize the divergence in the mediation process between the three balance billing scenarios explained in the Introduction section of this report. Under the "lack of in-network provider scenario" and "surprise billing scenario" it is possible to avoid mediation because the provider will have time and an opportunity to present a disclosure to the consumer before services are rendered. Whereas under the "emergency scenario," the statute does not provide an exemption from mediation for obtaining written acknowledgement of the disclosure because simply stated; there is not time. It is also important to recognize the inherent difference that the "emergency scenario" entails. Consumer groups summarized it well by stating, "[i]n an emergency, patients can't pick their doctors or control which facility the ambulance goes to. They need to get to the closest emergency room."¹⁹⁶ Furthermore, this divergence is reflected in mediation request numbers reported to the Committee by TDI which shows that anesthesiologists and emergency room physicians are the most frequent specialties associated with mediations.¹⁹⁷

Provider Type	CY 2013	CY 2014	CY 2015
Out-of-Network Anesthesiologist	122	792	922
Out-of-Network ER Physician	17	106	199
Out-of-Network Neonatologist	3	2	3
Out-of-Network Pathologist	11	25	79
Out-of-Network Radiologist	1	9	1

B. Mediation Process

1. Request for Mediation

Insurers must notify consumers of the opportunity for mediation when the insurer issues an explanation of benefits.¹⁹⁸ Providers must notify consumers of the opportunity for mediation when they send a balance bill.¹⁹⁹ The consumer must make a mediation request, but once they make the request they are no longer required to participate in the process.²⁰⁰ TDI must then notify the facility-based physician and the insurer of the request.²⁰¹

¹⁹⁵ TEX. INS. CODE §1467.051(d).

¹⁹⁶ *CPPP written testimony*, at 5.

¹⁹⁷ *Response to Questions*, at 5.

¹⁹⁸ 28 T.A.C. §3.3708(e).

¹⁹⁹ 22 T.A.C. §187.89(b).

²⁰⁰ TEX. INS. CODE §1467.054.

²⁰¹ TEX. INS. CODE §1467.054(c).

2. Informal Settlement

Before an official mediation commences, the three parties must attempt to settle the claim in an informal settlement teleconference within 30 days of the request.²⁰² If the parties fail to reach an agreement in the informal settlement, the case proceeds to mediation and the facility-based physician or their representative and the insurer must attend.²⁰³

3. Mediation

The mediation must take place in the county in which the services were rendered and the consumer has the choice to attend.²⁰⁴ A mediator is either randomly appointed by the Chief Administrative Law Judge of the State Office of Administrative Hearings (SOAH) from a list of mediators maintained by SOAH or chosen by both parties with notice to the Chief ALJ of SOAH.²⁰⁵ The mediator must be trained unless the parties agree otherwise and must not have had a business relationship with either the physician or insurance company in the past 3 years preceding the mediation.²⁰⁶ Furthermore, the physician and insurer split the mediator fees.²⁰⁷

The mediation must take place within 180 days after request—except at the request of the consumer.²⁰⁸ If either the insurer or physician fails to attend the mediation, provide necessary information, or send a representative, then the offending party may be subject to bad faith mediation penalties.²⁰⁹ All information and communications made during the mediation must be held in strict confidence by the mediator.²¹⁰ In the mediation, the parties must determine the amount the consumer owes. In determining that amount, the parties must evaluate whether the amount charged by the provider was excessive and whether the amount paid by the insurer represents the usual and customary rate for the service.²¹¹ If an agreement is reached, the mediator must prepare a confidential mediation agreement that states the amount the consumer is responsible for to the provider.²¹²

4. Special Judge

However, if no agreement is reached, the mediator must report the outcome to TDI, TMB, and the Chief ALJ of SOAH.²¹³ Once the Chief ALJ receives the report, he or she must enter an

²⁰² TEX. INS. CODE §1467.054(d).

²⁰³ TEX. INS. CODE §1467.051(b).

²⁰⁴ TEX. INS. CODE §1467.054(e-f).

²⁰⁵ TEX. INS. CODE §1467.053.

²⁰⁶ TEX. INS. CODE §1467.052(b-c).

²⁰⁷ TEX. INS. CODE, §1467.053(d).

²⁰⁸ TEX. INS. CODE, §1467.055(g).

²⁰⁹ TEX. INS. CODE §1467.101-102.

²¹⁰ TEX. INS. CODE §1467.055(c).

²¹¹ TEX. INS. CODE §1467.056(a).

²¹² TEX. INS. CODE §1467.059.

²¹³ TEX. INS. CODE §§1467.057(a), 1467.060.

order of referral to a special judge under Chapter 151 of the Civil Practice and Remedies Code.²¹⁴ The case must then proceed to a non-jury trial to finally have the dispute resolved.²¹⁵

B. Mediation is Working

TMA, TAHP, and the consumer groups each reported to the Committee that they agree that mediation is working.²¹⁶ What's more, all three agree that mediation should be expanded to some degree.²¹⁷ All agree that mediation should be expanded beyond facility-based physicians.²¹⁸ However, they differ in some respect on how far and to what degree mediation should be expanded. CPPP and the Texas Association of Business recommend bringing down the \$500 threshold to \$0.²¹⁹ Also, CPPP and TAHP recommend that enrollees should not be responsible for initiating mediation²²⁰, while TMA believes that that should remain a necessary requirement.²²¹

²¹⁴ TEX. INS. CODE §1467.057(b).

²¹⁵ TEX. INS. CODE §1467.057(b-c).

²¹⁶ *CPPP Written Testimony*, at 6; *TAHP Written Testimony*, at 3; *TMA Written Testimony*, at 6.

²¹⁷ *CPPP Written Testimony*, at 7-8; *TAHP Written Testimony*, at 3; *TMA Written Testimony*, at 6.

²¹⁸ *CPPP Written Testimony*, at 7; *TAHP Written Testimony*, at 12; *TMA Written Testimony*, at 6.

²¹⁹ June 1st Hearing at 3:12:00; *CPPP Written Testimony*, at 7.

²²⁰ June 1st Hearing at 2:13:15 & *CPPP Written Testimony*, at 8.

²²¹ *TMA Written Testimony*, at 7.

CHARGE #3 PROMPT PAY PENALTIES

Evaluate the statutory penalty calculations under Texas's prompt payment laws regarding health care claims. Include an analysis of whether the proper benchmarks are used to establish penalties commensurate with an improper payment and the effect of the abolition of the Texas Health Insurance Risk Pool on the use of funds collected under the statute.

Introduction

According to insurers Texas has one of the toughest prompt pay penalties in the country.¹ They recognize that in general, implementation of the prompt pay penalty statutes has been good public policy. The focus of their efforts has been on adopting a penalty system that is less onerous and in line with national trends. In particular they focus on the large penalties paid to hospitals that have garnered the attention of plaintiff attorneys. According to the Texas Association of Health Plans, most other states impose simple annual interest penalties in the range of 10 to 18 percent.² What's more, the penalty is out of line in comparison to other lines of insurance in Texas, including homeowner and auto coverage which is also based on an 18% annual interest rate.³ Penalties paid in Texas to hospitals exceeded \$80 million in 2013, which does not include amounts paid to physicians and pharmacies.

On the other hand, supporters of the current penalty structure say "if it ain't broke, don't fix it."⁴ They argue that prompt pay is working because since enactment of the penalties late payments have dropped. They warn that reform could lead to a repeat when insurers habitually paid claims late, leaving providers and patients with a financial burden.⁵ They stress that the prompt pay penalties are a "behavior modification device" which needs to be adequately punitive in order to be effective.⁶ Moreover, hospital representatives point out that that if health plans pay providers timely they are not subject to or impacted financially by the current prompt pay law.⁷ Since its passage, payors have implemented more streamlined and timely payment procedures. In 2012-2014, payors paid only 0.35% of claims late.

Tying the prompt pay penalties to the Texas Health Insurance Risk Pool was implemented to respond to the growing practice of suing health plans that violated the prompt pay statute. To

¹ March 30th Hearing on Charge #3 at: 1:57:00, available at: http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11837. [hereinafter March 30th Hearing].

² March 30th Hearing at: 3:05:00.

³ Texas Association of Health Plans, *Texas Prompt Pay Act: The Problem With Hospital Billed Charges Power Point*, at 13, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/c74f975a-a49c-4399-ab21-590ff58f7a4f.PDF>. [hereinafter *TAHP PowerPoint*].

⁴ Texas Association of Health Plans, *Texas Prompt Pay Act: The Problem With Billed Charges & The Need For Simplification*, at 1, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/894b9851-cf7c-466d-bc08-d6a5380183e0.PDF>. (TAHP written testimony submitted to the Committee for the March 30th Hearing).

⁵ March 30th Hearing at: 2:37:30.

⁶ March 30th Hearing at: 2:46:20; 2:50:00.

⁷ March 30th Hearing at: 3:29:00; Texas Hospital Association, *Texas Prompt Pay Act*, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/894b9851-cf7c-466d-bc08-d6a5380183e0.PDF>. [hereinafter *THA Written Testimony*].

disincentive this practice, the Legislature required that half of the penalties owed to hospitals and other medical facilities go to the Texas Health Insurance Risk Pool which was used to provide insurance for high risk consumers. The Legislature dissolved the Pool after the Affordable Care Act was enacted because the ACA prohibits health plans from denying coverage due to pre-existing conditions the very population the Pool was created to serve. However, the Legislature failed to appropriate the funds so currently, the funds are stuck in general revenue.

I. Overview of the Prompt Pay Statute

Texas's prompt pay statute is driven by the "contracted rate," which is an agreed upon payment for a service. The contracted rate is essentially an agreed upon discount off of the bill charge which is determined solely by the provider and discussed in detail below. The Committee was provided a helpful example of the "contracted rate" process. The hospital representative provided the following:

- Providers first determine the costs of supplies and services on a granular basis.
- Once they determine the costs, they then markup that number to take in account government payor reimbursements which then determines the "bill charge."
- Providers then use that "bill charge" as the base for contract rate negotiations with insurers (This is essentially negotiating for a discount percentage off of the bill charge).
- Once the insurer and provider agree upon a discount, that is the "contracted rate."⁸

The difference between the "bill charge" and "contracted rate" is the basis for the prompt pay penalties. Bill charges are set by providers, and insurers explained to the Committee that they do not have the ability to negotiate them down.⁹ The following is a summary of Texas's prompt pay penalty structure.

A. Prompt Pay Penalties

According to statute, insurers must pay or deny a clean claim¹⁰ within 30 days if the claim is submitted electronically (45 days if non-electronic).¹¹ According to statute and regulations a clean claim is defined as claim submitted using the Centers for Medicare and Medicaid (CMS) Form 1500 or one adopted by the Commissioner of Insurance by rule.¹² After receipt of a clean claim, a health plan must:

- pay the total amount of the clean claim as specified in the contract between the in-network provider and the health plan (notice that prompt pay is limited to contracts with in-network providers);
- deny the clean claim in its entirety and notify the in-network provider in writing why the clean claim will not be paid;

⁸ March 30th Hearing at: 2:51:00.

⁹ March 30th Hearing at: 2:53:50.

¹⁰ Defined in TEX. INS. CODE §§843.336, 1301.131.

¹¹ TEX. INS. CODE §§843.338, 1301.103.

¹² TEX. INS. CODE §§843.336, 1301.131.

- notify the in-network provider in writing that the entire clean claim will be audited¹³ and pay 100 percent of the contracted rate on the claim to the preferred provider; or
- pay the portion of the clean claim the health plan acknowledges liability and deny the remainder or notify the in-network provider in writing that the remainder of the clean claim will be audited and pay 100% of the contracted rate.¹⁴

If a health plan determines that a submitted claim is deficient, the health plan must notify the in-network provider submitting the claim that the claim is deficient within 45 calendar days of the health plan's receipt of the non-electronic claim, or within 30 days of receipt of an electronic claim.¹⁵

1. Late Payment Penalty

If the health plan fails to pay a clean claim within 30 days of receiving it then the plan owes a penalty determined by staggered dates. Penalty amounts are based on the differences between billed charges and contract rates and are staggered accordingly:

- Late but within 45 days after the due date, the penalty is 50% of the difference between the contracted rate and the providers billed charges, capped at \$100,000.
- 46 to 90 days after the due date, the penalty is 100% of the difference between the contracted rate and billed charges, capped at \$200,000.
- More than 90 days late, the penalty is 100% of the difference between the contracted rate and billed charge, capped at \$200,000, plus an additional 18% interest on that penalty amount.¹⁶

If the penalty is owed to a hospital or other medical facility then the health plan must pay 50% of the penalty to the hospital or facility and 50% to the Texas Health Insurance Risk Pool (Pool).¹⁷ Now that the Pool has been dissolved the 50% share goes to TDI.¹⁸ Physicians were left out of the penalty split. If the late payment penalty is owed to a physician, then the plan must pay 100% of the penalty to the physician.¹⁹

2. Underpayment Penalty

If the insurer only pays a portion of the amount owed on a clean claim, the insurer must pay a penalty in addition to the contracted amount owed determined accordingly:

¹³ If the health plan chooses to audit the claim, the plan must notify the provider within the 30 days for electronic or 45 days for non-electronic deadlines and must follow steps prescribed in 28 TAC §2809. TEX. INS. CODE §§843.340, 1301.105. The plan must complete the audit within 180 days but in the meantime pay 100% of the contracted rate. TEX. INS. CODE §§843.340(d), 1301.1051. If the plan determines that a refund is in order they cannot collect the refund until the audit is complete. TEX. INS. CODE §§843.340(e), 1301.1051.

¹⁴ 28 TAC §21.2807.

¹⁵ 28 TAC §21.2808.

¹⁶ TEX. INS. CODE §§ 843.342, 1301.137.

¹⁷ TEX. INS. CODE §§843.342(m), 1301.137(l).

¹⁸ 28 TAC §21.2815.

¹⁹ TEX. INS. CODE §§843.342(m), 1301.137(l).

- Late but within 45 days after the due date, the penalty is 50% of the underpaid amount, capped at \$100,000.
- 46 to 90 days after the due date, the penalty is 100% of the underpaid amount, capped at \$200,000.
- More than 90 days after the due date, the penalty is 100% of the underpaid amount, capped at \$200,000 plus 18% annual interest on that amount.²⁰

The "underpaid amount" is defined in statute as the ratio of the amount underpaid on the contracted rate as applied to an amount equal to the billed charges as submitted on the claim minus the contracted rate.²¹

3. Administrative Penalty

Furthermore, a health plan that fails to comply with clean claim requirements for more than 2% of clean claims submitted to the insurer is subject to an administrative penalty.²² The administrative penalty may not exceed \$1000 for each day the penalty is assessed, and the commissioner must consider paid claims and must compute a compliance percentage.²³

B. TDI Review Process

TDI reported the following review process to the Committee.

- TDI reviews the submitted claims data for clarity and consistency. For example, if a company reports no clean claims for a quarter, staff follows up with the carrier for an explanation. Many times this results in corrected information.
- TDI staff also reviews the reported information to determine if the carriers' data shows compliance with 98 percent of clean claims paid within the required statutory timeframes. For carriers that do not meet this requirement, staff asks the carrier for an explanation.
- Other TDI programs compare this data with other financial and operational information filed by the carrier with TDI.²⁴

Furthermore, TDI conducts comprehensive financial examinations, market conduct examinations, quality of care examinations, and limited scope examinations in their review of clean claims.²⁵

²⁰ TEX. INS. CODE §§843.342(d-f), 1301.137 (d-f).

²¹ TEX. INS. CODE §§843.342(g), 1301.137(g).

²² 28 TAC §21.2822.

²³ TEX. INS. CODE §§843.342(k), 1301.137(k).

²⁴ TDI, *Prompt Pay*, at 2, available at:

<http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/715806c6-2d36-4f82-8264-62bb45fdc7c0.PDF>. [hereinafter *TDI Written Testimony*].

²⁵ *Id.*

II. Prompt Pay History and Growth of a Cottage Industry

Prior to enactment of the prompt pay law, insurers were accused of dragging out payments to exhaust providers to prevent them from rightfully collecting payments owed to them. The Legislature responded to this problem by enacting stringent penalties for not timely paying providers. However, the evolution of the prompt pay penalty system has also led to lucrative opportunities for litigation that has fed the growth of a cottage industry. However, recent legislative trends are aimed at mitigating this practice.

A. Bill Charges Set as Basis of Prompt Pay Penalty

The prompt pay provisions' origins can be found in HB 610 of the 76th Regular Session and SB 418 of the 78th Regular Session. HB 610 introduced a deadline tied to penalties for payments that were paid late by insurers. Proponents of the bill argued that the new provisions were necessary because insurers were habitually paying claims late, leaving a financial burden on providers and patients, leading to providers cancelling contracts.²⁶ They claimed there were millions of dollars of claims sitting on the books and that some health plans waited as long as 180 days or more to pay claims which was slower than Medicare.²⁷

1. HB 610 of the 76th Regular Session

HB 610 provided that if the provider did not pay a clean claim before 60 days, they were assessed a penalty equal to 100% of the contract discount with no cap, which as stated above is the difference between the bill charge and contracted rate. The idea behind basing prompt pay penalties on bill charges is that an insurer should lose the discount if they fail to honor the agreement by not paying on time.²⁸ The bill also added an administrative penalty of \$1000 per day for non-compliance. While most carriers and HMO's achieve an accuracy rate of over 99% and pay penalties on less than one percent of their claims, the financial impact from large claims is significant. After HB 610 was passed, providers claimed that health plans were finding a way around the statute and holding up payments by claiming providers were not filing the claims properly.²⁹ So SB 418 was filed to more precisely define a "clean claim." SB 418 also introduced the gradual penalty structure in question for this charge.

2. Overview of Bill Charges

Many health policy commentators agree bill charges are always inflated.³⁰ It must be stated that for the most part—and commentators agree—that no one pays the full bill charge. However, because bill charges are the basis of the prompt pay penalty calculations, which makes this is one

²⁶ HB 610 HRO Report.

²⁷ HB 610 HRO Report pages 2-3.

²⁸ March 30th Hearing at: 3:38:30.

²⁹ SB 418 HRO Report.

³⁰ See Reinhardt, *The Pricing of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy*; Reinhardt, *Extreme Markup: The Fifty US Hospitals With The Highest Charge-to-Cost Ratios*; Tompkins, et. al. *The Precarious Pricing System For Hospital Services*; Brown, *Irrational Hospital Pricing*.

of the few circumstances in which the full bill charge is paid. As stated above, the contract rate is essentially the agreed upon discount from the bill charge for a particular service.

In the hospital context, this penalty can be extreme. For instance, insurers reported to the Committee that bill charge inflation is particularly large and subject to extreme variation among hospitals.³¹ In Texas, bill charges are unregulated which means providers are free to come up with any methodology to determine the value of their services. Like any other negotiation, providers start high and negotiate towards the middle. However, in this case, their high number—bill charge—also serves as the penalty marker for prompt pay violations. Insurers argue that this creates an inequitable penalty system that rewards the highest-cost providers, incentivizes hospitals to inflate billed charges, and creates substantial costs and litigation for insurers.³² This has led to a cottage industry for plaintiff attorneys since the penalties can get so high.

Hospital representatives explain that inflation of bill charges is necessary to cover costs associated with their indigent care mandates and cuts to public programs such as Medicare and Medicaid. This is called cost-shifting which is when health care providers, particularly hospitals, make up for losses they incur in treating uninsured patients by charging higher prices to and collecting higher payments from privately insured patients.³³ The following is a list of Federal and State programs that require indigent care and are leading causes of financial shortfalls that hospitals claim make cost-shifting necessary.

- **EMTALA** - requires hospitals that participate in Medicare and have an emergency department to ignore insurability and screen every patient that comes to the emergency department and stabilize them before transferring them to another hospital.³⁴
- **Texas Non-Profit Organization** - Non-profit hospitals in the state of Texas are required to provide community benefits, which include charity care and government sponsored indigent care in an amount that satisfies statutory requirements.³⁵
- **Federal 501(c)(3) Tax Exemption** - The tax exemption is for institutions that are organized exclusively for exempt purposes listed in the statute which for hospitals include charity care and education.³⁶
- **Texas Sec. 11.18 Charitable Organizations Tax Exemption** - Requires the hospital to be organized as a non-profit³⁷ and provide charity care³⁸ and community benefits.³⁹

³¹ *TAHP PowerPoint*, at 10.

³² *TAHP PowerPoint*, at 8.

³³ Kaiser Family Foundation, *Uncompensated Care for the Uninsured in 2013: A Detailed Examination*, <http://kff.org/report-section/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination-cost-shifting-and-remaining-uncompensated-care-costs-8596/>.

³⁴ 42 U.S.C. §1395dd.

³⁵ TEX. HEALTH & SAFETY CODE §311.043.

³⁶ 26 U.S.C. 501(c)(3).

³⁷ TEX.TAX CODE §11.18 (e).

³⁸ This is distinct from the providing care without regard to beneficiaries' ability to pay.

³⁹ TEX. TAX CODE §11.18(d).

This list is by no means exhaustive, but helps illustrate the breadth of programs under Federal and State law that require hospitals, specifically non-profit hospitals, to give uncompensated care. For-profit hospitals must meet the Medicare and Medicaid requirements but are not required to follow tax-exempt and non-profit requirements.

B. Legislative Attempts to Impede the Growth of the Cottage Industry

One of the first attempts to slow the growth of the cottage industry was in an amendment by Senator Averitt in HB 2064 of the 81st Legislature. The amendment added the requirement that health plans who violated the prompt pay statute pay 50% of the penalties to the Texas Health Insurance Risk Pool (Pool) if the provider who was paid late was a hospital or other medical facility. Penalties owed to physicians were not included in the split.⁴⁰ The policy behind this provision was to disincentive the growing litigation niche of suing health plans for the incredibly high penalty amounts that were obtainable with large hospitals. The Pool remained the insurer of last resort for the uninsurable until March 31, 2014.⁴¹

1. HB 1433 of the 84th Regular Legislative Session

The latest attempt at reform, HB 1433, was filed which in its original form would have lowered the \$100,000 cap to \$5,000 and the \$200,000 cap to \$10,000. This new penalty structure would have applied to all providers. Also the bill would have added a two-year statute of limitations. However, after the hearing on the bill, Rep. Smithee offered a committee substitute that addressed issues that were raised in the hearing. First, the committee substitute increased the statute of limitations from two years to three years. Second, the committee substitute limited reforms to late payment penalties to institutional providers defined as hospitals or other medical or health-related service facility.⁴² The substitute removed physicians from the bill so that penalties owed to them would remain under the existing penalty structure.

The new penalty structure for institutional claims would have required the penalty to be calculated one of two different ways and required the higher penalty to be paid.

- The penalty owed for institutional claims paid up to 45 days late is the greater of 18% per annum interest on the contracted rate owed or the lesser of 50% of the difference between the contracted rate and billed charge or \$5,000.
- The penalty owed for claims paid 46 to 90 days late is the greater of 18% per annum interest or the lesser of 100% of the difference between the contracted rate and billed charges or \$10,000.
- An additional 18% interest on the penalty amount is also owed for claims paid 91 days or later.

The new penalty structure would have continued the billed charges penalty structure for lower cost claims up to the caps of \$5,000 or \$10,000 and ensure a reasonable penalty of 18% per annum interest for higher dollar claims. This change focused reforms on the source of the

⁴⁰ TEX. INS. CODE §§843.342(m), 1301.137(l).

⁴¹ Texas Health Insurance Pool, *Attention Insurers & HMOs*, available at: <http://www.txhealthpool.org/>.

⁴² TEX. INS. CODE §§ 843.342(n), 1301.001(4)

controversy since it is only these large institutions who had the structure in place to aggregate enough penalty amounts to reach multi-million dollar levels.

2. Data Mining—Technology Accelerates Growth of Penalties

Despite the split penalty, plaintiff attorneys are still able to get considerably large penalties. By employing data mining software that finds late payments and aggregates them into very large sums, plaintiff attorneys have raised the penalty amounts to a considerable degree.⁴³ Typically the individual sums are small but when all the late penalties are combined into one the penalties can reach into the millions. Hospitals and some large physician groups are the only ones who can aggregate enough penalties to be worth a civil case.

C. Other Purposes Besides Litigation

However data mining also serves a useful purpose besides supporting litigation. Hospital representatives say that data mining is used to examine payor behavior which is important for rate negotiations. Hospitals use the frequency of on time payments and disputes as information to reward the most reliable payors and to take more caution with the less reliable.⁴⁴ Hospital representatives informed staff that contracts are currently in place that were signed with the presumption that the current prompt pay system would remain in place. These contracts with private insurance are long term, somewhere between 5-6 years. They stress that the volatility of changes in the public payor system has raised the importance of private payors. Private payor contracts have been the only reliable source of payments in their payor mix, so they are defensive over changes.

Hospitals also stressed to the Committee that due to sporadic payment behavior of public payors and cuts to those programs, hospitals have come to rely more on the steady funding stream that private insurers provide.⁴⁵ They warn that the system works and should not be reformed because it may jeopardize this reliability. However, if reform must happen, they testified that the penalty must be punitive enough to compel timely payment and at the same time offers enough incentives to entice plaintiff attorneys to take the case. They specifically request that some sort of multiplier be added because the 18% annual interest rate may not be enough.⁴⁶

To illustrate what happens when the penalty is not strong enough, hospital representatives pointed to the different experiences their organizations have had in obtaining late penalties and underpayment penalties. Although they admit much progress has been made on timely payments, they cite a growing trend by insurers to underpay.⁴⁷ They testified that they believe insurers have shifted their strategy to underpaying. According to their testimony, underpayment penalties—described in Section 1, Subsection A.2. of this report—are so low that pursuing them, and therefore deterring underpayment, would provide no economic advantage.⁴⁸ Hospitals also

⁴³ March 30th Hearing at: 4:29:30.

⁴⁴ March 30th Hearing at: 3:15:00.

⁴⁵ March 30th Hearing at: 3:26:30-3:27:30.

⁴⁶ March 30th Hearing at: 4:33:30.

⁴⁷ March 30th Hearing at: 2:43:30.

⁴⁸ March 30th Hearing at: 2:45:10.

recommend that attorney fees should be included in any penalty structure because without them no attorney would take their case.⁴⁹

Rural hospitals testified that this problem is especially burdensome for them. Specifically, rural hospitals face greater obstacles to their funding streams than their urban counterparts because they get crushed in price negotiations with insurers due to small market leverage.⁵⁰ Furthermore, the cuts to government programs have been devastating to them citing cuts in the range of up to \$100 million a year.⁵¹ So they rely more on the steady private insurer cash flow. What's more, rural representatives testified that they appreciate that a cottage industry for prompt pay penalties has arisen since without plaintiff attorneys they would not be able to collect the penalties that are owed to their hospitals.⁵²

III. Costs to Individuals and Businesses

An important point to always keep in mind, is that the costs of healthcare are not just bourn on the insurer but are also bourn on individuals and employers. The Texas Association of Business (TAB) characterized prompt pay penalties as a hidden tax since the penalties go to general revenue.⁵³ What's more, TAB claimed that employers and individuals are being charged an additional \$1500 a year on average because of uncompensated care which is on top of the large prompt pay penalties.⁵⁴ This is because of the cost shifting theory expounded by hospitals that says that when government payors fail to pay the full cost of uncompensated care, hospitals are forced to shift the cost to private insurers. These costs are passed down to the employer and ultimately the individual as payers of insurance.⁵⁵ Fortunately for large employers—like Exxon, AT&T, and Home Depot—prompt pay penalties do not apply to the health plans that they offer to their employees because of a recent ruling by the United States Fifth Circuit Court of Appeals (5th Circuit).

A. ERISA Background

One of the major benefits of choosing to sponsor a self-funded plan is that the plan enjoys ERISA preemption. ERISA stands for the Employee Retirement Income Security Act and is a federal act that applies to all employee benefit plans which the courts have interpreted to include health insurance self-funded plans. ERISA self-funded plans are regulated by the Department of Labor and are subject primarily to federal laws and regulations. This means that they typically escape state regulation such as the prompt pay act. However, there are still open questions as to when ERISA preemption applies to third-party administrators.

⁴⁹ March 30th Hearing at: 3:04:00.

⁵⁰ March 30th Hearing at: 2:41:30.

⁵¹ March 30th Hearing at: 3:27:30.

⁵² March 30th Hearing at: 3:33:00.

⁵³ March 30th Hearing at: 3:52:10.

⁵⁴ March 30th Hearing at: 3:53:00.

⁵⁵ March 30th Hearing at: 3:54:25.

B. Administrators of Self-funded Plans

Prior to 2016, there was an open question as to whether Texas's prompt pay penalty laws applied to administrator of ERISA self-funded plans (self-funded plans). These plans are sponsored by employers who have chosen to self-insure their employees' health insurance rather than purchasing an insurance product from an insurer. By consequence, they also assume the financial risk for their employees' healthcare costs. Typically, very large employers offer to their employees healthcare coverage through self-funded plans. However, most employers do not actually administer the health plans themselves. They contract out this responsibility to companies who have expertise in administering health insurance plans. Major insurers, such as Blue Cross Blue Shield and United Healthcare, have an administration division that offer administration services such as forming networks of providers and handling claims processing. However, there is common confusion in the public about these arrangements because although their companies' names are on the health insurance cards etc, the insurance company is not actually providing an insurance plan. They are simply administering it.

C. *Aetna v. Methodist Hospitals of Dallas* 5th Circuit Ruling

In February 2016, the 5th Circuit in *Aetna v. Methodist Hospitals of Dallas* was asked to rule on whether the Texas prompt payment penalties are preempted by ERISA. However, the 5th Circuit did not reach the ERISA preemption question because the court ruled that neither the express applicability provision of Chapter 1301 nor its extension to administrators applies to administrators of self-funded plans.⁵⁶ In coming to the conclusion, the 5th Circuit relied on their previous ruling—from a week earlier—in *Health Care Service Corp. v. Methodist Hospitals of Dallas*. In that case the court held that Chapter 1301 is inapplicable to administrators after analyzing both the "express" and "extension to administrators" applicability provisions of Chapter 1301 of the Insurance Code.⁵⁷ Those sections state:

Express Applicability - [Chapter 1301] applies to each preferred provider benefit plan in which an *insurer provides*, through the insurer's *health insurance policy*, for the *payment* of a level of coverage that is different depending on whether an insured uses a preferred provider or a nonpreferred provider.⁵⁸

Extension to Administrators Applicability - [Chapter 1301 also] applies to a person. with whom an *insurer* contracts to (1) *process or pay claims*; (2) obtain the services of physicians and health care providers to provide health care services to insureds; or (3) issue verifications or preauthorizations.⁵⁹

First, the court focused their analysis on the "provides. .for. .payment" "through the insurer's health insurance policy" language. The court stated that Methodist read that provision too broadly. They explained that since the "extension to administrators" section uses the words "process or pay claims" rather than "provides. .for. .payment," the code makes a distinction

⁵⁶ *Aetna v. Methodist Hospitals of Dallas*, No. 15-10210, at 7 (5th Cir. 2016).

⁵⁷ *Health Care Service Corp. v. Methodist Hospitals of Dallas*, No. 15-10154, at 7 (5th Cir. 2016).

⁵⁸ TEX. INS. CODE §1301.0041(a).

⁵⁹ TEX. INS. CODE §1301.109.

between the two actions.⁶⁰ This suggests that the "provides. .for. .payment" language does not encompass payments by others that are merely distributed by an administrator.⁶¹ Furthermore, the court found that the administrator did not make payments through its "health insurance policy" because the statutory definition of "health insurance policy"⁶² requires the policy to provide benefits for medical or surgical expenses.⁶³ The administrator does not do this but merely distributes claim payments from plans to providers.⁶⁴ Therefore, the court held that the administrator is not subject to the "express" applicability provision.

The 5th Circuit also held that the "extension to administrators" provision does not apply either. The court analyzed the statutory definition of "insurer," but, here instead of focusing on the administrator, the court focused on the "self-funded plan" who hires them. Remember, self-funded plans are sponsored by employers for the benefit of their employees. The 5th Circuit found that "self-funded plans. .are not insurers [as defined in] the insurance code because they do not operate under any of [the definition's] enumerated provisions."⁶⁵ Moreover, the court noted that case law precedent in conjunction with statute holds that in Texas self-funded plans are not authorized to issue, deliver, or issue for delivery health insurance policies.⁶⁶ Therefore, the court held that self-funded plans are not "insurers" who contract with administrators under that provision.

D. Amending the Prompt Pay Statute

At the moment, due to the 5th Circuit ruling, the Texas prompt pay penalty costs are limited to individual and small group market plans over which TDI has jurisdiction. However, hospital representatives reported to the Committee that a "fix" to the current law is needed because of the ruling since there are a growing number of self-funded health plans.⁶⁷ Furthermore, hospital representatives testified that the cottage industry window is closed due to the ruling but it left room for doubt which the Legislature could clarify.⁶⁸ As explained above, the doubt stems from the fact that the 5th Circuit did not actually reach the preemption question because, according to the court's interpretation, Chapter 1301 does not apply to self-funded plans. The supposed "fix" would be to amend that statute to include self-funded plans in the "express" and "extension to administrators" applicability sections. This would enable providers to ultimately send the ERISA preemption question back to the 5th Circuit to finally be answered. If successful, the cottage industry would be revitalized because plaintiff attorneys would have a new lucrative source of penalties to pursue. To illustrate how lucrative the source would be, in the *Aetna v. Methodist Hospitals of Dallas* the hospitals pursued penalties of more than \$73 million. However, instead of collecting the penalties from insurance companies, hospitals would obtain them from

⁶⁰ *Health Care Service Corp. v. Methodist Hospitals of Dallas*, at 7.

⁶¹ *Id.* at 10.

⁶² TEX. INS. CODE §1301.001(2).

⁶³ *Health Care Service Corp. v. Methodist Hospitals of Dallas*, at 11.

⁶⁴ *Id.*

⁶⁵ *Id.* at 13.

⁶⁶ *Id.* at n.36.

⁶⁷ *THA Written Testimony*, at 1.

⁶⁸ March 30th Hearing at: 4:17:20, 4:25:40.

employer funds. Therefore, any action to apply prompt pay penalties to self-funded plans should be pursued with extreme hesitance.

IV Texas Health Insurance Risk Pool

The Texas Health Insurance Risk Pool (Pool) was originally created in 1989 in the 71st Legislature but failed to get funding so it remained obsolete until 1997.⁶⁹ In 1997 the Legislature funded the Pool in HB 710 and gave it the authority to write individual and group insurance policies in Texas. The Pool was created as an insurer of last resort for people who were unable to obtain health insurance due to preexisting conditions.⁷⁰ In HB 710, the Legislature gave the Pool's board the authority to make advance interim assessments to fund it. As stated above, was not until 2009 in the 81st Legislature that the prompt pay penalties were tied to the Pool's funding.

After the Affordable Care Act (ACA) was passed, the Legislature dissolved the Pool in SB 1367 of the 83rd Legislature because the purpose of the Pool was negated since the ACA prohibits insurers from denying coverage due to preexisting conditions.⁷¹ SB 1367 transferred all authority and funds that belonged to the Pool to TDI to satisfy any remaining obligations. Any remaining funds and subsequent new funds were directed by SB 1367 to be used for new initiatives to improve access to health benefit coverage.⁷² However, the Legislature failed to actually appropriate the funds to TDI so the funds are currently in limbo but continue to accumulate in general revenue.⁷³ The Comptroller's office reported to the Committee that as of March 23, 2016 there was \$47,083,053 leftover from the Pool's dissolutions. Furthermore, there is \$86,833,9120 in penalties that were collected after dissolution of the Pool.⁷⁴ The followings is a chart provided by the Comptroller for the Committee:

	FY 14	FY 15	FY 16	Total
Leftover Pool Money	\$47,083,053.00			\$47,083,053.00
Penalties Collected After Dissolution	\$17,395,542.00	\$49,720,484.16	\$19,717,883.84	\$86,833,910.00

With the recent election of Donald Trump, the President-elect and the Republican Congress have called for a repeal of the ACA. Although President-elect Trump stated that he may keep parts of the ACA intact, there is a possibility that future reforms will lead to the High Risk Pool being needed again. Therefore, any plans relating to what to do with the funds should take into account they may be needed to accommodate new programs or initiatives from future reforms by the new administration.

⁶⁹ HB 710 (75R) HRO Report, at 1.

⁷⁰ SB 1367 (83R) HRO Report, at 1.

⁷¹ 42 U.S.C. §300gg-4(a).

⁷² TDI Written Testimony, at 2.

⁷³ *Id.*

⁷⁴ Texas Comptroller, *Prompt Pay Penalties Collected by the Texas Department of Insurance*, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/67392de9-6a10-4410-a8ce-01036c169d45.PDF>. (written testimony submitted to the Committee for March 30th hearing).

CHARGE #4: CREDIT FOR REINSURANCE

Study the Texas credit for reinsurance statutes and how they affect market capacity, the cost of regulatory compliance, and the prospect of federal preemption of the state's ability to regulate reinsurance. Examine how alternative credit for reinsurance statutes in other jurisdictions function, including in the regulatory and legal systems of those jurisdictions.

Introduction

Although reinsurance is the focus of this charge, ultimately the Committee is reviewing solvency standards for domestic ceding insurers (the rest of the report "ceding insurers" will be referred to as simply "insurers") for the protection of Texas consumers. A critical component to the solvency and performance of Texas insurers is their ability to collect reinsurance claims. It must be stressed that reinsurance transactions—in large part—are unregulated. This being that these transactions are more often than not conducted by sophisticated parties who have counsel that can protect their interests. Reinsurance is a:

form of insurance that insurance companies buy for their own protection, "sharing of insurance." An insurer reduces its possible maximum loss on either an individual risk or a large number of risks by giving (ceding) a portion of its liability to another insurance company (the reinsurer).¹

According to Commissioner David Mattax of the Texas Department of Insurance (Commissioner):

The regulation that does exist largely focuses on whether an insurer that buys reinsurance is allowed to count that reinsurance in the company's financial statements. If done in compliance with the law, insurance companies may reduce the amount of reserves they hold to pay insured losses on account of reinsurance. In other words, they get to take financial statement "credit", which is why we call these laws "credit for reinsurance" legislation.²

While reinsurance allows Texas domestic insurance companies the flexibility to manage their risk, these sophisticated transactions can have deleterious outcomes for downstream insurance consumers. Reinsurance transactions also introduce a counterparty credit risk to Texas domestic insurance companies. Ultimately, this counterparty credit risk could impact the solvency of the Texas insurer and prevent the insurer from paying claims to Texas residents and businesses. According to TDI, the goal of the Financial Regulation Division "is to protect consumers by detecting financial and other concerns promptly and taking action to mitigate problems caused

¹ Barron's Business Guides, *Dictionary of Insurance Terms*, 4th Edition, at 424.

² October 12th Hearing on Charge #4 at 8:03, available at: http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=12338 [hereinafter October 12th Hearing].

by troubled insurers.³ TDI has the ability to detect potential financial concerns within Texas domiciled insurers because state law requires Texas insurers to submit their audited annual financial statements and to comply with ongoing solvency regulations.⁴

The Committee has identified three major areas of focus for this charge and has divided the report accordingly. First, the report focuses on the solvency reforms introduced by the NAIC Credit for Reinsurance Model Law (Model Law) by providing a summary of current Texas law and the Model Law for comparison and provide an explanation of protections against counterparty credit risk. Second, since the committee was assigned the charge the NAIC has adopted the Model Law as an accreditation standard. This means that the scope of the charge has broadened to effect Texas domestic insurers who do business across state lines. So a summary of the NAIC accreditation process is provided with and explanation of its importance for insurance companies domiciled in Texas. Lastly, the report gives an overview of federal preemption and likelihood of it being invoked if the Model Law is not adopted.

I. Credit for Reinsurance Model Law (2016)

The NAIC Credit for Reinsurance Model Law can be viewed as a substantial piece of a continuum of national solvency reforms instigated by the financial collapse of 2008. At the helm of these reforms is the National Association of Insurance Commissioners (NAIC) which is an organization created and governed by the chief insurance regulators from the 50 states and certain U.S. jurisdictions.⁵ The mission of the organization is to support state regulators in the efficient facilitation of a fair competitive insurance market. In support of its mission and response to the financial crisis, the NAIC embarked on a critical self-examination of the United States' insurance solvency regulation framework called the Solvency Modernization Initiative (SMI).⁶ As part of this initiative, the NAIC reviews international developments regarding insurance supervision to determine their potential use in U.S. insurance regulation.⁷ In their examination the NAIC has identified five key components of the solvency framework and they are:

- Capital Requirements,
- Governance and Risk Management,
- Group Supervision,
- Statutory Accounting and Financial Reporting, and
- Reinsurance.⁸

³ TDI, *Texas Department of Insurance 2015 Annual Report*, at 13.

⁴ TEX. INS. CODE §§401.004, 421.001.

⁵ NAIC, ABOUT THE NAIC, available at: http://www.naic.org/index_about.htm.

⁶ NAIC, Solvency Modernization Initiative (SMI), available at: http://www.naic.org/index_smi.htm.

⁷ *Id.*

⁸ NAIC, *NAIC White Paper: THE U.S. NATIONAL STATE-BASED SYSTEM OF INSURANCE FINANCIAL REGULATION and the SOLVENCY MODERNIZATION INITIATIVE* (August 14, 2013), at 1.

The SMI led to the NAIC amending established model laws and adopting new ones which were then suggested to the states for adoption. For example, Texas amended its Insurance Holding Company Act multiple times to conform with the amended NAIC model act⁹, adopted the Own Risk Solvency Assessment Model Act¹⁰, and adopted principle based reserving for life insurance as well.¹¹ Each of these acts stem from one or combination of these areas of focus.

The Model Law is the central reform for the reinsurance key component; according to the NAIC—as of April 2016—32 jurisdictions have adopted the Model Law which represents 66% of total premiums.¹² In its current form, Texas law is substantially different from the Model Law, specifically in respect on how the state gives credit for risk ceded to foreign reinsurers. The following section outlines the Texas requirements for credit for risk ceded to foreign insurers which includes a summary of the form of trust mandated in Texas law. Then, the section provides an overview of the Model Law and describes the differences between the Texas and NAIC laws.

A. Texas Law

In Texas, an insurer is allowed credit for reinsurance only if the reinsurer meets one of four conditions. One, the insurer may get credit if the reinsurer is licensed by the state of Texas.¹³ Two, they may get credit if the reinsurer is accredited by Texas.¹⁴ Three, , they are allowed credit if they maintain a trust fund in a qualified United States financial institution of which the reinsurer is a fiduciary.¹⁵ Four, they are allowed credit in the amount of funds held by or on behalf of the insurer.¹⁶ Conditions three and four are the focus of this charge.

Foreign reinsurers are unable to meet the accreditation requirements because §§492.103 & 493.103 of the Insurance Code require the reinsurer to be either domiciled or licensed by a state of the United States.¹⁷ So, in order for Texas to grant credit for reinsurance to an insurer that uses a foreign reinsurer, the reinsurer typically forms a trust that meets the requirements laid out in Subchapter D of §§492 & 493 of the Insurance Code (Subchapter D). Subchapter D lists the composition, form, terms, reports, and contract requirements that the trust must take. They are the following:

⁹ SB 1431 Bill Analysis (82nd Regular Session) & HB 3460 Bill Analysis (83rd Legislature).

¹⁰ SB 655 Bill Analysis (84th Regular Session).

¹¹ SB 1654 Bill Analysis (84th Regular Session).

¹² TDI, *Map of Credit for Reinsurance States*, available at:

<http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016101210001/0a588d73-d80b-4fb7-a6b0-9c78ccc391d0.PDF> (written testimony submitted to the Committee for October 12th Hearing).

¹³ TEX. INS. CODE §§492.102(a)(1) & 493.102(a)(1).

¹⁴ TEX. INS. CODE §§492.102(a)(2) & 493.102(a)(2) which cross references §§492.103 & 493.103 which states: A reinsurer is accredited if: (1) Submits to the state's jurisdiction, (2) Submits to the state's authority to examine the insurer's books and records, (3) Domiciled and authorized to engage insurance in a state of the United States or is the US branch of a foreign reinsurer that is authorized to engage in insurance or reinsurance in at least 1 US state, (4) Annually files with TDI a copy of their annual statement they filed with their US domiciliary, and (5) Maintains a surplus of at least \$20 million.

¹⁵ TEX. INS. CODE §§492.102(a)(3) & 493.102(a)(3).

¹⁶ TEX. INS. CODE §§492.104 & 493.104.

¹⁷ TEX. INS. CODE §§492.103 & 493.103.

Composition of Trust - A trust must contain enough funds to cover all the liabilities that the foreign reinsurer has in the US including a \$20 million or \$100 million surplus.¹⁸

Terms of Trust - The terms of the trust must state that any final order issued by a court of the United States will be abided. Furthermore, the trust must vest legal title to the trust's assets in the trustees for the trust's US policyholders and ceding insurers.¹⁹

Reports and Certification - Trustee is required to report to TDI the balance of the trust and its investments from the previous year. Also must certify date of termination if termination of the trust is planned.²⁰

Certain Trusteed Assuming Insurers: Requirements for Reinsurance Contract - The reinsurance contract is required to contain a provision that submits the reinsurer to the jurisdiction of the any US court, agreement to comply with all requirements to submit the reinsurer to the US court's jurisdiction, and agreement to abide by any final order of the US court or appellate court if there is an appeal.²¹

Texas will also grant credit for reinsurance to an insurer that uses a foreign reinsurer if funds are held directly by the insurer, or on its behalf, to secure amounts due from the reinsurer in a manner that complies with §492.104 of the Insurance Code. Section 492.104 limits the amount of the credit for reinsurance to the amount of funds held by, or on behalf of, the insurer as security. These funds held as security must be held in the United States subject to withdrawal solely by and under the exclusive control of the insurer, or held in a trust at a qualified United States financial institution with fiduciary powers. Moreover, the funds held as security must be in the form of either (1) cash, (2) securities listed by the Securities Valuation Office of the NAIC that qualify as admitted assets, (3) certain letters of credit that meet the requirements of § 492.105 of the Insurance Code, or (4) another form of security acceptable to the Commissioner.

Remember, the Committee is ultimately reviewing the adequacy of a solvency standard for insurers domiciled in Texas. The Federal Insurance Office provides a helpful explanation and stated, "[u]nder the current state regulatory regime, states insurance regulators do not have direct oversight over non-U.S. reinsurers, but instead regulate the solvency of those U.S. insurers that purchase reinsurance."²² TDI is able to evaluate the counterparty credit risk when a Texas domestic insurer purchases reinsurance from a U.S. reinsurer because most U.S. reinsurers are licensed and/or accredited in the U.S. As previously noted, state law requires insurers to submit their financial statements and comply with ongoing solvency regulations. However, since non-

¹⁸ TEX. INS. CODE §§492.152 & 493.152. \$20 million for single reinsurer. \$100 million for group of reinsurers.

¹⁹ TEX. INS. CODE §§492.154 & 493.154.

²⁰ TEX. INS. CODE §§492.155 & 493.155.

²¹ TEX. INS. CODE §§492.156 & 493.156.

²² Federal Insurance Office, *How To Modernize And Improve The System Of Insurance Regulation In The United States*, at 37.

U.S. reinsurers are not generally licensed and regulated in the U.S., TDI is unable to assess the counterparty credit risk of non-U.S. reinsurers. The previous credit for reinsurance model act, which dates back to 1984, addressed this issue by only allowing U.S. insurers to take credit for reinsurance from non-U.S. reinsurers, if the non-U.S. reinsurer posted 100% collateral for all reinsurance liabilities assumed.²³

The ability for an insurance company to take credit for reinsurance on their balance sheet is important for Texas domiciled insurers' ability to meet ongoing solvency standards as required by TDI, particularly the "risk based capital" (RBC) requirement. RBC is a method of measuring and determining the statutory minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile (NAIC RBC info). If a Texas domiciled insurer is able to take credit for reinsurance on their balance sheet, then RBC will allow the insurer to maintain a lower amount of capital to absorb potential losses. On the other hand, if a Texas domiciled insurer is not able to take credit for reinsurance, then it will be required to maintain the same level of reserves as if the reinsurance had not been purchased. As a result, the RBC formula will require the insurer to maintain higher capital to absorb potential losses.

B. Credit for Reinsurance Model Law

The Model Law contains a series of suggested statutory language explaining when credit for reinsurance should be given to insurers. For example, the Model Law gives credit for reinsurance to insurers who use reinsurers licensed by the state, accredited, or meets trust fund rules. Credit is also allowed in the amount of funds held as security by, or on behalf of, the ceding insurer. For the most part Texas has adopted these sections of the Model Law. The critical point of deviation are the sections related to credit for risk ceded to a foreign reinsurers—which includes qualified jurisdictions—and concentration of risk sections of the Model Law. Texas has not adopted these sections.

1. Certification of Non-Domestic Reinsurer

The Model Law states that credit for reinsurance should be granted to a reinsurer that meets the following requirements. The reinsurer must be:

1. Domiciled and licensed in a qualified jurisdiction;
2. Maintain minimum capital and surplus or its equivalent;
3. Maintain financial strength ratings from 2 rating agencies;
4. Submit to the jurisdiction of the [state of Texas] and appoint the commissioner as agent for service and provide one hundred percent security if reinsurer resists US judgment;
5. Meet commissioner's filing requirements for both the initial application and on an ongoing basis; and

²³ Federal Insurance Office, *The Breadth and Scope of the Global Reinsurance Market and the Critical Role Such Market Plays in Supporting Insurance in the United States*, at 23.

6. Satisfy any other requirements deemed relevant by the commissioner.²⁴

2. Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions

In 2012 the NAIC Reinsurance Task Force was charged with creating a list of qualified jurisdictions.²⁵ From this task the Reinsurance Task Force in *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* (Qualified Jurisdiction Process) set forth principles to guide evaluators, developed an evaluation process, and set forth an evaluation methodology. It should be noted that TDI is a member of the NAIC Reinsurance Task Force, and also is a member of the NAIC working group that maintains the NAIC Qualified Jurisdiction list.

The principles set forth by the task force, in summary, are to identify non-U.S. jurisdictions whose governments have adequate authority to reliably regulate its domestic reinsurers for the protection of U.S. insurers and policyholders, with evidence of cooperation, in accordance with the Model Law.²⁶ In other words, if states adopt the Model Law, they should be able to trust the NAIC Qualified Jurisdiction list and save costs on conducting their own independent reviews. The NAIC stresses that this list is not intended to be binding or a delegation of regulatory authority to the NAIC.²⁷ Final approval resides solely in each state, in fact, the state may include non-NAIC List of Qualified Jurisdictions, however the NAIC will monitor those jurisdictions.²⁸ The following describes in detail the requirements laid out in the Model Law for certification of a non-domestic reinsurer.

i. Standard of Review & 7 Areas of Importance

The Qualified Jurisdiction Process provides a standard of review for evaluators. Evaluators must "reasonably" conclude:

that the jurisdiction's *reinsurance supervisory system* achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction's demonstrated *practices and procedures* with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction's *laws and practices* satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.²⁹ [emphasis added]

The evaluation methodology provided by the Qualified Jurisdiction Process is an outcomes-based analysis which borrows a number of key elements from the NAIC Accreditation Program

²⁴ NAIC, Credit for Reinsurance Model Law (2016), §2E(1).

²⁵ NAIC, *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions*, at 3.

²⁶ *Id.* at 4.

²⁷ *Id.* at 4.

²⁸ *Id.* at 4, 11.

²⁹ *Id.* at 8.

discussed in Section II of this report.³⁰ As the text states, the key elements are intended to provide a framework for the analysis and is not intended to be prescriptive.³¹ Evaluators are required to evaluate seven areas of importance which should determine the effectiveness of the entire reinsurance supervisory system within the jurisdiction. They are the following:

- Laws and Regulations
- Regulatory Practices and Procedures
- Jurisdiction's Requirements Applicable to U.S.-Domiciled Reinsurers
- Regulatory Cooperation and Information Sharing through Memoranda of Understanding
- History of Performance of Domestic Reinsurers
- Enforcement of Final U.S. Judgments
- Solvent Schemes of Arrangement³²

The Qualified Jurisdiction process also allows NAIC staff to consider additional information. They may consider documents, reports and information from appropriate international, U.S. federal and U.S. state authorities. Public comments from interested parties can also be considered as well as rating agency information. Finally, the evaluators are allowed to consider any other relevant information.³³

ii. Approval Procedures & Periodic Reevaluations

After NAIC staff has concluded its evaluation, the Qualified Jurisdiction Working Group will first determine in a preliminary evaluation report whether the jurisdiction satisfies its Standard of Review and should be included on the list of Qualified Jurisdictions.³⁴ The jurisdiction will have an opportunity to respond to the report and the working group will consider those responses in the adoption of the Final Evaluation Report.³⁵ Once the Final Evaluation Report is adopted, it will then be sent to the Reinsurance Task Force and then to the Executive Committee and Plenary for final approval for the list.³⁶ If the jurisdiction is denied, they will have an opportunity to reapply at the discretion of the NAIC.³⁷ Also, after the Final Evaluation Report is finally adopted, the report will be made available to state regulators upon request and confirmation that the regulator will keep the information confidential.³⁸

Finally, the Qualified Jurisdiction will be subject to periodic reevaluations every five years. However, if there is any material change in their reinsurance supervisory system or any adverse developments with respect to enforcement of U.S. judgments, then the Working Group will

³⁰ NAIC, *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions*, at 12.

³¹ *Id.*

³² *Id.* at 13-15.

³³ *Id.* at 8.

³⁴ *Id.* at 9.

³⁵ NAIC, *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions*, at 9-10.

³⁶ *Id.* at 10.

³⁷ *Id.*

³⁸ *Id.*

immediately determine whether to reevaluate the jurisdiction.³⁹ If the Working Group finds that the jurisdiction is out of compliance, they may place the jurisdiction on probation, suspension, or revocation.⁴⁰ Worst case scenario for the jurisdiction is revocation which will lead to all reinsurers domiciled in that jurisdiction being required to post 100% collateral for all reinsurance contracts with all U.S. insurers.⁴¹

3. Concentration of Risk

The Model Law also puts in place measures to motivate insurers to diversify their reinsurance programs in order to avoid over relying on a single reinsurer. The Model Law, provides two thresholds—one reactive and one anticipatory—that when reached, require insurers to notify TDI that there may be an over-concentration of risk. The reactive threshold requires an insurer to take steps to manage its reinsurance recoverables. When an insurer has recoverables from a single reinsurer or group of reinsurers that exceeds 50% of the insurers last reported surplus to policyholders, they must notify TDI of this fact and explain to TDI that the concentration of risk is safely managed.⁴² So, for example, let's say that an insurer suffers losses after an event and needs to recover \$5 million from their contracted reinsurer. Also, the insurer's last reported surplus to policyholders was \$9 million. Under this scenario the insurer will be required to notify TDI because \$5 million is more than 50% of the \$9 million in reported surplus, the insurer is required to report to TDI the \$5 million in recoverables. They must also demonstrate that the exposure is safely managed. It is reactive because the event of loss has already occurred.

The anticipatory threshold requires the insurer to notify TDI if they cede, or is likely to cede, more than 20% of their gross written premium in the prior calendar year to a single reinsurer or group of reinsurers. In the notification they must demonstrate to TDI that the risk is safely managed.⁴³ For example, if insurers cedes \$3 million to a reinsurer and their gross written premium the prior year was \$10 million, then the insurer must notify TDI. They must also demonstrate that they are safely managing the risk. It is anticipatory because the event of loss has not yet occurred, rather they are anticipating that the event of loss may occur.

C. Consequences of Application of the Model Law

The Committee took testimony from David Mattax the Commissioner of TDI and three insurers domiciled in Texas. Representing Texas domiciled insurers were two of Texas's largest insurers, American Insurance Group (AIG) and United States Automobile Association (USAA), and Redpoint Insurance Group which is a local county mutual insurance company. A general theme that led the testimony was the consensus that the Texas collateral requirements placed on foreign reinsurers is antiquated and out of sync with the modernization of regulations. Moreover, these requirements place Texas insurers at a competitive disadvantage with their competitors in other

³⁹ *Id.* at 11.

⁴⁰ NAIC, *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions*, at 11.

⁴¹ *Id.*

⁴² NAIC, *Credit for Reinsurance Model Law* (2016), §2J(1).

⁴³ NAIC, *Credit for Reinsurance Model Law* (2016), §2J(2).

states which ultimately raises the costs of insurance for Texas consumers. Commissioner Mattax stated:

In order to keep Texas law up to date with the reinsurance market in general, and the rest of the states, the law needs to provide an additional option for Texas insurance companies that buy reinsurance. [T]he current requirements were adopted by laws enacted over 25 years ago. These laws were needed at the time, but they are now outdated and there are better options. Ultimately, the consumers pay for these regulatory restrictions.⁴⁴

However, the Model Law is not without some reservations from the Committee. The Committee expressed concerns that although the state may gain some efficiencies, consumer protection should be of the utmost importance.⁴⁵ To get at this concern, the following first, explains the three areas that the Commissioner and stakeholders agree will improve for Texas insurers and consumers if the Model Law is adopted—they are capacity, choice, and competition. Second, the advantages and disadvantages of the Model Law as compared to the Texas collateral requirements are explained. Finally, the consumer protections identified by the witnesses are provided.

1. The 3 C's: Capacity, Choice, & Competition

Throughout the testimony, Commissioner Mattax and the domiciled insurers agreed on several key points. One, they agree that adoption of the Model Law will ease the entry of highly reputable reinsurers and encourage companies to domesticate in Texas which ultimately creates greater capacity for the Texas insurance market. Two, with the Model Law removing the 100% collateral barrier, insurers will have greater freedom of choice to tailor reinsurance transactions that best meets their commercial needs. Three, with improved capacity and greater choices, Texas insurers will be in better standing to compete nationally with insurers located in states that have adopted the Model Law.

i. "Capacity" in the Texas Insurance Market

According to testimony given to the Committee, the capacity issue is twofold. The first issue relates to capacity to obtain reinsurance which is constrained by the 100% collateral requirement which is an indirect effect on insurance capacity as a whole. The second issue is tied to NAIC accreditation discussed in detail in Section II of this report. If Texas fails to adopt the Model Law, then it is likely fewer insurers will domicile in Texas thus constraining capacity.

Capacity for the first issue should be seen in two stages. There is the first stage made up of insurer capacity which can be expanded by the second stage which is reinsurer capacity. Taken together, they make up capacity for the state as a whole. To frame this problem, a useful definition is in order. Capacity is the:

⁴⁴ October 12th Hearing at 2:20, 6:53.

⁴⁵ October 12th Hearing at 3:40.

maximum that an insurance company can underwrite. The limits of coverage that a property and casualty company can underwrite are determined by its retained earnings and invested capital. REINSURANCE is a method of increasing the insurance company's capacity, in that a portion of the unearned premium reserve maintenance requirement can be relieved.⁴⁶

In other words, an insurer's ability to underwrite, or capacity, is limited by their earnings and invested capital. Remember, according to the reinsurance definition provided above, insurers can transfer some of their liabilities to reinsurers. This frees up insurer capital which can instead be used to underwrite more insurance or used for company investments which in effect expands capacity.⁴⁷

According to testimony provided to the Committee, by placing the 100% collateral requirement on foreign reinsurers, Texas law constraints capacity for the state as a whole. A rudimentary understanding of economic theory would suggest this is true. Collateral requirements raise the costs of entry for foreign reinsurers who without the barrier would more likely enter the Texas market. Moreover, stakeholder testimony supports this assertion and stress the fact that firms are going to invest their money in states where their funds can most efficiently be used. USAA gave a useful explanation of the problem.

[The collateral requirement is] really a double whammy on a foreign reinsurer because their collateral is still being held while . . . claims are being paid. . . I think when [foreign reinsurers] have a choice to go to a state where this is not necessarily being required—versus one that is—they're going to go to the location where they can most efficiently use their funds.⁴⁸

Furthermore, the Committee was provided with examples of opportunities to expand reinsurance capacity that were thwarted due to not adopting the Model Law. AIG told the Committee that they explored the possibility of certifying their own reinsurance company in Texas but because the Legislature did not adopt the enhancements from the Model law, they were forced to certify their reinsurer in Missouri.⁴⁹ What's more, AIG testified that if this Model Law is passed they will be able to move more of their business to Texas which would mean, by one example given, an additional 150 jobs to the state.⁵⁰ Also, Redpoint testified that adoption of the Model Law will support their decision to domesticate future insurance carriers that they may acquire.⁵¹

⁴⁶ Barron's Business Guides, *Dictionary of Insurance Terms*, 4th Edition, at 73.

⁴⁷ See October 12th Hearing at 7:41. Commissioner Mattax testified that reinsurance supplements insurers' capital requirements which allows companies to write more insurance and pass some of the risk to other insurers. This in turn lowers the price of insurance and could lead to more potential insurers and thus more capacity.

⁴⁸ October 12th Hearing at 39:04-39:21.

⁴⁹ October 12th Hearing at 46:49.

⁵⁰ October 12th Hearing at 54:35.

⁵¹ October 12th Hearing at 29:52.

ii. "Freedom to Choose" What Fits Their Commercial Needs

Commissioner Mattax stressed to the Committee that the Model Law does not prohibit insurers from requiring reinsurers to post collateral. In fact, insurers will always have that option and he wants them to have that option.⁵² Furthermore, the Commissioner predicts that collateral will continue to be used.⁵³ The Model Law simply removes 100% collateral barrier that limits the reinsurance choices available to Texas domestics.⁵⁴ He predicts that "by offering choice, insurers should be able to negotiate better terms and pricing for reinsurance while remaining secure, the effects of which should benefit availability and pricing of insurance for Texas consumers."⁵⁵

Stakeholder testimony supports this claim. They argue that they should have the freedom to choose the reinsurance transaction that best fits their commercial needs.⁵⁶ They want the freedom to choose a financially strong reinsurer without requiring the extra burden of posting collateral.⁵⁷ As Commissioner Mattax stated, "most of the largest and financially strongest reinsurers are based outside of the U.S."⁵⁸ but the costs of their services are raised due to the 100% collateral law which makes these services more difficult to access for Texas insurers. By removing this barrier, the Model Law will provide greater negotiating flexibility between insurers and reinsurers in Texas, according to AIG.⁵⁹

iii. Competition

According to Commissioner Mattax, more capacity and greater freedom to choose the reinsurance product that best meets their business needs will allow Texas insurers to "compete on the same basis as insurers from one of the other 35 states that have already adopted it."⁶⁰ Redpoint's representative gave a helpful synopsis from the industry's standpoint. Mr. McClellan stated:

we operate in a very competitive market against insurers, many of which are domiciled in other states. Those competing insurers (if domiciled, for example, in California, Florida, or New York) have access to a more robust reinsurance market – with choices and flexibility unavailable to Texas domestic insurers.⁶¹

⁵² October 12th Hearing at 2:42.

⁵³ October 12th Hearing at 8:19.

⁵⁴ October 12th Hearing at 2:42-3:00.

⁵⁵ October 12th Hearing at 14:37.

⁵⁶ See Lloyd's Written Testimony available at:

<http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016101210001/42ff8235-503f-4d7f-8b5f-ff504a9019d5.PDF>.

⁵⁷ See American Insurance Association Written Testimony, available at:

<http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016101210001/9fa9e4b3-12a2-4e61-9cd7-2528b9a64dc2.PDF>.

⁵⁸ October 12th Hearing at 11:20.

⁵⁹ October 12th Hearing at 45:35.

⁶⁰ October 12th Hearing at 14:27.

⁶¹ Redpoint Written Testimony, available at:

<http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016101210001/d4964c3c-bdfa-401e-b78f-321aa4129292.PDF>.

Compared to other states that have adopted the law, the stakeholder witnesses agreed that they are at a competitive disadvantage because of the 100% collateral requirement.⁶² By removing the collateral requirement, Texas will be leveling the playing field for its insurers domiciled in the state.

2. Counterparty Credit Risk & the Limits of 100% Collateral

While the counterparty credit risk from a non-U.S. reinsurer is reduced when the non-U.S. reinsurer posts collateral, posting collateral does not completely eliminate that credit risk to the Texas insurer. Under current law, non-U.S. reinsurers are required to post collateral equal to 100% of the reinsurer's estimated liabilities.⁶³ However this safeguard does not account for losses in excess of the collateral requirement which means a credit risk still exists. For example,

Moreover, TDI reports that insufficient reserves are a typical problem found in insurer insolvencies.⁶⁴ In these instances, a reinsurer would have only been required to post collateral for an insufficient amount, meaning the concept of 100% collateral can be illusory. Commissioner Mattax stated:

It is a misnomer to say that 100% collateral will guarantee all the losses of that company. It only guarantees what the company has reported. Whereas, [a reputable reinsurer] will cover all the losses regardless of the amount.⁶⁵

In contrast to the Model Law, the Texas collateral requirement ignores the reinsurer's financial strength and ignores the quality of regulation that the reinsurer is subject.⁶⁶ Meaning, that if an event occurs that requires an insurer to collect more than the estimated liability, then the insurer will be at the mercy of the reinsurer and jurisdiction in which the reinsurer is domiciled. Under this scenario, the central purpose of the collateral requirement—to protect insurers and consumers from scrupulous companies outside U.S. jurisdiction—will be defeated. What's more, they will be in a worst position than under the Model Law because they will be without its safeguards and protections discussed in the next sub-section.

3. Consumer Protections—A Hook and Hammer

As explained above, one of the seven areas that evaluators must review before placing a jurisdiction on the qualified jurisdiction list is its history of enforcing U.S. judgments. Commissioner Mattax identified this requirement as one of two hooks insurers and consumers will have for their protection under the Model Law that they do not have now.⁶⁷ The second hook—which Commissioner Mattax also referred to as a hammer⁶⁸—is the possibility that an

⁶² See October 12th Hearing at 46:10 (Testimony by Ted Kennedy of AIG); see American Insurance Association Written Testimony.

⁶³ NAIC, *U.S. REINSURANCE COLLATERAL WHITE PAPER* (March 5, 2006), at 38.

⁶⁴ October 12th Hearing at 9:55.

⁶⁵ October 12th Hearing at 10:15.

⁶⁶ October 12th Hearing at 10:51.

⁶⁷ October 12th Hearing at 16:34.

⁶⁸ October 12th Hearing at 26:42.

entire jurisdiction's qualified status can be revoked if the NAIC finds as few as one reinsurer who refuses a U.S. judgment; meaning all reinsurers domiciled in that jurisdiction will be required to post 100% collateral. Commissioner Mattax explained that this puts pressure on the reinsurer from two fronts. One from the regulatory environment which will put pressure on that insurer to pay the claim. The second from other insurers in that jurisdiction who will otherwise lose that benefit as well if the reinsurer does not pay.⁶⁹

II. NAIC Accreditation—Key Tool in Maintaining State-based Regulation

Since the Committee was charged with examining the credit for reinsurance statutes, a major development has occurred with the NAIC accreditation standards. Adoption of the Model Law has become an accreditation standard. So if Texas does not adopt the Model Law, it will jeopardize its NAIC accreditation which would result in additional regulatory burdens on its domestic insurers. There are 181 domiciled insurance companies in Texas who do out of state business. This means that each one of these 181 companies would be subject to additional regulatory scrutiny by each individual state's insurance regulator in order to do business there—a major regulatory burden. What's more, no state has ever lost its accreditation.⁷⁰

The NAIC accreditation program was created as a response to the insolvency crisis that occurred in the 1980's. Many large insurers became insolvent which led to calls in Washington that insurance solvency should be federalized because the state-based system inadequately monitored and regulated the multi-state companies. The NAIC took preemptive measures to thwart the threat to state-based insurance regulation by developing a formal accreditation program, which is the current *Financial Regulation Standards and Accreditation Program*. From this initiative the NAIC identified three basic components of an effective system of solvency regulation a state should have. They are:

- Adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs.
- The necessary resources to carry out that authority.
- Organizational and personnel practices designed for effective regulation.⁷¹

The goal of the program is to ultimately retain insurance regulatory authority with the states. The NAIC writes, "the accreditation program is a key tool in promoting and maintaining state-based regulation of the insurance industry."⁷² The program has since helped states correct deficiencies in state regulations and has streamlined intra-state communications.⁷³

⁶⁹ October 12th Hearing at 16:55.

⁷⁰ Federal Insurance Office, *How To Modernize And Improve The System Of Insurance Regulation In The United States*, at 29.

⁷¹ *Id.* at 1.

⁷² NAIC, *Financial Regulation Standards and Accreditation Program* (April 2016), at 3.

⁷³ *Id.* at 3.

A. State of Domicile Accreditation

Meeting these three basic components is important for the foundation of the state-based regulatory system led by the NAIC. Specifically, under this system one accredited state must be able to rely on another accredited domestic regulator to fulfill a baseline level of effective financial regulatory oversight.⁷⁴ The NAIC writes:

[I]f a company is domiciled in an accredited state, the other states in which that company is licensed and/or writes business may be assured that, because of its accredited status, the domiciliary state insurance department is adequately monitoring the financial solvency of that company.⁷⁵

This system creates efficiencies because in each accredited state's laws or regulations contains a provision that requires a licensed insurance company to be periodically examined by the insurance department and be subject to various other types of regulatory scrutiny. However, in lieu of conducting their own examination, an insurance regulator may defer to the examination report from that company's state of domicile if the state is NAIC accredited.⁷⁶

B. Accreditation Standards

Currently, all 50 states and the District of Columbia and Puerto Rico are accredited.⁷⁷ Once a state is accredited, it is subject to full accreditation reviews every five years and interim annual reviews in between.⁷⁸ As part of the full accreditation review, NAIC staff examines the state's compliance with the accreditation standards. The accreditation standards are divided into four major categories categorized by:

- Part A: Laws and Regulations;
- Part B: Regulatory Practices and Procedures;
- Part C: Organizational and Personnel Practices; and
- Part D: Organization, Licensing and Change of Control of Domestic Insurers.⁷⁹

The most relevant category for this report is Part A. Under laws and regulations, the NAIC delineates a list of regulatory frameworks and NAIC model laws that states should adopt in order to be in compliance with NAIC accreditation standards such as guaranty funds, capital and surplus requirements, accounting practices and procedures, and receivership schemes.⁸⁰ On April 9, 2016 the NAIC adopted the Model Law as an accreditation standard which will become effective January 1, 2019.⁸¹

⁷⁴ NAIC, ACCREDITATION, available at: http://www.naic.org/cipr_topics/topic_accreditation.htm.

⁷⁵ NAIC, *Financial Regulation Standards and Accreditation Program* (April 2016), at 2.

⁷⁶ *Id.*

⁷⁷ *Id.* at 3.

⁷⁸ *Id.* at 2.

⁷⁹ *Id.* at 7.

⁸⁰ NAIC, *Financial Regulation Standards and Accreditation Program* (April 2016), at 8-10.

⁸¹ NAIC, FINANCIAL REGULATION STANDARDS AND ACCREDITATION (F) COMMITTEE, available at:

C. Increased Regulatory Burdens for Texas Domestics

Simply put, the states via the NAIC have agreed that they cannot trust the regulatory determinations by a state whose regulatory system does not meet NAIC standards. Furthermore, witness testimony stressed that if a company's state of domicile is not accredited, then the company would be subject to duplicative filings and unfortunately will lead to increased costs that will be passed on to consumers.⁸²

If Texas loses its accreditation, it would be an embarrassing setback for Texas regulators—especially in light of the fact that Commissioner Mattax chairs the NAIC Accreditation Committee.⁸³ AIG pointed out that state insurance departments must be accredited by the NAIC to hold positions of leadership. Therefore, if Texas loses its accreditation, the state will also lose influential positions at the NAIC. This point is not lost on major insurance companies who like AIG relocated some of its business to Texas because of the significant leadership role that TDI enjoys at the NAIC. AIG said, "as our primary domestic regulator, TDI is our voice and intelligence with the NAIC and the international regulatory community and, in fact, a major reason we moved our Consumer Lines headquarters to Texas."⁸⁴

This leads to another point elaborated in Section III of this report. As witnesses explained to the Committee, accreditation is the tool to maintain state-based regulation of insurance and is a defense against federal intrusion.⁸⁵ If Texas—the second largest insurance market in the U.S.—is not accredited, the State will be forfeiting its leadership roles in the NAIC. Moreover, this decision could undermine the validity of the NAIC if such a large regulator and sector of the market is not a member—let alone a leader. The consequence will be that those in favor of federal preemption will have more support for their case which place more pressure on the federal government to concede to international regulators' demands that the U.S.'s regulations be centralized.

III. Federal Preemption

US insurance regulation is primarily a state function granted by Congress via the McCarran-Ferguson Act.⁸⁶ However, the McCarran-Ferguson Act reserves the power to preempt state insurance law for future Congresses if Congress passes an Act that specifically relates to the business of insurance.⁸⁷ Congress exercised some of their preemption authority in the *Dodd-Frank Wall Street Reform and Consumer Protection Act* by creating the Federal Insurance Office (FIO) and prescribing circumstances in which federal law will preempt state insurance law. The following section provides first, an overview of the covered agreement preemption procedures

http://www.naic.org/cmte_f.htm.

⁸² October 12th Hearing at 42:10.

⁸³ NAIC, NAIC Names 2016 Committee Leadership, available at:

http://www.insurance.naic.org/Releases/2016_docs/naic_names_2016_committee_leadership.htm.

⁸⁴ October 12th Hearing at 47:55.

⁸⁵ October 12th Hearing at 33:15.

⁸⁶ 15 U.S.C. §1011.

⁸⁷ 15 U.S.C. §1012(b).

delegated to the FIO via Dodd-Frank. Second, the sub-section explains the international movements in insurance regulation that precipitated the covered agreement negotiations with the European Union (EU) which is the most likely path to triggering the FIO's federal preemption procedures.

A. Federal Insurance Office and Preemption

Congress gave the FIO—in consultation with state insurance officials—the responsibility of identifying gaps in regulation of insurers that could contribute to a systemic crisis.⁸⁸ These measures expanded federal oversight over the nation's insurance system but stopped short of immediate preemption. Instead, Congress laid a foundation for future preemption via the covered agreement process.

According to Dodd-Frank, a covered agreement is a:

written bilateral or multilateral agreement regarding prudential measures with respect to the business of insurance or reinsurance that is entered into between the United States and one or more foreign governments, authorities, or regulatory entities; and relates to the recognition of prudential measures with respect to the business of insurance or reinsurance that achieves a level of protection for insurance or reinsurance consumers that is substantially equivalent to the level of protection achieved under State insurance or reinsurance regulation.⁸⁹

Basically, under Dodd-Frank and in the reinsurance context, covered agreements are agreements with foreign nations that determine how each nation will recognize each other's reinsurance regulatory systems as it relates to consumer protection. The goal is reciprocity, where both governments give deference to each other's regulatory determinations. For example, a company approved by German regulators would be automatically approved by US regulators under reciprocity. To assist in the international negotiations, Congress also gave the FIO the authority to coordinate federal efforts for the negotiations and represent the United States.⁹⁰

An important limit set by the definition is that the nations achieve a level of protection for insurance and reinsurance that is substantially equivalent to the level of protection achieved under state law. The limit restricts negotiations to insurance and reinsurance regulations that are substantially similar to regulations under state law. This provision is important not only because the topics of negotiation are limited but also because it authorizes the U.S. Trade Representative and FIO to negotiate with foreign governments regulations that are currently under state jurisdiction. Furthermore, in effect the statute sets a floor for the level of protection determined by the covered agreement. So in order for preemption to go forward the state must have a level of protection that is less than the level in the covered agreement.

⁸⁸ 31 U.S.C. §313(c)(1)(A)(G).

⁸⁹ 31 U.S.C. §313(r)(2).

⁹⁰ 31 U.S.C. §313(c)(1)(E).

Once a covered agreement is agreed upon, Congress has given the FIO Director the responsibility of determining whether State insurance measures are preempted by the covered agreement.⁹¹ First—and foremost—the director must determine whether the state regulations are one, prejudicial against a non-United States insurer domiciled in foreign jurisdiction subject to the covered agreement, and two, whether the regulations are inconsistent with the covered agreement.⁹² However, before the Director makes that determination, he or she must follow notice requirements prescribed by Dodd-Frank, which require giving notice to the state, posting notice in the Federal Register, and notifying four Congressional committees.⁹³

B. European Union's Solvency II

Since the financial collapse of 2008, regulatory reform pressures have been placed on US regulators by international regulators with the aim of bolstering regulatory oversight in the financial and insurance markets. Specifically, international regulators criticize the US regulatory framework, which according to them, is fragmented and lacks centralized efficiencies. This is because insurance regulation occurs at the state level rather than the national level like other countries. For instance, prior to Dodd-Frank, financial enterprises were regulated by multiple federal agencies, such as the Office of Thrift Supervision and the Federal Reserve. Due to this split in authority, communication and coordination between regulators were inadequate and failed to spot the high degree of risk credit default swaps posed for AIG and the financial market as a whole. International regulators—especially those in the EU—argue that if regulatory oversight for all financial activity at AIG were centralized at the national level, regulators would have been able to prevent the risky activity which precipitated the financial collapse. When the credit default business failed it also affected AIG's insurance businesses because the financial subsidiaries' liabilities affected the holding company⁹⁴—a process called spillover.⁹⁵ This provided the opening for Congress to justify putting in place processes that could eventually lead to federal preemption of reinsurance regulation.

The most prominent movement to convince the U.S. to reform its insurance regulatory system comes through the covered agreement negotiations with the EU. On January 1, 2016, "Solvency II" went into effect in the EU and shortly thereafter the EU and U.S. Treasury Department

⁹¹ 31 U.S.C. §313(c)(1)(F).

⁹² 31 U.S.C. §313(f)(1).

⁹³ **1)** Give notice of potential inconsistency to the state, U.S. Trade Representative, publish notice in the Federal Register, and provide stakeholders an opportunity to submit written comments. 31 U.S.C. §313(f)(2)(A). **2)** If the Director determines there is an inconsistency, the Director must notify the state, establish a reasonable period of time before determination takes effect, and notify the Financial Services and Ways and Means Committees of the House of Representatives and the Banking, Housing, and Urban Affairs; and Finance Committees in the U.S. Senate. 31 U.S.C. §313(f)(2)(B). **3)** If the basis for the determination still exists after the reasonable period of time described above, the Director will publish a notice of preemption in the Federal Register and the preemption will become effective. 31 U.S.C. §313(f)(3).

⁹⁴ Federal Insurance Office, *How to Modernize and Improve the System of Insurance Regulation in the United States*, pages 18-20.

⁹⁵ Organisation for Economic Co-operation and Development, *Insurance Companies and the Financial Crisis*, at 5, 23.

released a joint statement announcing the beginning of the covered agreement negotiations.⁹⁶ Solvency II is an EU directive that codifies and harmonizes EU insurance regulations guided by three pillars related to solvency, governance, and transparency.⁹⁷ It also has a provision that lays out complicated procedures for determining whether other non-EU jurisdictions qualify as "equivalent regimes." Equivalent regimes are non-EU third countries that will be treated as if in the EU and will enjoy the same EU protections as EU member states.⁹⁸

If US regulators do not remove discriminatory collateral requirements for EU companies, then the EU has threatened to retaliate and raise their own barriers on US companies via the Equivalent Regimes procedure. Simply put, the equivalent regimes process is the stick the EU can use against the US if US governments do not take action that the EU considers necessary to achieve system reciprocity. When the US and EU announced intentions to negotiate the covered agreement, they outlined five specific prudential areas in letters to Congress that the parties would negotiation over. The most relevant related to reinsurance and this charge are:

- obtain treatment of the U.S. insurance regulatory system by the EU [in light of Solvency II] as "equivalent" to allow for a level playing field for U.S. insurers and reinsurers operating in the EU;
- afford nationally uniform treatment of EU-based reinsurers operating in the United States, including with respect to collateral requirements; and
- obtain permanent equivalent treatment for the solvency regime in the United States and applicable to insurance and reinsurance undertakings.⁹⁹

The letters specifically identify collateral requirements as negotiation topics and recognize maintaining equivalence as the ultimate goal. According to these prudential areas, there is a likely probability that the U.S. Trade Representative and FIO would agree to reform the nation's credit for reinsurance law in order to obtain full equivalency status for the US in the EU by bringing uniformity to the system. However, according to the process spelled out in Dodd-Frank, preemption is not a forgone conclusion if this happens.

C. "State-based regime is fighting for its life"¹⁰⁰—Quote by AIG

Remember, Dodd-Frank requires the FIO director to commence preemption procedures only if he or she determines that the state law is prejudicial against an insurer domiciled in a foreign jurisdiction subject to the covered agreement, and the state law is inconsistent with the covered agreement. Unfortunately for the state-based regime, the statute gives the FIO director a wide

⁹⁶ U.S. Dept. of Treasury, Joint Statement on U.S.-EU Negotiations for a Bilateral Agreement on Insurance and Reinsurance Measures, available at: <https://www.treasury.gov/press-center/press-releases/Pages/j10362.aspx>.

⁹⁷ European Commission, Solvency II Overview – Frequently asked questions, available at: http://europa.eu/rapid/press-release_MEMO-15-3120_en.htm.

⁹⁸ European Insurance and Occupational Pensions Authority, Equivalence, available at: <https://eiopa.europa.eu/external-relations/equivalence>.

⁹⁹ U.S. Dept. of Treasury, Treasury, USTR Announce Intention to Negotiate Covered Agreement with the European Union, available at: <https://www.treasury.gov/press-center/press-releases/Pages/j10284.aspx>.

¹⁰⁰ October 12th Hearing at 50:57.

degree of discretion in determining whether a state law is inconsistent by not defining what is an inconsistent state law. Unfortunately, it is extremely unlikely that Texas's 100% collateral requirement would survive a challenge to the FIO director's preemption determination. As stated above, a central demand by the EU regarding reinsurance is that their reinsurers be treated equally as U.S. domestics which requires removal of 100% collateral requirements on their reinsurers.

What's more, Commissioner Mattax testified there is a scenario where the FIO can agree in the covered agreement to completely remove the collateral requirement for EU companies: meaning 0% collateral.¹⁰¹ If the FIO is ultimately successful in this scenario, this would have profound effects for two reasons. One, it would prevent the flexibility that the Model Act provides to insurers which allows them to tailor reinsurance transactions that best fits their commercial needs. Two, it will force upon Texas and the other states regulations that provide less consumer protections than the Model Law.¹⁰² Therefore it is important that the states have an argument they can take to Congress and the Courts that the Federal government exceeded its preemption authority.¹⁰³ As stated above, consumer protections are an important measure for determining preemption. Adoption of the Model Law would be the first step fending off federal intrusion, since the Federal government will have preempted state law that provides more consumer protections than those in the covered agreement.

¹⁰¹ October 12th Hearing at 19:40.

¹⁰² October 12 Hearing at 20:15.

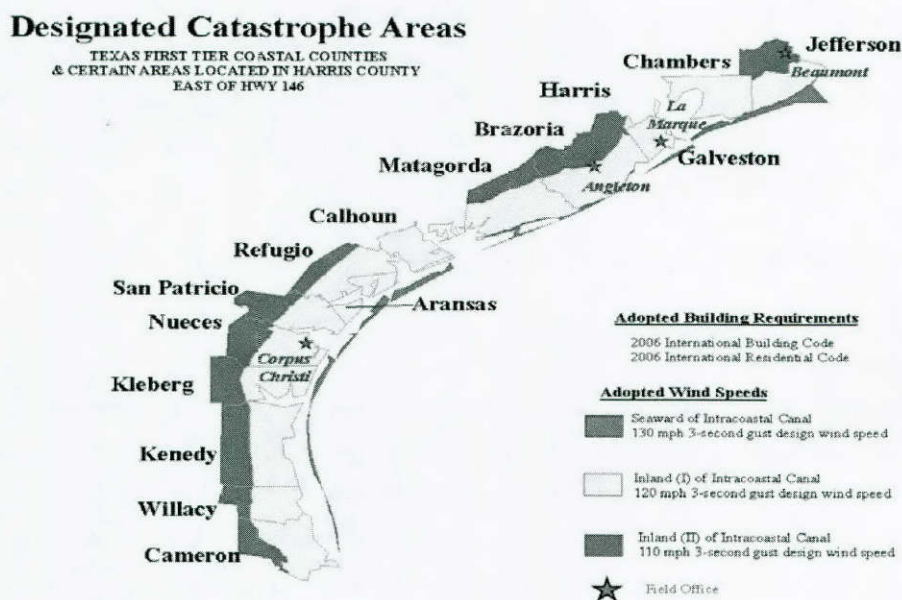
¹⁰³ October 12th Hearing at 20:05.

CHARGE #5: SB 900 IMPLEMENTATION

Monitor the implementation of SB 900 (84R), including the rulemaking process by the Texas Department of Insurance and the adoption of an updated plan of operation by the Texas Windstorm Insurance Association.

Introduction

The Texas Legislature created the Texas Windstorm Insurance Association (TWIA) in 1971 to provide windstorm and hail coverage to those who are unable to obtain insurance from the voluntary insurance market.¹ TWIA policies provide coverage for residential and commercial property located within the area designated by the Commissioner of Insurance. This area currently includes all 14 first tier coastal counties and parts of Harris County east of Highway 146, the following map outlines the tier 1 area:²



TWIA issues insurance policies like an insurance company; however it also functions as a pooling mechanism.³ All property insurers licensed in Texas are required to become TWIA *members* as a condition of doing business in the State.⁴ Losses covered under TWIA policies are first paid by TWIA premium revenue and then by funds held in the Catastrophe Reserve Trust Fund (CRTF). If TWIA experiences losses that exceed TWIA premium revenue and the amount held in the CRTF, a funding structure consisting of public securities and member assessments is

¹ TDI, *Texas Windstorm Insurance Association Overview*, page 4 available at: <http://www.tdi.texas.gov/pubs/pc/pctwiabrief.pptx>. [hereinafter *TWIA Insurance Overview*].

² *TWIA Insurance Overview*, at 5, 24.

³ *TWIA Insurance Overview*, at 7.

⁴ TEX. INS. CODE, §2210.051(a).

utilized to pay for the excess losses. For simplicity purposes, this report will refer to “member” assessments as “insurer” assessments. TWIA has made the following assessments to insurers to pay for excess losses resulting from a major loss event⁵:

- An assessment of \$157 million to insurers to pay for excess losses resulting from Hurricane Alicia, which struck Galveston Island in 1983;
- An assessment of \$100 million to insurers to pay for excess losses resulting from Hurricane Rita, which struck the upper Texas coast in 2005 causing major damage in Jefferson, Chambers, and Galveston counties;
- An assessment of \$100 million to insurers to pay for excess losses resulting from Hurricane Dolly, which struck the lower Texas coast in July of 2008 causing major damage in Cameron and Willacy counties; and
- An assessment of \$430 million to insurers to pay for excess losses resulting from Hurricane Ike, which struck the Texas coast in September of 2008 causing major damage in Brazoria, Chambers, Galveston, Harris, Jefferson, and Matagorda counties.

The 84th Texas Legislature enacted Senate Bill 900 (SB 900), which includes changes to TWIA’s funding structure and board composition, requires TWIA to establish a depopulation program, and requires the Texas Department of Insurance (TDI) to conduct a study of market incentives.⁶ On October 12th 2016, the Committee heard testimony from both TDI and TWIA on the actions they have taken to implement SB 900.

I. Actions Taken by TDI to Implement SB 900

A. New TWIA Board Appointed

Prior to SB 900, the TWIA board was composed of 4 members from the insurance industry, 4 members who reside in tier 1 (coastal) counties, and 1 member that is not located in the seacoast territory. SB 900 required the TWIA board to be composed of 3 members from the insurance industry, 3 members who reside in certain coastal counties, and 3 members who are located more than 100 miles from the Texas coastline.⁷ TDI Commissioner David Mattax (Commissioner) appointed a new TWIA board pursuant to SB 900 on October 1, 2015.⁸

B. Commissioners Order #4300

The Commissioner approved Commissioner’s Order #4300, which implemented provisions in SB 900 related to the changes in the funding structure for excess TWIA losses.⁹ Prior to SB 900, the funding of losses in excess of the TWIA premium revenue and the amount in the CRTF were

⁵ *TWIA Insurance Overview*, at 8.

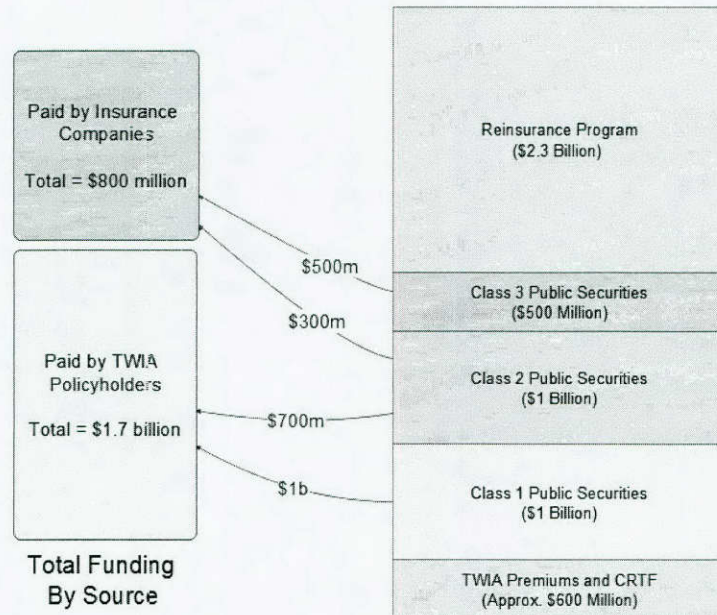
⁶ *TWIA Insurance Overview*, at 4.

⁷ Senate Bill 900 (84R), page 11, line 6-27 & page 12, line 1-15, available at: <http://www.capitol.state.tx.us/tlodocs/84R/billtext/pdf/SB00900F.pdf> [hereinafter Senate Bill 900(84R)].

⁸ TDI, “Insurance Commissioner Names New TWIA Board”, available at: <http://www.tdi.texas.gov/news/2015/twia1012015.html>

⁹ TDI, *Commissioners Order #4300*, available at: <http://www.tdi.texas.gov/rules/2015/documents/order4300.pdf>

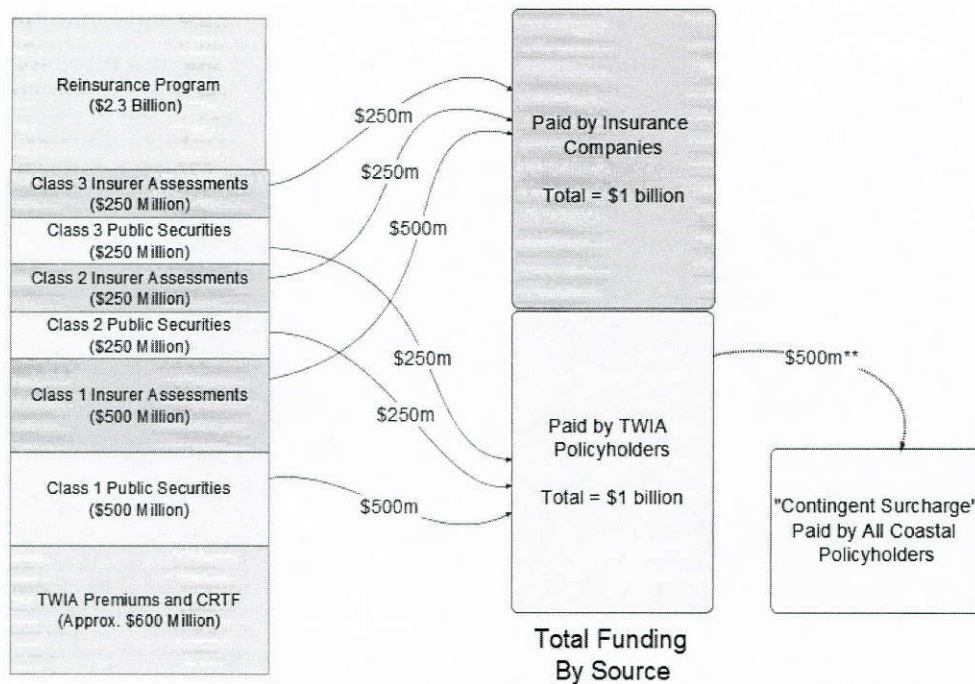
to be funded through the issuance of three classes of “public securities” that could have provided up to \$2.5 billion in funding.¹⁰ The following chart outlines the three classes of public securities and their sources of funding prior to the passage of SB 900:



Commissioner’s Order #4300 implemented the new funding system pursuant to SB 900 that can provide up to \$2 billion in funding for excess TWIA losses.¹¹ Specifically, Order #4300 implements the three new classes of funding and makes substantial changes to the existing classes of public securities. The following chart outlines the new funding structure and identifies the source of funding for each class:

¹⁰ TWIA, 2014 Statutory Financial Statements and Supplemental Information, page 6 available at: <https://www.twia.org/wp-content/uploads/2015/03/2014-TWIA-Audited-STAT.pdf.pdf>

¹¹ TWIA, 2015 Statutory Financial Statements and Supplemental Information, page 6 available at: <https://www.twia.org/wp-content/uploads/2015/03/TWIA-STAT-2015.pdf>



As you can see from this chart, there are three new classes of funding labeled “insurer assessments”. Prior to SB 900, insurers were subject to assessments in order to repay a portion of the Class 2 Public Securities and the entire Class 3 Public Securities. Going forward, insurers will be directly assessed by the three classes of “insurer assessments” instead of being required to repay public securities.¹²

SB 900 modified the funding sources for the existing three classes of Public Securities in a number of ways. As previously mentioned, insurer assessments will no longer be used to repay public securities. Instead, SB 900 utilizes the net revenue from TWIA premiums as the primary source of funding for all three classes of public securities.¹³ Once a class of public securities has been issued, if the net revenue from TWIA premiums is not sufficient to pay for any outstanding class of public securities, TWIA is required to “promptly” submit a request to the Commissioner to approve a surcharge on TWIA policies.¹⁴ The Order also authorizes the Commissioner to independently determine that net premium and other revenue are not sufficient to pay for any outstanding class of public securities and institute a surcharge on TWIA policies.¹⁵

SB 900 created a “contingent surcharge”¹⁶ that can be utilized in the event that Class 2 or Class 3 Public Securities are not marketable or are financially unreasonable. In order for TWIA

¹² TDI, *SB 900 (84R) Implementation*, at 3, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016101210001/b81da2f7-6551-4cd0-b0ef-f3598c7b3b4c.PDF> [hereinafter *TDI Written Testimony*].

¹³ TEX. INS. CODE §2210.612 (a)(1); 2210.613 (a)(1); 2210.614 (a)(1).

¹⁴ 28 T.A.C. §5.4126(a).

¹⁵ 28 T.A.C. §5.4126(d).

¹⁶ TEX. INS. CODE §2210.6132; see also 28 T.A.C. §5.4126(a). A **contingent surcharge** would be applied to certain policies that cover insured property located in a catastrophe area. Specifically, the surcharge would apply policies written for the following types of insurance: commercial fire; commercial allied lines; farm and ranch owners; residential property insurance; commercial multiple peril (nonliability portion); private passenger automobile no

to obtain approval to utilize the contingent surcharge, they must submit a written request to the Commissioner with information specified in 28 T.A.C. §5.4127(a).¹⁷ The Commissioner, after consultation with Texas Public Finance Authority (TPFA), may order that Class 2 or Class 3 Public Securities be paid by the contingent surcharge if either the TPFA is unable to issue the public securities or the issuance of the public securities is financially unreasonable for TWIA.¹⁸

Order #4300 outlines the process for initiating the different levels of funding within the TWIA funding structure. As previously stated, TWIA losses are first paid from the net TWIA premium revenue and then by the funds held in the CRTF. The Order then requires TWIA to request the issuance of the statutorily authorized principal amount of Class 1 Public Securities (\$500 million) before TWIA may request the Commissioner approve Class 1 Insurer Assessments.¹⁹ The Order addresses issues that could arise if TWIA begins to make principal payments on pre-event Class 1 Public Securities. In this scenario, any payments made to repay principal on pre-event Class 1 Public Securities would be considered depleted in the catastrophe year in which the principal payments were made.²⁰ Therefore, if TWIA made principal payments in catastrophe years prior to a large event, they would be required to re-issue Class 1 Public Securities in amount needed to reach the statutorily authorized principal amount (\$500 million) before insurers could be assessed through Class 1 Insurer Assessments. If the TPFA cannot issue all or any portion of the Class 1 Public Securities, TWIA may request and the Commissioner may approve the imposition of Class 1 Insurer Assessments.²¹ This addresses what happens if, for a catastrophe year, TPFA cannot issue all of the Class 1 Public Securities authorized by Insurance Code §2210.072.²² The amendments also make clear that if the commissioner approves a Class 1 Assessment under subsection (c), subsequent layers of public securities and assessments must be issued and ordered as provided for in statute.²³

C. Commissioners Order #4203

The Commissioner approved Commissioner's Order #4203, which started the process to implement depopulation programs as required by SB 900.²⁴ SB 900 authorized two different depopulation programs, the Voluntary Market Depopulation Program and the Assumption

fault (personal injury protection (PIP)), other private passenger automobile liability, private passenger automobile physical damage; commercial automobile no fault (PIP), other commercial automobile liability, and commercial automobile physical damage.

The contingent surcharge would not apply to a farm mutual insurance company; a nonaffiliated county mutual fire insurance company; a mutual insurance company or a statewide mutual assessment company engaged in business under Chapter 12 or 13, Title 78, Revised Statutes; and premium and policies issued by an affiliated surplus lines insurer that a federal agency or court of competent jurisdiction determines to be exempt from a premium surcharge under TEX. INS. CODE Chapter 2210.

¹⁷ 28 T.A.C. §5.4127(a).

¹⁸ 28 T.A.C. §5.4127(d).

¹⁹ 28 T.A.C. §5.4161(f).

²⁰ 28 T.A.C. §5.4125(d).

²¹ 28 T.A.C. §5.4161(c).

²² TDI, *Commissioners Order #4300*, page 11, available at:

<http://www.tdi.texas.gov/rules/2015/documents/order4300.pdf>

²³ *Id.*

²⁴ Senate Bill 900(84R), page 30, line 8-27; page 31-32; page 33, line 1-2.

Reinsurance Program. Order #4203 requires TWIA to obtain the Commissioner's approval for any depopulation program that encourages the transfer of TWIA policies to insurers through the private market.²⁵ Additionally, the Order requires TWIA to obtain the Commissioner's approval for any assumption reinsurance program.²⁶ Lastly, the Order specifies that only admitted insurance companies are able to participate in the program, which precludes surplus lines insurers from participating.²⁷

TWIA proposed a voluntary market program on February 22, 2016 and it was approved by the Commissioner on March 31, 2016.²⁸ No companies have asked to participate in the new voluntary program since its approval in March 2016.²⁹

TWIA proposed an assumption reinsurance program in June 2016 and the Commissioner approved the program in July 2016.³⁰ TDI and TWIA reported the following information to the Committee at the October 12th hearing:

Timeline for the Assumption Reinsurance Program:

- **8/25/2016** - Four companies completed the requirements for the Assumption Reinsurance Depopulation Program, and provided TWIA with their list of take-out offers. These four companies made 108,949 unique take-out offers to TWIA policyholders, which represents approximately \$32.6 billion in direct exposure.³¹
- **9/1/2016 – Agent Period Begins.** Agents are notified that their TWIA policyholder received a take-out offer. Agents are given the opportunity to review and approve or reject any take-out offers.³²
- **10/31/2016 – Agent Period Ends.** Last day for agents to approve take-out offers. If no action is taken by the agent, the take-out offer is automatically rejected.³³
- **12/1/2016 – TWIA Policyholders Period Begins.** TWIA policyholders are notified of the take-out offer, if their agent approved the offer. Policyholders must notify TWIA if they would like to decline the take-out offer.³⁴
- **5/31/2017 – TWIA Policyholder Period Ends.** Last day for TWIA policyholders to decline the take-out offer. If no action is taken, the take-out offer is automatically accepted.³⁵

²⁵ 28 T.A.C. §5.4306(c).

²⁶ 28 T.A.C. §5.4307(c).

²⁷ 28 T.A.C. §5.4307(c).

²⁸ 28 T.A.C. §5.4301(6).

²⁹ *TDI Written Testimony*, at 4.

³⁰ *TDI Written Testimony*, at 5.

³¹ TWIA, *Written Testimony Prepared for the Texas House Committee on Insurance*, at 9-10, 15, available at <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016101210001/c5d814ad-afb8-4142-8983-ff96c5a52ed3.PDF>.

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ *Id.*

II. Actions Taken by TWIA to Implement SB 900

A. Changes to the TWIA Plan of Operation

TWIA submitted a revised Plan of Operation to TDI on May 6th, 2016.³⁶ The “Summary of Changes” section provided by TWIA indicated that only change that was made to comply with SB 900 was for “revised language regarding investment of CRTF funds”³⁷

B. TWIA Board Actions

The TWIA Board took the following actions to implement provisions included in SB 900:

- SB 900 required TWIA to purchase reinsurance in an amount that would provide total funding for the 100 year probable maximum loss.³⁸ In 2015, TWIA purchased \$2.3 billion in total reinsurance, above a \$2.6 billion retention, thus providing \$4.9 billion in total funding.³⁹ In 2016, the Board approved the purchase of \$2.2 billion in total reinsurance, above a \$2.7 billion retention, thus providing \$4.9 billion in total funding.⁴⁰ The probable maximum loss for a 1 and 100 year event was \$4.9 billion in 2015⁴¹ and \$4.7 billion in 2016⁴²
- SB 900 required TWIA to offer a temporary policy to applicants who are unable to obtain a TWIA policy because the applicant is in the process of obtaining a WPI-8.⁴³ The TWIA Board approved language for temporary (30 day) policies on August 4th, 2015.⁴⁴ During testimony to the Committee, TWIA indicated that 53 policies have been issued on a temporary basis since they began to offer the temporary policy.⁴⁵
- SB 900 required TWIA to determine a sufficient balance for the CRTF, and notify the Comptroller if there are funds in excess of that sufficient balance.⁴⁶ The Comptroller is then required to invest the excess funds in a less restrictive manner using a “prudent investment standard”⁴⁷ The following excerpt is from the “Minutes at the TWIA Board Meeting” held on August 2, 2016:

³⁶ TWIA, *Cover Letter for Revised Plan of Operation*, available at:

<http://www.tdi.texas.gov/submissions/other/documents/twiapocoverltr.pdf>

³⁷ TWIA, *Revised Plan of Operation*, on page 5, available at:

<http://www.tdi.texas.gov/submissions/other/documents/twiaposummary.pdf>

³⁸ Senate Bill 900(84R), page 17, line 16-23.

³⁹ TWIA, *Board Meeting Materials for August 2, 2016*, page 12, available at: <https://www.twia.org/wp-content/uploads/2015/03/TWIA-Board-of-Directors-Meeting-Materials-May-2016-Final.pdf> [hereinafter *August 2, 2016 Board Meeting Materials*].

⁴⁰ TWIA, *Board Meeting Materials for August 4, 2015*, page 12, available at: <https://www.twia.org/wp-content/uploads/2015/07/August-TWIA-Board-of-Directors-Meeting-Materials.pdf> [hereinafter *August 4, 2015 Board Meeting Materials*].

⁴¹ *August 2, 2016 Board Meeting Materials*, at 41.

⁴² *August 2, 2016 Board Meeting Materials*, at 12.

⁴³ Senate Bill 900 (84R), page 13, line 18-24.

⁴⁴ TWIA, *Board Meeting Materials for February 23, 2016*, page 16, available at: <https://www.twia.org/wp-content/uploads/2015/04/February-TWIA-Board-Meeting-Materials.pdf>

⁴⁵ October 12th Hearing at 1:16:15.

⁴⁶ Senate Bill 900(84R), page 16, line 20-26.

⁴⁷ Senate Bill 900(84R), page 16, line 12-19.

Since there is a reasonable possibility that all of the funds in the CRTF may be required to be utilized in the event of a catastrophic event, TWIA staff believes that all the funds in the CRTF are necessary to meet the potential cash flow requirements of the fund in funding the payment of insured losses as provided by Section 2210.4521 (a). Thus, there are no excess funds in the CRTF at this time to be invested by the Comptroller under the prudent investor standard set forth in Chapter 424 of the Government Code. Mr. Gerik moved that based on Association staff analysis and recommendation of the Board of Directors hereby determines that at this time the entire balance of the Catastrophe Reserve Trust Fund is required to be kept available to meet the cash flow requirements of the fund in funding the payment of insured losses as provided by Section 2210.4521(a) of the Texas Insurance Code. Thus staff is directed to notify the Texas Comptroller's office that the fund balance does not exceed the sufficient balance as defined in statute. Mr. Fields seconded the motion. The motion passed unanimously.

III. SB 900 Provision Still to be Implemented

SB 900 requires TDI to perform a study on market incentives to promote participation in the voluntary coastal windstorm insurance market.⁴⁸ TDI sent a survey to voluntary insurers on February 18th, 2016 and responses were due on April 18th, 2016.⁴⁹ TDI staff is compiling the results and will include the study in its Biennial Report to the 85th Legislature.⁵⁰

SB 900 also requires the TDI to adopt, by rule, procedures related to the disbursement of money from the CRTF for TWIA's administration expenses directly related to funding the payment of insured losses, and for operating expenses, including reinsurance or alternative risk financing mechanism.⁵¹ According to the testimony from TDI, these rules are in progress.

⁴⁸ Senate Bill 900 (84R), page 2, line 1-11.

⁴⁹ *TDI Written Testimony*, at 1.

⁵⁰ *Id.*

⁵¹ *Id.* at 3.

CHARGE #7 POST-ACUTE BRAIN INJURY REHABILITATION

Review the implementation of HB 2929 (83R). Examine the bill's impact and compliance among affected health plans. Examine the costs incurred by the Employees Retirement System, Teacher Retirement System, and any other affected state health plans as a result of the legislation.

Introduction

According to the Brain Injury Association of America, an acquired brain injury is an injury to the brain, which is not hereditary, congenital, degenerative, or induced by birth trauma. An acquired brain injury is an injury to the brain that has occurred after birth.¹ Texas Law, requires health plans to cover treatment related to an acquired brain injury rehabilitation,² but how the plan administers those benefits depends on whether the plan is offered through the individual market or State Plans, or by a small employer. This regulatory distinction grants small employer plans more administrative flexibility and consequently, the loopholes and workarounds at issue in this charge only apply to individual and State plans since the controversial activities are statutorily allowed in small employer plans.³

Furthermore advocates for increased access to brain injury rehabilitation stress the unique severity that brain injuries cause for patients and highlight the important differences that rehabilitation treatments have compared to injuries such as a broken bone. Dr. Brent Masel representing the Texas Brain Injury Providers Alliance described the severity as the following:

A broken brain is not like a broken nose. It is the beginning of a disease process. A brain injury is disease causative and it is disease accelerative. Somebody with a [traumatic brain injury] is twice as likely to develop Alzheimer's disease. Their life expectancy reduction is between seven and a half and nine years. They have three times the likelihood of developing a brain tumor and have a [remarkably] increased risk for developing strokes I think a brain injury is the worst disease of all [A] brain injury, a brain injury will take your soul. It takes the essence of who you are.⁴

Dr. Masel also testified that rehabilitation centers like his provide both inpatient and outpatient treatment with the average length of stay being around 78 days. The patient receives five to six hours of organized licensed therapy including occupational therapy, physical therapy, speech

¹ Brain Injury Association of America, *What is the difference between an acquired brain injury and a traumatic brain injury?* available at: <http://www.biausa.org/FAQRetrieve.aspx?ID=43913>.

² TEX. INS. CODE §1352.001.

³ Small employers have more leeway to determine how they administer the brain injury rehab mandate and are regulated separately under §1352.0035 and 28 TAC §21.3106. Small employer health benefit plans are not subject to the same administrative constraints, such as lifetime and annual cap prohibitions, thus have more flexibility to authorize and deny treatment. Therefore, the controversies related to this charge do not apply to them. Since the loopholes and controversies in question for this charge occur only in individual and State Plans, the rest of this analysis focuses only on law and regulations that apply to individual and State plans.

⁴ March 30th Hearing on Charge #7 at 9:55 10:42, available at: http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11837. [hereinafter March 30th Hearing].

therapy, recreational therapy, neuropsychological therapy, and any other necessary medical treatment.⁵ Moreover, in 2007 the Texas Sunset Advisory Commission found that acquired brain injuries may result in temporary or permanent cognitive, physical and behavioral impairments. People with moderate or severe brain injuries may require weeks, months, or years of rehabilitative therapies to regain previous levels of functioning or learn ways to compensate for impairments.⁶

The Legislature recognized the seriousness of this treatment and passed legislation mandating coverage in insurance plans. To explain the evolution of the post-acute brain injury rehab mandate in Texas, the report is divided into three sections. Section one provides a summary of the history of the brain injury rehab mandate and the subsequent loopholes that followed its enactment. Section two explains the controversy at issue in this charge which has developed since enactment of HB 2929 of the 83rd Legislature. Section three gives the costs incurred by the state as reported to the Committee.

I. The Development of Post-Acute Brain Injury Rehab Regulations

As stated above, brain injury rehab has been a required benefit since 2001. Representative Lon Burnham authored HB 1676 which prohibited plans from denying coverage for brain injury rehab. According to the bill analysis, some plans did not offer brain injury rehab coverage and some health plans that did were characterizing brain injuries as mental illnesses rather than physical injuries. Since the plans did not offer mental care services, they denied the enrollee's benefit based on that characterization. HB 1676 ended this practice by delineating a detailed list of services that encompass a broad range of brain injury rehab services and subjecting them to the same copayment, deductible, and coinsurance requirements as other similar coverage under the plan. The following are the list of services that were originally enacted by HB 1676 but have since been modified by legislation. They are:

- cognitive rehabilitation therapy,
- cognitive communication therapy,
- neurocognitive therapy and rehabilitation,
- neurobehavioral,
- neurophysiological,
- neuropsychological, and
- psychophysiological testing or treatment,
- neurofeedback therapy,
- remediation required for and related to treatment of an acquired brain injury.
- post-acute transition services, or
- community reintegration services necessary as a result of and related to an acquired brain injury.⁷

⁵ March 30th Hearing at 14:04.

⁶ Sunset Advisory Commission, *Summary of Sunset Recommendations, Study of Health Benefit Plan Coverage for Brain Injuries*, page 197.

⁷ TEX. INS. CODE §1352.003(a-b).

Since the passage of HB 1676, subsequent legislation has made both psychological testing "and" treatment requirements mandatory—before, plans could make a choice between the two. After, the benefit became a mandate, certain health plans found ways to circumvent it. The following sub-sections address the loopholes in chronological order.

A. Assisted Living Facility Loophole

Assisted living facilities (ALF) are commonly associated with nursing homes, however not all facilities that fall under the definition of ALF. In Texas post-acute brain injury rehabilitation centers (rehab centers) are defined as ALFs for licensing purposes but are not nursing homes. Rehab centers do not have their own licensure category, so they must register as assisted living centers since it is the closest definition they meet.⁸ Since certain plans did not cover ALFs, they used the licensure definition as a loophole to deny coverage and circumvent the brain injury rehab mandate. In 2007, the Legislature closed this loophole in HB 1919 by Todd Smith.⁹ HB 1919 added §1357.007 of the Insurance Code which states that a:

health benefit plan may not deny coverage based *solely* on the fact that the treatment or services are provided at a facility other than a hospital. Treatment for an acquired brain injury may be provided at a facility at which appropriate services may be provided, including a hospital, an acute or post-acute rehabilitation hospital; and an *assisted living facility* regulated under Chapter 247, Health and Safety Code.

HB 1919 also added the requirement that individual and state plans must provide inpatient and outpatient day treatment services including post-acute care.¹⁰ The bill effectively closed the ALF loophole but a new loophole was found to continue circumventing the brain injury rehab mandate.

B. Custodial Care Loophole and Stronger ALF Protections

When the ALF loophole was closed certain plans continued using the nursing home care angle but instead of focusing on the licensure definition of the facility, they switched their attention on the treatment activity. Certain health plans began characterizing brain injury rehab as custodial care, which is non-medical assistance that takes place at home or in a nursing home. It consists of activity that the patient cannot do on their own such as bathing, cooking, and eating. However, brain injury rehab is more complex than help with bathing. According to the Brain Injury Association of America, post-acute brain injury rehab is described as inter-disciplinary multi-specialty rehabilitation programs intended for patients who are medically stable and at least

⁸ In fact, rehab centers attempted to get their own licensure category during the 81st Legislature in 2009. Senator Zaffirini authored SB 2260 but failed to get the bill out of committee.

⁹ HB 1919 also added requirement that health plans must give notice to enrollees that brain injury rehab is covered and prohibited plans from placing lifetime caps on the number of days of acute and post-acute care treatment. TEX. INS. CODE §1352.003 & §1352.005. Furthermore plans are required to cover the reasonable costs for periodic reevaluations of the injury. TEX. INS. CODE §1352.003(c)(e).

¹⁰ TEX. INS. CODE §1352.003 (a-b); In addition to these requirement small group health plans are also required to provide post-acute transition and community reintegration services, TEX. INS. CODE §1352.0035(a).

minimally responsive. Post-acute brain injury rehab services are considered medically necessary and provided under physician prescription. Admission may follow acute hospitalization, acute rehabilitation, psychiatric hospitalization, skilled nursing, nursing home, long-term acute care, or home.¹¹ The association includes a list of services that may compose these programs which is very similar to the list found in HB 1676 described above.

II. Development Since House Bill 2929 Was Enacted

HB 2929 strengthened the consumer protections by adding a provision that prohibited plans from placing annual caps on acute and post-acute treatment so long as the treatment was deemed medically necessary. All parties agree that inpatient "medical necessity" is determined by the treating physician. However there is disagreement over who determines "medical necessity" for outpatient care. Is it the treating physician or the health plan?¹² Also, the bill added the provision that prohibits health plans from characterizing brain injury rehab given at an assisted living facility as custodial care so long as the assisted living facility is accredited by CARF.¹³

HB 2929 closed this loophole by adding sub-section (e) to §1352.007 which prohibits plans from classifying brain injury rehab as custodial care if the care takes place at a facility that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or other nationally recognized accreditation program. Furthermore, HB 2929 strengthened the ALF protections by prohibiting health plans from refusing to contract with ALFs or deny admission to the facility solely because a facility is licensed by the state of Texas as an ALF.¹⁴ The bill also added a sub-section that requires health plans to ensure that brain injury rehab services are made available and accessible to the insureds at an adequate number of ALFs.¹⁵

Since the enactment of HB 2929, new complaints have been reported that plans have found a new way to circumvent the brain injury rehab. This one involves two different interpretations of the statute language laying out who determines medical necessity for outpatient care. At most, the language is ambiguous as to whether the treating physician or the health plan determines medical necessity for outpatient treatment.

A. Ambiguity on Who Determines "Medical Necessity"

The language in question is found in §1352.003(c-1) which states:

A health benefit plan may not limit the number of days of covered post-acute care, including [outpatient day treatment services¹⁶], or the number of days of covered inpatient care to the extent that the treatment or care is determined to be *medically necessary* as a result of and related to an acquired brain injury. The insured's or enrollee's *treating physician* shall determine whether treatment or care is *medically necessary* in consultation with the treatment or care provider,

¹¹ Brain Injury Association of America, *Navigating The Insurance Maze After Brain Injury*.

¹² TEX. INS. CODE §1352.003(c-1).

¹³ TEX. INS. CODE §1352.007(e).

¹⁴ HB 2929 by Sheets, TEX. INS. CODE §1352.007(c).

¹⁵ HB 2929 by Sheets, TEX. INS. CODE §1352.007(d).

¹⁶ TEX. INS. CODE §1352.003(b).

the insured or enrollee, and, if appropriate, members of the insured's or enrollee's family. The determination is subject to [a utilization review]. [emphasis added]

It is clear from this language that the health plan cannot limit the number of days for outpatient and inpatient care that is deemed medically necessary. Furthermore, all parties agree that inpatient care medical necessity is determined by the treating physician. Where they disagree, and where the language is ambiguous, is whether the treating physician also determines medical necessity for outpatient care. The health plans interpret the statute to read that the authority to determine medical necessity for outpatient care is reserved for them. This interpretation works in their interests because it allows them to end treatment for outpatient care unilaterally and without the permission of third parties such as a physician.

Also, Jane Boutte representing the Brain Injury Association of America - Texas Division testified to the Committee that some insurance carriers obstruct access to needed rehabilitation by:

- Placing arbitrary limits on rehabilitation, even when the patient's physician, treatment team, and family have determined the care was medically necessary.
- Denying request for admission to post-acute transitional rehabilitation because they inappropriately apply criteria for acute inpatient rehabilitation level of care.
- Denying pre-authorization requests on the basis that the individual does not have benefits for the services requested such as transitional rehabilitation; however, the services requested are listed as a benefit in their insurance policy booklet as well as their benefit summary and, are often listed almost word for word as outlined in Insurance Code 1352.
- Placing "hard limits" on benefits for various parts of the continuum, in violation of §1352 of the Insurance Code.
- Trying to combine benefit buckets for example between outpatient day neuro and traditional outpatient.
- Denying access to traditional outpatient services stating that there are no benefits available if requested 6 months after the onset of their acquired brain injury.¹⁷

However, these same advocates also acknowledged that many insurance companies comply with the requirement in §1352 of the Insurance Code and that the problem is limited to a minority of carriers.¹⁸

B. Determination of "Medical Necessity" and the Appeal Process

TDI testified before the Committee that they are unable to make a medical necessity determination because that would constitute the practice of medicine.¹⁹ However, they do have indirect influence on the review process through certification of utilization review agents (URA)

¹⁷ Brain Injury Association of America - Texas Division Written Testimony, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/4062b2e9-a6a2-45c8-ab6e-9196fc06c221.PDF>.

¹⁸ *Id* at page 1; March 30th Hearing at 13:50.

¹⁹ March 30th Hearing at 41:00.

and independent review organizations (IRO). Furthermore, TDI provided the Committee with the following overview of the medical necessity determination and appeals processes.

1. Utilization Review Process²⁰

Once a provider determines based on their professional opinion that a medical service is medically necessary either the provider or patient submits requests for medical services to the health plans.

- Once the request is received the plan's URA compares the patient's medical indications to the health plan's or URA's established medical guidelines and policies.
- If the requested service is within those guidelines, the URA may approve the requested service. If the URA determines that the services are not within the established guidelines, the URA is required to notify the patient, or person acting on behalf of the patient, and the provider. However, before issuing the adverse determination, the URA must provide a peer-to-peer discussion with the provider requesting the service.
- The provider, patient, or person acting on the patient's behalf may appeal the denial internally to the URA. In evaluating the appeal, the URA must use a different physician than the one who conducted the initial review.

2. Independent Review Organization Process

If the plan again upholds the denial of the requested service, the provider or patient can request a review by an IRO. In circumstances involving life threatening conditions or denials of prescription drugs and intravenous infusions, the parties have the right to seek a review by an IRO without initially filing an internal appeal with the URA.

- When a patient or provider requests an independent review, TDI assigns the request to a certified Texas IRO. The IRO has three days for expedited reviews and up to 20 days for non-expedited reviews to make a decision.
- The IRO reviewer must be appropriately licensed, trained, and qualified to review the case and determine medical necessity.
- The IRO's decision is binding on the health plan, and the health plan must pay for the independent review. The IRO must provide the decision to all involved parties.
- If the parties disagree with the IRO decision, they may pursue the issue in district court.

3. Complaint Process

TDI also explained to the committee that it has several enforcement tools that can be used when a carrier is found to be non-compliant with state requirements. Those tools include management conferences, warning letters, commissioner orders with restitution to policyholders, fines, emergency cease and desist orders, and revocation of the carrier's certificate of authority. Most

²⁰ TDI, *HB 2929 (Acquired Brain Injury)*, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/50b550bb-c1fb-4f20-9126-cf70545b01e0.PDF>. [hereinafter *TDI Written Testimony*].

acquired brain injury enforcement actions are resolved with an order and an administrative penalty. TDI outlined the process for the Committee and it is the following:

- TDI receives the complaint from the insured.
- The complaint is entered into a tracking database maintained by TDI.
- An acknowledgement letter is sent to the complainant.
- An inquiry letter is sent to the carrier.
- The carrier has 15 days to respond to the inquiry letter.
- Once the response is received a TDI specialist reviews the response.
- A response is then drafted to the complainant.

From this point the complaint is either resolved and closed, resolved and referred to fraud if any is suspected, or resolved and referred to enforcement.²¹

4. Committee's Response to the Medical Necessity and Appeals Processes

The Committee expressed some concerns in response to TDI's overview of the determination and appeals process. Specifically, some members explained that they are wary of the fact that Texas law does not require the reviewing physician to reside or be licensed in the State of Texas.²² Under current Texas law the only licensure requirement for the reviewing physician is that they be licensed by a United States jurisdiction.²³ However, licensure in another state does not give TDI any ability to directly discipline a reviewing physician who wrongfully denies a medical necessity request; a fact with which some Committee members were troubled.²⁴ Nevertheless, the department is not completely left without options. They can discipline the action of wrongfully denying a medical necessity request by disciplining the URA via an enforcement action for using an unqualified physician.²⁵ Another concern raised by the Committee is the order in which an IRO is able to review a medical necessity determination. Under current law, an insured must be denied twice before an IRO can review the case, as a result of the URA process. Some members expressed interest in exploring the feasibility of making the IRO reviewer the first to review.²⁶

III. Costs to the State

There are multiple ways that the brain injury rehab mandate can and does have a fiscal impact on the State. As stated above, HB 1919 expanded the mandate's scope to the Employment Retirement System (ERS), Teacher Retirement System (TRS), and University of Texas and Texas A&M health plans (University Plans). Moreover, HB 2929 expanded the mandate to Group Health Benefit Plans for School District Employees. ERS and TRS are administered by the State and are funded in part through general revenue. Furthermore, the denial of brain injury

²¹ *TDI Written Testimony*, at 1-2.

²² March 30th Hearing at 49:30.

²³ March 30th Hearing at 49:48. Except for Workers Compensation cases, where Texas law requires the physician to be licensed by the State of Texas, March 30th Hearing at 51:40.

²⁴ March 30th Hearing at 49:50.

²⁵ March 30th Hearing at 51:05.

²⁶ March 30th Hearing at 52:50.

rehab in the private market also has a State fiscal impact via the Comprehensive Rehabilitation Services program (CRS). CRS is a State funded program created to provide rehabilitation services for individuals with traumatic brain injuries who cannot gain coverage or were denied it in the private market.²⁷

A. Employment Retirement System

According to written testimony provided to the Committee by the ERS, HealthSelect of Texas was covering an unlimited number of medically necessary rehabilitation services for brain injury prior to the passage of HB 2929. The bill did not add or change any services or limit to the existing plan design. Therefore, it had no fiscal impact to the State. To date, the plan has incurred no additional expense due to HB 2929, other than the impact of normal medical inflation.²⁸

B. Teacher Retirement System

According to written testimony provided to the Committee by TRS, HB 2929 did not expand coverage materially for either its ActiveCare plan or its TRS-Care plan and as a result, TRS experienced no financial impact. For fiscal year 2015, TRS-Care and ActiveCare, the total expenditure for brain injury related care was less than \$1M in each plan.²⁹

C. Comprehensive Rehabilitation Services (CRS) program

The cost to the state occurs when the beneficiary's health plan denies treatment that they need. This is because Comprehensive Rehabilitation Services (CRS) coverage is triggered when the beneficiary no longer has private coverage. The Department of Assistive and Rehabilitative Services (DARS) CRS program was implemented to fill a service gap for intensive rehabilitation services for individuals who have experienced a traumatic brain injury (TBI) or traumatic spinal cord injury (SCI).³⁰ The CRS Program provides services needed to help consumers live independently in their home and community. The program focuses on three primary areas that affect both function and quality of life: mobility, self-care, and communication skills.³¹ Services are provided in the person's home, a hospital, a residential facility, an outpatient clinic, or in a combination of settings.

1. CRS Eligibility Requirements

Comparable benefits—when available—such as private insurance, crime victim's funds, Medicaid, Medicare, and indigent health organizations pay for these services. When a consumer has a comparable benefit, the program works with the CRS provider to ensure the comparable

²⁷ Texas Department of Assistive and Rehabilitative Services, Comprehensive Rehabilitation Services, available at: <http://www.dars.state.tx.us/drs/crs.shtml>.

²⁸ ERS Letter to the Chairman Frullo, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/2c6ff282-d550-460c-8989-68fa6da4bbd9.PDF> (written testimony submitted to the Committee for March 30th Hearing).

²⁹ Teacher Retirement System of Texas, *Texas House of Representatives Committee on Insurance*, at 2-3, available at: <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/06aae644-d8a4-425a-9b75-154f60c883ae.PDF> (written testimony submitted to the Committee for March 30th Hearing).

³⁰ HUM. RES. CODE § 111.052; 40 TAC §107.701.

³¹ 40 TAC §107.711.

benefit is billed by the provider prior to CRS funds being expended. CRS funds are expended only after other resources have been exhausted.

To be eligible for the CRS program, an individual must:

- have a traumatic brain injury or traumatic spinal cord injury;
- at least 15 years of age;
- U.S. citizen or lawful permanent resident, and a Texas resident;
- Denied access or treatment by health plan but the patient may participate in rehabilitation programs that offer complementary rehabilitation services;
- Be willing to participate in services; and
- be medically stable.³²

CRS provides time-limited services through contracts with local providers and may include:

In-patient Comprehensive Medical Rehabilitation - Medical experts provide consumers with therapy, medical care, and other help.

Outpatient Services - Therapists help consumers increase their ability to perform daily living activities through physical, occupational, speech, and/or cognitive rehabilitation.

Post-Acute Traumatic Brain Injury Services - These services help consumers deal with forgetfulness or difficulties in solving problems and other mental or thought issues related to their injury and are offered on a residential and non-residential basis.

In 1997 the 75th Legislature established the Comprehensive Rehabilitation Fund 107 (CRF 107). The CRF 107 provides approximately two-thirds of the CRS appropriations in any given fiscal year and is funded by a percent of funds collected on surcharges on all misdemeanor and felony convictions.³³

2. Costs to Individual Plans

TDI reported to the Committee it is "difficult to isolate HB 2929's impact on fully insured health plans sold in the individual market because the expanded coverage requirements took effect at the same time enrollment increased dramatically. as a result of the Affordable Care Act."³⁴ However, in 2015 TDI released a report that determined the costs associated with mandated health benefits which includes coverage for acquired brain injuries. Although this report did not limit its analysis to the costs incurred from reforms in HB 2929, it does provide important insight on the costs of the mandate to the individual market. In the report TDI determined that the acquired brain injuries mandate's cost on all health plans in the individual market was \$7,588,788 from October 2013 - September 2014, which was 0.24% of total claims paid

³² 40 TAC §107.707.

³³ TEX. INS. CODE §111.060; Statute referencing surcharges on misdemeanors and felony convictions can be found at LOC. GOV'T CODE §133.102.

³⁴ TDI Written Testimony, at 3-4.

(TCP).³⁵ The average premium cost for single coverage was \$20.61 and for family coverage \$49.80.³⁶ Plans also reported that they paid 42,312 claims (1.22% of TCP).³⁷

³⁵ TDI, *Texas Mandated Benefit Cost and Utilization Summary Report October 2013 – September 2014*, at 12.

³⁶ *Id.* at 15.

³⁷ *Id.* at 13.

CHARGE #8 WORKERS' COMPENSATION INSURANCE FRAUD

Review current statutory provisions regarding the prosecution of workers' compensation insurance fraud. Examine ways to maintain or enhance fraud prosecution while ensuring a fair process for all parties involved.

Introduction

According to §701.051 of the Insurance Code, insurance carriers must report within thirty days activities that they determined or reasonably suspect is fraud.¹ There are five categories of workers' compensation fraud which are benefit fraud, premium fraud, fraud by employees, fraud by employers, and fraud by healthcare providers² and §701.051 applies to all lines of insurance.³ Insurance carriers must report the suspected fraud in writing to the insurance Fraud Unit at Texas Department of Insurance (TDI) and may also report the information to another authorized government agency such as a local law enforcement, county attorneys, or US attorneys.⁴ Furthermore, if they report it to a statutorily authorized organization, a person who reports fraud or suspected fraud is immune from civil action, including libel or slander.⁵ However, according to §701.052, persons who report make the report with malice, fraudulent intent, or bad faith do not enjoy immunity.⁶

At the referral for prosecution stage, the process diverges based on whether the suspected workers' compensation (workers' comp) fraud was committed against Texas Mutual Insurance Company or one of the other workers' comp insurers in the state. Texas Mutual is the only workers' comp insurer that is statutorily authorized to enter into funding agreements with local prosecutors to prosecute their cases. At the time of the writing of this report, Texas Mutual has only entered into a funding agreement with the Travis County District Attorney's Office (Travis County D.A.). As a consequence of the arrangement, two systems of workers' comp fraud investigation and prosecution has arisen. One system requires all insurers, besides Texas Mutual, to refer these cases to the TDI Fraud Unit who investigates the cases and decides whether to refer it for prosecution. The other system allows Texas Mutual to independently investigate and refer their cases directly to the prosecutor—thus bypassing TDI.

As a result of recent pressure brought about from local leaders and the press, at the time of this writing, this system has been temporarily suspended until after the Legislature has had the opportunity to decide whether to extend Texas Mutual's authority to enter funding agreements. This report first outlines the investigation and prosecution process for workers' comp fraud in Texas and explains the separate investigation and prosecution process for Texas Mutual. Second

¹ TEX. INS. CODE §701.051

² TDI, Workers' Compensation Fraud Section, <http://www.tdi.texas.gov/fraud/frwcsection.html>.

³ Investigations may be made into matters ranging from Consumer Fraud, Provider Fraud, Insurer (agent or adjuster) Fraud or any other matter that is a penal violation and defined as a fraudulent insurance act across all lines of coverage from Auto, Home, Health, Life and even Workers' Compensation.

⁴ TEX. INS. CODE §701.051(a-b); TEX. INS. CODE §701.001(1)(A-B).

⁵ TEX. INS. CODE §701.052(a).

⁶ TEX. INS. CODE §701.052(c).

the report explains the recent controversy that led to suspending the agreement and the possible implications for TDI if the funding agreement authority were taken away from Texas Mutual.

I. Texas's Insurance Fraud Prosecution Framework

A. TDI Fraud Unit & Investigations

The TDI fraud unit is established by §701.101 of the Insurance code and is charged with investigating all fraudulent insurance acts including workers' comp. The insurance fraud unit is made up of commissioned peace officers⁷ who may request assistance from local law enforcement.⁸ Moreover, the Commissioner of Insurance is authorized by statute to issue subpoenas to compel the attendance and testimony of a witness or production of material relevant to a fraud investigation.⁹ Also, an insurance carrier that conducts an independent investigation is not required to complete the investigation before reporting fraud to TDI¹⁰ but once TDI begins the investigation they must provide information to the fraud unit.¹¹

According to testimony given to the Committee, the fraud unit is staffed with 51 positions made up of 36 investigators of which 34 are peace officers.¹² Of the 36 investigators, only 31 are assigned to investigate cases while the other three serve in a supervisory role.¹³ Of the 31 investigators only five are dedicated to investigating workers' comp fraud.¹⁴ Also, the fraud unit is funded through a maintenance tax paid by the insurance industry based on premium volume within the state. In fiscal year 2016 the budget for the fraud unit was \$3.4 million of which \$346,216 was dedicated to workers' comp fraud investigations.¹⁵

B. Workers' Comp Fraud Prosecutions and Texas Mutual's Unique Arrangement

When the fraud unit has developed sufficient evidence to warrant a prosecution they must refer the case to the appropriate prosecuting authority, which could be a local district attorney or U.S. attorney.¹⁶ Once the case is referred to the appropriate authority, TDI must assist the prosecutor when requested and provide all material, documents, reports, complaints, or other evidence requested by the prosecutor.¹⁷ In order to facilitate their obligation to assist local prosecutors, TDI developed a program which sends embedded prosecutors to certain counties to assist them in complex fraud cases. Currently TDI has embedded prosecutors in Dallas, Tarrant, Bexar, and Harris Counties.¹⁸

⁷ TEX. INS. CODE §701.104.

⁸ TEX. INS. CODE §701.105.

⁹ TEX. INS. CODE §701.106.

¹⁰ TEX. INS. CODE §701.108.

¹¹ TEX. INS. CODE §701.108.

¹² TDI, *Prosecution of Workers' Compensation*, available at:

<http://www.legis.state.tx.us/tlodocs/84R/handouts/C3202016033010001/f65f0718-c686-4ee8-8b43-be2d5631fcd4.PDF> [hereinafter *TDI Written Testimony*].

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ TEX. INS. CODE §701.103.

¹⁷ TEX. INS. CODE §701.103(b)(1-2).

¹⁸ *TDI Written Testimony*.

Since 2004, Texas Mutual has contracted with the Travis County D.A. to fund a unit dedicated solely to the prosecution of Texas Mutual fraud cases.¹⁹ According to the most recent modification of the contract, the funding is used to pay the salaries of two assistant district attorneys and three support personal as well as incidental expenses.²⁰ It is important to note, that Texas Mutual is also required under §701.051 to refer suspected fraud to the Fraud Unit. However, due to its funding agreement with the Travis County D.A., Texas Mutual's referrals to the Fraud Unit are obsolete since, by consequence of their referral authority, can rely on their own internal investigations for prosecution. According to TDI testimony, the Fraud Unit left the cases alone and did not initiate workers' comp fraud investigations for the company.²¹ That was until Texas Mutual and the Travis County D.A. agreed in October of 2015 to stop referring Texas Mutual fraud cases directly to the D.A.'s office.²² Until recently, the funding agreement was renewable on an annual basis, but since October has moved to a month to month renewal.²³

II. Issues and Concerns on Texas's Insurance Fraud Prosecution Framework

In September 2015, the Texas Tribune ran a story called "Paid to Prosecute" which investigated the funding agreement between Texas Mutual and the Travis County D.A. Office.²⁴ The report told the story of Roy Kyees who was indicted for insurance fraud by the Travis County D.A. even though he is a life-long resident of Odessa.²⁵ The charge burdened Kyees for over a year and was finally dismissed once his attorney provided a copy of the letter he sent to Texas Mutual. Kyees then sued Texas Mutual for malicious prosecution and reached a settlement for just under \$10,000.

A. History of Texas Mutual Funding Agreement

The legislative authority granted to Texas Mutual to enter funding agreements with local prosecutors is found in §2054.455 of the Insurance Code. This section is a vestige from the time when the predecessor to Texas Mutual, Workers' Compensation Insurance Fund, was a quasi-governmental agency operating under the authority and auspice of state government.²⁶ In the late 80's and early 90's the Texas's worker compensation system went under two waves of reform in response to numerous insolvencies which devastated the workers' comp system in Texas. The first wave created the Texas Workers' Compensation Insurance Facility which was the

¹⁹ Original Texas Mutual, Travis County DA Funding Agreement, at 4.

²⁰ Original Texas Mutual, Travis County DA Funding Agreement, at 12.

²¹ March 30th Hearing on Charge #8, at 1:13:30, available at: http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11837 [hereinafter March 30th Hearing].

²² March 30th Hearing at 1:13:30.

²³ Oct. 1, 2015 Letter to Travis County District Attorney Rosemary Lehmborg from Mary Barrow Nichols of Texas Mutual, available at: https://www.traviscountytexas.gov/images/district_attorney/docs/Press_Releases/2015/TXMutualAgreement100115.pdf.

²⁴ Root & Plohetski, *Paid to Prosecute*, available at: <http://apps.texastribune.org/paid-to-prosecute/>.

²⁵ Kyees suffered a back injury in the Midland oilfields and was evaluated by several doctors who gave him conflicting advice. After 10 months of evaluations Kyees obtained a part-time job with doctor approval that involved less strenuous work. Kyees informed Texas Mutual of his new job but they continued to send Kyees checks. However, Texas Mutual claimed they did not receive the letter and they subsequently accused him of insurance fraud and referred the case to the Travis County D.A. *Id.*

²⁶ March 30th Hearing at 1:40:55.

predecessor of Texas Mutual.²⁷ In 1989 the Legislature moved the assigned risk pool for Texas workers' comp to the Facility and added the administrative appeals process described above.²⁸

The second wave of reforms, enacted in HB 62 of the 2nd Called Special Session of the 72nd Legislature, gave the Texas Workers' Compensation Insurance Fund fraud investigation tools. The Legislature was satisfied with streamlining the benefits process but believed that there was nothing to address fraud in the industry. So the Legislature charged the Texas Workers' Compensation Insurance Fund with developing and implementing a program to identify and investigate fraud and violations of the Insurance Code relating to workers' compensation insurance by an applicant, policyholder, claimant, agent, or insurer.²⁹

In addition to developing the program the Legislature also gave them the authority to enter into funding agreements with local prosecutors. The idea was that local prosecutors needed additional financial resources to prosecute the complex insurance cases. This authority was intended to be used to aid multiple local prosecutors. However, neither Texas Mutual nor its predecessor used this authority to fund fraud prosecution with other local prosecutors besides the Travis County D.A.'s Office. Texas Mutual chose the Travis County D.A. because they are the only local prosecutors in the state that has statewide jurisdiction to prosecute criminal offenses related in insurance³⁰ and at the time of the first agreement, the D.A. had a state funded insurance fraud unit.³¹ Since they were originally given this authority, they have become a private mutual company with the only tie to state government being that the governor appoints its board.

B. Reactions and Fall Out

Since the story broke, local Travis County officials have weighed in on the funding agreement. State Senator Kirk Watson and the Travis County Commissioners office began a working group to come to a solution to the controversy. Texas Mutual officials showed a willingness to end the funding agreement so long as TDI is given more funding to investigate fraud.³² Texas Mutual claims they were forced to enter into the funding agreement with the Travis County D.A. because TDI does not have the man power and financial resources to properly investigate insurance fraud.³³

In December of 2015 Texas Mutual and the Travis County D.A. Office announced that they have moved to a month-to-month contract with the option for either party to terminate the contract with 20 days' notice. The month-to-month contract will continue through September 2017 to coincide with the 85th Regular Legislative Session. Both parties hope that the Legislature will fix the funding problem described above. Also, Texas Mutual agreed that all future suspected

²⁷ HB 3458 by Brimer (77th Regular Session) (Relating to the operation of the Texas Workers' Compensation Insurance Fund as a domestic mutual insurance company and to the continuation of that entity as the Texas Mutual Insurance Company).

²⁸ SB 1 by Montford (71st Second Called Session).

²⁹ HB 62 by Counts (72nd Second Called Session), at 237.

³⁰ TEX. INS. CODE §85.051.

³¹ March 30th Hearing at 1:28:30.

³² Root & Plohetski, Dec. 20th 2015, *Austin American Statesman*, *An overhaul for Travis County DA's insurance agreement*.

³³ March 30th Hearing at 1:53:00.

fraud cases will be referred to TDI who will then decide whether to refer the case to the Travis County D.A. Finally, both parties agreed that the Texas Mutual fraud unit will prosecute other workers' comp insurance company fraud cases in addition to Texas Mutual's. The unit is no longer exclusively dedicated to Texas Mutual cases—at least until 2017.

C. Two Issues Facing the Legislature in the 85th Regular Session

According to testimony taken by the Committee, the September 2017 expiration was intentionally picked by Texas Mutual and the Travis County D.A. in order to give the Legislature the opportunity to amend or repeal §2054.455.³⁴ Commissioner Mattax identified two issues that the Legislature must face when deliberating what to do. First, the immediate question before the Legislature is whether to end the funding agreement and direct what is currently Texas Mutual's prosecution referral functions through TDI like all other workers' comp insurers do.³⁵ Second, if the Legislature decides to repeal the statute, they must then face the broader question of how to provide additional funds to TDI in order to support the increased workload which will exceed the current Fraud Unit's capabilities and budget.³⁶

As stated above, TDI is funded by a maintenance tax and not by classic general revenue such as sales taxes.³⁷ The maintenance tax is levied against the insurance industry so insurers will pay for a larger fraud unit for workers' comp cases if the Legislature decides on expansion. Although TDI is self-funding through the maintenance tax, the Legislature still appropriates funds to TDI by determining the amount of funds the Department can raise through the maintenance tax.³⁸ So ultimately, the Legislature will decide how TDI will get the funds needed to expand the Fraud Unit if the Legislature chooses to end Texas Mutual's relationship with the Travis County D.A.

According to TDI, the Fraud Unit's workload will substantially expand if the unit were to take over Texas Mutual's fraud investigations. The Department provided statistics for the Committee to support this claim. Over a two-year period from 2014 to 2015, TDI reported that of the combined 515 workers' comp fraud investigations, Texas Mutual accounted for approximately 75% of the investigations.³⁹ Over that same period, Texas Mutual accounted for approximately 82% of the referrals for prosecution of workers' comp fraud.⁴⁰ As can be seen by these figures, the Fraud Unit investigates a small percentage of the workers' comp fraud investigations in the state. If they were to assume Texas Mutual's cases, major changes to the Fraud Unit's structure and resources must be contemplated.

III. *In Re Crawford* Texas Supreme Court Case

In February of 2015 the Texas Supreme Court ruled that the Division of Workers' Compensation has exclusive jurisdiction over a workers' compensation claim and the Workers' Compensation

³⁴ March 30th Hearing at 1:44:03.

³⁵ March 30th Hearing at 1:14:20.

³⁶ March 30th Hearing at 1:14:58.

³⁷ March 30th Hearing at 1:15:20.

³⁸ March 30th Hearing at 1:16:10.

³⁹ *TDI Written Testimony*, at 2.

⁴⁰ *Id.*

Act (Act) provides their exclusive remedies.⁴¹ In that case an injured worker sued his workers' compensation insurance provider for breach of contract, breaching statutory duties, and several torts including a malicious prosecution theory. Furthermore, Johnson attempted to sue the insurance carrier under the Unfair Methods of Competition and Unfair or Deceptive Acts and Practices statute which provides trebled damages and awards attorney's fees.⁴² The claimant Glenn Johnson accused the insurance company of wrongfully denying benefits and employing combative tactics to intimidate Johnson from pursuing his benefits. Specifically, Johnson claimed that the insurance company falsely accused Johnson of insurance fraud, leading to wrongful arrests and a two-year prosecution that ultimately terminated in Johnson's favor.

The crux of Johnson's argument rested on distinguishing these combative tactics as independent injuries from the workers' compensation injuries. If Johnson were successful in making the distinction, then he would be able to pursue his malicious prosecution cause of action because workers' comp injuries must be resolved through the prescribed administrative process provided in the Act.⁴³ The Court disagreed with Johnson and held that activity that arises out of an insurance carrier's investigation, handling, or settling of a claim for workers' compensation benefits is subject to the exclusive process and remedies listed in the Act. In other words, investigation activity arising out of the workers' compensation claims-handling process is not an independent injury.

A. *Texas Mutual Insurance Co. v. Ruttiger*

To support their holding the Court relied on their ruling in *Texas Mutual Insurance Co. v. Ruttiger* which emphasized the exclusivity of the structure and detailed process prescribed in the Workers' Compensation Act.⁴⁴ In that case, the Court explained that the Legislature intended to create an exclusive time-compressed process for carriers to handle claims and for dispute resolutions.⁴⁵ The Court stated "that allowing the carrier to risk common law liability in addition to liability under the Act 'distorts the balances struck in the [Workers' Compensation Act] and frustrates the Legislature's intent to have disputes resolved quickly and objectively' "⁴⁶ By recognizing that the Legislature intended this structure to control workers' comp claims handling and dispute resolutions, the Court concluded that the Legislature also intended to foreclose additional recoveries under other general provisions of the Insurance Code because they would be inconsistent with the Act's structure.⁴⁷

B. Exclusivity of the Workers' Compensation Act

Johnson pleaded the Court to read *Ruttiger* narrowly and limit its application to causes of action and relief that conflict or were inconsistent with the Act's procedures and remedies.⁴⁸ However, the Court explained that their ruling in *Ruttiger* was not based simply on inconsistencies but was

⁴¹ *In Re Crawford*, No. 14-0256, 4 (Tex. 2015).

⁴² *Id.* at 2, *See also* TEX. INS. CODE §541.152.

⁴³ TEX. LAB. CODE §408.001(a).

⁴⁴ 381 S.W.3d 430, (Tex. 2012).

⁴⁵ *In Re Crawford*, at 4-5 (citing *Ruttiger*).

⁴⁶ *Id.* at 6.

⁴⁷ *Id.* at 5.

⁴⁸ *Id.* at 2-3.

based on the exclusivity that the Legislature intended. This means that a carrier's investigation, handling, or settling of a claim for workers' compensation benefits falls within the Act. Other causes of action or sources of relief may not cause an inconsistency with the Act's purpose but allowing them would mean the Act is not the "exclusive" process for relief and resolving disputes. This would violate the Legislature's intent therefore this activity must fall under the Act.⁴⁹ By consequence of enacting these specific remedies and procedures, the Legislature intended to foreclose other common law or statutory causes of action that would have otherwise been available to the claimant. Therefore, the Court found that the tort for malicious prosecution is not available to a workers' compensation insurance claimant.

C. Mandatory Fraud Reporting & Criminal Penalties

To further support their holding the Court noted that according to §701.051 requires investigators are duty bound to report suspected fraud to TDI and, if they wish, other authorized government agencies. To allow the threat of malicious prosecution to hang over their heads would suppress their statutory duty to report "suspected" fraud to TDI. Also the Court pointed out that the claimant is not left without a remedy. The Act provides that if a beneficiary suspects an investigator of making false statements the claimant can report the investigator for making an intentional false statement under §418.001 of the Labor Code which provides criminal penalties. This section further demonstrates the Legislature's intent that this remedy to prevail over other statutory remedies.

⁴⁹*Id.* at 6-9, 11.

