Thompson Coe

2013 Life & Health Insurance Legislative Update

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INTRODUCTION AND OVERVIEW

The Texas Legislature began the 83rd legislative session in January 2013 without the dilemma of a $10-20 billion plus budget deficit but with an air of uncertainty, thanks to a total of 50 new members in the House and Senate. For 2013, there were forty-four new House members and five new members in the Texas Senate along with one unfilled Senate seat. Unlike the 2011 session, the question was not which programs would be cut and how could the state save money but instead was "how do we spend our new found surplus" in a conservative and responsible manner. In 2013, there were no emergency items declared for the session, and the "big issue" items were serious infrastructure concerns – funding for road development, water resources, and restoration of cuts to education funding from the 2011 session. The sunset review for the Texas Department of Insurance was concluded in 2011, and insurance was not anticipated to be a major topic of discussion for this session.

Of interest to the life and health industry, the Texas Legislature continued to deal with whether to implement portions of the federal health reform that had already taken effect. In most cases, particularly Medicaid expansion, the answer was "No!". The life and health insurance issues pushed by the life/health industry were bills to clean up laws relating to notices of premium increases on major medical health insurance and clarifying certain restrictions against "rebating" to allow for small promotional items to be given without running afoul of the law. The Texas Department of Insurance (TDI) proposed various issues as part of its biennial recommendations, including changes to confidentiality provisions throughout the Insurance Code, adoption of model laws for insurer risk assessment, and allowing the formation of Texas licensed captive insurers.

During the session, a bill severely limiting the subrogation recovery of health insurers garnered significant attention and support from both trial lawyers and tort reform groups. There were other numerous bills of interest relating to mandating coverages, prescribing requirements for contracts between providers and health insurers, and abolishing the Texas Health Insurance Pool. In addition, the insurance commissioner's Senate confirmation was the subject of much discussion. Ultimately, the commissioner was not confirmed, and her term concluded at the end of the session.

Numerous bills did not pass, including legislation that would have:

(a) imposed more stringent regulation of life settlements;

(b) required notices and disclosure to funeral homes on death benefits;

(c) restricted underwriting for criminal offenses; restricted underwriting based on sexual orientation; and

(d) legislation that would have limited an employer's right to regulate activities of employees on social media.

The dominant issue facing the 83rd Texas Legislature was how to deal with a budget surplus for the first time since 2007 while not going on a "spending spree," as many members and groups cautioned against any extra spending. Beyond the inevitable differences between Democrats and Republicans, there were also "intrasquad" disputes between conservative

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Republicans and Tea Party Republicans. This created some interesting votes on the House floor, as Democrats sometimes joined with "moderate" Republicans in supporting legislation.

Very early in the session legislative leaders were clear in their intention to address issues related to the state's infrastructure, funding for transportation projects across the state, and funding for water resources and projects to ensure Texans had access to water. The state's continued growth makes both issues important to ensuring that the state's future infrastructure is adequate to meet the needs of its increased population.

In 2011, the Legislature made cuts to education funding as a result of the budget deficit at that time. The budget surplus made many members and certain groups call for a restoration of the cuts made in 2011 with some calling for restoration and an increase in education spending. In between discussions on the budget, transportation, and water, there were numerous bills introduced and debated over guns on college campuses and guns and/or armed guards at grade schools, the role of the Regents of the University of Texas, and even a brief discussion of legalized gambling in Texas.

These important issues had to be dealt with by a Texas House having 44 new members for the 2013 session. Combined with the significant number of new members elected in 2010, nearly half the House had only one session experience or no experience. The Texas Senate had 5 new Senators and 1 vacancy when the session began. The vacancy was filled by Harris County Commissioner Sylvia Garcia (D-Houston) in a special election in March 2013.

After the 2012 elections, the House was comprised of 95 Republicans and 55 Democrats compared with 101 Republicans and 49 Democrats in 2011. The composition in the Senate was not materially changed, even with the new members, as the Senate remained 19 Republicans and 12 Democrats.

The Legislature was also confronted with the need to pass legislation to continue certain major state agencies because of the Sunset review process. These agencies included the Texas Railroad Commission, Texas Education Agency, and Department of Criminal Justice.

Against the backdrop of changes to legislative membership and attention to core issues, we monitored several hundred bills related to life and health insurance. Thompson Coe attorneys were involved in representing various individual insurance clients, including the Texas Association of Life and Health Insurers (TALHI), on a broad spectrum of issues impacting life and health insurance.

During the 83rd Session and Special Sessions, there were over 6,000 bills that were filed compared with a little over 5,700 in 2011. Jay Thompson and Albert Betts were directly involved in reviewing and analyzing over 225 bills that were identified to have some impact on the life and health insurance industry, and 61 of those bills became law.

In addition to these key issues, Jay Thompson was instrumental in negotiating changes to the proposed subrogation law to ensure that the final passed version of the bill was at least more favorable to health insurers as compared to the initial version of the bill.

The session resulted in the passing of bills that adopted the National Association of Insurance Commissioners' (NAIC) most recent model holding company act, including permitting certain transactions to be implemented without prior approval, along with bills addressing regulation of health care provider networks and addressing continuing silent PPO problems; the creation of a standard request form for prior authorization of health care services; and a bill requiring the regulation of

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navigators for health benefit exchanges (under the federal health care reform laws).

Insurance Commissioner Eleanor Kitzman, who was appointed by Governor Perry in August 2011, was not confirmed by the Texas Senate during the session. Various news articles speculated on the reasons why the commissioner was not confirmed; but, in the end, on May 27, 2013, the commissioner's tenure ended as required by law. On the same day, the Governor announced the appointment of Julia Rathgeber as Commissioner of Insurance for a term to end in February 2015. Commissioner Rathgeber previously served as deputy chief of staff for Lieutenant Governor Dewhurst. She was confirmed by the Texas Senate on June 14, 2013.

The Legislature was called back to Austin for a special session after the conclusion of the Regular Session. The 1st Called Special Session did not include any insurance-related issues and was initially called for redistricting. Subsequently, transportation funding, juvenile justice, and abortion regulation were added to the list of issues for consideration.

The 1st Called Special Session ended on the night of June 25 in the Senate after a 13-hour filibuster, a loud Senate gallery, and confusion over whether a vote on SB 5, relating to regulation of abortion facilities, occurred before or after the midnight deadline. During the debate on SB 5, a transportation funding bill and juvenile justice bill died, as House amendments to the bills were not voted on before the end of the special session. The Governor called for a 2nd Called Special Session that began on July 1, 2013. As of the date this paper was written, no life and health related legislation has been added to the list of called issues for this 2nd Called Special Session.

On July 8, 2013, Texas Governor Rick Perry announced that he was not seeking re-election in 2014. On July 14, Attorney General Greg Abbott announced he is running for the Republican nomination for Governor. Tom Pauken, former chair of the Texas Republican Party, had previously announced his candidacy. There are already multiple candidates announced to replace the Attorney General. The current Lt. Governor, David Dewhurst, has announced he will seek re-election in 2014. He will be opposed by Sen. Dan Patrick (R-Houston), Land Commissioner Jerry Patterson, and Agriculture Commissioner Todd Staples in the Republican primary for Lt. Governor. There are various other candidates for Comptroller, Agriculture Commissioner, Railroad Commission, and Land Commissioner. It promises to be another interesting election in 2014.

This newsletter provides a brief summary of the bills that passed along with the effective date for each bill. Many bills may have different effective dates for various sections of the bill. Where possible, the summary references any due dates for operational changes applicable under a new law. This report is not intended to give legal advice, nor should it be relied upon as a complete representation of the law. Any decision to act or not act should be made only after thorough review of the legislation passed and after consulting with legal counsel. Also, although the Legislature has passed a bill, the state agency responsible for administering the law may still be required to adopt administrative rules to implement a bill that has been passed. We urge you to pay close attention to the rule-making process that will occur over the next several months at the Texas Department of Insurance.

BILL SUMMARIES

AGENTS

HB 1305 PROHIBITED ACTS BY AGENTS. This bill amends the Insurance Code to make it a third-degree felony to act as an agent after suspension or revocation of a license. Effective September 1, 2013.

CAPTIVE INSURERS

SB 734 LICENSING OF CAPTIVE INSURERS. This was a TDI biennial recommendation on licensing of captive insurers. The bill adds chapter 964 to the Insurance Code to allow captive insurers to obtain a certificate of authority from the TDI. The bill defines a captive insurance company as one that insures the operational risks of the company's affiliates; is not subject to chapter 823, the Holding Company Act, unless the company is affiliated with another insurer that is subject to chapter 823; and is subject to for-profit corporations' laws in the Business Organizations Code. The bill describes the formation of a captive insurer, including certain requirements for the articles of incorporation. Captives can be incorporated as stock insurers. Captive insurers must obtain a certificate of authority subject to certain limitations related to doing business in Texas. The commissioner by rule can determine capital and surplus requirements. Capital requirement is not less than $250,000 or greater than $5 million. The application for a charter and certificate of authority are subject to a fee and the requirements outlined in section 964.008. TDI must examine the applicant after the application is filed and the application fee is paid. If TDI denies the application, it must be in writing. The applicant may request a hearing, and the commissioner has to set a hearing.

Among the requirements for captives, a captive insurer must file a verified report on financial condition by March 1 of each year and on June 1 must file a report on its financial condition as of last year-end, with an independent CPA's opinion, and is provided the option to request an alternative filing date on fiscal year end. Captives can write any type of insurance except life, annuities, title, accident and health, mortgage guaranty, residential property, personal automobile, or workers' compensation. Captive insurers may reinsure subject to certain conditions. A captive insurer, however, may not join or contribute to any pool, plan, association, or guaranty fund.

The bill establishes a tax rate of ½ of 1% on a captive's taxable premium receipts and other forms of revenue from written insurance policies in a calendar year. A captive's taxable receipts will not be deducted for premiums paid for reinsurance. The annual minimum tax for a captive will be $7,500, and the annual maximum will be $200,000 payable by March 1 after the end of the year for which the taxes are due.

Any information filed by an applicant or captive insurance company under chapter 964 is confidential and privileged for all purposes, including for purposes of the Texas Public Information Act, a response to a subpoena, or evidence in a civil action.

TDI can suspend or revoke the captive insurer's license after notice and opportunity for a hearing. Effective June 14, 2013.

FEDERAL HEALTH CARE REFORM

SB 1332 DEFINING EMPLOYEE IN LARGE AND SMALL EMPLOYER PLANS. This bill amends Insurance Code section 1501.002 to clarify who qualifies as an employee for large and small employer health benefit plans. It removes the word "eligible" in defining an employee. Effective September 1, 2013.

SB 1795 HEALTH EXCHANGE NAVIGATORS. This bill adds chapter 4154 to the Insurance Code to authorize various navigator activities, while prohibiting others, in Texas' health benefit exchange under the federal Affordable Care Act (ACA). The commissioner has to evaluate if the federal regulations sufficiently allow navigators to assist consumers in completing the uniform application, explain qualified health plan features, and establish standards to maintain privacy and data security, along with other listed factors. If the commissioner determines that federal standards did not ensure they were

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qualified to perform their duties or avoid conflicts of interest, the commissioner can establish standards and qualifications for navigators. The bill sets minimum requirements for the standards, if the commissioner adopts them by rule.

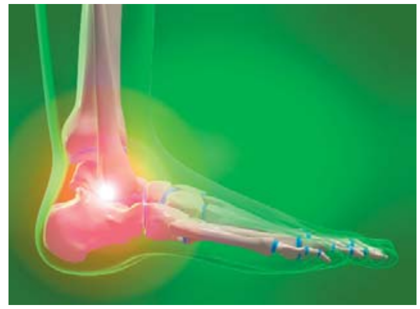
The bill defines "navigator" to include an individual or entity performing a navigator's duties as described in the ACA or any regulation enacted under the ACA. The bill will allow navigators to act without obtaining a license from TDI or any other state agency. The bill will not apply to licensed life, accident, and health insurance agents or licensed life and health insurance counselors or companies.

Under the bill, navigators are prohibited from receiving compensation from a health benefit plan issuer. Navigators can advertise their duties and services but cannot claim professional superiority or use phrases such as "insurance advisor," "insurance agent," or "insurance consultant." Also, navigators who are not licensed as agents cannot endorse, sell, solicit, or negotiate coverage under a health benefit plan. New chapter 4154 expires September 1, 2017. Effective September 1, 2013.

HEALTH CARE

SB 365 MANAGED CARE PLAN CONTRACTS WITH PODIATRISTS AND THERAPEUTIC OPTOMETRISTS. This bill requires managed care plans to treat applicant podiatrists as if they were a participating provider within the health plan network, for purposes of payment only, when the applicant podiatrist treats an enrollee. This bill requires the applicant podiatrist to have submitted all required documentation to enable the plan issuer to begin the credentialing process, and the podiatrist must also have agreed to comply with the terms of the managed care plan's participating provider contract currently in force with the applicant podiatrist's established professional practice.

Pending approval of the podiatrist's application, the managed care plan may exclude the applicant from the managed care plan's directory of participating podiatrists, the managed care plan's website listing of participating podiatrists, or any other listing of participating



podiatrists. The bill also provides a process for the plan to recover from the podiatrist if the podiatrist is not approved to participate in the plan.

The bill provides protection against liability arising from the payment to the applicant podiatrist for a managed care plan issuer that complies with the law. The bill makes similar changes for therapeutic optometrists. Effective September 1, 2013.

SB 632 CONTRACTUAL FEES FOR OPTOMETRISTS. The bill prohibits a contract between an insurer and an optometrist or therapeutic optometrist from limiting or discounting the fee the optometrist or therapeutic optometrist could charge for a product or service not covered by a health plan. The bill defines a "covered product or service" as a vision care product or service that could be reimbursed under an insurance enrollee's managed-care plan contract or which could be reimbursed subject to a contractual limitation, including a deductible, a copayment, coinsurance, a waiting period, an annual or lifetime maximum limit, a frequency limitation, or an alternative benefit payment. The bill applies to a contract entered into or renewed on or after January 1, 2014. Effective September 1, 2013.

SB 822 REQUIREMENTS FOR CONTRACTS WITH PROVIDERS. The bill adds chapter 1458 to the Insurance Code to describe certain requirements for an insurer and HMO contracting with providers. It establishes certain statutory requirements for a contracting entity, defined as a person who contracts directly with a provider for the delivery of health care services to covered individuals and who establishes a provider network or networks for access by another party.

If the person does not have a certificate of authority from the Department to be an insurer or HMO, the person is required to register with the TDI not later than 30 days after they begin acting as a contracting entity in

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Texas. New section 1458.052 requires the contracting entity to disclose certain information.

The bill applies to certain listed health benefit plans, defining a "health benefit plan," in part, as a hospital and medical expense incurred policy; a nonprofit health care service plan contract; a health maintenance organization subscriber contract; or any other health care plan or arrangement that pays for or furnishes medical or health care services. It does not include accident or disability income insurance; credit-only insurance, supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; discount health programs; and workers' compensation insurance, among others listed.

The commissioner is required to grant an exemption from registration for affiliates of a contracting entity, if the contracting entity holds a certificate of authority from TDI to engage in the business of insurance or is an HMO, and they are not subject to a disclaimer of affiliation, and the relationship between the holder of the certificate of authority and the affiliate is disclosed and clearly defined. In addition, the bill allows the TDI to establish a fee for the registration process.

The bill sets certain restrictions on selling and leasing of network discounts. It prohibits a contracting entity from selling, leasing, or transferring information regarding the payment or reimbursement terms of the provider network contract without the express authority of and prior notice to the provider. The bill also prohibits a contracting entity from providing a person access to health care services or contractual discounts under a provider network contract unless the provider network contract specifically states that the contracting entity may contract with a person to provide access to the contracting entity's rights and responsibilities under the provider network contract.

In addition, a provider network contract must specify or reference a separate fee schedule for each such line of business in order to be enforceable against the provider. The bill applies only to a provider network contract entered into or renewed on or after September 1, 2013. Effective September 1, 2013.

SB 1221 PROHIBITIONS ON TRANSFERRING DISCOUNTS BY INSURER IN MEDICAID OR CHIP. This bill prohibits an insurance company, health maintenance organization (HMO), or preferred provider organization (PPO) in the Medicaid or children's health insurance program (CHIP) from requiring that a contracted provider allow access to or transfer its name and discounted fee to other HMO and PPO benefit plans.

The bill allows such transfers only if the provider signed on a separate signature line near a written notice from the insurance company, HMO, or PPO that included a conspicuous statement similar to that outlined in the bill. Effective June 14, 2013.

SB 406 PHYSICIAN DELEGATION OF PRESCRIPTIVE AUTHORITY. This bill permits physicians to delegate prescriptive authority to advanced practice registered nurses (APRNs) and physician assistants (PAs). APRNs and PAs could prescribe or order drugs and devices, including certain controlled substances, under a physician's supervision. A physician could delegate to an APRN or PA the prescribing or ordering of drugs and devices, including nonprescription drugs and Schedule II controlled substances. A physician could only delegate prescription authority for Schedule II drugs if the patient was in hospice, admitted to a hospital for emergency care, or admitted to a hospital for a stay intended to be longer than 24 hours.

The physician's delegation to APRNs and PAs requires a prescriptive authority agreement. A physician could enter into agreements with up to seven APRNs or PAs. The limit does not apply to medically-underserved areas or facility-based practices at hospitals, unless the physician is delegating in a freestanding clinic or center. The prescriptive authority agreement requires

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the parties to disclose any disciplinary actions. The APRN or PA has to have an active license, be in good standing, and not be prohibited from executing an agreement. The Texas Board of Nursing must authorize an APRN's ability to prescribe or order drugs and devices. The agreements have to meet minimum requirements and include certain information but could contain other agreed-to provisions.

Under the bill, the Texas Medical Board is required to maintain online a public, searchable list of physicians, APRNs, and PAs who entered into agreements and work with the other boards to maintain a publicly available list of individuals prohibited from entering into agreements. The Texas Board of Nursing must adopt rules to license a registered nurse as an APRN and establish ways to train and approve APRNs to prescribe and order drugs and devices. The nursing board also has to create a system to issue prescription authorization numbers and renew licenses. Effective November 1, 2013.

HEALTH CARE COVERAGE

HB 2929 COVERAGE FOR BRAIN INJURIES. This bill amends the Insurance Code provisions regarding coverage for brain injuries to include basic coverage plans under chapter 1551 and group health coverage made available by a school district in accordance with Education Code section 22.004.

In addition, the bill prohibits a health benefit plan from limiting the number of days of covered post-acute care, including any therapy or treatment or rehabilitation, testing, remediation, or other services, 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. Effective September 1, 2013.

HB 3105 EXCLUSION FOR INTOXICATION. This bill repeals Insurance Code section 1201.227, which requires an individual accident and health insurance policy to contain an exclusion for losses for intoxication or being under the influence of any narcotic unless the narcotic is administered on the advice of a physician. The bill does not prohibit insurers from using policies that contain this exclusion.

The change applies to an individual accident and health insurance policy that was delivered, issued for delivery, or renewed on or after January 1, 2014. Effective September 1, 2013.

HB 3276 COVERAGE FOR AUTISM. This bill amends Insurance Code section 1355.015 to require health benefit plans to provide coverage for screening a child for autism spectrum disorder at 18 and 24 months of age. The bill permits an individual acting under the supervision of a certified health care practitioner to provide treatment for autism spectrum disorder and will specify that a health benefit plan include treatment of autism in its coverage of the disorder.

The bill also exempts health plans from the autism screening mandate, should it be determined that its inclusion will create a cost to the state by exceeding the essential health benefits required by the federal Patient Protection and Affordable Care Act of 2010 (ACA). Effective September 1, 2013.

SB 853 NOTICE OF PREMIUM INCREASE. This bill amends Insurance Code section 1201.109 to clarify that individual accident and health policies providing major medical expense coverage must provide notice of a premium increase 60 days prior to the increase. Excluded from this notice requirement will be health insurance policies such as disability income, accident only, limited benefit, or specified disease policies. Effective September 1, 2013.

SB 1057 DSHS BENEFITS TO INDIVIDUALS WITH PRIVATE INSURANCE. This bill prohibits the Texas Department of State Health Services (DSHS) from providing health services to an individual unless the applicant either confirmed they did not have access

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to private health insurance coverage for the services or they provided their insurance information and authorized DSHS to submit to their insurer a claim for reimbursement. This bill applies to DSHS health services anticipated to be impacted by a health benefit exchange under the federal Affordable Care Act.

DSHS is required to provide informational materials regarding health insurance coverage and subsidies available in the health benefit exchange to an individual applying for DSHS health services and having an income above 100% of the federal poverty level. Effective June 14, 2013.

SB 1484 COVERAGE FOR AUTISM DIAGNOSED BEFORE AGE 10. This bill amends Insurance Code section 1355.015 to require that, if a health benefit plan enrollee was diagnosed with autism spectrum disorder before the child's 10th birthday, the plan will provide coverage of generally-recognized services without consideration of the enrollee's age. The health benefit plan is not required to provide coverage for applied behavior analysis beyond $36,000 per year for enrollees 10 years of age and older.

The bill exempts health benefit plans from the expanded autism coverage requirement, if its inclusion will require the state to make additional payments under the federal Patient Protection and Affordable Care Act (ACA). Effective September 1, 2013.

HEALTH CARE SHARING MINISTRIES

SB 874 REGULATION OF HEALTHCARE SHARING MINISTRIES. This bill adds chapter 1681 to the Insurance Code to provide for the regulation of health care sharing ministries. The bill describes the qualifications for a health care sharing ministry as a faith-based, nonprofit organization that is tax-exempt under the Internal Revenue Code of 1986 and meets certain listed qualifications. These include, among other requirements, limiting its participants to individuals of a similar faith; providing for the medical bills of a participant through contributions from one participant to another; and disclosing administrative fees and costs to participants.

The bill specifically provides that a health care sharing ministry is not engaged in the business of insurance and also amends various other insurance code provisions to clarify that they do not apply to health care sharing ministries. The bill is effective September 1, 2013.

LIFE AND ANNUITIES

SB 1386 NONFORFEITURE REQUIREMENTS FOR LIFE POLICIES. This bill makes various changes to Insurance Code provisions in chapter 1105. The bill adopts the NAIC revisions to the Standard Nonforfeiture Law to implement principle-based reserves as adopted by the TDI by rule. Adoption of principle-based reserves cannot be finalized until other statutory changes are made and the NAIC adopts a new reserve manual rule. Even though the bill is effective January 1, 2014, no changes will be made until principle-based reserves are adopted by the NAIC and Texas adopts the rules. Note: There was another bill (SB 1379) which would have adopted revisions to the NAIC Standard Valuation Law for principle-based reserves implementation. SB 1379 did not pass; and, thus, SB 1386 cannot be fully implemented. Effective January 1, 2014.

LIFE SETTLEMENTS

HB 2383 REQUIREMENTS FOR LIFE SETTLEMENT CONTRACTS FOR MEDICAID ELIGIBILITY. This bill allows an owner of a life insurance policy with a face value of more than $10,000 to enter into a life settlement contract for the benefit of a recipient of long-term care services and support in exchange for direct payments to a health care provider for the provision of those services to that recipient or the state to offset the costs of providing those services to that recipient under the medical assistance program.

The life settlement contract must provide that the lesser of five percent of the face amount of the

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life insurance policy or $5,000 is reserved and is payable to the owner's estate or a named beneficiary for funeral expenses; provide that the balance of proceeds under the life settlement contract unpaid on the death of the owner must be paid to the owner's estate or a named beneficiary; and specify the total amount payable for the benefit of the recipient of long-term care services and support under the life settlement contract. The proceeds of the contract will be held in a state or federally-insured account and will be available to the owner to purchase the long-term medical care services of their choice.

The life settlement contract's value will not be considered an asset in determining eligibility for Medicaid. Until the life settlement contract's proceeds were exhausted, no state or federal funds could be used to purchase long-term medical care services for the owner.

The life settlement contract will require up to $5,000 be reserved for funeral expenses and will transfer any unpaid balance to a deceased owner's estate. A contracting entity will be required to maintain a surety bond, errors and omissions insurance, or a deposit valued at $500,000.

A life settlement contract provider who enters into life settlement contracts with owners of life insurance policies must file with the TDI all life settlement contract forms used by the provider and all advertising and marketing materials used by the provider.

HHSC, in consultation with TDI, can adopt rules to implement the bill. Effective September 1, 2013.

PHARMACY

HB 1358 AUDITS OF PHARMACIES. This bill establishes certain requirements and guidelines for health benefit plans and pharmacy benefit managers (PBM) audits of pharmacies. The bill requires that health benefit plan issuers and PBMs accommodate a pharmacy's schedule when conducting on-site audits. Unless the auditing entity had reason to suspect a pharmacy of fraud or intentional misrepresentation, they have to provide at least 14 days' written notice of the audit and include in the notice the claims subject to auditing.

Contracts between pharmacies and auditing entities have to include detailed audit procedures, and pharmacies will be notified of any change made to them within 60 days of the change. The bill also requires that, at the conclusion of an audit, the health plan benefit issuer must provide to the pharmacy a summary of its findings and allow the pharmacy to respond.

The bill sets time limits for the audit. Auditors will have 60 days to submit a preliminary report, followed by a 30-day period in which the pharmacy may challenge any findings. Within 120 days of submitting the preliminary report, the auditors will submit their final report of the audit results, including the amount of recoupments claimed after considering the pharmacy's response.

The bill prohibits unintentional clerical errors from being used as evidence of fraud. The bill also may not be used as a basis for payment recoupment unless they resulted in actual financial harm to a patient or health plan issuer.

The bill also prohibits on-site auditors from entering the pharmacy area unless escorted by a person authorized by the pharmacist or pharmacy. Further, the bill prohibits auditing entities from using "extrapolation," the use of a sample of audited claims to estimate results for a larger batch of claims, either in contracts or to determine payment owed. Auditors could not receive compensation based on the amount recovered as a result of the audit. Audits requiring a pharmacist's professional judgment will require consultation with a licensed pharmacist. Effective September 1, 2013.

SB 500 PHARMACY BOARD. This bill amends the Occupations Code to increase the Texas State Board of

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Pharmacy from 9 to 11 members and adds a pharmacy technician to the board. Effective September 1, 2013.

PREAUTHORIZATION FORMS

SB 644 STANDARD FORM FOR PREAUTHORIZATION OF PRESCRIPTION DRUGS. This bill will require certain health insurance plans to use a single, standard form prescribed by rule of the commissioner of insurance for requesting prior authorization of prescription drug benefits. The Department of Insurance, the health benefit plan issuers, and the agents of health benefit plan issuers will make the form available electronically on their websites.

The commissioner of insurance will develop the form with input from the advisory committee on uniform prior authorization and consider prior authorization forms widely used by the state or the Department of Insurance, forms established by the federal Centers for Medicaid and Medicaid Services, and national standards or draft standards for electronic prior authorization. The commissioner must prescribe the form by rule.

The commissioner must appoint an advisory committee and consult with the advisory committee on rules related to the prior authorization form. The commissioner has to convene the advisory committee every 2 years to review the standard form.

A health benefit plan issuer or its agent that managed or administered prescription drug benefits will be subject to penalties if they fail to use or accept the standard prior authorization form or fail to acknowledge the receipt of a completed form submitted by a prescribing provider.

The bill also requires that, within 2 years of adoption of national standards for electronic prior authorization of benefits, a health benefit plan issuer or its agent must accept electronic prior authorization requests for a prescribing provider with e-prescribing capability.

There are exceptions to the standard form requirement. The bill does not apply to a health benefit plan that provided coverage only for a specified disease or for another single benefit; only for accidental death or dismemberment; for a period during which an employee was absent from work because of sickness or injury; as a supplement to a liability insurance policy; for credit insurance; only for dental or vision care; only for hospital expenses; or only for indemnity for hospital confinement.

The bill also does not apply to Medicare supplemental policies; medical payment insurance under a motor vehicle policy; long-term care insurance, including a nursing home fixed indemnity policy, unless the commissioner determined that the policy provided benefit coverage so comprehensive that the policy was a health benefit; health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code; or workers' compensation.

The bill applies only to a request for prior authorization of prescription drug benefits made on or after September 1, 2015. The bill is effective September 1, 2013.

SB 1216 STANDARD FORM FOR PREAUTHORIZATION OF HEALTH CARE SERVICES. This bill requires certain health benefit plan issuers and their agents to use a single, standard form prescribed by rule of the commissioner of insurance for requesting prior authorization of health care services as required by a plan. The bill defines "health care services" to include medical or health care treatments, consultations, procedures, drugs, supplies, imaging and diagnostic services, inpatient and outpatient care, medical devices, and durable medical equipment.

The TDI, the health benefit plan issuers, and the agents of health benefit plan issuers will make the form available electronically on their websites. The bill establishes an advisory committee on uniform prior authorization forms. The commissioner has to develop the form with input from the advisory committee on uniform prior authorization forms for health care services benefits and will consider prior authorization forms widely used by the state or the TDI, forms established by the federal Centers for Medicaid and

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Medicaid Services, and national standards or draft standards for electronic prior authorization.

The bill requires that, within two years of adoption of national standards for electronic prior authorization of benefits, a health benefit plan issuer or its agent will exchange prior authorization requests electronically with a physician or health care provider who had electronic capability and who initiated a request electronically. A health benefit plan issuer or its agent will continue to accept prior authorization requests using the standard paper form for requests initiated on paper.

The bill does not apply to health plans for accidental death or dismemberment; wage replacement; credit; dental or vision; a Medicare supplemental policy; medical payment insurance coverage provided under a motor vehicle insurance policy; or workers' compensation, among others.

The commissioner is required to prescribe a standard form by rule no later than January 1, 2015.

The bill applies to a request for prior authorization of health care services made on or after September 1, 2015. Effective September 1, 2013.

PREPAID FUNERAL

SB 297 PREPAID FUNERAL CONTRACT REGULATIONS. This bill amends provisions in the Finance Code regarding prepaid funeral contracts and services. The bill requires a permit holder to notify the Banking Department of a transfer of ownership of 25% or more of the stock or other ownership or membership interest. The bill establishes certain time frame for notice and clarifies that, if the transferee will own 51% or more and is not a permit holder, the transferee has to apply with the Department.

The bill also describes how a seller must renew for a restricted or unrestricted permit depending upon whether the seller intends to continue selling prepaid funeral benefits. The holder of a restricted permit cannot sell prepaid funeral contracts.

The bill adds section 154.400 to describe how the commissioner may investigate if he or she has a reasonable suspicion of misallocation or defalcation of prepaid funeral funds or unauthorized sale of prepaid funeral benefits. The bill also allows the commissioner to issue a subpoena related to the investigation. It amends section 154.407 to allow the commissioner to bring suit in the county in which the alleged violation occurred.

Finally, the bill adds section 154.415 to allow the commissioner, in certain circumstances, to issue an order prohibiting a person from participating in the business of prepaid funeral benefits sales. A person subject to a prohibition order can apply to be released from the order after 10 years. Effective September 1, 2013.

REGULATORY

HB 2163 FINANCIAL EXAM ASSESSMENTS. This bill amends chapter 401 of the Insurance Code to include foreign insurers in the cost of examination for the overhead assessments imposed by the TDI to all insurers licensed in Texas – both domestic and foreign. Effective September 1, 2013.

HB 2645 INDEPENDENT REVIEW ORGANIZATION REGULATION. This bill amends chapter 4202 of the Insurance Code relating to certification and operation of independent review organizations (IROs). It requires TDI to adopt rules prohibiting an officer and director of an IRO from serving as the same for another IRO. This bill also prohibits an IRO from transmitting information protected under HIPAA from being publicly disclosed. IROs must maintain a Texas address and be incorporated in Texas. IROs also will be required to notify TDI of a sale of the IRO or a sale of shares in the IRO. The new law requires TDI to adopt certification for IRO services in both workers' compensation and healthcare. Effective September 1, 2013.

HB 3460 HOLDING COMPANY TRANSACTIONS. This bill amends the confidentiality provisions

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of chapter 823, Insurance Code, relating to holding company system transactions and reporting. It allows certain information to be shared with other state, federal, and international regulatory organizations, if they agree to keep the information confidential. This bill amends section 823.103 on the notice for approval of holding company transactions to add loan transactions with a non-affiliate if the proceeds are to be used to make loans or extensions of credit to an affiliate and also raises the standard for prior notice for certain transactions from the lesser of ½ of 1% of admitted assets or 5% of surplus to 3% or 25%, respectively, for non-life insurers and 3% of admitted assets for life insurers. Effective June 14, 2013.

SB 183 RESPONDING TO A TDI REQUEST FOR INFORMATION. This bill amends section 38.001 of the Insurance Code to increase the time to respond to a request for information from TDI from 10 days to 15 days. The bill also specifies that TDI, if it receives written notice from the person that additional time is required to respond to the inquiry, must grant a 10-day extension of the time to respond. The bill requires TDI to maintain a record of all such inquiries made by the department. Effective September 1, 2013.

SB 411 RESPONDING TO A TDI FRAUD INVESTIGATION REQUEST. This bill amends section 701.108 of the Insurance Code to require an insurer to respond to a request from the TDI for relevant information or material relating to a matter under investigation for insurance fraud within 15 days after the date the request is received. The bill requires TDI to extend the period 10 days on written request of the insurer. Effective September 1, 2013.

SB 631 WITHDRAWAL OF SPECIAL DEPOSITS. This bill amends section 406.006 of the Insurance Code to allow the commissioner to issue a letter approving, or an order denying, rather than an order approving or denying, an application from an insurer requesting withdrawal of all or part of a special deposit under Chapter 406. Effective June 14, 2013.

SB 840 EXCEPTIONS TO REBATING PROHIBITIONS. This bill amends various provisions of the Insurance Code defining rebates. This bill allows insurance agents and carriers to provide promotional advertising items and educational items, if valued at $25 or less, to potential customers in connection with the sale or solicitation of an insurance contract. It provides similar language to allow such practices for property and casualty in chapter 1806 and life and health in chapter 541. Effective September 1, 2013.

SB 841 INSURER INVESTMENTS. This bill amends Insurance Code sections 424.064 and 425.119 to exempt insurers with $10 billion or more in admitted assets from prohibitions against an insurer making certain investments in residential real estate. The bill also amends section 424.068 to allow investments in foreign jurisdictions other than Canada, along with other changes to the investment provisions. Effective September 1, 2013.

SB 1006 SHAREHOLDER AND POLICYHOLDER DIVIDEND APPROVAL. This bill amends various provisions in the Insurance Code relating to requirements regarding certain shareholder and policyholder dividends. The bill allows a Texas domiciled insurer to pay shareholder dividends from surplus profits arising from the insurer's business. The bill will require an insurer to notify the commissioner of insurance of each distribution of a policyholder dividend amount that is not greater than 10% of the surplus. The bill will also require an insurer to file an application for approval of any policyholder dividend payments that exceed 10% of the surplus. If the commissioner does not act on the application on or before the fifth business day after the application is received, the application is considered approved. Effective June 14, 2013.

SB 1074 ELECTRONIC TRANSACTIONS. This bill amends chapter 35 of the Insurance Code to establish minimum standards for conducting electronic transactions with consumers. Notice or other written

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communication in an insurance transaction may be delivered by electronic means only if it complies with Texas Business and Commerce Code, Chapter 322 (Uniform Electronic Transaction Act).

The bill permits written communication to be delivered by electronic means to a consumer by an insurer if the consumer affirmatively consented to delivery by electronic means and has not withdrawn the consent; and the consumer is given notice of their right to receive communication in paper or nonelectronic form and their right to withdraw consent. The consumer also has to consent to electronic delivery and has to be notified of the hardware and software used for the electronic transmission and any changes in that hardware or software.

The bill includes an exemption from the federal Electronic Signatures in Global and National Commerce Act (15 U.S.C. Section 7001, *et. seq.*) as authorized by Section 102 of that Act (15 U.S.C. Section 7002).

This bill applies only to a written communication delivered by electronic means on or after January 1, 2014. Effective September 1, 2013.

SB 1367 ABOLISHING THE HEALTH INSURANCE POOL. This bill abolishes the Texas Health Insurance Pool (THIP) subject to Texas' health benefit exchange becoming effective on January 1, 2014. The THIP will stop issuing policies as of December 31, 2013, and will terminate policy coverage as of January 1, 2014. The commissioner is authorized to delay dissolution of the THIP if the health care exchange is delayed.

The THIP's board of directors is required to develop and submit to the commissioner for approval a plan for dissolving the board and the THIP after its obligations to issue and maintain health benefit coverage terminate. The plan must also transfer to the commissioner and the TDI any assets, authority, accumulated rights, and continuing obligations of the board and the THIP. Effective September 1, 2013.

SB 1672 TRAVEL INSURANCE REGULATION. This bill allows an insurer that sells travel insurance in Texas to designate a supervising entity for travel retailers — either a licensed managing agent, a third-party administrator, or a licensed insurance agent. The travel retailer or supervising entity must provide a traveler with coverage terms, details of the claims filing process, cancellation process, and contact information of the provider. Coverage could be made available to an individual or a group.

The bill allows a travel retailer to offer travel insurance to its customers under the license and direction of a supervising entity that will cover events, medical expenses, sickness, personal items, or other expenses related to a trip cancellation or interruption, and will not have to obtain a license to do so. Travel insurance will not apply to major medical expenses for a person travelling more than six months, a person working abroad, an expatriate, or a deployed member of the military.

The bill also authorizes the insurance commissioner to issue a specialty license to sell travel insurance through a licensed insurer. An insurer will notify the insurance department of its designation of a supervising entity. The supervising entity will complete forms certifying that the retailers complied with federal insurance laws.

Travel retailers that offer travel insurance for compensation from a supervising entity have to register with an insurer and will be responsible for giving travelers brochures with the contact information for the supervising entity and insurer, along with other information. Effective September 1, 2013.

TAXES

HB 500 FRANCHISE TAX EXEMPTION. This bill makes various amendments to the franchise tax provisions of the Tax Code to exclude certain activities from taxation. The bill attempts to clarify the law to protect Texas-based insurance companies from retaliatory taxes that other states may levy in response to a Texas policy that denies insurance companies domiciled in those states the benefit of the franchise tax exemption and to eliminate potential constitutional challenges arising from

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a policy that imposes the franchise tax on out-of-state taxpayers only. Of interest to insurers, the bill amends section 171.052 of the Tax Code to provide that a non-admitted insurance organization subject to an occupation tax or any other tax imposed for the privilege of doing business in another state or a foreign jurisdiction, including a tax on gross premium receipts, is exempted from the franchise tax. Effective January 1, 2014.

TORT REFORM

HB 1869 HEALTHCARE SUBROGATION. This bill limits the subrogation for most health benefit plans but excludes self-funded plans under ERISA, workers' compensation, CHIP, Medicare and Medicaid plans, among others. This bill dealt only with contractual subrogation rights. "Payor" is broadly defined to include payors of benefits for health, accident and disability insurance. The bill also applies to the State of Texas and all political subdivisions, whether insured or self-funded.

Under the bill, if a covered individual was not represented by an attorney when seeking recovery, a payor's portion of the recovery will be limited to the lesser of one-half of the covered individual's gross recovery; or the total cost of the benefits paid, provided, or assumed by the payor as a direct result of the third party's tortious conduct. If the covered individual were represented by an attorney, the payor's portion of the recovery will be limited to the lesser of those amounts after the attorney's fees and procurements costs had been deducted.

The bill also describes how attorney fees will be paid in a recovery action. If a covered individual were represented by an attorney and the payor was not, the payor will pay an agreed-upon portion of the attorney's fees and a proportional share of incurred expenses. If the covered individual's attorney and the payor did not reach a fee agreement, the court will award a reasonable attorney's fee out of the payor's portion of the recovery. This award could not exceed one-third of the payor's recovery.

If both the covered individual and payor were represented by attorneys in a recovery action, the court will award the attorney's fees out of the payor's portion of the recovery. In awarding fees, the court will need to consider how the payor benefitted from each attorney's service, and total fees could not exceed one-third of the payor's recovery. If there were a declaratory judgment, a court could not award costs or attorney's fees to any party.

A health benefit payor is prohibited from pursuing in subrogation a portion of a covered individual's first-party recovery, except that a payor could pursue a portion of uninsured/underinsured motorist coverage or medical payment coverage if the covered individuals or their family did not pay the premiums. Effective January 1, 2014.

OTHER

HB 2459 DEBT CANCELLATION AGREEMENTS. This bill amends the Finance Code to cap the amount of interest that can be charged as part of a debt cancellation agreement at five percent (5%) of the amount financed under the contract. Currently, the amount charged must be made in good faith and be commercially reasonable. Effective September 1, 2013.

HB 3253 DATE OF DEATH ON BIRTH CERTIFICATE. This bill amends the Health and Safety Code to require the state registrar to note date of death on the birth certificate. Previously, this was required only for the death of persons under the age of 55. Effective September 1, 2013.

SB 162 EXPEDITED LICENSES BY MILITARY MEMBERS. This bill amends chapter 55 of the Occupations Code to require state agencies that issue licenses to expedite an application filed by a military member's spouse who has a current license issued by another jurisdiction with substantially equivalent licensing requirements.

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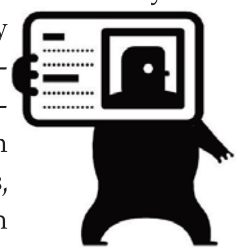
The bill also requires that licensing agencies give military members or veterans credit for their military service, training, or education, towards their licensing requirements. This credit does not include examination requirements.

Agencies are required to adopt rules, but the rules do not apply to applicants who hold a restricted license issued by another jurisdiction or if the applicant has an unacceptable criminal history per the agency's licensing laws. Agencies have until January 1, 2014, to adopt rules; and the new law applies to applications submitted on or after March 1, 2014. Effective May 18, 2013.

SB 166 ELECTRONIC INFORMATION ON DRIVERS LICENSES. This bill amends the Transportation Code to allow a health care provider to access the electronically readable information from a driver's license in order to provide health care services to the driver's license holder. Effective September 1, 2013.

SB 519 DEFINITION OF AUTISM. This bill amends Human Resources Code section 114.002 to change the definition of "autism and other pervasive developmental disorders" to reference the Diagnostic and Statistical Manual 5th Edition. Effective September 1, 2013.

SB 945 REQUIRING PROVIDERS AT HOSPITALS TO WEAR IDENTIFICATION BADGES. This bill amends chapter 241 of the Health and Safety Code to require hospitals to adopt a policy requiring a health care provider providing direct patient care at the hospital to wear a photo identification badge during all patient encounters, unless precluded by adopted isolation or sterilization protocols. The bill includes specific requirements for the information to be included on the badge. Effective January 1, 2014.



If you would like more information about the issues discussed in this newsletter, or you have a suggestion for a future article, please contact Newsletters@thompsoncoe.com.

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