THOMPSON COE

2007 Life & Health Insurance Legislation in Texas

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INTRODUCTION AND OVERVIEW

The 80th Legislature adjourned "sine die" on May 28, 2007. 4140 House bills were filed, and over 2058 Senate bills were filed during the 140-day session. 953 House bills were passed into law and 525 Senate bills were passed. Even though the session was described by the Governor as the "Good, the Bad and the Ugly", the 80th Legislature actually passed 76 more House bills than in 2005 and 13 more Senate bills.

Insurance law always seems to be a hot topic in any legislative session. Thompson Coe monitored 199 bills for the firm's life and health insurance clients of which 45 became law. Numerous positive reforms were enacted that will benefit the life and health insurance industry.

Thompson Coe publishes separate property/casualty insurance and life/health insurance newsletters. If you have received only one and would like both, please let us know; we will forward them to you.

The following is a summary report only, and contains brief descriptions of selected important features of the new laws affecting property and casualty insurance. In this report, reference may be made to the effective date of the legislation. This is the date the statute or amendment becomes law. Sometimes the operational changes in the law take effect on a different date than the effective date of the legislative act. Generally, most new laws take effect September 1, 2007.

We caution that this report is not intended to give legal advice nor is it be relied on as a complete presentation of the law. Any decision to act or not act should be made only after review of the entirety of the legislation and consultation with legal counsel.

Clients or others who have questions about any of the insurance legislation recently considered by the Texas Legislature should contact one of our attorneys.★

REGULATORY

Several bills passed which will affect the TDI and its ability to regulate the business of insurance. There were several TDI recommended bills that did not pass including legislation that would have given the Commissioner broad powers to regulate data mining and the use of new technology in developing new classifications; and legislation that would have required foreign companies to maintain their reserves in investments required for domestic companies. The following is a summary of new laws impacting the regulation of insurance:

Recodification. The legislature has been converting the Insurance Code of 1951 to a new Insurance Code which will conform to the uniform standards used by the Legislature. This is a part of the State's continuing statutory revision program where the law is to be re-codified into 27 codes without making substantive change to existing law. This is the fourth and probably the last session where parts of the Insurance Code of 1951 have been recodified.

HB 2636 accomplishes the recodification of the Insurance Code in three main sections. First, Article I of HB 2636 recodifies the remaining parts of the old 1951 Code into the new Code. Article II of HB 2636 updates cross references in previously recodified portions of the Code. Article III of HB 2636 incorporates amendments to statutes that were amended in 2005 that were also recodified in 2005. The portions of the Insurance Code that were recodified in 2005 were effective April 1, 2007. Several statutes that were repealed were also amended by other legislation in 2005. Article III would have placed those amendments into the recodified sections that were part of the 2005 legislation. Article I and Article II of HB 2636 are effective April 1, 2009. Article III is effective September 1, 2007.

Web Page Advertising. HB 2251 creates a new subchapter in the Insurance Code that includes statutory guidelines as to when an insurer's internet web site may be regulated as an insurance advertisement in this state. The new statute requires an insurer's internet web site to include all appropriate disclosures and information required by applicable rules adopted by the Commissioner relating to advertising only if the web page describes: (1) specific policies or coverage or (2) includes an opportunity to apply for coverage or obtain a quote. If permitted by rule, an insurer may comply with this requirement by including a link to a web page that includes the necessary information.

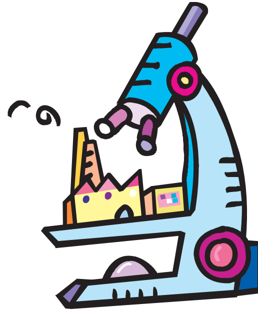
Web pages that do not refer to a specific insurance policy, certificate of coverage, or evidence of coverage, or that do not provide an opportunity for an individual to apply for coverage or request a quote from an insurer are considered institutional advertisements subject to rules adopted by the Commissioner relating to institutional advertising.

An insurer may advertise to the general public the policies or coverage available only to members of an association described by Section 1251.052, Insurance Code, which include labor unions, membership corporations organized or holding a certificate of authority under the Texas Nonprofit Corporation Act, and a cooperative or corporation subject to the supervision and control of the Farm Credit Administration. A person may not use an advertisement for an insurance product relating to Medicare coverage unless the advertisement includes in a prominent place the following language or similar language: "Not connected with or endorsed with United States Government or the Federal Medicare program."

An advertisement subject to requirements regarding filing of the advertisement with the TDI that is the same or substantially similar to an advertisement previously reviewed and accepted by the Department is not required to be filed for Department review. The bill takes effect September 1, 2007.

Frequency and expenses of examinations. Examinations of Texas insurance companies have been required once every three years unless the Commissioner determines that the financial strength of the carrier justifies less frequent examinations. In that case the TDI may conduct examinations at intervals not less frequent than every five years. Section 401.052, Insurance Code, is amended by SB

1253 to provide that the TDI shall visit and examine a carrier as frequently as the Department considers necessary. At a minimum, the Department shall examine a carrier not less frequently than once every five years. The Commissioner shall adopt the rules governing the frequency of examinations of carriers that have been organized or incorporated for less than five years.



This bill also amends Section 1305.251, Insurance Code, to provide that Workers Compensation health care networks are to pay for the expenses of examinations, including the salaries and expenses of the examiners directly attributable to the examination, as determined by rules adopted by the Commissioner. This Act is effective September 1, 2007.

Holding Company Registration Statements. SB 1542 amended Section 823.051, Insurance Code, to conform Texas law to NAIC standards on the filing of Form B registration statements. Under current law, a new registration statement must be filed every five years. However, annual filings are required when there are changes to a registration statement. The current registration statement in Texas is very detailed and requires a great deal more information than those filed in other states. The length and complexity of the statement should be reduced and more uniform to what is filed in other states.

Personal lines-only licenses. SB 1263 authorizes a new life-only license. This limited license allows applicants to take examinations which do not include questions dealing with commercial lines. A life-only license would allow solicitation of life and annuity products, but not accident or health insurance. This Act conforms Texas laws to those of most other states.

Conforming amendments are made to other insurance statutes, granting the life-only licensee equivalent status to a general life, accident and health agent licensee.

The effective date of the Act is September 1, 2007; however, the Commissioner is not required to adopt rules until December 1, 2007 and continuing education requirements for the new agent license will apply to renewals occurring on or after January 1, 2008.★

TAX

No new taxes were imposed on insurance companies during this session. There were amendments to the new Texas margin tax which is applicable to most corporate insurance agencies. The following tax bills may be of interest:

Contested cases before the Comptroller. SB 242 transfers all contested cases involving the collection, receipt, administration, and enforcement of taxes administered by the Comptroller to the State Office of Administrative Hearings (SOAH). Susan Combs, the new Comptroller, transferred the administrative law judges to SOAH under an interagency contract earlier this year. SB 242 codifies the transfer of the judges and makes related statutory changes concerning the administrative tax dispute resolution process. This Act is effective June 15, 2007.

CAPCO investments by insurance companies and tax credits. HB 1741 provides for the renewal of the Texas Certified Capital Companies ("CAPCO") program. CAPCO was established to create economic development focused on small and emerging businesses located throughout this state. This program targets certain low-income and rural areas of the state with a guaranteed minimum level of investment. This investment is funded by the securitization of insurance premium tax credits. To accomplish this purpose, legislation was enacted establishing premium tax credits for insurance companies that invested in state-approved certified capital companies.

Insurance companies were granted $200 million in available tax credits for investments in qualified debt instruments during 2005. The current credits cannot be utilized earlier than 2009 (for the 2008 tax year). HB 1741 adds an additional $200 million in available credits for investments in 2007. These credits may be utilized beginning with the tax report due in 2013 for the 2012 tax year. These premium tax credits are authorized to be used at a maximum rate of 25 percent per year. This Act is effective September 1, 2007.

Reciprocal or multi-state agreements relating to premium taxes. HB 3315 clarifies several issues that have led to litigation. First, it clarifies the taxability of home warranty insurance premiums. HB 3315 amends Section 221.002(b), Insurance Code, to require property and casualty insurers to include the total gross amounts of premiums, membership fees, assessments, dues, revenues, and any other considerations for insurance written by the insurer as taxable premiums.

HB 3315 amends the surplus lines insurance premium tax statutes to provide that the Comptroller may by rule establish that all premiums are considered to be on risks located in Texas if (1) the insured's home office or state of domicile or residence is located in Texas, or (2) as may be necessary to accommodate changes in federal statutes and regulations. Corresponding amendments are made to the unauthorized and independently procured insurance premium tax provisions to mirror the surplus lines tax provisions to allocate premium to Texas. The Comptroller is given the authority to adopt rules to change the trigger amount for the prepayment of surplus lines taxes. Currently surplus lines agents are required to prepay the tax when the accrued tax due is at least $70,000.

HB 3315 adopts a new Chapter 228 of the Insurance Code. This Chapter authorizes the Comptroller to enter into agreements or contracts with another state for the collection of surplus lines, unauthorized and independently procured insurance premium tax. This is designed to accommodate the potential adoption of federal legislation or multi-state compacts to allocate and pay these taxes.

HB 3315 amends the retaliatory tax provisions to allow the Comptroller by rule to enter into reciprocity agreements with other states. The parties can agree to mutually set aside retaliatory provisions in situations in which the contracting states determine that retaliation is not the preferred approach to protect their domestic insurers from excessive taxation or from other financial obligations. This Act is effective June 15, 2007.★

LIFE

Ancillary or non-insurance benefits for accident, health, life and long-term care insurance. Current law requires insurance companies to file policy forms for life, accident, health and long-term care insurance for approval by TDI. Many life and health companies have been able to get policy forms approved in other states that include non-insurance or ancillary benefits as part of the policy. These include such things as discount cards to health, vision, dental, prescriptions, physical fitness facilities, financial planning, will preparation or other similar services, and contributions for educational savings.

The TDI has been reluctant to approve policy forms that include such benefits in the absence of specific statutory authority. This bill adds Section 1701.061, Insurance Code, authorizing approval of life, accident and health policy forms that contain non-insurance benefits that are reasonably related to the type of insurance. HB 1847 permits the Department to approve a non-insurance benefit in a policy if it is reasonably related to the type of insurance. The policy form filing must include a description of the benefit and a notice that fully discloses the benefit to the policyholder and conditions upon which termination of the benefit would apply. This also clarifies current law, Section 1102.002, Insurance Code, which requires benefits to be payable in currency. This section of the law would not apply to non-insurance benefits included as part of the policy.

Specific examples of presumptive type of non-insurance benefits that should be approved include discount cards, financial planning, will preparation and contributions for educational savings. This Act is effective September 1, 2007.

Fees for valuing life insurance policies. Under current law, the Texas Department of Insurance is required to impose, and the Comptroller collects, a fee on all domestic life insurance companies for valuing life policies. The fee is set at $10 for each $1 million of insurance in force. This fee is

charged regardless of the nature or type of life insurance. For many years, a fee was required of domestic insurers in order to cover costs incurred by TDI actuaries to mathematically check the calculations of a life insurers mortality reserves. However, TDI no longer performs these valuation checks. HB 1849 repeals the life valuation fee and repeals the statute that currently authorizes domestic insurers to take a premium tax credit in the amount of evaluation fees paid. The act would apply to an insurer's liability for payment of valuation fees on or after January 1, 2008. The Act takes effect September 1, 2007.

Use of lapse rates in the calculation of reserves for secondary guarantees in universal life contracts. For many years, life insurance companies have been required by standard valuation laws to establish and maintain reserve liabilities for payment of policy obligations. Reserves have largely been determined by actuarial mortality tables, rates of interest and actuarial methods used in computing those reserves. The NAIC has recently adopted recommended changes to these standards because the reserve requirements have become outdated. The changes will involve a new mortality standard and change in the method of computing reserves related to specific classes of products. Even though the TDI could adopt mortality changes through regulation, a change in the statute is necessary in order to permit the recognition of lapse rates in the calculation of reserves for secondary guarantees in universal life contracts. The recognition of lapse rates would result in lower reserve requirements for companies. Reserve values would be more compatible with the underlying economics of the business. This will permit a more efficient use of capital by insurance companies, lower prices to consumers and less use of reinsurance or other financial tools.

HB 1590 adds Section 425.071, Insurance Code, to authorize the use of lapse rates in the calculation of reserves for secondary guarantees in universal life contracts issued after December 31, 2006. Lapse rates authorized by this section may not exceed 2% per year. This Act is effective June 1, 2007.

Suitability in certain annuity transactions with consumers. With the encouragement of TALHI and others, the TDI recommended in its biennial report that the Legislature consider the issue of new laws on suitability in annuity transactions. The NAIC has worked for years to develop a model law on suitability concerning recommendations of annuity sales to consumers age 65 and older based on information concerning the customer's financial condition. HB 2761 adopts the NAIC model act protecting consumers in annuity transactions. It adds Chapter 1115 to the Insurance Code on the suitability of a certain annuity for various consumers. The legislation requires an agent, or the insurer if no agent is involved, to make reasonable efforts to obtain certain information from the consumer to determine the suitability of the particular product for the consumer's needs. Each insurer is required to maintain a compliance system to determine compliance by agents in determining the suitability based on the individual's financial situation and needs. This Act will apply to annuity transactions on or after January 1, 2008, even though the effective date of the statutory provisions will be September 1, 2007.

Replacement of existing life insurance policies and certain annuities. The NAIC model regulation is designed to ensure that insurers and agents provide consumers with fair and accurate information about life insurance and annuity products being used to replace an existing policy. The level of disclosure is intended to prevent two unethical practices. The first is referred to as "twisting," which involves the failure to make complete comparisons of contracts for the purpose of persuading an insured to cancel an existing policy and to purchase another contract. The second practice is sometimes referred to as "churning," which involves the persuasion of a life insurance policyholder to purchase a higher death benefit policy. HB 2762 adopted the NAIC model regulation on replacement transactions. HB 2762 will require insurers

and agents to provide a consumer with relevant information and adequate protection against a "twist" or "churn" during a replacement. HB 2762 requires carriers to disclose if there is a replacement of an existing policy through forms approved by the commissioner or forms pre-approved by the TDI.

An insurer that uses agents replacing an existing policy is required to verify that the required forms are received and are in compliance with new Chapter 1114, Insurance Code. An insurer/agent that fails to comply with the chapter constitutes a violation of Chapter 541 as an unfair method of competition and unfair act. In addition to other sanctions as provided by law, the statute permits forfeiture of commissions or other compensation paid to an agent as the result of a transaction in which violations occur. The new statute is effective for applications on or after January 1, 2008.

Use of private placement accounts in variable insurance contracts. It has become a common practice for variable insurance providers to offer eligible customers numerous types of separate accounts that sometimes include "exempt" sub-accounts. These are sometimes referred to as "private placements" and often have restrictions on the liquidity of assets in the underlying portfolio. Liquidity restrictions are to be fully disclosed to policyholders before they are selected. The full liquidity date for an exempt sub-account may be on an annual basis, which would be longer than certain statutory and regulatory provisions requiring payment of cash values or death benefits.

Private placements are exempt from the Securities and Exchange Commission (SEC) registration. Only a "qualified investor" as defined in federal law can purchase or select private placements. A qualified investor is determined by net worth and annual income. Most policyholders that select these accounts have substantial amounts that are being placed into the exempt accounts. The selected exempt account may involve several million dollars worth of funds placed through the variable policy.

Insurers that have filed policy forms for approval in Texas which provide that the liquidity reserve value will be paid no later than 30 days after the completion of the annual audit of the exempt sub-account have been disapproved by the TDI on the basis that this may be longer than permitted under current Texas law. As a result, insurers could not offer exempt sub-accounts in variable policies in Texas.

Consumers desiring to purchase a variable life or annuity product with an exempt sub-account had to purchase this product through trusts in other states.

H.B. 2765 corrects this problem and will now permit the approval and use of private placement contracts forms. Section 1152.110 is added to the Insurance Code to specifically address these type of variable contracts. Other provisions of the Code are amended to make it clear that payment of death benefits and other benefits under a variable contract would permit payment timely after the private placement account is valued. This Act is effective September 1, 2007.

Refund of unearned premiums in credit insurance transactions. Credit life and disability insurance offers a debtor insurance protection for the period of a loan in the event he is unable to repay the loan due to death or disability. Section 1153.202, Insurance Code, governs the requirements for a refund of unearned premiums. The current statute is problematic because a credit insurance company must promptly refund premiums, yet there is no notice provision requiring debtors to notify the credit insurer that a loan has been paid off that would trigger a refund. In many circumstances, credit insurance companies do not know that debtors are entitled to a refund of unearned premiums.

Last year, the Texas Attorney General sued several credit insurance companies citing violations of the Texas Insurance Code and the Texas Deceptive Trade Practices Act, alleging they failed to refund unearned insurance premiums. SB 382 passed which corrects this problem and requires that each individual and group policy include a

written notice stating that if the underlying debt terminates before originally scheduled, the debtor shall be entitled to a refund of unearned premium. Further, in the event the underlying debt terminates before the regularly scheduled termination date of the insurance, SB 382 requires that the person who is the holder of the underlying debt instrument on the date the debt terminates, not later than 60 days after termination of the debt, provide notice to the insurer of the termination of the debt. The notice must include the name and address of the insured and the pay-off date of the underlying debt. The refund of unearned premiums must be paid not later than 30 days after receipt of such notice. In the event of a cause of action against an insurer for failure to return unearned premium, the insurer is entitled to indemnity from the holder who fails to provide notice. This applies only to credit life or credit A & H policies issued, delivered, or renewed after January 1, 2008. The Act is effective September 1, 2007.

Extension of group life insurance to certain eligible children. Under Section 1131.802, Insurance Code, group life can be made available to children who are younger than 21 years of age. HB 2549 extends the right to include natural children that are unmarried and younger than 25 years of age without regard to whether they are a full-time student. Also, natural or adopted grandchildren are eligible to be insured if the child is unmarried, younger than 25 years of age and a dependent for federal income tax purposes at the time the application is made. The statute will apply to policies issued, delivered or renewed after January 1, 2008.

Tax treatment of group life insurance issued through certain voluntary employee beneficiary associations. This legislation is aimed at a very small niche group that provides life insurance for armed services members. HB 2718 adds Subsection (c.) to Section 1131.503, Insurance Code, for certain non-profit membership associations. A qualified association under this act: (1) must qualify under § 501(c)(9), Internal Revenue Code; (2) have been in existence for 50 years and limit membership to members of the uniformed services of the United States active duty or reserves; (3) have no other separate membership category or enrollment; and (4) collect membership contributions or fees to the issuer following a retrospective premium determination and provide insurance and non-insurance benefits.

For purposes of determining premium taxes of an eligible association under Sections 222.002, 257.001, and 281.004, Insurance Code, only the final retrospectively determined premium is taxable as gross premiums. The Non-Profit Armed Services Association typically collects from its members, but calculates the group life premiums on a retrospective basis. Some of the money collected in this manner goes toward the purchase of a group life policy for its members. The Texas Comptroller has interpreted the current law to apply the premium tax calculation to the entire amounts collected from the membership without excepting the amount that is not used to pay premiums.

This bill provides that the premium taxes are only to be calculated on the final amount of money calculated retrospectively and paid to the insurer of the association's group life policy. This act applies only to premiums remitted on or after the effective date of the act. This Act is effective September 1, 2007.

Administrative requirements on 403(b) Insurance products. Under current Texas law, school districts and other educational institutions are prohibited from imposing restrictions on companies offering plans. HB 2341 was enacted to authorize an educational institution to refuse to enter into a salary reduction agreement with an employee if the qualified investment policy product does not comply with the educational institution's administrative requirements. The administrative requirements must be uniform to all companies and be necessary for the employer to comply with employer responsibilities imposed by § 403(b), Internal Revenue Code. This Act is effective for policies issued after January 1, 2008.★

HEALTH

Texas Health Insurance Risk Pool. Texans who cannot obtain insurance through a private insurer, are able to obtain insurance through the Texas Health Insurance Risk Pool. One of the primary purposes of this bill was to make changes to conform the Pool act to applicable state and federal law.

SB 1254 added definitions to the High Risk Pool Act for the terms: federally-defined eligible individual, government plan, group health plan, and significant break in coverage. The definitions are similar to the definitions in federal law. (ERISA) 29 U.S.C. § 1002.

The definition of health plan was also amended so that the following types of coverage would not be a health benefit plan and thus subject to assessments. These include the following: disability income, credit only, supplement to liability insurance, liability insurance, workers' compensation, coverage for on-site medical clinics, automobile medical payment, other similar coverage specified in HIPAA under which benefits for medical care are secondary or incidental to other benefits. Also not included are limited scope dental, vision, long-term care, and other limited benefit plans as defined under federal HIPAA law.

With respect to specified disease or illness, hospital indemnity or other fixed indemnity insurance, it would not be a health benefit plan under the Pool if: (1) such insurance is provided under a separate policy, certificate or contract of insurance, and (2) there is no coordination between the provision of the benefits and any exclusion of benefits under a new health plan made by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to an event which a group health plan is maintained by the same sponsor.

Section 1506.151(a), Insurance Code, was amended to require the Pool to offer coverage consistent with major medical expense coverage to each individual rather than to each eligible individual under the age of 65. The eligibility requirements in Section 1506.152 were amended to provide that a Texas resident is eligible if evidence is provided that the person is a federally-defined, eligible individual who has not experienced a significant break in coverage or is under age 65 and meets certain requirements.

SB 1254 clarifies the definitions of individuals who are not eligible for the Pool and may otherwise meet the requirements if the individual is eligible for other health care benefits, including an offer of benefits for continuation of coverage other than certain coverage maintained for pre-existing condition waiting period under a Pool policy or other coverage.

Section 1506.154, Insurance Code, is amended to require the Pool board of directors to develop a list of medical conditions for which an individual would be eligible rather than showing that the individual is covered by a substantially similar individual coverage excluding one or more conditions by a rider.

Section 1506.202, Insurance Code, is amended to authorize the board on a competitive bid basis to contract rather than to select health benefit plan issues or third-party administrators to administer the Pool.

The interest rate for delinquent assessments accrues on the unpaid amount of the assessment at a rate equal to the prime lending rate as published in the Wall Street Journal and determined on the first day of each month during which the assessment is delinquent, rather than the date the assessment becomes delinquent, plus 3%. This Act applies to policies issued, renewed or delivered on or after January 1, 2008.

Powers of certain health cooperatives. Four years ago, legislation was passed creating health

group cooperatives in order to facilitate the purchase of group insurance for large and small employers. Each session attempts to make cooperatives more viable. SB 1255 amended Chapter 1501, Insurance Code, to permit membership in a cooperative to be restricted to small and large employers within a single-industry group as defined in the United States Census North American Industry classification system. A cooperative that is composed of both small and large employers may be treated in the same manner as a large employer for the purposes of Chapter 1501. The intent of SB 1255 is to allow flexibility in the structure of a health cooperative to lessen the difficulties in developing a cooperative within a particular community. This Act is effective September 1, 2007.

Expedited credentialing for certain physicians. The caption of HB 1594 is entitled "expedited credentialing." However, HB 1594 adds a new Subchapter C to Chapter 1452, Insurance Code, that applies only to a physician who joins an established medical group that has a current contract in force with a managed care plan. A physician who applies to be credentialed with a managed care plan under this Subchapter is entitled to payment by the managed care plan as if the physician were a participating provider. If, on the completion of the credentialing process, the managed care entity determines the applicant/physician does not meet their credentialing requirements, the management care issuer may recover an amount equal to the difference between the payments for in-network and out-of-network benefits. An enrollee would not be responsible and would be held harmless for the differences in those fees. A physician may not be considered to be a primary care physician until credentialed. This Act is effective September 1, 2007.

Reporting of claims information to plan sponsors. Under current law, there are several statutes requiring insurers to report claims costs to employers in order to permit employers, as sponsors of health plans, to examine how their money is being spent and to determine whether to become self-funded or change carriers. HB 2015 adds Chapter 1215 to the Insurance Code for reporting of claims information to plan sponsors. Definitions for employer, health benefit plan issuer, plan sponsor, and plan administrator are added to conform Texas law to similar definitions in federal law and regulations. (ERISA and HIPAA)

On receipt of a request from a plan sponsor for claim information, an insurer must provide detailed claim information as set forth in Sections 1215.003 and 1215.004, Insurance Code.

Detailed claims information for a 36-month period must be provided and includes: aggregate paid claims by month, total premium paid by month, total number of covered employees and total dollar amount of claims pending. A separate description of claims for any individual whose total claims exceed $15,000 in a preceding period must also be provided. However, the detailed information containing protected health information and pre-certifications for a specific individual can only be provided if the plan sponsor provides a certification that the plan documents meet the requirements of HIPAA regarding the safeguard and limited use and disclosure of protected health information. A plan sponsor that does not provide this certification is not entitled to receive the detailed protected health information set forth in Section 1215.004(c)(5) and (6).

The reporting requirements contained in Art. 21.49-15, Chapter 1209, and Section 1501.614, Insurance Code, are repealed. The change of law applies only to reported claims information requested on or after January 1, 2008.

Modification of policy forms for certain small and large employer health benefit plans on renewal. HB 2467 authorizes carriers under state law to modify guaranteed renewable policies under certain circumstances. A health benefit plan may modify a small or large employer plan if the modification occurs at the time of coverage renewal, the modification is effective uniformly under all small or large employers covered by the plan, and the health insurer notifies the commissioner and each effective covered large or small employer of the modification not later than the

60th day before the date the modification is effective. The act applies to policies delivered, issued or renewed on or after January 1, 2008.

Creditable Coverage. Many health benefit plans exclude coverage for pre-existing conditions. As a result of changes to federal and state law, most plans provide creditable coverage to a person against pre-existing condition exclusions if a person moves to a new health benefit plan. This encourages portability so that pre-existing conditions can be covered under the new policy, and encourages persons to purchase and maintain qualified health benefit plan coverage.

Both group and individual health carriers are required to credit qualified coverage, but a carrier issuing individual policies is required to do so only if a person's most recent creditable coverage was under a group health plan, a government plan or an individual plan. This disparity between coverage credit in group and individual plans has produced some inequitable results.

HB 2548 amends Section 1201.154, Insurance Code, on individual policies to permit credited coverage in individual policies using the same standard as in the group market. HB 2548 also amends Section 1506, Insurance Code, for the high risk pool to allow an individual to be eligible for the pool even though a limited employer health plan is offered. An individual would be eligible if: (1) the individual is a part-time employee; (2) the employer plan is limited or more restrictive than the coverage available from the pool; and (3) there is no employer contribution for the premium for the individual. This Act is effective June 16, 2007.

Prompt payment penalties and the calculation of underpayment penalties. In 2003, the legislature enacted the Texas Prompt Pay Act, which created a graduated penalties scale for late payments. The most severe penalty for a late-pay of a clean claim is the total of billed charges plus 18%. SB 1884 amends the Insurance Code by changing the calculation for underpaid claims. Under the amended formula, the penalty increases as the under payment amount increases. The maximum penalty for under payments would be same as for late payments. This bill increases the period of time that providers have to identify and notify health plans of underpayments from the current 180 days to 170 days. Finally, SB 1884 decreases the amount of time that health plans have to correct an underpayment after notification without being penalized, from the current 45 days to 30 days.

The change in law has made been prospective in nature and applies to payment of claims on or after the effective date of the act. The effective date is September 1, 2007.

Long-term care partnership program. In order to create an incentive for individuals to purchase long-term care policies and thus avoid the drain on anticipated public financing of long-term care in Texas, SB 22 has created a long-term care partnership program in Texas. Persons who purchase long-term care policies under the program will be eligible for "asset disregard" up to the value of services covered by the insurance policy should they apply for long-term care coverage under Medicaid.

The program will be administered by the Health and Human Services Commission with the assistance of the Texas Department of Insurance. The program is to be consistent with the Federal Deficit Reduction Act of 2005.

Medical assistance services covered under the medical assistance program that are also covered by the individual's benefits under an approved long-term care plan are not available until the individual has fully exhausted the individual's benefits under the plan.

The Commissioner of Insurance is required to adopt minimum standards for an approved long-term care benefit plan after consultation with the Health and Human Services Commission. The Texas Department of Insurance must make sure that individuals who sell the long term care benefit under the partnership program receive proper training, and each issuer of such a plan must certify to the Commissioner of Insurance that the individuals who sell the plan on behalf of the issuer have completed the training and have demonstrated they understand the plans and how they relate to other public and private long-term care coverage. The Act takes effect March 1, 2008.★

CONCLUSIONS

There have been many words to describe the results from the 80th Legislature. Governor Perry described it as the "good, bad, and ugly." A record budget was passed which significantly increased funding for higher education and restored funding for CHIP. Battles between the Legislature and the Governor started early with disputes on the HPV vaccine, Texas Youth Commission, cancer research, and transportation issues, particularly the use of toll roads to complete the Trans Texas Corridor. Lt. Governor Dewhurst was proud of the legislative accomplishments in education, transportation, crack down on child predators, and a comprehensive water bill. The House started with a contentious, contested Speaker's race and ended with an even more contentious debate about whether the House rules, or lack of rules, permit a vote on the removal of the Speaker from office.

The 80th Legislature enacted many important changes for life and health insurers. The interim will be busy for several reasons. First, there is always a flurry of new rules. Most importantly, the TDI will be undergoing a Sunset Review which may occupy a great deal of its time and attention.★

TEXAS SUPREME COURT UPDATE

Contractual Subrogation Trumps "Made Whole" Doctrine

In *Fortis Benefits v. Cantu*, 2007 WL 1861000 (Tex. June 29, 2007), the Texas Supreme Court held that the insurer's contractual subrogation right entitled it to recover the amount of medical benefits it paid, even though the insured was not "made whole" in her settlement with third parties.

The insured, Cantu, was injured in a severe automobile accident. Her medical insurer paid $247,534.14 in medical expenses. Cantu also sued several defendants for allegedly causing her injuries. Her insurer intervened in the lawsuit and asserted a contractual subrogation right to recover the medical benefits it had paid. Cantu settled her claims against the defendants before trial for $1.445 million, and argued that the insurer's subrogation claim was barred by the "made whole" doctrine.

The "made whole" doctrine is an equitable rule that provides that an insurer is not entitled to subrogation if the insured's loss is more than the total amount recovered from both the insurer and the third parties causing the loss. Cantu's past medical expenses were $378,500, and she had evidence estimating her future medical expenses to be between $1.7 million and $5.3 million. Since her past and future medical expenses ($378,500 plus $1.7 million) were more than the total amount paid by the insurer and the defendants ($247,534.14 plus $1.445 million), Cantu had not been "made whole."

In its analysis, the Court distinguished equitable subrogation from contractual subrogation, and explained that it had previously applied the "made whole" doctrine only in the context of equitable subrogation. In this case, the specific language of the policy gave the insurer a contractual right to subrogation, and such contractual subrogation clauses "express the parties' intent that reimbursement should be controlled by agreed contract terms rather than external rules imposed by the courts." The Court further noted that "[w]here a valid contract prescribes particular remedies or imposes particular obligations, equity generally must yield unless the contract violates positive law or offends public policy."

The Court concluded that "the 'made whole' doctrine is not applicable if the parties' agreed contract provides a clear and specific right of subrogation." Consequently, the insurer was entitled to recover the $247,534.14 it had paid in medical benefits from the $1.445 million settlement that Cantu obtained from the defendants.

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