THOMPSON COE

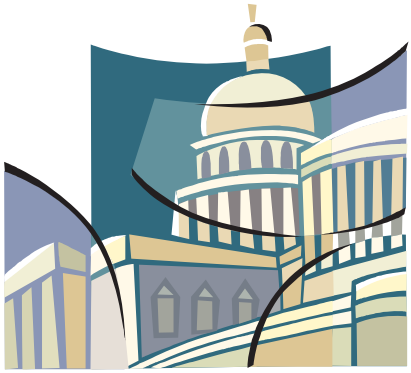
2005 LIFE AND HEALTH INSURANCE LEGISLATION IN TEXAS

Jack M. Cleaveland, Jr.
Rodney D. Bucker
Michael W. Jones
Jay A. Thompson
Shannon M. Phillips
Emory L. White
Richard S. Geiger
Ira Lee Allen
William H. Huff, III

IMPORTANT 2005 LIFE AND HEALTH INSURANCE LEGISLATION IN TEXAS

Introduction

The 79th Legislature considered a number of important issues in 2005. This is our biennial report of the significant insurance legislation and legislation affecting the insurance business. A complete summary of all legislation passed can be provided. A number of significant insurance issues that were introduced but did not pass included legislation that would have: imposed franchise taxes on insurers; banned the sale of corporate owned life insurance; clarified dental PPO laws; provided relief from Health Risk Pool assessments; provided for better regulation of viatical settlement transactions; regulated the use of balance billing by providers; provided relief from excessive valuation fees on group life insurance; a multitude of bills that have added new mandates to health insurers; and other bills that would impose onerous burdens on insurers.



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 and we will forward the other to you.

This is a summary report only, and contains brief descriptions of selected important features of the new laws affecting life and health 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 legislation. Generally, most new laws take effect September 1, 2005.

We caution that the report is not intended to give legal advice nor is it to be relied on as a complete presentation of the law. Any decision to act or not to 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.

Life Insurance Issues

Most of the bills dealing with life insurance affected group life. These bills included:

Limits on Coverage. H.B. 526 removes the caps placed on the face amount of group life insurance policies or certificates. It prohibits the amount of insurance on a life from exceeding the amount of the debtor's indebtedness except as otherwise provided by Section 1131.455, I.C. It removes the limitation that the initial amount of insurance issued to a debtor may not exceed $100,000 on any one life.

Payment of Group Life Premiums. Current statutes authorize a group policyholder to pay the premium for the policy either wholly from funds contributed by the employer, or partly from the employer's funds and partly from funds contributed by the employees.

H.B. 1571 adds a third alternative to the source of the premium funds: premiums can be paid wholly from funds contributed by the insured employees. This change broadens the opportunity for employees to have access to group life insurance.

Minimum Enrollment. S.B. 88 changes the minimum number of employees a business must employ to

700 North Pearl Street
Twenty-fifth Floor
Dallas, Texas 75201
(214) 871-8200 - Main
(214) 871-8209 - Fax

701 Brazos
1500 Austin Centre
Austin, Texas 78701
(512) 708-8200 - Main
(512) 708-8777 - Fax

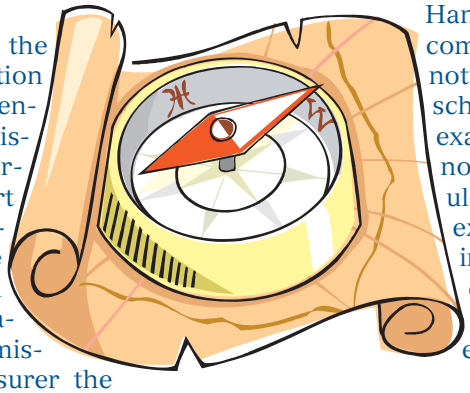
One Riverway
Suite 1600
Houston, Texas 77056
(713) 403-8210 - Main
(713) 403-8299 - Fax

408 Saint Peter Street
Suite 510
Saint Paul, Minnesota 55102
(651) 389-5000 - Main
(651) 389-5099 - Fax

be eligible for group life insurance coverage from ten to two.

Regulation

Market Conduct Examinations. A very important provision in **SB 14** is an amendment that adds Chap. 751 dealing with the regulation of insurer market conduct surveillance. This provision is based on the NCOIL Model Law. This chapter describes how TDI must perform its market conduct oversight. Market conduct examinations must be focused on general business practices rather than on individual consumer complaints or infrequent or unintentional random errors that do not cause significant consumer harm. The new law encourages TDI to consider other actions such as correspondence with the insurer, interviews, and interrogatories before proceeding with a targeted examination, and also to perform desk examinations rather than on-site examinations. TDI is given authority to contract with outside personnel to perform activities, including examinations and market conduct surveillance. Coordination with other states is required and qualified immunity is provided for providing information in the course of an examination in good faith and without fraudulent intent or intent to deceive.



The examination reports and the information provided in connection with the examination are confidential. The commissioner may disclose the contents of a final market conduct examination report to another insurance department or federal agency if the department or agency agrees in writing to maintain the information as confidential. The commissioner must disclose to the insurer the fact that the examination has been released to another department or agency within five days after the release of the information.

The commissioner is required to collect and report market data to the NAIC and coordinate the department's market analysis and examinations with other states through the NAIC. At least annually, the TDI must provide information to insureds and agents regarding new laws, rules, enforcement actions and other information relevant to ensure compliance with market conduct requirements.

The commissioner is given the responsibility for conducting market conduct examinations on domestic insurers. The commissioner has authority to delegate responsibility for market conduct examination for foreign insurers to the insurance commissioner of another state and the Texas Commissioner is required to accept a report prepared by an insurance commissioner to whom the responsibility has been delegated. Insurers that are members of a holding company system may be subject to an examination in Texas, but the examination of insurers that are not Texas domestics requires the consent of the insurance commissioners of the states in which the affiliates are organized.

The law authorizes the commissioner to impose sanctions for violations detected through a market conduct examination and oversight. However, the law requires the commissioner to consider whether an insurer is a member and complies with the standards of a best practice organization, as well as the extent to which the insurer maintains an internal self-assessment compliance program.

The bill has guidelines for conducting an examination and requires the department to prepare a work plan that includes a statement of the reasons for the examination, the scope of the examination, an estimate of the time for the examination, and a budget for the examination if the cost is to be billed to the insurer. A target examination is to be conducted in accordance with the Market Conduct Uniform Examination Procedures and the Market Conduct Examiners Handbook adopted by the NAIC. The commissioner is required to give insurers notice not later than 60 days before the scheduled date of an examination. Pre-examination conferences are to be held not later than 30 days before the scheduled date of an examination. A final examination report must include an insurer's response to the report. The commissioner may only conduct a market conduct examination once every three years.

Interstate Compact. **H.B. 2613** adopts the NAIC Model Law concerning an interstate insurance product regulation compact. The compact is a model representing an agreement among member states to create and implement a streamlined system of insurance product regulation through the employment of national uniform product standards. The compact creates a multi-state commission to receive, review and make decisions on product filings according to national uniform standards, thereby reducing the number of variations of the same product the company must produce. This bill is intended to provide a more efficient review and approval process for four specific product lines: life insurance, annuities, disability income and long-term care insurance. A management committee of 14 members is to oversee the day-to-day activities of the compact. H.B. 2613 permits Texas to serve as a member of the management

committee and permits Texas to participate with other states to create and refine uniform product standards. This will be done through the rulemaking process. Once 26 states, or states representing 40% of the premium volume for designated products have adopted the compact, then Texas would have the right to participate. The commissioner is given broad authority, not only in the establishment of uniform standards for life insurance and other products, but also in the receipt and review of product filings and in evaluating whether adopted product standards have been adhered to in particular compact states.

Conversion to Mutual Holding Company. A life insurance company has the authority to convert directly to a stock insurance company with approval of the commissioner. **S.B. 449** authorizes conversion through a mutual holding company. Under this type of conversion, a nonprofit corporation would be the holding company that owns the stock of the converted mutual corporation. Similar types of laws exist in most states. In 1995, Texas adopted a law to allow a property casualty mutual company to convert to a stock company or convert through a mutual holding company.

Reports on Convictions. The 1994 Federal Crime Act (18 U.S.C. § 1033) makes it a federal crime for an individual who has been convicted of a criminal felony involving dishonesty or breach of trust to be engaged in the business of insurance. As a result, insurance companies must be certain that none of its officers, directors or agents has been convicted of such activity. Sec. 20.05(a)(4), B.&C.C., currently prohibits a consumer reporting agency from providing a consumer report that discloses an arrest, indictment or conviction of a crime that is more than seven years old. **H.B. 1893** amends that provision to allow a consumer reporting agency to furnish to a person a consumer report that contains the information that is more than seven years old if it is needed by the entity to avoid a violation of federal law. This bill is effective June 17, 2005.

Telemarketing. **H.B. 210** is intended to resolve some differences between the Texas "no-call" list adopted in 2001 and the Federal Trade Commission's National Do Not Call Registry adopted in 2002. The PUC is authorized to contract with a private vendor that has maintained no-call list databases. The Texas do-not call list would be a combined list of those persons registered in Texas and those on a national call registry maintained by the United States government as it relates to Texas. The commission is allowed to have an individual place his name on the do-not call list by use of the Internet at no charge. The Texas agency is authorized to furnish names on the Texas list to the administrative and national do-not call registry and may allow placement of the names on the Texas no-call list in the national do-not call registry. Information on both the Texas list and national do-not call registry is exempted from the provisions in the Open Records Act that requires public information be made available to the public during normal business hours.

Restrictions on Underwriting for Asbestos. **S.B. 15**, the Asbestos/Silica Reform Legislation, was the result of a negotiated compromise of several groups. It will impact life and health insurers by adding Art. 21.53X, I.C. that will restrict underwriting and rating. This statute provides that an insurer that offers a health benefit plan or an annuity or life insurance policy or contract may not use the fact that a person has been exposed to asbestos fibers or silica or has filed a claim governed by Chap. 90, C.P.R.C., to reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect the person's eligibility for or coverage under the policy or contract.

Privacy

There was a lot of discussion and debate on privacy and identity theft issues. GLB exclusions were included in most legislation that passed on privacy issues. However, careful consideration should be given to the application of these bills to non-licensed entities. Three bills passed dealing with identity theft, destruction of records and creation of a privacy policy. In each bill, an exemption was added for insurers subject to federal and state privacy laws. A short synopsis of the bills that passed follows:

Prevention of ID Theft. **S.B. 122** enacts Chap. 48, B.&C.C. relating to the unauthorized use of personal identifying information. This new chapter makes it an offense to obtain, possess, transfer or use personal identifying information of another person without his consent and with the intent to obtain a good, a service, insurance, an extension of credit, or a thing of value. *This portion of the new law would not apply to a covered entity as defined in Chapters 601 and 602, I.C., which includes any person or entity licensed by the TDI.*

The bill also requires every business to implement and maintain reasonable procedures to protect and safeguard from unlawful use or disclosure of any sensitive

personal information. A business shall either destroy or arrange for the destruction of customer records containing sensitive personal information by shredding, erasing, or otherwise modifying the sensitive personal information in the records to make it unreadable or undecipherable. *This portion of the new law applies to all businesses except for financial institutions as defined by 15 U.S.C. §6809, the Gramm-Leach-Bliley Act, which includes insurance companies and agents. It may not exempt other licensed persons or entities.*

The bill deals with breaches of security of computerized data and applies to all businesses and also contains requirements for notice when there has been a breach. The unauthorized use or possession of personal identifying information is also identified as a deceptive trade practice.

Disposal of Business Records. **H.B. 698** requires a business disposing of business records that contain personal identifying information of a customer to shred, erase or use other means to make personal identifying information unreadable or undecipherable. A business that does not properly dispose of a business record would be liable for a civil penalty up to $500 for each record. A business would not be liable for the civil penalty if the record was reconstructed in whole or in part through extraordinary means. A business is considered to comply with the requirements of this act if it contracts with a person engaged in the business of disposing records. *The disposal requirements do not apply to a financial institution defined by federal law or to a covered entity defined in the privacy law of Chaps. 601 or 602 I.C., which includes insurance companies and agents.*

Privacy Policy for disclosures of SSN. **H.B. 1130** adds Sec. 35.581 B.&C.C. to make a privacy policy necessary when a person requires disclosure of an individual's social security number to obtain goods or services or enter into a business transaction. The policy must be made available to the individual and the policy must provide for confidentiality and security of the social security number.

This bill does not apply to a person required to maintain a privacy policy under the Gramm-Leach-Bliley Act, the Family Educational Rights and Privacy Act, or the Health Insurance Portability and Accountability Act of 1996, which includes insurers and agents.

Receivership & Financial Regulation

Receivership. **H.B. 2157** adopts the *draft* NAIC Insurer Receivership Model Act. The purpose of the bill is to clarify the law and promote cooperation in multi-state receiverships. This bill also gives the commissioner additional authority to act sooner to take control of a failed insurer. This bill repeals the current statute, Art. 21.28, I.C., relating to the liquidation, rehabilitation, and reorganization of insurers. The new act will apply to receiverships that have not been finally closed.

Life & Health Guaranty Fund. **H.B. 2883** updates the Texas Life and Health Guaranty Act to conform the bill closer to the NAIC model act. The last change in the Texas law was 1991. The NAIC has revised and updated its model act on at least five different occasions since that date, including an increase of coverage limits to provide greater protection.

The bill amends various provisions to limit coverage to residents of Texas except in limited circumstances. For example, this bill would not apply coverage to an owner of an unallocated annuity contract or structured settled annuity, unless certain conditions are met. Those conditions generally allow coverage if the owner of an unallocated annuity contract issued to or in connection with a government lottery is a Texas resident.

Structured settlements would not be covered unless a person is a payee and is a Texas resident. If the payee is not a resident, the contract owner of the structured settlement annuity must be a resident and the payee is not eligible for coverage by the association in the state where the payee resides. If both the payee and contract owner of a structured settlement are not residents, coverage under the act could be provided if the insurer that issued the structured settlement annuities is domiciled in the state and neither the payee or payee's beneficiary or contract owner would be eligible for coverage by an association in another state.

The residence for a plan sponsor is defined to mean the place where 50% or more of the participants reside or an employer or employee organization has the largest investment in the benefit plan.

Coverage amounts are increased for accident, health and long-term care policies to the following:

- $500,000 for basic hospital;

- $300,000 for disability long-term care insurance;
- $200,000 for coverages not defined as basic hospital, major medical or long-term care;
- The amount in excess of $100,000 in present value annuity benefits, including net cash surrender, net cash withdrawal values with respect to an individual participating in a government retirement benefit plan established under Sections 401, 403b or 457, I.R.C.;
- $100,000 in present value benefits in the aggregate for each payee of structured settlement annuity or beneficiary if the payee is deceased.

Assessments on insurers are changed from an annual basis to a premium basis for the three most recent calendar years preceding the date in which an insurer becomes insolvent. The limit on assessments is increased. Under the old law, assessments were limited to one percent of an insurer's premiums in one year. The new limit is two percent during the three calendar years preceding the date of insolvency. The limit is a per insolvency limit.

Tax credits for assessments are allowed under the act and are changed from a 10-year recoupment period to five years.

Accounting Practices for Audits. **S.B. 1591** gives the TDI greater ability to rely on CPA audits of insurers by amending the Insurance Code to require CPAs to consider the procedures illustrated in the NAIC Examiner's Handbook while performing insurer audits. It amends Sec. 12(c), Art. 1.15A, I.C., to prohibit the commissioner from accepting an audited financial report prepared by an individual or firm who the commissioner finds has entered into an agreement of indemnity or release of liability regarding an audit of an insurer. An insurer may not be compelled to disclose a self-audit document or waive any statutory or common law privilege.

Special Deposits. **S.B. 1592** adds Art. 1.33, I.C, which gives the commissioner broad authority to require special deposits to address case specific instances of an insurer's potentially hazardous financial condition. A deposit under this section is in addition to any other deposit required by law. The effective date is June 17, 2005.

Holding Company Act Exemption. The Holding Company Act (Chap. 823, I.C.) is amended to make all domestic insurers subject to the Holding Company Act.

HMO's subject to Holding Company Act. S.B. 1284 makes HMOs subject to the Holding Company Act (Chap. 823, I.C.). Additionally, the bill makes the merger of a HMO with another HMO subject to Chap. 824 relating to mergers and acquisitions of insurers.

The bill amends Chap. 843, I.C. relating to the HMO Solvency Surveillance Committee. This committee has the authority to assess members in the event of a rehabilitation, liquidation or supervision. The bill amends Sec. 843.441 to allow assessments to include the expenses incurred by the commissioner acting as a receiver or by a special deputy receiver.

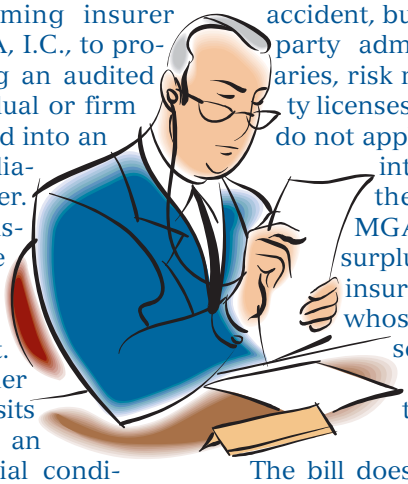
Agent Issues

Agent Disclosure. **H.B. 2941** arose out of the Spitzer investigation of broker compensation in New York. The bill is largely the NCOIL Model Law.

The bill requires written or electronic acknowledgement, before a purchase of an insurance product, that an agent is to receive compensation both from the customer and from an insurer or third party. Exemption is made for reimbursement of expenses, an inspection fee or an application fee.

The disclosure must include a description of the method and factors used to compute the compensation the agent will receive from the insurer or other third party for placement of the policy.

The new law applies to almost all types of agents, whether property and casualty, or life, health and accident, but it does not apply to adjusters, third party administrators, reinsurance intermediaries, risk managers, or agents holding specialty licenses. The provisions of this new law also do not apply to (1) an agent that acts only as an intermediary between an insurer and the customer's agent, including an MGA; (2) a reinsurance intermediary or surplus lines agent placing surplus lines insurance or reinsurance; or (3) an agent whose sole compensation for placing or servicing of an insurance product is derived from remuneration paid by the insurer.



The bill does not abolish contingency payments nor does it specifically require disclosure of the exact amount of the compensation. The TDI will likely issue disclosure regulations.

Continuing Education. **S.B. 265** authorizes the commissioner, by rule, to grant not more than four hours of continuing education credit to an agent who is an active member of a state or national insurance association. The rule would specify the types of associations and establish reasonable requirements for active participation in the association. C.E. credit would not be available where classroom hours or ethics are statutorily required. Agents must file a sworn affirmation on the number of education hours claimed. The agent must also certify that the agent has either reviewed education materials provided by the association or attended educational presentations sponsored by the association.

Premium Finance. **H.B. 2965** Chap. 651, I.C. regulates licensing of premium finance companies and transactions involving premium finance agreements. This bill puts limitations and restrictions on agents and premium finance companies. The bill places limitations or inducements on sharing of profits and fees.

Currently, Sec. 651.051 requires licenses in order to do business as a premium finance company. H.B. 2965 provides that requirement does not apply to a person or entity who purchases or acquires a premium finance agreement from a premium finance company, if the premium finance company: (1) retains the right to service the agreement and to collect payments due under the agreement; and (2) remains responsible for servicing the agreement in compliance with the statute.

An insurance agent or employee may receive an article of merchandise having a value of $10 or less on which there is an advertisement of the premium finance company.

Another exception to the limitations on the sharing of fees and profits is that the restrictions do not apply premiums for commercial lines of insurance under specified circumstances.

Health & Accident Insurance

Committees & Oversight

Several bills passed that established advisory, study, oversight, coordination, or public awareness committees. These include the following bills:

Public Awareness. **S.B. 261** creates the Health Coverage Awareness and Education program through the TDI. The program goals would be to increase public awareness of health coverage options available in Texas, educate the public on the value of health coverage, and provide information on health coverage options, including health savings accounts and compatible high deductible health benefit plans. TDI is not permitted to favor or endorse any particular health coverage issuer over another, but could include information about specific health coverage issuers. TDI is authorized to develop public service announcements and a new website to educate consumers on the availability of health coverage in Texas. The Insurance Commissioner is directed to appoint a task force to make recommendations regarding the health coverage public awareness and education program. The TDI will also be permitted to accept gifts and grants from any party to fund the program, including a health benefit plan issuer.

Technology Advisory Committee. **S.B. 45** establishes an advisory committee which is required to develop a long-range plan for healthcare information technology, including the use of electronic medical records and other methods of incorporating information technology to improve outcomes and cost effectiveness. The committee will be composed of interested groups, including health plans, pharmacies and doctors' associations. At least one member is required to have ten years experience in the healthcare information technology industry.

Governor's Coordinating Council. **H.B. 916** is designed to help the state develop a coordinated approach to healthcare delivery. The Governor's Healthcare Coordinating Council is composed of the administrative heads of various state agencies including the Health & Human Services Commission, the Department of State Health Services, the Department of Aging, the Texas Work Force Commission, the Texas Higher Education Coordinating Board, ERS, TRS, TDI and each healthcare licensing agency identified by the Governor. This coordinating council would consider healthcare issues submitted to the Governor by the Speaker and Lt. Governor. Issues could include disparities in levels of care, uninsured individuals, cost of healthcare pharmaceuticals and other issues. The Governor is given authority to set priorities and is charged with establishing an information clearing

house to assist communities in assessing the needs of local healthcare systems.

Preferred Provider Plans

As usual, a lot of legislation was aimed at regulating preferred provider contracts. This session was no exception. The following bills impact PPO and HMO networks:

Contracts with Hospitals. **H.B. 2999** prohibits an insurer from denying a hospital the opportunity to participate in a preferred provider network solely because the hospital is not accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other national accrediting body. If a hospital is a certified Medicare program or accredited by JCAHO member, an insurer shall accept certification or accreditation. The bill contains a provision that makes clear that an insurer's authority to establish other reasonable terms under which a hospital may provide health care services is not limited.

Reimbursement Levels for Preferred Providers. **H.B. 1030** amends Chap. 1301, I.C., relating to preferred provider contracts with health insurers. A section is added to require that the chapter may not be construed to limit the level of reimbursement, coverage, deductibles, co-payments, co-insurance or other cost-sharing provisions that are applicable to preferred providers or non-preferred providers. A new section dealing with co-insurance provides that current insurance applicable to non-preferred providers may not exceed 50% of the total covered amount applicable to medical or healthcare services. The bill is effective for policies issued, delivered or renewed after January 1, 2006.

Bundled Clean Claims. Under the provisions of the Clean Claims Act, health plan insurers are required to pay within 30 days electronically submitted clean claims that have been affirmatively adjudicated. In some cases, HMOs or insurers have been inappropriately rejecting clean claims due to their presence in electronic batches of claims containing one or more non-clean claims.

S.B. 50 requires an insurer or HMO to include in a contract with a provider, upon request of the provider, provisions relating to the submission of bundled claims and the payment of clean claims bundled with non-clean claims. This act applies prospectively to contracts entered into or renewed after January 1, 2006.

Administration of Plans. **S.B. 51** amends Chapters 1301 and 843, I.C., dealing with insurer and HMO preferred provider plans. When a contract between and insurer and a group policyholder has a preferred provider plan, the contract must require that the group policyholder is also liable for an individual insured's premiums from the time the individual is no longer part of the group until the end of the month in which the group policyholder notifies the insurer that the individual is no longer part of the group. An individual remains covered under a policy until the end of that period.

The bill also amends Sec. 843.347, I.C., which applies to health maintenance organizations. This section deals with the provision in the Insurance Code where an HMO is required to provide verification during certain hours. An exception to verification is made for a single service plan such as vision services and dental services. HMOs would have to only have verification personnel available for such single service plans between 8:00 a.m. and 5:00 p.m., Monday through Friday, and have a system of accepting a recording of incoming calls on weekends and legal holidays. This act will apply to contracts entered into or renewed after January 1, 2006.

Information for Providers. **S.B. 1149** adds Chap. 1274, I.C. to require each health benefit plan to make available to each participating provider by telephone, electronic means or Internet information sufficient for the provider to determine at the time of the enrollee's visit the following:

- Enrollee's identification number
- Name of the enrollee and covered dependents
- Birth date of the enrollee and covered dependents
- Gender of an enrollee and covered dependents
- Current enrollment and eligibility status
- Whether a specific type of category of service is covered
- Enrollee's excluded benefits or limitations
- Co-payment requirements

The unmet amount of the enrollee's deductible or financial responsibility.

The bill applies to health benefit plans, but does not include accident, credit, disability, specified disease coverage, long-term care, limited scope, dental or vision, or single service HMOs, liability insurance, workers' comp., hospital indemnity or fixed payments, or reinsurance contracts issued on a stop loss, quota share or similar basis.

Health Savings Accounts

Two bills were passed designed to make Health Savings Account plans more attractive. These included:

Exemption from Creditors Claims. **H.B. 330** exempts Health Savings Accounts, created by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (P.L. 108-173), from being attached or seized for the satisfaction of debts unless certain conditions apply. The exemption includes all contributions made under Sec. 223, IRC.

High Deductible Plans. The Medicare Prescription Drug Improvement and Modernization Act of 2003 included provisions authorizing "tax favored" health saving's accounts (HSAs) for the payment of qualified medical expenses. Participants in HSAs must also be covered by a high deductible health plan, which meets certain minimum annual deductible requirements. Currently, HSAs may only be offered alongside a high deductible health plan in Texas until January 1, 2006. In order to continue to offer HSAs in 2006, Texas must address current law that impedes the offering of HSAs. **H.B. 1602** addresses this issue in order to make HSAs available after January 1, 2006. This change is effective May 21, 2005.

Mandated Benefits

The usual large number of mandates were filed and heard this session including several bills adding significant new mandates for mental health coverage. The onerous mandates did not pass. Two bills did pass including:

Tests for Cancer. **H.B. 1485** mandates that a health benefit plan that provides coverage for diagnostic medical procedures must provide coverage for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Notice of coverage is required to be given to each woman enrollee 18 years or older. This bill amends the Texas Consumer Choice statute passed in 2003 to require coverage under HB 1485 be a mandated benefit on consumer choice plans. This bill is effective for policies delivered, issued or renewed on or after January 1, 2006.

Post Partum Depression Study. **S.B. 826** started as a mandated benefit but passed as authorizing a study of providing coverage for post-partum depression. The bill requires the Health and Human Services Commission to conduct a study examining the feasibility and effects of providing twelve months of health services under the Medicaid program to women who are diagnosed with post-partum depression.

Cooperatives. **S.B. 805** amends various provisions of Chap. 1501, I.C. dealing with small and large employer health group cooperatives. First, it makes clear that an insurer may elect not to participate in a health benefit plan cooperative. Second, it provides that membership in a cooperative may consist only of small employers or may consist of only large employers, but may not consist of both large and small employers.

The bill also allows a cooperative consisting of only small employers to restrict membership in the group if the cooperative makes the election to restrict membership at the time it was initially formed. Evidence of the election must be filed in writing with the commissioner. An election to restrict membership must also be based on the fact that the total number of eligible employees employed by all small employers participating in the cooperative would not exceed fifty. A small employer cooperative that has not made the election to restrict membership shall be treated in the same manner as a larger employer for the purposes of Chap. 1501, including purposes of any provision relating to premium rates and issuance and renewal of coverage.

The bill also places a temporary limit on the total assessments for the small employer reinsurance facility. The maximum assessment for a calendar year may not exceed 10% of the total premiums earned in the preceding calendar year from small employment plans delivered in this state. The temporary limit will expire September 1, 2007.

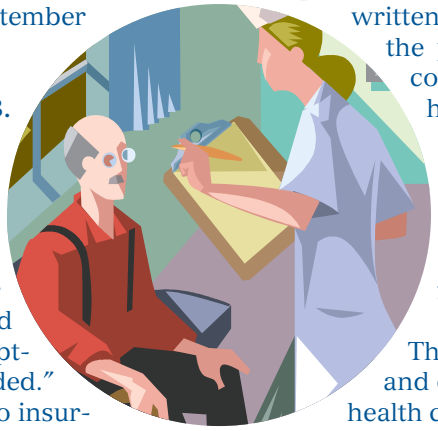
High Risk Pool Assessments. The Risk Pool was created by the Legislature to provide health insurance to Texas residents who are unable to obtain coverage from commercial insurers. In the event it is necessary to obtain additional funds to cover pool losses, Texas law allows an assessment on each health benefit plan issued in the state. The assessment is based on the company's gross premiums as the percentage of the total premiums sold in the state. **S.B. 809** changes the method of assessment. The bill authorizes the board to assess health benefit plans based on the number of lives covered rather than by premium volume. Health benefit plan issuers are required to submit to the Risk Pool board the number of Texas residents enrolled in the benefit plan, including those covered under an excess loss, stop loss or reinsurance

policy. For purposes of determining each plan's assessment, ten employees covered under a policy of excess stop loss or reinsurance would be counted as one employee for a 10:1 ratio. Dependents of individual policyholders or those covered under Medicare would not be counted.

The bill adds a new subchapter outlining the Risk Pool subrogation rights and provides that benefits are not payable for an injury or illness for which a third party may be liable under a contract, tort law or other law.

The bill amends the definition of health benefit plan, to exempt accident insurance, fixed indemnity, hospital indemnity, specified disease coverage and other limited benefit coverages. Limited benefit coverages would not be subject to assessment.

The bill is effective January 1, 2006. Insurers exempted from assessment by the bill would be entitled to refund of assessments paid after September 30, 2005.



Specified Disease Policies. **H.B. 1775** adds Sec. 1201.0601, I.C. to require the inclusion of the definition of "actual charge" or "actual fee" in a specified disease policy if that policy uses one of those terms. The definition provided for "actual charge" or "actual fee" is "the amount actually paid by or on behalf of the insured and accepted by a provider for services provided." This bill will be applied prospectively to insurance policies delivered, issued for delivery, or renewed after the effective date of September 1, 2005.

Genetic Testing. Chapter 546, I.C., applies to regulation of genetic tests for group health benefit plans. **S.B. 53** amends the chapter to apply to both group and individual health insurance policies. The act applies only to a health benefit plan delivered, issued or renewed after January 1, 2006.

Underwriting Factors Individual Policy Applications. **H.B. 2810** prohibits a health benefit plan issuer from using an applicant's previous denial of health insurance as an underwriting factor.

The basis for this bill was the concern that a large number of Texans are not offered health insurance through their employer. Insurance coverage may only be available in the individual insurance market. If someone searching for health insurance is denied by one company, that denial can often make it more difficult, or even impossible, for the person to find health insurance from another company. Health insurance companies often ask applicants if they have been denied health insurance. If the applicant answers yes, the health insurance company may deny coverage outright, even if the company would have insured them had they not been denied by the first company. This creates an extra hurdle to obtaining health insurance and contributes to the large number of uninsured Texans.

Provider Charges for Medicaid. **S.B. 500** amends Chap. 552, I.C., ("Illegal Pricing Practices") which defines fraudulent insurance act as knowingly or intentionally charging two different prices for providing the same product and service and the higher price is charged based on the fact that an insurer will pay the entire price of the product or service.

Sec. 552.001, I.C., is amended to provide that the chapter does not apply to: health care service for a patient covered under a federal, state or local government program; a financially indigent person who qualifies for care based on a sliding scale or a written charity care policy established by the provider; or a person who is not covered by a health policy, but the healthcare provider provides services for the insured based on a written policy. This chapter allows a healthcare provider to enter into a contract with an insurer or other health benefit plan that has a preferred provider plan.

This bill allows hospitals, physicians, and other health care providers to offer health care discounts to people who do not have health insurance and who do not qualify for Medicare or Medicaid benefits. Under current Texas law, these health care providers cannot legally discount their regular prices to uninsured patients. The change in law applies only to services provided after the effective date of June 17, 2005.

Minimum Annual Limits on Group A & H Policies. **H.B. 765** requires an insurer under a group policy to include in a Certificate of Insurance the annual deductibles, annual and lifetime policy limits and maximum out-of-pocket expenses under the policy. Notice must also be given to an employer or member of the availability of the premiums for a rider or separate insurance that would provide coverage in addition to the coverage provided under the policy. An insurer is not required to provide more than one certificate or notice to each family.

This bill also requires notice to certain employer health benefit plans that are offered under a Consumer Choice plan under the provisions in Art. 3.80, I.C. The Consumer Choice Plan does not contain all of the mandates in Texas law. If an employer offers a standard benefit plan, which is part of the Consumer

Choice, it must provide a disclosure statement to each employee before the initial enrollment in the plan. The notice and disclosure is a disclosure that the standard health benefit plan does not provide some or all of the state mandates.

This bill is effective for policies delivered, issued or renewed after January 1, 2006.

HMO Quality Assurance. Before a health plan is given a certificate of authority to issue policies in this state, the TDI is required to perform an extensive review and evaluation of the plan's compliance with various statutory and regulatory requirements. Many insurers also are subjected to review by the Joint Commission on Accreditation of Healthcare Organizations based on safety, quality and industry best practices. Many insurers seek this accreditation as an assurance of quality to potential subscribers and for re-insurance.

S.B. 155 establishes that a health plan with a national accreditation or a health plan that has offered a Medicaid managed care plan or plan under contract with federal centers for Medicare and Medicaid is in compliance with the state and regulatory requirements for health plans. To use a national accreditation in lieu of TDI evaluation, TDI would require the plan to submit the report. It would be confidential and not subject to subpoena and would have limited internal distribution.

The bill also requires TDI to monitor national accreditation standards to ensure they are at least as stringent as state law. Plans under contract with HHSC, Medicaid or C.H.I.P. could also present national accreditation in lieu of review for compliance.

The bill also adds Chap. 1457, I.C., dealing with provisional credentialing status. This section of the bill requires a health benefit plan to have a process for provisional credentialing in compliance with the National Committee on Quality Assurance. This permits physicians to obtain provisional credentialing status. A health benefit plan must complete the credentialing process within 60 days of the date a physician is granted provisional status. This act is effective June 17, 2005.

Insurance Fraud Legislation

Thompson Coe was very much involved with the Fraud Task Force, TDI and others in drafting and lobbying several important bills to strengthen Texas laws to prevent insurance fraud. These bills included the following:

Fraud Reporting Requirements. H.B. 2388 amends Sec. 701.051,I.C. to require a person who determines or reasonably suspects that insurance fraud has been or is about to be committed to submit a report to TDI within 30 days of the determination or suspicion of fraud. The report must be submitted to the TDI's Fraud Unit in the format prescribed by NAIC or TDI. A report to TDI constitutes notice to other appropriate authorized governmental agencies. A person may comply with this law by authorizing an organization which investigates and prosecutes insurance fraud on their behalf to report suspected fraud to TDI, but retains liability for the organization's failure to report. Insurance fraud or suspicion of fraud may be reported to the TDI anonymously by an individual.

The bill eliminates the requirement that an insurer conducting an investigation of insurance fraud complete the investigation in order to request an investigation by TDI or law enforcement. An insurer conducting an investigation of suspected insurance fraud is required to report the findings on conclusion of the investigation.

Sec. 701.052(f), I.C., is repealed. This section required insurers to exercise "reasonable care" when reporting fraud.

Criminal Offenses on Theft and Fraud. **H.B. 3376** amends the offenses of money laundering and insurance fraud to streamline the investigation and prosecution of those offenses.

Punishments for those offenses are standardized to make them consistent with the rest of the Penal Code value ladder (this lowers the penalties compared to current law), and adds them to Engaging in Organized Criminal Activity (which returns the offense level to current law, but only if three or more defendants commit the offense together). Aggregation of amounts is allowed so they can be handled in a single prosecution.

The statute of limitations is increased for felony insurance fraud to match the federal period.

Prosecution for Unauthorized Insurance. **S.B. 781** amends Chap. 101, I.C., by changing the required culpable mental state for commission of an offense of conducting the business of unauthorized insurance to "reckless, knowing or intentional" from "knowing or intentional".

Tort Reform

Tort reform legislation was minimal on issues affecting life and health insurers. However, three bills that may have some indirect impact including the following:

Settlement Credits. In 2003, the tort reform bill H.B. 4, amended the settlement provisions in C.P.R.C. to require reductions to a claimant's recovery for amounts received from settling defendants based on their percentage of responsibility. Prior to this change, reductions in a claimant's recovery were based on an election by a nonsettling party. Reductions could be either a percentage of fault or the dollar amount received in settlement. The change in H.B. 4 was inadvertent except for cases other than medical professional liability claims. **S.B. 890** intends to correct that error. Determination of percentage credits can often be difficult to administer whereas it is easy to determine how much was received in a settlement. Now, except cases against a health care provider, a claimant's recovery is reduced by the dollar amounts paid in settlements.

Forum Non Conveniens. **H.B. 755** is an attempt to give a trial court more discretion in deciding whether to grant a motion to stay or dismiss a lawsuit under the doctrine of forum non conveniens. It removes the prohibition that a case may not be dismissed on grounds of forum non conveniens if the injury or death occurred in this state. Instead, the bill requires the court to consider the extent to which an injury or death resulted from acts or omissions that occurred in this state. The amended law requires the court to consider the following factors when determining whether to grant a motion to stay or dismiss for forum non conveniens: (1) whether an alternate forum exists in which the claim may be tried; (2) whether the alternate forum provides an adequate remedy; (3) whether maintenance of the claim in the courts of Texas would work a substantial injustice to the moving party; (4) whether the alternate forum, as a result of the submission of the parties or otherwise, can exercise jurisdiction over all the defendants properly joined to the plaintiff's claim; (5) whether the balance of private interests of the parties and the public interest of the state predominate in favor of the claim being brought in an alternate forum, which shall include the consideration of the extent to which an injury or death resulted from acts or omissions that occurred in Texas; and (6) whether the stay or dismissal would not result in unreasonable duplication or proliferation of litigation. The law requires the court to state specific findings of fact and conclusions of law.

Asbestos and Silica. **S.B. 15** accomplished the following goals:

- establish sound medical criteria for determining impairment caused by asbestos or silica, and thereby remove the unimpaired claimants from litigation.
- apply non-joinder to asbestos and silica claims, so that they are tried as they should be, one case at a time;
- make asbestos and silica cases eligible for the Multi-District Litigation ("MDL") court; and
- apply the legislation to pending claims as well as prospective claims.

S.B. 15 also includes a provision that assures that this law will not prevent otherwise eligible claimants from filing claims in bankruptcy where trusts are established to pay asbestos and silica claims.

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Thompson Coe understands insurance. Since its inception, the Firm has dedicated itself to being a national authority on insurance law. Thompson Coe clients depend on its broad insurance background and knowledge to provide reliable and efficient legal advice and assistance for all insurance business and regulatory matters. Whether giving advice pertaining to insurance laws; representing a client before an insurance regulator; handling mergers, acquisitions or formations of insurance companies and agencies; or drafting or reviewing documents needed for insurance-related transactions, the Firm brings its experience to areas of law which are unfamiliar to many. In 2005, Thompson Coe was selected by Chambers, USA as the number one insurance firm in Texas for the third straight year.

In addition to insurance business and corporate practices, Thompson Coe represents clients before insurance regulatory bodies, such as the Texas Department of Insurance. The Firm's attorneys appear in administrative proceedings, before arbitration panels, and at the courthouse. Thompson Coe clients include all kinds of insurance-related entities, such as insurance companies, brokers, agents, reinsurers, risk retention and purchasing groups, premium finance companies, HMOs, self-insureds and insurance industry trade associations. Thompson Coe attorneys provide legal services in all lines of insurance, including property, casualty, life, accident, health, surplus lines, reinsurance, premium finance, and agency matters.

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Thompson, Coe, Cousins & Irons, LLP
700 North Pearl Street, Twenty-Fifth Floor, Dallas, Texas 75201
701 Brazos, Suite 1500, Austin, Texas 78701
One Riverway, Suite 1600, Houston, Texas 77056
408 Saint Peter Street, Suite 510, Saint Paul, Minnesota 55102

Insurance Law Group