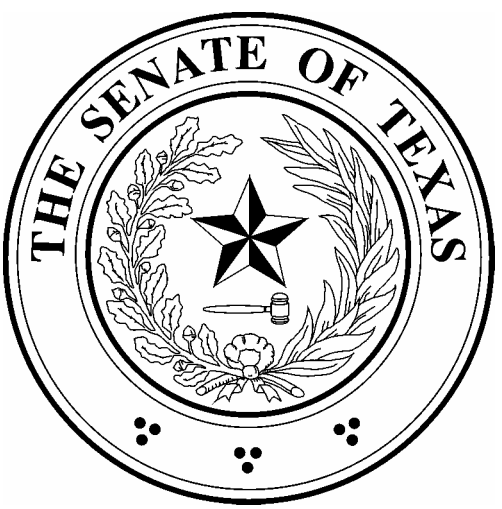
Senate Committee on State Affairs

Interim Report
to the
79th Legislature



December 2004

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December 1, 2004

Senator Robert Duncan
Chairman

The Honorable David Dewhurst
Lieutenant Governor of Texas
Members of the Texas Senate
Texas State Capitol
Austin, Texas 78701

Dear Governor Dewhurst and Fellow Members:

The Committee on State Affairs of the Seventy-Eighth Legislature hereby submits its interim report including findings and recommendations for consideration by the Seventy-Ninth Legislature.

Respectfully submitted,

Senator Robert Duncan, Chair

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December 16, 2004

Senator Robert Duncan, Chair
Senate State Affairs Committee
Texas Legislature
Austin, Texas 78711

I would like to respectfully express my concern regarding recommendation 1.d.2. under Charge 1 of the Senate State Affairs Interim report.

Last session, I authored SB 1652, which changed the retirement eligibility requirements for employees in the UT-EGIP and A&M EGIP systems to include the 10 year service requirement. This legislation also grandfathered employees who were employed before August 1, 2003 and eligible for retirement on or before January 1, 2003 from being under the new requirement.

At this time, I do not feel that hearings nor findings received by the committee provide any compelling evidence to recommend this change.

Very truly yours,

Florence Shapiro

FS/jlh

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Interim Charges

The Senate State Affairs Committee is charged with conducting a thorough and detailed study of the following issues, including state and federal requirements, and preparing recommendations to address problems or issues that are identified.

1. Study the implementation of changes made to the state group health insurance plans and identify additional cost-saving measures. Study the feasibility and practicality of offering health reimbursement accounts as an alternate health insurance plan for those insured in ERS, TRS, and university plans. Provide recommendations regarding whether the current method of administering these programs is in the best interest of the State of Texas and the various insured populations, or whether such programs might be more efficiently administered in another fashion.

2. Monitor the implementation of H.B. 1549, 78th Legislature, the Federal Help America Vote Act of 2002, to assure that Texas meets the criteria to secure the proposed federal funding. Make recommendations for statutory changes required to implement federal legislation and improve the efficiency of the process.

3. Study the implementation of S.B. 10 and S.B. 541, and make recommendations, as needed, to make health insurance more accessible, and affordable for all Texans.

4. Study the April 2003 United States Supreme Court decision in *Kentucky Association of Health Plans v. Miller* to determine its impact on Texas laws regulating health insurance plans under the Employee Retirement Income Security Act of 1974 (ERISA) and make recommendations to changes in state law to conform with recent federal court decisions.

5. Study the reimbursement methodology of health care plans operating in Texas for out-of-network claims, specifically focusing upon the reimbursement of "usual and customary" charges, and make recommendations on how to improve their effectiveness. The study and recommendations should encompass all plans, including those participating in Texas' Medicaid managed care program and should consider federal and state laws as well as Health & Human Services Commission rules relating to the reimbursement of out-of-network claims.

6. Study the implementation of House Bill 4 and Proposition 12 in achieving lower medical malpractice rates and providing more access to affordable health care. Monitor and report on trends in medical malpractice insurance rates and the effect of tort reform on access to health care and provider shortages in certain regions, particularly along the Border.

7. Study and report on the affordability, reasonableness, and impact of mandatory liability insurance on the nursing home industry. Assess and report on the effects of the admissibility of quality reports.

Senate Committee on State Affairs Interim Hearings

May 17, 2004, *Capitol Extension Rm. E1.028*
The Committee took invited and public testimony on Charge No. 2.

June 7, 2004, *Capitol Extension Rm. E1.030*
The Committee held a joint hearing with the Senate Finance Committee and took invited testimony on Charge No. 1.

August 11, 2004, *Senate Chamber*
The Committee took invited testimony on Charge Nos. 3, 4 and 5.

September 20, 2004, *Senate Chamber*
The Committee took invited testimony on Charge Nos. 6 and 7 and public testimony on Charge Nos. 3, 4, 5, 6, and 7

September 21, 2004, *Senate Chamber*
The Committee took invited and public testimony on Charge No. 1.

Executive Summary

Interim Charge No. 1

Study the implementation of changes made to the state group health insurance plans and identify additional cost-saving measures. Study the feasibility and practicality of offering health reimbursement accounts as an alternate health insurance plan for those insured in ERS, TRS, and university plans. Provide recommendations regarding whether the current method of administering these programs is in the best interest of the State of Texas and the various insured populations, or whether such programs might be more efficiently administered in another fashion.

Background

The Employees Retirement System Group Benefit Program (ERS-GBP) was established by the 64th Legislature to provide high quality health insurance to state employees, retirees and their eligible dependents. In 1993, Texas colleges and universities were given the option to join ERS-GBP thereby allowing their employees, faculty and eligible dependents access the state's health plan. All institutions joined the system with the exception of the University of Texas System and the Texas A&M University System. The institutions opting into the ERS Higher Education Group Insurance Program (ERS-HEGI) receive identical benefits and are subject to the same premium structure. All totaled (GBP and HEGI), ERS currently covers approximately 501,000 lives.

In addition, H.B. 725 as passed by the 78th Legislature in 2003 authorized community supervision and corrections departments (CSCDs) to be included in the ERS-GBP beginning September 1, 2004. The Legislature authorized ERS to assess members of this group a one-time fee to cover administrative and actuarial costs, as well as a participation premium to cover all costs (both direct and indirect) associated with inclusion of this group in ERS-GBP.

Today, ERS-GBP offers two major options for health coverage. HealthSelect, a self-funded, point of service plan is by far the largest. With 462,000 participants, this plan includes 92 percent of the ERS-GBP's covered lives. HealthSelect is currently administered by Blue Cross/Blue Shield of Texas (Blue Cross) and provides both in-network and out-of-network benefits. Pharmacy benefits for the plan are administered by Medco Health Solutions. Benefit levels for the plan are primarily established by the ERS board. However, the Legislature may also direct changes through statutory revisions.

The second option offered under ERS-GBP includes a number of HMO plans across the state. This coverage is provided through contracts with private HMOs. Current HMO providers are: Community First Health Plans, Inc., FIRSTCARE, Mercury Health Plans, Scott & White Health Plan, and Valley Health Plans. Approximately 42,000, or eight percent, of ERS-GBP participants are enrolled in one of the HMO options. In order to be selected, an HMO must be able to provide benefits at a lower rate than the self-funded plan.

Premium costs for all full-time, active state employees enrolled in any ERS-GBP health plan are covered 100 percent with eligible dependents receiving 50 percent coverage. Employees working fewer than forty hours a week receive 50 percent coverage of their premiums and 25 percent of their dependents.

As previously mentioned, all institutions of higher education were given the opportunity to join ERS-HEGI in 1993. Only the University of Texas System and the Texas A&M System passed on this opportunity and instead opted to continue their self-insured health plans for employees, dependents and retirees. The relative size of these two systems, along with a long history of running their own programs, influenced their decision to continue with the self-funded option. Today, the University of Texas System Employee Group Insurance Program (UT-EGIP) covers more than 146,000 lives and the Texas A&M University System Employee Group Insurance Program (A&M-EGIP) covers approximately 55,000 lives.

Benefit levels and premium structures for UT-EGIP and A&M-EGIP are set by each system's Board of Regents. Similar to ERS-GBP, the Legislature may also direct changes through statutory revisions. Medical benefits for both UT-EGIP and A&M-EGIP are administered by Blue Cross. Pharmacy benefits for UT-EGIP are managed by Medco Health Solutions with A&M-EGIP pharmacy benefits managed by Eckerd Health Services. Benefit structures for these plans as well as ERS-GBP are fairly comparable. However, A&M-EGIP is driven by the management philosophy that those who utilize the benefits should pay more of the cost than those who do not. As a result, A&M-EGIP has sought to keep down out-of-pocket premium costs by asking those who utilize plan benefits to pay more of the costs at the time of service. The result has been a slightly lower premium structure with co-payments, coinsurance and deductibles slightly higher than the other two plans.

Created in 1985, Teacher Retirement System-Care (TRS-Care) was designed to provide basic health insurance for eligible retired teachers. During the past twenty years, as additional coverages have been made available, participation in the program has slowly grown. Today, TRS-Care provides three levels of benefits ranging from basic catastrophic coverage to comprehensive benefits including prescription drug coverage. Benefit levels for the plan are primarily established by the TRS board; however the Legislature may also direct changes through statutory revisions. Currently, Aetna administers medical benefits for the program, with Caremark managing prescription drug benefits.

At this time, TRS-Care covers over 188,000 lives including retirees, spouses and a small number of dependents. Enrollment growth in the program has averaged eight percent over the past several years. However, for a variety of reasons, retirement figures spiked in August 2004. Early retirement incentives and the federal closure of a Social Security benefit loophole all contributed to the 11 percent growth in TRS-Care participation that occurred going into fiscal year 2005.

TRS-Active Care was created by the 77th Legislature to provide a statewide health care benefit to active employees of state schools districts, charter schools, regional service centers,

and other educational districts. This self-funded program offers three coverage choices to participants. Benefit levels range from basic catastrophic to a comprehensive plan including prescription drug coverage. Medical benefits are administered by Blue Cross with prescription drug benefits managed by Medco Health Solutions. Coverage in the program began on September 1, 2002, and effective September 1, 2003, HMO plans were made available in metropolitan areas of the state. Currently, there are more than 1,000 entities participating with enrollment approximately 248,000. This represents a 40 percent increase in participation since October 2002.

All of the above mentioned plans have seen costs escalate in recent years. To address the rising costs, each of the plans has implemented various cost containment measures; some because of legislative mandates and others based on their individual board's decision. However, medical costs continue to rise, therefore, further cost containment measures may be necessary.

Recommendations

During the process of receiving testimony and examining issues relating to rising medical costs in state group health insurance plans, a number of issues relating to recently implemented cost containment initiatives were raised. In addition, the Committee was presented with a variety of additional cost savings measures. Below is a summary of some of the options and issues the Legislature should consider:

1.a. Creating a three-tiered provider network to encourage participants to utilize providers with histories of efficient care. Currently, state group health plans only offer in-network and out-of-network medical benefits without provisions to encourage patients to seek care from efficient in-network providers. Lower co-payments, coinsurance rates and deductibles are all tools that could be utilized to entice patients to desirable providers.

1.b. Requiring disease management programs to be implemented in all state group health insurance plans. At present, only UT-EGIP and A&M-EGIP have broad disease management programs in place. Health conditions such as heart disease, asthma, diabetes, obesity, and smoking-related conditions should be targets of any program implemented. While short-term cost savings may be minimal, long-term benefits should be significant.

1.c. Requiring all state-administered health plans to conduct regular audits of all claim payments made in a fiscal year. Such audits could be done in-house or by third-party auditors, but should be performed independent of the general claims administrators. The audits should focus on overpayments, payment errors, eligibility qualifications, and fraud.

1.d. Clarifying legislative intent regarding retiree eligibility for health insurance coverage within the higher education population to achieve equity among employees of all institutions. This could be accomplished in one of two ways:

1.d.1. Allow ERS-HEGI institutions to fund some portion of health coverage for retirees *employed* by the institution on or before August 31, 2003, or *eligible* to

retiree on or before January 1, 2003, from non-General Revenue-related appropriations. Participating institutions could be required to pay either the *normal* or *full-actuarial* cost of this coverage; or

1.d.2. Eliminate the provision that allowed employees of the UT and A&M systems *employed* on or before August 31, 2003, or *eligible* to retiree on or before January 1, 2003, to be grandfathered from new eligibility requirements.

1.e. Implementing an incentive plan where employees and retirees with alternate health care options are allowed to opt out of state health care coverage. This same type of program has been implemented for several years within UT-EGIP and A&M-EGIP with great success.

1.f. Amending certain provisions within TRS-Care that limit the application of out-of-state service credit purchases in qualifying for health insurance eligibility. Such limits have created recruiting difficulties for school districts seeking to hire teachers from other states. This problem seems to be particularly acute in districts bordering other states.

1.g. Clarifying legislative intent to require all groups accessing health insurance benefits through ERS to meet the same eligibility standards required of general state employees. Furthermore, the Legislature should consider specifically designating ERS as the sole authority to determine questions relating to an individual's eligibility to receive group benefits including those associated with retiree eligibility.

1.h. Implementing a broad consumer-directed care initiative for all state group health insurance plans. In conjunction with this plan, the state should consider utilizing either a Health Reimbursement Account (HRA) or a Health Savings Account (HSA).

1.i. Merging A&M-EGIP, UT-EGIP and ERS-GBP into one consolidated program. Given some of the findings in the recent actuarial report regarding the feasibility of a merger of the A&M and ERS systems, a combined insurance pool could improve the overall actuarial condition of the ERS-GBP.

1.j. Continuing the 90-day waiting period for TRS.

1.k. Requiring all state group health plans to quarterly update the Legislature on state health expenditure trends. Such reports should be provided in a standardized format and compare actual trends to projected trends.

1.l. Directing ERS, UT, A&M and TRS health care experts to meet regularly to discuss and compare cost containment strategies. The group should also discuss provider contract provisions and rates.

In addition to these options, both ERS and TRS have identified possible cost-shifting initiatives for the Legislature's consideration.

Interim Charge No. 2

Monitor the implementation of H.B. 1549, 78th Legislature, the Federal Help America Vote Act of 2002, to assure that Texas meets the criteria to secure the proposed federal funding. Make recommendations for statutory changes required to implement federal legislation and improve the efficiency of the process.

Background

The 2000 presidential election and the infamous Florida recount illustrated significant problems with voting machines and ballots, not only in Florida, but across the nation. In response, Congress passed the Help America Vote Act (HAVA) of 2002, designed to ensure that no eligible voter is denied the right to vote or have that vote counted. The 78th Legislature implemented the provisions of HAVA with the passage of H.B. 1549, signed into law June 22, 2003.

House Bill 1549 makes several changes to the Texas Election Code including the implementation of a statewide voter registration list, a provisional voting system, as well as a number of other technical changes. HAVA also requires each polling place to provide at least one accessible voting system for individuals with disabilities. These systems must meet the certification criteria established by the Texas Secretary of State, are to be acquired and maintained by the counties, and must be in place by January 1, 2006.

Recommendations

2a. The Committee recommends the Legislature continue to monitor the progress of all provisions of H.B. 1549, keeping in mind that unforeseen problems requiring additional legislative action could potentially arise as new voting systems are put into use statewide.

2b. With regard to the issue of whether to require a voter-verified paper trail with electronic voting machines, the Committee recommends that Texas proceed with caution until sufficient electronically-administered election history exists in Texas and other states to assess the level of assurance in the integrity of voting systems. Additionally, Texas should monitor the successes and problems encountered in other states and be fully prepared to implement its own system should federal legislation mandate such measures. Finally, if state or federal legislation is enacted requiring a voter-verified paper trail, Texas should consider legislation providing a penalty for false claims of voting system errors.

2c. The Committee recommends that the State approve an appropriation for matching funds requested by the Secretary of State's office in order to draw down all possible federal dollars available through HAVA. This includes the approval of an emergency appropriation as requested by the Secretary.

Interim Charge No. 3

Study the implementation of S.B. 10 and S.B. 541, and make recommendations, as needed, to make health insurance more accessible, and affordable for all Texans.

Background on S.B. 10

House Bill 2055, as passed by the 73rd Texas Legislature, authorized employers to join together in private purchasing cooperatives to obtain group health insurance coverage. Utilization of these cooperatives to purchase health coverage, however, has been sparse. One reason cited for the infrequent creation of these cooperatives is reluctance by carriers to issue coverage to cooperatives due to their potential for instability and adverse selection.

Senate Bill 10 created a new type of private purchasing cooperative, the health group cooperative, which relies on cooperation between carriers and their sponsoring entities to address the underutilization of this form of purchasing entity. The bill's provisions allow multiple employers to group together to purchase coverage and be treated collectively as a small employer, thereby enjoying the protections granted to small employers under Chapter 26 of the Texas Insurance Code. Once a health group cooperative is formed and actively purchasing coverage, any employer in the cooperative's service area may join. Large employers, which may also experience difficulty in finding affordable coverage, may also participate, at the discretion of the cooperative and the carrier. A carrier issuing coverage to a health group cooperative may choose to file with the Texas Department of Insurance (TDI) a health plan specifically designed for an S.B. 10 health group cooperative.

Recommendations on Implementation of S.B. 10

Pursuant to the direction in the charge, the Committee focused on implementation of S.B. 10 and S.B. 541 and did not debate the underlying concepts. To that end, the recommendations simply reflect clarification of legislative intent and do not reflect substantive changes in the policies as passed by the 78th Legislature.

3a. The Legislature should consider dividing health group cooperatives into two groups – small employers and large employers. This option would allow employers of all sizes to purchase coverage through a health group cooperative while resolving concerns about administering groups from both markets in a single entity.

3b. The restrictions of "small business regulations" could negatively impact the benefits of S.B. 10. Accordingly, the Legislature should consider excluding small businesses within a health care cooperative from the "small business regulations."

3c. During the rulemaking process, questions arose as to whether the carriers' participation was voluntary with a health care cooperative. That issue was clarified in the final version of the rule. However, interested parties would like to see the issue finally resolved in statute.

Background on S.B. 541

Senate Bill 541, as passed during the 78th Regular Session, amended Insurance Code chapters 3, 20A and 26 to increase the availability of health care coverage by giving employer groups and individuals the opportunity to purchase Consumer Choice Plans. These are health benefit plans that, in total or part, do not offer or provide state-mandated health benefits. For small employers, the bill also deleted the requirement that small employer carriers offer the promulgated catastrophic care and basic service plans; instead, the new law requires those carriers to offer small employers the opportunity to purchase a Consumer Choice Plan in addition to a plan that contains all state-mandated benefits. It also changed the definition of basic health care services for purposes of Health Maintenance Organization (HMO) benefits. Although the bill did not take effect until January 1, 2004, Texas Department of Insurance (TDI) first approved an indemnity insurance consumer choice plan on November 20, 2003, and an HMO consumer choice plan on November 14, 2003.

Recommendations on Implementation of S.B. 541

While carriers have been offering consumer choice plans since the bill took effect, reports required by the rule are not yet due. Informal queries of carriers indicate they cannot yet fully gauge the effect of these plans on the employer and individual markets. Therefore, it is not possible to accurately report the specific factors affecting the availability and affordability of these plans at this time. The Committee recommends the Legislature consider the following:

3d. Ensuring the coverage for supplies and services associated with the treatment of diabetes is included in the HMO portion of the statutory provisions for Consumer Choice Plans;

3e. Providing that dialysis is a treatment associated with the care of diabetes; and

3f. Ensuring the HMO requirement for coverage of referral to a non-network provider when medically necessary, covered services are not available through network providers is included in the statutory provisions for Consumer Choice Plans.

Interim Charge No. 4

Study the April 2003 United States Supreme Court decision in Kentucky Association of Health Plans v. Miller to determine its impact on Texas laws regulating health insurance plans under the Employee Retirement Income Security Act of 1974 (ERISA) and make recommendations to changes in state law to conform with recent federal court decisions.

Background

The Committee examined two recent decisions by the United States Supreme Court relating to health insurance plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). In *Kentucky Ass'n of Health Plans v. Miller*, the Court effectively reversed a prior Fifth Circuit opinion which held that the "any willing provider" provisions of the Texas

Insurance Code were invalid because they were preempted by ERISA. Therefore, the existing provisions are, arguably, not preempted by ERISA and are enforceable.

In *Aetna Health Inc. v. Davila*, the Court struck down the Texas Health Care Liability Act (THCLA) provisions that create a private cause of action against health insurance carriers, HMOs and other managed care entities for failure to exercise ordinary care when making health treatment decisions. The Court held that determinations of plan coverage are not treatment decisions and therefore, the state law cause of action is preempted by ERISA in qualified plans.

Recommendations

4a. To provide clarification of the current effect of the pharmacy any willing provider statute, the Committee recommends that the Legislature reconsider this issue. If the public policy considerations underlying Article 21.52B are still valid and appropriate, the provision should be reenacted in accordance with the holding in *Miller*. If the public policy considerations are no longer appropriate, the statute should be repealed. Additionally, the Committee recommends that the non-severability clause included in the 1991 Session Laws be reexamined.

4b. Under the Supreme Court's ruling in *Davila*, the cause of action created by the Texas Health Care Liability Act (THCLA) is pre-empted under the federal ERISA statute with respect to employee health benefits plans established under ERISA. The provisions under the THCLA that do not relate to the cause of action are unaffected by the Court's ruling. The Committee recommends revising the THCLA to accurately reflect the sections affected by the *Davila* ruling.

Interim Charge No. 5

Study the reimbursement methodology of health care plans operating in Texas for out-of-network claims, specifically focusing upon the reimbursement of "usual and customary" charges, and make recommendations on how to improve their effectiveness. The study and recommendations should encompass all plans, including those participating in Texas' Medicaid managed care program and should consider federal and state laws as well as Health & Human Services Commission rules relating to the reimbursement of out-of-network claims.

Background

Out-of-network claims are a component of managed care plans. However, the reimbursements paid to providers and the percentage of the patients' benefit covered are addressed differently in the two types of managed care plans (HMOs and PPOs). In Health Maintenance Organizations (HMO), plans typically require enrollees to use network providers and hospitals only. The individual's personal gatekeeper physician must provide a referral to go to a specialist or provider outside the HMO's network for treatment. For Preferred Provider Organizations (PPO), plans are issued by an insurance company and those plans provide higher levels or percentages of reimbursement if the patient goes to PPO network providers and

hospitals who have agreed to provide services. In both instances, the plan's network has agreed to a contractual rate with the carrier that is often less than the billed charges rate in exchange for the patient volume experienced as the exclusive or preferred plan provider.

Each of these plans is set up in a way to create incentives for those covered to use the in-network facilities as much as possible. These incentives help the plans manage costs of health care and therefore, justify the lower reimbursement rate paid to in-network providers. However, in the normal course of business, there are instances where out-of-network becomes a necessity or a more appealing option. An individual enrolled in a managed care plan may receive out-of-network services.

Health plans are not obligated by contract to reimburse the out-of-network providers at a pre-established rate. After an individual accesses an out-of-network service, the plan and provider must agree to a rate of reimbursement. However, in certain circumstances, that rate of reimbursement to those providers is dictated by the Texas Insurance Code.

In circumstances outside the bounds of statutory direction, out-of-network reimbursements are paid through negotiations between providers and health plans. These rates, and some of the above provisions, are based on the "usual and customary" rate for the service provided. "Usual and customary" rates are not defined in the Texas Insurance Code, but are set by the health plan carriers.

Due to the lack of statutory definition, the policy language concerning "usual and customary" varies between carriers. The plans reference and negotiate with a mixture of terms and standards to determine "usual and customary" rates. In order to increase transparency in the health plans' methodology, the 77th Legislature passed a measure requiring that, upon written request, a managed care entity must provide to an out-of-network provider the methodology used in determining the "usual and customary" reimbursement. As a result of this out-of-network reimbursement process, providers claim to be paid a rate that is less than their billed charges and health plans claim to often pay more than their comparable, in-network rate. Both of which claim to increase the cost of health care.

Recommendations

5a. The Legislature may wish to consider encouraging stricter enforcement of current restrictions for out-of-network facilities' waiver of co-payments, co-insurance and deductibles. The consequences associated with this prohibition should result in enforceable, state regulatory sanctions and licensure penalties.

5b. Additionally, the Committee recommends consideration of enhancing, through adequate disclosure, the transparency of medical costs for both health plans and providers. Allowing patients to fully realize the true cost of health care results in a better understanding and possibly more appropriate utilization of health care. Realizing these benefits will help move the state toward better understanding and predicting the cost of health care.

5c. In relation to the issue of facility based balanced billing, this issue, its complexity and frequency are still developing. As in many legislative quandaries, a wide spectrum of options are available ranging from disclosure to complete prohibition. Although the issue begs for legislative action, the degree of action should be fully vetted and debated. This debate should include, but not be limited to the following options:

5.c.1. Requiring full disclosure by facilities that their physicians may or may not be included in the same network structures as the facility.

5.c.2. Prohibiting balanced billing in all circumstances or, at minimum, when a patient exerted a "good faith effort" to stay within network.

5.c.3. Authorizing state regulations on contract negotiations between facilities and their physicians which would require all physicians at the facility to also negotiate to be part of the same network structures.

5.c.4. Altering reimbursement processes to allow the patients to receive funds from the health plan for out-of-network payments therefore empowering the patients to negotiate on their own behalf for out-of-network payments.

Interim Charge No. 6

Study the implementation of House Bill 4 and Proposition 12 in achieving lower medical malpractice rates and providing more access to affordable health care. Monitor and report on trends in medical malpractice insurance rates and the effect of tort reform on access to health care and provider shortages in certain regions, particularly along the Border.

Background

In June of 2003, the 78th Legislature adopted landmark tort reform legislation, H.B. 4, which was ratified by popular vote on Proposition 12. A key piece of H.B. 4 was a statutory cap on noneconomic damages in medical malpractice lawsuits. New section 74.301, Civil Practice & Remedies Code, caps noneconomic damages at $250,000 per provider, up to a $750,000 maximum depending on the type of provider joined in the suit. The purpose of capping noneconomic damages in medical malpractice lawsuits was to provide relief to health care providers who were being charged high premiums by medical malpractice insurers. During the H.B. 4 debate insurers assured both the Legislature and the public that damage caps would allow them to lower the rates charged to health care providers. Lower rates would in turn help reduce the overall rate at which medical costs were rising and would allow more providers to practice in high risk specialties and in rural or low-population areas of the state. The noneconomic damage caps in H.B. 4 became effective in lawsuits filed on or after September 1, 2003.

Recommendations

6.a. Texas should continue to strive to find the appropriate balance between market forces and regulation that will provide assurances to insurers, physicians and patients that access to health care will remain open for all Texans, in all areas of the state.

6.b. Because the tort reform measures in H.B. 4 and Proposition 12 have been in effect for just more than a year, true increases in access to health care for all Texans are still uncertain. Therefore, the Committee recommends that the Texas Department of Insurance develop a model to provide for an "apples-to-apples" comparison of insurance rates, given the differences in types of policies provided and the legislative need to accurately track and analyze insurance premium costs in health care.

6.c. The Committee also recommends that the Legislature continue to monitor the situation and to look for other methods of addressing provider shortages and access to health care. While not necessarily related to liability issues, the Committee recommends the Legislature reevaluate its funding for Graduate Medical Education and work with the Texas Congressional Delegation to enhance federal funding for GME, specifically, to make Medicare funding more geographically equitable. Additionally, the Legislature should promote the use of telemedicine in rural areas. Finally, Texas must establish public policy that encourages all doctors to come to, and stay in, Texas.

Interim Charge No. 7

Study and report on the affordability, reasonableness, and impact of mandatory liability insurance on the nursing home industry. Assess and report on the effects of the admissibility of quality reports.

Background

The Omnibus Nursing Home Legislation, S.B. 1839, was passed by the 77th Legislature to address potentially devastating economic and legal issues facing the nursing home industry. At that time, the industry was facing numerous bankruptcies, diminished quality of care, frequent legal challenges and insurance coverage shortfalls. S.B. 1839 attempted to address the entire spectrum of challenges facing the industry in order to preserve those vital services and businesses.

One component of S.B. 1839 required long term care facilities to carry liability insurance. Coverage was mandated at $1 million per occurrence or $3 million aggregate (total in a year). Professional liability insurance may be provided by the Texas Medical Liability Insurance Underwriting Association (JUA), any admitted carriers, or surplus-lines carriers. Self-insurance was not an acceptable method of meeting this requirement.

Originally, S.B. 1839 set September 1, 2003, as the implementation date for mandatory insurance. The Legislature specifically chose a delayed implementation date acknowledging availability issues and an unreasonable financial burden on the nursing homes. The September 1, 2003, date was intended to provide time to review the fiscal implications during the 78th Legislative session.

The Long Term Care Legislative Oversight Committee was charged during the 77th Interim with monitoring the implementation of S.B. 1839. Specifically, the Committee watched the long term care liability insurance market to determine if mandatory insurance was plausible.

Prior to the 78th Legislative session in 2003, it was determined that the long term care liability insurance market had not recovered and instituting the mandatory provision would have resulted in unintended harm to the long term care industry. Therefore, S.B. 588, 78th Legislative session, was introduced to postpone implementation of mandatory insurance until September 1, 2005. This date again allowed time for the legislative changes to positively impact the insurance market and make mandatory long term care liability insurance a possibility.

During the 78th session, the provisions of S.B. 588 were rolled into H.B. 4. However, the statute containing the mandatory provision was ultimately repealed in H.B. 2292. Despite the repeal, questions surrounding the possible positive impact of mandatory insurance continue to circulate.

Recommendations

7.a. The Legislature should consider re-enacting the mandatory liability insurance provision. Mandatory insurance is a laudable goal. While current market conditions affecting availability and affordability would probably place an unreasonable financial requirement for many facilities, delaying implementation would maintain this goal as a legislative priority.

7.b. Also, the Legislature may consider redefining what is considered insurance. Allowing a variety of definitions of what qualifies as insurance will include a wider spectrum of varieties, such as self-insurance, which facilities are currently accessing.

7.c. The Legislature should also consider reducing the mandatory limits to lower levels. The original amounts were set prior to H.B. 4 passage and the limits may need to be lower now that H.B. 4 provisions are in effect. Lowering these limits would significantly help the affordability of mandatory insurance.

7.d. If funds are available, the Legislature should consider increasing the reimbursement rate for the insurance portion of the nursing home payments to better cover the actual cost of liability insurance payments.

Interim Charge Discussion and Recommendations

Charge No. 1

Study the implementation of changes made to the state group health insurance plans and identify additional cost-saving measures. Study the feasibility and practicality of offering health reimbursement accounts as an alternate health insurance plan for those insured in ERS, TRS, and university plans. Provide recommendations regarding whether the current method of administering these programs is in the best interest of the State of Texas and the various insured populations, or whether such programs might be more efficiently administered in another fashion.

Employees Retirement System of Texas

Background

The Employees Retirement System Group Benefit Program (ERS-GBP) was established by the 64th Legislature to provide high quality health insurance to state employees, retirees and their eligible dependents.[1] In 1993, Texas colleges and universities were given the option to join ERS-GBP thereby allowing their employees, faculty and eligible dependents access the state's health plan. All institutions joined the system with the exception of the University of Texas System and the Texas A&M University System. The institutions opting into the ERS Higher Education Group Insurance Program (ERS-HEGI) receive identical benefits and are subject to the same premium structure. All totaled (GBP and HEGI), ERS currently covers approximately 501,000 lives.

In addition, H.B. 725 as passed by the 78th Legislature authorized community supervision and corrections departments (CSCDs) to be included in the ERS-GBP beginning September 1, 2004.[2] The Legislature authorized ERS to assess members of this group a one-time fee to cover administrative and actuarial costs, as well as a participation premium to cover all costs (both direct and indirect) associated with inclusion of this group in ERS-GBP.

Today, ERS-GBP offers two major options for health coverage. HealthSelect, a self-funded, point of service plan is by far the largest. With 462,000 participants, this plan includes 92 percent of the ERS-GBP's covered lives. HealthSelect is currently administered by Blue Cross/Blue Shield of Texas (Blue Cross) and provides both in-network and out-of-network benefits. Pharmacy benefits for the plan are administered by Medco Health Solutions. Benefit levels for the plan are primarily established by the ERS board. However, the Legislature may also direct changes through statutory revisions.

The second option offered under ERS-GBP includes a number of HMO plans across the state. This coverage is provided through contracts with private HMOs. Current HMO providers are: Community First Health Plans, Inc., FIRSTCARE, Mercury Health Plans, Scott & White

[1] Acts 1975, 64th Leg., ch. 79.
[2] Acts 2003, 78th Leg., ch. 1030.

Health Plan, and Valley Health Plans. Approximately 42,000, or eight percent, of ERS-GBP participants are enrolled in one of the HMO options. In order to be selected, an HMO must be able to provide benefits at a lower rate than the self-funded plan.

Premium costs for all full-time, active state employees enrolled in any ERS-GBP health plan are covered 100 percent with eligible dependents receiving 50 percent coverage. Employees working fewer than forty hours a week receive 50 percent coverage of their premiums and 25 percent of their dependents.

Discussion

Funding

ERS-GBP health plans are funded primarily through a combination of state and employee contributions. State appropriations are made by the Legislature on an *estimated* basis each biennial budget cycle for general state employees and on a sum-certain amount for ERS-HEGI participants. In addition, state law requires that benefit contributions by the state be made proportional to the funding source. Therefore, those contributions must be made from any funding source in the same proportion used to fund an employee's salary.

Overall, funding levels are typically based on actuarial predictions of how much plan expenditures will be in the coming two-year cycle. Benefit levels, utilization and price inflation are the primary elements considered in determining the level of state appropriation. Enrollment projections must also be considered. Since 1998, enrollment has actually declined averaging a 0.3 percent reduction annually or around two percent for the seven-year period. During that same period, health care expenditures have increased on average 11.2 percent annually. As shown in the ERS-GBP financial statement, this has resulted in total expenditures more than doubling in that time frame

ERS Health Plan Financial History
Based on Data Through March, 2004
Assuming No Change in Benefits
($Millions)

	Actual FY 2000	Actual FY 2001	Actual FY 2002	Actual FY 2003	Estimated[a] FY 2004	Projected[a] FY 2005	Projected[a] FY 2006	Projected[a] FY 2007
Health Care Expenditures:								
Health Plan	$1,084.2	$1,211.7	$1,408.9	$1,527.1	$1,443.8	$1,620.6	$1,832.8	$2,071.4
Member Cost Sharing	153.9 [c]	204.3 [c]	215.3 [c]	270.5 [c]	496.7	528.6	555.0	582.8
Total	$1,238.1	$1,416.0	$1,624.2	$1,797.6	$1,940.5	$2,149.2	$2,387.8	$2,654.2
Enrollment (Participants)	522,074	521,095	531,117	527,916	502,691	500,583	500,583	500,583
Expenditures Per Participant								
Health Plan	$2,077	$2,325	$2,653	$2,893	$2,872	$3,237	$3,661	$4,138
Member Cost Sharing	$295	$392	$405	$512	$988	$1,056	$1,109	$1,164
Total	$2,372	$2,717	$3,058	$3,405	$3,860	$4,293	$4,770	$5,302
Percent Change	8.2%	14.5%	12.6%	11.3%	13.4%	11.2%	11.1%	11.2%
Revenue from State/Members:								
State Contribution	$798.3	$867.8	$1,119.1	$1,229.3	$1,175.2	$1,236.4	$1,437.9	$1,670.6
Member Contribution	199.9	226.8	261.8	279.5	284.6	297.2	347.5	403.7
Member Cost Sharing	153.9 [c]	204.3 [c]	215.3 [c]	270.5 [c]	496.7	528.6	555.0	582.8
Total	$1,152.1	$1,298.9	$1,596.2	$1,779.3	$1,956.5	$2,062.2	$2,340.4	$2,657.1
Shortfall	-$86.0	-$117.1	-$28.0	-$18.3	$16.0	-$87.0	$47.4	$2.9
Other Funding Sources:								
Hospital/Formulary Refunds	$7.2	$7.6	$24.0	$22.0	$22.0	$22.0	$22.0	$22.0
Net Investment Income[b]	16.2	11.6	5.0	2.9	0.5	0.6	0.0	0.8
Reserve Fund	62.6	97.9	0.0	0.0	0.0	64.4	0.0	0.0
Total, Other Funding Sources	$86.0	$117.1	$29.0	$24.9	$22.5	$87.0	$22.0	$22.8
Reserve Fund Balance	$116.1	$18.3	$19.3	$25.9	$64.4	$0.0	-$25.4	$0.3

[a]Expenditure and revenue amounts assume current level of benefits and membership at March, 2004 level.
[b]Net investment income represents the excess of investment income over ERS operating expenses related to the insurance program.
[c]Based on actual data for HealthSelect and estimated amounts for HMOs and HealthSelect Plus.

Figure 1 - 1 -- ERS-GBP Financial Statement
Source: Employees Retirement System of Texas

These trends can be analyzed in terms of utilization and cost inflation. While costs associated with physician related services continue to be driven primarily by increases in utilization, the following chart illustrates that ERS projections for fiscal year 2005 show increasing costs per unit of care to be the most significant driver in hospital and pharmacy expenditures.

	Projected Annual Increase in Utilization[1]	Projected Annual Increase in Plan Cost Per Unit of Care: Average Cost/Unit[2]	Member Cost Share Leveraging[3]	Total	Benefit Cost Trend[4]
Hospital[5]	3.1%	8.6%	2.0%	10.6%	14.0%
Other Medical Expense[6]	7.3%	1.9%	0.6%	2.5%	10.0%
Pharmacy[7]	5.2%	7.0%	5.2%	12.2%	18.0%
Total					13.3%

[1]Increase in units of care per participant.
(a) Hospital utilization is measured based on the number of inpatient and outpatient admissions per participant.
(b) OME utilization is measured based on the number of services per participant.
(c) Pharmacy utilization is measured based on the number of days of therapy per participant.

[2]In addition to price increases, increases in the average cost per unit of care reflect:
(a) changes in the mix of units (for example, prescribing more expensive drugs results in an increase in the average cost per day of therapy that is greater than the average increase in the price of the drugs;
(b) increases in the intensity of care that result from new technology or revised treatment patterns; and
(c) changes in case mix (for example, more premature births).

[3]Leveraging accounts for the diminishing impact that fixed deductibles, copayments and coinsurance maximums have on increasing plan cost. For example, with a $25 prescription drug copayment a $50 drug costs the plan $25, but if the cost of that drug increases 10% to $55, the cost to the plan increases 20%, i.e., from $25 to $30.

[4]Benefit cost trend is the projected annual increase in plan cost per participant. It is the product of the projected utilization increase and the projected increase in plan cost per unit of care.

[5]Hospital includes all inpatient and outpatient facility-related expense.

[6]OME includes all expenses other than facility and pharmacy. The largest category of OME is physician-related expenses. The 7.3% increase in OME services is expected to result from a 5.6% increase in the number of OME visits per participant and and a 2.6% iincrease in the number of services per visit.

[7]Pharmacy includes all prescription drugs dispensed through retail pharmacies and mail service.

Figure 1 - 2 -- ERS Utilization vs. Inflation Analysis
Source: Employees Retirement System of Texas

In an effort to counter these dramatic increases, many changes in plan design and structure have been made. A summary of many of the adjustments made over the past 12 years is provided below.

Historic Cost Containment Initiatives	
1993	• Required primary care physician to manage medical care • Negotiated discounted payments to network providers • Implemented out-of-pocket cost incentives to use network providers
1996	• Restructured retail pharmacy network
1997	• Introduced mail order prescription drug program
1998	• Increase generic and brand name prescription drug co-payments • Implemented reduction in hospital reimbursement rates • Eliminated early refills of prescription drugs

1999	• Negotiated 2-year contract for competitively bid HMOs • Standardized HMO physician co-payment
2000	• Converted to independent pharmacy benefit manager for HealthSelect • Increased HealthSelect and HealthSelect Plus brand drug co-payments • Increased HealthSelect out-of-network deductibles
2001	• Implemented 3-tier prescription drug program • Increased prescription drug co-payments • Eliminated retail maintenance drug benefit • Implemented specific drug quantity limits
2002	• Required prior authorization on certain prescription drugs • Expanded use of quantity limits on prescription drugs
2003	• Continued HealthSelect Plus only in major metropolitan areas • Froze enrollment in HealthSelect Plus

Figure 1 - 3 -- ERS Historic Cost Containment Initiatives
Source: Employees Retirement System of Texas

Member contribution levels are set by the ERS board. Their primary decision involves striking a balance between premiums and benefit levels. In making these decisions, the board takes into account the same variables considered by the Legislature. However, this analysis is typically performed on an annual basis. Both the level of state appropriation and member contributions are set at levels expected to be sufficient to cover projected plan costs.

Recent Benefit Changes

Facing a $10 billion state budget shortfall for the 2004-05 biennium, members of the 78th Legislature were faced with difficult funding decisions in all areas of the budget. ERS-GBP alone needed more than $900 million in additional funding to maintain premiums and levels of benefits in place at that time. To bridge this significant financial gap, a combination of actions was taken by the ERS board and the Legislature that helped reduce the needed financial allocations from the state. A summary of the changes in benefits and eligibility made during the Spring and Fall of 2003 is provided below.

Recent Plan Changes	All Funds 2004-05 (Millions)	Effective 5/1/2003	Effective 9/1/2003
Implement 90-day waiting period for new hires and those not retiring directly from state.	$58.9		✓
Establish minimum eligibility for retiree insurance as (a) age 65 and 10 years of service or (b) satisfaction of Rule of 80 - future retirees only.	15.0		✓
Reduce contribution for the estimated 3,200 employees working 20-39 hours to 50% of full time.	17.7		✓
Implement $15/$25 per month SKIP employee contribution.	3.0		✓
Discontinue contribution for an estimated 500 non-employee board members.	5.1		✓
Reduce contribution for an estimated 4,000 graduate teaching assistants to 50% of full.	21.7		✓
Eliminate HealthSelect Plus.	62.6	✓	
Standardize retail pharmacy reimbursement.	6.0	✓	
Increase primary care co-payment from $15 to $20 for HealthSelect; from $10 to $30 for HMOs.	52.3	✓	
Add $10 co-payment for specialists for HealthSelect and HMOs; retain gatekeeper.	40.0	✓	
Implement $100 per day inpatient hospital co-payment - applicable to first 5 days.	38.6	✓	
Implement $100 outpatient co-payment.	10.6	✓	
Change HealthSelect coinsurance from 90%/70%/80% to 80%/60%/70%.	58.4	✓	
Change HealthSelect coinsurance stop loss from $500/$1,500/$800 to $1,000/$3,000/$1,000.	46.7		✓
Change emergency room co-payment from $50 to $100.	7.1	✓	
Implement $50 annual prescription drug deductible.	21.5		✓
Change prescription drug co-payment from $5/$20/$35 to $10/$25/$40.	67.3	✓	

Implement mandatory generic prescription drug requirement - member pay the difference.	7.1	✓	
Implement retail maintenance fee to encourage use of mail order for maintenance medications with co-payment for each 30-day supply.	81.7	✓	
Sub-Total	621.3		

Figure 1 - 4 -- ERS Recent Cost Containment Initiatives
Source: Employees Retirement System of Texas

Once all of these plan adjustments had been implemented, state contributions for the 2004-05 biennium were projected to total $2.4 billion. That represents a $63.2 million increase over the previous biennium's allocation, or an additional 2.7 percent. The state's share of total biennial revenues at that level of funding accounts for 60 percent of total plan dollars.

Under the revised plan, member premiums for the biennium were projected to total $581.8 million. That increase of $40.5 million represents 7.5 percent more than the previous biennium. However, facing a projected revenue shortfall of more than $104 million entering fiscal year 2005, the ERS board made the decision to raise premiums. HealthSelect premiums were increased by an additional 5.13 percent, with HMO rates increasing on average 8.9 percent. This change had no financial impact on the 54 percent of state employees and retirees who have individual coverage paid in full by the state. The remaining members who cover dependents did experience increases ranging from $8.78 per month to $14.67 per month for those enrolled in HealthSelect.

The changes in the premium structure generated $78 million in additional funding with state employees contributing $13.4 million of the total. To fill the remaining $26.3 million projected hole, the ERS board implemented additional cost containment strategies including: lowering reimbursement rates for specialty pharmacy medications used in doctor's offices; negotiating lower HMO rates than originally anticipated; renegotiating the pharmacy benefit manager contract to increase discounts on brand named drugs dispensed by mail; implementing additional pharmacy management tools for specific categories of drugs; enhancing management of radiology services; and communicating to participants the potential cost savings for the plan if they use physicians in the new HealthSelect BlueChoice Solutions network.

The most significant increases in revenue occurred as a result of changes in participant cost sharing. As indicated above, many of the changes occurred through increases in co-payments, coinsurance, and deductibles. All totaled, participants saw increases in cost sharing of more than $540 million or a 111 percent increase.

Other Issues

While most of the plan revisions were applied to the entire GBP population, participating colleges and universities were allowed two notable exceptions. Graduate teaching assistants who had seen their state premium contributions cut in half were allowed to be covered as full-time employees provided their employing institution made up the difference in funding from non-

General Revenue-related funds.[3] In addition, newly hired employees and retirees not retiring directly from state service were required to wait 90 days before enrolling in health coverage.[4] Colleges and universities were allowed to provide immediate access provided no General Revenue-related dollars were used to cover the cost.

Also, during the 3rd Called Session of the 78th Legislature, one amendment was made to the retiree eligibility provisions made during the regular session.[5] With minimum eligibility requirements for retiree health coverage adjusted from 65 years of age with 10 years of service to 60 with 10 years of service, many soon-to-be retirees found themselves on the eve of retirement without long-term access to health coverage. Retirees must have retired on or before August 31, 2003, to avoid application of this new provision. Those not able to meet this deadline faced as many as five years without access to the health coverage on which they had planned. As a result, the Legislature amended this provision to allow eligible retirees the option of purchasing health coverage through ERS-GBP until they turn 65 or meet the Rule of 80,[6] provided the retiree paid the *full actuarial cost* of the coverage.[7]

Finally, prior to the inclusion of Community Supervision and Corrections Departments (CSCDs) on September 1, 2004, questions arose regarding qualification for retiree health coverage for this group. As members of a separate retirement system, CSCD employees are eligible to retire when they have accrued 10 years of service and are at least 60 years old, or they meet a Rule of 75. ERS members are also eligible for general retirement at 60 years of age with 10 years of service, but must meet a Rule of 80. However, for health insurance benefits, all ERS retirees do not qualify until 65 years of age with 10 years of service, or when the Rule of 80 is met. Based on this, ERS determined that CSCD retirees should also have to meet this standard to qualify for insurance coverage.

Because of a disagreement regarding interpretation of the law, the Attorney General was asked to provide an opinion on the issue. Opinion number GA-0234 was issued August 17, 2004, and concluded that CSCD retirees may qualify for access to ERS-GBP without requirements beyond those necessary for general retirement in their own system.[8] Access must now be given to the ERS health insurance plan once CSCD retirees meet their Rule of 75.

Conclusion

While actual savings from cost reduction measures are not yet fully known, ERS remains confident that projected savings will be realized. However, the State Auditor's Office (SAO), in a recently concluded audit, raises concerns that projected cost savings may fall short by approximately $178 million.[9] ERS does not agree with the SAO's methodology in calculating

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[3] Several statutory plan revisions were included in S.B. 1370. Acts 2003, 78th Leg., ch. 366.
[4] *Id.*
[5] Acts 2003, 78th Leg. 3rd C.S., ch. 3.
[6] The "Rule of 80" requires that an individual's years and months of qualified employment (a minimum of five years) plus their years and months of age equal or exceed 80. TEX. GOV'T CODE § 814.104(a)(2) (Supp. 2004-05).
[7] Acts 2003, 78th Leg. 3rd C.S., ch. 3.
[8] *See* Appendix I for a copy of Attorney General Opinion GA-0234.
[9] State Auditor's Office, *An Audit Report on Health Plan Cost-Reduction Measures and Contract Management at Employees Retirement System and the Teacher Retirement System* (SAO Report No. 05-011, 2004).

projected savings and points out "the actual savings resulting from the cost reduction measures will be greater, not less than amounts projected…."[10] The actual impact of plan changes should become apparent in the coming months as calculations are made regarding the level of appropriation needed to fund ERS-GBP in the coming biennium. Fiscal year 2004 data will soon become finalized, and will provide better insight into the impact of plan design changes on utilization and cost.

University of Texas System Employee Group Insurance Program and Texas A&M System Employee Group Insurance Plan

Background

As previously mentioned, all institutions of higher education were given the opportunity to join ERS-HEGI in 1993. Only the University of Texas System and the Texas A&M System passed on this opportunity and instead opted to continue their self-insured health plans for employees, dependents and retirees. The relative size of these two systems, along with a long history of running their own programs, influenced their decision to continue with the self-funded option. Today, the University of Texas System Employee Group Insurance Program (UT-EGIP) covers more than 146,000 lives and the Texas A&M University System Employee Group Insurance Program (A&M-EGIP) covers approximately 55,000 lives.

Benefit levels and premium structures for UT-EGIP and A&M-EGIP are set by each system's Board of Regents. Similar to ERS-GBP, the Legislature may also direct changes through statutory revisions. Medical benefits for both UT-EGIP and A&M-EGIP are administered by Blue Cross. Pharmacy benefits for UT-EGIP are managed by Medco Health Solutions with A&M-EGIP pharmacy benefits managed by Eckerd Health Services. As shown on the following graph, benefit structures for these plans as well as ERS-GBP are fairly comparable.

[10] *Id.* at 3.

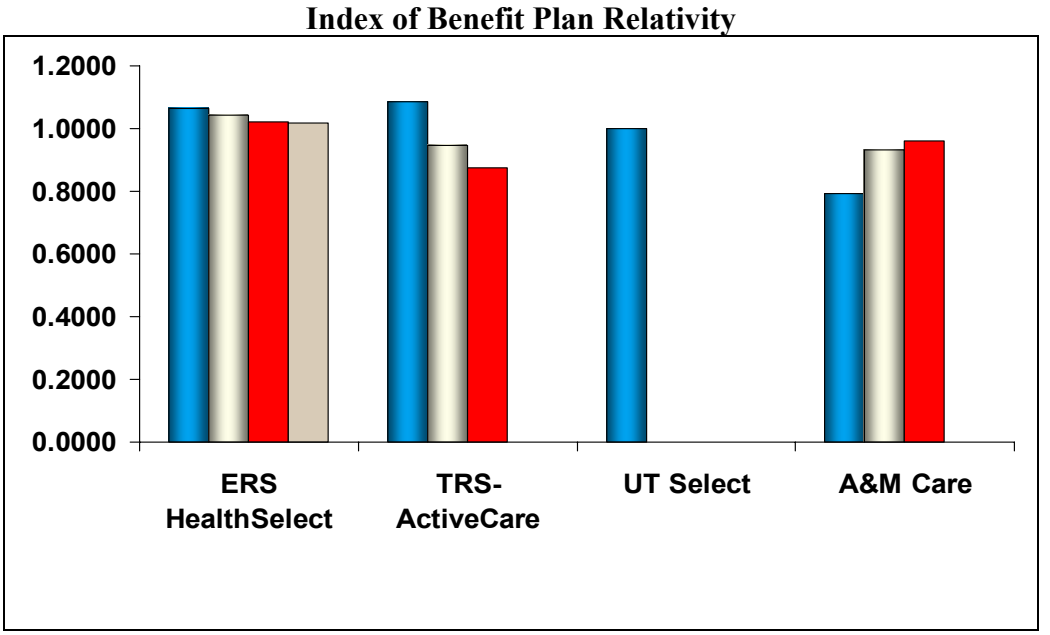

Figure 1 - 5 -- Index of Benefit Plan Relativity
Source: Blue Cross & Blue Shield of Texas

However, A&M-EGIP is driven by the management philosophy that those who utilize the benefits should pay more of the cost than those who do not. As a result, A&M-EGIP has sought to keep down out-of-pocket premium costs by asking those who utilize plan benefits to pay more of the costs at the time of service. The result has been a slightly lower premium structure with co-payments, coinsurance and deductibles slightly higher than the other two plans.

Discussion

Funding

Funding for UT-EGIP and A&M-EGIP is provided through a combination of state appropriation, institutional funds, member premiums and participant cost sharing. Similar to ERS-HEGI, state appropriations are made on a *sum-certain* basis and are required to be proportional by funding source. Generally, funding decisions are based on the dollar figures anticipated to be necessary to cover ERS-GBP costs for its participants under its own benefit and premium structure. For the 2004-05 biennium, cost saving measures enacted by the ERS board on May 1, 2003, as well as those anticipated to be made by the Legislature, were factored into the calculation. UT and A&M were provided funding based on that methodology and provided general flexibility to allocate those dollars within their systems. To the extent either institution decided not make the changes in plan design as anticipated in the calculation, each was required to balance those differences by its own means. For the 2004-05 biennium, UT-EGIP was appropriated $241.5 million while A&M-EGIP was allocated $135.3 million.[11]

[11] General Appropriations Act for the 2004-05 Biennium, 78th Leg., Art. III at 41-44 (2003).

Recent Benefit Changes

UT-EGIP and A&M EGIP continue to see costs rising at significant rates with projected 14 percent increases anticipated in the current fiscal year. Like ERS-GBP, these trends are occurring in an environment where enrollment has been essentially flat. To combat these trends, both systems have undertaken cost containment initiatives similar to ERS. Increases on co-payments, coinsurance and deductibles have all be implemented. In addition, UT-EGIP has implemented disease management programs; audits of dependent eligibility; and introduced additional web tools to enhance member health care knowledge. A&M-EGIP also has implemented similar initiatives, as well as improved its efforts to coordinate benefits where other coverage, such as Medicare, exists. Finally, both UT and A&M have programs in place that allow employees and retirees with alternate health care options to opt out of health care coverage and be provided a partial cash benefit payment for application towards those benefits.

The 78th Legislature also directed UT and A&M to implement several cost containment initiatives similar to those required of ERS-GBP.[12] Limits on contributions for part-time employees and graduate teaching assistant coverage, and a 90-day waiting period for new employees, and retirees not retiring directly from state service, were required unless covered by the institution with non-General Revenue-related funds.

In addition, revisions to minimum eligibility requirements for retiree health coverage were enacted.[13] Because identical requirements were made of ERS-HEGI participants, policy makers felt the application of these provisions should be made across all of higher education to ensure a level playing field in recruitment and retention of faculty and staff. As with ERS-GBP, retirees in these two systems were required to be at least 65 years of age with 10 years of service or satisfy the Rule of 80 to qualify for health coverage. Retirees must have retired on or before August 31, 2003, to avoid application of this new provision. Similar to the other state programs, eligible retirees were provided the option of purchasing health coverage until they turn 65 or met the Rule of 80 provided the retiree paid the *full actuarial cost* of the coverage.[14]

During the course of the legislative process conflicting legislation, S.B. 1370 and S.B. 1652, passed that allowed employees of the UT and A&M systems *employed* on or before August 31, 2003, or *eligible* to retiree on or before January 1, 2003, to be grandfathered from these provisions.[15] Concerned about how the two provisions could be reconciled, the A&M system sought guidance from the Attorney General. Although no formal opinion was provided, First Assistant Attorney General Barry McBee provided "informal advice" in a letter to the System date July 18, 2003.[16] His conclusion was that both amendments could be "harmonized" such that the grandfather provision would apply. Based on this advice, both UT and A&M have implemented the grandfather provision and continue to fund retiree health benefits for those affected retirees.

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[12] Acts 2003, 78th Leg., ch. 366.
[13] *Id.*
[14] *Id.*
[15] Acts 2003, 78th Leg., ch. 366; Acts 2003, 78th Leg., ch. 1266.
[16] *See* Appendix I.

Finally, the 78th Legislature directed an actuarial study assessing the financial feasibility of merging A&M-EGIP into ERS-GBP.[17] The study was conducted by ERS consulting actuary Philip S. Dial in August 2004.[18] The general conclusions offered by the analysis were that ERS-GBP costs would be reduced slightly by inclusion of the A&M-EGIP population. This was attributed to the younger, healthier population enrolled in A&M-EGIP. In addition, because of the relatively richer benefit structure in ERS-GBP, A&M participants would see improvements in coverage. However, because premiums in the ERS-GBP are higher, A&M employees purchasing spouse, dependant or family coverage could see increases in premium costs. Finally, based on the actuary's analysis of the state appropriation process and the various methodologies used in calculating health insurance allocations, the study concluded that A&M could see financial liabilities significantly increase if they joined ERS-GBP. As of December 1, 2004, the A&M Board of Regents has made no decision regarding the potential merger. With a new chancellor recently employed it is anticipated that a decision will be made in the coming weeks.

Teacher Retirement System of Texas - TRS-Care

Background

Created in 1985, Teacher Retirement System-Care (TRS-Care) was designed to provide basic health insurance for eligible retired teachers. During the past twenty years, as additional coverages have been made available, participation in the program has slowly grown. Today, TRS-Care provides three levels of benefits ranging from basic catastrophic coverage to comprehensive benefits including prescription drug coverage. Benefit levels for the plan are primarily established by the TRS board; however the Legislature may also direct changes through statutory revisions. Currently, Aetna administers medical benefits for the program, with Caremark managing prescription drug benefits.

At this time, TRS-Care covers over 188,000 lives including retirees, spouses and a small number of dependents. Enrollment growth in the program has averaged eight percent over the past several years. However, for a variety of reasons, retirement figures spiked in August 2004. Early retirement incentives and the federal closure of a Social Security benefit loophole all contributed to the 11 percent growth in TRS-Care participation that occurred going into fiscal year 2005.

In addition to enrollment growth, TRS-Care has seen significant cost escalations in recent years. Total plan expenditures have almost doubled since fiscal year 2000. This trend is expected to continue for the coming years with TRS projecting expenditures to more than double again by the end of fiscal year 2007. Projections through 2009 are shown on the chart below. In an effort to curb these trends, TRS has implemented numerous cost containment measures over the years.

[17] General Appropriations Act for the 2004-05 Biennium, 78th Leg., Art. III at 44 (2003).
[18] *See* Appendix I.

TRS-Care Fund Balance
Data Through August 2004

		Revenue						Expenditures				
	Beginning Balance	Retiree Premiums	State Contributions	Supplemental Appropriations	Member Contributions	District Contributions	Investment Income	Incurred Medical Claims	Incurred Drug Claims	Claims Processing	Internal Administration	Ending Balance
1986	$0	$0	$0	$250,000	$17,625,194	$0	$572,153	$0	$0	$0	$362,371	$18,084,976
1987	$18,084,976	$22,617,624	$25,931,680	$0	$18,522,629	$0	$2,568,998	$50,988,845	$7,044,825	$3,552,911	$389,025	$25,750,301
1988	$25,750,301	$23,948,600	$31,357,632	$0	$19,598,520	$0	$5,703,832	$16,157,649	$12,441,672	$4,130,071	$484,684	$73,144,809
1989	$73,144,809	$25,428,632	$37,420,711	$0	$20,789,215	$0	$8,802,914	$32,926,324	$15,458,710	$4,650,730	$561,343	$111,989,174
1990	$111,989,174	$37,556,561	$44,369,915	$0	$22,184,958	$0	$13,098,835	$50,171,919	$19,835,965	$6,497,731	$689,120	$152,004,708
1991	$152,004,708	$46,563,787	$47,277,743	$0	$23,638,871	$0	$15,801,047	$82,697,189	$28,683,081	$7,269,406	$988,623	$165,647,857
1992	$165,647,857	$56,395,797	$50,392,512	$0	$25,196,592	$0	$17,314,372	$74,307,953	$33,829,694	$7,957,901	$904,659	$197,946,923
1993	$197,946,923	$65,154,653	$54,029,406	$0	$27,014,703	$0	$17,181,190	$101,627,864	$40,700,513	$9,107,944	$959,415	$208,931,140
1994	$208,931,140	$80,128,944	$56,912,083	$0	$28,456,041	$0	$16,467,438	$108,284,693	$45,712,060	$10,742,076	$926,752	$225,230,065
1995	$225,230,065	$89,006,331	$59,849,850	$0	$29,924,925	$0	$16,841,673	$122,054,551	$50,782,093	$11,393,649	$826,198	$235,796,353
1996	$235,796,353	$82,622,236	$63,634,087	$0	$31,817,043	$0	$16,818,747	$135,982,304	$57,074,921	$12,491,199	$1,102,379	$224,037,663
1997	$224,037,663	$87,657,784	$67,616,395	$0	$33,808,197	$0	$16,202,440	$148,823,489	$62,530,982	$12,880,395	$1,217,059	$203,870,554
1998	$203,870,554	$91,390,173	$72,210,190	$0	$36,105,095	$0	$15,260,517	$156,537,913	$76,256,158	$12,748,881	$1,867,797	$171,425,780
1999	$171,425,780	$96,474,107	$76,488,424	$0	$38,244,213	$0	$9,762,741	$184,398,533	$93,459,890	$13,232,423	$1,672,773	$99,631,646
2000	$99,631,646	$120,227,960	$85,505,637	$0	$42,738,069	$0	$6,923,485	$203,029,971	$110,903,247	$14,682,301	$2,154,826	$24,256,452
2001	$24,256,452	$131,213,445	$90,118,787	$76,281,781	$45,059,394	$0	$5,824,134	$250,691,897	$139,774,848	$15,881,566	$2,356,201	($35,950,520)
2002	($35,950,520)	$143,797,748	$94,792,026	$285,515,036	$47,378,092	$0	$7,140,560	$287,729,918	$163,979,754	$16,714,233	$2,303,059	$71,945,979
2003	$71,945,979	$162,954,010	$98,340,798	$124,661,063	$49,170,399	$0	$3,394,956	$368,462,963	$203,281,400	$19,276,054	$2,414,275	($82,967,486)
2004	($82,967,486)	$248,552,679	$198,594,194	$298,197,463	$99,297,097	$79,457,387	$4,840,982	$381,833,457	$199,521,500	$23,914,851	$2,417,349	$238,285,159
2005	$238,285,159	$389,553,396	$204,552,020	$64,172,167	$102,276,010	$81,820,808	$3,702,359	$469,603,904	$325,554,755	$27,599,937	$2,538,216	$259,065,107
2006	$259,065,107	$425,308,184	$216,040,118	$0	$108,020,059	$86,416,047	$2,369,606	$578,183,401	$425,516,120	$31,602,566	$2,665,127	$59,251,908
2007	$59,251,908	$472,264,938	$224,681,723	$0	$112,340,861	$89,872,689	$0	$730,963,348	$559,727,865	$36,360,717	$2,798,384	($371,438,195)
2008	($371,438,195)	$531,561,191	$228,051,949	$0	$114,025,974	$91,220,779	$0	$942,820,011	$741,054,652	$42,036,228	$2,938,303	($1,135,427,495)
2009	($1,135,427,495)	$603,990,699	$231,472,728	$0	$115,736,364	$92,589,091	$0	$1,232,700,893	$985,439,943	$48,827,998	$3,085,218	($2,361,692,665)

Figure 1 - 6 -- TRS-Care Financial Statement
Source: Teacher Retirement System of Texas

TRS-Care
History of Key Plan Design Changes

- 2004-2005 (as of 9/1/04)
  - Eligibility changes per legislation
  - Premium restructure per legislation based on Medicare coverage and years of service; resulting premium increases in certain categories of coverage
  - Varied deductible levels in catastrophic coverage; new Care 2 $1,000 deductible; increased deductible in Care 3 from $240 to $300
  - Non-Medicare out-of-network coinsurance goes from 80/20 to 60/40 for all levels of coverage
- 2003-2004
  - Increased premiums for Care 3
  - Increased office visit co-pay
  - Increased Rx co-pays
    - Restructured to three-tiers: generic, brand formulary, and brand non-formulary
  - Switched from TRS Coordinated Care Network to more cost-effective Aetna network in most areas of the state
- 2001-2002
  - Increased Rx mail order co-pays
- 1999-2000
  - Increased premiums for Care 3
  - Increased Rx mail order co-pays
- 1997-1998
  - Decreased co-insurance
  - Increased Rx retail co-pays
  - Imposed mandatory generic substitution
- 1996-1997
  - Added office visit co-pay
- 1995-1996
  - Reduced premiums and deductibles
- 1994-1995
  - Increased premiums for Care 3
  - Increased deductibles and co-insurance
  - Modified Rx co-pays
- 1993-1994
  - Increased premiums, deductibles, and co-insurance
- 1992-1993
  - Increased premiums for Care 3
  - Increased deductibles and co-insurance
- 1991-1992
  - Increased premiums, deductibles, and co-insurance
- 1989-1990
  - Increased premiums
  - Reduced deductibles
- 1987-1988
  - Reduced mail order Rx co-pay
- 1986-1987
  - Began mail order Rx co-pay

Figure 1 - 7 -- TRS Historic Cost Containment Initiatives
Source: Teacher Retirement System of Texas

Discussion

Funding

Funding for TRS-Care has historically been provided through a combination of state, member, and retiree contributions. Originally responsible for the payment of approximately one-third of one percent of total covered payroll, the state's contribution level was soon increased to one-half of one percent. In addition, active employee contributions have historically been limited to one-quarter of one percent of their salaries. The remaining funds necessary to operate the program have to come from retiree premiums and cost sharing. These original funding elements were projected to be sufficient to maintain the program for 10 years.

Beginning in 1993, these methods of finance failed to generate sufficient revenues to cover plan expenditures. While investment income and cash reserves were able to keep the program solvent for several more years, in 2001 the program required its first supplemental appropriation from the Legislature. To cover expenses, the 76th Legislature appropriated an additional $76 million.[19]

Recent Benefit Changes

Entering the 78th legislative session, almost $785 million in supplemental appropriations had been made to meet the financial demands of the program. Facing an additional supplemental appropriation request of $1.1 billion for the biennium, lawmakers were forced to restructure the program. Working together with TRS, major legislative and administrative adjustments were made to both the financing structure and plan design of the program.

To solidify the financial base of the program, legislators adjusted the basic funding elements by increasing the state's responsibility to one percent of covered payroll.[20] Active teachers also saw their contribution rate increased to one-half of one percent. In addition, the state established for the first time a responsibility for school districts to help fund health insurance coverage for their former employees. A range of one-quarter to three-quarters of one percent of district payroll was set in statute for the school district's contribution with the final assessment set by the General Appropriations Act (GAA).[21] For the 2004-05 biennium, the GAA established the school district contribution rate at four-tenths of one percent. Finally, the Legislature statutorily limited the state's overall funding obligation to not more than 55 percent of total program costs, while requiring TRS retirees to cover at least 30 percent of those same plan expenditures.[22]

To curb escalating cost trends, legislators also made significant adjustments to eligibility requirements and plan design.[23] As the state did with ERS, UT, and A&M, minimum eligibility requirements were set so that only those retirees 65 years of age with 10 years of service or satisfying the Rule of 80 could qualify for state-funded health coverage. Retirees must have

[19] General Appropriations Act for the 2000-01 Biennium, 76th Leg., Art. III at 35 (1999).
[20] Several statutory plan revisions were included in S.B. 1369. Acts 2003, 78th Leg., ch. 1231.
[21] *Id.*
[22] *Id.*
[23] *Id.*

retired on or before August 31, 2004, to avoid application of this new provision. Those not able to meet this deadline faced retirement without access to the health coverage. As a result, the Legislature amended this provision to allow eligible retirees the option of purchasing health coverage through TRS until they turn 65 or meet the Rule of 80 provided the retiree paid the *full actuarial cost* of the coverage.

In addition, "years of service" were limited to those actually performed *in the state of Texas*.[24] This put an end to the practice of purchasing out-of-state service credits and "air-time" for the purpose of qualifying for health coverage. Service credit purchases made prior to September 1, 2003, were grandfathered provided the member retires prior to August 31, 2009. The Legislature also chose to continue allowing up to five years of military service to be applied toward qualifying for health insurance. All service credit purchases were continued for the purpose of qualifying for general retirement.

The Legislature also established a 90-day delay in eligibility for participation in all TRS programs.[25] This included TRS-Care and the TRS-Active Care pass-through. Unlike similar provisions applied to ERS, UT and A&M, these provisions include a date of August 31, 2005.

To ensure those enrolled in TRS-Care were willing participants, the process of automatic enrollment was discontinued. Retirees are now required to opt into the health care program. The Legislature also directed TRS to establish various premium levels for retirees taking into account their Medicare eligibility and years of service.[26] Finally, members were provided an open enrollment period at age 65.

In the most dramatic move, TRS redesigned the entire TRS-Care benefit structure. The reconstituted program was implemented on September 1, 2004. Like the previous program, three basic options are still available. The new TRS-Care 1 continues to provide basic catastrophic coverage previously provided in TRS-Care 1 and 2. Members opting into this choice pay no premium, but are subject to high deductibles and out-of -pocket expenses. No prescription drug benefit is provided. Benefits offered in the new TRS-Care 3 closely resemble those previously provided. With a low deductible and smaller out-of-pocket limits than those in TRS-Care 1, as well as a rich prescription drug benefit, TRS-Care 3 offers the most generous benefits. TRS-Care 2 provides a totally new level of comprehensive coverage. Deductibles and out-of-pocket limits fall between those of TRS-Care 1 and TRS-Care 3. Members are also provided a prescription drug benefit with co-payments slightly higher than those offered in TRS-Care 3. In addition to having differing premiums levels, each plan also has variations in coverage based on Medicare enrollment.

The overall objective of the redesign was to induce enrollees into the most cost efficient coverage. The following charts summarize and compare some of the changes made in TRS-Care. Since the reconstituted program has only been fully implemented for less than four months, the full impact of these adjustments on costs trends will not be known for some time.

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[24] *Id.*
[25] Acts 2003, 78th Leg., ch. 201.
[26] *Id.*

The Legislature should carefully monitor the progress of the program and continue to look for additional cost savings. In the short term, major revisions to plan design should be kept to a minimum.

TRS-Care Plan Design

Note: TRS-Care pays after Medicare for those covered by Medicare Part A.

Before 9-1-04

- TRS-Care 1
  (Catastrophic coverage w/o Medicare)
  - Free coverage for TRS retirees without Medicare
  - $4,500 annual deductible
  - $9,500 annual out-of-pocket limit
  - Rx discount; pays as medical
- TRS-Care 2
  (Catastrophic coverage w/ Medicare)
  - Free coverage for TRS retirees with Medicare
  - $1,800 annual deductible
  - $6,800 annual out-of-pocket limit
  - Rx discount; pays as medical
- TRS-Care 3
  - $240 annual deductible
  - $5,240 annual out-of-pocket limit
  - Rx program; 3-tiered copays

After 9-1-04

- TRS-Care 1
  (Catastrophic coverage, combined old Care 1 and 2)
  - Free coverage, three levels:
    - With Medicare Part A
      - $1,800 deductible
      - $6,800 max. out-of-pocket
    - Without Medicare Part A, but with Med Part B
      - $3,000 deductible
      - $8,000 max. out-of-pocket
    - Not eligible for Medicare
      - $4,000 deductible
      - $9,000 max. out-of-pocket
  - Rx same as medical
- New TRS-Care 2
  - $1,000 deductible
  - $6,000 max. out-of pocket
  - Rx program; 3-tiered copays; slightly higher than Care 3
- TRS-Care 3
  - $300 deductible
  - $5,300 max. out-of pocket
  - Rx program; 3-tiered copays

Figure 1 - 8 -- Old vs. New TRS-Care Plan Design
Source: Teacher Retirement System of Texas

TRS-Care as of September 1, 2004

	TRS-Care 1		
	Retirees or Surviving Spouses enrolled in Medicare Part A and Eligible for Medicare Part B	**Retirees or Surviving Spouses not enrolled in Medicare Part A but eligible for Medicare Part B**	**Retirees or Surviving Spouses not eligible for Medicare**
Deductible	$1,800	$3,000	$4,000
Network Coinsurance	80% / 20%	80% / 20%	80% / 20%
Out-of-Network Coinsurance---Medical and Part B Expenses	80% / 20%	80% / 20%	60% / 40%
Out-of-Network Coinsurance---Hospital and Part A Expenses	80% / 20%	60% / 40%	60% / 40%
Coinsurance Limit	$5,000	$5,000	$5,000
Maximum Out-of-Pocket	$6,800	$8,000	$9,000
Prescription Expenses	Same as Medical	Same as Medical	Same as Medical
Retail (up to 30-day supply)			
Mail (up to 90-day supply)			

	TRS-Care 2		
	Retirees or Surviving Spouses enrolled in Medicare Part A and Eligible for Medicare Part B	**Retirees or Surviving Spouses not enrolled in Medicare Part A but eligible for Medicare Part B**	**Retirees or Surviving Spouses not eligible for Medicare**
Deductible	$1,000	$1,000	$1,000
Network Coinsurance	80% / 20%	80% / 20%	80% / 20%
Out-of-Network Coinsurance---Medical and Part B Expenses	80% / 20%	80% / 20%	60% / 40%
Out-of-Network Coinsurance---Hospital and Part A Expenses	80% / 20%	60% / 40%	60% / 40%
Coinsurance Limit	$5,000	$5,000	$5,000
Maximum Out-of-Pocket	$6,000	$6,000	$6,000
Office Visit Co-payment	N/A	N/A	$35
Prescription Co-payments Generic/Preferred/Non-Preferred			
Retail (up to 30-day supply)	$10/$30/$50	$10/$30/$50	$10/$30/$50
Mail (up to 90-day supply)	$20/$75/$125	$20/$75/$125	$20/$75/$125

	TRS-Care 3		
	Retirees or Surviving Spouses enrolled in Medicare Part A and Eligible for Medicare Part B	**Retirees or Surviving Spouses not enrolled in Medicare Part A but eligible for Medicare Part B**	**Retirees or Surviving Spouses not eligible for Medicare**
Deductible	$300	$300	$300
Network Coinsurance	80% / 20%	80% / 20%	80% / 20%
Out-of-Network Coinsurance---Medical and Part B Expenses	80% / 20%	80% / 20%	60% / 40%
Out-of-Network Coinsurance---Hospital and Part A Expenses	80% / 20%	60% / 40%	60% / 40%
Coinsurance Limit	$5,000	$5,000	$5,000
Maximum Out-of-Pocket	$5,300	$5,300	$5,300
Office Visit Co-payment	N/A	N/A	$25
Prescription Co-payments Generic/Preferred/Non-Preferred			
Retail (up to 30-day supply)	$10/$25/$40	$10/$25/$40	$10/$25/$40
Mail (up to 90-day supply)	$20/$50/$80	$20/$50/$80	$20/$50/$80

Figure 1 - 9 -- New TRS-Care Benefit Structure
Source: Teacher Retirement System of Texas

TRS-Care Premiums Effective September 1, 2004

* "Part B of Medicare Only" means the individual is not covered by Medicare Part A and is Eligible to purchase Medicare Part B

	Retiree Premium TRS-Care 1	Retiree Premium TRS-Care 2			Retiree Premium TRS-Care 3		
		Years of Service			Years of Service		
		<20	20-29	30+	<20	20-29	30+
Retiree or Surviving Spouse Only							
With Part A&B of Medicare	$0	$80	$70	$60	$110	$100	$90
With Part B of Medicare Only*	$0	$165	$155	$145	$245	$230	$215
Not Eligible for Medicare	$0	$210	$200	$190	$310	$295	$280
Retiree and Spouse							
Both with Part A&B of Medicare	$20	$190	$175	$160	$275	$255	$235
Both with Part B Only of Medicare*	$75	$360	$340	$320	$535	$505	$475
Neither Eligible for Medicare	$140	$450	$430	$410	$665	$635	$605
Retiree with A&B/Spouse with B Only*	$60	$275	$255	$235	$400	$375	$350
Retiree with A&B/Spouse not Eligible for Medicare	$90	$320	$300	$280	$465	$440	$415
Retiree with B Only/Spouse not Eligible for Medicare*	$120	$405	$385	$365	$600	$570	$540
Retiree with B Only/Spouse with A&B	$25	$275	$260	$245	$410	$385	$360
Retiree not Eligible for Medicare/Spouse with A&B	$30	$320	$305	$290	$475	$450	$425
Retiree not Eligible for Medicare/Spouse with B Only*	$80	$405	$385	$365	$600	$570	$540
Retiree or Surviving Spouse and Child(ren)							
With Part A&B of Medicare	$41	$142	$132	$122	$192	$182	$172
With Part B of Medicare Only*	$34	$227	$217	$207	$327	$312	$297
Not Eligible for Medicare	$28	$272	$262	$252	$392	$377	$362
Retiree, Spouse and Children							
Retiree and Spouse with Medicare A&B	$61	$252	$237	$222	$357	$337	$317
Retiree and Spouse with Medicare B Only*	$109	$422	$402	$382	$617	$587	$557
Retiree and Spouse not Eligible for Medicare	$168	$512	$492	$472	$747	$717	$687
Retiree with A&B/Spouse with B Only*	$101	$337	$317	$297	$482	$457	$432
Retiree with B Only/Spouse not Eligible for Medicare*	$154	$467	$447	$427	$682	$652	$622
Retiree with B Only/Spouse with A&B*	$59	$337	$322	$307	$492	$467	$442
Retiree not Eligible for Medicare/Spouse with A&B	$58	$382	$367	$352	$557	$532	$507
Retiree not Eligible for Medicare/Spouse with B Only*	$108	$467	$447	$427	$682	$652	$622
Surviving Child(ren) Only	$28	$62	$62	$62	$82	$82	$82

Figure 1 - 10 -- New TRS-Care Premium Structure
Source: Teacher Retirement System of Texas

Teacher Retirement System of Texas - TRS-Active Care

Background

TRS-Active Care was created by the 77th Legislature to provide a statewide health care benefit to active employees of state schools districts, charter schools, regional service centers, and other educational districts.[27] This self-funded program offers three coverage choices to participants. Benefit levels range from basic catastrophic to a comprehensive plan including prescription drug coverage. Medical benefits are administered by Blue Cross with prescription drug benefits managed by Medco Health Solutions. Coverage in the program began on September 1, 2002, and effective September 1, 2003, HMO plans were made available in metropolitan areas of the state. Currently, there are more than 1,000 entities participating with enrollment approximately 248,000. This represents a 40 percent increase in participation since October 2002.

Discussion

Funding

Funding for the program is provided through a combination of state, school district and participant cost sharing. School districts are required to contribute $150 per month, per employee for health care coverage. The state provides an additional $75 per month, per employee to districts to help offset health care expenditures. The state also provides a direct supplement or "pass- through" to teachers via TRS. Originally set at $1,000 per year, the 78th Legislature was forced to temporarily reduce the pass-through amount to $500 for full-time employees and $250 for those working part-time.[28] The pass-through for administrators was eliminated for the biennium. Finally, all remaining funds necessary to operate the program are required to come from participant premiums and cost sharing.

Recent Benefit Changes

Like the other programs administered by the state, TRS-Active Care has experienced significant increases in health care expenditures. Although some of this is attributable to a rapidly expanding active teacher workforce, general utilization trends and cost inflation are major drivers as well. To counter this trend, TRS has implemented a number of cost containment initiatives including increases in co-payments and out-of-pocket expenses. With state and district shares of funding set, any increases in plan cost must be covered by the participants. However, continued monitoring and management of health care trends in this program are in the state's interest.

During the 78th Legislature, H.B. 3257 was passed which directed the TRS health care "pass-through" to be deposited in Health Reimbursement Accounts (HRAs).[29] These tax-advantaged accounts would operate much like flexible spending accounts (FSAs) which have been available for a number of years. Limited to use for "qualifying health care expenditures,"

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[27] Acts 2001, 77th Leg., ch. 1419.
[28] General Appropriations Act for the 2004-05 Biennium, 78th Leg., Art. III at 39 (2003).
[29] Acts 2003, 78th leg., ch. 313.

dollars held in HRAs, may be deposited only by employers. In addition, there is no "use it or lose it" provision. Dollars held in an HRA may be rolled over from year-to-year.

To implement this new provision, TRS issued a Request for Proposals (RFP) seeking administrative assistance. Aetna was ultimately selected and began the process of establishing more than 500,000 accounts and educating teachers about the program. To implement the HRAs, Aetna announced that administrative fees ranging from $30-$42 per year would be required. Concerned that these fees were being deducted from an already reduced pass-through and with a growing interest in the newly enacted health savings accounts (HSAs), policy makers began to reexamine the program.

In September 2004, Lieutenant Governor David Dewhurst and Speaker Tom Craddick, with the support and encouragement of the legislation's author and sponsor, and based on legal advice provide by the Attorney General, directed TRS to discontinue their implementation of the HRA program.

Since the passage of the legislation creating the TRS-Active Care HRA program, the dialog regarding general health saving arrangements and consumer directed care has burgeoned. This is evident with the recent federal enactment of HSAs and the increasing popularity in the private sector of HRAs and consumer directed health plans.[30]

Recommendations

During the process of receiving testimony and examining issues relating to rising medical costs in state group health insurance plans, a number of issues relating to recently implemented cost containment initiatives were raised. In addition, the Committee was presented with a variety of additional cost savings measures. Below is a summary of some of the options and issues the Legislature should consider:

1.a. Creating a three-tiered provider network to encourage participants to utilize providers with histories of efficient care. Currently, state group health plans only offer in-network and out-of-network medical benefits without provisions to encourage patients to seek care from efficient in-network providers. Lower co-payments, coinsurance rates and deductibles are all tools that could be utilized to entice patients to desirable providers.

1.b. Requiring disease management programs to be implemented in all state group health insurance plans. At present, only UT-EGIP and A&M-EGIP have broad disease management programs in place. Health conditions such as heart disease, asthma, diabetes, obesity, and smoking-related conditions should be targets of any program implemented. While short-term cost savings may be minimal, long-term benefits should be significant.

1.c. Requiring all state-administered health plans to conduct regular audits of all claim payments made in a fiscal year. Such audits could be done in-house or by third-party auditors, but should be performed independent of the general claims administrators.

[30] *See* Appendix I for a detailed comparison.

The audits should focus on overpayments, payment errors, eligibility qualifications, and fraud.[31]

1.d. Clarifying legislative intent regarding retiree eligibility for health insurance coverage within the higher education population to achieve equity among employees of all institutions. This could be accomplished in one of two ways:

1.d.3. Allow ERS-HEGI institutions to fund some portion of health coverage for retirees *employed* by the institution on or before August 31, 2003, or *eligible* to retiree on or before January 1, 2003, from non-General Revenue-related appropriations. Participating institutions could be required to pay either the *normal* or *full-actuarial* cost of this coverage; or

1.d.4. Eliminate the provision that allowed employees of the UT and A&M systems *employed* on or before August 31, 2003, or *eligible* to retiree on or before January 1, 2003, to be grandfathered from new eligibility requirements.

1.e. Implementing an incentive plan where employees and retirees with alternate health care options are allowed to opt out of state health care coverage. This same type of program has been implemented for several years within UT-EGIP and A&M-EGIP with great success.

1.f. Amending certain provisions within TRS-Care that limit the application of out-of-state service credit purchases in qualifying for health insurance eligibility. Such limits have created recruiting difficulties for school districts seeking to hire teachers from other states. This problem seems to be particularly acute in districts bordering other states.

1.g. Clarifying legislative intent to require all groups accessing health insurance benefits through ERS to meet the same eligibility standards required of general state employees. Furthermore, the Legislature should consider specifically designating ERS as the sole authority to determine questions relating to an individual's eligibility to receive group benefits including those associated with retiree eligibility.

1.h. Implementing a broad consumer-directed care initiative for all state group health insurance plans. In conjunction with this plan, the state should consider utilizing either a Health Reimbursement Account (HRA) or a Health Savings Account (HSA).

1.i. Merging A&M-EGIP, UT-EGIP and ERS-GBP into one consolidated program. Given some of the findings in the recent actuarial report regarding the feasibility of a merger of the A&M and ERS systems, a combined insurance pool could improve the overall actuarial condition of the ERS-GBP.

1.j. Continuing the 90-day waiting period for TRS.

1.k. Requiring all state group health plans to quarterly update the Legislature on state health expenditure trends. Such reports should be provided in a standardized format and

[31] The SAO in a recent audit also identified this as an area of potential improvement for ERS and TRS. *See* State Auditor's Office, *An Audit Report on Health Plan Cost-Reduction Measures and Contract Management at Employees Retirement System and the Teacher Retirement System* (SAO Report No. 05-011, 2004). In addition, the Senate Finance Subcommittee on Rising Medical Cost made a similar recommendation in its January 2003 Interim Report.

compare actual trends to projected trends.

1.l. Directing ERS, UT, A&M and TRS health care experts to meet regularly to discuss and compare cost containment strategies. The group should also discuss provider contract provisions and rates.

In addition to these options, both ERS and TRS have identified possible cost-shifting initiatives for the Legislature's consideration.[32]

Charge No. 2

Monitor the implementation of H.B. 1549, 78th Legislature, the Federal Help America Vote Act of 2002, to assure that Texas meets the criteria to secure the proposed federal funding. Make recommendations for statutory changes required to implement federal legislation and improve the efficiency of the process.

Background

The 2000 presidential election and the infamous Florida recount illustrated significant problems with voting machines and ballots, not only in Florida, but across the nation. In response, Congress passed the Help America Vote Act of 2002 (HAVA), designed to ensure that no eligible voter is denied the right to vote or have that vote counted. The 78th Legislature implemented the provisions of HAVA with the passage of H.B. 1549, signed into law June 22, 2003.[33]

Discussion

House Bill 1549 makes several changes to the Texas Election Code.[34] Below is a summary of those changes, as provided by the Texas Secretary of State, along with the status of implementation for each of the changes.[35]

Voter Registration Changes

An application for voter registration must now include the applicant's Texas driver license number or Department of Public Safety identification number. If the applicant has neither identification, they must provide the last four digits of their Social Security Number. If the applicant has none of those identification numbers, they must state that fact and a unique identifier will be assigned. Applicants who are registering to vote for the first time in Texas must provide a copy of identification when they register or when they vote for the first time. The Secretary of State's office is required to revise the voter registration application to accommodate these changes.

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[32] *See* Appendix I.

[33] Election law changes to implement the federal Help America Vote Act of 2002 went into effect January 1, 2004, with the exception of Sections 5 through 11 (effective January 1, 2006) and Section 13 (effective September 1, 2003).

[34] Acts 2003, 78th Leg., ch. 1315.

[35] *See* Appendix II for a detailed Secretary of State HAVA Update.

Pre-printed checks and "two other forms of identification" are no longer acceptable polling place identification. New types of acceptable identification include: a copy of a current utility bill; bank statement; government check; paycheck; or other government document that shows the name and address of the voter.

Implementation Status: *These changes have been implemented and require no new legislation at this time.*

Statewide Voter Registration List

HAVA requires a statewide list of registered voters be established, including each voter's name, registration information and a unique identifier to be assigned to each registered voter. This system must be maintained at the state level as the official voter registration list, and must be available to any election official in the state through immediate electronic access.

Implementation Status: *H.B. 1549 amended the Election Code to require an official statewide list maintained at the Secretary of State's office. The Secretary of State is currently in the procurement process to implement this requirement, and a contract for development of a compliant statewide system is expected by January 1, 2006. No additional legislation should be needed.*

Provisional Voting

A new process, provisional voting, is to be used in instances when a voter's name does not appear on the roll for a polling place. Generally, it is similar to the challenge process under pre-HAVA law, but the voter's ballot is not counted until after the voter's registration status has been verified by the Early Voting Ballot Board and county voter registrar.[36] Provisional ballots are to be placed inside a provisional envelope which is then placed in a ballot box separate from the regular ballots. The provisional affidavit, which states that the voter is a registered voter in that precinct, is printed on the outside of the provisional envelope. The envelope also contains the elements of a voter registration application so that in any event the voter would be registered for future elections. The law also requires a free access system to allow a provisional voter to contact the elections office confidentially to find out whether his or her ballot was counted, and if not, the reason it was not counted.

To allow time for processing provisional ballots, H.B. 1549 changes the canvass date to the eighth day after election day for the general election for state and county officers. For all other elections, the canvass date shall be between the eighth and eleventh day after election day. Ballots cast outside normal voting hours in the event of a state or federal court order extending the polling hours will be segregated in a separate ballot box. On the same note, a voting system must also provide for a separate count of the votes cast during this extended voting time. The Early Voting Ballot Board is charged with counting these ballots along with the provisional ballots.

[36] Under the previously used challenge process, challenged votes were initially counted and only reviewed if a challenge was issued. Provisional votes will not be counted until they are verified.

Implementation Status: *All aspects of the provisional voting process have been addressed either through state law or rulemaking. No further action is required at this time.*

Voting System Standards

After January 1, 2006, the use of lever and punch card machines will be prohibited. Additionally, each polling place is required to provide at least one accessible voting system for individuals with disabilities. These systems must meet the certification criteria established by the Secretary of State, are to be acquired and maintained by the counties, and must be in place by January 1, 2006. To date, only Direct Recording Electronic (DRE) voting systems have been certified as acceptable accessible voting systems. While the counties are responsible for the purchase of these machines, the state is permitted to use Chapter 19 funds as the matching funds necessary to qualify for federal HAVA funds.[37] The voting system's audit records are added to the list of materials the custodian of election records shall make available to the recount committee on written order of the recount supervisor. Additionally, H.B. 1549 provides definitions for what constitutes a "vote" for each type of voting method as required by HAVA.[38]

Implementation Status: *Currently, the state is in partial compliance with this requirement. While a small number of counties have purchased accessible voting machines, the majority have not. Most are exploring their options in procuring these machines; however many are awaiting monetary assistance in the form of federal HAVA dollars before moving forward with such purchases.*

Associated Issues - Voter-Verified Paper Trail

With the influx of computerized voting in the United States, an issue receiving significant media attention is the voter-verified paper trail. If a voter-verified paper trail is implemented, computerized voting systems would be outfitted with the ability to print out a ballot after the voter has voted electronically. Those who support implementation of a voter-verified paper trail suggest every citizen should have the opportunity to review a printed paper receipt listing their votes to ensure each vote is reflected as it was intended. Once this hard copy ballot is verified by the voter, it would be retained by election administrators. In the event of a recount, these paper ballots would be the evidence of the election.

Proponents of instituting voter-verified paper trails in Texas have cited California as a case study. In April 2003, California Secretary of State Kevin Shelley banned the use of one Direct Recording Electronic (DRE) voting system, Diebold's AccuVote-TSX, for the November 2004 election. Shelley's decision resulted from the machine's failure to receive federal qualification as well as the "disenfranchisement of voters attempting to use it during the March 2

[37] Chapter 19 of the Election Code provides that each county is entitled to an amount of funds that is calculated according to the formula in Section 19.002. The funds may be used to enhance voter registration, but may not be used to fund statutory duties of the voter registrar. TEX. ELEC. CODE, ch. 19 (Supp. 2004-05).

[38] The Election Code includes criteria for evidence of voter intent for each voting system currently in use. TEX. ELEC. CODE § 65.009(d) (Supp. 2004-05).

presidential primary election."[39] In addition, Secretary Shelley declared all DRE systems that had previously been approved by his office "defective or unacceptable," which required all systems to be either fitted with the capability to produce a voter-verified paper trail or be adapted to meet 23 new security measures before they may be re-certified.[40] This notion has gained some momentum as experts on both sides continue to make their cases. The argument, in its simplest form, is prevention of error versus detection of error.

Prevention of Error

Those who subscribe to the prevention approach to DRE voting systems maintain that the testing and certification process which every voting unit must undergo prior to use is adequate to ensure the integrity of the systems. The systems are stand-alone, thus inaccessible to hackers attempting to sabotage or alter elections through use of the worldwide web.[41] Additionally, based on the timeline of software development, a hacker would have to know the names on a ballot up to two years in advance of an election to know the appropriate code to move votes from candidate to candidate.[42] Prevention advocates have said the complexity of mounting such an attack on an election through electronic tampering is enough to make it an *almost* impossible task, especially given the rigorous and thorough testing and certification processes.

According to some representatives of the DRE manufacturing industry, concern about election employees tampering with the system once votes are cast could be addressed by increased background and security checks on such employees. On May 5, 2004, Neil McClure, Vice President of Hart InterCivic, Inc., one of the primary providers of election products and services for state and local governments for more than 90 years, outlined a possible scenario should the voter-verified paper trail be mandated and implemented:

> It has been further recommended that if the paper verification does not match, the voter must be given the opportunity to reject the paper verification and be allowed to vote again, up to as many as three times. This process amounts to giving the voter three opportunities to change his/her mind. The reality is, if the paper ballot does not match what the voter entered on the DRE, the system is not functioning properly and voting should immediately cease. In fact, all equipment becomes suspect at that moment and the entire election should be stopped and the appropriate legal authorities notified. Then a decision should be made whether to shut down all equipment nationally that is the same make and model or that is running on the same version of software. This is why if any form of the paper ballot receipt is implemented, a law providing for severe criminal penalties should go into effect simultaneously if a false claim is made concerning the accuracy of a system. Those of us who have experience with voters know this will occur.[43]

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[39] Order of California Secretary of State, *Decertification and Withdrawal of Approval of AccuVote-TSX Voting System as Conditionally Approved November 20, 2003, and Rescission of Conditional Approval* (April 30, 2004) (http://www.ss.ca.gov/elections/touchscreen.htm#A).
[40] *Id.*
[41] Senate Committee on State Affairs Hearing, May 17, 2004 (statement of Dana DeBeauvoir, Travis County Clerk).
[42] Senate Committee on State Affairs Hearing, May 17, 2004 (statement of Jerry Meadows, Hart InterCivic).
[43] Senate Committee on State Affairs Hearing, May 17, 2004 (statement of Jerry Meadows, Hart InterCivic, referencing statement of Neil McClure, Vice President, Hart InterCivic).

There is no disagreement that such a situation could be catastrophic. However, those who maintain that a voter-verified paper trail is necessary would contend that without it, such malfunctions might not be discovered.[44]

Detection of Error

Those who support using a voter-verified paper trail have an opposing opinion about the security of voting systems. While most agree DRE testing and certification processes are thorough, it has been suggested that the mere *possibility* for corruption of an election is enough to justify additional measures.[45] There is much disagreement regarding the ease of tampering with an election. Those in favor of a voter-verified paper trail claim the task would not be difficult while, as mentioned earlier, DRE vendors claim the complexity of mounting a successful attack on an election is almost impossible.[46] The difficulty of carrying out such a task is the main deterrent for potential saboteurs, however, given the complexity of the attack on the World Trade Center on September 11, 2001, the fact that a plan is extremely difficult to execute does not alleviate the fear of a threat as it may have just a decade ago.

Despite differing viewpoints, all opinions surrounding the voter-verified paper trail issue share one common belief: *The citizens of this country must have complete trust and confidence in the integrity of their elections.* This means several things should be examined, including the degree to which public opinion should guide the actions of government, or whether the voter-verified paper trail should be put in place simply to ensure the public has faith in the system.

Cost

The most prohibitive aspect of implementing a voter-verified paper trail in Texas is the cost associated with such a task. Printers and paper factor into the final cost of putting in a system, as does training for poll workers. Differing opinions exist as to what type of printers would be required at the polling places; therefore a specific cost projection has not been established.[47] Regardless, if a law was to pass requiring such a system, additional funding for the counties would need to be explored. Otherwise, the requirement would essentially be an unfunded mandate to the counties that are responsible for the purchase of voting equipment.

Pursuant to HAVA, H.B. 1549 requires all polling places to be equipped with at least one DRE voting machine by January 1, 2006. Although anyone may use them, the machines are being placed in each polling place specifically to ensure accessible voting to disabled voters. While the counties are responsible for purchasing these machines, the current funding available to them is insufficient to cover the cost of these purchases statewide. An additional $103 million in federal funding is available. However, in order to draw down that funding, the state is required to put up matching funds in the amount of five percent of the total ($5.4 million).[48] The Texas Office of the Secretary of State currently has a significant portion of this money. The

[44] Senate Committee on State Affairs Hearing, May 17, 2004 (statement of Adina Levin, ACLU).
[45] Senate Committee on State Affairs Hearing, May 17, 2004 (statement of Dr. Dan Wallach, Rice University).
[46] Senate Committee on State Affairs Hearing, May 17, 2004 (statement of Jerry Meadows, Hart InterCivic).
[47] Senate Committee on State Affairs Hearing, May 17, 2004 (combined statements of Dr. Dan Wallach, Rice University and Jerry Meadows, Hart InterCivic).
[48] Help America Vote Act of 2002 § 253(b)5, 42 U.S.C. § 15301.

remainder ($3.04 million) is included in the Secretary of State's Legislative Appropriations Request (LAR) and is divided as follows:

- $2,874,436 - included in the baseline request of the LAR
- $165,286- listed as exceptional item number two in the LAR

The Secretary of State has also requested an emergency appropriation to draw down this remaining available federal money as soon as possible. Several factors contribute to the reasoning behind this request. First, the funding received to date is not sufficient to fully cover the cost of getting all counties into compliance. Second, many counties are hesitant to purchase any machines until adequate funding is made available. Third, if the match for the additional funding does not become available until September 1, 2005, counties will only have four months to acquire, deploy and test the systems, train staff, and still meet the January 2006 mandate. It is unlikely this will be enough time to perform this task, especially for those counties that must delay their purchases until they have cash-in-hand.

2004 Election Report[49]

On the whole, the November 2, 2004, general election ran smoothly. There were 13,098,329 eligible registered voters, which represents 82% of the voting age registered. Turnout was the highest since the 1992 presidential election at 57% of registered voters voting. No significant voting system problems were reported, but there were a few trouble spots: Wichita County was late counting punch card ballots due to a faulty program; Matagorda County's optical scan central tabulator malfunctioned and had to be replaced; and Harris County's vote count was reported late, though that was due to the heavy volume of mail ballots and not voting system problems.

This was the first major election in which provisional voting procedures were implemented. On election night, the counties reported an estimated 23,000 provisional ballots cast. The Secretary of State will be collecting data from all counties for the exact number of provisional ballots cast, the number counted, and the reasons why provisional ballots were not counted. In addition, the Secretary of State will be collecting data regarding "by mail" ballots.

The most significant problem involved several counties receiving their official ballots late, resulting in late mailing of the ballots to military and overseas citizens. To address that problem, the Secretary of State authorized counties to create emergency ballots so that they could be mailed and allow for the minimum recommended ballot transmission time of 30 days.

Recommendations

General Findings and Recommendations

The Committee, after studying the implementation of the Federal Help America Vote Act in Texas through H.B. 1549, finds that the implementation of H.B. 1549 is progressing smoothly to date, with all implementation deadlines being met in a timely fashion. Therefore, the

[49] Information provided by the Office of the Secretary of State Elections Division (Nov. 19, 2004).

Committee recommends the following:

2.a. The Legislature continue to monitor the progress of all provisions of H.B. 1549, keeping in mind that unforeseen problems requiring additional legislative action could potentially arise as new voting systems are put into use statewide.

Recommendations Concerning a Voter-Verified Paper Trail

An April 1, 2003 memorandum from Texas Secretary of State Geoffrey S. Connor does not decisively say whether he favors a voter-verified paper trail for Texas. However, he does state, "Quite simply from a policy perspective, any discussion of unilaterally requiring VVPTs for DREs through a rulemaking process conducted by this office is premature given the debate currently ongoing at the federal and state level." In the same memo, he states, "…there is a healthy debate currently ongoing in Congress with respect to the issue of VVPTs. Legislation has been filed by various members of Congress calling for a VVPT requirement."[50]

The Committee agrees any legislation passed on the state level would also be premature. Therefore, the Committee recommends:

2.b. Texas proceed with caution until sufficient electronically-administered election history exists in Texas and other states to assess the level of assurance in the integrity of voting systems. Additionally, Texas should monitor the successes and problems encountered in other states and be fully prepared to implement its own system should federal legislation mandate such measures. Finally, if state or federal legislation is enacted requiring a voter-verified paper trail, Texas should consider legislation providing a penalty for false claims of voting system errors.

Matching Funds

The Secretary of State's office has requested funds sufficient to cover the cost of the five percent match required to draw down additional federal dollars for HAVA implementation. Additionally, the Secretary of State may seek an emergency appropriation in order to ensure that Texas receives federal funding in a timely manner. To that end, the Committee recommends:

2.c. An appropriation for matching funds requested by the Secretary of State's office in order to draw down all possible federal dollars available through HAVA. This includes the approval of an emergency appropriation as requested by the Secretary.

Charge No. 3

Study the implementation of S.B. 10 and S.B. 541, and make recommendations, as needed, to make health insurance more accessible, and affordable for all Texans.

[50] Texas Secretary of State Memo, *Electronic Voting System Certification and Voter-Verified Paper Trails* (April 1, 2004).

Senate Bill 10 – Health Group Cooperatives

Background[51]

House Bill 2055, as passed by the 73rd Legislature, authorized employers to join together in private purchasing cooperatives to obtain group health insurance coverage.[52] Utilization of these cooperatives, however, has been sparse. One reason is reluctance by carriers to issue coverage to cooperatives due to the potential for instability and adverse selection.

Senate Bill 10, passed by the 78th Legislature, created a new type of private purchasing cooperative, the health group cooperative, which relies on cooperation between carriers and their sponsoring entities to address the underutilization of this form of purchasing entity.[53] The bill's provisions allow multiple employers to group together to purchase coverage and be treated collectively as a small employer, thereby enjoying the protections granted small employers under Chapter 26 of the Texas Insurance Code.[54] Once a cooperative is formed and actively purchasing coverage, any employer in the cooperative's service area may join. Large employers, which may also experience difficulty in finding affordable coverage, may also participate, at the discretion of the cooperative and the carrier. A carrier issuing coverage to a health group cooperative may choose to file with the Texas Department of Insurance (TDI) a health plan specifically designed for an S.B. 10 health group cooperative.

Discussion

Texas Department of Insurance Report

TDI adopted rules for implementing S.B. 10 on August 10, 2004. Working with the bill author, TDI consulted employers and carriers to identify and address possible problems regarding implementation.[55] The final rules are a product of these discussions.[56]

The rules require carriers preparing to participate in the health group cooperative to file their intent with the Commissioner. Carriers may enter the market at any time upon notification. Carriers may define their participation in the market by specifying the geographic area(s) in which the carrier is available to issue coverage to health group cooperatives and by placing limits, pursuant to TEX. INS. CODE Article 26.15(b), on the potential size of cooperative with which the carrier can contract.[57]

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[51] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[52] Acts 1993, 73rd Leg., ch. 607.
[53] Acts 2003, 78th Leg., ch. 782.
[54] This provision is a source of concern for stakeholder groups as discussed subsequently in this report. Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Bill Hammond, Texas Association of Business).
[55] *See* Appendix III for TDI's S.B. 10 Implementation Timeline.
[56] *See* 28 T.A.C. ch. 26, subch. D (2004).
[57] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).

TDI requires carriers that issue plans to cooperatives report data that will provide a clear picture of the health group cooperative market.[58] The required data includes:

- total number of health benefit plans newly issued and renewed to cooperatives;
- total number of Texas lives covered under newly issued and renewed health benefit plans issued through a cooperative;
- total number of cooperative health benefit plans covering Texas lives that were cancelled or non-renewed during the previous calendar year;
- gross premiums received for newly issued and renewed cooperative health benefit plans covering Texas lives;
- number of cooperative health benefit plans covering individuals in Texas that were previously uninsured; and
- number of cooperative health benefit plans in force in Texas on December 31, and the number of Texas lives covered under those plans, based on the first three digits of the five-digit zip code of the employer´s principal place of business in Texas.

Stakeholder Concerns

Senate Bill 10 contains a number of provisions that create incentives for carriers to enter the market.[59] To promote stability in the health care cooperatives, the new legislation requires employers to make a two-year minimum commitment to the cooperative. Employers that leave the cooperative prior to the termination of the two-year period are subject to a contractual penalty from the cooperative, unless they can show financial hardship. Carriers are exempt from premium and retaliatory taxes for two years for any previously uninsured person covered through the cooperative. Plans are not required to include state-mandated health benefits (other than diabetes supplies and services pursuant to TEX. INS. CODE Article 21.53G). Finally, plans do not have to comply with TDI regulations concerning the differences in benefit levels for in- and out-of-network services.

TDI did encounter some concerns during the rulemaking process. These concerns relate to carrier participation, cooperative size, definition of financial hardship, and the impact of insuring a previously uninsured client.

Carrier Participation:[60]

- The predominant issue that may hinder carriers from entering the health group cooperative market is the potential for significant changes in a cooperative's size. While the statute limits the time of enrollment in the cooperative to the annual open enrollment period, the availability of cooperative membership to any small employer in the cooperative's service area could create the potential for a large population of

[58] 28 T.A.C. § 26.413 (2004).
[59] Acts 2003, 78th Leg., ch. 782.
[60] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).

new enrollees annually. The ability of cooperatives to elect to allow large employers to join as well heightens the potential that populations may fluctuate significantly. However, TDI believes a carrier should be able to address this issue in an agreement with a cooperative prior to declaring its entry into the cooperative market.

- Other concerns included a carrier's ability to adequately administer a large beneficiary group as a small employer, and the requirement of applying state-mandated small employer rating requirements to this larger group. In other words, a scenario of a large group of individuals in a plan that is still regulated with small business (fewer covered lives assumed) standards. To answer this concern, TDI's rule allows carriers that file their intent to offer coverage to cooperatives to limit the scope of that intended coverage. This rule is consistent with the S.B. 10 concept of a voluntary and negotiated cooperative marketplace where carriers, cooperatives and sponsoring entities come together to find solutions for delivering coverage to employers. The rule allows these parties to negotiate freely the best terms for all. A cooperative or sponsoring entity may discuss coverage issues with a carrier prior to formation, and the parties may reach agreement prior to a carrier's entry into the cooperative market.

Cooperative size:[61]

- The potential for a cooperative to lose employer members and fall below the minimum size of 10 employers presented some concern during implementation. The rules give a cooperative the opportunity to address this problem by allowing it to add new employers during the next required open enrollment period. If, after completion of the next open enrollment period, the cooperative continues to have less than 10 employers, the carrier may terminate the contract at the carrier's option. This standard is similar to treatment of individual employer groups that fall below minimum participation or contribution levels.

Financial Hardship:[62]

- The rule allows cooperatives to contractually define financial hardship. However, if the cooperative chooses not to address the issue by contract, the proposed rules deem financial hardship to occur when an employer demonstrates its premium costs to gross receipts ratio has increased by a factor of at least .50. This is another area where carriers and cooperatives may reach agreement to ensure all are comfortable with both the stability and flexibility of the cooperative.

Previously Uninsured:[63]

- The rule defines an uninsured employee or dependent for the purposes of the S.B. 10 premium and retaliatory tax exemption. The term includes an individual insured through a cooperative that lacked creditable coverage for 63 days preceding the

[61] *Id.*
[62] *Id.*
[63] *Id.*

effective date of the coverage purchased through the cooperative.[64] This standard is consistent with the Health Insurance Portability and Accountability Act definition of a significant gap in coverage. A carrier must maintain documentation demonstrating an insured's qualification for the exemption.

Currently, only one cooperative has filed with TDI and only one carrier has expressed an interest in writing a policy. TDI continues to provide assistance to carriers, employers, and agents interested in health care cooperatives.

Stakeholder Positions

National Federation of Independent Business

National Federation of Independent Business (NFIB) has persistently pursued solutions to rising cost problems for employers that provide health insurance. According to testimony before the Committee, 40 percent of NFIB members are currently without insurance.[65] NFIB contributed to the development and implementation of S.B. 10 and group members believe the concepts could become a model for future national and state programs.

Primarily, NFIB advocates for flexibility from state mandates and regulations for the cooperative carriers. This flexibility should provide greater opportunity for the carriers to offer a viable and successful product to Texas businesses. NFIB shares the concern that allowing a single pool with both large and small businesses is an administrative challenge.[66] This challenge will create too great an unknown for the carriers to comfortably set rates. With the complexity of state law and the mixture of these two insurance groups, NFIB leaders worry carriers will not be able to assess their risk and therefore, not write policies for this Texas market.

Texas Association of Business

The Texas Association of Business (TAB) has also been involved in the development of S.B. 10 policies.[67] Expanding on the concerns regarding the separation of large and small businesses, TAB members believe it is imperative for the state to remove the application of "small business regulations" to small businesses within a cooperative.[68] A primary reason referenced for small businesses to choose cooperatives before going at it alone, is the benefit of a larger cooperative purchasing power. However, the restriction of the small business regulations on what is now a large group of small businesses may compromise the success of the cooperative approach.[69] Once these small businesses group together they no longer resemble a single small

[64] *See* 28 T.A.C. § 26.405 (2004). Pursuant to 28 T.A.C. § 21.1101(5) an individual's coverage is "creditable" if the coverage is provided under one of the health plans listed in the rule (e.g. an ERISA-qualified group plan; a state or political subdivision risk pool).
[65] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Jeff Clark, National Federation of Independent Business).
[66] *Id.*
[67] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Bill Hammond, Texas Association of Business).
[68] Chapter 26 of the Department's rules implements the provisions of the Health Insurance Portability and Availability Act relating to small and large employers. Subchapter A sets out specific regulations relating to small employer health insurance. These "small business regulations" currently apply to cooperatives made up of small and large employers. *See* 28 T.A.C. ch. 26 (2004); 28 T.A.C. § 26.404(c) (2004).
[69] *Id.*

business but rather a larger entity, and should therefore benefit from being regulated as a large business.

In addition to the concepts contained in S.B. 10, TAB members spoke to the more general issue of reducing the rising cost of health care. According to testimony, TAB leadership feels rising costs could be impacted by policies that more adequately inform health care consumers of the actual cost of health care.[70] Today, most employees quantify the cost of their health care only as the personal, out-of-pocket expenses (co-insurance, co-payments, premiums, etc.). Policies that make the actual cost more transparent and available to both employer and employee could curb overall costs of health care by encouraging the consumer to make more appropriate health care choices. Similarly, TAB members support consumer direct care programs such as Health Care Accounts (HCAs) and Health Savings Accounts (HSAs).[71] As these types of programs continue to be developed and approved under federal law, it is important that Texas investigate them as possible options for Texans.

Texas Association of Health Plans

Scott & White Health Plan testified on behalf of the Texas Association of Health Plans (TAHP).[72] They are a non-profit health plan that has been providing health care plans in the Central Texas region for 22 years. Their leadership is supportive of the cooperative concept and believe it is a viable option to help address problems in offering employee health insurance.

TAHP assisted TDI and the bill author during the rulemaking and implementation process. This involvement by the TAHP was important to ensure the cooperative rules would be written and established in such a way to create the least regulatory interference and greatest amount of stability.

It is generally accepted that most insurance reform takes quite some time to have the desired impact. Therefore, the effects of S.B. 10 are still developing. Its impact will be determined in the future. As an example, the changes in S.B. 10 required more than one year to develop and will most likely take one to two years for employers to have sufficient information to take advantage of a health care cooperative option.[73]

Members of TAHP agree with NFIB and TAB that large and small employers within health care cooperatives should be in separate pools.[74] The combination of small and large employers creates too great an unknown in growth of covered lives for the carriers to comfortably set rates and assess risk. Additionally, TAHP concurs that "small business regulations" should not be applied to small businesses that have formed a cooperative. Once these small businesses have joined a cooperative, now appearing as a large employer, they should not be subject to the more restrictive small business regulations.[75]

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[70] *Id.*
[71] *Id.*
[72] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Alan Einboden, Scott & White Health Plan on behalf of Texas Association of Health Plans).
[73] *Id.*
[74] *Id.*
[75] *Id.*

Finally, TAHP testified that the incentives in S.B. 10 are being recognized by the carriers and are serving as incentive for their participation.[76] The success of cooperatives depends upon these groups being regulated differently than a normal health plan. The specialized, regulatory provisions contained in S.B. 10 should provide specific advantages to this market, help attract a wide spectrum of interest, and avoid attracting only high-risk groups.

Recommendations[77]

Pursuant to the direction in the charge, the Committee focused on implementation of S.B. 10 and S.B. 541 and did not debate the underlying concepts. To that end, the recommendations simply reflect clarification of legislative intent and do not reflect substantive changes in the policies as passed by the 78th Legislature.

3.a. The Legislature should consider dividing cooperatives into two groups – small employers and large employers. This option would allow employers of all sizes to purchase coverage through a cooperative while resolving concerns about administering groups from both markets in a single entity.[78]

3.b. The restrictions of "small business regulations" could negatively impact the benefits of S.B. 10. Accordingly, the Legislature should consider excluding small businesses within a health care cooperative from the "small business regulations."

3.c. During the rulemaking process, questions arose as to whether the carriers' participation was voluntarily with a health care cooperative. That issue was clarified in the final version of the rule which stated that participation was voluntary. However, interested parties would like to see the issue finally resolved in statute.

Senate Bill 541 - Consumer Choice Health Benefit Plans

Background[79]

Senate Bill 541, as passed during the 78th Regular Session, amended Insurance Code chapters 3, 20A and 26 to increase the availability of health care coverage by giving employer groups and individuals the opportunity to purchase Consumer Choice Plans.[80] These are health benefit plans that, in total or part, do not offer or provide state-mandated health benefits. For small employers, the bill also deleted the requirement that small employer carriers offer the promulgated catastrophic care and basic service plans. Instead, the new law requires those carriers to offer small employers the opportunity to purchase a Consumer Choice Plan in addition to a plan that contains all state-mandated benefits. It also changed the definition of basic health care services for purposes of Health Maintenance Organization (HMO) benefits. Although the bill did not take effect until January 1, 2004, Texas Department of Insurance (TDI) first

[76] *Id.*
[77] Recommendations are supported by Senate Bill 10 author, Senator Kip Averitt.
[78] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[79] *Id.*
[80] Acts 2003, 78th Leg., ch. 1179.

approved an indemnity insurance consumer choice plan on November 20, 2003, and an HMO consumer choice plan on November 14, 2003.[81]

Discussion

Texas Department of Insurance Position

TDI adopted rules to implement S.B. 541 on May 9, 2004. These rules delineated the state-mandated benefits that a carrier does not have to include in Consumer Choice Plans; established required carrier notices and disclosures to employers; established procedures for offering plans to consumers; and required carriers to report certain information to TDI.[82]

Implementation Issues[83]

As part of TDI's rulemaking process, many parties contributed comments, both formal and informal, during the development of the rule. Four issues arising during the implementation are discussed below.

Handling of disclosure statement.

- The disclosure statement verifies that applicants and policyholders understand the scope and/or limitations of coverage under a Consumer Choice Plan. The Insurance Code requires each applicant for initial coverage and each policyholder upon renewal of coverage to sign the disclosure statement provided by the carrier and return it to the insurer.[84]

Right to a copy.

- Although the statutory language does not address the applicant/policyholder's right to a copy of the disclosure statement, TDI has included this right in its rule.[85]

Return of signed statement.

- The statute does not address what happens if the policyholder, upon renewal, does not return the signed statement. TDI recognized that a policyholder may not complete its obligation to sign and return the disclosure and sought to determine an appropriate remedy. Absent an appropriate rule, the only direct action available against the policyholder would be cancellation/nonrenewal, which would be contrary to the goals of the legislation. Thus, TDI's remedy was to require the carrier to verify that it provided the disclosure to the policyholder. However, whether the policyholder chooses to sign and return the form is beyond the control of the carrier or TDI. Therefore, TDI requires a signed and returned disclosure statement from the policyholder before the carrier will process the

[81] *See* Appendix III for TDI's S.B. 541 Implementation Timeline.
[82] 28 T.A.C. ch. 21, subch. AA (2004).
[83] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[84] TEX. INS. CODE Arts. 3.80, §6(b); 20A.09N(h) (Supp. 2004-05).
[85] 28 T.A.C. § 21.3530(e) (2004).

application.[86] This process ensures required disclosure without punishing carriers that appropriately distributed the disclosure statement when the policyholder is non-compliant.

Scope of distribution.

- Some of the comments to the proposed rules advocate requiring carriers that issue group plans to provide a copy of the disclosure to all certificate holders, not just to the group policy or plan holder. However, TDI declined to require carriers to expand disclosure to this level. TDI will monitor complaints to determine whether problems arise related to the absence of disclosure to individual enrollees.

Diabetes coverage.

- S.B. 541 provisions exclude "supplies and services associated with the treatment of diabetes" from the definition of "state-mandated health benefits", thus requiring Consumer Choice Plans to comply with mandatory coverage for diabetes care.[87] However, the portion of the bill addressing HMOs inadvertently left out the necessary parallel reference.[88] Recognizing this inadvertent omission, TDI's rule does require HMOs to comply with the state-mandated coverage of supplies and services associated with the treatment of diabetes.

Uniformity of names.

- S.B. 541 refers to Consumer Choice Plans by various terms, including "consumer choice of benefits health insurance plan" and "standard health benefit plan." The corresponding HMO portions of the bill present the same inconsistency. TDI's rule uses the term "consumer choice health benefit plan" to refer to the health plans the statute authorizes.

HMO coverage of non-network referrals.

- S.B. 541 requires coverage for referral to a non-network physician or provider when medically necessary covered services are not available through network physicians or providers.[89] This provision is also directed toward HMOs, but the portion of the bill addressing HMOs does not include the necessary cross-reference. In keeping with legislative intent, TDI's rule, however, requires HMOs to comply with this requirement.

Stakeholder Position

Texas Association of Business

The Texas Association of Business (TAB) sees S.B. 541 as a vehicle for reducing costs to employers providing health care. The benefits are particularly beneficial for small businesses. According to testimony by TAB staff, their membership has already been impacted even in the

[86] 28 T.A.C. § 21.3535 (2004).
[87] TEX. INS. CODE art. 3.80, §3(b)(6) (Supp. 2004-05).
[88] TEX. INS. CODE art. 20A.09N (Supp. 2004-05).
[89] *See generally,* TEX. INS. CODE art. 20A.09(a)(3)(C) (Supp. 2004-05).

short time since S.B. 541's passage.[90] TAB provided examples of a Preferred Provider Organization (PPO) plan with a 16 percent reduction in costs and a Health Maintenance Organizations (HMO) with a 12 percent to 45 percent reduction in costs.[91] TAB suggested the State could go further to allow carriers to offer exclusive provider networks. These carrier-established networks would be under the control of the carriers, allowing them to dictate which services will be provided for these policyholders.

National Federation of Independent Business

Similar to TAB, the National Federation of Independent Business (NFIB) is supportive of and has participated in the implementation of S.B. 541. In addition to that support, NFIB staff said the provision in S.B. 10 that provides a premium tax credit for moving employees from being uninsured to insured should be applied to plans created under S.B. 541.[92] This tax credit provides carriers with an incentive to attract businesses to find alternative means of providing health care to their employees and could reduce the number of the employed uninsured.[93.]

Texas Association of Health Plans

Scott & White Health Plan testified on behalf of the Texas Association of Health Plans (TAHP).[94] Scott & White filed a Consumer Choice Plan in January 2004. The plan was approved in March 2004 and the company has subsequently started to offer these type of plans in Texas. While the provisions of S.B. 541 have become effective, Scott & White continues to indicate the full impact has yet to be seen. Scott & White projects the benefits will continue to unfold as more time passes.[95]

Scott & White's testimony provided examples from their health plans as to the reduction of costs to the health plans under a Consumer Choice Plan.[96] Scott & White offers an HMO plan for independent, small and large businesses, with a $250 deductible, $30 office visit and 20 percent coverage for all other services. Under this Consumer Choice Plan, Scott & White has implemented a 26.5 percent reduction in price.

Scott & White created a 24 hour-a-day, 7 days-a-week, on-call nurse service to answer individual concerns or questions regarding appropriate access to medical care under Consumer Choice Plan health plans. They also have an online medical dictionary and assistance site to further help their Consumer Choice Plan clients.[97]

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[90] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Bill Hammond, Texas Association of Business).
[91] *Id.*
[92] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Jeff Clark, National Federation of Independent Business).
[93] Seventy-five percent of the uninsured in Texas are employed or are living in employed households. Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Bill Hammond, Texas Association of Business).
[94] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Alan Einboden, Scott & White Health Plan on behalf of Texas Association of Health Plans).
[95] *Id.*
[96] *Id.*
[97] *Id.*

Consumer Groups

Texas Diabetes Association

During the 78th Session, the Texas Diabetes Association was able to ensure that the mandated coverage for supplies and services associated with the treatment of diabetes are included in plans created under the provisions in S.B. 541. While pleased with that success, they are still working to guarantee that the coverage is correctly enforced.[98] The Association has heard anecdotes describing lack of coverage for the entire spectrum of diabetes care. For example, the question of a health plan not covering dialysis services was discussed. However, at the time of the testimony, the Texas Diabetes Association was unable to discern whether this example related to coverage under a Consumer Choice Plan or a fully mandated benefit plan.[99]

Multiple Sclerosis Society, Texas Chapter

The Texas MS Society has been an active participant in the discussions surrounding the impact of S.B. 541 and testified to the Committee on behalf of a variety of consumer advocacy groups. Consumer groups' discussions about the impact of S.B. 541 revolve around four key concerns: (1) realized premium savings for employer are costs that are passed on to employees; (2) appropriate levels of consumer awareness and education; (3) potential negative impact on the uninsured; and (4) more extensive data collection.[100]

First, the Texas MS Society's analysis of the TDI approved plans indicates savings for the employers in premium cost reduction. However those savings are merely a cost shift to the employee. The highest estimated savings from these plans are derived from a carrier's ability to increase the enrollee's share of costs rather than the elimination of mandated coverage of specific illnesses and treatments.[101] As the carriers offer health plans with much higher deductibles, an employee with a chronic disease will very easily pay the maximum deductible year after year.[102]

Second, there is concern whether Plan consumers are sufficiently educated and receive proper disclosure in regard to coverage and/or limitations of these types of plans. The provisions of S.B. 541 provide for disclosure of scope and cost of coverage for the employers. However, consumer groups feel the employee, in light of the costs being passed to them, should be considered a consumer of the plans equal to the employer and therefore entitled to the disclosure information.[103] This disclosure should provide complete information regarding what is and is not covered. Additionally, these groups advocate for TDI to create an employee education program to help the employees better understand these unique coverage plans. They fear the average

[98] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Veronica De La Garza, American Diabetes Association on behalf of Texas Diabetes Association).
[99] *Id.*
[100] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Suiter, MS Society, Texas Chapter).
[101] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[102] $0 - $7500 per individual and $0-$22,000 per family annual premium. Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Suiter, MS Society, Texas Chapter).
[103] *Id.*

person does not fully understand the plans' complexities and are not equipped to decide if a reduced coverage plan adequately fulfills their medical needs.

Third, consumer groups question whether these plans will have the desired effect of moving the uninsured to the rolls of the insured. Testimony cited a TDI study of 13,000 small employers. According to the study, the average monthly premium per employees is $218 each month. Further, 75 percent of the employers surveyed could only really afford a $100 per month premium for employees.[104] Therefore, employers would need to realize a 55 percent reduction in premium costs to get to the $100 per month rate. According to TDI, for indemnity plans, the savings estimates are generally in single digits, but range as high as 38.3 percent. HMOs filing consumer choice plans have estimated generally greater cost savings, with the highest estimate being a 26.5 percent savings.[105] With this data, those savings are not at the 55 percent reduction level needed to get to the reported $100 per month rate. Therefore, the reductions may not be sufficient to impact a large number of employed uninsured.[106]

Additionally, consumer groups fear the availability of consumer choice plans will entice large employers that currently offer full coverage plans to move to a consumer choice plan rather than entice small employers that offer no health plans to offer a consumer choice plan. They assert this movement is encouraging employers to move from fully insured plans to, what may be considered underinsured plans. In effect, such plans do not attract the uninsured but rather increase the numbers that are underinsured.[107]

Finally, consumer groups would like to see more information and data collected to better understand the dynamics of the costs and changes to health care insurance policies.[108] They would like to see the following collected and reported: number of individuals that are moving from uninsured to insured using fully mandated benefits plans; number of large employers that move from full coverage plan to a consumer choice plan; comparison of most popular health plans with consumer choice plans on how much of the savings/costs are passed on to the employees and whether that amount exceeds the premium savings realized by the employers.[109]

Recommendations

While carriers have been offering consumer choice plans since the bill took effect, reports required by the rules are not yet due. Informal queries of carriers indicate they cannot yet fully gauge the effect of these plans on the employer and individual markets. Therefore, it is not

[104] Fourteen percent of small employers would not provide health insurance regardless of price. *Id.*
[105] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[106] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Suiter, MS Society, Texas Chapter).
[107] *Id.*
[108] To this point, TDI has been cooperative and open with the consumer groups in regard to the requests for further data collection and analysis. *Id.*
[109] *Id.*

possible to accurately report the specific factors affecting the availability and affordability of these plans at this time.[110] The Committee recommends the Legislature consider the following:

3.d. Ensuring the coverage for supplies and services associated with the treatment of diabetes is included in the HMO portion of the statutory provisions for Consumer Choice Plans;

3.e. Providing that dialysis is a treatment associated with the care of diabetes; and[111]

3.f. Ensuring the HMO requirement for coverage of referral to a non-network provider when medically necessary, covered services are not available through network providers is included in the statutory provisions for Consumer Choice Plans.

Charge No. 4

Study the April 2003 United States Supreme Court decision in Kentucky Association of Health Plans v. Miller to determine its impact on Texas laws regulating health insurance plans under the Employee Retirement Income Security Act of 1974 (ERISA) and make recommendations to changes in state law to conform with recent federal court decisions.

The Committee examined two recent decisions by the United States Supreme Court relating to health insurance plans governed by the Employee Retirement Income Security Act of 1974 (ERISA).[112] In *Kentucky Ass'n of Health Plans v. Miller*,[113] the Court effectively reversed a prior Fifth Circuit opinion which held that the "any willing provider" provisions of the Texas Insurance Code were invalid because they were preempted by ERISA. Therefore, the existing provisions are, arguably, not preempted by ERISA and are enforceable.

In *Aetna Health Inc. v. Davila*,[114] the Court struck down the Texas Health Care Liability Act (THCLA) provisions that create a private cause of action against health insurance carriers, HMOs and other managed care entities for failure to exercise ordinary care when making health treatment decisions. The Court held that determinations of plan coverage are not treatment decisions and therefore, the state law cause of action is preempted by ERISA in qualified plans.

Kentucky Ass'n of Health Plans v. Miller -- "Any Willing Provider" Statutes

In *Kentucky Ass'n of Health Plans v. Miller*, health maintenance organizations (HMOs) challenged Kentucky's "any willing provider" ("AWP") statutes. Kentucky's AWP statutes prohibit HMOs from discriminating against any provider within the relevant geographic area who is willing to meet the terms and conditions for participation in the HMO network. In other words, an HMO must let any willing provider participate in its network. The HMOs challenged the AWP laws on the grounds that they were preempted by the ERISA. In a unanimous decision

[110] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[111] *Id*. TDI has approved at least one CCP health plan that opted not to cover dialysis services. Discussion with the bill author lead to the need for ensuring that those services be covered under the diabetes mandated coverage.
[112] *See* Appendix IV for Supreme Court slip opinions.
[113] 538 U.S. ___, 123 S. Ct. 1471 (2003).
[114] 542 U.S. ___, 124 S. Ct. 2488 (2004).

the Court held that AWP laws "regulate insurance" and therefore are not preempted by ERISA under the "savings clause."[115]

The Court's decision in *Miller* was the latest in a long line of decisions interpreting ERISA's "savings clause" which exempts from preemption "law[s]…which regulat[e] insurance, banking, or securities."[116] The McCarren-Ferguson Act, an antitrust law, also includes a similar preemption exemption for laws that "regulate insurance."[117] Over the years, lower courts had held that the question of whether a law would be interpreted to "regulate insurance" depended upon satisfaction of a three-part test developed by the Supreme Court for the McCarren-Ferguson Act savings clause.[118] This is precisely what the federal district court and the United States Sixth Circuit Court of Appeals did; and both lower courts held that Kentucky's AWP laws passed the three-part test and were not preempted by ERISA.[119]

The Supreme Court affirmed the lower courts, but most importantly, the Court seized the opportunity to expressly state that the traditional antitrust principles did not apply and that ERISA's savings clause should be interpreted broadly.[120] In place of the three-part-McCarren-Ferguson Act test the Court set out two clear factors for determining whether a statute qualifies for the ERISA preemption exception: (1) "the state law must be specifically directed toward entities engaged in insurance;" and (2) "the state law must substantially affect the risk pooling arrangement between the insurer and the insured."[121] Based on these two factors, the Court held that Kentucky's AWP statute was not preempted by ERISA.

Discussion -- Application to Texas Law

Texas does not have a blanket AWP statute like that upheld by the Supreme Court in *Miller*. However, Texas does have an AWP statute relating solely to pharmacists and pharmacies, Texas Insurance Code Article 21.52B, Section 2, and this provision is affected by the Supreme Court's decision.

Texas' pharmacy AWP statute has an interesting history. It was adopted by the Legislature and became effective September 1, 1991. As adopted in 1991 it read in part:

> (a) A health insurance policy that is delivered, issued for delivery, or renewed or for which a contract is executed may not:
>
> . . . (2) deny a pharmacy or pharmacist the right to participate as a contract provider under the policy if the pharmacy or pharmacist agrees to provide pharmaceutical services that meet all terms and requirements and to include the

[115] Miller, 123 S. Ct. at 1472.
[116] 29 U.S.C. § 1144(b)(2)(A).
[117] 15 U.S.C. § 1012.
[118] Miller, 123 S. Ct. at 1478-79.
[119] Community Health Partners, Inc. v. Nichols, 14 F. Supp.2d 991 (W.D. KY 1998); Kentucky Ass'n of Health Plans v. Nichols, 227 F.3d 352 (6th Cir. 2000).
[120] The Supreme Court distinguished the McCarren-Ferguson factors by noting that they were relevant to characterizing conduct by private actors and not state laws and what they regulate. Miller, 123 S. Ct. at 1476-77, 1479.
[121] *Id.* at 1479.

> same administrative, financial, and professional conditions that apply to pharmacies and pharmacists who have been designated as providers under the policy.[122]

Four years after it was enacted, in 1995, the Texas Pharmacy Association sued Prudential Insurance Company for violations of the AWP statute.[123] In that case, Prudential argued the AWP statute was preempted by ERISA and was therefore unenforceable. However, the federal district court held that the pharmacy AWP statute was a "law relating to insurance" and was therefore exempt from preemption under ERISA's "savings clause."[124] Prudential appealed the decision to the United States Fifth Circuit Court of Appeals. While the issue was pending before the Fifth Circuit however, the 74th Legislature amended the pharmacy AWP statute to provide in part (amendments emphasized):

> (a) A health insurance policy *or managed care plan* . . . may not:
>
> . . . (2) deny a pharmacy or pharmacist the right to participate as a contract provider under the policy *or plan* if the pharmacy or pharmacist agrees to provide pharmaceutical services that meet all terms and requirements and to include the same administrative, financial, and professional conditions that apply to pharmacies and pharmacists who have been designated as providers under the policy *or plan*.[125]

The amendments also added a section that defined a "managed care plan" to include "a health maintenance organization, a preferred provider organization, or other organization that, under a contract or other agreement entered into with a participant in the plan . . . provides health care benefits . . . ."[126]

The Fifth Circuit handed down its decision in *Tex. Pharmacy Ass'n v. Prudential Ins. Co. of America* in February of 1997.[127] The Court reviewed the amended version of the pharmacy AWP statute in effect in 1997. Based on the 1995 amendments, the Court held that the AWP statute was not excepted from preemption by ERISA.[128] The Court analyzed the statute against the three-part-McCarren-Ferguson Act test and held that consistent with the Supreme Court's decision in *Metropolitan Life Ins. v. Massachusetts*, Texas' pharmacy AWP law failed the third factor of the test.[129] The Court reasoned that the addition of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and "other organizations" broadened the scope of the AWP statute to entities outside of the insurance industry. The Court did note that absent the 1995 amendments, the pharmacy AWP statute would have passed the test and been saved from ERISA preemption.[130]

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[122] Acts 1991, 72nd Leg., ch. 182, § 1.
[123] Tex. Pharmacy Ass'n. v. Prudential Ins. Co. of America, 907 F. Supp. 1019 (W.D.Tex. 1995).
[124] *Id.* at 1026.
[125] Acts 1995, 74th Leg., ch. 852, §§ 1, 2, 3, and 4.
[126] *Id.*; TEX. INS. CODE ART. 21.52B §1(6) (Supp. 2004-05).
[127] 105 F.3d 1035 (5th Cir. 1997).
[128] *Id.* at 1038.
[129] *Id.* (*citing* Metropolitan Life Ins. v. Mass., 471 U.S. 724, 105 S. Ct. 2380 (1985)).
[130] *Id.* at 1040.

There is another interesting facet to the pharmacy AWP statute. The Fifth Circuit noted that the original 1991 legislation contained a "nonseverability clause."[131] Section 3 of the bill read:

> If any provision of this Act or if application to any person or circumstance is held invalid, this entire Act is invalid and to that end the provisions of this Act are not severable.[132]

Based on this nonseverability clause, the Fifth Circuit held the entire AWP statute invalid, not just the portions applicable to HMOs, PPOs and "other organizations."[133]

Prior to the Supreme Court's decision in *Miller*, Texas' pharmacy AWP statute was invalid based on the Fifth Circuit's opinion in *Tex. Pharmacy Ass'n*. Now that the Supreme Court has expressly stated that the three-part-McCarren-Ferguson Act test does not apply to ERISA preemption questions, Texas' pharmacy AWP statute is, arguably, not preempted by ERISA and is enforceable. The only question remaining is whether the statute satisfies the two factors outlined by the Court: (1) "the state law must be specifically directed toward entities engaged in insurance;" and (2) "the state law must substantially affect the risk pooling arrangement between the insurer and the insured." Based on the reasoning of the Court in *Miller*, Texas' pharmacy AWP statute should pass this test.

Recommendations

4.a. To provide clarification of the current effect of the pharmacy any willing provider statute, the Committee recommends that the Legislature reconsider this issue. If the public policy considerations underlying Article 21.52B are still valid and appropriate, the provision should be reenacted in accordance with the holding in *Miller*. If the public policy considerations are no longer appropriate, the statute should be repealed. Additionally, the Committee recommends that the non-severability clause included in the 1991 Session Laws be reexamined.

Aetna Health Inc. v. Davila -- Independent Cause of Action

Another recent decision decided by the Supreme Court, *Aetna Health Inc. v. Davila*,[134] relates directly to Texas law. In 1997, the 75th Legislature enacted the Texas Health Care Liability Act (THCLA).[135] The Act amended the Texas Civil Practice and Remedies Code to hold health insurance carriers, HMOs and other managed care entities liable for failure to exercise ordinary care when making health treatment decisions. Additionally, the Act created standards under the Texas Insurance Code for the creation of utilization review and independent review organizations.[136]

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[131] *Id.* at 1039.
[132] Acts 1991, 72nd Leg., ch. 182, § 3.
[133] Tex. Pharmacy Ass'n, 105 F.3d. at 1039.
[134] 542 U.S. ___, 124 S. Ct. 2488 (2004).
[135] Texas Health Care Liability Act., TEX. CIV. PRAC. & REM. CODE §§ 88.001-88.003 (Supp. 2004-05).
[136] TEX. INS. CODE art. 21.58A (Supp. 2004-05).

In *Davila*, patients sued their HMOs under the THCLA for refusing to cover certain medical services in violation of an HMO's duty to exercise ordinary care. Plaintiffs Juan Davila and Ruby Calad were covered by ERISA-regulated employee benefits plans, Aetna Health, Inc. and CIGNA Healthcare of Texas, respectively.[137] Plaintiff Davila took a prescription medication which caused him to have a severe negative reaction after Aetna refused to pay for the specific medication prescribed by his physician. Plaintiff Calad experienced post-surgical complications after being discharged from the hospital post-surgery, contrary to her physician's recommendation that she extend her hospitalization period. Both Plaintiffs asserted that the Defendants' refusal to cover the requested service violated the duty to exercise ordinary care and that such refusal proximately caused the Plaintiffs' injuries.[138]

Aetna and CIGNA removed the cases to federal court, asserting that the Plaintiffs' claims were preempted by the remedies available under ERISA. The federal district court agreed.[139] Plaintiffs appealed to the United States Fifth Circuit Court of Appeals which reversed the District Court holding that because the Act did not duplicate the ERISA causes of action, the claims were not pre-empted by ERISA.[140] Thereafter, Defendants appealed to the United States Supreme Court.

In a unanimous opinion written by Justice Thomas, the Supreme Court held that the patients' THCLA claims were preempted by ERISA because the patients could have brought their claims under ERISA § 502(a)(1)(B).[141] The Court rejected the argument that the claims were independent from any ERISA duty and not preempted. The Court clearly stated that decisions regarding plan coverage were not "treatment decisions" but were coverage determinations and appeals of these determinations were preempted by ERISA.[142]

Discussion

In *Davila*, the Supreme Court went to great lengths to explain the legislative intent regarding ERISA, namely, to provide uniform regulation of employee benefit plans.[143] These regulations include extensive civil enforcement procedures balancing the need for an efficient and workable system while still encouraging the formation of employee benefit plans. The Court, citing its ruling in *Pilot Life Ins. Co. v. Dedeaux*, opined that the intent of ERISA would be thwarted if ERISA-plan participants and beneficiaries could obtain remedies outside of those articulated in ERISA.[144] Specifically, the Court found that allowing respondents to proceed with their state-law suits would pose an obstacle to the purposes and objectives of Congress.[145]

Ultimately, the Supreme Court did not completely strike down the THCLA, but found that any state-law cause of action that duplicates, supplements, or supplants the ERISA civil

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[137] Davila, 124 S. Ct. at 2493.
[138] *Id.*
[139] Davila v. Aetna Health Inc., 4:00-CV-1855-Y (N.D. Tex. 2001).
[140] Roark v. Humana Inc., 307 F.3d 298 (5th Cir. 2002).
[141] Aetna Health Inc., 124 S. Ct. at 2498.
[142] *Id*.
[143] *Id.* at 2495.
[144] *Id.* (*citing* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52-54 (1987)).
[145] *Id.*

enforcement remedy conflicts with the Congressional intent to make the ERISA remedy exclusive and is pre-empted.[146] As a result, the cause of action created by the THCLA was rendered invalid except as it may still apply to non-ERISA group health plans. However, to date, there are only a few non-ERISA group health plans offered in Texas.

The THCLA will continue to be effective in the event the HMOs do in fact control the care that is provided. For example, in *Pegram v. Herdrich*, the plaintiff's treating physician was also the person charged with administering the plaintiff's benefits and it was that physician who decided whether certain treatments were covered.[147] The Supreme Court reasoned that "the physician's eligibility decision and the treatment decision were inextricably mixed."[148]

Although the cause of action portion was severely limited by the Court, a number of other provisions in the THCLA remain intact. Specifically, the standards for utilization reviews and independent review organizations created under the THCLA will continue in effect as they did prior to the ruling in *Davila*.[149]

Recommendations

4.b. Under the Supreme Court's ruling in *Davila*, the cause of action created by the Texas Health Care Liability Act (THCLA) is pre-empted under the federal ERISA statute with respect to employee health benefits plans established under ERISA. The provisions under the THCLA that do not relate to the cause of action are unaffected by the Court's ruling. The Committee recommends revising the THCLA to accurately reflect the sections affected by the *Davila* ruling.

Charge No. 5

Study the reimbursement methodology of health care plans operating in Texas for out-of-network claims, specifically focusing upon the reimbursement of "usual and customary" charges, and make recommendations on how to improve their effectiveness. The study and recommendations should encompass all plans, including those participating in Texas' Medicaid managed care program and should consider federal and state laws as well as Health & Human Services Commission rules relating to the reimbursement of out-of-network claims.

Background and Discussion

Out-of-network claims are a component of managed care plans. However, the reimbursements paid to providers and the percentage of the patients' benefit covered are addressed differently in the two types of managed care plans (HMOs and PPOs). In Health Maintenance Organizations (HMO), plans typically require enrollees to use network providers and hospitals only. The individual's personal gatekeeper physician must provide a referral to go

[146] *Id.*
[147] Pegram v. Herdrich, 530 U.S. 211 (2000).
[148] *Id.* at 229.
[149] *See* TEX. INS. CODE art 21.58A (Supp. 2004-05).

to a specialist or provider outside the HMO's network for treatment.[150] Preferred Provider Organizations (PPO) provide higher levels or percentages of reimbursement if the patient goes to PPO network providers and hospitals who have agreed to provide services.[151] In both instances, the plan's network has agreed to a contractual rate with the carrier that is often less than the billed charges rate in exchange for the patient volume experienced as the exclusive or preferred plan provider.

Each of these plans is set up in a way to create incentives for those covered to use the in-network facilities as much as possible. These incentives help the plans manage costs of health care and therefore, justify the lower reimbursement rate paid to in-network providers. However, in the normal course of business, there are instances where out-of-network becomes a necessity or a more appealing option. An individual enrolled in a managed care plan may receive out-of-network services:[152]

- in a PPO plan on a voluntary basis if the insured chooses to seek care outside the network (with this choice, the individual bears an increased out-of-pocket expense);
- in all managed care plans, in emergency situations where it was unreasonable to seek care from an in-network provider; and
- in all managed care plans, due to the unavailability of services from an in-network provider.

The health plans are not obligated by contract to reimburse the out-of-network providers at a pre-established rate. After an individual accesses an out-of-network service, the plan and provider must agree to a rate of reimbursement. However, in certain circumstances, that rate of reimbursement to those providers is dictated by the Texas Insurance Code, as follows:

- In PPO plans, "if the insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits…."[153] Further, "if services are not available through preferred providers within the service area, non-preferred providers shall be reimbursed at the same percentage level of reimbursement as the preferred providers would have been reimbursed had the insured been treated by them."[154]
- For HMOs, "if medically necessary covered services are not available through network physicians or providers, the health maintenance organization, on the request of a network physician or provider, within a reasonable period, shall allow referral to a non-network physician or provider and shall fully reimburse the non-network physician or provider at the usual and customary or an agreed rate."[155] And, "A health maintenance organization

[150] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[151] *Id.*
[152] *Id.*
[153] TEX. INS. CODE art. 3.70-3C(5) (Supp. 2004-05).
[154] TEX. INS. CODE art. 3.70-3C(8)(b) (Supp. 2004-05).
[155] TEX. INS. CODE art. 20(A).09(f) (Supp. 2004-05).

shall pay for emergency care services performed by non-network physicians or providers at the negotiated or usual and customary rate…."[156]

In circumstances outside the bounds of the above referenced statutory direction, out-of-network reimbursements are paid through negotiations between providers and health plans. These rates, and some of the above provisions, are based on the "usual and customary" rate for the service provided. "Usual and customary" rates are not defined in the Texas Insurance Code, but are set by the health plan carriers. However, the Texas Department of Insurance (TDI) regulations define reasonable and customary charges as:[157]

> The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments, or supplies; provided the charge is not excess of the general level of charges made by others who render or furnish the same or similar services, treatments, or supplies to persons: (1) who reside in the same service are; (2) whose illness or injury in comparable in nature and severity.[158]

Due to the lack of statutory definition, the policy language concerning "usual and customary" varies between carriers. The plans reference and negotiate with a mixture of terms and standards to determine "usual and customary" rates. Examples of these terms are allowable amount, reasonable and customary, eligible expenses, and maximum allowable fee.[159] Providers testified that with this inconsistency in terminology and standards from carrier to carrier neither they nor the patient are able to adequately determine the amount of risk or out-of-pocket costs that may be billed.[160]

In order to increase transparency in the health plans' methodology, the 77th Legislature passed a measure requiring that, upon written request, a managed care entity must provide to an out-of-network provider the methodology used in determining the "usual and customary" reimbursement.[161] Providers who encounter managed care entities that refuse to disclose this information may file a complaint with the Department. At the time of the hearing, TDI had received no complaints under this provision.[162]

As a result of this out-of-network reimbursement process, providers claim to be paid a rate that is less than their billed charges and health plans claim to often pay more than their comparable, in-network rate. Both of which claim to increase the cost of health care.

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[156] TEX. INS. CODE art. 20(A).09Y (Supp. 2004-05).
[157] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[158] 28 T.A.C. § 26.27, Figure 33 (2004).
[159] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[160] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Greg Smith, Assistant Vice President Managed Care, Memorial Hermann Healthcare System on behalf of Texas Hospital Association).
[161] H.B. 2831 by Smithee (Acts 2001, 77th Leg., ch. 672); TEX. INS. CODE art. 21.60 (Supp. 2004-05). Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Suiter, Texas Department of Insurance).
[162] *Id.*

Texas Medicaid Managed Care

The Texas Medicaid Managed Care program provides a service delivery model that provides savings in comparison to the traditional Medicaid, fee-for-service model.[163] The Medicaid Managed Care model applies an HMO model of controlling costs and utilization. Currently, the managed care models are only available in certain, urban Medicaid Service Delivery Areas:

- Bexar County
- Dallas County
- El Paso County
- Harris County
- Harris County Contiguous
- Lubbock County
- South East Region
- Tarrant County
- Travis County

As in commercial managed care programs, Medicaid Managed Care out-of-network usage is unavoidable and requires a separate reimbursement methodology. The most common instances of Medicaid Managed Care resulting in out-of-network care are:[164]

- to prevent disruption of care of newly enrolled members in the midst of a course of treatment;
- based on difficulties associated with establishing a full-service network in rural regions;
- based on difficulties in contracting with physicians in particular specialties; and
- to allow members to obtain care from the nearest providers in medical emergencies, regardless of network issues.

The majority of these Service Delivery Areas' hospitals and providers have broad in-network arrangements, as well as acceptable out-of-network arrangements.[165] Historically, some providers have raised concerns regarding excessive out-of-network usage by health plans that result in instability of network benefits and higher costs.[166] To address the concerns of inappropriate out-of-network payment methodology and usage, the 78th Legislature established directives in H.B. 2292 that:[167]

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[163] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Billy Millwee, Deputy Medicaid/CHIP Director for Health Services, Texas Health and Human Services Commission).
[164] *Id.*
[165] *Id.*
[166] *Id.*
[167] House Bill 2292 was an omnibus piece of legislation that re-organized and addressed numerous facets of the State's Health and Human Services arena. Acts 2003, 78th Leg, ch. 198.

- Establish maximum limits for out-of-network access by provider type and service delivery area.
- Develop objective standards for determining network adequacy.
- Develop reasonable rate methodology for payment of out-of-network services.
- Develop a standard protocol for a corrective action plan for managed care organizations that fail to maintain an adequate provider network or that do not reimburse providers according to a reasonable rate methodology.
- Develop guidelines on managed care organization reporting of out-of-network services.[168]

In response to directives in H.B. 2292, in December 2003, the Health and Human Services Commission (HHSC) competitively awarded a contract to The Lewin Group to complete an analysis and develop recommendations related to the out-of-network provisions of Medicaid Managed Care.[169] The HHSC proposed methodology addresses five aspects of Medicaid Managed Care out-of-network services. The rules implementing these proposals have an anticipated effective date of February 2005 and are outlined below.[170]

First, to address the allegations that the health plans allow excessive utilization of out-of-network services, HMOs must establish maximum limits for out of network access:

- No more than 25 percent of a managed care organization's total hospital admission, by service area, may occur in non-contracted facilities.
- No more than 30 percent of a managed care organization's total emergency room visits, by service area, may occur in non-contracted facilities.
- No more than 30 percent of total dollars billed to a managed care organization for "other outpatient services" by service area may be billed by out-of-network providers.[171]

Second, the health plans must develop objective standards for determining network adequacy by provider type and services delivery area (each of the following standards mandates that the providers must accept new patients):

- Access to an age appropriate primary care physician within 30 miles of the member's residence.
- Access for female plan members to an OB/GYN in the provider network within 30 miles of the member's residence.

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[168] Acts 2003, 78th Leg., ch. 198 §§ 2.203, 2.35.
[169] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Billy Millwee, Deputy Medicaid/CHIP Director for Health Services, Texas Health and Human Services Commission).
[170] *Id.*
[171] *Id.*

- Access to an outpatient Behavioral Health Service Provider in the network within 75 miles of the member's residence.
- Access to a network specialist physician within 75 miles of the member's residence for common medical specialties.
- Access to an acute care hospital in the provider network within 30 miles of the member's residence.
- Access to at least one network provider for all other covered services within 75 miles of the member's residence.[172]

Third, the health plans must develop a reasonable rate methodology for payment of out-of-network services:

- *Out-of-network/In-area* - HMOs must reimburse out-of-network providers in the service delivery area no less than the fee-for-service rate less three percent.
- *Out-of-network/Out-of-area* - HMOs must reimburse out-of-network outside the service delivery area the amount mutually negotiated between the HMO and the provider.[173]

Fourth, the health plans must develop a standard protocol for a corrective action plan for managed care organizations that fail to maintain an adequate provider network or that do not reimburse providers according to a reasonable rate methodology. HMOs are required to submit a corrective action plan and report monthly on the implementation of that plan. If the HMO does come into compliance, HHSC will withhold up to five percent of all capitation funds due to the HMO until the plan comes into compliance.[174]

And finally, HHSC established standards for reporting Medicaid Managed Care, out-of-network usage. The HMOs will be required to report to HHSC:

- The total number of hospital admissions and number of admissions that occur at each out-of-network hospital.
- The total number of emergency room visits and the total number of emergency room visits that occur at each out-of-network hospital.
- The total dollars billed for all other services and the total dollars billed by out-of-network providers for all other services.[175]

Facility Based Balance Billing

Facility based balance billing occurs when health plan enrollees receive out-of-network services and are billed for the difference between a provider's billed charges and the amount paid

[172] *Id.*
[173] *Id.*
[174] *Id.*
[175] *Id.*

by the carrier to that provider. The carrier normally bases the amount it pays on what it determines to be the "usual and customary" amount for the service.[176]

Balance billing commonly occurs when an insured seeks services from an in-network facility but receives some or all of that medical care from a provider that has not contracted with the carrier.[177] For example, an individual could go to an in-network hospital and be treated by a hospital-based physician who is not an in-network, plan physician, making that encounter an out-of-network service. Once the plan and the out-of-network provider agree to an out-of-network reimbursement rate, that out-of-network provider would be permitted to bill the patient for the difference between the plan's reimbursement and those billed charges.

These encounters can occur without the knowledge of the insured who believed he was choosing an in-network provider. Currently, there are no requirements to disclose this dynamic to the patients.[178]

This practice can also impact enrollees who knowingly choose an out-of-network provider. In this instance, the individual believes their out-of-pocket expenses will only be the policy defined, out-of-network percentage of the bill. However, their expenses could be much more if their provider also balance bills the difference between reimbursement and billed charges.[179]

Attorney General Greg Abbott issued an opinion addressing the ability of TDI to assert enforcement authority over providers in these scenarios.

> [The] Health Maintenance Organization Act does not prohibit a physician who is not under contract with an HMO from billing an HMO enrollee for charges not paid by the HMO. The Department of Insurance is not authorized to enforce the Act to prohibit such a physician from balance billing an enrollee of the HMO (citations omitted).[180]

While TDI had never asserted enforcement authority over providers, prior to the Attorney General's opinion, the Department was able to encourage the parties to agree to a rate so as to protect the interest of the patient. The Attorney General Opinion has resulted in greater resistance to TDI's efforts.[181]

The health plans find that balance billing most often occurs with the hospital-based physicians, radiologists, pathologists, and anesthesiologists.[182] Under the shadow of balance

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[176] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[177] *Id.*
[178] *Id.*
[179] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance). *See also* Appendix V for examples.
[180] Attorney General Opinion, GA-0040 (2003).
[181] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[182] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Bill Thames, Chief Operating Officer, FIRSTCARE).

billing, the health plans have a difficult time negotiating with these hospital-based physicians because the doctors are receiving closer to, if not the full amount of billed charges for these services.[183] According to complaints to the health plans, hospitals present the second largest number of balance billing complaints, and account for the greater amount of dollars billed to Texans.[184] Figure 5-1 is an example of the complaint dynamics of facility-based balanced billing for FIRSTCARE.

FIRSTCARE Balance Billing Complaints
January - June 2004

Radiologists	23%
ER Physicians	11%
Pathologists	7%
Anesthesiologists	5%
Hospitals	40%
Other Physician Specialties and Ancillaries	14%

Figure 5 - 1 -- Balance Billing Complaints
Source: FIRSTCARE

Some health care providers assert that balance billing is one of their few options to rectify the inadequate reimbursements from health plans based on "usual and customary" standards. For the providers, "usual and customary" charges are vague and can vary greatly, even within a single hospital system.[185]

While hospitals do not control the health plan negotiating decisions or network status of their hospital-based physicians, there is some attempt to curb the hospital service dissatisfaction that results from unexpected balance billing. For example, Memorial Hermann requires their physicians to disclose to patients or patients' family their status in the patient's network. While tracking this disclosure is difficult, proven failure to not do so can result in non-renewal of the physician's contract with the hospital.[186]

Physicians testified that there are circumstances when out-of-network services occur unexpectedly to both patient and physician. Physicians will perform their due diligence to ensure their patients are in their network, however, health plans will carve out certain procedures

[183] *Id.*
[184] *Id.*
[185] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Greg Smith, Assistant Vice President Managed Care Administration, Memorial Hermann Healthcare System on behalf of Texas Hospital Association).
[186] *Id.*

in certain commercial contracts of which physicians are unaware.[187] These circumstances create challenges for physicians and a patient's ability to ensure they are fully aware of their financial risks in a health care encounter.

Facility Waiver of Co-payments and Deductibles

Another topic discussed during testimony was increased utilization of a waiver of patients' out-of-network co-payments and deductibles by certain facilities as incentive for patients to come to their non-network facility.[188] These facilities will entice patients by offering to waive the patients' out-of-pocket expenses that would be incurred by going to an out-of-network facility.

In the course of negotiations, the in-network hospitals accept a lower payment rate from health plans in exchange for receiving the volume of patient care from the plan's enrollees. When the financial cost containment strategy of higher co-payments for out-of-network, which encourages in-network usage, is negated by these waivers, the promised volume to the in-network hospital is compromised. This lack in volume can eventually cause the network facilities to decrease the discount they give the plans. This loss in discounts will therefore increase the cost of health care for the employers and employees in the form higher premiums.[189]

A coalition of non-profit hospital systems, Texas Association of Business and Texas Association of Health Plans have joined to fight this practice. According to testimony provided to the Committee, it is unclear if the routine practice of waiving co-payments is prohibited and if state enforcement authority is defined.[190]

On April 26, 2004, Baptist Saint Anthony's Health System filed a complaint with the Texas Department of Insurance against health care providers that routinely waive co-payments and deductibles. However, TDI lacks enforcement authority over health care providers.[191]

Recommendations

5.a. The Legislature should consider encouraging stricter enforcement of current restrictions for out-of-network facilities' waiver of co-payments, co-insurance and deductibles. The consequences associated with this prohibition should result in enforceable, state regulatory sanctions and licensure penalties.

5.b. Additionally, the Committee recommends consideration of enhancing, through adequate disclosure, the transparency of medical costs for both health plans and providers. Allowing patients to fully realize the true cost of health care results in a better understanding and possibly more appropriate utilization of health care. Realizing

[187] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Matt Thompson, President , Capitol Pediatrics Associates, on behalf of Texas Medical Association and Texas Medical Group Management Association).
[188] Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Jerry Bell, Fulbright & Jaworski on behalf of Texas Association of Health Plans).
[189] *Id.*
[190] *Id.*
[191] *Id.*

these benefits will help move the state toward better understanding and predicting the cost of health care.

5.c. In relation to the issue of facility based balanced billing, this issue, its complexity and frequency are still developing. As in many legislative quandaries, a wide spectrum of options are available ranging from disclosure to complete prohibition. Although the issue begs for legislative action, the degree of action should be fully vetted and debated. This debate should include, but not be limited to the following options:

5.c.1. Requiring full disclosure by facilities that their physicians may or may not be included in the same network structures as the facility;

5.c.2. Prohibiting balanced billing in all circumstances or, at minimum, when a patient exerted a "good faith effort" to stay within network;

5.c.3. Authorizing state regulations on contract negotiations between facilities and their physicians which would require all physicians at the facility to also negotiate to be part of the same network structures; and

5.c.4. Altering reimbursement processes to allow the patients to receive funds from the health plan for out-of-network payments therefore empowering the patients to negotiate on their own behalf for out-of-network payments.

Charge No. 6

Study the implementation of House Bill 4 and Proposition 12 in achieving lower medical malpractice rates and providing more access to affordable health care. Monitor and report on trends in medical malpractice insurance rates and the effect of tort reform on access to health care and provider shortages in certain regions, particularly along the Border.

Background

In June of 2003, the 78th Legislature adopted landmark tort reform legislation, H.B. 4, and Proposition 12, which was ratified by popular vote.[192] A key piece of H.B. 4 was a statutory cap on noneconomic damages in medical malpractice lawsuits which was constitutionally authorized by the ratification of Proposition 12.[193] New section 74.301, Civil Practice & Remedies Code, caps noneconomic damages at $250,000 per provider, up to a $750,000 maximum depending on the type of provider joined in the suit. The purpose of capping noneconomic damages in medical malpractice lawsuits was to provide relief to health care providers who were being charged high premiums by medical malpractice insurers. During the H.B. 4 debate insurers assured both the Legislature and the public that damage caps would allow them to lower the rates charged to health care providers. Lower rates would in turn help reduce the overall rate at which medical costs were rising and would allow more providers to practice in high risk specialties and in rural or low-population areas of the state. The noneconomic damage caps in H.B. 4 became effective in lawsuits filed on or after September 1, 2003.

[192] Acts 2003, 78th Leg., ch. 204; Acts 2003, 78th Leg., H.J.R. no. 3.
[193] CIVIL PRAC. & REM. CODE § 74.301 (Supp. 2004-05).

Discussion

Medical Malpractice Insurance

One year after the effective date of the tort reform measures in H.B. 4, improvements in medical malpractice insurance can be seen in the increase in the number of insurers writing policies, the current rates being charged by those insurers, and a reduction in the number of insurance claims being filed. In 1999, there were 17 companies writing medical malpractice insurance, but by 2002 the number had fallen to four. As of September 2004, there were 13 new medical malpractice carriers in the market, bringing the total number to 24; and four existing carriers announced they would expand their writings in Texas.[194] One new entrant, Advocate, MD, specifically cited H.B. 4 and Proposition 12 as the reason for entering the Texas market.[195]

Insurance Rates

In addition to increasing the availability of medical malpractice policies in Texas, H.B. 4 and Proposition 12 can be credited with reducing rates. It should be noted that the majority of policies, approximately 45.5 percent, have primary liability limits of $200,000 despite the availability of higher policy limits as either primary or secondary policies. This is especially true of policies issued by the Texas Medical Liability Insurance Underwriting Association (also known as the Joint Underwriting Association or JUA) where the percentage of policies with primary limits of $200,000 or less is about 74 percent.[196] Therefore, the H.B. 4 caps on noneconomic damages do little to affect the JUA's rates or rates on policies with lower limits.[197]

Data collected by the Texas Department of Insurance (TDI or "the Department") shows that overall, medical malpractice rates have declined since the passage of H.B. 4 and Proposition 12. The following chart illustrates approximately $78 million in premium reductions attributable to the four largest medical malpractice insurers.[198]

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[194] The number of insurers includes admitted insurers, surplus lines insurers and Risk Retention Groups. Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Jose Montemayor, Commissioner, Texas Department of Insurance).

[195] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Howard Lamb, President, Advocate, MD).

[196] The JUA was established by the Legislature in 1975 to insure physicians and other health care providers who cannot obtain insurance in the voluntary market. It is commonly referred to as the 'insurer of last resort." *See* TEX. INS. CODE art. 21.49-3 (Supp. 2004-05).

[197] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Howard Lamb, President, Advocate MD); Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Joe Chilton, General Manager, JUA).

[198] Four companies, Texas Medical Liability Trust (TMLT), Medical Protective Company (MedPro), The Doctors' Company, and Texas Medical Liability Insurance Underwriting Association (JUA) write the vast majority of medical malpractice policies in this state. Together they hold approximately 77% of the market based on premiums. Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Jose Montemayor, Commissioner, Texas Department of Insurance).

Physicians & Surgeons Medical Malpractice
Top 4 Writers Filing Rates
Indicated Rate Level vs. Actual Rate Level

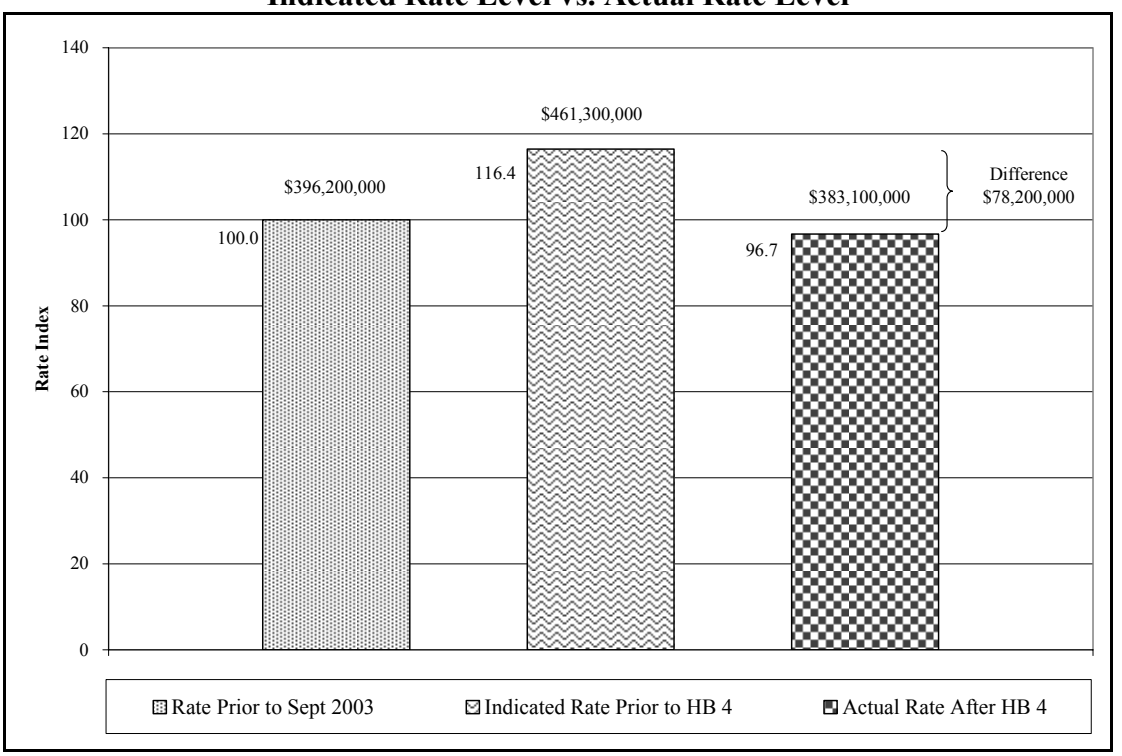

Figure 6 - 1 -- Medical Malpractice Rate Index
Source: Texas Department of Insurance

Texas Medical Liability Trust (TMLT), Texas' largest insurer with $189 million in premiums, reduced their rates by 12 percent in 2004 and plans to reduce rates an additional five percent in 2005.[199] Other smaller insurers have reduced their rates as well.[200] However, most carriers have not yet changed their rates. The two major insurers that filed for increases in rates include the JUA which filed for a 35.8 percent increase and the Medical Protective Company (MedPro) which filed for a 19 percent increase.[201] The Department disapproved both rate increases.[202]

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[199] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of W. Thomas Cotton, President and CEO, TMLT).

[200] For example, Continental Casualty Company, with $800,000 in premiums, reduced their rates by 11.5 percent on February 1, 2004. Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Jose Montemayor, Commissioner, Texas Department of Insurance).

[201] MedPro and the JUA are the second and third largest insurers with $134,000,000 and $58,000,000 in premiums respectively. Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Jose Montemayor, Commissioner, Texas Department of Insurance).

[202] *Id. See also* Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Tim Kenesy, President, Medical Protective Company); Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Joe Chilton, General Manager, JUA). MedPro's response to the Department's disapproval was to move its physicians to a risk purchasing group and extend its insurance to the group at a 10 percent increase. TDI staff filed an enforcement action against MedPro challenging both the 19 percent and 10 percent increases. The JUA did not take any action in response to TDI's disapproval. *Id.*

When individual insurers' rates are compared (regardless of recent reductions), they prove to be competitive. Although each insurer develops its own line of products, each with different coverage levels and underwriting guidelines, health care providers situated in similar practice areas and similar geographic regions now have options they did not have before the passage of H.B. 4 and Proposition 12. For example, an anesthesiologist in Harris County may find that rates vary among insurers by as much as $7,500 per year. However, the variance may be understood when the specific insurers and the policies are compared. One insurer's standard limits may be $200,000/$600,000, while another's limits may be $250,000/$750,000; or, one insurer may have stricter underwriting guidelines than its counterparts.[203]

Additionally, each carrier has its own strengths and weaknesses that influence a provider's choice. MedPro consistently touts its strong financial ratings because its leadership believes they provide physicians with greater security and confidence.[204] It is not always an "apples-to-apples" comparison. The bottom line is that physicians and other providers have more choices and there is more competition in the medical malpractice market than there was prior to the passage of H.B. 4 and Proposition 12. This allows providers to find the company and the policy that best suits their needs.

The Texas Medical Association (TMA) and the Texas Hospital Association (THA) also support the Department's data that medical malpractice rates are lower. THA surveyed its members and found that rates and claims overall are declining or leveling off (only 19 percent of responding hospitals reported an increase in premiums for 2005, compared to 95 percent in 2003 and 45 percent in 2004).[205] Hospitals that are part of a system generally have received a larger decrease in premiums than non-system hospitals.[206] Most importantly, the hospitals responding to the THA survey indicated they will use premium savings to expand patient safety programs, improve access to care, update equipment, subsidize governmental payment shortfalls, or expand coverage for uninsured/underinsured patients. Fifty percent of the responding hospitals noted they will be able to maintain or expand obstetrics/gynecology services and one-third indicated that general surgery services will be expanded. Additionally, almost half of the responding hospitals indicated it has been easier for them to recruit physicians, particularly those specializing in general surgery and emergency medicine.[207]

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[203] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Howard Lamb, President, Advocate MD).
[204] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Tim Kenesy, President, Medical Protective Company).
[205] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Matthew T. Wall, Associate General Counsel, THA); *Study: Hospitals and Their Patients Reap Benefits of Medical Liability Reform*, Texas Hospital Association (Aug. 2004). The report is attached at Appendix VI and is available at the Texas Hospital Association website: http://www.thaonline.org/Advocacy/HospitalImpact.pdf).
[206] *Id.*
[207] *Id.*

Insurance Claims

Data collected by the Department shows that medical malpractice claims began to rise in June 2003, with a peak in September 2003.[208] The following graph shows that data collected from TMLT and the JUA supports the conclusion that 2004 claims are leveling off at a rate lower than those submitted at the same time in 2003.

TMLT and the JUA Combined Medical Malpractice Claims by Month

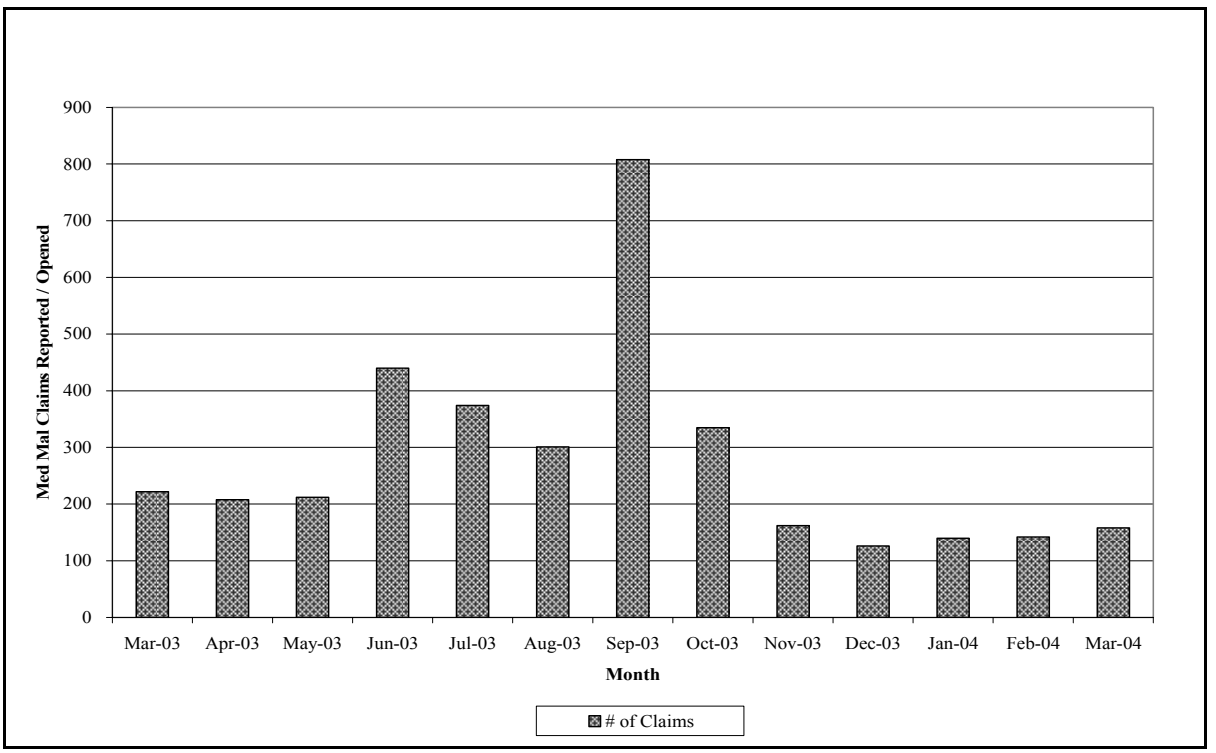

Figure 6 - 2 -- Medical Malpractice Claims
Source: Texas Department of Insurance

Insurance Commissioner Montemayor believes insurers have recognized that the spike in claims in September 2003 is an anomaly due to the timing of the effective date of H.B. 4 and as such, the insurers have not over-adjusted for or treated the spike in claims as a long-term trend.[209] Additionally, in determining future rates, the current number of claims is used by insurers to forecast the future number of claims. Therefore, as time goes on and the number of claims

[208] H.B. 4 applied to all lawsuits filed on or before September 1, 2003. If a lawsuit was filed in August, the provider's claim would be evidenced in the number of claims made to insurers in September. Therefore, the spike in the number of claims in September 2003 can be directly attributed to the rush in filing prior to the effective date of H.B. 4.

[209] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Jose Montemayor, Commissioner, Texas Department of Insurance).

continues at the current reduced levels, insurers should continue to set lower, more cost effective rates; then, the true effects of H.B. 4 and Proposition 12 will be more fully realized.[210]

Access to Health Care in Rural Areas and the Border Region

The difficulty for Texans living in rural and border regions of the state in accessing health care is not a new issue. For years, various groups have been collecting statistical data intended to show the particular plight of these regions. In fact, the Texas Tech University Health Sciences Center Rural and Community Health is the recipient of the first grant from the National Institutes of Health for the study of rural health. Beginning in 2004, the grant of $1.2 million over a three-year period will benefit the West Texas Rural EXPORT Center.

As of 2002, the data shows that there were 21 counties without any physicians and 62 counties without hospitals. Additionally, although there are 11 Level 1 trauma care facilities in Texas, a large part of the state is more than 60 miles from those hospitals. This severely affects the ability of rural residents to get the care needed in the critical first hour following a severe injury.[211] The following maps illustrate some of the acute problems faced by rural Texans.[212]

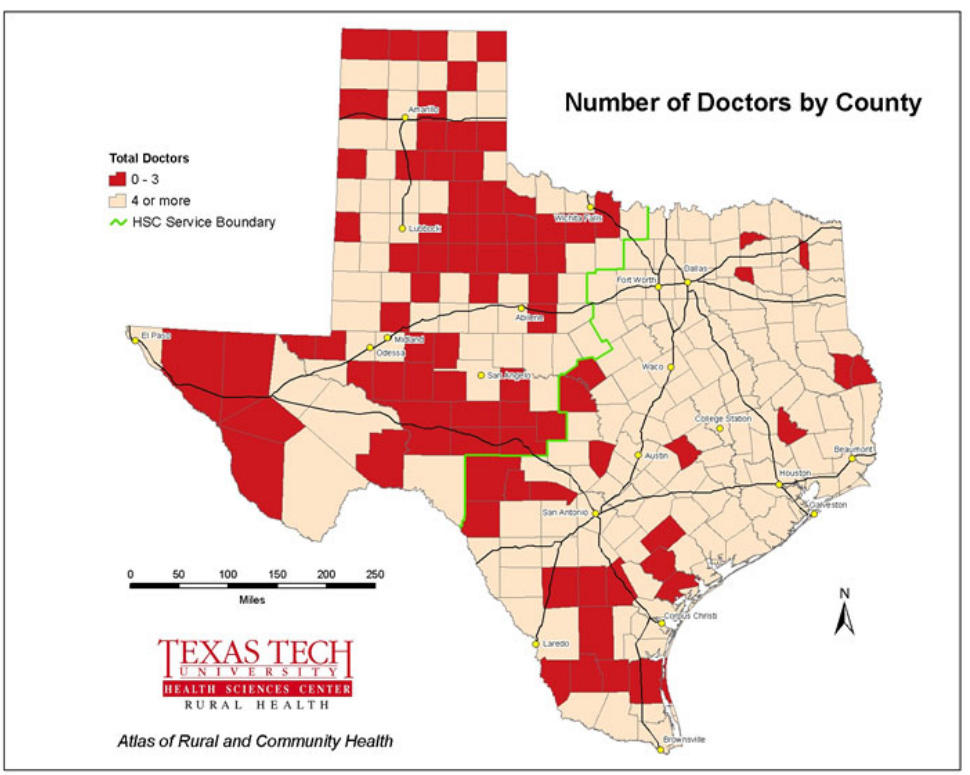

Figure 6 - 3 -- Number of Doctors by County
Source: Texas Tech University Health Sciences Center Rural and Community Health

[210] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of W. Thomas Cotton, President and CEO, TMLT).
[211] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Patti J. Patterson, MD, Vice President, Texas Tech University Health Sciences Center Rural and Community Health).
[212] Additional maps may be found attached hereto in Appendix VI and at http://gis.geog.ttu.edu/arch/index.htm.

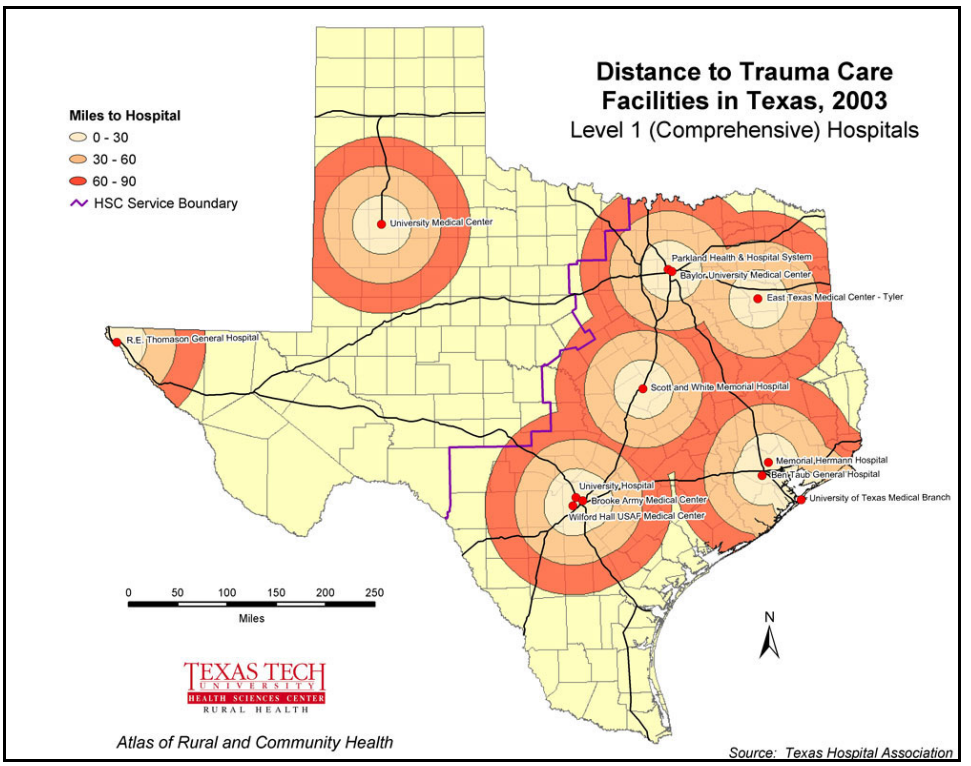

Figure 6 - 4 -- Distance to Trauma Care Facilities
Source: Texas Tech University Health Sciences Center Rural and Community Health

Telemedicine

One tool available to increase access to health care in the rural and border regions is telemedicine. Telemedicine is simply the practice of medicine over distance with the use of specialized telecommunications equipment.[213] The aim of telemedicine is to make primary and specialty medical care available to residents in the most remote areas of the state without requiring the residents to leave their communities and travel sometimes hundreds of miles to the appropriate facility. In addition to supporting rural clinics, examples of telemedicine programs include the treatment of patients in the Texas Department of Corrections system; assisting school nurses in rural districts; filling of prescriptions through the telepharmacy program; and assisting doctors in El Paso to treat burn victims without forcing a burn victim to travel over 600 miles round-trip to Lubbock.[214]

In Texas, the Health Sciences Center at Texas Tech has a telemedicine program in place serving rural West Texas while the Health Sciences Center at the University of Texas San Antonio and the University of Texas Medical Branch in Galveston both have programs serving

[213] Telemedicine involves computer and telecommunications equipment specifically designed for interactive doctor-patient care such as exam cameras and stethoscopes hooked directly into the telecommunications equipment. This specialized equipment allows actual doctor-patient consultations to occur over great distances.
[214] For more information see http://www.ttuhsc.edu/telemedicine/default.htm or http://telemedicine.uthscsa.edu/index.html.

clinics in South Texas. As discussed above, a large part of the state is more than 60 miles from the nearest Level 1 trauma facility. Telemedicine has the potential to link those Level 1 trauma facilities and fill in gaps in access to critical health care in the rural and border regions of the state. Additionally, as of 2002, there were nine counties that had a skilled nursing facility, but without a resident physician.[215] Telemedicine could link each of those facilities with physicians in other counties to increase the level of care available to the facility residents.

However, in addition to the ever-present funding hurdles, as well as physician acceptability, telemedicine faces technology challenges in the rural and border regions as many of the areas needing telemedicine do not have access to broadband telecommunications.[216] Therefore, for telemedicine to reach its full potential, up-to-date telecommunications equipment must be installed in many of the rural areas.

Provider Shortages

Access to health care throughout the state is affected by physician shortages. There are many factors that contribute to physician shortages, three of which are medical malpractice insurance rates, funding for Graduate Medical Education (GME), and utilization of international medical graduates (IMGs). As discussed above, implementation of the tort reform measures in H.B. 4 and Proposition 12 have enabled insurers to reduce rates for medical malpractice insurance. This has already helped hospitals and other communities recruit and retain physicians. Statewide data is not yet available, but specific examples include a new anesthesiologist in Beaumont, a new cardiovascular surgeon in El Paso, a number of obstetricians in Fredericksburg and Austin delivering babies again, and neurologists in Dallas and Fort Worth taking trauma calls again.[217]

GME plays an important part in fulfilling physician need in Texas. GME is the portion of a physician's education after medical school often referred to as "residency." Typically, physicians who "train in Texas, stay in Texas."[218] Studies show that approximately 57 percent of Texas graduates remain in Texas for their residencies. Additionally, 38 percent of graduating medical students who accept residencies in other states would prefer to remain in Texas if there were more GME positions available.[219] However, public funding for GME has been drastically reduced in recent years. Medicare continues to be the largest contributor to GME funding, but it has undergone a series of cuts essentially freezing Medicare GME funding at 1996 levels.[220]

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[215] *See* map in Appendix VI.

[216] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Patti J. Patterson, MD, Vice President, Texas Tech University Health Sciences Center Rural and Community Health).

[217] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Stanley Fisch, MD, Texas Medical Association); Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of J. Manuel de la Rosa, MD, Regional Dean, Texas Tech Medical Center El Paso).

[218] *Id*. Studies by the Texas Medical Association have shown that physicians who complete undergraduate and graduate education in Texas are almost three times more likely to stay in Texas to establish their practice. See study summaries attached hereto in Appendix VI.

[219] *See* Appendix VI.

[220] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Stanley Fisch, MD, Texas Medical Association). *See also Funding Graduate Medical Education In Texas*, Division of Finance, Campus Planning, and Research, Texas Higher Education Coordinating Board at 3 (Aug. 23, 2004) (available at www.thecb.state.tx.us).

State funding of GME has also been reduced. There are three state funding mechanisms for GME in Texas: (1) Medicaid payments to teaching hospitals; (2) general revenue funds trusteed to the Texas Higher Education Coordinating Board; and (3) line item funding to three medical schools and one teaching hospital. During the 78th Legislative session, budget constraints forced the state to eliminate the traditional Medicaid payments. However, a rider in the appropriations bill largely restored the funding by allowing the Health and Human Services Commission to access unclaimed lottery funds to make GME Medicaid payments.[221] The rider funds will allow the state to receive federal matching funds as well. The state was forced to cut other funding mechanisms too. General Revenue funds trusteed to the Coordinating Board for the 2004-05 biennium were reduced by 53 percent to $24.3 million and special line item funding to individual medical schools and hospitals was reduced by 12.5 percent to $1.15 million for the 2004-05 biennium.[222]

International medical graduates (IMGs) are a large part of the total number of residents in Texas. In 2004 alone, 24% of new medical licenses issued in Texas were to IMGs. IMGs are foreign physicians who have attended medical school in the United States and remain in the U.S. after graduation. Many of these foreign physicians are able to remain in the country under the Conrad 30 program. The Conrad 30 program is a federal program that allows states to recruit J1 Visa physicians. Pursuant to the Health & Safety Code, the Texas Department of Health is able to request visa waivers for physicians who agree to practice medicine in a "medically underserved area or health professional shortage area" as designated by the federal Department of Health and Human Services.[223] Typically these areas are along the border and the IMGs fulfill a vital role in the health care delivery system in those areas.

Recommendations

The certainty and protections afforded to insurers by the caps on noneconomic damages in H.B. 4 and Proposition 12 are moving medical malpractice insurance towards a more market-driven industry. The reforms in H.B. 4 and Proposition 12 have begun to produce desired results. There are a greater number of participants in the medical malpractice insurance market. Because rates are more competitive and subject to market influences, physicians and other providers are able to "shop around" for their liability insurance.

6.a. Texas should continue to strive to find the appropriate balance between market forces and regulation that will provide assurances to insurers, physicians and patients that access to health care will remain open for all Texans, in all areas of the state.

6.b. Because the tort reform measures in H.B. 4 and Proposition 12 have been in effect for just more than a year, true increases in access to health care for all Texans are still uncertain. Therefore, the Committee recommends that the Texas Department of Insurance develop a model to provide for an "apples-to-apples" comparison of

[221] General Appropriations Act for the 2004-05 Biennium, 78th Leg., Art. II at 59 (2003).
[222] *Funding Graduate Medical Education In Texas*, Division of Finance, Campus Planning, and Research, Texas Higher Education Coordinating Board at 3 (Aug. 23, 2004) (available at www.thecb.state.tx.us).
[223] TEX. HEALTH & SAFETY CODE § 12.0127 (Supp. 2004-05).

insurance rates, given the differences in types of policies provided and the legislative need to accurately track and analyze insurance premium costs in health care.

6.c. The Committee also recommends that the Legislature continue to monitor the situation and to look for other methods of addressing provider shortages and access to health care. While not necessarily related to liability issues, the Committee recommends the Legislature reevaluate its funding for Graduate Medical Education and work with the Texas Congressional Delegation to enhance federal funding for GME, specifically, to make Medicare funding more geographically equitable. Additionally, the Legislature should promote the use of telemedicine in rural areas. Finally, Texas must establish public policy that encourages all doctors to come to, and stay in, Texas.

Charge No. 7

Study and report on the affordability, reasonableness, and impact of mandatory liability insurance on the nursing home industry. Assess and report on the effects of the admissibility of quality reports.

Mandatory Liability Insurance

Background

The Omnibus Nursing Home Legislation, S.B. 1839, was passed by the 77th Legislature to address potentially devastating economic and legal issues facing the nursing home industry. At that time, the industry was facing numerous bankruptcies, diminished quality of care, frequent legal challenges and insurance coverage shortfalls. S.B. 1839 attempted to address the entire spectrum of challenges facing the industry in order to preserve those vital services and businesses.

One component of S.B. 1839 required long term care facilities to carry liability insurance. Coverage was mandated at $1 million per occurrence or $3 million aggregate (total in a year). Professional liability insurance may be provided by the Texas Medical Liability Insurance Underwriting Association (JUA),[224] any admitted carriers, or surplus-lines carriers.[225] Self-insurance was not an acceptable method of meeting this requirement.

Originally, S.B. 1839 set September 1, 2003, as the implementation date for mandatory insurance. The Legislature specifically chose a delayed implementation date acknowledging availability issues and an unreasonable financial burden on the nursing homes. The September 1, 2003, date was intended to provide time to review the fiscal implications during the 78th Legislative session.[226]

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[224] The JUA is a quasi-state agency required to sustain itself and its operations, but it does not have additional profit margin requirements. *See* TEX. INS. CODE art. 21.49-3 (Supp. 2004-05).

[225] Surplus-line companies are non-admitted insurance companies authorized to conduct business in the State of Texas. Surplus-lines exist to provide insurance to those who cannot acquire insurance in the admitted market. Surplus-line companies cannot advertise in the state and the surplus-line agent must show proof that a nursing home was unable to secure admitted insurance rates before writing an insurance policy.

[226] Long Term Care Legislative Oversight Committee 77th Interim Report, December 2002.

The Long Term Care Legislative Oversight Committee was charged during the 77th Interim (2001-2002) with monitoring the implementation of S.B. 1839. Specifically, the Committee watched the long term care liability insurance market to determine if mandatory insurance was plausible. Prior to the 78th Legislative session in 2003, it was determined that the long term care liability insurance market had not recovered and instituting the mandatory provision would have resulted in unintended harm to the long term care industry.[227] Therefore, S.B. 588, 78th Legislative session[228], was introduced to postpone implementation of mandatory insurance until September 1, 2005. This date again allowed time for the legislative changes to positively impact the insurance market and make mandatory long term care liability insurance a possibility.

During the 78th session, the provisions of S.B. 588 were rolled into H.B. 4.[229] However, the statute containing the mandatory provision was ultimately repealed in H.B. 2292.[230] Despite the repeal, questions surrounding the possible positive impact of mandatory insurance continue to circulate.

Discussion

Current Market Conditions

Availability

The Texas Department of Insurance conducted a telephone survey of insurers and brokers investigating the current market for long term care liability insurance. The survey found ten companies are writing professional liability insurance for long term care facilities. Within those ten, eight are surplus lines companies, one is an admitted company and one a risk retention group.[231] Seven of the companies are currently accepting new applications. Two companies report they only write renewals, but they are considering writing new business in light of H.B. 4. The study also found one company that is "aggressively studying re-entry into the Texas market for new business" as a direct result of H.B. 4.[232]

The JUA issued its first nursing home policy in early 2002 after the reforms of S.B. 1839. In that time, the JUA has avoided rate increases and policyholder assessments for all insured nursing homes.[233] Of the 29 nursing homes insured by the JUA:

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[227] *Id.*
[228] SB 588, 78th Legislature, was introduced by Senator Robert Duncan, co-author of SB 1839 (which contained the mandatory provision), 77th Legislative session.
[229] House Bill 4, 78th Legislature, was an omnibus tort reform legislation passed on June 6, 2003 and signed by the Governor on June 11, 2003. *See* Acts 2003, 78th Leg., ch. 204.
[230] House Bill 2292, 78th Legislature, was a Health and Human Services reorganization bill passed on June 6, 2003 and signed by the Governor on June 10, 2003 H.B. 2292 contained language that allows its own provisions to override the legislative guidelines set out in the Code Construction Act, Government Code, Section 311.025 which dictates the resolution of conflicting legislation. *See* Acts 2003, 78th Leg., ch. 198.
[231] These numbers include nursing homes and assisted living facilities. Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).
[232] *Id.*
[233] *Id.*

- 16 are not-for-profit and 13 are for-profit;
- limits of liability range from $100,000 per occurance/$300,000 aggregate to $1 million per occurance/$3 million aggregate, (most common, $1 million/$3 million);
- deductibles range from $0 to $25,000 (most common, $25,000);
- average premium per occupied bed is $1,231 (lowest, $575 - highest, $2,107) [234]

Senate Bill 1839 directed the JUA to establish a system to rate facilities by their performance and risk level. These five tiers provide a range in premium costs. A home's designation in the different tiers is based on historical data and their adoption of a set of "Best Practices." TDI's "Best Practices" were adopted in December 4, 2001, and the JUA, among other insurers, may consider a nursing home's adoption and implementation of these practices when determining premium rates for nursing homes.[235] The JUA reported that 14 homes recently left the JUA to enter a CNA Alternative Risk Management Program. This program was created specifically to attract nursing homes.

The CNA Alternative Risk Management Program is an insurance program with a large per claim indemnity deductible (in the hundreds of thousands). The CNA program applies after the deductible on each claim. The nursing homes pay a premium that is a fraction of the cost of the JUA coverage and use the savings to pay the claims below the deductible. The nursing homes believe tort reform changes make this type of arrangement viable.[236]

JUA Total Insurance Nursing Home Policy Count by Year

Date of Count	Nursing Home Policies in Force at Date	% Change from Previous Year
February 2001	0	
February 2002	1	
April 2002	11	1000%
July 2002	19	73%
November 2002	40	111%
December 2002	45	13%
January 2003	45	0%
February 2003	46	2%
April 2003	45	-2%
December 2003	46	2%
February 2004	47	2%
September 2004	29	-38%[237]

Figure 7 - 1 - JUA Policy Count
Source: Texas Department of Insurance

[234] *Id.*
[235] *Id.*
[236] *Id.*
[237] This reduction is due to 14 nursing homes recently moving to the CNA Insurance Companies program. Senate Committee on State Affairs Hearing, Aug. 11, 2004 (statement of Kim Stokes, Senior Associate Commissioner, Texas Department of Insurance).

Cost

This Committee requested that TDI analyze the potential for increased affordability of insurance if the state were to institute mandatory insurance at lower limits. TDI testified that reducing the limits on liability to $100,000 per occurrence and $300,000 aggregate could result in approximately a 25-50 percent reduction in rates.[238]

The cost of liability insurance is a reimbursable expense under the Medicaid program.[239] This provision does not affect those homes that are entirely private-pay facilities. Currently, there are 1,162 total nursing facilities in Texas; 1,135 of the homes are certified as eligible to collect Medicaid reimbursement for professional liability insurance. Of those that are eligible, only 674 (59 percent) facilities applied for and are receiving the Medicaid add-on payment to help cover the cost of liability insurance. Of the homes receiving the reimbursements, 71 percent are insured with a TDI-licensed company, 24 percent have independently procured plans,[240] and 5 percent report captive insurers.[241]

The Texas Association of Homes and Services for the Aging (TAHSA) conducted a survey of its members to assess their liability insurance status.[242] The study found premiums for non-profit nursing facilities dropped 67 percent from their 2002-2003 rates. TAHSA attributes this reduction to recent tort reform, a higher percentage of facilities going bare, and the creation of risk retention groups.[243] The TAHSA survey found the average cost for liability insurance for 2003-2004 was $1,071 per bed. However, Medicaid reimbursement for insurance costs is $613.20 per bed.[244]

TAHSA supports the concept of mandatory insurance, but with stipulations. The law would need to maximize availability, affordability and flexibility. For example, the definition of insurance should be flexible enough to include self-insurance programs, risk pools, and captives.[245] TAHSA also said the tiered system at the JUA should be re-evaluated to more realistically reflect facilities history and insurability.

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[238] TDI was unable to provide more precise estimation due to the high numbers of nursing home business written in non-TDI regulated surplus lines. *Id.*

[239] House Bill 154, 77th Legislature, required the Health and Human Services Commission only reimburse those homes that actually purchased insurance. Acts 2001, 77th Leg., ch.974.

[240] Some facilities are part of large national companies that buy their liability insurance outside the State of Texas for the company's entire slate of nursing homes.

[241] Long Term Care Legislative Oversight Committee Hearing, Oct. 14, 2004 (statement of Jose Montemayor, Commissioner, Texas Department of Insurance); *see also* Appendix VII. A captive is defined as "A legally recognized insurance company organized and owned by a corporation or firm whose purpose is to use the captive to write its own insurance at rates lower than those of other insurers." Merritt's Glossary of Insurance Terms

[242] TAHSA represents non-profit facilities only.

[243] Long Term Care Legislative Oversight Committee Hearing, Oct. 14, 2004 (statement of David Thomason, TAHSA).

[244] *Id.*

[245] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Ann Meador, VP of Public Relations and Communications, Methodist Retirement Communities on behalf of TAHSA).

Texas Health Care Association (THCA) has also been working with its membership to address and investigate the issue of liability insurance availability.[246] Since the passage of H.B. 4, the THCA has attempted to attract insurance companies to return to Texas and write policies. While THCA's meetings with carriers have resulted in some interest, many companies claim the Texas long term care market is still too unstable.[247] While the companies can appreciate the potential impact of H.B. 4 reforms, those changes are too recent to warrant their entry in the Texas market.[248] The Association testified that until the market has more carriers, the cost will continue to be too high for their members to purchase insurance.

Recommendations

7.a. The Legislature should consider re-enacting the mandatory liability insurance provision. Mandatory insurance is a laudable goal. While current market conditions affecting availability and affordability would probably place an unreasonable financial requirement for many facilities, delaying implementation would maintain this goal as a legislative priority.

7.b. Also, the Legislature may consider redefining what is considered insurance. Allowing a variety of definitions of what qualifies as insurance will include a wider spectrum of varieties, such as self-insurance, which facilities are currently accessing.

7.c. The Legislature should also consider reducing the mandatory limits to lower levels. The original amounts were set prior to H.B. 4 passage and the limits may need to be lower now that H.B. 4 provisions are in effect. Lowering these limits would significantly help the affordability of mandatory insurance.

7.d. If funds are available, the Legislature should consider increasing the reimbursement rate for the insurance portion of the nursing home payments to better cover the actual cost of liability insurance payments.

Admissibility of Quality Reports.

Background

Quality reports are survey documents used by the Department for Aging and Disability Services (DADS)[249] to regulate long term care institutions. Some have claimed the admissibility of these documents unfairly prejudiced nursing homes defending liability claims. Previous admissibility was restricted to the application of the Texas Rules of Evidence. However, H.B. 4 mandated that the survey reports are admissible only under specific conditions.[250]

Discussion

Pursuant to Human Resources Code, section 32.060, the following are <u>not admissible</u> as evidence in a civil action:

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[246] THCA represents for-profit and not-for profit facilities.
[247] Senate Committee on State Affairs Hearing, Sept. 20, 2004 (statement of Gavin Gadberry, THCA).
[248] *Id.*
[249] Formerly at the Department of Human Services.
[250] Acts 2003, 78th Leg., ch. 204 §16.01.

- any finding by the department that an institution licensed under Chapter 242, Health and Safety Code, has violated a standard for participation in the Medicaid program, and
- the fact of the assessment of a monetary penalty against an institution under Section 32.021 or the payment of the penalty by an institution.

Additionally, under Health and Safety Code section 242.017, the above mentioned findings and facts are admissible as evidence in a civil action only if:

- related to a material violation of the chapter or a rule adopted or an assessment of a monetary penalty with respect to:
  - the particular incident and the particular individual whose personal injury is the basis of the claim being brought in the civil action; or
  - a finding by the department that directly involves substantially similar conduct that occurred at the institution within a period of one year before the particular incident that is the basis of the claim being brought in the civil action; and
- a material violation has been affirmed by the entry of a final adjudicated and unappealable order of the department after formal appeal; and
- the record is otherwise admissible under the Texas Rules of Evidence.

While some interested parties are not pleased with the policy restricting the admissibility, the Senate Committee on State Affairs restricted its oversight to only the implementation of the new H.B. 4 admissibility provisions. The Committee requested comments from affected parties regarding the impact of new admissibility standards. The experience under H.B. 4 is very limited; however, the recent practical application of H.B. 4 provisions regarding admissibility of survey documents has been implemented without confusion or need for subsequent clarification.

Recommendation

The Committee makes no recommendation as to the statutory provisions related to the admissibility of quality reports issued by DADS.

APPENDIX I

1. Attorney General Opinion GA-0234
2. Attorney General Advisory Letter
3. ERS/A&M Merge Actuarial Study
4. Comparison of HRA/FSA/HAS
5. ERS Cost Containment Options
6. TRS Cost Containment Options

ATTORNEY GENERAL OF TEXAS
GREG ABBOTT

August 17, 2004

The Honorable Ray Allen
Chair, Committee on Corrections
Texas House of Representatives
Post Office Box 2910
Austin, Texas 78768-2910

Opinion No. GA-0234

Re: Whether, under section 1551.114 of the Insurance Code, an eligible retiree of a community supervision and corrections department may participate in the Employees Retirement System group benefits program after meeting the requirements of subsection (c)(2), with no further requirements, such as the "rule of 80" set out in section 1551.102 (RQ-0213-GA)

Dear Representative Allen:

Section 1551.114 of the Insurance Code, adopted in 2003, provides that retired employees of community supervision and corrections departments ("CSCDs") may participate in the state employees' group benefits program, administered by the Employees Retirement System ("ERS"), effective September 1, 2004. *See* TEX. INS. CODE ANN. § 1551.114 (Vernon 2004); Act of May 26, 2003, 78th Leg., R.S., ch. 1030, §§ 1.03, 3.01(b), 2003 Tex. Gen. Laws 2975, 2976-77, 2978. You ask whether, under section 1551.114, an eligible retiree of a CSCD may participate in the ERS group benefits program after meeting the requirements of subsection (c)(2), with no further requirements, such as the "rule of 80" set out in section 1551.102.[1]

I. CSCDs and Their Employees Generally

The district judge or judges trying criminal cases in a judicial district must establish a CSCD to "conduct presentence investigations, supervise and rehabilitate defendants placed on community supervision, enforce [community supervision] conditions . . . , and staff community corrections facilities." TEX. GOV'T CODE ANN. § 76.002(a)(2) (Vernon 1998). The judge appoints or the judges appoint CSCD employees as necessary to accomplish these tasks, and the judicial districts served by a CSCD pay the employees' salaries. *See id.* §§ 76.002(a)(2), .006(b) (Vernon 1998 & Supp. 2004). As section 76.006 of the Government Code stipulates, these employees generally are not state employees, although they are state employees for limited purposes: "Except as provided by Subsection (c), [CSCD] employees are not state employees." *Id.* § 76.006(a) (Vernon Supp. 2004).

[1]*See* Letter from Honorable Ray Allen, Chair, Committee on Corrections, Texas House of Representatives, to Honorable Greg Abbott, Texas Attorney General (Mar. 25, 2004) (on file with the Opinion Committee, *also available at* http://www.oag.state.tx.us) [hereinafter Request Letter].

Subsection (c) expressly deems CSCD employees "state employees for the purposes of Chapter 104, Civil Practice and Remedies Code[, which governs state liability for public servants' conduct], and Chapter 501, Labor Code[, which concerns state employees' workers' compensation insurance coverage]." *Id.* § 76.006(c).

At present, and until September 1, 2004, CSCD employees' benefits are provided under a contract with one of the counties that the CSCD serves. *See id.* § 76.006(a). CSCD employees are then governed by the personnel policies of that county, and both employees and retired employees receive benefits "equal to . . . benefits of other employees of that county." *Id.* On and after September 1, under the version of subsection (c) that will become effective on that date, CSCD employees and retired employees are "eligible to participate in the group benefits program established under" chapter 1551 of the Insurance Code, as provided by section 1551.114 of the Insurance Code. *Id.* § 76.006(c).

II. Relevant Statutes

A. Insurance Code Chapter 1551, the "Texas Employees Group Benefits Act"

Chapter 1551, the Texas Employees Group Benefits Act, *see* TEX. INS. CODE ANN. § 1551.001 (Vernon 2004), is expressly intended to, among other things, "provide uniformity in life, accident, and health benefit coverages for all state officers and employees and their dependents" and to "recognize the service to the state by employees and retired employees of [CSCDs] by extending to them and their dependents the same life, accident, and health benefit coverages as those provided under this chapter to state employees, retired state employees, and their dependents." *Id.* § 1551.002(1), (7); *see also id.* § 1551.005(a) (defining the term "health benefit plan" as "a plan that provides, pays for, or reimburses expenses for health care services"). Section 1551.101 governs a state employee's eligibility in the ERS group benefits program, *see id.* § 1551.101(b); *see also id.* §§ 1551.003(6), .008 (defining the term "employee" and limiting its use to an individual eligible to participate in the group benefits program under section 1551.101 "unless a different meaning is plainly required"); section 1551.102 governs an annuitant's participation in the group benefits program, *see id.* § 1551.102(a); *see also id.* §§ 1551.003(2), .008 (defining the term "annuitant" and limiting its use to an individual eligible to participate in the group benefits program under section 1551.102 "unless a different meaning is plainly required").

Section 1551.102(b)(2)(A) lists, among the retired employees who are eligible to participate as annuitants in the ERS group benefits program, individuals who retire under ERS jurisdiction and who "receive[] or [are] eligible to receive an annuity under Section 814.104(a)(2), Government Code, and [have] at least 10 years of eligible service credit." *Id.* § 1551.102(b)(2)(A). Section 814.104(a)(2), which provides for an ERS member's eligibility for service retirement generally, states that, "a member who has service credit in the [ERS] is eligible to retire and receive a service retirement annuity if the member: . . . has at least 5 years of service credit in the employee class and the sum of the member's age and amount of service credit in the employee class, including months of age and credit, equals or exceeds the number 80." TEX. GOV'T CODE ANN. § 814.104(a)(2) (Vernon Supp. 2004). This is the "rule of 80" about which you ask. *See* Request Letter, *supra* note 1, at 1.

Under section 1551.114, a CSCD employee or retired employee "shall be treated as an employee [eligible to participate in the ERS group benefits program] or annuitant [eligible to participate in the ERS group benefits program] . . . only as provided by this section." TEX. INS. CODE ANN. § 1551.114(b) (Vernon 2004). Rather than contract with a county for group benefits, section 1551.114 requires a CSCD to "participate[] in the group benefits program administered by the" ERS board of trustees. *Id.* § 1551.114(c). Participation is limited to:

> (1) active employees of a [CSCD];
>
> (2) retired employees of a [CSCD] who retire on or after September 1, 2004, and who:
>
> > (A) have been employed by one or more [CSCDs] for a total of at least 10 years of creditable service; and
> >
> > (B) *meet all the requirements for retirement benefits prescribed by the Texas County and District Retirement System*; and
>
> (3) eligible dependents of the active employees and retired employees described by Subdivisions (1) and (2).

Id. (emphasis added). A retired employee is eligible to participate in the ERS group benefits program "on application to the" ERS board of trustees. *Id.* § 1551.114(f). "On application," the employee automatically receives ERS "basic coverage for annuitants unless the retired employee specifically waives coverage or unless the retired employee is expelled from the program." *Id.* The Texas Department of Criminal Justice is responsible for paying contributions for CSCDs' retired employees:

> A retired employee is not eligible to receive a state contribution . . . for premiums. The community justice assistance division of the Texas Department of Criminal Justice is responsible for payment of the contributions for each of a department's retired employees and the retired employees' participating dependents that the state would make . . . if the retired employees were retired state employees. Each participating retired employee shall pay that portion of the cost of group coverage selected by the retired employee that exceeds the amount of division contributions. The retired employee shall pay contributions required from the retired employee in the manner prescribed by the [ERS] board of trustees. Each [CSCD] shall notify each of its retired employees of the eligibility for participation and the costs associated with participation.

Id. All contributions received under section 1551.114 from the community justice assistance division of the Texas Department of Criminal Justice and retired employees "for basic, optional, and

voluntary coverages under the [ERS] group benefits program shall be paid into the employees life, accident, and health insurance and benefits fund" and the ERS must use it "to provide those coverages as provided by this chapter." *Id.* § 1551.114(g).

B. The Statute Creating the Texas County and District Retirement System

The Texas County and District Retirement System is established under title 8, subtitle F of the Government Code (chapters 841-845). *See* TEX. GOV'T CODE ANN. tit. 8, subtit. F (Vernon 1994 & Supp. 2004). Under section 844.102(a)(1) and (2), which sets out general eligibility criteria for County and District Retirement System employees, an employee must be "at least 60 years old and [have] at least 12 years of credited service" or have "at least 30 years of credited service" to receive retirement benefits. *Id.* § 844.102(a)(1)-(2) (Vernon Supp. 2004). Section 844.102 also recognizes four alternative eligibility criteria that a county and district may choose instead of the general criteria. *See id.* § 844.102(a)(3).[2] For example, section 844.207 applies to subdivisions that began participating in the county and district retirement system after September 1, 1985 and "to all other subdivisions that have adopted" the section's plan provisions. *Id.* § 844.207(a). Under section 844.207(c), a member who is younger than sixty years old may receive retirement benefits if he or she meets the rule of 80. *See id.* § 844.207(c)(2). Section 844.210, which applies to any subdivision that adopts its plan provisions, also sets the rule of 80 as a means by which a member younger than sixty years may be eligible to receive retirement benefits. *See id.* § 844.210(a), (c)(2). Section 844.211, which likewise applies to any subdivision that adopts its plan provisions, establishes a rule of 75 for members less than sixty years old. *See id.* § 844.211(a), (c)(1). Thus, a member who is less than sixty years old is eligible for retirement benefits if the member "has a sufficient amount of eligible credited service . . . that, when added to the members attained age, equals or exceeds the number 75." *Id.* § 844.211(c)(1). Finally, under section 844.212, which applies to any subdivision that has adopted its plan provisions, a member is eligible to receive retirement benefits if the member has at least twenty years of "eligible credited service." *Id.* § 844.212(b)-(c).

III. Analysis

A. The Issue

Although we have set out all of the provisions of section 1551.114 relating to retired CSCD employees, your question implicates in particular section 1551.114(c)(2)(B), which we have italicized above. *See* Request Letter, *supra* note 1, at 1-2; *supra* p. 3 (quoting section 1551.114(c)(2)(B)). You explain that the ERS has indicated that a retired CSCD employee who has at least ten years of creditable service will be eligible to participate in the ERS group benefits program only if he or she satisfies the "rule of 80." Request Letter, *supra* note 1, at 1.[3] Letters we

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[2]*See generally* Brief attached to Letter from Honorable Larry Gist, Chairman, Texas Board of Criminal Justice Judicial Advisory Council, District Senior Judge, to Nancy Fuller, Chair, Opinion Committee, Office of the Attorney General, at 2 (May 18, 2004) (on file with the Opinion Committee).

[3]*See also* Letter from Leighton Iles, Director, Fort Bend County CSCD, to Honorable Greg Abbott, Texas Attorney General, at 1-2 (May 17, 2004) (on file with the Opinion Committee).

have received from current employees of the Travis County CSCD indicate that, under the Travis County system, they can retire with benefits when they satisfy the rule of 75.[4] After September 1, 2004, however, under the ERS policy you have described, the employees would be able to retire with benefits only if they satisfy the rule of 80. You suggest that the rule of 80 is not necessarily consistent with eligibility standards of the Texas County and District Retirement System and therefore contravenes section 1551.114(C)(2)(B) of the Insurance Code. *See* Request Letter, *supra* note 1, at 1.

A brief we have received from the ERS contends that it alone has authority to determine questions relating to individuals' eligibility to receive group benefits under chapter 1551.[5] While the ERS has statutory authority to determine issues related to enrollment, it may not impose upon CSCD employees standards for participating in the group benefits program as an annuitant that differ from those expressed in section 1551.114. The ERS, as an administrative agency of the state, may not impose requirements additional to those set forth in statute. *See Tex. Dep't of Pub. Safety v. Story*, 115 S.W.3d 588, 592 n.10 (Tex. App.–Waco 2003, no pet.) (stating that "an agency rule may not impose additional burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions") (quoting *R.R. Comm'n of Tex. v. ARCO Oil & Gas Co.*, 876 S.W.2d 473, 481 (Tex. App.–Austin 1994, writ denied)). Additionally, the ERS's construction of chapter 1551 is entitled to judicial deference, but only if the statute is unclear. *See Bd. of Trs. of Employees Ret. Sys. v. Benge*, 942 S.W.2d 742, 744 (Tex. App.–Austin 1997, writ denied); *McMullen v. Employees Ret. Sys.*, 935 S.W.2d 189, 191 (Tex. App.–Austin 1996, writ denied).

Section 1551.114(c)(2)(B) is not unclear. By its plain terms, the section incorporates as the standard for group benefits participation "the requirements for retirement benefits prescribed by the Texas County and District Retirement System." TEX. INS. CODE ANN. § 1551.114(c)(2)(B) (Vernon 2004). As we have explained, the requirements for retirement benefits under title 8, subtitle F of the Government Code, providing for the County and District Retirement System, depend upon whether the particular county has adopted the general plan provisions of section 844.102 or the optional plan provisions of section 844.207, .210, .211, or .212. Consistently with section 844.211 of the Government Code, some counties may have implemented the rule of 75 rather than the rule of 80. Requiring an employee who is currently subject to the rule of 75 to work additional years to become eligible for ERS group benefits upon the employee's retirement is an additional requirement that the ERS may not impose.

Moreover, section 1551.114(b) states, on its face, that a retired CSCD employee "shall be treated as an . . . annuitant *only* as provided by this section." TEX. INS. CODE ANN. § 1551.114(b)

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[4]*See* Letter from Diana Loving, Travis County CSCD, to Ed Burbach, Deputy Attorney General for Litigation, Office of the Attorney General (May 11, 2004) (on file with the Opinion Committee); Letter from Gene D. Oakes, Travis County CSCD, to Ed Burbach, Deputy Attorney General for Litigation, Office of the Attorney General (May 11, 2004) (on file with the Opinion Committee).

[5]*See* Letter from Paula A. Jones, General Counsel, Employees Retirement System of Texas, to Nancy S. Fuller, Chair, Opinion Committee, Office of the Attorney General, at 2 (June 25, 2004) (on file with the Opinion Committee) [hereinafter ERS Brief].

(Vernon 2004) (emphasis added). The ERS argues that the term "annuitant" is a term of art that refers back to section 1551.102, which establishes the rule of 80 for annuitant eligibility generally. *See* ERS Brief, *supra* note 5, at 4-5. Thus, according to the ERS, retired CSCD employees must comply with section 1551.102's eligibility standards before becoming eligible for retirement benefits from the ERS. *See id.* at 4-7. Yet, as the statute expressly states, CSCD employees are annuitants "only as provided by" section 1551.114. TEX. INS. CODE ANN. § 1551.114(b) (Vernon 2004). In addition, retired CSCD employees by definition could never become annuitants under section 1551.102: under subsection (b), an individual is eligible to participate in the group benefits program if "the individual retires under the jurisdiction of the" ERS. *Id.* § 1551.102(b). The ERS admits, in its brief, that CSCD employees do not "retire under ERS'[s] jurisdiction." ERS Brief, *supra* note 5, at 6.

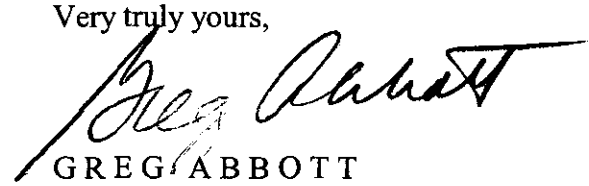
Finally, nothing in the 2003 legislation makes CSCD employees "state employees" who would be subject to the eligibility standards set out in section 1551.101 or 1551.102 of the Insurance Code. Section 1551.114 does not expressly make CSCD employees "state employees" and in fact stipulates that neither an active CSCD employee nor a retired CSCD employee is "eligible to receive a state contribution . . . for premiums." *See* TEX. INS. CODE ANN. § 1551.114(e)-(f) (Vernon 2004). Likewise, section 76.006(c) of the Government Code, which addresses CSCD employees' status, has not been amended to state that CSCD employees are state employees for the purposes of Insurance Code chapter 1551. *See* TEX. GOV'T CODE ANN. § 76.006(c) (Vernon Supp. 2004).

We conclude, therefore, that, under the explicit terms of section 1551.114(c)(2)(B), a CSCD employee is eligible to participate in the ERS group benefits program under section 1551.114 when the employee satisfies the eligibility standards that have been adopted in the county that currently provides the employee's benefits. For example, a CSCD employee in a county that has implemented the rule of 75 may retire and participate in the ERS group benefits program under section 1551.114 of the Insurance Code when the employee satisfies the rule of 75.

SUMMARY

In accordance with section 1551.114 of the Insurance Code, a retiree of a community supervision and corrections department may participate in the Employees Retirement System group benefits program after meeting the requirements of section 1551.114(c)(2), with no further requirements, such as the "rule of 80" set out in section 1551.102.

Very truly yours,



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NANCY S. FULLER
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OFFICE of the ATTORNEY GENERAL
GREG ABBOTT

July 18, 2003

Mr. Delmar L. Cain, General Counsel
The Texas A&M University System
John B. Connally Building, 6th Floor
301 Tarrow
College Station, Texas 77840-7896

Re: Construing amendments to section 1601.102 of the Insurance Code

Dear Mr. Cain:

The Texas Legislature, in its Seventy-eighth Regular Session, twice amended section 1601.102 of the Insurance Code, which regulates the eligibility of a retiree from The University of Texas System or The Texas A&M University System to participate in a uniform insurance benefits program. *See* Act of June 1, 2003, 78th Leg., R.S., S.B. 1370, § 4.03 (to be codified at TEX. INS. CODE ANN. § 1601.102) ("S.B. 1370"); Act of June 1, 2003, 78th Leg., R.S., S.B. 1652, § 2.08 (to be codified at TEX. INS. CODE ANN. § 1601.102) ("S.B. 1652"). You ask whether these amendments can be harmonized or whether one prevails over the other.

Your letter of June 23 requested the Attorney General's opinion on this issue. To expedite a response, we have elected, after consulting with you and with your consent, to address your question with an informal letter rather than a formal opinion. Thus, this letter is not the product of our formal opinion process, but represents our informal advice. This letter also serves to document the withdrawal of your request for a formal opinion.

Section 1601.102 of the Insurance Code, part of the State University Employees Uniform Insurance Benefits Act, governs retirees' eligibility to participate in the benefits program established under chapter 1601 (the "uniform program"). *See* TEX. INS. CODE ANN. § 1601.102 (Vernon 2003), *amended by* S.B. 1370, S.B. 1652; *see also id.* § 1601.003(10) (defining "uniform program"). On January 1, 2003, prior to the start of the Seventy-eighth Legislature's Regular Session, section 1601.102(b) provided that an individual is eligible to participate in the uniform program if:

> (1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;
>
> (2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teachers Retirement System of Texas . . . ;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

Id. § 1601.102(b) (Vernon 2003). For the sake of brevity, we will use the term "qualifying retirement system" to describe a retirement program included within subsection (b)(3).

Two bills passed by the Seventy-eighth Legislature amend the eligibility requirements in section 1601.102. S.B. 1370, which makes cost-saving changes to group health insurance benefit programs provided by the Employees Retirement System, the Teachers Retirement System, The University of Texas System, and The Texas A&M University System, adds to the previous eligibility requirements:

(f) . . . [A]n individual is eligible to participate in the uniform program only if the individual:

(1) has at least 10 years of service credit and the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80; or

(2) is at least 65 years old and has at least 10 years of service credit.

S.B. 1370, § 4.03 (to be codified at TEX. INS. CODE ANN. § 1601.102(f)). S.B. 1370, which is effective September 1, 2003, expressly prevails "[t]o the extent of any conflict, . . . over another Act of the 78th Legislature, Regular Session, 2003, relating to nonsubstantive codifications of law or nonsubstantive additions to and corrections in enacted codes." *Id.* §§ 5.01, 5.02.

S.B. 1652 also revises the eligibility requirements, but it expressly provides in new subsections (f) and (g) for certain individuals who would have been eligible to participate in the uniform program but for the new requirements:

(f) Notwithstanding Subsection (b) [with the increased ten-year service

requirement], an individual to whom this subsection applies is eligible to participate in the uniform program . . . if:

> (1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;
>
> (2) the individual's last state employment before retirement was with that system; and
>
> (3) the individual retires under the jurisdiction of [a qualified retirement system].
>
> (g) Subsection (f) applies only to a person who, on August 31, 2003:
>
> (1) was eligible to participate in the uniform program as an employee under Section 1601.101; or
>
> (2) was eligible to participate in the uniform program as a retired employee under this section as this section existed on January 1, 2003.

S.B. 1652, § 2.08 (to be codified at TEX. INS. CODE ANN. § 1601.102(f), (g)); *see also id.* (to be codified at TEX. INS. CODE ANN. § 1601.102(b)) (increasing years-of-service-credit requirement from three to ten). S.B. 1652 became effective on June 21, 2003, the day Governor Perry signed the bill. *See id.* § 10.01.

Because S.B. 1652 "grandfathers" employees who were eligible to participate in the uniform program as an employee on August 31, 2003 and those who were eligible to participate as a retired employee on January 1, 2003, while S.B. 1370 does not grandfather the same employees, you suggest that the two amendments may be said to conflict irreconcilably, and you ask whether the amendments can be harmonized.

We presume that the amendments can be harmonized. In general, if one session of the legislature adopts multiple amendments to the same statute, none of which refer to the other amendments, we must harmonize the amendments if it is possible to do so, so that each is effective. *See* TEX. GOV'T CODE ANN. § 311.025(b) (Vernon 1998). The amendment that is the "latest in date of enactment prevails" over other amendments only if the amendments are "irreconcilable." *Id.*; *see also id.* § 311.025(d) (stating that "the date of enactment is the date on which" the legislature last votes "on the bill enacting the statute"). Thus, like a court, we attempt to "carry out the full legislative intent, by giving effect to all laws and provisions being on the same subject," particularly with respect to "acts passed at the same session of the legislature." *Ex parte Harrell*, 542 S.W.2d 169, 172 (Tex. Crim. App. 1976).

You suggest that S.B. 1370 and S.B. 1652 may be harmonized by construing section 1601.102 to make eligible three categories of employees:

> (1) those who have at least ten years of service credit and meet the rule of eighty test; or
>
> (2) those who have at least ten years of service credit and are at least sixty-five years of age; or
>
> (3) those who, as of August 31, 2003, are eligible to participate as an employee or who, under the January 1, 2003 version of section 1601.102 are eligible to participate as a retiree, so long as: (a) the individuals have at least three years of service credit; (b) are serving with either The University of Texas System or The Texas A&M University System at the time of their final state employment; and (c) retire under a qualifying retirement system.

In this way, you continue, both bills are effective with respect to their amendment of Insurance Code section 1601.102.

Attorney General Opinion JC-0137 suggests that the bills should be harmonized as you suggest unless one bill expressly prevails over conflicting bills. *See* Tex. Att'y Gen. Op. No. JC-0137 (1999) at 5. Attorney General Opinion JC-0137 addressed two amendments enacted by the Seventy-sixth Legislature, both of which amended chapter 814 of the Government Code by providing "temporary service retirement options for certain state employees who are members of the Employees Retirement System of Texas ('ERS')." *Id.* at 1. One, S.B. 1130, however, provided a temporary service retirement option for ERS members "employed by the Texas Workforce Commission, the Texas Department of Human Services, the Texas Department of Mental Health and Mental Retardation, and the Texas Department of Health whose jobs are eliminated as a result of contracts with private service providers or other reductions in services." *Id.*; *see* Act of May 29, 1999, 76th Leg., R.S., ch. 1541, 1999 Tex. Gen. Laws 5292, 5295-96. The other, H.B. 3504, enacted "a temporary service retirement option for a special subset of ERS members—employees of the South Texas Hospital who separate from state service on or before September 1, 2000"—so that these members would have "the same temporary service retirement options available" prior to the changes made by S.B. 1130. Tex. Att'y Gen. Op. No. JC-0137 (1999) at 3-4; *see* Act of May 21, 1999, 76th Leg., R.S., ch. 1106, § 9, 1999 Tex. Gen. Laws 3975, 3977. Normally, the opinion states, we would harmonize the amendments by construing them "to establish special retirement options for ERS members leaving state employment between August 30, 1999 and September 1, 2000, as a result of the Texas Department of Health's withdrawal from the management and operation of South Texas Hospital." Tex. Att'y Gen. Op. No. JC-0137 (1999) at 5. In that case, however, S.B. 1130 expressly provided that its amendment "prevails over any other Act of the 76th Legislature, . . . regardless of the relative dates of enactment, that purports to . . . create a similar provision to allow a temporary retirement option for members of the [ERS] whose positions are subject to privatization or a reduction in workforce . . . ." *Id.* at 4-5 (quoting Act of May 29, 1999, 76th Leg., R.S., ch. 1541, § 60, 1999 Tex. Gen. Laws 5292, 5308). Given this express language, the opinion concludes that the

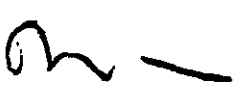
two bills could not be harmonized and that the relevant provision in H.B. 3504 "has no effect." *Id.* at 6.

Here, by contrast, neither S.B. 1370 nor S.B. 1652 contains language comparable to the conflict provision considered in Attorney General Opinion JC-0137 that would prohibit harmonizing these provisions. S.B. 1652 contains no conflict provision whatsoever. And the conflict provision in S.B. 1370, which provides that this bill prevails over any other act of the Seventy-eighth Legislature "relating to nonsubstantive codifications . . . or nonsubstantive additions to and corrections in enacted codes," is markedly different from that in S.B. 1130, which stated that it prevailed over any conflicting act of the Seventy-sixth Legislature, without limitation. *Compare* Act of June 1, 2003, 78th Leg., R.S., S.B. 1370, § 5.01 (2003), *with* Act of May 29, 1999, 76th Leg., R.S., ch. 1541, § 60, 1999 Tex. Gen. Laws 5292, 5308 (S.B. 1130). Because S.B. 1652 substantively amends section 1601.102, S.B. 1370's conflict provision does not apply.

Based on this preliminary review, we accordingly construe S.B. 1370 and S.B. 1652 to make eligible for participation in a uniform program under section 1601.102 of the Insurance Code three classes of individuals:

> (1) those with at least ten years of service credit who meet the rule of eighty test;
>
> (2) those with at least ten years of service and who are at least sixty-five years of age; and
>
> (3) in accordance with S.B. 1652, those who (a) are eligible to participate as an employee as of August 31, 2003 or are eligible to participate as a retiree under section 1601.102 as it existed on January 1, 2003, and (b) have at least three years of service credit, are serving with either The University of Texas System or The Texas A&M University System at the time of their final state employment, and retire under a qualifying retirement system.

Very truly yours,



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June 23, 2003

The Honorable Greg Abbott
Attorney General, State of Texas
Post Office Box 12548
Austin, Texas 78711-2548

Dear General Abbott:

Chapter 1601, Insurance Code, the Uniform Insurance Benefits Act for Employees of the University of Texas System and The Texas A&M University System, was amended by two Acts of the 78th Texas Legislature. Specifically, §1601.102 was amended by both Senate Bill 1370 and Senate Bill 1652. A question has arisen regarding the proper construction of §1601.102 in light of the changes made by both bills.

We request an opinion from your office regarding the effects of these two legislative acts on §1601.102, Insurance Code. Specifically, we inquire as to the proper reading of the provisions that affect the eligibility of retirees to receive group insurance benefits if they retire after August 31, 2003. It is the opinion of The Texas A&M University System that current employees who met the requirements of §1601.102 before it was amended and who remain employed with the A&M System after August 31, 2003 are "grandfathered" from the higher service and age requirements enacted by the two bills.

Code Construction Standards

The Code Construction Act[1] governs the interpretation and construction of the Insurance Code.[2] Section 311.025(b) states as follows:

> **§ 311.025. Irreconcilable Statutes and Amendments.** (a) Except as provided by Section 311.031(d), if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails.
>
> *(b) Except as provided by Section 311.031(d), if amendments to the same statute are enacted at the same session of the legislature, one amendment without reference to another, the amendments shall be harmonized, if possible, so that effect may be given to each. If amendments are irreconcilable, the latest in date of enactment prevails.*
>
> (c) In determining whether amendments are irreconcilable, text that is reenacted because of the requirements of Article III, Section 36, of the Texas Constitution is not considered to be irreconcilable with additions or omissions in the same text made by another amendment. Unless clearly indicated to the contrary, an amendment that reenacts text in compliance with that constitutional requirement does not indicate legislative intent

[1] V.T.C.A. Insurance Code Ch. 311 (Vernon 2003)
[2] V.T.C.A. Insurance Code §311.002 (Vernon 2003)

that the reenacted text prevails over changes in the same text made by another amendment, regardless of the relative dates of the enactment.

(d) In this section, the date of enactment is the date on which the last legislative vote is taken on the bill enacting the statute.

(e) If the journals or other legislative records fail to disclose which of two or more bills in conflict is latest in date of enactment, the date of enactment of the respective bills is considered to be, in order of priority:

(1) the date on which the last presiding officer signed the bill;
(2) the date on which the governor signed the bill; or
(3) the date on which the bill became law by operation of law.[3] [Emphasis added.]

Both bills amended §1601.102, and neither bill makes reference to the other. S.B. 1370 added new subsections (f) and (g) to §1601.102. S.B. 1652 also added new subsections (f) and (g), and amended subsections (a) and (b). The Texas Legislative Service reported that both bills were passed on June 1, 2003. S.B. 1370 passed about two hours after S.B. 1652. However, the record also indicates that a technical correction to S.B. 1652 was made and passed both houses on June 2, 2003.[4] If this qualifies as a "last action," and if the two bills cannot be harmonized, S.B. 1652 would appear to control over S.B. 1370.

S. B. 1370 was signed by the governor on June 18, 2003, to be effective September 1, 2003. S.B. 1652 was signed on June 21, 2003, effective immediately.

Law Prior to Enactment of Legislation by the 78th Legislature

Prior to the enactment of the two bills, §1601.102 of the Insurance Code read as follows:

§ 1601.102. Participation Eligibility: Retirees. (a) An individual who retires in a manner described by this section is eligible to participate as a retired employee in the uniform program.

(b) An individual is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;
(2) the individual's last state employment before retirement was with that system; and
(3) the individual retires under the jurisdiction of:

[3] Tex. Gov't Code Ann. §311.025(b) (Vernon 2003); Sec. 311.031(d) states, "If any provision of a code conflicts with a statute enacted by the same legislature that enacted the code, the statute controls." This is not applicable to the given situation.

[4] See House Journal, p. 6659, 78th Legis.; see also Texas Legislature Online, http://www.capitol.state.tx.us/hjrnl/78r/html/day85final.htm

(A) the Teachers Retirement System of Texas under Subtitle C, Title 8, Government Code;
(B) the Employees Retirement System of Texas; or
(C) subject to Subsection (c):
(i) the optional retirement program established by Chapter 830, Government Code; or
(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(c) An individual retiring in the manner described by Subsection (b)(3)(C) is a retired employee only if the individual meets all applicable requirements for retirement, including service and age requirements, adopted by the system comparable to the requirements for retirement under the Teachers Retirement System of Texas.

(d) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual:
(1) meets the minimum requirements under Subsection (b) except that the last state employment before retirement is not at the employing system; and
(2) does not meet the requirements for an annuitant under Section 1551.102.

(e) An individual is eligible to participate in the uniform program as provided by Subsection (a) if the individual retired under Subtitle C, Title 8, Government Code, before September 1, 1991, with at least five and less than 10 years of service.

Comparison of Changes Made by 78th Legislature

Section 4.03 of S.B. 1370 amends subsection (a) of Section 1601.102, and adds a new subsections (f) and (g). Section 2.08 of S.B. 1652 amends subsection (b) and adds its own subsections (f) and (g). The following is a side-by-side view of the changes made by each bill.

§1601.102 Govt. Code as amended by S.B. 1370, Section 4.03	**§1601.102 Govt. Code as amended by S.B. 1652, Section 2.08**
(a) An individual who retires in a manner described by this section <u>and who meets the requirements of Subsection (f)</u> is eligible to participate <u>, subject to Section 1601.1045,</u> as a retired employee in the uniform program.	*No effect on (a)*

No effect on (b)

(b) An individual is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least 10 [~~three~~] years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher [~~Teachers~~] Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(f) Notwithstanding Subsections (b)-(d), an individual is eligible to participate in the uniform program only if the individual:

(1) has at least 10 years of service credit and the sum of the person's age and amount of service credit, including

(f) Notwithstanding Subsection (b), an individual to whom this subsection applies is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least three years of service with a system for

months of age and credit, equals or exceeds the number 80[5]; or

(2) is at least 65 years old and has at least 10 years of service credit.

which the individual was eligible to participate in the uniform program under Section 1601.101;

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or
(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(g) A person eligible to participate and participating in the uniform program as an annuitant on September 1, 2003, may continue to participate in the program as an annuitant if a lapse in coverage has not occurred.

(g) Subsection (f) applies only to a person who, on August 31, 2003:

(1) was eligible to participate in the uniform program as an employee under Section 1601.101; or

(2) was eligible to participate in the uniform program as a retired employee under this section as this section existed on January 1, 2003.

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[5] This formula is commonly referred to as the Rule of 80.

Harmonizing the Acts

If the statutory requirement to harmonize is followed, any analysis must begin with a presumption that both are intended to be valid.[6] We are of the opinion that S.B. 1652 adds as a category of persons entitled to benefits upon retirement those persons who on August 31, 2003, either were employees or were eligible to participate as retirees under the law as it read before the changes made by the 78th Legislature. The result is that as of September 1, 2003 there will be three different means by which an employee may qualify for benefits upon retirement:

(1) have at least 10 years of service credit and meet the rule of 80 test, *or*

(2) have at least 10 years of service credit and be age 65 or older, *or*

(3) as of August 31, 2003 be eligible to participate as an employee or under the January 1, 2003 version of §1601.102 as a retiree, *and* have at least three years of service *and* the last state employment is with one of the two systems, *and* retire under the jurisdiction of TRS, ERS, ORP, or another qualifying retirement system.

The qualifications listed in (3), above, are the same as those in the current law.[7] In our opinion, the proper application of the rules of statutory construction leads to the conclusion that the legislature intended current employees to retain these requirements rather than having to meet the higher level of service and age requirements added in (1) and (2), above.

Similarly, the two subsections (g) that were created by the two bills may be read in tandem rather than as one excluding or modifying the other. As created by S.B. 1370, subsection (g) addresses persons who are already retired and participating in the benefits programs as annuitants as of September 1, 2003 so long as they do not experience a lapse in coverage. This is distinctly different from subsection (g) under S.B. 1652 which is clearly a "grandfather" clause, i.e., one that attempts to protect or mitigate the effects of the new requirements as applied to current employees and retirees of the two systems.

Alternative Harmonization of the Acts

It has been posited that a different reading of the effect of the two bills requires that persons covered by the "grandfather" wording in S.B. 1652 meet the Rule of 80. The rationale for this position is that both bills clearly indicate that the legislature intended to raise the minimum number of service years from three to 10, and that the effect of the simultaneous passage of S.B. 1652 was to create a lower threshold (i.e., three years) for current employees *but only as it relates to years of service*. The result is that these employees would have to either meet the Rule of 80 or be at least 65 years old. This reading, in effect, inserts subsection (f) from S.B. 1652 as a subpart of subsection (f)(1) as created by S.B. 1370. A graphic representation of this interpretation would read as follows:

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[6] *H&C Communications, Inc. v. Reed's Food Intern., Inc.* (Tex. App.—San Antonio, 1994) 887 S.W.2d 475. Tex. Govt Code Ann. §311.021 (Vernon 2003)

[7] 1601.102(b), Govt Code (Vernon 2003)

(f) Notwithstanding Subsections (b)-(d), an individual is eligible to participate in the uniform program only if the individual:

(1) has at least 10 years of service credit [or (1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101, (2) the individual's last state employment before retirement was with that system; and (3) the individual retires under the jurisdiction of: (A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code; (B) the Employees Retirement System of Texas; or (C) subject to Subsection (c): (i) the optional retirement program established by Chapter 830, Government Code; or (ii) any other federal or state statutory retirement program to which the system has made employer contributions,] **and** the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80; or

(2) is at least 65 years old **and** has at least 10 years of service credit [or (1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101, (2) the individual's last state employment before retirement was with that system; and (3) the individual retires under the jurisdiction of: (A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code; (B) the Employees Retirement System of Texas; or (C) subject to Subsection (c): (i) the optional retirement program established by Chapter 830, Government Code; or (ii) any other federal or state statutory retirement program to which the system has made employer contributions,]

The retirement systems have their own years of service requirements in order for an employee to qualify. For example, in the Teacher Retirement System a member is eligible to retire at age 55 with five years of credit.[8] Reading S.B. 1652 as subordinate to S.B. 1370 would mean that a 55 year old TAMUS employee who has five years credit with TAMUS and retires under TRS after August 31, 2003 would not be eligible for group benefits because he does not meet the Rule of 80, nor is he 65 years old. If the purpose of using the Rule of 80 or 65 years of age is to set standards for service and age eligibility, then arguably such an employee would be subjected to a two-level test in order to be able to receive his retirement annuity *and* his insurance benefits. This type of tortured result is not consistent with a plain reading of the two bills. As we have demonstrated above, the provisions can be harmonized without resorting to such "stacking" of requirements.

If the bills cannot be harmonized, we request that you provide us with your opinion regarding which one is controlling.

[8] Tex. Govt Code Ann. §824.202. TRS requires all members to have at least five years of service with TRS to be eligible for retirement benefits. The retirement ages and years of service under TRS are (minimum age/years): 65/5, 60/20, 50/30. Members who meet the Rule of 80 and those with 30 years of service may retire at any age. Members who are at least 55 may retire with five years of service and receive a reduced annuity amount.

We respectfully request an opinion of your office regarding the proper interpretation and implementation of these two legislative enactments.

Sincerely,

Delmar L. Cain

Delmar L. Cain
General Counsel

xc: Senator Robert Duncan
Senator Steve Ogden
Senator Florence Shapiro
Representative Fred Brown
Representative Dianne White Delisi
Representative Geanie W. Morrison

Mr. Blaine Brunson
Ms. Nancy Fisher

SECTION 2.08. Section 1601.102, Insurance Code, is amended by amending Subsection (b) and adding Subsections (f) and (g) to read as follows:

(b) An individual is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least 10 [~~three~~] years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher [~~Teachers~~] Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(f) Notwithstanding Subsection (b), an individual to whom this subsection applies is eligible to participate in the uniform program as provided by Subsection (a) if:

(1) the individual has at least three years of service with a system for which the individual was eligible to participate in the uniform program under Section 1601.101;

(2) the individual's last state employment before retirement was with that system; and

(3) the individual retires under the jurisdiction of:

(A) the Teacher Retirement System of Texas under Subtitle C, Title 8, Government Code;

(B) the Employees Retirement System of Texas; or

(C) subject to Subsection (c):

(i) the optional retirement program established by Chapter 830, Government Code; or

(ii) any other federal or state statutory retirement program to which the system has made employer contributions.

(g) Subsection (f) applies only to a person who, on August 31, 2003:

(1) was eligible to participate in the uniform program as an employee under Section 1601.101; or

(2) was eligible to participate in the uniform program as a retired employee under this section as this section existed on January 1, 2003.

Rudd and Wisdom, Inc.

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August 31, 2004

Ms. Ann Fuelberg
Executive Director
Employees Retirement System
of Texas
Post Office Box 13207
Austin, Texas 78711-3207

Re: Texas A&M University System Actuarial Study

Dear Ann:

Attached is the Actuarial Study of the Costs and Actions Involved in the Merger of the Texas A&M University System Group Benefits Plans into the State Employees Group Benefits Plans administered by the Employees Retirement System.

We appreciate the assistance that the staffs of the Employees Retirement System and the Texas A&M University System have provided to us during the course of this study.

Please let us know if you have questions or if you need additional information.

Sincerely,

Philip S. Dial

PSD:nlg

Enclosure

cc: Mr. William S. Nail
Mr. Steve Hassel
Mr. Paul Bozeman

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Employees Retirement System of Texas

Actuarial Study of the Costs and Actions Involved in the Merger of the Texas A&M University System Group Benefits Plans into the State Employees Group Benefits Plans Administered by the Employees Retirement System

This actuarial study is conducted at the request of the Employees Retirement System of Texas (ERS) in response to a directive from the Texas Legislature to examine the costs and actions necessary to merge the Texas A&M University System (TAMUS) group benefit plans into the state employees group benefits plans administered by ERS. The former are referred to collectively herein as the TAMUS program, while the latter are referred to as the GBP.

Background

Article III of the General Appropriations Act, 2004-2005 Biennium (FY04/05), Seventy-Eighth Legislature, Regular Session pertaining to the appropriation for higher education group insurance included Rider No. 2 which states as follows:

> 2. **Actuarial Study.** The Employees Retirement System is directed to conduct an actuarial study to determine the costs and actions necessary to merge employees currently insured under group benefit plans offered by the Texas A&M University System into the state employee group benefit plans administered by the Employees Retirement System. The Texas A&M University System and the Employees Retirement System shall cooperate in assessing the costs and actions needed to replace all Texas A&M University System employee group benefit plans with the state employee group benefit plans administered by the Employees Retirement System under Chapter 1551 of the Insurance Code. This study shall be provided to the Legislative Budget Board and the Governor by no later than September 1, 2004. The Texas A&M University System and the Employees Retirement System shall evenly divide the costs of this study using existing resources. The replacement of the Texas A&M University System's benefit plans with the state employee group benefit plans administered by the Employees Retirement System may not take place unless authorized under certain conditions set by general law.

The rider requires a determination of the actuarial impact of the potential merger on both TAMUS and the GBP. In order to make this determination, we have analyzed the actuarial experience as well as the risk composition of the TAMUS membership in order to project the anticipated impact on GBP cost. This analysis provides the expected impact on GBP costs and contribution rates as well as the information necessary for TAMUS to evaluate the impact of the proposed merger on its insurance costs. In conducting the actuarial analysis, we have also identified and commented on other, more general factors which we believe are also important to consideration of this issue.

The study focuses primarily on the health coverage due to its dominance in the TAMUS program and the GBP. We have also analyzed the impact of the merger on TAMUS and GBP optional coverages, but such analysis is less extensive than that applicable to the health coverage. In addition, we have compared the appropriation for TAMUS with that applicable to higher education institutions participating in the GBP in order to provide perspective from which to consider the full impact on TAMUS of the merger under consideration.

Comments Regarding the Differing Risk Characteristics of the Plans

Throughout this document references are made to the costs of the two programs and comparisons are made between pre-merger and post-merger costs. It is extremely important to emphasize that both programs are equally efficiently managed, financed and administered. Both use the same health care provider network administered by the same vendor. The pharmacy benefit managers of both programs operate in very similar manners. Both programs are easily large enough to have predictable experience that is immune to sharp variations due to statistical anomalies. In short neither is employing any techniques that would change the underlying risk of the other. As noted below, in this case the whole is equal to the sum of the parts.

As a result, and this cannot be overemphasized, **the differences in cost between the two programs pre-merger are entirely attributable to differences in the risk composition of the two groups and benefit differentials.** As discussed below, the merger would not change the risk characteristics of the two populations; instead, it would change the manner in which the costs are spread. In any insured population, some members of the population subsidize others, e.g., the healthy subsidize the unhealthy, the young subsidize the old, those who do not have accidents subsidize those who do, etc. Of course the membership of these segments is ever-changing and, in most cases, an individual does not know which group he will fall into during a given period. Basically, the decision that TAMUS will be called upon to make in connection with the legislative directive comes down to whether TAMUS and its members are better off standing on their own or sharing risk with the current membership of the GBP.

Summary and Conclusions

The following summarizes the key findings of this analysis:

1. A review of the methodology used to develop the state appropriation for higher education group insurance indicates that the merger alone would not result in an increase in the TAMUS appropriation. In fact, application to TAMUS of the same methodology as was applied in the development of the appropriation for insurance for ERS higher education institutions would have produced a lower general revenue (GR) appropriation for TAMUS for the FY04/05 biennium.

2. The actuarial analysis indicates, on average, that provision of the GBP-level of health benefits by ERS for the TAMUS membership would be less expensive than provision of those benefits for the GBP membership. The less expensive nature of the TAMUS membership is attributable to demographic, geographic and health status characteristics of the TAMUS that are more favorable than those of the GBP membership. The less expensive nature of TAMUS is not unexpected for a higher education institution.

3. Merger of two separate insurance pools has no impact on the per capita cost of benefits for the members of the respective pools since both are equally efficiently managed. The total benefit cost for the merged program would be the same as the sum of the benefit

cost for the two programs before merger, assuming that both continue the same level of benefits. The merger, however, would result in a per capita cost for the merged program that is different from that of either of the separate programs. The per capita cost for the merged program will be greater than that of the program that was less expensive before the merger and less than that of the program that was more expensive before the merger. In this case, following the proposed merger, the per capita cost to TAMUS would be greater and the per capita cost of the GBP would be slightly less.

4. The cost of the merger to TAMUS and its members (used herein to refer to employees and retirees) would be even greater than that which would be incurred through picking up a share of the higher cost associated with current members of the GBP. This additional cost would result from the more generous benefits provided through HealthSelect, the plan in which almost two-thirds of the TAMUS membership would be expected to enroll. For current A&M Care members, the additional cost to TAMUS institutions and agencies resulting from their enrollment in HealthSelect would be expected to about $12.1 million per year, while the additional cost to the members would be about $3.9 million per year, based on FY05 costs.

5. Because of significant differences in the manner in which the two programs allocate cost among members with and without dependent coverage, there would be significant shifts in equities among the members depending upon whether or not they purchase dependent coverage. For example, TAMUS members who currently purchase A&M Care 350 member only coverage would experience a reduction in their contribution of almost $34 per month (even though they would have better benefits), while members purchasing member and family coverage would experience an increase in their contribution of over $69 per month, although they, too would have better benefits. Within the TAMUS membership there would be vast differences in the impact of the merger.

6. Because the GBP does not include multiple plan options, current A&M Care 1250 and A&M Care 65+ members purchasing dependent coverage would experience large increases in monthly contributions, albeit in return for substantially more generous benefits.

7. TAMUS members purchasing optional coverages would experience significant changes in cost. Those with dental coverage would save money under the GBP, while those with life and/or long term disability coverage would spend more. Of course, many combinations of changes in cost would occur depending on the mix of optional coverage. As a result, the acceptance of the merger would vary greatly among the TAMUS members.

8. Both programs would have many transitional issues to overcome as TAMUS relinquishes control and ERS assumes control. For ERS, there would be substantial additional work with accompanying expense and many complications as the staff seeks to communicate the GBP, a new and different program, to some 28,500 new members and an equal additional number of dependents. For TAMUS, there would be major adjustments

required to become comfortable with an arrangement in which it could offer input, but over which it has no authority.

Based on this analysis, under the proposed merger, TAMUS would experience no financial benefit while losing the ability to independently design and manage insurance benefits for its employees and retirees. At the same time, while the merger would seem to offer some minor cost distribution advantages to GBP members, it would significantly increase the complexity of ERS communication and administration, at least over the short term.

The remainder of this document presents a detailed discussion of the analysis as well as our observations.

Data Sources

As the consulting actuaries to ERS for insurance matters, we maintain an extensive actuarial data base related to GBP benefit cost experience and enrollment. In addition, as ERS actuaries, we have access to all information related to the operation and administration of the GBP such as plan design, administrative arrangements, vendor contracts and internal administrative expenses. We have utilized all necessary GBP information in this study.

TAMUS, with the assistance of various contractors associated with the TAMUS program, has provided extensive enrollment and experience data as well as information concerning plan benefits, rates and administrative arrangements.

Impact of a Potential Merger on the State Appropriation for the TAMUS Program

In our role as consulting actuary to ERS for insurance matters, we have extensive background in the appropriation process for state agency and higher education insurance provided through the GBP. The observations and conclusions presented herein in regard to the impact of a potential merger on the state appropriation for the TAMUS program is based on our knowledge of that process, not on discussions with the Legislative Budget Board or other state officials. For reasons stated below, we believe that a review of the process used in developing the appropriation for FY04/05 provides a reliable basis for our observations and conclusions.

Although the appropriations for state agency and higher education insurance are developed independently of one another, the appropriations for all higher education institutions are developed in a consistent manner, with little variation among the methodologies applied in such development for (a) the higher education institutions that participate in the GBP, (b) TAMUS or (c) the University of Texas System (UTS). Higher education and state agency insurance appropriations are handled by different LBB analysts and, at least in the House, proceed through different subcommittees. While there is communication among the various parties, there are differences in the methodologies that are applied. While this leads to different results for state agencies as compared to higher education institutions, it produces very similar results for all higher education institutions. In fact, there is complete consistency in treatment among all ERS higher education institutions. This treatment differs only slightly from that which is applied to TAMUS and UTS.

As a result, we believe that a merger is unlikely to increase the TAMUS appropriation. In fact, though the methodology is similar for ERS higher education institutions, those institutions received about 1.5% less per capita than both TAMUS and UT. One might reasonably conclude from this review that TAMUS might actually receive a smaller appropriation if it was included among the ERS higher education institutions for appropriation purposes.

Exhibit 1 presents a comparison of the determination of the actual FY04/05 GR funding for TAMUS with that which would have been determined under the same methodology as was applied to ERS higher education institutions. Overall, application of the ERS methodology to all TAMUS components would have produced approximately $3.4 million less in GR funding for the biennium.

An important component of this differential is the statutory difference between the two programs concerning the "Insurance Waiver". Under the statute governing the TAMUS program, a member may waive health coverage if he/she certifies that he/she has other health coverage. Such a member is then entitled to 50% of the state contribution, an amount which is included in determining the state appropriation. For the current biennium, the TAMUS appropriation includes approximately $1.5 million for those waiving coverage. Under the GBP, a member is not eligible for a state contribution if he/she waives coverage. We expect that the GBP provision would be applied to TAMUS in the event of merger, thus reducing the appropriation, at least initially. Over time, TAMUS would receive an appropriation for those members who decided that waiver was no longer in their best interests and rejoined the plan.

The merger alone seems unlikely to affect the appropriation process. It seems that changes in the appropriation process for group insurance for all higher education institutions would be required in order for TAMUS to receive additional funding, a proposition that seems unlikely under current budgetary conditions.

Since it is unlikely that TAMUS would receive greater state funding if it were to merge its program with the GBP, compelling expense reductions would be necessary to make the merger attractive to TAMUS from a financial perspective.

Impact on GBP Health Plan

In order to determine the impact of the merger on the GBP Health Plan we have modeled the expected cost under the two GBP health plans, HealthSelect and Scott and White Health Plan (SWHP) that would likely absorb 96% of the TAMUS membership. Current A&M Care members (comprising 63% of the total membership) would be expected to enroll in HealthSelect, while current SWHP members (comprising 33% of the total membership) would be expected to remain in SWHP when merged into the GBP. With the remaining 4% of the membership spread among four HMOS, we did not attempt to model their expected cost in GBP HMOs for which there is not an exact match between the two programs. We did perform, however, a cursory review of this small group in comparison to their statistical counterparts in HealthSelect.

For the A&M Care and SWHP members, we modeled their expected cost in HealthSelect and GBP SWHP, respectively for FY05. Even though TAMUS would not participate in the GBP until FY06 if it chooses to merge into the GBP, we believe that analysis under hypothetical participation in FY05 provides a reliable basis for developing conclusions, since rates applicable to FY05 and state funding available for FY05 are already known.

Current A&M Care members would be expected to generate a per capita cost under HealthSelect that is about 8% less than the per capita cost attributable to current GBP members participating in HealthSelect. This analysis is based on an actuarial review of the A&M Care experience through May, 2004, adjusted to account for the benefit differential between A&M Care and HealthSelect and projected to FY05 using the same assumptions currently in use for projecting HealthSelect cost for the remainder of FY04 and FY05. The analysis is facilitated since Blue Cross Blue Shield of Texas (BCBS) is the administrator and network manager under both A&M Care and HealthSelect and since the pharmacy reimbursement arrangements under both plans are quite similar, even though the plans use different pharmacy benefit managers (PBMs). This consistency eliminates any need to adjust the experience in an attempt to account for differences in provider reimbursement and health care management.

Our analysis of A&M Care enrollment and claims experience indicates that the lower expected per capita cost is attributable to:

- Demographic and geographic characteristics that would be expected to produce lower cost for A&M Care members, specifically, (a) a slightly younger average age which correlates with lower health care utilization rates and (b) a lower concentration of members in higher cost locations.
- A smaller incidence of members with annual claims in excess of $100,000, which may be attributable to statistical fluctuation.
- Utilization of health care that is below that which would be expected based on the more favorable demographic and geographic characteristics of the membership discussed above. This is not unexpected given the different socio-economic mix of employees between TAMUS and the GBP, a population of which only about 28% is employed by higher education institutions. The observed cost differential is consistent with cost differentials observed when GBP higher education employees first joined the GBP in FY92. The lower utilization is probably also due in part to the A&M Care plan design which includes higher employee out-of-pocket expenses at the time of service.

Impact on HealthSelect - As result, we expect the merger of the A&M Care members into HealthSelect would reduce the overall per capita cost of HealthSelect by approximately 0.6%. This should not be interpreted to indicate that the cost of coverage for current HealthSelect members will be reduced; instead it simply indicates that their cost would be averaged over a different and larger group, the new members of which are expected to be less expensive to cover than those currently in the plan. In other words, the merger would result in higher per capita cost for TAMUS than would otherwise be required to provide a HealthSelect level of benefits in a separate plan and slightly lower per capita cost for the GBP than would be required in the absence of the merger. In any arrangement that includes an averaging of costs, there will be winners and losers. In this case, the merger which would produce a small reduction in per capita

cost (0.6%) for the relatively larger GBP (245,000 members), but it would produce a higher per capita cost (about 8% more) than would otherwise be required to provide HealthSelect benefits for the relatively smaller A&M Care (18,000 members) through a separate plan.

Impact on GBP SWHP - In our analysis of the impact of combining the SWHP members from each program, we assumed that the FY05 rates for SWHP for each program are indicative of the actual cost of such coverage; i.e., the rates are adequate, but not excessive. We then adjusted the TAMUS SWHP rates to the levels that would be expected if the GBP SWHP benefits were in place. We found that under current GBP benefits, TAMUS SWHP members would be expected to cost an average of about 8.7% less than current GBP SWHP members. This differential is almost entirely explained by the different demographic composition of the two groups of employees; i.e., the TAMUS SWHP members are, on average, younger than the GBP SWHP members.

If the programs were merged in FY05, the SWHP rates for the merged plan would be 3.9% less than the current GBP SWHP rates and 5.3% more than would be required to provide GBP-level SWHP benefits to TAMUS SWHP members. As with the A&M Care members, merger would reduce per capita SWHP cost for the GBP members and increase it for TAMUS members.

Although a detailed analysis was not conducted for the TAMUS plans with low participation, a review of the relative enrollments and demographic/geographic compositions of the TAMUS members in those plans indicate that they would likely have little impact on the GBP plan, although, they too are somewhat younger on average than the GBP members.

In conclusion, this analysis indicates that the GBP would benefit through the merger of TAMUS into the program due to the generally lower per capita cost that would be required to provide GBP-level benefits to the TAMUS members. This lower per capita cost results from the different demographic, geographic and socio-economic characteristics of the TAMUS members. The benefit that would accrue to the GBP would result from the advantage that would be gained by spreading the higher average cost of the current GBP members over the expanded group which would include the lower average cost TAMUS members. This is a zero-sum situation in which any gain to the GBP would be exactly offset by a loss to TAMUS. Because the GBP is much larger, the positive impact on the GBP would be smaller than the negative impact on TAMUS.

Impact on TAMUS Heath Care Benefit Expenditures

The foregoing analysis indicates that TAMUS would be disadvantaged by the merger if they wished to provide the same level of benefits; i.e., they would be able to provide GBP-level benefits less expensively on their own since they would not have to share in the cost of coverage for the generally older, higher cost members who comprise the GBP membership. But TAMUS has already made the decision not to provide the GBP-level of benefits. They indicate that this decision was based on the limited level of state funding available and a benefit plan design philosophy emphasizing lower monthly contributions for all employees and higher employee out-of-pocket expenses at the time of service for those employees who utilize services. As a

result, merger would be an even more disadvantageous proposition for TAMUS than indicated by the previous discussion.

Our analysis indicates that the cost for FY05 coverage for A&M Care members would be 16.8% greater or about $16.0 million more per year under HealthSelect, based on the FY05 contribution rates for both programs. This is the collective additional cost to TAMUS and the members. The additional cost would break down as $12.1 million more for TAMUS (an increase of 15.7%) and $3.9 million more for the members (an increase of 21.9%) during FY05. Exhibit 2 provides detailed information on this projection.

Similar analysis for TAMUS's SWHP members indicates that although the cost to both TAMUS and the members would be about 0.4% less, the GBP SWHP benefits have an actuarial value that is about 10% less than the TAMUS SWHP benefits. Therefore, although less clearly quantifiable than for the A&M Care members, the merger would also be costly to TAMUS and its SWHP members. Detailed calculations are presented in Exhibit 3.

In conclusion, the merger would increase cost to TAMUS, without the prospect of additional state funding.

Impact on TAMUS Health Plan Management

A review of the TAMUS health plan indicates significant differences in the plan management philosophies exercised by TAMUS as compared with those exercised by ERS in its management of the GBP. While the relative merits of these strategies can be debated, that is beyond the scope of this study. Instead, the significance of these differences lies in the reality that a merger would result in TAMUS compliance with GBP strategies and procedures whether or not those were consistent with previous plan management philosophy. At a minimum, a merger into the GBP would result in significant changes for TAMUS and its employees and retirees. While these changes might prove to be acceptable over the long term, in the short term, they would likely be considered undesirable.

The following are the more significant of the differences we noted:

1. TAMUS offers multiple health plans within A&M Care. In order to avoid adverse selection, ERS does not utilize multiple health plans within HealthSelect. As a result, in the event of merger, all A&M Care members would be required to enroll in HealthSelect in order to maintain PPO/POS-type benefits. Although benefits would be better for all members currently enrolled in A&M Care, the cost would also be greater for both TAMUS and the members, collectively. The increase would be especially significant for members currently enrolled in A&M Care 1250 and A&M Care 65+.

2. ERS does not require a contribution for member only coverage. TAMUS does for both A&M Care 350 and SWHP. As a result, TAMUS would experience an increase in its cost for member only coverage, while members purchasing member only coverage would experience a commensurate reduction.

3. ERS develops GBP contribution rates for the various coverage categories based on rating relativities that reflect the expected cost of coverage for each of three risk groups: member, spouse and children. TAMUS establishes contribution rates based on rating relativities that differ significantly from those used by ERS. Under the merger, application of the GBP rating relativities to TAMUS would result in a number of changes in equities among TAMUS members depending on whether they purchase dependent coverage.

   The cost of coverage for those in A&M Care who currently have member only coverage (approximately 9,400) would decrease or remain unchanged, while the cost of coverage for all members who purchase dependent coverage (approximately 8,600) would increase. Increases would range from about $5 per month to over $200 per month. About 7,300 current TAMUS SWHP members would also experience a reduction in their contribution rate, while about 2,200 such members would experience an increase in their contribution rate. Exhibits 4 and 5 provide detail on this determination.

4. In FY05, TAMUS will allow graduate students to enroll in a student insurance plan with member contribution rates for member only and member and children that are lower than those required under A&M Care 350. ERS does not maintain a separate plan for graduate students. Consequently, certain TAMUS graduate students who enroll in the student plan for FY05 would experience a sharp increase in their contributions or, more likely, would drop coverage in the event of merger.

Statutory Differences

There are at least two key differences between the statutes governing the TAMUS program and the GBP that would have a significant impact on TAMUS members.

1. TAMUS and UTS members are entitled to receive 50% of the state contribution for member only health and basic life insurance if they waive participation in those plans. They are then able to use that contribution to apply toward the cost of optional coverages. There is no similar provision under the GBP. The some 500 TAMUS members who currently waive basic coverage would lose access to the state contribution unless they chose to participate in the basic coverage, which they would likely do if the 50% state contribution were not available upon waiver.

2. SB1370, adopted by the 78th Texas Legislature, Regular Session, increased the qualifications for retiree health insurance under the statute governing the GBP (Chapter 1551) to require (a) satisfaction of the Rule of 80 or (b) attainment of age 65 and completion of 10 years of service for members retiring on or after September 1, 2003. Although SB1370 also applies to the statute governing the TAMUS and UTS programs (Chapter 1601), SB1652, also adopted by the Texas Legislature in its 78th Regular Session, includes a grandfathering provision that exempted those employed by TAMUS and UTS on August 31, 2003, from the more stringent requirements. A letter from the Office of the Attorney General resolved the apparent conflict between these two bills in favor of SB1652; i.e., the more stringent provisions are not applicable to those employed

by TAMUS and UTS as of August 31, 2003. Since TAMUS would be governed under the statute applicable to the GBP in the event of termination, the more stringent provision would presumably become applicable to employees not yet retired as of September 1, 2005. This could present important employment problems for TAMUS.

Health Plan Benefit Differentials

From a benefit perspective, all TAMUS members moving from A&M Care to HealthSelect would be generally pleased due to the more generous benefits included in HealthSelect. They would likely feel inconvenienced, however, by the primary care physician (PCP) requirement in HealthSelect. This provision requires that the participant obtain a referral from a PCP of their choice before visiting a specialist. Plan utilization data demonstrates that this is an effective cost containment tool, but it is not always popular with the members or their specialists.

As noted above, the GBP SWHP benefit level is less generous than the TAMUS SWHP benefit level. Although the GBP plan is less expensive, TAMUS members moving between the two SWHP plans as a result of merger would likely be disappointed and, perhaps confused.

Basic Life Coverage

GBP basic life insurance is priced less expensively than TAMUS basic life, but the TAMUS plan includes coverage for dependent children and greater coverage for retirees. In any event, basic life is a relatively small component of either program. The basic life-related savings to TAMUS that would result from merger is projected to be about $200,000 per year, a small offset to the additional health cost discussed above.

Optional Coverages

Although the health plan is the focus of this study and, we believe, the primary reason the merger is under consideration, it is also important to spend some time on the optional coverages. It appears from the wording of the rider (which makes no distinction among the various "group plans") that all coverage for TAMUS employees and retirees would be obtained through the GBP in the event of merger. This would have important ramifications, primarily for TAMUS members. As with the health plan, it is almost certain that the plans available to TAMUS members would be those presently available in the GBP. Based on that premise, the following observations are important.

1. **Optional Life Insurance** - The member contribution rates for the GBP optional life plan are higher than the corresponding rates for the TAMUS optional life plan. As a result, TAMUS members would experience an increase in cost in order to maintain their life insurance coverage following merger. The increase would vary by age, but in total would be about $3.0 million per year.

    a. The difference is primarily attributable to different cost characteristics of the insured populations. The GBP rates are determined based on the actual experience of the plan; i.e., contribution rates are determined so as to produce the

amount of revenue required to provide for the claims expected under the plan. TAMUS indicates that its optional life rates are similarly determined, so part of the rate differential is attributable to a difference in mortality experience of the two populations. Such difference, which favors TAMUS, is not unexpected given the significant employment differences that exist between the two populations. The GBP population includes a greater proportion of members in high risk employment such as law enforcement, highways, and mental institutions. It should be noted that the GBP optional life plan includes accidental death and dismemberment (AD&D) coverage equal to the amount of the life insurance. Under the TAMUS program, the optional life plan does not include AD&D.

b. It should also be noted that the GBP plan includes a coverage maximum of the lesser of four times pay or $400,000, while the TAMUS plan includes a coverage maximum of six times pay or $1 million. As a result, 6,200 TAMUS employees would experience a reduction in their optional life coverage in the event of merger.

2. **Dental Insurance** – Both programs offer PPO and DHMO dental plans. There are significant differences in plan design between the GBP PPO dental plan and the TAMUS plan. The GBP plan provides benefits that are somewhat more generous than those provided under the TAMUS plan for those who have participated in the plan for two or more years, but it has a phased in approach whereby benefits for the first two years of enrollment are significantly lower. The GBP plan is less expensive to the member. TAMUS DHMO benefits are somewhat more generous, but the GBP DHMO plan is significantly less expensive. We estimate that TAMUS members would pay approximately $3.0 million per year less for dental coverage under the GBP.

3. **Disability Insurance** – Both programs offer long term disability insurance (LTD). The TAMUS plan provides slightly more generous benefits (65% of pay as compared with 60% of pay under the GBP), a higher maximum benefit ($8,000 vs. $6,000 under the GBP) and a substantially lower member contribution rate. In the event of merger, TAMUS members participating in the LTD plan would experience a reduction in benefits and an increase in contributions. We estimate that TAMUS members would pay approximately $1.7 million per year more for LTD coverage under the GBP

   The higher cost of the GBP LTD plan is attributable to differences in the insured populations of the two programs. The GBP LTD plan covers 41% of the active employees, while the TAMUS LTD plan covers about 50 % of the active employees. The GBP's lower enrollment level indicates greater adverse selection against the plan, thus driving the required contribution rate higher. The rate differential also reflects socio-economic differences in the two populations as discussed above.

   The GBP offers a short term disability plan not currently available to TAMUS members.

4. **Long Term Care Insurance** – Both programs offer long term care insurance through the plan operated by TAMUS. Presumably this could be continued under the same terms and

conditions in the event of merger, but it might be necessary to transfer the operation of the plan to ERS.

5. **Vision Insurance** – The GBP does not include a separate vision plan. The 7,000 members who currently participate in the TAMUS vision plan would lose their coverage in the event of a merger.

6. **Other Coverages** – There are also differences in the more minor coverages such as voluntary accident and dependent life insurance that would certainly be noticed by many of the members, but that would not have financial implications to TAMUS.

Impact on ERS Administrative Cost

ERS has well-established, effective and efficient administrative and communication divisions which handle insurance plans for some 265,000 GBP members. It is expected that these divisions could accommodate the additional 28,500 members that would result from the merger, although commensurate increases in staffing, equipment, supplies, etc. would be required. Based on the expense associated with operation of the current GBP, it is estimated that the merger would increase ERS operating expenses by $39 per year for each new member, or by about $1.1 million per year.

Presently, ERS operating expenses for the GBP are covered by investment income generated by the program. Expansion of the program through the merger would result in additional investment income that, over time, would be expected to cover the additional cost of administration and communication on an ongoing basis. Nevertheless, there could be initial shortfalls, especially considering that there would be start-up expenses for which there is presently no source of supporting revenue.

Post-Merger GBP Benefit Design and Policy

The GBP has experienced 28 years of successful operations under the leadership of the ERS Board of Trustees. The Trustees have delegated to the ERS Executive Director the authority to conduct the day-to-day operations of the program under policies adopted by the Trustees based on input provided by the Executive Director and her staff. The Board of Trustees (three members of which are elected by state agency employees and retirees) and the staff consider input from the members, state agencies and higher education institutions, but the various constituents have no official role in GBP policy or operations.

The GBP has been designed to meet the needs of all state agencies and higher education institutions currently participating in the program. The program has been designed to achieve a balance between cost and benefits. A program as large as the GBP cannot address the specialized needs of any single agency. While the GBP works well for participating components, the one-size fits all strategy would likely be a shock to an organization with the size and diversity of TAMUS. The difficulty of assimilating into a program in which an individual component has little influence over policy was evident in 1992 when higher education institutions other than TAMUS and UTS joined the GBP. While it would be possible that

specific needs could be addressed through modification of the GBP, it is unlikely that such action would occur either quickly or frequently given the many components that would be affected.

Impact on TAMUS Administration

TAMUS would experience a reduction in its administrative activity in connection with the insurance program following the merger. All of its policymaking, contract procurement, contract management, and much of its financial and legal responsibilities would be eliminated under the merger. Its activities would be limited to those applicable to the Benefits Coordinator role in state agencies and GBP higher education institutions. This would likely result in a significant reduction in administrative expense, executive time and operational complexity. Although an examination of those factors is beyond the scope of this study, we believe that the savings in administrative expense would be small in comparison to the additional cost discussed above.

Maintenance of Per Capita Reserve Balance

The U. S. Department of Health and Human Services (DHHS) determined in connection with the merger of certain higher education insurance programs into the GBP in 1992 that it was necessary to maintain the GBP reserve balance at the same per capita level post-merger as existed pre-merger. Recent correspondence between ERS and DHHS has confirmed that this same requirement would be applied to subsequent mergers as well, specifically to the merger which is the subject of this study. In order to satisfy this requirement, it would be necessary for TAMUS to make a supplemental contribution at the time of the merger in the amount required to maintain the reserve balance at the same per capita level existing on August 31, 2005.

The amount of this supplemental contribution cannot be determined until ERS completes its Comprehensive Annual Financial Report (CAFR) for FY05. The CAFR will be completed during the fall of 2005. In connection with the community supervisors and correction department employees that will join the GBP beginning September 1, 2004, we have estimated that the required supplemental contribution will be approximately $242 per employee. Using this amount as a basis, the required supplemental contribution for TAMUS would be approximately $6.9 million, assuming 28,500 TAMUS members would join the GBP in the event of merger. Of course, this amount could be either lower or higher depending on the actual GBP experience over the remainder of the biennium.

Rudd and Wisdom, Inc. Response to Issues Raised by TAMUS Regarding Draft Actuarial Report

Unless otherwise noted below, changes recommended by TAMUS have been incorporated into the final report, although in some cases we have revised the suggested language.

1. We have not included the bulleted summary that was recommended as we are concerned that such a summary could lead the reader to overlook important qualifications applicable to the cost estimates which are included in the report, e.g., the $6.9 million estimate of the amount required to maintain the per capita reserve balance could be either higher or lower depending on the actual reserve balance on August 31, 2005. Of course, TAMUS staff could utilize such a summary for purposes of its own decision making process.

2. We decided not to include commentary on the historical appropriation process as was recommended. Our only reason for including the appropriation discussion was to make the point that merger would not be likely to increase the state's appropriation for TAMUS insurance. While the analysis leads to the conclusion that the merger might actually result in less revenue from the state, even the former methodology would not have produced more, which may have been a misunderstanding from the outset. Comparison of the current and the historical methodologies might be viewed as critical of the legislative appropriation process, a controversy we did not wish to engage in.

3. In No. 1 on page 8, TAMUS took exception to our discussion of multiple plans. Our comments were intended as necessary explanation of the reasoning behind ERS's policy concerning multiple plans which, in the experience of ERS, presents significant actuarial problems. While we would not want to create external criticism of TAMUS plan design, we also would not want external parties to question why ERS does not follow the TAMUS model. In an attempt to balance these concerns, we revised the sentence in question as follows:

   "In order to avoid adverse selection, ~~which can undermine financial stability and plan viability,~~ ERS does not utilize multiple health plans within HealthSelect."

   This is a statement of fact which explains ERS policy, yet it avoids debate by eliminating the further clarification which we had originally included.

4. In the first paragraph of No. 3 on page 8, TAMUS requested a modification to our discussion regarding rating relativities. We are unable to independently confirm the methodology that you described in your recommended addition and we do not think that the sentence that was added applies to this issue. Under both A&M Care and SWHP the spouse is rated at less than the cost of the employee, a result that is not supported by either A&M Care experience (FY03 plan experience indicates that the spouse costs about 20% more than the employee) nor by our experience with other plans. The optional nature of spouse coverage almost guarantees that there will be selection in the election of spouse coverage. While

we are unwilling to include the recommended language, we have revised the sentence in question as follows:

"TAMUS establishes contribution rates based on ~~pre-determined rating relativities that do not necessarily reflect the relative costs of the three risk groups.~~ rating relativities that differ significantly from those used by ERS."

This is a statement of fact that avoids criticism of the A&M Care relativities.

5. In the last paragraph of No.3 on page 9, TAMUS recommended the inclusion of a phrase acknowledging that TAMUS participants would experience a reduction in benefits in the event of merger. We did not adopt this recommendation since it would have required that we note, in the previous sentence, that A&M Care participants would experience an increase in benefits in the event of merger. Besides, the SWHP benefit differential is mentioned elsewhere in the document.

6. On page 11 in the discussion of the optional life plan, TAMUS recommended that we include language regarding imputed income for tax purposes. We have not included the recommended language since it over generalizes a complicated issue. In addition, we did not believe that it added to the analysis.

Exhibit 1

Employees Retirement System

TAMUS Actuarial Study

Comparison of FY04/05 Higher Education General Revenue Appropriation Methodology

The following Monthly Appropriation Factors (MAF) were used by LBB in developing the higher education GR appropriations for group insurance for the FY04/05 Biennium.

Coverage Category No.	Coverage Category	Monthly Appropriation Factor (MAF) ERS	TAMUS
1	Employee Only	$243.98	$247.53
2	Employee and Child(ren)	336.77	341.66
3	Employee and Spouse	382.57	388.13
4	Employee and Family	475.36	482.27
5	Insurance Waiver	0.00	123.76
6	No Insurance	0.00	0.00

The GR Appropriation for each institution for each year was determined as follows:

GR Appropriation = $SUM_{c=1-6}(12 \times MAF_c \times GRE_c)$, where
c = Coverage Category Number
MAF = Monthly Appropriation Factor
GRE = Number of GR employees from Schedule 3B

			Annual Appropriation for FY04/05 for All TAMUS Institutions			
			Actual		Hypothetical Based on ERS MAF	
Coverage Category No.	Coverage Category	GRE	TAMUS MAF	Appropriation	ERS MAF	Appropriation
1	Employee Only	8,231	$247.53	$24,448,902	$243.98	$24,098,716
2	Employee and Child(ren)	1,793	341.66	7,351,261	$336.77	$7,245,968
3	Employee and Spouse	3,647	388.13	16,986,112	$382.57	$16,742,817
4	Employee and Family	3,156	482.27	18,264,377	$475.36	$18,002,773
5	Insurance Waiver	505	123.76	750,012	$0.00	$0
6	No Insurance	58	0.00	0	$0.00	$0
	Total	17,390	$324.90	$67,800,663	$316.71	$66,090,272

Actual Appropriation for the FY04/05 Biennium	$135,601,325 (=2 x $67,800,663)
Hypothetical Appropriation for the FY04/05 Biennium Based on ERS MAF	132,180,545 (=2 x $66,090,272)
Reduction Based on Hypothetical	$3,420,780 *

* Collectively, TAMUS Institutions would have received $3.4 million less in GR funding for group insurance for the FY04/05 biennium if the ERS higher educatior methodology had been applied in the development of their respective appropriation amounts.

Exhibit 2

Employees Retirement System

TAMUS Actuarial Study

Comparison of Actual and Hypothetical Contribution Amounts for TAMUS A&M Care Enrollment[1]

		Projected Actual TAMUS FY05 Contributions						Projected Hypothetical TAMUS FY05 Contributions Based on GBP Rates					
	Number	TAMUS Contribution		Member Contribution		Total Contribution		TAMUS Contribution		Member Contribution		Total Contribution	
Coverage Category	Enrolled	Rate	Amount	Rate	Amount	Rate	Amount	Rate	Amount	Rate	Amount	Rate	Amount
A&M Care 350 Enrollment													
EO	7,844	$288.35	$2,261,817	$33.75	$264,735	$322.10	$2,526,552	$313.33	$2,457,761	$0.00	$0	$313.33	$2,457,761
ES	2,782	420.08	1,168,663	165.48	460,365	585.56	1,629,028	493.50	1,372,917	180.16	501,205	673.66	1,874,122
EC	1,360	370.69	504,138	116.08	157,869	486.77	662,007	433.96	590,186	120.63	164,057	554.59	754,243
EF	1,895	485.95	920,875	231.31	438,332	717.26	1,359,207	614.13	$1,163,776	300.79	569,997	914.92	1,733,773
Option Total	13,881		$4,855,493		$1,321,301		$6,176,794		$5,584,640		$1,235,259		$6,819,899
A&M Care 1250 Enrollment													
EO	1,123	$288.35	$323,817	$0.00	$0	$288.35	$323,817	$313.33	$351,870	$0.00	$0	$313.33	$351,870
ES	678	420.08	284,814	50.24	34,063	470.32	318,877	493.50	334,593	180.16	122,148	673.66	456,741
EC	489	370.69	181,267	25.59	12,514	396.28	193,781	433.96	212,206	120.63	58,988	554.59	271,194
EF	1,022	485.95	496,641	83.08	84,908	569.03	581,549	614.13	$627,641	300.79	307,407	914.92	935,048
Option Total	3,312		$1,286,539		$131,485		$1,418,024		$1,526,310		$488,543		$2,014,853
A&M Care 65+ Enrollment													
EO	466	$288.35	$134,371	$0.00	$0	$288.35	$134,371	$313.33	$146,012	$0.00	$0	$313.33	$146,012
ES	387	420.08	162,571	50.87	19,687	470.95	182,258	493.50	190,985	180.16	69,722	673.66	260,707
EC	0	370.69	0.00	0.00	0	370.69	0.00	433.96	0.00	120.63	0.00	554.59	0.00
EF	0	485.95	0.00	0.00	0	485.95	0.00	614.13	0.00	300.79	0.00	914.92	0.00
Option Total	853		$296,942		$19,687		$316,629		$336,997		$69,722		$406,719
A&M Care Monthly Total	18,046		$6,438,974		$1,472,473		$7,911,447		$7,447,947		$1,793,524		$9,241,471
A&M Care Annual Total			$77,267,688		$17,669,676		$94,937,364		$89,375,364		$21,522,288		$110,897,652
Annual Increase									$12,107,676		$3,852,612		$15,960,288
Percentage Increase									15.7%		21.8%		16.8%

[1]Assuming enrollment in HealthSelect

Exhibit 3

Employees Retirement System

TAMUS Actuarial Study

Comparison of Actual and Hypothetical Contribution Amounts for TAMUS SWHP Enrollment[1]

		Projected Actual TAMUS FY05 Contributions						Projected Hypothetical TAMUS FY05 Contributions Based on GBP Rates					
	Number	TAMUS Contribution		Member Contribution		Total Contribution		TAMUS Contribution		Member Contribution		Total Contribution	
Coverage Category	Enrolled	Rate	Amount	Rate	Amount	Rate	Amount	Rate	Amount	Rate	Amount	Rate	Amount
EO	4,706	$288.35	$1,356,975	$10.00	$47,060	$298.35	$1,404,035	$267.32	$1,258,008	$0.00	$0	$267.32	$1,258,008
ES	1,306	420.08	548,624	154.35	201,581	574.43	750,205	421.03	549,865	153.71	200,745	574.74	750,610
EC	1,243	370.69	460,768	126.73	157,525	497.42	618,293	370.24	460,208	102.92	127,930	473.16	588,138
EF	2,174	485.95	1,056,455	222.34	483,367	708.29	1,539,822	523.95	$1,139,067	256.63	557,914	780.58	1,696,981
SWHP Total	9,429		$3,422,822		$889,533		$4,312,355		$3,407,148		$886,589		$4,293,737
SWHP Annual Total			$41,073,864		$10,674,396		$51,748,260		$40,885,776		$10,639,068		$51,524,844
Annual Increase									-$188,088		-$35,328		-$223,416
Percentage Increase									-0.5%		-0.3%		-0.4%

[1]Assuming enrollment in SWHP under GBP

Exhibit 4

Employees Retirement System

TAMUS Actuarial Study

Comparison of A&M Care and HealthSelect Monthly Contribution Rates for TAMUS A&M Care Enrollment

		TAMUS FY05 A&M Care Rates			GBP FY05 HealthSelect Rates			
	May, 2004 Enrollment	Total	TAMUS	Member	Total	TAMUS	Member	Member Change
A&M Care 350								
E/O	7,844	$322.10	$288.35	$33.75	$313.33	$313.33	$0.00	-$33.75
E/S	2,782	585.56	420.08	165.48	673.66	493.49	180.16	14.68
E/C	1,360	486.77	370.69	116.08	554.59	433.96	120.63	4.55
E/F	1,895	717.29	485.95	231.34	914.92	614.13	300.80	69.46
A&M Care 1250								
E/O	1,123	$288.35	$288.35	$0.00	$313.33	$313.33	$0.00	$0.00
E/S	678	470.32	420.08	50.24	673.66	493.49	180.16	129.92
E/C	489	396.28	370.69	25.59	554.59	433.96	120.63	95.04
E/F	1,022	569.03	485.95	83.08	914.92	614.13	300.80	217.72
A&M Care 65+								
E/O	466	$288.35	$288.35	$0.00	$313.33	$313.33	$0.00	$0.00
E/S	387	470.95	420.08	50.87	673.66	493.49	180.16	129.29

Members with Reduction in Contribution Rate	7,844
Members with No Change in Contribution Rate	1,589
Members with Increase in Contribution Rate	8,613
	18,046

Exhibit 5

Employees Retirement System

TAMUS Actuarial Study

Comparison of TAMUS SWHP and GBP SWHP Monthly Contribution Rates for TAMUS SWHP Enrollment

		TAMUS FY05 SWHP Rates			GBP FY05 SWHP Rates			
	May, 2004 Enrollment	Total	TAMUS	Member	Total	TAMUS	Member	Member Change
E/O	4,706	$298.35	$288.35	$10.00	$267.32	$267.32	$0.00	-$10.00
E/S	1,306	574.43	420.08	154.35	574.74	421.03	153.71	-0.64
E/C	1,243	497.42	370.69	126.73	473.16	370.24	102.92	-23.81
E/F	2,174	708.29	485.95	222.34	780.58	523.95	256.63	34.29

Members with Reduction in Contribution Rate	7,255
Members with No Change in Contribution Rate	0
Members with Increase in Contribution Rate	2,174
	9,429

TOWERS PERRIN

HR SERVICES

September 2, 2004

Mr. Steven W. Hassel
Director, Benefits Program
Texas A & M University System
200 Technology Way
College Station, TX 77845-3424

Dear Steve:

This letter provides our summary analysis of the Actuarial Study of the Cost and Actions Involved in the Merger of the Texas A&M University System Group Benefits Plan into the State Employees Group Benefits Plans Administered by the Employees Retirement System (the "Study") and our assessment of the implications of a merger with the State plans for the Texas A&M University System (TAMUS). It follows our recent telephone conversation on this subject.

Summary

Our analysis of the Study indicates that there would be essentially no benefit to the State plan and significant harm to the Texas A&M University System and its plan participants were the proposed merger to take place. While it is usual in such an analysis to find that a proposed action could be positive or negative depending on one's perspective, this is one of the rare instances where the proposed action has universally negative consequences.

Analysis

To focus on the impact such a merger would have on TAMUS, we note that the financial impact of such a merger on the System would be a $20.7 million increase in cost in the initial year with ongoing annual increased cost of $13.8 million per year. Plan participants would see an annual increase in cost of $3.7 million in initial and subsequent years. The $24.4 million total first year increase in cost and $17.5 million future year total annual increase in cost break out as follows:

Annual Cost of Merger ($ in Millions)					
TAMUS			**Participants**		**Total**
– Additional cost to move to State "Health Select" Plans	$12.1	–	Additional cost to move to state "Health Select" Plans	$3.9	16.0
– Annual reduction in TAMUS appropriation	1.7	–	Increased cost of optional life	$3.0	4.7
		–	Decreased cost of basic life	(0.2)	(0.2)
		–	Decreased cost of dental	(3.0)	(3.0)
Net ongoing cost	13.8			3.7	17.5
-- One time cost of entry to maintain ERS reserve balance	6.9			0.0	6.9
Net first year cost	$20.7			$3.7	$24.4

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In short, TAMUS and participants would incur at least $94.4 million in increased costs, purely as a result of the plan merger, during the first five years of the new arrangement.

These cost increases would likely have more than a financial impact on plan participants. It is likely the merger would:

- make dependent coverage unaffordable for lower income TAMUS employees
- reduce retiree medical eligibility for current employees
- functionally eliminate medical coverage for existing and future dependents of retirees by making it unaffordable

Comments on the Study

While we agree with the conclusion of the study that the proposed merger offers no benefit to TAMUS and little or no benefit to ERS, we did have some concerns regarding study methodology:

1) The study is not always "symmetrical", a symmetrical analysis requires that any positive impact for one party include documentation of any negative impact on the other party if such an impact exists.

2) There are inconsistencies in the factors used to analyze benefit costs and in the reporting of results.

3) Supporting analysis is limited and in our opinion, insufficient. Important statements in the report are unsupported by data.

As none of the above issues have a material effect on the outcome of the analysis (addressing them would make a negative analysis more negative), we do not suggest that TAMUS pursue them at this time.

Conclusion

The proposed merger would have a catastrophically negative effect on TAMUS and its plan participants without improving the ERS program or reducing the combined overall cost to the State of providing benefits to both organizations in any material way. We consider it a bad idea and recommend against it.

Sincerely,

MAB:dlm

COMPARISON OF HEALTH SAVINGS ACCOUNTS (HSAS) WITH HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS), AND FLEXIBLE SPENDING ARRANGEMENTS (FSAS)

	HSA	HRA	FSA
I. IN GENERAL			
Definitions and Overview	Effective January 1, 2004, an HSA is a tax-advantaged trust or custodial account created for the benefit of an individual (not limited to employees) who is covered under a high deductible health plan ("HDHP"). The trustee may be a bank, any insurance company (not just a life insurance company), other persons already approved to be trustees or custodians of IRAs or MSAs, or another person (*e.g.*, a third party administrator) approved by the Secretary of Treasury. Contributions may be made by an employer, the individual, or a family member (subject to gift tax). Contributions are deductible if made by an individual and are excludable from income and wages if made by an employer. Earnings grow tax-free and distributions for qualified medical expenses are tax-free. Nonqualified withdrawals are subject to income and penalty taxes. Excess contributions are subject to a 6-percent excise tax. Like an IRA, the HSA is owned by the individual and is portable. Debit or credit cards may be used for reimbursement. HSAs may be established in the same way that individuals establish IRAs or MSAs. IRS permission or employer involvement is not required. The HSA provider need not require proof of HDHP coverage but may desire to do so for purposes of its recordkeeping and reporting. If an employer sets up an HSA for an employee, however, the employer must verify that the employee is enrolled in an HDHP offered by the employer. Code § 223, §4973. Notice 2004-2, Rev. Rul. 2004-45, Rev. Rul. 2004-38, Rev. Proc. 2004-22, Notice 2004-23, Notice 2004-25, and Notice 2004-50.	A health reimbursement arrangement ("HRA") is an arrangement funded solely by the employer. HRAs may be offered to employees or former employees. Amounts must be used for qualified medical expenses and balances may be carried forward. Depending upon the terms of the HRA, coverage may (or may not) continue if the employee terminates service. HRAs are not portable. HRAs are described in administrative guidance. *See* Notice 2002-45, 2002-2 C.B. 93; Rev. Rul. 2003-43, 2003-21 I.R.B. 935.	A health flexible spending arrangement ("FSA") is an arrangement that may be funded by the employer and/or the employee via salary reduction. Health FSAs may be offered only to employees (self-employed persons are not eligible). Amounts must be used for qualified medical expenses and balances may not carry forward beyond the coverage period. FSAs are not portable. FSAs were codified in Code §106(c) under § 301(c)(2) of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). However, FSAs previously existed through administrative guidance. In 1989, the IRS issued proposed regulations that apply to health FSAs. *See* Prop. Reg. § 1.125-2, Q&A-7.

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	HSA	HRA	FSA
II. RULES ON CONTRIBUTIONS			
A. Employer Contributions Generally	Employer contributions are excludable for income and employment tax purposes. Code §§ 106(d), 3306(b)(18) & 3401(a)(22), respectively; Notice 2004-2 Q/A-19. Once an employer makes the contributions to an HSA, an employer cannot require that the HSA distributions be made exclusively for medical expenses or place any other restrictions or limitations on the HSA, including any limitation on rollovers or transfers. See Notice 2004-50 Q/A 59. A requirement that HSA distributions satisfy reasonable administrative rules imposing minimum dollar amounts or limits on the frequency of distributions is allowed. Notice 2004-50 Q/A-80. If an employer makes an excess contribution to an HSA, the employer may not recoup the excess contribution from the HSA itself. Notice 2004-50 Q/A-82. [Note that this situation may occur where an employer funds an HSA on January 1 for the full-year deductible and before the close of the year the employee has a change in status that results in a change from family to individual coverage or in terminating HDHP coverage altogether. The excess contribution may violate the comparability rule, if applicable (discussed at box II.B. below). In addition, the employer will have wage reporting issues for the excess contribution and the employee will have an increased income tax obligation and, if the excess contribution is not timely distributed, an excise tax.]	These arrangements are unfunded. Payments from the employer and coverage under the HRA are excluded from the employee's income under Code §§105, 106.	Same as HRA
B. Employer Contributions – Comparability	Employer contributions must satisfy either the "comparability" rules or the cafeteria plan nondiscrimination rules, but not both. The cafeteria plan nondiscrimination rules are discussed in box IV.F. below. Employer contributions that are not provided through a cafeteria plan must be provided on a "comparable" basis to all eligible employees in order to avoid a 35-percent excise tax. Code §4980G. For these purposes	HRAs are subject to the nondiscrimination tests under Code § 105(h).	Same as HRA.

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	HSA	HRA	FSA
Employer Contributions – Comparability (continued)	"comparable" means that an employer must make the same HSA contribution for all eligible employees either as a dollar amount or as a percentage of the deductible. Thus, the dollar amount of contributions may reflect the differences in deductible for family versus individual coverage or other differences in deductibles that apply to different employee groups covered by the HDHP as long as the contributions are the same percentage of the deductible. The only exception from the comparability rules is that an employer may exclude or make different HSA contributions to otherwise eligible part-time employees (*i.e.* employees customarily working less than 30 hours per week.) The comparability rules are violated if an employer makes contributions to the HSA in greater amounts for nonhighly compensated employees, imposes a vesting requirement on contributions, or imposes a condition precedent on an HSA contribution, such as requiring that the employee complete a health assessment or participate in a disease management program. Code §4980G; Notice 2004-50, Section VI.		
C. Tax Treatment of Individual Contributions	Contributions are deductible on an individual's income tax return or excludable from income if made through an employer salary reduction contribution. Code § 223(a); Notice 2004-2 Q/A-18.	Employee contributions are not permitted, although an HRA can be offered in conjunction with an FSA, subject to ordering rules discussed below.	Same as HSA.
D. Restriction for Individuals Covered by Medicare	No contributions to an HSA can be made once an individual becomes eligible for Medicare, which is interpreted to require actual enrollment in Medicare and not merely attaining the age of eligibility. Code § 223(b)(7). Notice 2004-50 Q/A-50.	No restriction.	No restriction.

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	HSA	HRA	FSA
E. Maximum Deduction and Exclusion	The deduction and exclusion for contributions to an HSA cannot exceed the lesser of the applicable deductible under the HDHP (see discussion below at box IV.C.) or the statutory maximum. In 2004, the statutory maximum is: $2,600 (self-only coverage), or $5,150 (family coverage). Code § 223(b). These maximums are indexed for cost of living, beginning in 2005. Code § 223(g); Notice 2004-2 Q/A-12. Individuals who are age 55 or older may deduct an additional $500 in 2004. This catch-up amount will increase in $100 increments annually, until it reaches the limit of $1,000 in 2009. Code § 223(b)(3); Notice 2004-2 Q/A-14. If an individual has other coverage that does not provide benefits until the HDHP deductible has been satisfied (*e.g.*, a post-deductible HRA as described below in box IV.E.), the allowable contribution to the HSA is the lower of the deductible under the HDHP or the deductible under the other coverage. Notice 2004-50 Q/A-33. The maximum contribution and exclusion is decreased by the aggregate amount paid into an MSA. Code § 223(b)(4). Administrative fees for an HSA that are paid from HSA assets are not taxable distributions but do not increase the contributions allowed to the HSA. Administrative fees paid outside of the HSA do not decrease the contributions otherwise allowable. Notice 2004-50 Q/A-69, 70, 71.	No statutory limit but benefits for highly-compensated employees may be limited by the application of nondiscrimination rules under Code §105(h).	No statutory limit but benefits and salary reduction for highly-compensated employees may be limited by the application of nondiscrimination rules under Code §105(h).

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	HSA	HRA	FSA
III. TAXATION OF DISTRIBUTIONS AND EARNINGS			
A. Qualified Medical Expenses	No tax on distributions for qualified medical expenses. Code § 223(f)(1); Notice 2004-2 Q/A-25. Qualified medical expenses are expenses for medical care defined under § 213(d) (including nonprescription drugs), for the individual, spouse, and dependents. Qualified medical expenses incurred in 2004 may be reimbursed from an HSA established no later than April 15, 2005. Notice 2004-25. For calendar year 2005 and thereafter, reimbursable medical expenses must be incurred after the HSA has been established. There is no requirement that an HSA distribution be made within any particular time period after the medical expense has been incurred. Code § 223(d)(2)(A); Notice 2004-2 Q/A-26; Notice 2004-50 Q/A-39. EXCEPTIONS: Reimbursable medical expenses from an HSA do not include expenses for health insurance *except*: (i) long-term care insurance, (ii) COBRA coverage, (iii) premiums for health care coverage while an individual is receiving unemployment compensation under federal or state law, and (iv) for Medicare eligibles, premiums for any health insurance other than a Medicare supplemental policy. Code § 223(d)(2)(B); Notice 2004-2 Q/A-27. Neither trustees, nor custodians, nor employers have any obligation to determine whether HSA distributions are used for qualified medical expenses. Notice 2004-2 Q/A-29 & -30.	No tax. Qualified medical expenses are expenses for medical care as defined under Code § 213(d) for the employee, spouse, and dependents, and depending on the HRA's terms may include premiums for any accident or health coverage, including long-term care, for current employees, retirees, and COBRA qualified beneficiaries.	No tax. Qualified medical expenses are expenses for medical care as defined under Code § 213(d) for the employee, spouse, and dependents. FSAs may *not* be used to reimburse insurance premiums, including long-term care.

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	HSA	HRA	FSA
B. Other Nonqualified Withdrawals	Distributions that are not reimbursements for qualified medical expenses are subject to income tax plus a 10-percent penalty, with exceptions to the penalty for Medicare eligibles, disability, or death. Code § 223(f)(2) & (4); Notice 2004-2 Q/A-25.	Amounts cannot be used for any purpose other than to cover qualified medical expenses.	Amounts cannot be used for any purpose other than to cover qualified medical expenses.
C. Tax Treatment of Earnings	Earnings on HSA assets are not subject to tax while they are held in the HSA and are never taxed if they are distributed to reimburse for qualified medical expenses. Notice 2004-2 Q/A-20.	N/A	N/A
IV. ELIGIBILITY			
A. Eligible Individual	HSAs are available to any individual covered under an HDHP who is not simultaneously covered under a *non*-HDHP (*i.e.* another health plan). Code § 223(c)(1)(A); Notice 2004-2 Q/A-5. Eligible individuals do not include individuals who may be claimed as dependents on another person's tax return or who are Medicare enrollees. Code § 223(b)(6) & (7); Notice 2004-2 Q/A-2 & -18.	HRAs may be offered to current and former employees and individuals electing COBRA.	FSAs may be offered to current and former employees and individuals electing COBRA.
B. Other Coverage Allowed for Eligible Individuals	For purposes of determining eligibility, other non-HDHP coverage does not disqualify the individual from contributing to an HSA if the coverage is provided under one of the enumerated exceptions. The exceptions are: long-term care, dental or vision, accident, or disability, or "permitted insurance" (*e.g.*, insurance covering certain types of liabilities, specific illnesses or diseases, or hospitalization). Code § 223(c)(1)(B) and (c)(3); Notice 2004-2 Q/A-6. Prescription drug coverage under a rider or separate plan is disregarded coverage that does not disqualify an eligible individual from HSA contributions only for a 2-year grace period. Rev. Proc. 2004-22. On January 1, 2006 and thereafter an individual covered under an	N/A	N/A

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	HSA	HRA	FSA
Other Coverage Allowed for Eligible Individuals (continued)	HDHP who has prescription drug coverage under a separate plan or rider that is not itself an HDHP fails to be an eligible individual. Rev. Rul. 2004-38. Eligibility under an employee assistance program ("EAP"), disease management or wellness program is not other coverage that disqualifies an otherwise eligible individual from HSA contributions as long as these arrangements do not provide "significant" medical benefits. [The typical EAP that provides short-term counseling and referrals should not affect HSA eligibility.] Notice 2004-50 Q/A-10.		
C. High Deductible Health Plan In General	For 2004, a health plan is considered to be an HDHP if it has an annual deductible of at least $1,000 for self-only coverage (or $2,000 for family coverage) and the total out-of-pocket expenses is not more than $5,000 for self-only coverage (or $10,000 for family coverage). The deductibles and out-of-pocket limitations are determined on a 12-month period. If an HDHP is based on a 12-month period other than the calendar year (*i.e.* a fiscal year plan), the deductible and out-of-pocket limitations that apply in the first month of the HDHP coverage may be applied for the next 11 months and need not be adjusted mid-coverage period. Notice 2004-50 Q/A-86. Deductible and out-of-pocket limits will be adjusted for cost of living increases in $50 increments, beginning in 2005. Code § 223(g). Family coverage is any coverage for more than one person and is not limited to spouses and dependents. [Thus, if coverage includes a domestic partner, the domestic partner may become eligible to fund his or her own HSA.] Notice 2004-50 Q/A-12.	N/A	N/A

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	HSA	HRA	FSA
High Deductible Health Plan In General (continued)	Out-of-pocket expenses include the deductible and co-pay amounts but not premiums. A family coverage plan will not fail to qualify as an HDHP if it provides an out-of-pocket limit of at least $2,000 for individual family members. Notice 2004-2 Q/A-3. If the HDHP has "embedded" deductibles for each individual under family coverage, the embedded deductible may not cause the family to exceed the overall $10,000 out-of-pocket limit in the aggregate. Notice 2004-50 Q/A-30. [*E.g.*, To comply with the $10,000 maximum out-of-pocket rule where family coverage is for six or more persons, the HDHP must pay for the sixth family member after all others have met their deductible even if the sixth family member has not met his or her embedded deductible.]		
D. Preventive Care Exceptions	HDHPs may have a zero deductible or a deductible below the minimum annual deductible for preventive care. Code § 223(c)(2)(C); Notice 2004-2 Q/A-3. In general, preventive care is treatment for a condition for which symptoms are not yet manifest, although the individual may have developed risk factors. Preventive care may include prescription drug treatment for an asymptomatic person (*e.g.*, statins to prevent heart disease or ACE inhibitors to prevent reoccurrence in stroke or heart attack victims). Preventive care also may include treatment that is incidental or ancillary to a procedure that constitutes preventive care (*e.g.*, removal of polyps during a diagnostic colonoscopy.) Notice 2004-50 Q/A-26, 27. State law characterizations of preventive care are not determinative.	N/A	N/A

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	HSA	HRA	FSA
E. Combining Arrangements	In general, an individual will not be eligible for HSA contributions at the same time he or she is covered by a general purpose health FSA or HRA of the individual or the individual's spouse. However, an individual will be eligible to contribute to an HSA if such general purpose health FSA or HRA permits payments or reimbursements only after the statutory minimum annual deductible for an HDHP has been satisfied. These arrangements are referred to as post-deductible HRAs or FSAs. [Note that a post-deductible HRA or FSA may pay prior to the HDHP if the HDHP has a higher deductible than the statutory minimum.] Rev. Rul. 2004-45 (Situation 4). An individual will continue to be eligible for HSA contributions if he or she is covered only by a limited-purpose FSA or HRA. A limited-purpose FSA is an arrangement that pays benefits for permitted coverage (but not through insurance or for long-term care services). A limited purpose HRA pays benefits for permitted coverage provided directly by the HRA or through insurance. Permitted coverage (*i.e.*, coverage for long-term care, dental or vision, accident or disability, or insurance covering specific diseases, illness, or hospitalization) may be combined with an HSA regardless of whether the minimum annual deductible under the HDHP has been satisfied. A limited purpose FSA or HRA also may provide preventive care without disqualifying the individual from HSA contributions. An HRA or FSA for prescription drug coverage may satisfy the special transition rule for coverage only prior to January 1, 2006. After January 1, 2006, separate plans or riders for prescriptions drugs may not be provided in conjunction with an HDHP, because such coverage would be considered other insurance. (*See* box IV.B. regarding	See discussion on HSAs. An individual also may contribute to an HSA if his or her general purpose HRA is suspended during a coverage period, or if the HRA covers medical expenses incurred after the individual retires. Specifically, an individual with an HRA may elect on a prospective basis to forgo the payment of medical expense from the HRA. Medical expenses incurred during the suspension period cannot be reimbursed; however, reimbursements for permitted coverage or preventive services are allowed. An employer is not precluded from contributing to the HRA during the suspension period. In addition, an individual remains an eligible individual if an HRA is established to reimburse medical expenses incurred after an individual retires. Once the individual retires, but before he becomes eligible for Medicare, he will no longer be eligible for contributions to an HSA unless he suspends the HRA coverage	See discussion for HSAs and HRAs. Note that long-term care coverage, which can be offered in an HSA and an HRA, cannot be offered in an FSA pursuant to Code §106(c).

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	HSA	HRA	FSA
	transition relief.) An employer may offer a combination of HRAs, FSAs, and other permitted coverage consistent with the requirements described in this box IV.E. without disqualifying an otherwise eligible individual from contributing to an HSA. Rev. Rul. 2004-45.	as discussed above. An individual with coverage under a combination of an FSA, HRA, and HSA may receive reimbursements through the FSA or HRA prior to taking distributions from the HSA, as long as the individual does not seek multiple-tax favored reimbursements for the same expense. If an HRA is provided in addition to an FSA, special rules apply to the ordering of payments. Absent a specific ordering rule in the HRA document, the HRA funds must be used first if the FSA covers a medical expense that also is covered by the HRA.	
F. Cafeteria Plans and Discrimination Testing	Contributions to HSAs may be made through an employer-sponsored cafeteria plan, which includes salary reduction contributions to the HSA or employer contributions to the HSA. If made through a cafeteria plan, the contributions to the HSA generally are not subject to the special rules for health FSAs that are designed to make the health FSA function as "insurance." For example, the rules for health FSAs that require the maximum employer contribution be available for the full 12 months is not applicable to an HSA that is funded through a cafeteria plan and employees may change their salary reduction contributions to an HSA at any time. Code § 125(d)(2)(D); Notice 2004-2 Q/A-33; Notice 2004-50 Q/A-57; Notice 2004-50 Section VIII.	A health option in a cafeteria plan may include coverage in an HRA as long as it does not result in deferred compensation. HRAs are subject to the nondiscrimination rules under Code § 105(h), which prohibit benefit or coverage discrimination in favor of highly compensated employees.	Health FSAs may be offered under a cafeteria plan. Health FSAs are subject to the nondiscrimination rules under Code § 105(h), which prohibit benefit or coverage discrimination in favor of highly compensated employees. Health FSAs also are subject to rules that are designed to make the health FSA function like insurance. For example, employees in the health FSA must have the maximum contribution under the FSA

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	HSA	HRA	FSA
Cafeteria Plans and Discrimination Testing (continued)	Employer contributions to HSAs must satisfy either the comparability rule discussed above at box II.B. or be offered through a cafeteria plan arrangement that satisfies the nondiscrimination tests under Code §125. [To be a cafeteria plan, the employee must have a choice between cash or nontaxable benefits. There are a number of possible designs for incorporating an HSA into a cafeteria plan. The employee may be given a choice between cash and the HSA contribution itself, which would occur where the employee funds all or part of the HSA through salary reduction contributions. Alternatively, the employee may be given a choice between cash and an employer contribution to the HSA, which may be less desirable from an employer perspective, or the employee may be given the choice between cash and a menu of benefits, including the HDHP/HSA coverage. For example, an HSA presumably would be part of a cafeteria plan if the only choice between cash and benefits given to the employee is a choice between paying any employee portion of the HDHP premiums on a pre- or post-tax basis (a so-called premium conversion arrangement.)] The nondiscrimination test under Code §125 requires generally that the eligibility for and utilization of the benefits under a cafeteria plan (i) not discriminate in favor of highly compensated employees and (ii) not provide more than 25 percent of benefits to "key employees" (which includes all 5 percent or more owners of the business as well as lesser owners and officers whose compensation exceeds certain statutory thresholds). See Code § 125(b); Code § 416(i). [The nondiscrimination testing rules for cafeteria plans have never been finalized in regulations. Currently, testing is based upon the Code §125 statutory rules, proposed regulations, and legislative history. There are many		available at all times during the coverage period; employees cannot change their health FSA elections absent certain changes in events; the coverage period must be 12 months; and health FSA amounts that are unused at the close of the coverage period must be forfeited.

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	HSA	HRA	FSA
Cafeteria Plans and Discrimination Testing (continued)	unanswered questions about the valuation of benefits and the various testing methods that may be used to show that a cafeteria plan satisfies the nondiscrimination rules.]		
G. Number of Accounts	An HSA may be established for each spouse covered under an HDHP (*e.g.*, each spouse may have his or her own HSA) but they are subject to the combined deduction limit. Spouses may not jointly own a single HSA. Notice 2004-50 Q/A-63. Eligible individuals may maintain more than one HSA.	Presumably an employer could design an HRA with subaccounts for particular family members, but there appears to be no tax advantage for doing so.	Same as HRA.
V. OTHER			
A. Trustee Obligations	Trustees are not obligated to substantiate that an individual is covered by an HDHP. Trustees are required to ensure that contributions do not exceed the statutory maximum contributions for HSAs, including catch-up contributions if the individual is age 55 or older. Trustees may rely upon an individual's representation as to age. Trustees may impose reasonable administrative rules, such as rules that impose a minimum dollar amount on distributions or limit the frequency of distributions. Trustees may not require substantiation as to qualified medical expenses because the owner must be allowed to take distributions from the HSA regardless of whether qualified medical expenses have been incurred. [Presumably, a debit card system that allocates medical expenses to an HSA need not provide a cash distribution option to the owner of the HSA as long as the owner has another method to obtain a cash distribution from the HSA.] Notice 2004-50, Section X.		
B. Rollovers	Rollovers are permitted from MSAs and other HSAs. Code § 223(f)(5); § 220(f)(5)(A); Notice 2004-2 Q/A-23. There is no limit on the number of trustee-to-trustee	Rollovers to HSAs are not permitted. Any contribution to an HSA from an HRA account	Rollovers not permitted.

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	HSA	HRA	FSA
Rollovers (continued)	transfers that may be made during a 12-month period, but only one rollover may be made by the owner of the HSA during a 12-month period (*i.e.* a distribution of the HSA that is re-contributed to an HSA within 60 days.) Notice 2004-50, Section VII.	would be a contribution that would reduce the HSA deduction limit.	
C. Transfers Incident to Divorce	Transfers of an individual interest to a spouse or former spouse under a divorce or separation agreement are not subject to tax. Upon such transfer the spouse is considered the new account beneficiary. Code § 223(f)(7).	Subject to COBRA rules. See discussion below.	Same as HRA.
D. Surviving Spouse	The surviving spouse who is the beneficiary of the HSA becomes the new account beneficiary and the decedent's estate receives a deduction. Code § 223(f)(8)(A); Notice 2004-2 Q/A-31.	May depend upon the terms of the particular HRA and application of COBRA.	FSA coverage may not continue upon the death of the employee, unless continuation coverage is elected under COBRA.
E. Estate or Other Beneficiary	On the date of death, the HSA loses its status as an HSA; in general, the estate or other non-spouse beneficiary will be subject to income tax in an amount equal to the fair market value of the assets, subject to special rules. Code § 223(f)(8)(B); Notice 2004-2 Q/A-31.	May depend upon the terms of the particular HRA and application of COBRA.	FSA coverage may not continue upon the death of the employee, unless continuation coverage is elected under COBRA.
F. COBRA	COBRA is inapplicable to HSAs, but it would apply to an HDHP that is an employer plan. [Query whether other court orders could be obtained by a former spouse or children to access the HSA.] Notice 2004-2 Q/A-35.	COBRA is applicable, but it is unclear how the account dollars are shared among all potential beneficiaries. Treasury/IRS have promised guidance on this issue.	COBRA is applicable.
G. Investment and Taxation of Assets	The same investment rules that apply to IRAs apply to HSAs. [Presumably, the ERISA fiduciary rules on investment of assets do not apply even if the HSA is part of an employer arrangement because the employee owns the account and must have the choice of changing trustees or custodians and taking a distribution.] Code § 223(e)(1).	N/A	N/A

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	HSA	HRA	FSA
H. DAC Tax	Excepted from the DAC tax. Code § 848(e)(1)(b).	N/A	N/A
I. Deduction Limits for Employer Welfare Funds	HSAs are not subject to the deduction limits for "welfare benefit funds" under § 419(e)(1). Notice 2004-2 Q/A-35.	N/A	N/A
J. Other Laws	The Department of Labor has issued Field Assistance Bulletin 2004-1 (April 7, 2004) that makes clear that an HSA generally is not an ERISA plan even if an employer contributes to an HSA through payroll or utilizes a single HSA provider for payroll contributions for its employees. The guidance assumes that the employer does not limit the portability of the HSA assets, put restrictions on the utilization of HSA assets, or control the investment options of the HSA assets. Thus, the implication is that that an employer who does impose these kinds of restrictions on employee HSAs would create an ERISA arrangement. [Note that subsequent guidance clarifies that such restrictions would cause the arrangement not to qualify as an HSA.] Notice 2004-50 Q/A-78, 79. Depending on their design, HSAs also may raise HIPAA compliance questions. State law tax conformity will need to be reviewed.	An HRA is an ERISA welfare plan.	A health FSA is an ERISA welfare plan.

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Options to Reduce State Contribution for ERS Health Plan for FY06-07

Options Which Would Reduce Benefits	All Funds FY06-07 (Millions)*	Requires Board Action	Requires Legislative Action
Increase Rx copay from $10/$25/$40 to $10/$30/$50 for 30 day supply; increase Rx deductible from $50 to $100	$74.0	x	
Increase physician office copay $10	$77.5	x	
Decrease HealthSelect coinsurance from 80%/60%/70% to 70%/50%/70%	$72.2	x	
Increase coinsurance stop loss from $1,000/$3,000/$1,000 to $1,500/$4,500/$3,000	$20.2	x	
Change annual medical services deductible from $0/$500/$200 to $100/$750/$300.	$26.0	x	
Change annual medical services deductible from $0/$500/$200 to $150/$750/$300.	$34.0	x	
Change annual medical services deductible from $0/$500/$200 to $250/$1000/$500.	$78.0	x	
Implement high deductible health plan with $5,000 out-of-pocket maximum	$395.0	x	

*Preliminary estimates
Source: Employees Retirement System of Texas

Options to Reduce State Contribution for ERS Health Plan for FY06-07

Options Which Would Change State Contribution Policy	All Funds FY06-07 (Millions)*	Requires Board Action	Requires Legislative Action
Eliminate state contribution subsidy for State Kids Insurance Program (SKIP).	$26.3		x
Reduce state contribution for dependent coverage for all employees and retirees from 50% to 40%.	$122.4		x
Reduce state contribution for dependent coverage for all employees and retirees from 50% to 30%.	$244.8		x
Reduce state contribution for dependent coverage for all employees and retirees from 50% to 25%.	$306.0		x
Require member to contribute $10 per month for Member Only coverage	$62.4		x
Require member to contribute 5% of the cost of Member Only coverage	$120.3		x
Require member to contribute 10% of the cost of Member Only coverage	$240.5		x

*Preliminary estimates

Source: Employees Retirement System of Texas

Options to Reduce State Contribution for ERS Health Plan for FY06-07

Options Which Would Manage Care More Stringently	ALL FUNDS FY06-07 ($millions)*	Requires Board Action	Requires Legislative Action
Replace HealthSelect network with alternative network	$108.0	x	
Replace retail pharmacy network with alternative network	$16.0	x	
Additional imaging management	$10.0	x	
Managed injectable drug program	$3.0	x	
More aggressive care management	$1.4	x	
Flexible pharmacy formulary	$30.0	x	
Put certain medications on Tier 3	$9.4	x	
Additional prior authorization programs	$8.4	x	
Limit quantity dispensed per prescription for certain meds	$4.0	x	

*Preliminary estimates

Source: Employees Retirement System of Texas

Cost Drivers for TRS-Care
Cost Containment Options for Any Health Care Plan

Cost Drivers	Cost Containment Options
Increase in number of retirees - More retirees younger than Medicare age (15% growth in non-Medicare Care 3 retirees)	Limit eligibility - Specific age requirements - Service based contributions
Increase in medical costs	Reduce utilization; restrict payment for certain procedures
Increase in Rx cost	Reduce utilization; limit access to or restrict payment for high cost drugs
Maintaining access and choice in managing providers	Tighten network; deeper provider discounts and reduced choices
Increased utilization due to aging population	Limit payments to certain covered procedures

Source: Teacher Retirement System

Spectrum of State Alternatives in Addressing Health Care and Funding Options Can Vary Widely

- Coverage and funding similar to state employees
  - State pays retiree premium and half of dependents
- State stipend for health care
  (i.e., Defined Contribution approach)
  - State program for access to coverage, *or*
  - Stipend used in private marketplace to acquire coverage
- Coverage and/or funding only *before* age 65
  - Or could end only for those that are Medicare eligible after 65
- Coverage and/or funding only *after* age 65
  - Could be further limited to only those covered by Medicare
- State-purchased private market Medicare supplement
  - No state program of coverage options

Source: Teacher Retirement System

APPENDIX II

Implementation of the Help America Vote Act of 2002 (HAVA), Texas Office of the Secretary of State.

HAVA UPDATE

Voting System Standards	Sec. 301	
HAVA Requirement	**State of Texas Current Status**	**Action Planned**
All voting systems shall permit a voter to verify/review selections before casting the vote.	Meets the requirement. Texas Election Code (TEC) Sections 64.007 and 129.001(b).	No action needed.
Allow voter to change or correct any error on the ballot before casting the vote.	Meets the requirement. TEC Section 64.007.	No action needed.
Prevent or alert voter if he/she over-votes on the ballot.	Partially meets the requirement. DRE systems and precinct count optical scan systems alert the voter of an over-vote. Manually counted paper ballots, centrally counted optical scan ballots, and punch card ballots do not alert the voter of over-votes. Current process on mail-in paper absentee ballots would not meet the requirement.	A voter education campaign will be implemented in all centrally counted optical scan and paper ballot precincts no later than January 1, 2006, to educate voters on the effect of an over-vote on these systems.
All voting systems must be able to produce a paper audit trail of all votes cast.	Meets the requirement; state law currently requires real time audit of all election activity. TEC Section 122.001(a)	No action needed.
Voting systems must be accessible for individuals with disabilities, including non-visual accessibility for the blind and visually impaired, in a manner that provides the same opportunity for privacy and independence as other voters. This requirement may be met by having at least one DRE or other system equipped for individuals with disabilities at each polling site.	Partially meets the requirement. 13 counties have adopted an accessible DRE voting system. Most counties do not meet this requirement.	Upgrade existing voting systems or purchase new systems. All polling places will be required to be equipped with at least one DRE no later than January 1, 2006 pursuant to House Bill 1549.
Voting systems shall provide alternative language accessibility pursuant to the requirements of Section 203 of the Voting Rights	All certified voting systems meet this requirement for Spanish language, and one voting system has been certified for the Vietnamese language.	No action needed.

Act of 1965.		
All voting systems shall have error rates (machine errors only) that do not exceed the Federal Election Commission standards.	Meets the requirement. This requirement was added to state law in H.B. 1549.	No action needed.
A uniform definition of what constitutes a vote for each voting system in use in the state.	Meets this requirement. State law was passed to provide a uniform definition for what constitutes a vote. House Bill 1549 (2003)	No further action required.

Provisional Voting and Voting Information Requirements	**Sec. 302**	
HAVA Requirement	**State of Texas Current Status**	**Action Planned**
A provisional voter is to be allowed to vote a paper ballot or an electronic ballot upon the completion of an affidavit. The ballot will be sealed in an envelope or electronically stored separately from the regular votes. The provisional ballot is to be transported to the appropriate election officials for determination of eligibility and counted if voter is deemed eligible.	State law was amended to provide procedures to meet this requirement effective January 1, 2004 pursuant to House Bill 1549. The Secretary of State has adopted administrative rules to provide specific procedures and has adopted forms to assist in the implementation of this new process.	No further action needed.
Each voter who casts a provisional vote shall be given written information on how he or she can ascertain whether his or her vote was counted, and if not why.	State has developed administrative rules and has adopted forms to implement this requirement.	No further action needed.
Establish a free access system, such as toll-free phone number or Internet website, allowing provisional voters to ascertain whether their vote was counted, and if not why.	State rules require the provisional voter to be notified via mail whether the voter's ballot was counted, and if the ballot was not counted, the reason why it was not counted.	No further action needed.
Post in each polling place a sample version of the ballot that will be used on election day.	State law passed to make it mandatory to post a sample ballot at each polling location.	No further action needed.
Post information regarding the day of the election and polling hours.	State law passed to require this posting.	No further action needed.

Post general information on state and federal voting rights and the right to a provisional vote if the requirements to vote are met.	State has prescribed language on the voter information poster required to be posted at each polling place beginning January 1, 2004.	No further action needed.
Post general information on federal and state laws prohibiting acts of fraud and misrepresentation.	State has prescribed language on the voter information poster required to be posted at each polling place beginning January 1, 2004.	No further action needed.
Any voter who casts a vote as the result of a federal or state court order extending polling hours, shall do so on a provisional ballot, and it shall be kept separate from other provisional ballots.	State law amended to provide for this occurrence and law became effective January 1, 2004. Precinct election forms were designed to accommodate this occurrence.	No further action needed.

Computerized Statewide Voter Registration System	**Sec. 303**	
HAVA Requirement	**State of Texas Current Status**	**Action Planned**
State shall implement a uniform, official, centralized, interactive computerized statewide voter registration list.	Does not meet the requirement. Currently, 160 counties use the Secretary of State voter registration program to register and maintain their lists of voters. The data is held at the Secretary of State's Office. State law requires the state to maintain a copy of the list of registered voters, and counties have to update to the state database once a week. The state database is not considered the official list of voters.	State law was amended to require a statewide official list maintained at the Secretary of State's office. The state is currently in the procurement process and contract for the development of a complaint statewide system is expected to be signed soon and should be ready by January 1, 2006.
Perform list maintenance to ensure only qualified voters appear on the list, including felons and deaths of registrants. Ensure that only voters who are not registered or who are not eligible are removed from the computerized list.	State meets this requirement. State receives information from other state agencies regarding deaths and felons and provides this information to county voter registrars on a weekly basis. State meets this requirement. State law prescribes narrow guidelines regarding canceling a voter's registration. Only with a positive name and identification number match can a voter be canceled. The local county voter registrar, not the state, cancels voters. Voter registrars may not cancel based on information provided by a vendor unless that information is verified by the voter registrar by a public record. TEC, Chapter 16 and Section 18.0121.	No action needed. No action needed.

Ensure that voter registration records are accurate and updated regularly.	Does not meet the requirement.	State law was amended to require a statewide official list maintained at the Secretary of State's office. The state is currently in the procurement process and contract for the development of a complaint statewide system is expected to be signed soon and should be ready by January 1, 2006.
State to verify applicant's driver's license or social security number prior to approval of applicant.	Does not meet the requirement.	State law was amended to require a statewide official list maintained at the Secretary of State's office. The state is currently in the procurement process and contract for the development of a complaint statewide system is expected to be signed soon and should be ready by January 1, 2006.
State to assign unique identifier if applicant does not have driver's license or social security number.	Does not meet this requirement.	State law was amended to require a statewide official list maintained at the Secretary of State's office. The state is currently in the procurement process and contract for the development of a complaint statewide system is expected to be signed soon and should be ready by January 1, 2006.
Require appropriate identification for first time voters if a computerized list has not been implemented.	State law was amended to require identification at time of registration for first time voters voting by mail effective January 1, 2004.	No further action required.

Voter registration application is required to have additional information printed on it.	State has prescribed new form, and has distributed to all counties.	No further action required.

APPENDIX III

1. *Senate Bill 10 Implementation Timeline,* Texas Department of Insurance.

2. *Senate Bill 541 Implementation Timeline,* Texas Department of Insurance.

SENATE BILL 10 IMPLEMENTATION TIMELINE

Date(s)	Description
11/6/03	Commissioner's Bulletin #B-0043-03 (78th Session – Bill Summary and Highlights Pertinent to Life and Health Coverage)
12/29/03	28 TAC §§26.401 – 26.411 – Proposed rules relating to health group cooperatives were sent to Texas Register for publication on 01/09/04. Comment period expired at 5:00 pm on 02/09/04.
02/06/04	The commissioner held a formal hearing on the proposed rules at 1:30 pm in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. The docket number was 2588.
04/26/04	28 TAC §§26.401 – 26.411 – Proposed rules relating to health group cooperatives were withdrawn.
04/26/04	28 TAC §§26.401 – 26.413 – Proposed rules relating to health group cooperatives were sent to Texas Register for publication on 05/07/04. Comment period expired at 5:00 pm on 06/07/04.
08/11/04	28 TAC §§26.401 – 26.411 - Adoption order relating to health group cooperatives was signed and sent to the Texas Register for publication on 08/27/04. The rules were effective 08/31/04.
09/16/04	An informal discussion for all interested parties on the S.B.10 & H.B.897 Cooperatives was held in Austin, Texas.

Source: Texas Department of Insurance

SENATE BILL 541 IMPLEMENTATION TIMELINE

Date(s)	Description
09/30/03	FAQs were put on TDI's Website.
11/6/03	Commissioner's Bulletin #B-0043-03 (78th Session – Bill Summary and Highlights Pertinent to Life and Health Coverage)
11/21/03	28 TAC §§11.2, 11.508, & 11.509 - Informal draft rules relating to HMOs were posted to the Texas Department of Insurance Website with informal comments due by 5:00 pm, 12/01/03.
11/21/03	28 TAC §§21.3501-21.3505, 21.3510-21.3518, 21.3525-21.3530, 21.3535, & 21.3540-21.3544 - Informal draft rules relating to indemnity and HMO plans were posted to the Texas Department of Insurance Website with informal comments due by 5:00 pm, 12/01/03.
12/02/03	An informal discussion for all interested parties on the informal draft rules was held from 1:30 – 2:30 pm in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.
12/29/03	Commissioner's Bulletin #B-0051-03 (A Reminder to File Consumer Choice Plan Forms)
12/29/03	28 TAC §§11.2, 11.508, & 11.509 – Proposed rules relating to HMOs were sent to the Texas Register for publication on 01/09/04. Comment period expired at 5:00 pm on 02/09/04.
12/29/03	28 TAC §§21.3501-21.3505, 21.3510-21.3518, 21.3525-21.3530, 21.3535, & 21.3540-21.3544 – Proposed rules relating to indemnity and HMO plans were sent to the Texas Register for publication on 01/09/04. Comment period expired at 5:00 pm on 02/09/04.
02/06/04	The commissioner held a formal hearing on the Plan rules at 9:30 am in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. The docket numbers were 2586 and 2587.
05/10/04	28 TAC §§11.2, 11.508, & 11.509 - Adoption orders relating to HMOs were signed and sent to the Texas Register for publication on 05/21/04. The rules were effective 05/30/04.
05/10/04	28 TAC §§21.3501-21.3505, 21.3510-21.3518, 21.3525-21.3530, 21.3535, & 21.3540-21.3544 - Adoption orders relating to indemnity and HMO plans were signed and sent to the Texas Register for publication on 05/21/04. The rules were effective 06/02/04.
05/24/04	Consumer Choice Plan-1 Notice Forms posted to TDI's Web.
06/24/04	HMO CCP EOC checklists updated and put on Web.
06/28/04	A&H and HMO checklists updated and put on Web.
06/29/04	Consumer Choice Plans Charts (carrier lists) are posted to TDI's Web.
07/02/04	HMO audit/exam tools updated and put on TDI's Web.

Source: Texas Department of Insurance

APPENDIX IV

1. *Kentucky Association of Health Plans v. Miller*, 538 U.S. ___, 123 S. Ct. 1471 (2003).

2. *Aetna Health Inc. v. Davila*, 542 U.S. ___, 124 S. Ct. 2488 (2004).

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL. *v.* MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 00–1471. Argued January 14, 2003—Decided April 2, 2003

Petitioner health maintenance organizations (HMOs) maintain exclusive "provider networks" with selected doctors, hospitals, and other health-care providers. Kentucky has enacted two "Any Willing Provider" (AWP) statutes, which prohibit "[a] health insurer [from] discriminat[ing] against any provider who is . . . willing to meet the terms and conditions for participation established by the . . . insurer," and require a "health benefit plan that includes chiropractic benefits [to] . . . [p]ermit any licensed chiropractor who agrees to abide by the terms [and] conditions . . . of the . . . plan to serve as a participating primary chiropractic provider." Petitioners filed this suit against respondent, the Commissioner of Kentucky's Department of Insurance, asserting that the AWP laws are pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA), which pre-empts all state laws "insofar as they . . . relate to any employee benefit plan," 29 U. S. C. §1144(a), but saves from pre-emption state "law[s] . . . which regulat[e] insurance . . . ," §1144(b)(2)(A). The District Court concluded that although both AWP statutes "relate to" employee benefit plans under §1144(a), each law "regulates insurance" and is therefore saved from pre-emption by §1144(b)(2)(A). The Sixth Circuit affirmed.

Held: Kentucky's AWP statutes are "law[s] . . . which regulat[e] insurance" under §1144(b)(2)(A). Pp. 3–12.

(a) For these statutes to be "law[s] . . . which regulat[e] insurance," they must be "specifically directed toward" the insurance industry; laws of general application that have some bearing on insurers do not

qualify. *E.g., Pilot Life Ins. Co.* v. *Dedeaux*, 481 U. S. 41, 50. However, not all state laws "specifically directed toward" the insurance industry will be covered by §1144(b)(2)(A), which saves laws that regulate *insurance*, not insurers. Insurers must be regulated "with respect to their insurance practices." *Rush Prudential HMO, Inc.* v. *Moran,* 536 U. S. 355, 366. Pp. 3–4.

(b) Petitioners argue that the AWP laws are not "specifically directed" towards the insurance industry. The Court disagrees. Neither of these statutes, by its terms, imposes any prohibitions or requirements on providers, who may still enter exclusive networks with insurers who conduct business outside the Commonwealth or who are otherwise not covered by the AWP laws. The statutes are transgressed only when a "health insurer," or a "health benefit plan that includes chiropractic benefits," excludes from its network a provider who is willing and able to meet its terms. Pp. 4–6.

(c) Also unavailing is petitioners' contention that Kentucky's AWP laws fall outside §1144(b)(2)(A)'s scope because they do not regulate an insurance practice but focus upon the relationship between an insurer and *third-party providers*. Petitioners rely on *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U. S. 205, 210, which held that third-party provider arrangements between insurers and pharmacies were not "the 'business of insurance' " under §2(b) of the McCarran-Ferguson Act. ERISA's savings clause, however, is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize *conduct* undertaken by private actors, but with how to characterize *state laws* in regard to what they "regulate." Kentucky's laws "regulate" insurance by imposing conditions on the right to engage in the business of insurance. To come within ERISA's savings clause those conditions must also substantially affect the risk pooling arrangement between insurer and insured. Kentucky's AWP statutes pass this test by altering the scope of permissible bargains between insurers and insureds in a manner similar to the laws we upheld in *Metropolitan Life*, *UNUM*, and *Rush Prudential*. Pp. 6–9.

(d) The Court's prior use, to varying degrees, of its cases interpreting §§2(a) and 2(b) of the McCarran-Ferguson Act in the ERISA savings clause context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis. The Court has never held that the McCarran-Ferguson factors are an essential component of the §1144(b)(2)(A) inquiry. Today the Court makes a clean break from the McCarran-Ferguson factors in interpreting ERISA's savings clause. Pp. 9–12.

227 F. 3d 352, affirmed.

SCALIA, J., delivered the opinion for a unanimous Court.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

No. 00–1471

KENTUCKY ASSOCIATION OF HEALTH PLANS, INC., ET AL., PETITIONERS *v.* JANIE A. MILLER, COMMISSIONER, KENTUCKY DEPARTMENT OF INSURANCE

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

[April 2, 2003]

JUSTICE SCALIA delivered the opinion of the Court.

Kentucky law provides that "[a] health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships." Ky. Rev. Stat. Ann. §304.17A–270 (West 2001). Moreover, any "health benefit plan that includes chiropractic benefits shall . . . [p]ermit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan." §304.17A–171(2). We granted certiorari to decide whether the Employee Retirement Income Security Act of 1974 (ERISA) pre-empts either, or both, of these "Any Willing Provider" (AWP) statutes.

I

Petitioners include several health maintenance organizations (HMOs) and a Kentucky-based association of HMOs. In order to control the quality and cost of health-care delivery, these HMOs have contracted with selected doctors, hospitals, and other health-care providers to create exclusive "provider networks." Providers in such networks agree to render health-care services to the HMOs' subscribers at discounted rates and to comply with other contractual requirements. In return, they receive the benefit of patient volume higher than that achieved by nonnetwork providers who lack access to petitioners' subscribers.

Kentucky's AWP statutes impair petitioners' ability to limit the number of providers with access to their networks, and thus their ability to use the assurance of high patient volume as the *quid pro quo* for the discounted rates that network membership entails. Petitioners believe that AWP laws will frustrate their efforts at cost and quality control, and will ultimately deny consumers the benefit of their cost-reducing arrangements with providers.

In April 1997, petitioners filed suit against respondent, the Commissioner of Kentucky's Department of Insurance, in the United States District Court for the Eastern District of Kentucky, asserting that ERISA, 88 Stat. 832, as amended, pre-empts Kentucky's AWP laws. ERISA pre-empts all state laws "insofar as they may now or hereafter relate to any employee benefit plan," 29 U. S. C. §1144(a), but state "law[s] . . . which regulat[e] insurance, banking, or securities" are saved from pre-emption, §1144(b)(2)(A). The District Court concluded that although both AWP statutes "relate to" employee benefit plans under §1144(a), each law "regulates insurance" and is therefore saved from pre-emption by §1144(b)(2)(A). App. to Pet. for Cert. 64a–84a. In affirming the District Court, the Sixth Circuit also

concluded that the AWP laws "regulat[e] insurance" and fall within ERISA's savings clause. *Kentucky Assn. of Health Plans, Inc.* v. *Nichols*, 227 F. 3d 352, 363–372 (2000). Relying on *UNUM Life Ins. Co. of America* v. *Ward*, 526 U. S. 358 (1999), the Sixth Circuit first held that Kentucky's AWP laws regulate insurance "as a matter of common sense," 227 F. 3d, at 364, because they are "specifically directed toward 'insurers' and the insurance industry. . . ," *id.*, at 366. The Sixth Circuit then considered, as "checking points or guideposts" in its analysis, the three factors used to determine whether a practice fits within "the business of health insurance" in our cases interpreting the McCarran-Ferguson Act. *Id.*, at 364. These factors are: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Union Labor Life Ins. Co.* v. *Pireno*, 458 U. S. 119, 129 (1982). The Sixth Circuit found all three factors satisfied. 227 F. 3d, at 368–371. Notwithstanding its analysis of the McCarran-Ferguson factors, the Sixth Circuit reiterated that the "basic test" under ERISA's savings clause is whether, from a common-sense view, the Kentucky AWP laws regulate insurance. *Id.*, at 372. Finding that the laws passed both the "common sense" test and the McCarran-Ferguson "checking points," the Sixth Circuit upheld Kentucky's AWP statutes. *Ibid.*

We granted certiorari, 536 U. S. 956 (2002).

II

To determine whether Kentucky's AWP statutes are saved from preemption, we must ascertain whether they are "law[s] . . . which regulat[e] insurance" under §1144(b)(2)(A).

It is well established in our case law that a state law must be "specifically directed toward" the insurance industry in order to fall under ERISA's savings clause; laws of general application that have some bearing on insurers do not qualify. *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U. S. 41, 50 (1987); see also *Rush Prudential HMO, Inc.* v. *Moran*, 536 U. S. 355, 366 (2002); *FMC Corp.* v. *Holliday*, 498 U. S. 52, 61 (1990). At the same time, not all state laws "specifically directed toward" the insurance industry will be covered by §1144(b)(2)(A), which saves laws that regulate *insurance*, not insurers. As we explained in *Rush Prudential*, insurers must be regulated "with respect to their insurance practices," 536 U. S., at 366. Petitioners contend that Kentucky's AWP laws fall outside the scope of §1144(b)(2)(A) for two reasons. First, because Kentucky has failed to "specifically direc[t]" its AWP laws towards the insurance industry; and second, because the AWP laws do not regulate an insurance practice. We find neither contention persuasive.

A

Petitioners claim that Kentucky's statutes are not "specifically directed toward" insurers because they regulate not only the insurance industry but also doctors who seek to form and maintain limited provider networks with HMOs. That is to say, the AWP laws equally prevent *providers* from entering into limited network contracts with *insurers*, just as they prevent insurers from creating exclusive networks in the first place. We do not think it follows that Kentucky has failed to specifically direct its AWP laws at the insurance industry.

Neither of Kentucky's AWP statutes, by its terms, imposes any prohibitions or requirements on health-care providers. See Ky. Rev. Stat. Ann. §304.17A–270 (West 2001) (imposing obligations only on "health insurer[s]" not to discriminate against any willing provider); §304.17A–

171 (imposing obligations only on "health benefit plan[s] that include chiropractic benefits"). And Kentucky health-care providers are still capable of entering exclusive networks with insurers who conduct business outside the Commonwealth of Kentucky or who are otherwise not covered by §§304.17A–270 or 304.17A–171. Kentucky's statutes are transgressed only when a "health insurer," or a "health benefit plan that includes chiropractic benefits," excludes from its network a provider who is willing and able to meet its terms.

It is of course true that as a *consequence* of Kentucky's AWP laws, entities outside the insurance industry (such as health-care providers) will be unable to enter into certain agreements with Kentucky insurers. But the same could be said about the state laws we held saved from pre-emption in *FMC Corp.* and *Rush Prudential*. Pennsylvania's law prohibiting insurers from exercising subrogation rights against an insured's tort recovery, see *FMC Corp.*, *supra*, at 55, n. 1, also prevented insureds from entering into enforceable contracts with insurers allowing subrogation. Illinois' requirement that HMOs provide independent review of whether services are "medically necessary," *Rush Prudential*, *supra*, at 372, likewise excluded insureds from joining an HMO that would have withheld the right to independent review in exchange for a lower premium. Yet neither case found the effects of these laws on noninsurers, significant though they may have been, inconsistent with the requirement that laws saved from pre-emption by §1144(b)(2)(A) be "specifically directed toward" the insurance industry. Regulations "directed toward" certain entities will almost always disable other entities from doing, with the regulated entities, what the regulations forbid; this does not suffice to place such

regulation outside the scope of ERISA's savings clause.[1]

B

Petitioners claim that the AWP laws do not regulate

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[1] Petitioners also contend that Ky. Rev. Stat. Ann. §304.17A–270 (West 2001) is not "specifically directed toward" insurers because it applies to "self-insurer or multiple employer welfare arrangement[s] not exempt from state regulation by ERISA." §304.17A–005(23). We do not think §304.17A–270's application to self-insured non-ERISA plans forfeits its status as a "law . . . which regulates insurance" under 29 U. S. C. §1144(b)(2)(A). ERISA's savings clause does not require that a state law regulate "insurance *companies*" or even "*the business of insurance*" to be saved from pre-emption; it need only be a "law . . . which regulates *insurance*," *ibid.* (emphasis added), and self-insured plans engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan. Any contrary view would render superfluous ERISA's "deemer clause," §1144(b)(2)(B), which provides that an employee benefit plan covered by ERISA may not "be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts . . ." That clause has effect only on state laws saved from pre-emption by §1144(b)(2)(A) that would, in the absence of §1144(b)(2)(B), be allowed to regulate self-insured employee benefit plans. Under petitioners' view, such laws would never be saved from pre-emption in the first place. (The deemer clause presents no obstacle to Kentucky's law, which reaches only those employee benefit plans "not exempt from state regulation by ERISA").

Both of Kentucky's AWP laws apply to all HMOs, including HMOs that do not act as insurers but instead provide only administrative services to self-insured plans. Petitioners maintain that the application to noninsuring HMOs forfeits the laws' status as "law[s] . . . which regulat[e] insurance." §1144(b)(2)(A). We disagree. To begin with, these noninsuring HMOs would be administering self-insured plans, which we think suffices to bring them within the activity of insurance for purposes of §1144(b)(2)(A). Moreover, we think petitioners' argument is foreclosed by *Rush Prudential HMO, Inc.* v. *Moran*, 536 U. S. 355, 372 (2002), where we noted that Illinois' independent-review laws contained "some overbreadth in the application of [215 Ill. Comp. Stat., ch. 125,] §4–10 [(2000)] beyond orthodox HMOs," yet held that "there is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation saved from preemption."

insurers with respect to an insurance practice because, unlike the state laws we held saved from pre-emption in *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U. S. 724 (1985), *UNUM*, and *Rush Prudential*, they do not control the actual terms of insurance policies. Rather, they focus upon the relationship between an insurer and *third-party providers*—which in petitioners' view does not constitute an "insurance practice."

In support of their contention, petitioners rely on *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U. S. 205, 210 (1979), which held that third-party provider arrangements between insurers and pharmacies were not "the 'business of insurance'" under §2(b) of the McCarran-Ferguson Act.[2] ERISA's savings clause, however, is not concerned (as is the McCarran-Ferguson Act provision) with how to characterize *conduct* undertaken by private actors, but with how to characterize *state laws* in regard to what they "regulate." It does not follow from *Royal Drug* that a law mandating certain insurer-provider relationships fails to "regulate insurance." Suppose a state law required all licensed attorneys to participate in 10 hours of

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[2] Section 2 of the McCarran-Ferguson Act provides:

"(a) *The business of insurance*, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

"(b) No Act of Congress shall be construed to invalidate, impair, or supersede *any law enacted by any State for the purpose of regulating the business of insurance*, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law. 59 Stat. 34, 15 U. S. C. §1012 (emphasis added).

continuing legal education (CLE) each year. This statute "regulates" the practice of law—even though sitting through 10 hours of CLE classes does not constitute the practice of law—because the state has *conditioned* the right to practice law on certain requirements, which substantially affect the product delivered by lawyers to their clients. Kentucky's AWP laws operate in a similar manner with respect to the insurance industry: Those who wish to provide health insurance in Kentucky (any "health insurer") may not discriminate against any willing provider. This "regulates" insurance by imposing conditions on the right to engage in the business of insurance; whether or not an HMO's contracts with providers constitute "the business of insurance" under *Royal Drug* is beside the point.

We emphasize that conditions on the right to engage in the business of insurance must also substantially affect the risk pooling arrangement between the insurer and the insured to be covered by ERISA's savings clause. Otherwise, any state law aimed at insurance companies could be deemed a law that "regulates insurance," contrary to our interpretation of §1144(b)(2)(A) in *Rush Prudential*, 536 U. S., at 364. A state law requiring all insurance companies to pay their janitors twice the minimum wage would not "regulate insurance," even though it would be a prerequisite to engaging in the business of insurance, because it does not substantially affect the risk pooling arrangement undertaken by insurer and insured. Petitioners contend that Kentucky's AWP statutes fail this test as well, since they do not alter or affect the terms of insurance policies, but concern only the relationship between insureds and third-party providers, Brief for Petitioners 29. We disagree. We have never held that state laws must alter or control the actual terms of insurance policies to be deemed "laws . . . which regulat[e] insurance" under §1144(b)(2)(A); it suffices that they substantially affect the

risk pooling arrangement between insurer and insured. By expanding the number of providers from whom an insured may receive health services, AWP laws alter the scope of permissible bargains between insurers and insureds in a manner similar to the mandated-benefit laws we upheld in *Metropolitan Life*, the notice-prejudice rule we sustained in *UNUM*,[3] and the independent-review provisions we approved in *Rush Prudential*. No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium. The AWP prohibition substantially affects the type of risk pooling arrangements that insurers may offer.

III

Our prior decisions construing §1144(b)(2)(A) have relied, to varying degrees, on our cases interpreting §§2(a) and 2(b) of the McCarran-Ferguson Act. In determining whether certain practices constitute "the *business of* insurance" under the McCarran-Ferguson Act (emphasis added), our cases have looked to three factors: "*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between

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[3] While the Ninth Circuit concluded in *Cisneros* v. *UNUM Life Insurance Co.*, 134 F. 3d 939, 945–946 (1998), aff'd in part, rev'd and remanded in part, *UNUM Life Ins. Co. of America* v. *Ward*, 526 U. S. 358 (1999), that "the notice-prejudice rule does not spread the policyholder's risk within the meaning of the first McCarran-Ferguson factor," our test requires only that the state law substantially *affect* the risk pooling arrangement between the insurer and insured; it does not require that the state law actually spread risk. See *ante*, at 8–9. The notice-prejudice rule governs whether or not an insurance company must cover claims submitted late, which dictates to the insurance company the conditions under which it must pay for the risk that it has assumed. This certainly qualifies as a substantial effect on the risk pooling arrangement between the insurer and insured.

the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry." *Pireno*, 458 U. S., at 129.

We believe that our use of the McCarran-Ferguson case law in the ERISA context has misdirected attention, failed to provide clear guidance to lower federal courts, and, as this case demonstrates, added little to the relevant analysis. That is unsurprising, since the statutory language of §1144(b)(2)(A) differs substantially from that of the McCarran-Ferguson Act. Rather than concerning itself with whether certain practices constitute "[t]he business of insurance," 15 U. S. C. §1012(a), or whether a state law was "enacted . . . *for the purpose of* regulating the business of insurance," §1012(b) (emphasis added), 29 U. S. C. §1144(b)(2)(A) asks merely whether a state law is a "law . . . which regulates insurance, banking, or securities." What is more, the McCarran-Ferguson factors were developed in cases that characterized *conduct* by private actors, not state laws. See *Pireno*, *supra*, at 126 ("The only issue before us is *whether petitioners' peer review practices* are exempt from antitrust scrutiny as part of the 'business of insurance'" (emphasis added)); *Royal Drug*, 440 U. S., at 210 ("The only issue before us is whether the Court of Appeals was correct in concluding that *these Pharmacy Agreements* are not the 'business of insurance' within the meaning of §2(b) of the McCarran-Ferguson Act" (emphasis added)).

Our holdings in *UNUM* and *Rush Prudential*—that a state law may fail the first McCarran-Ferguson factor yet still be saved from pre-emption under §1144(b)(2)(A)—raise more questions than they answer and provide wide opportunities for divergent outcomes. May a state law satisfy *any* two of the three McCarran-Ferguson factors and still fall under the savings clause? Just one? What happens if two of three factors are satisfied, but not "securely satisfied" or "clearly satisfied," as they were in

UNUM and *Rush Prudential*? 526 U. S., at 374; 536 U. S., at 373. Further confusion arises from the question whether the *state law itself* or the *conduct regulated by that law* is the proper subject to which one applies the McCarran-Ferguson factors. In *Pilot Life*, we inquired whether Mississippi's *law of bad faith* has the effect of transferring or spreading risk, 481 U. S., at 50, whether *that law* is integral to the insurer-insured relationship, *id.*, at 51, and whether *that law* is limited to the insurance industry, *ibid.*[4] *Rush Prudential*, by contrast, focused the McCarran-Ferguson inquiry on the *conduct regulated* by the state law, rather than the state law itself. 536 U. S., at 373 ("It is obvious enough that the independent review requirement *regulates* 'an integral part of the policy relationship between the insurer and insured'" (emphasis added)); *id.*, at 374 ("The final factor, that the law be aimed at *a 'practice* . . . limited to entities within the insurance industry' is satisfied . . ." (emphasis added; citation omitted)).

We have never held that the McCarran-Ferguson factors are an essential component of the §1144(b)(2)(A) inquiry. *Metropolitan Life* initially used these factors only to buttress its previously reached conclusion that Massachusetts' mandated-benefit statute was a "law . . . which regulates insurance" under §1144(b)(2)(A). 471 U. S., at 742–743. *Pilot Life* referred to them as mere "considerations [to be] weighed" in determining whether a state law falls under the savings clause. 481 U. S., at 49. *UNUM* emphasized that the McCarran-Ferguson factors were not "'require[d]'" in the savings clause analysis, and were only

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[4] This approach rendered the third McCarran-Ferguson factor a mere repetition of the prior inquiry into whether a state law is "specifically directed toward" the insurance industry under the "common-sense view." *UNUM Life Ins. Co. of America* v. *Ward*, 526 U. S. 358, 375 (1999); *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U. S. 41, 50 (1987).

"checking points" to be used after determining whether the state law regulates insurance from a "common-sense" understanding. 526 U. S., at 374. And *Rush Prudential* called the factors "guideposts," using them only to "confirm our conclusion" that Illinois' statute regulated insurance under §1144(b)(2)(A). 536 U. S., at 373.

Today we make a clean break from the McCarran-Ferguson factors and hold that for a state law to be deemed a "law . . . which regulates insurance" under §1144(b)(2)(A), it must satisfy two requirements. First, the state law must be specifically directed toward entities engaged in insurance. See *Pilot Life*, *supra*, at 50, *UNUM*, *supra*, at 368; *Rush Prudential*, *supra*, at 366. Second, as explained above, the state law must substantially affect the risk pooling arrangement between the insurer and the insured. Kentucky's law satisfies each of these requirements.

* * *

For these reasons, we affirm the judgment of the Sixth Circuit.

It is so ordered.

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

AETNA HEALTH INC., FKA AETNA U. S. HEALTHCARE INC. ET AL. *v.* DAVILA

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 02–1845. Argued March 23, 2004—Decided June 21, 2004*

Respondents brought separate Texas state-court suits, alleging that petitioners, their health maintenance organizations (HMOs), had refused to cover certain medical services in violation of an HMO's duty "to exercise ordinary care" under the Texas Health Care Liability Act (THCLA), and that those refusals "proximately caused" respondents' injuries. Petitioners removed the cases to federal courts, claiming that the actions fit within the scope of, and were thus completely preempted by, §502 of the Employee Retirement Income Security Act of 1974 (ERISA). The District Courts agreed, declined to remand the cases to state court, and dismissed the complaints with prejudice after respondents refused to amend them to bring explicit ERISA claims. Consolidating these and other cases, the Fifth Circuit reversed. It found that respondents' claims did not fall under ERISA §502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan, because petitioners were being sued for mixed eligibility and treatment decisions that were not fiduciary in nature, see *Pegram* v. *Herdrich,* 530 U. S. 211; and did not fall within the scope of §502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, because THCLA did not duplicate that cause of action, see *Rush Prudential HMO, Inc.* v. *Moran,* 536 U. S. 355.

Held: Respondents' state causes of action fall within ERISA

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*Together with No. 03–83, *CIGNA HealthCare of Texas, Inc., dba CIGNA Corp.* v. *Calad et al.,* also on certiorari to the same court.

§502(a)(1)(B), and are therefore completely pre-empted by ERISA §502 and removable to federal court. Pp. 4–20.

(a) When a federal statute completely pre-empts a state-law cause of action, the state claim can be removed. See *Beneficial Nat. Bank* v. *Anderson,* 539 U. S. 1, 8. ERISA is such a statute. Because its purpose is to provide a uniform regulatory regime, ERISA includes expansive pre-emption provisions, such an ERISA §502(a)'s integrated enforcement mechanism, which are intended to ensure that employee benefit plan regulation is "exclusively a federal concern," *Alessi* v. *Raybestos-Manhattan, Inc.,* 451 U. S. 504, 523. Any state-law cause of action that duplicates, supplements, or supplants ERISA's civil enforcement remedy conflicts with clear congressional intent to make that remedy exclusive, and is therefore pre-empted. ERISA §502(a)'s pre-emptive force is still stronger. Since ERISA §502(a)(1)(B)'s pre-emptive force mirrors that of §301 of the Labor Management Relations Act, 1947, *Metropolitan Life Ins. Co.* v. *Taylor,* 481 U. S. 58, 65–66, and since §301 converts state causes of actions into federal ones for purposes of determining the propriety of removal, so too does ERISA §502(a)(1)(B). Pp. 4–7.

(b) If an individual, at some point in time, could have brought his claim under ERISA §502(a)(1)(B), and where no other independent legal duty is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA §502(a)(1)(B). Respondents brought suit only to rectify wrongful benefits denials, and their only relationship with petitioners is petitioners' partial administration of their ERISA-regulated benefit plans; respondents therefore could have brought §502(a)(1)(B) claims to recover the allegedly wrongfully denied benefits. Both respondents allege violations of the THCLA's duty of ordinary care, which they claim is entirely independent of any ERISA duty or the employee benefits plans at issue. However, respondents' claims do not arise independently of ERISA or the plan terms. If a managed care entity correctly concluded that, under the relevant plan's terms, a particular treatment was not covered, the plan's failure to cover the requested treatment would be the proximate cause of any injury arising from the denial. More significantly, the THCLA provides that a managed care entity is not subject to THCLA liability if it denies coverage for a treatment not covered by the plan it administers. Pp. 7–12.

(c) The Fifth Circuit's reasons for reaching its contrary conclusion are all erroneous. First, it found significant that respondents asserted tort, rather than contract, claims and that they were not seeking reimbursement for benefits denied. However, distinguishing between pre-empted and non-pre-empted claims based on the par-

ticular label affixed to them would allow parties to evade ERISA's pre-emptive scope simply by relabeling contract claims as claims for tortious breach of contracts. And the fact that a state cause of action attempts to authorize remedies beyond those that ERISA §502(a) authorizes does not put it outside the scope of ERISA's civil enforcement mechanism. See, *e.g., Pilot Life Ins. Co.* v. *Dedeaux,* 481 U. S. 41, 43. Second, the court believed the plans' wording immaterial because the claims invoked an external ordinary care duty, but the wording is material to the state causes of action and the THCLA creates a duty that is not external to respondents' rights under their respective plans. Finally, nowhere in *Rush Prudential* did this Court suggest that ERISA §502(a)'s pre-emptive force is limited to state causes of action that precisely duplicate an ERISA §502(a) cause. Nor would it be consistent with this Court's precedent to do so. Pp. 12–14.

(d) Also unavailing is respondents' argument that the THCLA is a law regulating insurance that is saved from pre-emption by ERISA §514(b)(2)(A). This Court's understanding of §514(b)(2)(A) is informed by the overpowering federal policy embodied in ERISA §502(a), which is intended to create an exclusive federal remedy, *Pilot Life,* 481 U. S., at 52. Allowing respondents to proceed with their state-law suits would "pose an obstacle" to that objective. *Ibid.* Pp. 14–16.

(e) *Pegram*'s holding that an HMO is not intended to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians is not implicated here because petitioners' coverage decisions are pure eligibility decisions. A benefit determination under ERISA is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan. That it is infused with medical judgments does not alter this result. *Pegram* itself recognized this principle, see 530 U. S., at 231–232. And ERISA and its implementing regulations confirm this interpretation. Here, petitioners are neither respondents' treating physicians nor those physicians' employees. Pp. 16–19.

307 F. 3d 298, reversed and remanded.

THOMAS, J., delivered the opinion for a unanimous Court. GINSBURG, J., filed a concurring opinion, in which BREYER, J., joined.

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

SUPREME COURT OF THE UNITED STATES

Nos. 02–1845 and 03–83

AETNA HEALTH INC., FKA AETNA U. S. HEALTHCARE INC. AND AETNA U. S. HEALTHCARE OF NORTH TEXAS INC., PETITIONER

02–1845 *v.*

JUAN DAVILA

CIGNA HEALTHCARE OF TEXAS, INC., DBA CIGNA CORPORATION, PETITIONER

03–83 *v.*

RUBY R. CALAD ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

[June 21, 2004]

JUSTICE THOMAS delivered the opinion of the Court.

In these consolidated cases, two individuals sued their respective health maintenance organizations (HMOs) for alleged failures to exercise ordinary care in the handling of coverage decisions, in violation of a duty imposed by the Texas Health Care Liability Act (THCLA), Tex. Civ. Prac. & Rem. Code Ann. §§88.001–88.003 (2004 Supp. Pamphlet). We granted certiorari to decide whether the individuals' causes of action are completely pre-empted by the "interlocking, interrelated, and interdependent remedial scheme," *Massachusetts Mut. Life Ins. Co.* v. *Russell,* 473 U. S. 134, 146 (1985), found at §502(a) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat.

891, as amended, 29 U. S. C. §1132(a) *et seq*. 540 U. S. 981 (2003). We hold that the causes of action are completely pre-empted and hence removable from state to federal court. The Court of Appeals, having reached a contrary conclusion, is reversed.

I

A

Respondent Juan Davila is a participant, and respondent Ruby Calad is a beneficiary, in ERISA-regulated employee benefit plans. Their respective plan sponsors had entered into agreements with petitioners, Aetna Health Inc. and CIGNA Healthcare of Texas, Inc., to administer the plans. Under Davila's plan, for instance, Aetna reviews requests for coverage and pays providers, such as doctors, hospitals, and nursing homes, which perform covered services for members; under Calad's plan sponsor's agreement, CIGNA is responsible for plan benefits and coverage decisions.

Respondents both suffered injuries allegedly arising from Aetna's and CIGNA's decisions not to provide coverage for certain treatment and services recommended by respondents' treating physicians. Davila's treating physician prescribed Vioxx to remedy Davila's arthritis pain, but Aetna refused to pay for it. Davila did not appeal or contest this decision, nor did he purchase Vioxx with his own resources and seek reimbursement. Instead, Davila began taking Naprosyn, from which he allegedly suffered a severe reaction that required extensive treatment and hospitalization. Calad underwent surgery, and although her treating physician recommended an extended hospital stay, a CIGNA discharge nurse determined that Calad did not meet the plan's criteria for a continued hospital stay. CIGNA consequently denied coverage for the extended hospital stay. Calad experienced postsurgery complications forcing her to return to the hospital. She alleges that

these complications would not have occurred had CIGNA approved coverage for a longer hospital stay.

Respondents brought separate suits in Texas state court against petitioners. Invoking THCLA §88.002(a), respondents argued that petitioners' refusal to cover the requested services violated their "duty to exercise ordinary care when making health care treatment decisions," and that these refusals "proximately caused" their injuries. *Ibid.* Petitioners removed the cases to Federal District Courts, arguing that respondents' causes of action fit within the scope of, and were therefore completely preempted by, ERISA §502(a). The respective District Courts agreed, and declined to remand the cases to state court. Because respondents refused to amend their complaints to bring explicit ERISA claims, the District Courts dismissed the complaints with prejudice.

B

Both Davila and Calad appealed the refusals to remand to state court. The United States Court of Appeals for the Fifth Circuit consolidated their cases with several others raising similar issues. The Court of Appeals recognized that state causes of action that "duplicat[e] or fal[l] within the scope of an ERISA §502(a) remedy" are completely preempted and hence removable to federal court. *Roark* v. *Humana, Inc.,* 307 F. 3d 298, 305 (2002) (internal quotation marks and citations omitted). After examining the causes of action available under §502(a), the Court of Appeals determined that respondents' claims could possibly fall under only two: §502(a)(1)(B), which provides a cause of action for the recovery of wrongfully denied benefits, and §502(a)(2), which allows suit against a plan fiduciary for breaches of fiduciary duty to the plan.

Analyzing §502(a)(2) first, the Court of Appeals concluded that, under *Pegram* v. *Herdrich,* 530 U. S. 211 (2000), the decisions for which petitioners were being sued

were "mixed eligibility and treatment decisions" and hence were not fiduciary in nature. 307 F. 3d, at 307–308.[1] The Court of Appeals next determined that respondents' claims did not fall within §502(a)(1)(B)'s scope. It found significant that respondents "assert tort claims," while §502(a)(1)(B) "creates a cause of action for breach of contract," *id.*, at 309, and also that respondents "are not seeking reimbursement for benefits denied them," but rather request "tort damages" arising from "an external, statutorily imposed duty of 'ordinary care.'" *Ibid.* From *Rush Prudential HMO, Inc.* v. *Moran,* 536 U. S. 355 (2002), the Court of Appeals derived the principle that complete pre-emption is limited to situations in which "States . . . duplicate the causes of action listed in ERISA §502(a)," and concluded that "[b]ecause the THCLA does not provide an action for collecting benefits," it fell outside the scope of §502(a)(1)(B). 307 F. 3d, at 310–311.

II

A

Under the removal statute, "any civil action brought in a State court of which the district courts of the United States have original jurisdiction, may be removed by the defendant" to federal court. 28 U. S. C. §1441(a). One category of cases of which district courts have original jurisdiction are "federal question" cases: cases "arising under the Constitution, laws, or treaties of the United States." §1331. We face in these cases the issue whether respondents' causes of action arise under federal law.

Ordinarily, determining whether a particular case arises under federal law turns on the "'well-pleaded com-

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[1] In this Court, petitioners do not claim or argue that respondents' causes of action fall under ERISA §502(a)(2). Because petitioners do not argue this point, and since we can resolve these cases entirely by reference to ERISA §502(a)(1)(B), we do not address ERISA §502(a)(2).

plaint'" rule. *Franchise Tax Bd. of Cal.* v. *Construction Laborers Vacation Trust for Southern Cal.,* 463 U. S. 1, 9–10 (1983). The Court has explained that

> "whether a case is one arising under the Constitution or a law or treaty of the United States, in the sense of the jurisdictional statute[,] . . . must be determined from what necessarily appears in the plaintiff's statement of his own claim in the bill or declaration, unaided by anything alleged in anticipation of avoidance of defenses which it is thought the defendant may interpose." *Taylor* v. *Anderson,* 234 U. S. 74, 75–76 (1914).

In particular, the existence of a federal defense normally does not create statutory "arising under" jurisdiction, *Louisville & Nashville R. Co.* v. *Mottley,* 211 U. S. 149 (1908), and "a defendant may not [generally] remove a case to federal court unless the *plaintiff's* complaint establishes that the case 'arises under' federal law." *Franchise Tax Bd.*, *supra*, at 10. There is an exception, however, to the well-pleaded complaint rule. "[W]hen a federal statute wholly displaces the state-law cause of action through complete pre-emption," the state claim can be removed. *Beneficial Nat. Bank* v. *Anderson*, 539 U. S. 1, 8 (2003). This is so because "[w]hen the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *Ibid.* ERISA is one of these statutes.

B

Congress enacted ERISA to "protect . . . the interests of participants in employee benefit plans and their beneficiaries" by setting out substantive regulatory requirements for employee benefit plans and to "provid[e] for appropriate remedies, sanctions, and ready access to the Federal

courts." 29 U. S. C. §1001(b). The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans. To this end, ERISA includes expansive pre-emption provisions, see ERISA §514, 29 U. S. C. §1144, which are intended to ensure that employee benefit plan regulation would be "exclusively a federal concern." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U. S. 504, 523 (1981).

ERISA's "comprehensive legislative scheme" includes "an integrated system of procedures for enforcement." *Russell*, 473 U. S., at 147 (internal quotation marks and citation omitted). This integrated enforcement mechanism, ERISA §502(a), 29 U. S. C. §1132(a), is a distinctive feature of ERISA, and essential to accomplish Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans. As the Court said in *Pilot Life Ins. Co.* v. *Dedeaux,* 481 U. S. 41 (1987):

> "[T]he detailed provisions of §502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. 'The six carefully integrated civil enforcement provisions found in §502(a) of the statute as finally enacted . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.'" *Id.*, at 54 (quoting *Russell*, *supra*, at 146).

Therefore, any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to

make the ERISA remedy exclusive and is therefore pre-empted. See 481 U. S., at 54–56; see also *Ingersoll-Rand Co.* v. *McClendon,* 498 U. S. 133, 143–145 (1990).

The pre-emptive force of ERISA §502(a) is still stronger. In *Metropolitan Life Ins. Co.* v. *Taylor,* 481 U. S. 58, 65–66 (1987), the Court determined that the similarity of the language used in the Labor Management Relations Act, 1947 (LMRA), and ERISA, combined with the "clear intention" of Congress "to make §502(a)(1)(B) suits brought by participants or beneficiaries federal questions for the purposes of federal court jurisdiction in like manner as §301 of the LMRA," established that ERISA §502(a)(1)(B)'s pre-emptive force mirrored the pre-emptive force of LMRA §301. Since LMRA §301 converts state causes of action into federal ones for purposes of determining the propriety of removal, see *Avco Corp.* v. *Machinists*, 390 U. S. 557 (1968), so too does ERISA §502(a)(1)(B). Thus, the ERISA civil enforcement mechanism is one of those provisions with such "extraordinary pre-emptive power" that it "converts an ordinary state common law complaint into one stating a federal claim for purposes of the well-pleaded complaint rule." *Metropolitan Life*, 481 U. S., at 65–66. Hence, "causes of action within the scope of the civil enforcement provisions of §502(a) [are] removable to federal court." *Id.*, at 66.

III

A

ERISA §502(a)(1)(B) provides:

> "A civil action may be brought—(1) by a participant or beneficiary— . . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U. S. C. §1132(a)(1)(B).

This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised to him under the terms of the plan are not provided, he can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to "enforce his rights" under the plan, or to clarify any of his rights to future benefits. Any dispute over the precise terms of the plan is resolved by a court under a *de novo* review standard, unless the terms of the plan "giv[e] the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U. S. 101, 115 (1989).

It follows that if an individual brings suit complaining of a denial of coverage for medical care, where the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no legal duty (state or federal) independent of ERISA or the plan terms is violated, then the suit falls "within the scope of" ERISA §502(a)(1)(B). *Metropolitan Life*, *supra*, at 66. In other words, if an individual, at some point in time, could have brought his claim under ERISA §502(a)(1)(B), and where there is no other independent legal duty that is implicated by a defendant's actions, then the individual's cause of action is completely pre-empted by ERISA §502(a)(1)(B).

To determine whether respondents' causes of action fall "within the scope" of ERISA §502(a)(1)(B), we must examine respondents' complaints, the statute on which their claims are based (the THCLA), and the various plan documents. Davila alleges that Aetna provides health coverage under his employer's health benefits plan. App. H to Pet. for Cert. in No. 02–1845, p. 67a, ¶11. Davila also alleges that after his primary care physician prescribed Vioxx, Aetna refused to pay for it. *Id.*, at 67a, ¶12. The only action complained of was Aetna's refusal to approve

payment for Davila's Vioxx prescription. Further, the only relationship Aetna had with Davila was its partial administration of Davila's employer's benefit plan. See App. 25, 31, 39–40, 45–48, 108.

Similarly, Calad alleges that she receives, as her husband's beneficiary under an ERISA-regulated benefit plan, health coverage from CIGNA. *Id.,* at 184, ¶17. She alleges that she was informed by CIGNA, upon admittance into a hospital for major surgery, that she would be authorized to stay for only one day. *Id.,* at 184, ¶18. She also alleges that CIGNA, acting through a discharge nurse, refused to authorize more than a single day despite the advice and recommendation of her treating physician. *Id.*, at 185, ¶¶20, 21. Calad contests only CIGNA's decision to refuse coverage for her hospital stay. *Id.*, at 185, ¶20. And, as in Davila's case, the only connection between Calad and CIGNA is CIGNA's administration of portions of Calad's ERISA-regulated benefit plan. *Id.,* at 219–221.

It is clear, then, that respondents complain only about denials of coverage promised under the terms of ERISA-regulated employee benefit plans. Upon the denial of benefits, respondents could have paid for the treatment themselves and then sought reimbursement through a §502(a)(1)(B) action, or sought a preliminary injunction, see *Pryzbowski* v. *U. S. Healthcare, Inc.*, 245 F. 3d 266, 274 (CA3 2001) (giving examples where federal courts have issued such preliminary injunctions).[2]

Respondents contend, however, that the complained-of

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[2]Respondents also argue that the benefit due under their ERISA-regulated employee benefit plans is simply the membership in the respective HMOs, not coverage for the particular medical treatments that are delineated in the plan documents. See Brief for Respondents 28–30. Respondents did not identify this possible argument in their brief in opposition to the petitions for certiorari, and we deem it waived. See this Court's Rule 15.2.

actions violate legal duties that arise independently of ERISA or the terms of the employee benefit plans at issue in these cases. Both respondents brought suit specifically under the THCLA, alleging that petitioners "controlled, influenced, participated in and made decisions which affected the quality of the diagnosis, care, and treatment provided" in a manner that violated "the duty of ordinary care set forth in §§88.001 and 88.002." App. H to Pet. for Cert. in No. 02–1845, at 69a, ¶18; see also App. 187, ¶28. Respondents contend that this duty of ordinary care is an independent legal duty. They analogize to this Court's decisions interpreting LMRA §301, 29 U. S. C. §1081, with particular focus on *Caterpillar Inc.* v. *Williams,* 482 U. S. 386 (1987) (suit for breach of individual employment contract, even if defendant's action also constituted a breach of an entirely separate collective bargaining agreement, not pre-empted by LMRA §301). Because this duty of ordinary care arises independently of any duty imposed by ERISA or the plan terms, the argument goes, any civil action to enforce this duty is not within the scope of the ERISA civil enforcement mechanism.

The duties imposed by the THCLA in the context of these cases, however, do not arise independently of ERISA or the plan terms. The THCLA does impose a duty on managed care entities to "exercise ordinary care when making health care treatment decisions," and makes them liable for damages proximately caused by failures to abide by that duty. §88.002(a). However, if a managed care entity correctly concluded that, under the terms of the relevant plan, a particular treatment was not covered, the managed care entity's denial of coverage would not be a proximate cause of any injuries arising from the denial. Rather, the failure of the plan itself to cover the requested

treatment would be the proximate cause.[3] More significantly, the THCLA clearly states that "[t]he standards in Subsections (a) and (b) create no obligation on the part of the health insurance carrier, health maintenance organization, or other managed care entity to provide to an insured or enrollee treatment which is not covered by the health care plan of the entity." §88.002(d). Hence, a managed care entity could not be subject to liability under the THCLA if it denied coverage for any treatment not covered by the health care plan that it was administering.

Thus, interpretation of the terms of respondents' benefit plans forms an essential part of their THCLA claim, and THCLA liability would exist here only because of petitioners' administration of ERISA-regulated benefit plans. Petitioners' potential liability under the THCLA in these cases, then, derives entirely from the particular rights and obligations established by the benefit plans. So, unlike the state-law claims in *Caterpillar*, *supra*, respondents' THCLA causes of action are not entirely independent of the federally regulated contract itself. Cf. *Allis-Chalmers Corp.* v. *Lueck*, 471 U. S. 202, 217 (1985) (state-law tort of bad faith handling of insurance claim pre-empted by LMRA §301, since the "duties imposed and rights established through the state tort . . . derive[d] from the rights and obligations established by the contract"); *Steelworkers* v. *Rawson,* 495 U. S. 362, 371 (1990) (state-law tort action brought due to alleged negligence in the inspection of a mine was pre-empted, as the duty to inspect the mine arose solely out of the collective-bargaining agreement).

Hence, respondents bring suit only to rectify a wrongful

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[3] To take a clear example, if the terms of the health care plan specifically exclude from coverage the cost of an appendectomy, then any injuries caused by the refusal to cover the appendectomy are properly attributed to the terms of the plan itself, not the managed care entity that applied those terms.

denial of benefits promised under ERISA-regulated plans, and do not attempt to remedy any violation of a legal duty independent of ERISA. We hold that respondents' state causes of action fall "within the scope of" ERISA §502(a)(1)(B), *Metropolitan Life*, 481 U. S., at 66, and are therefore completely pre-empted by ERISA §502 and removable to federal district court.[4]

B

The Court of Appeals came to a contrary conclusion for several reasons, all of them erroneous. First, the Court of Appeals found significant that respondents "assert a tort claim for tort damages" rather than "a contract claim for contract damages," and that respondents "are not seeking reimbursement for benefits denied them." 307 F. 3d, at 309. But, distinguishing between pre-empted and non-pre-empted claims based on the particular label affixed to them would "elevate form over substance and allow parties to evade" the pre-emptive scope of ERISA simply "by relabeling their contract claims as claims for tortious breach of contract." *Allis-Chalmers*, *supra*, at 211. Nor can the mere fact that the state cause of action attempts to authorize remedies beyond those authorized by ERISA §502(a) put the cause of action outside the scope of the ERISA civil enforcement mechanism. In *Pilot Life*, *Metro-*

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[4] Respondents also argue that ERISA §502(a) completely pre-empts a state cause of action only if the cause of action would be pre-empted under ERISA §514(a); respondents then argue that their causes of action do not fall under the terms of §514(a). But a state cause of action that provides an alternative remedy to those provided by the ERISA civil enforcement mechanism conflicts with Congress' clear intent to make the ERISA mechanism exclusive. See *Ingersoll-Rand Co.* v. *McClendon,* 498 U. S. 133, 142 (1990) (holding that "[e]ven if there were no express pre-emption [under ERISA §514(a)]" of the cause of action in that case, it "would be pre-empted because it conflict[ed] directly with an ERISA cause of action").

politan Life, and *Ingersoll-Rand*, the plaintiffs all brought state claims that were labeled either tort or tort-like. See *Pilot Life*, 481 U. S., at 43 (suit for, *inter alia*, "Tortious Breach of Contract"); *Metropolitan Life*, *supra,* at 61–62 (suit requesting damages for "mental anguish caused by breach of [the] contract"); *Ingersoll-Rand*, 498 U. S., at 136 (suit brought under various tort and contract theories). And, the plaintiffs in these three cases all sought remedies beyond those authorized under ERISA. See *Pilot Life*, *supra*, at 43 (compensatory and punitive damages); *Metropolitan Life*, *supra*, at 61 (mental anguish); *Ingersoll-Rand*, *supra*, at 136 (punitive damages, mental anguish). And, in all these cases, the plaintiffs' claims were pre-empted. The limited remedies available under ERISA are an inherent part of the "careful balancing" between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans. *Pilot Life*, *supra*, at 55.

Second, the Court of Appeals believed that "the wording of [respondents'] plans is immaterial" to their claims, as "they invoke an external, statutorily imposed duty of 'ordinary care.'" 307 F. 3d, at 309. But as we have already discussed, the wording of the plans is certainly material to their state causes of action, and the duty of "ordinary care" that the THCLA creates is not external to their rights under their respective plans.

Ultimately, the Court of Appeals rested its decision on one line from *Rush Prudential*. There, we described our holding in *Ingersoll-Rand* as follows: "[W]hile state law duplicated the elements of a claim available under ERISA, it converted the remedy from an equitable one under §1132(a)(3) (available exclusively in federal district courts) into a legal one for money damages (available in a state tribunal)." 536 U. S., at 379. The point of this sentence was to describe why the state cause of action in *Ingersoll-Rand* was pre-empted by ERISA §502(a): It was pre-

empted because it attempted to convert an equitable remedy into a legal remedy. Nowhere in *Rush Prudential* did we suggest that the pre-emptive force of ERISA §502(a) is limited to the situation in which a state cause of action precisely duplicates a cause of action under ERISA §502(a).

Nor would it be consistent with our precedent to conclude that only strictly duplicative state causes of action are pre-empted. Frequently, in order to receive exemplary damages on a state claim, a plaintiff must prove facts beyond the bare minimum necessary to establish entitlement to an award. Cf. *Allis-Chalmers,* 471 U. S., at 217 (bad-faith refusal to honor a claim needed to be proved in order to recover exemplary damages). In order to recover for mental anguish, for instance, the plaintiffs in *Ingersoll-Rand* and *Metropolitan Life* would presumably have had to prove the existence of mental anguish; there is no such element in an ordinary suit brought under ERISA §502(a)(1)(B). See *Ingersoll-Rand*, *supra*, at 136; *Metropolitan Life*, *supra*, at 61. This did not save these state causes of action from pre-emption. Congress' intent to make the ERISA civil enforcement mechanism exclusive would be undermined if state causes of action that supplement the ERISA §502(a) remedies were permitted, even if the elements of the state cause of action did not precisely duplicate the elements of an ERISA claim.

C

Respondents also argue—for the first time in their brief to this Court—that the THCLA is a law that regulates insurance, and hence that ERISA §514(b)(2)(A) saves their causes of action from pre-emption (and thereby from complete pre-emption).[5] This argument is unavailing. The

[5] ERISA §514(b)(2)(A), 29 U. S. C. §1144(b)(2)(A), reads, as relevant: "[N]othing in this subchapter shall be construed to exempt or relieve

existence of a comprehensive remedial scheme can demonstrate an "overpowering federal policy" that determines the interpretation of a statutory provision designed to save state law from being pre-empted. *Rush Prudential*, 536 U. S., at 375. ERISA's civil enforcement provision is one such example. See *ibid.*

As this Court stated in *Pilot Life*, "our understanding of [§514(b)(2)(A)] must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA §502(a), 29 U. S. C. §1132(a)." 481 U. S., at 52. The Court concluded that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Id.*, at 54. The Court then held, based on

> "the common-sense understanding of the saving clause, the McCarran-Ferguson Act factors defining the business of insurance, and, *most importantly*, the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive, . . . that [the plaintiff's] state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by §514(b)(2)(A)." *Id.*, at 57 (emphasis added).

Pilot Life's reasoning applies here with full force. Allowing respondents to proceed with their state-law suits would "pose an obstacle to the purposes and objectives of Congress." *Id.*, at 52. As this Court has recognized in both *Rush Prudential* and *Pilot Life*, ERISA §514(b)(2)(A) must be interpreted in light of the congressional intent to

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any person from any law of any State which regulates insurance, banking, or securities."

create an exclusive federal remedy in ERISA §502(a). Under ordinary principles of conflict pre-emption, then, even a state law that can arguably be characterized as "regulating insurance" will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.

IV

Respondents, their *amici*, and some Courts of Appeals have relied heavily upon *Pegram* v. *Herdrich,* 530 U. S. 211 (2000), in arguing that ERISA does not pre-empt or completely pre-empt state suits such as respondents'. They contend that *Pegram* makes it clear that causes of action such as respondents' do not "relate to [an] employee benefit plan," ERISA §514(a), 29 U. S. C. §1144(a), and hence are not pre-empted. See Brief for Respondents 35–38; *Cicio* v. *Does*, 321 F. 3d 83, 100–104 (CA2 2003); see also *Land* v. *CIGNA Healthcare*, 339 F. 3d 1286, 1292–1294 (CA11 2003).

Pegram cannot be read so broadly. In *Pegram*, the plaintiff sued her physician-owned-and-operated HMO (which provided medical coverage through plaintiff's employer pursuant to an ERISA-regulated benefit plan) and her treating physician, both for medical malpractice and for a breach of an ERISA fiduciary duty. See 530 U. S., at 215–216. The plaintiff's treating physician was also the person charged with administering plaintiff's benefits; it was she who decided whether certain treatments were covered. See *id.*, at 228. We reasoned that the physician's "eligibility decision and the treatment decision were inextricably mixed." *Id.*, at 229. We concluded that "Congress did not intend [the defendant HMO] or any other HMO to be treated as a fiduciary to the extent that it makes mixed eligibility decisions acting through its physicians." *Id.*, at 231.

A benefit determination under ERISA, though, is gener-

ally a fiduciary act. See *Bruch,* 489 U. S., at 111–113. "At common law, fiduciary duties characteristically attach to decisions about managing assets and distributing property to beneficiaries." *Pegram*, *supra*, at 231; cf. 2A A. Scott & W. Fratcher, Law of Trusts §§182, 183 (4th ed. 1987); G. Bogert & G. Bogert, Law of Trusts & Trustees §541 (rev. 2d ed. 1993). Hence, a benefit determination is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan. See *Varity Corp*. v. *Howe*, 516 U. S. 489, 512 (1996) (relevant plan fiduciaries owe a "fiduciary duty with respect to the interpretation of plan documents and the payment of claims"). The fact that a benefits determination is infused with medical judgments does not alter this result.

Pegram itself recognized this principle. *Pegram*, in highlighting its conclusion that "mixed eligibility decisions" were not fiduciary in nature, contrasted the operation of "[t]raditional trustees administer[ing] a medical trust" and "physicians through whom HMOs act." 530 U. S., at 231–232. A traditional medical trust is administered by "paying out money to buy medical care, whereas physicians making mixed eligibility decisions consume the money as well." *Ibid*. And, significantly, the Court stated that "[p]rivate trustees do not make treatment judgments." *Id*., at 232. But a trustee managing a medical trust undoubtedly must make administrative decisions that require the exercise of medical judgment. Petitioners are not the employers of respondents' treating physicians and are therefore in a somewhat analogous position to that of a trustee for a traditional medical trust.[6]

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[6] Both *Pilot Life* and *Metropolitan Life* support this understanding. The plaintiffs in *Pilot Life* and *Metropolitan Life* challenged disability determinations made by the insurers of their ERISA-regulated employee benefit plans. See *Pilot Life Ins. Co.* v. *Dedeaux,* 481 U. S. 41, 43 (1987); *Metropolitan Life Ins. Co.* v. *Taylor,* 481 U. S. 58, 61 (1987). A

ERISA itself and its implementing regulations confirm this interpretation. ERISA defines a fiduciary as any person "to the extent . . . he has any discretionary authority or discretionary responsibility in the administration of [an employee benefit] plan." §3(21)(A)(iii), 29 U. S. C. §1002(21)(A)(iii). When administering employee benefit plans, HMOs must make discretionary decisions regarding eligibility for plan benefits, and, in this regard, must be treated as plan fiduciaries. See *Varity Corp.*, *supra*, at 511 (plan administrator "engages in a fiduciary act when making a discretionary determination about whether a claimant is entitled to benefits under the terms of the plan documents"). Also, ERISA §503, which specifies minimum requirements for a plan's claim procedure, requires plans to "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim." 29 U. S. C. §1133(2). This strongly suggests that the ultimate decisionmaker in a plan regarding an award of benefits must be a fiduciary and must be acting as a fiduciary when determining a participant's or beneficiary's claim. The relevant regulations also establish extensive requirements to ensure full and fair review of benefit denials. See 29 CFR §2560.503–1 (2004). These regulations, on their face, apply equally to health benefit plans and other plans, and do not draw distinctions between medical and nonmedical benefits determinations. Indeed, the regulations strongly imply that

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disability determination often involves medical judgments. See, *e.g.*, *ibid.* (plaintiff determined not to be disabled only after a medical examination undertaken by one of his employer's physicians). Yet, in both *Pilot Life* and *Metropolitan Life*, the Court held that the causes of action were pre-empted. Cf. *Black & Decker Disability Plan* v. *Nord,* 538 U. S. 822 (2003) (discussing "treating physician" rule in the context of disability determinations made by ERISA-regulated disability plans).

benefits determinations involving medical judgments are, just as much as any other benefits determinations, actions by plan fiduciaries. See, *e.g.*, §2560.503–1(h)(3)(iii). Classifying any entity with discretionary authority over benefits determinations as anything but a plan fiduciary would thus conflict with ERISA's statutory and regulatory scheme.

Since administrators making benefits determinations, even determinations based extensively on medical judgments, are ordinarily acting as plan fiduciaries, it was essential to *Pegram*'s conclusion that the decisions challenged there were truly "mixed eligibility and treatment decisions," 530 U. S., at 229, *i.e.*, medical necessity decisions made by the plaintiff's treating physician *qua* treating physician and *qua* benefits administrator. Put another way, the reasoning of *Pegram* "only make[s] sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer." *Cicio*, 321 F. 3d, at 109 (Calabresi, J., dissenting in part). Here, however, petitioners are neither respondents' treating physicians nor the employers of respondents' treating physicians. Petitioners' coverage decisions, then, are pure eligibility decisions, and *Pegram* is not implicated.

V

We hold that respondents' causes of action, brought to remedy only the denial of benefits under ERISA-regulated benefit plans, fall within the scope of, and are completely pre-empted by, ERISA §502(a)(1)(B), and thus removable to federal district court. The judgment of the Court of Appeals is reversed, and the cases are remanded for fur-

ther proceedings consistent with this opinion.[7]

It is so ordered.

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[7] The United States, as *amicus*, suggests that some individuals in respondents' positions could possibly receive some form of "make-whole" relief under ERISA §502(a)(3). Brief for United States as *Amicus Curiae* 27, n. 13. However, after their respective District Courts denied their motions for remand, respondents had the opportunity to amend their complaints to bring expressly a claim under ERISA §502(a). Respondents declined to do so; the District Courts therefore dismissed their complaints with prejudice. See App. 147–148; *id.*, at 298; App. B to Pet. for Cert. in No. 02–1845, pp. 34a–35a; App. B to Pet. for Cert. in No. 03–83, p. 40a. Respondents have thus chosen not to pursue any ERISA claim, including any claim arising under ERISA §502(a)(3). The scope of this provision, then, is not before us, and we do not address it.

SUPREME COURT OF THE UNITED STATES

Nos. 02–1845 and 03–83

AETNA HEALTH INC., FKA AETNA U. S. HEALTHCARE INC. AND AETNA U. S. HEALTHCARE OF NORTH TEXAS INC., PETITIONER

02–1845 *v.*

JUAN DAVILA

CIGNA HEALTHCARE OF TEXAS, INC., DBA CIGNA CORPORATION, PETITIONER

03–83 *v.*

RUBY R. CALAD ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

[June 21, 2004]

JUSTICE GINSBURG, with whom JUSTICE BREYER joins, concurring.

The Court today holds that the claims respondents asserted under Texas law are totally preempted by §502(a) of the Employee Retirement Income Security Act of 1974 (ERISA or Act), 29 U. S. C. §1132(a). That decision is consistent with our governing case law on ERISA's preemptive scope. I therefore join the Court's opinion. But, with greater enthusiasm, as indicated by my dissenting opinion in *Great-West Life & Annuity Ins. Co.* v. *Knudson,* 534 U. S. 204 (2002), I also join "the rising judicial chorus urging that Congress and [this] Court revisit what is an unjust and increasingly tangled ERISA regime." *DiFelice* v. *AETNA U. S. Healthcare*, 346 F. 3d 442, 453 (CA3 2003) (Becker, J., concurring).

Because the Court has coupled an encompassing inter-

pretation of ERISA's preemptive force with a cramped construction of the "equitable relief" allowable under §502(a)(3), a "regulatory vacuum" exists: "[V]irtually all state law remedies are preempted but very few federal substitutes are provided." *Id.*, at 456 (internal quotation marks omitted).

A series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief. First, in *Massachusetts Mut. Life Ins. Co.* v. *Russell,* 473 U. S. 134 (1985), the Court stated, in dicta: "[T]here is a stark absence—in [ERISA] itself and in its legislative history—of any reference to an intention to authorize the recovery of extracontractual damages" for consequential injuries. *Id.*, at 148. Then, in *Mertens* v. *Hewitt Associates,* 508 U. S. 248 (1993), the Court held that §502(a)(3)'s term "'equitable relief' . . . refer[s] to those categories of relief that were *typically* available in equity (such as injunction, mandamus, and restitution, but not compensatory damages)." *Id.*, at 256 (emphasis in original). Most recently, in *Great-West*, the Court ruled that, as "§502(a)(3), by its terms, only allows for *equitable* relief," the provision excludes "the imposition of personal liability . . . for a contractual obligation to pay money." 534 U. S., at 221 (emphasis in original).

As the array of lower court cases and opinions documents, see, *e.g.*, *DiFelice; Cicio* v. *Does*, 321 F. 3d 83 (CA2 2003), cert. pending *sub nom. Vytra Healthcare* v. *Cicio*, No. 03–69, fresh consideration of the availability of consequential damages under §502(a)(3) is plainly in order. See 321 F. 3d, at 106, 107 (Calabresi, J., dissenting in part) ("gaping wound" caused by the breadth of preemption and limited remedies under ERISA, as interpreted by this Court, will not be healed until the Court "start[s] over" or Congress "wipe[s] the slate clean"); *DiFelice*, 346 F. 3d, at 467 ("The vital thing . . . is that either Congress or the Court act

quickly, because the current situation is plainly untenable."); Langbein, What ERISA Means by "Equitable": The Supreme Court's Trail of Error in *Russell*, *Mertens*, and *Great-West*, 103 Colum. L. Rev. 1317, 1365 (2003) (hereinafter Langbein) ("The Supreme Court needs to . . . realign ERISA remedy law with the trust remedial tradition that Congress intended [when it provided in §502(a)(3) for] 'appropriate equitable relief.'").

The Government notes a potential amelioration. Recognizing that "this Court has construed Section 502(a)(3) not to authorize an award of money damages against a *non-fiduciary*," the Government suggests that the Act, as currently written and interpreted, may "allo[w] at least some forms of 'make-whole' relief against a breaching *fiduciary* in light of the general availability of such relief in equity at the time of the divided bench." Brief for United States as *Amicus Curiae* 27–28, n. 13 (emphases added); cf. *ante*, at 19 ("entity with discretionary authority over benefits determinations" is a "plan fiduciary"); Tr. of Oral Arg. 13 ("Aetna is [a fiduciary]—and CIGNA is for purposes of claims processing."). As the Court points out, respondents here declined the opportunity to amend their complaints to state claims for relief under §502(a); the District Court, therefore, properly dismissed their suits with prejudice. See *ante*, at 20, n. 7. But the Government's suggestion may indicate an effective remedy others similarly circumstanced might fruitfully pursue.

"Congress . . . intended ERISA to replicate the core principles of trust remedy law, including the make-whole standard of relief." Langbein 1319. I anticipate that Congress, or this Court, will one day so confirm.

APPENDIX V

Senate Committee on State Affairs Hearing, Aug. 11, 2004, (written testimony of Texas Department of Insurance).

Out-of-Network Services
Examples Compiles by Texas Department of Insurance

Examples of Situations Resulting in Out-of-Network Services - PPO

- Insured chooses to receive services from an out-of-network provider. The insured's out-of-pocket costs are higher due to: (1) higher coinsurance responsibility for insured, (2) the lack of a negotiated network discount, and (3) the difference between the provider's billed charges and the insurer's determination of a "usual and customary" amount for the purpose of calculating payment to the out-of-network provider. To illustrate this situation, assume:

  - Out-of-network provider bills $1,000 for the service.
  - Insurer will pay at the policy's out-of-network coinsurance percentage (e.g. 60% of "usual and customary").
  - Insurer determines that the "usual and customary" amount for the service is $800 rather than the $1,000 billed.
  - Insurer pays the provider 60% of $800 or $480.
  - Insured is responsible for 40% of $800 ($320), and the $200 difference between the provider's billed charges and the insurer's determination of "usual and customary". The insured/patient's total responsibility for the $1,000 service is $520.

- Insured receives emergency treatment from an out-of-network provider. The Insurance Code requires insurer to pay at higher level of reimbursement (lower coinsurance for the insured) for the emergency services. (Art. 3.70-3C(5)). However, most policies provide for payment of out-of-network providers at a "usual and customary" rate rather than the provider's billed charges. This creates the potential for balance billing. For example:

  - Insured/patient receives emergency treatment from out-of-network provider.
  - Out-of-network provider bills $1,000 for the service.
  - Insurer will pay at the preferred level of benefits in the policy (e.g. 80% of the "usual and customary" amount).
  - Insurer determines that the "usual and customary" amount is $800 and pays $640 (80% 0f $800).
  - Insured is responsible for 20% of $800 ($160) as well as difference between $1,000 and $800 which leaves $200.
  - Total cost to patient for $1,000 charge is $360.

- If services are not available from an in-network provider, the out-of-network provider must be reimbursed at the in-network percentage of reimbursement. (Art. 3.70-3C(8)(b)) There is a potential for balance billing due to the insurer's use of a "usual and customary" amount as a basis for payment. For example:
  - Insured schedules a surgical procedure by network surgeon at a network hospital.
  - Radiologist on duty at the hospital at the time of the surgery is not contracted with the carrier, but provides necessary radiology services.
  - Out-of-network radiologist bills $1,000 for services.

- The preferred provider insurer must, by law, pay the radiologist at the preferred provider level of coinsurance (e.g. 80%). Therefore, the insurer pays 80% of $800 ($640), the amount it considers to be the "usual and customary" amount.
- Insured is responsible for the coinsurance amount of $160 (20% of $800) and must also pay the $200 difference between billed charges and the "usual and customary" amount.
- Total cost to the patient for the $1000 charge is $360.
- If radiologist was a network provider, enrollee would be responsible for the 20% coinsurance amount ($160).

Examples of Situations Resulting in Out-of-Network Services – HMO

- Enrollee receives emergency treatment from an out-of-network provider. The Insurance Code Art. 20A.09Y requires the HMO to pay the emergency provider at the "negotiated or "usual and customary" rate." There is potential for balance billing because the out-of-network provider's billed charges may be higher than the HMO's determination of a "usual and customary" rate. For example:

  - Enrollee receives emergency services from out-of-network provider. Out-of-network provider bills $1,000 for services.
  - HMO is unable to reach agreement with provider on a rate, so the HMO pays the $800 amount it determines to be "usual and customary".
  - Provider may bill the enrollee for the $200 difference between billed charges and "usual and customary" amount.
  - If emergency services were performed by an in-network provider, or if the HMO and provider were able to agree on an amount, enrollee would be responsible for a co-payment.

- If a contracted specialist is not available to the enrollee, HMO must allow for a referral to an out-of-network specialist and "shall fully reimburse the non-network provider at the "usual and customary" or an agreed rate." (Art. 20A.09(f)) There is potential for balance billing because the out-of-network provider's billed charges may be higher than the HMO's determination of a "usual and customary" amount. Generally where referral occurs on an outpatient basis, the HMO can agree with the physician or provider on a rate prior to approving the referral. The majority of problems in this area arise where an enrollee has entered a network hospital. For example:

  - Enrollee schedules a surgical procedure by network surgeon and at a network hospital.
  - Anesthesiologist on duty at the hospital at the time of the surgery is not contracted with the HMO, but provides necessary anesthesia services.
  - The out-of-network anesthesiologist bills $1,000 for services.
  - The HMO and anesthesiologist are unable to reach agreement on an amount to be paid. Therefore, the HMO pays $800, the amount it considers to be "usual and customary".
  - Provider may bill enrollee for the $200 difference between billed charges and "usual and customary" amount.
  - If anesthesiologist was a network provider, enrollee would be responsible for only a co-payment.

APPENDIX VI

1. *Study: Hospitals and Their Patients Reap Benefits of Medical Liability Reform*, Texas Hospital Association (Aug. 2004).

2. *Role of Graduate Medical Education in Addressing Physician Workforce Needs in Texas September 2004*, Senate State Affairs Hearing, Sept. 20, 2004 (written testimony of Texas Medical Association).

3. *2004 Texas Medical Graduates by Specialty Category and Expected Location of Residency Training*, Texas Medical Association.

4. *Graduate Medical School Data Compilation*, Texas Medical Association.

5. *Atlas of Rural Community Health Maps*, Texas Tech University Health Sciences Center Rural Health.
   a. Number of Doctors by County
   b. Access to Level 1 Trauma Care in High Hispanic Growth Areas
   c. Access to Primary Medical Care in High Hispanic Growth Areas
   d. Distance to Cardiovascular and Vascular Specialists in Texas, 2002
   e. Distance to Pediatricians in Texas, 2002
   f. Distance to Prenatal and Neonatal Care in Texas, 2002
   g. Distance to Primary Care Physicians (PCP) in Texas, 2002
   h. Distance to Trauma Care Facilities in Texas, 2003
   i. Elderly Care Service Options in Texas Counties, 2002

Study: Hospitals and Their Patients Reap Benefits of Medical Liability Reform

TEXAS HOSPITAL ASSOCIATION

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Executive Summary

With the passage of House Bill 4 – which was effective Sept. 1, 2003 – many key medical liability reforms were enacted to help restore access to physician and hospital services across Texas. Nearly one year later, in July 2004, the Texas Hospital Association conducted a survey of its hospitals to assess the impact of these reforms. Hospitals were asked to provide data concerning their hospital professional liability coverage, lawsuit activity, physician recruitment efforts and plans to expand services. THA received approximately 42 responses, representing more than 172 acute-care hospitals, from a potential of some 236 hospitals, resulting in a response rate of 72 percent. Key results of the analysis of the aggregated data are presented below.

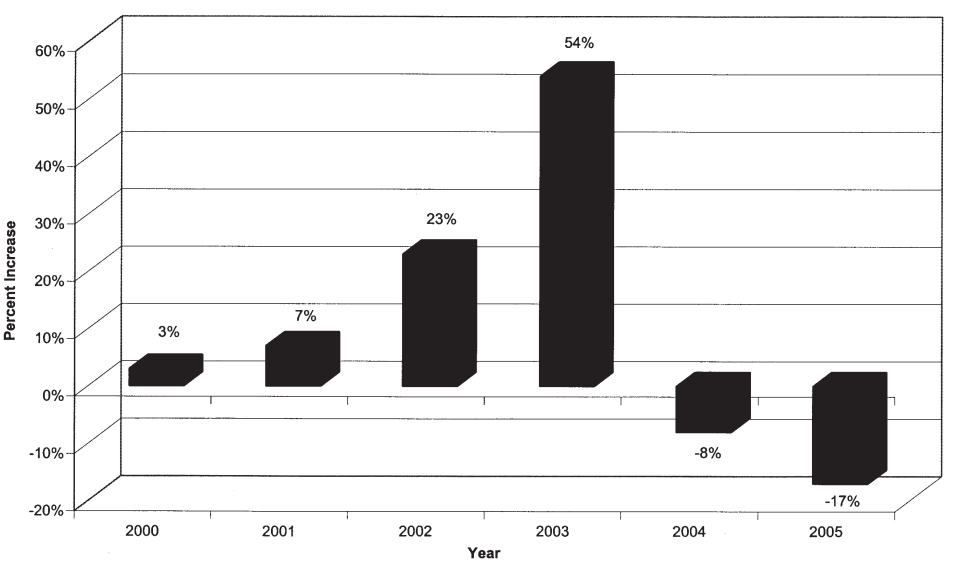
GENERAL FINDINGS

- Hospitals are seeing a decrease in their overall costs for hospital professional liability coverage.
- The number of lawsuits filed against hospitals has declined significantly (70 percent).
- As a result of the cost savings and improved liability climate, hospitals are better able to recruit physicians (particularly specialists) and, in turn, are expanding some hospital services and enhancing patient care.

PREMIUM INCREASES ARE DECLINING OR LEVELING OFF

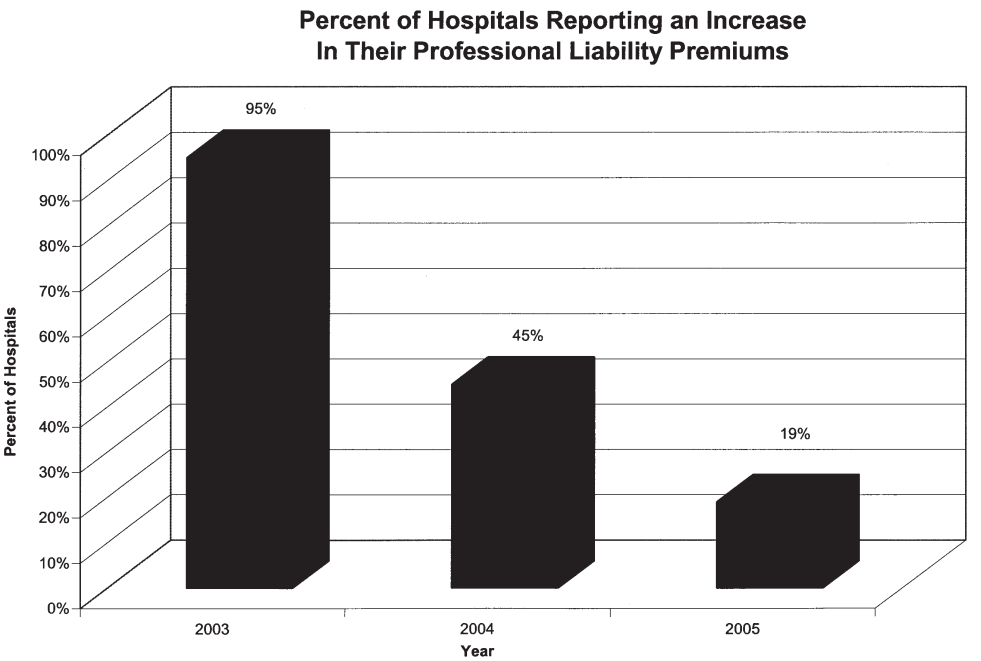
- Hospital professional liability premiums have been increasing for the past 10 years. Between 1995 and 2000, hospital premiums rose at a steady rate of approximately 3 percent per year. Between 2000 and 2001, premiums rose 7 percent, followed by a substantial increase of 23 percent between 2001 and 2002. In 2003, premiums rose more than 50 percent on average – representing an increase in premiums of more than 75 percent in a two-year period. Some hospitals began to see a drop in their premiums in 2004, with an average decrease of 8 percent. For the upcoming renewal period, a significant number of hospitals have reported either a decrease or a leveling off of their premiums. An overall 17 percent decrease was reported by Texas hospitals for the period 2004-2005.

Average Yearly Increase In Hospital Professional Liability Premiums



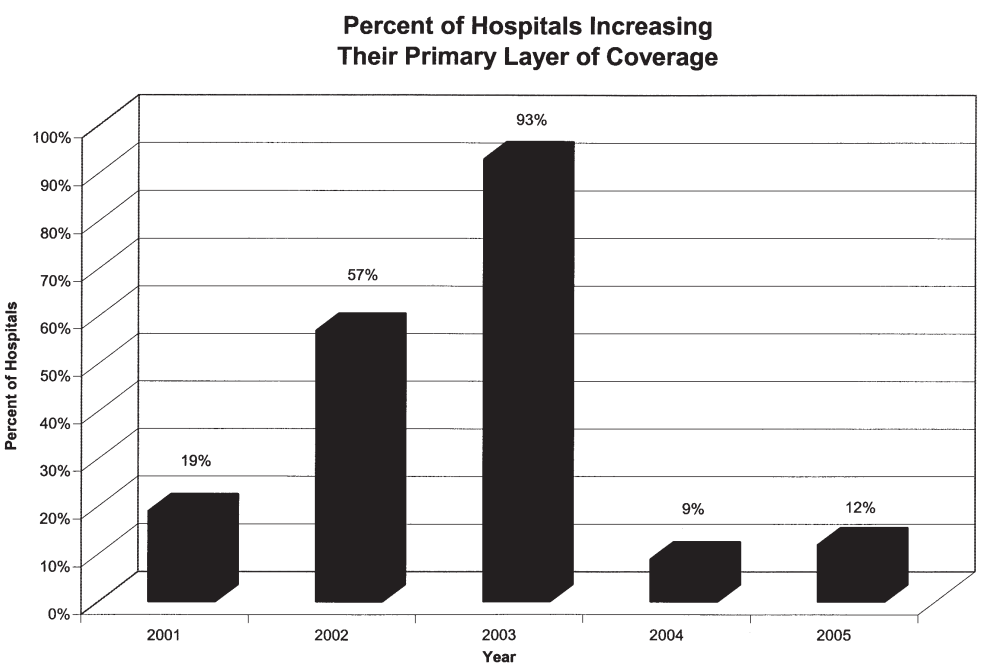
FEWER HOSPITALS ARE REPORTING AN INCREASE IN PREMIUMS

- During 2003, almost all hospitals in Texas experienced an increase in their professional liability premiums. As hospitals renew their policies during 2004, they are seeing a decrease in their premiums. During this transition period, less than half of the hospitals reported an increase in their premiums. For those hospitals reporting renewals for 2005, only 19 percent reported an increase. While the industry as a whole is experiencing a decrease in premiums, not all hospitals have seen a reduction. Hospitals that are part of a system generally have received a larger decrease than non-system hospitals.



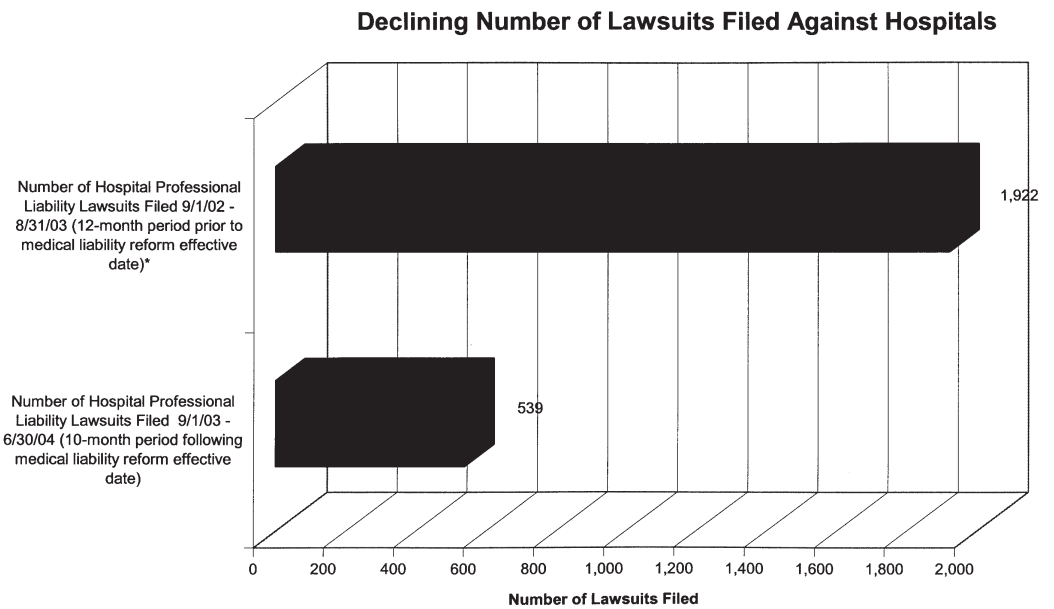
FEWER HOSPITALS ARE BEING FORCED TO INCREASE THEIR PRIMARY LAYER OF COVERAGE

- During 2003, more than 90 percent of hospitals reported taking on more risk by increasing their first layer of coverage. For the 2004 and 2005 renewal period, only 10 percent of hospitals reported having to increase their first layer of coverage.
- Options for the first layer of professional liability coverage in Texas include contracting with a commercial carrier or structuring a self-insured mechanism. The vast majority of hospitals in Texas use a self-insured mechanism as their first layer of coverage.
- During the period of 2001 through 2003, many insurance carriers that provide additional levels of coverage required hospitals to increase their first layer of coverage. Other hospitals increased their first layer of self-insurance in an attempt to minimize any increase in hospital premiums.



THE NUMBER OF LAWSUITS FILED AGAINST HOSPITALS IS DECLINING SIGNIFICANTLY

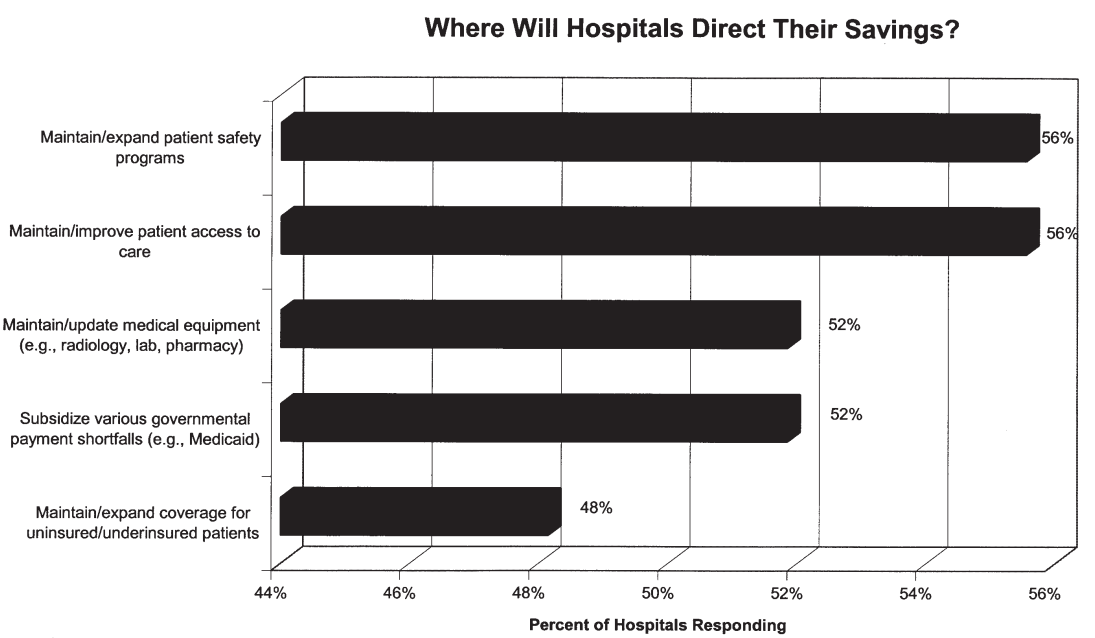
- In anticipation of limits being placed on non-economic damages, hospitals experienced a flurry of lawsuit filings prior to Sept 1, 2003. Some hospitals reported a 300 percent increase in the number of lawsuits filed during the last month before medical liability reform was enacted in Texas. For the 12-month period of Sept. 1, 2002, through Aug. 31, 2003, hospitals reported nearly 2,000 lawsuit filings. Of those cases, approximately 40 percent already have been dismissed. For the 10-month period of Sept. 1, 2003, through June 30, 2004, the number of lawsuits filed has dropped more than 70 percent.



*Note: Of the approximately 2,000 lawsuits filed between Sept.1, 2002, and Aug. 31, 2003, 770 cases (nearly 40 percent) were dismissed.

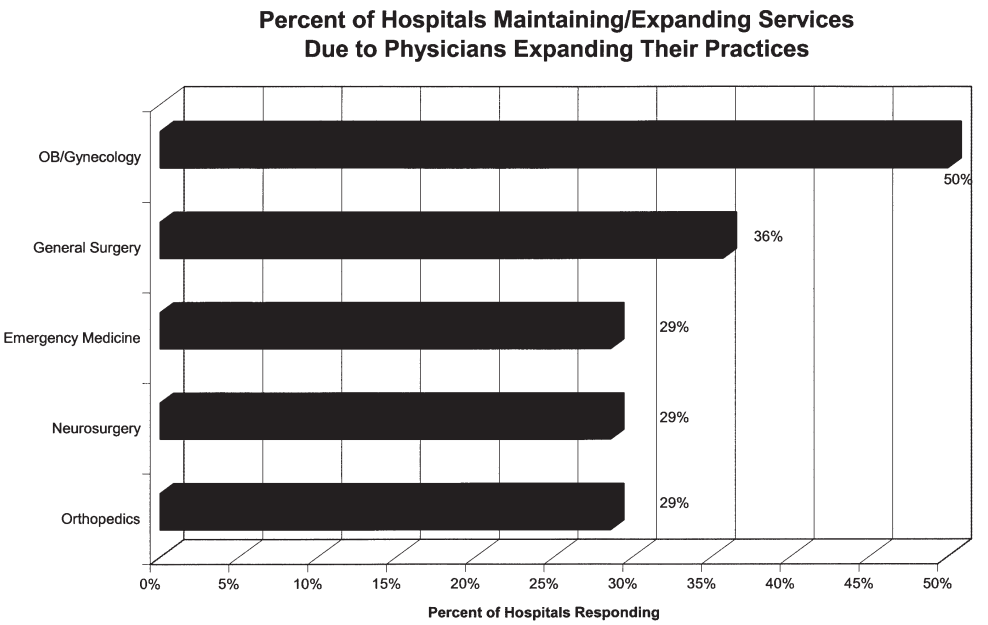
WHEN HOSPITALS SAVE MONEY ON INSURANCE PREMIUMS, PATIENTS BENEFIT

- As the number of lawsuits and size of the judgments decrease, professional liability premiums for hospitals will continue to decline. Many hospitals have indicated that they plan to reinvest these financial savings in patient care. For those hospitals indicating a focused activity for these savings, more than half plan to maintain or expand their patient safety programs or enhance patient services and access to care. Other hospitals will focus their savings on maintaining/updating medical equipment, subsidizing various governmental payment shortfalls (e.g., Medicaid), or maintaining/expanding coverage for uninsured/underinsured patients.



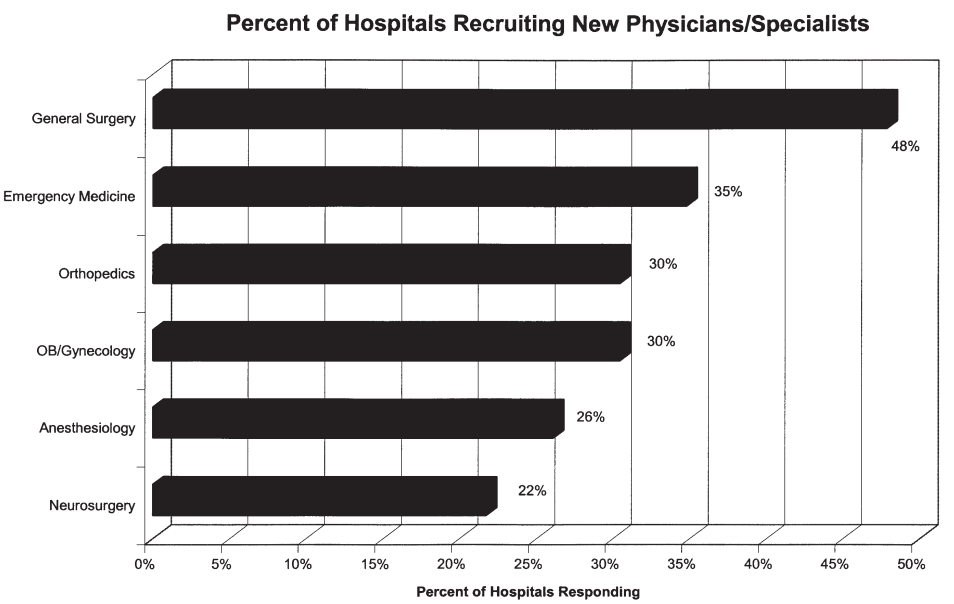
HOSPITAL SERVICES ARE BEING MAINTAINED/EXPANDED AS PHYSICIANS EXPAND THEIR PRACTICES

- As the liability climate in Texas becomes more favorable, hospitals will be able to either maintain or expand their services due to expanded physician practices. For those hospitals reporting a positive impact, half indicated they will maintain or expand obstetrics/gynecology services, and one-third indicated that general surgery services will be expanded. Almost 30 percent of these hospitals indicated that emergency medicine, neurosurgery and orthopedics will see a positive impact.



A MORE FAVORABLE LIABILITY CLIMATE HELPS HOSPITALS TO RECRUIT PHYSICIANS

- With the enactment of medical liability reforms, many hospitals report an easier time recruiting physicians to their communities. Of those hospitals reporting success recruiting physicians, almost half of the physicians recruited to their communities were general surgeons. One-third of the hospitals were able to recruit emergency medicine physicians to their area, and more than a quarter of these hospitals also had success recruiting physicians specializing in orthopedic surgery, obstetrics/gynecology, anesthesiology and neurosurgery.



TEXAS HOSPITAL ASSOCIATION

Founded in 1930, the Texas Hospital Association is the leadership organization and principal advocate for the state's hospitals and health care systems. Based in Austin, THA enhances its members' abilities to improve accessibility, quality and cost-effectiveness of health care for all Texans. One of the largest hospital associations in the country, THA represents more than 85 percent of the state's hospitals and health care systems, which employ some 300,000 health care professionals statewide.

August 2004

Role of Graduate Medical Education in Addressing Physician Workforce Needs in Texas
September 2004

Graduate medical education (GME) refers to the specialized training physicians receive after completing medical school—the lengthy period of time during which they immerse themselves in learning a specific field of medicine. GME programs play an important role in giving physicians the skills they need to become independent practitioners; in providing patient care, often to the most needy; and in improving the health of all Texans through medical research and innovations.

Executive Summary

The once-predicted oversupplies of physicians by the year 2000 did not materialize. In fact, the opposite has occurred: a growing shortage of physicians in many specialties and a continued shortage in some geographic areas. Shortages are likely being caused by a combination of state demographics, the growing complexity of illnesses, patients' renewed ability to self-refer to specialists, and ongoing innovations and expansions of health care technology.

Texas' ability to rely on physicians relocating from other states to meet the state's physician workforce needs may be coming to an end. The in-migration of physicians peaked in 1998 and reached a 10-year low in 2003. Additional GME slots are needed to retain more Texas graduates and to prepare adequate numbers of physicians to meet the state's growing health care needs. Teaching hospitals, however, have expressed concerns about their ability to sustain GME programs due to narrow operating margins and low financial reserves. This is largely due to the recent whittling-away of GME funding sources; the number of slots supported by Medicare is frozen at 1996 levels and Medicaid GME funding was eliminated for the current biennium.

Purpose of GME

Although state funding for medical education primarily focuses on undergraduate programs, a physician's education continues for three to seven years after medical school, depending on the specialty selected. The minimum requirement for licensure of a domestic graduate in Texas is one year of GME, however, completion of a residency program and most often certification by the corresponding national specialty board are typically required for hospital admitting privileges or participation in a health care network or on a provider panel. Physicians may then pursue even more specialized education in fellowship programs where they receive intensely focused training on specific body organs, systems, or life stages. The increased specialization in medicine is reflective of the proliferation of scientific advancements and has been driven largely by patient demand.

The federal government has long recognized the value of medical training to society as reflected in Medicare's financial support for GME across the country. Almost 40 years after its creation, Medicare remains by far the largest financier of GME. Medicare GME has undergone a series of damaging cuts in recent years due largely to erroneous predictions of physician oversupplies. As a result, the number of GME slots supported by Medicare is generally frozen at 1996 levels. Current Medicare funding policies also result in large regional disparities; Texas teaching hospitals come up far short in GME funding in comparison to their counterparts, including New York, New Jersey, and California.

In Texas, a majority of state GME funds are allocated by the Texas Higher Education Coordinating Board to help support primary care GME. In the 2002-03 Biennium, this agency distributed $51 million in state funds to primary care GME programs. That was *reduced by 37*

percent to $27.5 million for the 2004-05 Biennium. A smaller amount of state support ($9.2 million in 2002-03 Biennium; recently *scaled back 12 percent* to $8 million for 2004-05) is provided directly to selected GME programs.

On top of the recent cuts in direct funding for GME, Medicaid's longstanding role in supporting Texas GME was *completely eliminated for the 2004-05 Biennium – a loss of an estimated $127 million in state and federal matching funds.* Gov. Rick Perry partially restored these funds for Fiscal Year (FY) 2005 with a transfer of $3 million from unclaimed lottery winnings on August 23, 2004. These funds garnered a 60-percent federal match for an additional $4.2 million. As much as $20 million in one-time state funding may become available in FY 2005 for Medicaid GME and possibly used to qualify for federal matching funds. (Note: Medicare and Medicaid GME support are not open-ended but are tied to the volume of health care services individual GME programs provide to Medicare and Medicaid patients.)

Programs	2002-03 Funding	2004-05 Funding	Net Difference 2004-05/2002-03	% Difference 2004-05/2002-03
State GME Funding for:				
Primary Care Residency Programs				
Family Practice Residency	$20,599,709	$18,383,522	-$2,216,187	-11%
Primary Care Residency	5,886,460	5,253,104	-633,356	-11%
Graduate Medical Education	15,200,000	3,828,222	-11,371,778	-75%
Family Practice Pilot Programs	1,974,400	0	-1,974,400	-100%
Subtotal	*43,660,569*	*27,464,848*	*-16,195,721*	*-37%*
Teaching Hospitals				
Resident Physician Compensation	8,070,238	0	-8,070,238	-100%
Medicaid GME*	E126,800,000	0	E-126,800,000	-100%
Subtotal	*E134,870,238*	*0*	*E-134,870,238*	*-100%*
Total: GME Programs	***E178,530,807***	***27,464,848***	***E-151,065,959***	***E-85%***

E=Estimated.
Note: Adjustments were made to FY 2004-05 budget to reflect 0.26 percent decrease as directed by Section 56, Article III, General Appropriations Act, 2003.
***No Medicaid GME funds were allocated for 2004-05 Biennium. One-time relief funding using unclaimed lottery winnings has been approved for FY 2005 and as of Sept. 1, 2004, $3 million in state and $4.2 million in federal matching dollars were approved for allocation to teaching hospitals. (Rider 48, Article IX, General Appropriations Act, allows for this allocation). Up to $20 million in Medicaid GME relief funds may be forthcoming for FY 2005. For FY 2003, Texas teaching hospitals identified $63.4 million in Medicaid GME payments in the Coordinating Board's study of GME revenues and costs. Allocations for FY 2002 are not available and are assumed to be the same as 2003.**

Historical Interest in Establishing State GME Formula Funding

Following the 1998 creation of state formula funding for undergraduate medical education, attention turned to the feasibility of creating a similar funding structure for GME. This effort, however, was stymied because of the complicated nature of GME funding; shared responsibility for GME among teaching hospitals and medical schools; and various contractual and funding arrangements among individual teaching hospitals and medical schools.

This complexity led state leaders to issue Rider 43 in 2001 (77th Legislature, Regular Session, General Appropriations Act), which culminated in the report, "Funding Graduate Medical Education in Texas, August 2004," by the Coordinating Board. This report found a *gap* of approximately $510.3 million between annual funds *designated* for GME and funds actually needed and *used* for this purpose as identified by study participants.

As noted, Medicare support is frozen at 1996 levels with few exceptions and state GME support has been significantly reduced for the current biennium. This federal and state scale-back is

occurring at a time of growing demand for new physicians in Texas, particularly in highly specialized fields. The state cannot afford to ignore this looming crisis and the potential impact on the physician workforce and patient care.

Benefits to Texas from GME

What does GME mean for Texas? Home-grown physicians have a higher tendency than others to remain in the state to enter practice. Research has shown a strong relationship between where physicians train and where they choose to enter practice. (Texas Medical Association Survey, 2003; *Annals of Emergency Medicine*, 1998; *Journal of American Medical Association*, 1995; and *Academic Medicine*, 1991.)

TMA studies have shown that **physicians who complete BOTH undergraduate and graduate medical education in the state are almost three times more likely to practice in Texas**. Similar findings have been reported by The University of Texas System (Presentation by Kenneth Shine, MD, UT System, House Appropriations Subcommittee on GME, Public Hearing, March 23, 2004).

Most GME programs are large providers of health care to un- and under-insured Texans. The relatively low salaries of residents (generally, less than $40,000 per year) help residency programs afford to serve indigent patients.

In 2002, the combined total economic impact of medical schools and teaching hospitals for Texas was $19.6 billion. Of this, $8.5 billion had a direct impact and $11.1 billion was indirect. Texas ranked *fifth* in the nation, following New York, Pennsylvania, California, and Massachusetts. Medical schools and teaching hospitals are major employers and are recipients of spending by hospital patients, patients' visitors, students and their visitors. They also bring in federal and private research dollars. The multiplier effect for these types of institutions averages 2.3—every dollar spent by a medical school or teaching hospital indirectly generates another $1.30 for a total impact of $2.30. (Source: Association of American Medical Colleges, Nov. 2003.)

Shortage of GME Slots

The current limits on Medicare and Medicaid support for GME require teaching hospitals to find alternative funding sources to open, maintain, or grow a GME program. **The number of Texas GME slots not paid by Medicare is estimated as high as 2,300 (39 percent).** This includes slots in hospitals and community settings. Although much of GME training has followed the recent movement of patient care from inpatient to ambulatory or community settings, Medicare's GME support is allocated through hospitals, providing little if anything for slots outside the hospital.

Teaching hospitals have expressed concerns about their ability to sustain GME operations due to narrow operating margins and low financial reserves (Public testimony, House Appropriations Subcommittee on GME, March 23 and July 6; and Senate Subcommittee on Higher Education, April 8). On top of falling hospital revenues, national limitations put in place in 2003 on the number of hours physicians-in-training may work placed a financial hardship on teaching hospitals that has them scrambling to hire additional staff.

Further**, there are concerns Texas does not have enough slots to train the number of physicians needed for our growing population.** At least 1,200 students graduate from Texas medical schools each year in comparison to about 1,350 entry-level GME slots. After counting a slot for each Texas graduate, only about 150 GME slots are available for out-of-state and international graduates to train in Texas (Source: UT System, public testimony at legislative hearings referenced above).

Without enough slots, Texas is losing graduates to other states. In response to requests from Rep. Dan Branch (Dallas), and Sen. Royce West (Dallas), TMA and Texas medical schools polled 2004 medical graduates who were leaving the state for GME to identify how many would have preferred to stay in the state. A total of 137 (38 percent) of this year's graduates who left the state for GME training indicated they would have preferred to remain in Texas had a slot been available. **Additional GME slots are needed to retain the state's substantial investment in undergraduate medical education and provide better educational opportunities for our own graduates. Approximately $50,000 a year in state support is provided for each Texas medical student through the formula funding process. If they are forced to leave the state due to a shortage of GME slots, few are likely to return to Texas to enter practice and the state's $200,000 investment leaves with them. For the 137 medical graduates who would have preferred to stay in the state for GME, the loss was $27.4 million.**

Growth is also needed to correct national and state policy missteps that were based on predictions of physician oversupplies that did not materialize. Further, physicians are needed to lead research in medical biotechnology, an industry with growth potential for the state.

Growing GME is contingent on the availability of financial resources to support the additional slots. Any additional GME funding, however, should not come at the expense of funding for undergraduate medical education.

Physician Workforce Needs

Popular thinking in the 1990s was of an impending glut of physicians by the year 2000. That did not materialize. In fact, the opposite has occurred: a growing shortage of physicians in many specialties and a continuing shortage in some geographic areas. Shortages are likely being caused by a combination of:

- rising health care demands stemming from the state's population growth, growing complexity of medical needs, growth in elderly population and longer life spans;
- renewed ability of patient's to self-refer to specialists; and
- ongoing innovations and expansions of health care technology.

In Texas, there are increased demands for a number of specialties, including but not limited to:

- anesthesiologists,
- gastroenterologists,
- neurosurgeons,
- pediatric subspecialists (anesthesiologists, surgeons, cardiologists, and neurosurgeons),
- orthopedic surgeons,
- radiologists, and
- urologists.

Patients are feeling the effects of the shortages by experiencing longer waiting times for appointments with many physician specialists.

A shortage of most surgical specialists is predicted by 2020, including ophthalmologists and cardiothoracic surgeons. Shortages in these specialties are particularly hard to reverse because training periods span 9 to12 years.

Further, national studies by two prominent physician workforce experts predict shortages of 50,000 physicians by 2010 and 150,000 to 200,000 by 2020. They recommend the United

States train an additional 3,000 medical students per year by 2015 to help address the shortage. Currently, there are about 66,000 medical students in the U.S.

Not only are there shortages in numbers of physicians but also a growing trend among young physicians to pursue more balanced lifestyles and dedicate time for non-work interests. Some of this is driven by the increased number of two-doctor households and the need to share family responsibilities. Other young physicians consider this trend a reaction to the less rewarding aspects of medicine, i.e. hassles with business operations that are driving physicians to make time for less stressful pursuits.

In Texas, women represented the majority in the medical school entering class of 2003. With fewer men attending college, the percentage of women in medical school is expected to further increase. Traditionally, women have chosen different medical specialties than men, with a strong interest in specialties focused on babies and children. Women have shied away from surgical specialties, and it is not known if growing demand in these areas will influence their future choices. Women physicians also tend to work fewer hours than men. The combined effect is that greater numbers of physicians will be needed to replace retiring physicians.

Texas' long-enjoyed position of being a "net-importer" of physicians is becoming less reliable. Texas medical school enrollments and GME programs saw little growth over the past 20 years despite the substantial population increase during this period. The state's rising physician demand during these years was met largely by physicians relocating to Texas from other states and countries, peaking in 1998. Educational and business opportunities for themselves and their families, the mild climate, the lack of a state income tax, and recreational opportunities were cited as primary reasons physicians chose to relocate to Texas. Although physician in-migration patterns were stable and little cause for worry in the past, the pattern has begun to change. With this change, it has become more obvious that the state has only limited influence on physician in-migration patterns. This calls into question how reliable the external pipeline will be in providing for the state's future physician workforce needs.

The recent professional liability crisis contributed to an **unstable practice environment that caused physicians to limit their practices and discontinue "high-risk" procedures.** Further, it **may have had a chilling effect on physicians relocating from other areas. A 10-year low in new physicians was seen in FY 2003** before the passage of comprehensive health care liability reforms and Proposition 12. Benefits of these reforms are beginning to be seen through restored stability of the practice environment.

There has also been a **decline in the number of international medical graduates (IMGs) training in the U.S. since 1998.** Heightened national security concerns and a curtailment in immigration visas are expected to continue the trend. This development is important in that **one in four Texas physicians is an IMG.**

TMA responded to these signs of a progressive physician shortage by reversing its long-held opposition to medical school expansions. The previous anti-growth policy called for no GME expansions and was firmly embedded, having been reaffirmed numerous times over a 13-year period. National groups such as the American Medical Association, Association of American Medical Colleges, and the federally established Council on Graduate Medical Education made similar policy shifts recently.

<u>In recognition of the state's physician workforce needs and the role of GME in meeting those needs, the following policy statements were recently adopted by the TMA</u>:

- TMA recognizes the growing specialty shortage and strongly supports efforts to increase

access to specialty care in Texas through adequate training opportunities in shortage specialties. *Expansion of GME slots would also help provide greater educational opportunity for Texas medical school graduates within the state which increases the likelihood they will remain in the state to enter practice.*

- The Texas Medical Association: (1) reaffirms its policy that Texas GME programs should be fully and appropriately funded, but not at the expense of current undergraduate medical education funding; and (2) urges the Texas Legislature to restore funding of state GME programs at least to previous levels and reinstate Medicaid GME funding at an acceptable level.

- TMA supports state formula funding for GME for all accredited residency programs.

- TMA encourages the Texas Legislature to provide adequate support for the instructional costs of GME. *These costs include faculty costs that are not supported by Medicare and Medicaid*.
- TMA advocates the development and maintenance of a strong educational pipeline into medical schools and GME programs, particularly the identification, recruitment and retention of minority students.

- TMA will serve as an informational resource to the Texas Legislature in working with the Texas Congressional Delegation to increase support at the federal level for GME health service delivery costs. Efforts are needed to (1) eliminate the current outdated caps on Medicare-funded GME slots, and (2) work for increased and geographically equitable Medicare GME funding. *Texas teaching hospitals should receive payment based on the same funding policies as other states and no longer be penalized by region-specific policies.*

The need for quality health care is a common thread throughout the state's increasingly diverse and growing population. Barriers to access to care impact the health of Texans. For Texas to continue to be a strong and productive state, access to quality health care must be assured – an assurance that can come only from having a sufficient number of appropriately trained physicians. Physician workforce needs are critical and should not be ignored. The educational pipeline for physicians is long, and long-term state investments are needed to keep pace with the growing complexities in health care needs that lie ahead for Texans.

Prepared by: Medical Education Department, Texas Medical Association, 9/2004.

Texas Medical Association
2004 Texas Medical Graduates by Specialty Category and Expected Location of Residency Training

	Family Practice									Medical Specialty									Surgical Specialty									Other Specialty									
Hea Sci Ctrs	CA	IL	MD	NC	NY	WA	OTH	TX	Subtotal	CA	IL	MD	NC	NY	WA	OTH	TX	Subtotal	CA	IL	MD	NC	NY	WA	OTH	TX	Subtotal	CA	IL	MD	NC	NY	WA	OTH	TX	Subtotal	Grand Total
Baylor	1	0	0	0	0	0	3	2	**6**	2	3	1	2	1	5	14	42	**70**	2	1	3	0	2	2	9	12	**31**	4	1	1	0	1	0	9	29	**45**	**152**
TAMUS	0	0	0	0	0	1	1	5	**7**	2	1	0	1	1	0	3	12	**20**	1	1	0	0	0	0	6	9	**17**	0	1	0	1	0	0	6	6	**14**	**58**
UNT	2	0	0	0	0	0	6	16	**24**	2	0	1	1	1	0	6	21	**32**	0	0	0	1	1	0	8	8	**18**	2	0	1	1	2	0	12	22	**40**	**114**
UT- Houston	0	0	0	1	0	0	0	21	**22**	1	1	0	1	0	0	15	30	**48**	4	0	0	2	1	1	20	23	**51**	6	1	0	2	5	0	18	32	**64**	**185**
Southwestern	1	2	0	0	0	1	3	7	**14**	6	3	2	2	2	4	28	51	**98**	1	3	0	0	3	1	13	25	**46**	0	0	1	1	3	0	10	23	**38**	**196**
Texas Tech	0	0	0	1	0	1	2	6	**10**	2	1	0	1	0	0	12	19	**35**	0	1	0	2	1	0	10	25	**39**	1	1	0	0	2	1	13	21	**39**	**123**
UT-SA HSC	0	0	0	0	0	0	4	11	**15**	6	4	1	0	3	0	17	29	**60**	1	3	0	0	2	0	16	28	**50**	2	1	0	2	3	0	26	33	**67**	**192**
UTMB	0	0	0	2	0	0	5	21	**28**	1	0	3	2	1	1	13	41	**62**	2	0	2	1	1	0	11	22	**39**	2	0	0	1	2	0	9	36	**50**	**179**
Subtotal	**4**	**2**	**0**	**4**	**0**	**3**	**24**	**89**	**126**	**22**	**13**	**8**	**10**	**9**	**10**	**108**	**245**	**425**	**11**	**9**	**5**	**6**	**11**	**4**	**93**	**152**	**291**	**17**	**5**	**3**	**8**	**18**	**1**	**103**	**202**	**357**	**1199**

TOTAL

California (CA) 54 (5%)
Illinois (IL) 29 (2%)
Maryland (MD) 16 (1%)
North Carolina (NC) 28 (2%)
New York (NY) 38 (3%)
Washington (WA) 18 (2%)
Other (OTH) 328 (27%)
Texas (TX) 688 (57%)

Source: TMA Survey of Texas Medical Schools, May 2004
Prepared by: TMA Medical Education Department 6/04.

Graduate Medical School Data Compilation
Survey of 2004 Graduating Students Leaving the State for GME, May 2004

Medical School	Total 2004 Expected Graduates	%(#) of Graduating Medical Students		% (#) Leaving Tx Who Would Have Preferred to Stay in Texas	Total Responses*
		Staying in Texas	Leaving Tx		
Baylor College of Medicine, Hstn	157	54.1% (85)	72	19% (13)	67
Texas A&M Univ System, Collg Sta	59	54.2% (32)	27	67% (6)	9
Texas Tech HSC, Lubbock	126	54.8% (69)	57	50% (1)	2
Univ of North Texas HSC, Ft Wo	114	58.8% (67)	47	61% (20)	33
Univ of Texas HSC, San Antonio	192	52.6% (101)	91	46% (19)	41
Univ of Texas-Houston HSC	192	58.9% (113)	79	25% (19)	76
Univ of Texas Med Branch, Galv	183	67% (122)	61	70% (43)	61
Univ of Texas Southw MC, Dallas	199	53.2% (106)	93	22% (16)	72
STATE TOTALS AND AVERAGES	***1222***	***56.9% (695)***	***527***	***38% (137)***	***361***

*Note: Low response rates for Texas Tech and Texas A&M medical graduates.

Research on Relationship Betw. Location of Residency Training & Practice Location

TMA Survey of Residents Completing Training in 2003, Texas

Res. Plan to Remain in State to Practice	55%

Natl Conf of State Legislators 2003

Phys Who Are In-State Graduates	
Texas	45%
California	63%
National Average	39%

JAMA, 1995, US Average

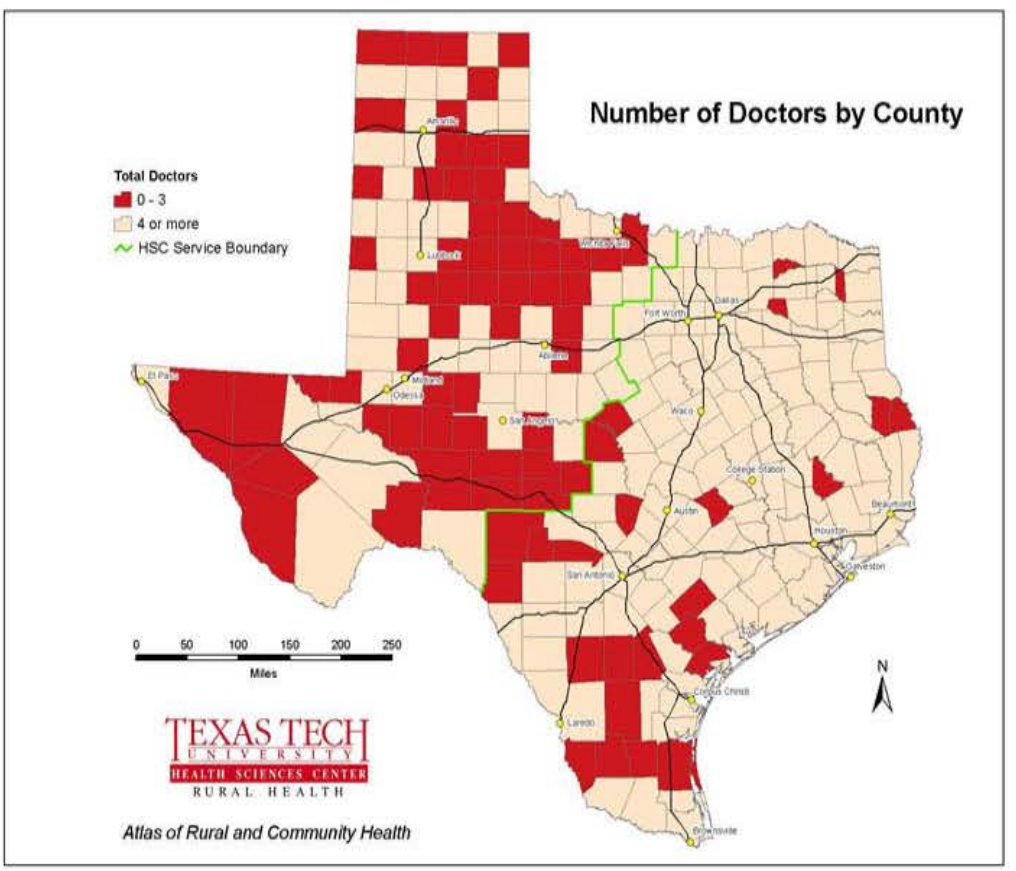
Phys Retained in State Post Residency	57%

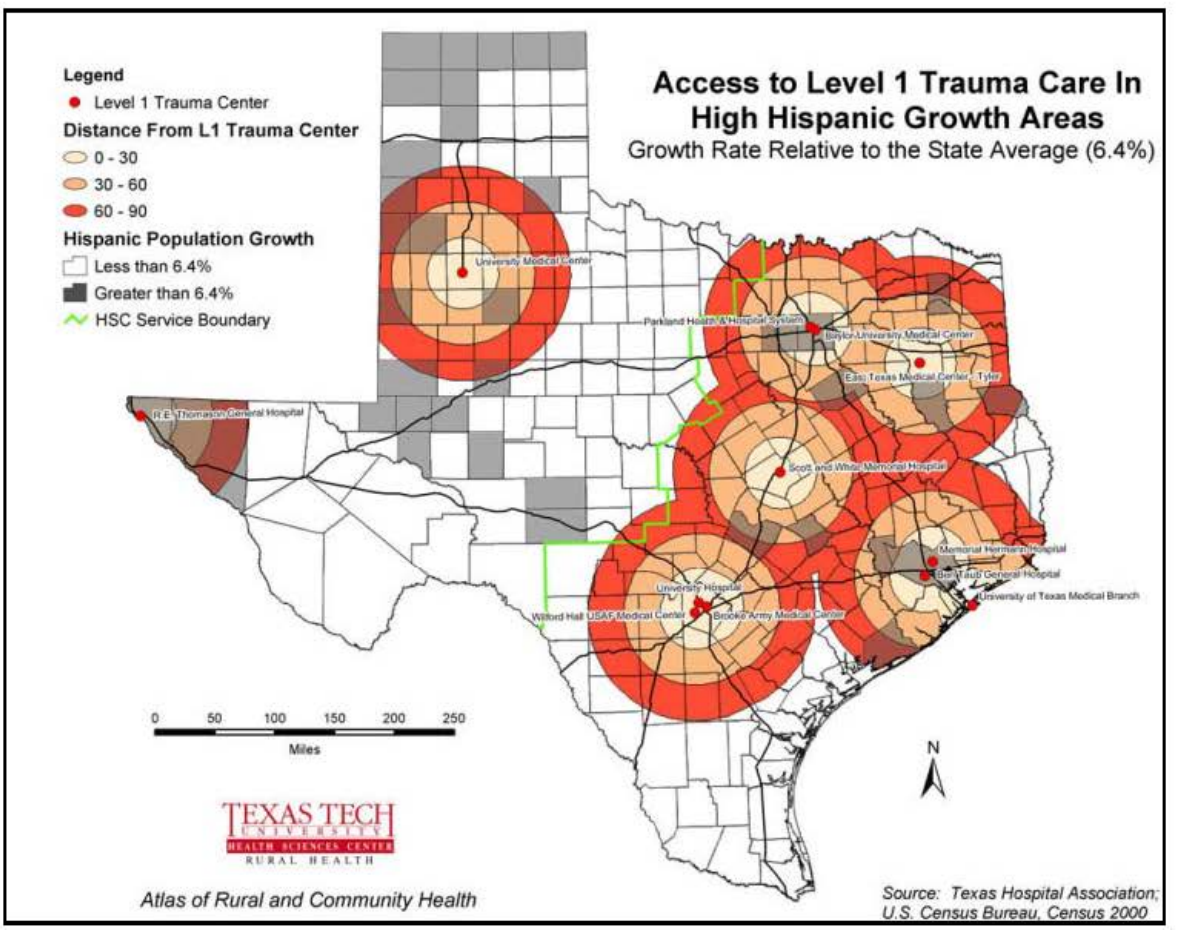
Academic Medicine, 1991

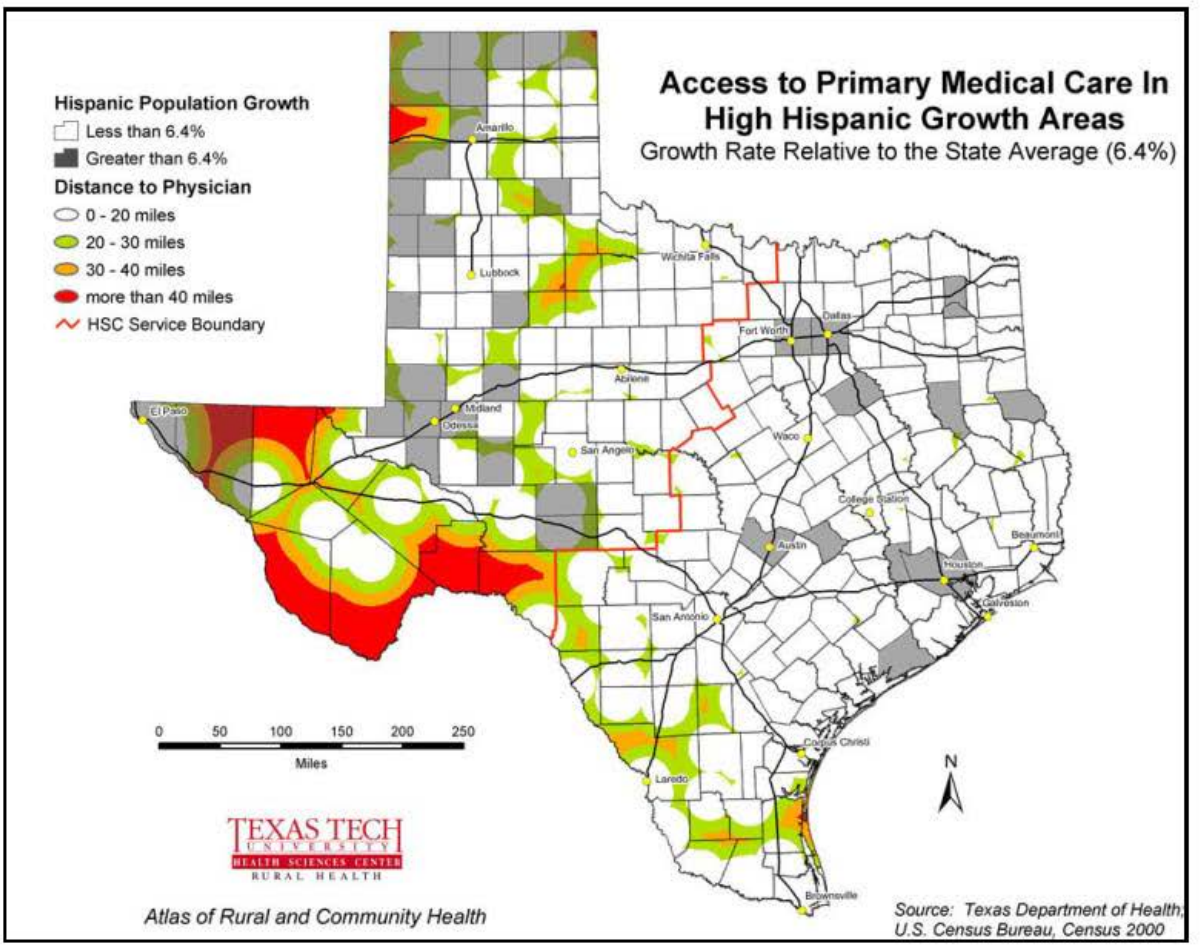
Retained <75 miles from training location	50+%

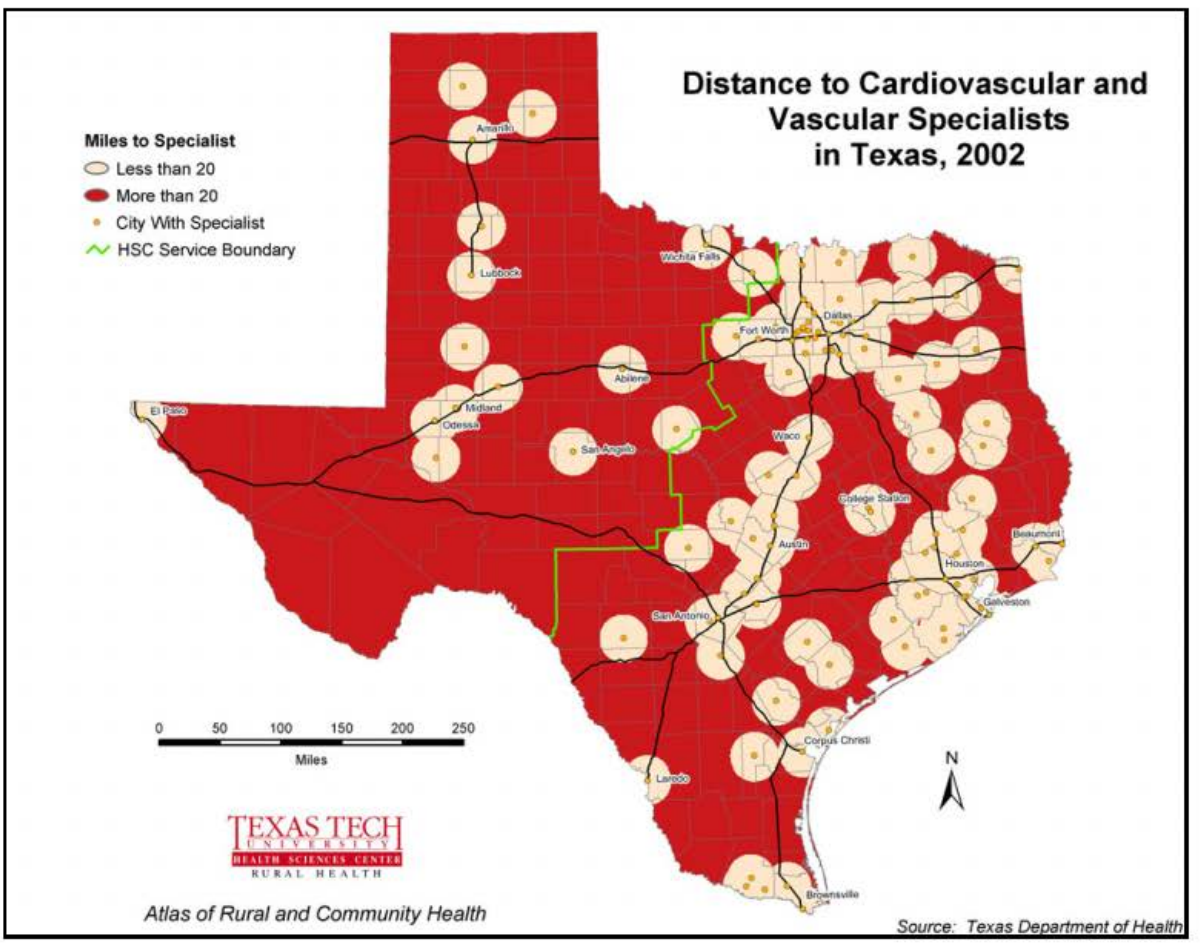
Sources: Texas medical schools.

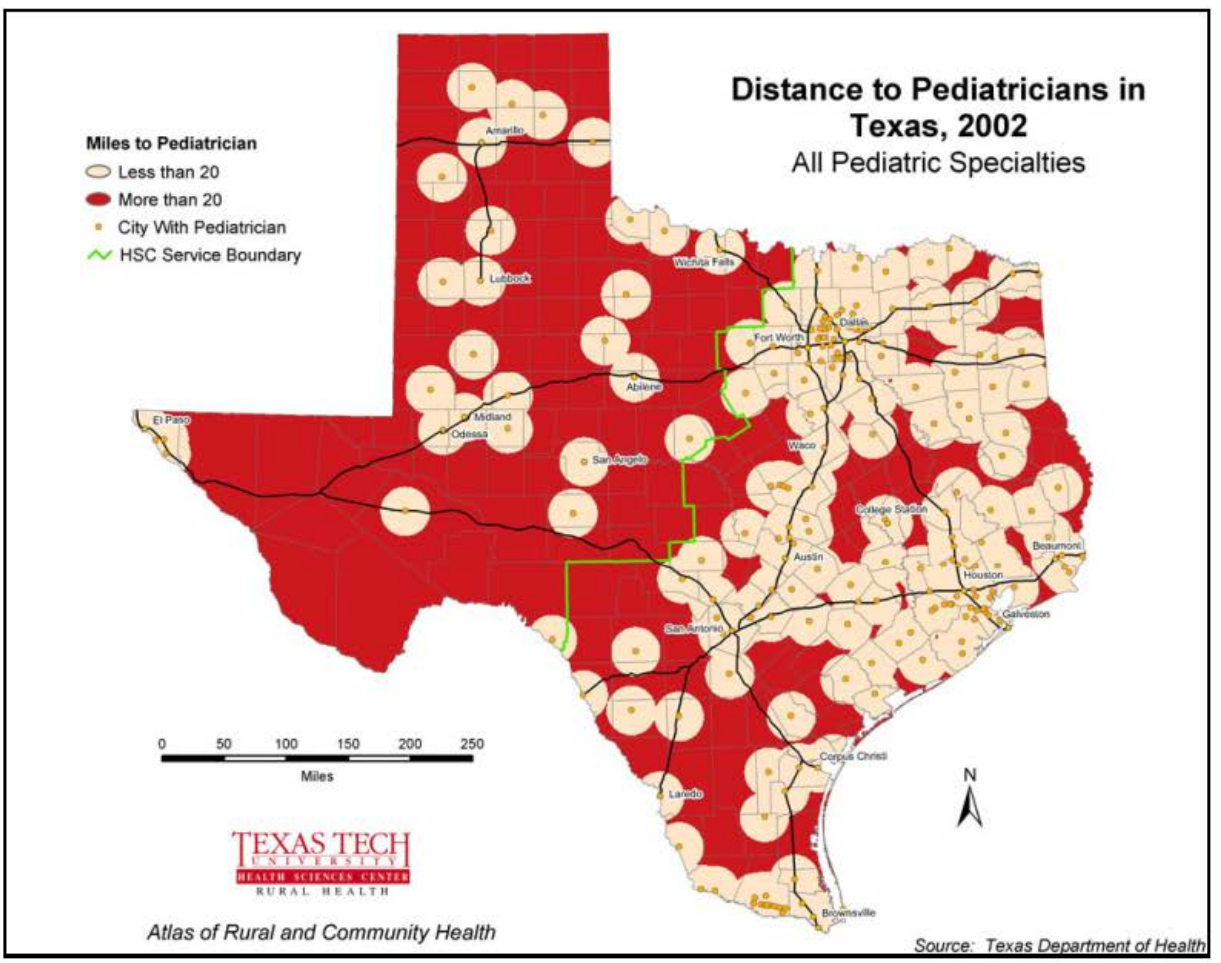
Prepared by: Medical Education Department, Texas Medical Association 6/04.

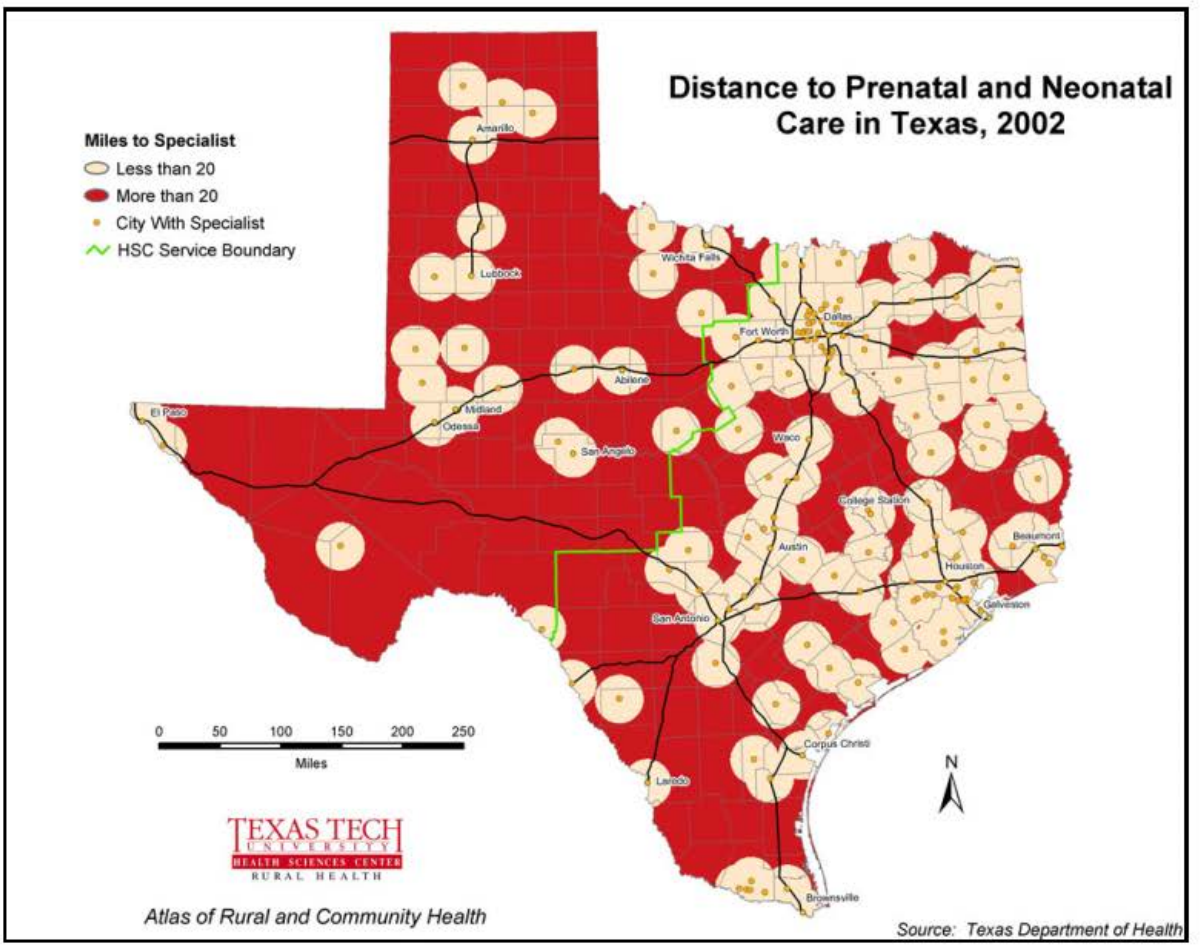

Number of Doctors by County
Total Doctors
0 - 3
4 or more
HSC Service Boundary
Amarillo
Lubbock
Wichita Falls
Dallas
Fort Worth
Abilene
El Paso
Midland
Odessa
San Angelo
Waco
College Station
Austin
Beaumont
Houston
Galveston
San Antonio
Corpus Christi
Laredo
Brownsville
0 50 100 150 200 250
Miles
N
TEXAS TECH
UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health

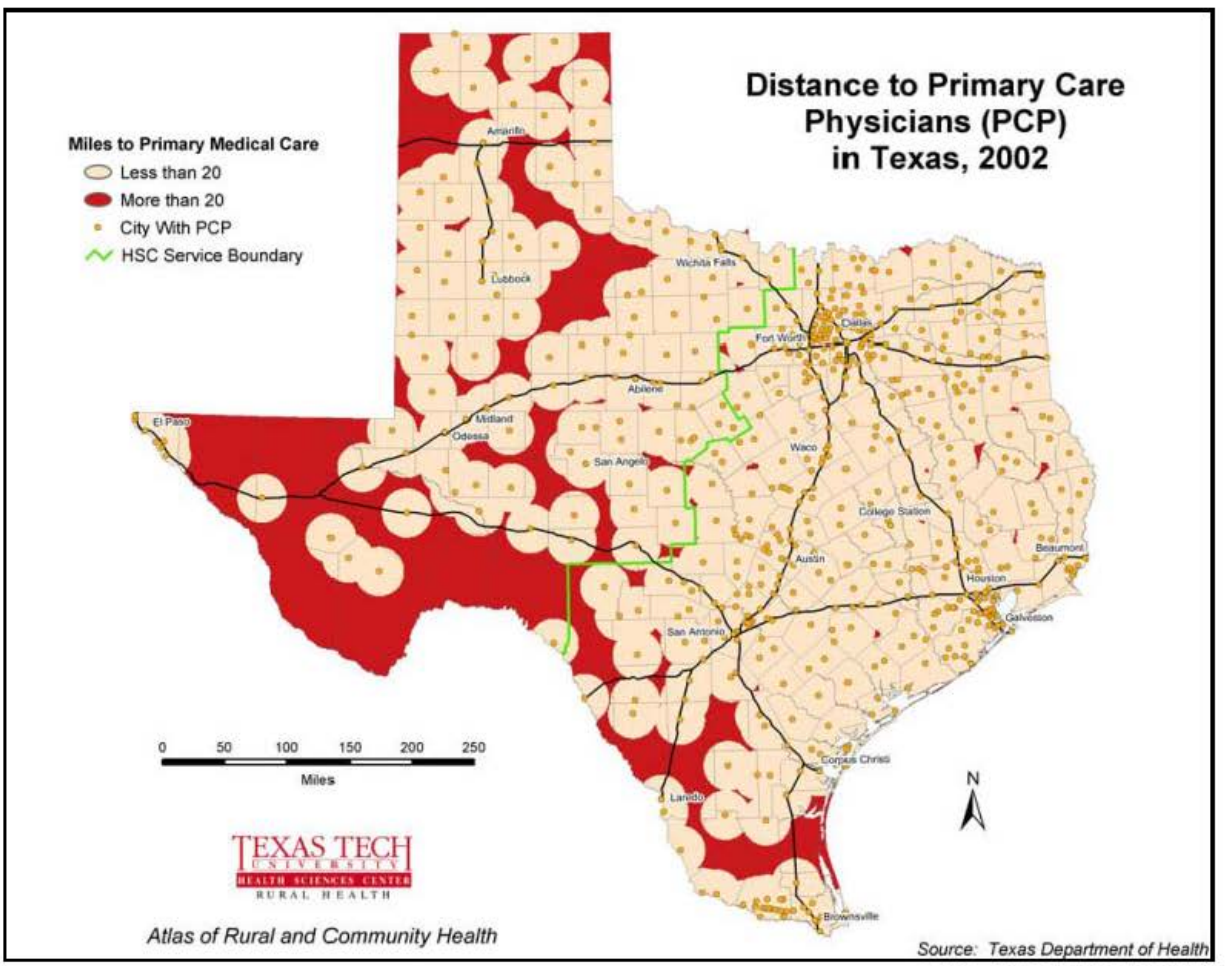

Access to Level 1 Trauma Care In High Hispanic Growth Areas
Growth Rate Relative to the State Average (6.4%)
Legend
Level 1 Trauma Center
Distance From L1 Trauma Center
0 - 30
30 - 60
60 - 90
Hispanic Population Growth
Less than 6.4%
Greater than 6.4%
HSC Service Boundary
University Medical Center
Parkland Health & Hospital System
Baylor-University Medical Center
East Texas Medical Center - Tyler
R.E. Thomason General Hospital
Scott and White Memorial Hospital
Memorial Hermann Hospital
Ben Taub General Hospital
University of Texas Medical Branch
University Hospital
Wilford Hall USAF Medical Center
Brooke Army Medical Center
0 50 100 150 200 250
Miles
N
TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Hospital Association; U.S. Census Bureau, Census 2000

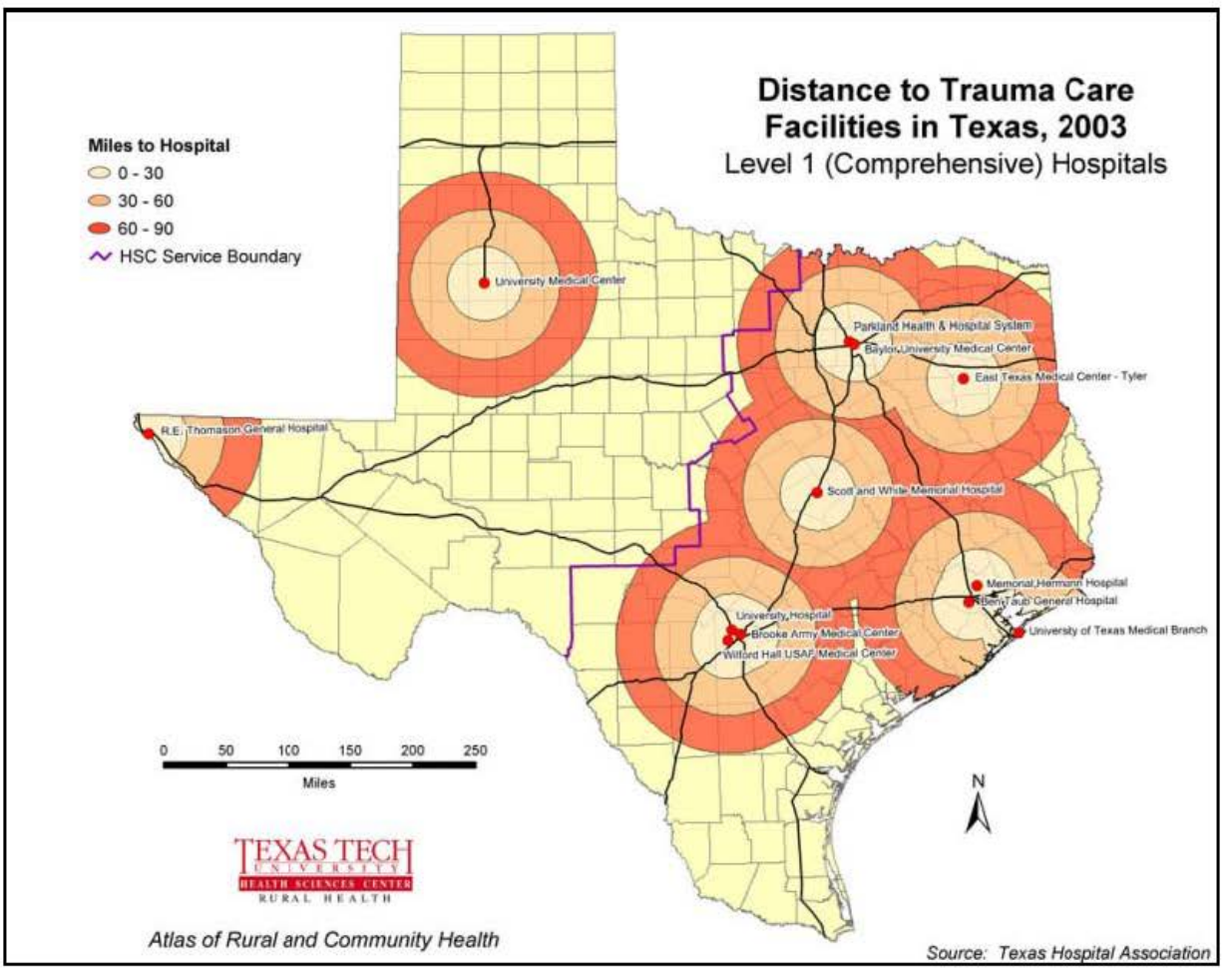

Access to Primary Medical Care In High Hispanic Growth Areas
Growth Rate Relative to the State Average (6.4%)
Hispanic Population Growth
Less than 6.4%
Greater than 6.4%
Distance to Physician
0 - 20 miles
20 - 30 miles
30 - 40 miles
more than 40 miles
HSC Service Boundary
Amarillo
Lubbock
Wichita Falls
Dallas
Fort Worth
Abilene
Midland
Odessa
El Paso
San Angelo
Waco
College Station
Austin
Beaumont
Houston
Galveston
San Antonio
Corpus Christi
Laredo
Brownsville
0 50 100 150 200 250
Miles
N
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Department of Health; U.S. Census Bureau, Census 2000

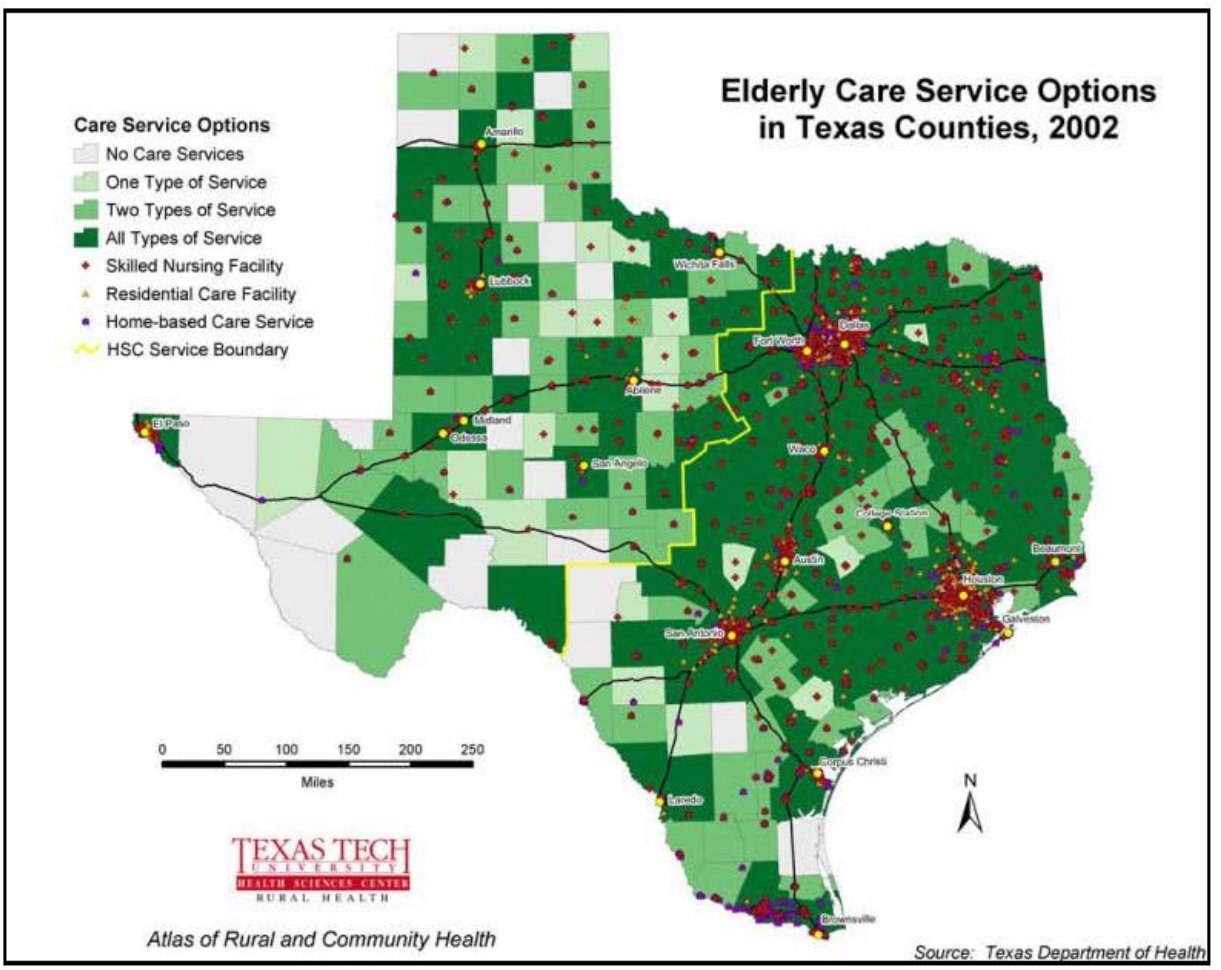

Distance to Cardiovascular and Vascular Specialists in Texas, 2002
Miles to Specialist
Less than 20
More than 20
City With Specialist
HSC Service Boundary
Amarillo
Lubbock
Wichita Falls
Dallas
Fort Worth
Abilene
El Paso
Midland
Odessa
San Angelo
Waco
College Station
Austin
Beaumont
Houston
Galveston
San Antonio
Corpus Christi
Laredo
Brownsville
0 50 100 150 200 250
Miles
N
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Department of Health


Distance to Pediatricians in Texas, 2002
All Pediatric Specialties
Miles to Pediatrician
Less than 20
More than 20
City With Pediatrician
HSC Service Boundary
Amarillo
Lubbock
Wichita Falls
Dallas
Fort Worth
Abilene
El Paso
Midland
Odessa
San Angelo
Waco
College Station
Austin
Beaumont
Houston
Galveston
San Antonio
Corpus Christi
Laredo
Brownsville
0 50 100 150 200 250
Miles
N
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Department of Health


Distance to Prenatal and Neonatal Care in Texas, 2002
Miles to Specialist
Less than 20
More than 20
City With Specialist
HSC Service Boundary
Amarillo
Lubbock
Wichita Falls
Dallas
Fort Worth
Abilene
El Paso
Midland
Odessa
San Angelo
Waco
College Station
Austin
Beaumont
Houston
Galveston
San Antonio
Corpus Christi
Laredo
Brownsville
0 50 100 150 200 250
Miles
N
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Department of Health


Distance to Primary Care Physicians (PCP) in Texas, 2002
Miles to Primary Medical Care
Less than 20
More than 20
City With PCP
HSC Service Boundary
Amarillo
Lubbock
Wichita Falls
Dallas
Fort Worth
Abilene
El Paso
Midland
Odessa
San Angelo
Waco
College Station
Austin
Beaumont
Houston
Galveston
San Antonio
Corpus Christi
Laredo
Brownsville
0 50 100 150 200 250
Miles
N
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Department of Health


Distance to Trauma Care Facilities in Texas, 2003
Level 1 (Comprehensive) Hospitals
Miles to Hospital
0 - 30
30 - 60
60 - 90
HSC Service Boundary
University Medical Center
Parkland Health & Hospital System
Baylor University Medical Center
East Texas Medical Center - Tyler
R.E. Thomason General Hospital
Scott and White Memorial Hospital
Memorial Hermann Hospital
Ben Taub General Hospital
University Hospital
Brooke Army Medical Center
Wilford Hall USAF Medical Center
University of Texas Medical Branch
0 50 100 150 200 250
Miles
N
TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Hospital Association


Elderly Care Service Options
in Texas Counties, 2002
Care Service Options
No Care Services
One Type of Service
Two Types of Service
All Types of Service
Skilled Nursing Facility
Residential Care Facility
Home-based Care Service
HSC Service Boundary
Amarillo
Lubbock
Wichita Falls
Dallas
Fort Worth
Abilene
Midland
Odessa
El Paso
San Angelo
Waco
College Station
Austin
Beaumont
Houston
Galveston
San Antonio
Corpus Christi
Laredo
Brownsville
0 50 100 150 200 250
Miles
N
TEXAS TECH
UNIVERSITY
HEALTH SCIENCES CENTER
RURAL HEALTH
Atlas of Rural and Community Health
Source: Texas Department of Health

APPENDIX VII

Nursing Facilities Receiving Medicaid Reimbursement for Professional Liability Insurance, Texas Department of Insurance

Nursing Facilities Receiving Medicaid Reimbursement for Professional Liability Insurance
Source: Texas Department of Insurance

- There are 1162 total nursing facilities in Texas.[251]
- 1135 homes (98%) are certified nursing facilities eligible to collect Medicaid reimbursement for Professional Liability Insurance.
  - 461 (41%) of these nursing facilities are not receiving reimbursement.
  - 674 nursing facilities (59%) applied for and are receiving reimbursement.
- The homes receiving Medicaid reimbursement for Professional Liability Insurance include the following classes:
  - 477 (71%) nursing facilities with insurance from insurers that are Texas Admitted, eligible, registered, or the Texas JUA.
  - 163 (24%) nursing facilities reporting independently procured insurance plans with Independently Procured Tax paid to the Texas Comptroller of Public Accounts, and
  - 34 (5%) nursing facilities reporting captive insurers with Independently Procured Tax (insurance procured out-of-state) paid to the Texas Comptroller of Public Accounts.

[251] This data compiled through cooperation with the Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS). HHSC collects liability information on Medicaid-licensed facilities for the purpose of providing reimbursement for liability insurance coverage in accordance with H.B. 154, 77th Legislative Session of 2001 and 1 TAC 355.312, Reimbursement Setting Methodology--Liability Insurance Costs. DADS is the licensing authority for Texas nursing facilities. This data includes facilities assumed to be in the process of renewing coverage.