Interim Report

to the 87th Texas Legislature

House Committee on Insurance

December 2020

HOUSE COMMITTEE ON INSURANCE
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2020

A REPORT TO THE
HOUSE OF REPRESENTATIVES
87TH TEXAS LEGISLATURE

EDDIE LUCIO, III
CHAIRMAN

COMMITTEE CLERK
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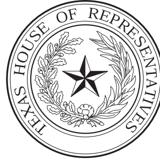

Committee On
Insurance

December 18, 2020

Eddie Lucio, III
Chairman

P.O. Box 2910
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The Honorable Dennis Bonnen
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

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

Respectfully submitted,

Eddie Lucio, III

Tom Oliverson, M.D.

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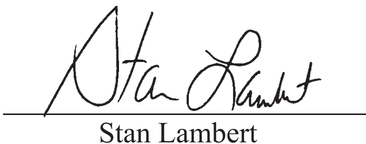
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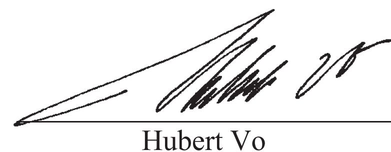
Hubert Vo

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INTRODUCTION

In the 86th Legislative Session, the Honorable Dennis Bonnen, Speaker of the Texas House of Representatives, appointed nine members to the House Committee on Insurance. The Committee's membership is comprised of Representatives Eddie Lucio, III (Chair), Tom Oliverson, M.D. (Vice-Chair), Greg Bonnen, M.D., Sarah Davis, Julie Johnson, Stan Lambert, Dennis Paul, Chris Turner, and Hubert Vo.

Pursuant to House Rule 3, Section 18, the Committee was given jurisdiction over all matters pertaining to:

- insurance and the insurance industry;
- all insurance companies and other organizations of any type writing or issuing policies of insurance in the State of Texas, including their organization, incorporation, management, powers, and limitations; and
- the following state agencies: the Texas Department of Insurance, the Texas Health Benefits Purchasing Cooperative, and the Office of Public Insurance Counsel.

The Committee conducted one interim hearing on January 15, 2020 in Rockport, TX during which the Texas Windstorm Association provided testimony on the implementation of HB 1900 (Interim Charge 1). Due to the COVID-19 pandemic, the Committee did not conduct additional hearings but issued formal requests for information on August 11, 2020.

INTERIM CHARGES

1. Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 86th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure intended legislative outcome of all legislation, including the following:
   - **HB 259**, which prohibits certain practices related to the delivery, issuing of delivery, or renewing of named driver policies. Determine if there are any changes regarding policy affordability or the uninsured motorist population.
   - **HB 1900**, which amends the Texas Windstorm Insurance Association (TWIA) operations and funding practices. Review the rulemaking process by the Texas Department of Insurance (TDI) and the adoption of an updated plan of operation by TWIA. Monitor whether the purchase of reinsurance has increased or declined and determine whether this provision of the legislation has had any impact on premium rates. Monitor the appointment and work of the Legislative Funding and Funding Structure Oversight board.
   - **HB 2536**, which requires certain reporting requirements for drug manufacturers, pharmacy benefit managers, and health insurers on certain pharmaceutical practices, including the pricing and availability of insulin. Examine its effect on drug pricing in the market and how to increase transparency in pricing associated with delivery of drugs, such as insulin, to the end user patient.
   - **SB 442**, which requires insurers that do not provide flood coverage in their policy to disclose that the policy does not cover flood events. Determine whether consumers are being properly informed of whether they have flood coverage. Examine the development of standardized disclosure forms for all insurance policies in Texas (health, homeowners, and personal auto) to provide more clarity to consumers about what the policy covers and any exclusions.
   - **SB 1264**, which prohibits balance billing (surprise billing) and creates an arbitration system to settle balance bills. Monitor the implementation of the mediation and arbitration programs, including the establishment of a portal on the TDI website through which requests for mediation and arbitration may be submitted. Determine whether the appropriate state agencies are enforcing the prohibition on balance billing. Review the Department's rules implementing the legislation's exception for non-emergency "elective" services to determine whether the rules limit the exception to out-of-network services that a patient has actively elected after receiving a complete written disclosure. Monitor or follow up on TDI's process for selecting the benchmarking database and determine whether the database chosen provides the most accurate available data and its sources are transparent. Evaluate the fiscal impact of the legislation on the Employees Retirement System of Texas and the Teacher Retirement System of Texas. Review costs to the systems and savings to employees and teachers.
   - **SB 1852**, which requires certain disclosures for insurers that offer short-term limited duration plans. Study whether similar consumer disclosures and other safeguards are needed for non-traditional health coverage products marketed to individuals or small 28 employers in Texas. Identify any gaps that leave

consumers without needed information or consumer protections, including network adequacy and protections from surprise medical bills.

- **SB 1940**, which extends to August 31, 2021, TDI's authority to revise and administer the temporary health insurance risk pool to the extent federal funds are available. Study ways to foster a competitive market and reduce the uninsured rate, including by exploring flexibility available through federal waivers. Study the impact to health care systems if the Affordable Care Act is ruled unconstitutional, including identifying which mandates, consumer protections, and subsidies will be lost and which have equivalents in state law.

2. Study the adequacy of the state's insurance laws on regulating the introduction of insurtech products into the Texas insurance market. Include in the study the impact of big data, blockchain, internet of things, and artificial intelligence technologies on industry practices such as claims handling, underwriting, and policy writing. Study whether these technologies present challenges for any of the state's insurance laws, including the state's antidiscrimination, data privacy, anti-rebate, and licensing laws and regulations. Additionally, examine the pros and cons of adopting a regulatory sandbox and consider sandbox programs that are implemented in other states.

3. Monitor the State Auditor's review of agencies and programs under the Committee's jurisdiction. The Chair shall seek input and periodic briefings on completed audits for the 2019 and 2020 fiscal years and bring forth pertinent issues for full committee consideration

INTERIM CHARGE #1

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HB 259

Background

A named driver policy is defined as an automobile insurance policy that provides any type of coverage for individuals named on the policy but that does not provide coverage for every individual who has permission to use a covered vehicle and who resides in a named insured's household.[1] Due to concerns that the coverage restrictions in named driver policies are misunderstood by policyholders, HB 259 sought to address these concerns by prohibiting delivery, issuance, or renewal of named driver policies.

Although it prohibited the current iteration of named driver policies, HB 259 did authorize insurers to utilize a named driver exclusion, which would operate as a provision or endorsement of an automobile insurance policy that excludes specified drivers from coverage under the policy.[2] This exclusion would need to explicitly name each excluded driver, could not exclude a class of drivers, and the named insured would need to accept the exclusion in writing.[3]

As a result of the passage of HB 259, stakeholders expressed concern that the elimination of these policies might impact policy affordability and the uninsured motorist population. The Committee determined that it would be imperative to monitor the impact that removal of these policies would have on the insurance market and on the uninsured motorist population in particular.

I. Impact on the Insurance Market & Uninsured Population Provided by TDI

The Texas Department of Insurance (TDI) provided written testimony to the Committee in response to the formal request for information related to this interim charge.[4] In its submission, TDI stated that there is limited data on HB 259's impact at this time.[5] However, TDI did state that there is not currently any data to suggest that it has affected policy affordability or the uninsured motorist population.[6]

TDI also reports that TexasSure, the state's program to reduce the number of uninsured motorists, gauges the number of registered vehicles not matched to a valid insurance policy–one indication of the prevalence of uninsured drivers.[7] TexasSure's "unmatch" rate was 11% through May 2020 of fiscal year 2020, down from 12% in fiscal year 2019 and 13% in each of the previous two years.[8]

The Texas Automobile Insurance Plan Association (TAIPA), the state's auto insurer of last resort vendor, reports that the number of drivers needing policies is on the decline as it was the previous four years.[9] Additionally, TDI has only received one complaint from consumers about a named driver policy not being available.[10]

II. Industry Comments on HB 259's Impact on the Insurance Market

Several industry groups provided written testimony to the Committee in response to the formal request for information related to this interim charge. The Association of Fire and Casualty Companies of Texas (AFACT) provided extensive testimony discussing specific observations and comments on the impact of HB 259.[11]

AFACT stated that named driver policies could have been issued on either a 30-day, 6 month, or 1 year term.[12] However, TDI's enforcement division required many named driver insurers to issue only 1 year policies.[13] Thus, AFACT stated that there could have been a number of 1 year named driver policies renewed before January 1, 2020 that may make it difficult to know if there will be any rate impact when the non-named driver policy is issued, and it may make it difficult to make definitive conclusions about the impact of HB 259 on premiums and the uninsured population.[14]

Additionally, AFACT stated that COVID-19 may make it difficult to draw precise conclusions about whether HB 259 itself has impacted pricing or the uninsured population.[15] Since COVID-19 has caused considerable changes to the automobile insurance industry, it may make it difficult to draw conclusions on whether HB 259 had an impact on affordability.

In terms of the impact on the uninsured population, AFACT stated that some of its member companies reported that the number of Uninsured Motorist (UM) claims declined between 2018 and 2019.[16] However, the annualized number of UM claims in 2020 has shown an increase over the number of UM claims received in 2019 and 2018.[17]

The trend in Underinsured Motorist (UIM) claims for this year was similar.[18] The number of UIM claims in 2019 increased significantly over 2018 and 2020 annualized UIM claims are expected to exceed 2019.[19] While insureds were driving less overall, the number of both UM and UIM claims this year has increased over the last two years.[20] Other member companies of AFACT reported a slight decrease in UM claims in 2020 due primarily to less driving during the pandemic.[21]

The Independent Insurance Agents of Texas (IIAT) also provided written comments related to this interim charge.[22] IIAT stated that reports of incidences of uncovered drivers being reported to IIAT by their members has gone down dramatically.[23] IIAT's concern with HB 259 was that eliminating named driver policies would move "marginally insured" drivers under a named driver policy to become uninsured.[24]

However, IIAT states that although it does not keep statistics on UM/UIM drivers, their members have not reported an increase in UM drivers since the implementation of HB 259.[25] They also state that the number of complaints being reported to IIAT members has dropped off since implementation of HB 259.[26]

Recommendations

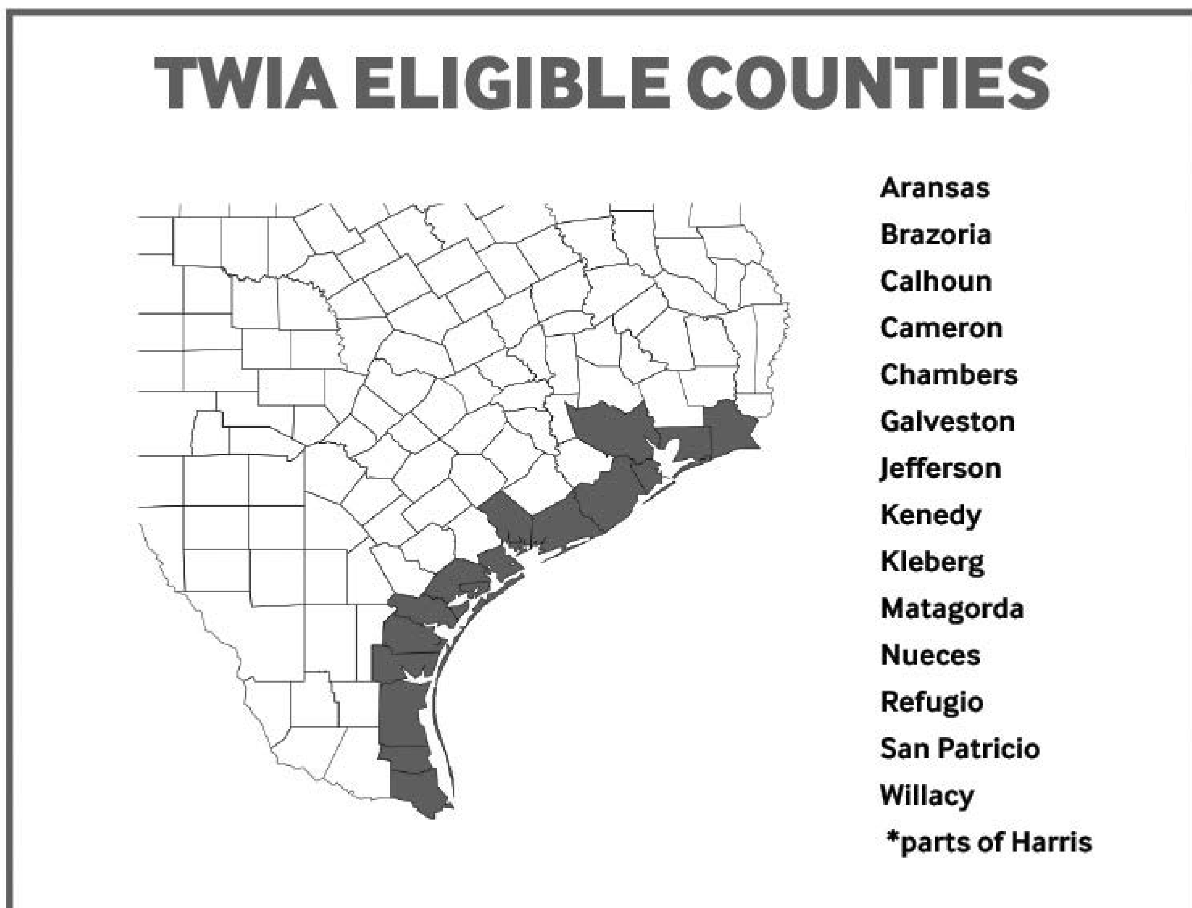
- The Legislature should remain vigilant of the possible impacts HB 259 could have on the uninsured and underinsured motorist population. The lack of available data from TDI at this time combined with the uncertainty in the market caused by COVID-19 makes it difficult to accurately assess the bill's impact. However, the preliminary data provided by insurers related to increased UM and UIM claims is concerning. Although this may not be directly attributable to the elimination of these policies, the Legislature should continue to request relevant data to determine the true impact of HB 259's implementation on policy affordability and the uninsured motorist population.

HB 1900

Background

The Texas Windstorm Insurance Association (TWIA) was formed by the Texas Legislature in 1971 to provide an adequate market for windstorm and hail insurance in the seacoast territory of the state.[27] Due to the inability for many coastal consumers to obtain insurance from the voluntary insurance market, TWIA was created to serve as the insurer of last resort.

TWIA provides coverage for residential and commercial property designated by the Commissioner of Insurance, which currently includes all 14 first tier coastal counties and parts of Harris County east of Highway 146.[28] In order to receive coverage from TWIA, the applicant must have been denied coverage by at least one authorized insurer actively writing or renewing windstorm and hail coverage in the designated area.[29]



The 86th Texas Legislature enacted HB 1900, which amended TWIA operations and funding practices. HB 1900 made significant changes to the manner in which TWIA purchases reinsurance in excess of the statutorily required minimum funding level.[30] Additionally, HB 1900 established the Legislative Funding and Funding Structure Oversight Board to study the

association's current funding and the manner in which the funding structure operates.[31] These reforms collectively made substantial changes to the operations of TWIA and were closely monitored by the Committee throughout the interim.

I. Rulemaking by TDI to Implement HB 1900

In order to help implement HB 1900, TDI has proposed rules that are expected to be adopted in the near future.[32] These rules will require TWIA to disclose its methodology for calculating its 1-in-100-year probable maximum loss (or 1% PML).[33]

The proposed rules prescribe information TWIA must provide to TDI before assessing the industry for the purchase of reinsurance to fund losses above the 1% PML.[34] TWIA would issue any required reinsurance assessment no later than December 1 of the relevant year.[35]

Under the proposed rules, TWIA annually must:[36]

- Provide TDI with the data and methodology used to determine the 1% PML. TDI will post this information to its website.
- Publicly discuss the methodology at each year's first TWIA board meeting.
- Disclose its reinsurance premiums including quotes given for coverage at TWIA's statutorily required minimum coverage level (a 1% PML).

II. Actions Taken by TWIA to Implement HB 1900

On January 15, 2020, the Committee conducted an interim hearing in Rockport, TX to receive invited testimony from TWIA in order to assess their progress in implementing HB 1900. In addition to the testimony provided at the January 15th hearing, TWIA also provided the Committee with written testimony in response to the Committee's formal request for information.[37] TWIA's progress in implementing the various aspects of HB 1900 are included in the tables below.[38]

A. Underwriting and Policy Administration

Underwriting and Policy Administration

Insurance to Value Determination — **Effective Date: January 1, 2020**

Determination of replacement cost value at the time of policy issuance.

- TWIA's new policy contracts reflecting this change have been approved by TDI and went into use on January 1, 2020.

Certificates of Compliance for Completed Improvements — **Effective Date: June 1, 2020**

Transfer of the WPI-8-C process to TDI with additional modifications designed to strengthen oversight over the process.

- TDI has assumed responsibility for the issuance of Certificates of Compliance for completed improvements as of June 1, 2020.

B. Claims Handling and Deadlines

Claims Handling and Deadlines

Claim Deadline Extensions **Effective Date: September 1, 2019**

Authorization for the Insurance Commissioner to extend TWIA policyholder claim-handling deadlines at his discretion and extend the claim-handling deadlines applicable to TWIA to a maximum of 120 days.

- While the Commissioner has not yet had a need to extend claim-handling deadlines under this provision, the Association is fully prepared should the Commissioner do so in the future.

Replacement Cost Coverage Claims **Effective Date: January 1, 2020**

Modifications to deadlines and processes related to the payment of replacement cost coverage claims.

- TWIA's claim notices include language as required to comply with this provision and policy forms are updated to reflect the law changes.

C. Transparency

Transparency

Rate Adequacy Analysis **Effective Date: June 10, 2019**

New requirement to make Association rate adequacy analyses, with specific format requirements, publicly available on TWIA.org at least 14 days before a vote of the board on a proposed rate filing. Also requires TWIA to accept public comment prior to the TWIA Board's vote on a proposed rate filing.

- TWIA posted its 2019 and 2020 rate adequacy analyses by the required deadlines ahead of the August Board meetings at which the required annual rate filings were considered. Public comments on the Association's rate adequacy analyses have been accepted in writing and in person at all applicable meetings of the Board of Directors since the law passed.

D. Funding

Funding

Emergency Board Meeting for Planned Member Company Assessment **Effective Date: June 10, 2019**

New requirement to call an emergency meeting of the TWIA Board for the purpose of notifying member companies of the need for an assessment to pay storm losses.

- TWIA announced a third potential member insurer assessment at its August 2019 meeting and the Board of Directors approved submitting a request to the Commissioner of Insurance for a $90 million member insurer assessment for losses from Hurricane Harvey at its December 2019 meeting.

Member Company Purchase of Reinsurance **Effective Date: June 10, 2019**

New requirement that TWIA assess member companies for any purchase of reinsurance above the 1-in-100-year funding requirement.

- The TWIA Board purchased reinsurance equal to the 1-in-100 probable maximum loss for the 2020 hurricane season, therefore no member assessment was necessary.

Use of Premiums **Effective Date: June 10, 2019**

New requirement clarifying TWIA's use of premiums and reserves for the payment of storm losses.

- Since this provision went into effect, the Texas coast has not experienced a storm requiring any expenditures on claims beyond that which TWIA can cover with current-year premiums.

E. Legislative Oversight Boards

Legislative Oversight Boards

Funding Study **Due: November 15, 2020**

Creates the Legislative Funding and Funding Structure Oversight Board to submit a report by November 15, 2020.

- TWIA is prepared to assist the Legislative Oversight Board in its deliberations and has worked with the Legislative & External Affairs Committee of the TWIA Board of Directors to include information on the Association's funding and possible funding solutions for consideration by the Legislature in its 2020 Biennial Report.

Merger Study **Due: January 1, 2021**

Requires the Windstorm Legislative Oversight Board to evaluate a merger of TWIA and TFPA and submit a report by January 1, 2020.

- TWIA is prepared to assist the Legislative Oversight Board in its deliberations.

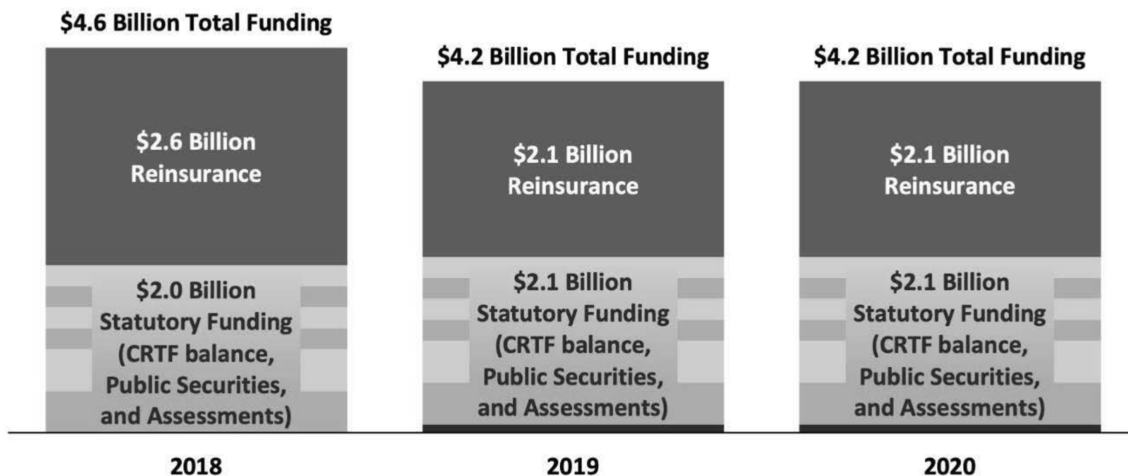
F. TDI Rulemaking and Plan of Operation Updates

TWIA is authorized to propose rules to TDI that govern TWIA's core operations and requires TDI to begin its review process within 30 days. To date, TWIA has not proposed any rules to TDI. TWIA and TDI are developing plans to review previously filed revisions to the Plan of Operation and additional revisions necessitated by legislation enacted by the 86th Legislature.

G. 2020 Hurricane Season Funding and Purchase of Reinsurance

TWIA has secured a total of $4.2 billion in funding for the 2020 hurricane season. This is equal to the minimum funding level required by Texas Insurance Code, Section 2210.453. TWIA filed for a 0% change in its annual rate filings in both 2019 and 2020.

No reinsurance was purchased in excess of the minimum required funding level. The total reinsurance in place for 2020 is $2.1 billion, which is unchanged from 2019 and less than 2018 as shown in the funding comparison below:



III. Reinsurance Purchases and PML Calculations

The Coastal Windstorm Insurance Coalition (CWIC) submitted extensive testimony to the Committee and placed particular emphasis on TWIA's reinsurance purchasing practices.[39] CWIC stated that the amount of reinsurance purchased by TWIA for the 2020 hurricane season was $2.1 billion in coverage, which was identical to the amount of reinsurance purchased for the 2019 hurricane season.[40]

However, CWIC observed that TWIA purchased the same amount of reinsurance even though its policy count declined by 5.5% between April of 2019 and April of 2020.[41] CWIC determined that in both 2019 and 2020 TWIA purchased reinsurance in excess of how it had calculated its 100-year PML prior to HB 1900.[42] The intent of HB 1900 was to limit policyholders' responsibility for reinsurance costs to TWIA's 100-year PML.[43] CWIC stated that TWIA has circumvented the intent of HB 1900 by changing the way it calculates its 100-year PML by adding an additional 15% for loss adjustment expense.[44]

CWIC estimates that the impact of this change has been to shift from member insurers back onto policyholders estimated reinsurance costs of $24 million in 2019 and $28 million in 2020.[45] CWIC states that if TWIA had instead assessed its member insurers for these reinsurance costs in compliance with the intent of HB 1900, its indicated rate increases would have been reduced by 6.0% to 7.0% for both residential and commercial in both 2019 and 2020.[46]

In early 2019, TWIA estimated its 100-year PML to be approximately $3.65 billion and the TWIA board had approved the purchase of $2.1 billion of reinsurance to provide total funding of $4.2 billion.[47] The other $2.1 billion was to be provided by approximately $100 million from the CRTF, public securities and member assessments.[48]

CWIC states that the TWIA Board intended to purchase reinsurance to provide total funding of $550 million in excess of TWIA's own estimate of its 100-year PML of $3.65 billion.[49] It's important to note that prior to HB 1900, TWIA could pass along the total cost of reinsurance to be funded by policyholders and would not be subject to the 100-year PML limit established by by the bill.

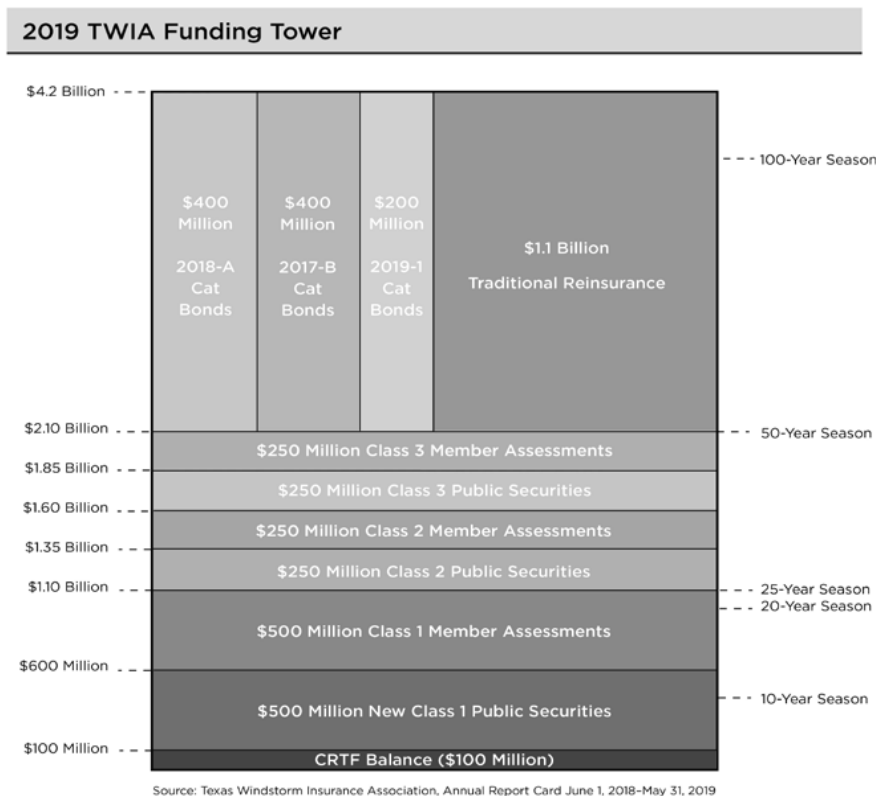
Governor Abbott signed HB 1900 into law on June 10th, 2019.[50] CWIC notes that at this point TWIA had a problem since it had purchased $550 million of reinsurance in excess of its previously estimated 100-year PML of $3.65 million and would be required to assess its member insurers for the cost of $550 million of reinsurance.[51]

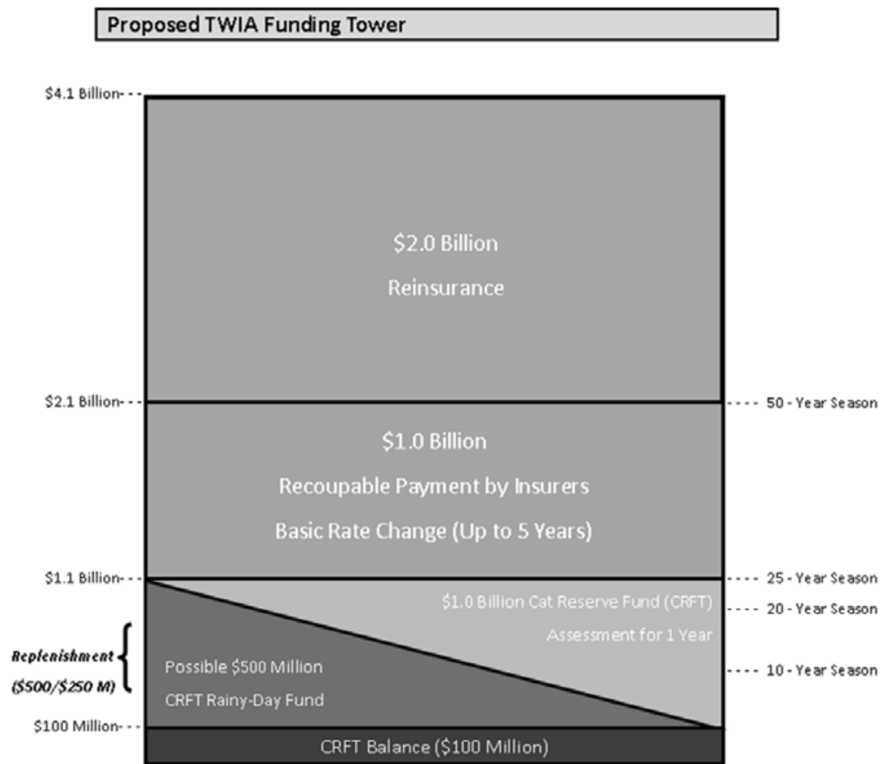
CWIC states that TWIA solved this problem by simply adding 15% for loss adjustment expense to its 100-year PML, something it had never done before, and something that appears to violate Texas law, so policyholders rather than member insurers would pay for the cost of $550 million of reinsurance.[52] CWIC determined that it is clear from TWIA's prior rate filings with TDI and prior board meeting materials that TWIA had always considered its 100-year PML to exclude loss adjustment expenses prior to HB 1900.[53]

Texas law requires: "The association shall maintain total available loss funding in an amount not less than the probable maximum loss for the association for a catastrophe year with a probability of one in 100".[54] CWIC states that loss adjustment expenses are not insured losses under the terms of TWIA's insurance contracts with its policyholders but rather are classified as a separate line item of operating expense in its statutory financial statements.[55]

IV. Alternative Funding Methods

As a result of extensive discussions related to the funding structure in light of the recovery from Hurricane Harvey and other natural disasters, industry groups have proposed an alternative funding structure that would provide TWIA with a stable funding regime moving forward. Their proposal is reproduced below.[56]





Proposed Structure

Restructure the first several layers of TWIA with a more stable allocation.[57] TWIA would be funded (beyond premiums) through two main layers before relying upon other financing mechanisms, such as reinsurance or cat bonds.[58]

- Establish and sustain a $1 billion minimum first layer composed of current available premium plus the catastrophe reserve fund trust (CRTF). There would be a statewide surcharge on <u>all Texas property insurance policyholders (personal and commercial)</u> collected by insurers to fund this.
- The $1 billion would be collected by insurers and transparently shown on the Declarations page of each policy.
- The CRTF would be accessed once TWIA premiums are exhausted.
- The CRTF would be used to pay for catastrophic event claims made by TWIA policyholders.
- Once available premium plus the CRTF falls below a “to be determined” threshold (e.g., $250-$500 million), another assessment on all Texas property insurance policyholders would be levied to “make it whole” and prepare for the next such event.
- **The second/next $1 billion (in excess of the CRTF) would be paid by the p/c insurance industry providing property insurance coverage in Texas** and be recoupable through reinsurance and/or including it in rates charged to property insurance policyholders owners throughout the state.
- The first layer would be “funded” and not established through pre-event or post-event bonds and the industry would be responsible for the second billion when needed.

- Amounts in excess of $2 billion would be covered (up to at a minimum the 100-year PML – currently) by reinsurance products purchased by TWIA.
- There would be a **statutory MINIMUM 5 percent premium increase in TWIA rates** until such time as the rates are adequate, within 20 percent of the indicated rate established by an outside actuarial firm, or five years.
- There would be a strengthening of the TWIA building codes through rulemaking adoption of the strongest codes as recommended by the Insurance Institute for Business and Home Safety (IBHS).
- Consideration should be given for a plan to fund $500 million of the CRTF from Texas' rainy-day fund to reduce the subsidy amount and make it more politically affordable/acceptable initially. It would also allow this fund to be set up and fully funded more quickly and mean a lower assessment for property policyholders.

Advantages to this proposal:[59]

- $1 billion from property policyholders across the state would include a one-year initial surcharge of approximately 7% per policy.
- $1 billion (from industry) would be stable
- $2 billion (or more) from reinsurance marketplace (perhaps at a lower cost due to the stability of the underlying funds and other TWIA changes (premium increases, mitigation, building codes, etc.).
- Removes the "stigma" associated with bonding, having to pay the bonds back, etc.
- It is temporary, unless there's a significant drain on the CRTF and then it could be replenished quickly through another property policyholder assessment
- It would be based on a percentage of the premiums paid – not a flat amount
- Everyone has a "stake in the game" and it would be transparent to all involved: coastal property owners, inland property owners, the state, insurers, reinsurers, etc.
- There's an opportunity (no events for a year or more) to grow the fund – i.e., investment income.
- Language would be included in the legislation that would prevent the state from accessing the funds for any other purpose. This would allow for market (property growth) and further, at least in theory, stabilize the marketplace
- The gradual, but mandatory rate increase means that the private market may be more willing to compete, so the TWIA would get smaller.
- Since assessments would be on all properties in the state, if TWIA shrinks, the potential losses (and proportionate surcharges) will as well.

Separately, consider a plan to fund $500 million of the CRTF from Texas' rainy-day fund to reduce the subsidy amount and make it more politically affordable/acceptable initially.[60] It would also allow this fund to be set up and fully funded more quickly and mean a lower assessment for property policyholders.[61]

Recommendations

- The Legislature should ensure that HB 1900 is being implemented as intended. In light of the concerns related to the purchase of reinsurance, the Legislature should amend the statute to specify that loss adjustment expenses are not insured losses and should thus not be factored into the 100-year PML calculation.
- The Legislature should consider adding additional requirements to ensure transparency in TWIA's purchasing of reinsurance. The Legislature should consider adding requirements that TWIA utilize a single model to determine its 1 in 100-year PML and that the entity executing the model not have a financial interest in the outcome of the model.
- The Legislature should consider alternative funding methods for TWIA that would eliminate the need to constantly increase rates for coastal policyholders. Coastal policyholders are rightfully frustrated by the constant threat of rate increases from TWIA. Additionally, many coastal policyholders are either still recovering from the substantial damage from Hurricane Harvey or other more recent natural disasters. The Legislature should craft a funding structure that provides a better balance of the financial burdens faced by coastal policyholders, the growing reliance of TWIA on bonding debt, and the insurance industry's role in being assessed.

HB 2536

Background

In light of concerns about the growing prices of prescription drugs, HB 2536 sought to address this by requiring the disclosure of certain information by actors in the drug supply chain.[62] HB 2536 requires that pharmaceutical drug manufacturers submit a report to the Health & Human Services Commission (HHSC) stating the current wholesale acquisition cost information for drugs sold in or into this state by the manufacturer.[63]

HHSC is required to develop an internet website to provide the information related to drug pricing to the general public.[64] The website is to be made available on HHSC's website with a dedicated link that is prominently displayed on their home page or by separate easily identifiable Internet address.[65]

Pharmacy Benefit Managers (PBM's) are also required to file reports with TDI detailing significant information relevant to drug pricing such as the aggregated rebates and fees collected from pharmaceutical manufacturers along with whether or not these rebates or fees were passed along to health benefit plans, enrollees at the point of sale, or retained as revenue by the PBM.[66] This information must then be compiled by TDI and published on the department's website.[67]

Health Benefit Plans face reporting requirements as well, including needing to report the names of the 25 most frequently prescribed prescription drugs, the percent increase in annual net spending for prescription drugs, the percent increase in premiums that were attributable to prescription drugs, along with several others.[68] This information must also be submitted to TDI for the department to publish it on its website for public access.[69]

I. Actions Taken by HHSC to Implement HB 2536

The Texas Health and Human Services Commission (HHSC), in coordination with the Department of State Health Services, implemented the requirements of Chapter 441, Subchapter A of the Texas Health and Safety Code, as adopted by House Bill 2536, 86th Legislature, Regular Session, 2019.[70]

Drug cost data is available to the public through the newly created drug cost transparency website www.texasrx.org.[71] By March 15, 2020, pharmaceutical drug manufacturers reported to HHS their January 1, 2020, wholesale acquisition cost (WAC) information for U.S. Food and Drug Administration approved drugs sold in or into Texas.[72] This information was posted to the drug cost transparency website on April 15, 2020; the data is searchable and downloadable.[73] Beginning 2021, manufacturers will submit their January 1 WAC price by January 15 of the reporting year.[74]

For the 2020 annual WAC report, 341 pharmaceutical manufacturers submitted WAC price information for a total of 18,653 national drug code (NDC) descriptions.[75] Fifty-eight of the NDCs were for insulin manufactured by three pharmaceutical manufacturers.[76] Insulin prices ranged from $21.76 (insulin glargine, human recombinant analog) to $3,464.14 (insulin aspart

injection).[77] The average price was $869.18.[78] Note that insulin prices can vary based on the package size (e.g., 1 bottle versus10 bottles per package); newness of the drug; time on the market; whether or not it is an equivalent to a previous brand name drug; or costs associated with development of the drug and complexity of production.

On June 15, 2020, HHS began collecting price increase information on drugs that increased in price as specified in Chapter 441.[79] Price increases with effective dates from January 1, 2020, through June 14, 2020, were due by August 15, 2020; that information is now posted on the drug cost transparency website.[80] Drug price increases with effective dates after June 15, 2020, are due within 30 days of the price increase effective date; this information is posted on the drug cost transparency website within 60 days of submission.[81] To date, none of the price increases reported represent insulin drugs.

Because Texas's drug cost transparency requirements were recently implemented and currently represent just over six months of price increase data to date, HHS examined price increase information obtained by other states with similar legislation requiring drug price increase reporting.[82] In 2019, the Nevada Department of Health and Human Services reported that 22.4 percent of diabetes-related drugs reported to the state increased in price significantly from one or two years prior when compared to the consumer price index.[83] California requires reporting of WAC prices that increase by greater than 16 percent compared to the current quarter and two prior calendar years for drugs that cost more than $40 for a course of therapy.[84] HHS reviewed California's publicly available data for all four quarters for 2019, and first quarter 2020, and none of the drugs with reported increases were for insulin.[85]

Vermont, in 2018, also required drug price reporting.[86] Vermont law requires the Department of Vermont Health Access (DVHA) to report on the 10 top prescription drugs on which the state spends significant health care dollars and for which:

- The wholesale acquisition cost has increased by 50 percent or more over the past five years or by 15 percent or more during the previous calendar year; and
- DVHA's net cost has increased by 50 percent or more over the past five years or 15 percent or more over the previous calendar year (ranked from the greatest to least net cost increase).

HHS reviewed the DVHA website and insulin was not listed as one of the drugs in either of the two reports posted on the DVHA website.[87]

Oregon also requires drug price increase reporting.[88] The Oregon Prescription Drug Price Transparency Act requires prescription drug manufacturers to report on prescription drugs that experienced net yearly price increases of 10 percent or more and had a price of $100 or more for a one-month supply during the previous year. In the posted 2018 report, five of the reported prescription drugs with price increases were for insulin.[89]

As HHS continues to collect information from drug manufacturers, it will gain greater visibility into drug prices and how they change over time for the drugs sold in and into Texas. Encouraging greater compliance will help to ensure more comprehensive data to better understand drug prices in the state.

II. Actions Taken by TDI to Implement HB 2536

HB 2536 requires pharmacy benefit managers and health insurers to annually submit reports related to prescription drug cost transparency to TDI. In May 2020, TDI posted the first collection of aggregated data and it is reproduced below:[90]

Prescription Drug Cost Transparency
Issuers Excluding Medicaid and CHIP

This document contains aggregate data from 30 health benefit plan issuers from the 2019 calendar year. The data was collected under House Bill 2536, passed by the 2019 Texas Legislative Session. The Texas Department of Insurance did not audit the data; instead, the agency is reporting the data as reported by the issuers.

Most frequently prescribed drugs

Each health benefit plan issuer submitted a list of its 25 most frequently prescribed drugs. The table below shows the number of times that each drug appeared on issuers' lists. Of the 91 drugs that appeared on the lists from issuers, this table shows the 32 drugs cited by at least 20 percent of issuers.

Drugs most cited by 30 issuers

Drug name	Drug class	Conditions treated*	Issuers
Amoxicillin	antibiotic	bacterial infections	29 (97%)
Azithromycin	antibiotic	bacterial infections	29 (97%)
Montelukast	leukotriene receptor antagonist	allergies; asthma	29 (97%)
Amlodipine	calcium channel blocker	chest pain; high blood pressure	28 (93%)
Atorvastatin	statin	high cholesterol	28 (93%)
Levothyroxine	thyroid hormone	hypothyroidism	28 (93%)
Lisinopril	ACE inhibitor	high blood pressure; heart failure	27 (90%)
Losartan	angiotensin II receptor blocker	high blood pressure	27 (90%)
Prednisone	corticosteroid	inflammatory conditions	27 (90%)
Metformin	anti-diabetic	type 2 diabetes	26 (87%)
Metoprolol	beta blocker	high blood pressure; chest pain	23 (77%)
Escitalopram	SSRI	anxiety; depression	22 (73%)
Hydrochlorothiazide	diuretic	high blood pressure; fluid retention	22 (73%)
Gabapentin	anticonvulsant	epilepsy; shingles pain	21 (70%)
Amoxicillin and clavulanate potassium	antibiotic	bacterial infections	20 (67%)
Fluticasone propionate	corticosteroid	asthma; COPD	20 (67%)
Rosuvastatin	statin	high cholesterol	20 (67%)
Bupropion	antidepressant	depression	19 (63%)
Pantoprazole	proton pump inhibitor	gastroesophageal reflux	19 (63%)
Amphetamine and dextroamphetamine	stimulants	narcolepsy; ADHD	17 (57%)
Albuterol	bronchodilator	asthma; COPD	16 (53%)
Omeprazole	proton pump inhibitor	gastroesophageal reflux	16 (53%)

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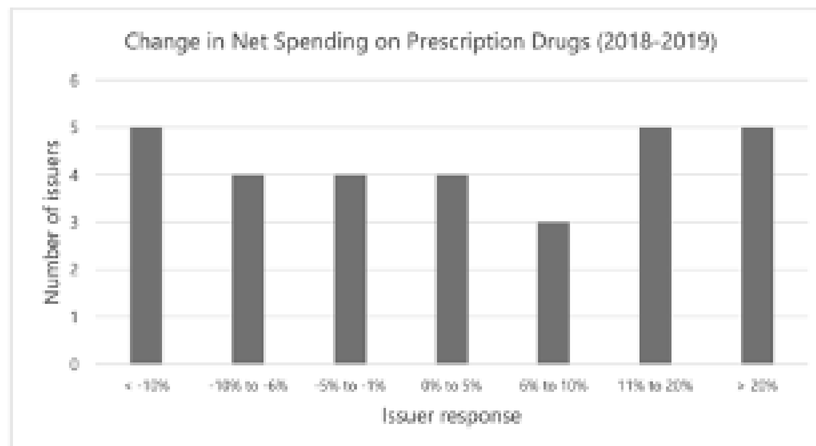
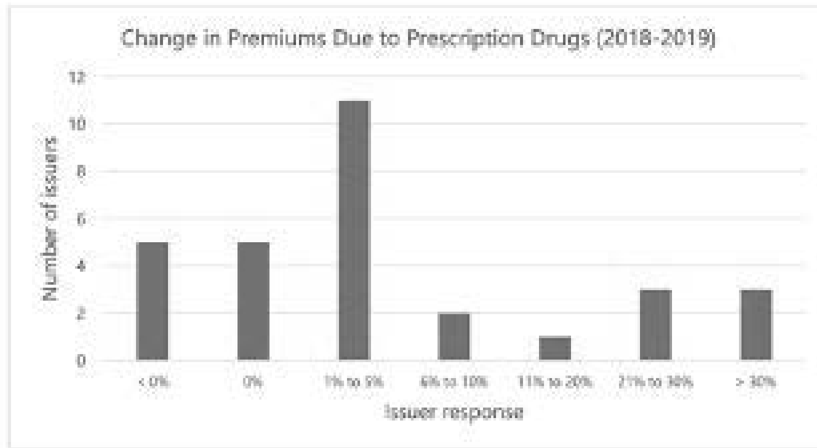
Drug name	Drug class	Conditions treated*	Issuers
Sertraline	SSRI	anxiety; depression; OCD	16 (53%)
Alprazolam	benzodiazepine	anxiety	14 (47%)
Hydrochlorothiazide and lisinopril	ACE inhibitor	high blood pressure	14 (47%)
Hydrocodone and acetaminophen	opioid and pain reliever	moderate to severe pain	13 (43%)
Simvastatin	statin	high cholesterol	12 (40%)
Ibuprofen	nonsteroidal anti-inflammatory	inflammation; fever; pain	11 (37%)
Vitamin D	vitamin	bone disorders	9 (30%)
Meloxicam	nonsteroidal anti-inflammatory	arthritis	6 (20%)
Tramadol	analgesic	moderate to severe pain	6 (20%)
Zolpidem	nonbenzodiazepine	insomnia	6 (20%)

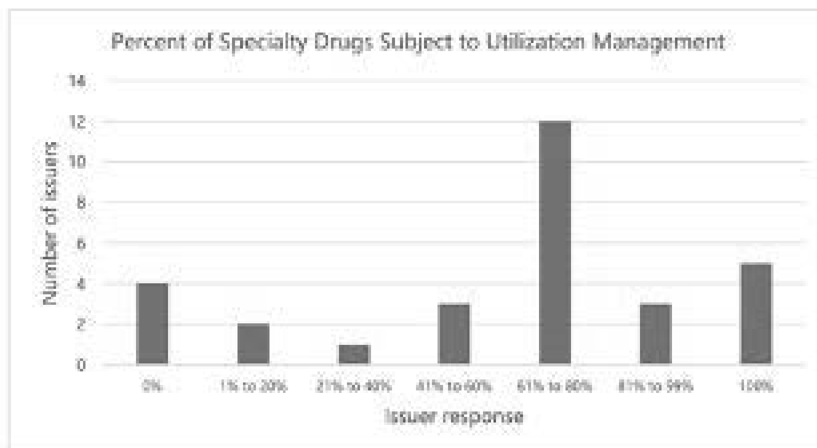
* The conditions listed in this column illustrate common uses of the drug and are not intended to be an exhaustive list.

Drug spending data

The following graphs illustrate how the 30 issuers responded to questions about prescription drug spending.







The issuers reported aggregate savings of $232 million due to specialty drug utilization management.

Prescription Drug Cost Transparency
Issuers Including Medicaid and CHIP

This document contains aggregate data from 40 health benefit plan issuers from the 2019 calendar year. The data was collected under House Bill 2536, passed by the 2019 Texas Legislative Session. The Texas Department of Insurance did not audit the data; instead, the agency is reporting the data as reported by the issuers.

Most frequently prescribed drugs

Each health benefit plan issuer submitted a list of its 25 most frequently prescribed drugs. The table below shows the number of times that each drug appeared on issuers' lists. Of the 110 drugs that appeared on the lists from issuers, this table shows the 41 drugs cited by at least 20 percent of issuers.

Drugs most cited by 40 issuers

Drug name	Drug class	Conditions treated*	Issuers
Albuterol	Bronchodilator	asthma; COPD	39 (98%)
Montelukast	leukotriene receptor antagonist	allergies; asthma	39 (98%)
Azithromycin	antibiotic	bacterial infections	38 (95%)
Amoxicillin	antibiotic	bacterial infections	37 (93%)
Fluticasone Propionate	corticosteroid	asthma; COPD	34 (85%)
Levothyroxine	thyroid hormone	hypothyroidism	34 (85%)
Metformin	anti-diabetic	type 2 diabetes	31 (78%)
Atorvastatin	statin	high cholesterol and triglycerides	29 (73%)
Amlodipine	calcium channel blocker	chest pain; high blood pressure	28 (70%)
Lisinopril	ACE inhibitor	high blood pressure; heart failure	28 (70%)
Losartan	angiotensin II receptor blocker	high blood pressure	27 (68%)
Amoxicillin and clavulanate potassium	antibiotic	bacterial infections	26 (65%)
Prednisone	corticosteroid	inflammatory conditions	25 (63%)
Cetirizine	antihistamine	Allergies	21 (53%)
Gabapentin	anticonvulsant	epilepsy; shingles pain	21 (53%)
Ibuprofen	nonsteroidal anti-inflammatory	inflammation; fever; pain	21 (53%)
Metoprolol	beta blocker	high blood pressure; chest pain	21 (53%)
Escitalopram	SSRI	anxiety; depression	19 (48%)
Hydrochlorothiazide	diuretic	high blood pressure; fluid retention	19 (48%)
Rosuvastatin	statin	high cholesterol and triglycerides	18 (45%)
Sertraline	SSRI	anxiety; depression; OCD	18 (45%)
Amphetamine and dextroamphetamine	stimulants	narcolepsy; ADHD	17 (43%)
Bupropion	antidepressant	depression	17 (43%)
Ondansetron	5-HT3 antagonist	nausea; vomiting	15 (38%)
Pantoprazole	proton pump inhibitor	gastroesophageal reflux	15 (38%)
Cefdinir	antibiotic	bacterial infections	14 (35%)

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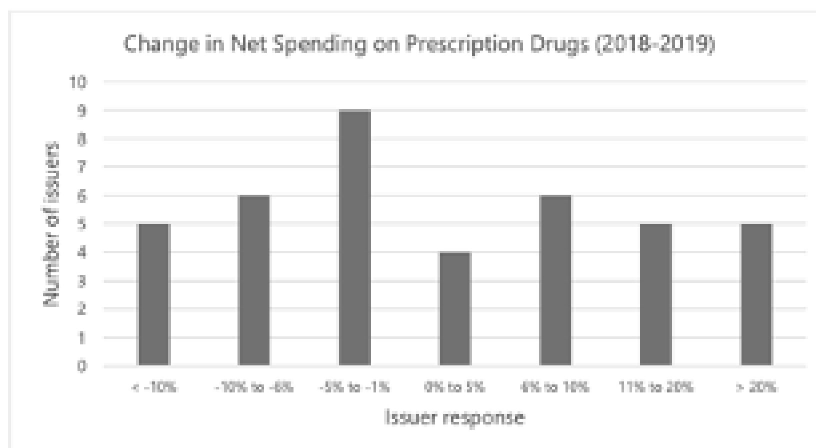
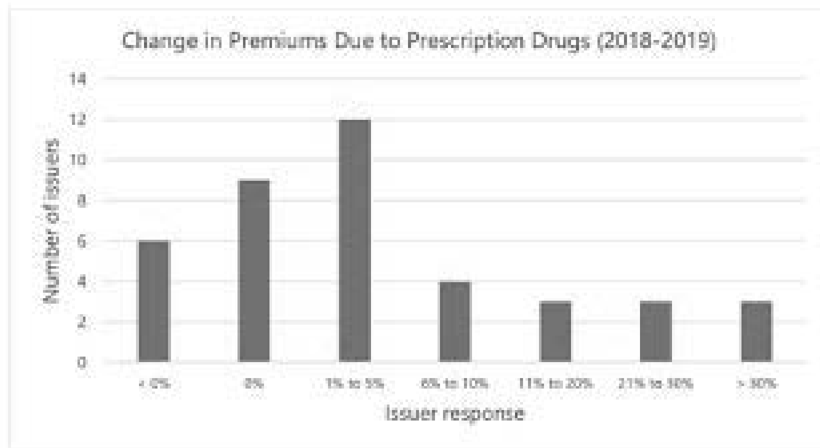
Drug name	Drug class	Conditions treated*	Issuers
Omeprazole	proton pump inhibitor	gastroesophageal reflux	14 (35%)
Oseltamivir	antiviral	flu	14 (35%)
Alprazolam	benzodiazepine	anxiety	13 (33%)
Hydrochlorothiazide and lisinopril	ACE inhibitor	high blood pressure	13 (33%)
Hydrocodone and acetaminophen	opioid and pain reliever	moderate to severe pain	12 (30%)
Lisdexamfetamine	stimulant	ADHD	12 (30%)
Methylphenidate	stimulant	narcolepsy; ADHD	12 (30%)
Simvastatin	statin	high cholesterol and triglycerides	11 (28%)
Prednisolone	corticosteroid	inflammatory conditions	10 (25%)
Clonidine	alpha-2-agonist	high blood pressure	9 (23%)
Mupirocin	topical antibiotic	skin infections	9 (23%)
Triamcinolone	corticosteroid	eczema; psoriasis	9 (23%)
Brompheniramine and pseudoephedrine	antihistamine and decongestant	common cold; allergies	8 (20%)
Trazodone	SSRI	depression	8 (20%)
Vitamin D	vitamin	bone disorders	8 (20%)

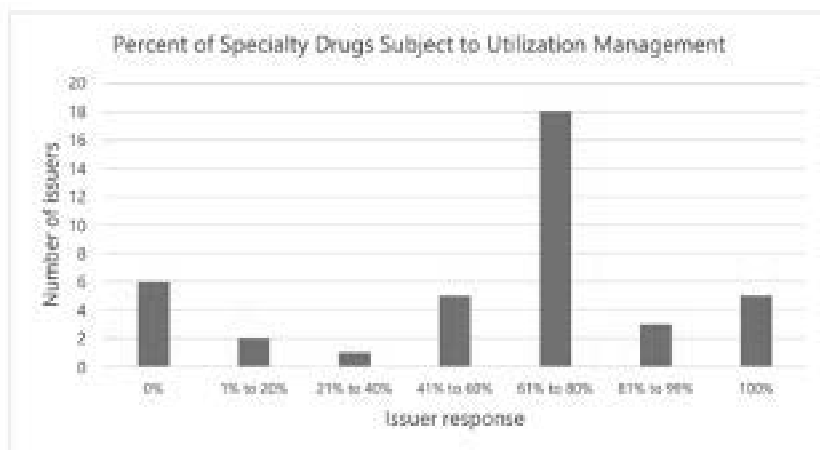
* The conditions listed in this column illustrate common uses of the drug and are not intended to be an exhaustive list.

Drug spending data

The following graphs illustrate how the 40 issuers responded to questions about prescription drug spending.







The issuers reported aggregate savings of $281 million due to specialty drug utilization management.

Prescription Drug Cost Transparency
Pharmacy Benefit Managers

This document contains aggregate data from 19 pharmacy benefit managers (PBMs) from the 2019 calendar year. The data was collected under House Bill 2536, passed by the 2019 Texas Legislative Session. The Texas Department of Insurance did not audit the data; instead, the agency is reporting the data as reported by the PBMs.

The following table shows the aggregated rebates, fees, price protection payments, and any other payments collected from pharmaceutical drug manufacturers as reported by PBMs that responded to the data call. One PBM out of 19 was excluded from the table because it could not provide a breakdown of total payments passed to issuers and enrollees or the amount retained as revenue. The excluded PBM accounted for less than 1 percent of total payments to PBMs.

Aggregate payments from pharmaceutical drug manufacturers to 18 PBMs

Year	Amount passed to issuers	Amount passed to enrollees	Amount retained as revenue	Total
2016	520,195,278	-	38,052,803	558,248,081
2017	614,188,333	-	63,650,933	677,839,266
2018	784,453,352	1,404	77,311,117	861,765,873
2019	663,899,766	16,016,601	177,564,011	857,480,378
Total	**$2,582,736,729**	**$16,018,005**	**$356,578,864**	**$2,955,333,598**

Recommendations

- The Legislature should consider adopting a proposal to cap copayments for insulin to ensure that growing costs do not prevent diabetic Texans from having access to this necessary drug.
- The Legislature should consider creating an insulin safety net program, similar to Minnesota's, to ensure that the neediest Texans have reliable access to insulin in emergency situations. Although pharmaceutical manufacturers have their own programs that seek to provide insulin at low or no cost to individuals, these programs are generally not widely known and do not provide a centralized platform for diabetic Texans to contact in order to receive an emergency supply of insulin.
- The Legislature should require manufacturers to detail specific factors and the portion of the price increase related to that factor as was required in the House passed version of HB 2536.
- The Legislature should require further detail in explaining price increases including specific information on the drug's acquisition and specific cost attributed to the drug.

SB 442

Background

The 86th Texas Legislature passed SB 442, which requires insurers that do not provide flood coverage in their policy to disclose that the policy does not cover flood events.[91] This was a significant issue during Hurricane Harvey and was identified by TDI as a recommendation for the Legislature to pursue in order to ensure consumers were properly informed of their coverage restrictions.

A property located within a Federal Emergency Management Agency 100-year flood plain must have flood coverage in order to obtain a federally backed mortgage.[92] However, according to TDI, more than half the homes flooded during Hurricane Harvey were outside of the 100-year flood plain, and most of these properties did not carry flood insurance.[93] A lack of consumer awareness about both flood insurance and flood-prone areas has generated considerable discussion about how to best educate consumers about flood coverage options and to encourage participation in the National Flood Insurance Program (NFIP).[94]

The required conspicuous disclosure is as follows for policies initiated or renewed after January 1, 2020:

"Your insurance policy does not include coverage for damage resulting from a flood even if hurricane winds and rain caused the flood to occur. Without separate flood insurance coverage, you may have uncovered losses caused by a flood."

I. Actions Taken by TDI to Implement SB 442

TDI provided written testimony to the Committee regarding their efforts to implement SB 442.[95] TDI stated that state law does not require insurers to file the new disclosures with TDI.[96] However, as insurers make filings for new or revised policies, TDI checks for the disclosure as part of the state review.[97]

Since the law took effect, about 40 filings have had a flood disclosure; however, some companies did not use the specific wording required in SB 442.[98] In those cases, TDI required the company to revise the disclosure or affirm that the correct phrasing will appear in another policy document.[99]

II. SB 442's Impact on the Flood Insurance Market

Since the implementation of SB 442, industry members report that there has been an increase in both the number of policies/premiums in the National Flood Insurance Program (NFIP), as well as in the private market.[100]

For example: In the NFIP from January through July (the latest data available) the number of policies in force countrywide has grown from 5,053,386 to 5,053,886 (45,000 new policies for 0.9% growth) while number of NFIP policies in force in Texas in has grown from 763,150 to

791,012, or approximately 3.65 percent over the same time period.[101] This goes against the trend of a decreasing number of policies being purchased in all but a very few states (Michigan, North Dakota, and South Carolina in addition to Texas) in 2020.[102]

On the private flood side, the growth has been significant, but still represents just a fraction of the properties insured against flood loss in Texas.[103] Since 2015, the Texas direct written premium for private flood insurance has grown from roughly $11.271 million to $49.03 million, approximately 435 percent over the 5-year period.[104]

However, there is still more work to do as according to CoreLogic, nationally, more than 29 million properties (29,437,151), or 23 percent, are outside a designated Special Flood Hazard Area (SFHA) despite being at *High* or *Moderate* risk of flooding.[105] In Texas, there are 3,292,082 properties, or 31 percent of all the properties in the state that are at high or moderate risk of flooding.[106] Even with the private sector growth and the number of policies in the NFIP, only about 25 percent of the properties that have a significant chance of flooding have this needed coverage.[107]

Recommendations

- The Legislature should continue to monitor the impact of flood disclosures and the associated prevalence of flood insurance policies in Texas. However, the Legislature should also consider the possibility of innovative ideas to provide more consumer-friendly disclosures. Since consumers often complain that they receive too many disclosures/notices in their policies as it is, it would be worth considering innovative ideas that provide more efficient disclosures that will actually be read by consumers.

SB 1264

Background

The 86th Texas Legislature passed SB 1264 to prevent consumers from receiving surprise medical bills in situations where the consumer has no choice over who provides their care. SB 1264 prohibits all non-network facility-based providers at network hospitals and all non-network emergency care providers from sending surprise balance bills to consumers.[108]

The legislation requires health plans, including preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and health maintenance organizations (HMOs), to pay reasonable or agreed-upon amounts to out-of-network emergency care and facility-based providers.[109] In order to balance the interests of payers and providers, the bill allows providers to dispute payment amounts through TDI's existing mediation program and through a new option for arbitration.[110]

SB 1264 applies these surprise billing protections to over 420,000 enrollees in the Texas Employees Group Benefits plan (ERS), 250,000 enrollees in the Teacher Retirement System (TRS-Care), and 430,000 enrollees in the self-funded TRS-ActiveCare program.[111] Additionally, SB 1264 also allows federally regulated, self-funded health benefit plans (around 40% of Texas's health insurance market) to opt into the strong consumer protections provided by this legislation.[112]

The bill required extensive rulemaking in order to be implemented and the Committee closely monitored TDI's efforts to do so. TDI was required to develop a portal for submission of arbitration and mediation requests along with rules to implement the bill's exception for non-emergency "elective" services where the patient has actively elected to limit their rights to these protections after receiving a complete written disclosure.[113] Additionally, TDI was required to select a benchmarking database to satisfy the legislation's requirements on conflicts of interest.[114]

I. Actions Taken by TDI to Implement SB 1264

A. Waiver Rule

TDI posted a rule outlining the narrow exception when a consumer chooses an out-of-network doctor or provider at an in-network facility.[115] The rule was first adopted on an emergency basis to meet the law January 1, 2020, implementation date and then made permanent through the normal rule-making process.[116]

TDI also developed a waiver form in plain language that consumers must sign at least 10 business days before receiving out-of-network care if the provider wants to balance bill the consumer instead of requesting arbitration or mediation.[117]

The Waiver Rule[118] does the following:

- Clarifies that consumers can waive SB 1264 balance billing protections only in cases where they have a choice between an in-network provider and an out-of-network provider. The waiver can't be used in an emergency or when an out-of-network doctor was assigned to a case, such as when an anesthesiologist is assigned to a surgery.
- Includes the form consumers must sign at least 10 business days before receiving out-of-network care if the provider wants to balance bill the consumer instead of requesting arbitration or mediation.
- Applies only to state-regulated insurance plans and people with coverage through the state employee or teacher retirement systems. Insurance cards for state-regulated plans have either "DOI" (for department of insurance) or "TDI" (Texas Department of Insurance) printed on them. It does not apply to self-funded employer-sponsored health plans or Medicare.

The waiver form and its associated instructions are reproduced below:

Instructions for the balance billing waiver

For purposes of these instructions, "patient" means the consumer of the service or supplies or the patient's guardian or legal representative.

General instructions

- Give a copy of all pages of the balance billing waiver (Form AH025) to the patient before scheduling services or supplies.
- Type in the information needed for each fillable field. Do not write in by hand.
- Do not change the form, including the font style and size.
- Do not include these instructions with the form given to the patient.

Page 1, "Estimate of what you may pay" section:

In the field for "Out-of-network doctor or provider name," enter only one facility or provider / person's name. **Do not enter a group or practice name.**

Page 2, "Notice of my right to cancel" section:

- In the field for "You must notify the provider in writing at," enter a website, fax, or other secure method where the patient can send a cancellation notice. The transmission must be secure because the form has protected health information.
- In the field for "You must send the notice to the provider on or before," enter the date that is five business days from the date the form was signed by the patient.

Page 3 and copies of Page 3, "More details about your estimate" section:

- In the "Service or supply – code and name" column, enter only one service or supply per row. Also include the CPT code for that service or supply.
- In the "Amount to be billed" column, enter a good faith estimate of the amount you expect to bill the patient for the service or supply listed in that row.
- In the "You may need to pay" column, enter a good faith estimate of the amount the patient will need to pay out of pocket for the service or supply.
- The total at the bottom of Page 3 (or your last page if more space is needed) must match the total you entered on Page 1.

To learn more, see 28 Texas Administrative Code Sections 21.4901 to 21.4904.

AH025 | 1219 • Balance billing waiver

TDI | Texas Department of Insurance

Do you agree to pay more for out-of-network care and give up important legal protections?

This doctor or provider is not in your health plan's network. This means the doctor or provider does not have a contract with your plan.

If the service or supply is medically needed:

- State law protects patients with some types of health plans from higher bills from out-of-network providers. If you sign this form, you lose the protection of the law.
- If you sign this form, you agree to pay up to the full billed charges for these services and supplies.
- Your health plan might not count the extra amount you pay toward your out-of-pocket limit.
- Before you sign this form, you can ask your health plan to find an in-network provider. If there isn't one, your health plan might work out an agreement with this provider or another provider.
- If you have a plan that is an HMO (health maintenance organization) or EPO (exclusive provider benefit plan), it may not pay anything for out-of-network services and supplies.
- You should **not** sign this form if you believe your case is an emergency.
- You should **not** sign this form if you did not have a choice of providers. For example, if a doctor was assigned to you.

Estimate of what you may pay

Patient name: ______________________________

Out-of-network doctor or provider name: ______________________________

The charges may change if the type or amount of services or supplies changes.

Total estimate of what you may need to pay (insurance will not cover):	**$**

► **Detailed estimate.** See Page 3 for the estimated charge for each service or supply you get.

► **Call your health plan.** Your plan may have better information about how much you may need to pay. You also can ask about your provider options.

► **Questions about your rights?** Call the Texas Department of Insurance at 1-800-252-3439 or go to www.tdi.texas.gov.

I agree to give up (waive) my rights for consumer protection

- I understand I am giving up some consumer protections under state law.
- I understand I may get a bill for up to the full billed charges for these services and supplies. (This is called balance billing.)
- I signed this form at least 10 business days before getting services or supplies.
- I understand I have 5 business days to cancel this agreement (see "Notice of my right to cancel" below). I also understand I can't cancel after I get the services or supplies listed on this form.
- I was able to get my questions answered before signing this form.

______________________	or	______________________
Patient's signature		Guardian or legal representative's signature
______________		______________________
Date of signature		Print the guardian or legal representative's name

Keep a copy of this form. It contains important information about your rights.

Notice of my right to cancel

You have 5 business days to cancel this agreement to give up (waive) your consumer protections.

To cancel:

- You must notify the provider in writing at: ______________________________

  ____
- You may sign below or use any written statement that is signed and dated and states that you want to cancel.
- You must send the notice to the provider on or before:______________.

I wish to cancel this agreement

______________________	or	______________________
Patient's signature		Guardian or legal representative's signature
______________		______________________
Date of signature		Print the guardian or legal representative's name

If you cancel, keep a copy of your notice and proof that you sent it.

More details about your estimate

Patient name: ____

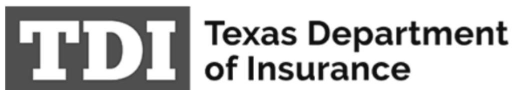
Out-of-network doctor or provider name: ______________________________

The charges may change if the type or amount of services or supplies changes.

Date of service	Service or supply – code and name	Amount to be billed	You may need to pay
Total estimate of what you may need to pay (insurance will not cover):			**$**

B. Online Portal for Arbitration and Mediation Submissions

In July 2020, TDI published their preliminary report on implementation of SB 1264 including the launch of the online portal for providers, health plans, and facilities to request arbitration or mediation.[119] The portal is readily accessible and provides distinct instructions for health plans, providers, and arbitrators/mediators. The portal is reproduced below:



Secured login Request access

Independent Dispute Resolution

Request and view billing dispute claims.

Do you want to set up an account?

- **Health plans:** Email IDR@tdi.texas.gov and we will set up an account for you.
- **Mediators and arbitrators:** When you are certified by TDI, you will get an email with instructions on how to set up an account.
- **Health care providers:** After you request access, we will send you a temporary password.

Questions about this portal?

Email IDR@tdi.texas.gov or call 855-839-2427.

Are you a consumer / patient who got a medical bill you weren't expecting?

If yes, go to our Get help with a surprise medical bill webpage.

Username

Password

Did you forget your password?

Log in

Texas Department of Insurance

333 Guadalupe, Austin TX 78701 | P.O. Box 149104, Austin, TX 78714 | 512-676-6000 | 800-578-4677

Accessibility | Compact with Texans | Privacy / Security | Linking | Texas Homeland Security | Texas.gov |
Texas Veterans Portal | TRAIL | To Report Fraud | State Auditor's Office Hotline: 1-800-TX-AUDIT |
Texas State Spending | Viewers / PDF Reader

C. Benchmarking Database Selection

To select a benchmarking database, TDI performed a comprehensive selection process to identify a database that could provide the data required by SB 1264 and meet the legislation's requirements on conflicts of interest.[120] As part of the search, TDI:

- Researched benchmarking databases certified by the Centers for Medicare & Medicaid Services as part of its qualified entity program. These databases meet federal standards for privacy and security.
- Sent a survey to nine databases that had Texas or national data.
- Received and evaluated three responses. FAIR Health was the only respondent that met all the all requirements.

As part of its agreement with FAIR Health, TDI negotiated free access to FAIR Health data benchmark products for health plans that contribute data. FAIR Health indicated it has sufficient data to calculate reliable Texas benchmarks using data from existing contributors.[121] Thus, health plans are not required to submit data but receive access to the database for free if they do submit.

D. Preliminary Data & Trends

In TDI's six-month preliminary report on SB 1264 implementation, the Department identified early trends and provided relevant data to the Committee and stakeholders.[122] Since SB 1264 requires TDI to issue a comprehensive report on the impact of the legislation each biennium, TDI expects to provide the first report to the Legislature by December 1, 2020. Thus, the data provided below only reflects the first six months of 2020 and the Committee expects more comprehensive data from TDI in December of 2020.[123]

Because SB 1264 applies to bills for services provided on or after January 1, 2020, TDI didn't receive the first arbitration request until February 12, 2020, but requests have risen each month.[124] The largest number of requests by far was received in June.[125] In addition, the ban on elective surgeries due to the COVID-19 pandemic may have reduced the number of requests for mediation and arbitration that TDI would have otherwise received for out-of-network providers at in-network facilities.[126] For these reasons, TDI is cautious about identifying early trends.[127] However, there are some notable data points.[128]

- In the first six months, about 85% of dispute resolution requests are coming from three large physician staffing and billing firms.
- TDI has received 19 consumer complaints about balance billing in the first six months of 2020, down from 546 for the same period in 2019.
- Provider complaints have decreased more than 70% this year. Before SB 1264, consumers could request mediation for certain surprise bills, but the only recourse available through TDI for providers seeking to resolve billing disputes was to file a complaint. TDI received 1,770 complaints from health care providers and billing services in the first six months of 2020, down from 6,461 for the same period in 2019.
- TDI is seeing a higher proportion of requests related to emergency services than in the previous mediation system. The elective surgery ban may be a factor in this difference.

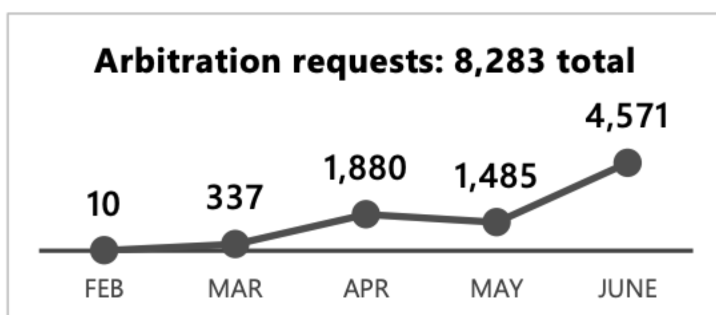
Specialty	SB 1264 submissions through June	2019 mediations under prior system
Emergency physicians	85%	10%
Anesthesiologists	4%	33%
Assistant surgeons	1%	0.6%

- The final payment agreed to during informal settlement discussions appears similar to those decided by arbitrators based on a look at requests involving a single claim for emergency physician services. TDI does not have information on the services, or CPT codes, included in the requests for dispute resolution so we cannot compare how the decisions differ on specific services.

Requests with single claim for ER physician	Informal settlement	Decided by arbitrator
Original bill	$1,497	$1,699
Original payment	$144	$229
Final amount	$612	$688

E. Arbitration Implementation Data

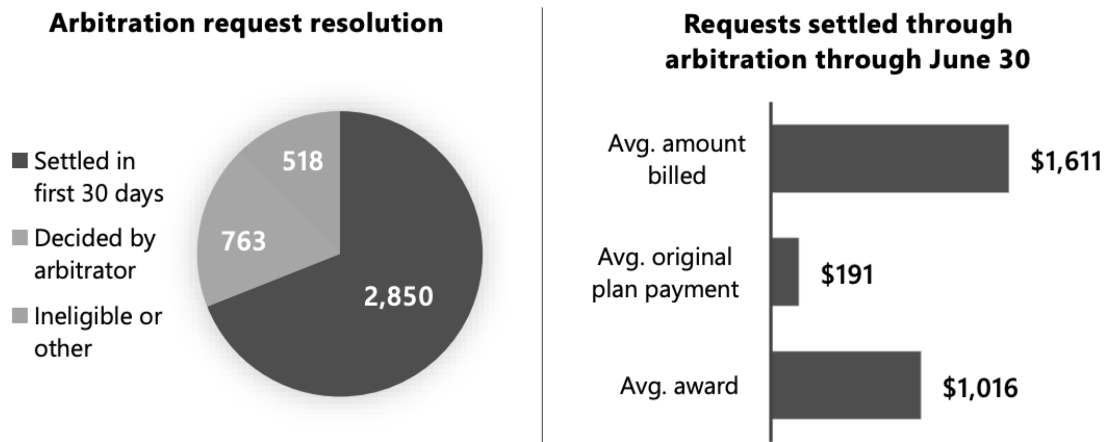
SB 1264 outlines an arbitration process for billing disputes between out-of-network health care providers (not facilities) and health plans.[129] It outlines 10 factors to be considered by the arbitrator, and it sets aggressive timelines to conclude cases.[130]



Arbitration Timeline[131]

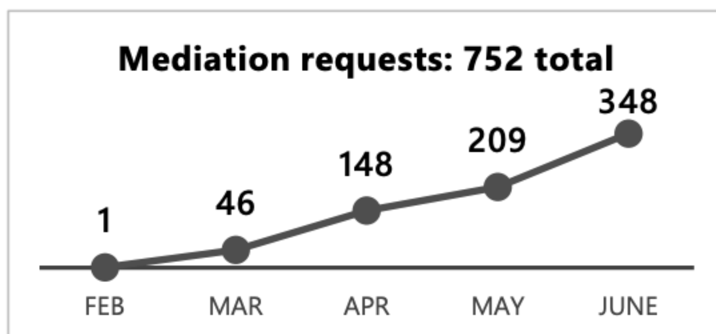
- **Request:** A request for arbitration can be made between 20 and 90 days after the date the out-of-network provider receives the first claim payment.
- **First 30 days:** Once the request has been submitted, there is a 30-day informal settlement period. During this time, the provider and health plan can reach a settlement or select an arbitrator. This period can be extended by mutual agreement of the parties.

- **Day 31:** The TDI portal will assign an arbitrator if one has not been agreed to by the parties.
- **Day 51:** Deadline for arbitrator's decision.



F. Mediation Implementation Data

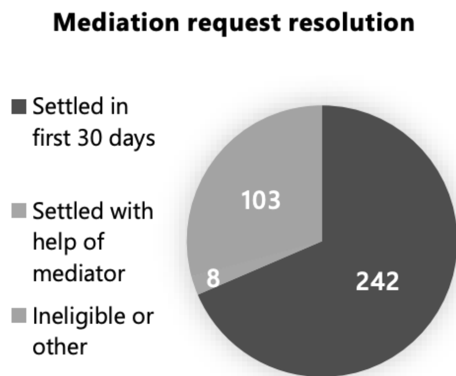
SB 1264 outlines a mediation process for billing disputes between out-of-network facilities and health plans.[132] At the time of the preliminary report, TDI had received far fewer requests for mediation than for arbitration.[133] The reasons for the difference are unclear. However, unlike arbitration, there is no deadline under the law to submit a mediation request.[134]

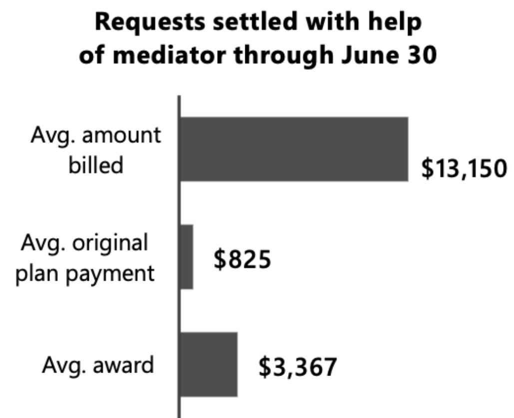


Mediation Timeline[135]

- **Request:** A request can be made any time 20 days after the date the out-of-network facility receives the first claim payment.
- **First 30 days:** Once the request has been submitted, there is a 30-day informal settlement period. During this time, the facility and health plan can reach a settlement or select a mediator. This period can be extended by mutual agreement of the parties.

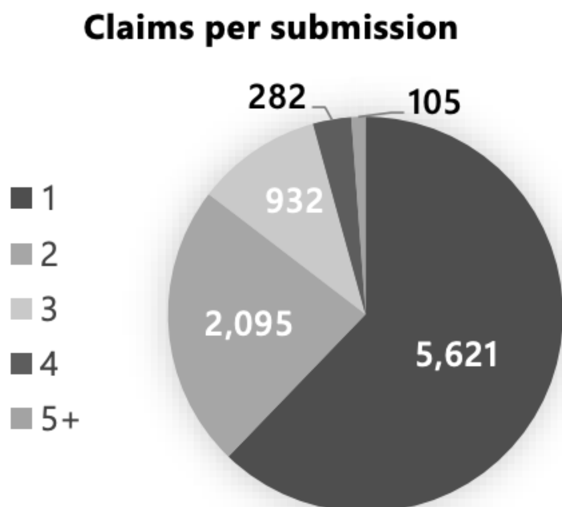
- **Day 31:** The TDI portal will assign a mediator if one has not been agreed to by the parties.
- **Day 180:** Deadline for mediation to have taken place.





G. Bundled Requests

SB 1264 allows providers to include multiple claims on a single arbitration request, as long as the total amount in dispute is $5,000 or less and involves a single provider.[136] TDI rules allow parties to a mediation to combine claims, regardless of the amount, for a single facility into one request. For the first six months of 2020, 38% of requests have involved multiple claims.[137]



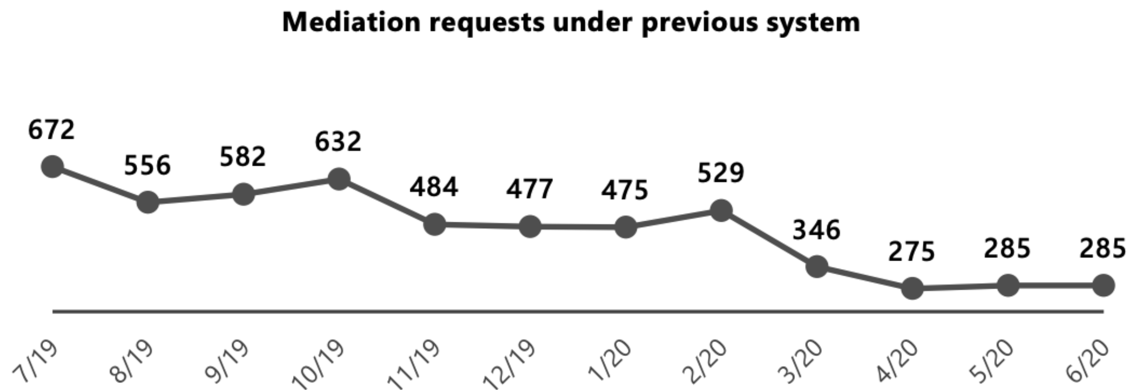
H. Arbitrator and Mediator Fees

SB 1264 does not limit the fees charged by mediators or arbitrators.[138] Instead, arbitrators and mediators set their own fixed fees per case. There is no fee to submit a request for dispute resolution or take part in informal settlement discussions. Each party pays half the fee once TDI assigns the case to a mediator or arbitrator. The parties also may strike up to two mediators or arbitrators from the list of five options provided after a request is submitted.

Fees	Mediation	Arbitration
Median fee	$750	$1,000
Lowest fee	$80	$270
Highest fee	$3,000	$3,200
Total fees paid	$122,983	$1,967,585

I. Requests Processed Under the Pre-SB 1264 System

For services provided before January 1, 2020, consumers could seek alternative dispute resolution (only in the form of mediation) for certain balance bills over $500.[139] TDI is continuing to process mediation requests received through this system.[140]



II. Fiscal Impact on ERS

During the first half of Plan Year 2020 (9/1/19 – 2/29/2020), while the combined medical and pharmacy plan trend was slightly lower than the original projected trend, ERS observed that it was well within the normal year-to-year variance range.[141] Beginning in March 2020; however, with the impact of the COVID-19 pandemic, medical utilization dropped sharply, and lower medical utilization is expected to continue through the remainder of the year.[142] With lower plan utilization, fewer services were impacted by the policies in SB 1264.[143] It is unknown whether the pandemic affected a provider's ability and/or desire to make use of the arbitration process.[144]

As of July 31, 2020, HealthSelect of Texas received 1192 arbitration requests.[145]

- 494 are listed as complete resulting in a total of $256,859 in additional payments to providers.[146]
    - 488 arbitrations, 297 in favor of the provider
    - 6 successful negotiations
- 267 are listed as open resulting in a total of $141,359 in additional payments to providers.[147]
    - 125 arbitrations, 73 in favor of the provider
    - 142 successful negotiations
- 431 are listed as outstanding with no listed resolution.[148]
    - The difference between the billed and allowed amount for these outstanding claims is $930,646.

Of the 1,192 requested arbitrations, the vast majority (1,175) are from ER physicians, the other 17 are from anesthesiologists, nurse anesthetists, surgical assistants, and surgeons.[149]

With SB 1264 preventing emergency room providers from balance billing patients, ERS identified an opportunity to modify its reimbursement strategy for out-of-network emergency room (ER) services as a cost savings initiative.[150] Effective January 1, 2020, rather than reimbursing at billed charges for out-of-network ER services, ERS began reimbursing based on the BCBSTX PPO network rate in the applicable region.[151] While this is a slightly higher reimbursement than HealthSelect of Texas network rates, it is less than billed charges.[152]

At this time, the plan savings attributed to the modified ER physician reimbursement policy are greater than the additional costs to the plan due to arbitration results.[153] Should the use of arbitration increase by non-ER physicians, there could be a negative impact on plan costs and network.[154] Additionally, plan cost impact has been less than anticipated due to the smaller number of received arbitration requests.[155]

ERS points out that this is still a new process and providers are dealing with a drastically changed world and health care system in 2020.[156] Therefore, experience could change as providers familiarize themselves with the arbitration system and as health care trends return to normal, pre-pandemic levels.[157] ERS will continue to monitor and provide updates should the experience change.

III. Fiscal Impact on TRS

TRS-ActiveCare provides health coverage for more than 440,000 active employees and their families, and it funds that coverage through a self-funded health plan model.[158] The premiums paid by public school employees are combined with district funds (a minimum of $150 per employee per month) and state funds ($75 per employee per month) into a fund that makes up TRS-ActiveCare.[159]

TRS-Care provides health care coverage for more than 230,000 retired educators and their families and is funded on a pay-as-you-go basis.[160] TRS-Care is funded by a percentage of

payroll, with 1.25% contributed by the state, 0.75% contributed by the employer, and 0.65% contributed by active employees.[161] Retirees contribute a premium that varies based on Medicare status and number of dependents.[162]

Senate Bill 1264 prevents an out-of-network emergency care, facility-based provider, out-of-network laboratory service, or an out-of-network diagnostic imaging service from balance billing patients in TRS-ActiveCare and TRS-Care.[163] The bill requires mediation for participants in TRS health care programs for disputed out-of-network facility claims.[164] For out-of-network physicians' charges, TRS and the physician will either settle claims in an informal teleconference or in arbitration.[165] During the 86th Legislative Session, TRS estimated that the bill would have a significant impact on TRS health plan costs; however, important factors have played a role in mitigating the cost impact of the new law on TRS' self-funded health plans:[166]

- The reduction in elective procedures due to the COVID-19 pandemic has meant that there are fewer health care services being performed since the law took effect that may have been eligible for arbitration or mediation. Providers may have also not been able to file requests during the early phases of the pandemic as they dealt with other challenges and were learning about the arbitration and mediation processes. Similar to what the Texas Department of Insurance described in their statewide report,[167] the volume of requests started increasing substantially in the summer of 2020. As of mid-April, there were 16 total requests for TRS-ActiveCare and TRS-Care Standard. By August, there were 282.
- TRS underwent a competitive procurement and selected new health plan administrators for its self-funded TRS-ActiveCare and TRS-Care plans. The new administrators have additional contracted providers in network, which is expected to result in a lower number of requests for arbitration or mediation from out-of-network providers going forward.

As of August 2020, TRS has experienced a lower-than-expected volume of requests for arbitration and mediation than initially projected, but the cost per settlement is higher than projected.[168]

For TRS-ActiveCare Plans:[169]

- TRS has resolved 167 cases and paid out a total of $110,000 in additional payments to providers.
- While the case volume remains low, on average, per case payments are higher than previously estimated by TRS.
- There are currently 85 cases pending with a total disputed amount of $490,000.

For TRS-Care Standard:[170]

- TRS has resolved 17 cases and paid out $28,000.
- Case volume for TRS-Care also remains low, but similar to TRS-ActiveCare, average payments are higher than previously estimated by TRS.
- There are currently 13 cases pending with a total disputed amount of $31,000.

For TRS-Care Medicare Advantage:[171]

- TRS has not received any cases.

Medicare members were already protected from balance billing.[172] Providers treating Medicare members are generally required to accept payment in full as a condition of participating in Medicare and therefore cannot balance bill.[173] While a small number of "non-participating" providers can bill an additional 15%, Medicare members are not exposed to catastrophic balance billing.[174]

Medicare Advantage plans are regulated by the federal government.[175] States set rules on the financial solvency of the insurers and basic licensing requirements, but otherwise federal laws preempt state law when it comes to the regulation of Medicare Advantage.[176] As such, Senate Bill 1264 is not applicable to Medicare advantage plans.[177] TDI has communicated this on their website and in rulemaking.[178]

TRS estimated that the majority of the cost impact due to the law would result from arbitration; based on the lower-than-expected number of cases, that does appear to be the case.[179] Arbitration accounts for 75% of cases for TRS-ActiveCare and 93% of cases for TRS-Care.[180]

TRS is monitoring whether the transition to a new administrator with more extensive contract arrangements will reduce the projected cost impact of the new law and is evaluating the effect of COVID-19 on the utilization of health care services that would be eligible for arbitration and mediation.[181]

Recommendations

- The Legislature should consider expanding the prohibition on balance billing patients to include ambulatory services. Throughout the COVID-19 pandemic, several patients have reported receiving substantial surprise medical bills from ambulance services.[182] By expanding the prohibition to include ambulatory services, the Legislature would be building on the consumer-oriented progress made by SB 1264 by ensuring that surprise medical billing protections are comprehensive of all costs associated with emergency care.
- The Legislature should consider offering a clarification to the "prudent layperson" standard to require health plans to determine whether patients qualify for emergency care based on their presenting symptoms, not their ultimate diagnoses. SB 1264 was intended to remove patients from payment disputes and this goal would be furthered by ensuring patients are held harmless when they're experiencing symptoms that lead to emergency care.
- The Legislature should consider providing the TDI Commissioner with the authority to set a maximum arbitrator fee by rule. Early data provided by TDI indicates that there is wide variation in the fees set by arbitrators so far. By providing the Commissioner with the ability to authorize a maximum fee, the Legislature could ensure predictability and affordability in the arbitration process.
- The Legislature should work to improve data collection to ensure TDI can better monitor the impact of arbitration and billed charges as a part of arbitration to determine the whole impact on healthcare spending. Additionally, the Legislature should work with TDI to include data about how allowing a revised bill and revised insurance reimbursement might be impacting arbitration decisions.

SB 1852

Background

Short-term limited duration (STLD) health plans have become more common in Texas in recent years, however, there are growing concerns that these plans are being marketed to consumers as substitutes for more traditional, comprehensive health insurance. These plans also traditionally lack many of the standard consumer protections and coverage requirements provided by traditional plans.

One particular issue of note is that many of these plans often have blanket exclusions for consumers with pre-existing conditions. This is concerning given the strategies employed to market and sell these plans, which is often done by telemarketers that refer to buzzwords like Healthcare.gov or Obamacare to imply that their plan is compliant with consumer protections set by the Affordable Care Act. Due to this, consumers are often purchasing these plans without knowing that there are actually key exclusions that preclude them from coverage. They also often do not realize that there are significant coverage limitations offered by these plans.

While the premiums for these plans are typically low, the limited benefits and broad exclusions can expose patients to extremely high costs in the event of a need for emergency care or a new diagnosis. Additionally, these plans have an impact on the rest of the health insurance market in Texas. By siphoning off healthy people that are typically attempting to minimize their health insurance costs, these plans actually serve to destabilize the market and can drive up premiums for those seeking comprehensive coverage.

As a result of many of these concerns, SB 1852 was passed during the 86th Texas Legislature to ensure that consumers are provided with proper disclosures when purchasing these plans.[183] The legislation authorized the TDI Commissioner to develop a disclosure form to be provided with these policies and their related applications.[184] It also requires these plans to obtain a signed form from the insured acknowledging receipt of the disclosure form authorized by the Commissioner.[185]

I. Actions Taken by TDI to Implement SB 1852

A. Adoption of Rules Required by SB 1852 for STLD Health Plans

TDI adopted rules for a plain language disclosure for STLD health plans in December 2019 as required by SB 1852.[186] The agency also issued a bulletin to encourage plans to include similar disclosure information during 2019 open enrollment even though SB 1852 did not apply to plans until January 1, 2020.[187]

TDI does not track issuers marketing STLD plans.[188] However, TDI has received SB 1852 disclosure form filings from 12 issuers; nine have been reviewed and approved, three remain pending.[189] In reviewing each form filing, TDI checks whether the underlying policy complies with the disclosure law.[190]

B. Disclosures

SB 1852 requires a specific consumer disclosure form for STLD plans.[191] Other alternative plans issued directly to individuals must provide an outline of coverage, consistent with Sections 1201.107 and 1201.108 of the Texas Insurance Code.[192]

Associations issuing plans are not required to provide an outline of coverage or other disclosure document.[193] People insured through such plans must receive a certificate under Section 1251.201 of the code.[194] The certificate must identify the person to whom benefits are payable and summarize the coverage and specify annual deductibles, annual and lifetime policy limits, and maximum out-of-pocket expenses.[195]

C. Other Alternative Plans

The types of alternative plans or products marketed in Texas include:[196]

- Short-term limited duration (STLD)
- Accident-only (including accidental death and dismemberment)
- Specified disease (sometimes called critical illness)
- Hospital indemnity or other fixed indemnity

1. TDI Oversight of Alternative Plans

Alternative plans issued to individual policyholders must file rates with TDI, consistent with Section 1701.057(c) of the Texas Insurance Code.[197] These plans also must file policy forms with TDI, but they can file as exempt from TDI review if a company certifies that its forms comply with the appropriate TDI checklist.[198] TDI audits a sample of exempt filings. If a filing fails audit, the issuer must submit corrections and issue amendments to achieve compliance.[199]

2. Data Related to Alternative Plans

Nationally, there is limited information about the number of people who purchase alternative health products.[200]

The NAIC Accident and Health Policy Experience Report provides national data on premium volume, loss ratio, and covered lives.[201] It separately delves into short-term medical, accident only or AD&D, specified/named disease, and other medical (non- comprehensive) plans, which includes hospital indemnity.[202] The NAIC report presents information on group versus individual coverages differently.[203] That makes it difficult to estimate the number of covered lives by each product type.

3. Alternative Plan Complaints

TDI received 159 complaints about alternative health plans in calendar year 2019 and 192 complaints in 2018 – representing just more than 1% of the complaints related to the life and

health policies over those two years.[204] More detailed data about these complaints is in the accompanying "Part 6 - Alternative health plan complaints" spreadsheet.[205]

In general, state law requires TDI to code complaints as confirmed or not confirmed. A confirmed complaint is:[206]

- An apparent violation of a policy provision, contract provision, rule, or statute.
- A valid concern that a prudent layperson would regard as a practice or service that is below customary business or medical practice.

TDI does not compile a complaint index by company for alternative plans.[207] The TDI complaint index for insurance companies includes all products that the company sells, both the company's traditional health plans and any alternative products.[208]

4. State Network Adequacy Requirements and Surprise Billing Protections

Network adequacy requirements and surprise billing protections are based on Chapter 1301 of the insurance code related to preferred provider benefit plans and inclusive of exclusive provider benefit plans.[209] These requirements apply to plans that cover "medical or surgical expenses incurred as a result of an accident or sickness," and provide different levels of benefits for in-network vs. out-of-network care.

Few, if any, alternative plans are structured in a way that would make network adequacy requirements and balance billing protections under Chapter 1301 apply.[210]

Most alternative plans exclude coverage for preexisting conditions, regardless of whether underwriting occurred on an individual basis at the time coverage was issued.[211] Some alternative plans provide medical expense benefits. But they are based on a traditional indemnity structure, subject to a reimbursement methodology and a maximum amount regardless of the medical provider.[212]

Some alternative plans are marketed as a substitute for more expensive major medical plans.[213] These plans often include a provider network that functions as a discount plan alongside fixed indemnity benefits.[214]

To draw a clear line between major medical coverage and alternative health plans, TDI does not permit alternative benefit plans to combine different types of coverage under a single policy if that combination includes benefits based on expenses incurred and coverage for both accident and sickness.[215] That combination of factors disqualifies a plan from treatment as an "excepted benefit" (exempt from federal ACA requirements) and subject to review as major medical coverage, subject to all applicable state-mandated benefits and guaranteed renewability requirements.[216]

5. Mental Health Parity

Neither accident-only, specified disease, nor fixed indemnity plans are subject to parity requirements.[217] A STLD plan is subject to parity requirements if it covers mental health or substance abuse disorder (MH/SUD). But individual STLD plans may choose to exclude coverage for MH/SUD—avoiding parity requirements.[218]

Association STLD plans are subject to mandates to cover serious mental illness under Section 1355.004 of the insurance code; autism under Section 1355.015; and chemical dependency under Section 1368.004. If an association purchases a "consumer choice" plan authorized under Chapter 1507 of the insurance code, the plan could elect to exclude coverage for autism and chemical dependency.[219]

6. Prompt Pay Laws

Alternative plans issued to individual policyholders must pay "immediately on receipt of due written proof of loss" under Section 1201.214 of the Insurance Code.[220]

Alternative plans issued to associations must pay "not later than the 60th day after the date the proof of loss is received," as stated in Section 1251.113 of the Insurance Code.

Requirements under Insurance Code Chapter 542, related processing and settlement of claims also apply to the extent that they provide greater protections than other requirements.

Prompt pay requirements and associated penalties under Chapter 1301 do not generally apply to alternative benefit plans.[221]

7. Health Care Discount and Health Care Sharing Ministries Products

Health care discount and health care sharing ministry products are not considered insurance.[222] TDI generally classifies consumer calls about them as inquiries.[223] In fiscal year 2019, TDI received 22 consumer inquiries about health care discount products and 14 consumer inquiries about heath care sharing ministries.[224]

A health care sharing ministry that meets state requirements presented in Chapter 1681 of the Texas Insurance Code is not considered insurance and is not subject to regulation by TDI.[225] But a sharing program that does not meet the statutory requirements may be considered unauthorized insurance.[226]

Discount health care programs are likewise not classified as insurance though they are required under Chapter 7001 of the code to register with TDI, which regulates the programs.[227] A program that is inappropriately marketed or otherwise violates legal requirements is subject to TDI enforcement.[228]

8. Total Number of Complaints about Alternative Health Plans

Total number of complaints about alternative health plans

CY 2020 data is through August 20, 2020

	CY 2018	CY 2019	CY 2020	TOTAL
Complaints received	192	159	117	468
Number confirmed	16	14	20	50
Number not confirmed	176	145	97	418

Breakdown by major types of plans
Hospital indemnity plans

	CY 2018	CY 2019	CY 2020	TOTAL
Complaints received	56	44	23	123
Number confirmed	4	3	3	10
Number not confirmed	52	41	20	113

Short-term limited duration plans

	CY 2018	CY 2019	CY 2020	TOTAL
Complaints received	83	62	58	203
Number confirmed	6	9	11	26
Number not confirmed	77	53	47	177

Specified disease plans

	CY 2018	CY 2019	CY 2020	TOTAL
Complaints received	66	63	45	174
Number confirmed	8	2	8	18
Number not confirmed	58	61	37	156

Complaints about alternative plans by company	TOTAL
GOLDEN RULE INSURANCE COMPANY	51
FREEDOM LIFE INSURANCE COMPANY OF AMERICA	37
NATIONAL HEALTH INSURANCE COMPANY	32
LIFESHIELD NATIONAL INSURANCE CO.	30
SOUTHWEST SERVICE LIFE INSURANCE COMPANY	20
AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS	19
PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY	16
FEDERAL INSURANCE COMPANY	15
TRANSAMERICA LIFE INSURANCE COMPANY	14
AMERICAN FINANCIAL SECURITY LIFE INSURANCE COMPANY	13
INTERNATIONAL BENEFITS ADMINISTRATORS, LLC	10
UNITEDHEALTHCARE INSURANCE COMPANY	9
METROPOLITAN LIFE INSURANCE COMPANY	9
WASHINGTON NATIONAL INSURANCE COMPANY	8
NATIONAL TEACHERS ASSOCIATES LIFE INSURANCE COMPANY	7
MUTUAL OF OMAHA INSURANCE COMPANY	7
MANHATTANLIFE ASSURANCE COMPANY OF AMERICA	7
AXIS INSURANCE COMPANY	7
WILCO LIFE INSURANCE COMPANY	6
LIFE INSURANCE COMPANY OF NORTH AMERICA	5
CONTINENTAL AMERICAN INSURANCE COMPANY	5
COMBINED INSURANCE COMPANY OF AMERICA	5
UNITED AMERICAN INSURANCE COMPANY	4
UNIFIED LIFE INSURANCE COMPANY	4
TRANSAMERICA PREMIER LIFE INSURANCE COMPANY	4
AMERICAN HERITAGE LIFE INSURANCE COMPANY	4
AGENTRA, LLC	4
UNUM LIFE INSURANCE COMPANY OF AMERICA	3
RESERVE NATIONAL INSURANCE COMPANY	3
MERITAIN HEALTH, INC.	3
MANHATTAN LIFE INSURANCE COMPANY, THE	3
LINCOLN NATIONAL LIFE INSURANCE COMPANY, THE	3
JACKSON NATIONAL LIFE INSURANCE COMPANY	3
INDEPENDENCE AMERICAN INSURANCE COMPANY	3
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY	3
EVEREST REINSURANCE COMPANY	3
CONTINENTAL GENERAL INSURANCE COMPANY	3
COMPANION LIFE INSURANCE COMPANY	3
CHESAPEAKE LIFE INSURANCE COMPANY, THE	3
BLUE CROSS AND BLUE SHIELD OF TEXAS, A DIVISION OF HEALTH CARE SERVICE CORPORATION	3
STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK	2
STANDARD LIFE AND CASUALTY INSURANCE COMPANY	2
STANDARD LIFE AND ACCIDENT INSURANCE COMPANY	2
SECURIAN LIFE INSURANCE COMPANY	2
RELIABLE LIFE INSURANCE COMPANY, THE	2
PRUDENTIAL INSURANCE COMPANY OF AMERICA, THE	2
PREMIER HEALTH SOLUTIONS, LLC	2
NEW YORK LIFE INSURANCE COMPANY	2
NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.	2
NATIONAL FOUNDATION LIFE INSURANCE COMPANY	2
NATIONAL FAMILY CARE LIFE INSURANCE COMPANY	2
NASSAU LIFE INSURANCE COMPANY OF TEXAS	2
LOYAL AMERICAN LIFE INSURANCE COMPANY	2

Complaints about alternative plans by company	TOTAL
LIBERTY NATIONAL LIFE INSURANCE COMPANY	2
INTERNATIONAL MEDICAL ADMINISTRATORS, INC.	2
GUARANTEE TRUST LIFE INSURANCE COMPANY	2
FIDELITY SECURITY LIFE INSURANCE COMPANY	2
FAMILY HERITAGE LIFE INSURANCE COMPANY OF AMERICA	2
EBIX HEALTH ADMINISTRATION EXCHANGE, INC.	2
COLONIAL LIFE AND ACCIDENT INSURANCE COMPANY	2
BOSTON MUTUAL LIFE INSURANCE COMPANY	2
BANKERS LIFE AND CASUALTY COMPANY	2
AMERICAN WORKERS INSURANCE SERVICES, INC.	2
ALLIED NATIONAL, INC.	2
ADMINISTRATIVE CONCEPTS, INC.	2
WESTERN AND SOUTHERN LIFE INSURANCE COMPANY, THE	1
UNITED OF OMAHA LIFE INSURANCE COMPANY	1
UNDERWRITERS AT LLOYD'S, LONDON	1
TIME INSURANCE COMPANY II	1
THE THORNTON INSURANCE AGENCY, LLC	1
THE BOON GROUP, INC	1
STATE MUTUAL INSURANCE COMPANY	1
SEVEN CORNERS, INC.	1
RELIASTAR LIFE INSURANCE COMPANY	1
REGAL LIFE OF AMERICA INSURANCE COMPANY	1
PROTECTIVE LIFE INSURANCE COMPANY	1
PROFESSIONAL INSURANCE COMPANY	1
PENNSYLVANIA LIFE INSURANCE COMPANY	1
NEO INSURANCE SOLUTIONS	1
NATIONWIDE LIFE INSURANCE COMPANY	1
NATIONAL GENERAL INSURANCE COMPANY	1
MINNESOTA LIFE INSURANCE COMPANY	1
MADISON NATIONAL LIFE INSURANCE COMPANY, INC.	1
INSURANCETPA.COM, INC.	1
HUMANA INSURANCE COMPANY	1
HEALTH PLAN INTERMEDIARIES HOLDINGS, LLC	1
HARTFORD ACCIDENT AND INDEMNITY COMPANY	1
GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, THE	1
GLOBE LIFE AND ACCIDENT INSURANCE COMPANY	1
GENWORTH LIFE INSURANCE COMPANY	1
FIRST CONTINENTAL LIFE & ACCIDENT INSURANCE COMPANY	1
EVEREST NATIONAL INSURANCE COMPANY	1
DIRECT RESPONSE INSURANCE ADMINISTRATIVE SERVICES, INC.	1
DEARBORN LIFE INSURANCE COMPANY	1
CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE	1
CONSTITUTION LIFE INSURANCE COMPANY	1
CONSECO LIFE INSURANCE COMPANY OF TEXAS	1
CIGNA HEALTHCARE OF TEXAS, INC.	1
CIGNA HEALTH AND LIFE INSURANCE COMPANY	1
BAY BRIDGE ADMINISTRATORS, LLC	1
AMERICAN PUBLIC LIFE INSURANCE COMPANY	1
AMERICAN INCOME LIFE INSURANCE COMPANY	1
AMERICAN HEALTH AND LIFE INSURANCE COMPANY	1
AMERICAN FIDELITY ASSURANCE COMPANY	1
ADROIT HEALTH GROUP LLC	1
AAA LIFE INSURANCE COMPANY	1

D. Consumer Support Tools

TDI developed a useful page on their website to serve as a resource for consumers that may be considering alternative health plans.[229] Additionally, the Department has developed a useful health plan shopping guide that can assist consumers in their health insurance purchasing decisions.[230] The shopping guide is reproduced below:

TDI

Health plan shopping guide

Use these tips to shop smart for health coverage.

If you're looking for low cost health insurance, make sure you know what you're buying. There are many options today. Some may have fewer benefits and more limits than traditional health insurance.

Here's a list of questions you should ask before you decide on health coverage:

Regulation

- ☐ Is this insurance? Or is it a discount card, health sharing ministry, or other non-insurance product?
- ☐ How long does this plan last? Do I have the right to renew it if I want to? Or can the plan deny me at renewal?
- ☐ Who regulates this plan or product? (Is it the state, federal government, no one?) Who would I complain to if I have a problem?

Coverages

- ☐ Does the plan cover existing health conditions, like diabetes and high blood pressure?
- ☐ Is emergency care covered?
- ☐ Are hospital stays covered? Is there a limit to the number of days?
- ☐ What does the plan NOT cover, like pregnancy or mental health?
- ☐ Do I get drug coverage with this plan? If so, are brand name drugs covered or only generics? Does it cover the drugs I take?
- ☐ Does the plan limit how many times I can see a doctor?
- ☐ Is lab work covered?
- ☐ Is there a waiting period before I can start using this plan?

Costs

- ☐ Can I get a Marketplace subsidy (www.healthcare.gov) to help pay for this plan?
- ☐ Is there a limit to how much I may have to pay out-of-pocket for covered medical care?
- ☐ How much is the deductible? (That's the amount you will have to pay before the health plan pays.)
- ☐ What are the copays? (These are fixed amounts you will pay for certain services. For example, an emergency room visit may have a $200 copay.)
- ☐ Will I pay coinsurance (a percentage of the costs) for certain services?
- ☐ Does the plan pay my medical providers? Or does it pay me, and I pay the medical bills?

Doctors

- ☐ Do I have to use doctors, hospitals, and urgent care centers in your network or can I use any that I want?
- ☐ Do I have to ask the plan before I can see a specialist?
- ☐ Can you check to see if my current doctor is in network with this plan?

Avoid scams

Here are some warning signs that you might want to move on to another company.

- The agent or salesperson cannot answer basic questions about the plan, such as those on our shopping checklist.
- You feel pressured to decide right away. There are no limited time offers in health insurance. No one can promise you a special deal.
- A price that is much lower than other companies you've checked with probably means the plan has fewer benefits and more limits.
- You get a call or email from a company or person you didn't contact first.

Need more help?

Call our Help Line at 1-800-252-3439 to see if a company is licensed, check their complaint history, or ask questions.

Resources

Healthcare.gov (www.healthcare.gov): You can shop for insurance on the federal marketplace during open enrollment from November 1 to December 15 each year. You might also qualify for a special enrollment period.

Texas Health Options (www.texashealthoptions.com): Compare health plans, benefits, and networks. Learn more about using your health plan.

Recommendations

- The Legislature should expand the strong, up-front consumer disclosure requirements from SB 1852 to all alternative health plans marketed to individuals in Texas. As evident by the data provided by TDI, alternative health plans are becoming more common in Texas. The Legislature should ensure that consumers have proper disclosure associated with the policies they purchase so that they are not surprised by uncommon exclusions or ambiguous policy terms.
- The Legislature should provide TDI and other relevant agencies with sufficient authority to collect necessary data from alternative health plans moving forward. Additionally, the Legislature should consider providing these agencies with additional enforcement authority to protect consumers from the many of the questionable practices currently occurring in the marketing of these alternative plans.
- The Legislature should continue to study ways to ensure alternative health plans are also subject to strong consumer protections such as the prohibition on surprise medical billing, mental health parity requirements, network adequacy standards, and prompt pay requirements.

SB 1940

Background

In light of pending litigation related to the Affordable Care Act, SB 1940 provides the TDI Commissioner with the authority to revise and administer the temporary health insurance risk pool to the extent that federal funds are available.[231] Although the original risk pool was dissolved in response to changes in federal law, this temporary risk pool would serve as a necessary safety net for the most vulnerable Texans.

In order to do so, SB 1940 would provide the Commissioner with the authority to establish this temporary risk pool to guarantee quality individual health insurance coverage to individuals with preexisting conditions.[232] The temporary risk pool would be substantially similar to the risk pool previously authorized by the Legislature.

If the Commissioner chose to adopt such a rule to provide for the temporary risk pool, the rule would remain in effect until 30 days following the end of the next regular session of the Legislature unless a law is enacted that authorizes coverage to be issued by the temporary risk pool and provides for funding for coverage under the temporary risk pool.[233] Thus, the temporary risk pool would provide the Legislature with ample time to be able to act on their own to address the issue if it does present itself.

I. Actions Taken by TDI to Implement SB 1940

In 2018, the U.S. Department of Health and Human Services and the U.S. Department of the Treasury revised the federal guidance on Section 1332 waivers.[234] In response to the new guidance, TDI has issued a request for proposal (RFP) for an actuarial analysis as authorized by Insurance Code 1510.002.[235] The actuarial analysis will examine the costs and options for three possible 1332 waiver strategies:[236]

- A reinsurance program to cover a portion of claim costs above an attachment point for each insured individual.
- A high-risk pool, in which high-risk individuals are rated separately and possibly offered different plans from healthy individuals, and waiver funds cover a portion of claim costs for the high-risk pool.
- An invisible high-risk pool, in which high-risk individuals are offered the same plans and rated the same as healthy individuals, and waiver funds cover a portion of claim costs for high-risk individuals.

The actuarial analysis will enable TDI, state leadership, and stakeholders to evaluate the potential effects of a waiver on:[237]

- Overall enrollment in the individual market.
- Enrollment by county and on/off exchange.
- Enrollment by age and health status.

- Average premium by rating area and on/off exchange.
- Estimated federal pass-through funding.
- Estimated cost to the state.

II. Possible Options to Reduce the Uninsured Rate

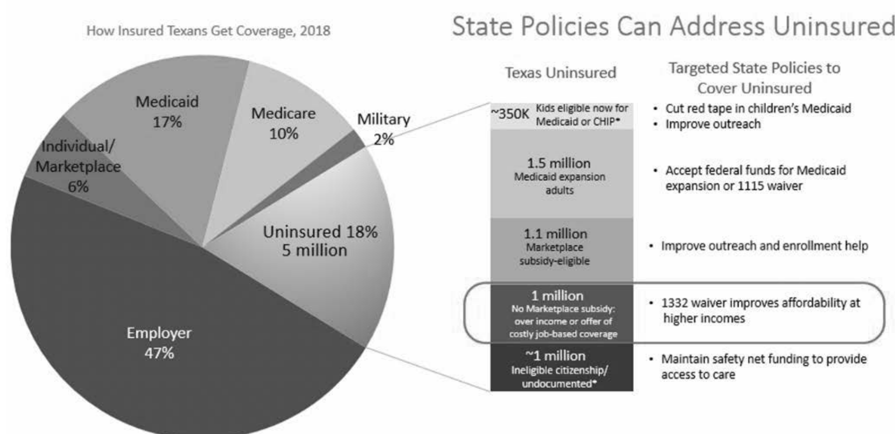
A. 1332 Waivers

Every Texan provided testimony to the Committee regarding options Texas should consider in pursuing a 1332 waiver.[238] Every Texan believes that if Texas pursues a 1332 waiver, as is authorized temporarily in SB 1940, it should do so with the aim of covering more Texans with quality, affordable health insurance and only as part of a comprehensive state approach to significantly reduce the state's high uninsured rate.[239] They believe a 1332 waiver alone will be insufficient to address Texas' substantial uninsured challenge.[240]

Texas has the highest uninsured rate in the nation and it's getting worse. Even before staggering job losses due to COVID-19, 5 million Texans (18%) were uninsured.[241] In just March and April, 1.6 million Texans lost job-based health insurance because of COVID-related job losses.[242] Only half of Texans who lose job-based health insurance during the pandemic will find other coverage; the other half will become uninsured.[243]

The vast majority of uninsured Texans are U.S. citizens; have low or moderate incomes; and work or are in a family with a worker, but are not offered or cannot afford health insurance with a low-wage job.[244] Texas policymakers can use a range of available tools to lower Texas' high uninsured rate and reduce the burden it places on families, communities, and our health care system (see Figure 1 below).[245]

Figure 1: Targeted state policy options to reduce Texas' uninsured rate



Data on Texas coverage sources from U.S. Census Bureau, 2018 American Community Survey. Eligibility status among uninsured are estimates by Every Texan using the following data sources: Urban Instituted, Improvements in Uninsurance and Medicaid/CHIP Participation among Children and Parents Stalled in 2017, May 2019; Kaiser Family Foundation (KFF), The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid, January 2020; KFF, Distribution of Eligibility for ACA Health Coverage Among those Remaining Uninsured as of 2018; KFF, Distribution of Nonelderly Uninsured Individuals who are Ineligible for Financial Assistance due to Income, Offer of Employer Coverage, or Citizenship Status; US Census Bureau, 2018 American Community Survey; and Migration Policy Institute, Profile of the Unauthorized Population: Texas. *Categories subject to additional uncertainty related to undocumented population. Uninsured population excluded from all programs due to citizenship status could be larger.

1. Medicaid Expansion

In order to reduce the uninsured rate, Every Texan stated that it believes Medicaid expansion must be a part of Texas' approach to do so.[246] Along with any 1332 waiver, they believe Texas must accept federal funding to expand Medicaid coverage to Texas adults below 138% of the federal poverty level, which includes low-wage working parents and adults caring for a disabled family member.[247]

A 1332 waiver cannot extend coverage to working poor adults in the "coverage gap" who are excluded from Texas Medicaid today, but earn too little to get Marketplace subsidies under federal law.[248] Federal funding to cover working poor adults can only be accessed through Medicaid expansion or a Medicaid 1115 waiver.[249] All 14 states with approved 1332 "reinsurance" waivers today have already closed their Medicaid coverage gap, ensuring that uninsured adults in low-wage jobs that do not offer coverage have access to Medicaid.[250]

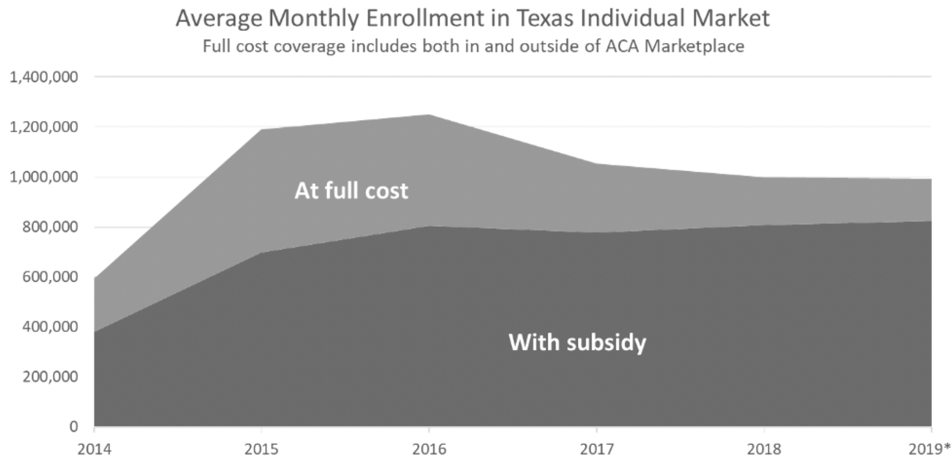
2. Limited Benefits in Premium Reduction from 1332 Reinsurance Waivers

Today, 14 states have federally-approved 1332 waivers that establish a state-administered reinsurance program.[251] Reinsurance programs provide payments to individual-market health insurers that help offset the costs of enrollees with high health care spending. Insurers, in turn, reduce their premiums because they face less risk from high-cost enrollees.[252]

Reinsurance reduces the price of full-cost premiums for people who *do not* qualify for Marketplace subsidies.[253] It does not further reduce premiums for people who have Marketplace

subsidies.[254] This primarily benefits higher-income individuals (with incomes over 400% of the federal poverty level or about $51,000/year for an individual and $105,000/year for a family of four in 2020) and others ineligible for subsidies. Unsubsidized enrollment in the Texas individual market has declined since 2016, while subsidized enrollment has increased (see Figure 2 below).[255]

Figure 2: Texas enrollment in full-cost individual market coverage has declined since 2016, while subsidized enrollment has increased slightly



2014 – 2018 data from CMS, Trends in Subsidized and Unsubsidized Enrollment, August 12, 2019. *2019 data is an estimate from Charles Gaba, ACASignUps.com, August 15, 2019, http://acasignups.net/19/08/15/subsidy-cliff-reckoning-here-six-years-entire-indy-market-one-graph.

1332 reinsurance waivers in other states have reduced full-cost, individual-market premiums by 17% on average.[256] These states generally anticipate a relatively small increase in coverage to result.[257] Most states that have established a 1332 reinsurance program estimate that coverage in the individual insurance market would increase from 1-3% (see Figure 3 below).[258] A recent market analysis estimates that 1.3 million Texans have individual market coverage today.[259] Growth of 1-3% in Texas would translate to an additional 13,000 - 39,000 people covered.[260]

Figure 3: Expected outcomes from approved 1332 reinsurance waivers

State	Targeted premium reduction	Estimated growth in individual market enrollment
Alaska	20%	7.7%
Colorado	16%	2.9%
Delaware	14%	2.3%
Maine	9%	1.1%
Maryland	30%	5.8%
Minnesota	20%	13.0%
Montana	8%	1.0%
New Hampshire	16%	2.4%
New Jersey	15%	2.7%
North Dakota	20%	1.0%
Oregon	8%	1.7%
Pennsylvania	5%	0.5%
Rhode Island	6%	0.9%
Wisconsin	11%	1.0%

Data from applications of states with federally approved 1332 waivers at https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.

Reducing premiums for higher-income individuals to cover tens of thousands of additional Texans is a worthy goal that lawmakers should pursue, but not without also ensuring an affordable coverage option for 1.5 million uninsured, low-income Texans who would be eligible under Medicaid expansion.[261]

3. State Financing of 1332 Reinsurance Waivers

Reinsurance payments come from federal "pass-through" funding available through 1332 waivers, combined with a state share. Among states with 1332 reinsurance programs, the state share of program costs ranges from 3% to 56%, with states financing about one-third of the program's costs, on average.[262]

Most states finance their state share through an assessment on health insurers, though a few states use other methods including General Revenue, provider assessments, and penalties from state-level individual coverage mandates (see Figure 4 below).[263]

Figure 4: Funding for state share of approved 1332 waiver reinsurance programs

State	Source of state funds	State share amount
Alaska	Funded via assessments on all insurers- Health: 6% of premiums net of claims, Title: 1% of gross premiums, Other: 2.7% of gross premiums	$1.5 million in 2018
Colorado	Fee assessed on Colorado hospitals determined annually by state insurance commissioner, General Fund, premium tax revenues, fee on health insurance carriers	$87 million
Delaware	1.00% – 2.75% assessment on issuers premium tax liability	$6.9 million for 2020
Maine	Assessment on health insurers and third-party administrators of $4 PMPM (Individual, Small Group, Large Group, and Self-insured markets); 90% of enrollee premium for ceded members and dependents	$59.6 million in 2019
Maryland	2.75% assessment on Maryland health plans and Medicaid MCOs, based on annual net premiums	$365 million in 2019
Minnesota	Dedicated funding from Health Care Access Fund (financed via 2% provider assessment) and General Fund	$271 million annually
Montana	1.2% assessment on major medical health insurance premiums	$12.4 million in 2020
New Hampshire	Per-member, per-month assessment on health insurers of 0.6% of the prior year's Second Lowest Cost Siler Plan without-waiver rate.	$13.4 million in 2021
New Jersey	Penalties from state individual coverage mandate, general fund	$105.8 million in 2019
North Dakota	Assessment against the small and large group health insurance market	$21.2 million for 2020
Oregon	1.5% assessment on fully insured commercial major medical premiums	$90 million in 2018
Pennsylvania	3% fee on monthly premiums for health and dental products offered on PA Health Insurance Exchange Authority (funds reinsurance and exchange)	$44.2 million in 2021
Rhode Island	Penalties from state individual coverage mandate	$8.3 million in 2020
Wisconsin	State general fund	$34 million in 2019

Source: SHADAC, "State-Based Reinsurance Programs via 1332 State Innovation Waivers," https://www.shadac.org/publications/resource-state-based-reinsurance-programs-1332-state-innovation-waivers, other than Alaska's state share amount, calculated from Alaska's 1332 waiver application and CMS' determination of Alaska pass-through funding for 2018.

4. Keeping What's Working from the Affordable Care Act

The Affordable Care Act (ACA) greatly expanded access to individual market coverage by creating sliding-scale subsidies for people with incomes from 100-400% of the federal poverty level and prohibiting insurers from denying coverage or charging more because of pre-existing conditions.[264] Under the ACA, coverage in the individual market has grown and Texas has seen historic declines in its uninsured rate (though Texas still has the highest uninsured rate and

population).[265]

More than 1 million Texans have enrolled in 2020 Marketplace coverage, and 9-in-10 of them receive a federally funded subsidy to make monthly premiums affordable.[266] In addition, 6-in-10 have plans with reduced out-of-pocket costs, like deductibles and copays, to improve access to care.[267] Maintaining adequate financial assistance is critical to ensure that both health coverage and health care are affordable for Texans with lower incomes.

Today, individual market coverage provides comprehensive benefits and strong protections for people with pre-existing conditions. Plans cover Essential Health Benefits (which includes benefits for maternity, mental health and substance use, prescription drugs, and more) with no annual or lifetime limits, and insurers cannot deny coverage or charge more due to pre-existing conditions.

Every Texan states that any Texas 1332 waiver must immediately result in more Texans getting enrolled in coverage that is as affordable (premiums and out-of-pocket costs), with benefits that are as comprehensive, and with pre-existing condition protections that are as strong as in Texas' ACA-compliant market today.[268] The 14 states with approved reinsurance waivers have achieved this outcome. Should Texas want to build upon reinsurance in a 1332 waiver, it should consider ways to further address affordability challenges, particularly for consumers with low and moderate incomes.[269]

Additionally, HealthCare.gov gives clear, comparable, and unbiased information to consumers on their health plan options and supports enrollment assistance through agents, community-based organizations, community health centers, and hospitals.[270] It also provides a "no-wrong-door" approach that ensures Marketplace applicants who are Medicaid- or CHIP-eligible get the correct coverage. On top of this, the federal Marketplace *already* supports direct enrollment through third-party web-brokers and insurers, so that consumers who want to, can enroll without going to HealthCare.gov.

5. Considerations for a State-Based Marketplace

Other states and advocates are closely watching Pennsylvania, which plans to switch from HealthCare.gov to a state-based marketplace, hopes to operate its marketplace at a lower cost, and intends to use the savings to fund the state's 1332 waiver reinsurance program.[271] Pennsylvania's plan is innovative, but it also presents risks for consumers, as well as costs and challenges to the state. Savings projected at the beginning of a complex and lengthy project could fail to fully materialize. The state is still in the process of building and testing its IT infrastructure and developing consumer assistance functions needed to switch to a state-based marketplace.

Switching to a state-based marketplace is a complex undertaking. Texas should not do it as a means to save money, because the savings may not materialize. It also should not consider such a complicated undertaking if the result would be to merely replicate HealthCare.gov, which works pretty well today.[272] There are, of course, many ways to build upon and improve HealthCare.gov, which could be done by the state or federal government. For changes to benefit

marketplace consumers, regardless of whether they are made at the state or federal level, they should lead to increased comprehensive coverage, streamlined enrollment, an improved user experience, increased outreach and enrollment assistance, improved coordination between Medicaid and the Marketplace, and/or other improved consumer protections.[273] Only if Texas has a clear intention and measurable goals to achieve several of these outcomes, not just cost savings, would a discussion about a state-based marketplace make sense.[274]

Recommendations

- The Legislature should consider a reinsurance program through a 1332 waiver in order to help reduce the cost of health coverage for Texans. Data has indicated that 1332 reinsurance waivers have reduced premiums in other comparable states and would be a positive step in seeking to reduce the uninsured population in Texas.
- The Legislature should strongly consider the benefits that could be achieved by expanding Medicaid in Texas. The COVID-19 pandemic has only exasperated this problem as more and more individuals continue to lose their employer-sponsored health insurance. Due to the growing uninsured rate, Texas should consider this in order to ensure Texans have equitable access to healthcare.
- The Legislature should study the possibility of setting up a state-based exchange. In light of efforts by Pennsylvania to accomplish this in their own state, the Legislature should closely monitor their progress to assess if Texas could experience similar cost-savings and improved coverage outcomes.

INTERIM CHARGE #2

2. Study the adequacy of the state's insurance laws on regulating the introduction of insurtech products into the Texas insurance market. Include in the study the impact of big data, blockchain, internet of things, and artificial intelligence technologies on industry practices such as claims handling, underwriting, and policy writing. Study whether these technologies present challenges for any of the state's insurance laws, including the state's antidiscrimination, data privacy, anti-rebate, and licensing laws and regulations. Additionally, examine the pros and cons of adopting a regulatory sandbox and consider sandbox programs that are implemented in other states.

I. TDI's Assessment of the Adequacy of State's Insurance Laws on Regulating the Introduction of Insurtech Products into the Texas Insurance Market

Texas law does not prohibit the use of big data or artificial intelligence by insurance companies.[275] However, insurers are responsible for the accuracy of all data used in rating, underwriting, and claims handling – even if the data is provided by a third party.

Technological advancements allow insurers access to vast amounts of data that can be used in underwriting and pricing. The appropriate use of big data can be beneficial to consumers.[276] For instance, telematics programs monitor driving and can result in safe driver discounts. Greater access to data also can help insurers improve efficiency and accuracy processing claims, deliver quicker settlements, and result in more accurate loss reserving.[277]

Big data's use also is increasingly the focus of scrutiny over possible discriminatory effects.[278] Data elements that in isolation are not discriminatory could, when combined with other data elements, create a discriminatory impact.[279] If a carrier is using devices or technology to serve insurance customers, there could be discrimination among people of the essentially the same hazard if the issuance of the devices or technology is not uniform and consistent.[280]

State law requires rates to be set following sound actuarial principles. Section 544.052 of the Texas Insurance Code says insurers may not engage in unfair discrimination between individuals of the same class and of essentially the same hazard. Section 544.002 of the code says insurers may not discriminate based on race, color, religion, national origin, age, gender, marital status, geographic location, disability, or partial disability. Sections 544.003 and 544.053 allow for exceptions.[281]

A. Blockchain

Blockchain is a ledger technology allowing the making of transactional records verifiable and permanent.[282] It uses a decentralized network to maintain a continuously growing chain of data records, which are secure from tampering and revision. Each block may hold one or more transactions or batches of transactions. Also, each block contains a timestamp and a link to a previous block. This makes it extremely resistant to modification of the data and provides a reliable audit trail. Blockchain can be used to create "smart contracts," or self- executing contracts, in which any decision is executed by a computer algorithm on a blockchain.

In the insurance context, some insurers are using or exploring blockchain to reduce fraud risk, streamline policy administration, and manage claims in a transparent and immutable manner.[283] TDI is participating in a National Association of Insurance Commissioners (NAIC) sponsored pilot project to determine if blockchain is a viable solution to support a faster, more efficient, and flexible method for data collection.[284]

Texas lawmakers in 2019 amended the state's Business & Commerce Code to allow domestically formed entities, including insurance companies and agencies, to store business records using blockchain technology and to transfer ownership of the domestic entity using blockchain technology.[285] Separately, Chapter 35 of the Texas Insurance Code allows insurers to

deliver information by electronic means, but the definition does not mention blockchain technology or contemplate digital transactions. This could impede the full use and potential of blockchain by insurers.

B. Internet of Things

In the context of insurance, the "internet of things" refers to an insurer providing technology to customers to help the insurer rate a policy or mitigate risks.[286] For instance, a telematics device placed in a car can monitor driving habits.

State laws, including the Insurance Code's anti-discrimination statutes, could affect whether insurers expand the internet of things. Anti-rebating laws bar giving things of value to a customer that are not specified in the insurance policy. (Texas Insurance Code sections 541.056, 543.003, 1806.053 - 1806.059, 1806.153, and 4005.053.) State law allows promotional giveaways of incentive or educational items valued at $25 or less—in some cases higher. (Texas Insurance Code sections 1806.059 and 1806.1541)

C. Data Privacy

Texas laws generally govern data privacy. However, no privacy law focuses specifically on insurance.[287] (Business & Commerce Code Chapter 521; Government Code Chapter 2054; Health & Safety Code Chapter 181, 182; Insurance Code Chapters 601, 602)

The NAIC Insurance Data Security Model Law contains provisions for notice to TDI if a data breach occurs and safeguards related to securing insurance data.[288] In October 2017, the U.S. Department of the Treasury recommended that states adopt the model law. Treasury also recommended that Congress impose national standards of implementation of the model law by states does not, within five years, result in uniform data security regulation. As of June 2020, 11 states have adopted versions of the model law. It's not yet clear if revisions by states to the NAIC model law will affect the ability to achieve a uniform national standard.[289]

D. Regulatory Sandbox

A "regulatory sandbox" is intended to promote innovation in insurance when laws and regulations might not keep pace with technological advancements.[290] In 2019, Kentucky's governor signed into law legislation creating a regulatory sandbox in that state through 2025. Under such a law, a state could waive enforcement of rules or laws to allow for technologies or innovations otherwise considered violations of law.[291] Regulatory guardrails would need to be in place to ensure that participants meet licensing and financial requirements and that waivers are issued uniformly and consistently.[292]

E. On-Demand Insurance

There has been interest in the market for commercial "on-demand" insurance, which is typically short term in duration, such as coverage for a few hours or days.[293] For example, on- demand

insurance would allow a business to quickly cover a one-day marketing event with a general liability policy.

In the realm of general liability insurance, Section 551.054 of the Texas Insurance Code requires that an insurer give 60 days' notice of nonrenewal. This implies that policies must be at least 60 days in duration—an impediment to an insurer writing on-demand policies. This statute could be amended to shorten the amount of notice required for general liability insurance, or a statute could explicitly allow limited-terms on-demand coverage for specified lines of commercial coverage.

II. Office of Public Insurance Counsel (OPIC) Response

Insurtech has the potential to make insurance more convenient for consumers.[294] For example, smartphones are ubiquitous and available 24 hours a day for consumers to access apps that let them connect with their insurers to get information, choose or change coverages, file claims, and more.[295] Insurer apps could also improve access to coverage for people who might otherwise be priced out or not think the cost of the coverage they need is worth the benefit.[296] For example, a person who delivers goods or services part time could potentially "swipe on" coverage for business use only when delivering goods or providing livery service, instead of having to pay for business use coverage all the time or risk being uninsured.[297]

As with any new product, however, there are risks.[298] Insurtech is no exception. There are potential legal and consumer protection challenges to consider with new insurtech products and services. In addition to the more apparent issues like privacy concerns, here are a few issues for consideration in the discussion about or development of related legislation.

Insurtech can promote micro-tiering in the development of rates, especially personal auto rates, when companies use individual-specific data gathered electronically from consumers. Insurance depends on pooled risk.[299] If it were merely a disaster savings account for each consumer, insurance would not be terribly useful, especially for disasters, because the amount the consumer paid/saved in premiums would probably not be enough to cover the loss.[300] Instead, insurance depends on a large number of people paying premiums, and only some of those people needing to file claims, often at different points in time.[301] When consumers are broken down into groups so small that they are essentially paying premiums only for their own risk level, the shared risk system may be compromised.[302] This could circumvent many of the rate standards set by the Texas Legislature in Chapter 2251 of the Insurance Code.[303]

Certain features, like swiping on and off for coverage, may also circumvent consumer protections, such as notice of nonrenewal or cancellation in Chapter 551 of the Insurance Code.[304] The potential limitations on the Texas Department of Insurance (TDI) and OPIC review of certain items also removes oversight needed to ensure that unlawful forms of discrimination against consumers do not take place, including those set forth in Chapter 544 of the Insurance Code.[305]

Many of the existing insurance laws potentially conflict with, or do not address, insurtech products and uses.[306] *See below a preliminary list of laws for property and casualty insurance*

that could be affected by insurtech.[307] Depending upon the extent to which the Texas Legislature chooses to allow insurtech as a market option, existing laws will likely need to be revised to resolve conflicts, address new issues, and provide adequate consumers protections for insurtech products.[308] The same holds true for consideration of any regulatory sandbox—preserving consumer safeguards, such as those against discrimination, excessive rates, and disclosure of personal data, should be part of the conversation when considering the benefits of innovation.[309]

OPIC stands ready to serve as a resource on this issue as requested by the Texas Legislature.

Potential Laws Impacted by Insurtech:[310]

- Insurance Code Chapter 551 (Practices Relating to Declination, Cancellation, and Nonrenewal of Insurance Polices), especially Sections 551.054, 551.104, 551.105, 551.106
- Insurance Code Chapter 552 (Illegal Pricing Practices)
- Insurance Code Chapter 542 (Processing and Settlement of Claims)
- Insurance Code Chapter 543 (Prohibited Practices Related to Policy or Certificate of Membership), especially Section 543.003
- Insurance Code Chapter 544 (Prohibited Discrimination)
- Insurance Code Chapter 560 (Prohibited Rates)
- Insurance Code Chapter 601 (Privacy)
- Insurance Code Chapter 602 (Privacy of Health Information)
- Insurance Code Chapter 2251 (Rates)
- Insurance Code Chapter 2301 (Policy Forms)
- Insurance Code Chapter 35 (Electronic Transactions)
- Business and Commerce Code Chapter 322 (Uniform Electronic Transactions Act)
- Business and Commerce Code Chapter 521 (Unauthorized Use of Identifying Information)
- Business and Commerce Code Chapter 522 (Identity Theft by Electronic Device)

Recommendations

- The Legislature should require that online providers selling or servicing insurance policies be licensed insurance agents. While technological innovation is incredibly beneficial, it is important to ensure that consumers have confidence that those selling them insurance policies are appropriately knowledgeable.
- The Legislature should consider adopting the NAIC Insurance Data Security Model Law. Since 11 states have already adopted it, it would be worth studying the model law's progress and efficacy in these states before adopting it in Texas.
- The Legislature should continue to study this issue and work with industry groups and state agencies to ensure that any reforms properly balance the interests of protecting consumers and technological innovation.

INTERIM CHARGE #3

3. Monitor the State Auditor's review of agencies and programs under the Committee's jurisdiction. The Chair shall seek input and periodic briefings on completed audits for the 2019 and 2020 fiscal years and bring forth pertinent issues for full committee consideration.

I. Reports Provided by the State Auditor's Office

Report	Number	Date
A Report on Analysis of Quality Assurance Team Projects	20-010	11/22/2019

Entities included:

- Department of Insurance
- Health and Human Services Commission
- Department of Motor Vehicles
- Texas Workforce Commission
- Department of State Health Services

Report	Number	Date
An Audit Report on Performance Measures at the Office of Public Insurance Counsel	20-009	11/21/2019
A Report on an Audit of Financial Transactions Associated with the Suspension of Operations of the Texas Health Reinsurance System	19-033	02/27/2019

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