

# Texas

Texas Insurance Commission  
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## Summary of Important Regulations

MEWA Regulations .....	Yes
TPA Regulations .....	Yes
Stop-Loss Regulations .....	No
UR Regulations .....	Yes

## NAIC Model Laws and Regulation

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Health Insurance Reserves Model Regulation	28 Tex. Admin. Code §§ 3.7001 to 3.7010	None
Comprehensive Health Ins. Cost Containment Model Act	None	None
Standardized Health Claims Form Model Regulation	None	None
Small Employer Health Insurance Availability Model Law	None	Tex. Ins. Code Ann. art. 26.01 to 26.76
Model Regulation To Eliminate Unfair Sex Discrimination	Tex. Admin. Code §§ 21.401 to 21.409	None
Health Information Privacy Model Law	None	None
Preferred Provider Arrangements Model Law	None	Tex. Admin. Code §§ 3.3701 to 3.3705
Utilization Review Model Law	None	Tex. Ins. Code Ann. art. 21.58A to 21.58C; 28 Tex. Admin. Code §§ 19.1701 to 19.1719; §§ 19.2001 to 19.2021
Managed Care Plan Network Adequacy Model Law	None	None
Third Party Administrator Law	None	Tex. Ins. Code Ann. art. 21.07-6; 28 Tex. Admin. Code §§ 7.1601 to 7.1613
Stop-loss Insurance Model Law Texas	None	None

## NAIC Model Laws and Regulation

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Jurisdiction of Health Care Providers Model Law	None	Tex. Ins. Code Ann. art. 3.51-6B
Standard Group Health Model Law	Tex. Ins. Code Ann. art. 3.51-6	None
Group Health Insurance Mandatory Conversion Law	None	Tex. Ins. Code Ann. art. 3.51-6 § 1 1(a)(3); Tex. Admin. Code §§ 3.501 to 3.520
Group Coverage Discontinuance/ Replacement Model Regulation	Tex. Ins. Code Ann. art. 3.51-6A	None
Premium Rates and Renewability of Coverage-Small Groups	None	Tex. Ins. Code Ann. art. 26.01 to 26.76
Group Coordination of Benefits Model Law	28 Tex. Admin. Code §§ 3.3501 to 3.3511	None
Model Regulation for Certification of Health Plans	None	None
Off-Label Drug Use Model Law	None	Tex. Ins. Code Ann. art. 21.53M
Group Health Mandatory Drug/ Alcohol Dependency Law	Tex. Ins. Code Ann. art. 3.51-9	None
Model Newborn Children's Law	None	Tex. Ins. Code Ann. art. 3.70-2(E); Tex. Admin. Code §§ 3.3401 to 3.3403
Health Examination Benefits Availability Law Texas	None	Tex. Ins. Code Ann. art. 21.53F

## NAIC Model Laws and Regulation

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Accident and Sickness Insurance Minimum Standards Model Law	Tex. Ins. Code Ann. art. 3.70-1	None
Agents and Brokers Licensing Model Law	None	Tex. Ins. Code Ann. art. 21.01 to 21.15-5
MEWA Licensing Model Law	None	None
Managing General Agents Law	28 Tex. Admin. Code §§ 19.1201 to 19.1206	Tex. Ins. Code Ann. art. 21.07-3
Health Maintenance Organization Model Law	Tex. Ins. Code Ann. art. 20A.01 to 20A.35	None
Insurance Information and Privacy Protection Law	None	None
Unfair Trade Practices Law	Tex. Ins. Code Ann. art. 21.21 and 21.21-2; 21.21-6; Tex. Admin. Code § 21.203	None
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basics of Physical or Mental Impairment	Tex. Ins. Code Ann. art. 21.21-3	None
Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basics of Total or Partial Blindness	28 Tex. Admin. Code § 21.702	None

## NAIC Model Laws and Regulation

<u>Name of Model Law/Regulation</u>	<u>Model/Similar</u>	<u>Related</u>
Unfair Discrimination against Subjects of Domestic Abuse in Health Benefit Plans Model Law	None	Tex. Ins. Code Ann. art. 21.21-5
Unfair Claims Settlement Practices Law	Tex. Admin. Regs. § 21.203	Tex. Ins. Code Ann. art. 21.55
Improper Termination Practices Law	None	None
Employee Leasing Registration Model Law	None	Bd. Order 59807
Private Employer Workers' Ann. Compensation Group Self-Insurance Model Law	None	Tex. Labor Code §§ 407.001 to 407.133
Public Employee Workers' Ann. Compensation Group Self-Insurance Model Law	None	Tex. Labor Code §§ 407.001 to 407.133
Twenty Four Hour Coverage Pilot Project Model Law	None	None

## State-Mandates

### **Benefits That Must Be Covered**

- Alcoholism treatment
- Bone mass measurement
- Breast reconstruction
- Childhood immunizations
- Contraceptives (oral only and only if prescription drugs are also covered)
- Diabetic supplies, education
- Drug abuse treatment (group only)
- Emergency services
- Formula for PKU (group only and only if prescription drugs are also covered)
- Hearing screening for children
- Mammography screening
- Mental health, parity (large-employer group only)
- Mental health, serious (group only, mandated offer for small-employer groups)
- Minimum mastectomy stays
- Minimum maternity stays
- Off-label drug use
- Prostate cancer screening
- TMJ disorders
- Well-child care (HMO plans only)

### **Benefits That Must Be Offered**

- Home health care
- Infertility services
- Well-child care

### **Persons Who Must Be Allowed Coverage**

- Adopted children
- Continuation/dependents
- Continuation/employees
- Conversion to non-group
- Dependent students
- Handicapped dependents
- Newborns
- Non-custodial children

### **Providers Who Must Be Covered**

- Chiropractors

- Dentists
- Marriage/Family Therapists
- Occupational Therapists
- Optometrists
- Osteopaths
- Pharmacists
- Physical Therapists
- Podiatrists
- Professional Counselors
- Psychologists
- Social Workers
- Speech/Hearing Therapists

**Coordination of Benefits**

- |                            |     |
|----------------------------|-----|
| • Birthday Rule?           | Yes |
| • Divorced/Separated Rule? | Yes |
| • Joint Custody Rule?      | No  |
| • Active v. Inactive Rule? | Yes |
| • Longer v. Shorter Rule?  | Yes |
| • Managed Care Rule?       | No  |
| • COBRA Rule?              | No  |
| • Preservation Rule?       | Yes |

**Patient's Bill of Rights Legislation**

Yes

**High Risk Health Pool**

Yes – capped at 150-200%

**External Grievance System**

Yes – all health plans

**Basis of Filing Grievances**

Medical Necessity

**Status of Decision of Grievance Panel**

Binding on both parties

**Prompt Payment of Health Claim Requirement**

Yes – 45 days for undisputed claims

**Miscellaneous**

- Outpatient expenses arising from in vitro fertilization procedures, if the policy or plan otherwise provides pregnancy-related benefits.
- An annual screening by low-dose mammography for the presence of an occult breast cancer, on a basis that is not favorable than for other radiological examinations.

- Group health insurance policies providing benefits for the medically necessary diagnostic and/or surgical treatment of temporomandibular (jaw or craniomandibular) joints.
- All policy provisions generally applicable to surgical treatment may apply, including any requirements for precertification of benefits.
- Group accident and health insurance policies delivered or issued for delivery or renewed may not exclude or deny coverage for HIV, AIDS, or HIV-related illnesses.
- If a group policy covers Alzheimer's disease and requires demonstrable proof before authorization benefit payments, a clinical diagnosis of Alzheimer's disease by a physician licensed in the state, including history and physical, neurological, psychological and/or psychiatric evaluations, and laboratory studies satisfies the requirement for demonstrable proof of organic disease or other proof under the coverage.
- Texas requires health plans providing maternity benefits must provide for coverage of at least 48 hours following a normal delivery and 96 hours following caesarean section. For patients discharged prior to the expiration of 48 or 96 hours, timely post-delivery care must be provided.

## MEWA Regulation

Self-Funded MEWA<sup>1</sup>. A self-funded MEWA, which is not exempt from Texas law under ERISA, must comply with the Texas law and with the Texas coverage replacement law, including the 90-day extension of benefits requirement upon termination of the plan.

All self-funded MEWAs in Texas are required to obtain a certificate of authority from the Texas Department of Insurance and meet capital, reserve, underwriting, and financial requirements unless they can certify that the plans are fully insured. All self-funded MEWAs must file notice with the Insurance Commissioner and must file for the certificate. The statute restricts self-funded MEWAs to 5 employers in the same industry with at least 200 employees in the plan or it must be an association plan. Under Texas law they must have stop-loss and a minimum 12/15 contract. The MEWA statute subjects the MEWAs to state insurance code regulations that include treble damages and criminal penalties for deceptive trade practices.

## TPA Regulations

Texas adopted an administrator law in 1987<sup>2</sup>. It has captured the attention of the self-funders because of the self-funders because of its bold provisions. Because of its controversial nature, it is treated with some thoroughness in this book.

*Purpose.* The purpose of the law is to deal with a TPA "who, in a fiduciary capacity, or otherwise, manages or handles funds..." This introductory statement implies that the TPA may be a fiduciary.

*Definitions.* The law tracks the NAIC model administrator law as regards definitions, who may be, and who is not, a TPA. The term plan includes a MEWA. It excludes Taft-Hartley plans. It excludes plans that are tax exempt.

*Certificate of Authority.* A certificate of authority is required by a TPA if it is (a) domiciled in Texas, (b) has its principal administrative offices in Texas, or (c) administers any self-funded plan that has any Texas residents as participants. Thus, an Indiana TPA, with an Iowa client, which client has a Texas sales office of several persons, must be certified. If the Indiana TPA firm's name is similar to a presently licensed Texas TPA,

the Indiana TPA could be denied a license, thereby causing it to lose its Iowa client.

*Application Procedure.* The licensing procedure is most thorough and requires these items:

- Basic organizational and corporate papers.
- Resumes of key persons of the TPA.
- General description of the TPA, its services, personnel, and facilities.
- The appointment by the TPA of the Commissioner of Insurance as its legal agent for service of process.
- Three years of fully audited financials. Some of the requirements may be waived if facts and circumstances dictate that they are not necessary.
- Any other information that the Commissioner may reasonably require.

The TPA is obligated to inform the Commissioner of any material modification to the required information within 30 days of such change.

*Reasons for Certificate Denial.* There are numerous reasons why the Commissioner may deny the TPA a certificate.

- TPA has inadequate facilities or incompetent personnel.
- TPA has inadequate financial conditions.
- Success of the TPA is improbable.
- TPA is lacking competency, experience, or trustworthiness.
- TPA's management is inexperienced, lacks both ability and standing, and does not have a good record.
- TPA has not acted in good faith.
- TPA has not complied with Commissioner's rule or regulations.

*Fees to Unlicensed Persons.* TPA A may not surpass anything valuable to TPA B for services within Texas unless TPA B is also licensed. One certificate is all that the TPA needs; it can serve all carriers, plans, etc.

*Denial of Authority.* Such denial will occur only after adequate hearing and review. Reasons include the following:

- Willful violations of laws, rules, regulations
- Intentionally-made material misrepresentations
- Being guilty of fraud or misrepresentations
- Misappropriating monies
- Acting in an untrustworthy manner
- Being guilty of dishonest practices or material misrepresentation of policy terms and conditions
- Failure to be of good character or reputation
- Having had a TPA license canceled, denied, or suspended for cause within the previous five year period.

*Fees.* The initial filing fee is \$3,000; the annual renewal fee is \$500; each service agreement is \$100 plus a myriad of minor fees:

- Seal - \$20
- Name reservation - \$200 initial, \$50 renewal
- Service of process designation - \$50
- Security deposit acceptance - \$200 initial, \$100 amendment or change

*Service Agreements Fiduciary Capacity.* To provide any service, there must be a written agreement.

The TPA must maintain five years of records and transactions by either accounting rules or ERISA rules. Copies of service contracts must be on file with the Commissioner and shall be treated with confidentiality. The TPA is a fiduciary when "collecting, expanding, and maintaining money for the payment of claims  
Texas

pursuant to the service contract.”

*Confidentiality.* The TPA must maintain confidentiality over its records, claims, or other types of records as well. There are important reasons to make exception to the above rule of confidentiality:

- Claims adjudication or verification
- To insurer or ERISA plan administrator or other plan fiduciary
- To Commissioner of Insurance
- As may otherwise be required by law

*Annual Report.* The TPA shall submit an annual report (calendar year basis) due by March 31 of the year following on a form prescribed by the Commissioner.

*Prohibited Claims Processing.* In processing claims, there are certain acts that must be avoided:

- Misrepresentation of pertinent facts
- Failure to process in good faith, with promptness and respect
- Failure to adopt and implement and follow reasonable standards for prompt investigation
- Failure to make good faith effort to process a claim promptly and fairly
- Discrimination due to age, sex, race, creed marital status, color, residence, national origin, handicap, or lawful occupation
- Compelling or inducing a settlement, or delay in payment, by means of arbitration, legal actions, etc.

*Prohibited Inducements.* No payments, rebates or valuable considerations may pass between TPA, employer, insurer, stop-loss carrier, or other TPA, unless it is plainly set forth in the service agreement; that is, fees are to be set apart from and not adjusted by any outside deals. No statements may be made that misrepresent the terms, advantages, or true nature of the arrangement being proposed.

*TPA's Intermediary Status.* Under no circumstances may funds passing through the TPA be deemed its funds; they are either the employer's, the insurer's, or the plan's funds. There must never be any commingling.

*Record Maintenance.* There must be five-year records retention at the TPA's principal administrative offices. The five-year period begins when the service agreement is terminated. Records definition is such that the TPA, to be on the safe side, should save it all. The Commissioner may promulgate reasonable rules regarding record retention.

*Advertising.* The TPA may not advertise in the name of the plan without the employer's, or insurer's, advance permission.

*Underwriting standards.* Two administrative or service agreements are contemplated:

- TPA – insurer (fully insured plans)
- TPA – employer (self-funded plans)

The law requires that each such agreement sets forth the “underwriting or other standards pertaining to the business underwritten by the plan, insurance carrier, or person that self-insures.” The law further provides for actuarial certification of rates relative to benefits –for both fully insured and self-funded plans. Such certification must be by a Fellow of the Society of the American Academy of Actuaries (life or casualty) or a Member of the American Academy of Actuaries. A copy of such certification must be on file with the Commissioner. Such certification does not apply to stop-loss premiums.

*Fiduciary Duty – Fiduciary Account.* The TPA must handle funds as a fiduciary and strictly in accordance with the written agreements and without any delays.

*Claims Payment.* Payment must be by either check or draft as authorized by the plan.

*Contingent Commissions.* If the TPA adjusts or settles claims, its commissions (with regard to these policies) may in no way be contingent on claims experience.

*Identity of TPA.* The TPA must disclose, in writing, the TPA-insurer relationship as well as the net rates to the carrier.

*Bond or Securities Deposit.* The TPA must deposit securities with the Commissioner in an amount not to be less than \$50,000 or to exceed \$500,000. The amount shall be determined by the amount of funds handled. The purpose of the deposit is to protect the insured's due to the TPA's (a) actionable acts or (b) insolvency or impairment. The Commissioner will hold such funds in a trust capacity. The Commissioner will release such funds when the TPA has no further obligations or influence on plan funds. The Commissioner and the protection to insured's must be no less than with deposited securities. Bonds/securities are not required where the TPA (a) does not handle plan funds; (b) administers only fully insured plans and provides an acceptable bond in accordance with such contracts; (c) handles funds through a trust account over which it has no control, provided that it has a bond acceptable to the Commissioner providing coverage against loss of any funds handled; or (d) administers a single employer plan in accordance with ERISA and complies with the bonding requirements of that Act.

*Levy on Deposit.* The Commissioner shall pay out from deposited securities, when required in accordance with applicable laws.

*Nonapplicability.* If a plan is administered by the employer, by the sponsor or a trustee thereof, a license is not required. However, the Commissioner shall be notified in writing of such relationship each year.

*Administrative Rules.* Regulations will be promulgated as needed.

## Stop-Loss Regulation

No regulation is reported.

## Utilization Review Regulations

Agency Responsible <sup>3</sup> .....	Dept. of Insurance
Requirements .....	Registration - Certification
Exemptions .....	ERISA plans, Workers' Compensation
Waivers .....	None
Comments .....	Special confidentiality rules apply to mental and substance abuse care.

## Miscellaneous

### Small Group Reform

Texas sets standards for insurers to offer group health benefit plans to small employers. A small employer is an employer that has three to 50 employees (including those of any affiliate) on at least 50% of its working days during the preceding calendar year, a majority of whom worked in Texas.

Only full-time employees who usually work at least 30 hours a week are counted for the Act's purposes. A sole proprietor, partner, or independent contractor is counted if covered by the plan, but part-time, temporary, seasonal, and substitute employees are not. Also, employees are covered by another health benefit plan (including a self-funding ERISA plan) are not counted, and those covered by Medicaid, another

federal program (for example, CHAMPUS or Medicare), or a foreign plan are not counted if they elect not to be covered. Employees of an *affiliate* are counted if the two entities are connected by common ownership, common directors, or the filing of a consolidated tax return.

Plans offered in compliance with the Act are exempted from the benefit requirements otherwise mandated by state law. However, plans that provide for coordination of benefits must comply with regular coordination rules and guidelines established by the state Insurance Commissioner.

Small employer insurers must make their plans available without regard to claim experience, health status, or medical history.

The Act does not require an employer to provide health insurance nor to contribute to the premium paid for small employer health benefit plans. However, a particular insurer may require an employer contribution under the plan it offers in Texas. Any required contribution level must be applied uniformly to all small employers, except that an insurer may comply with a different level set by a purchasing cooperative for policies marketed through it. If a small employer elects to make premium contributions, it need not pay any amount with respect to an employee who declines coverage.

### **MSA Legislation**

No action.

### **State Premium Taxes**

Commercial insurers pay 1.75%; Blue Cross is not taxed. HMOs are taxed at 1.75%; this rate is reduced for smaller HMOs; Texas HMOs also get credit for Texas Investments.

### **Continuation of Coverage and Conversion of Benefits**

Texas requires group health plans to allow covered employees and dependents to continue group coverage, or convert to individual coverage, if their group coverage ends for any reason except termination of employment for cause. To be eligible, individuals must have been covered by the group policy for at least three months when coverage ends.

Texas requires insurers to allow employees and their dependents to convert to individual coverage when their group coverage ends for any reason except termination of employment for cause. This rule does not apply in cases in which coverage terminated due to failure to pay premiums or because the policy terminated and was replaced by a similar plan within 31 days.

### **Registration of Self-funded Plans**

A self-funded plan must register with the state Insurance Department. If the plan cannot show that it is subject to the jurisdiction of some other state or federal agency, it must meet certain solvency requirements and must comply with the insurance code.

## Endnotes

<sup>1</sup> Tex. Ins. Code Ann. art. 3.51-6.

<sup>2</sup> Tex. Ins. Code § 31.51-6B.

<sup>3</sup> Tex. Ins. Code § 21.58A; Tex. Admin. Code. tit. § 2819.1701.