Senate Committee on State Affairs

Interim Report
to the
80th Legislature

December 2006

SENATE COMMITTEE ON STATE AFFAIRS

SENATOR ROBERT DUNCAN, Chairman
SENATOR TOMMY WILLIAMS, Vice-Chairman
SENATOR KEN ARMBRISTER
SENATOR RODNEY ELLIS

SENATOR TROY FRASER
SENATOR CHRIS HARRIS
SENATOR MIKE JACKSON
SENATOR EDDIE LUCIO, JR.
SENATOR FRANK MADLA

January 8, 2006

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

Dear Governor Dewhurst and Fellow Members:

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

Respectfully submitted,

Senator Robert Duncan, Chair

Senator Tommy Williams, Vice-Chair

Senator Rodney Ellis

Senator Troy Fraser

Senator Chris Harris

Senator Mike Jackson

Senator Eddie Lucio, Jr.

P.O. Box 12068 • Room 348, Sam Houston Building • Austin, Texas 78711
(512) 463-0380 • FAX (512) 463-0362 • Dial 711 for Relay Calls

The Senate of
The State of Texas
Austin, Texas 78711

January 5, 2007

The Honorable Robert Duncan
Chairman, Senate Committee on State Affairs
PO Box 12068
Austin, TX 78711

Dear Chairman Duncan:

Congratulations on the completion of the Senate Committee on State Affairs' Interim Report. The Committee did an excellent job of identifying important issues to examine and identified sound and appropriate recommendations relating to its charges.

Despite our support for most of the Committee's recommendations, we take exception to the findings associated with Charge 3 on voter identification. Although the report explicitly states, "The Committee makes no recommendation regarding policy issues in favor of or in opposition to voter identification and/or ballot authenticity," we feel the conclusion implies that photo ID requirements are desirable. Furthermore, with respect to claims that additional voter ID requirements may disenfranchise certain populations, the conclusion asserts, "there are no studies presenting data to support such claims." However, Georgia Secretary of State, Cathy Cox, recently completed a demographic analysis reveling that between a quarter and a third of senior and African American voters lack state issued photo identification, thus disenfranchising them from the elections process. The Secretary's findings can be found at: http://www.sos.state.ga.us/pressrel/062306.htm

In the conclusion of the report, photo identification requirements for participation in state administered services such as the Food Stamp Program are citied. However, the ability to vote is a basic right for all citizens and therefore, should not be likened to services that require additional documentation. Texas should do everything in its power to facilitate ease of voting and we feel additional ID requirements would present an undue burden for voters.

Requiring additional personal identification for voters would also result in an unnecessary cost to the State. Furthermore, the report includes the following statement which implies that additional voter identification requirements would serve little practical purpose with respect to decreasing instances of voter fraud, "It is unknown whether the current level of voter fraud will decrease, but a voter photo ID law will certainly prevent some fraud." Testimony provided by the Office of the Secretary of State indicates extremely low instances of in-person voter fraud. It is our shared belief that anti-fraud measures adopted by the federal Help America Vote Act (HAVA), sufficiently deter voter fraud and that additional photo identification measures are unnecessary.

Please do not hesitate to contact either one of us regarding this issue, or any other matter of concern to the Committee. Thank you very much for your attention to this matter and for outstanding work on the report.

Sincerely,

Eddie Lucio, Jr.
State Senator, District 27

Rodney Ellis
State Senator, District 13

Table of Contents

Interim Charges ..... **i**
Senate Committee on State Affairs Interim Hearings ..... **i**
Executive Summary ..... **i**
Interim Charge Discussion and Recommendations **1**
Charge Nos. 1 and 2 1
Health Care Issues 1
ERS-GBP 1
UT-GBIP and A&M-GBIP 2
TRS-Care and TRS-ActiveCare 2
Healthcare Cost Trends 3
Additional Cost Savings Possibilities 3
Pension Issues 5
Employees Retirement System (ERS) 5
The Teacher Retirement System (TRS) 8
Recommendations 12
Charge No. 3 13
Background 13
Voter Registration 14
Voting 15
Vote-by-Mail System 15
Voter ID: 78th Legislature 16
Discussion 16
Photo Identification Laws 16
Challenges to Voter Identification Laws 17
Voter Fraud 24
Vote-By Mail 27
Conclusion 28
Recommendations 29
Charge No. 4 30
Background and Discussion 30
Recommendations 32
Charge No. 5 34
Background 34
Discussion 36
Transparency 36
Usual & Customary Rates, Health Plan Network Adequacy, and Balance Billing 38
Waiving Co-payments, Co-insurance and Deductibles 40
Additional Issues 41
Recommendations 41
Charge No. 6 43
Background 43
The History of the Doctrine of Eminent Domain 43
Kelo et. al. v. City of New London, et. al. 44

Legislative Response to Kelo 45
Discussion 47
"Public Use" 47
"Blight" 47
Burden of Proof 48
Grants of Eminent Domain Authority 49
Right of First Refusal 49
Recommendations 49
Provide a statutory definition of "public use." 49
Charge No. 7 50
Background 50
Discussion 55
Costs to Insurance Companies 55
Costs to State 58
Mandates in Other States 59
Recommendations 60
Charge No. 8 60
Background 60
Discussion 61
Lobbying 61
Public Education 62
Higher Education 66
Recommendations 68
Charge No. 9 69
Background 69
Texas Regulatory Structure 70
Texas EMS Systems 71
EMS Staffing Strategies 72
Discussion 72
Adequate Funding Sources and Reimbursement Levels 73
Medicare Reimbursement Methodology 73
Medicaid Reimbursement Methodology 73
Private Health Plans Reimbursement Methodology 74
Reimbursement Challenges for Rural Texas 74
Recruiting and Retention of Employees and Training Issues 75
EMS Equipment Issues 76
Recommendations 77
Charge No. 10 77
Statutory Employer 77
Background 77
Etie v. Walsh & Albert Co., Ltd 78
Indemnity Provisions 80
Availability of Insurance 80
Recommendations 81
Consolidated Insurance Programs 81
Types of Programs 82

Proponents of CIPs 83
Opponents of CIPs 84
Recommendations 86
Charge No. 11 86
Background 86
Discussion 88
Sovereign Immunity 88
Charitable Immunity Act 89
Liability Insurance 90
Recommendations 90
APPENDIX I 1
APPENDIX II 1
APPENDIX III 2
APPENDIX IV 1
APPENDIX VII 1
APPENDIX VIII 2
APPENDIX XI 1

Table of Figures

Figure 3 - 1 19
Figure 3 - 2 25
Figure 3 - 3 25
Figure 3 - 4 26

Figure 5 - 1 35

Figure 7 - 1 55
Figure 7 - 2 56
Figure 7 - 3 57
Figure 7 - 4 59

Figure 8 - 1 63
Figure 8 - 2 64
Figure 8 - 3 64
Figure 8 - 4 65
Figure 8 - 5 67
Figure 8 - 6 68

Figure 9 - 1 76

Figure 10 - 1 79
Figure 10 - 2 82

Figure 11 - 1 87

Interim Charges

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

1. Study the Employees Retirement System of Texas ("ERS") including the actuarial soundness of the ERS pension fund; the implementation of cost-saving measures in the ERS group health insurance plan; the suggestion of further cost-saving measures such as the implementation of a 3-tiered provider network; the effectiveness of the third party administrator of the ERS group health insurance plan in managing inflation; and the feasibility of consolidating the administration of all state group health plans under a single state agency.
2. Study the Teachers Retirement System of Texas ("TRS") including the actuarial soundness of the TRS pension fund; the implementation of cost-saving measures in the TRS group health insurance plan; the suggestion of further cost-saving measures such as the implementation of a 3-tiered provider network; the implementation of S.B. 1370, 79th Legislature; the effectiveness of the third party administrator of the TRS group health insurance plan in managing inflation; and the feasibility of consolidating the administration of all state group health plans under a single state agency.
3. Study and make recommendations on how election officials could verify the identity of a voter without hindering a person's right to vote. Include an analysis of the extent to which individuals are casting multiple votes because of any lack of voter identification verification. Make recommendations on how the state could improve its vote-by-mail system to ensure the authenticity of those ballots.
4. Monitor the implementation of H.B. 7, 79th Legislature, Regular Session, relating to the workers compensation system of this state.
5. Study the regulation and management of health care plans, including the following:
    - Study the reimbursement methodology of health care plans for out-of-network claims, the adequacy of health plan networks to provide appropriate coverage, the impact of out-of-network balance billing by physicians and health care providers and the accurate disclosure of patients' out-of-pocket costs.
    - Study the discounting and/or waiving of co-pays, deductibles and co-insurance by physicians and health care providers. Specifically, how this practice can impact the cost to private and public health plans and the impact to acute, multi-service hospitals, including safety net hospitals.
    - Evaluate health care cost transparency by health care providers and access to that information by patients.
    - Review data reported to the Texas Department of Insurance by health care plans, investigate possible expansion of health plans' reportable data, including, but not

limited to, administrative costs, and what, if any, is the appropriate release and publication of that information.

6. Study and review current law on the doctrine of eminent domain, including the U.S. Supreme Court case in *Kelo v. City of New London*. Monitor the implementation of S.B. 7 (79th Legislature, 2nd Called Session) and make any necessary recommendations as to the use of eminent domain for economic development purposes and the issue of what constitutes adequate compensation for property taken through the use of eminent domain.
    - Determine whether a constitutional amendment is prudent and/or necessary to protect private property owners from condemnations for economic development purposes.
    - Determine which state, regional, and local governmental entities have eminent domain powers and how those powers may be used. Make recommendations regarding their necessity, fairness, and effectiveness.
    - Study the public policy implications relating to Chapter 2007, Government Code, Private Real Property Rights Preservation Act, its effectiveness in protecting private property rights, and the current impact of regulatory takings on private property owners.
7. Study the costs associated with mandates to insurance companies for increased coverage for specific illnesses, medical conditions, or diseases, including obesity. Provide a cost assessment of the impact of such mandates to the state and local units of government. Include data and analysis of the costs and medical impact associated with insurance mandates which have been enacted in other states, as well as any short- and long-term cost-savings. Develop recommendations on how to provide increased cost-effective coverage, especially to populations with impairments and diseases, as well as the underinsured/uninsured.
8. Study the prevalence, legality and ethics of entities that actively lobby the Legislature to impact the lawmaking process while that entity is in any way a recipient of state funds.
9. Study and make recommendations regarding the cost drivers of emergency medical services. Make recommendations on how to improve and sustain EMS services for Texas, as well as reduce costs to health care plans, businesses, and individuals.
10. Study and review current Texas law on the doctrine of statutory employer, including the 2004 First District Court of Appeals' decision in Etie v. Walsh & Albert Co. and make recommendations of changes in state laws, if necessary, regarding the doctrine of statutory employer and indemnification in construction contracts. Study the current use of Consolidated Insurance Programs and make legislative recommendations, if appropriate.
11. Assess the benefit of limiting the civil liability for noneconomic damages against non-profit organizations involved in the privatization of child welfare services.

Senate Committee on State Affairs Interim Hearings

April 18, 2006, *Senate Chamber*
The Committee took invited and public testimony on Charge Nos. 3, 6 and 8.

June 27, 2006, *Senate Chamber*
The Committee took invited and public testimony on Charge Nos. 1 and 2.

July 26, 2006, *Room E1.036*
The Committee took invited and public testimony on Charge Nos. 5 and 9.

July 27, 2006, *Room E1.036*
The Committee took invited and public testimony on Charge Nos. 7 and 11.

August 23, 2006, *Room E1.036*
The Committee and the Health & Human Services Committee took invited and public testimony on Joint Charge No. 3.

August 23, 2006, *Room E1.028*
The Committee took invited and public testimony on Charge No. 10.

October 17, 2006, *Senate Chamber*
The Committee and the Health & Human Services Committee took invited and public testimony on Joint Charge Nos. 1 and 2 and on Charge Nos. 1 and 2.

October 18, 2006, *Senate Chamber*
The Committee took invited and public testimony on Charge Nos. 1, 2 and 4.

Executive Summary

Interim Charge Nos. 1 and 2

Study the Employees Retirement System of Texas ("ERS") including the actuarial soundness of the ERS pension fund; the implementation of cost-saving measures in the ERS group health insurance plan; the suggestion of further cost-saving measures such as the implementation of a 3-tiered provider network; the effectiveness of the third party administrator of the ERS group health insurance plan in managing inflation; and the feasibility of consolidating the administration of all state group health plans under a single state agency.

Study the Teachers Retirement System of Texas ("TRS") including the actuarial soundness of the TRS pension fund; the implementation of cost-saving measures in the TRS group health insurance plan; the suggestion of further cost-saving measures such as the implementation of a 3-tiered provider network; the implementation of S.B. 1370, 79th Legislature; the effectiveness of the third party administrator of the TRS group health insurance plan in managing inflation; and the feasibility of consolidating the administration of all state group health plans under a single state agency.

Recommendations

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

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

1.c. The Legislature should direct all state group health plans to quarterly update the Legislature on state health expenditure trends. Such reports should be provided in a standardized format and compare actual trends to projected trends. In addition, ERS, UT, A&M and TRS health care experts should consider meeting regularly to discuss and compare cost containment strategies. The group should also discuss provider contract provisions and rates.

1.d. The Legislature, through the Legislative Budget Board (LBB), should consider hiring an outside consultant to more closely examine the possibility of merging the contracting and administrative oversight functions of all the state administered health plans.

1.e. To alter the actuarial position of the ERS pension fund, the Legislature should consider raising the state and active member contribution rates to a combined level sufficient to bring the fund into actuarial solvency. The state should also look to re-establish a permanent funding mechanism for the LECOSRF.

1.f. The state should also consider providing a financial match (at even a modest level) to state employees choosing to participate in one of ERS' deferred compensation retirement plans.

1.g. To provide a more stable funding base that is better positioned to provide long-term support to the types of benefit enhancement desired by TRS active and retired members, the state should consider increasing the active member contribution rate modestly. The state should also consider increasing its contribution rate to a level equal to that of active members. Finally, the state should consider requiring local employers to contribute to the pension fund at a rate set by the GAA within a statutory range.

1.h. The state should also consider providing a financial match (at even a modest level) to active members who choose to participate a TRS certified deferred compensation retirement plan, provided their local employer also provides a match at least equivalent to that of the state.

1.i. The state should consider modifying the retire/rehire grandfather provision provided for in SB 1691 so that local employers would not be required to pay surcharges to employ any individual who was retired prior to September 1, 2005.

1.j. The state should more closely examine the possibility of allowing ORP members to transfer limited numbers of those years of service to TRS should they make long term commitments to teach in critical shortage areas of public education.

Interim Charge No. 3

Study and make recommendations on how election officials could verify the identity of a voter without hindering a person's right to vote. Include an analysis of the extent to which individuals are casting multiple votes because of any lack of voter identification verification. Make recommendations on how the state could improve its vote-by-mail system to ensure the authenticity of those ballots.

Recommendations

The Committee is charged to make recommendations concerning methodologies for verifying identity of voters and improving the vote-by-mail system to insure authenticity of mail-in ballots. The recommendations herein are made in accordance with this charge. The Committee makes no recommendation regarding policy issues in favor of or in opposition to voter identification and/or ballot authenticity.

3.a. Any legislation to require presentation of photo identification at the polling place prior to voting should at a minimum provide for the following:
- ample time for implementation by the Secretary of State, including associated rule makings and public education, and
- issuance of qualifying photo IDs free of charge to any voter requesting, regardless of personal income level.

3.b. Require the Secretary of State to monitor the effectiveness of the identification verification provisions codified in the Election Code and to monitor the legal challenges to other state's voter photo ID laws.

3.c. With regard to the vote-by-mail process, Texas currently has several safeguards in place to address voter fraud, therefore, the Committee only recommends increased awareness by law enforcement as well as continued investigation and prosecution of offenders.

Interim Charge No. 4

Monitor the implementation of H.B. 7, 79th Legislature, Regular Session, relating to the workers compensation system of this state.

Recommendations

The Committee makes two recommendations relative to the larger policy issues considered by H.B. 7. The Committee believes these recommendations will enhance the future success of the workers' compensation system:

4.a. Continue to approve the creation of new networks without any undue delay.

4.b. Support the transfer of 25 Dispute Resolution Officers from the Texas Department of Insurance - Division of Workers' Compensation to the Office of Injured Employee Counsel as requested in both agencies' Legislative Appropriations Requests (LAR); and support OIEC's LAR request to increase the number of customer service representatives by 38.

Interim Charge No. 5

Study the regulation and management of health care plans, including the following:

- *Study the reimbursement methodology of health care plans for out-of-network claims, the adequacy of health plan networks to provide appropriate coverage, the impact of out-of-network balance billing by physicians and health care providers and the accurate disclosure of patients' out-of-pocket costs.*
- *Study the discounting and/or waiving of co-pays, deductibles and co-insurance by physicians and health care providers. Specifically, how this practice can impact the cost to private and*

public health plans and the impact to acute, multi-service hospitals, including safety net hospitals.

- *Evaluate health care cost transparency by health care providers and access to that information by patients.*
- *Review data reported to the Texas Department of Insurance by health care plans, investigate possible expansion of health plans' reportable data, including, but not limited to, administrative costs, and what, if any, is the appropriate release and publication of that information.*

Recommendations

5.a. Transparency.

The Legislature should:

- Implement a process for the dissemination of reliable data that will reflect a market value of health care services by geographic region.
- Support the expansion and use of the reporting of the cost data from the Texas Health Care Information Council. Further, investigate possible changes to shorten the reconciliation process, while still maintaining the highest levels of accuracy, to ensure the more timely reporting of data.
- Continue discussions with impacted parties on possible means of increased reporting and publication of the health plans' cost data and financial information.

5.b. Usual and Customary.

The Committee makes no recommendation regarding a legislative or regulatory definition of usual and customary. The Committee finds that this definition and concept is more appropriately addressed by contract.

5.c. Network adequacy.

The Legislature, by granting rule making authority to the Texas Department of Insurance, should work with stakeholders to implement a standard for network adequacy with regard to hospital-based physicians at facilities who contract to be an in-network provider.

5.d. Balance Billing.

The Legislature should investigate a spectrum of solutions suggested to the committee, including, but not limited to:

- Disclosing to the patient and enrollee of the possibility of balance billing. The responsibility of this disclosure lies with both providers and health plans. Ensuring that all Texans understand the dynamics of their coverage and network status of their physicians is imperative.
- Allowing hospitals to negotiate with health plans on behalf of their hospital-based physicians.

- Requiring that hospitals and hospital-based physicians contract with the same health plans. This concept would be most important in scenarios where the hospital-based physicians have an exclusive contract with a hospital to provide their particular health services.
- Establishing minimum standards of network adequacy for hospital-based physicians.
- Encouraging the increased use of "smart cards" for enrollees of health plans. Utilizing technology as a means to ascertain enrollees' coverage levels, network status and health plan specifics could help decrease unexpected balance billing scenarios.

5.e. State Data Reporting for Health Plans.

The Legislature should continue to work with all interested parties to discuss the possible expansion of data that health plans report to the state. This expansion could include, but not limited to:

- Complaints filed by providers or enrollees against health plans
- Various financial data relative to the cost to provide medical care, reimbursements to providers, and administrative services.
- Expanding current Health Maintenance Organization reporting requirements to Preferred Provider Organizations.
- Publishing ranges for regional in-network contract rates paid for certain health care services.

5.f. Waiving of Co-payments, Co-insurance and Deductibles.

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

Interim Charge No. 6

Study and review current law on the doctrine of eminent domain, including the U.S. Supreme Court case in Kelo v. City of New London. Monitor the implementation of S.B. 7 (79th Legislature, 2nd Called Session) and make any necessary recommendations as to the use of eminent domain for economic development purposes and the issue of what constitutes adequate compensation for property taken through the use of eminent domain.

- *Determine whether a constitutional amendment is prudent and/or necessary to protect private property owners from condemnations for economic development purposes.*
- *Determine which state, regional, and local governmental entities have eminent domain powers and how those powers may be used. Make recommendations regarding their necessity, fairness, and effectiveness.*
- *Study the public policy implications relating to Chapter 2007, Government Code, Private Real Property Rights Preservation Act, its effectiveness in protecting private property rights, and the current impact of regulatory takings on private property owners.*

Recommendations

6.a. Amend the language of Chapter 374, Local Government Code (the Texas Urban Renewal Act), to provide for the use of objective and quantifiable factors in determining whether a property is worthy of condemnation.

6.b. Provide, by statute, that the condemning authority shall have the burden of proof to establish, by a preponderance of the evidence that the condemnation is for "public use" and is reasonably necessary.

6.c. Direct the Comptroller of Public Accounts to identify all public and private entities with eminent domain authority and make recommendations to the Legislature and the Governor as to which entities: (1) have, need or should have, eminent domain authority; (2) whether that power should be continued, expanded, limited, or eliminated; and (3) the cause and effect of such changes.

6.d. Provide, by statute, a right of first refusal to the condemnee in repurchasing the property if the purpose for which the property was taken is no longer valid. The condemnee should be allowed to repurchase the property at the price paid when it was condemned.

6.e. Amend the Texas Constitution to require that all laws passed by the Legislature that grant eminent domain authority or authorize the taking of private property by condemnation, after January 1, 2007, do so with a two-thirds vote of the membership of each house of the Legislature. No such law may be passed on the Local and Consent calendar of either chamber.

Interim Charge No. 7

Study the costs associated with mandates to insurance companies for increased coverage for specific illnesses, medical conditions, or diseases, including obesity. Provide a cost assessment of the impact of such mandates to the state and local units of government. Include data and analysis of the costs and medical impact associated with insurance mandates which have been enacted in other states, as well as any short- and long-term cost-savings. Develop recommendations on how to provide increased cost-effective coverage, especially to populations with impairments and diseases, as well as the underinsured/uninsured.

Recommendations

The Committee concludes that every health insurance mandate involves a policy decision based on that particular illness or treatment and the healthcare needs of the citizens of this state. Costs are not generally the driving factor behind a mandate. Therefore, the Committee makes no recommendations at this time. However, the Committee advises caution and careful deliberation concerning the consideration of additional mandates, if any. Proliferation of mandates that are not limited in scope or carefully defined can result in a substantial increase in premiums.

Interim Charge No. 8

Study the prevalence, legality and ethics of entities that actively lobby the Legislature to impact the lawmaking process while that entity is in any way a recipient of state funds.

Recommendations

8.a. The Committee recommends that the 80th Legislature consider legislation to "pierce the veil" of employment of a lobbyist when the lobbyist is employed by a private entity but serves at the direction of the president or chancellor of an institution of higher education.

8.b. To ensure that the taxpayers who elect school board members have appropriate information before them, the Committee recommends the Education Code should be amended to require the Texas Education Agency to permanently collect information included in Executive Order RP-47 on an annual basis.

Interim Charge No. 9

Study and make recommendations regarding the cost drivers of emergency medical services. Make recommendations on how to improve and sustain EMS services for Texas, as well as reduce costs to health care plans, businesses, and individuals.

Recommendations

A majority of the issues presented to the Committee were related to funding, rather than statutory issues; therefore, many concerns are outside the jurisdiction of the Senate Committee on State Affairs. The Committee will submit a copy of this report to the Senate Finance Committee for use during discussion in the creation of the 2008-2009 General Appropriations Budget.

9.a. Considering available funds:

- The Medicaid program has not increased reimbursement rates for Texas EMS since 1992. Implementing an increase in the Medicaid reimbursement rate, keeping in mind the unique factors for rural EMS systems, could greatly increase the quality and reliability for EMS in Texas.
- The Texas Ambulance Association is working with the state to explore improvements to the Medicaid reimbursement methodology. The proposal would be the implementation of the Medicare fee schedule system, with fee variations for locality and for rural versus urban status. The estimated impact to the budget for this proposal would be $30.2 million in general revenue and $78.7 million in all funds.

9.b. To address the difficulties in recruiting and retaining EMS personnel, establish incentives for participation, such as funding scholarships for volunteer EMS education, training and continuing education.

Interim Charge No. 10

Study and review current Texas law on the doctrine of statutory employer, including the 2004 First District Court of Appeals' decision in Etie v. Walsh & Albert Co. and make recommendations of changes in state laws, if necessary, regarding the doctrine of statutory employer and indemnification in construction contracts. Study the current use of Consolidated Insurance Programs and make legislative recommendations, if appropriate.

Statutory Employer

10.a. The Committee recommends no changes to the statutory employer doctrine.

10.b. The Committee recommends that the use of broad form indemnity be made void as a matter of public policy.

Consolidated Insurance Programs (CIPs)

10.c. The Committee makes the following recommendations to be included in any legislation considered by the 79th Legislature relating to CIPs:

- Insurers providing coverage under a CIP must separately underwrite each entity to be covered.
- Copies of policies or coverage certificates must be given to each subcontractor prior to the commencement of work. Periodic updates must be communicated to each subcontractor detailing coverage limits and claims.
- The Insurance Code should be amended to clarify the duty of a broker/agent/administrator in a CIP arrangement.
- CIP coverage that includes completed operations must be consistent with 10-year statute of repose.

Interim Charge No. 11

Assess the benefit of limiting the civil liability for noneconomic damages against non-profit organizations involved in the privatization of child welfare services.

Recommendations

Based on the legal experts' conclusions that the Charitable Immunity Act would apply to a nonprofit corporation involved in the privatization of child welfare services, the Committee does not recommend any statutory revisions.

Interim Charge Discussion and Recommendations

Charge Nos. 1 and 2

Study the Employees Retirement System of Texas ("ERS") including the actuarial soundness of the ERS pension fund; the implementation of cost-saving measures in the ERS group health insurance plan; the suggestion of further cost-saving measures such as the implementation of a 3-tiered provider network; the effectiveness of the third party administrator of the ERS group health insurance plan in managing inflation; and the feasibility of consolidating the administration of all state group health plans under a single state agency.

Study the Teachers Retirement System of Texas ("TRS") including the actuarial soundness of the TRS pension fund; the implementation of cost-saving measures in the TRS group health insurance plan; the suggestion of further cost-saving measures such as the implementation of a 3-tiered provider network; the implementation of S.B. 1370, 79th Legislature; the effectiveness of the third party administrator of the TRS group health insurance plan in managing inflation; and the feasibility of consolidating the administration of all state group health plans under a single state agency.

Health Care Issues

To meet the healthcare needs of active and retired state employees and teachers, the State of Texas administers five main group health insurance programs. Each program offers a different benefit structure aimed at providing comprehensive coverage to the enrolled population while balancing the unique financial issues surrounding each plan. To assist in the management and administration of these programs the state employs third-party administrators (TPAs). Selected through a competitive bid process, the TPAs not only process claims, but typically provide a broad network of cost-effective providers, and help the state actively manage its healthcare programs in an effort to save costs.

ERS-GBP

The Employees Retirement System Group Benefit Program (ERS-GBP) provides health insurance to state employees, retirees and their eligible dependents.[1] In 1993, the insurance programs for most Texas colleges and universities were merged into the ERS-GBP. The Texas Tech University System and the University of Houston System were provided the option to join and both did. The University of Texas System and the Texas A&M University System were not provided the option to join. Today, those institutions continue to maintain and operate their own health insurance programs. The institutions that joined the ERS Higher Education Group Insurance Program (HEGI) historically have received identical benefits and been subject to the same premium structure as general state employees. All totaled, ERS currently covers approximately 504,000 lives.

[1] Acts 1975, 64th Leg., ch. 79.

Today, ERS-GBP offers two major options for health coverage. HealthSelect, a self-funded, point of service plan, is by far the largest. With 448,000 participants, this plan includes 89 percent of the GBP's covered lives. HealthSelect is currently administered by Blue Cross/Blue Shield of Texas (Blue Cross) and provides both in-network and out-of-network benefits. Pharmacy benefits for the plan are administered by Medco Health Solutions. Total plan expenditures for FY 2006 totaled just under $1.7 billion.

The second option offered under ERS-GBP includes a number of Health Maintenance Organization (HMO) plans across the state. This coverage is provided through contracts with private HMOs. Current HMO providers are: Community First Health Plans, Inc., FIRSTCARE, Mercury Health Plans, Scott & White Health Plan, and Valley Baptist Health Plans. Approximately 55,000, or 11 percent, of GBP participants are enrolled in one of the HMO options. To be selected, an HMO must be able to provide benefits in each proposed service area at a lower cost than can otherwise be provided through the self-funded plan.

UT-GBIP and A&M-GBIP

The University of Texas System Employee Group Insurance Program (UT-EGIP) and the A&M University System Employee Group Insurance Program (A&M-EGIP) also provide health insurance to employees, retirees and their eligible dependents. In FY 2006, the UT-EGIP covered more than 160,000 lives with total plan expenditures of $531.5 million. During that same time period, the A&M-EGIP covered more than 55,000 lives with expenditures of $166.8 million.

Benefit levels and premium structures for UT-EGIP and A&M-EGIP are set by each system's Board of Regents. Medical benefits for both institutions are administered by Blue Cross. Pharmacy benefits for UT-EGIP are managed by Medco Health Solutions with A&M-EGIP's pharmacy benefits managed by Eckerd Health Services.

TRS-Care and TRS-ActiveCare

The Teacher Retirement System (TRS) administers two group health insurance programs: TRS-Care and TRS-Active Care.

TRS-Care offers retirees and their dependents three levels of benefits, ranging from basic catastrophic coverage to comprehensive benefits that include prescription drug coverage. Benefit levels for these plans are primarily established by the TRS Board; however the Legislature may also direct changes through statutory revisions. Currently, Aetna administers medical benefits for the program, with Caremark managing prescription drug benefits. In FY 2005 TRS-Care covered 189,000 lives and had total expenditures of $694 million.

TRS-Active Care was created by the 77th Legislature to provide a statewide health care benefit to active employees of state school districts, charter schools, regional service centers, and other educational districts.[2] This self-funded program offers three coverage choices to participants. Benefit levels range from basic catastrophic to a comprehensive plan including

[2] Acts. 2001, 77th Leg., ch. 1419.

prescription drug coverage. Medical benefits are administered by Blue Cross with prescription drug benefits managed by Medco Health Solutions. Currently, there are 1,057 entities participating and enrollment is approximately 275,900. Plan expenditures total around $800 million.

Healthcare Cost Trends

Each of the group health insurance plans administered by the state generally is funded through a combination of employer, employee, and retiree contributions. In addition, each plan relies on participant cost sharing within the benefit design structure to also fund these programs. Cost sharing typically includes co-payments, deductibles, and co-insurance.

Funding levels for each plan are typically based on predictions as to what plan expenditure levels will be in the coming two-year cycle. Enrollment projections, benefit levels, utilization and provider price inflation are the primary elements considered in determining cost trends for these program.

Included in Appendix I is a presentation prepared by the Legislative Budget Board that provides an overview of each of these programs.[3] In addition, recent legislative changes affecting benefits are highlighted as are other plan design changes made by the governing agencies. Finally, a historic look at percent cost changes in each of the programs during the past decade is provided.

Additional Cost Savings Possibilities

Health care cost savings can be achieved in several ways including benefit adjustments, cost shifting, administrative efficiency, and better controlling provider cost inflation. Many of the cost savings measures highlighted in Appendix I have focused on benefit adjustments and cost shifting. Efforts to improve administrative efficiency and better control provider inflation have proven more of a challenge. However, Interim Charge Nos. 1 and 2 direct the Committee to specifically examine several potential cost savings measures associated with these.

Three-Tiered Provider Networks

In an effort to better control cost and encourage appropriate utilization, many health plans and third-party administrators are turning to "high performance networks" as a possible solution. These "high performance" or "efficient" networks primarily rely on a smaller set of healthcare providers chosen because of a demonstrated ability to manage care at or below the cost of their peers without a lower quality of care.

While the overall structure of each network differs from plan to plan, as does the provider selection methodology, the overarching goal remains the same: provide employers with an additional tool to help manage cost that does not involve benefit reductions or cost shifting.

[3] *See also* Senate Committee on State Affairs Hearing, June 27, 2006 (statements of Jennifer Schiess and John Wielmaker, Legislative Budget Board).

In an effort to balance cost savings with the availability of a full provider network, some plans have developed a hybrid system that creates incentives for participants who choose to see providers in the performance network. These three-tiered networks (out-of network, in-network, performance network) allow patients the flexibility to continue to see providers in the general network, while creating financial incentive to see those who have shown an ability to effectively deliver high quality care at a manageable cost.

Blue Cross has estimated that a shift to their performance network by the state plans they administer (ERS, UT, A&M, and TRS-Active Care) would result in a savings of $81.7 million *annually*.[4]

Administrative Functions

As discussed earlier in this report, the state administers five main group health insurance programs at four separate institutions and agencies. The benefit design and financing structure for each plan is unique, however the agencies all utilize third party administrators to process claims and assist in the management of the programs. Each entity also employs external consultants and actuaries. In addition, internal staff is used to perform some of the following functions: customer service, contract development, contract monitoring, program governance, financial processing and oversight, and general support.

While the plans typically utilize many of the same companies and outside consultants to perform these functions, contract terms and fees are all negotiated independently and with little, if any, inter-agency consultation. In addition, no formal structure exists to require the agencies to *regularly* share information with each other regarding these and other potential cost savings issues.

Concerns about this type of duplication of effort and lack of coordination have given rise to recent calls to merge the administrative and contracting functions of all these health plans under a single agency. When presented with this suggestion the agencies have commonly challenged the assertion that meaningful costs savings could be realized through such an arrangement.[5] They each point to their low program administration costs as evidence to support this assertion.

Because of the complex nature of health care and the decentralized structure of the state administered health plans, it was difficult for the Committee to examine with any accuracy the potential cost savings associated with a possible reorganization around these plans. In addition, each agency's distinctive format and terminology for presenting information regarding their plans made comparative analysis even more challenging.

[4] Senate Committee on State Affairs Hearing, June 27, 2006 (statement of Darren J. Rodgers, Blue Cross Blue Shield of Texas).
[5] Senate Committee on State Affairs Hearing, June 27, 2006 (statements of Ann Fuelberg, Employees Retirement System of Texas and Ronnie Jung, Teachers Retirement System of Texas).

Pension Issues

The State administers several pension funds for former state and school district employees. The funding mechanisms, governance structures, eligibility criteria, benefit calculations, and underlying actuarial assumptions all differ slightly from plan to plan. But for each, the general goal is constant: provide retirees with a predictable income stream to assist in covering their living expenses at a time in their lives when many are unable to work or would prefer not to work.

Employees Retirement System (ERS)

The Employees Retirement System (ERS) was established in 1947 to provide retirement benefits to state employees. ERS administers four basic retirement funds. The general ERS fund serves full and part-time state agency employees, and elected state officials including legislators, district attorneys, and statewide elected officials. The Law Enforcement & Custodial Officer Supplemental Retirement Fund (LECOSRF) provides supplemental benefits to state law enforcement officers commissioned by DPS, TABC, TBPC, TDP&W, as well as certain custodial and parole officers employed by TDCJ. Finally, the Judicial Retirement System Plan I & Plan II provide benefits to judges and justices of the Supreme Court, Court of Criminal Appeals, Court of Appeals, and District Courts.

ERS Trust Fund

The main ERS retirement program is financed primarily with income generated from trust fund investments. For FY 2006, 73 percent of trust fund revenues came from investment income. As of August 31, 2006, the market value of that fund is $21.5 billion and returned 8.8 percent for FY 2006. This return outperformed the actuarially assumed rate of return of 8.0 percent.

Only on four occasions since 1990 has the fund failed to meet its investment return benchmark. However, in two of those years (2001 and 2002) the fund actually experienced negative growth losing $3.4 billion in market value.

In order to better adjust for these types of peaks and valleys in investment returns, ERS utilizes a smoothing methodology that prevents the fund from fully recognizing market gains and losses immediately. This actuarial calculation of fund value allows for better year to year planning because of the more predictable annual funding stream. The effect of this policy can be seen on the graph in Appendix II. As of August 31, 2006, the *actuarial* value of the pension fund was $21.8 billion.

Active employees and the State also provide revenue to the pension fund. State employees currently contribute the constitutional minimum of 6 percent of their salary to the fund. This level has remained unchanged since 1972. Currently, there are slightly more than 132,000 active members. In FY 2006, active members contributed $292 million to the trust fund.

The state is directed by the Constitution to also contribute at least 6 percent of payroll, but not more than 10 percent. Last session the Legislature increased the state contribution to 6.45 percent in order to cover the plan's normal or ongoing costs. The state had been contributing at the constitutional minimum since 1996, but with normal costs exceeding total contributions since 1999, and the annually required contribution exceeding both normal costs and total contributions since 2002, the Legislature decided an increase in the state contribution rate was necessary. For FY 2006, state contributions totaled $316.2 million. The combination of state and employee contributions comprises just over 27 percent of annual revenue streams to the pension trust fund.

In order to determine the financial ability of the fund to cover both current and future benefits, ERS looks at a variety of variables. The number of current retirees (or annuitants), future retirees expected, the amount of anticipated monthly annuity payments, and the predicted length of the annuity payment period must be considered. Assumptions made about each of these variables can be affected from year to year through changes made to state employee compensation, early retirement incentives, benefit adjustments, or modifications in the size of the state workforce.

In addition to the active employees mentioned above, there are also 67,596 ERS annuitants. At an average age of 67 years old, these annuitants are receiving average monthly payments of $1,472. There are also 61,567 ERS members not currently employed by the state who have yet to retire.

New retirees have exceeded expectations each of the past eight years, and overall the number of retirees is expected to grow significantly. While largely attributable to the current demographic of state employees, benefit enhancements approved in the 1990s and recently adopted early retirement incentives have also contributed significantly to this trend.

For the most recent valuation, *actuarially accrued liabilities* totaled $22.9 billion. The $1.1 billion in unfunded actuarially accrued liability (UAAL)[6] combined with the current funding levels has created a somewhat dichotomous situation where the pension fund is not technically actuarially sound despite the fact that it continues to be financially solid with a 95.2 percent funded ratio. This condition began in 2002 primarily as a result of the major market loses in 2001 and 2002. As a result, the fund has been precluded from providing retirees with any additional benefits such as a 13th monthly check or cost of living adjustment.

Until a better mix of actuarially accrued liabilities and actuarial value of assets is achieved, the fund will continue in its current state. This can be achieved by reducing future liabilities and/or through revenue enhancements.

Benefit adjustments and changes to retirement eligibility are two of the primary tools to control future liabilities. Because the financial condition of the fund is not grave, major changes such as multiplier adjustments and increasing the Rule of 80 are not necessary. However, more

[6] This is the difference between the $21.8 billion in actuarial value of assets and the $22.9 billion in actuarially accrued liabilities.

closely scrutinizing early retirement incentives that serve to lower the retirement age and increase the annuity payment period could be helpful.

An injection of additional revenue to the fund would also improve its position. A contribution increase of 0.85 percentage points on the part of employees and/or the state would immediately render the fund actuarially sound. The cost to achieve this in FY 2008 would be approximately $44.7 million per year.

Alternatively, should the state decide to maintain current contribution levels for itself and active members, it is not expected that actuarial solvency would be attained anytime in the near future. Even if the market continues to meet its 8 percent return target and other actuarial assumptions are met, the fund will maintain its current path and retirees will continue to be precluded from receiving any additional benefits.

Law Enforcement & Custodial Officer Supplemental Retirement Fund

Created in 1979 as a supplemental retirement benefit for ERS members who have completed 20 or more years of service as commissioned law enforcement officers, the Law Enforcement & Custodial Officer Supplemental Retirement Fund (LECOSRF) currently provides benefits to 5,318 annuitants.

The actuarial value of assets is just under $720.3 million. However, neither the state nor the 37,103 active members contribute to this fund. Originally designed to be funded with vehicle registration and title fees, the 74th Legislature repealed this method of finance. Despite its lack of a continuous revenue source, the fund has historically been financially well-positioned. However, with major market losses at the beginning of the decade and dramatic increases in the numbers of retirees, the fund is quickly deteriorating. ERS will need an appropriation beginning in FY 2008 of approximately $21.3 million annually to cover the normal costs associated with this fund.

Judicial Retirement System Plan I & Plan II (JRS I & JRS II)

Judges and justices appointed or elected prior to September 1, 1985, receive their retirement benefits through JRS I. This pay-as-you go plan in not pre-funded. Instead, active members contribute 6 percent of their salary to the program during their first 20 years of service and may elect to continue contributing for up to 10 additional years in order to accrue additional benefits. The state contributes all additional revenue necessary to cover ongoing costs of retirees. At the end of FY 2006, there were 43 active members, 32 of whom were still contributing. In addition, there were 12 non-contributing, inactive members. At that time, 486 retirees and their beneficiaries were receiving annuities. ERS has requested $56.7 million for the coming biennium to cover current benefit levels.

All judges and justices taking office after August 31, 1985, receive their retirement benefits through JRS II. With an actuarial value of assets at $186.4 million, this plan operates as a traditional, pre-funded annuity plan. Like with JRS I, active members contribute 6 percent of payroll during their first 20 years of service and may elect to continue contributing for up to 10 additional years. For the 2006-07 biennium the state has contributed 16.83 percent to cover

normal costs. As of August 31, 2006, there were 498 active members, 494 of whom are still contributing. In addition, there were 95 non-contributing, inactive members. Only 89 annuitants were receiving benefits at that time. ERS has requested $20.2 million for the next biennium in order maintain the current contribution rate.

The Teacher Retirement System (TRS)

The Teacher Retirement System (TRS) was established in 1937, and provides retirement benefits to employees of public school districts and institutions of higher education. As with the main ERS trust fund, today the TRS pension trust fund is predominately funded with investment returns. For FY 2006, 73 percent of new revenues to the fund were generated from returns on investments. Currently, the market value of the fund is $100.2 billion and it returned 9.6 percent last year. This return outperformed the actuarially assumed rate of 8 percent. This is the fourth year in a row of solid investment returns. However, in 2001 and 2002, the fund experienced negative growth losing $18.3 billion in market value.

In order to better adjust for these types of peaks and valleys in investment return, TRS utilizes a five-year smoothing methodology that prevents the fund from fully recognizing market gains and losses immediately. This actuarial calculation of fund value allows for better year-to-year planning because of the more predictable annual funding stream. The effect of this policy can be seen on the graph in Appendix II. As of August 31, 2006, the actuarial value of the pension fund was $94.2 billion.

Active employees and the state also provide revenue to the fund. Active members currently contribute 6.4 percent of their salary to the fund. This level has remained unchanged since 1985. Currently, there are just under 762,000 active members. Payroll for those members has increased annually an average of 5.9 percent over the past ten years. For FY 2006, payroll for active members increased 9.4 percent. This generated $1.7 billion in active member contributions to the trust fund.

The state is directed by the Constitution to contribute at least 6 percent of payroll but not more than 10 percent. Since 1997, the state has contributed at the constitutional minimum. For FY 2006, state contributions totaled $1.3 billion.

Local employers, like school districts and institutions of higher education, also provide a limited level of funding to the trust fund. During an active employee's first 90 days of TRS membership, the state does not make a contribution on behalf of that member. Instead the local employer picks up this cost. In addition, school districts must make contributions at the state contribution rate on any salary paid that is beyond the state minimum salary scale. For FY 2006, local employers contributed $181 million to the trust fund.

Beyond that mentioned above, most school districts contribute very little to the retirement benefits of their employees. Since the creation of the pension trust fund, districts have never been required to make contributions on the full salary of their employees. In addition, most districts make no contribution to Social Security. Provided with the opportunity to opt out of this federal program in 1983, most districts took the option. Today, 95 percent of the school districts

do not participate in Social Security. Finally, while TRS provides the local employers with access to 403(b) products for their employees, most employers offer no contribution match and participation in the program is low.

As with ERS, TRS regularly examines the financial ability of the fund to cover both current and future benefits. The number of current retirees or beneficiaries, future retirees expected, the amount of anticipated monthly annuity payments, and the predicted length of the annuity payment period must be considered. Assumptions made about each of these variables can be affected from year to year through changes made to employee compensation, early retirement incentives, benefit adjustments, or trends that affect the overall size of the active member workforce.

Although annual increases in the number of TRS active members has averaged a modest 1.6 percent over the past decade, the number of retired members has grown more aggressively. During that same period, just under 105,000 new retirees have been added. This represents an average annual increase of 5.4 percent. However, for FY 2006, the rate of retiree growth slowed to 3.5 percent.

Today there are approximately 257,000 retired members. At an average age of 69.4 years, these annuitants are receiving average monthly payments of $1,796. There are also another 48,324 inactive members who are vested but have yet to retire.

For the most recent valuation actuarially accrued liabilities totaled $107.9 billion. The $13.7 billion in unfunded actuarially accrued liabilities (UAAL)[7] combined with the current funding levels has created a situation like that with ERS where the fund is technically not actuarially sound despite the fact that it continues to be generally well-positioned financially with an 87.3 percent funded ratio. This condition began in 2002, primarily as a result of the major market loses in 2001 and 2002. As a result, the fund has been precluded from providing retirees with any additional benefits such as a 13th monthly check or cost of living adjustment.

The last time any benefit enhancements were provided was in 2001. At that time, the Legislature funded both an increase in the multiplier[8] and a 6 percent ad hoc increase for all retirees. The combination of these actions positioned retirees 15 percent ahead of inflation at the time, and provided a significant benefit increase to all future retirees. With no enhancements since then however, inflation pressures have steadily eaten away at many of the gains provided.

Until a better mix of actuarially accrued liabilities and actuarial value of assets is achieved the fund will continue in its current state. This can be achieved by reducing future liabilities and/or through revenue enhancements.

[7] This is the difference between the $94.2 billion in actuarial value of assets and the $107.9 billion in actuarially accrued liabilities.

[8] In 1999 the multiplier was increased from 2.0 percent to 2.2 percent and in 2001 it was increased from 2.2 percent to 2.3 percent.

Benefit adjustments and changes to retirement eligibility are two of the primary tools available to help control future liabilities. Senate Bill 1691 passed by the 79th Legislature made modest adjustments to several of these types of provisions.[9] All totaled, the bill reduced the UAAL by $1.5 billion. Although the legislation helped better position the fund financially, its condition was not improved enough to be considered "sound." Additional changes such as adjusting the multiplier, broadening the application of the minimum retirement age, or increasing the Rule of 80, do not seem necessary given the steadily improving financial condition of the fund. However, continuing to closely examine early retirement incentives that serve to lower the retirement age and increase the annuity payment period could be helpful.

An injection of additional revenue to the fund would also improve its position. A contribution increase of 1.02 percentage points on the part of the state, active members, and/or the employing school districts would immediately render the fund actuarially sound. The cost to achieve this is approximately $250 million annually.

Alternatively, should the state decide to maintain the current combined contribution rate, actuarial solvency could be attained in 2008. This assumes that investments continue to meet the 8 percent return target and that other actuarial assumptions are met. In the interim, however, retirees would not receive any additional benefits.

Senate Bill 1691

As discussed above, the 79th legislature passed S.B. 1691 in an effort to improve the long-term actuarial condition of the pension fund. To prevent an unfair impact on those members near retirement, the legislation included fairly significant grandfathering provisions. Members who were 50 years old, had met the Rule of 70, or had 25 years experience as of August 31, 2005, were exempted from three major provisions of the bill: the change from three to five year final average salary, elimination of subsidized early retirement, and the Rule of 90 requirement to qualify for a partial lump sum. In addition, the provision to reduce benefits for members retiring prior to age 60 was limited to only those individuals joining TRS on or after September 1, 2007. Given the breadth of these grandfathering provisions, the Committee received little to no input from TRS members regarding these provisions.

The Committee did however receive significant feedback regarding provisions of S.B. 1691 relating to "return to work." Under retire/rehire arrangements, local employers rehire recently retired educators to fill positions previously occupied by active TRS members. By doing this, local employers eliminate many of their benefit costs associated with employing an active member. This includes health insurance contributions for both active and retired members, as well as any limited retirement contributions the district may have been making. At the same time, retirees are able to access their retirement benefit earlier than they may have otherwise while also drawing their regular salaries. In addition, the retired employee is no longer required to make contributions to the retirement fund as an active employee would.

[9] Acts 2005, 79th Leg., ch. 1359. *See* Appendix II for a summary of S.B. 1691.

While the local employer and the retiree are better financially positioned under this arrangement, both the TRS pension fund and retiree health insurance plan have suffered. The loss of revenue from contributions results in some financial strain; however, the downward pressure on retirement age has perhaps been the most problematic.

To address both concerns, S.B. 1691 required employers to contribute to the pension fund at the combined rate of both the state and active member and to cover the state's share of retiree healthcare costs for that employee. Retirees employed as of January 2005, were grandfathered from these surcharges as long as they did not change employers.

The relatively limited nature of this grandfather clause has been the source of the majority of concerns expressed about S.B. 1691. Because the provision was not in place at the time most retirees initiated their retirement, many feel this change is unfair. This concern is compounded by the fact that most school districts in the state are now refusing to hire retirees because of the financial considerations associated with the surcharge. As a result, many retirees who thought they would have the option to return to employment are finding themselves shut out. Most argue that had they known about these provisions at retirement their decision may have been affected.

Other Issues

In addition to concerns relating to S.B. 1691, the Committee also heard testimony regarding provisions in law that prevent Optional Retirement Program (ORP) participants from ever transferring those years of service to TRS.[10] ORP is a defined contribution plan created in 1967 for *higher education* faculty and administrators as an alternative to the TRS pension.

New qualifying higher education employees may choose between ORP and TRS; however, once years are accrued in ORP they may not be brought into TRS. As a result, ORP participants who wish to transition into public education teaching positions are finding major disincentive in doing so.

Their inability to consolidate their years of service into one system may prevent otherwise highly qualified, and much needed educators from moving into public education. Given the shortage of qualified educators that already exists in many areas of public education, and considering staffing strains that the additional math and science requirements provided for in House Bill 1, 79th Legislature (3rd Called) may create, the existence of these types of barriers is certainly worthy of note.

TRS Active and Retired Member Survey

To better ascertain active member and retiree opinions about TRS benefits the Committee contracted with the University of North Texas, Survey Research Center (SRC) to seek input on these issues.[11] The SRC conducted 1,100 telephone interviews with active and retired members.

[10] Senate Committee on State Affairs Hearing, October 18, 2006 (statement of Greg Hilley).
[11] Senate Committee on State Affairs Hearing, October 18, 2006 (statement of James Glass, University of North Texas Survey Research Center).

Surveyors sought opinions on a number of aspects of TRS benefits including both pension and healthcare. Members were also asked about various possible benefit adjustments. The results of the survey are summarized in Appendix II.

Recommendations

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

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

1.c. The Legislature should direct all state group health plans to quarterly update the Legislature on state health expenditure trends. Such reports should be provided in a standardized format and compare actual trends to projected trends. In addition, ERS, UT, A&M and TRS health care experts should consider meeting regularly to discuss and compare cost containment strategies. The group should also discuss provider contract provisions and rates.

1.d. The Legislature, through the Legislative Budget Board (LBB), should consider hiring an outside consultant to more closely examine the possibility of merging the contracting and administrative oversight functions of all the state administered health plans.

1.e. To alter the actuarial position of the ERS pension fund, the Legislature should consider raising the state and active member contribution rates to a combined level sufficient to bring the fund into actuarial solvency. The state should also look to re-establish a permanent funding mechanism for the LECOSRF.

1.f. The state should also consider providing a financial match (at even a modest level) to state employees choosing to participate in one of ERS' deferred compensation retirement plans.

1.g. To provide a more stable funding base that is better positioned to provide long-term support to the types of benefit enhancement desired by TRS active and retired members, the state should consider increasing the active member contribution rate modestly. The state should also consider increasing its contribution rate to a level equal to that of active members. Finally, the state

should consider requiring local employers to contribute to the pension fund at a rate set by the GAA within a statutory range.

1.h. The state should also consider providing a financial match (at even a modest level) to active members who choose to participate a TRS certified deferred compensation retirement plan, provided their local employer also provides a match at least equivalent to that of the state.

1.i. The state should consider modifying the retire/rehire grandfather provision provided for in S.B. 1691 so that local employers would not be required to pay surcharges to employ any individual who was retired prior to September 1, 2005.

1.j. The state should more closely examine the possibility of allowing ORP members to transfer limited numbers of those years of service to TRS should they make long term commitments to teach in critical shortage areas of public education.

Charge No. 3

Study and make recommendations on how election officials could verify the identity of a voter without hindering a person's right to vote. Include an analysis of the extent to which individuals are casting multiple votes because of any lack of voter identification verification. Make recommendations on how the state could improve its vote-by-mail system to ensure the authenticity of those ballots.

Background

The history of elections and voting in Texas reveals periods when all elections were not free and fair. Like many southern states, until the 1960s and 1970s, Texas engaged in certain practices to limit or prevent minority participation in elections.[12] Additionally, until 1966, when the poll tax was overturned, elections were often controlled by local political bosses who paid all of the poll taxes and then personally voted each ballot.[13] George Parr of South Texas was the most notorious. The Parr-controlled counties insured Lyndon B. Johnson's 1948 Democratic U.S. Senate primary victory over Coke Stevenson.[14]

Great strides have been made in the last 30 years to increase the electorate's confidence. Texas now endeavors to ensure fair and accurate elections; however, some pitfalls remain, as shown most recently in the November 2000 federal elections, particularly in Florida. Following

[12] *See* Bullock v. Carter, 92 S.Ct. 849 (1977) (struck down system of filing fee financed primary); White v. Regester, 93 S.Ct. 2332 (1973) (holding certain multimember districts unconstitutional); Terry v. Adams, 73 S.Ct. 809 (1953) (enjoined Democratic Party Jaybird primary process); Smith v. Allwright, 64 S.Ct. 757 (1944) (overturned Democratic State Convention adopted ban on Negro participation in primaries); Grovey v. Townsend, 55 S.Ct. 622 (1935) (affirmed Democratic State Convention adopted ban on Negro participation in primaries); Nixon v. Condon, 52 S.Ct. 484 (1932) (overturned statute delegating power to set qualifications for voting to Democratic Party State Committee); Nixon v. Herndon, 47 S.Ct. 446 (1927) (overturned statute prohibiting Negros from voting in Democratic primaries).

[13] U.S. v. Texas, 252 F.Supp. 234 (W.D. Tex. 1966).

[14] ROBERT A. CARO, THE YEARS OF LYNDON JOHNSON MEANS OF ASCENT 303 (1990).

those elections, Congress adopted several measures to address irregularities including those relating to voter fraud.[15] The federal Help America Vote Act of 2002 (HAVA) mandated additional voter identification for new registrants and the development of a statewide voter registration list with identification verification cross-checks.[16] House Bill 1549, adopted by the 78th Texas Legislature, amended the Election Code to implement the federal mandates contained in HAVA.[17]

Although the changes made in response to HAVA include measures intended to limit voter fraud, some states have enacted statutes requiring each voter to present photo identification at the polling place prior to receiving their ballot. These statutes are intended to aid in the investigation and prosecution of persons perpetrating voter fraud and to improve voter confidence in the process. Although such statutes have been met with legal challenges, federal courts have been reluctant to strike down voter photo ID laws completely.

Voter Registration

Prior to 2004, a Texas voter could register to vote by filling out a voter registration card and providing their name, birthdate, address, and affirming statements pertaining to U.S. citizenship, county residence, mental competency and lack of felony convictions.[18] In compliance with HAVA, an application for voter registration submitted after January 1, 2004, must now also include the applicant's Texas driver's license number or Department of Public Safety identification number.[19] If the applicant has neither form of identification, they must provide the last four digits of their Social Security Number. If the applicant has none of those identification numbers, they must state that fact and a unique identifier will be assigned.

In addition to the new identification requirements for voter registration, HAVA mandated that each state develop a statewide computerized voter registration list.[20] As administrator of the list, the Secretary of State, is required to cross-check driver's license and social security numbers with the Texas Department of Public Safety and the Social Security Administration. The Secretary of State must also collect information from other state agencies to identify convicted felons and persons who have died. This new statewide list was in place as of January 1, 2006.[21]

From January 1, 2004, until January 1, 2006, applicants who were registering to vote by mail had to provide appropriate identification with their voter registration card or present such ID at the polling place when they voted for the first time.[22] This requirement was part of HAVA and was intended to increase identity verification pending the development of a statewide voter registration list. The statutory provision requiring additional identification expired January 1,

---

[15] *See* State Affairs Committee Interim Report to 78th Leg. at 22 (2004).
[16] Help America Vote Act of 2002, Pub. L. No. 107-252 (2002).
[17] Acts 2003, 78th Leg., ch. 1315.
[18] TEX. ELEC. CODE § 13.002(c) (2003).
[19] TEX. ELEC. CODE § 13.002(c)(8) (Supp. 2005).
[20] Help America Vote Act of 2002, Pub. L. No. 107-252, § 303 (2002); 42 U.S.C. § 15483 (2002); TEX. ELEC. CODE § 18.061 (Supp. 2005).
[21] An upgraded, fully electronic system is expected to be in place in Spring 2007. http://www.sos.state.tx.us/elections/forms/team_schedule.pdf
[22] TEX. ELEC. CODE § 18.005(a)(4) (Supp. 2005).

2006, the date of implementation of the statewide voter registration list.

Voting

Prior to 2004, during early voting or on election day, a voter had to present one of the following to the election official prior to receiving their ballot: voter registration card; driver's license; or other statutorily defined proof of identification. Acceptable "other proof of identification" included:

> (2) a form of identification containing the person's photograph that establishes the person's identity; (3) a birth certificate or other document confirming birth that is admissible in a court of law and establishes the person's identity; (4) United States citizenship papers issue to the person; (5) a United States passport issued to the person; (6) *pre-printed checks* containing the person's name that are issue for a financial institution doing business in this state; (7) official mail addressed to the person by name from a governmental entity; (8) *two other forms of identification* that establish the person's identify; or (9) any other form of identification prescribed by the secretary of state.[23]

In 2003, the Legislature modified the list of allowable polling place identification to be consistent with HAVA.[24] It replaced "pre-printed checks" and "two other forms of identification" with "a copy of a current utility bill; bank statement; government check; paycheck; or other government document that shows the name and address of the voter."[25]

Vote-by-Mail System

HAVA did not mandate any changes to the vote-by-mail system. To vote by mail, a registered voter must simply request a mail ballot by proper application at least seven days prior to election day.[26] Grounds for voting by mail include: absence from the county of residence on election day; age or disability; or confinement in jail.[27] Upon receipt of a vote-by-mail application, the clerk verifies the information in the application and sends out a ballot. Once the ballot is received, the voter must mark their ballot, place it in the official envelope, seal the envelope and sign the certificate printed on the outside.[28] A vote-by-mail ballot must be received by the clerk before the polls close on election day; or in the case of a ballot coming from outside the U.S., by the fifth day following election day.[29]

---

[23] TEX. ELEC. CODE §§ 63.008; 63.0101 (2003) (emphasis added).
[24] Acts 2003, 78th Leg. ch. 1315 § 27.
[25] TEX. ELEC. CODE § 63.0101(7) (Supp. 2005). This language was used in HAVA. *See* HAVA § 303(b); 42 U.S.C. § 15483 (2005). A similar law is currently being challenged in Ohio. Northeast Ohio Coalition for the Homeless v. Blackwell, No. C2-06-896 (S.D. Ohio Oct. 26, 2006) (Temporary Restraining Order). Ohio's statute states in part, "a copy of a current utility bill, bank statement, government check, paycheck, or other government document." In granting the TRO the federal district court held that the phrases "current," "other government document," "military identification" and "driver's license number" were unconstitutionally vague and were "being unequally applied by the Boards of Elections" in a manner which violated both the Due Process Clause and the Equal Protection Clause of the U.S. Constitution. *Id.* at 3. An appeal to the Sixth Circuit has been filed.
[26] TEX. ELEC. CODE § 84.007 (2003).
[27] TEX. ELEC. CODE § 84.002 (2003).
[28] TEX. ELEC. CODE § 86.005 (Supp. 2005).
[29] TEX. ELEC. CODE § 86.007 (Supp. 2005).

As with in-person voting between January 1, 2004 and January 1, 2006, if the requesting voter registered to vote by mail and their application was for the first election following registration, they must include a copy of appropriate identification with their ballot when it is returned to the clerk.[30]

Voter ID: 78th Legislature

During the 78th Regular Session, Rep. Mary Denny introduced H.B. 1706 which would have required each voter to present identification in addition to their voter registration card at each polling place. The legislation also allowed the Department of Public Safety to issue personal identification certificates at no cost, to individuals who were unable to pay the required fee. The fiscal note prepared by the Legislative Budget Board projected the cost of issuing these identification certificates at $130,110 per year. The Legislature did not pass H.B. 1706.

Discussion

Photo Identification Laws

To address voter fraud, some states have adopted more stringent voter identification laws in addition to the HAVA requirements discussed above. Because HAVA required identification verification for first time voters as well as cross-checking of driver's license and social security numbers, the policy debate surrounds whether requiring photo identification at the polls for every voter hinders a person's right to vote.

Arizona citizens adopted Proposition 200, which requires all registrants to prove U.S. citizenship at *registration* by providing one of the following: state issued driver's license; birth certificate; passport; original naturalization document; other immigration document that proves citizenship; or a Bureau of Indian Affairs card number.[31] The Proposition was challenged in Arizona federal District Court and the court issued an order denying the plaintiff's request for preliminary injunction.[32] The plaintiffs appealed and the Ninth Circuit issued an emergency injunction in their favor.[33] However, the injunction was vacated by the Supreme Court due to a lack of justification in the Ninth Circuit's order.[34] Therefore, the case is now proceeding in the District Court.

Ohio adopted a provision allowing poll workers to request that naturalized citizens show proof of citizenship upon request.[35] The statute was challenged in federal District Court and on October 26, 2006, the court held the provisions placed an undue burden on naturalized citizens in Ohio in violation of the 14th Amendment to the U.S. Constitution.[36]

---

[30] TEX. ELEC. CODE § 18.005(a)(4) (Supp. 2005).
[31] ARIZ. REV. STAT. §§ 16-152; 16-166 (2006).
[32] Gonzalez v. Arizona, No. 2:06-CV-01268-ROS (D. Ariz. Sept. 11, 2006) Order Denying Motion for Preliminary Injunction. The Order was followed 30 days later with the court's Findings of Fact and Conclusions of Law. Gonzalez v. Arizona, No. 2:06-CV-01268-ROS (D. Ariz. Oct. 11, 2006) (Order).
[33] Gonzalez v. Arizona, No. 06-16702 (9th Cir) (Oct. 5, 2006).
[34] Purcell v. Gonzalez, No. 06A375, ___ U.S. ___ (Oct. 20, 2006).
[35] OHIO REV. CODE € 3505.20 (2006).
[36] Boustani v. Blackwell, No. 1:06-CV-02065-CAB (N.D. Ohio Oct. 26, 2006).

To date, eight states have enacted laws relating to voters' presentation of photo identification at the polling place. Three states, Hawaii, Louisiana and South Dakota, *request* that each voter show a photo ID at the polling place. If they do not have a photo ID, they are required to sign an affidavit and are then allowed to vote a regular (non-provisional) ballot.[37] Five states, Indiana, Georgia, Michigan, Missouri and Florida, have enacted legislation *requiring* all voters to show photo identification at the polling place.[38]

Challenges to Voter Identification Laws

A law requiring voters to present photo identification at the polling place will probably be challenged under numerous constitutional and statutory theories. It may be challenged as an undue burden on the voter or as a poll tax in violation of the 14th and 24th amendments to the U.S. Constitution, respectively. It may also be challenged on the grounds that it is discriminatory and violates the Equal Protection Clause of the 14th Amendment and the Civil Rights Act of 1964. Finally, any such law adopted in Texas may be challenged as a violation of the federal Voting Rights Act of 1965.[39] The following chart summarizes current voter photo ID laws and the associated legal challenges.

[37] http://www.electionline.org/Default.aspx?tabid=364

[38] The City of Albuquerque, New Mexico, amended their city charter to require voters in municipal elections to present photo ID at their polling place. A court challenge is pending alleging the requirement violates the Equal Protection Clause of the U.S. Constitution, the Civil Rights Act of 1964 and the Voting Rights Act of 1965. American Civil Liberties Union of New Mexico et. al. v. Santillanes, No. CV 05-1136 MCA/WDS (D. N.M. Jan. 3, 2006).

[39] Experts suggest that a voter photo ID law may also be challenged on the grounds that such laws are enacted "for the purpose of diminishing electoral participation by citizens possessed of views the lawmakers disfavor," contrary to the Supreme Court's decision in Carrington v. Rash, 380 U.S. 89 (1965). However, to date, plaintiffs have yet to advance this argument. *See* Christopher Elmendorf, *Burdick or Carrington?: "Fencing Out" and the Voter ID Litigation*, Election Law @ Moritz (Sept. 12, 2006) <http://moritzlaw.osu.edu/electionlaw/comments/2006/060912.php>

State Voter Photo ID Laws

State	Voter ID Law Description	Court Challenges
Indiana IND. CODE § 3-11-8-25.1 (2005).	Voters must present photo ID at the polling place. Acceptable forms of ID include driver's license; non-driver's license identification; passport; military ID; and select Indiana State University student IDs. Exemptions are made for indigent, those "with a religious objection to being photographed" and those living in state-licensed facilities that serve as their precinct's polling place. To claim an exemption, the voter must cast a provisional ballot and within 10 days go to the county election office or vote absentee-in-person at the county election office before election day. A state identification card may be obtained free of charge through the Bureau of Motor Vehicles.	*Indiana Democratic Party, et al. v. Rokita*, No. 1:05-CV-0634-SEB-VSS, 2006 U.S. Dist. LEXIS 20321 (S.D. Ind.) (April 14, 2006) (Order Granting Defendants' Motions for Summary Judgment, Denying Plaintiffs' Motions for Summary Judgment, and Denying Plaintiffs' Motions to Strike). Appeal pending. *Indiana Democratic Party v. Rokita*, No. 06-2218 (7th Cir.). Oral arguments presented Oct. 18, 2006.
Georgia GA. CODE ANN. § 21-2-417 (2005).	Voters must present photo ID at the polling place. Acceptable forms of ID include: driver's license; passport; military identification; tribal identification card; or photo voter identification card. Eligible voters may receive a photo voter identification card free of charge if they do not have one of the other requisite IDs.	*Common Cause/Georgia v. Billups*, No. 4:05-CV-00201-HLM (N. D. Ga. July 14, 2006) (Order Granting Preliminary Injunction). Proceeding stayed pending resolution of appeal to Georgia Supreme Court of declaratory judgment and permanent injunction issued by Superior Court of Fulton county in *Lake v. Perdue*. *Lake v. Perdue*, No. 2006-CV-119207 (Supr. Ct. Ga. July 7, 2006) (Preliminary Injunction). Appeal pending.
Michigan Mich. Comp. Laws § 168.523 (1997)	Voters must present photo ID at the polling place. Acceptable forms of ID include "official state identification card," driver's license, or "other generally recognized picture identification card."	Pursuant to an attorney general opinion in 1997, the statute has never taken effect. However, recently, the Michigan Supreme Court granted a request by the House of Representatives for an advisory opinion on the constitutionality of the statute. *In Re Request for Advisory Opinion Regarding Constitutionality of 2005 PA 71*, No. 130589 (April 16, 2006).
Missouri MO. REV. STAT. § 115.427 (2006)	Voters must present photo ID at the polling place. Acceptable forms of ID include: driver's license; non-driver's license identification; passport; or military identification. Non-driver's license IDs may be obtained free of charge.	*Jackson County v. Missouri*, No. 06AC-CC00587 (Cole Cty. Dist. Ct.); *Weinshenk v. Missouri*, No. 06AC-CC00656 (Cole Cty. Dist. Ct.) (Sept. 14, 2006) (Judgment in favor of Plaintiffs). Appeal to Missouri Supreme Court, *Weinshenk, et. al. v. Missouri*, No. SC88039 (Oct. 16,

	If a voter does not have an acceptable ID, they may cast a provisional ballot which will be counted if the signature matches that on the voter registration card on file. After November 2006, a voter without acceptable ID may not cast a provisional ballot.	2006). The Court, sitting en banc, affirmed the trial court's holding that the photo ID law violates the state constitution. *NAACP v. Carnahan*, No. 06-04200-CV-C-SOW, (W.D. Mo. Oct. 3, 2006). Proceeding stayed pending order in *Weinshenk v. Missouri*.
Florida FLA. STAT. § 101.043 (2005).	Voters must present photo ID at the polling place. Acceptable forms of ID include: driver's license; identification card issued by the Dept. of Highway Safety and Motor Vehicles; passport; employee badge or identification; buyer's club identification; debit or credit card; military identification; student identification; retirement center identification; neighborhood association identification; and public assistance identification. If the ID does not contain a signature, the voter will be asked to provide an additional identification with signature. Voters without the requisite identification may cast a provisional ballot.	None

Figure 3 - 1

The "Undue Burden" Challenge

State laws that "abridge the privileges or immunities of citizens of the United States" are prohibited under Section 1 of the 14th Amendment to the U.S. Constitution. Courts have interpreted this language to prohibit undue burdens that infringe upon a person's right to vote.[40] Opponents assert voter photo ID laws place an undue burden on some voters because voters may have to travel to motor vehicle departments or other county or state offices to secure appropriate identification.[41]

When faced with a constitutional challenge, courts apply either a strict scrutiny standard or a lesser standard of reasonableness. In *Indiana Democratic Party v. Rokita* and *Common Cause/Georgia v. Billups*, two federal district courts determined that although the Supreme Court had applied strict scrutiny in the past, the most recent line of Supreme Court cases sanctioned a lesser standard for election law challenges.[42] In *Burdick v. Takushi*, the Supreme Court stated:

[40] Burdick v. Takushi, 504 U.S. 428 (1992).

[41] Senate Committee on State Affairs Hearing, April 18, 2006 (statements of Luis Figueroa, Mexican American Legal Defense and Educational Fund; Laurie Vanhoose, Advocacy Inc.).

[42] Indiana Democratic Party, et al. v. Rokita, No. 1:05-CV-0634-SEB-VSS, (S.D. Ind.), Order Granting Defendants' Motions for Summary Judgment, Denying Plaintiffs' Motions for Summary Judgment, and Denying Plaintiffs' Motions to Strike at 76-86 (April 14, 2006) (appeal pending, 7th Cir.); Common Cause/Georgia v. Billups, No. 4:05-CV-00201-HLM (N. D. Ga.) Order Granting Preliminary Injunction at 146-149 (July 14, 2006). It should be noted that Georgia passed its first photo ID law in 2005 and the Court issued its first preliminary in junction on October 18, 2005. Common Cause/Georgia v. Billups, 406 F.Supp.2d 1326 (2005). In its first injunction order, the court applied both standards. With regard to the strict scrutiny standard, the court held that Georgia's law failed the standard stating, "[A]ccepting that preventing voter fraud is a legitimate and important state concern, the statute is not narrowly drawn to prevent voter fraud." *Id.* at 1361. In response, Georgia amended its law to allow IDs free of

"[T]o subject every voting regulation to strict scrutiny and to require that the regulation be narrowly tailored to advance a compelling state interest … would tie the hands of states seeking to assure that elections are operated equitably and efficiently."[43] Therefore, to invoke a strict scrutiny standard of review, plaintiffs must proffer evidence of individuals unable to vote due to severe burdens, as well as statistics or data that demonstrate an extension of that burden to a group.[44] After analyzing the evidence, both courts held that a standard of reasonableness weighing the degree of burden on the voter against the state interest being served was appropriate.[45]

The interest served by voter photo ID laws is the validation of a voter's identity to prevent voter fraud at the polls as well as increase the level of confidence citizens have in the electoral process and in their election administrators.[46] A state certainly has a valid interest in preventing voter fraud; the question is whether the restriction or burden placed on voters is reasonable.

With regard to the degree of burden, opponents assert that many eligible voters do not have the requisite identification and would have to obtain such for the sole purpose of voting. In addition, opponents argue that many voters do not have the certificates or identification needed to obtain the requisite photo ID. Therefore, those individuals will be forced to travel to multiple government offices (often being forced to take time off of work), stand in multiple lines, and pay multiple fees to be able to vote.[47]

To counter opponents' arguments and reduce the potential burden on voters, Indiana, Georgia and Missouri laws all provide a method for voters to obtain acceptable photo identification free of charge.[48] Georgia also has a mobile ID unit that travels throughout the state, targeting locations where certain residents, such as the elderly, reside.[49] Florida has taken a different approach by accepting a wide variety of photo IDs at the polling place. Additionally, Indiana, Georgia and Florida have a "no excuse" policy for absentee voting-by-mail.[50] Therefore, any voter lacking appropriate photo identification may cast an absentee ballot.

After weighing the burdens and the state interest in *Rokita*, the federal District Court concluded that Indiana's voter photo ID law did not place an undue burden on an individual's

---

charge to anyone swearing "that he or she desires an identification card in order to vote … and … does not have any other form of identification that is acceptable…." GA. CODE § 21-2-417 (2006). In the meantime, the federal district court in Indiana handed down its opinion which concluded that a strict scrutiny standard did not apply. *Rokita* at 76. Thereafter, in its second preliminary injunction, the Georgia District Court did not apply the strict scrutiny standard, but instead looked to *Burdick* for guidance, like the *Rokita* court.

[43] *Burdick*, 504 U.S. 428, 433 (1992).

[44] *Rokita* at 80.

[45] *Rokita* at 85-86 *quoting* Griffin v. Roupas, 385 F.3d 1128, 1130 (7th Cir. 2004); *Billups* at 146-149 *citing Burdick*, 504 U.S. at 433-34.

[46] *Rokita* at 87.

[47] *See* Senate Committee on State Affairs Hearing, April 18, 2006 (statements of Luis Figueroa, Mexican American Legal Defense and Educational Fund; Laurie Vanhoose, Advocacy Inc.); *Rokita* at 15-16; *Billups* at 150-155.

[48] IND. CODE § 3-11-8-25.1 (2005); GA. CODE ANN. § 21-2-417 (2005); MO. REV. STAT. § 115.427 (2006).

[49] *Billups*, 406 F.Supp.2d at 1363.

[50] See chart in Appendix III.

right to vote that outweighed the justification for the restriction.[51] The court dismissed plaintiffs' argument that there had been no documented cases of in-person voter impersonation by stating "the State is not required to produce such documentation prior to enactment of a law."[52]

By contrast, in *Billups*, the federal District Court in Georgia held that the photo ID law requirements placed undue burdens on voters that outweighed the state's interest in preventing voter fraud. First, the court found the lack of evidence of in-person voter fraud was significant in its evaluation of whether the statute was narrowly tailored to the state's interest.[53] The court noted the only evidence put forth by the defendants pertained to voter fraud through the registration or vote-by-mail process. The court also noted the availability of alternatives to the state to address voter fraud, such as criminal statutes. In concluding that the statute was not narrowly drawn, the court cited the Supreme Court's decision in *Dunn v. Blumstein*:

> Statutes affecting constitutional rights must be drawn with "precision," and must be "tailored" to serve their legitimate objectives. And if there are other, reasonable ways to achieve those goals with a lesser burden on constitutionally protected activity, a State may not choose the way of greater interference. If it acts at all, it must choose "less drastic means."[54]

Second, in its analysis of the degree of burden on eligible voters, the Georgia federal District Court focused on the implementation of Georgia's law. Georgia's legislature adopted the first photo ID law in April 2005. It was enjoined on October 18, 2005, and then refiled and passed again by the Legislature in January 2006. The Department of Justice pre-cleared the changes in April 2006, and the court held an injunction hearing on July 12, 2006, to address the enforcement of the law during the next scheduled elections which were primaries set for July 18, 2006.

The court concluded that generally, Georgia's voter photo ID law would not place an unjustifiable burden on voters; however, due to the limited period of time before the next election cycle, the court determined that few voters would know about absentee voting or the free IDs, or have access to the mobile unit which was intended to serve Georgia's 159 counties in just a few weeks.[55] Therefore, the court concluded that the burden outweighed the justification for the photo ID law and it granted the plaintiffs' request for injunctive relief.

It should be noted, the District Court sent a very clear signal in its decision about the future of the Georgia's photo ID law. It stated:

> In issuing this Order, the Court does not intend to imply that all Photo ID requirements would be invalid or overly burdensome on voters. Certainly, the Court can conceive of ways that the State could impose and implement a Photo ID

[51] *Rokita* at 96.
[52] *Id.* at 87-88.
[53] *Billups* at 165.
[54] *Billups* at 166 quoting *Dunn*, 405 U.S. 330, 343 (1972).
[55] *Billups* at 163-164. Although the election officials attempted to educate the public about the new ID requirement, actual education materials (pamphlets, television and radio announcements) did not begin until the beginning of July due to the pending court challenges. *Id.* at 168.

> requirement without running afoul of the requirements of the Constitution. Indeed, if the State allows sufficient time for its education efforts with respect to the 2006 Photo ID Act and if the State undertakes sufficient steps to inform voters of the 2006 Photo ID Act's requirements before future elections, the statute might well survive a challenge for such future.[56]

The outcomes of *Rokita* and *Billups* are significant. In both cases the courts looked at similar statutes, applied the same standard of review, and came to different conclusions. The timing in Georgia contributed greatly to the court's decision that the voter photo ID law did in fact place an undue burden on the voters. Additional time to educate voters about the new requirement, coupled with sufficient evidence of in-person voter fraud may tip the scales and result in a finding that Georgia's law is constitutional. Most importantly, it should be noted that the Georgia District Court decision was preliminary and both parties will still have an opportunity to make their case. Additionally, an appeal of *Rokita* is pending in the Seventh Circuit. Therefore, caution should be taken when relying on these decisions as precedent.

The "Poll Tax" Challenge

The 24th Amendment to the U.S. Constitution prohibits states from requiring citizens to pay a poll tax, or other tax, as a condition for voting. Additionally, poll taxes have been held to be in violation of the Equal Protection Clause of the 14th Amendment.[57]

Opponents to photo identification laws contend that requiring voters to purchase a government-issued photo ID places a *de facto* poll tax on voters.[58] Even if state law allows for the issuance of IDs free of charge, a voter will have to bear the cost of travel to the state or county office and may have to secure other documents, such as a birth certificate, by paying a fee.

In both *Rokita* and *Billups*, the federal District Courts held that the photo ID laws at issue did not create a poll tax.[59] Noting that voters could obtain a voting photo ID free of charge or vote absentee, both courts determined that the plaintiffs failed to prove the additional costs associated with procuring documents to obtain a voting photo ID were sufficiently tied to voting as to constitute a poll tax. Relying on the Supreme Court's decision in *Burdick*, both courts noted "[T]he imposition of tangential burdens does not transform a regulation into a poll tax."[60]

Equal Protection Clause and Civil Rights Act of 1964 Challenge

The Equal Protection Clause in the 14th Amendment to the U.S. Constitution prohibits states from adopting discriminatory laws. Additionally, the voting provisions of the Civil Rights Act of 1964 flow from the 15th Amendment to the U.S. Constitution and prohibit a state from abridging a person's right to vote by applying different standards to different groups of citizens

[56] *Id.* at 168.
[57] Harper v. Virginia State Board of Elections, 383 U.S. 664 (1966).
[58] *See* Senate Committee on State Affairs Hearing, April 18, 2006 (statements of Luis Figueroa, Mexican American Legal Defense and Educational Fund; Laurie Vanhoose, Advocacy Inc.); *Rokita* at 89; *Billups* at 170.
[59] *Rokita* at 91; *Billups* at 178 (citing *Rokita).*
[60] *Rokita* at 90; *Billups* at 177.

or by using an immaterial error or omission in paperwork to disqualify the voter.[61] Opponents of photo ID laws contend that requiring a photo ID for in-person voting and not for absentee or by-mail voting is discriminatory.[62]

Proponents argue that absentee voting is inherently a different process from in-person voting; therefore, the state is justified in treating each process differently.[63] Additionally, all absentee voters are treated the same. Finally, proponents note that extending the voter photo ID law to mail-in ballots would be pointless as there is no way to verify the voter's identity. The Indiana federal District Court agreed and held the Indiana photo ID law did not violate the Equal Protection Clause or the Civil Rights Act.[64] The Georgia federal District Court, in denying the plaintiff's preliminary injunction on grounds of discrimination, again relied on *Rokita* and concluded that the plaintiffs did not have a substantial likelihood of success on these claims.[65]

Voting Rights Act of 1965 Challenge

Opponents to photo ID laws contend that such requirements treat absentee and in-person voters differently and therefore disproportionably affect minority voters in violation of the Voting Rights Act of 1965.[66] Under the Voting Rights Act of 1965, certain states, including Texas, may not pass a law that "results in a denial or abridgement of the right of any citizen of the United States to vote on account of race or color."[67] To prevail on a claim under the Act, plaintiffs must establish that the

> [P]olitical processes leading to nomination or election in the State or political subdivision are not equally open to participation by members of a class of citizens protected by subsection (a) of this section in that its members have less opportunity that other members of the electorate to participate in the political process and to elect representatives of their choice.[68]

Although the plaintiffs in *Billups* asserted this claim, they did not address it in their brief; therefore the court did not address it in its second preliminary injunction order.[69] However, the Department of Justice pre-cleared Georgia's voter photo ID law, stating it had no objections.[70] It should be noted that because of the procedural posture of the *Billups* case, the Georgia district court did not foreclose the opportunity for the plaintiffs to prove their Voting Rights Act and Civil Rights Act claims.

---

[61] *Rokita* at 113-114 citing 42 U.S.C. § 1971(a)(2) (A) & (B).
[62] Senate Committee on State Affairs Hearing, April 18, 2006 (statements of Luis Figueroa, Mexican American Legal Defense and Educational Fund; Laurie Vanhoose, Advocacy Inc.); *Rokita* at 96; *Billups* at 180.
[63] *Rokita* at 97; *Billups* at 183.
[64] *Id.* at 100.
[65] *Billups* at 184.
[66] *Rokita* at 115; *Billups* at 189.
[67] 42 U.S.C. § 1973(a).
[68] 42 U.S.C. § 1973(b).
[69] *Billups* at 189.
[70] Letter from John Tanner, Chief, Voting Section, U.S. Dept. of Justice, to Thurbert Baker, Georgia Attorney General (Apr. 21, 2006).

State Law Challenges

Recently, the Missouri Supreme Court affirmed a trial court's decision that the state's voter photo ID law violates the Missouri Constitution.[71] The court distinguished Missouri's law from those considered by federal district courts in Indiana and Georgia on the grounds that Missourians' right to vote is enshrined in the state constitution to a greater degree than the right to vote found in the U.S. Constitution.[72] Based on this distinction and the extensive detailed evidence provided by the parties supporting a substantial burden on the right to vote, the court applied a strict scrutiny standard. The court concluded that the state has a compelling interest in combating election fraud; however, the photo ID requirement was not narrowly tailored to meet that interest. The court stated

> The Photo-ID Requirement could only prevent a particular type of voter fraud that the record does not show is occurring in Missouri, yet it would place a heavy burden on the free exercise of the franchise for many citizens of this State. Appellants also urge that the State has a compelling interest in combating perceptions of voter fraud. While the State does have an interest in combating those perceptions, where the fundamental rights of Missouri citizens are at stake, more than mere perception is required for their abridgment.[73]

Voter Fraud

Investigations - Texas

This committee is charged with investigating "the extent to which individuals are casting multiple votes because of any lack of voter identification verification." The Election Code defines illegal voting as: voting or attempting to vote in an election in which the voter knows they are not entitle to vote; knowingly voting or attempting to vote more than once in the same election; knowingly impersonating another person and voting or attempting to vote as that person; or knowingly marking or attempting to make another person's ballot without the consent of that person. Illegal voting is a third degree felony and attempted illegal voting is a Class A misdemeanor.[74]

Investigations of Election Code violations are performed in Texas by the Special Investigations Unit of the Office of the Attorney General (OAG) based on referrals from the Secretary of State's Office, district and county attorneys, or citizens.[75] Jurisdiction to prosecute offenses lies with the OAG; local district attorneys may also investigate and prosecute Election Code violations in cooperation with the OAG.[76]

---

[71] Weinschenk, et al., v. Missouri, No. SC88039 (Mo. Oct. 16, 2006) *affirming* Weinschenk v. Missouri, No. 06AC-CC00656 (Judgment Sept. 14, 2006).
[72] *Id.* at sec. II.B.
[73] *Id.* at sec. II.F.
[74] TEX. ELEC. CODE § 64.012 (Supp. 2006).
[75] TEX. ELEC. CODE Ch. 273
[76] From 2002 to 2005, the OAG conducted 17 investigations of voter fraud, based on referrals. Letter from Barry McBee, First Assistant Attorney General, to Robert Duncan, Chairman, Senate Committee on State Affairs (May 2, 2006).

To address voter fraud, the OAG began an education campaign in January 2006 targeted at local law enforcement officers in cities with more than 100,000 residents or cities that were the source of prior voter fraud referrals.[77] From January to September 2006, the OAG investigated a total of 59 allegations of voter fraud. The following charts, Figures 3-2 and 3-3, reflect the disposition of those investigations.[78]

2006 Voter Fraud Investigations

Disposition	Number of Investigations
Closed/No further action	30
Referred for prosecution	10
Investigation pending as of Sept. 1, 2006	19
TOTAL	**59**

Figure 3 - 2
Source: Office of the Attorney General, Special Investigations Unit

2006 Voter Fraud Investigations

General Subject Matter	Number of Investigations
Mail-in-ballot fraud	12
Election procedure violations	7
Polling place violations	7
Unspecified allegations	5
Electioneering	4
Use of government funds or office for campaign purposes	4
Polling place violations including illegal voting	3
Unlawful voter assistance	2
Candidate residency	2
Unlawfully accepting a voter and illegal voting	2
Illegal campaign contributions	2
Vote buying/Attempted vote buying	2
Voter registration fraud	2
Illegal ballot handling	1
Forged signatures on petition	1
Crossover signatures on petition	1
Illegal campaign signs	1
Refusal of candidate application	1
TOTAL	**59**

Figure 3 - 3
Source: Office of the Attorney General, Special Investigations Unit

[77] OAG Press release http://www.oag.state.tx.us/oagnews/release.php?id=1423
[78] There has been no formal study of voter fraud or Election Code violations by a state agency. The information presented is a collection of information available as of September 1, 2006, and does not represent statistical data.

In addition to the investigations summarized above, the OAG has documented 12 voter fraud convictions from 2005 to September 1, 2006.

Voter Fraud Convictions 2005-Sept. 1, 2006

General Subject Matter	Number of Convictions
Mail-in-ballot fraud	9
Attempted illegal voting	1
Illegal voting	1

Figure 3 - 4
Source: Office of the Attorney General, Special Investigations Unit

As shown above, the highest concentration of voter fraud is in the vote-by-mail process. Although there have been three instances of alleged illegal voting, which may include circumstances preventable by a voter photo ID law, only one of these has been fully investigated and referred for criminal prosecution. If that case is prosecuted successfully, it would bring the total number of illegal voting convictions to three since 2005.

Investigations - Federal and Other States

The nonpartisan Commission on Federal Election Reform concluded that election fraud may be difficult to measure, but is occurring in the United States.[79] The Commission noted that the U.S. Department of Justice has pursued 180 investigations of voter fraud since October 2002. These investigations related to offenses such as vote buying, submitting false voter registration information and voting-related offenses by non-citizens. The Commission cited certain factors contributing to the low number of prosecutions and convictions:

- difficulty in obtaining evidence sufficient for prosecution;
- low priority often assigned to voter fraud because it is considered a victimless and nonviolent crime; and
- low incentive to investigate and/or prosecute allegations when there is a large margin of victory.[80]

The Commission recommended the Department of Justice issue a biennial public report on its investigations as well as increase its staff to investigate and prosecute election fraud. It also recommended penalties for persons interfering, through violence or otherwise, with an individual's right to vote.[81]

Experiences in other states should also be noted. For instance, the Indiana federal District Court accepted books and media reports into evidence in support of the state's position in *Rokita.*[82] Additionally, in 1996, a Superior Court in Georgia voided an election for county

[79] Report of the Commission on Federal Election Reform, *Building Confidence in U.S. Elections* at 45 (2005).
[80] *Id.*
[81] *Id.* at 45-46.
[82] *Rokita* at 23.

commissioner because of voting irregularities amounting to 20 percent of the total vote.[83] In 1997, the *Los Angeles Times* reported that one organization had registered more than 600 legal immigrants (non citizens), 407 of whom voted in the November 1996 election.[84]

Vote-By Mail

All states allow absentee voting by mail.[85] Twenty-one states, including Texas, require voters to certify they qualify to vote by mail.[86] In Texas, a voter must cite one of the following grounds: (1) absence from the county of residence on election day; (2) age or disability; or (3) confinement in jail.[87] Twenty-nine states, including Georgia, allow a voter to request a mail ballot without stating a reason or excuse.[88]

As of 1998, Oregon conducts all of their elections entirely by mail.[89] To safeguard the integrity of the ballots, Oregon has in place a rigorous signature matching requirement. Additionally, mailed ballots may not be forwarded; each voter is required to personally update their registration data. Finally, state and local officials have fostered a relationship with the postal service to encourage carriers to report suspicious activity, such as a ballot addressed to someone who does not normally receive mail at the state address.[90]

To protect mail-in ballots from voter fraud, experts make two primary recommendations. One recommendation is to verify a voter's identity through the matching of signatures on the envelope certificate with the signature on the voter's registration. In Texas, the Election Code provides that it is the responsibility of the early voting ballot board to verify signatures.[91] Additionally, the early voting clerk in each county *may* call for the appointment of a signature verification committee.[92] If appointed, the committee is charged with comparing the signature on each mail-in ballot with the signature on the voter's mail-in ballot application and/or the voter's registration application and then delivering the sorted ballots to the early voting ballot board.[93] The board makes the final determination whether to accept or reject the ballot.[94]

---

[83] Hans A. Von Spakovsky, *Voter Fraud: Protecting the Integrity of Our Democratic System*, Georgia public Policy Foundation (March 24, 1997).
[84] *Id. See also*, *Securing the Integrity of American Elections: The Need for Change*, 9 TEX. REV. OF LAW & POLITICS 277 (2005); Report of the Commission on Federal Election Reform, *Building Confidence in U.S. Elections* at 18-21 (2005).
[85] Nineteen states allow "in-person absentee voting" which may be distinguished from early voting. In-person absentee voters must apply for an absentee ballot whereas early voters do not. Fourteen states do not allow early voting or in-person absentee voting. *See* "Early and Absentee Voting Laws" *http://www.electionline.org%5C/*; *Task* Force on the Federal Election System, *Early Voting, Unrestricted Absentee Voting, and Voting by Mail* (July 2001).
[86] http://www.electionline.org/Default.aspx?tabid=474
[87] TEX. ELEC. CODE § 84.002 (2003).
[88] *See* Appendix III.
[89] OR. REV. STAT. § 254.465 (2005).
[90] http://www.progressivestates.org/content/272/legalert
[91] TEX. ELEC. CODE § 87.041 (Supp. 2006).
[92] TEX. ELEC. CODE § 87.027 (Supp. 2006).
[93] *Id.* at § 87.027(i).
[94] TEX. ELEC. CODE § 87.041 (Supp. 2006).

Another recommended method is to allow only the voter, a family member, a postal carrier, or election official to handle a mail-in ballot.[95] This is intended to combat the practice of third parties, including political organizations and candidates, from collecting and delivering absentee ballots. Over the years, Texas has amended the Election Code to effectuate this safeguard. First, a postal carrier may not deliver ballots originating from the address of a political party or candidate; a political action committee involved in the election; or an entity that requested that the election be held.[96] Second, the Election Code prohibits persons from possessing a mail-in ballot of another voter, unless the ballot belongs to a relative or other person registered to vote at the same address or the person possessing the ballot was a witness for the voter and has appropriately documented that fact on the outside of the envelope.[97] Depending on the number of ballots in the person's possession, an offense may be classified as a state jail felony.[98]

Conclusion

It is not uncommon for the state to require photo identification to ensure security or to validate someone's identity. For instance, to qualify for food stamps a person must provide their driver's license or other photo identification and a social security number.[99] The first chart in Appendix III reflects current state laws and the requisite identification.

Driver's licenses and identification cards may be obtained at any of the Texas Department of Public Safety's Driver License Offices located throughout the state. The office locations are based on population, and many counties have more than one office. Two hundred forty-four of Texas' 254 counties, 96 percent, have at least one office. By contrast, the state of Georgia has 159 counties, few with driver's license offices, and it provides only one piece of equipment for issuing voter IDs per county, regardless of population.[100]

Opponents of voter ID legislation assert that requiring a photo ID would disenfranchise poor and elderly voters. However, as with the lack of reports on voter fraud, there are no studies presenting data to support such claims. Opponents also note that in-person voting is but one of many pieces in the election process; the vast majority of voter fraud occurs at registration and absentee voting. However, there is no dispute that the state has a legitimate interest in preventing voter fraud. It is unknown whether the current level of voter fraud will decrease, but a voter photo ID law will certainly prevent some fraud. At the very least, it would increase voter confidence.

The nonpartisan Commission on Federal Election Reform examined the voter identification issue.[101] It concluded that photo identification is the best method for assuring the

[95] Commission on Federal Election Reform, *Building Confidence in U.S. Elections* at 47 (Sept. 2005)
[96] TEX. ELEC. CODE § 86.006(d) (Supp. 2006).
[97] TEX. ELEC. CODE § 86.006(f) (Supp. 2006).
[98] TEX. ELEC. CODE § 86.006(g) (Supp. 2006).
[99] 7 C.F.R. § 273.2(f)(1)(vii).
[100] *Billups* at 154.
[101] Report of the Commission on Federal Election Reform, *Building Confidence in U.S. Elections* at 18-21 (2005).

person at the polling place is the person the represent themselves as being. The Commission stated

> A good ID system could deter, detect, or eliminate several potential avenues of fraud -- such as multiple voting or voting by individuals using the identities of others or those who are deceased -- and thus it can enhance confidence. We view the other concerns about IDs -- that they could disenfranchise eligible voters, have an adverse effect on minorities, or be used to monitor behavior -- as serious and legitimate, and our proposal below aims to address each concern.[102]

The Commission recommended the expansion of the REAL ID Act signed into law by the President in 2005, which requires states to verify certain information prior to issuing a driver's license or personal ID card.[103] It recommended that federal law be amended to require presentation of identification complying with the REAL ID Act requirements at the polling place prior to voting. However, the Commission tempered its recommendations by acknowledging opponents' concerns and by also recommending that states establish legal protections and strict procedures for managing voter data, as well as creation of ombudsman to assist voters to overcome bureaucratic mistakes and hurdles associated with voting or the use of personal information.[104]

Recommendations

The Committee is charged to make recommendations concerning methodologies for verifying identity of voters and improving the vote-by-mail system to insure authenticity of mail-in ballots. The recommendations herein are made in accordance with this charge. The Committee makes no recommendation regarding policy issues in favor of or in opposition to voter identification and/or ballot authenticity.

3.a. Any legislation to require presentation of photo identification at the polling place prior to voting should at a minimum provide for the following:

- ample time for implementation by the Secretary of State, including associated rule makings and public education, and
- issuance of qualifying photo IDs free of charge to any voter requesting, regardless of personal income level.

In addition to the above, the Committee also recommends the following:

3.b. Require the Secretary of State to monitor the effectiveness of the identification verification provisions codified in the Election Code and to monitor the legal challenges to other state's voter photo ID laws.

3.c. With regard to the vote-by-mail process, Texas currently has several safeguards in place to address voter fraud, therefore, the Committee only recommends increased

[102] *Id.* at 18-19.
[103] REAL ID Act of 2005, Pub. L. 109-13 (2005).
[104] Report of the Commission on Federal Election Reform, *Building Confidence in U.S. Elections* at 20 (2005).

awareness by law enforcement as well as continued investigation and prosecution of offenders.

Charge No. 4

Monitor the implementation of H.B. 7, 79th Legislature, Regular Session, relating to the workers compensation system of this state.

Background and Discussion

The Workers' Compensation program in Texas was created as a no-fault, state-supervised system established under the Worker's Compensation Act.[105] The system provides income-replacement benefits and medical care to workers injured on-the-job. Unlike other states, Texas does not require employers to carry workers' compensation insurance. However, employers who choose to carry workers' compensation insurance are protected from legal liability arising from employees' injuries on-the-job.

Prior to the changes enacted by H.B. 7 in 2005, workers' compensation was regulated by the Texas Workers Compensation Commission (TWCC). From 1990 to 2005, TWCC administered key parts of the system, including oversight of medical and income benefits delivered to injured workers, dispute resolution, and workplace safety services. During that period, TWCC was found to be inefficient and ineffective with the demonstration of overwhelming dissatisfaction expressed by those involved in the system including injured workers, doctors, employers, insurance companies, and attorneys.

As satisfaction with the system decreased, costs within the system clearly increased. In 2000, Texas participated in a multi-state study comparing its workers' compensation with several other states.[106] Deeper imperfections and disparities in Texas' system became more evident. In Texas, the average medical payment per claim (2000-2001) was $9,300. This figure is $400 more than the second-highest state. Utilization was found to be much greater in Texas, especially in certain treatment areas, such as chiropractic care. Texas averaged 131 services per claim, while the median for all the participating states was 72 services per claim. Between 1999 and 2003, the overall cost of a claim in Texas increased 35 percent despite prices for most medical services having remained unchanged. This overall cost increase led to an increase in premiums during the same time period. The study also found that Texas' return-to-work outcomes were worse than those of the other states. More Texas injured workers missed at least a week of work compared to other states; once those Texas workers missed a week, they

[105] TEX. LAB. CODE Title 5, subtitle A (2006).
[106] *See* Research and Oversight Council on Workers' Compensation, *Striking the Balance: An Analysis of the Cost and Quality of Medical in the Texas Workers' Compensation System: A Report to the 77th Legislature* (2001); Research and Oversight Council on Workers' Compensation, *Returning to Work: An Examination of Existing Disability Duration Guidelines and Their Application to the Texas Workers' Compensation System: A Report to the 77th Legislature* (2001); Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *Medical Cost and Quality of Care Trends in the Texas Workers' Compensation System* (2004); Workers' Compensation Research Institute, *CompScope Benchmarks for Texas, 6th Edition* (2006).

continued to stay off work longer than other states. Customer satisfaction was at or below that of the other states.

The higher premiums coupled with the high medical cost per claim arguably resulted in a higher percentage of larger employers deciding not to purchase workers' compensation insurance than found in previous years. In 2001, 35 percent of employers did not subscribe to the workers' compensation system; by 2004, that number increased to 38 percent, and significantly more of these businesses were large employers.[107] Because a larger percentage of these employers were large employers, the percentage of Texas employees employed by non-subscribing employers increased to the highest levels seen since 1993.[108] The increase of non-subscribers was particularly troublesome as the integrity of any insurance system depends the existence of "good risk" to balance the "bad risk."

In addition to the bleak insurance business atmosphere preceding the 79th legislative session, the Texas Sunset Advisory Commission reviewed TWCC.[109] The Sunset Commission recommended an overhaul of the workers' compensation system.[110]

Armed with the Sunset Commission recommendations, the 79th Legislature began the regular session with the intention of accomplishing several major goals:

- Abolish the Texas Workers' Compensation Commission in place;
- Clarify the mission and goals of a new agency (in whole or part of another) and require the agency to meet those goals;
- Require the agency to implement a regulatory approach that emphasizes overall compliance, rewards performance and efficiently handles complaints;
- Streamline processes within the agency to make them more efficient and user friendly;
- Establish a truly independent office to address the issues of injured employees;
- Address the issue of souring medical costs and over-utilization by allowing -- in fact, encouraging -- the use of networks similar to those used in group health. Permit group health carriers to operate workers' compensation networks;
- Enhance the delivery and quality of benefits for injured workers with a focus on substantially improving return-to-work outcomes;

[107] Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, *Employer Participation in Texas: 2004 Estimates* (2004).
[108] This was the year the state first started tracking such numbers (24 percent of Texas year-round employees employed by non-subscribing employers in 2004 versus 16 percent in 2001). *Id*.
[109] The Texas Legislature created the Sunset Advisory Commission in 1977 to identify and eliminate waste, duplication, and inefficiency in government agencies. The 12-member Commission reviews the policies and programs of more than 150 state agencies and questions the need for each agency; looks for duplication of other public services or programs; and considers changes to improve each agency's operations and activities. The Commission seeks public input through hearings on every agency under Sunset review and recommends actions on each agency to the full Legislature. In most cases, agencies under Sunset review are automatically abolished unless legislation is enacted to continue them.
[110] Sunset Advisory Commission, *Report to the 79th Legislature* at 197 (2005).

- Streamline the medical and income benefit dispute resolution process; and
- Encourage good doctors to remain in the system while ensuring that problem doctors no longer were gaming the system.

These goals served as the basis for the provisions found in H.B. 7.[111] Specifically, H.B. 7 made the following major changes:[112]

- Abolished the Texas Workers' Compensation Commission and transferred its duties to a separate division at the Texas Department of Insurance - Division of Workers' Compensation;
- Created the Office of Injured Employee Counsel as a stand-alone, independent agency to represent the interests of the injured workers;
- Authorized changes in rate settings;
- Provided for the establishment of medical networks to provide care to injured employees and developed standards for workers' compensation insurance carriers not using a network;
- Increased the maximum income benefits; and,
- Changed the indemnity dispute resolution process.

House Bill 7 included a very specific timeline for the implementation for the various provisions of the bill. The timeline can be found at www.tdi.state.tx.us/wc/transition/hb7timeline.html .

Recommendations

The Texas Department of Insurance (TDI) has been steadily working to implement the provisions of H.B. 7 since the Act took effect on September 1, 2005. The Texas Workers' Compensation Commission was abolished, and TDI has completed the huge task of transferring all of its functions over to the agency. Albert Betts was appointed by the Governor to be the new Commissioner of Workers' Compensation. The Office of Injured Employee Counsel (OIEC) was created on March 1, 2006, and Norman Darwin was appointed by Governor Rick Perry to serve as OIEC's first Public Counsel.

TDI and the Office of Injured Employee Counsel (OIEC) are both statutorily required to report to the Legislature regarding the implementation of H.B. 7. Their recommendations for any necessary legislative changes can be found on their respective websites.[113] Each agency is recommending a relatively small number of mechanical changes to the process; this committee recommends the 80th Legislature give just consideration to these recommendations.

[111] Acts 2005, 79th Leg., ch. 265.
[112] A complete summary of these provisions can be found on the Texas Department of Insurance website at www.tdi.state.tx.us/commish/hb7changes.html .
[113] TDI's website is www.tdi.state.tx.us and OIEC's website is www.oiec.state.state.tx.us .

The Committee makes two recommendations relative to the larger policy issues considered by H.B. 7. The Committee believes these recommendations will enhance the future success of the workers' compensation system:

4.a. Continue to approve the creation of new networks without any undue delay.

As of the printing of this report, 17 networks extending over 164 counties have been certified.[114] Relatively few injured workers are currently using these networks; however, insurance carriers expect these numbers to increase over the next two years. As with every major piece of legislation, the implementation of significant changes to the process takes time. TDI is tasked with providing a report card regarding the networks 18 months from the time the initial network was certified. That report card is not due until the fall of 2007. At this time, it is too premature to make any wholesale changes to H.B. 7 as we have not given the provisions adequate time to work. One of the major goals of H.B. 7 was to encourage the use of networks to improve availability of doctors and manage health care costs and utilization within the system. Any unnecessary delay in approving these networks is contrary to the public policies embodied in the bill.

4.b. Support the transfer of 25 Dispute Resolution Officers from the Texas Department of Insurance - Division of Workers' Compensation to the Office of Injured Employee Counsel as requested in both agencies' Legislative Appropriations Requests (LAR); and support OIEC's LAR request to increase the number of customer service representatives by 38.

The Office of Injured Employee Counsel (OIEC) was established under H.B. 7 to represent the interests of injured employees of Texas. OIEC's statutory duties are to provide assistance to injured employees and to advocate on behalf of injured employees as a class. OIEC operates the Ombudsman Program, which assists unrepresented injured employees in obtaining benefits at administrative dispute resolution proceedings before TDI Division of Workers' Compensation. A significant part of OIEC's mission is to enable workers to return-to-work in a timely, yet appropriate, manner. Two of the requests in OIEC's LAR would greatly enhance the agency's ability to achieve this goal.

First, OIEC has requested the transfer of 25 Dispute Resolution Officers from the TDI-Division of Workers' Compensation to OIEC and that those officers be reclassified as ombudsmen to allow OIEC to become involved in the dispute resolution process earlier. Currently, an injured worker does not have contact with OIEC until a dispute arises and is set for an administrative proceeding. As with most disputes, early intervention often leads to a more timely and successful return-to-work outcomes.

Second, OIEC has requested an additional 36 customer service positions (Full Time Employees). These individuals will serve as the initial point of contact for an injured worker. The ability to respond to injured employees quickly and effectively will go a long way to appropriate efficiency in the system.

[114] A list of these networks is included in Appendix IV.

Charge No. 5

Study the regulation and management of health care plans, including the following:

- *Study the reimbursement methodology of health care plans for out-of-network claims, the adequacy of health plan networks to provide appropriate coverage, the impact of out-of-network balance billing by physicians and health care providers and the accurate disclosure of patients' out-of-pocket costs.*
- *Study the discounting and/or waiving of co-pays, deductibles and co-insurance by physicians and health care providers. Specifically, how this practice can impact the cost to private and public health plans and the impact to acute, multi-service hospitals, including safety net hospitals.*
- *Evaluate health care cost transparency by health care providers and access to that information by patients.*
- *Review data reported to the Texas Department of Insurance by health care plans, investigate possible expansion of health plans' reportable data, including, but not limited to, administrative costs, and what, if any, is the appropriate release and publication of that information.*

Background

During the 78th legislative interim, the Committee was directed to study Texas health plans' usual and customary reimbursement rate and methodology.[115] That study also involved a discussion surrounding the lack of health care cost transparency and the impact of balance billing on Texans.[116] As a result, S.B. 1738 was introduced during the 79th legislative session to address those issues along with additional items suggested for consideration.

As introduced, S.B. 1738 drew opposition from various health care providers. Hospitals did not agree with some portions of the transparency concepts, and the hospital-based physicians opposed the initial proposal to ban balance billing. In response to this opposition, the authors of S.B. 1738 and the stakeholders negotiated to forward the legislative goals embodied in the original bill. Through those negotiations, a legislative compromise was reached, which successfully passed the Senate.

---

[115] Senate Committee on State Affairs, 78th Interim Charge #5 - "*Study the reimbursement methodology of health care plans operating in Texas for out-of-network claims, specifically focusing upon the reimbursement of usual and customary charges, and make recommendations on how to improve their effectiveness. The study and recommendations should encompass all plans, including those participating in Texas Medicaid managed care program and should consider federal and state laws as well as Health & Human Services Commission rules relating to the reimbursement of out-of-network claims.*"

[116] "Balance Billing" is when a health care provider bills a patient for the remainder of the providers charge not covered in the "usual and customary" rate paid by a health plan for out-of-network providers. Balance billing often occurs when a hospital-based physician operates in a facility that is an in-network facility but they themselves are not an in-network participant. There is often no disclosure of this scenario and the additional bill is an unanticipated financial burden for the patient.

As S.B. 1738 reached the House of Representatives, various health care providers raised old and new concerns. This opposition included groups previously not engaged in negotiations as well as individual members of organizations that had agreed to the Senate compromise. There were further attempts to negotiate; however, S.B. 1738 ultimately died in the House Calendars Committee. The following chart provides a summary of the final version of S.B. 1738.

S.B. 1738 - Summary of Final Version

1) Health Care Cost Transparency
   a) Facilities required to make available and free, a copy of the facilities 50 common in- and out-patient procedures costs. List to be created and maintained by DSHS.
   b) Prior to non-emergency treatment or service, patient has the ability to receive a free written estimate of charges.
2) Required that facilities only have one charge master.
3) Billing Statement Transparency
   a) Facilities shall develop and post written policies for the billing of services and supplies.
   b) Facilities must provide, when requested an itemized statement of a bill, date of services, whether claim has been submitted to a third party payer and if that claim has been paid, clear statements if payment is not required, and a telephone number to call for explanation of items on bill
4) Instituted facility billing complaint resolution process
5) Balanced Billing Restrictions
   a) Required disclosure that provider, while within an in-network facility, may not be an in-network provider and may send an additional bill to the patient.
   b) Required billing transparency, explanation of bill and allowance of one year for payment.
6) Directed Texas Department of Insurance to study network adequacy of Texas health plans.

Figure 5 - 1

A common thread running through the final version of S.B. 1738 was transparency. One of the goals of transparency, as it was addressed in the legislative compromise, was to establish a framework for determining a market value for health care services.

Under the current state of the law, it is difficult, if not impossible, to determine a market value for health care. Most charge and cost data is developed and published as part of the Medicare reimbursement schedule which is, arguably, of limited value in the context of transparency in the commercial health care market. Without disclosure of relevant price and cost elements, commercially funded health care tends to operate outside traditional market influences and economic principles.

Discussion

Transparency

Hospitals

Nationwide, there is a trend to require reporting of hospital health care pricing information. Thirty-two states currently have statutes requiring hospitals to report information on hospital charges or payment rates for public use.[117] Most states base information collection on uniform billing claim forms (UB-92) implemented nationwide in 1992. States use both state agencies and state professional associations for the collection, distribution and publication of this pricing data.

Currently in Texas, the Department of State Health Services (DSHS) collects hospital data through the Texas Health Care Information Council (THCIC). THCIC receives approximately $1 million dollars in state appropriations and employs five positions. THCIC collects in-patient data based on 310 data elements on a quarterly schedule. Five hundred Texas hospitals participate in this data collection program.[118] The data collected through THCIC is used for two main purposes.

First, THCIC creates a report on hospital quality for public use. Prior to the posting of this data, THCIC participates in a comment and reconciliation period relative to each hospital's data. On average, this reconciliation process takes 10 months to complete. As a result, the data published by THCIC is generally a year old and, arguably, obsolete.

Second, THCIC sells the collected data to interested parties. Various groups use the data for research or for different cost and quality reports around the state. THCIC collects approximately $225,000 per year on the sale of this data. That revenue is returned to THCIC to offset the cost of the program.

Senate Bill 1738 sought to expand the data collected by THCIC to include out-patient data and directed DSHS to publish data regarding the average charge for certain procedures in Texas hospitals. DSHS testified that expanding the scope of collection and adding new reporting requirements would require additional appropriations. Most of this additional funding would be used to increase the staff at THCIC to facilitate the increased demand for data collection and reporting.

In recent discussions with various hospital systems, it appears the concept of transparency has become less objectionable. However, in looking to expand the scope of data collection and reporting, the Committee was encouraged to include quality indicator data alongside cost/charge data. Many health care facilities testified that cost/charge reporting

[117] Senate Research Center; *Hospital Cost Transparency and Quality of Care Reporting* (July 21, 2006) (report created upon the request of Senate Committee on State Affairs).
[118] Approximately 100 rural hospitals are statutorily exempt from reporting requirements because reporting is cost prohibitive for these small, rural facilities.

without consideration for quality can be misleading. Merely providing a service cheaper may not ensure the highest quality of care.

Recently, the Texas Hospital Association (THA) has agreed to publish a pricing report for Texas hospitals without using state funds. THA has started an initiative within the organization to purchase and compile the currently reported data from THCIC, generate a user-friendly report that includes pricing and quality data, and post this report on their website for public use.

However, as a *caveat*, "cost data" reported to THCIC is actually "charge data". The *charge* is the rate a hospital publishes in the facility charge master, a complicated data file listing what a hospital claims to charge for every facility procedure. In most cases, however, the charge listed in the charge master is not the amount actually paid by a health plan or cash paying patient. Therefore, charge data does not necessarily represent the market value for health care.

Health Plans

Health plans report a substantial amount of information to the Texas Department of Insurance (TDI) for regulatory purposes. Financial data is collected to determine the financial stability of health plans and a series of data sets are collected for the TDI licensing division. However, as a major partner in the health care market, the issue of increasing the information collected and published by the health plans was also raised in the transparency discussions.

The Committee has explored a concept of compiling contractual rates paid by health plans to providers for health care services and publishing a summary of these rates. The report would reflect a range of contract rates for specific index services by geographic region. These contract rates would reflect reimbursement values providers are willing to accept and health plans are willing to pay for index services. As opposed to charge data, publishing a range of contract rates would provide a more accurate reflection of the true market value of health care.

Health plans and providers assert that this negotiated rate is proprietary and should not be publicly available. Providers are concerned that if their rates are higher than other providers in the area, the health plans may force a lower price in future negotiations. There are also concerns that the price of health care for a region may rise because providers will negotiate for reimbursements at the highest published rate, rather than the lowest. However, while this may occur at the outset, it is argued that market forces will eventually encourage rate competition.

State Data Reporting for Health Plans

The Texas Department of Insurance collects data related to the regulation and oversight of the Texas health insurance market. The information collected is used for a variety of purposes and by an array of entities.

The TDI Financial Division collects and reviews financial information filed in a mandatory annual survey. This data is used by TDI to determine and monitor the financial health of insurers and Health Maintenance Organizations (HMOs). The TDI Consumer Protection Division collects limited information on health insurance products based primarily on

complaints received by the agency. TDI annually publishes a complaint ratio for each health insurer and HMO. Additionally, this division collects and publishes information on prompt payment of claims for companies subject to prompt payment requirements for HMOs and Preferred Provider Organizations (PPOs). The TDI Life, Health and Licensing Division collects and maintains all other health insurance data and information required by TDI. This data is used for a variety of legislative, regulatory and enforcement purposes.

In Texas, PPOs are not required to report the same information to TDI as HMOs. With the recent rise in PPO products, many feel it would be advantageous to extend similar reporting requirements to PPOs and ensure that all data is available in a user-friendly format to the public. Allowing employers, providers and enrollees the opportunity to access a health plan's financial profile and stability extends the increased transparency concept to the health plans and gives the public a better idea of what health plans are paying to provide health care coverage.

Usual & Customary Rates, Health Plan Network Adequacy, and Balance Billing

Usual and Customary Rates

"Usual and customary" is a term of art associated with the amount a health plan will pay an out-of-network provider. Health plans use a formula for determining usual and customary amounts but that formula is not defined in statute or subject to approval by TDI.

The Committee heard numerous suggestions for potential legislative action regarding usual and customary rates, including: (1) a statutory definition of usual and customary; (2) a statutory definition of what is not usual and customary; (3) increased authority for TDI to establish upper and lower parameters for usual and customary; (4) a state process for resolving usual and customary rate disputes; and (5) no change in the process.[119]

Under current out-of-network reimbursement arrangements, providers claim to be paid at below market rates while health plans claim they often pay more than their comparable, in-network rates. Establishing a system that provides contractual rate transparency would provide a reference point for usual and customary reimbursement.

Network Adequacy

The term "network adequacy" is also an undefined term of art. TDI regulates a health plan's network only by the maximum distance an enrollee must travel to access certain services from a health plan's network. TDI regulations do not address the number of in-network providers needed to qualify as a sufficient network.

Health care providers claim that health plans do not establish adequate networks of certain specialty physicians within in-network hospitals. For example, a health plan may contract with a hospital as an in-network provider, but not with the hospital-based physicians that

[119] Senate Committee on State Affairs Hearing, July 26, 2006.

practice within that hospital.[120] Health plans claim that many hospital-based physicians choose not to contract for in-network services to get better cost recovery accepting the plan's usual and customary reimbursement and billing the patient for the balance (balance billing). On the other hand, hospital based physicians claim health plans offer in-network rates that are significantly less than their cost because there is no requirement for hospital-based physicians to be included in the network.

Attempting to define network adequacy presents a number of challenges. For example, legislation or rules that would mandate health plans to provide a minimal level of specialty physicians within the network at a facility would probably result in a superior negotiating position for physicians. Also, different regions may have different specialty and subspecialty resources. Therefore, mandating an appropriate general minimum standard for network adequacy for all specialties is probably not practical. However, creating a standard for network adequacy, as it relates to hospital based physicians may be appropriate as it relates to resolving issues arising from balance billing.

Balance Billing

Balance billing is a concern for many policy makers because of its direct and sometimes harsh impact on constituents. Balance billing scenarios frequently occur when an enrollee receives health care at an in-network hospital but, unknown to the patient, the hospital-based physicians do not participate in their plan's network. The patient believes they are receiving treatment that is covered by their health care plan for which a substantial premium has been paid. However, because the health plan and hospital-based physician are unable to agree to in-network payment rates, the patient bears a larger financial burden.

There have been attempts to address balance billing concerns in previous legislative sessions. Most of these proposals were drafted to ban balance billing. Hospital-based physicians are opposed to a ban because they fear it compromises their bargaining position with health plans. They fear that, if they are unable to balance bill for amounts above the usual and customary rate, they will be forced to enter into a contract with the health plan regardless of the appropriateness of the rate offered.

In recent discussions, providers assert that health plans are the most appropriate place to minimize the impact of balance billing. Health plans are responsible for ensuring that their enrollees are educated regarding the dynamics of the coverage and network. Often, hospitals and physicians are unable to ascertain a patient's health plan coverage at the time of treatment. Various health plans across the nation are piloting on-line resource programs that assist enrollees to find in-network providers, get an estimate of all out-of-pocket costs, and avoid scenarios that result in balance billing. Additionally, the use of "smart cards" by health plans could be a

[120] Hospital-based physicians are doctors that practice exclusively in a hospital setting but are only contracted providers for the hospital and not covered by the hospitals contracts with health plans. Hospital-based physicians are most often, anesthesiologists, pathologists, radiologists, and ER physicians. In some instances, the hospital-based physicians have an exclusivity contract with the hospital which ensures they are the only such provider for the hospital.

solution. Allowing enrollees to carry accurate and real-time health plan coverage information could help alleviate many problems that lead balance billing.

Ultimately, balance billing results from the refusal of the plan and provider to agree on a contract rate for health care services. The industry has been unable to solve the balance billing problem. The most equitable solution would appear to be implementation of a price transparency model that will help establish a true market value for covered services which would encourage more physicians to participate in the network. As an alternative, the Legislature could consider establishing a minimum standard for network adequacy as it relates to hospital-based physicians. In the end, the solution must prioritize the patients while ensuring adequate health care for enrollees and appropriate reimbursements for all partners in the health care system.

Waiving Co-payments, Co-insurance and Deductibles

Oftentimes, health plans will choose to contract with only a few, select facilities in a certain area. They are able to promise a certain volume of patients in exchange for a price discount and in-network status with a health plan. Health plans use these networks to manage rates and utilization. In some areas of the state, some out-of-network providers have engaged in the practice of waiving co-payments and deductibles as a means to compete with in-network providers. This practice compromises the benefits of being an in-network provider by reducing patient volume anticipated in the contract. Without guaranteed patient volume, the in-network facility is unable to maintain the discount, increasing the cost of health care and insurance premiums.

Current state statutes address the waiver of co-payments and deductibles by stating that if a covered person makes a valid assignment of benefit and the insurer receives it, the insurer must pay benefits directly to the physician or provider, not to the covered person.[121] Further, the statute prohibits a physician or other health care provider from waiving a deductible or co-payment by the acceptance of an assignment.[122]

While the Insurance Code expressly prohibits the waiver of co-pays and deductibles, TDI's enforcement authority is limited as it lacks appropriate licensure authority over physicians and hospitals. The current statutory language imposes a criminal penalty[123] for charging a higher price for the same product or service based on the fact that an insurer will pay all or part of the price.[124] TDI has attempted to refer cases for prosecution without success.

The Texas Medical Board has addressed this issue, as it relates to physicians, by rule. The rule states that an advertisement is false, deceptive, or misleading if it represents that required health care insurance deductibles or co-payments may be waived or are not applicable to health care services, or if the advertisement represents that the payment by the health plan as full payment.[125] Violation of this rule results in an administrative penalty.

[121] TEX. INS. CODE § 1204.054 (Supp. 2006).
[122] TEX. INS. CODE § 1204.055(b) (Supp. 2006).
[123] Class B misdemeanor
[124] TEX. INS. CODE § 552.003 (Supp. 2006).
[125] 22 T.A.C. § 164.3 (11), (12) (2006).

The Department of State Health Services (DSHS) has regulatory authority over hospitals. DSHS has also adopted a rule authorizing denial, suspension or revocation of a hospital's license if the hospital has aided, abetted or permitted the commission of an illegal act; the waiver of co-payments and deductible qualifies.[126] DSHS has cited the provision in a letter to facilities stating the waiver of co-payments is prohibited. Despite this warning, facilities continue to utilize this practice.

The Committee finds that more effective remedies are necessary to enforce the policy objectives of prior enactments prohibiting such waivers.

Additional Issues

There were reports to the Committee regarding inappropriate competitive activity by large hospital systems. These reports state that some large hospitals are making a coordinated effort to affect health plans consideration of contracting with certain other hospitals. Use of influence by these hospitals has resulted in health plans deciding to delay or cease negotiations in order to accommodate the demands of the large hospital systems. The Committee is continuing to examine such conduct and proposals for appropriate regulatory and private remedies against hospitals and health plans who participate in organized boycotts.

Recommendations

5.a. Transparency.
The Legislature should:

- Implement a process for the dissemination of reliable data that will reflect a market value of health care services by geographic region.
- Support the expansion and use of the reporting of the cost data from the Texas Health Care Information Council. Further, investigate possible changes to shorten the reconciliation process, while still maintaining the highest levels of accuracy, to ensure the more timely reporting of data.
- Continue discussions with impacted parties on possible means of increased reporting and publication of the health plans' cost data and financial information.

5.b. Usual and Customary.
The Committee makes no recommendation regarding a legislative or regulatory definition of usual and customary. The Committee finds that this definition and concept is more appropriately addressed by contract.

5.c. Network adequacy.
The Legislature, by granting rule making authority to the Texas Department of Insurance, should work with stakeholders to implement a standard for network adequacy with regard to hospital-based physicians at facilities who contract to be a in-network provider.

[126] 25 TAC § 133.121(a)(1)(F)

5.d. Balance Billing.

The Legislature should investigate a spectrum of solutions suggested to the committee, including, but not limited to:

- Disclosing to the patient and enrollee of the possibility of balance billing. The responsibility of this disclosure lies with both providers and health plans. Ensuring that all Texans understand the dynamics of their coverage and network status of their physicians is imperative.
- Allowing hospitals to negotiate with health plans on behalf of their hospital-based physicians.
- Requiring that hospitals and hospital-based physicians contract with the same health plans. This concept would be most important in scenarios where the hospital-based physicians have an exclusive contract with a hospital to provide their particular health services.
- Establishing minimum standards of network adequacy for hospital-based physicians.
- Encouraging the increased use of "smart cards" for enrollees of health plans. Utilizing technology as a means to ascertain enrollees coverage levels, network status and health plan specifics could help decrease unexpected balance billing scenarios.

5.e. State Data Reporting for Health Plans.

The Legislature should continue to work with all interested parties to discuss the possible expansion of data that health plans report to the state. This expansion could include, but not limited to:

- Complaints filed by providers or enrollees against health plans
- Various financial data relative to the cost to provide medical care, reimbursements to providers, and administrative services.
- Expanding current Health Maintenance Organization reporting requirements to Preferred Provider Organizations.
- Publishing ranges for regional in-network contract rates paid for certain health care services.

5.f. Waiving of Co-payments, Co-insurance and Deductibles.

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

Charge No. 6

Study and review current law on the doctrine of eminent domain, including the U.S. Supreme Court case in Kelo v. City of New London. Monitor the implementation of S.B. 7 (79th Legislature, 2nd Called Session) and make any necessary recommendations as to the use of eminent domain for economic development purposes and the issue of what constitutes adequate compensation for property taken through the use of eminent domain.

- *Determine whether a constitutional amendment is prudent and/or necessary to protect private property owners from condemnations for economic development purposes.*
- *Determine which state, regional, and local governmental entities have eminent domain powers and how those powers may be used. Make recommendations regarding their necessity, fairness, and effectiveness.*
- *Study the public policy implications relating to Chapter 2007, Government Code, Private Real Property Rights Preservation Act, its effectiveness in protecting private property rights, and the current impact of regulatory takings on private property owners.*

Background

On June 23, 2005, the U.S. Supreme Court ruled in *Kelo et. al. v. City of New London, et. al.*, that a city's use of eminent domain to take private land for economic development did not violate the Fifth Amendment of the U.S. Constitution.[127]

The Texas Legislature responded to the public outcry to the decision and passed S.B. 7 which statutorily prohibited the use of eminent domain for purely economic development purposes.[128] Property rights proponents, however, believe that some of the exceptions in the statute render the law less than effective. Accordingly, the Committee has been tasked with reviewing the *Kelo* decision and relevant statutes to make necessary recommendations.[129]

The History of the Doctrine of Eminent Domain

The doctrine of eminent domain has been part of the jurisprudence of this country since its inception. Eminent domain is the power of the state to appropriate private property for its own use without the owner's consent. Predominantly landowners, the Founders had a certain mistrust of governmental power. To protect from abuses, they limited the government's power to take property in the Fifth Amendment. The Amendment provides that private property may not be taken for public use by the federal government without just compensation (known as the "Takings Clause"). The 14th Amendment applies the Fifth Amendment to state and local governments.

---

[127] 545 U.S. 469, 125 S.Ct. 2655 (2005).
[128] Acts 2005, 79th Leg. 2nd C.S., ch. 1.
[129] The Joint Interim Committee on Eminent Domain, created by S.B. 7 (79th Legislature, 2nd Called Session) will be focusing on the issue of adequate compensation. The State Affairs Committee will defer to the work of the Interim Committee on that issue.

Historically, governments commonly used the power of eminent domain when the acquisition of real property was necessary for the completion of a public project such as a road, school, park, courthouse, or post office. These public projects fell squarely within the traditional definition of "public use." Beginning in the 1950's, however, governments expanded the public use doctrine to accommodate rebuilding under the ever-growing urban renewal movement. In order to remove "slum" or "blighted" neighborhoods, cities were authorized to use the power of eminent domain. In 1957, in keeping with the times, Texas passed the Texas Urban Renewal Law which is still applicable today.[130] The expansion of the public use doctrine to include urban renewal was affirmed by the U.S. Supreme Court in *Berman v. Parker*, ruling that the removal of blight was a public purpose; thus deeming such takings are constitutional under the Fifth Amendment.[131]

Kelo et. al. v. City of New London, et. al.

On June 23, 2005, the U.S. Supreme Court ruled in *Kelo et. al. v. City of New London, et. al.*, that a city's use of eminent domain to take private land for economic development did not violate the Fifth Amendment.[132]

The City of New London, Connecticut, was in serious economic distress. To revitalize the city, several state agencies as well as local government officials approved an economic development plan on New London's waterfront that included both public and private uses. The city, through its development agent, purchased most of the property earmarked for the project, but initiated condemnation proceedings against those few who refused to sell their property. These property owners asserted that the taking of their property did not constitute public use under the U.S. Constitution.

Connecticut's statute states that economic development is a public use and authorizes the use of eminent domain for that purpose. The statute expresses a legislative determination that the taking of land, even developed land, as part of an economic development project is a public use and in the public interest. The city asserted the takings served a public use because the redevelopment plan would create jobs; increase tax and other revenues; revitalize the economically distressed city; and create leisure and recreational opportunities. Relying on this statute, the Connecticut Supreme Court held that economic development qualified as a public use under both the state and U.S. Constitutions.

Unhappy with the decision of the Connecticut Supreme Court, Kelo and the other property owners appealed to the U.S. Supreme Court. In granting certiorari, the Supreme Court was poised to answer the narrow question of whether a city's decision to take property for the purpose of economic development satisfied the public use requirement under the Fifth Amendment. In a 5-4 decision, the Supreme Court upheld the takings, on the grounds that they qualified as public use within the meaning of the Takings Clause. The Court's majority opinion can be dissected into three major areas of discussion.

---

[130] TEX. LOC. GOV'T CODE ch. 374 (2005).
[131] 348 U.S. 26 (1954).
[132] 125 S. Ct. 2655 (2005).

First, under the U.S. Constitution, the City of New London could not simply take the petitioners' land to confer a private benefit on a particular private party. Rather, the city claimed the taking was justified as the approved redevelopment plan constituted a appropriate public use under the U.S. Constitution and Connecticut law. Historically, the Supreme Court has rejected the literal requirement that condemned property must be put into use for the general public because application of such a standard would be difficult to administer. In reaching its conclusion in *Kelo*, the Court adopted the broader interpretation of public use as "public purpose."

Second, significant deference was given to the fact the state agencies and local government had reviewed and approved the redevelopment plan. Additionally, the majority also deferred to the trial judge and the members of the Connecticut Supreme Court, all of whom found there was no evidence of an "illegitimate purpose" in taking the properties. Specifically, the U.S. Supreme Court noted the city was trying to coordinate a variety of commercial, residential, and recreational land uses, with the hope they would form a whole greater than the sum of its parts. Citing as precedent *Berman v. Parker*, the Supreme Court analyzed New London's redevelopment plan not in its effect on the individual owners of the property, but rather in light of the entire plan.

Third, the majority found that the petitioner's proposal that the Court assert that economic development does not qualify as public use was not supported by precedent or logic. The Court found that promoting economic development is a traditional and long-accepted governmental function, and there is no principled way of distinguishing it from the other public purposes the Court has recognized.

At the end of the majority opinion, the Court,

> emphasized that nothing in our opinion precludes any State from placing further restrictions on its exercise of the takings power. Indeed, many States already impose "public use" requirements that are stricter than the federal baseline. Some of these requirements have been established as a matter of state constitutional law, while others are expressed in state eminent domain statutes that carefully limit the grounds upon which takings may be exercised.[133]

Legislative Response to Kelo

In the summer of 2005, public outcry to *Kelo*, especially in Texas, was substantial. The Legislature, which happened to be in Special Session at that time, debated extensively how Texas should respond to the decision. Some legislators wanted statutory changes while others wanted a constitutional amendment, requiring a public referendum. Most, however, agreed that *Kelo* should not be the law of the land in Texas. Given that a Special Session in Texas only lasts 30 days, the Legislature took the more prudent approach and developed a statutory prohibition to using the power of eminent domain for economic development. On November 18, 2005, S.B. 7 was signed into law with immediate effect.[134]

[133] *Id*. at 2667-68.
[134] Acts 2005, 79th Leg. 2nd C.S., ch.. 1.

Senate Bill 7 prohibits governmental or private entities from using eminent domain to take private property if the taking conferred a private benefit on a particular private party or was for a public use merely as a pretext to confer a private benefit on a particular private party. It also prohibits the exercise of eminent domain to seize private property for economic development purposes, unless the economic development was a secondary purpose to municipal community development or municipal urban renewal activities to eliminate an existing affirmative harm on society. This would be enforceable under Local Government Code, chapters 373 or 374, or the Tax Code provision that allows certain vacant buildings to be declared a tax reinvestment zone.

Senate Bill 7 did not affect the authority of any entity authorized to use eminent domain for:

- transportation projects, including railroads, airports, or public roads or highways;
- ports;
- water supply, wastewater, flood control, and drainage projects;
- the provision of utility services;
- a sports and community venue project approved by voters at an election held on or before December 1, 2005, under Local Government Code, Chapters 334 or 335;
- pipeline operations;
- a purpose authorized by Utilities Code, Chapter 181, regulating private gas and electric utilities;
- oil and gas underground storage operations subject to Natural Resources Code, Chapter 91; or
- a waste disposal project.

These provisions would apply to the use of eminent domain under all state laws, including a local or special law, by any governmental or private entity including

- a state agency, including an institution of higher education,
- a political subdivision of the state, or
- a corporation created by a governmental entity to act on behalf of the entity.

The law governing Texas Department of Transportation (TxDOT) toll roads would be amended to prohibit the agency from using eminent domain to take property for an ancillary facility necessary or convenient to a state highway to unless

- subject to provisions in current law granting authority to the Texas Transportation Commission to take property for a right-of-way or location for a facility for the

Trans-Texas Corridor, the purpose was for a gas station, convenience store, or similar facility, or

- the purpose was to provide a location between the main lanes of a highway or between a highway and a department rail facility for a gas station, convenience store, or similar facility that provided services to and directly benefited users of a toll project and was not located within ten miles of an intersection of the toll project and a segment of an interstate highway.

Discussion

"Public Use"

A number of property rights advocates argue that the lack of a definition of "public use" in Texas' statute and Constitution allow for exceptions which may permit takings for economic development purposes. As stated above, the courts have long-held that the definition of public use does not require that the property be in use by the public. Because statutes and case law differ throughout the nation, property rights advocates argue that a definition of public use for Texas is necessary. Such a definition could be amended to the existing eminent domain statute or could be amended to the state Constitution.

Some believe that a constitutional amendment is essential because all changes to the state Constitution require a vote by the citizens of the State of Texas; thus, references in the Constitution citing appropriate and inappropriate uses of eminent domain would more likely remain in perpetuity. Others argue the power to grant and restrict eminent domain should remain with the Legislature, ensuring the necessary flexibility by those accountable to the public.

Below is a definition of public use that is being proposed by the Institute for Justice, the public interest law firm which represented the plaintiffs in the *Kelo* case:[135]

> The term "public use" shall only mean (1) the possession, occupation, and enjoyment of the land by the general public, or by public agencies; (2) the use of land for the creation or functioning of public utilities or common carriers; (3) where the use of eminent domain (a)(i) removes a public nuisance; (ii) removes a structure that is beyond repair or unfit for human habitation or use; (iii) is used to acquire abandoned property; and (b) eliminates a direct threat to public health or safety caused by the property in its current condition. The public benefits of economic development, including an increase in tax base, tax revenues, employment, general economic health, shall not constitute a public use.

"Blight"

One of the primary complaints is that the Texas Urban Renewal Act definition of "blight" is so vague that the designation can literally apply to any property. Moreover, critics argue that what the Supreme Court originally sanctioned as a way to remove dangerously dilapidated and abandoned properties has been perverted. The new application gives the government the ability

[135] Senate Committee on State Affairs Hearing, April 18, 2006 (statement of Clark Neily, Institute of Justice).

to level an ordinary neighborhood in order to increase taxes and create jobs. One way to counter this argument would be to redraft the statute using more objective and quantifiable factors.

Once again, the Institute for Justice has proposed language which tightens our blight law:[136]

> Condemnation-eligible property shall include:
>
> (1) premises that because of physical condition, use or occupancy constitutes a public nuisance or attractive nuisance;
>
> (2) structures that, because of dilapidation, unsanitary, unsafe or vermin-infested conditions, has been designated by the agency responsible for enforcement of the housing, building or fire codes as unfit for human habitation or use;
>
> (3) structures that in current condition, feature a fire hazard or is otherwise dangerous to the safety of persons or property;
>
> (4) structures from which the utilities, plumbing, heating, sewerage or other facilities have been disconnected, destroyed, removed, or rendered ineffective so that the property is unfit for its intended use;
>
> (5) a vacant or unimproved lot or parcel of ground in a predominantly built-up-neighborhood, which by reason of neglect or lack of maintenance has become a place for accumulation of trash and debris, or a haven for rodents or other vermin;
>
> (6) property that has tax delinquencies exceeding the value of the property;
>
> (7) property with code violations affecting health or safety that has not been substantially rehabilitated within one year of the receipt of notice to rehabilitate from the appropriate code enforcement agency;
>
> (8) property which, by reason of environmentally hazardous conditions, solid waste pollution or contamination, poses a direct threat to public health or safety in its present condition; or
>
> (9) abandoned property, defined as property not occupied by a person with a legal or equitable right to occupy it and for which the condemning authority is unable to identify and contact the owner despite making reasonable efforts or which has been declared abandoned by the owner, including an estate in possession of the property.

Burden of Proof

Under the current condemnation procedure, the burden of proving that the property is being taken for nefarious reasons lies with the property owner. Governmental entities are given deference by the courts who assume that the takings are proper. For example, once a plan has been approved by the local governments, courts rarely challenge whether the motive or purpose was proper. Rather, the presumption is that the taking is appropriate. Some have proposed

[136] *Id.*

shifting the burden of proof to require the condemning authority to establish that the use of eminent domain complies with the public use definition and is reasonably necessary.

Grants of Eminent Domain Authority

The Legislature, with little deliberation, routinely grants powers of eminent domain to any number of entities each legislative session. At last count, there were almost 100 different entities that were granted the power of eminent domain. Approximately 200 more statutory references authorize an entity to exercise such power. Each legislative session, new entities and statutory references are added. This lack of legislative discipline could be addressed by imposing a constitutional requirement that eminent domain authority may only be granted upon a 2/3 majority of both houses of the Legislature.

Additionally, a comprehensive inventory of all the entities, both public and private, with eminent domain authority and the scope of that authority would be extremely helpful in controlling inappropriate use of eminent domain. The Committee recommends the Comptroller of Public Accounts identify these entities and make recommendations to the Legislature and the Governor as to which entities: (1) have, need or should have, eminent domain authority; (2) whether that power should be continued, expanded, limited, or eliminated; and (3) the cause and effect of such changes.

Right of First Refusal

Under the current eminent domain statute, once a property has been condemned, the condemnor is not required to use it for the purpose for which it was taken. There is a provision that allows for repurchase of property if the public use for which it was taken is cancelled. However, that provision applies for only ten years after the taking and must be purchased back at the current market value at the time the use was cancelled, not the price paid to the former land owner. The market value is often inflated and the original property owner can longer afford to repurchase it. The Committee recommends that the property owner be given the right of first refusal in repurchasing the property if the purpose for which the property was taken is no longer valid. The Committee further recommends the property owner be allowed to re-purchase the property at the price paid the date it was condemned.

Recommendations

Provide a statutory definition of "public use."

6.a. Amend the language of Chapter 374, Local Government Code (the Texas Urban Renewal Act), to provide for the use of objective and quantifiable factors in determining whether a property is worthy of condemnation.

6.b. Provide, by statute, that the condemning authority shall have the burden of proof to establish, by a preponderance of the evidence, that the condemnation is for "public use" and is reasonably necessary.

6.c. Direct the Comptroller of Public Accounts to identify all public and private entities with eminent domain authority and make recommendations to the

Legislature and the Governor as to which entities: (1) have, need or should have, eminent domain authority; (2) whether that power should be continued, expanded, limited, or eliminated; and (3) the cause and effect of such changes.

6.d. Provide, by statute, a right of first refusal to the condemnee in repurchasing the property if the purpose for which the property was taken is no longer valid. The condemnee should be allowed to repurchase the property at the price paid when it was condemned.

6.e. Amend the Texas Constitution to require that all laws passed by the Legislature that grant eminent domain authority or authorize the taking of private property by condemnation, after January 1, 2007, do so with a two-thirds vote of the membership of each house of the Legislature. No such law may be passed on the Local and Consent calendar of either chamber.

Charge No. 7

Study the costs associated with mandates to insurance companies for increased coverage for specific illnesses, medical conditions, or diseases, including obesity. Provide a cost assessment of the impact of such mandates to the state and local units of government. Include data and analysis of the costs and medical impact associated with insurance mandates which have been enacted in other states, as well as any short- and long-term cost-savings. Develop recommendations on how to provide increased cost-effective coverage, especially to populations with impairments and diseases, as well as the underinsured/uninsured.

Background

The State of Texas has adopted several health insurance mandates which identify certain illnesses, medical conditions or diseases that must be covered by group health insurance policies in Texas. As health insurance costs continue to rise, a balance must be struck between the public policy for mandating certain coverage and the additional costs attached to those mandates. Therefore, the Committee examined the current mandates and their attenuated costs and attempted to collect data relating to additional mandates adopted in other states.

It should be noted, not all group health insurance policies must include the state mandated benefits. For instance, self-funded group policies issued pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA) are not required to comply.[137] Additionally, S.B. 541, passed during the 78th Legislative Session, amended the Insurance Code to increase the availability of health care coverage by giving employer groups and individuals the opportunity to purchase Consumer Choice Plans.[138] These Consumer Choice Plans are exempt from many of the mandated benefits.

[137] Self-funded ERISA plans must only comply with the mandates required by federal law, such as maternity and newborn coverage and mastectomy benefits.

[138] Acts 2003, 78th Leg., ch. 1179. *See also* Senate Committee on State Affairs Report to the 79th Legislature at 34 (2004).

The coverage requirements are set forth in various sections of the Insurance Code. The following chart sets forth the current mandates.[139]

Minimum required benefits in individual health plans				
Benefit	**Fee for Service Plan**		**HMO**	
	SMP	**CCP**	**SMP**	**CCP**
Mammography	Yes	Yes	Yes	Yes
Emergency care	Yes, if PPO	Yes, if PPO	Yes	Yes
Alzheimer's disease (certain requirements if coverage for Alzheimer's disease is provided)	Yes	Yes	Yes	Yes
Contraceptive drugs and devices (if prescription drugs are covered)	Yes	No	Yes	No
Diabetes equipment, supplies, and training	Yes	Yes	Yes	Yes
Guidelines for diabetes care	Yes	No	Yes	No
Childhood immunizations	Yes	Yes	Yes	Yes
Telehealth and telemedecine	Yes	No	Yes	No
Hearing screenings	Yes	Yes	Yes	Yes
Certain therapies for children with developmental delays	Offer	No	Yes	No
Maternity minimum stay (if maternity is covered)	Yes	Yes, federal	Yes	Yes, federal
Prostate testing	Yes	Yes	Yes	Yes
Reconstructive surgery incident to mastectomy	Yes	Yes, federal	Yes	Yes, federal
Mastectomy minimum stay	Yes	No	Yes	No
Off-label drug use	Yes	No	Yes	No

[139] "SMP" denotes a State-Mandated Plan; "CCP" denotes a Consumer Choice Plan. Benefits labeled "Yes" must be included as part of the plan; benefits labeled "No" are not required; benefits labeled "Offer" must be offered, but any or all of them may be declined. Excerpt from "Your Health Care Coverage" online brochure, Texas Department of Insurance, http://www.tdi.state.tx.us/consumer/cb005.html. *See also* Appendix VII for a more detailed chart.

Acquired brain injury	Yes	No	Yes	No
Detection of colorectal cancer	Yes	Yes	Yes	Yes
Reconstructive surgery for craniofacial abnormalities in a child	Yes	Yes	Yes	Yes
Mental/nervous disorders with demonstrable organic disease	Yes	No	No	No
Transplant donor coverage (certain requirements if transplant coverage is provided)	Yes	No	No	No
Complications of pregnancy	Yes	Yes	Yes	Yes

Minimum required benefits in small-employer health plans

Benefit	**Fee for Service Plan**		**HMO**	
	SMP	**CCP**	**SMP**	**CCP**
In vitro fertilization	Offer	No	Offer	No
HIV, AIDS, or related infection	Yes	No	Yes	No
Chemical dependency, chemical dependency treatment facility	Yes	No	Yes	No
Serious mental illness	Offer	No	Offer	No
Treatment of mental or emotional illness	Yes	No	Yes	Yes
Inpatient mental health, psychiatric day treatment facility	Yes	No	Yes	No
Speech and hearing	Offer	No	Offer	No
Mammography	Yes	Yes	Yes	Yes
Home health care	Offer	No	Yes	Yes
Emergency care (only stabilization)	Yes, if PPO	Yes, if PPO	Yes	Yes
Crisis stabilization unit and	Yes	No	Yes	No

residential treatment center for children and adolescents				
Alzheimer's disease (certain requirements if coverage for Alzheimer's disease is provided)	Yes	Yes	Yes	Yes
PKU treatment (if prescription drugs are covered)	Yes	Yes	Yes	Yes
Contraceptive drugs and devices (if prescription drugs are covered)	Yes	No	Yes	No
Bone mass measurement for osteoporosis	Yes	No	Yes	No
Maternity minimum stay (if maternity is covered)	Yes, state & federal	Yes, federal	Yes, state & federal	Yes, federal
Prostate testing	No	No	No	No
Reconstructive surgery incident to mastectomy	Yes, state & federal	Yes, federal	Yes, state & federal	Yes, federal
Acquired brain injury	Yes	No	Yes	No
Complications of pregnancy	Yes	Yes	Yes	Yes

Minimum required benefits in large-employer health plans

Benefit	**Fee for Service Plan**		**HMO**	
	SMP	**CCP**	**SMP**	**CCP**
In vitro fertilization	Yes	No	Yes	No
HIV, AIDS, or related infections	Yes	No	Yes	No
Chemical dependency, chemical dependency treatment facility	Yes	No	Yes	No
Serious mental illness	Yes	Yes	Yes	Yes
Outpatient treatment of mental or emotional illness	Offer	No	Yes	Yes
Inpatient mental health, psychiatric day treatment facility	Yes	No	Yes	No
Speech and hearing	Offer	No	Yes	No

Mammography	Yes	Yes	Yes	Yes
Home health care	Yes	No	Yes	Yes
Emergency care	Yes, if PPO	Yes, if PPO	Yes	Yes
Crisis stabilization unit and residential treatment center for children and adolescents	Yes	No	Yes	No
Alzheimer's disease (certain requirements if coverage for Alzheimer's disease is provided)	Yes	Yes	Yes	Yes
PKU treatment	Yes	Yes	Yes	Yes
Mastectomy minimum stay	Yes	No	Yes	No
Drug formulary, continuation of benefits	Yes	No	Yes	No
Contraceptive drugs and devices (if prescription drugs are covered)	Yes	No	Yes	No
TMJ, coverage for person unable to undergo dental treatment in an office setting or under local anesthes ia	Yes	No	Yes	No
Bone mass measurement for osteoporosis	Yes	No	Yes	No
Childhood immunizations	Yes	Yes	Yes	Yes
Telehealth and telemedecine	Yes	No	Yes	No
Hearing screenings	Yes	Yes	Yes	Yes
Certain therapies for children with developmental delays	Offer	No	Yes	No
Maternity minimum stay, if maternity is covered	Yes	Yes, federal	Yes	Yes, federal
Prostate testing	Yes	Yes	Yes	Yes
Diabetes equipment, supplies, and training	Yes	Yes	Yes	Yes
Guidelines for diabetes care	Yes	No	Yes	No
Reconstructive surgery incident to mastectomy	Yes	Yes, federal	Yes	Yes, federal
Off-label drug use	Yes	No	Yes	No
Acquired brain injury	Yes	No	Yes	No

Detection of colorectal cancer	Yes	Yes	Yes	Yes
Reconstructive surgery for craniofacial abnormalities in a child	Yes	Yes	Yes	Yes
Point of service coverage	No	No	Yes	Yes
Complications of pregnancy	Yes	Yes	Yes	Yes

Figure 7 - 1
Source: Texas Department of Insurance

Discussion

Costs to Insurance Companies

Current Mandates

Since 2001, the Texas Department of Insurance (TDI or Department) has been required to annually collect, summarize and report data relating to mandated benefits.[140] The most recent report was issued in August 2006 and covers a reporting period of October 2004 through September 2005.[141] TDI collects and analyzes information on 20 mandated benefits.[142] For each mandated benefit, the insurers are asked to provide the number of claims paid; the total dollar value of claims paid; the average annual premium cost; and the estimated annual administrative cost. The following chart summarizes some of the Departments findings in its most recent report.

[140] TEX. INS. CODE Ch. 38, Subch. F (Supp. 2006).
[141] Texas Department of Insurance, *Texas Mandated Benefit Cost and Utilization Summary Report* (2006).
[142] Some benefits that require coverage are not associated with a specific medical procedure or diagnosis code (e.g. newborns with birth defects). Therefore, the costs cannot be identified by insurers based on the information included in the standard insurance claim format, which is the source of data insurers report to the Department. *Id.* at 3.

Overview of Group Mandated Benefit Plans 2004-05

	2004	2005	% Change
Overall Group Accident and Health Data			
Total Premiums Earned	$9,649,698,364	$9,631,046,021	-0.19%
Total Claims Paid	$7,361,288,019	$7,643,208,512	3.83%
Mandated Benefit Data*			
Total Mandated Benefit Claims Paid	$345,188,716	$375,950,869	8.91%
Number of Mandated Benefit Claims Paid	4,235,030	3,951,847	-6.69%
Mandated Benefit Costs as a Percentage of Total Claims Paid	4.69%	4.92%	4.90%
Mandated Benefit Costs as a Percentage of Total Premiums Earned	3.58%	3.90%	8.94%
Average Annual Premium Cost Estimate of Mandated Benefits– Single (i.e., Employee-only) Coverage	$97.34	$105.98	8.88%
Average Annual Premium Cost Estimate of Mandated Benefits – Family (i.e., Employee and Family) Coverage	$202.84	$222.14	9.51%
Total Estimated Administrative Costs for Mandated Benefits	$51,231,424	$65,849,921	28.53%
Mandated Benefit Administrative Costs as a Percentage of Total Claims	0.70%	0.86%	22.86%

Figure 7 - 2
Source: Texas Department of Insurance, *Texas Mandated Benefit Cost and Utilization Summary Report*

In addition to claims data, the Department also collected data on premium costs attributable to mandated benefits. For the 12-month reportable period, insurers reported average single premium costs of $54.52, representing a $1.01 decrease from 2004, and average group premium costs for family coverage at $117.72, representing an increase of $14.81 over 2004 levels.[143] When compared to claims costs for mandated benefits, premium costs increased at a lower rate.

[143] *Id.* at 32.

Individual Benefit Plans
Mandated Benefit Costs:
A Comparison of Actual Claims Costs-per-Certificate with Average Annual Premium Costs for Single and Family Coverage

Mandated Benefit	Average Annual Claim Cost Per Certificate	Average Annual Premium Cost Estimates - Single Coverage	Average Annual Premium Cost Estimates – Family Coverage
Acquired Brain Injury	$1.37	$2.79	$6.14
AIDS/HIV Treatment	$15.45	$0.93	$4.11
Childhood Immunizations	$17.07	$10.63	$22.37
Colorectal Cancer Testing	$9.40	$3.11	$7.90
Craniofacial Surgery for Children	$0.50	$0.44	$0.89
Diabetes Education and Supplies	$15.33	$6.98	$14.66
Hearing Screening	$12.48	$4.58	$11.42
Mammography Screening	$8.94	$8.34	$13.14
Oral Contraceptives	$3.74	$3.31	$7.75
Prescription Contraceptive Drugs, Devices and Services	$5.27	$4.61	$11.52
PSA Testing for Prostate Cancer	$1.08	$2.17	$3.04
Reconstructive Breast Surgery Following a Mastectomy	$57.69	$6.46	$14.37
Telemedicine	$0.00	$0.16	$0.42
TOTAL	**$141.42**	**$54.52**	**$117.72**

Figure 7 - 3
Source: Texas Department of Insurance, *Texas Mandated Benefit Cost and Utilization Summary Report*

With regard to Consumer Choice Plans, many insurers reported significant savings to consumers -- some as much as 30 percent. However, the savings were typically associated with increased deductible and coinsurance requirements and not the elimination or reduction of mandated benefits. According to TDI, savings associated with fewer mandated benefits accounts for between one and five percent of savings.[144]

[144] Letter from Jennifer Ahrens, Associate Commissioner, Texas Department of Insurance, to Sen. Robert Duncan, Senate Committee on State Affairs (Aug. 21, 2006).

Additional Mandates -- Obesity

The Committee is charged with studying the costs associated with coverage for additional mandates, particularly obesity. Medical experts consider obesity a chronic disease. A diagnosis of obesity is reserved to persons with a body mass index (BMI) greater than 30 kg/m^2. Morbid obesity is diagnosed for persons with a BMI greater than 40 kg/m^2. Obesity often leads to other illnesses and conditions such as diabetes or heart disease. According to the Department, most insurers cover treatment for illnesses that result from obesity however, they do not always cover the costs for treatment of the underlying weight problem.[145] Attempting to estimate the costs associated with coverage for obesity is particularly difficult.

In 2004, TDI conducted a survey of group health insurers relating to coverage for treatment of obesity.[146] Twenty-one insurers responded to the survey, and 12 of them indicated they provide some type of group coverage for obesity. The survey revealed varying treatment options available for obesity. Approximately half of the insurers covered prescription drugs, nutritional counseling and medically-supervised weight-loss programs; 10 of the companies covered bariatric surgery.

TDI also surveyed HMOs. Eighteen HMOs responded and half indicated that some of their plans included morbid obesity coverage. Of the nine HMOs providing some level of coverage only one covered treatment for prescription drugs, six for nutritional counseling, three for medically-supervised weight-loss programs and seven for bariatric surgery.[147]

Both group insurers and HMOs were asked for premium costs associated with treatment for morbid obesity. Only three group insurers and four HMOs provided the cost data. Two associated 1.1 percent of premium to obesity coverage while two others assigned about $35 of each premium to such coverage. One insurer stated there were no additional costs while the remaining HMOs varied widely with one claiming increases of $3.26 of each premium and the other claiming $456.

Costs to State

To estimate the costs to the state for mandates, the Committee looked to the health care costs of the Group Benefit Plan of the Employee Retirement System (ERS). Although ERS is expressly exempt from the mandates set forth in the Insurance Code, it has included the mandated coverage in its plan. ERS covers over 500,000 lives each year at an annual cost of over $1.7 billion. The current plan administrator is Blue Cross and Blue Shield of Texas (BCBS).

The Committee requested that BCBS provide an estimate of the financial impact of specific, additional mandates on the Health Select program of ERS. BCBS estimated the following:

---

[145] Letter from Mike Geeslin, Commissioner, Texas Department of Insurance, to Sen. Robert Duncan, Senate Committee on State Affairs (July 21, 2006).

[146] Texas Department of Insurance, *2004 Texas Group Health Insurance Survey Results: Coverage for Treatment of Morbid Obesity* (2004) (*see* Appendix VII).

[147] *Id.*

Cost Estimate of Additional Coverage for ERS

Covered Disease/Illness/Treatment	Percentage of Program Costs	Amount
Mental Health Parity	0.42%	$4.2 million
Eating Disorders (anorexia, bulimia, binge eating)	0.10%	$1 million
Bariatric surgery	1.2% to 2.5%	$12 million to $25 million

Figure 7 - 4
Source: Blue Cross and Blue Shield of Texas[148]

Mandates in Other States

Other states have adopted many of the same mandates as Texas. As shown in the chart in Appendix VII, some mandates, such as diabetes supplies and education are virtually universal (47 states) whereas others, such as home health care and colorectal screening, are not as common (20 and 27 states, respectively). Still other mandates are covered by only a handful of states. For example only four states mandate coverage for morbid obesity, seven states mandate rehabilitation services, and six states cover hair prostheses.[149]

Cost data associated with other state mandates would vary greatly as the methodology for calculating costs would be subject to each state's laws and regulations. At least one private company has attempted to estimate costs for mandated coverage for obesity. Milliman USA issued a research report on obesity treatment in March 2004.[150] In that report, Milliman stated,

> Health plans or employers trying to determine the medical costs of obesity through claims data will likely grossly underestimate aggregate costs. Currently, few obese patients will have any claims coded with an obesity diagnosis, although the increased focus on obesity may lead to improved coding by practitioners. We believe that the patients associate with obesity codes tend to be those with morbid obesity or those undergoing treatment explicitly for obesity. . . . Because of undercoding, the results of this database search cannot be used to characterize total costs.[151]

To estimate the costs for bariatric surgery coverage, the most costly of obesity treatments, Milliman noted, "When a plan first offers bariatric surgery as a covered benefit, it may see a

[148] Letters from Charles Stuart, Executive Director Government Relations, Blue Cross and Blue Shield of Texas, to Sen. Robert Duncan, Chairman, Senate Committee on State Affairs (Sept. 13, 2006, Oct. 20, 2006).
[149] Blue Cross and Blue Shield Association, State Mandated Benefits and Providers (Dec. 2005) (*See* Appendix VII).
[150] Milliman USA, Research Report, *Obesity: A Big Problem Getting Bigger* (March 2004).
[151] *Id*. at 16.

surge in utilization as the 'pent-up' demand is released."[152] In the end, Milliman estimated a typical case of bariatric surgery may cost a health plan $60,000.[153]

Recommendations

Currently claims for mandated coverage account for less than 5 percent of all claims made to insurers. Additionally, as demonstrated by the Consumer Choice Plans, reducing or eliminating mandates do not necessarily result in great savings. The Committee concludes that each mandate involves a policy decision based on that particular illness or treatment and the healthcare needs of the citizens of this state. Costs are not generally the driving factor behind a mandate. Therefore, the Committee makes no recommendations at this time.

However, the Committee advises caution and careful deliberation concerning the consideration of additional mandates, if any. Proliferation of mandates that are not limited in scope or carefully defined can result in a substantial increase in premiums.

Charge No. 8

Study the prevalence, legality and ethics of entities that actively lobby the Legislature to impact the lawmaking process while that entity is in any way a recipient of state funds.

Background

During each regular session, the Legislature adopts a General Appropriations Act (GAA) which is the law containing the state's budget for the following biennium. The GAA appropriates all state funds to the various governmental and quasi-governmental entities that operate throughout the state. Although the GAA is a lengthy law, it does not necessarily list every entity that is a recipient of state funds. For example the GAA appropriates funds to the Foundation School Program which are then distributed to school districts by the Texas Education Agency (TEA) pursuant to statutorily defined formulas.

The Committee is charged with examining the lobby activities of entities that receive state funds. Due to recent emphasis on education, the Committee chose to direct its inquiry into the use of state funds for lobbying by entities in education which includes school districts and institutions of higher education.

The Legislature appropriates billions of dollars from state coffers to school districts and institutions of higher education thus those entities have a vested interested in their allocation. Naturally, they want to participate in the process and provide information on their entity to the Legislature during its deliberations. Current law prohibits state entities from using state funds to lobby the legislature. However, institutions of higher education may use state funds to finance government relations offices and school districts and institutions of higher education may use other, non-state appropriated funds to hire a lobbyist.

[152] *Id.* at 19.
[153] *Id.* at 20.

Discussion

Lobbying

The Government Code does not expressly define "lobbying;" instead, it delineates who must register with the Texas Ethics Commission as a lobbyist. Pursuant to Government Code § 305.003, a person must register if, as part of their regular employment, they meet the compensation and expenditure thresholds and they have,

> [C]ommunicated directly with a member of the legislative or executive branch to influence legislation or administrative action on behalf of the person by whom he is compensated or reimbursed, whether or not the person receives any compensation for the communication in addition to the salary for that regular employment.[154]

The statute expressly exempts members of the judicial, legislative, or executive branches or an officer or employee of a political subdivision.[155]

The Ethics Commission, through Ethics Advisory Opinions, provides further direction as to what constitutes lobbying. The Commission has determined that "direct communications" includes contact in person or by telephone, telegraph, or letter directed to the member.[156] Additionally, a "member of the legislative or executive branch" includes an officer, officer-elect, candidate for, or employee of the legislature or any state agency, department, or office in the executive branch.[157] The lobby law does not apply to communications with members of the judicial branch as those communications are regulated elsewhere.

Finally, with regard to communications intended to influence legislation or administrative action, the Ethics Commission has stated:

> The fact that a communication does not include a discussion of specific legislation or administrative action does not mean that the discussion is not a lobby communication. If a communication is intended to generate or maintain goodwill for the purpose of influencing potential future legislation or administrative action, the communication is a lobby communication.[158]

Once a person determines that they are in fact lobbying and they meet or exceed the expenditure or compensation thresholds, they must register with the Ethics Commission and file periodic reports.[159] The reports include the names of employers and clients, compensation

---

[154] TEX. GOV'T CODE § 305.003(b) (Supp. 2006) *See also* Ethics Commission rules which define "lobby activity" as "Direct communications with and preparation for direct communication with a member of the legislative or executive branch to influence legislation or administrative action." 34 T.A.C. § 34.1(3) (2006).

[155] TEX. GOV'T CODE § 305.003(b-1) (Supp. 2006).

[156] Ethics Advisory Opinion No. 85 (1992). The opinion includes the following example, "[I]f an organization publishes a newsletter for its members, the individuals writing the newsletter are not 'communicating directly' with members of the legislature, even if a legislator may read the newsletter."

[157] TEX. GOV'T CODE § 305.002(7) (Supp. 2006).

[158] Ethics Commission, *Lobbying in Texas, A Guide to the Texas Law* at 2 (quoting Ethics Advisory Opinion Nos. 94, 90, 89, 34, 4 (1992)).

[159] The compensation threshold is $1,000 in a calendar quarter and the expenditure threshold is $500 in a calendar quarter. 1 T.A.C. §§ 34.41; 34.43 (2006).

received or expected, and the subject matters on which they lobby. The Ethics Commission compiles the information submitted into periodic reports and posts these reports on their website.[160]

The lobby reports are currently the only public source for information on lobbyists, their clients and compensation. It should be noted that the information is not necessarily easy to ascertain as there is no rule addressing how a lobbyist must report the entity names. For instance, the Houston school district is listed as "Houston ISD" by some and "Houston Independent School District" by others. More problematic are different listings such as "University of Houston-Foundation" and "The University of Houston-Foundation" which place some information under "University" and other under "The." Public interest groups testifying before the Committee requested that the Government Code be amended to require consistent name reporting.[161] Additionally, current law requires that the reporting lobbyist state a range of compensation for each entity, not an actual dollar amount. Witnesses asserted that the ranges were too large to be informative.[162]

Public Education

Legality

School district employees (e.g. superintendents; governmental relations staff) may lobby the Legislature on behalf of the district and are exempt from registering as a lobbyist under Government Code § 305.003(b-1). With regard to the hiring of an outside lobbyist, current laws contain no blanket prohibitions on school districts.[163] However, the General Appropriations Act prohibits the use of state appropriated funds to compensate a lobbyist.[164] Finally, although Government Code § 305.026 appears to restrict the use of "public funds" by school districts for lobbying expenditures, this section includes an exemption for compensation of a registered lobbyist.[165] In a nutshell, a school district may hire an outside lobbyist as long as it pays that lobbyist out of non-state appropriated funds.

Prevalence

Texas Ethics Commission

In the realm of public education, lobbying the Legislature can be divided in three ways: (1) individual school districts retain lobbyists; (2) school districts join with other similarly situated districts to hire a lobbyist; and (3) school districts pay membership dues to organizations that hire a lobbyist or lobby the Legislature. All of these scenarios involve the expenditure of public funds. The following is a discussion of the lobby expenditures in 2005.[166]

---

[160] http://www.ethics.state.tx.us/main/search.htm

[161] Senate Committee on State Affairs Hearing, April 18, 2006 (statements of Peggy Veneble, Americans for Prosperity - Texas; Andrew Wheat, Texans for Public Justice).

[162] *Id.*

[163] Former Education Code § 21.939 prohibited a school district from employing a person who is required to register as a lobbyist. This section was repealed by the 74th Legislature in 1995.

[164] Acts 2005, 79th Leg., ch. 1369, Art. IX, § 6.35(a).

[165] TEX. GOV'T CODE § 305.026 (c). *See also* OAG Opinion JC-0089 (Aug. 10, 1999).

[166] The Legislature met for one regular session and two special sessions in 2005.

The Ethics Commission 2005 List of Registered Lobbyists shows 26 school districts, out of the over 1,000 school districts in Texas, retained registered lobbyists during 2005.[167] As set forth below, these school districts paid between $707,000 and $1,693,943 to their lobbyists.[168]

School Districts

School District	Minimum	Maximum[169]
Abilene ISD	$25,000	$49,999
Arlington ISD	$13,000	$54,996
Austin ISD	$45,000	$99,997
Carrollton/Framers Branch ISD	$25,000	$49,999
Dallas ISD	$108,000	$254,992
Eanes ISD	$1,000	$9,999
El Paso ISD	$50,000	$99,999
Galveston County ESD 1	$1,000	$9,999
Graham ISD	$1,000	$9,999
Harris County ESD 11	$1,000	$9,999
Harris County ESD 28	$1,000	$9,999
Harris County ESD 46	$1,000	$9,999
Harris County ESD 48	$1,000	$9,999
Harris County ESD 7	$10,000	$24,999
Harris County ESD 9	$10,000	$24,999
Harris-Fort Bend ESD 100	$10,000	$24,999
Houston ISD	$227,000	$469,991
Lubbock ISD	$25,000	$49,000
Northwest ISD	$58,000	$179,990
Round Rock ISD	$1,000	$9,999
San Antonio ISD	$11,000	$34,998
San Gertrudis ISD	$1,000	$9,999
South Texas ISD	$1,000	$9,999
Spring Branch ISD	$10,000	$24,999
Stafford Municipal School District	$50,000	$99,998
White Deer ISD	$20,000	$49,998
TOTALS	**$707,000**	**$1,693,943**

Figure 8 - 1
Source: Ethics Commission 2005 List of Registered Lobbyists

Additionally, school districts often join together with other similarly situated districts to form organizations whose primary purpose was to hire lobbyists for the advancement of those common interests. The following chart reflects the lobby activity of such organizations.

[167] See Appendix VIII for report excerpts. The full report may be found at: http://www.ethics.state.tx.us/dfs/loblists.htm .
[168] The compensation threshold for lobbying is $1,000 per calendar quarter. Therefore, for contracts with a stated value of less than $10,000, a value of $1,000 was used to calculate the minimum amount paid.
[169] The minimum/maximum values define the range of compensation under the lobby contract.

School District Associations

Organization	Minimum	Maximum
Center for Equity and Adequacy	$60,000	$124,998
Central Texas Coalition for Equitable School Funding	$25,000	$49,999
Coalition for Improving Educational Access	$3,000	$29,997
Fast Growth School Coalition	$112,000	$244,994
Small Rural School Finance Coalition	$25,000	$49,999
South Texas Association of Schools	$45,000	$99,997
Texas Association of Mid-Size Schools	$25,000	$49,999
Texas Association of Rural Schools	$1,000	$9,999
Texas School Alliance	$76,000	$159,996
TOTALS	**$372,000**	**$819,978**

Figure 8 - 2
Source: Ethics Commission 2005 List of Registered Lobbyists

Public funds are also used to pay dues to organizations that lobby the Legislature.[170] These organizations also perform other services for their members such as providing access to legal counsel, leadership training, and risk management programs. The following chart shows the amounts spent on lobbyists by these associations.[171]

Educator Associations

Organization	Minimum	Maximum
Texas Association of School Administrators	$53,000	$129,995
Texas Association of School Boards	$350,000	$649,992
TOTALS	**$403,000**	**$779,987**

Figure 8 - 3
Source: Ethics Commission 2005 List of Registered Lobbyists

As illustrated by the following graph, public funds from school districts represent less than 1 percent of all funds spent on lobbying during 2005.

[170] Dues are commonly assessed on a sliding scale based on the size of the school district. Also, some services provided by an association may require additional payment. Senate Committee on State Affairs Hearing, April 18, 2006 (statement of Catherine Clark, Texas Association of School Boards).
[171] Other similar organizations may exist, but they are not included in this chart because they did not hire a lobbyist in 2005.

School District Funds as Part of All Funds

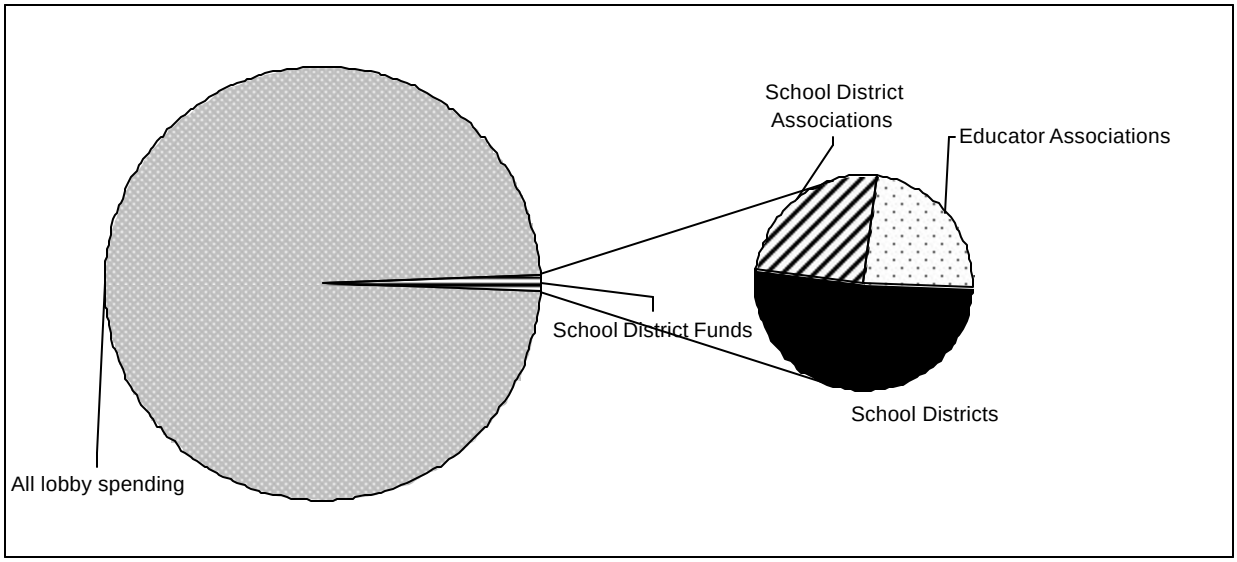


Figure 8 - 4
Source: Ethics Commission 2005 List of Registered Lobbyists

Texas Education Agency

On August 22, 2005, Governor Perry issued an executive order requiring the Texas Education Agency (TEA) to implement a comprehensive financial accountability and reporting system for data from school districts.[172] Among the information to be gathered are expenditures for "non-instructional" organizations, and payments to "any person or organization for the purpose of lobbying."[173] In response to the executive order, TEA amended their administrative rules to update School FIRST (Financial Integrity Rating System of Texas); however, the amendments did not include the collection of lobby expenditures. Instead, on October 27, 2006, the agency made a one-time request for the information from school districts.[174] The information is due to be submitted to TEA on November 30, 2006. The agency does not intend to collect lobby data on an ongoing basis absent further instruction in the form of another executive order or legislation.[175]

Ethics

Whether it is ethical for a school district to expend public funds for the purposes of lobbying the legislative or executive branch is a policy question with a rather amorphous answer. At its April 18, 2006, hearing, the Committee heard from one public interest representative who argued that a school district's employment of a lobbyist is unethical because it pits the tax

[172] Exec. Order RP-47 (Aug. 22, 2005).
[173] *Id.* at 2.
[174] *See* Letter from Adrian Johnson, Associate Commissioner, Texas Education Agency, to School Administrators statewide (Oct. 27, 2006); Appendix VIII.
[175] Senate Committee on State Affairs Hearing, April 18, 2006 (statement of Adam Jones, Texas Education Agency).

spender against the tax payer.[176] Because taxpayers are represented by elected officials whose policy decisions are made in their best interests, the taxpayers own money should not be used to influence those decisions. In essence, public money is used to "drown out the voice of the people" in favor of a special interest. The Committee also heard testimony about general flaws in the current lobby system in Texas. Such testimony ranged from the inaccurate reporting done by legislators and lobbyists to general dismay about the amount of money spent on lobbying in Texas.[177]

In evaluating the ethics of school districts who hire lobbyists either directly or indirectly, one very important fact must be kept in mind -- school districts are run by elected officials. There are checks and balances in place for taxpayers who believe their elected officials are inappropriately spending taxpayer funds. Additionally, principles of open government make sure voters are aware of how those officials are spending taxpayer dollars.

Accountability is the key. If a school board votes to retain a lobbyist and the members of the school board continue to be elected by their communities it can be said that that electorate does not find the expenditure of public funds for lobbying unethical. On the other hand, if the community does in fact believe such expenditures are unethical, they may replace the school board members. The appropriate role for the Legislature is to ensure local communities have access to the deciding information through open government laws. What they choose to do with the information is up to them.

Higher Education

Legality

Current law is abundantly clear that state agencies and institutions of higher education may not use state appropriated funds to "attempt to influence the passage or defeat of a legislative measure," or to employ a lobbyist.[178] However, unlike state agencies, institutions of higher education may use other funds under their control to employ a lobbyist.[179] Additionally, a state agency or institution of higher education may use state resources to "provide public information or to provide information responsive to a request."[180] Therefore, many agencies and institutions of higher education have in-house government relations departments intended to facilitate the communications with state and local elected officials.

Prevalence

There are six university systems in Texas: the University of Texas System, the Texas A&M University System, the Texas Tech University System, the University of Houston System, the University of North Texas System, and the Texas State University System. All six systems

[176] Senate Committee on State Affairs Hearing, April 18, 2006 (statement of Peggy Veneble, Americans for Prosperity - Texas).
[177] Senate Committee on State Affairs Hearing, April 18, 2006 (statements of Peggy Veneble, Americans for Prosperity - Texas; Andrew Wheat, Texans for Public Justice).
[178] TEX. GOV'T CODE § 556.005; § 556.006(a) (Supp. 2006); Acts 2005, 79th Leg., ch. 1369, Art. IX, § 6.35(a).
[179] TEX. GOV'T CODE § 556.005(a) (Supp. 2006).
[180] TEX. GOV'T CODE 556.006(b) (Supp. 2006).

have in-house government relations offices which serve as the point of contact for local and state government officials and their staffs. These departments vary in size and scope, but all of them serve to facilitate communications between the institutions and state and local government by providing information of interest to officials on their own or by request. The Committee heard substantial testimony from institution representatives that their government relations staff does not engage in lobbying activity. The following chart compares the various system government relations departments.

University System Government Relations

Institution(s)	System Government Relations Employees	Non-System Government Relations Employees
University of Texas System	13 FTEs $984,665	37 FTEs $1,598,703
A&M University System	13 FTEs $806,856	7 FTEs $397,826
Texas Tech University System	4 FTEs $522,941	$0
University of Houston System	5 FTEs $413,847	$0
University of North Texas System	3 FTEs $360,863	UNT Health Science Center 1 FTE $257,643
Texas State University System	1.5 FTEs $45,000	$0

Figure 8 - 5
Source: Individual University Systems

With regard to the non-system institutions of higher education, Midwestern State University and Stephen F. Austin State University do not have government relations staff. On the other hand, Texas Woman's University allocates 25 percent of the chancellor's assistant to government relations, Texas Southern University has a government relations office employing three people, and the Texas State Technical College System has one employee in their government relations office.

Some institutions of higher education employ registered lobbyists or consultants, paying them with non-state appropriated funds pursuant to current law. Also, foundations or other entities connected to an institution of higher education may higher a lobbyist. The following chart reflects such arrangements.

Non-State Fund Compensated Lobbyists

Entity	Compensation	
Houston Community College System	$102,000 - $219,995	
Texas Southern University	$72,000	Directed by Office of External Affairs
Texas State University System	$12,000	Directed by Chancellor[181]
University Health System	$75,000 - $149,997	
Midwestern State University Foundation	$50,000	Directed by President
Southwestern Medical Foundation	$10,000 - $24,999	Directed by Foundation President and CEO
Texas Women's University Foundation	$120,000	Directed by Chancellor/ President
University of Houston-Foundation	$25,000 - $49,000	

Figure 8 - 6
Source: Individual Institutions and Ethics Commission 2005 List of Registered Lobbyists

Ethics

As discussed above, the law is clear that state institutions of higher education may not compensate a lobbyist with state appropriated funds, but they may use other funds within their control to hire a lobbyist and, as set forth above, some do. Additionally, some institutions work with associated foundations to pay for lobbyists that report to institution heads. Most institutions, however, choose to employ government relations staff instead of lobbyists; in fact, some systems employ a considerable number of staff at a considerable expense.

The ethical considerations for evaluating the employment of a lobbyist by an institution of higher education vary greatly from those applied to the same actions by school districts. Institutions of higher education are not run by publicly elected officials, nor do they operate solely with public funds. However, they are state-chartered entities that act under the auspices of the state of Texas; therefore, the Legislature must maintain some oversight for their actions on behalf of taxpayers. To that end, in-house government relations departments are preferable to outside lobbyists. Additionally, an institution should not be able to hide their lobby activity behind a related foundation, especially if the lobbyist operates at the direction of the institution head.

Recommendations

The evidence suggests that the use of state funds by school districts to pay for lobbyists is not widespread. Only 26 of the over 1,000 school districts in Texas hired lobbyists during the 2005 legislative session. Additionally, the amount of public funds used to pay lobbyists on behalf of school districts totals about 1 percent of all funds spent on lobbying in 2005. With

[181] Consultant paid out of funds from Chancellor, and former Railroad Commissioner, campaign account.

regard to higher education, the evidence shows some institutions use non-state appropriated funds to hire lobbyists and most institutions maintain government relations staff.

Accountability is the key to ethical behavior. School districts are accountable to their communities for the way they spend taxpayer dollars as long as the information is public and available. However, the weakest point of accountability is when an institution of higher education hires a lobbyist through a related foundation. Ethics Commission reports reflect the name of the foundation as the lobbyist's client, however, the lobbyist works at the direction of the institution head. If the institution desires to hire a lobbyist, it can do so with non-state appropriated funds and the Ethics Commission reports will correctly reflect the lobbyist's employer. Additionally, if a foundation desires to hire a lobbyist it may do so, but the lobbyist should report to the foundation head, not to the Chancellor or President of the institution.

8.a. The Committee recommends that the 80th Legislature consider legislation to "pierce the veil" of employment of a lobbyist.

8.b. To ensure that the taxpayers who elect school board members have appropriate information before them, the Education Code should be amended to require TEA to permanently collect information included in Executive Order RP-47 on an annual basis.

Charge No. 9

Study and make recommendations regarding the cost drivers of emergency medical services. Make recommendations on how to improve and sustain EMS services for Texas, as well as reduce costs to health care plans, businesses, and individuals.

Background

Texas Emergency Medical Services (EMS) provides a variety of transportation services to transport Texans in medically necessary circumstances ranging from facility transfers to critical emergencies. EMS services include ground and air transportation.

In the past 30 years, EMS services have transformed from the collection of the deceased to what is now essentially a mobile emergency room.[182] The range of services varies depending on the EMS provider funding level, geographic location and personnel availability and training. With the expansion of care provided by EMS, the education and regulatory requirements have subsequently increased.

The U.S. Department of Transportation provides national EMS standards, but those standards may be enhanced by state or local entities.[183] In 1973, the Texas Legislature created the EMS Division at the Texas Department of Health (TDH) and required the creation of a

[182] Texas Department of State Health Services, *Texas Elected Officials' Guide to Emergency Medical Services.*
[183] University of Houston Law Center, Health Law Policy and Institute, *Legislative Briefing: EMS Services* (May 12, 2006).

coordinated EMS system.[184] At that time, TDH established guidelines for EMS staffing, training, and equipment; however, the compliance to these guidelines was voluntary.[185] In 1983, the Legislature amended TDH authority to establish required, minimum guidelines for EMS.[186] During a consolidation of several state agencies, the EMS Division was transferred to the Texas Department of State Health Services (DSHS) and renamed EMS Trauma Systems.

The charge given to the Committee spoke to the cost impact of EMS to health plans, businesses and individuals. As the Committee conducted research and spoke with interested parties, stakeholders were unable to pinpoint significant cost drivers that EMS systems may have on health insurance or the business community. However, a common issue and concern brought forward by the EMS provider industry is the low reimbursement levels for services and the geographic availability concerns of EMS across the state. In response to that discussion, the Committee focused the hearing and discussion on the regulatory and funding structures of Texas EMS systems and the availability and adequacy of EMS across the state.

Texas Regulatory Structure

To effectively monitor and respond to regional needs for a wide spectrum of healthcare services, DSHS divides the state into Health Service Regions (HSRs). Each region has DSHS field offices and staff that provide technical assistance to EMS providers and personnel, and ensure regulatory compliance.

The DSHS regulatory division licenses EMS providers,[187] EMS personnel, and EMS coordinators, instructors, and examiners. The Department lists the following numbers of licenses issued:[188]

<u>EMS Providers Licenses</u>	
EMS Providers	872
First Responder Organizations	491
<u>EMS Personnel Certifications</u>	
Emergency Care Attendant (ECA)	3,900
Emergency Medical Technician (EMT)	27,967
EMT - Intermediate (EMT-1)	3,708
EMT - Paramedic (EMT-P)	11,103
Licensed Paramedic (LP)	5,559

[184] In 2004, the Texas Department of Health was changed to the Texas Department of State Health Services.
[185] University of Houston Law Center, Health Law Policy and Institute, *Legislative Briefing: EMS Services* (May 12, 2006).
[186] Emergency Medical Services Act, 68th Leg., ch 516 § 1; 1983 Tex. Gen. Laws 2987.
[187] EMS Providers are defined as a "person who uses or maintains emergency medical service vehicles, medical equipment, and emergency medical services personnel to provide emergency medical services." TEX. HEALTH & SAFETY CODE § 773.003 (11) (2005).
[188] EMS Trauma Systems, *EMS Certification and Provider Licensing Statistics*, (Aug. 3, 2006); http://www.tdh.state.tx.us/hcqs/ems/statistics.htm.

Coordinator, Instructor and Examiner Certifications	
Advanced Coordinator	233
Coordinator (basic)	116
Instructor	1,964

While the state's regulatory standards are consistent statewide, there is no state mandated standard for EMS coverage levels.[189] The method and organizational structure of EMS delivery varies from community to community. Texas EMS is a "patchwork" of services in which each community selects a level of service based its unique needs, funding, and staffing availability. As a result, no two communities offer the same EMS services. The lack of a statewide EMS coverage mandate has led to disparity between counties' levels of EMS coverage, particularly between urban and rural counties.

Texas EMS Systems

Texas EMS is provided, funded, and staffed through a variety of structures. Communities may determine which structure best fits the needs of their citizens, the amount of funding available, and the availability of personnel.

EMS Provider Systems

EMS providers exist through city and county programs, fire departments, hospital systems, hospital districts, private EMS firms, and citizen volunteer groups. Of the 872 licensed EMS providers, approximately 50 percent are owned and operated by private EMS firms.

EMS Funding Systems

EMS services are funded from a variety of sources that often parallel their operating structure. Funding for EMS can be entirely from one of these systems or a mixture of numerous funding sources. The following are the funding strategies available for Texas EMS systems:[190]

County Based - EMS is funded with tax money from a county's general budget and tax revenue.

City Based - EMS is funded by a city's budget and tax revenue. This version includes fire department-based EMS systems

Private Provider Based - These are private provider EMS firms that contract with city or county for EMS and receive subsidies from either or both entities to operate.

Hospital Based - Funded by hospital systems or hospital district tax revenues that are voted on and approved by the voters of the hospital district

Emergency Service District (ESD) - These are districts that are created by certain cities in order to provide fire and EMS services.[191] The maximum

[189] For the purposes of this report, "EMS coverage" relates to the availability of EMS in geographic regions of the state.

[190] Texas Department of State Health Services, *Texas Elected Officials' Guide to Emergency Medical Services*

[191] Texas cities with a population between 25,000 and 550,000 or greater than 1.9 million are allowed to create a "Fire Control, Prevention, and Emergency Medical Services District," which can levy up to one-half percent sales

tax rate and revenue are voted upon and approved by the voters within the ESD.

State Grants, Donations, Local Fundraisers Based - Many purely volunteer EMS systems depend entirely on funds that are raised by local events and donations.

The state does provide some appropriations for EMS. Since 1997, the Legislature has appropriated $4 million to the Texas EMS/Trauma Fund.[192] Additionally, in 1999, the Legislature created the permanent Emergency Medical Services and Trauma Care endowment appropriating $100 million of tobacco proceeds and approximately $3 million per year of interest. These funds are directed to EMS Local Projects Grants Program and to regional EMS advisory councils.[193] Finally, in 2003, the Legislature passed legislation that directs funds to EMS from an additional $100 fee for certain intoxication offenses and from surcharges on the driver licenses of habitually poor drivers.[194]

EMS Staffing Strategies

The means of staffing EMS services is greatly dependant on available funding resources. Rural communities are predominately dependant on volunteer EMS providers and personnel because they lack the funds for paid services. DSHS figures show that 20 percent of all Texas EMS providers are volunteer systems. Those areas typically have smaller tax bases and fewer hospital systems to provide revenue, and few private firms are willing to operate in areas where they perceive an inability to profit.

These disparities in provider systems, available funding resources, and staffing options equate to the differences in quality and timeliness for EMS services between urban and rural counties.[195]

Discussion

Due to the lack of a statewide mandate on EMS coverage of care level and funding, challenges arise statewide for EMS systems. The majority of challenges for EMS systems are categorized as:

- funding and reimbursement,
- recruiting and retention of employees,
- adequate training and continuing education for personnel, and
- acquisition and maintenance of needed equipment.

---

tax for fund EMS systems in the district. TEX. TAX CODE § 321.106 (2005); TEX. LOCAL GOV'T CODE § 344.051(a) (2005).

[192] University of Houston Law Center, Health Law Policy and Institute, *Legislative Briefing: EMS Services* (May 12, 2006).

[193] *Id.*

[194] Acts 2003, 78th Leg., ch. 1325, § 12.01(a).

[195] Senate Committee on State Affairs Hearing, July 26, 2006 (statement of Kathryn Perkins, Texas Department of State Health Services).

Adequate Funding Sources and Reimbursement Levels

Funding is a challenge for EMS systems statewide. EMS providers have seen an increase demand for services without a subsequent increase in funding from any available funding strategy.[196] All areas of the state face the challenge of providing the level of care that is expected by its citizens in the most cost effective manner.

In urban counties, while the tax base opportunities are greater, so are the number of people who need services. Rural counties have smaller tax bases, and private EMS providers are abandoning rural programs because they lack profit potential.[197] Raising funds with a local chili cook-off will result in far fewer funds than instituting a district-wide tax.

Local funding challenges are exacerbated by the disparity in the actual cost and the reimbursements paid by Medicare, Medicaid, and private health plans.[198] Statewide, EMS is not reimbursed equally by these various healthcare payors. Medicare has the richest reimbursement, followed by private insurance and with Medicaid paying the least for EMS in Texas.[199] In addition to low reimbursement, approximately 20 percent of EMS services are for individuals who have no insurance or ability to pay.[200]

Medicare Reimbursement Methodology

Medicare reimburses EMS at a rate that is based on the lesser of the actual charge or the applicable fee schedule amount. The fee schedule payment equals a base rate for the level of service plus payment for mileage and applicable adjustment factors.[201] This fee schedule has been phased in over a five-year period to mitigate the negative impact on the federal budget.[202] Medicare reimburses EMS only on an assignment-related basis that requires EMS providers to accept the Medicare reimbursement as payment in full; consequently, they may not bill or collect from the patient any amount outside the coinsurance amounts.[203] The mileage reimbursement is currently set at $8.47 per mile.[204]

Medicaid Reimbursement Methodology

Medicaid reimbursement methodology for ground ambulance services is based on reasonable charges, which is the lesser of the provider's 1991 average adjusted charges, the published prevailing charges based on similar services in the same area in 1991, or the providers actual charge.[205] Medicaid reimbursement for air ambulance services is based on the lesser of

---

[196] *Id.*
[197] *Id.*
[198] Senate Committee on State Affairs Hearing, July 26, 2006 (statement of Jim Lyons, Texas Ambulance Association).
[199] *Id.*
[200] *Id.*
[201] Health and Human Services Commission, *Ambulance Services Report* (Jan. 2006).
[202] *Id.*
[203] *Id.*
[204] Senate Committee on State Affairs Hearing, July 26, 2006 (statement of Jim Lyons, Texas Ambulance Association).
[205] Health and Human Services Commission, *Ambulance Services Report* (Jan. 2006).

the provider's actual charges or the applicable published Medicaid fee schedule amount.[206] The mileage reimbursement is currently set at $3.30 per mile for ground EMS[207] and $16.24 per mile for air mileage.[208]

For the Medicaid program to increase ground ambulance rates to match Medicare rates, the estimated impact on the state budget would be $33.9 million in general revenue and approximately $88.6 million in all funds. For Texas Medicaid to match Medicare rates on air ambulance services, the estimated impact on the state budget would be $18 million in all funds.[209]

Private Health Plans Reimbursement Methodology

The Texas Association of Health Plans (TAHP) conducted a survey of members regarding EMS coverage. Every plan surveyed provides ambulance services at some level that varies by individual plan. EMS coverage ranges from an unlimited benefit with coinsurance of 20 percent, to a 20 percent coinsurance after plan deductible with an annual dollar maximum, to a 50 percent coinsurance. Almost all plans also have a requirement that transportation must be to the closest available facility that can appropriately treat the condition and arrange for transfer to an in-network facility occur after stabilization.

Private health plans' reimbursement methodology is based on a percentage of the Medicare fee schedule. EMS provider's often do not participate as in-network providers for health plans. Therefore, most EMS rates are negotiated between the EMS provider and the health plan after the care is provided. Each EMS provider negotiates reimbursement rates with health plans independently with considerations for location and area average costs.[210] These negotiated rates are not subject to approval by the Texas Department of Insurance.

Reimbursement Challenges for Rural Texas

While the reimbursement rates methodology is equal across the state, rural providers often earn less in total reimbursements. One reason for this reimbursement discrepancy is the lack of staff in rural EMS systems available to submit and negotiate billing charges for reimbursement. The lack of available billing staff results in few volunteer providers consistently billing for EMS.

Also, most reimbursement formulas factor in an average cost for the area. With the sporadic or limited billing services in rural areas, the average used by most reimbursement methodologies is not an accurate reflection of the actual costs. Therefore, when the rural EMS

---

[206] *Id.*
[207] Senate Committee on State Affairs Hearing, July 26, 2006 (statement of Jim Lyons, Texas Ambulance Association).
[208] Health and Human Services Commission, *Ambulance Services Report* (Jan. 2006).
[209] *Id.*
[210] Senate Committee on State Affairs Hearing, July 26, 2006 (statement of Jim Lyons, Texas Ambulance Association).

providers are able to bill for their services, the lack of billing history skews the averages resulting in an even lower reimbursement rate.[211]

The lack of consistency statewide with private health plan negotiations often means health plans reimburse rural EMS providers at a rate lower than that of urban providers. Additionally, the negotiating power between a volunteer EMS provider may be slightly less than that of a nationwide, health plan system resulting in lesser reimbursement rates.

Recruiting and Retention of Employees and Training Issues

Recruitment challenges exist in both rural and urban areas of the state. Salaries for EMS personnel are low, particularly in rural portions of the state. The cost and time required to meet the EMS personnel educational requirements can be prohibitively high.[212] Urban areas experience high response volume, rapid job-burnout and a high turn-over rate.[213] Recruitment for rural areas is a special challenge often related to the necessity to have a purely volunteer EMS system.

Challenges for Rural Texas

Providing appropriate training, especially advanced training; cost and unavailability of continuing education locally; and the inability to purchase quality equipment have resulted in the significant decline of volunteer EMS personnel.[214] According to DSHS testimony, during the past five years, the number of licenses issued to volunteer EMS providers has decreased from 30 percent to 20 percent of the total statewide providers. Additionally, Texas EMS is experiencing a reduction from 25 percent to 14 percent of certified individuals who are volunteer EMS personnel.[215]

In 2001, the Legislature addressed the difficulty in obtaining the appropriate level of training and continuing education for EMS personnel in rural and underserved areas. House Bill 2446 required DSHS to provide training for rural EMS personnel locally if none is readily available through private means eliminating the possible barrier of travel for training.[216]

The large geographic distances covered by rural EMS providers present a considerable challenge for the timeliness of emergency responses. The Texas Bureau of Epidemiology (a division of DSHS) reports that some areas throughout rural Texas have significantly higher patient response times. These areas have patient response times of up to 136 minutes and hospital transport times of up to 132 minutes, while the remainder of the state is reported at 20 minutes or less.[217]

---

[211] *Id.*
[212] Texas Department of State Health Services, *Texas Elected Officials' Guide to Emergency Medical Services.*
[213] *Id.*
[214] *Id.*
[215] Senate State Affairs Hearing, July 26, 2006 (statement of Kathryn Perkins, Texas Department of State Health Services).
[216] Acts 2001, 77th Leg., ., ch. 874, § 2, (2001).
[217] Texas Department of State Health Services, *Texas Elected Officials' Guide to Emergency Medical Services.*

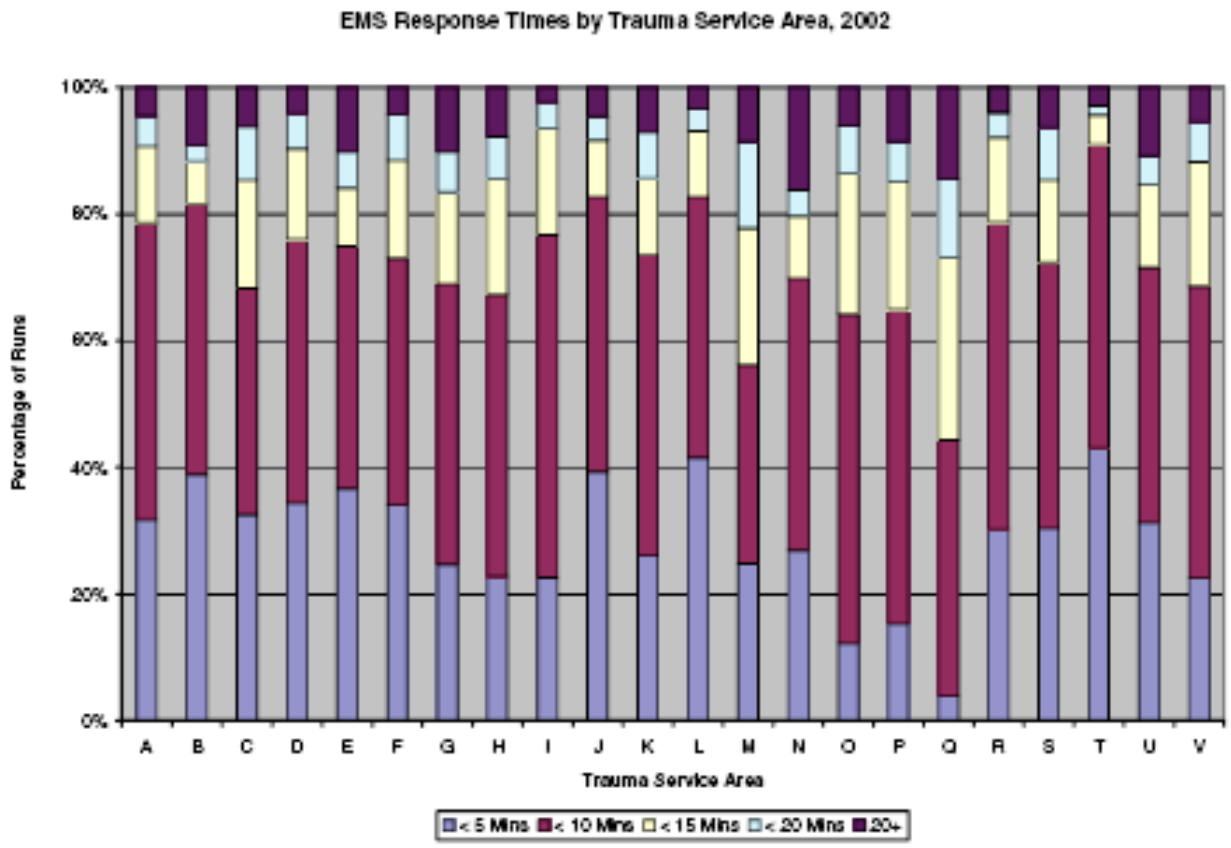


Figure 9 - 1
Source: Texas Department of State Health Services

Volunteer EMS personnel have agreed to take on a very serious and critical job for Texas communities, and they have agreed to do so on their own time and finances. Most volunteer EMS providers also maintain full-time employment, often in non-health related fields, in addition to their EMS duties.

It is important to note that while most Texans do not live in these rural portions of the state, large numbers of all Texans travel throughout the state and rely on the availability of local EMS services in the case of an accident. Volunteer EMS providers and personnel are an effective means of providing quality care, however, they must have adequate resources and training. Ensuring the stability and success of rural EMS is important to all Texans.

EMS Equipment Issues

Equipment for EMS systems is ever-changing and expensive. The cost of an ambulance ranges from $50,000 to $120,000. In Texas, there is a total of 3,106 licensed ground ambulances and only 696 are licensed in rural areas. Ambulances in rural areas average to one ambulance per 311 square miles and are on average eight years old.[218]

[218] Texas Department of State Health Services, *Texas Elected Officials' Guide to Emergency Medical Services.*

Raising funds to replace or repair EMS equipment places an additional burden on already limited funding strategies for EMS in rural Texas.

Recommendations

A majority of the issues that arose during this hearing were related to funding, rather than statutory issues; therefore, many concerns are outside the jurisdiction of the Senate Committee on State Affairs. The Committee will submit a copy of this report to the Senate Finance Committee for use during discussion in the creation of the 2008-2009 General Appropriations Budget.

9.a. Considering available funds:

1. The Medicaid program has not increased reimbursement rates for Texas EMS since 1992. Implementing an increase in the Medicaid reimbursement rate, keeping in mind the unique factors for rural EMS systems, could greatly increase the quality and reliability for EMS in Texas.

2. The Texas Ambulance Association is working with the state to explore improvements to the Medicaid reimbursement methodology. The proposal would be the implementation of the Medicare fee schedule system, with fee variations for locality and for rural versus urban status. The estimated impact to the budget for this proposal would be $30.2 million in general revenue and $78.7 million in all funds.

9.b. To address the difficulties in recruiting and retaining EMS personnel, establish incentives for participation, such as funding scholarships for volunteer EMS education, training and continuing education.

Charge No. 10

Study and review current Texas law on the doctrine of statutory employer, including the 2004 First District Court of Appeals' decision in Etie v. Walsh & Albert Co. and make recommendations of changes in state laws, if necessary, regarding the doctrine of statutory employer and indemnification in construction contracts. Study the current use of Consolidated Insurance Programs and make legislative recommendations, if appropriate.

Statutory Employer

Background

To adequately consider whether the Legislature should make changes to the doctrine of statutory employer, an analysis of the major statutory provisions concerning job site liability is helpful.

First, the Texas Worker's Compensation Act (the Act) immunizes employers who provide insurance coverage -- for medical expenses and lost wages -- to their employees from a lawsuit

by an employee for a work-related injury.[219] The Act expressly extends the statutory immunity of employers in one circumstance: a general contractor is treated as an employer of a subcontractor's employees when the general contractor provides worker's compensation coverage for the subcontractor and the subcontractor's employees.[220] The Act does not expressly state whether lower tier subcontractors are also statutory employees of the general contractor for purposes of worker's compensation if the coverage includes the lower tier subcontractors -- this issue was specifically addressed in *Etie v. Walsh & Albert Co.*, a discussion of which is found below.

Second, in 1995, Chapter 95 of the Civil Practices and Remedies Code was amended to provide owners with legal protections arising from accidents on the jobsite, unless the owner actually exercised control over the jobsite and had actual knowledge of the defect or condition that caused the injury.

Third, in 2003, the Legislature passed H.B. 4, which, among other things, permitted the jury to hear all the evidence regarding negligence, including evidence of involvement of entities not party to the lawsuit.[221] House Bill 4 also enabled the jury to assign responsibility for the accident to those non-parties. Prior to the passage of H.B. 4, the jury was not privy to this information nor were they allowed to assign non-party responsibility.

Moreover, since the mid-1990's, the courts have routinely held that the premise owner and the general contractor are not liable for injuries to the employees of an independent contractor unless the owner or general contractor exercised control over the manner and means of the work by the independent contractor.[222]

Etie v. Walsh & Albert Co., Ltd

The Texas Worker's Compensation Act does not expressly state whether a subcontractor, who is hired by another subcontractor, is considered a statutory employee of the general contractor for purposes of worker's compensation if the worker's compensation coverage covers that subcontractor. This is the very issue that the First Court of Appeals discussed in *Etie v. Walsh & Albert Co., Ltd.*[223]

An employee of Way Engineering (the subcontractor), Shelton Etie, was injured when a large piece of an air conditioning vent fell on him. Etie claimed that the vent fell as the result of negligence by a third party (a lower level subcontractor), Walsh & Albert Co., and he sued them. The entire worksite, however, was covered by a blanket worker's compensation policy purchased by the general contractor, Clark Construction. Etie received benefits under the worker's compensation policy purchased by Clark Construction. A diagram of the relationship between these companies may be helpful:

---

[219] TEX. LAB. CODE § 408.001(a) (1996).
[220] TEX. LAB. CODE § 406.123(a) and (e) (Supp. 2004).
[221] Acts 2003, 78th Leg., ch. 204.
[222] According to this line of cases, "control" is not exercised by the owner or general contractor providing and enforcing their safety programs and maintaining a safe workplace.
[223] 135 S.W. 3d 764 (Tex. App.-Houston [1 Dist.] 2004, pet. denied).

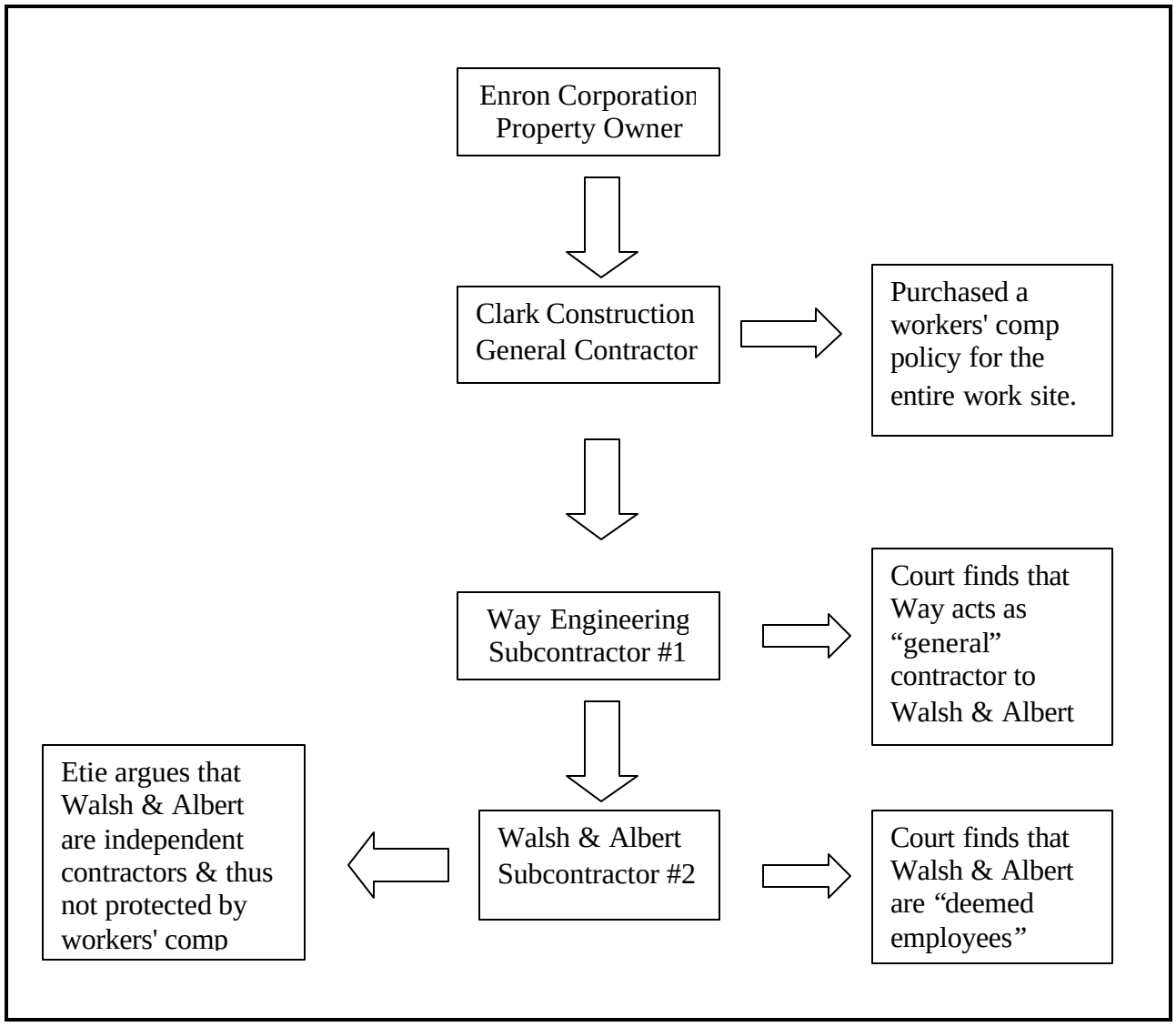


Figure 10 - 1

Etie argued that a subcontractor and the subcontractor's employees are not employees of the general contractor for purposes of the workers' compensation law if the subcontractor operates as an independent contractor.[224] All parties agreed that Walsh & Albert were, strictly speaking, independent contractors. As such, Etie argued that Walsh & Albert as an independent contractor (and not an "employee" as defined by the Act) was not immune from suit.

The First Court of Appeals disagreed stating:

> [c]learly, the Act contemplates that independent contractors may, in certain circumstances, be considered "employees" despite not meeting the definition of an "employee" in section 401.012(b)(2). Therefore, the "legal fiction" to which Etie refers when workers' compensation coverage is provided can encompass not

[224] *See* TEX. LAB. CODE § 401.012(b)(2).

> only subcontractors who would otherwise be considered independent contractors, but also lower tier subcontractors who would otherwise be considered independent contractors. We see no reason why this shift in status from "independent contractor" to "deemed employee", with its concomitant protections, should be denied to lower tier subcontractors.[225]

Applying this logic, the Court held that the Act's statutorily created employer/employee relationship extended throughout all tiers of subcontractors when the general contractor purchased workers' compensation insurance that covered all the workers on the site. Employees still reserved their subrogation rights in cases where workers' compensation coverage was not provided to the entire work site.

Indemnity Provisions

Most contracts between a general contractor and a subcontractor contain indemnification clauses; requirements to add the general contractor to the subcontractor's liability policy; and a waiver of any right to subrogation that the subcontractor or its insurers may have against the general contractor. The premises owner usually imposes the same obligations on the general contractor.

Indemnity clauses appear in two forms: "broad form" clauses or "limited form" clauses. A broad form clause requires the subcontractor to indemnify the general contractor or the premise owner for all losses caused by the subcontractors, the general contractor or anyone else on the job site. A limited form indemnity clause only requires that the subcontractor indemnify the general contractor or owner for losses caused by the negligent act of that subcontractor. The indemnification provision, however, requires that the subcontractor pay the entire cost of defending the claim, regardless of the percentage of fault.

Moreover, construction contracts typically require the subcontractor to add the general contractor to the subcontractor's general liability policy. The contract also designates that the subcontractor's liability policy be the primary policy with the general contractor's liability policy being secondary.

Availability of Insurance

Historically speaking, insurance companies have written general liability coverage that included indemnification provisions protecting a contractor or subcontractors from their own negligence. The cost of this insurance is included in the bid proposal provided by the subcontractor and has traditionally been a contractual shifting of the risk. However, with the recent move to require the subcontractor's insurer to cover the negligence of the general contractor or owner, the availability of this insurance has become limited. Specifically, insurance companies are having a difficult time adequately underwriting the exposure represented by the general contractor or the premises owner.

[225] *Etie*, 135 S.W.3d at 767.

Most insurance carriers will not provide coverage through the Insurance Services Office endorsement (ISO) because the language in the ISO covers additional insured for liability arising out of the subcontractor's work.[226] The provision could require an insurer to pay a general liability claim for the legal liability of the general contractor or owner listed as an additional insured well after the subcontractor's work has been completed because the ISO provisions do not place a time certain for liability to end.

Recommendations

10.a. The Committee recommends no changes to the statutory employer doctrine.

Rationale: The above-referenced statutory protections provided to the premise owners and general contractors are working. At this time, the need for changes to the statutory employer doctrine appears unnecessary.

10.b. The Committee recommends that the use of broad form indemnity be made void as a matter of public policy.

Rationale: The increased use of broad form indemnity coupled with the limited availability of insurance poses a more substantial problem. Customarily, parties have required indemnification agreements as part of the cost of doing business. This cost was borne by the party requiring the indemnification as the insurance premiums were simply added to the bid proposals. Requiring such clauses in construction contracts places an undue burden on the subcontractors, who are required to provide them.

The basic premise of tort reform has been to encourage parties to take responsibility for their own behavior. The use of broad form indemnity clauses is counter to this notion. Accordingly, this committee recommends that the use of broad form indemnity be declared void as a matter of public policy.

Consolidated Insurance Programs

A Consolidated Insurance Program (CIP) is an insurance program in which a principal, usually the owner or general contractor, provides insurance coverages that are bundled into one program for a single construction project or designated multiple projects. The policies provide coverage for everyone on the project(s). The program may include all applicable insurance such as general liability, workers compensation, errors and omissions, and builder's risk. The goal of a CIP is to reduce overall insurance costs because the general contractor or subcontractors are generally required to lower their bids by the amount they would have had to spend on insurance.

If designed and administered properly, CIPs have several advantages, including large cost savings; however, subcontractors and their employees suffer under poorly designed or managed programs. Currently, the Texas Department of Insurance does not regulate most CIPs; therefore, there are no statutes or rules effectuating appropriate administration.

[226] This information was provided to the Texas Department of Insurance from Managing General Agencies.

Types of Programs

There are two basic types of CIPs; one termed a Wrap-up Rating Plan (Wrap-Up) and others termed Owner Controlled Insurance Program (OCIP), Contractor Controlled insurance Program (CCIP) or Rolling Owner Controlled Insurance Program (ROCIP).[227] The differences are reflected in the chart below.

Consolidated Insurance Programs	
Wrap-Up Rating Plans	***vs.*** **OCIP/CCIP/ROCIP**
Single policy for all interests involved on the construction project	Individual policies for each contractor and subcontractor on the construction project
Owner passes through insurance costs to each contractor by including a requirement in the bid specifications that insurance costs be excluded in the bid.	Owner passes through insurance costs to each contractor by including a requirement in the bid specifications that insurance costs be excluded in the bid.
Owner receives premium discounts, dividends or retrospective returns.	Owner does not receive premium discounts, dividends or retrospective returns.
Contractors/Subcontractors do not receive premium discounts, dividends or retrospective returns for their individual experience	Contractors/Subcontractors receive premium discounts, dividends or retrospective returns for their individual experience.

Figure 10 - 2
Source: Texas Department of Insurance

At the Committee's August 23, 2006, hearing, the Texas Department of Insurance (TDI) testified that it does not regulate CIPs except to the extent the separate policies under the CIP are regulated.[228] In fact, it has been TDI's long-standing position that Wrap-up CIPs are not permitted under current rating laws because those laws require the insured to be rated on an individual risk basis. Under such programs, all risks are rated as one.[229] However, TDI clearly stated that if the contractor and subcontractors are individually underwritten for their own losses, as is typical of OCIPs, CCIPs and ROCIPs, there would be no conflict with current laws.[230]

During the 78th Legislature's regular session, S.B. 868, as filed, would have directed TDI to set up a regulatory scheme for CIPs. Subcontractors favored the bill because it narrowed the use of CIPs and addressed some of the administrative problems subcontractors experience. For example, CIPs would have been limited to projects valued at $100 million or more, and the principal would have been required to hire a separate administrator to manage the CIP. The Legislature did not pass S.B. 868.

---

[227] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of David Durden, Associate Commissioner, Texas Department of Insurance).
[228] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of David Durden, Associate Commissioner, Texas Department of Insurance).
[229] *Id*. *See also*, State Board of Insurance, General Casualty Bulletin No. 589, Workers Compensation Bulletin No. 525 (Sept. 25, 1981); State Board of Insurance, General Casualty Bulletin No. 450, Workers Compensation Bulletin No. 453 (Aug. 7, 1974).
[230] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of David Durden, Associate Commissioner, Texas Department of Insurance).

Proponents of CIPs

There are advantages and disadvantages to each type of CIP. CIPs are intended to reduce the insurance costs on a project by using economies of scale to purchase insurance at a lower rate. Proponents contend that many CIPs provide better insurance than a subcontractor may be able to procure on their own.[231]

The Committee heard testimony from witnesses for and against the use of CIPs. Proponents include public entities such as school districts and transit systems as well as private, non-governmental entities. Among the advantages of CIPs cited by proponents are the following:

- cost savings due to economies of scale and unused worker's compensation reserves;[232]
- lower deductibles for some subcontractors;
- emphasis on project safety through site visits by owner's safety engineer;
- creation of team atmosphere;
- reduced litigation costs through elimination of subrogation;
- adequate and uniform coverage;
- elimination of overlapping coverage and duplicate claims payments;
- elimination of coverage gaps;
- increased small and historically underutilized subcontractor participation in high value projects; and
- efficient claims management.

The most often cited advantage to CIPs is their potential for cost-savings. At the hearing, the Committee heard testimony that construction insurance typically costs between 5 and 7 percent of the project's total construction costs.[233] Representatives from East Side Independent School District (East Side ISD) testified that by using a ROCIP, their insurance costs were 2.78 percent of total construction costs in 1998.[234] Additionally, current insurance costs for Dallas Area Rapid Transit (DART) were estimated at $39 million or 2.78 percent of project costs of $1.4 billion.[235]

[231] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statements of James Terry, North East Independent School District; Ben Gomez, Dallas Area Rapid Transit).
[232] Under a traditional policy, unused worker's compensation reserves would go back to the general contractor as additional profit, but under an OCIP, the reserves stay with the owner. Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of David Durden, Associate Commissioner, Texas Department of Insurance).
[233] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of James Terry, North East Independent School District).
[234] *Id.*
[235] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of Ben Gomez, Dallas Area Rapid Transit).

Finally, a key point addressed by East Side ISD is the emphasis on safety.[236] Because the project owner or contractor is responsible for procuring all of the insurance for the project, and because they are paying the premiums for the project, it is in their best interested to develop and implement an effective safety program for all subcontractors working on the project. Additionally, unused workers compensation reserves are returned to the project owner or contractor.

Opponents of CIPs

To maximize the benefits of a CIP, it must include appropriate coverage and be effectively administered. Opponents, chiefly subcontractors, contend that many of the CIPs used in Texas do not always include appropriate coverage and often fail to be properly administered.[237] Opponents cite many drawbacks to CIPs. Coverage issues include:

- a subcontractor's ability to secure more insurance for the same price from their own agents;
- a subcontractor's loss experience is often used as a point of scoring on the subcontractor's bid, but is not used to underwrite their insurance coverage when a CIP is used;
- lesser coverage forces subcontractors to buy gap insurance;
- the owner or contractor may select premiums or deductibles that are not what the subcontractor believes is appropriate;[238]
- claims limit may be insufficient for the size of the project and the subcontractors have no information as to eroded limits when they begin their work on the project;
- the Point of Completion is ambiguous with a CIP, especially on a long-term project with multiple subcontractors; and
- completion coverage may not be consistent with the 10-year statute of repose.[239]

In addition to coverage issues, opponents argue improper administration of a CIP may result in serious consequences for a subcontractor. Examples include:

- lack of procedures for notifying subcontractor of claims resulting in eroded limits of liability;

[236] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of James Terry, North East Independent School District).
[237] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statements of Tim Thompson, Allison & Thompson; Jennifer Junker, American Subcontractors Association).
[238] For example, the workers compensation deductible selected for the Toyota plant construction in San Antonio was $250,000 per claim. Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of Tim Thompson, Allison & Thompson).
[239] This is a market problem encountered by both owners and subcontractors which is particularly problematic for subcontractors forced to participate in a CIP. Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statements of Ben Gomez, Dallas Area Rapid Transit; Jennifer Junker, American Subcontractors Association; Tim Thompson, Allison & Thompson).

- copies of policies or coverage certificates are not received by the subcontractor before work is commenced;
- untimely claims processing;
- extended time associated with post-completion audits which then delay payments to subcontractors;
- lack of involvement of subcontractors in claims management process; and
- no procedures or provisions to refund excess coverage payments to subcontractors.

Another objection raised by subcontractors is the confusion created by a CIP with regard to the traditional insurer/insured relationship.[240] Often one broker may design the CIP, obtain coverage, and then serve as the CIP administrator. Additionally, the name on the policy may vary. In a Wrap-Up plan, the insured may be the property owner or contractor -- whoever secured the policy; whereas with an OCIP or ROCIP, the named policyholder will most likely by the subcontractor, despite the fact that the property owner arranged for the coverage. The confusion created by the CIP is significant because of the relationships of the parties involved.

The Committee heard testimony that the relationship is often blurred and the broker/administrator is more closely tied to the property owner because they have an existing business relationship.[241] However, the subcontractor is the employer of the potential insured worker/claimant. Because the subcontractor is forced into the CIP policy, they want to be assured that they will be the primary concern of the administrator in the event of an injury.

Currently, the Insurance Code does not specifically address the relationships among parties to a CIP. Chapter 541, relating to Unfair Methods of Competition of Deceptive Acts, does include brokers in its definition of persons who are subject to the Act; however, it offers little protection to subcontractors under a CIP.[242]

Finally, opponents contend that the insurance they are mandated to accept as a part of their contract conflicts with the broad form indemnification clauses in the same contract.[243] The CIP policy may not provide the appropriate coverage a subcontractor needs to truly insure itself against the acts or omissions of parties they must indemnify. Additionally, because the project completion date in the CIP may not run with the 10-year statute of repose, the subcontractor faces added exposure. This forces the subcontractor to procure separate insurance beyond the CIP and at an added expense they alone must bear. In fact, the Committee heard testimony that many subcontractors are simply not able to secure additional insurance at any cost because insurers are unable to appropriately measure their risk.[244]

---

[240] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statement of Tim Thompson, Allison & Thompson).
[241] *Id.*
[242] TEX. INS. CODE § 541.002 (Supp. 2006).
[243] Senate Committee on State Affairs Hearing, Aug. 23, 2006 (statements of Tim Thompson, Allison & Thompson; Dennis Lewis, Potter Concrete).
[244] *Id.*

Recommendations

There are benefits and detriments to Consolidated Insurance Programs as they are used today. The potential for cost savings, especially in terms of taxpayer dollars saved by school district and transit systems, cannot be disregarded. Additionally, the Committee finds that some subcontractors are able to work on projects they would ordinarily be excluded from but for the use of a CIP. However, subcontractors, who have no control over the terms of the CIPs, employ the workers that are to be covered. Therefore, subcontractors should be able to rely on some certainties when an owner or contractor chooses to use a CIP for its insurance needs.

10.c. The Committee makes the following recommendations to be included in any legislation considered by the 79th Legislature:

- Insurers providing coverage under a CIP must separately underwrite each entity to be covered.
- Copies of policies or coverage certificates must be given to each subcontractor prior to the commencement of work. Periodic updates must be communicated to each subcontractor detailing coverage limits and claims.
- The Insurance Code should be amended to clarify the duty of a broker/agent/administrator in a CIP arrangement.
- CIP coverage that includes completed operations must be consistent with 10-year statute of repose.

Charge No. 11

Assess the benefit of limiting the civil liability for noneconomic damages against non-profit organizations involved in the privatization of child welfare services.

Background

The 78th Legislature adopted S.B. 6 relating to comprehensive reform of adult and child protective services.[245] With respect to the "privatization of child welfare services," S.B. 6 instructs the Department of Family and Protective Services (DFPS or Department) to develop a strategy for outsourcing or privatizing substitute care and case management services for children in DFPS managing conservatorship.[246] The timeline in S.B. 6 requires DFPS to outsource all substitute care and case management services statewide by September 1, 2011.[247] The first region (San Antonio) is to be implemented by December 31, 2007, followed by the second and third regions by December 1, 2009.

The Department has adopted the following mission statement as it relates to outsourcing: "Improve the safety, permanency and well-being outcomes for children in DFPS' legal conservatorship and their families through outsourcing of substitute care and case management

[245] Acts 2005, 79th Leg., ch. 268.
[246] Acts 2005, 79th Leg., ch. 268 § 1.46; FAM. CODE § 264.106 (Supp. 2006).
[247] Acts 2005, 79th Leg., ch. 268, §1.46; FAM. CODE § 264.106(i) (Supp. 2006).

services to community-based systems of care."[248] To fulfill their obligation, DFPS is to contract with an Independent Administrator (IA) to develop and manage a community-based network of service providers.[249] Regional IAs will not provide services directly, but will be responsible for developing subcontracts with service providers and referring clients for placement.[250]

The IA will be responsible for (1) development and management of service provider networks; (2) intake and initial placement; (3) quality assurance and monitoring of subcontractor performance; (4) training and technical assistance to subcontractors; (5) data systems to track and report performance date; and (6) community engagement.[251] The following chart illustrates the pieces of the child protective services puzzle that are being privatized pursuant to S.B. 6.

Outsourced Child Protective Services

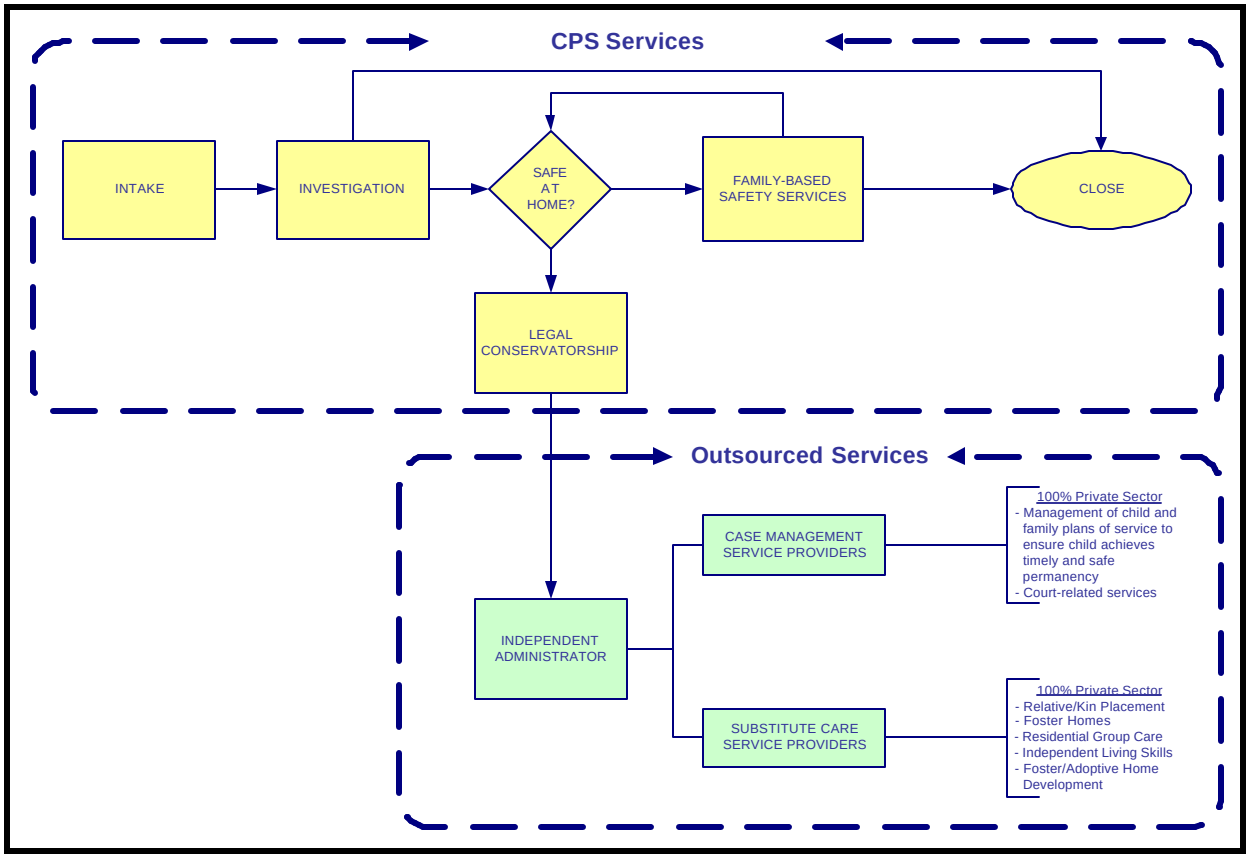


Figure 11 - 1
Source: Texas Department of Family and Protective Services

[248] Senate Committee on State Affairs Hearing, July 27, 2006 (statement of David Sheets, Director of Outsourcing, Texas Department of Family and Protective Services).
[249] Acts 2005, 79th Leg., ch. 268, §1.46; FAM. CODE § 264.106 (Supp. 2006).
[250] Senate Committee on State Affairs Hearing, July 27, 2006 (statement of David Sheets, Director of Outsourcing, Texas Department of Family and Protective Services).
[251] *Id.*

A request for proposals for an IA in the first region, San Antonio, was released by DFPS in May 2006. Two responses were received. As of the date of publication of this report, DFPS had yet to award the contract.

Discussion

Private independent administrators are not protected by sovereign immunity; therefore, such entities may have exposure to damage awards, including noneconomic damages, arising from personal injury litigation in the civil justice system.

The Texas Civil Practice and Remedies Code defines noneconomic damages as:

> [D]amages awarded for the purpose of compensating a claimant for physical pain and suffering, mental or emotional pain or anguish, loss of consortium, disfigurement, physical impairment, loss of companionship and society, inconvenience, loss of enjoyment of life, injury to reputation, and all other nonpecuniary losses of any kind other than exemplary damages.[252]

Sovereign Immunity

The doctrine of sovereign immunity is a long established common law doctrine intended to protect a government's ability to perform its traditional functions by providing immunity to public servants and government entities.[253] Absent an express waiver of sovereign immunity, such as that in the Texas Tort Claims Act,[254] an injured party may not sue the state for economic or noneconomic damages.[255] In general, the doctrine of sovereign immunity may not be extended to non-governmental entities.[256] Therefore, under the privatization of child welfare services process set forth in S.B. 6, an entity contracting with the state as an IA would not be eligible for sovereign immunity protection.

Proponents of reducing or waiving liability for non-economic damages assert that in the privatization context, the IA is performing a function originally, and until now, performed exclusively by state government. If an incident resulted in a lawsuit, the state agency would assert sovereign immunity; however, the newly created IA will not have the same legal protection.[257] Proponents argue that fairness dictates an extension of immunity.[258]

---

[252] TEX. CIV. PRAC. & REM. CODE § 41.001 (12) (2005).
[253] Hosner v. DeYoung, 1 Tex. 764 (1847). "[N]o state can be sued in her own courts without her consent, and then only in the manner indicated by that consent." *Id.* at 769.
[254] TEX. CIV. PRAC. & REM. CODE ch. 101 (Supp. 2005).
[255] Tooke v. City of Mexia, No. 03-0878, 2006 Tex. LEXIS 654 (Tex. June 30, 2006).
[256] An individual performing uniquely government services pursuant to a contract with a governmental entity may be protected by official immunity if they are performing discretionary duties within the scope of their authority in good faith. *See* Titus Regional Medical Center v. Tretta, 180 S.W.3d 271 (Tex.App. - Texarkana 2005).
[257] *See* Hernandez v. Hines, 159 F.Supp 378 (N.D. Tex. 2001).
[258] Senate Committee on State Affairs Hearing, July 27, 2006 (statements of Jack Downey, The Children's Shelter; Mike Foster, Texas Association of child Placing Agencies; Nancy Holman, Texas Alliance of Child and Family services; Kurt Senske, Lutheran Social Services).

The Committee concludes the outsourcing of child protective services does not necessarily warrant an extension of sovereign immunity to a private entity. Although a plaintiff may not be able to recover damages against the state if they are injured as the result of negligence by a state employee, there are checks and balances in place to correct bad behavior and protect others from the same fate. The same such protections do not necessarily exist if the injuring action is performed by an employee of a private company. Unless a damaged party is able to seek redress in a court of law, there are no incentives to a private company, for-profit or nonprofit, to change its behavior.

Charitable Immunity Act

During the July 27, 2006, hearing, the Committee heard from attorneys testifying on behalf of plaintiff and defense attorney associations who opined that Chapter 84 of the Civil Practice & Remedies Code, the Charitable Immunity and Liability Act of 1987 ("Charitable Immunity Act"), would apply to a bona fide charitable organization contracting with the state as an IA.[259] The Charitable Immunity Act was adopted with the intent to "reduce the liability exposure and insurance costs of [charitable] organizations and their employees and volunteers in order to encourage volunteer services and maximize the resources devoted to delivering these services."[260] The Committee requested that the Texas Legislative Council examine the issue and Council attorneys came to a similar conclusion.[261]

The Charitable Immunity Act contains a broad definition of "charitable organization" which includes, in part, a nonprofit corporation "organized and operated exclusively for the promotion of social welfare by being primarily engaged in promoting the common good and general welfare of the people in a community."[262] Volunteers are completely immune from civil liability.[263] Additionally, the liability of the charitable organization and its employees is limited to a maximum of $500,000 for each person and $1,000,000 for each occurrence of bodily injury or death and $100,000 for each occurrence of property damage.[264] The Charitable Immunity Act clearly states that it does not apply to "an act or omission that is intentional, willfully negligent, or done with conscious indifference or reckless disregard for the safety of others."[265]

To avail themselves of the protections in the Charitable Immunity Act, a charitable organization must carry liability insurance. The insurance must apply to the acts of the organization, its employees and volunteers, and must be in the amount of at least $500,000 for each person and $1,000,000 for each occurrence for death or bodily injury and $100,000 for each occurrence of property damage.[266]

---

[259] Senate Committee on State Affairs Hearing, July 27, 2006 (statements of David Chamberlain, Texas Association of Defense Counsel; Jay Harvey, Texas Trial Lawyers Association).
[260] TEX. CIV. PRAC. & REM. CODE § 84.002 (7) (2005).
[261] See Appendix XI.
[262] TEX. CIV. PRAC. & REM. CODE § 84.003(1)(A) (2005).
[263] TEX. CIV. PRAC. & REM. CODE §§ 84.004 (2005).
[264] TEX. CIV. PRAC. & REM. CODE §§ 84.005; 84.006 (2005).
[265] TEX. CIV. PRAC. & REM. CODE § 84.007(a) (2005).
[266] TEX. CIV. PRAC. & REM. CODE § 84.007(g) (2005)

Liability Insurance

The Committee heard testimony from foster care providers asserting that liability insurance for an IA is expected to become expensive and difficult to obtain.[267] Although this should be of concern to policymakers, at this time such an assertion is speculative. Additionally, it is unclear whether the providers' concerns would be better addressed through insurance reform rather than limits on liability for noneconomic damages.

All that is known as of the publication of the report is that DFPS' request for proposals required potential IAs to maintain comprehensive general liability insurance in a sum of not less than $1,000,000 per occurrence and not less than $3,000,000 in the aggregate.[268] Two respondents have filed proposals that conform to the request for proposals.[269]

Recommendations

Based on the legal experts' conclusions that the Charitable Immunity Act would apply to a nonprofit corporation involved in the privatization of child welfare services, the Committee does not recommend any statutory revisions.

With regard to liability insurance, the Committee concludes that it is unnecessary for DFPS to require a non-profit entity acting as an IA to procure insurance in excess of the requirements in the Charitable Immunity Act. However, because for-profit IAs would not be covered by the Charitable Immunity Act, higher liability limits may be justified for those entities. The issue of availability of liability insurance is one that bears monitoring. Any evidence of denial of insurance should be presented to the Committee as soon as possible.

---

[267] Senate Committee on State Affairs Hearing, July 27, 2006 (statements of Jack Downey, The Children's Shelter; Mike Foster, Texas Association of Child Placing Agencies; Nancy Holman, Texas Alliance of Child and Family services; Kurt Senske, Lutheran Social Services).

[268] Texas Department of Family and Protective Services, *Request for Proposals for Independent Administrator* at Art. 2.

[269] http://www.dfps.state.tx.us/About/Outsourcing/News.html

APPENDIX I

Senate State Affairs Hearing

June 27, 2006

Materials Prepared by

Legislative Budget Board Staff

Overview of Major State-Administered Health Insurance Programs

		Program Structure	Funding Structure
Employees Retirement System (ERS)	State Employees and Retirees and their dependents Participants: 448,000 (incl[illegible] HEGI)	The Employees Retirement System (ERS) HealthSelect Plan is a self-funded point of service (POS) plan, plus access to select health maintenance organizations (HMOs). The HealthSelect medical component is administered by BlueCross BlueShield of Texas and the pharmaceutical component is administered by Medco Health Solutions. ERS serves all higher education institutions, including community colleges, other than UT and TAMU component institutions.	Contributions from the state and employees are placed in the Employees Life, Accident and Health Insurance Benefits Fund and invested for maximum return until needed to pay claims and administrative costs.
Texas A&M System (TAMU)	Employees of Higher Education Institutions and their dependents Participants: TAMU: 57,000	Texas A&M System offers a self-funded health program that includes two enrollment options with varying deductibles. The plan's prescription drug program is managed by PharmaCare. Members also have the option to enrol in one or more HMOs in some locations.	*Sum certain appropriation to each institution. *Costs above appropriation funded by institutions out of other appropriated or local funds.
University of Texas System	Employees of Higher Education Institutions and their dependents Participants: UT System: 157,000	The University of Texas System offers a preferred provider organization (PPO) called UT Select and a health maintenance organization (HMO) called HMO Blue Texas. Both plans are administered by BlueCross BlueShield of Texas. The prescription drug plan is administered by Medco for UT Select and by Prime for HMO Blue Texas.	*Sum certain appropriation to each institution. *Costs above appropriation funded by institutions out of other appropriated or local funds.

Overview of Major State-Administered Health Insurance Programs

		Program Structure	Funding Structure
Teacher Retirement System, Retiree Group Insurance Program (TRS-Care)	TRS Retirees and their dependents Participants: 189,000	TRS-Care is a self-funded insurance program that offers three plans including a catastrophic plan, a high-deductible comprehensive plan, and a more generous comprehensive plan with higher premiums. Retiree monthly premiums in TRS-Care 3, the most popular plan, range from $90 to $310 depending on years of service and Medicare status.	Sources of funds include: 1. Annual payroll based contributions: *State contribution of 1% *Public education employee contribution of 0.65% *School district contribution of between 0.25% and 0.75% (set at 0.55% for current biennium) 2. Retiree monthly premiums 3. Additional state funds ($77 million in current biennium) 4. Investment Income
Teacher Retirement System, Public Education Employee Group Insurance Program (TRS-ActiveCare)	Public Education Employees of Participating Districts, Charter Schools, and Regional Education Service Centers. Participants: 276,000 members from over 1,000 entities	TRS-ActiveCare is a self-funded insurance program that offers 3 plans ranging from basic coverage to a plan similar to the HealthSelect plan offered to state employees, plus access to select HMOs for some districts. Monthly premiums for employee-only coverage range from $249 to $446 depending upon plan choice.	ActiveCare is funded entirely through premiums. No state funds are appropriated to support the program. In the current biennium, eligible public education employees receive a compensation supplement of $500 or $250 dollars per year that can be taken as salary or used to pay additional health care costs.

Significant Legislation Pertaining to Major State-Administered Health Insurance Programs

			Summary of Effect
78th Legislature	Senate Bill 1691	TRS-Care	* Increased active employee contribution rate from 0.5% to 0.65% * Required districts to contribute costs above premiums for certain return-to-work employees * Changed TRS-Care eligibility requirements.
	Senate Bill 1 (2006-07 General Appropriations Act)	TRS-Care	* Increased school district contribution rate from 0.4% to 0.55%
	Senate Bill 1 (2006-07 General Appropriations Act)	ERS, TRS, UT, A&M	*Reduced appropriations for Medicare Prescription Drug Reimbursement.
	Senate Bill 1363	ERS	* Implemented a health insurance "opt-out" provision with a financial incentive to waive participation in the Group Benefit Plan. * Implemented optional supplemental health coverage for members eligible under the TRICARE military health system.
78th Legislature	Senate Bill 1369	TRS-Care	* Increased active employee contribution from 0.25% to 0.5% * Added district contribution rate of between 0.25% and 0.75% to be set in the General Appropriations Act * Increased state contribution rate from 0.5% to 1.0% * Established cost-sharing standard whereby the state shall contribute no more than 55% of total cost and participants shall contribute no less than 30% of total cost. * Changed eligibility requirements to age 65 or the rule of 80 * Restructure retiree premiums; Medicare Part A&B, Medicare Part B Only, Non-Medicare and based on years of service.
	Senate Bill 1370	ERS, UT, A&M	* Established a 90 day waiting period for insurance coverage. * Required general state and higher education employees working less than 40 hours a week must contribute at least 50 percent of the cost of member-only coverage and at least 75 percent of the cost of dependent coverage. * Authorized higher education institutions to use non-General Revenue funds to retain the existing state contribution rates for graduate assistants and provide group insurance coverage to Adjunct Faculty. * Established minimum eligibility for retiree insurance as age 65 and 10 years of service , or the rule of 80 * Required members of boards and commissions be excluded from receiving state insurance contributions.
	Senate Bill 1652	UT, A&M	* "Grandfathered" UT and A&M System employees from "rule of 80" and "65/10" retirement guidelines.
	House Bill 1 (2004-05 General Appropriations Act)	TRS-Care	* School district contribution set at 0.4%
77th Legislature	House Bill 3343	TRS-ActiveCare	* TRS-ActiveCare established
	Senate Bill 292	ERS	* Increased benefit multiplier used in calculating pension benefits from 2.25% to 2.3%.

Compiled by Legislative Budget Board

LBB Document Sources:
ERS, TRS, UT and TAMU

Administrative Plan Design Changes Made to Health Plans	ERS	UT	TAMU	TRS-Care	TRS-Active
CoPay/Coinsurance Changes					
Increase primary care copay	1999 2003	2003 2004	2000 2003 2004	1997 2004	
Increase specialists copay	2003	2003 2004			2004
Implement inpatient hospital copay	2003	2004			2006
Implement outpatient hospital copay	2003				2006
Change/increase emergency room copay	2003	2002 2004			2006
Decreased plan coinsurance levels (relative to participant) or increase plan deductibles	2000 2003 2004	2004	1999 2003 2004	1998 2005	2004 2006
HMO/PPO Changes					
Expand cost-effective HMO service areas	1996				
Reduce/limit number of HMO offerings	2000-04 2007	2003 2005			
Rebid and/or renegotiated contracts to new third party administrator, HMOs	1999 2003 2006	2002	1998	2004 2005	
Included performance penalties in new PPO admin and HMO contracts	2000 2006	2002			
Prescription Drug Coverage					
Increase prescription drug copay	1998 2000 2001 2003	2000 2001 2002 2003	1998 1999 2000 2003	1998 2000 2002 2004	2005
Implement annual prescription drug deductible	2004	2004	2003		2006
Added coverage management/educational tools to limit overuse of certain medications, incentivize healthy behavior	2001 2002 2005	2001 2002 2003 2005	1999 2000 2002 2005		

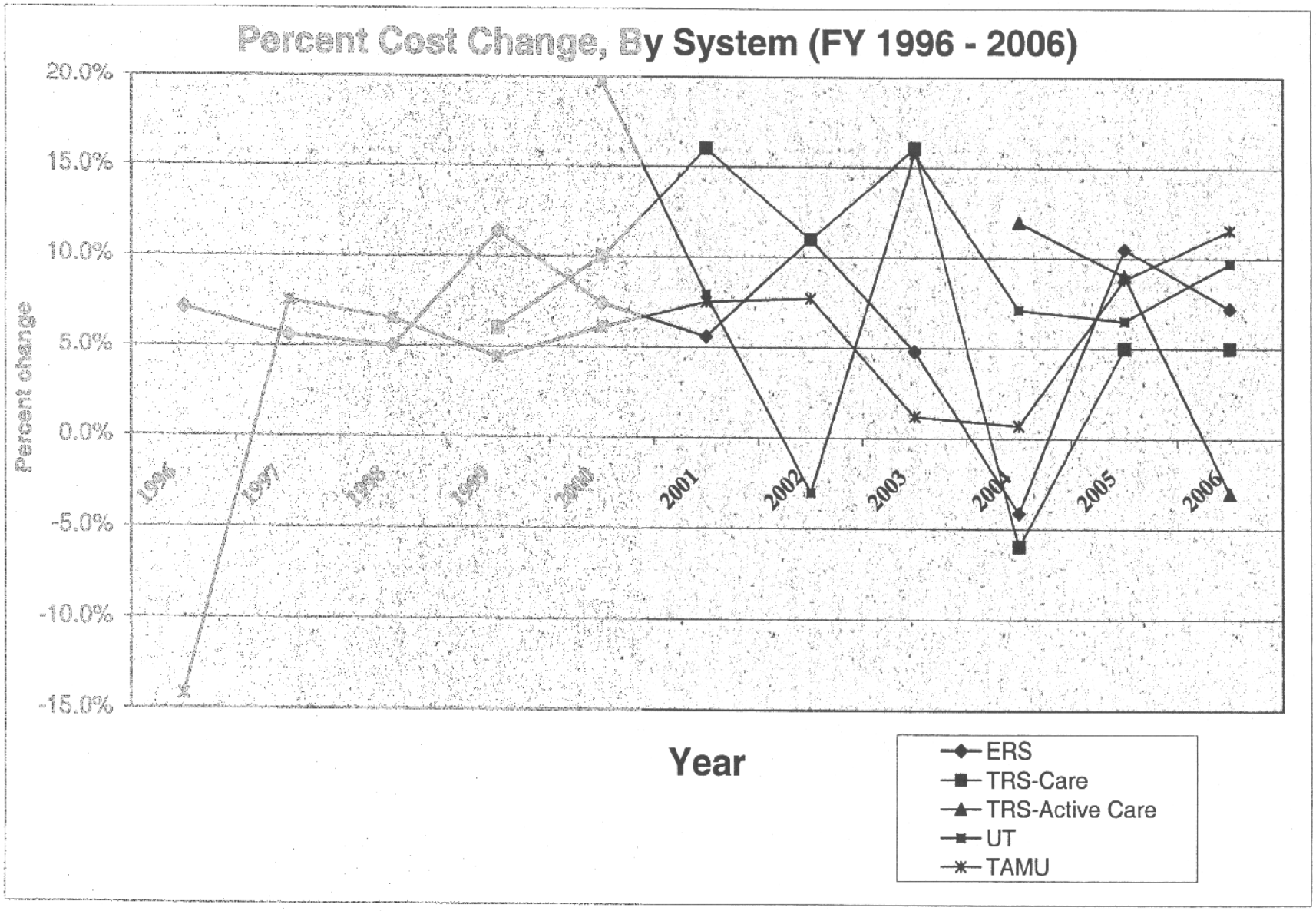
Compiled by Legislative Budget Board

LBB Document Sources:
ERS, TRS, UT and TAMU

Administrative Plan Design Changes Made to Health Plans	ERS	UT	TAMU	TRS-Care	TRS-Active
Rebid prescription drug program and/or awarded contract to new carrier	2000 2006	2001	1999 2006	1998 2002	
Added performance penalties in prescription drug program contracts	2000 2006	2001			
Created in-house Pharmacy Advisory Committee		2001			
Added prior authorization requirement for certain drugs	2002	2002		2002	
Implement optional prescription mail order	1997 2000	2001			
Implement mandatory generic prescription drug requirement	2003	2006			
Other Coverage Changes					
Removed benefit for annual vision exam			2004		
Dental coverage removed from basic package		2001			
Contract with an independent actuary to provide in-house consulting advice		2000			
Issued plan participant newsletters electronically biannually		2002			
Provided support to health and wellness fairs/health education programs	1998- 2006	2003-06	1998, 2001-06		2006
Created/eliminated health plan	2003			2005	
Increased member premiums and/or contribution rates	2000-03 2005-07			2000	
Increased certain discounts for physician and hospital				1997-99	
Other administrative changes			2004	1997 1998 2002	

Compiled by Legislative Budget Board

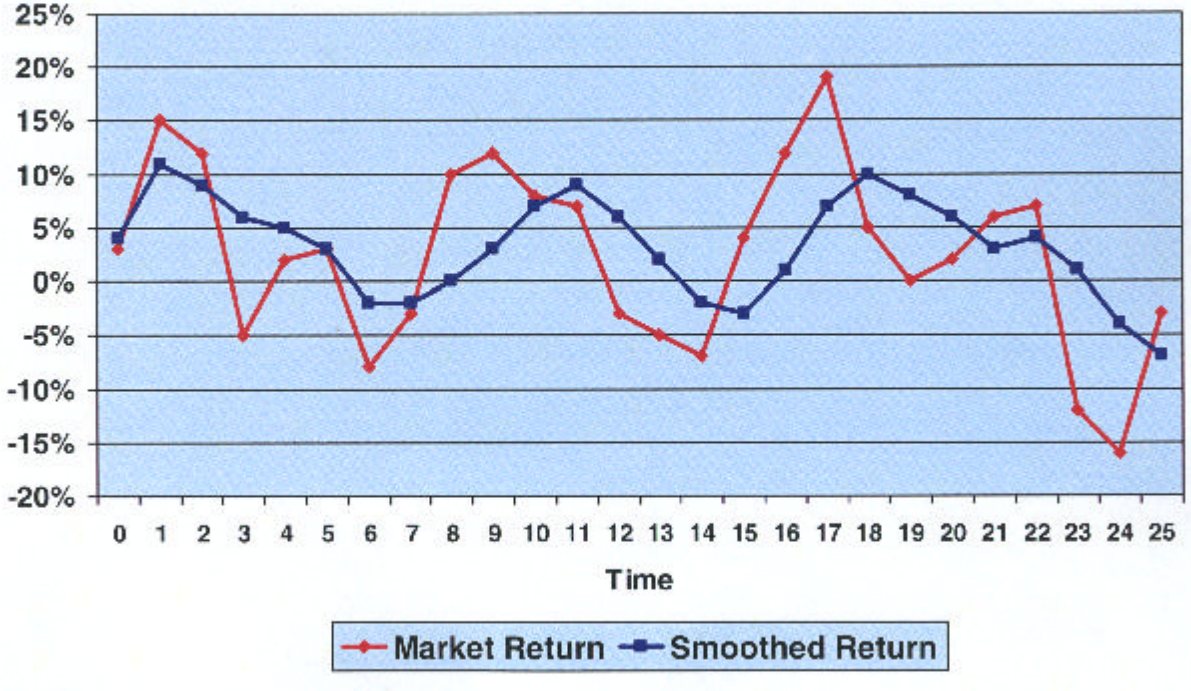
LBB Document Sources:
ERS, TRS, UT and TAMU



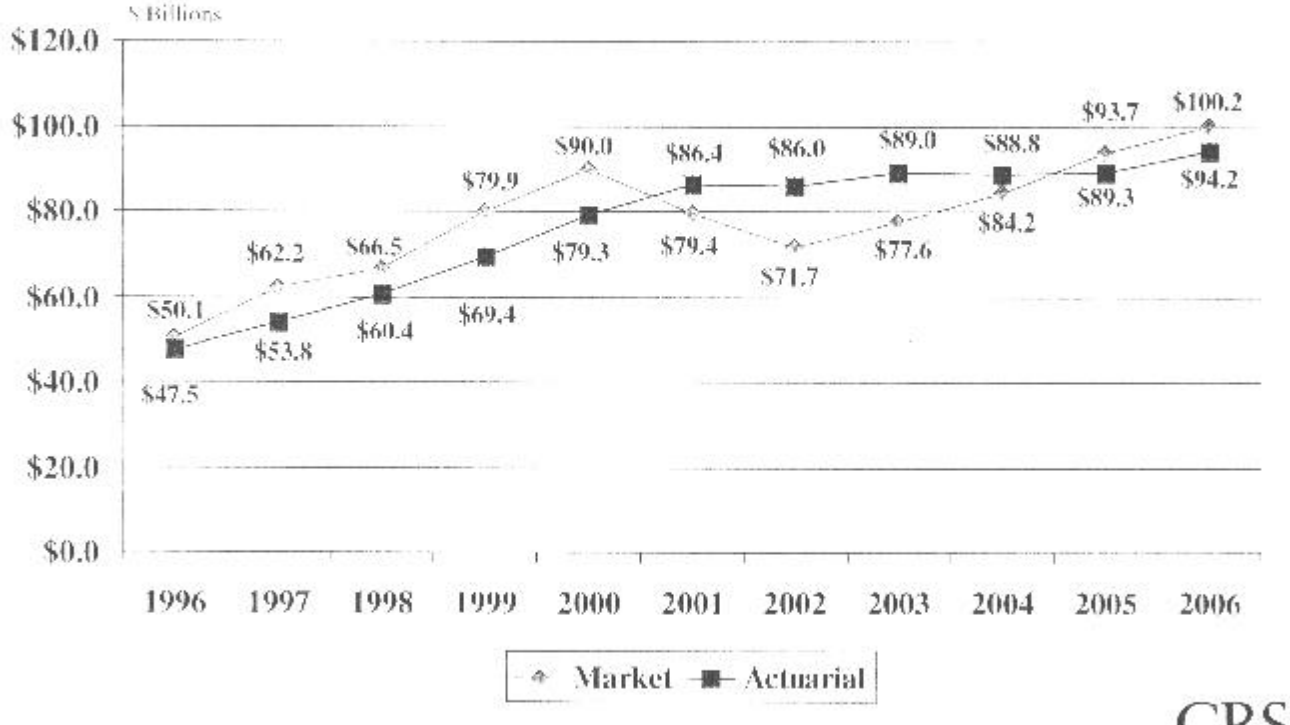
Compiled by Legislative Budget Board

APPENDIX II

Impact of Asset Smoothing



Market and Actuarial Values of Assets



AVA is 94.0% of MVA

GRS

SB 1691

Retirement Benefit Calculation

(effective September 1, 2005)

If not grandfathered*:

- **Final Average Salary** at retirement will be determined by the highest five years (instead of three years) of salary.
- **Subsidized early retirement** eliminated. Members age 55 or older with 20 to 24 years of credited service who take early retirement receive a greater reduction to their annuities.
- **Partial Lump Sum Option** (PLSO) eligibility will require meeting a "Rule of 90."

* TRS members were grandfathered if they met any one of these requirements on or before August 31, 2005:
  - at least 50 years old, or
  - age and years of service credit equal at least 70 ("Rule of 70"), or
  - have at least 25 years of service credit

SB 1691

Service Credit Purchase Option

- Repealed additional service credit purchase of 1-3 years by eligible members, as of January 1, 2006.

Out-of-state Service Credit

- Out-of-state service credit purchases will require increased contributions (actuarial equivalent) after January 1, 2006 for certain members.

SB 1691

Service Retirement Eligibility

- Retirement eligibility was not changed for current TRS members who maintain their membership status until retirement.

- **For new TRS members beginning on or after September 1, 2007:**
  - Age 65 with five years of service credit, *or*
  - Age 60 with at least five years service credit and meet the Rule of 80

Members who are subject to these new eligibility requirements and who retire before age 60 must have at least five years of service credit and meet the Rule of 80 but will have a 5% annuity reduction for each year under age 60. Members with at least 30 years of service credit but who do not meet the Rule of 80 may retire but will have a 5% reduction for each year under age 60.

SB 1691

Employment after Retirement Employer Surcharge

- Employers pay a monthly **pension surcharge** for certain return-to-work retirees. The pension surcharge equals the sum of the combined state and member contributions (currently 12.4% of salary).

- Employers also pay a **health benefit surcharge** for certain retirees enrolled in TRS-Care and working in a TRS-covered position. The amount of the health benefit surcharge is the amount of the difference between the retiree's premium (including dependent coverage) to TRS-Care and the actual cost of the coverage as determined by TRS.

SB 1691

90-day membership waiting period

expired September 1, 2005.

- Employers pay an amount to TRS equal to the state contribution (currently 6%) during the first 90 days of a new member's employment.

DROP

- Deferred Retirement Option Plan (DROP) was discontinued for *new* participation effective December 31, 2005.

SB 1691

Limits on Annual Compensation Used in Benefit Calculations

- Required TRS to adopt rules that include a percentage limit on amount of increases in annual compensation subject to credit and deposit during a member's final years of employment.

- Required TRS to adopt rules that exclude compensation subject to deposit and credit earned in the member's final years of employment before retirement that represents amounts converted from non-creditable compensation to creditable compensation.

SB 1691

TRS-Care Eligibility Changes

Retirement after September 1, 2005:

- Member must have at least 10 years of service credit* in TRS,
  AND
- must meet one of the following:
  - Rule of 80; *or*
  - 30 or more years of service credit** in TRS

*This service credit may include up to five years of military service credit, but may not include any other special or equivalent service credit purchased.

**Years of service credit can include all purchased service.

2006 TRS Active and Retired Member Survey

Prepared for:

The Texas Senate State Affairs Committee

By: D'Arlene Ver Duin
Paul Ruggiere
James Glass

Survey Research Center
University of North Texas

June 30, 2005

TABLE OF CONTENTS

TABLE OF CONTENTS I

LIST OF FIGURES II

LIST OF TABLES III

I. INTRODUCTION 1

II. METHODOLOGY 2

POPULATIONS 2
INSTRUMENTS 2
DATA COLLECTION 2
SAMPLE 3
WEIGHTING METHOD 4
ANALYSIS BY DEMOGRAPHIC GROUPS 4
REPORT FORMAT 5

III. FINDINGS: ACTIVE MEMBER 6

SAMPLE CHARACTERISTICS 6

IV. FINDINGS: RETIRED MEMBER 16

SAMPLE CHARACTERISTICS 16

V. SUMMARY 19

APPENDIX: SURVEY INSTRUMENT 20

LIST OF FIGURES

Figure 1 Age of Retirement from Teacher Retirement System 7
Figure 2 Salary Increase Would Encourage Working Longer and Delaying Retirement 12

LIST OF TABLES

Table 1 Distribution of Demographic Characteristics in the TRS Population 2
Table 2 Distribution of Demographic Characteristics in the TRS Sample 3
Table 3 Distribution of Demographic Characteristics in the TRS Respondents 4
Table 4 Active Member Demographics 6
Table 5 Age of Retirement from Teacher Retirement System By Selected Demographics 8
Table 6 Importance of Retirement Benefits 9
Table 7 Automatic Cost of Living Adjustments after Retirement By Selected Demographics 9
Table 8 Option to Retire Early By Selected Demographics 10
Table 9 Partial Lump Sum Cash Option at Retirement By Selected Demographics 10
Table 10 Ranking of Benefits 11
Table 11 Support for Adjustments to Pension Benefit Funding Structure 13
Table 12 Reduce Benefits/Not Increase Active Member Contributions By Selected Demographics 14
Table 13 Favor Changes to Retirement Benefits 15
Table 14 Retired Member Demographics 16
Table 15 Options for Increasing State Funding for TRS 17
Table 16 Favor Changes to Retirement Benefits 18

I. INTRODUCTION

The Texas Senate State Affairs Committee (TSSAC) contracted with the Survey Research Center (SRC) at the University of North Texas to conduct a survey of Texas Teacher Retirement System active and retired members. The purpose of the survey was to ask questions about retirement benefits and funding. The TSSAC survey was conducted as a part of the bi-annual Texas Teacher Retirement System (TRS) customer satisfaction survey with the full knowledge and approval of TRS.

Whenever applicable, responses of active members and retired members were compared. Other characteristics used for comparison were age, gender, and type of educational institution at which the member was employed.

II. METHODOLOGY

Populations

The conceptual population for the survey was all active and retired members of TRS. The populations were further stratified by age; gender and type of employer for each survey (see Table 1).

Table 1
Distribution of Demographic Characteristics in the TRS Population

	Higher Education		Public Schools		Total
	Male	Female	Male	Female	Counts
Active Members					
36 and under	15,906	27,139	45,294	154,782	243,121
37 to 45	11,997	20,698	34,825	130,265	197,785
46 to 51	8,020	15,796	25,900	98,896	148,612
52 and over	13,440	24,003	47,843	136,066	221,352
Total	49,363	87,636	153,862	520,009	810,870
Retired Members					
63 and under	2,239	4,645	13,901	49,104	69,889
64 to 69	2,386	4,355	11,249	34,773	52,763
70 to 74	2,113	3,088	8,916	23,309	37,426
75 and over	4,070	5,258	12,442	41,142	62,912
Total	10,808	17,346	46,508	148,328	222,990

Instruments

The survey instrument was constructed using questions provided by the Texas Senate State Affairs Committee. SRC staff made a draft questionnaire to address the topics of interest. Revisions to the instruments were made until the final instruments were agreed upon. The final instrument is available in the Appendix.

Data Collection

Trained telephone interviewers who had previous experience in telephone surveys were used to conduct the survey. Each interviewer completed an intensive general training session. The purposes of general training were to ensure that interviewers understood and practiced all of the basic skills needed to conduct interviews and that they were knowledgeable about standard interviewing conventions. The interviewers also attended a specific training session for the project. The project training session provided information on the background and goals of the study.

Interviewers practiced administering the questionnaire to become familiar with the questions.

All interviewing was conducted from a centralized telephone bank in Denton, Texas. An experienced telephone supervisor was on duty at all times to supervise the administration of the sample, monitor for quality control, and handle any problems.

Sample

TRS supplied SRC with contact records (see Table 1) for active members and retired members. All records included the names and addresses for all potential respondents. All but a few records lacked phone numbers. SRC began each lookup effort with a random sample of half of the supplied records. Internet phone directories were used to identify the phone numbers for each record. If a listing could not be found, directory assistance was called for a listing. If a listing obtained over the Internet was found to be incorrect once a call attempt was made, SRC used directory assistance in an attempt to obtain a new listing.

Table 2
Distribution of Demographic Characteristics in the TRS Sample

	Higher Education		Public Schools		Total
	Male	Female	Male	Female	Counts
Active Members					
36 and under	276	253	275	274	1,078
37 to 45	273	277	286	292	1,128
46 to 51	279	264	297	281	1,121
52 and over	302	159	296	296	1,053
Total	1,130	953	1,154	1,143	4,380
Retired Members					
63 and under	107	95	124	120	446
64 to 69	103	100	121	123	447
70 to 74	103	103	134	135	475
75 and over	107	107	132	137	483
Total	420	405	511	515	1,851

SRC conducted a total of 1,100 telephone interviews including 700 interviews with active members and 400 interviews with retired members. Four of the interviews were conducted in Spanish. The distribution of interviews was controlled so that an adequate number from each demographic group could be included (see Table 3).

Table 3
Distribution of Demographic Characteristics in the TRS Respondents

	Higher Education		Public Schools		Total Counts
	Male	Female	Male	Female	
Active Members 36 and under	21	19	37	51	128
37 to 45	36	38	51	49	174
46 to 51	34	43	56	58	191
52 and over	51	29	59	68	207
Total	142	129	203	226	700
Retired Members 63 and under	17	17	33	33	100
64 to 69	17	17	33	33	100
70 to 74	17	17	33	33	100
75 and over	17	17	33	33	100
Total	68	68	132	132	400

In a purely random sample of TRS members, 700 completed interviews with active members would yield a margin of error of +/- 3.7 percent at the 95 percent confidence level, and 400 completed interviews with retired members would yield a margin of error of +/- 4.9 percent. Since this sample was stratified by group, margin of error calculations cannot be directly applied. However, by weighting each member sample by the demographic distributions of the population, the margin of error can be approximated when presenting aggregate statistics for each of the member samples.

Weighting Method

Since one objective of the study was to obtain a sufficient number of responses in the various subgroups to permit analysis, quotas were necessary. When quotas are used, the resultant sample does not reflect the actual distribution of demographics in the population. In order to correct the disproportionate representation, when findings are presented for either all retired members or for all active members sample, the data will be weighted so that the results reflect the correct population proportions. Crosstabs by any single characteristic, such as age or gender, are also weighted.

Analysis by Demographic Groups

Each question in the survey was cross-tabulated with the following demographic categories:

- Age
- Gender
- Institution type (higher education or public schools)

Whenever the responses to a single question are divided by demographic groups, the percentage distribution of responses within one group rarely will match exactly the percentage distribution of another group; there will often be some variation between groups.

The most important consideration in interpreting these differences is to determine if the differences in the sample are representative of differences between the same groups within the general population. This consideration can be fulfilled with a test of statistical significance. The Survey Research Center only reports those differences between groups that are found to be statistically significant.

Report Format

The remainder of the report is arranged in three sections beginning with Section III. This section, "Findings: Active Member ," presents the findings for active respondents regarding their plans for retirement, importance of benefits, and preferences for change in retirement benefits if circumstances warrant it. Section IV, "Findings: Retired Member," presents the findings for retired respondents regarding their preferences for increasing state funding for TRS and shared costs for TRS-Care. The last section presents the summary of the study.

III. FINDINGS: ACTIVE MEMBER

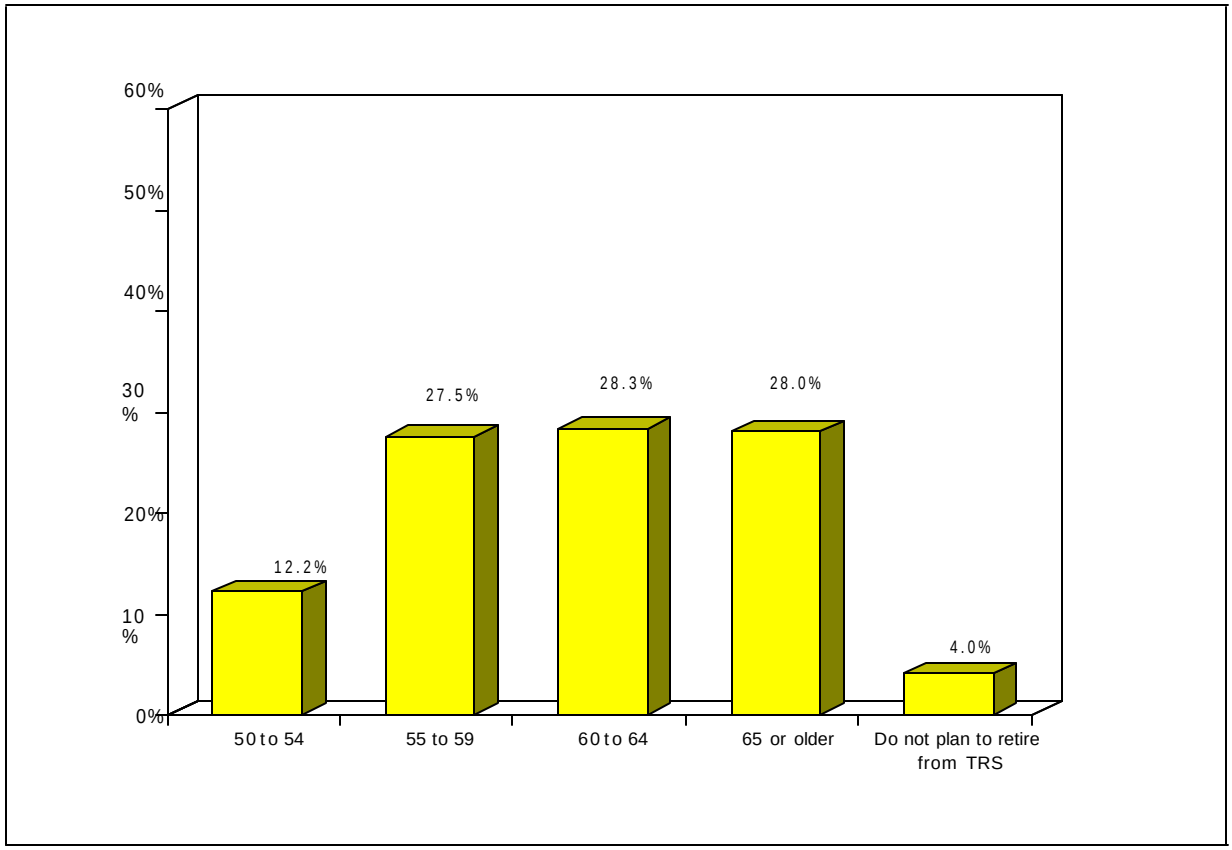
Sample Characteristics

Active member demographic characteristics in the sample are presented below in Table 4.

Table 4
Active Member Demographics
(n=700)

Demographics	Percentage Responding
Age of the respondent	
36 and under	30.0
37 to 45	24.4
46 to 51	18.3
52 and over	27.3
Education	
Public Schools	83.1
Higher education	16.9
Gender	
Male	25.1
Female	74.9

Figure 1
Age of Retirement from Teacher Retirement System
(n=566)*



- Active members were asked at what age they planned to retire from the Teacher Retirement System. Figure 1 shows that 12.2 percent planned to retire at age 50 to 54; 27.5 percent at age 55 to 59; 28.3 percent at 60 to 64; and 28.0 percent at age 65 or older. Four percent did not plan to retire from TRS.
- As shown in Table 5, 71.3 percent of public school respondents and 52.6 percent of higher education respondents plan to retire from TRS before age 65. Respondents age 45 and under are more likely than older respondents to report they plan to retire before age 65.

* Nineteen percent or 134 respondents answered "don't know" to this question.

Table 5
Age of Retirement from Teacher Retirement System
By Selected Demographics

	Percentage responding				
	Age 50 to 54	Age 55 to 59	Age 60 to 64	Age 65 or older	Do not plan to retire from TRS
Institution					
Public schools	13.9	28.4	29.0	25.2	3.6
Higher education	4.1	22.7	25.8	41.2	6.2
Age group					
36 and under	25.0	32.3	17.1	22.6	3.0
37 to 45	9.8	31.8	33.3	22.0	3.0
46 to 51	10.0	27.0	27.0	31.0	5.0
52 and over	2.4	19.6	36.9	35.7	5.4

Table 6
Importance of Retirement Benefits

	Percentage responding			
	Very Important	Important	Somewhat Important	Not important
Automatic cost of living adjustments after retirement (n=691)	70.6	27.0	1.5	0.9
Death benefits for beneficiaries (n=696)	59.7	33.5	4.3	2.4
Rule of 80 (age plus years of service) in order to retire with 100%	53.4	33.1	6.1	7.4
Option to retire early (n=691)	30.0	33.5	15.4	21.1
Partial "lump" sum cash option at retirement	19.4	38.2	20.6	21.7

- Active members were asked to rate the importance of the retirement benefits listed in Table 6. The benefits are listed in descending order of very important/important ratings.
- As shown in Table 6, 97.6 percent of the respondents indicated that automatic cost of living adjustments after retirement were either very important (70.6 percent) or important (27.0 percent). Seventy-two percent of public school respondents and 63.8 percent of higher education reported that automatic cost of living adjustments after retirement were very important (see Table 7).

Table 7
Automatic Cost of Living Adjustments after Retirement
By Selected Demographics

	Percentage responding			
	Very important	Important	Somewhat important	Not important
Institution				
Public schools	72.0	26.3	0.9	0.9
Higher education	63.8	30.2	4.3	1.7

- Ninety-three percent of the respondents reported that death benefits for beneficiaries were either very important (59.7 percent) or important (33.5 percent).

- The Rule of 80 (age plus years of service) to retire with 100 percent of benefits was either very important (53.4 percent) or important (33.1 percent) to 86.5 percent of the respondents.

- Sixty-four percent of the respondents indicated that the option to retire early was either very important (30.0 percent) or important (33.5 percent). As shown in Table 8, respondents age 52 and over were less likely than younger respondents to indicate that the option to retire early was either very important (20.9 percent) or important (19.4 percent).

Table 8
Option to Retire Early
By Selected Demographics

	Percentage responding			
	Very important	Important	Somewhat important	Not important
Age group				
36 and under	35.8	37.7	16.2	10.3
37 to 45	32.7	38.7	16.1	12.5
46 to 51	30.5	41.4	9.4	18.8
52 and over	20.9	19.4	18.3	41.4

- Fifty-eight percent report that the partial "lump" sum cash option at retirement was either very important (19.4 percent) or important (38.2 percent). As shown in Table 9, female respondents were more likely than male respondents to indicate that this option was either very important or important. Respondents age 52 or older were less likely than younger respondents to report this option was very important or important to them.

Table 9
Partial Lump Sum Cash Option at Retirement
By Selected Demographics

	Percentage responding			
	Very important	Important	Somewhat important	Not important
Gender				
Male	17.1	34.7	18.8	29.4
Female	20.2	39.5	21.2	19.1
Age group				
36 and under	16.7	41.9	26.1	15.3
37 to 45	16.2	48.5	18.6	16.8
46 to 51	25.8	35.5	14.5	24.2
52 and over	20.7	27.2	20.7	31.5

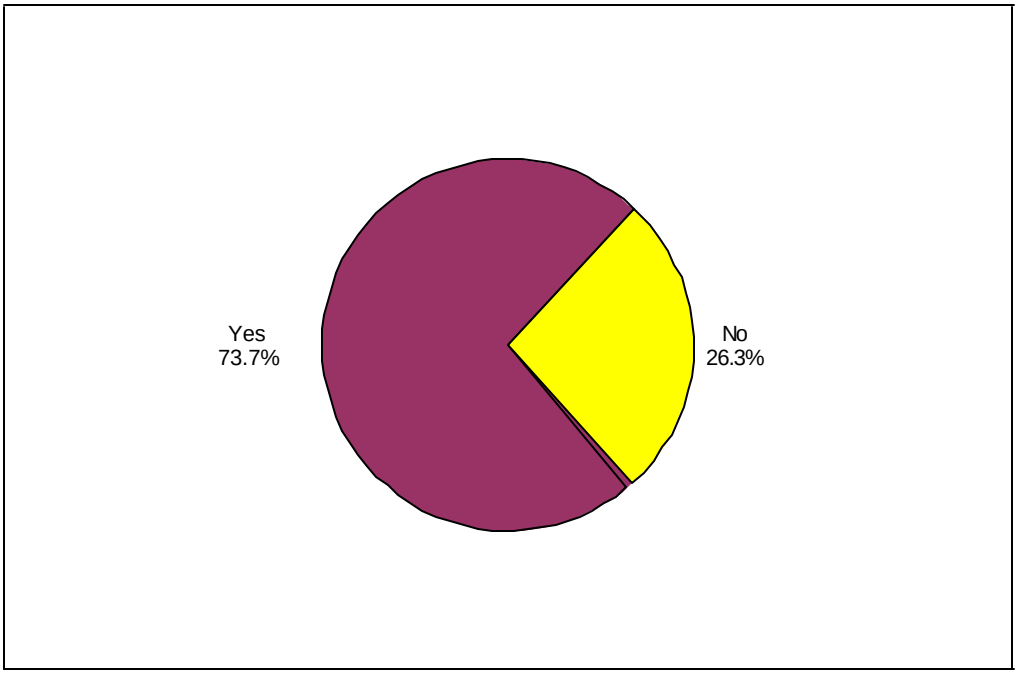
- Respondents that answered "very important" to more than two of the retirement options in Table 5 were asked to choose the two options that were most important to them. As shown in Table 10, 63.8 percent of those respondents selected automatic cost of living adjustments after retirement. Half (52.3 percent) selected the Rule of 80. Smaller percentages chose death benefits for beneficiaries (39.6 percent), the option to retire early (22.3 percent), and the partial "lump" sum cash option at retirement (13.2 percent).

Table 10
Ranking of Benefits
(n=351)

	Percentage responding*
Automatic cost of living adjustments after retirement	63.8
Rule of 80 (age plus years of service) in order to retire with 100% of benefits	52.3
Death benefits for beneficiaries	39.6
Option to retire early	22.3
Partial "lump" sum cash option at retirement	13.2

*Because each of these questions was asked separately, the percentages will not add to 100.0 percent.

Figure 2
Salary Increase Would Encourage Working Longer and Delaying Retirement
(n=647)



- Active respondents were asked if an increase in salary when they became eligible to retire would encourage them to work longer and delay retirement. Nearly three-quarters (73.7 percent) of the respondents answered "yes" (see Figure 2).

Table 11
Support for Adjustments to Pension Benefit Funding Structure

	Percentage responding			
	Very supportive	Somewhat supportive	Somewhat unsupportive	Not at all supportive
Require the local employer (i.e. school district or college) to contribute to the retirement fund (n=686)	57.8	33.3	3.5	5.4
Require equal contributions by the state, active members, and a new employer contribution (n=656)	47.9	41.6	3.0	7.4
Require equal contributions by the state and active members (n=659)	46.9	43.4	3.6	6.1
Increase state and active member contributions to the retirement fund (n=667)	34.2	49.5	8.0	8.3
Reduce benefits and not increase active member contributions (n=663)	10.7	20.0	16.2	53.1

- Active members were read a list of possible adjustments (see Table 11) that could be made to the pension benefit funding structure and asked which of these options they would support. The options are presented in descending order of "very supportive."
- As shown in Table 7, 57.8 percent of the respondents were very supportive of the option to require the local employer to contribute to the retirement fund.
- Nearly half (47.9 percent) were very supportive of the option to require equal contributions by the state, active members, and a new employer contribution.
- Forty-seven percent were very supportive of the option to require equal contributions by the state and active members.
- About one-third (34.2 percent) of the respondents were very supportive of the option to increase state and active member contributions to the retirement fund.
- Eleven percent of the respondents were very supportive of the option to reduce benefits and not increase active member contributions. Fifty-three percent were not at all supportive of this option. As shown in Table 12, 61.3 percent of male respondents and 50.4 percent of female respondents were not at all supportive of this option. The percentage of respondents who were not at all supportive of this option increased as the age of the respondent increased.

Table 12
Reduce Benefits/Not Increase Active Member Contributions
By Selected Demographics

	Percentage responding			
	Very supportive	Somewhat supportive	Somewhat unsupportive	Not at all supportive
Gender				
Male	10.4	13.3	15.0	61.3
Female	10.8	22.2	16.5	50.4
Age group				
36 and under	11.2	24.0	20.4	44.4
37 to 45	15.0	19.4	17.5	48.1
46 to 51	11.1	15.9	15.9	57.1
52 and over	6.1	18.9	10.6	64.4

Table 13
Favor Changes to Retirement Benefits

	Percentage responding		
	1st Choice (n=659)	2nd Choice (n=634)	Least-favored Choice (n=630)
Maintain the Rule of 80 but establish a minimum retirement age	48.8	20.4	6.2
Increase active member contributions	9.5	22.2	18.7
Require early age retirees to accept a reduced annuity benefit at retirement	14.0	16.9	36.0
Increase the Rule of 80	5.2	19.1	39.1
Do not like any	22.6	21.4	--

- Active members were asked which of the options listed in Table 13 they would favor most if changes to retirement benefits become necessary in the future. The options are listed in descending order of first and second choices.
- As shown in Table 13, 69.2 percent of the respondents indicated that maintaining the Rule of 80 but establishing a minimum retirement age was either their first (48.8 percent) or second choice (20.4 percent).
- Thirty-two percent of the respondents selected increasing active member contributions as their first (9.5 percent) or second choice (22.2 percent)
- Thirty-one percent reported that requiring early age retirees to accept a reduced annuity benefit at retirement was either their first (14.0 percent) or second choice (16.9 percent).
- Thirty-nine percent of the respondents indicated that increasing the Rule of 80 was their least-favored choice.
- Forty-four percent (22.6 percent - first choice; 21.45 percent - second choice) did not like any of the choices presented.

IV. FINDINGS: RETIRED MEMBER

Sample Characteristics

Retired member demographic characteristics in the weighted sample are presented in Table 14. The active member demographic characteristics in the weighted sample are presented in Table 4.

Table 14
Retired Member Demographics
(n=400)

Demographics	Percentage Responding
Age of the respondent	
63 and under	31.3
64 to 69	23.7
70 to 74	16.8
75 and over	28.2
Education	
Public Schools	87.4
Higher education	12.6
Gender	
Male	25.7
Female	74.3

Table 15
Options for Increasing State Funding for TRS

	Percentage responding	
	1st Choice (n=369)	2nd Choice (n=333)
An increase in the state contribution rate to the TRS pension fund to enhance the long-term funding of the program	44.4	30.9
A one-time additional partial month annuity payment (also known as a 13th month check)	17.4	30.8
Additional state funding for retiree health care (TRS-Care)	32.9	33.3
Do not like any option	5.3	4.9

- Retired members were asked which of the options listed in Table 15 they would favor most if the state were to increase its funding for TRS. A majority of respondents favored an increase in the state contribution rate to the TRS pension fund to enhance the long-term funding of the program. Public school respondents (66.6 percent) were more likely than higher education respondents (47.6 percent) to favor additional state funding for retiree health care.

Table 16
Favor Changes to Retirement Benefits

	Percentage responding		
	1st Choice (n=346)	2nd Choice (n=192)	Least-favored Choice (n=316)
Increased co-pays	25.3	25.4	13.7
Increased deductibles	10.0	36.7	11.1
Increased premiums	12.1	18.5	45.4
Exclusion or limitation of certain existing benefits	10.5	7.5	29.8
Do not like any	42.2	11.9	--

- Retired members were told that as health care costs increase, the state may have to make changes in the funding of TRS-Care. Respondents were then asked which of the options listed in Table 16 they would favor most if participants are required to share some of the increased costs. As shown in Table 16, retired members most favored increased co-pays followed by increased deductibles.
- Male respondents (39.3 percent) were more likely than female respondents (27.7 percent) to favor increased deductibles as a first or second choice.

V. SUMMARY

The findings from the TRS 2006 Retired and Active Member Survey can be used as an indication of member perceptions about retirement and retirement benefits among retired members and active members.

Active Members

Important retirement benefits, ranked by active members in descending order of very important/important percentages, were: automatic cost of living adjustments after retirement (97.6 percent), death benefits for beneficiaries (93.2 percent), Rule of 80 (86.5 percent), option to retire early (63.5 percent), and partial "lump" sum cash option at retirement (57.6 percent).

Nearly three-quarters (73.7 percent) of the active members reported that an increase in salary when they became eligible to retire would encourage them to work longer and delay retirement.

Support for adjustments to the pension benefit funding structure varied. Active members were very supportive of the following options: requiring the local employer to contribute to the retirement fund (57.8 percent), requiring equal contributions by the state, active members, and a new employer contribution (47.9 percent), and requiring equal contributions by the state and active members (46.9 percent). Active members were less supportive of increasing state and active member contributions to the retirement fund (34.2 percent), and reducing benefits and not increasing active member contributions (10.7 percent).

When asked which choices they would favor if changes to retirement benefits became necessary in the future, 69.2 percent indicated that maintaining the Rule of 80 but establishing a minimum retirement age was either their first or second choice. Thirty-two percent selected increasing active member contributions as their first or second choice.

Retired Members

When asked which options retired members would favor most if the state were to increase its funding for TRS, a majority (75.3 percent) favored an increase in the state contribution rate to the TRS pension fund to enhance the long-term funding of the program as their first or second choice. Smaller percentages of retired members favored additional state funding for retiree health care (66.2 percent) or a one-time additional partial monthly annuity payment (48.2 percent) as their 1st or 2nd choice.

Approximately half (50.7 percent) of the retired members favored (1st or 2nd choice) increased co-pays as an option if the state has to make changes in the funding of TRS-Care. Less favored options included: increased deductibles (46.7 percent), increased premiums (30.6 percent), or an exclusion or limitation of certain existing benefits (18.0 percent). Fifty-four percent did not like any of these options.

APPENDIX: SURVEY INSTRUMENT

These few questions are being asked on behalf of the Texas Senate State Affairs committee. As with the previous questions (*Note to the reader: these survey questions were added to the end of the bi-annual 2006 TRS Survey*), all of your answers will be kept confidential. The results of this section will be reported only to the Senate State Affairs Committee and not to TRS. If you have any questions about this section, please contact. the Senate State Affairs Committee at 512-463-0380.

Active Member Questions

1. At what age do you plan to retire from the Teacher Retirement System?
    1. Age 50 to 54
    2. Age 55 to 59
    3. Age 60 to 64
    4. Age 65 or older
    5. Do not plan to retire from TRS
    9. NR/DK

2a. Please tell me if the following retirement benefits are very important, important, somewhat important, or not important to you.

Benefit	Very important	Important	Somewhat important	Not important	NR/DK
a. Option to retire early	1	2	3	4	9
b. Partial "lump" sum cash option at retirement	1	2	3	4	9
c. Rule of 80 (age plus years of service) in order to retire with 100% of benefits?	1	2	3	4	9
d. Automatic cost of living adjustments after retirement	1	2	3	4	9
e. Death benefits for beneficiaries	1	2	3	4	9

2b. (If more than two from Q2 are rated "very important") You had mentioned the following services were very important [read list]. Of those benefits, which are the two most important to you?

3. If you were offered an increase in salary when you become eligible to retire, would this encourage you to work longer and delay retirement?
    1. YES
    2. NO
    9. NR/DK

4. I am going to list a number of possible adjustments to the pension benefit funding structure. Please tell me if you would be: very supportive; somewhat supportive; somewhat unsupportive; not at all supportive to each of the listed options.

a. Increase state and active member contributions to the retirement fund
b. Require equal contributions by the state and active members
c. Require the local employer (i.e. school district or college) to contribute to the retirement fund
d. Require equal contributions by the state, active members, and a new employer contribution
e. Reduce benefits and not increase active member contributions

5a. If changes to retirement benefits become necessary in the future, please tell me which one of the following options you would most favor

____Maintain the Rule of 80 *age plus years of service) but establish a minimum retirement age
____Increase the Rule of 80
____Increase active member contributions
____Require early age retirees to accept a reduce annuity benefit at retirement
DO NOT LIKE
ANY NR/DK

5b. What would be your next choice?
5c. What would be your least favored option?

Retiree Questions

1a. If the state were to increase its funding for TRS, which one of the following expenditure options would you most favor?

___ An increase in the state contribution rate to the TRS pension fund to enhance the long-term funding of the program.
___ A *one-time* additional partial month annuity payment (also known as a 13th month check).
___Additional state funding for retiree health care (TRS-Care)
DO NOT LIKE ANY
NR/DK

1b. What would be your next choice?

2a. As health care costs increase; the state may have to make changes in the funding of TRS-Care. If participants are required to share some of the increased costs, please tell me which of the following options you would most favor

___Increased premiums
___Increased deductibles
___Increased co pays
___Exclusion or limitation of certain existing benefits
DO NOT LIKE
ANY NR/DK

2b. What would be your next choice?

2c. What would be your least favored option?

APPENDIX III

Identification Requirements for State Government Services

Government Service and Agency	Identification or Information Required	Citation
Certified birth or death certificate, Texas Department of State Health Services	State-issued driver's license; state/county/city ID card; student ID; government employment badge; prison ID; or military ID.	25 T.A.C. § 181.1 (2006).
Children's Health Insurance Plan (CHIP), Health and Human Services Commission	Legal residence documents (if child is not a U.S. citizen) and Social Security Number. *	1 T.A.C. § 370.23 (2006).
Driver's license, Texas Department of Public Safety (DPS)	Proof of identity satisfactory to DPS. DPS requires proof of Social Security and proof of identity. Proof of identity can be established by means of an unexpired U.S. passport; a U.S. citizenship (naturalization) certificate with photograph; an unexpired U.S. Immigration and Naturalization Service document with verified data and photograph; an unexpired U.S. military ID card for active duty, reserve, or retired personnel; or a Texas driver's license or ID with photograph within two years after the expiration date. The Transportation Code also requires: (1) the thumbprints of the applicant or, if thumbprints cannot be taken, the index fingerprints of the applicant; (2) a photograph of the applicant; (3) the signature of the applicant; and (4) a brief description of the applicant.	TEX. TRANS. CODE § 521.142 (Supp. 2006); 37 T.A.C. § 15.24 (2006).
Food Stamp Program, Texas Health and Human Services Commission	Driver's license or other photo ID, legal residence documents (if child is not a U.S. citizen), and Social Security Number.[270]	7 C.F.R. § 273.2 (f)(1)(vii) (2006).
Marriage license (issued on behalf of the State by the county clerk in each county)	Identity may be established either by a certified copy of the applicant's birth certificate or by some certificate, license, or document issued by this state or another state, the United States, or a foreign government. Each applicant must also provide his or her Social Security Number.	TEX. FAM. CODE § 2.005 (Supp. 2006).
Public school enrollment, (Austin ISD used as	Birth certificate, parent's photo ID or driver's license, proof of address (contract or utility bill).	Austin Independent School District

[270] The Health and Human Services Commission states, "We must have a Social Security Number for each person for whom you are applying for assistance. We will not share any information you provide with the Bureau of Citizenship and Immigration Services (BCIS) and the BCIS cannot use this application to deny you admission to the U.S., to harm your permanent resident status, or to deport you."

example)		
Voter Registration, Texas Secretary of State	Identity may be established by (1) a driver's license or personal identification card issued to the person by the Texas Department of Public Safety or a similar document issued to the person by an agency of another state, regardless of whether the license or card has expired; (2) a form of identification containing the person's photograph that establishes the person's identity; (3) a birth certificate or other document confirming birth that is admissible in a court of law and establishes the person's identity; (4) United States citizenship papers issued to the person; (5) a United States passport issued to the person; (6) official mail addressed to the person by name from a governmental entity; (7) a copy of a current utility bill, bank statement, government check, paycheck, or other government document that shows the name and address of the voter; or (8) any other form of identification prescribed by the secretary of state.	TEX. ELEC. CODE § 13.002 (Supp. 2006); 1 T.A.C. §81.8 (2006);
Sampling of Professional Licenses		
Accountant	Government-issued photo ID plus one additional form of identification.	
Chiropractor	Driver's license and proof of Social Security.	
Land Surveyor	Government-issued photo ID.	
Optometrist	Government-issued photo ID and a certified birth certificate, naturalization papers, or U.S. passport.	
Professional Engineer	Government-issued photo ID.	
Veterinarian	Government-issued photo ID and a certified birth certificate, naturalization papers, or U.S. passport.	

Source: Senate Research Center

Eligibility Requirements

In States That Require a Reason or Excuse for Casting an Absentee Ballot

State	Requirements
Alabama	A voter may cast an absentee ballot if he or she: 1. Will be absent from the county on election day; 2. Is ill or has a physical disability that prevents a trip to the polling place; 3. Is a registered Alabama voter living outside the county, such as a member of the armed forces, a voter employed outside the United States, a college student, or a spouse or child of such a person; 4. Is an appointed election officer or poll watcher at a polling place other than his or her regular polling place; or 5. Works a required shift, 10 hours or more, that coincides with polling hours.
Arkansas	To be qualified to vote an absentee ballot, you must meet one of the following criteria: 1. You will be unavoidably absent from your polling site on election day (the law does not require you to give a reason). 2. You will be unable to attend your polling site on election day due to illness or physical disability. 3. You are a member of the U.S. armed forces, merchant marines or the spouse or a dependant family member. 4. A U.S. citizen domiciled in Arkansas but temporarily living outside the territorial limits of the United States.
Connecticut	Registered voters may vote by absentee ballot if they are unable to vote in person for any of the following reasons: 1. Absence from town of registration during all election hours; 2. Inability to attend polling place due to illness or physical disability; 3. Religious beliefs which forbid secular activity on election day; or 4. Service as an election official at a polling place other than the polling place where they vote.
Delaware	The following persons may vote absentee: 1. Work: The nature of your work prevents you from going to your polling place. 2. Public Service: Your service to the United States or to the State of Delaware prevents you from going to your polling place. Spouses or dependents of the person in service also qualify. (Includes military and diplomatic service.) 3. Religion: The tenets or teaching of your religion prevent you from going to your polling place. 4. Vacation: You are on vacation on election day. 5. Illness. 6. Disability, permanent or temporary. 7. Incarceration for other than a felony.
District of Columbia	Reasons for which a voter may request an absentee ballot:

	1. Temporarily outside the District of Columbia. 2. Will be hospitalized on Election Day. 3. Uniformed or overseas citizen. 4. Election board employee. 5. Confined to an institution but not judicially declared incompetent. 6. Physical handicap or disability. 7. Incarcerated but not on a felony conviction. 8. Temporary or permanent illness. 9. Sequestered for jury duty. 10. Religious reasons.
Georgia	A voter who requests an absentee ballot by mail is not required to provide a reason why he or she is voting absentee. You may vote by absentee ballot in person if: 1. You will be absent from your precinct from 7:00 a.m. until 7:00 p.m. on election day. 2. You are 75 years of age or older. 3. You have a physical disability which prevents you from voting in person or you are a constant caregiver of a person with a disability. 4. You are an election official. 5. You are observing a religious holiday which prevents you from voting in person. 6. You are required to remain on duty in your precinct for the protection of life, health, or safety of the public. 7. An elector may cast an absentee ballot in person at the registrar's office during the period of Monday through Friday of the week immediately preceding the date of the election without having to provide a reason.
Illinois	Voters who meet one of the following criteria may vote by absentee ballot: 1. Registered voters expecting to be absent from their county of residence on election day. 2. Registered voters appointed to be judges of election in a precinct different from where they reside. 3. Registered voters unable to be present at the polls because of a physical incapacity. 4. Registered voters observing a religious holiday and unable to be present at the polls because of the tenets of their religion. 5. Registered voters who because of election duties in the office of a state's attorney, county clerk, a board of election commissioners or State Board of Elections will be unable to be present at the polls. 6. Registered voters who are serving as sequestered jurors on a state or federal jury only. 7. Registered or non-registered members of the United States Armed Forces while on active duty, and members of

	the merchant marines, as well as their spouses and dependents who expect to be absent from their county of residence on election day. 8. Registered or non-registered members of religious groups, welfare agencies as well as their spouses and dependents who are officially attached to or assisting members of the armed forces who expect to be absent from the county in which they reside on election day. 9. State and federal employees who had a voting residence in the precinct at the time they entered employment, but who now reside elsewhere due to state or federal employment. 10. A registered citizen temporarily residing overseas may vote by absentee ballot. 11. Any citizen residing outside of the country, not registered to vote but qualified to vote in a federal election, may vote by absentee ballot for federal offices.
Kentucky	Voters may qualify for a mail-in absentee ballot based on the following criteria: 1. Advanced age, disability, or illness; 2. Military personnel, their dependents, or overseas citizens; 3. Students who temporarily reside outside the county; 4. A voter who temporarily resides outside of Kentucky, such as a vacationer; 5. Incarcerated but not yet convicted; 6. Employment which takes the voter out of the county during all hours the polling place is open.
Louisiana	The following persons, otherwise qualified to vote, who expect to be out of the parish on election day, may vote absentee by mail: 1. A member of the United States armed services, his spouse, and dependents. 2. A student, instructor, or professor in an institution of higher learning located outside the parish in which he is qualified to vote and who lives outside of said parish by reason thereof, and his spouse and any dependent accompanying and residing with him. 3. A minister, priest, rabbi, or other member of the clergy assigned to a religious post outside the parish in which he is registered and his spouse and any dependents accompanying and residing with him. 4. A person who is or who expects to be temporarily outside the territorial limits of the state or absent from the parish in which he is qualified to vote during the early voting period and on election day. 5. A person who, after the registration books have closed, has moved his residence to another parish and the new residence is more than one hundred miles from the parish seat of the parish of his former residence, in which case he may vote absentee by mail in the parish of his former residence. 6. A person involuntarily confined in an institution for mental treatment outside the parish in which he is qualified to vote, who is not interdicted and not judicially declared incompetent. 7. A person residing outside the United States.

	8. Sequestered jury member. A person who is otherwise qualified to vote, who is a member of a sequestered jury on election day. 9. Hospitalized. (a) A person who is otherwise qualified to vote, who expects to be hospitalized on election day and who did not have knowledge of his proposed hospitalization until after the time for early voting had expired. (b) A person who is otherwise qualified to vote, who expects to be hospitalized on election day and who was hospitalized during the time for early voting. (c) A person who was hospitalized and released prior to an election but who is either hospitalized or restricted to his bed by his physician during early voting and is restricted to his bed by his physician on election day. 10. Employed upon state waters. A person who by virtue of his employment or occupation expects to be out of his precinct of registration and upon the waters of the state both during the early voting period and on election day. 11. Special handicapped persons. A person who lives at home and is approved for participation in the Special Handicapped Program under Part III of Chapter 7-A of this Title. 12. Persons incarcerated. A person incarcerated in an institution inside or outside the parish in which he is qualified to vote, who is not under an order of imprisonment for conviction of a felony, may only vote absentee by mail upon certification to the appropriate registrar by the sheriff of the parish where the person is incarcerated that he is not a convicted felon.
Massachusetts	You may vote by absentee ballot if you: 1. will be absent from your city or town on election day, and/or 2. have a physical disability that prevents your voting at the polling place, and/or 3. cannot vote at the polls due to religious beliefs.
Michigan	As a registered voter, you may obtain an absentee voter ballot if you are: 1. age 60 years old or older; 2. unable to vote without assistance at the polls 3. expecting to be out of town on election day 4. in jail awaiting arraignment or trial; 5. unable to attend the polls due to religious reasons; or 6. appointed to work as an election inspector in a precinct outside of your precinct of residence.
Minnesota	You can vote by absentee ballot if you are unable to vote in person on election day because you are: 1. away from home; 2. ill or disabled; 3. an election judge serving in a precinct other than your own; or 4. unable to go to the polling place due to a religious observance or belief.
Mississippi	Voters are eligible to vote absentee by mail based upon:

	1. Age; 2. Ill health; 3. Work demands; 4. Affiliation with the U.S. armed forces; or 5. Temporary absence from the county on election day.
Missouri	A voter may vote absentee by mail for the following reasons: 1. Absence on election day from the jurisdiction of the election authority in which registered to vote. 2. Incapacity of confinement due to illness or physical disability, including a person who is primarily responsible for the physical care of a person who is incapacitated or confined due to illness or disability. 3. Religious belief or practice. 4. Employment as an election authority, as a member of an election authority, or by an election authority at a location other than your polling place. 5. Incarceration, provided all qualifications for voting are retained .
New Hampshire	A voter is eligible to vote an absentee ballot on the basis of: 1. Physical disability; 2. Religious beliefs; 3. Military service; or 4. Temporary absence from the county.
New York	Registered voters who cannot make it to the polls on election day because of occupation, business, studies, travel, imprisonment (other than a convicted felon), illness, disability and hospitalization or resident in a long term care facility, may vote by absentee ballot.
Pennsylvania	Absentee ballots are available to the following persons: 1. persons in the armed forces, their spouses and dependents; 2. other citizens in federal service attached to the armed forces; 3. persons absent from their municipality the entire time the polls are open; 4. those who cannot attend the polls because of illness or disability; 5. *county* employees whose election day responsibilities prohibit them from going to the polls; and 6. persons who will not go to the polls because of observing a religious holiday.
Rhode Island	If you are a registered voter, you may vote by mail only if: 1. You will be absent from the state on election day during the entire time the polls are open. 2. You will be absent from the city or town of your voting residence during the entire time the polls are open because you are a student or spouse of a student at an institution of higher learning within the state. 3. It would be an undue hardship for you to vote at the polls because you are incapacitated due to illness or mental

	or physical disability, blindness or serious impairment of mobility. 4. You are forbidden by the tenets of your religious faith from voting on election day. 5. You are confined to a hospital, rest home, convalescent home, nursing home or similar institution, public or private. 6. You are being detained while awaiting trial or imprisoned for any cause other than final conviction of a felony. 7. You will be temporarily absent from the state because of employment or service connected with military operations or are a spouse or dependent of such a person. 8. You are employed by the State Board of Elections or the local Board of Canvassers or a poll worker assigned to work on election day outside of your voting district.
South Carolina	Any registered voter who, for any of the following reasons, is eligible to vote an absentee ballot: 1. Students, their spouses and dependents residing with them. 2. Members of the armed forces, merchant marines, Red Cross, USO, government employees, their spouses and dependents residing with them. 3. For reasons of employment will not be able to vote on election day. 4. Physically disabled persons. 5. Persons on vacation. 6. Persons age 65 or older. 7. Persons admitted to the hospital as emergency patients on day of election or at least four days prior to the election. 8. Electors with a death or funeral in the family within three days before the election. 9. Persons confined to a jail or pre-trial facility pending disposition of arrest or trial. 10. Persons attending sick or physically disabled persons. 11. Certified poll watchers and poll managers.
Tennessee	To vote by mail, a registered voter must fall under one of the following categories: 1. The voter will be outside the county of registration during the early voting period and all day on election day. 2. The voter or the voter's spouse is enrolled as a full-time student in an accredited college or university outside the county of registration. 3. The voter's licensed physician has filed a statement with the county election commission stating that, in the physician's judgment, the voter is medically unable to vote in person. The statement must be filed not less than five days before the election and signed under the penalty of perjury. 4. The voter resides in a licensed facility providing relatively permanent domiciliary care, other than a penal institution, outside the voter's county of residence. 5. The voter will be unable to vote in person due to service as a juror for a federal or state court.

	6. The voter is sixty-five (65) years of age or older. 7. The voter has a physical disability and an inaccessible polling place. 8. The voter is hospitalized, ill, or physically disabled and because of such condition, cannot vote in person. 9. The voter is a caretaker of a person who is hospitalized, ill, or disabled. 10. The voter is a candidate for office in the election. 11. The voter serves as an election day official or as a member or employee of the election commission. 12. The voter's observance of a religious holiday prevents him or her from voting in person during the early voting period and on election day. 13. The voter possesses a valid commercial driver license and certifies that he or she will be working outside the state or county of registration during the early voting period and all day on election day. 14. The voter is a member of the military or is an overseas citizen.
Texas	To be eligible to vote early by mail in Texas, a voter must be: 1. 65 years of age or older; 2. disabled; 3. out of the county on election day and during the period for early voting by personal appearance; or 4. be confined in jail, but otherwise eligible.
Virginia	The following registered voters may vote by absentee ballot in any election in which they are qualified to vote: 1. Any person who, in the regular and orderly course of his business, profession, or occupation or while on personal business or vacation, will be absent from the county or city in which he is entitled to vote. 2. Any person who is (a) a member of a uniformed service of the United States, on active duty, or (b) a member of the merchant marine of the United States, or (c) who temporarily resides outside of the United States, or (d) the spouse or dependent residing with any person listed in (a), (b), or (c), and who will be absent on the day of the election from the county or city in which he is entitled to vote. 3. Any student attending a school or institution of learning, or his spouse, who will be absent on the day of election from the county or city in which he is entitled to vote. 4. Any person who is unable to go in person to the polls on the day of election because of a physical disability or physical illness. 5. Any person who is confined while awaiting trial or for having been convicted of a misdemeanor, provided that the trial or release date is scheduled on or after the third day preceding the election. Any person who is awaiting trial and is a resident of the county or city where he is confined shall, on his request, be taken to the polls to vote on election day if his trial date is postponed and he did not have an opportunity to vote absentee. 6. Any person who is a member of an electoral board, registrar, officer of election, or custodian of voting equipment.

	7. Any duly registered person who is unable to go in person to the polls on the day of the election because he is primarily and personally responsible for the care of an ill or disabled family member who is confined at home. 8. Any duly registered person who is unable to go in person to the polls on the day of the election because of an obligation occasioned by his religion. 9. Any person who, in the regular and orderly course of his business, profession, or occupation, will be at his place of work and commuting to and from his home to his place of work for eleven or more hours of the thirteen that the polls are open (6:00 a.m. to 7:00 p.m.).

Sources: Senate Research Center; Secretary of State websites for the cited states.

States Which Permit Any Registered Voter to Vote Absentee Without Stating a Reason or Excuse for the Ballot	
Alaska Arizona California Colorado Florida Hawaii Idaho Indiana Iowa Kansas Maine Maryland Montana Nebraska Nevada	New Jersey New Mexico North Carolina North Dakota Ohio Oklahoma Oregon * South Dakota Utah Vermont Washington West Virginia Wisconsin Wyoming *Oregon: All elections conducted entirely by mail.

Sources: Senate Research Center; National Conference of State Legislatures

Other Provisions for Absentee Ballots by Mail

State	Witness/Notary Signature	Postage for Ballot Return Paid by State	Due Date for Absentee Ballot
Alabama	Required	No	Close of polls on election day
Alaska	Required	No	Ten days after elections (15 days for overseas ballots)
Arizona	Not required	No	7:00 p.m. on election day
Arkansas	Not required	No	7:30 p.m. on election day / 5:00 p.m. 10 days after election, if postmarked by election day
California	Not required	No	8:00 p.m. on election day
Colorado	Not required	No	7:00 p.m. on election day
Connecticut	Not required	No	8:00 p.m. on election day
Delaware	Required	No	Noon on day before election
District of Columbia	Not required	No	Unknown
Florida	Required	No	7:00 p.m. on election day
Georgia	Required, if voter is assisted in filling out ballot	No	Close of polls
Hawaii	Required, if voter is assisted in filling out ballot	Postage paid by state	Close of polls
Idaho	Not required	No	8:00 p.m. on election day
Illinois	Not required	No	Close of polls
Indiana	Not required	No	Close of polls
Iowa	Not required	No	Close of polls / Monday after election if postmarked by election day
Kansas	Not required	No	Close of polls
Kentucky	Not required	No	Close of polls
Louisiana	Required	No	Midnight, day before election
Maine	Required	No	Close of polls
Maryland	Not required	No	Friday, week after election
Massachusetts	Not required	No	Ten days after election
Michigan	Required, if voter is assisted in filling out ballot	No	8:00 p.m. on election day
Minnesota	Required	Postage paid by state	Last mail delivery on election day
Mississippi	Required	No	Unknown
Missouri	Required	No	Close of polls
Montana	Not required	No	Close of polls
Nebraska	Required	No	10:00 a.m. second day after election
Nevada	Not required	Postage paid by state	Close of polls
New Hampshire	Not required	No	5:00 p.m. day before election
New Jersey	Required	No	8:00 p.m. on election day

New Mexico	Not required	No	7:00 p.m. on election day
New York	Required, if voter is assisted in filling out ballot	No	Postmarked day before election
North Carolina	Required	No	5:00 p.m. day before election
North Dakota	Required	No	Within two days after election
Ohio	Not required	No	Close of polls
Oklahoma	Required	No	7:00 p.m. on election day
Oregon	Not required	No	8:00 p.m. on election day
Pennsylvania	Required, if voter is assisted in filling out ballot	No	5:00 p.m. on Friday before election day
Rhode Island	Required	No	9:00 p.m. on election day
South Carolina	Required	No	Close of polls
South Dakota	Not required	No	Close of polls
Tennessee	Required, if voter is assisted in filling out ballot	No	Close of polls
Texas	Required	No	Before close of polls
Utah	Required, if voter is assisted in filling out ballot	No	Noon on Monday following election
Vermont	Not required	No	Close of polls
Virginia	Required	No	Close of polls
Washington	Not required	No	Ten days after election
West Virginia	Not required	Postage paid by state	Close of polls
Wisconsin	Required	No	Close of polls
Wyoming	Not required	No	7:00 p.m. on election day

Sources: Senate Research Center; National Conference of State Legislatures

APPENDIX IV

Certified WC Healthcare Networks' Service Area Information
(as of November 1, 2006)

WC Certified Network	Date Certified	Number of Counties in Service Area	Texas MSA Service Area
1.	Concentra Healthcare Network	4/14/2006	149Amarillo; Austin/Round Rock; parts of Beaumont/Port Arthur; Brownsville/Harlingen; College Station/Bryan; Corpus Christi; Dallas/Fort Worth/Arlington; El Paso; Houston/Sugar Land/Baytown; Killeen/Temple/Fort Hood; Longview; Lubbock; McAllen/Edinburg/Mission; San Angelo; San Antonio; Tyler; Victoria; Waco
2.	Corvel Healthcare Corporation	7/18/2006	37parts of Beaumont/Port Arthur; McAllen/Edinburg/Mission; Corpus Christi; parts of Dallas/Fort Worth/Arlington; parts of Houston/Sugar Land/Baytown; San Antonio (excluding Bandera)
3.	First Health/AIGCS TX HCN	8/23/2006	30parts of Beaumont/Port Arthur; College Station/Bryan; Houston/Sugar Land/Baytown (excluding Galveston)
4.	First Health TX HCN	8/15/2006	78parts of Beaumont/Port Arthur; College Station/Bryan; Dallas/Fort Worth/Arlington; Houston/Sugar Land/Baytown (excluding Galveston); Longview; Texarkana; Tyler; parts of Wichita Falls
5.	First Health/Travelers HCN	8/18/2006	30parts of Beaumont/Port Arthur; College Station/Bryan; Houston/Sugar Land/Baytown (excluding Galveston)
6.	Forte Inc.	8/28/2006	30parts of Beaumont/Port Arthur; College Station/Bryan; Houston/Sugar Land/Baytown (excluding Galveston)
7.	Genex Services Inc.	8/18/2006	30parts of Beaumont/Port Arthur; College Station/Bryan; Houston/Sugar Land/Baytown (excluding Galveston)

8.	The Hartford Workers' Compensation Health Care Network	10/02/2006	30parts of Beaumont/Port Arthur; College Station/Bryan; Houston/Sugar Land/Baytown (excluding Galveston)
9.	Imo Med/Select Network	10/23/2006	7parts of Dallas/Fort Worth/Arlington
10.	International Rehabilitation Associates; Inc.	08/21/2006	30parts of Beaumont/Port Arthur; College Station/Bryan; Houston/Sugar Land/Baytown (excluding Galveston)
11.	Liberty Mutual Managed Care, Inc.	08/22/2006	26parts of Austin/Round Rock ;parts of Beaumont/Port Arthur; parts of Dallas/Fort Worth/Arlington; parts Houston/Sugar Land/Baytown; parts of San Antonio
12.	Memorial Hermann Health Network Providers, Inc.	6/28/2006	11Parts of Houston/Sugar Land/Baytown
13.	http://www.tdi.state.tx.us/wc/wcnet/pct.htmlPhysicians Cooperative of Texas	10/02/2006	11parts of Austin/Round Rock; parts of Dallas/Fort Worth/Arlington; parts of San Antonio
14.	Sha, LLC	9/14/2006	9Lubbock

15.	Specialty Risk Services Texas Workers' Compensation Health Care Network	10/03/2006	30parts of Beaumont/Port Arthur; College Station/Bryan; Houston/Sugar Land/Baytown (excluding Galveston)
16.	Texas Star Network/Concentra	3/29/2006	149Amarillo; Austin/Round Rock; parts of Beaumont/Port Arthur; Brownsville/Harlingen; College Station/Bryan; Corpus Christi; Dallas/Fort Worth/Arlington; El Paso; Houston/Sugar Land/Baytown; Killeen/Temple/Fort Hood; Longview; Lubbock; McAllen/Edinburg/Mission; San Angelo; San Antonio; Tyler; Victoria; Waco
17.	Zurich Services Corporation Healthcare Network	10/26/2006	149Amarillo; Austin/Round Rock; parts of Beaumont/Port Arthur; Brownsville/Harlingen; College Station/Bryan; Corpus Christi; Dallas/Fort Worth/Arlington; El Paso; Houston/Sugar Land/Baytown; Killeen/Temple/Fort Hood; Longview; Lubbock; McAllen/Edinburg/Mission; San Angelo; San Antonio; Tyler; Victoria; Waco

Source: Texas Department of Insurance, Health and Workers' Compensation Network Certification and Quality Assurance Division and the Workers' Compensation Research and Evaluation Group, 2006.

APPENDIX VII

ACCIDENT & HEALTH INSURANCE
TEXAS MANDATED BENEFITS/OFFERS/COVERAGES
Including changes made by the 79th Legislature

MANDATED BENEFITS

KEY:
TIC = Texas Insurance Code
28 TAC = Title 28 Texas Administrative Code

ALZHEIMER'S DISEASE, BIOLOGICAL BRAIN DISEASE AND SERIOUS MENTAL ILLNESS **28 TAC §3.3826(a)(2)(A) & (B)**	No long-term care policy may exclude or limit coverage for covered services on the basis of a diagnosis of Alzheimer's disease or biologically-based brain disease/serious mental illness.	Applicable to any individual or group long-term care, home health or nursing home policy.
BRAIN INJURY **TIC Chapter 1352**	A policy may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury. Coverage may be subject to deductibles, copayments, coinsurance, or annual or maximum payment limits that are consistent with other similar coverage under the policy.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses, including an accident policy.
CHEMICAL DEPENDENCY **TIC Chapter 1368;** **28 TAC §§ 3.8001 - 3.8030**	Benefits for the necessary care and treatment of chemical dependency must be provided on the same basis as other physical illnesses generally. Benefits for treatment of chemical dependency may be limited to three separate series of treatments for each covered individual. The series of treatments must be in accordance with the standards adopted under 28 TAC §§3.8001 - 3.8030.	Applicable to any group policy providing basic hospital, surgical or major medical expense benefits.
COMPLICATIONS OF PREGNANCY **28 TAC §21.405**	Benefits for complications of pregnancy must be provided on the same basis as for other illnesses.	Applicable to any individual or group policy including major medical, hospital/medical/surgical, hospital indemnity, and disability coverages.

MANDATED BENEFITS - CONTINUED

COLORECTAL CANCER TESTING **TIC Chapter 1363**	A policy that provide benefits for screening medical procedures must provide coverage for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. An insured must have the choice of at least one of the following: (1) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years or (2) a colonoscopy performed every 10 years.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
DIABETES **TIC Chapter 1358;** **28 TAC §§21.2601 - 21.2607**	Medical or surgical expense polices which provide benefits for treatment of diabetes and associated conditions must provide coverage to each qualified insured for diabetes equipment, diabetes supplies and diabetes self-management training programs. The coverage must be provided in accordance with the standards adopted under 28 TAC §§ 21.2601 - 21.2607.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
EMERGENCY CARE • **EMERGENCY CARE PROVISIONS FOR PREFERRED PROVIDER PLANS** **TIC §1301.155**	Reimbursement for the following emergency care services must be at the preferred provider level of benefits, if an insured cannot reasonably reach a preferred provider: (a) any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital which is necessary to determine whether a medical emergency condition exists; (b) necessary emergency care services including treatment and stabilization of an emergency medical condition; and (c) services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition.	Applicable to any insurance policy that contains preferred provider benefits.
• **REIMBURSEMENT FOR EMERGENCY CARE UNDER UTILIZATION REVIEW** **TIC Article 21.58A, § 2(6)**	Carriers that apply utilization review must provide reimbursement for "emergency care" as that term is defined in Article 21.58A.	Applicable to carriers that apply utilization review.
• **DEFINITION OF EMERGENCY CARE** **TIC §1201.060**	Policies that provide an emergency care benefit must define emergency care to mean bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.	Applicable to any insurance policy that does not contain preferred provider benefits and does not apply utilization review.

MANDATED BENEFITS - CONTINUED

GOVERNMENT HOSPITAL COVERAGE **28 TAC §3.3040(d)**	Policies providing hospital confinement indemnity coverage may not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.	Applicable to any individual policy providing hospital indemnity coverage.
HEARING SCREENING FOR CHILDREN **TIC §1367.103**	Policies that provide benefits for a family member of the insured shall provide coverage for each covered child for: (1) a screening test (as provided by Chapter 47, Health and Safety Code) for hearing loss from birth through the date the child is 30 days old; and (2) necessary follow-up care related to the screening test from birth through the date the child is 24 months old. Benefits may be subject to copayment and coinsurance requirements, but may not be subject to a deductible requirement or dollar limits and this must be stated in the policy. (See also "Speech and Hearing" under the section for Mandated Offers.)	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
HUMAN PAPILLOMAVIRUS AND CERVICAL CANCER TESTING **TIC Chapter 1370**	A health benefit plan that provides coverage for diagnostic medical procedures must provide, for each woman enrolled in the plan who is 18 years of age or older, coverage for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Minimum benefits include a conventional Pap smear screening or a screening using liquid-based cytology methods alone or in combination with a test for the detection of the human papillomavirus approved by the United States Food and Drug Administration.	Applicable to any individual, group, blanket, franchise insurance policy, insurance agreement, group hospital service contract, an individual or group evidence of coverage, or a similar coverage document that provides coverage for medical or surgical expenses.
IMMUNIZATIONS **TIC §1367.053**	Policies that provide benefits for a family member of the insured shall provide coverage for each covered child from birth through the date the child is six years old for: (1) immunization against diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella; and (2) any other immunization that is required by law for the child. Immunizations may not be subject to a deductible, copayment or coinsurance requirement.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
MAMMOGRAPHY **TIC §1356.005**	Annual screening by low-dose mammography for females 35 years old or older must be provided on the same basis as other radiological examinations.	Applicable to any individual or group policy.

MANDATED BENEFITS - CONTINUED

MASTECTOMY • **MINIMUM LENGTH OF STAY FOLLOWING MASTECTOMY OR LYMPH NODE DISSECTION** **TIC §1357.054**	Policies that provide benefits for the treatment of breast cancer must include coverage for inpatient care for a covered individual for a minimum of: (a) 48 hours following a mastectomy; and (b) 24 hours following a lymph node dissection for the treatment of breast cancer. A policy is not required to provide the minimum hours of coverage of inpatient care required if the covered individual and the covered individual's attending physician determine that a shorter period of inpatient care is appropriate.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
• **RECONSTRUCTIVE SURGERY INCIDENT TO A MASTECTOMY** **TIC §§1357.003 and 1357.004**	Policies that provide coverage for mastectomy must provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. The coverage may be subject to annual deductibles, copayments, and coinsurance that are consistent with other benefits under the policy, but may not be subject to dollar limitations other than the policy lifetime maximum.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses, including cancer policies.
MATERNITY **MINIMUM STAY FOLLOWING BIRTH OF A CHILD** **TIC §1366.055**	Policies providing maternity benefits, including benefits for childbirth, must include coverage for inpatient care for a mother and her newborn child in a health care facility for a minimum of: (a) 48 hours following uncomplicated vaginal delivery; and (b) 96 hours following uncomplicated caesarean section. Policies that provides in-home postdelivery care are not required to provide the minimum number of hours unless the inpatient care is determined to be medically necessary by the attending physician or is requested by the mother.	Applicable to any individual, group, blanket or franchise insurance policy that provide benefits for medical or surgical expenses.
MENTAL/NERVOUS DISORDERS WITH DEMONSTRABLE ORGANIC DISEASE **28 TAC §3.3057(d), Exhibit A**	No individual policy may exclude mental, emotional or functional nervous disorders with demonstrable organic disease.	Applicable to any individual policy (primarily major medical, hospital indemnity and hospital/medical/ surgical coverages).
OSTEOPOROSIS, DETECTION AND PREVENTION **TIC Chapter 1361**	Policies that provide benefits for medical or surgical expenses incurred as a result of an accident or sickness must provide coverage to qualified individuals for medically accepted bone mass measurement to determine a person's risk of osteoporosis and fractures associated with osteoporosis.	Applicable to any group policy that provides benefits for medical or surgical expenses.

MANDATED BENEFITS - CONTINUED

PRESCRIPTION DRUGS • **FORMULARY** **TIC §1369.055;** **28 TAC §§21.3020 – 21.3023**	A group policy that provides benefits for prescription drugs shall make a prescription drug that was approved or covered for a medical condition or mental illness available to each covered individual at the contracted benefit level until the policy's renewal date, regardless of whether the prescribed drug has been removed from the policy's drug formulary.	Applicable to any group policy which provides coverage for prescription drugs and uses one or more drug formularies. Not applicable to a policy issued to a small employer.
• **OFF-LABEL DRUGS** **TIC §1369.004;** **28 TAC §§ 21.3010 – 21.3011**	A policy that provides coverage for drugs must provide coverage for any drug prescribed to treat a covered individual for a covered chronic, disabling, or life-threatening illness if the drug: (1) has been approved by the Food and Drug Administration for at least one indication; and (2) is recognized for treatment of the indication for which the drug is prescribed in: (a) a prescription drug compendium approved by the commissioner; or (b) substantially accepted peer-reviewed medical literature. Coverage shall include any medically necessary services associated with the administration of the drug.	Applicable to any individual, group, blanket or franchise insurance policy that provides coverage for prescription drugs. Not applicable to a policy issued to a small employer.
• **ORAL CONTRACEPTIVES** **28 TAC §21.404**	Benefits for oral contraceptives must be provided when all other prescription drugs are provided.	Applicable to any individual or group policy providing coverage for prescription drugs.
• **PRESCRIPTION CONTRACEPTIVE DRUGS AND DEVICES AND RELATED SERVICES** **TIC §1369.104**	A policy that provides benefits for prescription drugs or devices may not exclude or limit benefits to insureds for (1) a prescription contraceptive drug or device approved by the United States Food and Drug Administration; or (2) an outpatient contraceptive service. Coverage for abortifacients or any other drug or device that terminates a pregnancy is not required to be covered. A policy limitation that applies to all prescription drugs or devices or, all services for which benefits are provided may be imposed. Any deductible, copayment, coinsurance or other cost sharing provision applicable to prescription contraceptive drugs or devices or outpatient contraceptive services may not exceed that required for other prescription drugs or devices or outpatient services covered under the policy. Any waiting period imposed on benefits for prescription contraceptive drugs or devices or outpatient contraceptive services may not be longer than any waiting period applicable for other prescription drugs or devices or other outpatient services under the policy.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses.

MANDATED BENEFITS - CONTINUED

• **PHENYLKETONURIA (PKU)** **TIC Chapter 1359**	Policies that provide benefits for prescription drugs must include formulas for treatment of PKU or other heritable diseases.	Applicable to any group policy which provides coverage for prescription drugs.
PROSTATE TESTING • **COVERAGE OF CERTAIN TESTS** **TIC §1362.003**	Policies that provides benefits for diagnostic medical procedures must provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer. Minimum benefits must include: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is: (a) at least 50 years of age and asymptomatic; or (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.	Applicable to any individual, group, blanket, or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
• **PROSTATE-SPECIFIC ANTIGEN TEST** **TIC §1575.159**	A policy offered under the Texas Public School Retired Employees Group Insurance Act must provide coverage for a medically accepted prostate specific antigen test for each male who is enrolled in the plan and at least 50 years of age or at least 40 years of age with a family history of prostate cancer or another cancer risk factor.	Applicable to any policy offered under the Texas Public School Retired Employees Group Insurance Act.
RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES IN A CHILD **TIC §1367.153**	Policies that provide benefits to a child who is younger than 18 years of age must cover "reconstructive surgery for craniofacial abnormalities" and define it as surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.	Applicable to any individual, group, blanket, or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.

MANDATED BENEFITS - CONTINUED

SERIOUS MENTAL ILLNESS **TIC §§1355.004, 1355.151, 1551.205, and 1601.109**	A group policy (a) must provide coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (c) must include the same amount limits, deductibles, and coinsurance factors for serious mental illness as for physical illness – Section 1355.004.	Applicable to any group policy that provides benefits for medical or surgical expenses. (Note: Mandated Offer for a policy issued to a small employer.)
	The Texas State Employees Uniform Group Insurance Plan may not provide benefits for serious mental illness that are less extensive than the minimum coverage required by Section 1355.004.	Applicable to any policy offered under the Texas State Employees Uniform Group Insurance Benefits Act – Section 1551.205.
	Benefits for serious mental illness must be provided as extensive as any other physical illness. ♦ Texas State College and University Employees Uniform Insurance Benefits Act - Section 1601.109. ♦ Local Governments – Section 1355.151.	Applicable to the specific governmental employee policy referenced.
TELEMEDICINE/TELEHEALTH **TIC §1455.004**	A policy may not exclude a telemedicine medical service or a telehealth service from coverage solely because the service is not provided through a face-to-face consultation. Telemedicine medical services and telehealth services may be made subject to a deductible, copayment, or coinsurance requirement; however, the deductible, copayment, or coinsurance may not exceed that required for a comparable medical service provided through a face-to-face consultation.	Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
TEMPOROMANDIBULAR JOINT (TMJ) **TIC §1360.004**	A group policy that provides benefits for the medically necessary diagnostic or surgical treatment of skeletal joints must provide comparable coverage for the diagnosis or surgical treatment of conditions affecting the temporomandibular joint that is necessary as a result of: (1) an accident; (2) a trauma; (a) a congenital defect; (4) a developmental defect; or (5) a pathology.	Applicable to any group policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
TRANSPLANT DONOR COVERAGE **28 TAC §3.3040(h)**	A policy providing a specific benefit for the recipient in a transplant operation shall also provide reimbursement of any medical expense of a live donor to the extent that the benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.	Applicable to any individual policy providing for transplant coverage.

MANDATED OFFERS

ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE **28 TAC §3.3040(g)**	When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all eligible insureds under such coverage.	Applicable to any individual policy providing accidental death and dismemberment coverage.
CERTAIN THERAPIES FOR CHILDREN WITH DEVELOPMENTAL DELAYS **TIC Article 21.53F §9**	A health benefit plan that provides coverage for rehabilitative and habilitative therapies must offer coverage of certain therapies for children with developmental delays.	Applicable to any individual, group, blanket, or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
POINT-OF-SERVICE (POS) COVERAGE **TIC §1273.052;** **28 TAC §26.312** **POINT-OF-SERVICE ARRANGEMENTS** **28 TAC §§21.2901 – 21.2902**	If the only health coverage offered under a large employer's health plan is a network-based delivery system of coverage offered by one or more HMOs, all eligible employees must be offered the opportunity to obtain health coverage through a non-network plan at the time of enrollment and at least annually. Each HMO offering coverage under the large employer's health plan must offer a non-network plan, unless all the participating HMOs enter into an agreement designating one or more of the HMOs to offer the non-network plan. The POS coverage may be issued by (a) an HMO through a POS rider plan or (b) both an HMO and insurance company through either a blended contract POS plan or dual contract POS plan.	Applicable only to coverage under a large employer's health plan where there is only a network-based delivery system of coverage available to employees. Not applicable to a health plan offered to a small employer.
HOME HEALTH **TIC Chapter 1351**	Unless rejected in writing by the group policyholder or negotiated for lesser benefits, a group policy must provide services for skilled nursing; physical, occupational, speech, or respiratory therapy; home health aide; medical equipment and medical supplies other than drugs and medicines. Benefits must include at least 60 visits in any calendar year or in any continuous period of 12 months for each person covered under the policy.	Applicable to any group policy (primarily major medical and hospital/medical/surgical coverages).
IN VITRO FERTILIZATION Article **TIC §§1366.003 – 1366.004**	Unless rejected in writing by the group policyholder, benefits for in vitro fertilization must be provided to the same extent as benefits provided for other pregnancy-related procedures subject to certain requirements.	Applicable to any group policy providing coverage on an expense incurred basis (primarily major medical and hospital/medical/ surgical coverages).
MATERNITY BENEFITS **28 TAC §21.404(6)**	No insurer may refuse to offer maternity coverage in an individual policy when comparable family coverage policies offer maternity coverage.	Applicable to any individual policy (primarily major medical and hospital/medical/surgical coverages).

MANDATED OFFERS - CONTINUED

MENTAL HEALTH **TIC §1355.106**	The insurer must offer and the group policyholder shall have the right to reject benefits for mental or emotional illness.	Applicable to any group accident and sickness policy (primarily major medical and hospital/medical/ surgical coverages).
SERIOUS MENTAL ILLNESS **TIC §1355.004**	Small employer carriers must offer to small employers coverage for serious mental illness that complies with the following: (a) coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment in each calendar year; (b) the coverage may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the policy; and (c) the coverage must include the same amount limits, deductibles, and coinsurance factors for serious mental illness as for physical illness.	Applicable to a policy issued to a small employer.
SPEECH AND HEARING **TIC §§1365.003 – 1365.004**	Unless rejected by the group policyholder or an alternative level of benefits is negotiated, benefits must be provided for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally. (See also "Hearing Screening for Children" under the section for Mandated Benefits.)	Applicable to any group policy providing coverage on an expense incurred basis (primarily major medical and hospital/medical/ surgical coverages).

MANDATED COVERAGES

ASBESTOS EXPOSURE AND CLAIMS **Article 21.53X**	A policy may not reject, deny, limit, cancel, refuse to renew, increase the premiums for, or otherwise adversely affect the person's eligibility for or coverage under the policy or contract based on the fact that an enrollee has been exposed to asbestos fibers or silica or has filed a claim governed by Chapter 90, Civil Practice and Remedies Code	Applicable to any individual and group coverage.
CHEMICAL DEPENDENCY TREATMENT FACILITY **TIC §1368.005**	Treatment of chemical dependency in a chemical dependency treatment facility must be covered as favorable as any other physical illness and must be provided on the same basis as treatment in a hospital.	Applicable to any group policy (primarily major medical and hospital/medical/surgical coverages).
CONTINUATION • **CONTINUATION OF COVERAGE FOR CERTAIN DEPENDENTS** **TIC §§1251.301 – 1251.310**	Continuation of coverage for certain dependents is required for a period of three years upon termination of coverage due to divorce from or retirement or death of the insured member.	Applicable to any expense incurred group policy (primarily major medical and hospital/medical/ surgical coverages).
• **CONTINUATION OF COVERAGE DURING LABOR DISPUTE** **TIC §§1253.051 – 1253.060**	Continuation of coverage is required for a period of six months after cessation of work.	Applicable to any group policy resulting in all or a portion of premiums being paid though a collective bargaining agreement - could include any coverages.
• **CONTINUATION OF COVERAGE UPON DIVORCE** **28 TAC §21.407**	In individual policies, if a person loses coverage due to a change in marital status, that person shall be issued a policy which the insurer is then issuing which most nearly approximates the coverage in effect prior to the change in marital status. The policy will be issued without evidence of insurability and will have the same effective date and expiration date as the prior policy.	Applicable to any individual policy.
• **CONTINUATION OF COVERAGE FOR SPOUSE UPON DEATH OR AGE LIMIT OR OTHER OCCURRENCE** **28 TAC §§ 3.3050(b) and 3.3052(b) & (c)**	In the event of the insured's death, the spouse of the insured, if covered, shall become the insured in any guaranteed renewable, noncancellable, or limited guarantee of renewability individual policy.	Applicable to an individual policy issued on a guaranteed renewable, noncancellable, or limited guarantee of renewability basis.
	In a noncancellable or limited guarantee of renewability policy, which covers both the insured and spouse, the age of the younger spouse must be used for fulfilling the age or duration requirements however, this does not prevent termination of the older spouse upon attainment of the stated age limit.	Applicable to an individual policy issued on a noncancellable or limited guarantee of renewability basis.

MANDATED COVERAGES - CONTINUED

• **CONTINUATION OF COVERAGE FOR MENTALLY/PHYSICALLY HANDICAPPED CHILDREN TIC §1201.059; 28 TAC §3.3052(h)**	Continuation of coverage upon attainment of the limiting age is required for a child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the insured for support and maintenance.	Applicable to any individual or group policy that provides coverage for dependents.
• **CONTINUATION / CONVERSION TIC §§1251.251 - 1251.259; 28 TAC §§3.501 – 3.520**	Group policies must provide continuation of coverage for a period of six months upon termination of coverage for any reason, except involuntary termination for cause. If an employer is subject to COBRA, the six-month continuation must be provided after coverage under COBRA has been exhausted. Conversion coverage may be offered provided it meets the minimum standards for services and benefits for conversion contracts.	Applicable to any expense incurred group policy (primarily major medical and hospital/ medical/ surgical coverages).
CRISIS STABILIZATION UNIT & RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS TIC §§1355.051 – 1355.058	A policy providing benefits for treatment of mental or emotional illness or disorder when confined in a hospital must include benefits for treatment in a crisis stabilization unit or residential treatment center for children and adolescents. For purposes of determining policy benefits and benefit maximums, each two days of treatment in the facility will be considered equal to one day of treatment in a hospital or inpatient program.	Applicable to any group policy providing inpatient mental illness coverages (primarily major medical and hospital/medical/ surgical coverages).
DEPENDENTS • **CHILDREN GENERALLY TIC §§1201.053, 1201.062, 1201.065, 1251.151 – 1251.154, and 1501.002**	If children are eligible for coverage under the policy, any age limitation for an unmarried child may not be less than 25.	Applicable to any individual or group accident or sickness policy.
• **ADOPTED CHILDREN TIC §§1201.061, 1251.154, 1501.158, and 1501.608**	Policies providing coverage for the immediate family or children of an insured may not exclude or limit coverage for an adopted child. A child is considered to be a child of the insured, if the insured is a party in a suit in which the adoption of the child by the insured is sought. Natural or adopted children of the insured may not be excluded from coverage based on residency with or financial responsibility of the group member or insured.	Applicable to any individual or group accident or sickness policy.
• **CHILD OF THE SPOUSE TIC §1201.064**	Policies providing coverage for children of the insured may not exclude from coverage the natural or adopted children of the spouse of the insured.	Applicable to any individual or group accident or sickness policy.

MANDATED COVERAGES - CONTINUED

• **CERTAIN GRANDCHILDREN** **TIC §§1201.062 and 1251.151**	Policies that provide coverage for a child of the policyholder must provide coverage for any unmarried grandchildren if the child is younger than 25 years of age and a dependent of the policyholder for federal income tax purposes at the time of initial application for coverage. Coverage for a grandchild may not be terminated solely because the covered child is no longer a dependent of the policyholder for federal income tax purposes.	Applicable to any individual or group policy providing coverage for hospital, surgical or medical expense coverage.
• **CERTAIN STUDENTS** **TIC §§1503.001 – 1503.003**	Policies that condition coverage for a child 25 years of age or older, on the child's being a full-time student at an educational institution shall provide the coverage for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student. Coverage will continue until the 10th day of instruction of the subsequent academic term; on which date the plan may terminate coverage of the child if the child does not return to full time status before that date. A policy may not condition coverage for a child younger than 25 years of age on the child being enrolled at an educational institution.	Applicable to any individual, group, blanket or franchise policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.
• **MEDICAL SUPPORT FOR CHILDREN** **TIC Chapter 1504**	Policies that provide coverage for dependents must provide coverage for a child subject to a medical support order issued under Section 1.01, Subchapter A, Chapter 231 of the Family Code.	Applicable to any expense incurred individual or group policy that provides benefits for medical or surgical expenses.
• **MEDICAL SUPPORT FOR CHILDREN** **TIC §1201.063**	Policies that provide coverage for children of a group member or a person insured, must provide coverage for a child subject to a medical support order issued under Chapter 154 of the Family Code, or enforceable by a court in this state.	Applicable to any individual and group accident or sickness policy.
• **NEWBORN CHILDREN** **TIC §§1367.001 – 1367.003, 1501.157, and 1501.607;** **28 TAC §§3.3401- 3.3403**	Policies that provide maternity coverage or dependent coverage must provide automatic coverage to a newborn child for congenital defects or abnormalities for the initial 31 days. Coverage must be continued beyond the 31 days if notification of the birth is given and any required premium paid within the 31-day period, subject to exceptions for billing cycles.	Applicable to any individual or group policy providing accident and sickness coverage including major medical, hospital/medical/ surgical, and maternity.

MANDATED COVERAGES - CONTINUED

EXTENSION OF BENEFITS UPON TERMINATION BY INSURER (INDIVIDUAL COVERAGE) 28 TAC §3.3052(f)	An extension of benefits is required upon termination of any individual policy by the insurer. Termination shall be without prejudice to any continuous loss which commenced while the policy was in force; however, may be based on the continuous total disability of the insured and limited to the duration of the policy benefit period, payment of the maximum benefit, or a period of not less than three months.	Applicable to any individual policy.
• **FOR TOTALLY DISABLED PERSONS (GROUP COVERAGE) TIC §§1252.201 – 1252.207**	An extension of benefits is required upon termination of policy for totally disabled persons. In policies providing benefits for loss of time from work or specific indemnity during hospital confinement, benefits payable for that disability or confinement are not affected by the termination. In policies providing hospital or medical expense coverages, the extension must be provided at least for the period of the disability or 90 days, whichever is less.	Applicable to any group policy (primarily major medical, hospital/ medical/surgical, disability income, hospital indemnity, accident medical expense coverages).
• **UPON ACCEPTANCE OF PREMIUM (INDIVIDUAL COVERAGE) 28 TAC §3.3052(d)**	If an insurer accepts a premium for coverage extending beyond the date, age or event specified for termination of an insured family member, then coverage as to such person shall continue during the period for which an identifiable premium was accepted (unless due to a misstatement of age).	Applicable to any individual policy.
• **PREGNANCY BENEFITS (INDIVIDUAL COVERAGE) 28 TAC §3.3052(e)**	In the event of cancellation by the insurer or refusal to renew by the insurer of a policy providing pregnancy benefits, an extension of benefits is required for any pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy continued in force.	Applicable to any individual policy providing pregnancy benefits.
HIV, AIDS, OR HIV-RELATED ILLNESSES TIC §§1364.001 - 1364.053, 1364.101, 1551.205, and 1601.109; 28 TAC §3.3057(d), Exhibit A	A policy may not exclude or deny coverage, and cancellation is prohibited for HIV, AIDS, or HIV-Related illness.	Applicable to any individual or group policy (primarily major medical and hospital/medical/ surgical coverages).

MANDATED COVERAGES - CONTINUED

MENTAL HEALTH PARITY **28 TAC §§21.2401 – 21.2407**	If a policy provides medical/surgical benefits and mental health benefits neither an annual dollar limit nor a lifetime aggregate dollar limit may be impose on mental health benefits that is lower than the corresponding limit on medical/surgical benefits. If no annual limit or lifetime aggregate limit is placed on medical/surgical benefits, none may be imposed on mental health benefits.	Applicable to any group policy providing medical/surgical benefits and mental health benefits on an expense incurred basis. Exemptions are provided under certain circumstances, including but not limited to, small employer plans.
PODIATRIST CERTIFICATION **TIC §1451.351**	A policy providing disability income benefits may not deny payment of those benefits when the disability is certified by a licensed podiatrist and the sickness or injury may be treated by the podiatrist under the scope of his license.	Applicable to any individual or group policy providing benefits for disability.
PRACTITIONERS **TIC Chapter 1451**	Enables insureds to select certain practitioners to provide services scheduled in the policy that are within the scope of their licenses.	Applicable to any group, individual, blanket, or franchise policy.
PREEXISTING CONDITIONS • **INDIVIDUAL COVERAGE** **TIC §§1201.151 – 1201.154;** **28 TAC §3.3018**	An individual health carrier must waive or reduce the preexisting condition time period as follows: (a) The preexisting condition time period shall be waived for an individual who was continuously covered for an aggregate period of 18 months by creditable coverage that was in effect up to a date not more than 63 days before the effective date of the individual coverage provided the most recent creditable coverage was under a group health plan, governmental plan or church plan. (b) If there has been more than a 63 day break between coverage, the preexisting time period in an individual policy shall be reduced by the time the individual was covered under creditable coverage during the 18 months preceding the effective date of coverage under the individual coverage provided the most recent creditable coverage was under a group health plan, governmental plan or church plan.	Applicable to any individual hospital, medical or surgical coverages.
• **LONG-TERM CARE COVERAGE** **28 TAC §3.3824 (c)**	Replacing company shall waive any time periods applicable to preexisting conditions and probationary periods to the extent such time periods have been satisfied under the policy being replaced.	Applicable to any individual or group long-term care policy.

MANDATED COVERAGES - CONTINUED

• **MEDICARE SUPPLEMENT INSURANCE TIC 1652.057; 28 TAC §3.3306(1)(A)**	Replacing insurer shall waive any time periods applicable to preexisting condition waiting periods, elimination periods, and probationary periods to the extent such time was spent under the original policy.	Applicable to any individual or group Medicare supplement policy.
• **REPLACEMENT AND DISCONTINUANCE OF GROUP AND GROUP TYPE ACCIDENT AND HEALTH INSURANCE TIC §§1252.001 – 1252.207**	Benefits must be provided for preexisting conditions upon replacement of the master policy, but may provide the lesser of the benefits of the prior plan, or the benefits of the succeeding carrier's plan determined without application of the preexisting conditions limitation.	Applicable to any group policy (primarily major medical and hospital/medical/surgical coverages).
• **SMALL AND LARGE EMPLOYER COVERAGE TIC §1501.102**	A small or large employer carrier must waive or reduce the preexisting condition time period as follows: (a) The preexisting condition time period shall be waived for an individual who was continuously covered for an aggregate period of 12 months under creditable coverage that was in effect up to a date not more than 63 days before the effective date of coverage under the large or small employer policy. (b) If there has been more than a 63 day break between coverage, the preexisting condition time period of a large or small employer policy shall be reduced by the time the individual was covered under creditable coverage during the 12 months preceding the effective date of coverage under the large or small employer policy.	Applicable to policies issued to a large or small employer.
• **WAIVER OF WAITING PERIODS ON REPLACEMENT TIC §1652.057; 28 TAC §3.3312**	Replacing insurer shall waive any time periods applicable to preexisting condition waiting periods, and coverage shall be issued on a guaranteed issue basis, for the following individuals provided the individual applies to enroll under the Medicare supplement coverage not later than 63 days after termination of the individual's enrollment as follows: (1) an individual who is enrolled under an employee welfare benefit plan that either supplements Medicare benefits, or is primary to Medicare, and the plan terminates or ceases to provide all health benefits to the individual;	Applicable to any individual or group Medicare supplement policy.

MANDATED COVERAGES - CONTINUED

WAIVER OF WAITING PERIODS ON REPLACEMENT – continued	(2) an individual enrolled in a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, or an individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act and certain circumstances apply or would permit discontinuance of the individual's enrollment (refer to 28 TAC §3.3312(b)(2)); (3) an individual is enrolled with an entity described in 28 TAC §3.3312(b)(3) and enrollment ceases under circumstances described in 28 TAC §3.3312(b)(2); (4) an individual is enrolled under a Medicare supplement policy and the enrollment ceases under circumstances described in 28 TAC §3.3312(b)(4); (5) an individual who: (a) was enrolled under a Medicare supplement policy and terminates enrollment; (b) subsequently enrolls, for the first time with an entity described in 28 TAC §3.3312(b)(5); and (c) terminates the subsequent enrollment within the first 12 months; or (6) an individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare+Choice plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.	Applicable to any individual or group Medicare supplement policy.
PSYCHIATRIC DAY TREATMENT FACILITY **TIC §§1355.101 – 1355.106**	A policy providing benefits for treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Determination of policy benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or in-patient program. On rejection of mandated benefits the insurer shall offer and the policyholder can select an alternate level of benefits, but any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in hospital facilities.	Applicable to any group policy providing mental illness coverage (primarily major medical and hospital/medical/surgical coverage).
PUBLIC INSTITUTIONS **TIC §§1204.001 -1204.002 and 1355.202**	Policies may not exclude benefits when services are provided by tax supported institutions for which charges are made.	Applicable to any group or individual policy.

Texas Department of Insurance

2004 Texas Group Health Insurance Survey Results: Coverage for Treatment of Morbid Obesity

Each year, the Texas Department of Insurance conducts a survey of all group health maintenance organizations (HMOs) and a subset of group accident and health insurance carriers that issue approximately 70% of the group coverage issued in Texas. This report summarizes the data collected on insurance benefits provided for the treatment of morbid obesity. It is important to note that coverage for the treatment of morbid obesity is not a required benefit; companies that provide the coverage have elected to do so voluntarily. Information on benefits provided by HMOs and group insurers is reported separately.

Group Accident and Health Insurance Benefits

In the 2004 survey, 21 insurers provided information on the types of coverage that they provide for the treatment of morbid obesity. Of these, 12 responded that some of their policies include morbid obesity coverage, while eight indicated that no coverage is provided under any policy. The remaining insurer reported that obesity-related coverage is a normal exclusion in all policies, with the exception of one large employer that specifically requested the benefit for their group. The average cost of coverage (which includes bariatric surgery, nutritional counseling and medically-supervised weight-loss programs) for that one group is an additional $6 per-person per-year.

The other 12 companies that reported they provide morbid obesity coverage were asked to indicate the types of treatment covered under their plans. The table below summarizes their responses.

Group Accident and Health Insurance Coverage

Is This Type of Treatment Covered?	Of 12 Carriers That Provide Coverage, the Types of Treatment Covered for Morbid Obesity				
	Prescription Drugs	Nutritional Counseling	Medically-Supervised Weight-Loss Programs	Non-Medically-Supervised Weight-Loss Programs	Bariatric Surgery
Yes	5	6	6	0	10
No	7	6	6	12	2

Carriers were also asked to indicate their average annual premium cost-per-person for morbid obesity coverage, if such coverage was provided. Of the 12 companies that offer coverage, seven companies stated that average annual premium data was not available, and two others did not provide premium estimates because treatment for morbid obesity is

included in existing coverage or the underlying rate and a separate cost estimate is not calculated. One company stated that morbid obesity coverage is available at a cost of 1.1 percent of the annual premium cost per person and one reported the cost as $32.01 per person. The last insurer reported the cost as $0. For the three companies that provided an annual cost estimate, the following table shows how the average annual premium amounts relate to the type of obesity benefits provided by each company.

Company's Average Annual Premium	Morbid Obesity Benefits Provided				
	Prescription Drugs	Nutritional Counseling	Medically-Supervised Weight-Loss Programs	Non-Medically-Supervised Weight-Loss Programs	Bariatric Surgery
1.1% of premium	No	Yes	No	No	Yes
$32.01	Yes	No	Yes	No	Yes
$0	Yes	No	Yes	No	Yes

Finally, carriers were asked to provide both the total number and dollar value of claims paid where morbid obesity was either a primary diagnosis or a comorbidity factor. The results of their responses are summarized in the table below.

Health Insurance Claim Costs Associated with Morbid Obesity as Primary Diagnosis or Co-morbidity Factor			
Diagnosis Type	Number of Carriers that Reported Data	Total Value of Claims Paid	Total Number of Claims Paid
Primary Diagnosis	20	$6,661,339	8,229
Co-morbidity Factor	20	$30,994,334	43,901

It is important to note that the claim costs reported above reflect data reported on health care claims where the provider specifically indicated that obesity was a primary diagnosis or co-morbidity factor. Insurers have no way of identifying claims where obesity is a related factor unless the provider indicates such on the claim form. Previous studies have found that providers often do not report on claim forms that the individual is obese, or that obesity is a contributing factor, unless that information has some impact on the claim payment. As such, the claim costs reported by these carriers represent only a portion of the total claims that may be attributable to obesity, either directly or indirectly.

HMO Benefits

In a separate survey of basic-service health maintenance organizations, 18 HMOs provided information on coverage of morbid obesity under group health plans sold in Texas in 2004. Nine HMOs responded that some of their plans include morbid obesity coverage, while the remaining nine reported that no morbid obesity coverage is provided under any plan. The nine HMOs providing some level of coverage were then asked to indicate what types of treatment are covered under their plans. The table below summarizes their responses.

Group Health Maintenance Organization Coverage

Is Treatment Covered?	Of 9 HMO That Provide Coverage, the Types of Treatment Covered for Morbid Obesity				
	Prescription Drugs	Nutritional Counseling	Medically-Supervised Weight-Loss Programs	Non-Medically-Supervised Weight-Loss Programs	Bariatric Surgery
Yes	1	6	3	0	7
No	8	3	6	9	2

In addition to the information above, one HMO reports that physician office visits are covered for medically-supervised weight-loss programs, but other related costs are not covered.

HMOs were also asked to indicate their average annual premium cost-per-person, if any coverage for morbid obesity was provided. Four HMOs stated that average annual premium figures were not available, and another indicated that treatment for morbid obesity is included in an office visit rather than being billed separately. Three HMOs provided average annual premium amounts of $3.26, $36.40, and $456 per person. The one remaining HMO reported an average annual premium cost of 1.1% of the total premium. The following table shows how the premium cost estimates for each company relate to the covered services provided by each HMO that provided annual premium estimates.

Company's Average Annual Premium	Premiums Costs and Morbid Obesity Benefits Provided				
	Prescription Drugs	Nutritional Counseling	Medically-Supervised Weight-Loss Programs	Non-Medically-Supervised Weight-Loss Programs	Bariatric Surgery
1.1% of Premium	No	Yes	No	No	Yes
$3.26	No	Yes	No	No	Yes
$36.40	No	Yes	Yes	No	Yes
$456	No	Yes	No	No	Yes

Finally, HMOs were asked to provide both the total number and dollar value of claims paid where morbid obesity was either a primary diagnosis or a comorbidity factor. The results are summarized in the table below.

HMO Claim Costs Associated with Morbid Obesity as Primary Diagnosis or Co-morbidity Factor			
Diagnosis Type	**Number of HMOs that Reported Data**	**Total Value of Claims Paid**	**Total Number of Encounters**
Primary Diagnosis	16	$16,216,712	34,125
Co-morbidity Factor	13	$33,900,201	49,104

As indicated earlier, these claim costs reflect only those claims where a provider specifically indicated that morbid obesity was a primary diagnosis or comorbidity factor. The reported costs do not reflect many services provided that are attributable in part or in whole to the patient's obesity, but were not reported as such on the claim filed by the provider because the information has no bearing on the processing of the claim.

State Mandated Benefits and Providers–Part 1

Benefits	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	TOTAL
Alcoholism Treatment	80	83	02	77	**83**	83	**84**	89	78		87	86	80	**94**	**79**	**82**	89	**86**		**93**	87	82	88	**97**	44
Ambulance Transportation		89				01				84															9
Ambulatory Surgery						97				76															9
Blood Lead Screening				95									91										01		7
Bone Marrow Transplants			92	**95**												98				**94**					9
Bone Density Screening					97	02	99			96				98		96	95								15
Breast Reconstruction	98	83	97	97	98	97	97	98	98	97	98	97	96	98	98	97	97	98	98	98	85	02	97	98	51
Cervical Cancer Screening		89		01	92	02	91		92	04	93	94	88	98		**99**	05			96		00		01	29
Cleft Palate							92							00						96					10
Clinical Trials		05	00		01		01						94			05			01	99		03			19
Colorectal Screening		03		01			01			**01**	05		00			**03**	01			00		00		01	24
Contraceptives		99	99		03	02	99		91				00				01		**99**	**97**	01	05			26
Dental Anesthesia	01		98	99			99	99		98					99	01				00	01		97		28
Diabetic Supplies / Edu	**99**	**97**	**97**	**95**	**97**	**93**	**97**			**96**	**01**	**98**	**96**	**99**	**99**	**97**	**97**	**00**	**97**	**00**	**97**	**96**	**02**	**01**	**47**
Drug Abuse Treatment		83	02			87	**84**	89			87	89	87	**94**		**82**	89	**86**		**97**	87		88		33
Emergency Services	97	97	97	97	97	96	97	99	97	97	97	98		98	99	98	97	00	97	97	97	98	98		45
Hair Prostheses (Wigs)			92							00															6
Home Health Care		89		77	**84**	75							84*				**87**		76		**83**	**01**	78		20
Hospice Care		89				85														99	**83**				10
Infertility Treatment				01		02			91				91				97					95			14
Mammography Screening	95	89	98	91	90	02	91	89	92	89	93	92	66	98	91	69	87		91	96	89	89	90	01	50
Maternity				01	85	84	00	96			96								96	01	00				17
Mental Health (General)		99	02			77		99	83			98		94		98	91	00		97	93	90*	88		27
Mental Health (Parity)	99		02	99	00					96	05		01	05	99	99	97	00	97	99	05	02			38
Metabolic Disorders/PKU		97	95	97	03	93		97			97	96			02	98	89	96	93		96				31
Minimum Mastectomy Stay				97	97	97	97			97		97	97	98			97			98		02			22
Minimum Maternity Stay	97	97	96	95	95	96	95	97	96	96	97	96	96	96	96	95	97	97	96	96	96	97	97	96	51
Morbid Obesity Care																				00					4
Off-Label Drug Use	98	99	99	94	00	90	93	01	94	93			94	96	00	97	99			97					35
Orthotics/Prosthetics			03								01														9
Prostate Cancer Screening				96		00	93	97		99	05		00	98	00	97	97			98				01	28
Rehabilitation Services																	01					00			7
Second Med/Surg Opinion				79		76							83*									01	98		9
TMJ Disorders	98	89			89		95	89									89		99	95	00	00	97		18
Well-Child Care	94			02	97	93	01		93	94		92	04				99			01		94	00		32
TOTAL	11	19	18	21	18	23	20	12	11	17	14	12	19	15	11	18	22	9	12	24	16	19	14	9	832

Notes: The date refers to year enacted or significantly revised. Mandated offerings are in **bold**. Mandates that do not apply to BCBS Plans are asterisked. Includes federal mandates for maternity stay (1996) and breast reconstruction (1998).

Source: Blue Cross and Blue Shield Association, December 2006

State Mandated Benefits and Providers–Part 2

Providers	AL	AK	AZ	AR	CA	CO	CT	DC	DE	FL	GA	HI	ID	IL	IN	IA	KS	KY	LA	ME	MD	MA	MI	MN	MS	MO	MT
Acupuncturists					**84**					89										02							91*
Chiropractors	75	83	00	75	76	00	89		93	86	80			82	90	86	73	86	75	89	73	87	79	73	80	78	67*
Dentists	75	**92**	89	79	76	00	75			86	80	74			74	88	73	00	89	75	73	75	85*	73	74	78	83
Dieticians																											
Licensed Health Profs				75										82	85												
Marriage Therapists		02				00	92			92										05	03			93	05		
Massage Therapists										99																	
Naturopaths		87																									99
Nurses						90										**89**											
Nurse Midwives		83			91	90	84		88	83									84	02	**78**	85	04	83			87
Nurse Anesthetists	91*			93		90				**00**					95		90				84	93		83			87
Nurse Practitioners		88	85		91	90	84		90			02				96	90			02	**79**	93		88	99	01	87
Nurse, Psychiatric					82	90	84			83										83	83	86		88			
Occupational Therapists		87			78		82			87									**90**		83						
Optometrists	67	**92**	77	93	80	00	75		65*	89	88	02		80	74	**83**	73	00	90	82	73	75	85*	73	66	78	
Oral Surgeons										87				82													
Osteopaths		83				00				87				82	85		73	00			73			83			
Pastoral Counselors																				05							
Physical Therapists		87					75												90		83						01
Physician/Surg. Assistants	97	02							99							96	90	01			86		81				89
Podiatrists	76		77	79	76	00			85*	74				89	74		73	00	90		73	75	85*	73		78	
Professional Counselors				91	91	90				86				90						02	00	98			01		91
Psychologists	82	92	77	79	80	79	75			83	80	84		92	85		74		75	75	73	75	85*	89	74	83	81
Public and Other Facilities				91	84		84			88			90		85				98	79	82		48	73	98	00	73
Social Workers		92			76	91	74			84				90			89		89	83	77	91		93	92		85
Speech/Hearing Therapists		92		05	76														90		83	00				94	
Persons Covered																											
Adopted Children		01	86	87	00	00	02			88	88	99	01	91	88	00	90			02	91*	75		93		74	81
Continuation/Dependents			00	86	02	90	75	02		96	91			85	95	86	84	80	93	86	77	98		77	95	89	81
Continuation/Employees				86	02	90	75	02		96	92			84	95	86	84	80	93	86	75	98		75	73	88	81
Conversion to Non-Group			00	86	93	90		00		76	86		98	89	95	86	80	02	92	82	79		85	77		81	81
Dependent Students							82			92	78								79					93			
Handicapped Dependents			77	89	71		71			70	72	98	72	87	86	02			72		77	56	66	89	72		71
Newborns	75	75	74	93	71	75	74	80	74	84	74	74	74	78	78	74	74	78	73	78	79	74	85*	73	74	74	72
Grandchildren								00													01			01			
TOTAL	8	16	11	16	20	19	18	8	7	24	11	7	5	18	15	12	15	10	17	18	25	17	11	21	13	13	19

Notes: The date refers to year enacted or significantly revised. Mandated offerings are in bold. Mandates that do not apply to BCBS Plans are asterisked. Includes federal mandates for maternity stay (1996) and breast reconstruction (1998).

 Source: Blue Cross and Blue Shield Association, December 2006

State Mandated Benefits and Providers–Part 2

Providers	NE	NV	NH	NJ	NM	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	TOTAL
Acupuncturists		91			89								99				05			01	97				10
Chiropractors	67	82	75	**80**	84	97	73	89	80	89		80	87	80	80	81	79	75	99	88	**95**	96	**87**	71	47
Dentists	75	90		79	77*	75	75		73	89	80	49			80	74	83	86		68	81	96	75	71	42
Dieticians																	87	86						**91**	3
Licensed Health Profs		90													80			86						71	7
Marriage Therapists		01	99				01						93		03		91	86		01					**16**
Massage Therapists																					97				2
Naturopaths																		86			97				4
Nurses		85		84		**84**						86						86			81				8
Nurse Midwives	84	90		82	85	82	93	**85**	84	71		81	90		80	94		79		97	81	83			30
Nurse Anesthetists		90			85			**85**				88	95		89									71	17
Nurse Practitioners		90	85		98		93	**85**			79	88	91		80	96	99	86			81	00	01	71	32
Nurse, Psychiatric		90	85				93	89				88	91		89					89		77		71	18
Occupational Therapists		90				00											97	86						71	11
Optometrists	69	90	85	67	87*	75	73		80	00	71	78		85	80	65	79	75	01	77	00	00	75	71	46
Oral Surgeons		90	75											85											5
Osteopaths	67	90	75		87*				80	89		49			80			86		77		00		71	21
Pastoral Counselors							95																		2
Physical Therapists		90		75	97	73						82					97	86		87				71	14
Physician/Surg. Assistants		90					01				01				88		01	86						71	16
Podiatrists	69	90	85	53	87*	75	73		80	89		67	93	72	80	85	77	75		79	83	00	75	71	38
Professional Counselors			99				01	86				99		86	86	86	89	96		87					16*
Psychologists	74	80	75	73	87*	71	77	87	74	71	75	88		94	89	92	77	75		77	00		94	85	43
Public and Other Facilities	84		00				75		76		81		00			00	83			01	87	94	80	78	27
Social Workers		87	**94**			85	93	89		71	89				88	**85**	**87**	75		87	00			71	28
Speech/Hearing Therapists		90		01		93				99		94				89	83	86		89				71	17
Persons Covered																									
Adopted Children	00	89	00		88	92	91	87	89	86	91	95	00	00	83	00	89	85	01	91	88	94	85	89	43
Continuation/Dependents	89	95	81	00	83	92	83	87	84		83		83	78	80	86	79	86	85	79	85		80	96	42
Continuation/Employees	89	95	86	00	83	92	83	81	84		85		83	78	01	96	77	86	85	79	84		80	95	41
Conversion to Non-Group		95		00	83	81	82	83	84		85	78*	78	78	79	80	77	79	85	88	84	83	80	83	41
Dependent Students	78							81									97	90		01					10
Handicapped Dependents	76	95	69	66	69	89	73	83	71			68		70	69	69	81	75	83	74	69	00	75	71	39
Newborns	75	76	75	75	75	89	73	79	74	75	75	76	75	74	75	74	75	77	76	76	84	75	76	89	51
Grandchildren																	01						01		5
TOTAL	14	28	17	14	17	17	26	16	14	11	12	17	15	11	21	17	24	28	8	22	19	13	14	23	395

Notes: The date refers to year enacted or significantly revised. Mandated offerings are in **bold**. Mandates that do not apply to BCBS Plans are asterisked. Includes federal mandates for maternity stay (1996) and breast reconstruction (1998).

Source: Blue Cross and Blue Shield Association, December 2005

Additional Mandated Benefits

State	Additional Mandated Benefits	
California	AIDS vaccines (01) Domestic partners (04) Telemedicine (01)	Special footwear (01+) Reconstructive surgery (01) Pediatric asthma (04)
Colorado	Congenital defects (01) Dependent children to age 25 (05+)	Telemedicine (01)
Connecticut	Lyme disease (99) Pain management specialist (00) Ostomy related supplies (00)	Hearing aids (01) Special formulas (01) Psychotropic drugs (01)
District of Columbia	Hormone replacement therapy (01)	
Georgia	Chlamydia screening (99) Autism (01) Ovarian cancer screening (01) Telemedicine (05)	Heart transplants (01+) Nurse first assistant (01) Athletic trainer (00)
Hawaii	Telemedicine (01)	
Illinois	Pre-natal HIV testing (01) Ovarian cancer screening (05)	Prescription inhalants (03)
Kentucky	Long-term care (86) Nurse first assistant (01) Hearing aids (02)	Cochlear Implants (01) Autism (01)
Louisiana	Attention deficit disorder (01) Nurse first assistant (03)	Hearing aids (03)
Massachusetts	Hormone replacement therapy (02)	
Maine	Prescription drugs (83) Breast reduction surgery (05)	Domestic partners (01) Varicose vein surgery (05)
Maryland	Blood products (75) Hearing aids (01) Residential crisis services (02) Nicotine replacement therapy (05)	Alzheimer's (86+) Chlamydia screening (99) Minimum testicular cancer stays (99)
Minnesota	Elimination of port-wine stains (93) Lyme disease (96) Hearing aids (03)	Reconstructive surgery (01) Anti-psychotic drugs (01) Ovarian cancer screening (04)
Missouri	Developmentally disabled children (05)	
Nevada	Hormone replacement therapy (02)	
New Jersey	Special formulas (02) Congenital bleeding disorders (98) Domestic partners (04+)	Wilm's tumor (90) Wellness exams (98)
New Mexico	Lay Midwives (85) Oriental Medicine (01) Protein screening (04)	Smoking prevention (03) Circumcision (04)
New York	Ambulatory cancer treatment (82)	
North Carolina	Pharmacists (01) Ovarian cancer screening (03)	Foster children (01)
Oklahoma	Hearing aids (01)	
Oregon	Denturists (00)	Nurse first assistant (05)
Pennsylvania	Birth centers (82)	Ambulatory cancer treatment(99)
Rhode Island	Newborn sickle cell testing (88) Hearing aids (05)	Nurse first assistant (01) Lyme disease (03)
South Dakota	Dependent children to age 24 (05)	
Tennessee	Chemotherapy (86)	Chlamydia screening (99+)
Texas	Alzheimers (89) Brain injury (03)	Nurse first assistant (01) Telemedicine (01)
Utah	Unmarried children to age 26 (02)	
Virginia	HIV drugs (01) Opticians (77) Congenital bleeding disorders (98) Cancer pain drugs (99)	Minimum hysterectomy stays (01) Pharmacists (01) Lymphedema (03)
Vermont	Domestic partners (01)	
Washington	Neurodevelopment therapy (89)	Denturists (01)

Notes: The date refers to year enacted or significantly revised.
+ Indicates that the mandate only has to be offered to groups and/or individuals at their option, as opposed to a mandated requirement

 Source: Blue Cross and Blue Shield Association, December 2005

APPENDIX VIII

TEXAS EDUCATION AGENCY

1701 North Congress Ave. ★ Austin, Texas 78701-1494 ★ 512/463-9734 ★ FAX: 512/463-9838 ★ http://www.tea.state.tx.us

Shirley J. Neeley, Ed.D.
Commissioner

Action Required

October 27, 2006

Subject: Survey of School District Expenditures under Executive Order RP47

TO THE ADMINISTRATOR ADDRESSED:

The Texas Education Agency (TEA) is required to collect data from all school districts pursuant to Executive Order RP47 dated August 22, 2005. The financial accountability and reporting system now includes a requirement for clear and concise accounting of school district expenditures, including amounts expended on the following:

- Dues or contributions to a non-instructional club, committee, or organization
- Funds provided to any person or organization for the purpose of lobbying
- Funds expended for consulting services, media, and public relations services
- Funds expended for legal services, including legal fees spent on lawsuits against the state

A copy of the Executive Order is available at

http://www.governor.state.tx.us/divisions/press/exorders/rp47

The survey form is accessible at

http://landry.tea.state.tx.us/TEA_Survey/Audits/Expend_ExecOrder_RP47.htm

Actual expenditures are being collected for the 2005 and 2006 fiscal year (September 1, 2004 through August 31, 2006 or July 1, 2004 through June 30, 2006). Please note that the school will be contacted annually for updated information by survey unless the agency incorporates these expenditures into the PEIMS Data Standards.

The survey is to be completed on or before November 30, 2006. If you have any questions about this request, please call Janice Hollingsworth or Rita Chase in the TEA's Division of Financial Audits at (512) 463-9095.

Sincerely,

Adrián Johnson, Ed.D.
Associate Commissioner
School District Services

"Good, Better, Best–never let it rest–until your good is better–and your better is BEST!"

School District Expenditures under Executive Order RP47

1. GENERAL INSTRUCTIONS

2. Report actual costs for the twelve-month period September 1, 2004 through August 31, 2006 or July 1, 2004 through June 30, 2006 (report on the district's fiscal year end for the annual audit report submitted). Use all funds excluding 865, agency funds.

3. Maintain supporting documentation for the amounts provided.

4. Do not enter cents -- round to the nearest dollar.

5. See TO THE ADMINISTRATOR ADDRESSED letter dated October 27, 2006 for additional information.

6. Enter Six-Digit County District Number

7. Enter School District Name

8. Contact Person Name

9. Contact Person Phone Number

10. Questions 11 through 20 should be answered for the twelve-month period September 1, 2004 through August 31, 2005 or July 1, 2004 through June 30, 2005 depending on the district's fiscal year end

11. Dues or contributions to a non-instructional club, committee, or organization (exclude training costs, function 11)

12. Funds provided to any person or organization for the purpose of lobbying

13. Funds expended for consulting services (financial, curriculum, ESC, etc.)

14. Funds expended for media services (advertising, etc. - excludes school library-related functional activities)

15. Funds expended for public relations services (communications, press releases, etc. - include employee and outsourced)

16. Funds expended for legal services for employment issues (contract disputes, personnel issues, etc.)

17. Funds expended for legal services for purchasing/vendor issues (contract disputes, etc.)

18. Funds expended for legal services for state funding issues (including school finance related litigation)

19. Funds expended for legal services for student issues (special education, discipline, etc.)

20. Funds expended for legal services for other issues (all other not identified above)

21. Questions 22 through 31 should be answered for the twelve-month period September 1, 2005 through August 31, 2006 or July 1, 2005 through June 30, 2006 depending on the district's fiscal year end

22. Do the expenditures for fiscal year 2006 represent final audited numbers?

- ○ Yes
- ○ No

23. Dues or contributions to a non-instructional club, committee, or organization (exclude training costs, function 11)

24. Funds provided to any person or organization for the purpose of lobbying

25. Funds expended for consulting services (financial, curriculum, ESC, etc.)

26. Funds expended for media services (advertising, etc. - excludes school library-related functional activities)

27. Funds expended for public relations services (communications, press releases, etc. - include employee and outsourced)

28. Funds expended for legal services for employment issues (contract disputes, personnel issues, etc.)

29. Funds expended for legal services for purchasing/vendor issues (contract disputes, etc.)

30. Funds expended for legal services for state funding issues (including school finance related litigation)

31. Funds expended for legal services for student issues (special education, discipline, etc.)

32. Funds expended for legal services for other issues (all other not identified above)

Additional Comments:

Click Here to Send Information

Return to the Home Page, without sending answers.

APPENDIX XI

M E M O R A N D U M

TO: Senate Committee on State Affairs

FROM: Krissie Farmer
Legislative Counsel

DATE: September 29, 2006

SUBJECT: Applicability of Chapter 84, Civil Practice and Remedies Code (the Charitable Immunity and Liability Act of 1987), to a Private Nonprofit Independent Administrator

INTRODUCTION

Chapter 45, Human Resources Code, provides for the privatization of certain child and family welfare services administered by the Department of Family and Protective Services by September 1, 2011.[271] Specifically, Chapter 45 authorizes the department to contract with regional competitively procured independent agencies, referred to as independent administrators, for the management, procurement, and oversight of substitute care services[272] and case management services.[273] At issue is whether Chapter 84, Civil Practice and Remedies Code (the Charitable Immunity and Liability Act of 1987), applies to a nonprofit organization fulfilling the role of an independent administrator. Also addressed are other considerations relevant to the topic of nonprofit liability.

SUMMARY

If the nonprofit organization fulfilling the role of the independent administrator obtains the requisite insurance, does not otherwise fall within any of the other exceptions or limitations contained in Section 84.007, Civil Practice and Remedies Code, and meets the definition of "charitable organization" contained in Chapter 84, Civil Practice and Remedies Code, it is likely that the nonprofit independent administrator will enjoy limited liability under Chapter 84.

---

[271] Section 45.054, Human Resources Code.
[272] "Substitute care services" is defined in Section 45.001(13), Human Resources Code.
[273] Section 45.004, Human Resources Code. "Case management services" is defined in Section 45.001(1), Human Resources Code.

However, the determination is ultimately based on the resolution of certain questions of fact pertaining to the specific nonprofit organization contracted to be an independent administrator.

DISCUSSION

I. Chapter 84: The Charitable Immunity and Liability Act of 1987

Generally, Chapter 84, Civil Practice and Remedies Code, limits the liability of charitable organizations and their employees,[274] and provides almost total immunity to charitable organization volunteers.[275] In enacting Chapter 84, the 70th Legislature indicated that it did so in response to two concerns: (1) waning volunteerism and (2) the difficulty charitable organizations faced in obtaining affordable liability insurance.[276]

With respect to charitable organizations, Section 84.006, Civil Practice and Remedies Code, limits money damages for any act or omission by the organization or its employees or volunteers to a maximum of $500,000 for each person, $1,000,000 for each single occurrence of bodily injury or death, and $100,000 for each single occurrence for injury to or destruction of property. To enjoy this immunity, however, an organization must satisfy the requirements of Section 84.007, Civil Practice and Remedies Code. For example, to qualify for the immunity, an organization must carry the requisite amount of liability insurance.[277] Additionally, Section 84.007 establishes several exceptions to the circumstances in which the immunity applies. In particular, immunity does not apply to any act or omission that is "intentional, wilfully negligent, or done with conscious indifference or reckless disregard for the safety of others."[278] Section 84.007 lists additional exceptions and limitations to Chapter 84 that, while not necessarily applicable to the situation at hand, should be reviewed. (See Appendix A.)

---

[274] *See* Sections 84.005 and 84.006, Civil Practice and Remedies Code.
[275] *See* Section 84.004, Civil Practice and Remedies Code. Note the exception for liability in relation to the operation or use of any motor-driven equipment.
[276] *See* Section 84.002, Civil Practice and Remedies Code.
[277] Section 84.007(g), Civil Practice and Remedies Code, which provides, "Sections 84.005 and 84.006 of this Act do not apply to any charitable organization that does not have liability insurance coverage in effect on any act or omission to which this chapter applies. The coverage shall apply to the acts or omissions of the organization and its employees and volunteers and be in the amount of at least $500,000 for each person and $1,000,000 for each single occurrence for death or bodily injury and $100,000 for each single occurrence for injury to or destruction of property. The coverage may be provided under a contract of insurance or other plan of insurance authorized by statute and may be satisfied by the purchase of a $1,000,000 bodily injury and property damage combined single limit policy. Nothing in this chapter shall limit liability of any insurer or insurance plan in an action under Chapter 21, Insurance Code, or in an action for bad faith conduct, breach of fiduciary duty, or negligent failure to settle a claim."
[278] Section 84.007(a), Civil Practice and Remedies Code.

Provided the organization is otherwise entitled to immunity under Section 84.007, to qualify for the immunity, an organization fulfilling the role of the independent administrator must meet the definition of "charitable organization" contained in Chapter 84.[279]

A. Definition: "Charitable Organization"

Section 84.003(1), Civil Practice and Remedies Code, defines "charitable organization." Of the definitions given, two, listed in Sections 84.003(1)(A) and (B), are relevant to this discussion. It is important to note that there is substantial overlap between the two definitions. The primary difference between the two definitions is that Section 84.003(1)(A) is limited to certain organizations exempt from federal income tax under Section 501(c)(3) or 501(c)(4), Internal Revenue Code of 1986, while Section 84.003(1)(B) encompasses other "bona fide" charitable organizations.

1. Section 84.003(1)(A): Sections 501(c)(3) and 501(c)(4) Exempt Organizations

Under Section 84.003(1)(A), Civil Practice and Remedies Code, an organization exempt from federal income tax under Section 501(c)(3)[280] or 501(c)(4),[281] Internal Revenue Code of 1986, is considered a "charitable organization" provided (a) it is a nonprofit corporation, foundation, community chest, or fund, *and* (b) it is organized and operated *exclusively* for (1) charitable, (2) religious, (3) prevention of cruelty to children or animals, (4) youth sports and youth recreational, (5) neighborhood crime prevention or patrol, (6) fire protection or prevention, (7) emergency medical or hazardous material response services, or (8) educational purposes, or is organized and operated *exclusively* for the promotion of social welfare by being primarily engaged in promoting the common good and general welfare of the people in a community.

---

[279] *See* Section 84.003(1), Civil Practice and Remedies Code.

[280] Section 501(c)(3), Internal Revenue Code of 1986, lists as exempt organizations "Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office."

[281] Section 501(c)(4), Internal Revenue Code of 1986, lists as exempt organizations "Civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare, or local associations of employees, the membership of which is limited to the employees of a designated person or persons in a particular municipality, and the net earnings of which are devoted exclusively to charitable, educational, or recreational purposes." However, the exemption shall not apply to an entity "unless no part of the net earnings of such entity inures to the benefit of any private shareholder or individual."

Although the description contained in Sections 501(c)(3) and 501(c)(4) considerably parallels the purposes listed above in Section 84.003(1)(A), it is unclear whether an independent administrator that holds the Section 501(c)(3) or 501(c)(4) designation would, solely because it holds that designation, satisfy the definition of "charitable organization" found in Section 84.003(1)(A). By providing the designation, the Internal Revenue Service has determined, at least for federal income tax purposes, that the entity is a charitable organization. It would be reasonable, therefore, to find that a Section 501(c)(3) or 501(c)(4) designation is sufficient to satisfy the definition of "charitable organization" found in Section 84.003(1)(A). However, there is no case law on this subject. As a result, a Section 501(c)(3) or 501(c)(4) organization acting as independent administrator would be well advised to be certain that it fits within the entire definition set forth in Section 84.003(1)(A).

The definition requires an entity be either (1) organized and operated *exclusively* for one of the listed purposes or (2) organized and operated *exclusively* for the promotion of social welfare. Use of the term "exclusively" could be troublesome for an organization with multiple purposes if one of the purposes of the organization does not fit within the definition.

Also note that Chapter 84 does not define key terms such as "charitable purpose" or the "promotion of social welfare." The Office of the Attorney General of Texas, in its opinions on the subject, has attempted to define these terms in reference to other types of organizations.

Charitable Purpose

In determining whether the American Legion, Department of Texas, is a charitable organization for purposes of Chapter 84, the attorney general, in Tex. Att'y Gen. LO-98 (1997), cited Section 2(2)(A) of the Charitable Raffle Enabling Act (Article 179f, Vernon's Texas Civil Statutes),[282] which defines "charitable purpose" as:

> . . . benefitting needy or deserving persons in this state, indefinite in number, by enhancing their opportunities for religious or educational advancement, relieving them from disease, suffering, or distress, contributing to their physical well-being, assisting them in establishing themselves in life as worthy and useful citizens, or increasing their comprehension of and devotion to the principles on which this nation was founded and enhancing their loyalty to their government.

The attorney general, however, noted that the Charitable Raffle Enabling Act is only persuasive authority.

[282] The Charitable Raffle Enabling Act was codified in 1999 as Chapter 2002, Occupations Code.

Promotion of Social Welfare

The attorney general, in Op. Tex. Att'y Gen. No. JM-1257 (1990), determined that an organization that promotes social welfare is one "that provides services to individuals who are in need of them."

2. Section 84.003(1)(B): "Bona Fide" Charitable Organization

Under Section 84.003(1)(B), Civil Practice and Remedies Code, the term "charitable organization" includes any bona fide (1) charitable, (2) religious, (3) prevention of cruelty to children or animals, (4) youth sports and youth recreational, (5) neighborhood crime prevention or patrol, or (6) educational organization, excluding fraternities, sororities, and secret societies, or (7) other organization organized and operated *exclusively* for the promotion of social welfare by being primarily engaged in promoting the common good and general welfare of the people in a community, but only if the organization:

> (i) is organized and operated *exclusively* for one or more of the above purposes;
>
> (ii) does not engage in activities which in themselves are not in furtherance of the purpose or purposes;
>
> (iii) does not directly or indirectly participate or intervene in any political campaign on behalf of or in opposition to any candidate for public office;
>
> (iv) dedicates its assets to achieving the stated purpose or purposes of the organization;
>
> (v) does not allow any part of its net assets on dissolution of the organization to inure to the benefit of any group, shareholder, or individual; *and*
>
> (vi) normally receives more than one-third of its support in any year from private or public gifts, grants, contributions, or membership fees. (Emphasis added.)

Like its counterpart in Section 84.003(1)(A), the definition of "'bona fide' charitable organization" contained in Section 84.003(1)(B) applies to those entities organized and operated exclusively for one of the listed purposes or the promotion of social welfare. This definition also includes an organization that has a "charitable purpose" or that is organized for the "promotion of social welfare." Consequently, the discussion of these subjects above is equally applicable.

II. Nonprofit Independent Administrator as a Charitable Organization

An independent administrator is defined in Section 45.001(6), Human Resources Code, as follows:

> "Independent administrator" means an independent agency selected through a competitive procurement process to:
>
> (A) secure, coordinate, and manage substitute care services and case management services in a geographically designated area of the state; and
>
> (B) ensure continuity of care for a child referred to the administrator by the department and the child's family from the day a child enters the child protective services system until the child leaves the system.

There are some characteristics contained in both definitions of "charitable organization" that would appear to apply to a nonprofit entity assuming the role of an independent administrator. For example, each definition encompasses organizations formed for charitable, religious, or the prevention of cruelty to children purposes. Additionally, both definitions contain a catch-all provision for entities organized and operated for the "promotion of social welfare by being primarily engaged in promoting the common good and general welfare of the people in the community."

However, there is no requirement in Chapter 45, Human Resources Code, that an independent administrator be a nonprofit organization or otherwise meet the definition of "charitable organization" contained in Chapter 84, Civil Practice and Remedies Code. Further, as of the date of this memorandum, the department had not procured an independent administrator.[283] As a result, it is not possible to compare the characteristics of an existing nonprofit independent administrator to the requirements of Chapter 84. Under both definitions of "charitable organization" discussed above, an entity must be organized and operated *exclusively* for one of the listed purposes or for the promotion of social welfare. The purposes of a nonprofit are, therefore, a crucial fact required to conduct an evaluation. Consequently, the ultimate determination of whether the nonprofit organization fulfilling the role of an independent administrator is a "charitable organization" is one specific to the particular nonprofit entity.

Attachment

[283] Currently, the department is in the process of choosing an independent administrator for Region 8 (a 28-county region that includes San Antonio), the first region of the state to begin the transition. On May 1, 2006, the department issued a Request for Proposal for Outsourcing the Region 8 Independent Administrator. By September 30, 2006, the department plans to make a tentative award of the independent administrator contract. See the Department of Family and Protective Services website at www.dfps.state.tx.us/About/Outsourcing/News.html.