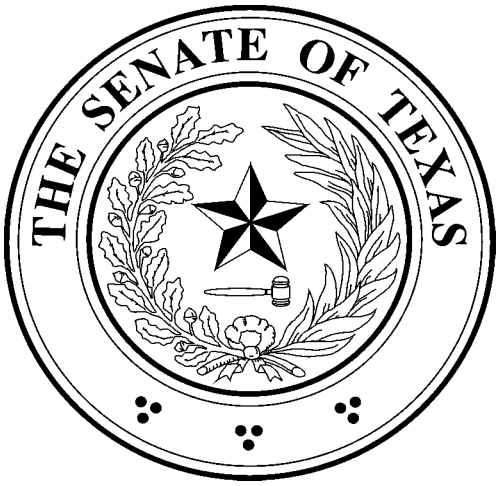
Senate Committee on State Affairs

Interim Report
to the
82nd Legislature



December 2010

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December 11, 2011

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

Dear Lieutenant Governor Dewhurst and Fellow Members:

The Committee on State Affairs of the Eighty-First Legislature hereby submits its interim report including findings and recommendations for consideration by the Eighty-Second Legislature.

Respectfully submitted,

Senator Robert Duncan, Chair

Senator Robert Deuell, Vice-Chair

Senator John Carona

Senator Rodney Ellis

Senator Troy Fraser

Senator Chris Harris

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P.O. Box 12068 • Room 380, Sam Houston Building • Austin, Texas 78711
(512) 463-0380 • FAX (512) 463-0342 • Dial 711 for Relay Calls

CHRIS HARRIS
District 9

The Senate of
The State of Texas
Austin 78711

2001 EAST LAMAR BLVD.
SUITE 150
ARLINGTON, TEXAS 76006
(817) 461-9109
FAX (817) 469-9652

522 SOUTH EDMONDS
SUITE 200
LEWISVILLE, TEXAS 75067
(972) 436-1001
FAX (972) 436-9829

CAPITOL STATION
P.O. BOX 12068
AUSTIN, TEXAS 78711
(512) 463-0109
FAX (512) 463-7003

DIAL 711 FOR RELAY CALLS

January 12, 2011

The Honorable Robert Duncan
Senate Committee on State Affairs
P.O. Box 12068
Austin, Texas 78711-2068

Dear Chairman Duncan,

Thank you for your dedication and leadership as Chair of the Senate Committee on State Affairs. The committee considered many issues over the interim that are vital to Texas. The 82nd interim report clearly displays the hard work of yourself and your staff. Your diligence and vision is undoubtedly seen in this report.

I am signing the report, but feel the need to clarify that I am not in support of all of the recommendations the committee will publish in this report. However, I sincerely look forward to working with you on these and many other important issues in the upcoming legislative session.

Thank you again for this opportunity to provide input on the committee's interim report. Please do not hesitate to contact me if you have any question.

Regards,

Chris Harris

Chris Harris

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Interim Charges

1. Upon passage of federal legislation relating to reform of the health care industry and health insurance industry, study the implications of such legislation on Texas, the health care industry, and public and private insurance. Study and monitor the implementation of the insurance regulatory changes, changes to high risk pool, and any other insurance mandates. Study the health care policy changes and the impact to the Medicaid and CHIP programs and the state budget. Assess the impact to all state uninsured and uncompensated care programs and county programs for the uninsured, including county property tax programs to pay for the uninsured. Make recommendations for the efficient implementation of programs. (Joint charge with Senate Health and Human Services Committee)

2. Monitor the actuarial and financial conditions of the pension and health care programs administered by the Teacher Retirement System and the Employees Retirement System. Assess the effectiveness of pilot programs designed to encourage the use of clinical integration, payments for good outcomes, use of best practices, focus on wellness and prevention, and bundling of costs for episodes of care, and other health care savings initiatives. Make recommendations for expanding the pilot programs for use across all private and state sponsored health care, including the Medicaid program, as a means to improve Texans' health and provide more effective care that allows for assistance for the uninsured. (SB 7, SB 8 and SB 10, 81st Legislature)

3. Study the implementation of the Healthy Texas program enacted by the 81st Legislature and the ongoing implementation of SB 1731, 80th Legislature, to determine if this program is effectively lowering health insurance costs and increasing access to health insurance for small business. Study and make recommendations about using this program to increase access to health insurance for sole proprietors. Review other states' efforts to lower health care costs to small business owners and sole proprietors and incentivize small business owners and sole proprietors to purchase insurance.

4. Examine best practices for increasing the affordability and availability of health insurance in the individual and small group market, including medical underwriting practices, rescission of coverage, cancellation of coverage, rate regulation, and reporting of medical loss ratios.

5. Study how increased out-of-pocket costs for medications and treatment impact consumers' compliance with health care recommendations and how that response impacts overall health care costs. Review available research into value design programs.

6. Study ways to improve the efficiency and accuracy of voter registration rolls, including the feasibility and security of online registration and automatic registration and the accuracy of verification and purging of voters. Recommend ways to ensure that deceased or otherwise ineligible voters are not included on rolls while also ensuring that all eligible applicants are efficiently registered.

7. Study the transparency of organizational structures, policies and coverage associated with health insurance underwriters/agents and the relationship between underwriters/agents and policyholders.

8. Study the sale of annuities in Texas, particularly to seniors. Evaluate the requirements relating to rescission of an annuity contract, payment of surrender fees, return of money, contract forms, including a standard contract form, buyer's guide, agent's commission and disclosure of an agent's commission. Make recommendations for legislation, if needed, and consider whether the insurance commissioner by rule may limit an agent's commission.

9. Study the effect Texas hospital billing and collection practices have on the uninsured's and under-insured's access to hospital health care services, on the uninsured's and under-insured's economic circumstances, and on medical debt recorded as bad debt on hospital books and records. Assess whether hospital billing disparities involving pricing discounts between the uninsured and insured exist and make recommendations for any changes necessary.

10. Study the adequacy of workers' compensation benefits in the following categories: lifetime income benefits, wage benefits for the high wage earner, and workers whose wage benefits stop before Social Security benefits begin. In order to determine the impact of increased benefits in one or more of these categories, work with the Texas Department of Insurance to develop a publicly accessible model to predict the costs related to those enhanced benefits, the effect of those costs on workers' compensation premiums, and whether enrollment in the workers' compensation system will be adversely impacted by increasing the benefits in one or more of the stated categories.

11. Study whether subrogation claims by writers of workers' compensation policies should be limited or prohibited. Study the effect on workers' compensation premiums, if any, if subrogation claims by writers of workers' compensation policies are limited or prohibited. Consider the feasibility of developing a publicly accessible model to predict the impact on workers' compensation premiums, if any, if subrogation claims by writers of workers' compensation policies are limited or prohibited, while protecting confidentiality as required by law and study whether the impact on workers' compensation premiums, if any, would adversely impact enrollment in the workers' compensation system.

12. Study and make recommendations regarding access to voting by members of the military serving in the United States and abroad, including the feasibility of electronic delivery of ballots.

13. Study the Public Information Act and the Open Meetings Act to ensure that government continues to operate in a way that is open and transparent. The study should consider how advances in technology and the emergence of various forms of social media (e.g. Facebook, MySpace, Twitter) have affected communications by and within governmental bodies.

14. Monitor the implementation of legislation addressed by the Senate Committee on State Affairs, 81st Legislature, Regular and Called Sessions, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation.

Senate Committee on State Affairs Interim Hearings

February 23, 2010, Room E1.036
The Committee received invited and public testimony on Charge Nos. 7 and 8.

March 31, 2010, Room E1.030
The Committee received invited and public testimony on Charge No. 2.

March 31, 2010, Room E1.030
The Committee met jointly with the Senate Committee on Health & Human Services and received invited testimony on Charge No. 1.

May 11, 2010, Senate Chamber
The Committee received invited and public testimony on Charge Nos. 5 and 13.

July 14, 2010, Senate Chamber
The Committee received invited and public testimony on Charge Nos. 6 and 12.

August 17, 2010, Senate Chamber
The Committee received invited and public testimony on Charge Nos. 10 and 11.

September 22, 2010, Senate Chamber
The Committee received invited and public testimony on Charge Nos. 2 and 9.

November 15, 2010, Senate Chamber
The Committee received invited and public testimony on Charge Nos. 2 and 3.

November 23, 2010, Room E1.030
The Committee met jointly with the Senate Committee on Health & Human Services and received invited and public testimony on Charge No. 1.

Audio/Video recordings, minutes and witness lists for the above referenced hearings may be found online at: http://www.senate.state.tx.us/75r/senate/commit/c570/c570.htm

Interim Charge Discussions and Recommendations

Charge No. 1

Upon passage of federal legislation relating to reform of the health care industry and health insurance industry, study the implications of such legislation on Texas, the health care industry, and public and private insurance. Study and monitor the implementation of the insurance regulatory changes, changes to high risk pool, and any other insurance mandates. Study the health care policy changes and the impact to the Medicaid and CHIP programs and the state budget. Assess the impact to all state uninsured and uncompensated care programs and county programs for the uninsured, including county property tax programs to pay for the uninsured. Make recommendations for the efficient implementation of programs. (Joint charge with Senate Health and Human Services Committee)

See Joint Report of Senate State Affairs Committee and Senate Health and Human Services Committee under separate cover.

Charge No. 2

Monitor the actuarial and financial conditions of the pension and health care programs administered by the Teacher Retirement System and the Employees Retirement System. Assess the effectiveness of pilot programs designed to encourage the use of clinical integration, payments for good outcomes, use of best practices, focus on wellness and prevention, and bundling of costs for episodes of care, and other health care savings initiatives. Make recommendations for expanding the pilot programs for use across all private and state sponsored health care, including the Medicaid program, as a means to improve Texans' health and provide more effective care that allows for assistance for the uninsured. (SB 7, SB 8 and SB 10, 81st Legislature)

Actuarial and Financial Conditions of Pension and Health Care Programs

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 the Department of Public Safety, Texas Alcoholic Beverage Commission, Texas Department of Parks & Wildlife, Texas Facilities Commission, as well as certain custodial and parole officers employed by the Texas Department of Criminal Justice. 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.

On November 15, 2010, ERS presented a summary of the actuarial valuations for each of these funds to the Committee.[1] This report may be found on the Committee's website at: http://www.senate.state.tx.us/75r/senate/commit/c570/handouts10/h111510a.htm. In addition a full copy of the actuarial valuation may be found on the ERS website at: http://www.ers.state.tx.us/news/reports/av_2010.aspx.

ERS Trust Fund

As of August 31, 2010, the market value of the ERS Trust Fund was $19.58 billion and it returned 6.7 percent for FY 2010. This return underperformed the actuarially assumed rate of return of 8.0 percent. While the 30-year rate of return for the fund is 8.54 percent, the return over the past decade has only been 3.42 percent. This is largely due to negative returns in 2001, 2002, 2008 and 2009. In five other years, however, the fund outperformed its assumed return.

To better adjust for the 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, 2010, the *actuarial* value of the pension fund was $23.5 billion.

Active employees also provide revenue to the pension fund. Pursuant to the enactment of H.B. 2559 (81st Session), the state employee contribution was raised in FY 2010 from 6 percent to 6.5 percent.[2] This increase was made contingent on a state contribution rate of at least the same level. Therefore, if at any time the State contributes at a rate below 6.5 percent, the state employee rate would be reduced accordingly.

The Constitution requires a state contribution of at least 6 percent of payroll, but not more than 10 percent. Last session, the Legislature ultimately funded a 6.95 percent contribution rate. This rate, along with the employee rate, more than covered the plan's normal or ongoing costs of 12.38 percent, but was well short of the 15.84 percent actuarially required contribution.

To determine the financial ability of the fund to cover both current and future benefits, ERS must consider 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 by changes made to state employee compensation, early retirement incentives, benefit adjustments, or modifications in the size of the state workforce.

There are 79,311 ERS annuitants. At an average age of 67.71 years old, these annuitants are receiving average monthly payments of $1,531. There are also 15,572 vested ERS members not currently employed by the State who have yet to retire.

For the most recent valuation, the fund continues to recognize unrealized losses that resulted from failure to meet market return projections in recent years. With a*ctuarially accrued liabilities* totaling $28.4 billion, and $23.5 billion in actuarial value of assets (as mentioned above), the result is an unfunded accrued liability of $4.78 billion or a funded ratio of 83.2

[1] Senate Committee on State Affairs hearing, Nov. 15, 2010 (testimony of Anne Fuelberg, Employees Retirement System of Texas).
[2] Acts 2009, 81st Leg., ch. 1308.

percent. The effect is a calculated actuarially sound contribution rate of 17.07 percent. An increase of 1.23 percent since the last valuation. This continues the "infinite" funding period the fund has experienced since 2001.

To address concerns arising from the unfunded accrued liabilities, the 81st Legislature enacted H.B. 2559. This legislation increased revenue through contribution enhancements and significantly reduced future liabilities by adjusting benefits for newly hired state employees. Specifically, the legislation increased the minimum retirement age to 65, adjusted the benefit calculation to consider an employee's highest 48 months of salary instead of the highest 6 months of salary and eliminated the use of sick leave to qualify for retirement under the rule of 80. Additionally, retirement/return-to-work opportunities were limited. This legislation resulted in an improvement in accrued liabilities by $448.5 million. Over the next several years, it will be important to carefully monitor these changes and their impact on the projected financial condition of the ERS Trust Fund.

It is important to note that the State of Texas is experiencing revenue shortfalls which will undoubtedly result in major budget reforms that may contemplate or include measures to reduce the state employee workforce. This was certainly an issue in the most recent shortfall occurring in 2003 (77th Legislature). To solve some of the State's budget problems at that time, agencies were encouraged, if not incented, to reduce workforce through retirement of senior employees who met eligibility requirements. While this is a tempting short-term budget maneuver, it can have a long-term catastrophic impact on the ERS pension fund. Unless contribution rates are increased sufficiently to offset the normal costs associated with a predicted spike in retirement, the pension fund cannot once again support this type of budget solution. In other words, the pension fund should not be a source of subsidy for the State's current budget shortfall.

Law Enforcement & Custodial Officer Supplemental Retirement Fund (LECOSRF)

Created in 1979 as a supplemental retirement benefit for ERS members who complete 20 or more years of service as commissioned law enforcement officers, LECOSRF currently provides supplemental benefits to 7,175 annuitants. The actuarial value of assets is just under $802.9 million. With accrued liabilities of $708.4 million, the fund currently has an unfunded liability of $163.7 million. The result is a funded ratio of 83.1 percent.

The fund has historically been financially well-positioned; however, major market losses have also taken their toll. Dramatic increases in the numbers of retirees have also created greater strain. Originally designed to be funded exclusively with vehicle registration and title fees, the 74th Legislature repealed this method of finance. Beginning in 2007, the State began contributing 1.59 percent of payroll to the fund, and last session H.B. 2559 established an employee contribution of 0.5 percent. The combined 2.09 percent contribution rate has been sufficient to cover the fund's normal costs of 2.07 percent; however it falls short of the calculated actuarially sound rate of 2.72 percent.

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 the Judicial Retirement System Plan I (JRS I). This pay-as-you-go plan is 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 2010, there were 22 active members. At that time, 447 retirees and their beneficiaries were receiving annuities. ERS has requested $54.5 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 the Judicial Retirement System Plan II (JRS II). With an actuarial value of assets at $264.5 million, and accrued liabilities totaling $281.8 million, the fund has unfunded accrued liabilities of $17.3 million. The result is a funded ration of 93.9 percent. This plan operates as a traditional, pre-funded annuity plan. As 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 2010-11 biennium the State has contributed 16.83 percent to cover normal costs. The 22.81 percent combined rate covered both the normal cost of 20.19 percent and the calculated actuarially sound rate of 21.68 percent. As of August 31, 2010, there were 539 active members; only 164 annuitants were receiving benefits at that time. ERS has requested $22.7 million for the next biennium in order to maintain the current contribution rate.

ERS-GBP

The Employees Retirement System Group Benefit Program (ERS-GBP) provides health insurance to state employees, retirees and their eligible dependents.[3] In 1993, the insurance programs for most Texas colleges and universities were merged into the ERS-GBP.[4] These higher education employees, spouses and dependents participate in the ERS-GBP through the Higher Education Group Insurance Program (HEGI).

Today, there are approximately 535,000 participants in the ERS administered health plan.[5] All participants receive access to the same benefits and coverage and are subject to the same contribution structure. The institutions of higher education, however, receive a sum certain appropriation and in recent years have received less money than necessary to fully cover their employer contribution obligations. In the current biennium, state institutions participating in HEGI received 97.5 percent of normal ERS-GBP contribution costs.

Currently, ERS-GBP offers two major options for health coverage. HealthSelect, a self-funded, point-of-service plan is by far the largest. With over 500,000 participants, this plan includes 94 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 Caremark.

The second option offered under ERS-GBP includes two regional Health Maintenance Organizations (HMOs). This coverage is provided through contracts with private HMOs. Current HMO providers are Community First Health Plans, Inc. and Scott & White Health Plan. Approximately 31,000, or 6 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.

[3] Acts 1975, 64th Leg., ch. 79.
[4] The University of Texas System and Texas A&M System were not provided the option to join. Today, those institutions continue to maintain and operate their own health insurance programs.
[5] State employees, spouses and dependents: 388,914; higher education institution employees, spouses and dependents: 145,791.

Funding needs for the ERS-GBP are calculated biennially by looking at anticipated claims costs and calculating what annual contribution levels will be necessary to cover those anticipated costs. With the State covering 100 percent of the cost of employee and retiree coverage and 50 percent of the cost of spouse and dependent coverage, funding requests are then estimated based on predicted participation in the program.

For the 2010-2011 biennium, ERS projected an increased need of 11.73 percent in annual funding to maintain the same level of benefits. This need included an anticipated 7.9 percent annual increase in cost and funding to cover allocations made from the contingency reserve fund in order to cover a funding shortfall from the previous biennium.

Despite this anticipated need, ERS was directed to discount their 2010-11 Legislative Appropriation Request (LAR) by using all but $50 million of their remaining $260 million reserve fund. The result was an adjusted funding request of 8.73 annually. Even at this funding level, ERS anticipated benefits could be maintained through the biennium.

Despite these projections, the 81st Legislature only provided a 6.5 percent increase in funding for FY 2010 and a 6.8 percent increase in FY 2011. At these funding levels, ERS anticipated complete depletion of its reserve fund and a need for modest benefit adjustments during FY 2011.

However, over the last half of FY 2009, the plan cost trend began to increase at an annual rate of 9.1 percent. This was over one percent higher than the expected 7.9 percent cost trend. The increase was attributable to an increase in the hospital benefit cost trend from 8.0 percent to 10.5 percent per year. The result was a projected funding shortfall for FY 2011 in excess of $250 million, leaving an expected contingency reserve fund deficit of about $154 million. In response, ERS began pursuing benefit design changes to eliminate the deficit by shifting additional cost to plan participants.

In May 2010, with a revised projected shortfall of $140.4 million, the ERS Board adopted plan design changes expected to generate plan savings of $143 to bridge the gap.[6] These changes were effective at the beginning of FY 2011.

As expected, total plan expenditures for FY 2010 ($2.35 billion) exceeded revenues ($2.2 billion) by $145.9 million, and projections for FY 2011 indicate that expenditures will outpace available revenue by approximately $120 million. These shortfalls, in conjunction with plan design changes and some provider contract renegotiations, should leave an $18.8 million reserve fund balance at the end of the current biennium.

As part of its 2012-13 LAR, ERS has projected a plan cost trend of 9.1 percent for FY 2012 and 8.89 percent for FY 2013. The base request calculation required by the Legislative Budget Board (LBB) utilizes an average of FY 2010 and FY 2011 expenditures instead of looking exclusively at the FY 2011 levels. The result is an embedded annual shortfall in the base request. In addition, the calculation required a five percent reduction. The total impact is a 2012-13 annual base request that is $90 million less than what the ERS-GBP will spend in 2011.

In addition to the base request, ERS projects that it will need the following additional funding to provide for (a) the normal health plan cost trend, (b) the projected cost increase

[6] *See* Appendix II.

attributable to federal health care reform, and (c) replacement of the funding supplements which will not be available from the contingency reserve fund in the next biennium.

Source	Requested Increase in Addition to Base Request for FY 2012-13 ($millions)
Increase Attributable to Normal Plan Cost Trend	$417.4
Increase Attributable to Federal Health Care Reform	$46.5
Replacement of Funding Supplements	$111.6
Total	**$575.5**

It should also be noted that the Insurance Code, Sec. 1551.21 requires ERS to maintain a contingency reserve fund equal to 60 days of claims payments. The ERS request for this item totals $311.2 million.

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. On November 15, 2010, TRS presented a summary of their actuarial valuations for their pension fund.[7] This report may be found on the Committee's website at: http://www.senate.state.tx.us/75r/senate/commit/c570/handouts10/h111510a.htm. Additionally, a full copy of the actuarial valuation may be found on the TRS website at: http://www.trs.state.tx.us/global.jsp?page_id=/about/actuarial_valuation_pension_fund.

As of August 31, 2010, the market value of the TRS pension fund was $95.69 billion and it returned 10.7 percent for FY 2010. This return outperformed the actuarially assumed rate of return of 8.0 percent. This follows two years during which the fund experienced negative growth losing $23.4 billion in market value.

To better adjust for peaks and valleys in investment return, TRS utilizes a 5-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, 2010, the *actuarial* value of the pension fund was $111.29 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 834,060 active members. Payroll for those members has increased annually an average of 5.32 percent over the past ten years. For FY 2010, payroll for active members increased 4.4 percent.

[7] Senate Committee on State Affairs hearing, Nov. 15, 2010 (testimony of Ronnie Jung, Teacher Retirement System of Texas).

The State is directed by the Texas Constitution to contribute at least 6 percent of payroll but not more than 10 percent. Last session, the Legislature ultimately raised the state contribution rate from 6.58 percent to 6.644 percent. This rate, along with the employee rate, more than covered the plan's normal or ongoing costs of 10.42 percent, but was short of the 14.17 percent actuarially required contribution.

Local employers (i.e. 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 beyond the state minimum salary scale. For FY 2010, local employers contributed $412.3 million to the trust fund while the State contributed $1.9 billion.

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. 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.

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 by 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 have averaged less than one percent over the past decade, the number of retired members has grown more aggressively. During that same period, TRS averaged around five percent net growth in annuitants. Today there are approximately 296,000 retired members; service retirees receive an average monthly payment of $1,863. There are also 61,502 vested TRS members not currently employed but who have yet to retire.

For the most recent valuation, the fund continued to recognize unrealized losses that resulted from failure to meet market return projections in recent years. With actuarially accrued liabilities totaling $134.2 billion, and $111.29 billion in actuarial value of assets (as mentioned above), the result is an unfunded accrued liability of $22.9 billion or a funded ratio of 82.9 percent. The effect is a calculated actuarially sound contribution rate of 14.17 percent. This continues the "infinite" funding period the fund has experienced since 2008.

Until a better mix of actuarial value of assets and actuarially accrued liabilities is achieved, the fund will continue in its current state. This could partially be accomplished through improved market returns over the next several years; however S.B. 1691 passed by the 79th Legislature made several modest adjustments to benefits thereby reducing the Unfunded

Actuarially Accrued Liability (UAAL) by $1.5 billion, and raising the State's contribution.[8] Over the next several years it will be important to continue to watch how all of these factors affect the projected financial needs of this fund.

TRS-Care & TRS-ActiveCare

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

TRS-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. TRS-Care is a self-funded program with Aetna currently administering medical benefits for the program and Caremark managing prescription drug benefits. In FY 2010 TRS-Care covered 205,000 lives and had total expenditures of $1,017 million.

TRS-Care offers participants three levels of coverage:

- TRS-Care 1 - a catastrophic plan with high deductibles;
- TRS-Care 2 - a comprehensive plan with a $1,000 deductible, $35 office visit co-pay, and managed pharmacy program; and
- TRS-Care 3 - a comprehensive plan with a $300 deductible, $25 office visit co-pay, and managed pharmacy program

TRS-Care 3 is the most popular program with approximately 147,000 participants; however enrollment in TRS-Care 2 has been steadily climbing since its redesign in 2005. Today there are approximately 30,500 participants in TRS-Care 2. Significant differences in claims costs per member exist between the programs. TRS-Care 3 records the highest claims cost per member. In 2010, average medical claims per non-Medicare TRS-Care 3 participant were $7,294 compared to $5,102 in TRS-Care 2.[9]

In general, claims costs for all programs have increased an average of 8.62 percent over the past five years. Total plan expenditures for FY 2010 totaled just over $1 billion. This was up 9.5 percent over expenditures in FY 2009. Recent increases have largely been driven by escalating hospital costs. Additionally, pharmacy costs, an aging/growing retiree population, and technology increases have contributed to the trend.

Funding for TRS-Care is primarily generated through contributions made by the state, local school districts, active teachers, and premiums paid by participating retirees.[10] State contributions comprised 27 percent of funding in FY 2010, with retiree premiums accounting for 32 percent. Active members contributed 17 percent of the revenue and school district

[8] Acts 2005, 79th Leg., ch. 1359.
[9] *See* Appendix II.
[10] Contribution rates for 2010-11 were: 1% of payroll - State; 0.55% of payroll - School Districts; 0.65% of salary - Active Employees. Premiums vary by coverage level chosen, years of service accrued and Medicare status.

contributions made up 15 percent. Medicare Part D subsidies and investment income accounted for the balance.[11]

Since 2006, revenues have exceeded expenditures in the program and as a result TRS-Care has accumulated a sizable fund balance. At the close of FY 2010, the TRS-Care fund balance was approximately $815 million. It is projected, however, that at current funding levels, expenditures will exceed revenues beginning in FY 2011. By FY 2014, it is expected that the program's fund balance will be completely exhausted.[12]

Although contributions made by the State, school districts and active employees have increased with payroll growth over the years, neither retiree premiums nor benefits have changed since the redesign of the program in 2005.

TRS-Active Care

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.[13] This self-funded program offers four coverage choices to participants: TRS-Active Care 1, TRS-Active Care 1 HD; TRS-Active Care 2 and TRS Active Care 3.[14] Benefit levels range from basic catastrophic to a comprehensive plan including prescription drug coverage. All of the plans' medical benefits are administered by Blue Cross with prescription drug benefits managed by Medco Health Solutions.

Of the 1,247 entities eligible to participate in TRS-Active Care, 1,107, or 88.8 percent, have joined. Current enrollment is approximately 414,000. Funding for the program is provided primarily through premiums for selected coverage. School districts are required to contribute at least $150 per month toward coverage, and the State provides an additional $75 per month. Participants cover any remaining amounts through premium payments.

With more affordable premiums, almost 75 percent of employees enrolled in TRS-Active Care 2 in 2010. This has driven significantly higher claims cost per employee in TRS-Care 3.

As with TRS-Care, significant differences in claims costs per employee exist between the programs. TRS-Active Care 3 records the highest claims cost per employee. In 2010, average claims per TRS-Active Care 3 employee were over $11,000 compared to approximately $6,000 in TRS-Active Care 2.[15]

In general, claims costs for all programs have increased an average of 6.4 percent over the past five years. Total plan expenditures for FY 2010 were approximately $1.4 billion. This was up 16 percent over expenditures in FY 2009. Recent increases have largely been driven by increased enrollment and escalating hospital costs. In addition, pharmacy costs and technology increases have contributed to the trend.

[11] *See* Appendix II.
[12] *See* Appendix II.
[13] Acts. 2001, 77th Leg., ch. 1419.
[14] *See* Appendix II.
[15] *See* Appendix II.

Health Care Savings Initiatives

Background

Much of the current health care system utilizes a payment methodology that is based on the quantity of services provided rather than the quality of those health care services. Quality-based payment methodologies are intended to realign reimbursement methodologies to support quality of care, rather than volume or quantity of care provided and provide incentives to appropriately control costs.[16] The 81st Legislature debated concepts related to these payment reforms in S.B. 7, S.B. 8 and S.B. 10.

Senate Bill 7

Although S.B. 7 in its entirety did not pass, some components were enacted by amendments to S.B. 203, S.B. 870 and H.B. 1218.[17] Refer to Appendix II for an implementation update of these provisions.

Senate Bill 8

According to the legislation's Background and Purpose:

> This legislation requires Texas Health Services Authority (THSA) to develop a statewide plan recommending improvements to the health care delivery system by ensuring health care providers have the tools they need to follow best practices. Specifically, THSA would develop and disseminate information about best practices and quality of care, develop recommendations to reduce administrative costs, study alternative payment methodologies that will reimburse health care providers based on quality rather than quantity, study payment incentives to increase access to primary care, and study payment incentives related to hospital and inpatient payments.

Although S.B. 8 did not pass and its provisions were not enacted by amendments to other pieces of legislation, the overarching concept of alternative payment methodologies is addressed in various health care programs and discussions around the state.

Senate Bill 10

As originally filed, S.B. 10 directed ERS and TRS to develop and implement pilot programs under which physicians and health care providers who provide services to certain employees would be compensated under an *alternative payment system*. This would include non-fee-for-service systems such as: a global payment system; an episode-based bundled payment system; a pay-for-performance payment system; or a blended payment system.

Although S.B. 10 did not ultimately pass, a provision was added to the Supplemental Appropriations Bill (H.B. 4586, SECTION 77) authorizing ERS to establish a pilot program to test alternative health care provider payment systems.[18] The language encouraged ERS to pursue

[16] Senate Committee on State Affairs hearing, Sept. 22, 2010 (testimony of Billy Millwee, Associate Commissioner, Medicaid and CHIP and Maureen Milligan, Deputy Director for Planning, Evaluation an Support, Health and Human Services Commission).
[17] Acts 2009, 81st Leg., ch. 724; Acts 2009, 81st Leg., ch. 1212; Acts 2009, 81st Leg., ch. 1120.
[18] Acts 2009, 81st Leg., ch. 1409

options that were based on nationally recognized quality of care standards and evidence-based best practices.

Employees Retirement System

For several years prior to the introduction of S.B. 10 or passage of H.B. 4586, ERS had been working with their third-party administrator to implement programs to help reduce plan costs while also increasing quality of care. Austin Pediatric Surgeons participated in a 12-month pay-for-performance program aimed at incenting providers to treat patients in lower cost settings. Historic cost trends were examined and new targeted benchmarks were established. As the group met or exceeded these benchmarks, the associated savings were shared between the provider group and the plan. Although the pilot was successful, all parties chose not to renew it. This was largely because additional savings became more difficult to attain as new lower target benchmarks were set.

One critical component not accounted for in the Austin Pediatric Surgeons pilot however, was *improved outcomes*. This was a key element of the program contemplated in S.B. 10 and the H.B. 4586 rider. Since the conclusion of the 81st Legislature, ERS has been pursuing provider groups to participate in a pilot where savings generated would be shared between the plan and provider group only if healthcare outcome targets were also met.

ERS has identified a number of provider groups interested in participating in this type of pilot and has been in active dialogue with each in hopes of bringing several on-line in early 2011.[19] Performance data on any of these pilots, however, will not be available until next interim.

Programs Implemented by the Health and Human Services Commission

The Health and Human Services Commission (HHSC) has explored or implemented various quality-based payment initiatives for the Medicaid program. Three quality initiatives within the Medicaid program have been implemented:[20]

- **Potentially Preventable Readmissions (PPR)** - House Bill 1218 (language originally from SB 7) defines a PPR as a return to hospitalization within a specified period that results from deficiency in care provided during a stay, or from deficiencies in discharge follow-up. High PPR rates at a hospital indicate opportunities for hospital quality improvement and indentify good candidates for care management after discharge. Hospital payments can then be adjusted based on their PPR rates as an indicator of the quality of care provided.

  HHSC is in the process of establishing state and hospital-specific PPR rates by disease condition and other variables. In January 2011, HHSC will start collecting PPR information from hospitals. Beginning in 2013, HHSC will implement a reimbursement system based on a new methodology that allows for the comparison of PPR rates by hospital service lines, individual physician performance and patient outcomes.

[19] *See* Appendix II.

[20] Senate Committee on State Affairs hearing, Sept. 22, 2010 (testimony of Billy Millwee, Associate Commissioner, Medicaid and CHIP and Maureen Milligan, Deputy Director for Planning, Evaluation an Support, Health and Human Services Commission).

- **Health Homes** - This quality initiative is focused on care for Medicaid children. These Health Home pilot projects will identify programs that use new and creative approaches to patient access, quality improvement, patient/family centeredness, coordinated care, team-based approach to care, population approach to care, and enhancing collaborative efforts among providers (especially in rural areas).[21]

  The goal of the Health Home pilot project is to increase access to care for children enrolled in Medicaid and increase the number of children receiving recommended primary medical and dental prevention services and any needed specialty and social support services, including behavioral health services. Additionally, the pilot programs must meet the goals in a cost-effective manner such that the innovations are sustainable over time and conducive to replication across the state.[22] HHSC will select up to eight, two-year pilot programs in the fall of 2010.

- **Health Maintenance Organization (HMO) Incentives** - HHSC has a two-part quality initiative to create initiatives for Medicaid HMOs.

  The *One Percent At-Risk* quality incentive program allows the state to withhold up to one percent of the premiums paid to any managed care organization (MCO) that fails to meet quality performance targets. When an MCO does not achieve their on-going, quality performance levels, HHSC adjusts their future monthly capitation payments.

  The *Quality Challenge Award* incentive program allows HHSC to reallocate the withheld premium funds to reward the MCOs that demonstrate superior clinical quality, service delivery, access to care and/or member satisfaction.

Programs Implemented at Federal Level

Quality initiative concepts have been addressed at the federal level in a variety of programs. Medicare has implemented outcome-based quality initiatives for their providers. Some of Medicare's more successful strategies include:[23]

- Utilizing nursing teams on the phone and in the field;
- Utilizing community health educators to connect beneficiaries with local resources;
- Utilizing nurses to coach patients after an acute hospitalizations; and
- Utilizing nurses for the coordination of delivery of actionable items to physicians.

HHSC has analyzed these Medicare program initiatives and established the following guidance for implementing successful quality-based initiatives:[24]

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[21] *HHSC Will Seek Health Home Pilot Proposals in 2010*, http://www.dshs.state.tx.us/thsteps/pdfdocs/Health%20Home%20Pilot%20Project%20Announcement.pdf.
[22] *Id.*
[23] Senate Committee on State Affairs hearing, Sept. 22, 2010 (testimony of Billy Millwee, Associate Commissioner, Medicaid and CHIP and Maureen Milligan, Deputy Director for Planning, Evaluation an Support, Health and Human Services Commission).
[24] *Id.*

- The program must be flexible but have rigorous evaluations to allow for rapid learning;
- The selection of beneficiaries for participation in the initiatives should focus on the at-risk population -- not those with already escalating illnesses;
- The initiatives should tie payments to the providers' outcomes, not tactics;
- The program should foster provider teams as active participants in the process; and
- The program must engage the beneficiaries in shared decision-making.

Additionally, the federal Patient Protection and Affordability Act (PPACA) contains language promoting the use of Accountable Care Organizations (ACO) in the Medicare program.[25] An ACO is a local health care organization and a related set of providers that can be held accountable for the cost and quality of all care delivered to a defined population.[26] This type of provider structure supports a patient-centered approach to care with integrated delivery systems and a quality-based payment structure that supports coordination between physicians, hospitals and other provider types within its organization.[27]

While ACOs and their concepts of care management are not new concepts, the focus on these types of programs in the federal legislation has brought the discussion of their organizational structure to the forefront. Concerns have been raised that these types of organizations could possibly violate federal anti-trust provisions. In October 2010, the Federal Trade Commission (FTC), Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services' Office of Inspector General held a stakeholder workshop to help identify possible strategies for creating "safe harbors" for some ACO model programs. To date, no new guidelines have been issued regarding these safe harbor policies.

Other state-level stakeholder concerns that should continue to be included in the ongoing discussion relate to whether the ACOs should be risk bearing entities and the requirements that go with that risk assumption, issues with fee-splitting and corporate practice of medicine prohibitions, and ensuring fairness across all providers in the ACO in the shared savings formulas.

Recommendations

The Committee makes no recommendations as to the actuarial and financial conditions of the State's pension and health care programs. With regard to health care savings initiatives, the Committee makes the following recommendations:

2.a. The Legislature and impacted state agencies should continue to pursue evidence-based, quality of care payment reform initiatives in the various, state-funded health plans.

[25] Patient Protection Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), *as amended* by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).
[26] Senate Committee on State Affairs hearing, Sept. 22, 2010 (testimony of Billy Millwee, Associate Commissioner, Medicaid and CHIP and Maureen Milligan, Deputy Director for Planning, Evaluation an Support, Health and Human Services Commission).
[27] *Id.*

2.b. The Legislature and impacted state agencies should continue to monitor the new pending regulation changes with the Federal Trade Commission (FTC), Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Human Services' Office of Inspector General regarding potential anti-trust safe harbor policies for Accountable Care Organizations and state-level issues raised by impacted stakeholders.

Charge No. 3

Study the implementation of the Healthy Texas program enacted by the 81st Legislature and the ongoing implementation of SB 1731, 80th Legislature, to determine if this program is effectively lowering health insurance costs and increasing access to health insurance for small business. Study and make recommendations about using this program to increase access to health insurance for sole proprietors. Review other states' efforts to lower health care costs to small business owners and sole proprietors and incentivize small business owners and sole proprietors to purchase insurance.

Implementation of Senate Bill 78, 81st Legislature - *Healthy Texas*

The concept of *Healthy Texas* is the result of a study conducted by the Texas Department of Insurance (TDI) in 2008 to investigate and develop recommendations for increasing small employer coverage in Texas. Texas is reported to have one of the highest uninsured rates in the nation and of those uninsured, most adults (69 percent) are employed.[28] Further, Texans employed by small firms (less than 100 employees) are more likely to be uninsured than those in larger firms.[29] Senate Bill 78, as adopted by the 81st Legislature, included language creating the *Healthy Texas* program at TDI.[30] *Healthy Texas* is a market-based, public/private insurance initiative within the small business market utilizing a reinsurance pool to reduce insurers' exposure to high-cost claims, lowering premium cost for enrollees. *Healthy Texas* is for small business owners who:

- employ between 2 and 50 employees;
- have not provided group insurance for the 12 months prior to a *Healthy Texas* application;
- have at least 30% of employees receiving annual wages at or below 300% of the Federal Poverty Level;
- pay at least 50% of the premium cost for employees; and
- have at least 60% of eligible employees elect to participate in the program.

Along with statutory authority creating *Healthy Texas*, the Legislature also appropriated $17.4 million per year for the Premium Stabilization Fund (PSF). The PSF covers 80 percent of all claims in the program between $5,000 and $75,000 with the private insurers covering all claims up to and following that set corridor. A reinsurance pool program model is based on the

[28] US Census Bureau, Current Population Survey (Texas Sample) (2008).
[29] *Report on Senate Bill 10, Section 25, 80th Legislature R.S., Healthy Texas Phase II Report*, Texas Department of Insurance at 2 (2009).
[30] Acts 2009, 81st Leg., Ch. 721.

concept that a small percentage of enrollees account for most health insurance claims and the reinsurance pool provides better predictability of the exposure to high cost claims for the insurers.[31] Reducing commercial insurers' responsibility for high-cost claims allows the insurers to lower premium amounts for the larger group with mostly lower cost claims.[32]

Implementation of the *Healthy Texas* program depended on input from a statewide group of stakeholders including providers, insurance carriers and HMOs, insurance agents, employers, local chambers of commerce across the state and various consumer organizations.[33] With stakeholder recommendations, TDI issued a Request for Proposals (RFP) for actuarial services and health plan participation.[34] From those RFPs two participating carriers (Celtic Insurance and United Healthcare) were competitively procured to provide plans for *Healthy Texas*.

In the Fall of 2010, TDI began holding informational events across the state to educate small employers about *Healthy Texas* and how to enroll.[35] Brochures have been developed in English and Spanish and a *Healthy Texas* website was launched for further outreach. Finally, TDI and *Healthy Texas* are working to educate health insurance agents on the available products.[36] Celtic Insurance began accepting applications October 1, 2010, with a November 1st effective date and currently, there are 17 groups enrolled, with a total of 31 enrollees. Additionally, 21 groups have applied and are close to completing the final enrollment process. United Healthcare will begin enrollment in December 2010.

All applicable components of the federal Patient Protection and Affordable Care Act (PPACA)[37] have been incorporated into the planning for *Healthy Texas* and an on-going evaluation of the role of *Healthy Texas* in light of the federal changes are being conducted by the program.[38]

Implementation of Senate Bill 1731, 80th Legislature

Senate Bill 1731, 80th Legislature, was an omnibus bill aimed at increasing transparency of the multiple facets of the health care arena -- health plans, physicians and hospitals.[39] Most components of the legislation were implemented in the interim immediately following its passage, however, three projects were not yet implemented at the time of the Senate Committee on State Affairs Interim Report to the 81st Legislature.[40]

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[31] *Id.*
[32] *Id.*
[33] *Id.* at 3-4 (2009).
[34] Senate Committee on State Affairs hearing, Nov. 14, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance).
[35] *Id.*
[36] *Id.*
[37] Patient Protection Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), *as amended* by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).
[38] Senate Committee on State Affairs hearing, Nov. 14, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance).
[39] Acts 2007, 80th Leg., ch. 997.
[40] Senate Committee on State Affairs Interim Report to the 81st Legislature at 36-39 (2008). http://www.senate.state.tx.us/75r/senate/commit/c570/c570.InterimReport80.pdf

Department of State Health Services

Collection of Outpatient Data

The Department of State Health Services (DSHS) was directed to expand their facility data collection to include outpatient data for hospitals and ambulatory surgical centers. Previously, DSHS only collected inpatient data from Texas facilities. Senate Bill 1731 directed the data collection expansion to "prioritize" the collection of radiological and surgical outpatient services and excluded emergency room services.

DSHS began collecting this data in the fourth quarter of 2009 and released the data in December of 2010.[41] In their first quarter of data collection, DSHS collected close to 2 million outpatient records.[42]

15 Most Frequent Outpatient Procedure Codes Reported[43]

- 357,451 Blood Count; complete (CBC)
- 279,174 Routine venipuncture
- 179,685 Electrocardiogram, tracing
- 176,933 Comprehensive metabolic panel
- 147,862 Injection ondansetron HCL per 1 mg
- 130,787 Emergency department visit
- 123,136 Basic metabolic panel
- 121,421 Computer algorithm analysis of digital image data for lesion detection; screening mammography
- 118,235 Chest x-ray
- 117,496 Injection fentanyl citrate 0.1 mg
- 116,013 Screening mammography, producing direct digital image, bilateral, all views
- 111,736 Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml
- 110,006 CT health/brain without dye
- 109,914 Therapeutic, prophylactic, or diagnostic injection
- 108,183 Urinalysis, auto without scope

15 Most Frequent Outpatient Principal Diagnosis Codes Reported[44]

- 200,348 Other screening mammogram
- 28,891 Colon screening for malignant neoplasms

[41] Senate Committee on State Affairs hearing, Nov. 14, 2010 (testimony of Sylvia Cook, Center for Health Statistics, Department of State Health Services).
[42] DSHS collects, on average, 750,000 records for inpatient data collection in the same period of time.
[43] Senate Committee on State Affairs hearing, Nov. 14, 2010 (testimony of Sylvia Cook, Center for Health Statistics, Department of State Health Services).
[44] *Id.*

- 25,793 Abdominal pain
- 23,695 Senile cataract nuclear sclerosis
- 23,355 Headache
- 20,415 Benign neoplasm of colon
- 20,198 Chest pain, unspecified
- 16,790 Lump or mass in breast
- 16,319 Chest pain, other
- 15,292 Thoracic or lumbosacral neuritis or radiculitis, unspecified
- 13,705 Coronary atherosclerosis of native coronary artery
- 13,138 Lumbago
- 12,692 Lumbar intervertebral disc without myelopathy
- 12,649 Lumbosacral spondylosis without myelopathy
- 12,423 Abnormal mammogram, unspecified

As the State continues to collect outpatient data, this data provides an opportunity to expand the State's scope of analysis of the various facilities in the state. For example, the State could report on the number of surgical procedures performed on an outpatient basis, regional variations in outpatient procedures performed, analysis on the shift of services from inpatient to outpatient facilities, or analysis of inpatient admission following outpatient procedures. This data can help better identify possible cost drivers and cost savings and compare various quality measures to better track the cost and utilization impact of these different health care delivery methods.

Texas Department of Insurance

Insurer Reimbursement Rate Reporting Requirements

The Texas Department of Insurance (TDI) was directed to implement a significant portion of S.B. 1731, two parts of which were new data collection projects. The first project was to collect reimbursement rates from health plans around the state. This provision of S.B. 1731 allowed TDI to adopt rules for a data call of aggregated reimbursement rates, by region, as a dollar amount.

Again, as the Legislature debates the rising cost of health care, the issue of cost versus charge is often discussed. Many times, health care costs are quoted in terms of "charges" rather than an actual cost or reimbursement rate. All health care providers have a chargemaster that serves as the price list for the services they provide. However, all stakeholders admit that the amounts listed on that chargemaster are not reflective of a true cost or a viable reimbursement rate by an insurer. Therefore, the only cost amount that policy makers are able to discuss is an inflated and rarely utilized number. The intent of this project was to create a report that would show a truer cost of health care for a list of common procedures.

Stakeholders were very helpful and involved in the rulemaking process for this data call. However, in the midst of the project, TDI discovered a significant barrier. Federal Health Insurance Portability and Accountability Act (HIPAA) standards require physicians to operate and bill under Current Procedural Terminology (CPT) codes. In order for TDI to publish the

data collected from this project in a means useful to the public, TDI would need to reference the CPT code and the corresponding common descriptor.

The CPT codes and their common descriptors are owned and copyrighted by the American Medical Association (AMA). When TDI approached the AMA regarding the use of the CPT codes and common descriptors, the AMA initially quoted a price that would have been prohibitive to the State. TDI and the AMA ultimately negotiated an agreement for limited permission to use CPT codes for this reporting project.[45] TDI was required to renegotiate with the AMA to address commenters' concerns with the originally drafted rule and the End Users Licensing Agreement. The final rule has been published and adoption is pending final action. Data will be reported annually with the first report from insurers due in January 2011 and publication of the rate data in March 2011.[46]

PPO and HMO Annual Report Requirements

Senate Bill 1731 established new reporting requirements for PPOs and HMOs. The goal of this provision was to align the PPO reported data with that of HMOs. Each are now required to report the following:

- Financial data
- Enrollment information

A Statement of:

- An evaluation of enrollee satisfaction
- An evaluation of quality of care
- Coverage areas
- Premium costs
- Plan costs
- Premium increases
- Range of benefits provided
- Co-payments and deductibles
- The accuracy and speed of claims payment
- Credentials of contracted physicians
- Number of providers

TDI met with stakeholders to identify potential data reporting options and terminology. TDI developed a draft rule to develop a web-based reporting system and interactive database for consumers.[47] The recent federal Patient Protection and Affordable Care Act (PPACA) requirements include reporting of similar data elements, however, many details are unknown pending publication of federal rules.[48] Requiring Texas insurance companies to comply with S.B. 1731 reporting requirements before the State has a full understanding of the federal

[45] Senate Committee on State Affairs hearing, Nov. 14, 2010 (testimony of Dianne Longley, Health Insurance Initiatives, Life, Health and Licensing, Texas Department of Insurance).
[46] *Id.*
[47] *Id.*
[48] *Id.*

requirements could create unnecessary administrative costs to insurers and duplication or conflict with the coming federal rules.[49] Due to this uncertainty with the federal rules, TDI has temporarily suspended the implementation of this portion of the S.B. 1731 reporting requirements.

Review of Other State Initiatives

See Appendix III for a review of other states' efforts to lower health care costs to small business owners and sole proprietors and incentivize small business owners and sole proprietors to purchase insurance.[50]

Charge No. 4

Examine best practices for increasing the affordability and availability of health insurance in the individual and small group market, including medical underwriting practices, rescission of coverage, cancellation of coverage, rate regulation, and reporting of medical loss ratios.

The issues contained in this charge are included in Sections 1001 and 1003 of the federal Patient Protection and Affordable Care Act (PPACA) signed into law March 23, 2010.[51]

Section 1001 of PPACA established new requirements for all health plans that impact medical underwriting practices, prohibit rescission, and set a minimum standard for medical loss ratios. PPACA § 1003 created new regulations that require the annual reporting and review of rate increases in premiums for all health plans.

The Senate Committee on State Affairs and the Senate Health and Human Services Committee are charged with monitoring the implementation of the federal legislation. Please see the joint report on Charge No. 1 for further information on the issues in this Charge.

Charge No. 5

Study how increased out-of-pocket costs for medications and treatment impact consumers' compliance with health care recommendations and how that response impacts overall health care costs. Review available research into value design programs.

Value Based Insurance Design

Employers often find it challenging to develop strategies that curtail the rising cost of healthcare while still aiming to maintain and improve their employees' health. As a cost cutting measure, many employers often raise out-of-pocket costs for medications, treatments and services. Concerns are raised that when a patient is faced with a high cost barrier to care they are

[49] *Id*.
[50] Senate Committee on State Affairs hearing, Nov. 14, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance).
[51] Affordable Care Act, Pub. L. No. 11-148, 124 Stat. 119 (Mar. 23, 2010) *as amended* by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

less likely to adhere to these treatment recommendations therefore experiencing an overall decline in health.

Value Based Insurance Design (VBID) is a concept purporting to curtail the problem of non-adherence while still containing healthcare costs. In a VBID program, a plan determines which healthcare services are medically valuable to its members and then applies "clinically sensitive" cost sharing. Clinically sensitive cost sharing means that the more beneficial or high value a service is for a patient, the lower the out-of-pocket costs.[52] For example, a company with a high number of employees who have diabetes could choose co-pays that are lower for those individuals to encourage them to obtain their diabetes treatment. Ideally, this type of cost sharing enables patients to utilize high-value services with the goal of minimizing more costly adverse health problems in the future that could occur if those medications or services are not accessed.[53]

Reducing the barriers to high value services is the core principal of Value Based Insurance Design. There are four basic approaches to designing a VBID-based program:[54]

- Design by service. Reduce or eliminate co-pays on certain drugs or services for all patients without any indication of whether they are being used.
- Design by condition. Reduce or eliminate co-pays for drugs or services based on a patient's specific clinical condition.
- Design by condition severity. Reduce or eliminate co-pays for high-risk members who are eligible to participate in a disease management program.
- Design by disease management participation. An extension of the design by condition severity approach with the addition of financial incentives.

Various employers have implemented VBID programs. Both Pitney Bowes and Marriott International, Inc. have adopted similar programs by waiving or reducing out-of-pocket costs for medications or services for those users who are diagnosed with diseases such as asthma, diabetes, hypertension or heart disease. The City of Asheville, N.C., through the Asheville Project, offers free medication and testing equipment to diabetics who attend educational seminars.[55] Other notable entities who have implemented VBID programs are IBM, Caterpillar, Inc., WellPoint, Inc., Mid-America Coalition on Health Care, Health Alliance Medical Plans, Inc., the City of Springfield, OR, and United Healthcare.[56]

VBID Implementation at the State Level

The Texas Department of State Health Services (DSHS) is currently in the second of a three year pilot project called the Value-Based Benefits Design project. The project is a component of the Cardiovascular Disease and Stroke Program and is funded through the Department's cooperative agreement with the Federal Centers for Disease Control. The goal of

[52] A. MARK FENDRICK, M.D., VALUE-BASED INSURANCE DESIGN LANDSCAPE DIGEST 4 (July 2009) (*see* Appendix V).
[53] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of A. Mark Fendrick, M.D., University of Michigan Center for Value-Based Design).
[54] FENDRICK, *supra* note 51.
[55] *Id.* at 7.
[56] *Id*. at 12-20.

the project is to help local health departments work with and inform local employers about incorporating VBID components in their health plans and provide technical assistance to those who have implemented VBID components.

DSHS subcontracted with the Austin/Travis County Health and Human Services Department and the San Antonio Metropolitan Health District to implement this project with ten public and private employers (five from each municipality). Participating employers are: National Instruments, Samsung, Dell, the City of Austin, Travis County, NuStar Energy, USAA Insurance Co., HEB, CPS Energy and San Antonio Water Systems.[57]

Several other states have implemented programs of their own based on VBID principals including Maine, Michigan, Wisconsin, Nebraska and Oregon.[58]

VBID at the Federal Level

Some concepts of VBID have been introduced at the federal level. Section 2713 (c) of the Patient Protection Affordable Care Act (PPACA) directs the Secretary of Health and Human Services to develop guidelines to allow health plans to use the concepts of Value-Based Insurance Design.[59] On July 19, 2010, a draft Interim Final Regulation implementing the preventive care requirements of the PPACA was published in the Federal Register.[60]

During the 111th Congress, Sen. Kay Bailey Hutchison introduced S.1040 or the Seniors' Medication Copayment Reduction Act of 2009. The bill directed the Secretary of Health and Human Services to establish a demonstration program to test VBID methodologies for Medicare beneficiaries with 15 different chronic conditions. The bill was referred to the Committee on Finance, but did not pass.[61]

Conclusion

These programs have merit in so far as they purport to reduce long term health care costs. However, the programs designed on investment in the short term may not be feasible given the budget issues facing employer-based and/or government-sponsored plans. Moreover, implementation of VBID programs should also include provider-based discounts or rebates for pharmaceutical products included in VBID programs.

[57] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of Rick Schwertfeger, Texas Department of State Health Services).
[58] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of A. Mark Fendrick, M.D, University of Michigan Center for Value-Based Insurance Design).
[59] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), *as amended by* the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).
[60] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41726 (2010) (to be codified at 45 C.F.R. Part 147) (proposed July 19, 2010).
[61] S. 1040, 11th Cong. (2009).

Charge No. 6

Study ways to improve the efficiency and accuracy of voter registration rolls, including the feasibility and security of online registration and automatic registration and the accuracy of verification and purging of voters. Recommend ways to ensure that deceased or otherwise ineligible voters are not included on rolls while also ensuring that all eligible applicants are efficiently registered.

Voter Registration Rolls

County Tax Assessor-Collectors and Election Administrators work with the Secretary of State's Office to maintain the state's voter registration rolls. The federal Help America Vote Act of 2002 (HAVA) mandated changes to state voter registration processes. Accordingly, the State maintains a statewide voter registration list through the Texas Election Administration Management (TEAM) system. Additional voter registration securities have been in place in Texas since 2006. Chief among these is the requirement that the Secretary of State verify a voter's identity prior to adding them to the statewide voter registration list.[62]

Because the State maintains the official list of registered voters, when a voter registers in a new county of residence, the Secretary of State automatically removes that voter from the rolls in their old county of residence. Additionally, county voter registrars are required to perform ongoing maintenance of the list as they receive notification of ineligibility due to death, mental incapacity, felony conviction, election contest, or citizenship status.[63] According to testimony received by the Committee, many counties have unique circumstances that affect their ability to maintain a completely accurate registration list.[64] Events affecting a voter's eligibility are often reported on a local level; therefore, local officials are trusted to implement state policies and keep the rolls as accurate as possible.

During the 81st legislative session, bills were filed in both houses to compress the process by which the voter registrar is notified by the county or district clerk when a potential juror returns their summons indicating they are not a U.S. citizen.[65] Currently, the clerk processing the summons notifies the voter registrar on a monthly basis and the registrar then notifies the voter and allows them 30 days to present proof of citizenship. If the voter fails to do so their registration is cancelled.[66] The filed legislation would have required automatic cancellation of the registration with a notice to the voter that they may re-register if they are in fact a U.S. citizen. Neither of the bills were adopted by the Legislature.

In addition to ongoing maintenance, the statewide voter registration list is purged on November 30th of even-numbered years in accordance with state and federal law.[67] In the event

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[62] TEX. ELEC. CODE ANN. § 13.002(c)(8) (Vernon 2010).
[63] *Id.* at §§ 13.001 (death), 16.002 (mental incapacity), 16.003 (felony conviction), 16.004 (election contest), 16.0332 (citizenship).
[64] For example, Cass County borders both Louisiana and Arkansas. Deaths often occur in these other states and there is no formal process for notification to the Cass County voter registrar. Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Becky Watson, Cass County Tax Assessor-Collector).
[65] S.B. 268, 81st Leg. (2009); H.B. 208, 81st Leg. (2009).
[66] TEX. ELEC. CODE ANN. § 16.0332 (Vernon 2010).
[67] 47 U.S.C. § 1973gg-6; TEX. ELEC. CODE ANN. § 16.032 (Vernon 2010).

a voter's registration is flagged as no longer residing in the county of registration or a voter registration certificate is returned, the voter is placed on the suspense list and will be removed from the rolls if two general elections have occurred since they were added to the suspense list and they failed to update their registration.[68]

Select voters may be placed on the suspense list if they have signed a Statement of Residence (SOR) at the polls because they have moved from the address listed in their voter registration application.[69] The Election Code instructs registrars to follow up on the SOR, correct addresses, and properly remove people from the suspense list.[70]

Agency-Based Voter Registration

Pursuant to the federal National Voter Registration Act of 1993 (NVRA), Texas has designated certain public assistance state agencies and agencies that provide services to the disabled to serve as voter registrars.[71] The designated agencies are the Health and Human Services Commission, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Department of State Health Services, the Department of Public Safety (DPS), each public library, each marriage license office, and any other agency or program as determine by the Secretary of State.[72] As a designated voter registration agency, each entity must select an Agency Coordinator, offer each person who applies for agency services the opportunity to register to vote, and provide the same degree of assistance with the completion of a voter registration application as if the person was completing agency paperwork (e.g. bilingual assistance).[73] Finally, other than DPS, the designated agencies must fill out a declination of voter registration form for each applicant choosing not to complete a voter registration form.[74]

During an interim hearing the Committee heard testimony from Jessica Gomez with Advocacy Inc. on the effectiveness of agency-based voter registration.[75] Ms. Gomez encouraged the State to adopt online voter registration through all designated agencies like that which is done by the DPS or "motor voter." Ms. Gomez asserted that having online registration by state agencies would increase the efficiency and accuracy of voter rolls and would be cost effective. Additionally, Ms. Gomez testified that there are not enough checks on the current agency-based voter registration system. Although the Secretary of State's Office is available to provide assistance, the agencies are left to their own devices to comply with the requirements of federal and state law.[76]

[68] TEX. ELEC. CODE ANN. §§ 15.081-.085 (Vernon 2010).
[69] *Id.* at. § 15.111.
[70] *Id.* at § 16.032; *see also* S.B. 438, 81st Leg. (2009); H.B. 1719, 81st Leg. (2009).
[71] National Voter Registration Act, Pub. L. No. 103-31, 107 Stat. 77 (May 20, 1993). *See* Appendix VI for Department of Justice NVRA Guidelines (July 2010).
[72] TEX. ELEC. CODE ANN. § 20.001 (Vernon 2010).
[73] *Id.* at §§ 20.004, 20.005.
[74] *Id.* at §§ 20.003, 20.036.
[75] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Jessica Gomez, Advocacy Inc.).
[76] *Id.*

Online Registration

Currently, nine states allow a person to register to vote online.[77] In Texas, the Secretary of State and several counties have long had voter registration materials available on their websites.[78] Voters may request paper voter registration materials or fill out a registration application online, print it out and mail it to their county's voter registrar. Additionally, a voter may register when applying for a driver license or personal identification card with DPS.[79] However, the state does not have one portal for complete, paperless online voter registration.

According to testimony received by the Committee, efficiency in the registration process is often complicated by the applicant (e.g. incomplete cards; illegible handwriting).[80] Additionally, when a registrar receives an application containing information that is similar to that of a registered voter they cannot assume that the two are duplicates (e.g. John Doe vs. Jonathan Doe).[81] These issues are addressed somewhat by the statewide TEAM system, but they would be addressed more efficiently with an online application system. However, human error will always be a part of the equation as long as there is a data entry component to the system.

One significant hurdle to an online system is the ability to obtain a signature from the voter. Currently, when a person registers to vote when they apply for a driver license, the driver license signature serves as the voter registration signature.[82] Absent another method for obtaining a signature, any online registration system would be limited to those persons with signatures in the Department of Public Safety's database; thus failing to expand online voter registration beyond the current system.[83]

Automatic Registration

The concept of automatic registration requires that the government automatically register every citizen to vote. Initiation of such a project would require culling through all government records to register all eligible citizens; afterwards the State would automatically register every citizen upon their 18th birthday. To date, no state has adopted automatic registration.[84]

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[77] According to information compiled by the National Conference of State Legislatures, online voter registration has been adopted by the following states: Arizona, California, Colorado, Indiana, Kansas, Louisiana, Oregon, Utah and Washington. http://www.ncsl.org/default.aspx?tabid=18421.

[78] *See* http://www.sos.state.tx.us/elections/voter/reqvr.shtml; http://www.hctax.net/voter/acquirevoterapp.aspx; http://www.traviscountytax.org/goVotersRegistration.do; http://www.co.lubbock.tx.us/Elec%20Admin/register.html; http://www.co.collin.tx.us/elections/voter_registration/voter_registration_application.jsp.

[79] TEX. ELEC. CODE ANN. § 20.0063 (Vernon 2010). Other agencies such as the Health and Human Services Commission assist citizens in the registration process, but none of them have an electronic method in place.

[80] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Becky Watson, Cass County Tax Assessor-Collector; Sharon Long, Bell County Tax Assessor-Collector; Jackie Callenen, Bexar County Elections Administrator).

[81] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Becky Watson, Cass County Tax Assessor-Collector).

[82] TEX. ELEC. CODE ANN. § 20.066(a)(2) (Vernon 2010).

[83] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Ann McGeehan, Secretary of State's Office; Becky Watson, Cass County Tax Assessor-Collector).

[84] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Ann McGeehan, Secretary of State's Office).

Recommendations

The integrity and accuracy of Texas' voter registration rolls should continue to be of utmost importance to the Legislature. To further this goal, the Committee recommends the following:

6.a. The Legislature consider amendments to streamline the process by which a voter claiming not to be a U.S. citizen in response to a jury summons is deemed ineligible to vote and is removed from the rolls, provided that proper safeguards need to be in place to ensure that otherwise eligible voters are not automatically removed from the rolls.

Charge No. 7

Study the transparency of organizational structures, policies and coverage associated with health insurance underwriters/agents and the relationship between underwriters/agents and policyholders.

Background

In response to the rising cost of health insurance, policy makers have researched and implemented increased transparency for the various stakeholders involved in the delivery of health insurance – from insurers to providers. These policies have focused on expanding disclosure to consumers regarding potential financial obligations and increasing data collection to help consumers make informed choices. To this point, it has been the goal for these changes to be shared equally by each impacted stakeholder group. No one single stakeholder group, insurers, providers, or policy holders, would be more or less a part of the solution. The responsibility for increased transparency and education belongs to all parties involved in the purchase and provision of health insurance services.

Key players in the health insurance market that have thus far not been included in the transparency discussion and policy changes are health insurance agents. Health insurance agents are a critical element in the health insurance marketplace operating as facilitators for the purchase of health insurance. Health insurance agents work in the individual, small and large group insurance markets. Agents assess the needs and health of their clients, research the market for products to meet the client's financial requirements and present their opinion on the best product for purchase.

Agents may operate under different employment and compensation agreements:[85]

- In House - salaried by one insurance company, may also earn commissions;
- Captive - sells products from one insurance company earning commission only; or
- Independent - sells for multiple insurance companies earning various commissions from the different insurance companies.

[85] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance).

The Texas Department of Insurance (TDI) is responsible for the licensure and regulation of agents in the state. In 2009, there were approximately 168,000 licensed life/health agents in Texas.[86] The initial licensure of an agent requires passing a test and completing a criminal background check with fingerprinting. Certain agents are required to complete additional training to sell specific products such as annuities, Medicare Advantage plans and small employer specialty certification.[87] In order to biennially renew their license, agents are required to complete 15 hours of continuing education each year.

TDI regulates a basic standard for agent behavior. The Department's licensure and regulatory division investigates and monitors if an agent:[88]

> (1) has willfully violated an insurance law of this state;
>
> (2) has intentionally made a material misstatement in the license application;
>
> (3) has obtained or attempted to obtain a license by fraud or misrepresentation;
>
> (4) has misappropriated, converted to the applicant's or license holder's own use, or illegally withheld money belonging to:
>
> (A) an insurer;
>
> (B) a health maintenance organization; or
>
> (C) an insured, enrollee, or beneficiary;
>
> (5) has engaged in fraudulent or dishonest acts or practices;
>
> (6) has materially misrepresented the terms and conditions of an insurance policy or contract, including a contract relating to membership in a health maintenance organization;
>
> (7) has made or issued, or caused to be made or issued, a statement misrepresenting or making incomplete comparisons regarding the terms or conditions of an insurance or annuity contract legally issued by an insurer or a membership issued by a health maintenance organization to induce the owner of the contract or membership to forfeit or surrender the contract or membership or allow it to lapse for the purpose of replacing the contract or membership with another;
>
> (8) has been convicted of a felony;
>
> (9) has offered or given a rebate of an insurance premium or commission to an insured or enrollee;
>
> (10) is not actively engaged in soliciting or writing insurance for the public generally as required by Section 4001.104(a); or
>
> (11) has obtained or attempted to obtain a license, not for the purpose of holding the applicant or license holder out to the general public as an agent, but primarily for the purpose of soliciting, negotiating, or procuring an insurance or annuity contract or membership covering:
>
> (A) the applicant or license holder;
>
> (B) a member of the applicant's or license holder's family; or

[86] *Id*.
[87] *Id*.
[88] TEX. INS. CODE ANN. § 4005.101(b) (Vernon 2009).

(C) a business associate of the applicant or license holder.

On average, there are approximately 1,000 complaints against life/health agents per year.[89] According to TDI, in fiscal year 2010 they issued 824 enforcement orders against health insurance agents.[90]

Discussion

Currently, there are no requirements for the disclosure of agent commission for the sale of health insurance products. Concerns have be raised that agents may be able to steer customers to the products that provide the agent with the highest commissions rather than the product that best fits the client's need, price requirement or is the least expensive plan. In this scenario, agents have the ability to impact the price of premiums sold in the market if the least beneficial commissions are tied to the lower cost products.

As is true with most professional ethics debates, a significant percentage of the industry operates with high standards and focus on the few bad actors can drive the discussion. Because there is no current requirement for disclosure of commissions, there have been no complaints filed at TDI regarding this type of professional behavior – only anecdotal examples.[91]

Other states have addressed this problem with increased commission disclosure requirements for agents. New York started much of the discussion when the New York Attorney General sued a number of insurance brokerages in the state for steering consumers toward insurance products that garnered the largest financial rewards for the agent. In response to these suits, New York approved regulations increasing transparency for agents. The New York requirements include the prominent disclosure of:

- a description of the role of the insurance agent in the sale;
- whether the agent will receive compensation from the sale and whom the compensation is from;
- a statement of whether the compensation varies depending on contract, volume of business the agent provides to the insurer, or the profitability of the contract that the agent provides to the insurer; and
- an explanation that the purchaser may request additional information regarding the commission. [92]

In addition to commission disclosure, questions arose regarding the responsibility of independent agents to disclose all offers to their clients – individuals or companies purchasing the health insurance products. After assessing the needs and requirements of their clients, agents will investigate the various products available in the market.[93] Currently, there is no requirement

[89] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance).
[90] *Id.* This count includes some cases with multiple enforcement actions against single licensees.
[91] *Id.*
[92] N.Y. COMP. CODES R. & REG. tit. 11, § 30.3 (2009). Colorado, New Jersey and Utah have enacted similar compensation disclosure laws.
[93] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Beth Ashmore, Texas Association of Underwriters).

that the agent disclose every offer found during their investigation. Agent stakeholders stated that the scaling down of offers to the fewer, most appropriate makes selecting a plan easier for the clients.[94] However, if an agent is not required to show all offers, the agent could steer their clients toward the products with more lucrative commissions for the agent rather than those that are the best fit or most affordable for the client.

Any changes to disclosure requirements for Texas agents should consider the complexity of the market and intend to make it easier for those purchasing health insurance. Increasing the amount of information at the point of purchase for health insurance could make an already frustrating and difficult process even harder.

Recommendations

The health insurance market in Texas is complex and diverse. In order for agent transparency to allow a consumer to assess whether the compensation arrangement is unduly influential, disclosure requirements must be meaningful and targeted. Additionally, the regulations must recognize the unique factors of the industry such as contingency commissions and commissions that may change throughout the year.

7.a. The Committee recommends that the Legislature consider establishing disclosure requirements for agents' sale commission in the health insurance market. Legislation should carefully consider the timing of the disclosure, applicability to new and/or renewal policies, inclusion of contingency or additional compensation, identification of the source of compensation, and who is required to provide the disclosure to the customer – the carrier or the agent.

7.b. The Committee recommends that the Legislature consider requiring agents to disclose all offers garnered on behalf of a client when purchasing health insurance. Legislation should carefully balance the benefits of stemming potential abuse and increased transparency with the need for simplicity for individuals and businesses purchasing health insurance with the help of an agent.

Charge No. 8

Study the sale of annuities in Texas, particularly to seniors. Evaluate the requirements relating to rescission of an annuity contract, payment of surrender fees, return of money, contract forms, including a standard contract form, buyer's guide, agent's commission and disclosure of an agent's commission. Make recommendations for legislation, if needed, and consider whether the insurance commissioner by rule may limit an agent's commission.

Background

Annuities are insurance contracts that serve as retirement savings tools rather than short-term investment options. Although an annuity is a life insurance product, it differs from a traditional life insurance policy. A life insurance policy is designed to provide a beneficiary with a benefit upon the death of the insured; however, an annuity is designed to provide a defined

[94] *Id.*

benefit during the life of the purchaser or retiree. In other words, life insurance provides a benefit based on an insured's death whereas an annuity's benefit is based on the beneficiary's life.

In its basic form, an annuity is an agreement for the payment of a lump sum at certain intervals. Annuities have evolved into several different products to address the various needs of an insurance company's customers. For instance, a modern-day annuity may be immediate or deferred, fixed or variable; and it may provide income for the life of the beneficiary or their spouse.[95]

Annuities are sold by agents licensed by the Texas Department of Insurance (TDI).[96] The agents may be independent agents who handle several different companies' annuities or they may only sell one company's products. Agents who sell the more complex variable annuities must be licensed by both TDI and the Financial Industry Regulatory Authority on behalf of the U.S. Securities and Exchange Commission.[97] Agents are paid a commission by the issuing insurance carrier pursuant to their agency contract. Commissions are not regulated by federal or state agencies.

Discussion

Statutory Provisions

As insurance products, the sale of annuities is governed by the Texas Insurance Code, chapters 1100 *et seq*., however, the majority of the Code is directed at traditional life insurance policies and not annuities. As such, TDI has minimal regulatory authority over the content of an annuity contract and the Commissioner generally only rejects forms that violate specific statutes of regulation or that are unjust, encourage misrepresentation, or are deceptive.[98]

In 2007 the Legislature adopted the National Association of Insurance Commissioners' (NAIC) model acts for suitability and replacement policies.[99] Suitability refers to the requirement that an agent obtain information from the consumer regarding their financial status, tax status and investment objectives and use that information to recommend annuities with terms that best suit their needs.[100] An agent selling an annuity intended to replace an existing life insurance policy or annuity contract must comply with additional requirements such as a 30-day free look period.[101]

In 2009, the Legislature enacted four major provisions relating to annuities. The first, contained in H.B. 1294, was the NAIC model for agent certification and designation.[102] This measure protects consumers by prohibiting agents from using misleading or false designations or

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[95] Texas Dept. of Insurance, *Understanding Annuities* http://www.tdi.state.tx.us/pubs/consumer/cb078.html. *See also* Appendix VIII.
[96] TEX. INS. CODE ANN. § 4052.001 (Vernon 2009).
[97] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance). Texas Dept. of Insurance, *Understanding Annuities* http://www.tdi.state.tx.us/pubs/consumer/cb078.html.
[98] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance). *See also* Appendix VIII.
[99] TEX. INS. CODE ANN. chs. 1114, 1115 (Vernon 2009 & Supp. 2010).
[100] TEX. INS. CODE ANN. § 1115.051 (Vernon 2009).
[101] *Id.* at § 1114.053(e).
[102] Acts 2009, 81st Leg., ch. 362.

certifications. The second measure, also included in H.B. 1294, required TDI to adopt education rules for life insurance agents who sell annuities (four hours of initial training and four hours of annual continuing education).[103] The third, H.B. 1919, limits surrender charges and states that the latest maturity date that may be included in an annuity is the annuitant's 70th birthday or 10 years from the date of purchase.[104]

Finally, the fourth measure, H.B. 1293, adopted the NAIC model annuity disclosure regulations.[105] Governor Perry vetoed H.B. 1293 based on his opposition to a provision which stated that a violation of the requirements would constitute an unfair or deceptive act or practice in the business of insurance. As an alternative, the Governor recommended that TDI adopt rules to implement the remaining portions of the bill.[106] The Department published proposed rules on August 13, 2010, based on the NAIC model.[107]

Disclosure Document and Free Look Period

The administrative rules proposed by TDI require insurers to provide certain disclosures to purchasers prior to and following the purchase of an annuity. As stated in the rule's preamble,

> The purpose of the disclosures proposed in this subchapter is to provide consumers with educational and identifying information regarding annuities that will enable them to make a decision that is more likely in their best interest and to reduce the opportunity for misrepresentation and incomplete disclosure.[108]

Specifically, the proposed rule addresses the following: (a) provision of a disclosure document and buyer's guide to the purchaser; (b) minimum content for the disclosure document; (c) a free look period; and (d) the report to contract owners.[109] With regard to a free look period, the draft rule imposes a mandatory 15-day free look period only in the event the buyer's guide and disclosure document are not provided at or before the time or application. This provision allows an applicant to return the contract without penalty in those circumstances.[110]

In addition to the proposed free look period, it should be noted that many annuity contracts include a 10-day free look period because many other states require one.[111] However, the Committee heard testimony from Tim Morstad with AARP recommending a 20-day free look period. Mr. Morstad stated that a longer period is necessary because senior citizens generally have sporadic contact with financial advisors or relatives. In support of this position Mr. Morstad noted that some states have up to a 30-day free look period for seniors.[112]

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[103] *Id.;* 28 TEX. ADMIN. CODE § 19.1029.
[104] Acts 2009, 81st Leg., ch. 408.
[105] H.B. 1293, 81st Leg. (2009).
[106] Veto Message of Gov. Perry, H.B. 1293, 81st Leg., R.S. (June 18, 2009).
[107] 35 Tex. Reg. 6924 (Aug. 13, 2010). *See also* Appendix VIII.
[108] *Id*.
[109] *Id.*
[110] *Id.*
[111] The Interstate Compact Commission (ICC) has adopted a 10-day free look standard for fixed and variable annuities. Texas joined 35 other states and became a member of the ICC in 2005; thus companies requesting product approval through the ICC would comply with this standard. Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Brenda Nation, American Council of Life Insurers and Texas Association of Life and Health Insurers).
[112] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Tim Morstad, AARP).

Agent Compensation

Although not required by statute or rule, most, if not all, of the agents selling annuities follow the model for compensation disclosure set forth by the NAIC.[113] The model includes a statement that the agent may be receiving compensation for selling the annuity; however, an express statement of the terms of the commission is generally not provided. One exception that has been codified in Texas requires affirmative approval by a purchaser if the agent is receiving a fee from the consumer in addition to their commission.[114]

During the 2009 legislative session, debate around S.B. 961 broached the subject of granting the Commissioner authority to unilaterally modify a company's commission structure in limited circumstances. Industry representatives opposed this, arguing that the Commissioner does not have the authority to do this for other lines of insurance. Consumer advocates argued that the Commissioner should be given such authority in egregious circumstances due to the nature of annuities and their purchasers.[115] Neither S.B. 961, nor its companion, H.B. 2650, passed.

During the Committee's interim hearing, Ron Mullen, testifying on behalf of the National Association of Insurance and Financial Advisors (NAIFA), recommended that in place of allowing the Commissioner to modify agents' commissions, the Department should focus on weeding out unsuitable products. Mr. Mullen posited that if the offending products are removed from the market, agents cannot sell them regardless of the commission structure.[116] However, Commissioner Geeslin countered that because suitability is a consumer-specific concept, it would not be feasible to remove all unsuitable products from the market.[117]

John Apostle, testifying on behalf of Genworth Financial, noted that regulating commissions may be difficult because insurance companies have contracts with warehouses and brokers to sell annuities and not necessarily with the individual agents.[118] For example, an insurance carrier may have a contract with a broker that includes a 10 percent commission; however, that broker's contract with their agents may specify a five percent commission regardless of which company's annuity is sold. The additional commission would go to cover the broker's indirect expenses or administrative costs.

Recommendations

As discussed above, the 81st Legislature adopted reforms and requirements for annuities which TDI and the industry are still in the process of implementing. In addition, the Committee recommends that the Legislature consider the following:

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[113] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Brenda Nation, American Council of Life Insurers and Texas Association of Life and Health Insurers).
[114] TEX. INS. CODE ANN. § 4005.004 (Vernon 2009).
[115] Senate Committee on State Affairs hearing, Mar. 30, 2009 (testimony of Jennifer Ahrens, Texas Association of Life and Health Insurers; Brenda Nation, American Council of Life Insurers; Des Taylor, NAIFA-Texas; Tim Morstad, AARP; and Carlos Higgins, Texas Silver Haired Legislature).
[116] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Ron Mullen, National Association of Insurance and Financial Advisors - Texas).
[117] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of Commissioner Mike Geeslin, Texas Department of Insurance).
[118] Senate Committee on State Affairs hearing, Feb. 23, 2010 (testimony of John Apostle, Genworth Financial).

8.a. Codification of a free look period; and

8.b. Granting authority to TDI to adopt rules specific to the regulation of annuities on par with their regulatory authority for other insurance products.

Charge No. 9

Study the effect Texas hospital billing and collection practices have on the uninsured's and under-insured's access to hospital health care services, on the uninsured's and under-insured's economic circumstances, and on medical debt recorded as bad debt on hospital books and records. Assess whether hospital billing disparities involving pricing discounts between the uninsured and insured exist and make recommendations for any changes necessary.

Background

Calculation for the various types of hospital payments is complex with a dynamic interplay between Medicare, Medicaid, private insurance payments and collections from cash paying (either uninsured or under-insured) patients. Each type of patient is billed at different, negotiated rates, often as a percentage of the hospital's chargemaster.[119] While the chargemaster is the one document that establishes a single set of prices for hospital services, it is widely accepted that the chargemaster rates are not a true representation of actual cost or anticipated collections for hospital services.

Three terms are most often used while discussing hospital financing related to care for the indigent or uninsured – uncompensated care, bad debt, and charity care. Each represent a portion of a hospital's accounting for care provided to the uninsured or the medically indigent.

- Uncompensated care is medical care for patients who are uninsured or who are unable to pay for services which the hospital anticipates no payment or no charge. Using Generally Accepted Accounting Principles (GAAP), uncompensated care is reported at the chargemaster rate but not collected by the hospital.
- Bad debt is actual or expected uncollectable payments resulting from the extension of credit. Bad debt is reported in gross charges as an expense rather than a loss of revenue.
- Charity care is health services provided that the hospital never expected to result in revenue and is recorded at chargemaster rates. Charity care is established as a policy by state statute or by the hospital to provide health care services at a reduced rate or free of charge to patients who meet certain, financial criteria.

In 1993, Texas passed the Texas Charity Care Law which established obligations for charity care and community benefits for nonprofit hospitals in order to maintain their tax-exempt status. These requirements were put into place to ensure a uniform application of charity care

[119] A hospital chargemaster is a hospital-specific list of all the procedures, services, supplies, and drugs that are provided by the facility. Most hospital chargemasters contain several thousand items.

policies at nonprofit hospitals around the state. To meet the requirements a nonprofit hospital must satisfy one of the following criteria:[120]

> (A) Provide a level of charity and government sponsored indigent health care which is reasonable in relation to the community needs, available hospital or system resources, and the tax-exempt benefits received by the hospital or system;
>
> (B) Provide a level of charity care and government-sponsored indigent health care at an amount equal to at least 100 percent of the hospital's or hospital system's tax-exempt benefits, excluding federal income tax; or
>
> (C) Provide charity care and community benefits at a combined amount equal to at least five percent of the hospital's or hospital system's net patient revenue, provided that charity care and government-sponsored indigent health care are provided in an amount equal to at least four percent of net patient revenue.

Additionally, the federal Patient Protection and Affordable Care Act (PPACA) includes language regarding nonprofit hospital charity care policies.[121] To earn 501(c)(3) tax-exempt status, hospitals must:[122]

- Conduct a "community health needs assessment" ("CHNA") every three years and then adopt and implement a strategic plan to meet the community's health needs identified through the assessment. The CHNA must take into account input from public health experts and individuals in the community who represent the broad interests of the community in the area served by the organization. The CHNA must be made available to the public.
- Submit on their Internal Revenue Service ("IRS") Form 990 a description of how the organization is addressing the needs identified in the CHNA and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed.
- Establish a written financial assistance policy, to include:
  - (a) The criteria for eligibility for financial assistance,
  - (b) The method for applying for financial assistance,
  - (c) The basis for calculating amounts charged to patients,
  - (d) The action to be taken in the event of nonpayment, and
  - (e) A description of the procedures to publicize the policy.

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[120] TEX. HEALTH & SAFETY CODE ANN. § 311.045(b)(1) (Vernon 2010).

[121] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), *as amended* by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

[122] Cynthia S. Marietta, *PPACA's Additional Requirements Imposed on Tax-Exempt Hospitals Will Increase Transparency and Accountability on Fulfilling Charitable Missions*, HEALTH LAW PERSPECTIVES (July 14, 2010) *at* http://www.law.uh.edu/healthlaw/perspectives/2010/(CM)%20Charitable.pdf *citing* Patient Protection and Affordable Care Act, Pub. L. No. 11-148, 124 Stat. 119, Tit. IX, § 9007, Tit. X, Subtit. H, § 10903 (Mar. 23, 2010), *as amended by* the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

- Establish a written policy concerning emergency medical care, requiring the organization to provide care for emergency medical conditions regardless of the patient's ability to pay.
- Limit the amounts charged for emergency or non-emergency medical care to patients eligible for financial assistance to not more than the amount generally billed and prohibit the use of gross charges.
- Refrain from engaging in extraordinary billing and collection actions until after reasonable efforts have been made to determine whether a patient is eligible for financial assistance.
- Provide audited financial statements of the organization.

The new requirement with the greatest possible impact is the concept that will "[l]imit the amounts charged for emergency or non-emergency medical care to patients eligible for financial assistance to not more than the amount generally billed and prohibit the use of gross charges."[123] To date, no federal rules have been promulgated to define "amount generally billed" or "gross charges."

Depending on which billing system (Medicare, Medicaid, chargemaster, private insured rates, etc.) is used as a base definition for "amount generally billed," this new policy could impact the final amount charged to charity care patients who are currently discounted and billed off of the hospitals' chargemaster rate. For instance, if Medicare becomes the new "amount generally billed" the charge that charity care is discounted from will be much lower, therefore, lowering the amounts billed to charity care patients.

No state or federal statutes establish minimum level of charity care requirements for for-profit hospitals or hospital systems; however, most have implemented some version of a charity care policy unique to their hospital or hospital system. Texas hospital districts are required to fund free care to the medically indigent who reside within the boundaries of their districts.

Senate Bill 1731, 80th Legislature (2007), established a requirement that all Texas hospitals develop and implement written policies for all billing services. The policy must address discounting for uninsured and medically indigent patients. All facilities are required to post in the general waiting area and in the waiting areas of any off-site or on-site registration, admission, or business office a clear and conspicuous notice of the availability of the policies for billing and payment.

Hospital Discounting Policies

Discounts are often given to cash-paying patients and the rate of discount is set by, and varies between, the individual hospitals.[124] Hospitals also negotiate various levels of discounts with private insurance companies depending on the amount of patient volume that is connected with the contract. As the discounts given to the private insurers vary, the discount given to cash-paying patients can be either greater or less than private insurer discounts.[125]

[123] *Id.*
[124] Senate Committee on State Affairs hearing, Sept. 22, 2010 (testimony of Glenda Owen, Seton Hospital).
[125] *Id.*

Most hospital financial assistance policies are based on a patient's Federal Poverty Level (FPL) as set by the United States Department of Health and Human Services.[126] The following are examples of financial assistance and discounting policies from different Texas hospitals:

Seton Healthcare (Ascension Health) - private, nonprofit facility[127]

- Charity Assistance
  - 0-250% FPL - Provides limited co-payment requirements (can be as little as $5) according to the ability of the patient to pay.
  - 251%-375% FPL - Provides a sliding fee scale, according to the ability of the patient to pay with expected patient maximum payment not to exceed 15% of annual income.
- Medical Indigence over 375% of FPL - A discount is offered to patients when medical bills exceed 50% of the patient's disposable/discretionary income.
- Uninsured Discount - Available to patients without insurance above 375% FPL, but who do not qualify for financial or charity assistance programs. The patient is given a 35% discount off the total charges for payment at the time of discharge or within 30 days of service or a 21% discount for patients that require an interest-free, extended monthly payment arrangement.

Sierra Providence (Tenet Healthcare) - private, for-profit facility[128]

- Charity Assistance - Provides limited co-payments for patients up to 200% FPL.
- Medical Indigence between 200% and 300% FPL - Provides a sliding scale fee with limits based on the gross family income. amount of total hospital charges, ratio of income to FPL and patient's ability to pay.
- Uninsured Discount - Offers discounted pricing for services provided at rates equivalent to the hospital's current managed care rates. Average 40% - 50% of chargemaster rate

University Health System San Antonio - public hospital[129]

- Charity Assistance - Provides coverage for 100% total amount for patients up to 150% FPL and 50% of total amount due for patients between 150% and 200% FPL.

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[126] Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010, 75 Fed. Reg. 45628 (2010). *E.g.*, 100% FPL: family of one - $10,830, family of four - $22,050; 200% FPL: family of one - $21,660, family of four - $44,100; 300% FPL: family of one - $32,490, family of four - $66,150.

[127] Senate Committee on State Affairs hearing, Sept. 22, 2010 (testimony of Glenda Owen, Seton Hospital).

[128] Sierra Providence Health Network Financial Assistance Programs, *available at* http://www.sphn.com/en-US/ourServices/hospitalServices/Pages/FinancialAssistancePrograms.aspx; (Nov. 10, 2010); Tenet Compact with Uninsured Patients; *available at* http://www.tenethealth.com/About/Documents/Compact%20With%20Uninsured%20Patients.pdf (Nov. 10, 2010).

[129] CareLink Member Handbook, *available at:* http://www.universityhealthsystem.com/files/CareLink-Member-Handbook-09-08.pdf (Nov. 10, 2010).

- CareLink Program - A non-insurance, managed care delivery model provided to, uninsured Bexar County residents with income below 300% FPL. CareLink is the payer of last resort with monthly payments and co-payments based on the member's ability to pay. CareLink only covers services provided within the University Health System and establishes a medical home to improve continuity of care.
- Medically Indigent - Provides up to 40% discount for patients whose total amount due after payment by a third party is 10% of the patient's annual gross income and the patient is unable to pay.

MD Anderson Cancer Center - University of Texas affiliated, nonprofit facility[130]

- Available to qualified Texas resident patients with or without insurance who need cancer treatment and have no other means to meet the personal financial responsibilities for care. Eligibility guidelines are based on residency, citizenship status and income/assets.
- Covers 100% of cost for patients with annual family income of less than 185% FPL for current year.
- Provides 50% discount from charges for patients with annual family income between 185% and 250% of FPL. Payment plans for remaining balance are available.

Billing and Collection Policies Impact on Personal Bankruptcy

The impact of medical debt on personal bankruptcy is difficult to accurately identify. Studies have tried to quantify the impact and the results differ from 17 percent to 54 percent of all national personal bankruptcies being caused by medical debt.[131] Bill collection policies are determined by the individual hospitals. The Seton Healthcare system provided testimony to the Committee as to their collection practices to serve as a reference for consideration. Seton Healthcare bill collection procedures include:[132]

- An early attempt at identification of eligibility for available funding sources and/or financial assistance;
- Patient statements that include reminders of availability of financial assistance;
- For patients who do not qualify for financial assistance or whose eligibility remains undetermined:
  - Statements and calls are made for 120 days after discharge or date of services for payment or the establishment of a payment plan

[130] Supplemental Financial Assistance: Information for Patients, *available at:* http://www.mdanderson.org/patient-and-cancer-information/guide-to-md-anderson/insurance-and-billing/sfa-english.pdf (Nov. 22, 2010).
[131] D.U. Himmelstein et al., *Illness and Injury as Contributors to Bankruptcy*, 24 HEALTH AFFAIRS (Feb. 2, 2005) *available at* http://content.healthaffairs.org/content/early/2005/02/02/hlthaff.w5.63; D. Dranove and M.L. Millenson, *Medical Bankruptcy: Myth Versus Fact*, 25 HEALTH AFFAIRS (Feb. 28, 2006) *available at* http://content.healthaffairs.org/content/25/2/w74.full.html.
[132] Senate Committee on State Affairs hearing, Sept. 22, 2010 (testimony of Glenda Owen, Seton Hospital).

- If there is no response or confirmation of eligibility in the first 120 days, the account is written off as bad debt and placed with the primary collection agency.
- The primary collection agency works the account for five months.
- If the primary collection agency fails to collect, a secondary agency is given the account and if there is still no response after 45 days (now approximately 10 months after the service), a report is then filed with the credit bureaus.

- Seton Healthcare and their contracted, bill collection agencies do not:
  - Place liens on a personal residence;
  - Take any action resulting in foreclosure on a personal residence;
  - Seek bench warrants, body attachments or orders for arrest; or
  - Charge interest on payment arrangement accounts.

Recommendation

Due to the varying types and levels of discounts and a lack of a single source of information for cost comparison in the market, cash-paying patients do not have a sense of the potential cost or possible negotiated rates available to them for hospital services. The new data collection project at the Texas Department of Insurance directing the agency to publish regional, aggregated reimbursement rates of frequent procedures will provide new data for these patients. This data will allow cash-paying patients to gain a better idea of the average, negotiated rates for hospital services and arm them with better information for negotiations with providers. The Legislature should continue to prioritize policies that will increase the quality and accuracy of health care cost data in the market.

Charge No. 10

Study the adequacy of workers' compensation benefits in the following categories: lifetime income benefits, wage benefits for the high wage earner, and workers whose wage benefits stop before Social Security benefits begin. In order to determine the impact of increased benefits in one or more of these categories, work with the Texas Department of Insurance to develop a publicly accessible model to predict the costs related to those enhanced benefits, the effect of those costs on workers' compensation premiums, and whether enrollment in the workers' compensation system will be adversely impacted by increasing the benefits in one or more of the stated categories.

Charge No. 11

Study whether subrogation claims by writers of workers' compensation policies should be limited or prohibited. Study the effect on workers' compensation premiums, if any, if subrogation claims by writers of workers' compensation policies are limited or prohibited. Consider the feasibility of developing a publicly accessible model to predict the impact on workers' compensation premiums, if any, if subrogation claims by writers of workers' compensation policies are limited or prohibited, while protecting confidentiality as required by

law and study whether the impact on workers' compensation premiums, if any, would adversely impact enrollment in the workers' compensation system.

Introduction

The Committee evaluated interim charge numbers 10 and 11 in the context of the Texas Supreme Court's 2009 decision in *Entergy Gulf States, Inc. v. Summers*.[133] The *Entergy* decision permits a premise owner to reduce its third party liability exposure by acting as a general contractor and providing workers' compensation insurance coverage for the employees of the general contractor and subcontractors working on the jobsite.[134] By doing so, the premise owner acquires the immunity afforded by the exclusive remedy doctrine.

Following *Entergy*, stakeholders and policymakers have begun to focus on its impact to the injured worker. A primary policy question is whether the current workers' compensation system adequately compensates a catastrophically injured worker at an *Entergy*-type workplace. In addition, the decision's effect on subrogation by workers' compensation insurance carriers has raised concerns. This report will discuss each in turn.

Adequacy of Workers' Compensation Benefits

Background

In an immune workplace under *Entergy*,[135] an injured worker's sole remedy is statutory benefits provided under the Texas Workers' Compensation Act.[136] The current system provides four different types of income benefits. Three may be classified as temporary and intermediate: temporary income benefits ("TIBs");[137] an impairment income benefits ("IIBs");[138] and a supplemental income benefit ("SIBs").[139] The fourth is considered permanent: lifetime income benefits ("LIB" or "LIBs").[140] Death income benefits ("DIB" or "DIBs") are also available under the current compensation structure.[141] The elimination of third party liability implicates the issue of benefit adequacy of LIBs and DIBs, as the injuries associated with these types of benefits are serious and have tended to result in tort-based lawsuits.

LIBs are paid if an injured worker sustains certain work-related injuries. Those injuries include the following:

- total and permanent loss of sight in both eyes;
- loss of both feet at or above the ankle;

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[133] Entergy Gulf States, Inc. v. Summers, 282 S.W.3d 433 (Tex. 2009).
[134] *Id.* at 435.
[135] Note that third party liability may still exist in cases involving, for example, products liability and auto insurance coverage liability.
[136] TEX. LAB. CODE ANN. § 408.001(a) (Vernon 2006).
[137] *Id.* at §§ 408.101-.105.
[138] TEX. LAB. CODE ANN §§ 408.121-.129 (Vernon 2006 & Supp. 2010).
[139] TEX. LAB. CODE ANN. §§ 408.141-.151 (Vernon 2006).
[140] *Id.* at §§ 408.161-.162. Medical benefits (those paid for necessary medical care to treat work-related injury or illness) are also available to injured workers for all health care reasonably required by the nature of the injury as and when needed. *Id.* at § 408.021(a).
[141] TEX. LAB. CODE ANN §§408.181-.185 (Vernon 2006 & Supp. 2010).

- loss of both hands at or above the wrist;
- loss of one foot at or above the ankle and the loss of one hand, at or above the wrist;
- an injury to the spine that results in permanent and complete paralysis of both arms, both legs, or one arm and one leg;
- a physically traumatic injury to the brain resulting in incurable insanity or imbecility;
- third degree burns that cover at least 40 percent of the body and require grafting, or third degree burns covering the majority of either both hands or one hand and the face.[142]

LIBs amount to 75 percent of the worker's average weekly wage ("AWW"), adjusted upward three percent each year.[143] The maximum weekly benefit for recovery of LIBs is 100 percent of the state average weekly wage ("SAWW"),[144] or $766 currently.[145] The duration of LIBs begin at the time a qualifying condition is determined and extend for the remainder of the worker's life.[146]

DIBs may be available to replace a portion of family income lost when an employee dies from a work-related injury or illness. Those eligible to receive DIBs are the surviving spouse, minor children, dependent grandchildren, other dependent family members, or non-dependent parents if there are no surviving eligible dependent family members.[147] DIBs amount to 75 percent of the deceased worker's AWW.[148] The maximum weekly benefit for recovery of DIBs is 100 percent of the SAWW,[149] or $766 currently.[150] The duration of DIBs to these legal beneficiaries begins the day after a worker's death and ends based on certain entitlement requirements for the different beneficiaries.[151] For example, a surviving spouse may receive benefits for life,[152] while a child may receive benefits until the age of 25 if enrolled in college.[153]

Discussion

The central issue that has developed post-*Entergy* is whether seriously or catastrophically injured workers are being compensated adequately, in the absence of third party tort liability. As demonstrated during the committee hearing, adequacy is difficult to define.

Following the 80th Legislature, proponents of maintaining the *Entergy* policy organized an advocacy group to evaluate how benefits could be improved. The group contends that an efficient, no-fault workers' compensation system should be appropriately funded to replace the unpredictable and inefficient delivery of benefits achieved through tort-based litigation.

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[142] TEX. LAB. CODE ANN § 408.161(a) (Vernon 2006).
[143] *Id.* at § 408.161(c).
[144] *Id.* at § 408.061(e).
[145] *See id.* at § 408.047.
[146] *Id.* at § 408.161(a).
[147] TEX. LAB. CODE ANN § 408.182 (Vernon 2006 & Supp. 2010).
[148] TEX. LAB. CODE ANN § 408.181(b) (Vernon 2006).
[149] *Id.* at § 408.061(d).
[150] *See id.* at § 408.047.
[151] *See* TEX. LAB. CODE ANN § 408.183 (Vernon 2006 & Supp. 2010).
[152] *Id.* at § 408.183(b).
[153] *Id.* at § 408.183(d)(2).

A 2009 study commissioned by Texans for Lawsuit Reform (the "Stradian Report") supports this assertion by observing that "only a few employees have access to the courts because of restrictions on suing a direct employer," which results in "a system of asymmetric distribution of benefits."[154] The Stradian Report concludes that after subtracting administrative and legal costs, "plaintiffs, on average, recover just 32 cents of every dollar spent compared to the traditional workers' compensation system[,] which returns 55 cents of every dollar spent to injured workers in the form of medical and wage replacement benefits."[155] The argument suggests that more dollars would reach more workers under a litigation-free regime.

The Stradian Report estimates that the total third party litigation cost in 2007, including "general liability premiums, deductibles and excess award payments," was $240 million.[156] Thus, it raises the question of whether significant savings in employer general liability insurance premiums from the elimination of tort-based lawsuits can be captured to offset the cost of legislative improvements to workers' compensation benefits. The Committee attempted to validate this theory, but did not find sufficient evidence to reach any conclusions.

The savings, if any, to commercial general liability ("CGL") lines related to the *Entergy* decision have yet to be fully quantified. The Texas Department of Insurance ("TDI") does not have administrative data to reflect claims affected by *Entergy*. TDI would need to identify those claims that involved premise owner third party liability prior to *Entergy* to evaluate savings carriers would observe as a result of their experience following the new doctrine of premise owner immunity. TDI advised the Committee that a data call on carriers would be necessary to accomplish this detailed identification.[157] A manual review of claim files by the carrier would be needed to produce the desired level of detail under the call. However, the savings information produced from the data call would not be necessarily reflected in liability premiums immediately. Carriers would likely wait to reduce premiums until lower costs are realized in their loss experience, which could take many years.

Even if these savings could be quantified, savings from the CGL line would have to be transferred to the workers' compensation line. While some carriers write both CGL and workers' compensation lines and in concept could credit a policy under the latter from savings under the former, many employers obtain single line coverage from different carriers on each line. For these employers, there is currently no regulatory mechanism for achieving credit assessment across different lines of insurance.

The advocacy group also analyzed data related to injured workers who receive LIBs from nonfatal, catastrophic injuries. These types of injuries are most closely associated with third party litigation. The analysis concluded that those receiving LIBs comprise a small universe of workers' compensation claimants. Over the last five years, the data reveals less than 120 LIB claims per year. Of these, only about 10 percent hit the statutory maximum benefit (12 claimants per year). In other words, the cap does not affect approximately 90 percent of those who claim

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[154] JASON KIRKPATRICK ET AL, TEXAS WORKPLACE INJURY COMPENSATION: ANALYSIS, OPTIONS, IMPACT , 30 (Stradian 2009), *available* at http://www.tlrfoundation.com/files/TexasWorkplaceCompensation.pdf (also asserting that total expenditures of third party lawsuits in 2007 only affected one in 475 injured workers).

[155] *Id.* at 28.

[156] *Id.* at 30.

[157] According to TDI, this data would represent the maximum potential savings as some premise owners may opt not to avail themselves in the future of the exclusive remedy bar for economical or other reasons.

LIB benefits. In total, LIB claims comprise less than one percent of all workers' compensation claims.[158]

The advocacy group determined that only a fraction of LIB injuries are affected by the *Entergy* decision. The group stated that not all LIB injuries are related to cases in which suit is brought against a premise owner, but there is no reliable data to identify such claims. Some LIB injuries are a result of vehicle accident and product liability injuries. This conclusion is based on data indicating that 60-66 percent of third party lawsuits involving workers' compensation claimants are categorized as vehicle accident cases. It is not known whether this correlation would apply to LIB injuries. The conclusion however, is that benefit enhancement, in light of *Entergy*, can be focused on a relatively small group of claimants.

Opponents of *Entergy* agree that current compensation is not adequate, but disagreed with the premise that third party immunity in a no-fault regime is needed. They assert system cost restraints will likely never allow compensation benefits to approach a level needed to make an injured worker whole; thus, third party liability is necessary to insure that damage recovery is available to augment system benefits.

Opponents of *Entergy* approached the question of benefit adequacy from a cost perspective. If benefits are increased in response *Entergy*, they contend that the costs would be socialized and not specifically allocated to the individuals responsible for the injury. Those absorbing the benefit costs (the worker, governmental assistance programs, and other employers in the workers' compensation system) would become the de facto insurer.

Opponents suggested that focusing on LIBs only is too narrow in scope. The group presented an example of an injured worker who was failed by the workers' compensation system in the absence of a tort remedy. He was an employee of a contractor who sustained severe burns on an industrial workplace, yet did not qualify for LIBs because the burn did not cover the threshold percentage of his body. He was burned to the third degree on 18.5 percent of his body, whereas the statutory minimum is 40 percent of the body or a majority of the face and one hand.[159]

This example also presented the conundrum for the high wage earner. Hearing testimony indicated that the particular injured contractor made over $100,000 per year.[160] Even if he would have qualified for LIBs, the maximum he would have been eligible to receive on a yearly basis is $39,832.[161] While this benefit would be increased by 3 percent each year, paid for the life of the

[158] Senate Committee on State Affairs hearing, Aug. 17, 2010 (testimony of Mike Hull, Texans for Lawsuit Reform) (also stating DIB claims comprise less than one percent of all workers' compensation claims).
[159] Senate Committee on State Affairs hearing, Aug. 17, 2010 (testimony of Jose Herrera). Testimony at the hearing also provided that the employee is only eligible for workers' compensation income benefits that expire at 401 weeks from the date of injury. *See* TEX. LAB. CODE ANN. § 408.083(b) (Vernon 2006). It is possible that the employee's workers' compensation income benefits could expire before he is eligible to receive Social Security Disability Income (SSDI) benefits depending on the employee's ability to meet certain SSDI eligibility requirements (e.g., that the employee paid Social Security taxes and that the employee met certain work duration and earning requirements). Assuming that the employee is unable to meet these SSDI eligibility requirements at the conclusion of the 401 weeks, the employee would not receive income benefits from either system.
[160] *Id.*
[161] *See* TEX. LAB. CODE ANN. §§ 408.061(e) and 408.047 (Vernon 2006 & Supp. 2010).

worker (not just his working life), and tax-free, it still does not compare to his pre-injury wage level or his loss of future wage earning capacity.

While there was no consensus among system participants on what amounts to an adequate income benefit, several options for benefit enhancement for catastrophically injured workers were developed from the Committee's evaluation of hearing testimony and comment: increasing or lifting the cap on LIBs and DIBs, establishing an impairment rating deemed to be catastrophic, and expanding the current LIB requirements for burn victims.[162]

The Committee evaluated various options to adjust the cap on LIBs. As previously stated, the current maximum benefit is set at 100 percent of the SAWW. According to TDI, approximately 2,500 workers have received LIBs since 1991.[163] In addition, roughly 110 new workers become eligible to receive LIBs each year. Documents in Appendix X illustrate the predicted effect and costs of several adjustments to the maximum benefit: increased from the current 100 percent by 10 percent increments up to 150 percent as well as no cap. The differences between the current level and a 150 percent cap are small: costs measure about $1.4 million over five years and represent a 10 percent increase over current payments. While 22 percent of LIB claimants hit the maximum under the current level, eight percent of claimants would reach the maximum at a 150 percent level. The difference between the current level and an uncapped LIB[164] would be $7.4 million over five years and represent a 53 percent increase over current payments.[165]

The Committee also analyzed options to adjust the cap on DIBs. As previously stated, the current maximum benefit is set at 100 percent of the SAWW. According to TDI, roughly 110-150 work-related fatalities become eligible to receive DIBs each year.[166] Documents in Appendix X illustrate the predicted effect and costs of several adjustments to the maximum benefit for DIBs: increased from the current 100 percent by 10 percent increments up to 150 percent as well as no cap. The differences between the current level and a 150 percent cap are small at about $2.6 million over five years. This represents a 17 percent increase over current payments. While 31 percent of DIB claimants reach the maximum under the current level, 10 percent of claimants would be capped at a 150 percent level. The difference between the current level and an uncapped DIB would be $10.2 million over five years and represent a 67 percent increase over current payments.[167]

These increases would help to ease the financial burden on injured workers and their families when benefits are the sole remedy, but the enhancements would not affect those who would not otherwise currently qualify for one of the statutorily designated injuries. To address

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[162] The Committee worked with TDI to develop a publicly accessible model to predict the costs associated with enhancing certain income benefits and the impact, if any, that these costs would have on insurance premiums and employer participation in the workers' compensation system. However, given the wide range of potential income benefit changes that could be proposed, combined with current limitations on TDI's collection of certain income benefit data, the development of a publicly accessible model to predict enhanced benefit costs would not be feasible. Thus, the Committee did not consider any resulting impact on premiums and employer enrollment.

[163] *See* Appendix X.

[164] Without a maximum cap on LIBs, the benefit would simply amount to 75 percent of the AWW. *See* TEX. LAB. CODE ANN. § 408.161(c) (Vernon 2006).

[165] *See* Appendix X.

[166] *Id.*

[167] *Id.*

this perceived deficiency, comments at the hearing raised the idea of assessing a statutory impairment rating that would serve to delineate a catastrophic injury and create an additional income benefit eligibility category. As previous research has shown, as the impairment rating increases, the return-to-work outcome is diminished and the injured worker may be positioned to rely more on benefits.[168]

According to TDI, there is no consensus on what impairment rating accompanies a catastrophic injury. Only one state uses such a metric. California compensates workers with an impairment rating of 70 percent or greater with a lifetime pension that is calculated at one and one half of one percent of the worker's AWW for each percentage point of impairment over 60 percent up to a certain maximum earnings limit.[169]

Therefore, the Committee asked TDI to consider the system impact if a statutory threshold impairment rating was established in Texas. For illustration, the Committee asked TDI to evaluate the predicted effect and costs of making an injured worker eligible for an income benefit if he received a 50 percent impairment rating or greater. TDI's research illustrated that only 45-56 workers per year have historically achieved this rating.[170] Interestingly, roughly 90 percent of these workers did not qualify for current LIBs. Thus, if this enhancement were added to the current system, it would seem to be successful at capturing an additional population of catastrophically injured workers. If this injury were compensated at 100 percent of the SAWW, the financial impact is estimated to be between $1.5 and $2 million per year. Without a maximum benefit, the impact would approach approximately $2.5 million per year.[171]

Another option to increase the scope of income benefit coverage to workers not currently captured by the system would be to expand the current burn injury requirements. The Committee asked TDI to study what other similarly situated states provide income benefits for burn injury workers. Florida statute provides permanent total disability benefits, similar to LIBs, for "second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands."[172] Louisiana statutory eligibility is similar to Texas',[173] but offers entitlement to a one-time payment of $30,000 to burn victims.[174]

It is unclear what impact expanding burn eligibility would have in Texas. According to TDI, roughly 1,000 total claims per year are attributable to burns. A vast majority of these

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[168] *Id.*

[169] Email from Amy Lee, Special Deputy Commissioner for Policy and Research Data, Texas Department of Insurance, to Committee staff (Dec. 21, 2010) (on file with Committee) (citing CAL. LAB. CODE § 4659(a) (West 2010)).

[170] It is important to note that Texas has utilized, since 2001, the American Medical Association's ("AMA") Guides to the Evaluation of Permanent Impairment, 4th Edition, for the calculation of impairment ratings in the workers' compensation system. The AMA has updated its publication with a 5th and 6th Edition, and stakeholders have noted that these more recent editions may impact impairment ratings. Notably, stakeholders have reported that the 5th Edition may increase impairment ratings over the 4th Edition and the 6th Edition may lower impairment ratings for certain types of severe injuries. *See* Informal Comments on Proposed Changes to 28 TEX. ADMIN. CODE, § 130.1 (2010) (on file with TDI).

[171] Email from Amy Lee, Special Deputy Commissioner for Policy and Research Data, Texas Department of Insurance, to Committee staff (Dec. 21, 2010) (on file with Committee).

[172] FLA. STAT. ch. 440.15(4) (2010).

[173] LA. REV. STAT. ANN. § 23:1221(4)(s)(iii)(bb) (West 2010) (requiring "third degree burns of 40 percent or more of the total body surface").

[174] *Id.* at § 23:1221(4)(s)(i).

claims likely cannot be categorized as severe as they did not receive IIBs, SIBs, LIBs, or DIBs. Roughly 73 to 78 percent only receive TIBs or employer wage continuation benefits. This remainder of some 200 claims is serious enough to qualify for benefits other than TIBs. Most of these 200 claimants received only IIBs meaning that they did not die to qualify for DIBs, did not qualify under a category for LIBs, or did not have a 15 percent impairment rating or went back to work to disqualify them for SIBs. With limited data, TDI was unable to drill down further on burn statistics. Thus, TDI was not able to determine how many of these 200 would be captured by expanding the LIB eligibility requirements for certain types of burn injuries using qualifications such as Florida's statute and therefore could not offer an estimated financial impact.[175]

The benefit enhancements discussed could be accomplished under the current system's benefit structure. The enhancement to LIBs and DIBs would simply adjust the percentage multiplier to the SAWW. As for the benefit enhancements that broaden qualifications (50 percent impairment rating and burn injury adjustment) an additional LIB category for each could also be created within the current structure and the benefit would be determined by the percentage multiplier to the AWW or SAWW.[176]

Conclusion

As TDI noted at the hearing, the workers' compensation benefit system was never designed to make the injured worker whole. The original purpose was to compensate for lost wages due to permanent impairment caused by workplace injury or illness. Thus, benefits have traditionally been inadequate when compared to the remedies available in the tort system. While *Entergy* changed this tradeoff, it did not change the absolute value of statutory benefits. To the

[175] Email from Amy Lee, Special Deputy Commissioner for Policy and Research Data, Texas Department of Insurance, to Committee staff (Dec. 21, 2010) (on file with Committee).

[176] With respect to expanding the eligibility requirements for LIBs to include employees with a 50 percent impairment rating, the Committee considered incorporating into the employee's benefit calculation a "loss of wage earning capacity" component, which is generally defined as the difference between what an employee made prior to a work-related injury and what the employee would be making if the injury never occurred. According to TDI, "[the] concept behind considering an employee's 'loss of wage earning capacity' when calculating an injured employee's income benefits…takes into account an individual employee's situation…[to] more accurately [compensate] the employee for lost wages, e.g., younger workers would have their benefits adjusted upward to take into account their potential greater loss in future wages compared to older workers. For example, California and New York incorporate such a consideration in their calculation of scheduled permanent partial income benefits, which are similar to Texas' [IIBs and SIBs]. *See* CAL. LAB. CODE §4660 (West 2010); NY. WORKERS' COMP. LAW §§ 15(3)(v) and (5-a) (McKinney 2010)… However, most states that adjust permanent partial income benefits based on an employee's loss of wage earning capacity do not make similar adjustments for permanent total benefits (also known as [LIBs] in Texas) because permanent total benefits are received for the employee's lifetime, regardless of whether the employee returns to work or not. Additionally, there is no consensus among state workers' compensation systems regarding the appropriate method for quantifying an employee's loss of wage earning capacity." Calculations may "consider factors such as age, type of work performed, the employee's level of education, etc... [T]he actual method for quantifying the employee's loss of wage earning capacity is often left for rulemaking," which is "often contentious [and] heavily litigated." Because Texas provides a comparatively high compensation rate for employees receiving LIBs, i.e., 75 percent of the AWW, with an annual three percent upward adjustment, versus 66 2/3 percent of the AWW in other states, "requiring the consideration of an employee's loss of wage earning capacity may actually result in some employees having their benefits reduced, rather than increased." Email from Amy Lee, Special Deputy Commissioner for Policy and Research Data, Texas Department of Insurance, to Committee staff (Dec. 21, 2010) (on file with Committee).

extent that third party damages have simply served to augment statutory benefits, the *Entergy* decision did not create benefit inadequacy, but it did eliminate a remedy for catastrophically injured workers to receive adequate compensation for their injuries. The Legislature should address this inadequacy by changing the benefit design for catastrophically injured workers, including those sustaining burn, paralysis, and fatality.

Subrogation

Background

Subrogation is the substitution of one person in the place of another, such as the possessor of a lawful claim, so that the substituting party succeeds to the rights of the substituted party in relation to the claim.[177] Texas statute grants a subrogation interest to a workers' compensation insurance carrier who has paid workers' compensation benefits to an injured employee.[178] The Labor Code provides that "if a benefit is claimed by an injured employee…, the insurance carrier is subrogated to the rights of the injured employee and may enforce the liability of the third party in the name of the injured employee…"[179] Common cases in which an injured employee may pursue third party litigation involve premise owner liability, product liability, and auto insurance coverage liability.

The *Entergy* decision limited a premise owner's third party liability exposure in an employee over action; thus, the workers' compensation insurance carrier's right to subrogate is now limited commensurately. However, the decision has spurred a discussion on the impact and value of subrogation in other third party liability events.

Discussion

At the Committee hearing, proponents asserted that subrogation should not be limited or prohibited. While *Entergy* foreclosed premise owner liability in a particular construction setting,[180] third party liability may still exist in other settings, such as in product liability and vehicle accident cases.[181] According to limited statistical information obtained by the proponents, these cases comprise a substantial portion of third party lawsuits involving workers' compensation.[182] Therefore, insurance carriers still benefit from the statutory subrogation right with respect to a large number of third party liability events.

Proponents argued that the policy justification for permitting subrogation is still valid: subrogation is a sound civil justice principle that provides a useful tool to allocate responsibility. The benefits originally paid by a carrier should be recoverable from the person responsible for

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[177] MICHAEL JACOBELLIS & JOHN C. KILPATRICK, TEXAS WORKERS COMPENSATION HANDBOOK 18-39, 40 (Matthew Bender 2009) (*citing* McBroome-Bennett Plumbing, Inc. v. Villa France, Inc., 515 S.W.2d 32, 36 (Civ.App.--Dallas 1974, writ ref'd n.r.e.).

[178] TEX. LAB. CODE ANN. § 417.001(b) (Vernon 2006).

[179] *Id.*

[180] However, note that proponents propose that at least some premise owners may not avail themselves of the decision's benefits and thus their insurance carriers would still enjoy a viable subrogation right in the event of a lawsuit.

[181] Third party liability may also still exist in hybrid cases, such as those involving both a liable product defendant and an immune premise owner.

[182] Senate Committee on State Affairs hearing, Aug. 17, 2010 (testimony of Mike Hull, Texans for Lawsuit Reform).

the injury requiring compensation. Further, claimants should not be able to recover double damages.

Opponents contended that subrogation should be limited in non-*Entergy* workers' compensation cases. They argued the common law made-whole doctrine should be restored. This doctrine sounds in equity and provides that "an insurer is not entitled to subrogation if the insured's loss is in excess of the amounts recovered from the insurer and the third party causing the loss."[183] However, the Texas Supreme Court recently expressed that equitable doctrines yield to statutory mandates,[184] such as the first-money, statutory subrogation right established for insurance carriers in 1989.[185]

Opponents reasoned that workers' compensation system benefits are not designed to make an employee whole. The tort system has traditionally provided the worker's opportunity to be made whole, acting as a safety valve to the system's partial benefits. Under current law, injured workers get the least priority to be compensated, while the carrier has first priority. There is no equitable basis for this, especially when the employer is partially responsible for the injury.

The Committee asked TDI to consider the feasibility of developing a publicly accessible model to predict the impact on premiums if subrogation claims by writers of workers' compensation policies are limited or prohibited. The Committee requested TDI to analyze this in the context of *Entergy*'s effect on a subset of subrogation claims. After the decision, workers' compensation benefit costs that would have otherwise been recovered by the workers' compensation insurance carrier through subrogation on third party liability claims involving premises owners now remain within the workers' compensation system.

TDI responded it does not currently collect subrogation data from workers' compensation carriers. As a result, TDI does not have administrative data regarding the impact on subrogation for those workers' compensation claims affected by the *Entergy* decision, despite carriers' experience with limited subrogation rights since the decision. It would be necessary to identify those claims that would have been subject to subrogation prior to the *Entergy* decision in order to understand the impact of the decision on workers' compensation system costs. TDI advised the Committee that a data call on carriers, involving a manual review of claim files, would be necessary to achieve this and that the resulting data would not likely represent the full impact of the *Entergy* decision since workers' compensation claim losses often take years to fully develop actuarially. As discussed previously, foregone lawsuit data under CGL lines would provide information to aid in this calculation, but that data is currently unavailable to TDI as well.

Without data to calculate the potential subrogation recovery that has been affected by the *Entergy* decision and the resulting workers' compensation benefit costs that can no longer be recovered through subrogation against premise owners, TDI would be unable to estimate the potential effect on workers' compensation insurance premiums.[186] Because the effect on

[183] Ortiz v. Great Southern Fire & Casualty Ins. Co, 597 S.W.2d 342, 343 (Tex. 1980).
[184] Fortis Benefits v. Cantu, 234 S.W.3d 642, 648 (Tex. 2007).
[185] Texas Workers' Compensation Act, S.B. 1, 71st Leg., 2d Spec. Sess. § 4.05 (Tex. 1989) (now codified at TEX. LAB. CODE ANN. § 417.001(b)).
[186] TDI also does not have administrative data on claims involving auto insurance coverage liability and products liability and similarly would be unable to estimate the effect on premiums in the event that subrogation in these cases were limited or prohibited.

premiums could not be calculated, the Committee did not consider any impact on enrollment in the system.

Conclusion

The Committee makes no recommendation on this issue.

Charge No. 12

Study and make recommendations regarding access to voting by members of the military serving in the United States and abroad, including the feasibility of electronic delivery of ballots.

Under current law, military and overseas voters may register and vote in Texas by either utilizing the regular registration and vote by mail process or by filing a Federal Postcard Application (FCPA) with their county officials. A military voter, their spouse or dependent, may use the FPCA to register and request their mail-in ballot if they will be some place other than their home Texas county for an election; however, a non-military voter must be overseas, or outside of the United States, to use the FPCA.

As discussed more fully below, once an FPCA has been received the early voting clerk mails a blank mail-in ballot to the voter. The voter then returns the ballot via either U.S. mail, a carrier service or, in limited circumstances via facsimile. The deadline for returning a mail-in ballot is 7:00 p.m. on election day or for overseas voters, within five days following election day.

Pilot Program

In 2007, the 80th Legislature adopted S.B. 90 which directed the Secretary of State to develop a pilot program for the transmission of blank mail-in ballots via e-mail.[187] The pilot program was limited to overseas voters who were members of the armed forces and was in effect for the November 2008 general election. Nineteen counties participated in the pilot program; less than 160 ballots were e-mailed to eligible voters and less than 70 ballots were returned. Although participation in the pilot program was limited, the response from voters and election officials was generally positive.[188] Several bills were filed during the 81st legislative session to expand and extend the pilot, however none of them were enacted.[189]

Military Overseas Voters Empowerment Act[190]

In the Fall of 2009 Congress passed the Military Overseas Voters Empowerment (MOVE) Act which requires changes to the way persons covered by the Uniformed and Overseas Citizens Absentee Voting Act (UOCAVA) (military and overseas voters) register and vote in federal elections. A majority of the Act applied to the November 2010 general election.

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[187] Acts 2007, 80th Leg., ch. 6.

[188] *See Report to the 81st Legislature on Senate Bill 90 (80th Legislature) Relating to the Pilot Program for E-mailing Balloting Materials to Overseas Military Personnel*, Secretary of State's Office, http://www.sos.state.tx.us/elections/sb90.shtml

[189] S.B. 92, 81st Leg. (2009); S.B. 1280, 81st Leg. (2009); H.B. 71, 81st Leg. (2009).

[190] Military Overseas Voters Empowerment Act, H.R. 2647; Subt. H; Pub. L. 111-84, 123 Stat. 2190 (Oct. 22, 2009) (hereinafter "MOVE Act").

In response, the Secretary of State's Office convened a focus group made up of voter registrars, county clerks and election administrators from large, medium and small counties. The focus group met in May and June of 2010 to assist the Secretary of State in the development of administrative rules to implement the MOVE Act. In July 2010 the Secretary adopted rules to implement the Act.[191] The rules address procedures for all elections which have a federal office on the ballot.

Department of Defense

The MOVE Act requires that the Department of Defense take several actions. Among these requirements is the obligation to develop a program to expedite the collection and delivery of voted ballots back to the appropriate election office. Currently, the Department has a system in place for the return of faxed ballots; however, it is only available to members of the military serving in a hostile fire zone.[192]

The Department is also obligated to maintain a public online database that includes state contact information for federal elections; improve voter registration outreach through online portals and the designation of offices on military installations as voter registration agencies; and utilize technology to benefit the UOCAVA voter. Finally, the Department, through the Federal Voting Assistance Program (FVAP), must submit a report to Congress assessing the implementation of the Act.[193]

State and Counties

In addition to the Department of Defense requirements, the MOVE Act places several obligations on state and local voter registration agencies – some more complex than others. For instance, the Act requires that each state provide a means for eligible voters to request voter registration applications and mail-in ballots electronically.[194] The Secretary of State and several other Texas counties have long had such voter registration materials available on their websites.[195] A voter may request paper voter registration materials or fill out a registration application online, print it out and mail it to their county's voter registrar. The Secretary of State has also set up a separate website to address the needs of military and overseas voters.[196]

The Act requires states and/or counties to develop a free tracking system that eligible voters can access to determine if their voted ballot has been received by the county.[197] Accordingly, pursuant to the Secretary of State's new rule, each early voting clerk submits a voter record for each Federal Postcard Application (FPCA) that is timely received by the Secretary of State. The early voting clerk imports or directly enters the record into the Texas Election Administration Management (TEAM) system or submits a spreadsheet in the format

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[191] 1 TEX. ADMIN. CODE § 81.39 (2010).
[192] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Elizabeth Winn, Secretary of State's Office).
[193] *See* Appendix XII for summary prepared by the National Association of Secretaries of State.
[194] MOVE Act § 577.
[195] *See* http://www.sos.state.tx.us/elections/voter/reqvr.shtml; http://www.hctax.net/voter/acquirevoterapp.aspx; http://www.traviscountytax.org/goVotersRegistration.do; http://www.co.lubbock.tx.us/Elec%20Admin/register.html; http://www.co.collin.tx.us/elections/voter_registration/voter_registration_application.jsp
[196] *See* https://texas.overseasvotefoundation.org/overseas/home.htm
[197] MOVE Act § 580(h).

prescribed by the Secretary of State. Pursuant to the Act the voter may track their ballot via the Secretary of State's military and overseas voter ballot tracking website.[198]

The MOVE Act also repeals the requirement that a voter's FPCA be effective for a period of two federal elections. Current state law is consistent with the former requirement, thus a statutory change would be necessary to make a corresponding change in state law. This change would take Texas back to pre-2003 status, which according to testimony received by the Committee, would be welcomed by election officials.[199]

E-mailing Ballots

Currently, the FPCA serves to register the military or overseas voter and to request a mail-in ballot be sent to the voter in advance of all elections indicated in which they are eligible to vote.[200] The address on the FPCA to which the balloting materials are to be mailed may be outside the county of residence or an address for forwarding to the voter at a location outside the United States.[201] Currently, the only method of sending blank mail-in ballots is through U.S. mail or courier. Marked ballots may be returned via U.S. mail, courier, or via facsimile if the voter is a member of the armed forces receiving hostile fire pay or serving in a combat zone.

One of the most significant provisions of the MOVE Act is the ability of an eligible voter to designate on their FPCA their preferred method of receiving their mail-in ballot – paper or electronic transmission (facsimile or e-mail). All counties were required to have the capability to e-mail a blank ballot to a voter by the November 2010 election.[202] The process for transmitting blank ballots adopted by the Secretary of State was substantially similar to that required by the pilot program in 2008.[203]

In addition to the MOVE Act requirements for electronic transmission of a blank ballot, the Committee heard testimony on the issue of allowing an eligible voter to return a marked ballot via e-mail. Currently, ten states allow e-mail return of a ballot. There are typically two areas of concern with e-mail voting: security and privacy. Mr. Paddy McGuire, testifying on behalf of the Federal Voting Assistance Program with the Department of Defense, noted that the level of secure transmission for returning a marked ballot may vary. Encrypting the e-mail would be up to the state or county sending and receiving the ballot. Additionally, if the e-mailing of a marked ballot would be open to all UOCAVA voters, a marked ballot may be returned via a ".mil" address or another, possibly less secure, e-mail account. However, he opined that the chance of tampering with a ballot would be low and the ability to influence an election via tampering would be even lower.[204]

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[198] 1 TEX. ADMIN. CODE § 81.39(j) (2010); https://webservices.sos.state.tx.us/FPCA/index.aspx

[199] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Jacquelyn Callanen, Bexar County Elections; Beth Rothermel, County and District Clerks Association; Elizabeth Winn, Secretary of State's Office).

[200] TEX. ELEC. CODE ANN. ch. 101 (Vernon 2010).

[201] *Id*. at § 101.007.

[202] Because the Secretary of State's Office is not designated as an early voting clerk in the Election Code the Office would not be able to act as an intermediary for small counties. Statutory changes would be necessary for this to be an option in future elections. Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Elizabeth Winn, Secretary of State's Office).

[203] 1 TEX. ADMIN. CODE § 81.39 (2010).

[204] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Paddy McGuire, Federal Voting Assistance Program).

Mr. McGuire also testified that the Department is considering a relay system for returning a marked ballot similar to the current system in place for facsimiles from military personnel serving in combat zones (e.g. transmission from voter to Department and then from Department to early voting clerk).[205] Such a system would add a layer of security; however, it would be limited to military voters.

In addition to security concerns, a voter returning their marked ballot via e-mail would be in effect disclosing their vote to the early voting clerk. Currently, a mail-in ballot is accompanied by a return envelope that is to be enclosed within a carrier envelope. This ensures the privacy and anonymity of the voter. Without the carrier envelope, the voter's selections would be disclosed to the early voting clerk and possibly others.

Transmission Deadline - Pre-MOVE Act[206]

As mentioned above, the FPCA may serve to register a voter who is not already registered in that county as well as request a mail-in ballot.[207] An FPCA may be submitted at any time during the calendar year in which the election for a ballot is requested occurs or 60 days prior to an election taking place in January or February of that year.[208] Practically speaking, an eligible voter will submit the FPCA prior to or relatively soon after leaving their home county. The FPCA stays on file with the county and is valid for two federal election cycles.

Pursuant to the Election Code, an FPCA may be received up to the 6th day prior to an election. For primary elections, general elections for state and county officers and November general elections, clerks must begin mailing ballots to FPCA voters on the 45th day prior to an election.[209] If an FPCA is received after the 45th day prior to the election, clerks are required to mail the blank ballot within seven days of receiving the FPCA.

If the voter is already a registered voter at the address contained in the FPCA and the FPCA is received before the sixth day prior to the election, the voter is entitled to receive the full ballot as if they were voting in-person, at home.[210] If the voter is not already registered at the address in the FPCA, but the FPCA is on file as of the 20th day prior to the election, the early voting clerk will mail a full ballot; however, the applicant is entitled to receive only a federal ballot if the FPCA is filed after the 20th day but before the sixth day prior to the election.[211]

With regard to primary runoff elections, a voter may register and request a mail-in ballot with an FPCA regardless of whether they voted in the primary election. Such an FPCA must be received by the early voting clerk by the seventh day prior to the primary runoff election day. Similarly to the primary election, if the voter is not already registered at the address on the FPCA, but submits the FPCA prior to the 20th day before the runoff election, they are entitled to

[205] *Id.*
[206] The MOVE Act applies to FPCA registered voters only. Therefore the following discussion will focus on deadlines relating to mailing ballots to those voters. For information on deadlines relating to non-FPCA voters see the Election Code, sections 84.001, 84.007 and 86.004.
[207] TEX. ELEC. CODE ANN. § 101.006 (Vernon 2010).
[208] *Id*. at § 101.004(b)(c).
[209] *Id*. at §101.004.
[210] *Id*. at § 101.004(h).
[211] *Id*. at § 101.004(e)(f).

receive a full primary runoff ballot; however, the applicant is entitled to receive only a primary runoff ballot for federal offices if the FPCA is filed after the 20th day.

On occasion, a special election may be necessary to fill a vacancy in office. Pursuant to the Election Code, the Governor may call a special election with as little as 36 days notice.[212] Additionally, in some circumstances a runoff special election may be required.[213] The process for early voting in special elections is conducted the same as for other general elections; however, due to time constraints, mail-in ballots generally may not be transmitted according to the default 45 days prior to the election.

In circumstances described above, the Election Code defers to the Secretary of State to monitor the timing for mailing ballots for primary runoff and special elections because the elections may take place less than 45 days from the date the election is noticed.[214] The Secretary of State advises early voting clerks to mail ballots as soon as they are available, however, the Election Code is silent on any recourse available to the Secretary of State, or a voter, in the event the early voting clerk unreasonably delays the transmission of ballots.

Transmission Deadline - Post-MOVE Act

The most problematic MOVE Act requirement mandates the transmission of a ballot 45 days before an election to all eligible FPCA voters.[215] If the FPCA is received less than 45 days before the election the requirement defaults to state law.[216] As discussed above, the current state law requires clerks to begin mailing ballots to eligible voters 45 days prior to the election or within seven days of receiving the FPCA; however, the law allows for some leeway in certain circumstances.

Transmission of the blank ballot by e-mail will certainly expedite the delivery process; however difficulty arises with some elections. In the event a primary runoff election is needed, a ballot is typically not available 45 days prior to election day. This applies equally for a special election and if necessary, a special election runoff. Statutory changes will be necessary to comply with the MOVE Act in such instances.

To comply with the MOVE Act requirements for primary and primary runoff elections, options include increasing the amount of time between the primary and primary runoff elections by moving the primary date earlier in the year or postponing the runoff election to 60 or more days after the primary. Runoff elections occurring close to the May uniform election date will increase the workload on early voting clerks and election administrators and potentially confuse voters. Conversely, if the primary election date is moved up, for instance to Super Tuesday in February, additional issues must be considered such as triggering the constitutional resignation requirement for some offices.[217]

In the event the Governor calls a special election a ballot generally will not be available 45 days in advance. Currently, a special election may be called to take place within 36 days. To comply with the MOVE Act, the Legislature should increase the amount of time between the

[212] *Id*. at § 201.052.
[213] *Id*. at § 203.003.
[214] *Id*. at § 86.004(b).
[215] MOVE Act §579.
[216] *Id.*
[217] TEX. CONST. ART. 16 § 65 (Vernon 1993 & Supp. 2010).

calling of a special election and the special election date. Sixty-two days should be sufficient to enable election officials to certify, print and transmit a ballot for a federal election. Increasing the time period may result in more special elections being held concurrently with general elections in May and November. Finally, in the event a special election runoff is necessary, statutory changes similar to those discussed above relating to primary runoff elections may be necessary.

Waiver

The MOVE Act provides a process whereby a state may request a temporary waiver of the requirements; however, the process requires the state to implement a portion of the Act and demonstrate undue hardship. The Act includes three situations that may rise to the level of undue hardship: (a) a primary election date that prohibits a state from complying, (b) a delay in generating ballots due to a legal contest, or (c) a state constitutional provision that prohibits compliance.[218]

In advance of the November 2010 elections, ten states as well as the District of Columbia and the U.S. Virgin Islands applied for waivers from the 45-day ballot mailing requirement. The Department of Defense granted five waivers and denied the remaining seven.[219] The states receiving waivers either made alternate balloting arrangements, such as sending a write-in ballot with a list of names; or they allowed for additional time after election day for the overseas voter to return the ballot.[220] However, as elaborated upon by the witness at our hearing, the waivers are temporary and are intended to cover the gap between the Act's passage and the states' ability to alter their election statutes and rules to comply with the new requirements.[221]

Federal HAVA Funds

The MOVE Act amends the Help America Vote Act (HAVA) by authorizing the appropriation of "such sums as necessary" for FY 2010 and beyond and requires payments to the States specifically for implementing the MOVE Act. Any funds under this provision may only be used to carry out the requirement of the MOVE Act[222]

Extension to State & Local Elections

Military and veterans groups advocate the extension of these requirements to state and local elections.[223] This position is consistent with the State's history as it applied HAVA to state and local elections. However, election officials may find applying the MOVE Act to state and local elections difficult. As illustrated above, moving one date in the election calendar has a domino effect on all other elections. This will be especially difficult in the instance of the 45-

[218] 42 USC 1973ff-1(g)(2)(B)i-iii; MOVE Act § 579 (a)(2).
[219] The Department granted requests from Deleware, Massachusetts, New York, Rhode Island and Washington; and denied requests from Alaska, Colorado, Hawaii, Wisconsin, the District of Columbia and the U.S. Virgin Islands.
[220] Zambon, *Defense Department Responds to MOVE Act Waiver Applications*, electionlineWeekly, www.electionline.org (Sept. 2, 2010).
[221] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Paddy McGuire, Federal Voting Assistance Program).
[222] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Elizabeth Winn, Secretary of State's Office).
[223] Senate Committee on State Affairs hearing, July 14, 2010 (testimony of James Carey, PEW Charitable Trusts; Morgan Little, Texas Coalition of Veterans Organizations).

day deadline for e-mailing ballots as the March primaries and the May elections are already close together.[224]

Uniform Law Commission Proposal

The National Conference of Commissioners on Uniform State Laws met in July 2010 and approved for enactment the Uniform Military and Overseas Voters Act.[225] This model act would serve to implement the MOVE Act in states and to extend the applicability of the Act to state and local elections. However, because it is a model act, it would not address some of the Texas-specific issues described above.

Recommendations

The Committee supports the Secretary of State's efforts to formalize the state's MOVE Act obligations in rule and to the extent possible, the Committee recommends that the requirements remain in rule to allow flexibility in the event the federal government amends the requirements of the MOVE Act. With regard to statutory changes, the Committee makes the following recommendations:

12.a. The 82nd Legislature should consider legislation to change the effective period for the FPCA back to one year.

12.b. With regard to the transmission of ballots 45 days prior to the election, the Legislature should consider extending the primary runoff, special election, and special election runoff timelines to allow for the mailing of FPCA ballots 45 days in advance of the election. If it is appropriate for a primary runoff election to be held concurrently with local elections on the May uniform election day, the Legislature should consider statutory changes to make it so.

Charge No. 13

Study the Public Information Act and the Open Meetings Act to ensure that government continues to operate in a way that is open and transparent. The study should consider how advances in technology and the emergence of various forms of social media (e.g. Facebook, MySpace, Twitter) have affected communications by and within governmental bodies.

Background

Texas' Public Information Act and Open Meetings Act were adopted in 1973 and 1967 respectively.[226] Since their adoption there have been significant developments in technology. On occasion, the Legislature has updated the statutes to address such changes. With the development of e-mail, text messaging, instant messaging, social media websites, and blogs, the statutes require more scrutiny.

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[224] *See* Senate Committee on State Affairs hearing, July 14, 2010 (testimony of Jacquelyn Callanen, Bexar County Elections; Beth Rothermel, County and District Clerks Association; Elizabeth Winn, Secretary of State's Office).
[225] UNIFORM MILITARY AND OVERSEAS VOTERS ACT (National Conference of Commissioners on Uniform State Laws 2010); Appendix XII.
[226] Acts 1973, 63rd Leg. R.S., ch. 424; Acts 1967, 60th Leg. R.S., ch.271.

The Attorney General is charged with developing training for public officials and assisting members of the public in the interpretation and understanding to the Public Information Act and the Open Meetings Act.[227] To wit, the Attorney General publishes an annual handbook on each act and provides online video training sessions.[228]

Discussion

Public Information Act

The Public Information Act (PIA) is contained in Chapter 552 of the Government Code. The PIA states that public information is to be made available to the public upon request.[229] It defines public information as: "[I]nformation that is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business: (1) by a governmental body; or (2) for a governmental body and the governmental body owns the information or has a right of access to it."[230]

The PIA also includes broad definitions as to what types of media the public information is stored on as well as what entities are considered governmental bodies.[231] Specifically, the types of media include "a magnetic, optical, or solid state device that can store an electronic signal" taking the form of "a voice, data, or video representation held in computer memory."[232]

The Attorney General has long held that the subject matter of the communication controls whether the communication is public information and therefore subject to disclosure under the PIA. Specifically, with regard to e-mails sent to and from personal e-mail accounts of public officials, the Attorney General has stated

> [T]he characterization of information as "public information" under the Act is not dependent on whether the requested records are in the possession of an individual or whether a governmental body has a particular policy or procedure that establishes a governmental body's access to information. … Thus, the mere fact that the city does not possess the information at issue does not take the information outside the scope of the Act. … Furthermore, the Act's definition of "public information" does not require that an employee or official of a governmental body create the information at the direction of the governmental body. Therefore, to the extent that the [records] relate to the transaction of official city business, we conclude that such information is subject to disclosure under the Act.[233]

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[227] TEX. GOV'T CODE § 552.011 (Vernon 2004).
[228] *See* Attorney General of Texas, Public Information 2010 Handbook; Open Meetings 2010 Handbook *available at* https://www.oag.state.tx.us/open/publications_og.shtml. For training information and materials, https://www.oag.state.tx.us/open/og_training.shtml.
[229] TEX. GOV'T CODE ANN. § 552.001 (Vernon 2004).
[230] *Id*. at § 552.002(a).
[231] *Id*. at §§ 552.002(b), 552.003(1).
[232] *Id*. at § 552.002.
[233] Tex. Att'y Gen. OR2003-1890 at 2 (2003). *See also* Tex. Att'y Gen. OR2005-06753 (2005); Tex. Att'y Gen. OR2005-01126 (2005); Tex. Att'y Gen. OR2003-0951 (2003).

In 2009, the Attorney General expanded on prior rulings and determined that e-mails to and from the personal e-mail account of the mayor of the City of Lubbock were not subject to disclosure under the PIA.[234] This determination was made based on facts presented by the City in their request for a ruling to the Attorney General. Specifically, the city attorney noted that the mayor's personal e-mail account was not located on a city computer server; the mayor does not hold his personal e-mail account out to the public as a means to contact him for city business; nor does the city expend funds or personnel costs for the e-mail account.[235] The requested information also included text messages to or from the mayor's personal cellular telephone. With regard to text messages, the Attorney General held that "to the extent the text messages maintained by the mayor relate to the official business of the city, they are subject to the Act."[236]

Although there have been suits filed in Texas courts relating to the applicability of the PIA to e-mails, there have been no recent opinions on point. One such case is *City of Dallas v. Dallas Morning News, LP*.[237] This case stemmed from two PIA requests from reporters at the Dallas Morning News. The requests included e-mails sent to and from the mayor's personal e-mail address. The City contended that the e-mails were not subject to disclosure under the PIA because they did not fall into the definition of public information. The City responded to the request accordingly; it did not request an opinion from the Attorney General on this matter.

The Dallas Morning News filed an action in district court seeking a writ of mandamus. The trial court granted partial summary judgment in favor of the newspaper thereby ruling that e-mails to and from the mayor's personal account that were made in connection with official city business were public information that the City has a responsibility to produce.[238] The City appealed. In its opinion, the appellate court affirmed in part and reversed in part the district court's ruling. The appellate court did not rule on the trial court's or the parties' interpretation of the PIA, but rather held that genuine issues of material fact existed which precluded the district court's ruling on summary judgment.[239]

Although the appellate court's opinion focused on the motions for summary judgment, the court did discuss factors relevant to an inquiry of whether the mayor's e-mails would have been subject to the PIA request. The court stated:

> We do not know what the terms of the personal account are; who has a right of access to the device or account; what type of access, if any, exists; who pays for the account; whether the city has any policies or contracts relating to personal e-mails or accounts; whether any e-mails exist falling within the News's requests; or

[234] Tex. Att'y Gen. OR2009-10762 (2009).
[235] *Id.* at 2.
[236] *Id.* at 3. The Attorney General issued a similar opinion relating to text messages to and from personal cellular phones of two members of the Lubbock City Council. The city councilmen have filed for a declaratory judgment contending that the text messages are not subject to disclosure under the PIA. The case is pending before a Travis County District Court. *See* Tex. Att'y Gen. OR2009-10781 (2009); City of Lubbock v. Greg Abbott, No. D-1-GV-09-001569 (419th Dist. Ct., Travis County, Aug. 17, 2009).
[237] City of Dallas v. Dallas Morning News, LP., 281 S.W.3d 708 (Tex. App.--Dallas 2009).
[238] *Id.* at 713.
[239] *Id.* at 710.

other information relevant to the inquiries explored in addressing the public's open records rights.[240]

The court went on to refer to an Attorney General open records decision setting forth factors relevant in deciding whether a document is governmental or personal.[241] The factors include: who prepared the document; the nature of the contents; the purpose of the document; who possessed the document; who had access to it; whether a governmental body required the preparation of the document; and whether its existence was necessary for official business.[242] This inquiry is substantially similar to that made by the Attorney General with regard to the City of Lubbock's request for a ruling. Therefore, governmental bodies should take note to include such relevant facts in future requests for open records opinions.

During the interim, the Committee heard testimony from representatives of the Texas Municipal League and the Texas Association of School Boards representing the position of governmental bodies charged with fulfilling their obligations under the PIA.[243] The chief concerns cited by these entities with regard to personal e-mail accounts is the fact that the governmental body does not have control over or access to e-mail accounts not maintained on the entity's computer server. This is compounded by the fact that the courts have held that the PIA does not apply to public officials as individuals.[244] The agreement is between the provider or administrator and the individual; therefore, the governmental body must rely upon the cooperation of their public officials and employees.

The Committee also heard testimony from representatives of the media and other concerned groups.[245] These witnesses agreed with the Attorney General's position of content-based determinations. They asserted that in the event a public official conducts public business using a personal e-mail account, the public official is responsible for granting access to such records in the event a PIA request is submitted. If an exemption to the PIA is created for e-mails or text messages to and from personal accounts, the purpose of the PIA would be thwarted.[246]

To date, there have been no Attorney General rulings or court determinations on the applicability of the PIA to other electronic communications such as blogs, social media web pages or online comments. Each of these communications raises its own set of questions; however, one common theme is whether the governmental body has access to the information. In some instances this is a more significant fact than in others.

Record Retention

Governmental bodies are required to maintain government data in accordance with record retention statutes.[247] These statutes control how an entity stores, and eventually destroys public

[240] *Id.* at 717 (*citing* Flagg v. City of Detroit, 252 F.R.D. 346, 348 (E.D.Mich. 2008)).
[241] *Id.* (*citing* Tex. Att'y Gen. ORD-3778 (1999)).
[242] *Id.*
[243] Senate Committee on State Affairs hearing, May, 11, 2010 (testimony of Scott Houston, Texas Municipal League; Ruben Longoria, Texas Association of School Boards).
[244] Keever v. Finlan, 988 S.W.2d 300 (Tex. App.--Dallas 1999).
[245] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of Michael Schneider, Texas Association of Broadcasters; Doug Toney, New Braunfels Herald-Zeitung; David Power, Public Citizen).
[246] *Id.*
[247] *See e.g.* TEX. GOV'T CODE ANN. §§441.180-.210 (Vernon 2004); TEX. LOC. GOV'T CODE ANN. §§ 201.001-.009 (Vernon 2008).

documents. Information subject to the Public Information Act is dependent upon these record retention requirements.

During the interim, the Committee heard testimony from Mr. Ruben Longoria on behalf of the Texas Association of School Boards. Mr. Longoria noted that the record retention requirements refer to the storage, organization, access and destruction of records. However, an e-mail is not necessarily a record but rather a form of storage. Therefore, the subject matter of an e-mail controls the time and manner of retention.[248] Mr. Longoria asserted that the current framework is inefficient and ineffective in fulfilling the purposes of the PIA.

Notwithstanding the issues raised by Mr. Longoria, e-mails sent to or from government sponsored e-mail accounts may be easily dealt with for retention purposes because they have a "home" on a government or government-accessible server. However, trying to apply the current record retention statutes to private e-mail accounts and other newer technologies raises several questions. With regard to postings on social networking websites such as Facebook, the information is by its nature, temporary. Therefore, to comply with record retention statutes is the "poster" charged with printing a snapshot of the webpage and storing it in an electronic or paper file? Is the provider or administrator responsible for responding to a request for all posts made by a certain person? What if the "poster" is a public official but the Facebook page belongs to a private individual? These questions multiply when you add in blogs and micro-blogs such as Twitter.

As discussed above, each e-mail, text, instant messaging, blog and social media account has its own terms of service. Social networking posts, blogs, micro-blogs and text messages are stored on a server somewhere (e.g. Facebook server; AT&T server), however, there is no requirement that these private entities comply with the statute's record retention requirements. Although the federal government has managed to negotiate their own terms of service with a few providers to further compliance with record retention requirements, this is not necessarily an option for smaller state and local governments.[249]

If a governmental body receives a request for social media-type information and it is determined that the information is subject to the PIA and must be produced; and if the governmental entity has access to the information pursuant to the account's terms of service, additional questions are raised. For instance, would the private entity be able to be compensated for their time gathering such information in the same manner a public entity would be under the PIA? These are all questions that must be considered in the event the Legislature amends the PIA or the record retention statutes.

Open Meetings Act

The Texas Open Meetings Act (TOMA) is contained in Chapter 551 of the Government Code. Pursuant to the TOMA all meetings of a governmental body must comply with public notice and access requirements.[250] A "meeting" is defined as a "deliberation between a quorum of a governmental body, or between a quorum of a governmental body and another person,

[248] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of Ruben Longoria, Texas Association of School Boards).
[249] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of Jonathon Frels, Office of the Attorney General).
[250] TEX. GOV'T CODE ANN. § 551.002 (Vernon 2004).

during which public business or public policy over which the governmental body has supervision or control is discussed or considered or during which the governmental body takes formal action."[251] A "quorum" is defined as "a majority of a governmental body, unless defined differently by applicable law or rule or the charge of the governmental body."[252] Members of the governmental body are prohibited from knowingly conspiring to circumvent the TOMA by meeting in numbers less than a quorum for the purpose of secret deliberations.[253] A violation of the Act is a misdemeanor punishable by a fine ($100 to $500) and/or confinement in county jail (1 month to 6 months).[254]

The Attorney General and the courts have interpreted the TOMA to include the concept of a "walking quorum."[255]

> If a governmental body may circumvent the Act's requirements by "walking quorums" or serial meetings of less than a quorum, and then ratify at a public meeting the votes already taken in private, it would violate the spirit of the Act and would render an unreasonable result that was not intended by the Texas legislature. Thus, a meeting of less than a quorum is not a "meeting' within the Act when there is no intent to avoid the Act's requirements. *On the other hand, the Act would apply to meetings of groups of less than a quorum where a quorum or more of a body attempted to avoid the purposes of the Act by deliberately meeting in groups less than a quorum in closed sessions to discuss and/or deliberate public business, and then ratifying their actions as a quorum in a subsequent public meeting.*[256]

It should be noted that the TOMA is not restricted to verbal communications. The Attorney General has determined that written communications such as memos or e-mails may also be a form of deliberation for a governmental body.[257] Therefore, a collection of e-mails or text messages between members of the governmental body may constitute a walking quorum.

Mr. Houston, testifying on behalf of the Texas Municipal League, noted that officials are not advocating for being able to conduct illegal meetings; their concern is over inadvertent violations of the TOMA which may result in criminal penalties.[258] However, the intent element required for a walking quorum serves to limit an official's exposure for inadvertent acts.

In 2005 criminal charges were brought against members of the Alpine City Council for violations of the TOMA. The council members allegedly violated the TOMA by sending a series of e-mails discussing a matter on the agenda of an upcoming council meeting.[259] The series of e-mails reached a quorum of the City Council. The criminal charges were later dropped; however,

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[251] *Id*. at § 552.001(4)(A).
[252] *Id*. at § 552.001(6).
[253] *Id*. at § 552.143(a).
[254] *Id*. at § 552.143(b).
[255] Op. Tex. Att'y Gen. No. GA -0326 (2005).
[256] Willmann v. City of San Antonio, 123 S.W.3d 469, 478 (Tex. App.--San Antonio 2003) (*citing* Esperanza Peace and Justice Ctr. v. City of San Antonio, 316 F. Supp 433, 473, 476 (W.D.Tex. 2001)).
[257] Tex. Att'y Gen. Opin. JC-307 (2000).
[258] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of Scott Houston, Texas Municipal League).
[259] *Id.*

two council members filed suit in federal district court challenging the constitutionality of the TOMA under § 1983 of the federal Civil Rights Act.[260] The plaintiffs contended that the criminal penalties in the TOMA violate their free speech rights under the First Amendment to the U.S. Constitution. Relying on the Supreme Court's decision in *Garcetti v. Ceballos*, the federal district court held that the TOMA was constitutional.[261] On appeal, the Fifth Circuit reversed the lower court by distinguishing *Garcetti* and stated: "We agree with the plaintiffs that the criminal provisions of TOMA are content-based regulations of speech that require the state to satisfy the strict-scrutiny test in order to uphold them."[262] Although the case was later dismissed as moot when the plaintiffs were not longer elected officials,[263] a new set of plaintiffs joined in a second suit in federal court raising the same challenges.[264] This suit is pending.

As with the Public Information Act, new technologies provide challenges for interpreting the TOMA. The walking quorum concept combined with newer technologies such as micro-blogs (e.g. Twitter), social media websites (e.g. Facebook), text messaging and instant messaging, raise new issues for consideration by the Attorney General, the courts and the Legislature. Neither the courts nor the Attorney General have determined the applicability of the TOMA to these new technologies; however, under the current interpretations of the Act, a quorum could exist if a majority of the governmental body discusses public business on a Facebook wall. The Facebook wall could be closed to the public, or open; however, absent prior notice of the "meeting" the commissioners would be in violation of the TOMA. A similar situation could arise with Twitter where members can have public or private accounts.

Another issue that is pertinent to this discussion is the transitory nature of online posts to social media websites. The TOMA does not have a time constraint associated with the walking quorum concept. Therefore, are communications relating to public business irrelevant once the subject action has been addressed in a public meeting?

Other Jurisdictions

Some jurisdictions have adopted policies for their elected officials and employees relating to their conduct of governmental business via electronic communications. For instance, the Board of County Commissioners in Escambia County, Florida, has adopted a policy which prohibits the use of e-mail, instant messages, texts or blogs from a personal account.[265] Similarly, the City of San Jose, California, expressly states that public records include communications on personal devices.[266] Moreover, a city councilmember must disclose any e-mails and/or texts relevant to a matter under consideration received during a meeting.[267]

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[260] *Id.*
[261] Rangra v. Brown, No. P-05-CV-075, 2006 WL 3327634 (W.D. Tex. Nov. 7, 2006).
[262] Rangra v. Brown, 566 F.3d 515, 521 (5th Cir. 2009).
[263] Rangra v. Brown, 584 F.3d 206 (5th Cir. 2009) (Dennis, J., Dissenting) *dismissing* Rangra v. Brown, 576 F.3d 531 (5th Cir. 2009).
[264] City of Alpine v. Abbott, No. P-09-CV-59, (W.D. Tex. Jan. 7, 2010).
[265] Board of County Commissioners, Escambia County, Florida, County Commissioners' Technology Policy (effective Aug. 20, 2009).
[266] City of San Jose, California, Public Records Policy and Protocol 0-33 amended March 2, 2010.
[267] City of San Jose, California, Resolution of the Council of the City of San Jose Approving Revisions to (1) City Council Policy 0-32, *Disclosure and Sharing of Material Facts*; and (2) City Council Policy 0-33, *Public Records Policy and Protocol* (March 2, 2010).

With regard to other forms of electronic communications, specifically social media, the City of Seattle has adopted a social media policy which states that the department maintaining the site is responsible for responding to public records request on social media. Additionally, the policy clarifies that state and local record retention requirements apply to social media format and contents. However, the policy does not address the use of personal social media sites to conduct public business.[268] The state of Michigan has formed a social media governance board staffed by state agency representatives. Additionally, Michigan is considering a broad statewide policy relating to the use of social media websites.[269]

In a related issue, the City of San Antonio has advocated for amendments to the PIA to allow for the recoupment of costs for the production of e-mail records requested for inspection only.[270] Additionally, the amendments would also re-set or toll the deadline for submitting a request for a ruling to the Attorney General until after the requestor has responded to the cost estimate.

These policies provide a starting point for discussions around the possibility of statewide and/or local policies on the use of personal e-mail, social media and blog accounts.

Recommendations

The Committee makes the following recommendations:

13.a. The Legislature should update the Public Information Act, the Open Meetings Act and record retention statutes to address newer technologies. At a minimum, the relevant statutes should be clarified with regard to e-mail communications. Any such update should consider the transient nature of some electronic media as well as varying user agreements.

13.b. The Legislature should consider forming an advisory board made up of state agency representatives to address ongoing public information and open meetings issues relative to current and future technology developments. Such a group should work with the Public Electronic Services On-the-Internet (PESO) workgroup coordinated by the Department of Information Resources.

13.c. Any amendments to the Public Information Act, the Open Meetings Act and/or record retention statutes should also include new and thorough training for all entities impacted by the changes.

Charge No. 14

Monitor the implementation of legislation addressed by the Senate Committee on State Affairs, 81st Legislature, Regular and Called Sessions, and make recommendations for any legislation needed to improve, enhance, and/or complete implementation.

[268] City of Seattle Social Media Use Policy *available at* http://www.seattle.gov/pan/SocialMediaPolicy.htm (accessed Dec. 15, 2010).
[269] *See* Appendix XIII for Michigan Department of Technology, Management and Budget, *Draft Uniform Standards for Online Social Networking*.
[270] Senate Committee on State Affairs hearing, May 11, 2010 (testimony of Helen Valkavich, City of San Antonio).

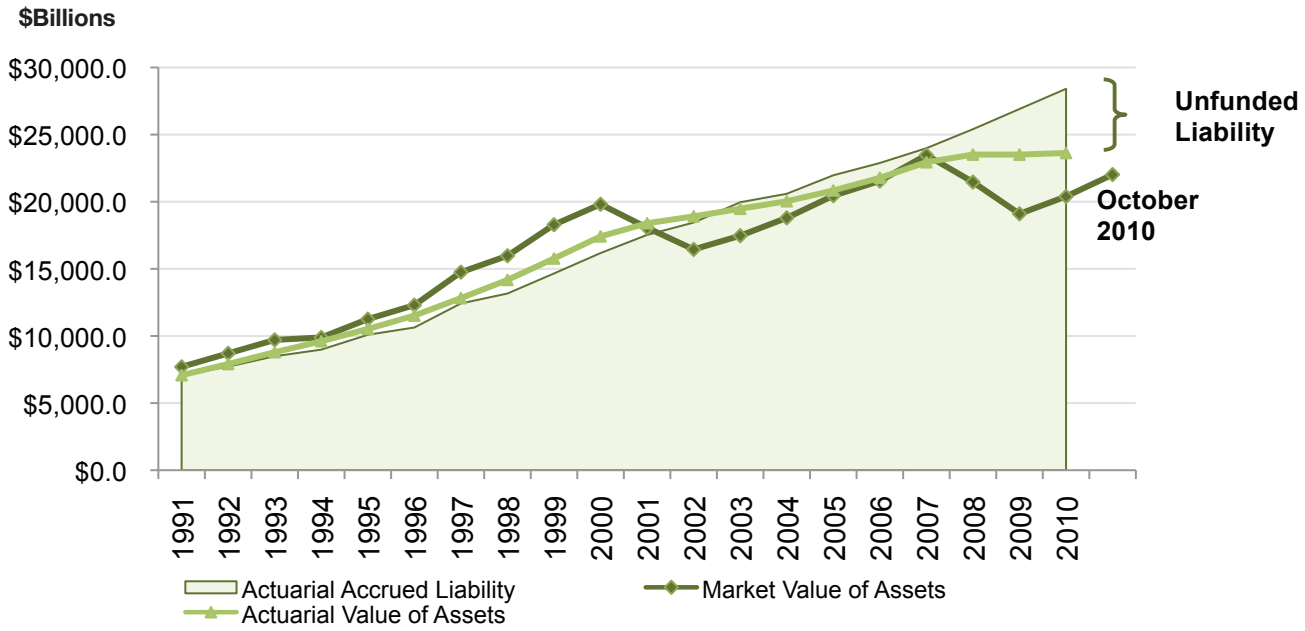
The Committee took no action relating to this charge.

APPENDIX II

- *History of ERS Investment Returns* (excerpt from *Financial Condition of the ERS Pension and Health Plans*), Employees Retirement System of Texas presentation to Senate Committee on State Affairs (Nov. 15, 2010).
- *Assessing the Impact of Approved Benefit Changes on FY2011 Costs*, (excerpt from *Financial Condition of the ERS Pension and Health Plans*), Employees Retirement System of Texas presentation to Senate Committee on State Affairs (Nov. 15, 2010).
- *Estimated Cost Impact of Federal Health Care Reform* (excerpt fro*m Financial Condition of the ERS Pension and Health Plans*), Employees Retirement System of Texas presentation to Senate Committee on State Affairs (Nov. 15, 2010).
- *Market and Actuarial Values of Assets* (excerpt from *Teacher Retirement System of Texas Actuarial Valuation as of August 31, 2010*), Gabriel Roeder Smith & Company.
- *TRS-Care Claims Cost*, (excerpt from Teachers Retirement System presentation), Senate Committee on State Affairs (Nov. 15, 2010).
- *TRS-Care Funding* (excerpt from Teachers Retirement System presentation), Senate Committee on State Affairs (Nov. 15, 2010).
- *TRS-Care Funding*, (excerpt from *TRS Health Benefits Briefing*), Gabriel Roeder Smith & Company (Nov. 8, 2010).
- *Overview of TRS-ActiveCare*, (excerpt from Teachers Retirement System presentation), Senate Committee on State Affairs (Nov. 15, 2010).
- *TRS-ActiveCare Claims Cost* (excerpt from *TRS Health Benefits Briefing*), Gabriel Roeder Smith & Company (Nov. 8, 2010).
- *An Update on HealthSelect's Alternate Health Care Payment Programs* (excerpt from Employees Retirement System presentation) Senate Committee on State Affairs (Sept. 22, 2010).
- *Status Update on SB 7 Provisions that were Enrolled in Other Bills*, Texas Health & Human Services Commission (Nov. 22, 2010).

History of ERS Investment Returns

Comparison of the Market and Actuarial Asset Values to Plan Liability



Assessing the Impact

Of Approved Benefit Changes on FY2011 Costs

Many have asked how much the September 1, 2010 changes will cost our participants. Because everyone uses the plan differently, there is no such thing as an average person or average cost—some people will pay more, and others will pay less. For example, 17% of participants had no medical costs last year. Here's a closer look based on last year's expenses.

Physician Office Visit Copayment Change	
PCP visit change to $25	38% of participants did not visit a primary doctor 20% of participants had 1 visit 14% of participants had 2 visits **Based on this plan change, the cost for 72% of participants would increase by $10 or less a year for primary care**
Specialist visit change to $40	52% of participants did not visit a specialist last year 19% of participants had 1 specialist visit 10% of participants had 2 specialist visits **Based on this plan change, the cost for 81% of participants would increase by $20 or less a year for speciality care**
HealthSelect Coinsurance Stop Loss Change	
Coinsurance change to: $2000 network/ $7000 out of network/ $3000 out of area	29,389 active participants or 5.9% of the total participants reached their coinsurance maximum 5,065 retired participants or 1.0% of the total participants reached their coinsurance maximum 3,735 unclassified participants or 0.7% of the total participants reached their coinsurance maximum **Based on this plan change, 93.4% of participants would not be affected**
Inpatient Copayment Change	
Inpatient copayment change to: $150 per day/5 day max	44,250 participants had a hospital admission or approximately 9% of the participants Of these participants, 64% had a hospital stay of 4 days or less **Based on this plan change, 91% of participants would not be affected**
Emergency Room Copayment Change	
Emergency room copay change to $150	78,569 (16%) of HealthSelect participants had an emergency room visit **Based on this plan change, 84% of participants would not be affected**
Prescription Drug Copayment Change	
Prescription drug copayments change to Tier 1 $15/Tier 2 $35/ Tier 3 $60	232,779 or 46.6% of participants utilized a tier 1 drug at least once 223,371 or 44.7% of participants utilized a tier 2 drug at least once 90,375 or 18.1% of participants utilized a tier 3 drug at least once Tier 3 drugs are the most expensive because lower cost alternatives are available
Chiropractic Care	
Chiropractic care change to 30 visits per year with a $75 maximum charge per visit	18,500 or 3.7% of participants received chiropractic care 1,461 had more than 30 visits 7,585 visits were more than $75 **Based on this plan change, 94.3% of participants would not be affected**
Urgent Care	
Lower non-emergency care copayment of $50	5,500 or 7% of all emergency room visits were for non-emergency care They would have saved $275,000 using this lower copay
High Tech Radiology	
$100 copay on all CT Scans, MRI and Nuclear Medicine +20% coinsurance	39,550 procedures were performed

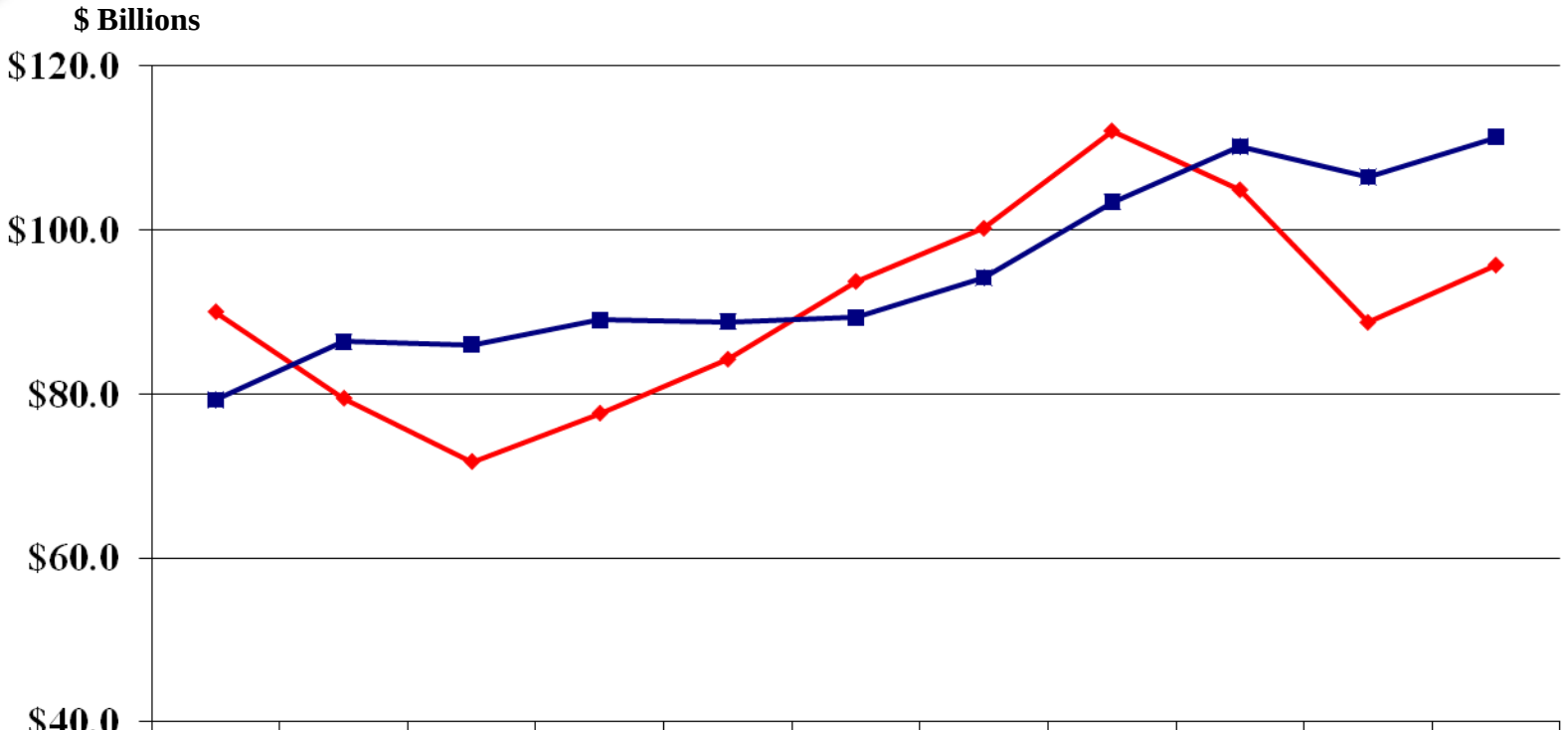
Senate State Affairs Committee

November 15, 2010

Estimated Cost Impact of Federal Health Care Reform

Estimated cost impact of selected federal health reform (PPACA) provisions on the Texas State Employees Group Benefits Program		
Provision	**Notes**	**Potential GBP Cost Impact**
Provides Free Preventive Care. All new plans must cover certain preventive services (ex. mammograms and colonoscopies) without charging deductibles, co-pays or coinsurance	The requirement to provide free preventive care has a potential cost impact to the plan of $46 per person. This does not include prescription drugs or nonprescription medications.	Increased cost 9/1/2011 (est. $14.2M in FY12; $15.5M in FY13)
Covers dependents up to age 26. The federal law requires plans to cover all children, regardless of marital status. It may allow previously excluded children back into the plan.	GBP covers all unmarried children up to age 25. There are 5,500 children age 25 who could rejoin the GBP.	Increased cost 9/1/2011 (est. $7.7M in FY12; $8.4M in FY13)
Eliminates Lifetime Limits on Insurance Coverage. Insurance companies cannot impose lifetime dollar limits on essential benefits, like hospital stays.	The GBP has a $1 million lifetime limit on out-of-network coverage. No limits apply to other coverage.	Increased cost 9/1/2011 (est. $87K in FY12; $101K in FY13)
Imposes Plan Sponsor Fees. Charges plan sponsors a $1 fee per covered life in 2013 and $2 fee per covered life in 2014. From 2014 to 2019, the fee is based on the percentage increase in health care costs.	The GBP covers 530,000 lives.	Increased cost 9/1/2013 (est. $309K in FY13)
Creates an Early Retiree Reinsurance Program. Allows ERS to apply for reimbursement of claims for retirees older than age 55 who are not qualified for Medicare. Reimbursement is for 80% of the cost of claims between $15,000 and $90,000.	The GBP application to apply for reimbursement was approved. $5 billion of federal funds are available nationwide. The potential positive impact on the GBP would be $60 million, if the GBP is reimbursed for eligible expenses.	Potential revenue for FY11 and FY12
Limits flexible spending account contributions. TexFlex contributions will be limited to $2,500 a year starting January 1, 2013.	Current annual limit is $5,000; 15% of TexFlex participants contribute more than $2,500	State's FICA tax will increase 1/1/2013
Limits waiting periods. Coverage waiting periods cannot exceed 90 days.	GBP coverage starts the first day of the month after the 90 day wait.	Increased cost 9/1/2014
Limits on increased member cost sharing. PPACA could limit the plan's options for increasing member costs in the future.	For example, if a member's health care contribution exceeds a certain percent of their household income, they could opt out of the GBP and get coverage from the exchange. In that case, the plan could be assessed penalties.	Potential increased cost 9/1/2014
Imposes a Cadillac Plan Excise Tax. Imposes an excise tax on "Cadillac Plans," defined as employer-sponsored health plans with aggregate values exceeding $10,200 for individual coverage and $27,500 for family coverage, an amount that will be adjusted for inflation in the future.	GBP does not currently meet the threshold for a "Cadillac Plan."	Neutral, may increase future costs. 9/1/2018
Closes the Medicare Part D "donut hole." Mandates prescription drug discounts for Medicare beneficiaries who reach the coverage gap, and gradually phases down the Medicare drug coinsurance rate to close the gap by 2020.	Unless there are structural changes to the Retiree Drug Subsidy program, closing the donut hole would not impact ERS.	Neutral

Market and Actuarial Values of Assets



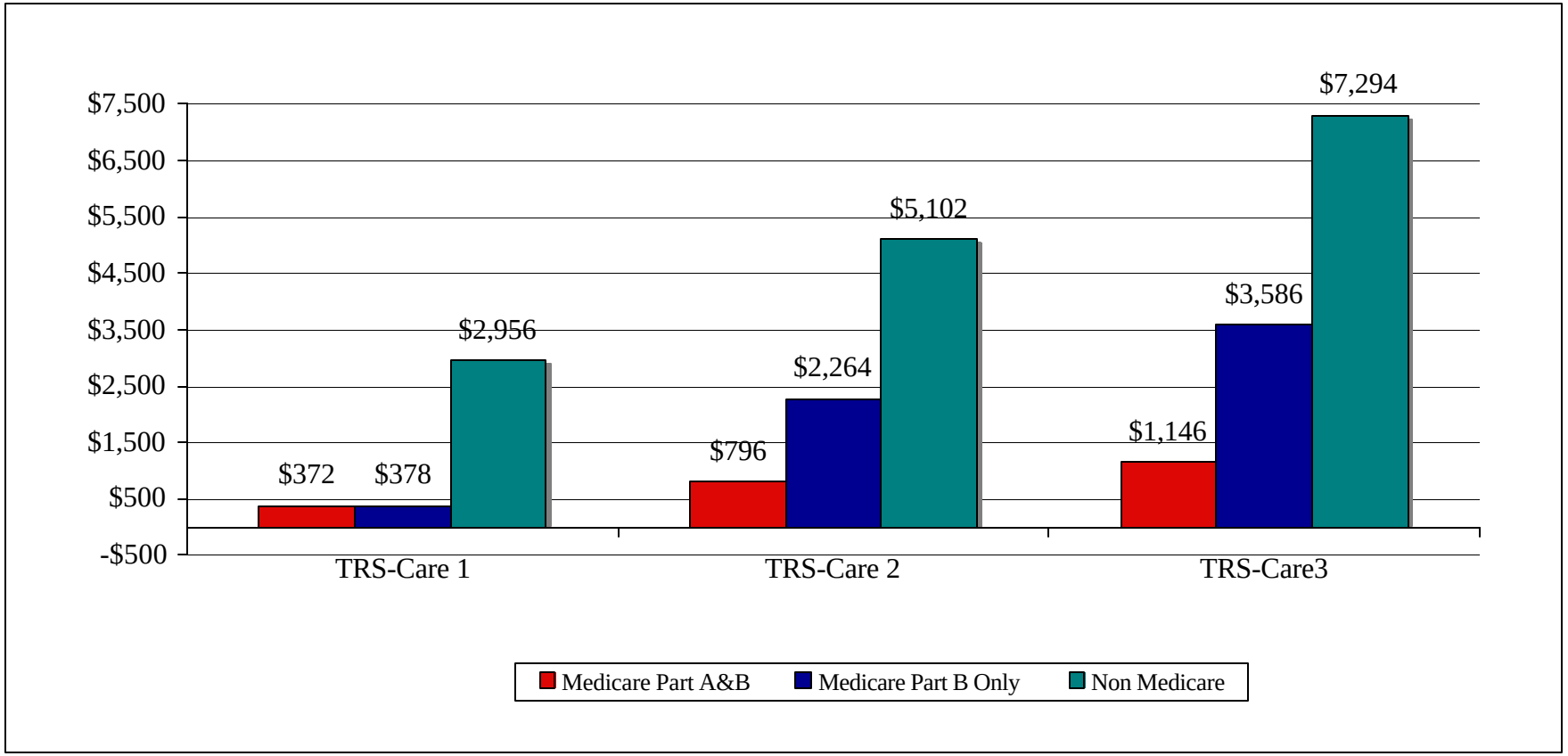
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Market	$90.0	$79.4	$71.7	$77.6	$84.2	$93.7	$100.2	$112.1	$104.9	$88.7	$95.7
Actuarial	$79.3	$86.4	$86.0	$89.0	$88.8	$89.3	$94.2	$103.4	$110.2	$106.4	$111.3

AVA is currently 116.3% of MVA compared to 120.0% last year

GRS

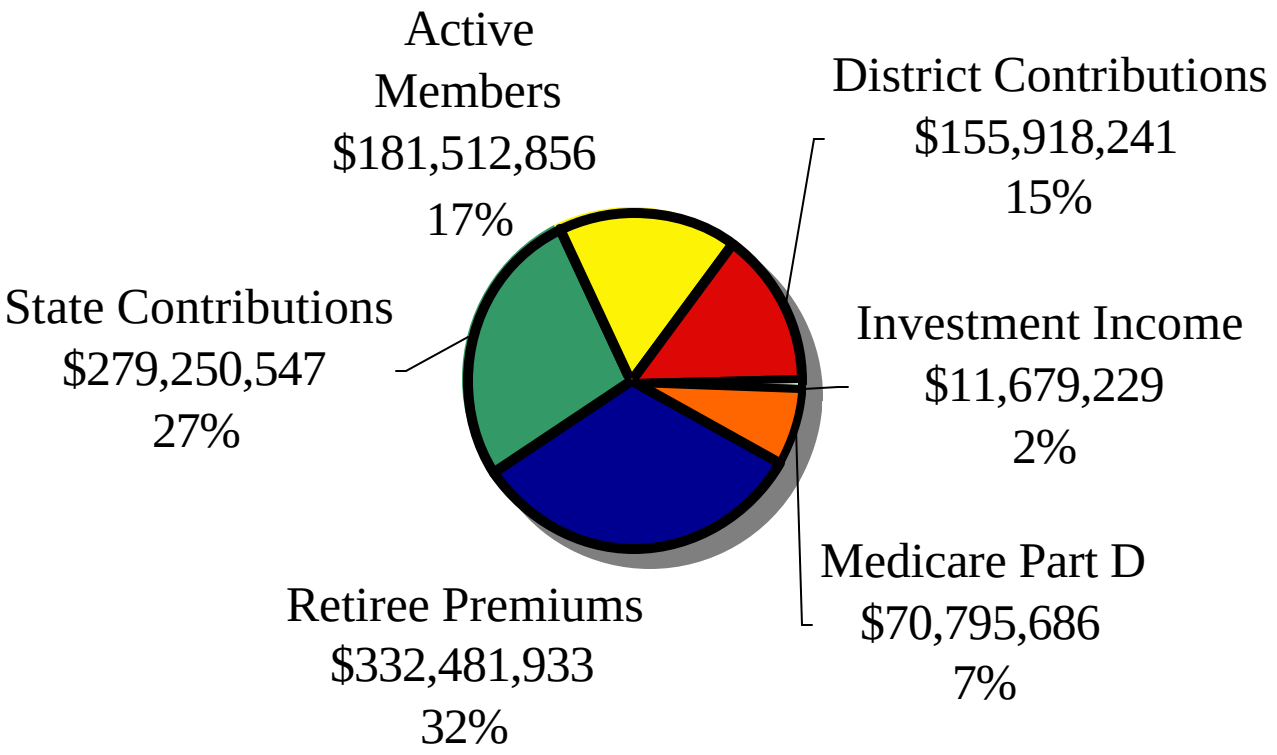
TRS-Care Claims Cost

FY 2010 Average Medical Claims Per Member By TRS-Care Level And Medicare Status



TRS-Care Funding

FY 2010 Distribution of Funding Sources



TRS-Care Funding

	Revenue							Expenditures			
	Retiree Premiums	State Contributions	Supplemental Appropriations	Member Contributions	District Contributions*	Investment Income	Part D Subsidy	Medical Incurred	Drug Incurred	Administration	Ending Fund Balance (Incurred Basis)
1986	$0	$0	$250,000	$17,625,194	$0	$572,153	$0	$0	$0	$362,371	$18,084,976
1987	$22,617,624	$25,931,680	$0	$18,522,629	$0	$2,568,998	$0	$50,988,845	$7,044,825	$3,941,936	$25,750,301
1988	$23,948,600	$31,357,632	$0	$19,598,520	$0	$5,703,832	$0	$16,157,649	$12,441,672	$4,614,755	$73,144,809
1989	$25,428,632	$37,420,711	$0	$20,789,215	$0	$8,802,914	$0	$32,926,324	$15,458,710	$5,212,073	$111,989,174
1990	$37,556,561	$44,369,915	$0	$22,184,958	$0	$13,098,835	$0	$50,171,919	$19,835,965	$7,186,851	$152,004,708
1991	$46,563,787	$47,277,743	$0	$23,638,871	$0	$15,801,047	$0	$82,697,189	$28,683,081	$8,258,029	$165,647,857
1992	$56,395,797	$50,392,512	$0	$25,196,592	$0	$17,314,372	$0	$74,307,953	$33,829,694	$8,862,560	$197,946,923
1993	$65,154,653	$54,029,406	$0	$27,014,703	$0	$17,181,190	$0	$101,627,864	$40,700,513	$10,067,359	$208,931,140
1994	$80,128,944	$56,912,083	$0	$28,456,041	$0	$16,467,438	$0	$108,284,693	$45,712,060	$11,668,828	$225,230,065
1995	$89,006,331	$59,849,850	$0	$29,924,925	$0	$16,841,673	$0	$122,054,551	$50,782,093	$12,219,847	$235,796,353
1996	$82,622,236	$63,634,087	$0	$31,817,043	$0	$16,818,747	$0	$135,982,304	$57,074,921	$13,593,578	$224,037,663
1997	$87,657,784	$67,616,395	$0	$33,808,197	$0	$16,202,440	$0	$148,823,489	$62,530,982	$14,097,454	$203,870,554
1998	$91,390,173	$72,210,190	$0	$36,105,095	$0	$15,260,517	$0	$156,537,913	$76,256,158	$14,616,678	$171,425,780
1999	$96,474,107	$76,488,424	$0	$38,244,213	$0	$9,762,741	$0	$184,398,533	$93,459,890	$14,905,196	$99,631,646
2000	$120,227,960	$85,505,637	$0	$42,738,069	$0	$6,923,485	$0	$203,029,971	$110,903,247	$16,837,127	$24,256,452
2001	$131,213,445	$90,118,787	$76,281,781	$45,059,394	$0	$5,824,134	$0	$250,691,898	$139,774,848	$18,237,767	($35,950,520)
2002	$143,797,748	$94,792,026	$285,515,036	$47,378,092	$0	$7,140,560	$0	$287,729,918	$163,979,754	$19,017,292	$71,945,979
2003	$162,954,010	$98,340,798	$124,661,063	$49,170,399	$0	$3,394,956	$0	$368,462,963	$203,281,400	$21,690,329	($82,967,486)
2004	$248,552,679	$198,594,194	$298,197,463	$99,297,097	$79,457,387	$4,840,982	$0	$366,840,457	$214,514,500	$26,332,200	$238,285,159
2005	$322,780,191	$202,397,566	$64,172,167	$101,198,783	$80,914,228	$11,300,868	$0	$431,036,095	$229,522,988	$33,333,010	$327,156,869
2006	$326,844,982	$215,666,940	$0	$140,183,511	$118,607,527	$21,435,792	$34,611,607	$427,553,404	$259,532,887	$34,434,969	$462,985,968
2007	$323,957,945	$238,190,720	$0	$154,823,968	$136,008,512	$32,671,539	$52,329,617	$437,519,747	$304,773,401	$35,878,194	$622,796,928
2008	$328,505,433	$254,722,174	$0	$165,569,413	$141,672,630	$29,252,347	$59,486,239	$498,767,038	$334,742,500	$39,656,301	$728,839,325
2009	$329,723,191	$267,471,299	$0	$173,856,344	$149,562,613	$17,482,143	$61,530,735	$531,239,020	$353,893,845	$43,184,393	$800,148,392
2010	$332,481,933	$279,250,547	$0	$181,512,856	$155,918,241	$11,679,229	$70,795,686	$575,539,788	$395,817,017	$45,465,776	$814,964,303
2011	$348,828,295	$294,872,757	$0	$191,667,292	$164,794,796	$18,092,322	$76,709,536	$664,478,998	$422,100,690	$52,977,533	$770,372,079
2012	$369,473,421	$309,616,395	$0	$201,250,656	$172,903,797	$42,742,843	$88,390,844	$784,451,698	$488,278,400	$55,462,349	$626,557,589
2013	$381,520,651	$325,097,214	$0	$211,313,189	$181,418,248	$33,574,276	$103,408,815	$869,482,298	$565,316,918	$57,414,863	$370,675,903
2014	$393,246,884	$341,352,075	$0	$221,878,849	$190,358,421	$17,900,119	$119,738,741	$971,768,799	$650,130,904	$59,262,892	($26,011,604)
2015	$403,613,253	$358,419,679	$0	$232,972,791	$199,745,603	$1,189,112	$138,302,444	$1,080,128,271	$744,415,018	$60,970,417	($577,282,429)
2016	$412,884,288	$376,340,663	$0	$244,621,431	$209,602,144	$0	$158,987,730	$1,197,765,198	$848,368,772	$62,545,017	($1,283,525,159)

* Includes employer surcharge beginning in FY 2006.

Assumptions: **Actual data through September 2010**
Medical Trend - 10% and Rx Trend - 9.5%

GRS

Overview of TRS-ActiveCare
Plan Design (FY 2011)

- **TRS-ActiveCare 1** – $1,200 deductible; 80% network/60% non-network plan coinsurance; $2,000 coinsurance maximum

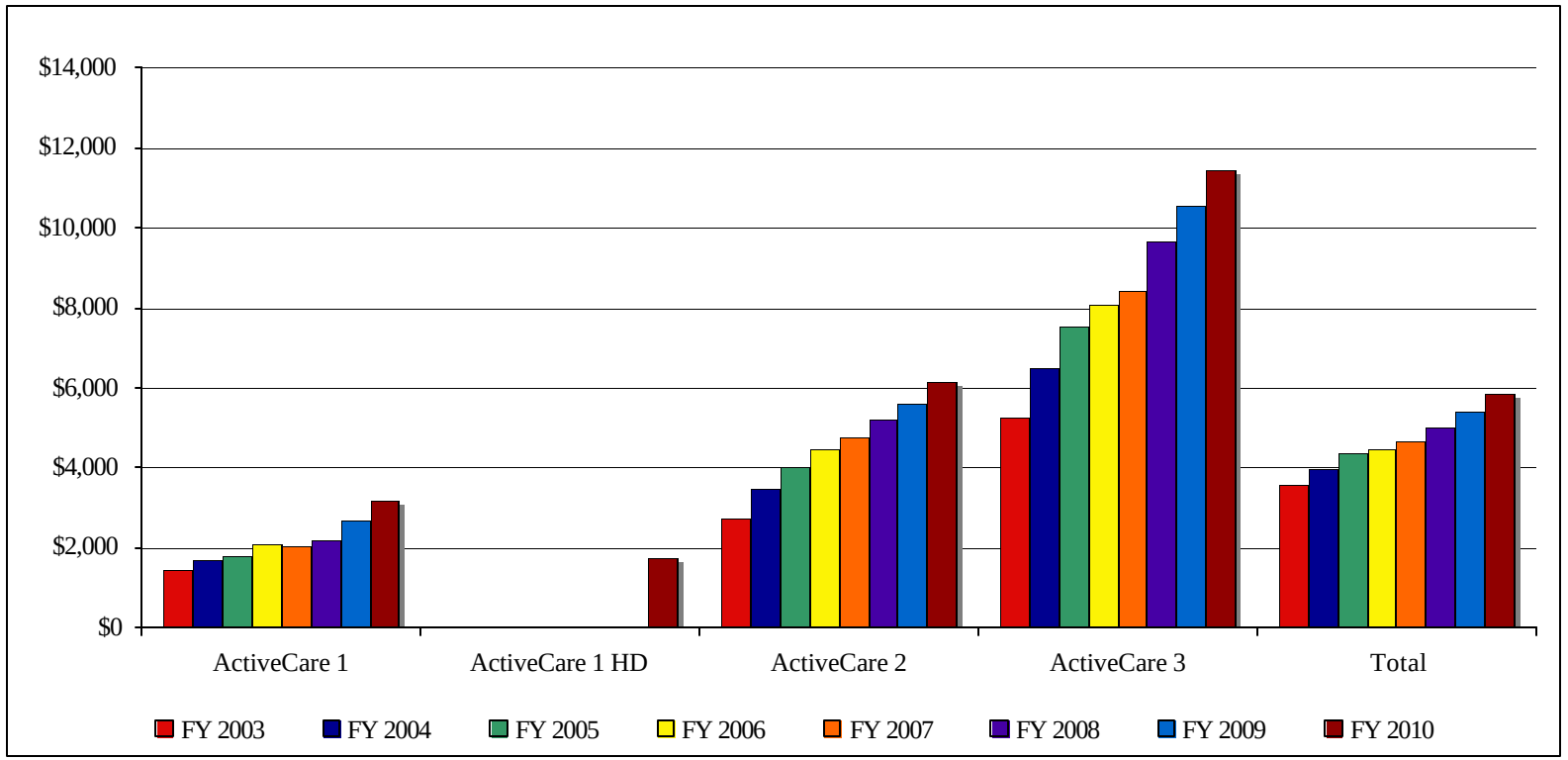
- **TRS-ActiveCare 1 - HD** - $2,400 deductible for EO, $2,300 per EF; $3,000 coinsurance maximum for EO, $5,000 coinsurance maximum for EF; 80% network/60% non-network plan coinsurance

- **TRS-ActiveCare 2** – $500 deductible; $100 per day hospital copay; 80% network/60% non-network plan coinsurance; $30 office visit copay/$50 specialist copay; $2,000 coinsurance maximum; managed drug card program

- **TRS-ActiveCare 3** – no network deductible; $100 per day hospital copay; $20 office visit copay/$30 specialist copay; $1,000 coinsurance maximum; managed drug card program

TRS-ActiveCare Claims Cost

Average Paid Claim Cost Per Employee



GRS

ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

APPENDIX A

An Update on HealthSelect's Alternate Health Care Payment Programs

September 2010

Background:

The 81st Legislature (H.B. 4586, Supplemental Appropriation Bill) authorized ERS to establish pilot programs in the Texas Employees Group Benefits Program (GBP) based on quality of care standards and evidence-based best practices. These programs compensate health care providers under alternative payment systems other than the traditional fee-for-service.

ERS has successfully concluded a pay-for-performance pilot program in Austin and continues to work with a number of groups throughout Texas to further explore innovative ways to improve quality and efficiency.

The following table summarizes ERS' progress toward implementing these systems within HealthSelect of Texas℠:

Provider Group	Program	Location	Status
Austin Pediatric Surgeons	Pay-for-Performance	Austin	Successful 12-month pilot resulted in GBP savings and provider group payments in the amount of $42,250 each. Although the pilot with this provider group was successful, all parties chose not to renew this pilot.
Austin Regional Clinic	Pay-for-Performance and Patient-centered Medical Home	Austin	This project is on target to implement January 2011.
Kelsey/Seybold Clinic	Pay-for-Performance and Patient-centered Medical Home	Houston	This project is on target to implement January 2011.
Trinity Clinic/ Mother Francis Hospital	Clinical Integration and Patient-centered Medical Home	Tyler	Initial meetings have been held. ERS is currently gathering cost data to establish performance targets. This project is on target to implement January 2011.

Texas Medical Home Initiative	Patient-centered Medical Home (multi-payor)	Dallas	This organization is attempting to establish a multi-payor medical home site and is having difficulty in achieving this goal. ERS has had no contact with TMHI since April 2010, but at that time, TMHI was recruiting medical groups and carriers to begin a demonstration project.
Memorial/Hermann Hospital System	Clinical Integration	Houston	Several meetings have been held to discuss clinical and financial targets. The medical group involved in this initiative, MH/MD, discontinued discussions and so ERS put the project on hold.
Covenant Health Partners	Clinical Integration	Lubbock	Covenant has agreed on evidence-based clinical quality targets, cost targets, administrative requirements, the participant study group, and how to measure the results and savings. Implementation of this project has been pending the outcome of a state and federal investigation of Covenant Health Partners. However, after several follow-up calls to Covenant Health Partners with either no response or action, it would appear that CHP is not pursuing this pilot any longer.
Grace Medical Clinic	Patient-centered Medical Home	Lubbock	Conducted initial discussions about a medical home for selected procedures, and the possible cost savings opportunities. This group has indicated that they wish to pursue this pilot and plans to meet with another provider group, Village Clinic in the Dallas area, who is also piloting a medical home.

Program Descriptions:

Pay-for-Performance: Clinical performance and economic benchmarks are set related to delivery of appropriate, quality care producing lower overall health care costs. These can include appropriate usage of outpatient facilities rather than in-patient; reducing duplicative lab work; and performing radiology services at lower cost facilities. A portion of the health plan's savings are shared with providers if both clinical and economical targets are achieved.

Patient-Centered Medical Home: Enhanced access and care that is coordinated among physicians and across facilities, including health information exchange, extended office hours and open scheduling. Enhanced services are paid for by the health plan through per participant/per member payments. If clinical quality and cost performance targets are met, the health plan shares savings with participating practices.

Clinical Integration: A physician network that is focused on improved patient outcomes, improved safety and reduced costs through ongoing evaluation and modification of practice patterns. If administrative, clinical quality and economic performance targets are met, the health plan's savings are shared with physicians.

Status Update on SB 7 Provisions that were Enrolled in Other Bills
November 22, 2010

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
1- Obesity Prevention Pilot Program	SB 870/ SECTION 2 Requires HHSC to coordinate with DSHS to establish a 24-month long obesity prevention pilot program for Medicaid and CHIP recipients. HHSC must submit a report to the Legislature on November 1 of each year the pilot is in place, as well as a final report not later than three months after the end of the pilot, detailing the results of the program.	• Pilot duration: November 2010 – October 2012 • Target group: Amerigroup-enrolled Medicaid children who live in the Travis STAR service area, are 6-11 years of age, pre-puberty, and are overweight with no co-morbid condition • The initial report to the Legislature was submitted in November 2010.	$1.1 GR
4- Electronic Health Information Exchange Program	**HB 1218/ SECTION 1; new provisions include an electronic health information exchange program**		
4- Electronic Health Information Exchange Program	Secs. 531.901, 531.904, 909-911 – General language about HIE system, advisory committee, incentives, reports and rules Sec. 531.904 – Electronic	• The committee was established and meets every other month; the next meeting is scheduled for December 1, 2010. • The names of the Committee members and presentation materials from the meetings are posted on the following website: http://www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/HIE.shtml.	

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
	Health Information Exchange System Advisory Committee - HHSC is required to establish an advisory committee of 12-16 members to advise HHSC on the development and implementation of the electronic health information exchange system including issues specified by HHSC, data included in electronic health records, presentation of the data, useful measures for quality of service and patient health outcomes, federal and state laws regarding privacy and management of private patient information, provider incentives for using the system, and data exchange with regional or local health information exchanges. Sec. 531.908 Incentives HHSC and the advisory committee are to develop		

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
	strategies that will encourage providers to use the health information exchange system, including incentives, education and outreach tools to increase usage. Sec. 531.909. Reports HHSC shall provide an initial report on the HIE system not later than January 1, 2011, and a subsequent report by January 1, 2013. Sec. 531.910 Rules HHSC may adopt rules for implementation.		
4- Electronic Health Information Exchange Program	Sec. 531.901-531.902 - Local/regional exchange pilot *(This wasn't part of SB 7, but relates to the HIE language from SB 7.)* Requires HHSC to establish an electronic health information exchange (HIE) system for Medicaid and CHIP in stages and in accordance	• HHSC is developing a pilot to provide Medicaid medication history information to six local health information exchanges in early 2011. The pilot will utilize the network connection being established by the pharmacy claims and rebate administrator (PCRA) vendor for e-prescribing. • An opt-out process is also being established to allow clients to exclude their data from being exchanged with HIE organizations.	

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
	with Medicaid Information Technology Architecture (MITA) standards. The HIE pilot project must include the participation of at least two local or regional health information exchanges.		
4- Electronic Health Information Exchange Program	Sec. 531.905 – Stage One – Electronic Health Record Requires HHSC to develop and establish a claims-based electronic health record (EHR) for each person in Medicaid. HHSC is required to adopt rules to specify the information that must be included in the EHR, which may include: the name and address of each of the persons physicians and health care providers; a record of each visit to a physician or health care providers, including diagnoses, procedures performed, and lab test results; an immunization record; a prescription	• The Medicaid Eligibility and Health Information System (MEHIS) will be operational Summer 2011 to replace the current paper Medicaid identification card with a plastic magnetic stripe card and serve as the platform for Medicaid health information exchange.	

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
	history; a list of due and overdue THSteps appointments; and any other available health history that providers determine is important. A patient's electronic health record must be accessible to the patient over the internet.		
4- Electronic Health Information Exchange Program	Sec. 531.9051 – Stage One – Encounter Data HHSC shall require each Medicaid MCO to submit complete encounter data for each month that includes all paid and processed claims for the month not later than the 30th day after the last day of the month to which the data relates.	• The requirement for managed care entities to submit encounter data within 30 days from adjudication was included in the managed care September 2009 contract amendment. Associated liquidated damages for failure to meet this requirement were also included.	
4- Electronic Health Information Exchange Program	Sec. 531.906 – Stage One – E-prescribing HHSC is to develop and coordinate electronic, web-based prescribing tools for use by Medicaid and CHIP	• By early 2011, the pharmacy claims and rebate administrator (PCRA) vendor will establish an interface with e-prescribing networks to enable prescribers and pharmacists to electronically exchange decision support information and prescriptions for Medicaid and CHIP clients. • MEHIS will include a web application to allow prescribers to perform e-prescribing for Medicaid clients at no cost to the prescriber.	

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
	health care providers and facilities. To the extent feasible, e-prescribing must include formulary information at the time the health care provider writes and prescription and support electronic transmission of prescriptions. HHSC also is to apply for and actively pursue any federal waiver for CHIP or Medicaid to remove an identified impediment of electronic prescribing tools under this section. If HHSC with assistance from the LBB determines that the operational modifications related to any such waiver result in cost increases in CHIP or Medicaid, HHSC must reverse the operational modifications.	Federal Regulations • Controlled Substances o The DEA has lifted the restriction of not allowing e-prescribing of controlled substances o Office E-Health Coordination and Medicaid are working with DPS and the Texas State Board of Pharmacy to review and possibly revise the State restrictions on Schedule II drugs. • Brand Medically Necessary Prescriptions o An electronic solution has been approved by CMS that allows a prescriber to request a brand named drug to be dispensed by the pharmacy when a generic is available. Opt-Out • An Opt-Out policy has been approved by the Executive Commissioner for e-prescribing.	
4- Electronic Health	Sec. 531.907 – 531.908 – Stages Two and Three	An update at this time on stages two and three is not needed at this time.	

Status Update on SB 7 Provisions that were Enrolled in Other Bills
November 22, 2010

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
Information Exchange Program	Based on the recommendations from the advisory committee and feedback from interested parties, HHSC may expand the health information exchange system in stages two and three.		
4- Electronic Health Information Exchange Program	HB 1218 / SECTION 2 – Health Information Technology Standards	HHSC plans to use health information technology standards adopted by CMS in all aspects of electronic health information exchange including the HIE Pilot, EHR and e-prescribing functions.	
6 - Quality Based Payments - Reducing Preventable Readmissions into hospitals	HB 1218	• HHSC will begin reporting Medicaid Potentially Preventable Readmission (PPR) information confidentially to hospitals in January 2011.	
6 - Report Preventable Adverse Events (Never Events)	SB 203 – Section 2 Requires hospitals to report preventable adverse event information to DSHS.	• DSHS published rules in the Texas Register for public comment in October 2010.	
6 - Reducing	SB 203 – Section 3	• Implemented September 1, 2010 (including requiring that hospitals submit present	

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
Payments in Medicaid for Preventable Adverse Events (Never Events)		on admission indicators on claims).	

9- Long-Term Care Incentives	HB 1218/SECTION 1
	
	Section 531.912 requires that, if feasible, the Executive Commissioner establish a quality of care health information exchange with nursing facilities that choose to participate in a program designed to improve the quality of care and services provided to Medicaid recipients. The program may include incentive payments only if money is specifically appropriated for that purpose.
		• DADS contracted with Myers and Stauffer LC and Vital Research, LLC to develop and implement a nursing home incentive payment program
		  • Will recommend methods for measuring the quality of nursing home care and rewarding facilities that provide better care.
		  • Will include information gathering about the quality of nursing home care and patient/family satisfaction surveys.
		  • Project completion by August 2011, including recommended quality measures and methods for rewarding better care.
			$2.5 million GR for 10-11 to develop the system

7 – Requirements of Third-Party Health Insurers (DRA Compliance)	SB 531 / SECTION 3 Section 3 of SB 531 amends state statute by adding section 32.0424 to the Human Resources	• The related State Plan Amendment (SPA) was approved by CMS with an effective date of December 1, 2009. The SPA documents Texas' compliance with third party recovery requirements contained in the DRA of 2005. • OIG Third Party Recovery (TPR) continues to work with the Texas Medicaid & Healthcare Partnership (TMHP) to update all applicable letters with the new Human Resources Code reference.	

SB 7 Section	New Bill/Section	Status Update (Activities completed, major activities planned and timelines, any major issues that may impact implementation)	SB 7 Rider Approps
	Code concerning third-party health insurers to render Texas statute into compliance with state law third party recovery requirements contained in the Deficit Reduction Act (DRA) of 2005.		

APPENDIX III

- *State Strategies for Covering Small Employers*, Texas Department of Insurance.

STATE STRATEGIES FOR COVERING SMALL EMPLOYERS

In an effort to expand access to coverage for small employers at an affordable rate, states have employed a variety of strategies to address making health insurance more affordable and more accessible to the small employer market. Some of the strategies that states have focused on include:

- Using reimbursement from a state-funded source – typically a reinsurance program
- Developing plans that exclude or limit coverage of certain mandated benefits
- Developing group purchasing arrangements

STATE-FUNDED REIMBURSEMENT OR REINSURANCE

Some states have used reinsurance or other state-funded reimbursement-type approaches to maintain or increase health coverage for small employers. These approaches allow some of the expenses for high-cost enrollees to be shifted to a third party, that could be a reinsurance carrier, a reinsurance pool or the state.

States taking this approach include Texas, Connecticut, New Mexico and New York.

Impact

Reinsurance can promote a competitive market by smoothing price volatility in existing markets by spreading risk and keeping carriers in the small employer market. In addition, this approach has reduced premiums.

LIMITED-BENEFIT PLANS

In an attempt to make coverage more affordable and accessible to the small employer market, a number of states have enacted legislation that allows carriers to offer small employers plans with either no state-mandated benefits or limited state-mandated benefits.

States taking this approach include Texas, Kentucky, Maryland and Washington.

Impact

According to information published by the State Coverage Initiatives, limited-benefit plans reduce premium costs but do so only marginally. Costs are reduced on average between 5 and 9 percent and the dollars saved may be offset since individuals holding limited-benefit policies often access uncompensated care services through the safety net. Currently, limited-benefit products have not sold well since many insurers are reluctant to sell these types of policies and consumers aren't interested in purchasing them.

GROUP PURCHASING ARRANGEMENTS

Group purchasing arrangements (GPAs) such as a health purchasing cooperative or health coalition assist small employers to realize savings as a larger group by allowing employers to join together to purchase more affordable health insurance. Several different types of purchasing cooperatives and coalitions exist with variations in membership requirements. GPAs may take the shape of association health plans (AHP), employer alliances or health insurance purchasing coalitions (HIPC).

States taking this approach include Texas, Arkansas, Kansas and New Mexico.

Impact

Existing GPAs have expanded consumer choice, but little evidence shows that the current models have significantly reduced the number of uninsured. Contrary to what has been predicted, evidence suggests prices are comparable inside and outside the purchasing groups.

APPENDIX V

- MARK A. FENDRICK, M.D., VALUE-BASED INSURANCE DESIGN LANDSCAPE DIGEST (July 2009).

National Pharmaceutical Council

Value-Based Insurance Design Landscape Digest

A. Mark Fendrick, M.D.
Professor, Internal Medicine and Health Management and Policy
Co-Director, Center for Value-Based Insurance Design
University of Michigan

July 2009

VBID

Center for Value-Based Insurance Design

AUTHOR:

A. Mark Fendrick, M.D.
Professor, Internal Medicine and Health Management and Policy
Co-Director, Center for Value-Based Insurance Design
University of Michigan

CONTRIBUTING AUTHOR:

Mari L. Edlin
Freelance Health Care Writer/Journalist
Sonoma, California

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National Pharmaceutical Council

TABLE OF CONTENTS

BRIDGING THE DIVIDE BETWEEN QUALITY IMPROVEMENT AND COST CONTAINMENT

As private and public purchasers of health care struggle to constrain rising costs, they must also strive to maximize the clinical benefit achieved for the money spent. Although expenditures are the driving force behind health care reform, concerns regarding access to medical services and quality of care also share the limelight. Thus, the need for meaningful cost containment and quality improvement has led to two prevailing trends in benefit design:

1) the use of financial incentives to alter behavior and to change utilization, and
2) the implementation of wellness and disease management (DM) initiatives to help individuals manage their health in an effort to avoid future costly events.

In addition, provider-based interventions are disseminating widely, such as Patient Centered Medical Homes (PCMH), Accountable Care Organizations (ACO) and Pay-for-Performance (P4P) programs, which pay bonuses to clinicians for adhering to evidence-based practices and attaining specific quality measures.

It is a critical challenge to develop strategies that simultaneously address the problem of spending growth and aim to improve population health. Value-Based Insurance Design (VBID) incorporates complementary features to produce effective and efficient care delivery, to ultimately **maximize health outcomes at any level of health care expenditure.**

This report, "Value-Based Insurance Design Landscape Digest," defines the VBID concept; outlines key objectives, design features and potential barriers to implementation, and describes evaluation tools for measuring the outcomes of VBID programs. In addition, the report provides examples of existing VBID programs and reviews the clinical and economic implications of VBID.

THE ROLE OF COST SHARING IN HEALTH INSURANCE

Patient cost sharing is one of the fundamental mechanisms available to change consumers' behavior and therefore will remain an important cost containment tool. It is widely accepted that higher patient cost sharing reduces utilization of health care services and consequently lowers health care spending, at least in the short-term. **Ideally, higher patient copayments would discourage only the utilization of low-value care.** However, for this important assumption to be achieved, patients must be able to distinguish between high-value and low-value interventions. When this ability to differentiate among services does not occur, increased cost sharing has the potential to cause negative clinical outcomes. A large and growing body of evidence demonstrates that in response to increased cost sharing, patients decrease the use of both high-value and low-value services.[1,2,3]

The evidence linking modifications in patient cost sharing to changes in the use of prescription drugs is relatively unambiguous, consistent from the time of the Health Insurance Experiment undertaken in the 1970's.[4] Specifically, increases in drug copayments and shifts to tiered formularies result in decreased use of medications and lower treatment adherence. Consequently, higher cost sharing for prescription drugs lowers pharmaceutical spending.

However, many observers have noted that reduced spending on prescription drugs does not necessarily result in lower total spending on health care because prescription drugs are only one of several important components of health care expenditure. Medications keep patients healthy. Healthy patients are less likely to use expensive non-drug services such as hospitalizations and emergency rooms. **Thus, the degree to which higher cost sharing for prescription drugs affects overall health care spending crucially depends on the magnitude of any cost-offsetting effects that result in other sectors of health care.** These offsets from increased use of non-drug services indicate that aggregate decreases in total health care spending will be less than the savings resulting from higher copayments in the pharmaceutical sector. In the extreme case, the increases in costs arising from increases in non-drug services may exceed the prescription drug savings achieved from lower utilization. The result is an association of higher copayments for prescription drugs with higher overall medical spending. A 2009 Canadian study reported that increases in patient cost-sharing for drugs to treat asthma led to an overall *increase* in total medical expenditures in that patient cohort.[5]

A 2007 *Journal of the American Medical Association* study examining the relationships among cost sharing, outcomes and utilization found that increased cost sharing was associated with lower rates of drug treatment, worse adherence among existing users and more frequent discontinuation of therapy. Although increased cost sharing highly correlated with reductions in pharmacy use, the study concluded that the long-term consequences of benefit changes on health were still uncertain.[6] Therefore, while cost sharing is likely to continue as a benefit design strategy, it is ill-advised in certain clinical circumstances, and alternatives to high copayments should be considered.

VALUE-BASED INSURANCE DESIGN: "CLINICALLY SENSITIVE, FISCALLY RESPONSIBLE" COST SHARING

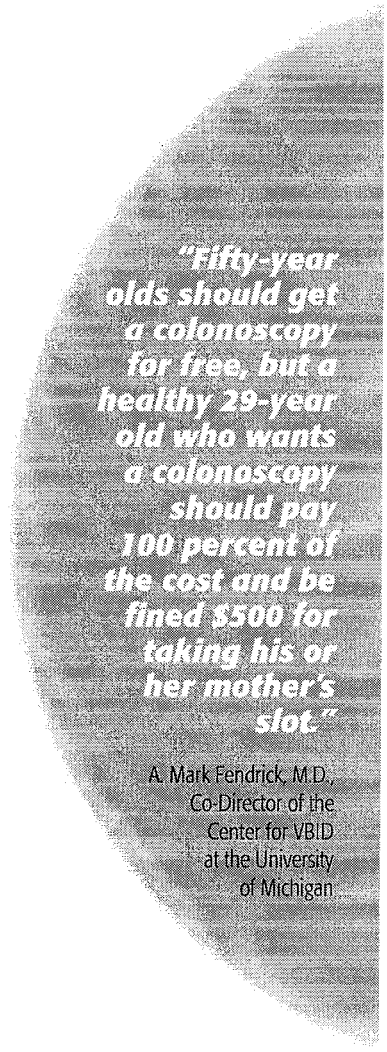
VBID offers a potential incremental solution to a key problem in the health care financing crisis – how to maximize health outcomes with available health care dollars. Instead of simply asking patients to pay more for all of their care, as is currently the case, a VBID plan adjusts out-of-pocket costs based on an assessment of the clinical benefit value – not simply the cost – to a specific patient population. **Thus, the more clinically beneficial the service for the patient, the lower that patient's cost-share would be.** In a VBID program, this "clinically sensitive" cost sharing is explicitly applied to mitigate the adverse health consequences that result when high out-of-pocket expenditures lower utilization of high-value clinical services. By aligning financial incentives, this strategy encourages the use of high-value care while discouraging the use of low-value or unproven services.[7,8,9,10]

VBID is centered on the theory that reducing or removing financial barriers to essential treatments and high performance providers will steer consumers toward value-based health care and improved health status. While a variety of stakeholders have defined VBID differently, there is consensus on the core element of VBID: **getting more health out of every health care dollar.** All parties also agree that benefit design changes must be accompanied by education and strategies for consumer engagement in order to have maximum impact.

VBID begins with its simplest definition: the lowering or elimination of financial barriers to the purchase of "high-value" drugs or services in hope of

raising compliance and avoiding more expensive future medical costs, such as hospitalization. As VBID becomes more widely adopted, the defining strategy is expanding from the targeting of high-value drugs and services for copayment reduction to the inclusion of an emphasis on the individual patient's condition and its severity, and a focus on providers of care. Next generation offerings are expected to incorporate aspects of wellness programs, disease management and patient centered medical homes.

As defined by the University of Michigan's Center for Value-Based Insurance Design, "value" is the amount of health gained per dollar spent on health care services or health benefits.[11] Therefore, assessing the value of a treatment or benefit package requires taking both cost and quality of services into consideration simultaneously. **"Value-based" does not necessarily equate to less expensive.** Contrary to popular opinion, less costly services may not always generate sufficient health benefits to be considered of value.



Regardless of the definition, VBID encompasses several key principles:

- Value equals the clinical benefit achieved for the money spent.
- Health care services differ in the health benefits they produce.
- The value of health care services depends upon the individual who receives them.

VBID packages adjust patients' out-of-pocket costs for health services based on an assessment of the clinical benefit to the individual patient. Thus, the more clinically beneficial a therapy is for a patient, the lower the patient's cost share. The same concept applies to lower copayments for using quality providers. VBID encourages demand for medically necessary utilization of evidence-based medical services through appropriate cost sharing, and reduces barriers to access for these services.

VBID challenges the postulation that increased cost sharing lowers costs by noting that in many instances, **reduced utilization – without consideration of health effects – may not be a desirable goal.** Reduced use of high-value clinician visits, medications, diagnostic tests, and procedures for patients with chronic disease can result in costly adverse events and, in some instances, higher aggregate medical care costs.

OBJECTIVES OF VBID

Cost savings should not be the exclusive goal applied to health care reform efforts, which is not to say that VBID principles cannot facilitate cost containment. Rather, VBID should be considered as a set of principles that can help guide an inevitable increased reliance on cost containment initiatives. Barriers for high-value services should remain low; but, on the other hand, services of lesser or uncertain value may be subject to higher cost sharing. VBID's objectives align with other strategies promoting cost savings and higher quality care, such as pay-for-performance initiatives; high-deductible consumer-directed health plans; and wellness, prevention and disease management programs. Although it remains uncertain whether short-term, direct medical cost savings result from a VBID program, studies have linked lower copayments for drugs to higher compliance, which ultimately has potential to yield long-term savings as a result of healthier members/employees.[12]

With multiple stakeholders involved in and affected by VBID programs, there is no one VBID design. Each program must address the cultural context in which it is implemented. Although all VBID programs should focus on value, the definition of value is subjective.

That being said, VBID programs strive to meet the following objectives:

- Obtain the greatest positive health impact from medical expenditures.
- Create an opportunity to restructure health benefits and to change the focus of the health care debate away from cost alone, to the clinical value of health services.
- Minimize the lack of adherence to evidence-based services that may result from setting across-the-board cost sharing levels.

APPROACHES TO VBID

There are four basic approaches to VBID:

1. Design by service. Waive or reduce copayments or coinsurance for select drugs or services, such as statins or cholesterol tests, no matter which patients are utilizing them. This is the strategy employed by Pitney Bowes, which in 2002 reduced the copayments for drugs that treat asthma, diabetes and hypertension.[13] Marriott International, Inc., adopted a similar approach for drug classes used to treat diabetes, asthma and heart disease.

2. Design by condition. Waive or reduce copayments or coinsurance for medications or services, based on the specific clinical conditions with which patients have been diagnosed. This approach is illustrated by the University of Michigan Focus on Diabetes Program, which lowered copayments for selected evidence-based medications and services for all employees with diabetes.[14]

3. Design by condition severity. Waive or reduce copayments or coinsurance for high-risk members who would be eligible for engagement in a disease management program.

4. Design by disease management participation. An extension of the third design approach, this VBID solution provides reduced or waived copayments or coinsurance to high-risk members who actively participate in a disease management program. The City of Asheville Project highlighted this approach through offering free medications and testing equipment only for diabetics who attended educational seminars. Wisconsin-based QuadMed, a subsidiary of QuadGraphics, sponsors eight worksite clinics and three pharmacies that play an integral role in its value-based insurance design. Employees who utilize an onsite clinic have a lower copayment than that for alternative care sites. Moreover, if they choose a preferred PPO network, employees pay a lower coinsurance rate for an office visit than for non-preferred network physicians. In addition, employees earn financial incentives if healthy behaviors are achieved, such as exercising three times a week or reaching certain clinical benchmarks, like improvement in diabetes management measured by reductions in HbA1c levels.

"Value-based design is a viable and compelling approach that – when integrated with other employee initiatives such as focused communications, disease management, coaching and wellness programs – can better support and influence the interactions between patients and providers and enable positive patient behaviors while improving health outcomes."

Jennifer Boehm,
Principal,
Hewitt Associates

FINANCIAL IMPACT OF VBID

The financial impact of VBID programs on health care spending depends on the level and precision of clinical targeting and the extent of the changes in copayments. Since many clinical services provide higher value for a select subset of patients, the better the system is at identifying those patients, the greater the likelihood of achieving a high financial return. More careful targeting of interventions results in lower program costs, because fewer individuals are eligible for copayment reductions.

Offsetting the added costs of collecting lower copayments and the related increased use of high-value services are the savings incurred by reductions in future adverse events, which are avoided by achievement of better clinical outcomes. For example, the increased direct costs of lower patient cost sharing for asthma control medications would be at least partially offset by savings resulting from fewer emergency room visits for acute asthma.

Additional return on investment accrues if the non-medical benefits of improved health are considered, such as reduced disability and absenteeism, and enhanced productivity.

The net financial benefit of the VBID program improves if:

- the underlying risk of an adverse outcome is high;
- the cost of that adverse outcome is high;
- consumers are responsive to lower copayments; and,
- the service is effective at preventing the adverse outcome.

Additional return on investment accrues if the non-medical benefits of improved health are considered, such as reduced disability and absenteeism, and enhanced productivity.

A recent *Medical Care* editorial reviewed the literature on the financial impact of changes in patient copayments, and found that cost offsets do occur, particularly among those with chronic diseases. Several studies evaluated how decreases in prescription drug spending that resulted from higher patient copayments led to increases in utilization of non-drug services such as hospitalizations, emergency room visits, etc. Offsets tended to be higher in the more targeted populations with chronic medical diagnoses.[15]

VBID EXPERIENCE

Several private and public sector employers, health plans, and pharmacy benefit managers have implemented VBID programs providing incentives to increase the use of high-value services. Notable early adopters include the City of Asheville, North Carolina; Pitney Bowes; Marriott International, Inc.; the State of Maine and the University of Michigan. In most cases, VBID programs simply lowered copayments on classes of medications identified as high value, typically those used for managing diabetes or heart disease, as in Approach 1, above. In other cases, such as the Asheville Project, the Focus on Diabetes program at the University of Michigan, and the UnitedHealthcare Diabetes Health Plan, the VBID program targets patients with a particular clinical condition.

From the experience of these early programs and efforts that followed, it is clear that to be successful, VBID programs need to adhere to the "clinically sensitive" principle, recognizing that the value of various services differs and the value of any specific intervention likely varies among patients. Allocation of resources is more efficient when the amount of patient cost sharing is based on the value of the specific health care service to a targeted patient group. The archaic "one-size-fits-all" approach, in which employers focus exclusively on reducing costs by increasing copayments across the board, fails to acknowledge the unique differences in clinical value among medical interventions and among patients.

POTENTIAL BARRIERS TO VBID

Although there is growing interest from employer groups and health plans in VBID programs, their uptake is gradual, indicating that there are some barriers to implementation. Recognition of these possible obstacles is part of the solution to overcoming them.[9]

Potential for short-term increase in utilization and cost. Lowering costs for targeted drugs will increase short-term pharmacy spending and utilization. Yet, the expectation is that better adherence will result in better health and fewer adverse complications in chronic conditions. There is a concern, however, that when copayments are reduced and costs rise, clinical status may not improve for enough of the targeted population to offset the costs associated with increased use of benefits.

Need for sophisticated data systems to identify high-value services, specific patient groups using them, and compliance. Broader data are the key to understanding opportunities and integrating VBID into existing and emerging health information systems and disease management programs.

Negative reactions from plan members whose copayments are higher than those of other members for the same medical service or drug. VBID programs that target specific diagnoses or high-risk patients may encounter this problem, but clear communication of VBID objectives can engender a positive response from employees.

Privacy issues. The transfer of data and communications efforts must comply with the Health Insurance Portability and Accountability Act (HIPAA), the same compliance issue that arises with disease management programs.

Quantifying clinical and economic return on investment (ROI). Although there is an ongoing debate about whether VBID strategies produce a short-term positive ROI, expanded use of VBID and improved adherence to beneficial therapy hold the prospect of improved health outcomes, lower costs, and healthier, more productive employees.

Measuring outcomes. There are few studies on the impact of decreased copayments on utilization of and adherence to clinically sensitive health care services. It is critical, however, to measure outcomes, specifically increased utilization and adherence, with the appropriate clinical outcome metrics associated with targeted therapy.

Unintended incentives. If copayments are lowered for all products to treat the conditions targeted by the VBID program, use of some products for other conditions that would otherwise provide high value for the health care plan may, in effect, be discouraged.

Adverse selection. VBID may attract a disproportionate number of patients with chronic conditions by specifically targeting those patients or the services they use. Adverse selection will be less of an issue when the health plan population is relatively stable.

Difficulty in accurately determining the value of services. Measuring value requires using a blend of clinical judgment, health economics, and actuarial techniques. Setting copayments appropriately takes robust actuarial analysis. VBID programs become easier to create as we learn more about high-value services through comparative effectiveness research.

Potential for fraud. VBID programs may have difficulty in differentiating between patients who qualify for lower copayments and those who do not, encouraging some providers and patients to misreport information in order to qualify for the reduced copayment. Information that identifies and classifies patients could prevent this type of fraud.

VBID CASE STUDIES

As VBID matures, a variety of organizations – business coalitions, health insurers, employers, managed care organizations, and labor unions – have created programs that reflect the ideals of value-based design: clinically sensitive to the variation in benefits both across medical services and among patients, and yielding the most value out of each health care dollar spent. Some of the case studies presented here describe programs that are in their development stages; other examples have a longer track record.

WellPoint, Inc.

BUSINESS DESCRIPTION: Headquartered in Indianapolis, Indiana, WellPoint is a health benefits company serving the needs of approximately 35 million medical members nationwide.

INITIATION OF VBID PROGRAM/STRATEGY: Late 2002.

PROGRAM OBJECTIVE: To determine the effect toward improving member health care of increased member education and waived or reduced copayments for drugs used to treat chronic disease states.

VBID PROGRAM COMPONENTS: WellPoint developed four similar pilot programs testing the benefits of a VBID model: the State of Maine, with 40,000 employees, targeting diabetes; a large retailer, with 24,000 employees, addressing diabetes and transplant medications; a large laboratory company, with 25,000 employees, targeting diabetes; and a midwestern city, with 5,000 employees, targeting diabetes and hypertension. WellPoint waived or reduced copayments for all four pilots. In the case of the retailer, WellPoint waived the copayment for transplant drugs for the first year, with a 10 percent coinsurance during subsequent years. The rationale, says Brian Sweet, WellPoint's chief pharmacy officer, is based on the expense and quality-of-care consequences of organ rejection without appropriate medications.

In addition, for 2009, WellPoint is offering four value-based benefit designs that correspond to the four basic VBID models: 1) design by service, 2) design by condition, 3) design by condition severity, and 4) design by disease management participation. Four groups have adopted model #1, and one group is using model #4, with other clients exploring various models expected to be available in 2010.

PROGRAM RESULTS: Preliminary results for the City of Maine pilot, the Telephonic Diabetes Education and Support program, show an improvement in medication possession rate (MPR), jumping from 77 percent to 86 percent after the program. In addition, compared to a randomly matched control group, members who participate in this program have an adjusted average cost of $1,300 less over 12 months of follow-up, according to HealthCore, WellPoint's outcomes research subsidiary.

Caterpillar, Inc.

BUSINESS DESCRIPTION: Based in Peoria, Illinois, Caterpillar is a Fortune 50 company specializing in forestry, construction and mining equipment, and energy solutions, with 80,000 employees and 120,000 covered lives.

INITIATION OF VBID PROGRAM/STRATEGY: January, 2005.

PROGRAM OBJECTIVE: To develop a risk management strategy to identify those at highest risk for coronary, diabetes or stroke events. These conditions were not only contributing to claims costs, but also to disability and unscheduled absences. Direct health care costs had increased 20 percent over four years.

PROGRAM COMPONENTS: According to Michael Taylor, M.D., medical director for health promotion at Caterpillar, the program, although not yet entirely founded on value, encompasses:

- One hundred percent coverage for well-women and well-baby care; zero copayments for drugs for diabetes and its associated co-morbidities, and free colorectal screenings for those at high-risk for colon cancer.
- Tracking of both financial and clinical outcomes over time.
- Health Risk Assessment (HRA), which earns employees, spouses and retirees under 65 a $900 reduction on their yearly insurance premium. Disease management programs to reflect HRA information.
- Risk stratification by cardio-metabolic indicators for diabetes, such as blood pressure, lipids, triglycerides and fasting glucose, in order to target members most at-risk for an adverse event.
- A Healthy Lifestyle index to encourage employees to make behavioral changes.
- Onsite nurse coaches who schedule one-on-one meetings with program participants, offer classes, and coordinate awareness and screening campaigns.

PROGRAM RESULTS: Caterpillar's diabetes program has rendered positive results:

- Fifty percent of enrollees experience HbA1c reduction, from 8.7 to 7.2, on average, over the course of a year;
- Ninety-six percent of enrollees measure their HbA1c levels.
- Seventy-two percent meet activity recommendations promoted by the Surgeon General.

Service Employees International Union (SEIU) Health Care Access Trust

BUSINESS DESCRIPTION: Headquartered in Washington, D.C., the two million-member union represents workers in three sectors: health care, including hospitals, nursing homes, and home care; property services, including building cleaning and security; and public services.

INITIATION OF VBID PROGRAM/STRATEGY: Spring, 2009.

PROGRAM OBJECTIVES:

- Expand first-dollar coverage for building cleaning and security personnel.
- Provide insurance for all union members.
- Improve quality of health care.
- Help members better manage health.

PROGRAM COMPONENTS: SEIU introduced a pilot program in Minneapolis, Minnesota, and Milwaukee, Wisconsin, addressing janitorial and security employees. The program established a zero copayment tier for drugs for asthma, hypertension and diabetes, based on information gleaned from health risk assessments. In addition, if employees participated in a disease management program, they were reimbursed for their doctor visit copayment or received a free debit card to cover copayments. Those without a chronic disease but who participated in telephonic coaching for weight loss or smoking cessation received the same debit card or reimbursement benefits. The benefits will be expanded to other conditions.

PROGRAM RESULTS: Although results for the program are not yet available, Dania Palanker, deputy administrator of the SEIU Health Care Access Trust, expects the program to be cost-neutral, while improving the health of members.

"We want to make our members as healthy as possible. We don't provide insurance to make money but rather to get the most value for each health care dollar spent."

Dania Palanker, Deputy Administrator, SEIU Health Care Access Trust

Mid-America Coalition on Health Care (MACHC)

BUSINESS DESCRIPTION: MACHC is an employer-driven, non-profit collaboration of stakeholders in the bi-state Kansas City region, including 465,000 covered lives.

INITIATION OF VBID PROGRAM/STRATEGY: November, 2008.

PROGRAM OBJECTIVES: Use value-based design principles to develop data-driven tools and resources to:

- Help employers improve the health of employees and their families.
- Promote employee wellness.
- Manage longer-term health care costs.

PROGRAM COMPONENTS: Called the Kansas City Collaborative (KC2), this two year collaborative, employer-based national pilot program is not simply an insurance program, but also one that encompasses health and wellness. "KC2 aims to educate employers on the value of aligning incentives for desired health behaviors and removing health care barriers for their employees. It also seeks to build data-driven resources and tools to demonstrate how Value Based Benefits concepts can be implemented across a broad range of workforces and corporate cultures to improve employee health and manage health care costs. Key learnings from Kansas City employers will be shared so that Value Based Benefits concepts can be replicated by other employers across the country." The National Business Coalition on Health (NBCH) will disseminate the strategies; Pfizer Inc. is providing technical and financial assistance.[16]

Prior to launch, KC2 offered a series of educational sessions to support employers in implementing value-based benefit initiatives, which will be introduced during the second year of the project. The collaboration also is developing an Employer Guide, which will track informational content gathered during the project and highlight the experience of coalition members in applying the value-based strategies to their organizations.

PROGRAM RESULTS: Results are not yet available.

"The program is not just a drug design, but we are putting our arms around the total health care spend and return."

Bill Bruning, President and CEO, MACHC

Health Alliance Medical Plans, Inc. (HAMP)

BUSINESS DESCRIPTION: Health Alliance Medical Plans, based in Urbana, Illinois, is a provider-sponsored health insurer providing health care coverage to more than 310,000 members in Illinois and Iowa.[17]

INITIATION OF VBID PROGRAM/STRATEGY: October, 2008.

PROGRAM OBJECTIVES:

- Increase medication compliance.
- Reduce cost barriers to accessing drugs.
- Achieve better health outcomes.
- Manage disease states more effectively.
- Reduce medical costs for asthma and diabetes.

PROGRAM COMPONENTS: Available to 86,000 fully insured members and dependents, the HAMP program has developed a fourth copayment tier called the Value Based Benefit tier, which addresses members with diabetes, hypertension and asthma. The new benefit makes specific drugs related to the three conditions available for a 10 percent copayment (10 percent of the retail cost), a copayment less than HAMP's second tier $22 copayment. All statins are available for $10 or less. Health Alliance expects to expand the program to include drugs for multiple sclerosis, rheumatoid arthritis and other rare diseases, using incentives based on compliance, both to encourage compliance and to reward it. It also moved lower value drugs to higher tiers and chose not to cover over-the-counter non-sedating antihistamines, the latter decision saving $2 million.

PROGRAM RESULTS: A pilot group demonstrated increased compliance due to the new fourth tier; better blood sugar control; a move from rescue to control drugs for asthma; and fewer heart attacks, strokes, and kidney failures. Although utilization and monthly prescription drug costs increased for diabetes and asthma, medication adherence (medication possession rates) for diabetics and asthmatics increased 10.6 percent and 32.7 percent, respectively. Christina Barrington, HAMP's director of pharmacy, anticipates that the program will generate long-term medical savings.

Hannaford Brothers Company

BUSINESS DESCRIPTION: Founded in 1883 and based in Maine, Hannaford Brothers Company operates 167 supermarkets in the northeastern United States, employing more than 27,000 associates. Hannaford is a part of the Brussels-based Delhaize Group, a global food retailer with $27.8 billion in annual sales.[18]

INITIATION OF VBID PROGRAM/STRATEGY: January, 2004, for the VBID program addressing incentives for selecting top-quality providers; January, 2008, for the non-invasive surgery program.

PROGRAM OBJECTIVES:

- Improve quality of care for employees.
- Provide safer care by promoting the use of minimally invasive surgery.
- Deliver care more efficiently.
- Reward employees for using higher performing providers.

PROGRAM COMPONENTS: Hannaford has promoted richer benefits for individuals using top-tier providers; reduced copayments for certain disease states; offered healthy behavior credits; maintained real-time data on biometric outcomes for patients and providers and offered incentives for using certain providers for minimally invasive procedures. Hannaford has pushed for changes in surgical standard practice in Maine hospitals toward less-invasive techniques. Because minimally invasive surgery for hysterectomies, appendectomies and gastric bypass can shorten the length of hospital stay, reduce complications and speed up return to work, Hannaford wanted to make these procedures more available to its workers.

Hannaford worked with Eastern Maine Healthcare Systems on the project. Surgeons at the system's 337-bed Eastern Maine Medical Center in Bangor now use minimally invasive surgery as the default for hysterectomies and a number of other procedures.

PROGRAM RESULTS: According Peter Hayes, Hannaford's director of associate health and wellness, Hannaford has realized improvements in diabetes biometrics and decreased the risk of heart attacks, and has saved both employees and the company money through incentives for choosing top-tier providers.

"For every medical dollar saved, we could save two to three dollars in absenteeism and productivity."

Peter Hayes, Director of Associate Health and Wellness, Hannaford Brothers Company

City of Springfield, Oregon

BUSINESS DESCRIPTION: Springfield is a municipality with 241 employees, excluding fire and police, and 1,140 covered lives with a fully insured benefit plan.

INITIATION OF VBID PROGRAM/STRATEGY: December, 2005.

PROGRAM OBJECTIVES:

- Promote a value-based benefit design similar to the successful one embraced by the City of Asheville.
- Produce evidence that the model, which waives copayments and provides pharmacist counseling for diabetics, could positively affect business.

PROGRAM COMPONENTS: Based on the Asheville model, the city conducted a study called EMPOWER for patients with both type 1 and type 2 diabetes. Patients were enrolled from December, 2005, through February, 2006. Copayments and coinsurance were waived for drugs and physician office visits related to diabetes control, and the intervention group also received referrals to a participating pharmacist for individualized consultation. The program focused on improvement in HbA1c and cholesterol levels, medication adherence, and sick leave.

PROGRAM RESULTS: Upon entry into the program, the mean HbA1c levels were 7.25 percent and 7.32 percent for those in the control and intervention groups, respectively. After the waived copayment for both groups and additional counseling for the intervention patients, HbA1c levels decreased 30 percent and 50 percent for control and intervention groups, respectively.

The study also looked at the percentage of patients at an HbA1c target level of less than or equal to 7 percent, as recommended by the American Diabetes Association. Data showed that in the control group the percentage that achieved the target level decreased from 50 percent to 48 percent before and after the program, but for the intervention patients the percentage rose from 46 percent to 63 percent.

Mean serum cholesterol dropped by 8.7 mg/dL for the control group and 13.5 mg/dL for the intervention group, while LDL decreased by 1.6 mg/dL and 5.8 mg/dL for the two groups, respectively. On the other hand, HDL decreased in both groups. Sick leave decreased dramatically for those in the intervention group, from 83.7 hours to 68.4 hours, but rose for the control group, from 87.7 hours to 90.4 hours. Although the average cost per intervention patient was $950, compared to $500 per patient in the control group, intervention patients showed better glycemic control and took fewer days off work.

Ardis Belknap, human resources manager for the City of Springfield, Oregon, is optimistic that the program may translate into improved health for those with diabetes – not immediately, but in the future – and remove barriers to access to care. She says that the value-based design has been adopted by other employers and organizations and is slated to include more diseases, such as depression. Because of the success of the program, the benefit became a regular offering available to all covered lives with diabetes in early 2008.

Midwest Business Group on Health (MBGH)

BUSINESS DESCRIPTION: Based in Chicago, the Midwest Business Group on Health is a not-for-profit coalition of 90-plus private and public employers that promotes collaboration to improve the cost and quality of health care.

INITIATION OF VBID PROGRAM/STRATEGY: Summer, 2007.

PROGRAM OBJECTIVES:

- Adopt a VBID program.
- Improve diabetes chronic disease management.
- Balance quality and costs.
- Demonstrate clinical improvements in employees with diabetes.

PROGRAM COMPONENTS: MBGH's VBID program, "Taking Control of Your Health," is part of the Diabetes Ten City Challenge in which employers provide employees, dependents and retirees who have diabetes with a voluntary health benefit, waive the copayments for diabetes medications and supplies, and help people manage their diabetes with the help of a specially-trained pharmacist "coach." "Taking Control of Your Health" is a multi-year effort to address diabetes and other conditions that represent a significant health issue in the seven-county Chicago metropolitan area and in North Carolina. About 200 people are participating in the program, representing employees from Hospira, Inc., the Jewish Federation of Metropolitan Chicago, and Pactiv Corporation. Jessica Westhoff, director of projects and communications at MBGH, says the consultations with pharmacists have been a positive addition to the waived copayments. MBGH is actively recruiting other employers to participate.

PROGRAM RESULTS: Although statistics on adherence to medications and costs associated with the program are not yet available, MBGH does indicate positive process measures after a year in the program: on average, patients' HbA1c levels dropped from 7.1 percent to 6.9 percent; systolic and diastolic blood pressure decreased from 129 and 78 to 125 and 76, respectively; LDL cholesterol fell from 92 to 87; and body mass index (BMI) fell from 32.3 to 31.

UnitedHealthcare

BUSINESS DESCRIPTION: UnitedHealthcare, part of the UnitedHealthcare Group, provides benefit plans and service solutions on a dedicated basis to large, multi-site employers, and coordinates network-based health care benefits and services on behalf of small to mid-sized employers, as well as individuals and families. UnitedHealthcare offers a full spectrum of consumer-oriented health benefit plans and services to 26 million covered lives.[19]

INITIATION OF VBID PROGRAM/STRATEGY: January, 2009.

PROGRAM OBJECTIVES:

- Help diabetics and pre-diabetics manage their conditions more effectively.
- Control employers' escalating costs in insuring this diabetes population.
- Delay the progression of the disease in people with diabetes.

PROGRAM COMPONENTS: The Diabetes Health Plan, a first-of-its-kind program, rewards diabetics and pre-diabetics who routinely follow medically proven steps to help manage their condition, including regular blood sugar checks, routine exams, preventive screenings and wellness coaching. The benefit incentives include some diabetes-related supplies and prescription drugs at no charge (insulin, oral anti-glycemics, anti-depressants, statins, angiotensin receptor blockers and ACE inhibitors), lower copayments for related doctor visits, and a voluntary screening model to help members determine if they have undiagnosed diabetes or suffer from pre-diabetes conditions. Participants also have access to online monitoring and education tools at no cost, and they must comply with diabetes and preventive care evidence-based guidelines to remain in the plan.

PROGRAM RESULTS: UnitedHealthcare anticipates that the Diabetes Health Plan will result in a savings of $500 a year per member. According to UnitedHealthcare data, treating pre-diabetic patients costs $5,000, while the average annual cost of diagnosed diabetics with complications, such as heart disease or kidney failure, can be as high as $30,000.[20]

"The Diabetes Health Plan provides incentives to empower diabetics and pre-diabetics to take charge of their health and well-being, helping them delay or prevent the onset of dangerous diabetic complications later in life, which in turn should help employers lower the cost of providing health benefits."

Sam Ho, M.D.,
Executive
Vice President and
Chief Medical Officer,
UnitedHealthcare

EVIDENCE-BASED VBID PROGRAM EVALUATION

As employers seek to become more prudent purchasers of health care, they need value-based measurement tools to help assess the benefits of their expenditures. Avalere Health and its research partners – the Center for Value-Based Insurance Design, the National Business Coalition on Health and Pfizer Inc. – concluded in an analysis published in November, 2007, that employers lacked reliable ways to evaluate the value of the pharmacy benefits they purchase. Of the more than 175 existing pharmacy benefit-related measures identified in the analysis, only 4 percent focused on value. The researchers' white paper, "Assessing Value in Pharmacy Benefits/Do Employers Have the Right Tools?" studied the landscape of measures used to evaluate the U.S. health care system. The paper classified the measures according to whether they assess cost, quality or value, the latter defined as taking into account both cost and quality.[21] In light of the current lack of value measures, the report recommends five areas for employers to consider:

- Acknowledge the tension between cost constraint and quality improvement by encouraging the development of measures of value.
- Acknowledge that health care services differ in the value they provide; thus, treat high-value services differently.
- Attain information on value across the health care system by investing in information technology and linking all claims data.
- Acknowledge that patients respond to both financial and non-financial incentives when it comes to medication adherence.
- Understand the value of benefits offered in terms of the entire health care spectrum.

MEASURING THE EFFECTS OF VBID PROGRAMS

An essential yet underestimated component of the VBID agenda is the requirement for rigorous evaluations of both the clinical and economic aspects of these innovative programs. An ideal evaluation should:

- Measure patient-reported clinical outcomes in addition to process measures that predict high-quality care.
- Use appropriate control groups. Controls make it possible to determine the extent to which observed clinical and economic changes are the result of the VBID design.
- Incorporate long-term follow-up to more effectively reveal the clinical gains of high-value services.
- Measure the non-medical benefits of health improvement, such as effects on productivity and disability.

"In developing a value-based design, you have to consider the impact of productivity, not just the design's effect on pharmacy or medical costs. The impact of lost time from presenteeism is significantly larger than time lost from incidental absence and must be measured."

Thomas Parry, PhD,
President, Integrated
Benefits Institute

The reported clinical and economic effects of VBID programs – from studies with marked variation in scientific rigor and often published in non-peer reviewed sources – shed some preliminary light on the impact of different cost sharing arrangements on health outcomes and utilization of services. These studies, for the most part, use a "pre-post" research design without a control group, are of short duration, and focus on process measures. One study, the "Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment," did use an appropriate control group to assess the effects of reducing copayments for five chronic medication classes in the context of a disease management program.[12] This study found increased adherence in four of the five classes and a decrease in non-adherence by 7 percent to 14 percent. It also concluded that the full financial and clinical consequences were difficult to assess because health gains and financial offsets associated with better adherence may accrue over time.

MODELS FOR EMPLOYERS

San Francisco-based Integrated Benefits Institute (IBI) offers a variety of tools to help employers benchmark their benefits programs and assess the health and productivity of their workforces. IBI President Thomas Parry, PhD, is concerned about conditions that may not incur high medical costs but do have a huge impact on productivity, such as depression, which is a large driver of presenteeism (working at impaired levels). IBI's models can measure a medical condition's contribution to lost productivity and identify interventions to increase productivity. Parry supports the use of valid employee self-reported data, such as health risk assessments, as a means of uncovering medical conditions that affect productivity. With this information in hand, he believes that employers can align benefits with employee needs.

Based on data from 10 corporations, a 2009 study reported in the *Journal of Occupational and Environmental Medicine* indicates that health-related lost productivity costs are 2 to 3 times greater than measures of direct spending alone. Researchers found that, when full costs are measured rather than medical costs alone, health conditions such as depression, obesity, arthritis, and other musculoskeletal problems have a stronger influence on driving up health care costs. To fully gauge health-related productivity costs, researchers measured direct medical and pharmaceutical spending along with calculations of the monetary value of lost productivity when employees were absent or working at impaired levels known as "presenteeism." The study notes that employers have not historically assessed costs in this way, preferring instead a "siloed" approach that seeks to manage single health-cost categories, such as medical visits or pharmaceuticals, through benefit-package design.[22]

Additionally, Hewitt Associates has developed a real-time Value-Based Design Model that analyzes the effect of reducing employee cost sharing for specific health care services and increasing employee cost sharing for others. The consulting group is helping companies develop evidence-based VBID programs that reduce or remove financial barriers for health care services proven to be effective for treating certain conditions, while potentially increasing cost sharing for services that have proven to be less effective. The model's objective is to create value-based designs that enable employers to minimize costs while ensuring that their employees receive the highest quality health care. Hewitt creates ROI scenarios for employers based on specific diseases, employee participation in disease management programs, and focus on target audiences.

Prime Therapeutics, a pharmacy benefits manager owned by 10 Blue Cross and Blue Shield plans, and subsidiaries and affiliates of those plans, has developed its Efficiency Program. The program stratifies members by risk for a future adverse medical event, provides a metric to understand how well pharmacy dollars are being spent, and allows for the implementation of targeted clinical programs and benefit designs based on member needs. The program focuses on therapeutic categories in which there are proven health outcomes, using predictive modeling and medical claims data to identify the high-risk members, and pharmacy claims data to determine who is adherent to their medications. An efficiency report documents utilization and spending; an efficiency ratio displays how effective an employer is in spending pharmacy dollars. Prime Therapeutics designs value-based benefits and clinical intervention programs aligned with certain conditions. They include exemption from step therapy and prior authorization for high-risk members, a lower cost share for drugs and services for those at high-risk, and inclusion of disease management and compliance programs.

The goal of the health care system is to improve health, not save money.

Aetna is in the midst of a multi-year prospective study that is looking at a group of heart attack patients who have no copayments for their cardiac drugs versus a control group that has a normal copayment for the drugs. The objective is to measure the effect of the copayment on compliance and on the incidence of second heart attacks.

ALIGNING INCENTIVES: THE EFFECT OF VBID

If an immediate monetary return on investment (ROI) on direct medical expenditures is a major objective of a value-based insurance design, then the program sponsors may be disappointed. The VBID proposition implies that all benefits that come from improvement in health are to be considered, encompassing benefits beyond those in expenditure on health care. Value implies cost effectiveness, not cost savings, although VBID offers a set of principles that can help guide the inevitable increased reliance on demand-side containment initiatives. **The goal of the health care system is to improve health, not save money.**[9]

In the long run, VBID will guarantee more health per dollar spent by increasing the use of highly valued services and decreasing use of those of lesser value. The economic impact of a VBID program, however, largely depends on the details of each program. The likelihood of lowering medical expenditures is directly related to the decreased use of medical interventions that do not produce value.[23]

WAYS TO MEET COST TARGETS

Assuming that high-value and low-value services can be adequately distinguished, it is possible to achieve any cost target by financing the costs of lower copayments for high-value services through higher copayments for those services of lesser value. Distributing costs over a wide list of services helps minimize the copayment increase for any one service. However, because health and financial outcomes are dependent not only on benefit structure, but also on such elements as care management initiatives, pricing, and provider reimbursement and incentives, it is difficult to determine ROI exclusively as a result of VBID.

VBID will not necessarily save money by reducing the use of expensive services; however, there is a possibility that it could succeed if services are well targeted to those patients at high risk for expensive adverse outcomes. Employers with more targeted programs incur lower costs because only a limited number of services are eligible for lower copayments. Most of the financial and clinical gains are still realized because patients who benefit most from the services pay the lower copayment.

One concern is whether or not health status from extra health services will improve enough in the targeted population to offset the costs associated with lower copayments and more use. Measuring adherence to therapy and clinical outcomes against baseline measures for the therapy would help quantify and qualify ROI. Other savings may be accrued through improved productivity and lower disability resulting from increased utilization of highly valued services.

The following financial scenarios are likely to occur, depending on the goals of the VBID program and the willingness to raise copayments on low-value services:

- Targeted copayment reductions only. Result: higher value for each market basket of services because of incentives to use services that produce high levels of health benefit. Uncertain effect on total health care cost trend.
- Targeted copayment reductions and targeted copayment increases to offset short-term costs of increased utilization of high-value services (actuarial equivalence). Result: higher value for each market basket of services because of incentives to use services that produce high levels of health benefit. Equal or lower costs, depending on the extent of savings arising from offsets from improved health and lower utilization of low-value services because of higher copayments.

EVALUATING ROI

The Pacific Business Group on Health, a San Francisco-based employer coalition, and the California HealthCare Foundation engaged PricewaterhouseCoopers (PwC) to assess the state of research evidence regarding quality-based benefit design, which they define as, "a process of designing a health plan that explicitly takes into account the effect that a design element will have on the delivery of health care and health outcomes of covered individuals." PwC reviewed about 100 articles published since the year 2000, both from health services research (HSR), or academic, peer-reviewed literature, and from applied health benefits research (AHBR), or what is called "gray literature." In general, PwC concluded that the HSR literature yielded few studies that were specific to benefit design tactics, while the AHBR literature lacked sufficient disclosure for employers to judge the quality and strength of the evidence.[24]

The study focused on six elements of quality-based tactics/benefit design strategies that seek to increase the net value of health care spending: 1) health plan options, eligibility and premium contributions; 2) provider selection and differentiation of provider performance; 3) inpatient/outpatient benefit design; 4) pharmacy benefit design; 5) health promotion/risk reduction and chronic care management; and 6) provision of price and quality information to health care consumers. In general, the study found that for four of the six tactics – excluding pharmacy benefit design and health promotion programs – there was only partial evidence that they improved the quality of care and limited or reduced costs. The study also found that there was little good evidence in the reviewed literature indicating a positive ROI, a factor that is one of the challenges facing employers who are determining whether they should implement value-based insurance designs.

Other findings include:

- Employees' share of premium costs is still the most important factor in their choice of a health plan.
- Consumers are generally willing to accept less choice of providers if their share of costs is lower, which can lead to short-term savings. In turn, employers are less interested in offering benefits plans that have high-quality providers but cost more.
- Case studies suggest that high-deductible plans can lead to lower claims in the short term, over a two- or three-year period.

- Some evidence indicates that greater cost sharing reduces spending, but none demonstrates maintenance of, or improvement in, quality of care.
- Health promotion programs can improve workers' health and productivity, but only over many years.
- Evidence that consumers' use of health care information has an impact on their health or their health care purchasing decisions is limited.

It may be safe to say that, although there is no conclusive evidence as to ROI accrued through VBID programs, **a plan design that aligns incentives to encourage use of high-value services and discourage use of services of marginal value will improve the effectiveness and efficiency of utilization of health care resources.**

ESTABLISHING A SYNERGY WITH ONGOING HEALTH CARE REFORM

Balancing cost growth and quality gaps in health care is no easy task, but there are several tools being tried to address quality improvement while containing costs on regional and national levels. Frequently mentioned reform platforms include: health information technology (HIT), consumer-directed health plans (CDHPs), pay-for-performance (P4P), comparative effectiveness research (CER), and patient centered medical homes (PCMH).

Providing Information Through Technology. Ultimately, sophisticated information systems will tie together electronic medical records, clinical information (e.g., comparative effectiveness research, evidence-based guidelines, etc.), and financial data to create "personalized benefits" that encourage value and discourage waste. An IT infrastructure is not yet established that will allow consumers better access to unbiased information on quality and cost of care, a situation that causes unwanted clinical effects that are directly related to misaligned financial incentives. Access to more information in and of itself doesn't produce value, but combining an HIT infrastructure with VBID principles should facilitate attainment of this goal. Such health information technology, which the Obama administration and the U.S. Congress have deemed crucial to an economic recovery, is clearly consistent with the objectives of VBID and other health care reform initiatives.

In a 2007 *Health Affairs* article, Troyen Brennan, M.D., executive vice president and chief medical officer of CVS Caremark, and Lonny Reisman, M.D., chief medical officer of Aetna, wrote that information technology should be "fused" into benefit design and used to identify by reported claims which patients have suffered a medical event or what medications patients are taking. Then it would be possible to change the benefits to reflect individual needs.[25]

VBID/CDHPs: Complementing Each Other. Consumer-directed health plans and VBID complement each other by aligning clinical and financial incentives to encourage the use of high-value services and discourage services of lesser value. Similar to VBID programs, some CDHPs offer no deductible, first-dollar coverage for certain medications, preventive care, and services that are critical for chronic disease patients. Both models promote greater consumer responsibility and use evidence-based information to induce consumers to be more cost-conscious and purchase clinically appropriate, high-value care. The next generation of consumer-driven care will require more attention to value-based insurance design so as to ensure that patients have access to appropriate and high-quality care. This can be accomplished so long as insurers carefully integrate financial incentives into benefit design, build advice about evidence-based medicine into their plans and thoroughly use the increased facility of information technology in their efforts. [26]

Physician Payment Reform. One primary principle behind P4P and PCMH is to reward providers for achieving quality measures, increase preventive care, and decrease overuse of services, all based on evidence-based medicine. For the health care system to become efficient, it must achieve an alignment of incentives, both non-financial and financial, for all stakeholders. Patients should have minimal or no barriers to accessing those services for which providers receive incentives; if they do, this constitutes a direct conflict with the fundamental tenets of these initiatives.

Patient centered medical homes, an idea which has been in formation for several decades, also shares many of the same features as VBID: evidence-based support for clinical decisions, information systems, provider incentives and quality improvement along with cost effectiveness. The medical home concept endorses the delivery of primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective. It emphasizes collaboration between patients and personal physicians. Several organizations have put forth basic principles for medical

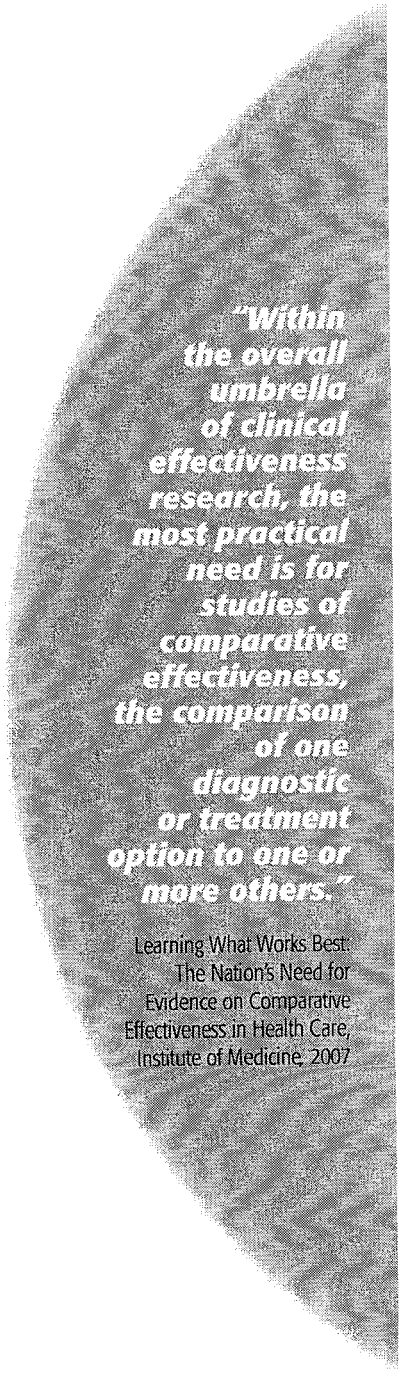
homes that focus on practice redesign that is delivered in response to patients' needs and preferences; adoption of health information technology to facilitate evidence-based integrated care; structuring of payment to align with measurable improvement in care; and accountability.

Comparative Effectiveness Research. Comparative effectiveness research assesses how various procedures or interventions compare with each other for a given medical condition for a specific group of patients, and thus contributes to maximizing the value realized from those procedures or interventions. In 2007, the Institute of Medicine published "Learning What Works Best: The Nation's Need for Evidence on Comparative Effectiveness in Health Care." The report states:

> "Within the overall umbrella of clinical effectiveness research, the most practical need is for studies of comparative effectiveness, the comparison of one diagnostic or treatment option to one or more others. In this respect, CER involves the direct generation of clinical information on the relative merits or outcomes of one intervention in comparison to one or more others."

Without a strong investment in CER, patients and providers are more likely to face unintended "across-the-board" restrictions on the provision of valuable care. Although some have argued that CER should include cost-effectiveness analysis, recent legislative efforts to expand the national capacity for CER have focused on outcomes and effectiveness, and not cost.[27]

VBID's synergism with key reform initiatives – health information technology, CDHPs, P4P, comparative effectiveness and medical homes – is indicative of the new role that value is playing in the utilization and purchase of health care. It also is indicative of a trend toward integrated health care, away from the siloed perspective of traditional health care and an emphasis on individual consumers and their responsibility for their own well being.[15]



VBID IN A TRANSFORMED HEALTH CARE SYSTEM

Payers desiring to optimize health gains per dollar spent should adopt a "clinically sensitive" design that removes barriers and provides incentives to encourage desired behaviors. VBID programs become easier to create as more is learned about high-value services through comparative effectiveness research, and easier to implement with the wider dissemination of health information technology.

The alignment of financial incentives – for patients and providers – would encourage the use of high-value care, while discouraging the use of low-value or unproven services, and ultimately produce more health at any level of health care expenditure.

While barriers to VBID implementation certainly exist, such as concern over beneficiary reaction to the program and implementation costs, private purchasers are increasingly adopting VBID programs as they acknowledge that **efforts to control health spending through patient cost sharing should not produce preventable reductions in quality of care.** This realization also has spread to the Medicare program; legislation entitled, "Seniors' Medication Copayment Reduction Act of 2009," was introduced in Congress (S.1040) to require Medicare to test the impact of reduced cost sharing for medications used to treat 15 common clinical conditions in the Medicare population.[28] Moreover, the June, 2009, MedPAC Commissioners Report acknowledges VBID as an important part of a more efficient Medicare system.[29]

Experience in the field indicates that VBID programs are feasible, acceptable by all vested stakeholders, and have been very well received by beneficiaries. VBID can address several important inconsistencies in the current system and work synergistically with other initiatives such as HDHP, DM, PCMH, and P4P programs. By allowing different cost sharing provisions for different services, value can be enhanced without removing the role of cost sharing in the system overall. Targeted efforts to reduce utilization of low-value services are more likely to contain cost growth while maintaining quality of care.

We do not expect VBID to solve our health care crisis. Technological advances will continue to generate upward pressure on costs, and the ability of individuals and their employers to afford such coverage will be increasingly strained. However, the inability to construct the perfect benefit design should not lead to abandonment of key VBID principles that explicitly aim for more efficient allocation of health care resources. **The alignment of financial incentives – for patients and providers – would encourage the use of high-value care, while discouraging the use of low-value or unproven services, and ultimately produce more health at any level of health care expenditure.** The cost of maintaining the status quo, in terms of higher spending and worse health outcomes, is undesirable.

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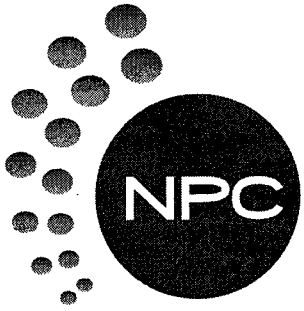
Uncited quotations in this paper are from interviews conducted by Mari Edlin.



1894 Preston White Drive
Reston, VA 20191-5433

1501 M Street, NW
Suite 650
Washington, DC 20005

Phone: 703.620.6390
Fax: 703.476.0904

www.npcnow.org

APPENDIX VI

- *The Voter Registration Requirements of Sections 5, 6, 7 and 8 of the National Voter Registration Act (NVRA) Questions and Answers*, Department of Justice Civil Rights Division, accessed online http://www.justice.gov/crt/voting/nvra/nvra_faq.php.

The Voter Registration Requirements of Sections 5, 6, 7 and 8 of the National Voter Registration Act (NVRA) Questions and Answers

OVERVIEW

1. What is the NVRA?

The National Voter Registration Act of 1993 (also known as the "NVRA" or "motor voter law") sets forth certain voter registration requirements with respect to elections for federal office. Section 5 of the NVRA requires that States offer voter registration opportunities at State motor vehicle agencies. Section 6 of the NVRA requires that States offer voter registration opportunities by mail-in application. Section 7 of the NVRA requires that States offer voter registration opportunities at certain State and local offices, including public assistance and disability offices. Section 8 of the NVRA contains requirements with respect to the administration of voter registration by States.

2. What States are covered by the NVRA's requirements?

The requirements of the NVRA apply to 44 States and the District of Columbia. Six States (Idaho, Minnesota, New Hampshire, North Dakota, Wisconsin, and Wyoming) are exempt from the NVRA because, on and after August 1, 1994, they either had no voter-registration requirements or had election-day voter registration at polling places with respect to elections for federal office. Likewise, the territories are not covered by the NVRA (Puerto Rico, Guam, Virgin Islands, American Samoa). While the NVRA applies to elections for federal office, States have extended its procedures to all elections.

SECTION 5 – MOTOR VEHICLE AGENCIES

3. What voter registration opportunity is required by Section 5 of the NVRA?

Each State motor vehicle driver's license application (including any renewal application) submitted to a State motor vehicle authority must serve as a simultaneous voter registration application unless the applicant fails to sign the voter registration application. This application for voter registration must be considered as updating any previous voter registration by the applicant.

In addition, any change of address form submitted for State driver's license purposes must also serve as notification of change of address for voter registration purposes unless the registrant states on the form that the change of address is not for voter registration purposes. This means that all changes of address submitted to State motor vehicle offices must be forwarded to election authorities unless the registrant affirmatively requests otherwise by opting out on the form.

4. Do the voter registration requirements of Section 5 of the NVRA apply to all driver's license transactions with driver's license offices?

Yes. The NVRA defines the term "motor vehicle driver's license" to include "any personal identification document issued by a State motor vehicle authority." Hence, the NVRA voter registration opportunity applies to applications, renewals, and change of address transactions regarding any personal identification document issued by a State motor vehicle authority.

Moreover, to the extent that the State provides for remote applications for driver's licenses, driver's license renewals, or driver's license changes of address, via mail, telephone, or internet or other means, then provision must be made to include the required voter registration opportunity as well.

5. Does Section 5 of the NVRA mandate the use by States of any particular forms or procedures?

Yes. Each State must include a voter registration form as part of an application for a State driver's license and any application for driver's license renewal.

The voter registration portion of the application may not require any information that duplicates information required on the driver's license portion of the application and may require only the minimum amount of information necessary to prevent duplicate voter registrations and permit State officials both to determine the eligibility of the applicant to vote and to administer the voting process.

The voter registration application must state each voter eligibility requirement (including citizenship), contain an attestation that the applicant meets each requirement, state the penalties provided by law for submission of a false voter registration application and require the signature of the applicant under penalty of perjury. In addition, the application shall also include statements specifying that: 1) if an applicant declines to register to vote, the fact that the applicant has declined to register will remain confidential and will be used only for voter registration purposes; and 2) if an applicant does register to vote, the identity of the office at which the applicant submits a voter registration application will remain confidential and will be used only for voter registration purposes.

6. What is a motor vehicle agency required to do with completed voter registration applications accepted at its offices?

Completed voter registration applications accepted at a motor vehicle agency must be transmitted to the appropriate State election official no later than ten days after acceptance. However, if an application is accepted at a motor vehicle agency within five days of a voter registration deadline for an election, the application must be transmitted to election officials no later than five days after acceptance. The agency providing voter-registration services may not require a registrant to mail in the form himself or herself or discourage him or her in any manner from submitting the

form to the agency. .Similarly, if it is agency practice to make sure that agency forms are completed and signed when submitted by an applicant, the same practice should apply to a voter registration application submitted by that applicant.

SECTION 6 – MAIL REGISTRATION

7. What are the requirements for voter registration by mail provided by Section 6 of the NVRA?

Section 6 of the NVRA requires each State to accept and use the federal mail voter registration application form developed by the U.S. Election Assistance Commission. This form is available on the EAC's web site at http://www.eac.gov/program-areas/national-voter-registration-form. In addition to containing a voter-registration application, this EAC application booklet describes certain state-specific requirements. The national form and booklet have been developed by the EAC in consultation with the States.

8. Can a State develop its own mail voter registration application?

Yes. Section 6 of the NVRA also provides that, in addition to accepting and using the federal mail application, a State may develop and use its own mail voter registration form, if it meets all of the same criteria the NVRA requires for the EAC's national mail voter registration application.

9. What are the requirements for the national mail voter registration application?

Section 9 of the NVRA provides that the national mail voter registration application may require only such identifying information (including the signature of the applicant) and other information (including data relating to previous registration by the applicant), as is necessary to enable the appropriate State election official to assess the eligibility of the applicant and to administer voter registration and other parts of the election process.

The application also must include a statement that specifies each eligibility requirement (including citizenship), contain an attestation that the applicant meets each such requirement and require the signature of the applicant under penalty of perjury. The mail application must also include a statement of the penalties provided by law for submission of a false voter registration application.

The mail application must also include statements specifying that: 1) if an applicant declines to register to vote, the fact that the applicant has declined to register will remain confidential and will be used only for voter registration purposes; and 2) if an applicant does register to vote, the identity of the office at which the applicant submits a voter registration application will remain

confidential and will be used only for voter registration purposes. The mail application may not include any requirement for notarization or other formal authentication.

Section 303(b) of the Help America Vote Act of 2002 (HAVA) also requires that the national mail application include certain additional information: First, the question "Are you a citizen of the United States of America?" and boxes for the applicant to check to indicate whether the applicant is or is not a citizen of the United States. Second, the question "Will you be 18 years of age on or before election day?" and boxes for the applicant to check to indicate whether or not the applicant will be 18 years of age or older on election day. Third, the statement, "If you checked 'no' in response to either of these questions, do not complete this form." Fourth, a statement informing the individual that if the form is submitted by mail and the individual is registering for the first time, the appropriate identification required by HAVA must be submitted with the mail-in registration form to avoid the additional identification requirements upon voting for the first time. (See Response to Question 11 below for a list of these forms of identification).

10. Does the NVRA require States to make mail voter registration applications available?

Yes. The chief election official of each State must make mail voter registration applications available for distribution through governmental and private entities, with particular emphasis on making them available for organized voter registration programs. Most states satisfy these requirements by, among other things, making applications available at local registrar offices, driver license offices, public assistance offices and disability-service offices, to groups doing voter registration drives, and through the internet on the website of the chief election official. These forms are also available on the website of the U.S. Election Assistance Commission.

11. What requirements does federal law place on first-time voters who register to vote by mail?

If a person registers to vote by mail and has not previously voted in a federal election in a State, Section 303(b) of the Help America Vote Act of 2002 established new requirements.

Where a person registers to vote by mail and has not previously voted in a federal election in a State, if the voter does not qualify for one of the exemptions in Section 303(b)(3) of HAVA (described below), then he or she must submit one of the forms of identification required by Section 303(b)(2)(A) of HAVA the first time that he or she votes in a federal election. These forms of identification are: 1) a current and valid photo identification; or 2) 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. If the voter does not present the required identification, Section 303(b)(2)(B) of HAVA provides that he or she may nonetheless cast a provisional ballot.

Sections 303(b)(3)(A)-(C) of HAVA create certain exemptions from these identification requirements. An applicant who provides the specified identification documents with his or her

registration application (or otherwise provides such documentation to election officials before Election Day), is exempt from the requirement to show identification the first time he or she votes in a federal election. Likewise, an applicant who provides his or her driver's license number or last four digits of his or her social security number, and the State is able to match this information against an existing State record, is exempt from the requirement to show identification the first time he or she votes in a federal election. In addition, persons entitled to vote by absentee ballot under the Uniformed and Overseas Citizens Absentee Voting Act, or entitled to vote other than in person under the Voting Accessibility for the Elderly and Handicapped Act or other federal law, are exempt from HAVA's identification requirements.

SECTION 7 – VOTER REGISTRATION AGENCIES

12. Under Section 7 of the NVRA, which offices must offer voter-registration services?

Any office in a covered State that provides either public assistance or state-funded programs primarily engaged in providing services to persons with disabilities must offer voter-registration services. Armed Forces recruitment offices must also provide voter registration services. In addition, a State must designate other offices in the State as voter-registration agencies. (See Response to Question 15 below for a description of these other offices).

13. What is an office that provides public assistance under Section 7?

"Public assistance" offices that must offer voter-registration services under Section 7 of the NVRA include each agency and office in a State that administers or provides services or assistance under any public assistance programs. This includes any of the following federal public assistance programs: the Supplemental Nutrition Assistance Program (SNAP, formerly the food-stamp program), the Special Supplemental Food Program for Women, Infants and Children (WIC), the Temporary Assistance for Needy Families (TANF) program (formerly the Aid to Families with Dependent Children or AFDC program), the Medicaid program, and the State Children's Health Insurance Program (SCHIP). This also includes state public assistance programs.

14. What is an office that provides state-funded programs primarily engaged in providing services to persons with disabilities?

Offices that provide state-funded programs primarily engaged in providing services to persons with disabilities include offices providing vocational rehabilitation, transportation, job training, education counseling, rehabilitation, or independent-living services for persons with disabilities. Because States vary greatly in the manner in which they provide services to persons with disabilities, each State must identify the specific offices and agencies that fit this definition. In doing so, States may want to consult with offices that deal with issues related to persons with disabilities, such as the protection and advocacy offices and client assistance program offices within that State. A list of such offices for each State is available at:

http://www.napas.org/aboutus/PA_CAP.htm. Section 7 also requires that if an office provides services to a person with disabilities at the person's home, the office must provide the opportunity to register to vote at home. Offices serving persons with disabilities often offer specialized assistance in completing the agency service or benefit application forms, and Section 7 requires such offices to offer voter registration applicants the same degree of assistance in completing voter registration forms as is offered in completing the agency's own application forms.

15. Does Section 7 require designation of other offices as voter registration agencies?

Yes. In addition to offices providing public assistance and services to persons with disabilities, States are also required by Section 7 to designate "other offices" within a State as voter-registration agencies. A State is free to determine which other agencies/offices should be designated, according to its needs and preferences, but it must make additional designations. Such other agency designations may include State or local government offices such as public libraries, public schools, State colleges, universities and community colleges, city and county clerks offices, marriage license offices, fishing and hunting license offices, government revenue offices, and unemployment compensation offices. Offices not otherwise covered under the NVRA that provide services to persons with disabilities may also be designated. In addition, with the agreement of such entities, States may designate as voter-registration agencies nongovernmental offices (such as private colleges) or Federal government offices.

16. Do armed forces recruitment offices have to provide voter-registration services?

Yes. The NVRA provides that all federal Armed Forces recruitment offices in each State subject to the NVRA must provide voter registration services. Within the Department of Defense, the Federal Voting Assistance Program (FVAP) maintains a web site that contains information concerning voter registration at such recruitment offices: http://www.fvap.gov/reference/laws/nat-vote-reg-act.html and http://www.fvap.gov/reference/milinfo.html.

17. What voter-registration services must be made available?

Each office designated as a voter registration agency under Section 7 that provides service or assistance in addition to conducting voter registration must do the following:

i) distribute voter-registration application forms;

ii) provide a "preference/declination" form that contains information on the voter-registration process (see Response to Question 21 below for a description of the "preference/declination" form);

iii) provide the same level of assistance to all applicants in completing voter-registration application forms as is provided with respect to every other service or application for benefits (unless the applicant specifically refuses such assistance);

iv) accept completed voter-registration forms from applicants; and

v) transmit each completed voter-registration application to the appropriate State election official within a prescribed time frame.

18. What persons must be provided the opportunity to register to vote by Section 7 designated offices and agencies?

Designated agencies must provide the opportunity to register to vote to persons when: (1) applying for the agency's assistance or services; (2) seeking recertification or renewal of those services; and (3) changing address for the assistance or services.

19. What does Section 7 require with regard to distribution of voter registration forms and preference/declination forms?

Each office designated under Section 7 that provides services or assistance must distribute to each applicant for services or assistance, and each applicant for recertification, renewal or change of address with respect to such services or assistance, one of the voter registration application forms described in paragraph 20 below. In addition, each such office also must distribute to each applicant a form, known as a preference or declination form, described in paragraph 21 below.

20. What types of voter-registration forms can be distributed to applicants?

Section 7 agencies must distribute one of the three voter-registration forms listed below:

1) National Mail Voter Registration Form — The agency may use this federal form, which has been developed by the U.S. Election Assistance Commission. This form is available on the EAC's web site at http://www.eac.gov/program-areas/national-voter-registration-form. In addition to containing a voter-registration application, this document lists certain state-specific voting requirements.

2) State mail voter-registration form — The agency may use its State mail voter-registration form, so long as it meets the requirements of Section 9 of the NVRA. This State form would not be as lengthy as the federal form, which contains information about voter registration in each state. Such a form should be easier for applicants to navigate and easier for agencies and election officials to process.

3) Designated agency's own form — The agency also may use its own version of a voter-registration form, if it is equivalent to the federal form and has been approved by the State. This type of form may lead to more efficient voter-registration transactions at designated agencies that provide services or assistance, since it could be made a seamless part of the forms normally used by the designated agency. As an example, where agency assistance/services forms are generated by computer during the process of interviewing the applicant, the voter-registration form likewise might be generated during this same process, pre-populated with information already provided by the applicant. Or a perforated voter-registration application might be attached at the bottom of a State services form, so that it can be easily completed, detached, and transmitted to the appropriate election official.

21. What is the "preference/declination form," and what should States put on it?

Section 7 requires that designated offices provide each applicant for services or assistance a preference or declination form containing specific information concerning the individual's opportunity to register to vote. This form, which may be part of or separate from the voter-registration form, must include the following information:

1) the question, "If you are not registered to vote where you live now, would you like to apply to register to vote here today?";

2) if the agency provides public assistance, the statement, "Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.";

3) boxes for the applicant to check to indicate whether the applicant would like to register to vote or declines to register to vote (failure to check either box is interpreted as declining to register), together with the statement (in close proximity to the boxes and in prominent type), "IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.";

4) the statement, "If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private."; and

5) the statement, "If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with _____." The blank should be filled by the name, address, and telephone number of the appropriate official to whom such a complaint should be addressed.

No information relating to a declination to register to vote may be used for any purpose other than voter registration. If the preference/declination form is separate from the voter-registration

form, it is recommended that a statement regarding this non-use of declination information be included on the voter-registration form, as well as a statement that if the applicant registers to vote, information submitted will be used only for voter-registration purposes.

22. Are Section 7 agencies required to assist persons in completing a voter-registration application?

Yes. Section 7 agencies must provide to each applicant the same degree of assistance in completing the voter-registration application form as is provided by the office in completing its own agency forms, unless the applicant declines to register to vote or declines such assistance.

As an example, if it is the practice of a Section 7 agency for its employees to take time to explain to each applicant the various forms involved in the agency application, recertification or other process and answer applicant questions before the applicant completes the forms, this type of assistance must also be given at that time to such applicants with regard to the voter registration application process. Similarly, if it is agency practice to make sure that agency forms are completed and signed when submitted by an applicant, the same practice should apply to a voter registration application submitted by that applicant.

Offices serving persons with disabilities often offer specialized assistance in completing the agency service or benefit application forms. Section 7 requires such offices to offer voter registration applicants the same degree of assistance in completing voter registration forms as is offered in completing the agency's own application forms.

23. Does Section 7 put any restrictions on how office staff may interact with applicants?

Yes. Any person who provides voter-registration services at a Section 7 agency is prohibited from: 1) seeking to influence an applicant's political preference or party registration; 2) displaying any political preference or party allegiance; 3) taking any action or making any statement to an applicant to discourage the applicant from registering to vote; or 4) taking any action or making any statement that may lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

24. Do the voter registration requirements of Section 7 of the NVRA apply to all application, renewal, recertification and change of address transactions with designated offices?

Yes. The NVRA requires that voter registration opportunities be provided with respect to all application, renewal, recertification and change of address transactions regarding service and assistance with Section 7 offices. Many Section 7 designated agencies/offices routinely provide services/assistance such as application for, or renewal of, services or change-of-address notification through the internet, by telephone, or by mail. States should ensure the availability of voter-registration opportunities to individuals using such remote service/assistance

opportunities from designated agencies. Thus, for all such internet transactions, States should advise of the opportunity to register to vote, and should provide some online capability to download or request a voter-registration form. For phone transactions, designated-agency personnel should advise applicants of the opportunity to register to vote and to request a voter registration form. Materials sent by mail to individuals completing phone or internet transactions (such as statements confirming a phone transaction, or renewal or change-of-address forms) should contain a voter-registration form.

In all such internet, phone, and mail transactions, individuals should be given a toll-free phone number, where possible, to call for information and instruction on how to complete the voter-registration process. Where feasible, as is done at many motor-vehicle agencies, States may consider providing for a simultaneous voter-registration opportunity through the electronic portal when individuals apply for services or assistance at a designated agency by that means. In addition, where possible, agencies may consider assisting the applicant in registering to vote by automatically filling in appropriate fields on voter-registration applications with information previously provided by the applicant in order to make the registration process easier and more efficient.

When upgrading technology related to the application/recertification/change of address process at Section 7 agencies, States should ensure that such upgrade includes the voter registration process.

25. What is a Section 7 agency required to do with completed voter registration applications accepted at its offices?

The designated agency must submit the completed voter-registration application to the appropriate State or local election official within a prescribed period of time unless the applicant desires to submit it himself or herself. The agency providing voter-registration services may not require a registrant to mail in the form himself or herself or discourage him or her in any manner from submitting the form to the agency. When an applicant submits a completed voter-registration application to an agency, the agency must transmit the form to the appropriate State or local election official within ten days. However, if the agency receives a completed voter-registration application within five days before the last day to register to vote in an election, the application must be transmitted to the appropriate State or local election official within five days.

SECTION 8 – ADMINISTRATION OF VOTER REGISTRATION

26. What does Section 8 of the NVRA require States to do?

Section 8 mandates certain action by States concerning the administration of voter registration for elections for federal office. These requirements involve important issues such as the date by which valid voter registration applications must be accepted and eligible persons registered, rules for changing a registrant's address information, rules for removing names from the voter

registration list, and administration of a uniform, nondiscriminatory voter registration list maintenance program that complies with the Voting Rights Act.

27. Does Section 8 impose a time deadline on States for accepting voter registration applications and registering eligible applicants?

Yes. States must set a voter registration cutoff for federal elections of no more than 30 days before the election. A valid voter registration application from an eligible applicant is considered timely and the State has to ensure that the applicant is registered to vote if it is: 1) submitted not later than the lesser of 30 days, or the period provided by State law, before the date of a federal election to a driver's license office, designated public assistance or disability office, other designated office, or an appropriate State or local election official, or 2) postmarked not later than the lesser of 30 days, or the period provided by State law, before a federal election when submitted by mail. **States can set a voter registration deadline for federal elections shorter than 30 days, and a number of States do so, but cannot set a longer deadline.**

28. Are States required to let an applicant know what has happened to his or her application?

Yes. Section 8 requires State election officials to notify each applicant of the disposition of his or her registration application, e.g., a voter registration card if the application is accepted, a notice of rejection if the application is not accepted, or a notice of additional information needed if critical elements of the application are left incomplete.

29. Under the NVRA, what are the circumstances under which a State can remove a person's name from the voter registration rolls?

Section 8 permits States to remove the name of a person from the voter registration rolls upon the request of the registrant, and, if State law so provides, for mental incapacity or for criminal conviction. The Act also requires States to conduct a general voter registration list maintenance program that makes a reasonable effort to remove ineligible persons from the voter rolls by reason of the person's death, or a change in the residence of the registrant outside of the jurisdiction, in accordance with procedures set forth in the NVRA. The list maintenance program must be uniform, nondiscriminatory and in compliance with the Voting Rights Act.

30. Does the NVRA contain any prohibitions on removal of persons' names from the voter registration list?

Yes. Section 8 of the NVRA contains several restrictions on removals from the voter registration list. It prohibits removing registrants from the voter registration list solely because of the failure to vote. It also prohibits removing registrants from the registration list due to a change of address to another location within the same registrar's jurisdiction, even if the voter has failed to notify the registrar of the move within the jurisdiction. It also places restrictions of notice and

timing on removals from the voter registration list when second-hand information is received, such as returned mail, which suggests a registrant may have moved outside of the registrar's jurisdiction.

31. What is "removal at the request of the registrant" under Section 8?

A "removal at the request of the registrant" under the NVRA involves first-hand information from a registrant that can originate in at least three ways: 1) an unsolicited direct request from the registrant to remove his or her name from the voting registration list, 2) a registrant completing and returning a confirmation card indicating an address change outside the jurisdiction, or 3) a registrant submitting a new application registering to vote a second time in a new jurisdiction, and providing information regarding the registrant's prior voter registration address on the new application, which the State can treat as a request to cancel or transfer his or her prior registration. A registrant advising of a new address within the same jurisdiction, or registering to vote a second time at a new address within the same jurisdiction, should trigger an updating of the original registration, rather than its cancellation.

32. Are there any required procedures in the NVRA concerning removal of a person's name from the voter registration rolls for mental incapacity, criminal conviction or death?

The NVRA does not require any particular process for removing persons who have been disqualified from voting pursuant to State law by virtue of being convicted of a crime or being adjudged mentally incompetent. Moreover, while the NVRA requires States to make reasonable efforts to remove persons who have died, it does not require any particular process for doing do. Under the NVRA, States can follow whatever State law process exists for doing this, and there is no federal process to be met. Section 303(a) of HAVA adds an additional requirement for NVRA covered States to coordinate the statewide voter registration database with State records on felony status and death.

33. Is there a "safe harbor" program for list maintenance which a State can implement to satisfy the NVRA's requirements?

Yes. The NVRA gives one example of such a safe harbor program for list maintenance: a) the NVRA provides that a State may utilize change of address information supplied by the United States Postal Service through its National Change of Address program (NCOA) to identify registrants whose addresses may have changed; b) because this is second-hand information, not directly from the registrant, the NVRA prescribes a subsequent forwardable confirmation notice procedure that States must follow to verify possible address changes outside the jurisdiction generated from the NCOA program; and c) the NVRA specifies a subsequent waiting period after the confirmation notice is sent before a State can remove voters from the rolls for address changes outside the jurisdiction absent written confirmation from the voter. Other possible examples of a general list maintenance program could include States undertaking a uniform

mailing of a voter registration card, sample ballot, or other election mailing to all voters in a jurisdiction, for which the State could use information obtained from returned non-deliverable mail as the basis for correcting voter registration records (for apparent moves within a jurisdiction) or for sending a forwardable confirmation notice and beginning the two federal general election waiting period before removal (for apparent moves outside a jurisdiction or non-deliverable mail with no forwarding address noted).

34. Under what circumstances does the NVRA allow States to remove the names of persons from the voting rolls based on change of residence?

A State can only remove the name of a person from the voter registration list on grounds of change of residence upon: 1) the voter's written first-hand confirmation of a change of address to a location outside of the registrar's jurisdiction, **or** 2) reliable second-hand information indicating a change of address outside of the jurisdiction from a source such as the NCOA program, or a general mailing to all voters, **plus** the subsequent failure of the person to respond to a specific forwardable confirmation mailing sent by the State **and** the failure of the person to vote or appear to vote during the period ending on the day after the second federal general election subsequent to the confirmation notice being sent.

35. What is the NVRA confirmation mailing/notice process to which States must adhere to verify a registrant's change of residence?

Where a State that has obtained reliable information indicating a possible change of residence for a registrant through the NCOA program (or another uniform list maintenance program like a general mailing to all registrants), it must take certain steps to confirm such address change since it is second-hand information not coming directly from the registrant. These steps differ depending on whether the apparent change of address is inside or outside a registrar's jurisdiction:

1) In the case of a person who appears to have moved to a new address **inside** the same registrar's jurisdiction, the registrar shall not remove the voter's name from the list, but must update the registration records to show the new address and send a forwardable mail notice of the address change to the registrant along with a prepaid pre-addressed return form for the registrant to verify or correct the residence information. If such person fails to return this form, however, the registrant cannot be removed from the voter rolls by reason of this apparent change of residence within the jurisdiction and should not be designated as inactive;

2) In the case of a person who appears to have moved to a new address **outside** the registrar's jurisdiction, the registrar must initiate an address confirmation procedure before removing the voter. This entails sending a forwardable notice, in the form of a postage-prepaid and pre-addressed return card, on which the registrant may state his or her current address. The notice must track the specific language in Section 8(d)(2) of the NVRA, i.e., it must advise that if the registrant did not change his or her residence, or changed residence but remained in the registrar's jurisdiction, the registrant should return the card not later than the voter registration

deadline, and that if the card is not returned, affirmation or confirmation of the registrant's address may be required before the registrant is permitted to vote in a federal election during the period beginning on the date of the notice and ending on the day after the date of the second general election for Federal office that occurs after the date of the notice, and if the registrant does not vote in an election during that period the registrant's name will be removed from the list of eligible voters. The jurisdiction may designate the registrant as inactive if the registrant fails to return the confirmation notice by the voter registration deadline for the next election after the confirmation notice is sent. If the registrant subsequently provides written confirmation of a change of address to outside of the jurisdiction, the registrant can be immediately removed from the rolls. If the registrant has not moved outside the jurisdiction and subsequently votes or appears to vote in an election before the second general election for Federal office after the confirmation notice is sent, the registrant should be restored to active status.

36. If this confirmation notice card is not returned within the specified time, can the State then remove the voter from the registration rolls for an apparent address change?

No. A voter can be removed from the voter rolls for an apparent address change **only** if he or she has not responded to the confirmation notice sent by forwardable mail with a postage prepaid and pre-addressed return card, **and** if she or she has not voted or appeared to vote in an election beginning on the date the notice is sent and ending on the day after the date of the second federal general election after the date of the confirmation notice.

37. Does Section 8 impose any time restrictions on States as to when a general list maintenance program can be conducted?

Yes. Section 8 requires States to **complete** any program for systematic removal of the names of ineligible voters from the voter rolls no later than **90 days** prior to the date of a primary election or general election for federal office. This 90 day deadline does not, however, apply to removal of names at the request of the registrant, removal due to death of the registrant, removal due to criminal conviction or mental incapacity of the registrant as provided by State law, nor to correction of a registrant's address information.

38. Are there any protections in the NVRA for those eligible registered voters who have changed address to another location within a registrar's jurisdiction, or are otherwise on an inactive voter list, but have not notified the registrar prior to the date of a federal election?

Yes. The NVRA contains fail-safe provisions to enable such persons who show up to vote on a federal election day to update their registration and to vote in that election even though they have not notified the registrar of the address change:

1) An eligible registered voter who has moved to an address in an area covered by the same polling place as his or her previous address is permitted to vote at that same polling place upon oral or written affirmation by the registrant of the change of address at the polling place;

2) An eligible registered voter who has moved to an address in an area covered by a different polling place from the polling place for his or her previous address, **but within the same registrar's jurisdiction and the same congressional district,** at the option of the registrant:

(a) shall be permitted to correct the voting records and vote at the old polling place upon oral or written affirmation by the registrant of the new address before an election official at that polling place; or

(b) shall be permitted to correct the voting records and vote at a designated central location within the same registrar's jurisdiction, upon written affirmation by the registrant of the new address on a standard form provided by the registrar; or

(c) shall be permitted to correct the voting records for purposes of future elections at the new polling place, and shall be permitted vote in the current election at that polling place if allowed under State law, upon confirmation by the registrant of the new address by such means as are required by law.

A central voting location need not be made available by the registrar if State law allows the person to vote at either the old or new polling place in the current election upon oral or written affirmation of the address change.

The failsafe provisions of Section 8 draw a distinction between the registrant's need for "affirmation" or "confirmation" of a new address, depending upon the circumstances in which the failsafe voting occurs.

39. What if a mistake has been made, and registration records indicate that a person has moved from an address covered by a polling place when that person has in fact not moved?

If a person has not moved, but the registration records indicate that a person has moved from an address covered by a polling place, that person shall be permitted to vote at that polling place upon oral or written affirmation by the registrant that the registrant continues to reside at his or her address previously known to the registrar.

40. Are States required to keep records of their voter registration activities under the NVRA?

Yes. Section 8 of the NVRA requires that States keep and make available for public inspection, for a period of at least two years, all records concerning the implementation of programs and activities conducted for the purpose of ensuring the accuracy and currency of official lists of eligible voters, except to the extent that such records relate to a declination to register to vote or to the identity of a voter registration agency through which any particular voter is registered.

The records to be kept shall include lists of the names and addresses of all persons to whom confirmation notices are sent, and information concerning whether or not each such person has responded to the notice, as of the date that inspection of the records is made.

In addition, an independent requirement in 42 U.S.C. 1974 mandates that all records and papers relating to any application, registration, or other act requisite to voting in any election for federal office, be preserved for a period of twenty-two months from that federal election. Since voter registration is unitary and permanent, this obligation is ongoing, such that registration records must be preserved as long as the voter registration to which they pertain is considered an "active" one under local law and practice, and those records cannot be disposed of until the expiration of twenty-two months following the date on which the registration ceased to be "active." Hence, States should maintain all written records related to applications to register to vote as well as declinations to register to vote.

COORDINATION, REPORTING, AND ENFORCEMENT

41. What are the State's obligations to coordinate voter registration activities?

The State is responsible for ensuring compliance with the NVRA. The NVRA requires each State to designate a State officer or employee as the chief State election official to be responsible for coordinating State responsibilities under the Act. States may also consider employing a person at the State level to serve as the NVRA coordinator for the State. This person could be responsible for coordinating and overseeing all NVRA activity at designated voter-registration agencies/offices in the State. In addition, States may consider employing a person at each designated voter-registration agency, and at each designated agency office, whose ongoing responsibility would be coordinating and overseeing the conduct of all voter registration activities in that agency/office. This person's responsibilities could include ensuring that the voter registration responsibilities are carried out, ensuring that the voter registration system is administered in a uniform and non-discriminatory manner, reviewing monthly data of voter-registration activity at voter registration offices, monitoring voter-registration activities, training new employees and providing for training updates at periodic intervals, ensuring an adequate supply of forms, and resolving voter-registration coordination issues that arise between State and local officials.

42. Are States required to report on their NVRA voter-registration and list maintenance efforts?

Yes. States must report various voter registration information to the U.S. Election Assistance Commission (EAC), in response to the EAC survey, every two years. This includes the number of voter-registration applications by mail and from motor vehicle offices, public-assistance offices, offices providing state-funded programs primarily serving persons with disabilities, Armed Forces recruitment offices, and other state-designated offices and agencies. To fulfill these reporting requirements, States should consider having a system in place to track the number of voter-registration applications from each voter registration source. Likewise, States

must report voter registration list maintenance information in response to the EAC survey every two years.

These biennial NVRA reports are available on the EAC web site at the following link: http://www.eac.gov/program-areas/research-resources-and-reports/completed-research-and-reports/national-voter-registration-act-studies.

43. For jurisdictions covered by the language minority provisions of the Voting Rights Act, what obligations do such jurisdictions have to ensure voter registration access under the NVRA to covered limited-English proficient citizens?

Certain States and local jurisdictions are covered by the language minority requirements of the Voting Rights Act (VRA) for specific language minority groups. The VRA requires that when covered states and jurisdictions provide voter registration or voting notices, forms, instructions, assistance, or other materials or information relating to the electoral process, including ballots, they must provide them in the language of the applicable minority group as well as in the English language. The NVRA provides that its requirements do not supersede, restrict, or limit the application of the requirements of the VRA. Thus, each State or jurisdiction covered by the language minority requirements of the VRA should consider how to ensure that NVRA voter registration opportunities are conducted so as to provide language access to covered limited-English proficient language minority citizens so that they have equal access to the voter registration process.

To assist covered States and jurisdictions, extensive information regarding the language minority requirements is available on the Voting Section's website: http://www.justice.gov/crt/voting/sec_203/activ_203.php. Various language resources are also available on the EAC website. These include versions of the national mail voter registration form translated into Spanish, Chinese, Japanese, Korean, Tagalog and Vietnamese. http://www.eac.gov/voter/Register to Vote. These resources also include translated versions of a voter's guide to federal elections. http://www.eac.gov/voter/voters-guides. And these resources also include a glossary of election terms in six languages. http://www.eac.gov/voter/language-accessibility-program-1.

44. What agency is responsible for enforcement of the NVRA?

The U.S. Department of Justice has enforcement responsibility under the NVRA. The Department conducts investigations and ,where appropriate, files litigation in federal court to enforce the NVRA's requirements. Private parties may also bring litigation in federal court to enforce the requirements of the NVRA. The U.S. Election Assistance Commission is responsible for administration of the national voter registration form, as well as State reporting under the NVRA.

45. What are some examples of the Department's activities to enforce the provisions of the NVRA?

An extensive description of the Department's NVRA enforcement activities can be found on the Voting Section's website: http://www.justice.gov/crt/voting/litigation/caselist.php#nvra_cases. In particular, significant NVRA decisions or settlements have been obtained by the Department in litigation with the State of Tennessee (Sections 5 and 7 of the NVRA), http://www.justice.gov/crt/voting/nvra/tn_cd.pdf, Cibola County, New Mexico (Section 8 of the NVRA), http://www.justice.gov/crt/voting/sec_203/documents/cibola_stip_3.pdf, and the State of New York (Section 7 of the NVRA), http://www.justice.gov/crt/voting/nvra/nynvra_order.pdf.

46. How can I contact the Department of Justice about the NVRA's voter registration requirements?

As a general matter, the Department of Justice does not issue advisory opinions concerning the statutes that it enforces. The Department will certainly consider inquiries from State officials concerning the NVRA, however, in the hope of providing assistance. Within the Department of Justice, the responsibility for NVRA enforcement is committed to the Voting Section of the Civil Rights Division. You may reach the Voting Section at its toll-free telephone number, 800-253-3931.

APPENDIX VIII

- *The Value of Annuities: Retirement Savings to Last a Lifetime,* American Council of Life Insurers.
- *Charge 8 -- Annuities*, Texas Department of Insurance
- *Proposed New Subchapter PP, §§ 3.9701 - 3.9712*, Texas Department of Insurance (Aug. 13, 2010).

ACLI
Financial Security. For Life.

The Value of Annuities

Retirement Savings to Last a Lifetime

101 Constitution Ave., NW, Washington, DC 20001-2133

Annuity Basics
What is an Annuity?

ACLI
Financial Security. For Life.

An annuity:

- is an insurance contract.
- helps you amass money for retirement and converts those savings into income you cannot outlive.
- is a retirement savings vehicle, not a short-term financial product.
- can complement 401(k)s and IRAs.
- assists those without access to workplace retirement plans.

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Annuity Basics

Types

ACLI
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Two Basic Types of Annuities

- Deferred annuity
- Immediate annuity

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Annuity Basics

Types

ACLI
Financial Security. For Life.

Deferred Annuity

- Accumulates savings and converts those savings into guaranteed lifetime income.
- Accounted for 94.9% of annuity considerations in 2007.
- Can be paid for with a single premium (payment) or multiple premiums.
- Premiums can be fixed or flexible.

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Annuity Basics

Types

ACLI
Financial Security. For Life.

Deferred Annuity

- Earnings build free of current federal income taxes.
- Once a withdrawal is made or payouts begin, earnings are taxed at ordinary income rates.
- You choose how and how often to receive payments.
- Payout options for spouse and beneficiaries.

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Annuity Basics

Types

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Immediate Annuity

- Converts a lump sum into guaranteed lifetime payments.
- Purchase with money from sale of home/business, life insurance proceeds, or other savings.
- Can convert money from 401(k)/IRA to a guaranteed income stream for life.

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Annuity Basics

How will the value of my annuity grow?

ACLI
Financial Security. For Life.

Fixed Deferred Annuity

- Money earns interest at a guaranteed rate.
- Savings grow for a specific period of time.

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Annuity Basics

How will the value of my annuity grow?

ACLI
Financial Security. For Life.

Index Deferred Annuity

- Earnings accumulate at formula linked to an equity-based index (e.g. S&P 500).
- Guarantees a minimum interest rate
- Annuity value will not drop below a guaranteed minimum.

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Annuity Basics

How will the value of my annuity grow?

ACLI
Financial Security. For Life.

Variable Deferred Annuity

- Earnings based on the performance of money placed in subaccounts invested in stocks and bonds, or a fixed rate account.
- Returns subject to market fluctuation.
- Additional riders available to guarantee minimum returns (payouts) and guaranteed minimum policy value at death.

101 Constitution Ave., NW, Washington, DC 20001-2133

Annuity Basics

What are my income (payout) options?

ACLI
Financial Security. For Life.

- You choose how and when you will receive income.
- No requirement to begin withdrawals at age 70 ½ .

101 Constitution Ave., NW, Washington, DC 20001-2133

Annuity Basics

What are my income (payout) options?

ACLI
Financial Security. For Life.

Guaranteed Income for Life *(Annuitization)*

- **Life** – Guarantees income as long as you live.
- **Joint and Survivor Life** – Guarantees income as long as you or your joint annuitant live.
- **Additional Options** – e.g. life income with period certain or life income with refund.

Annuity Basics

What are my income (payout) options?

ACLI
Financial Security. For Life.

Guaranteed Living Benefits

- Provide additional savings and income protection.
  - Guaranteed Minimum Income
  - Guaranteed Minimum Accumulation
  - Guaranteed Minimum Withdrawal for Life

101 Constitution Ave., NW, Washington, DC 20001-2133

Annuity Basics

What are my income (payout) options?

ACLI
Financial Security. For Life.

Options Without Lifetime Income

- Period certain – a series of payouts for a specified number of years.
- Lump sum payout.

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Annuity Basics

What if I need access to my money now?

ACLI
Financial Security. For Life.

- Withdrawal and surrender charges apply for early withdrawals.
- Charges decrease with each passing year.
- No charges after surrender period ends.
- Most annuities allow for a penalty-free 10% withdrawal each year until payouts begin or surrender period ends.
- No-charge withdrawals may be available for nursing home costs or a terminal illness.
- Tax penalties apply for additional early withdrawals.

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Annuity Basics

What if I need access to my money now?

ACLI
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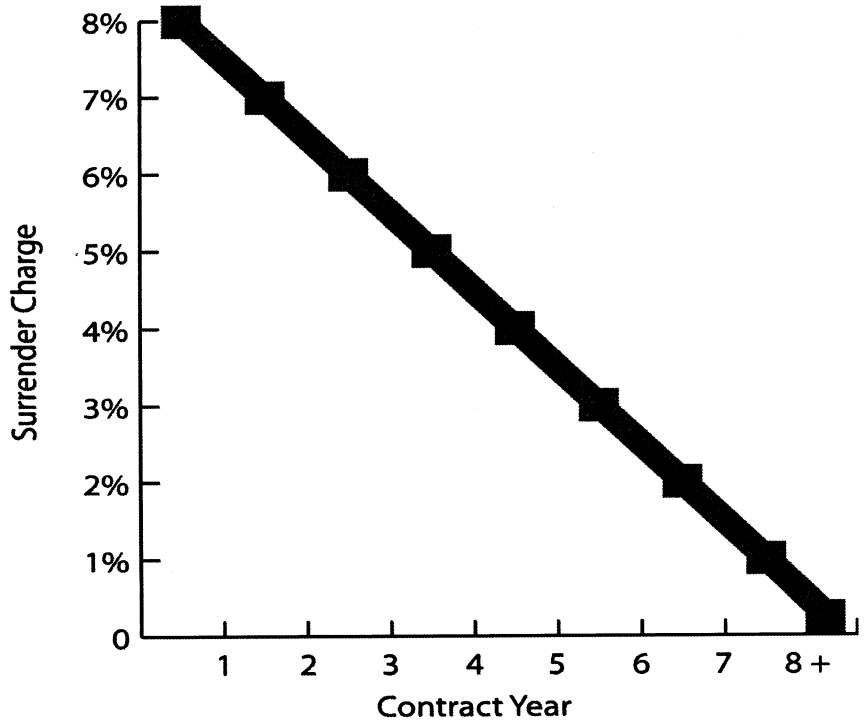
Surrender Charges Decrease Over Time



This chart represents the surrender fee schedule for a fixed, single-premium deferred annuity with an 8 year surrender period.

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Annuity Basics

What is the maximum annuitization date?

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- All annuities have a date at which time you need to annuitize the contract.
- Has been incorrectly called a maturity date.
- Does not restrict when you can cancel your annuity, take withdrawals, or annuitize.

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Annuity Basics

What happens when I die?

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- **Before payouts start**
  - Beneficiary receives full amount of annuity.
  - Minimum death benefit (for variable annuities) may apply.
- **After payouts start**
  - Depending on the type of payout chosen, the beneficiary can receive the remaining value of annuity.

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Annuity Basics

What if I made the wrong choice and change my mind?

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"Free look" period

- Depending on state requirement, consumers receive a full refund of the premium (fixed annuity) or the market value (variable).
- Interstate Compact Standard: 10 days.

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How Annuities are Sold

Where can I buy an annuity?

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- Only life insurers issue annuities.
- Distributed/sold through various channels.
- All sellers must be licensed to sell insurance.
- Variable annuity sellers must be additionally licensed by FINRA.

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How Annuities are Sold

Where can I buy an annuity?

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Career Agent

- Career agents may sometimes sell multiple insurers' annuities.
- Captive agents only sell annuities from one company.
- Insurer contracts with, supervises, and compensates agent.
- Agent performs suitability analysis, makes recommendation, submits application to insurer.
- Insurer must have a system in place to monitor suitability.

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How Annuities are Sold

Where can I buy an annuity?

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Independent Agency

- Offers multiple insurers' annuities.
- Agent performs suitability analysis, makes recommendation, submits application to insurer.
- Insurer issues annuity.
- Insurer must have a system in place to monitor suitability.

Examples: AMZ, Financial Brokers Int'l

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How Annuities are Sold

Where can I buy an annuity?

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Bank

- Insurer contracts with bank insurance agency.
- Bank representative performs suitability analysis.
- Bank submits application to insurer.
- Insurer must have a system in place to monitor suitability.

Examples: Chase, PNC

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How Annuities are Sold

Where can I buy an annuity?

ACLI
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Wirehouses

- Offers multiple insurers' annuities.
- Wirehouse performs suitability analysis.
- Wirehouse submits application to insurer.
- Insurer must have system in place to monitor suitability.

Examples: Merrill Lynch, Morgan Stanley

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Charge 8 – Annuities

1. What complaints does TDI currently receive relative to annuities that would not have been addressed by the 2009 legislation?

Answer: The number of complaints regarding annuities received by the Department has declined slightly over the last three years, with 141 justified complaints received in 2007 and 129 in 2009.[1]

Passed in 2009, HB 1294 provides new education requirements for the sale of annuities and prohibits the use of certain senior-specific professional certifications and designations in marketing. The education requirements have not been in place for a sufficient time period to have an impact on current complaints. However, the Department expects that the additional education for agents and the prohibition on misleading designations will lead to a decrease in some types of complaints, especially those cases in which the agent might have acted differently in the sales process if they had a better understanding of the product and the applicable regulations and in those cases specifically relating to improper certifications and designations.

Also passed in 2009, HB 1919 limits in most cases the charges imposed on those who surrender their annuities, but is not effective except for annuities issued after June 1, 2010. Carriers have begun to file revised annuity forms in anticipation of this change, and the Department expects that HB 1919 will limit the use of very high surrender charges. However, while consumers with lower surrender charges may be able to surrender their annuities more easily, it is still unclear the extent to which complaints of "unsuitable" annuity sales will continue to be received even after HB 1919 is effective and surrender charges are somewhat lower.

Note that it is difficult to attribute any change in complaint numbers to any particular legislation in light of the dramatic changes in the economy in the last few years. Many of those that might have complained previously about annuity sales practices, when their assets could have made more money in other financial vehicles than an annuity, might not file a complaint now because their annuity might have maintained the value of their assets better during the recent extreme market fluctuations than other available investments would have.

2. Provide a list of recommendations for legislation.

Answer: The Texas Insurance Code contains sections of law that specifically address life insurance regulations. Few provisions are specific to annuities. Over the last 10 years, however, annuities have overtaken life insurance in premium volume, and now annuity premiums are more than double that of life insurance.

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[1] A complaint against multiple parties is counted as a single complaint.

Similar to that for life insurance, the Legislature could consider adoption of basic regulations applicable to annuities, either by statute or by providing explicit rulemaking authority to do so. Currently the Department relies on Chapter 1701 of the Code (relating to the approval of forms) to reject some annuity form filings, but its authority is generally limited to the rejection of forms that either violate specific statutes or regulations or that are unjust, encourage misrepresentation, or are deceptive. Additional regulations would clarify the Department's ability to require some basic elements similar to those required of life insurance policies.

Below is a sample list of the types of provisions that could be addressed by statute or by providing rulemaking authority.

Cover Page Brief Description – require descriptions of the type of annuity contract being issued, i.e., single premium or flexible premium and variable, or non-variable.

Entire Contract - require descriptions of what constitutes the entire contract, i.e., that the contract and the application for the contract constitute the entire contract between the parties.

Free Look Period or Right to Examine Period – require in all cases a period of time in which an owner could return their annuity contract and receive the premiums paid or the contract value.

Maturity Date – require a specification of the latest available maturity date provided for in the contract. The maturity date would have to be defined by reference to a specified age or a fixed number of years.

Ownership Designation – require a specification of who the owner is, the rights, responsibilities, effect of any change in ownership, any contingent owner, the status of the contract upon the death of the owner prior to the maturity date, and the status of the contract upon the death of the annuitant (if different) prior to the maturity date. This will also specify the effective date for changes of ownership. Any change in ownership provision which attempts to restrict the owner's rights would not be permitted unless the owner and annuitant are the same person and an appropriate IRA endorsement is attached.

SUBCHAPTER PP. Annuity Disclosures
28 TAC §§3.9701 - 3.9712

1. INTRODUCTION. The Texas Department of Insurance (Department) proposes new Subchapter PP, §§3.9701 – 3.9712, concerning disclosures pertaining to annuities. These rules are proposed to require insurers to provide annuity applicants and contract owners with necessary information regarding annuities. The purpose of the disclosures proposed in this subchapter is to provide consumers with educational and identifying information regarding annuities that will enable them to make a decision that is more likely in their best interest and to reduce the opportunity for misrepresentation and incomplete disclosure. On April 15, 2010, the Department made an informal posting on its website of proposed rule text and cost note estimates. On April 26, 2010, the Department held a public meeting to receive comments relating to the informal rule text and cost note estimates. The proposed subchapter is based on the National Association of Insurance Commissioners (NAIC) Annuity Disclosure Model Regulation.

The proposed sections apply to all group and individual annuity contracts and certificates unless specifically excepted by the rules. The proposed rules require that insurers provide specific disclosures to both annuity applicants and annuity contract owners. The disclosures required under the proposed sections consist of a report to contract owners on at least an annual basis and a disclosure document and a buyer's guide for annuity applicants. The report to contract owners provides consumers with information regarding the current status of their contract and changes that have occurred to their account since the inception of their contract or their last report. The

buyer's guide provides annuity applicants with educational information regarding annuity types and features. The disclosure document provides annuity applicants with information regarding the features and restrictions of a particular annuity product. The proposed rules specify that if the required buyer's guide and disclosure document are not provided to an applicant at or before the time of application, a free look period of at least 15 calendar days beginning upon contract receipt must be provided during which the applicant may return the contract without penalty.

The following statutes provide the authority for the proposed new subchapter. The Insurance Code §1108.002 provides that for the purpose of regulation under the Insurance Code, an annuity contract is considered an insurance policy or contract if the annuity contract is issued by a life, health, or accident insurance company, including a mutual company or fraternal benefit society, or issued under an annuity or benefit plan used by an employer or individual. Under the Insurance Code §101.051(b)(1), an insurer that makes or proposes to make an insurance contract is engaging in the business of insurance in this state. The Insurance Code §101.051(b)(3) specifies that taking or receiving an insurance application constitutes the business of insurance in this state. The Insurance Code §101.051(b)(5)(A) specifies that issuing or delivering a contract to a resident of this state constitutes the business of insurance. The Insurance Code §31.002 specifies in pertinent part that in addition to other required duties, the Department shall regulate the business of insurance in this state and ensure that the Insurance Code and other laws regarding insurance and insurance companies are executed. The Insurance Code §36.001 authorizes the Commissioner of Insurance to adopt any rules necessary and appropriate to implement the powers and duties of the

Texas Department of Insurance under the Insurance Code and other laws of this state. Because the proposed new subchapter applies to annuities issued by life, health, or accident insurance companies, including a mutual company or fraternal benefit society, or issued under an annuity or benefit plan used by an employer or individual, the subchapter regulates annuities that are considered insurance contracts for the purpose of regulation under the Insurance Code pursuant to the Insurance Code §1108.002. The acts that trigger the requirements of the proposed new subchapter are the taking of an annuity application and an insurer's issuance of an annuity contract. Both of these acts are expressly listed among the acts that constitute the business of insurance under the Insurance Code §101.051(b). Therefore, because the proposed new subchapter applies to annuities that constitute insurance contracts for the purpose of the Insurance Code, and because the acts that trigger the requirements of the proposed new subchapter are expressly listed in the Insurance Code as acts constituting the business of insurance, the Department has the authority to propose the new subchapter pursuant to the Insurance Code §§31.002 and 36.001. Sections 1108.002, 101.051(b)(1), 101.051(b)(3) and 101(b)(5)(A) specify business transactions and subject matters for which the Commissioner is authorized pursuant to the Insurance Code §36.001 to adopt necessary and appropriate rules. It is the Department's position that the provision of basic educational and identifying information relating to annuities is necessary to effectively regulate the sale of annuities in this state.

In addition to this generally applicable authority, §§1152.005 and 1114.007 provide rulemaking authority for certain transactions that will be regulated under the proposed new rules and specific types of annuities that will be subject to the proposed

new rule requirements and procedures. The Insurance Code §1152.005 specifies that the Commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement the Insurance Code Chapter 1152, relating to separate accounts and variable annuity contracts, including rules establishing agent licensing, standard policy provisions, and disclosures. Although the proposed new rules will apply to all types of annuities and not just variable annuity contracts, §1152.005 expressly authorizes the Commissioner to adopt rules relating to disclosures for variable annuities. Additionally, in the context of annuity replacement transactions, the Commissioner has specific authority to promulgate rules pertaining to (i) regulating the actions of insurers and agents concerning annuity replacement transactions; (ii) ensuring that purchasers receive information with which a decision in the purchaser's best interest may be made; and (iii) reducing the opportunity for misrepresentation and incomplete disclosure. The Insurance Code §1114.007 specifies that the Commissioner may adopt reasonable rules in the manner prescribed by Subchapter A, Chapter 36, to accomplish and enforce the purpose of Chapter 1114. The Insurance Code §1114.001 in pertinent part states that the purpose of Chapter 1114 is to regulate the activities of insurers and agents with respect to the replacement of existing annuities; protect the interests of purchasers of annuities by establishing minimum standards of conduct to be observed in certain transactions; ensure that purchasers receive information with which a decision in the purchaser's best interest may be made; reduce the opportunity for misrepresentation and incomplete disclosure; and establish penalties for failure to comply with the requirements adopted under Chapter 1114. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary

and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

Proposed §3.9701 specifies that the purpose of the subchapter is to provide standards for the disclosure of certain minimum information about annuity contracts and to assist purchasers of annuity contracts to understand basic features of annuity contracts.

Proposed §3.9702 specifies the applicability and scope of the subchapter. Proposed §3.9702(a) specifies that the subchapter applies to all group and individual annuity contracts and certificates, except as provided in §3.9702(b). Proposed §3.9702(b) specifies that except as provided in §3.9702(c), the subchapter does not apply to certain annuity products. Proposed §3.9702(b)(1) specifies that the subchapter does not apply to immediate and deferred annuities that contain only guaranteed elements. Proposed §3.9702(b)(2) specifies that the subchapter does not apply to annuities used to fund: (i) an employee pension plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (ii) a plan described by the Internal Revenue Code of 1986 §§401(a), 401(k), or 403(b), in which the plan, for purposes of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), is established or maintained by an employer; (iii) a governmental or church plan as defined by the Internal Revenue Code of 1986 §414, or a deferred compensation plan of a state or local government or a tax-exempt organization under the Internal Revenue Code of 1986 §457; (iv) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor; or (v) prepaid funeral benefits, as defined by the Finance Code Chapter 154.

Proposed §3.9702(b)(3) specifies that the proposed subchapter does not apply to a structured settlement annuity. Proposed §3.9702(b)(4) specifies that the proposed subchapter does not apply to a charitable gift annuity qualified under the Insurance Code Chapter 102. Proposed §3.9702(b)(5) specifies that the proposed subchapter does not apply to a funding agreement. Proposed §3.9702(c) specifies that notwithstanding the exemptions specified in §3.9702(b), the subchapter applies to an annuity used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, if the insurer has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by an agent for the purchase of an annuity contract. As used in this subsection, “direct solicitation” does not include a meeting held by an agent solely for the purpose of educating or enrolling employees in the plan or arrangement.

Proposed §3.9703 specifies that the subchapter shall apply only to annuity transactions subject to regulation under the subchapter that occur on or after the effective date of the subchapter.

Proposed §3.9704 specifies that words and terms defined in the Insurance Code Chapter 102 shall have the same meaning when used in the subchapter. The proposed section defines the terms *agent*, *buyer’s guide*, *contract owner*, *disclosure document*, *funding agreement*, *generic name*, *and structured settlement annuity*. The proposed section defines *agent* as an individual who holds a license under the Insurance Code Chapter 4054 and who sells, solicits, or negotiates annuities in this state. The proposed section defines *buyer’s guide* as a document specified as a buyer’s guide and adopted

by the NAIC to be used in implementation of the NAIC Annuity Disclosure Model Regulation. The proposed section defines *contract owner* to be the owner named in the annuity contract or, in the case of a group annuity contract, the certificate holder. The proposed section defines *disclosure document* as a document intended for consumers that provides information regarding the features and restrictions of a specific annuity product and that satisfies the requirements of §3.9709 of the subchapter. The proposed section defines *funding agreement* as an agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies. The proposed section defines *generic name* as a short title descriptive of the annuity contract being illustrated or for which an applicant is applying, such as "single premium deferred annuity." The proposed section defines *structured settlement annuity* as a "qualified funding asset," as defined by the Internal Revenue Code of 1986 §130(d), or an annuity that would be a qualified funding asset but for the fact that the annuity is not owned by an assignee under a qualified assignment.

Proposed §3.9705 defines and gives example of the term *determinable elements*. Proposed subsection 3.9705(a) specifies that for the purpose of the subchapter, the phrase means elements derived from processes or methods that are guaranteed at issue and are not subject to company discretion, but for which the values or amounts cannot be determined until some point after issue. The proposed section specifies that the term includes: (i) premiums; (ii) credited interest rates, including any bonus; (iii) benefits; (iv) values; (v) non-interest based credits; (vi) charges; and (vii) elements of formulas used to determine any element described by paragraphs (1) - (6)

of this subsection. Proposed subsection 3.9705(b) specifies that determinable elements may be described as guaranteed but not determined at issue, and that an element is considered determinable if the element was computed from only underlying determinable elements, or from both determinable and guaranteed elements.

Proposed §3.9706 defines the terms *guaranteed element* and *non-guaranteed element.* Proposed subsection 3.9706(a) specifies that for the purposes of the subchapter, *guaranteed element* means an element listed in subsections §3.9705(a)(1) - (7) that is guaranteed and determined at issue. The proposed subsection specifies that an element is considered guaranteed if all of the underlying elements used in its computation are guaranteed. Proposed subsection 3.9706(b) specifies that for the purposes of the subchapter, "non-guaranteed element" means an element listed in subsections §3.9705(a)(1) - (7) that is subject to the insurer's discretion and is not guaranteed at issue, and that an element is considered non-guaranteed if any underlying elements used in its computation is non-guaranteed.

Proposed §3.9707 specifies that compliance with the subchapter is not a defense in any action brought by or for the Department alleging a violation of the Insurance Code, or, except for this subchapter, any rule adopted pursuant to the Insurance Code.

Proposed §3.9708 specifies certain consumer notices required under the subchapter. Proposed §3.9708(a) specifies that if an application for an annuity contract or certificate is taken in a face-to-face meeting, the applicant shall be given at or before the time of application both a disclosure document and the appropriate buyer's guide specified in §3.9710 of the subchapter. Proposed §3.9708(b) specifies that if the application is taken by means other than in a face-to-face meeting the applicant shall be

sent not later than the fifth business day after the date on which the completed application is received by the insurer both a disclosure document and the appropriate buyer's guide specified in §3.9710 of the subchapter. Proposed §3.9708(c) specifies that if the insurer receives the application as a result of a direct solicitation through the mail, the insurer providing the appropriate buyer's guide and a disclosure document in a mailing inviting prospective applicants to apply for an annuity contract or certificate is considered to satisfy the requirement in §3.9708(b) that the appropriate buyer's guide and the disclosure document be provided not later than the fifth business day after the date of receipt of the application. Proposed §3.9708(d) specifies that if the application is received through the Internet, the insurer must take reasonable steps to ensure that the appropriate buyer's guide and a disclosure document are available for viewing and printing on the insurer's website and opened or acknowledged by the prospective applicant in order to satisfy the requirement that the appropriate buyer's guide and the disclosure document be provided not later than the fifth business day after the date of receipt of the application. Proposed §3.9708(e) specifies that a solicitation for an annuity contract that is provided in a manner other than a face-to-face meeting must include a statement that the proposed applicant may contact the insurer for a free annuity buyer’s guide.

Proposed §3.9709 specifies the minimum requirements for the disclosure document required under the subchapter. Proposed §3.9709(a) specifies that the following minimum information must be included in the required disclosure document: (i) the generic name of the contract, the insurer product name, if different from the generic name, the product’s form number, and a statement of the fact that the contract

is an annuity; (ii) the insurer's name and address; (iii) a description of the contract and the benefits provided under the contract that emphasizes the long-term nature of the contract and includes examples of the long-term nature as appropriate; (iv) the guaranteed, non-guaranteed, and determinable elements of the contract, any limitations of those elements, and an explanation of how those elements operate; (v) an explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the initial crediting rate, and the fact that rates may change from time to time and are not guaranteed; (vi) periodic income options, both on a guaranteed and non-guaranteed basis; (vii) any value reductions caused by withdrawals from or surrender of the contract; (viii) how values in the contract can be accessed; (ix) the death benefit, if available, and how the death benefit is computed; (x) a summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; (xi) the impact of any rider, such as a long-term care rider; (xii) a list of the specific dollar amount or percentage charges and fees, with an explanation of how those charges and fees apply; and (xiii) information about the current guaranteed rate for new contracts that contains a clear notice that is reasonably intelligible to the average consumer that the rate is subject to change. Proposed §3.9709(b) specifies that an insurer shall define terms used in the disclosure document in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure document is directed. This provision is intended to require insurers to craft disclosures relevant to the intended market for the particular product discussed in the disclosure. For example, a product intended for senior citizens or retirees may have a disclosure document printed in larger font to facilitate easier reading. Proposed

§3.9709(c) specifies that a disclosure document that complies with the Financial Industry Regulatory Authority (FINRA) Conduct Rules and the United States Securities and Exchange Commission (SEC) prospectus requirements satisfies the requirements of this section for disclosure documents. Proposed §3.9709(c) further specifies that the subsection does not limit the commissioner's ability to enforce the provisions of this section or require the use of a FINRA-approved disclosure document. The subsection specifies that it provides a safe harbor under this subchapter for an annuity contract that is regulated by, and complies with, the FINRA Conduct Rules and the SEC prospectus requirements pertaining to disclosure.

Proposed §3.9710 specifies that for the purposes of the subchapter, an appropriate buyer's guide is the latest version of the buyer's guide adopted by the NAIC that applies to the particular type of annuity (such as fixed deferred annuity, equity-indexed annuity, or variable annuity) that is the subject of the transaction. The subsection specifies that if the NAIC has not adopted a buyer's guide for the particular type of annuity that is the subject of the transaction, then the appropriate buyer's guide is Buyer's Guide to Fixed Deferred Annuities that has been most recently adopted by the NAIC.

Proposed §3.9711 specifies the provisions relating to the free look period required in certain circumstances. Proposed §3.9711(a) specifies that if the buyer's guide and the disclosure document required by the subchapter are not provided at or before the time of application, a free look period of at least 15 calendar days must be provided during which the applicant may return the contract without penalty. Proposed §3.9711(b) specifies that notice of the free look period required under this section must

be provided to consumers in a notice that is included on or attached to the cover page of the delivered annuity contract, and that the notice must prominently disclose the 15 day free-look period. Proposed §3.9711(c) specifies that the free look period begins the date the consumer receives the contract and shall run concurrently with any other free look period required under the Texas Administrative Code, the Texas Insurance Code, or another law of this state. Proposed §3.9711(d) specifies that an unconditional refund without penalty for purposes of the section for variable or modified guaranteed annuity contracts shall mean a refund equal to the cash surrender value provided in the annuity contract, plus any fees or charges deducted from the premiums or imposed under the contract. Proposed §3.9711(e) specifies that the refund and free look period requirements in this subsection do not apply if the prospective owner is an accredited investor, as defined in Regulation D as adopted by the United States Securities and Exchange Commission.

Proposed §3.9712 specifies the provisions relating to the report to contract owners. Proposed §3.9712(a) specifies that for annuities in the payout period with changes in non-guaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract. Proposed §3.9712(b) specifies that report must contain: (i) the beginning and ending dates of the current reporting period; (ii) the accumulation and cash surrender value, if any, at the end of the previous reporting period and the current reporting period; (iii) the total amounts, if any, that have been credited, charged to the contract or certificate value, or paid during the current reporting period; and (iv) the amount of any outstanding loans as of the end of the current reporting period.

2. FISCAL NOTE. Doug Danzeiser, Deputy Commissioner for the Life, Health & Licensing Division, has determined that for each year of the first five years the proposed sections are in effect, there will be no fiscal implications to state or local government as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Mr. Danzeiser also has determined that for each year of the first five years the proposal is in effect, there is an anticipated public benefit of increased economic welfare of insurance consumers, as well as potential costs for persons required to comply with the proposal. The Department, however, drafted the proposed rules to maximize public benefits while mitigating costs. Annuities are complex insurance products with numerous features and restrictions that vary between annuity type, product, and issuer. The purchase of an inappropriate or unsuitable annuity product can lead to severe adverse financial consequences for consumers. The Department has determined that the buyer's guide, disclosure document, and report to contract owners are necessary to decrease the likelihood of consumer financial harm resulting from inappropriate annuity contract purchases. The buyer's guide informs annuity applicants of common features and varieties of annuity contracts so that they may make a decision most appropriate for their specific financial needs. The disclosure document provides annuity applicants with basic identifying information regarding a specific annuity product so that they can compare the product being offered with their needs. The report to contract owners gives annuity purchasers information regarding

the performance and operation of their annuity contract so that they may make informed choices regarding continuation, surrender, exchange, or replacement of that contract. Therefore, the requirements of the proposed subchapter will substantially contribute to the economic welfare of insurance consumers by providing them with specific information that will assist them in making financial decisions in their best interest. Some companies currently provide Texas applicants with buyer's guides and disclosure documents on a voluntary basis, and other companies have implemented the documents as part of a company-wide compliance effort resulting from similar requirements in other states. The current industry standard practice is to provide contract owners with the report required by the proposed subchapter or a similar report. Further, since 2000, the Department's product checklists for individual and group deferred annuities have contained an item regarding annuity issuers providing annual status reports to its customers. Product checklists are documents issued by the Department to facilitate company filings by notifying companies of provisions that Department reviewers analyze upon filing receipt. Therefore, to the extent that companies issuing annuities in Texas are already providing annual status reports to customers, the requirement in the rule will not represent an additional cost. It is not anticipated that the rule will result in any costs to companies that currently provide annuity applicants with buyer's guides and disclosure documents and contract holders with reports. However, companies that do not currently provide these documents to applicants and contract owners will incur costs as a result of the compliance with the rule. The costs incurred will depend on the number of annuity contracts offered for sale or sold by a particular company. Therefore, because the costs are related to the

number of sales or sales offers, large insurers may incur more expenses than smaller insurers. The Department anticipates that the following cost components will result from compliance with the rule: (1) initial implementation costs; (2) costs specific to buyer's guides; (3) printing costs for disclosure documents and annual reports; (4) distribution costs; and (5) costs relating to the free look period.

1. Initial Implementation Costs. The Department anticipates that initial implementation cost estimates range from $7,500 to $10,000. These costs will be incurred only once and relate to computer system programming, website redesign, agent training, changes in form ordering procedure, and direct solicitation marketing. For the purpose of this cost note, the Department assumes that the majority of direct solicitation business done by annuity insurers is conducted though a insurer's internet website. This cost estimate of $7,500 to $10,000 is based on information received from an insurer that has implemented distribution of the buyer's guides, disclosure documents, and annual status reports to contract owners in states other than Texas.

2. Costs Specific to Buyer's Guides. The buyer's guides currently adopted by the NAIC include the *Buyer's Guide to Fixed Deferred Annuities* and the *Buyer's Guide to Fixed Deferred Annuities with Appendix for Equity-Indexed Annuities*. Insurers have three options for implementing the requirements relating to buyer's guides: (i) they may purchase printed copies from the NAIC; (ii) they may print copies themselves; or (iii) they may offer electronic access to consumers on their websites. The NAIC supplies insurers with printed copies of these buyer's guides and charges $0.60 per copy for the 12 page *Buyer's Guide to Fixed Deferred Annuities* and $0.63 per copy for the 20 page *Buyer's Guide to Fixed Deferred Annuities with Appendix for Equity-Indexed Annuities*.

However, this cost may vary depending on these factors: (1) the NAIC offers volume discounts for insurers ordering in large quantities; (2) the cost per copy does not include shipping charges; and (3) the NAIC may require an additional charge for customization or artwork printed on the buyer's guides. The volume discount pricing structure for the *Buyer's Guide to Fixed Deferred Annuities* is as follows: $0.60 for 999 or fewer copies; $0.56 for 1,000 to 9,999 copies; $0.53 for 10,000 to 49,999 copies; $0.48 for 50,000 to 74,999 copies; $0.44 for 75,000 to 99,999 copies; and $0.40 for 100,000 to 10,000,000 copies. The NAIC has not established sales volume discount prices for the purchase of more than 10,000,000 copies of the *Buyer's Guide to Fixed Deferred Annuities* in a year. The volume discount price printing costs for the *Buyer's Guide to Fixed Deferred Annuities with Appendix for Equity-Indexed Annuities* are as follows: $0.63 for 999 or fewer copies; $0.58 for 1,000 to 9,999 copies; $0.55 for 10,000 to 49,999 copies; $0.50 for 50,000 to 74,999 copies; $0.45 for 75,000 to 99,000 copies; and $0.43 for 100,000 to 10,000,000 copies. The NAIC has not established sales volume discount prices for the purchase of more than 10,000,000 copies of the *Buyer's Guide to Fixed Deferred Annuities with Appendix for Equity-Indexed Annuities* in a year.

An insurer may also contractually agree with the NAIC to reprint or provide electronic access to the buyer's guides. The contractual agreement requires insurers to pay the NAIC a reprinting or viewing fee on an annual basis and a royalty for electronic viewing or each copy of the buyer's guide the insurer prints. The NAIC charges the same amount for each insurer-printed copies as they do for a viewing of an electronic version on the insurer's website. The NAIC charges insurers a base standard licensing fee of $3,500, and a tiered royalty fee based on the number of copies printed by the

insurer or website views the insurer receives during the year. According to the NAIC, the costs for viewings of the electronic version or insurer-printed copies of the online buyer's guides are as follows: $500.00 for one to 999 views or reprintings; $1,075 for 1,000 to 4,999 views or reprintings; $1,900 for 5,000 to 9,999 views or reprintings; $4,375 for 10,000 to 24,999 views or reprintings; and $8,500 for 25,000 or more views or reprintings. These costs are the same for both the *Buyer's Guide to Fixed Deferred Annuities* and the *Buyer's Guide to Fixed Deferred Annuities with Appendix for Equity-Indexed Annuities.*

3. Printing costs for Disclosure Documents and Annual Reports. Insurers will incur costs in printing the disclosure documents. The proposed rule requires distribution of a disclosure document which the Department estimates will be two pages in length. The Department assumes disclosure documents will be two pages in length based upon information contained in the publication *Improving Annuity Disclosure* written by the American Council of Life Insurers, the National Association of Variable Annuities, and the National Association of Insurance and Financial Advisors. This publication provides disclosure document templates and guidance for insurers on compliance with the NAIC Annuity Disclosure Model Regulation on which the proposed rule is based. The Department estimates the cost of printing a disclosure document to be $0.16 based on its cost estimate for a printed page of $0.08.

The proposed rule also requires that insurers provide annuity owners with a report, at least annually, on the status of an in-force annuity contract. Based upon the amount and type of information required, the Department estimates that the annual status reports will be two pages in length. The Department estimates the cost of

printing a report to contract owners to be $0.16 based on its cost estimate for a printed page of $0.08. The Department assumes that the information required in the reports is readily available, easily compiled, and will not impose additional costs for insurers to prepare. The Department has been informed by insurance industry representatives that the current industry standard practice is to provide this report or a similar report. Further, since 2000, the Department's product checklists for individual and group deferred annuities have contained an item regarding annuity issuers providing annual status reports to its customers. Product checklists are documents issued by the Department to facilitate company filings by notifying companies of provisions that Department reviewers analyze upon filing receipt. Therefore, to the extent that companies issuing annuities in Texas are already providing annual status reports to its customers, the requirement in the rule will not represent an additional cost.

4. Distribution costs. The Department does not anticipate any costs relating to distribution of the buyer's guides or disclosure documents by agent or internet website distribution additional to those previously discussed. The Department does anticipate costs relating to sending these documents in the mail. Assuming the disclosure document and buyer's guides are sent in a single mailing, the anticipated cost estimates for such a mailing range from $1.06 to $1.87. This estimate is based on United State Postal Service first class mail costs. This estimate assumes that the 14 pages of the disclosure document and *Buyer's Guide to Fixed Deferred Annuities* weigh no more than five ounces, and that the 22 pages for the disclosure document and *Buyer's Guide to Fixed Deferred Annuities with Appendix for Equity-Indexed Annuities* weigh no more than eight ounces. The Department anticipates that costs associated with mailing these

documents may be less if mailed together with documents that are already being provided to consumers.

5. Free Look Period. The proposed rule requires that if an insurer does not provide the buyer's guide and the disclosure document, the insurer must provide a free look period of at least 15 days beginning on the date the consumer receives the contract and during which the applicant may return the contract without penalty. Notice of the free look period must be provided to the consumers in a notice included on or attached to the cover page of the delivered annuity contract. The Department anticipates that if not included on the cover page, this notice will be a single page in length and estimates a cost for the notice to be $0.08. The Department assumes that all carriers will provide the required buyer's guide and disclosure documents and that applicants will thus not be entitled to the free look required under the proposed rule. Thus, the Department does not anticipate any costs associated with the return of contracts without penalty.

The cost elements and estimates identified in this cost note are based upon the April 15, 2010 informal posting on the Department's website. The April 15, 2010 informal cost estimate also noted that insurer staff time would be required to comply with the proposed rule text, but that insurers would be able to absorb additional staff time requirements with their existing resources. In its April 15, 2010 posting, the Department sought additional information on the above cost estimates and components. The Department did not receive any information additional to or conflicting with these cost estimates.

All of the analyses in this cost note are equally applicable to and do not vary for

small or micro businesses.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on approximately 31 to 47 small or micro-businesses that are required to comply with the proposed rules. The Department does not have precise information regarding the number of small or micro insurers administering or offering annuity contracts for sale in Texas. However, for the purpose of this estimate, the Department assumes that between 10 to 15 percent

of the 312 licensed companies doing annuity business in Texas as of December 31, 2009, are small or micro-businesses. The cost of compliance with the proposal will not vary between large businesses and small or micro-businesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note portion of this proposal is equally applicable to small or micro-businesses. However, as noted in the Public Benefit/Cost Note portion of this proposal, the costs associated with the proposed subchapter depend upon the number of annuity contracts sold or offered for sale. Therefore, to the extent that a small or micro business sells or offers for sale fewer annuity contracts, these costs are expected to be lower than they would be for a larger insurer.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though the proposal may have an adverse economic effect on small or micro-businesses that are required to comply with the proposal, the proposal does not require a regulatory flexibility analysis that is mandated by §2006.002(c)(2) of the Government Code. Section 2006.002(c)(2) requires that a state agency, before adopting a rule that may have an adverse economic effect on small businesses, prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory flexibility analysis "consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and

micro-businesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

The purpose of this proposal is to protect the economic welfare of Texas annuity applicants and contract owners by providing them with educational and identifying information regarding annuities that will enable them to more likely make a decision in their best interest and reduce the opportunity for misrepresentation and incomplete disclosure. The severe adverse financial consequences that can result from the uninformed purchase of an annuity product can be significantly mitigated through the use of the disclosures required by the proposed subchapter. The buyer's guide informs annuity applicants of common features and varieties of annuity contracts so that they may choose a product and features most appropriate for their specific situation. The disclosure document provides annuity applicants with basic identifying information regarding a specific annuity product so that they can compare the product being offered with their needs. The report to contract owners gives annuity purchasers information regarding the performance and operation of their annuity contract so that they may make informed choices regarding continuation, surrender, exchange, or replacement of that contract. Therefore, the proposed subchapter will substantially contribute to the economic welfare of insurance consumers by allowing them to make more informed decisions regarding annuities.

Therefore, the Department has determined in accordance with §2006.002(c-1) of the Government Code, that because the purpose of the proposal is to protect consumer economic interests, there are no regulatory alternatives to the required notices in this

proposal that will sufficiently protect the economic interests of consumers purchasing insurance from small or micro-business insurers.

5. TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 13, 2010, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments must be simultaneously submitted to Doug Danzeiser, Deputy Commissioner for the Life, Health & Licensing Division, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing should be submitted separately to the Office of the Chief Clerk before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The new subchapter is proposed under the Insurance Code §§1108.002, 31.002, 101.051(b)(1), (b)(3), and (b)(5)(A), 1152.002, 1114.007, 1114.001, and 36.001. Section 1108.002 specifies that for the purpose of regulation

under the Insurance Code, an annuity contract is considered an insurance policy or contract if the annuity contract is issued by a life, health, or accident insurance company, including a mutual company or fraternal benefit society or issued under an annuity or benefit plan used by an employer or individual. Section 31.002 specifies that in addition to other required duties, the Department shall regulate the business of insurance in this state; administer the workers' compensation system of this state as provided by the Labor Code Title 5; and ensure that the Insurance Code and other laws regarding insurance and insurance companies are executed. Section 101.051(b)(1) specifies that the making or proposing to make, as an insurer, an insurance contract constitutes the business of insurance in this state. Section 101.051(b)(3) specifies that taking or receiving an insurance application constitutes the business of insurance in this state. Section 101.051(b)(5)(A) specifies that issuing or delivering a contract to a resident of this state constitutes the business of insurance. Section 1152.005 specifies that the Commissioner may adopt rules that are fair, reasonable, and appropriate to augment and implement the Insurance Code Chapter 1152, relating to separate accounts and variable annuity contracts, including rules establishing agent licensing, standard policy provisions, and disclosure. Section 1114.007 specifies that the Commissioner may adopt reasonable rules in the manner prescribed by Subchapter A, Chapter 36, to accomplish and enforce the purpose of Chapter 1114. Section 1114.001 states that the purpose of Chapter 1114 is to regulate the activities of insurers and agents with respect to the replacement of existing life insurance and annuities; protect the interests of purchasers of life insurance or annuities by establishing minimum standards of conduct to be observed in certain transactions; ensure that purchasers

receive information with which a decision in the purchaser's best interest may be made; reduce the opportunity for misrepresentation and incomplete disclosure; and establish penalties for failure to comply with the requirements adopted under Chapter 1114. Section 36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule	Statute
§§3.9701 - 3.9712	Insurance Code §§101.051(b),(1) 101.051(b)(3), 101.051(b)(5)(A), 1152.005, and 1114.007

9. TEXT.

SUBCHAPTER PP. Annuity Disclosures
28 TAC §§3.9701 - 3.9712

§3.9701. Purpose. The purpose of this subchapter is to:

(1) provide standards for the disclosure of certain minimum information about annuity contracts; and

(2) assist purchasers of annuity contracts to understand certain basic features of annuity contracts.

§3.9702. Applicability and Scope.

(a) This subchapter applies to all group and individual annuity contracts and certificates except as provided by subsection (b) of this section.

(b) This subchapter does not apply to the following annuity products except as provided in subsection (c) of this section:

(1) immediate and deferred annuities that contain only guaranteed elements;

(2) annuities used to fund:

(A) an employee pension plan subject to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

(B) a plan described by the Internal Revenue Code of 1986 §§401(a), 401(k), or 403(b), in which the plan, for purposes of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), is established or maintained by an employer;

(C) a governmental or church plan as defined by the Internal Revenue Code of 1986 §414, or a deferred compensation plan of a state or local government or a tax-exempt organization under the Internal Revenue Code of 1986 §457;

(D) a nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor; or

(E) prepaid funeral benefits, as defined by the Finance Code Chapter 154;

(3) a structured settlement annuity;

(4) a charitable gift annuity qualified under the Insurance Code Chapter 102; or

(5) a funding agreement.

(c) Notwithstanding the exemptions specified in subsection (b) of this section, this subchapter applies to an annuity used to fund a plan or arrangement that is funded solely by contributions an employee elects to make, whether on a pre-tax or after-tax basis, if the insurer has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by an agent for the purchase of an annuity contract. As used in this subsection, "direct solicitation" does not include a meeting held by an agent solely for the purpose of educating or enrolling employees in the plan or arrangement.

§3.9703. Effective Date. This subchapter shall apply only to annuity transactions subject to regulation under this subchapter that occur on or after the effective date of this subchapter.

§3.9704. Definitions.

(a) Words and terms defined in the Insurance Code Chapter 102 shall have the same meaning when used in this subchapter.

(b) The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) Agent--An individual who holds a license under the Insurance Code Chapter 4054 and who sells, solicits, or negotiates annuities in this state.

(2) Buyer's guide--A document specified as a buyer's guide and adopted by the National Association of Insurance Commissioners (NAIC) to be used in implementation of the NAIC Annuity Disclosure Model Regulation.

(3) Contract owner--The owner named in the annuity contract or, in the case of a group annuity contract, the certificate holder.

(4) Disclosure document--A document intended for consumers that provides information regarding the features and restrictions of a specific annuity product and that satisfies the requirements of §3.9709 of this subchapter (relating to Disclosure Document).

(5) Funding agreement--An agreement for an insurer to accept and accumulate funds and to make one or more payments at future dates in amounts that are not based on mortality or morbidity contingencies.

(6) Generic name--A short title descriptive of the annuity contract being illustrated or for which an applicant is applying, such as "single premium deferred annuity."

(7) Structured settlement annuity--A "qualified funding asset," as defined by the Internal Revenue Code of 1986 §130(d), or an annuity that would be a qualified funding asset but for the fact that the annuity is not owned by an assignee under a qualified assignment.

§3.9705. Determinable Elements.

(a) For the purposes of this subchapter, "determinable elements" means elements derived from processes or methods that are guaranteed at issue and are not

subject to company discretion, but for which the values or amounts cannot be determined until some point after issue. The term includes:

(1) premiums;

(2) credited interest rates, including any bonus;

(3) benefits;

(4) values;

(5) non-interest based credits;

(6) charges; and

(7) elements of formulas used to determine any element described by paragraphs (1) - (6) of this subsection.

(b) Determinable elements may be described as guaranteed but not determined at issue. An element is considered determinable if the element was computed from only underlying determinable elements, or from both determinable and guaranteed elements.

§3.9706. Guaranteed and Non-guaranteed Elements.

(a) For the purposes of this chapter, "guaranteed element" means an element listed in subsection §3.9705(a)(1) - (7) of this subchapter (relating to Determinable Elements) that is guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements used in its computation are guaranteed.

(b) For the purposes of this subchapter, "non-guaranteed element" means an element listed in subsections §3.9705(a)(1) - (7) of this subchapter that is subject to the insurer's discretion and is not guaranteed at issue. An element is considered non-guaranteed if any underlying element used in its computation is non-guaranteed.

§3.9707. Effect on Other Law. Compliance with this subchapter is not a defense in any action brought by or for the department alleging a violation of the Insurance Code, or, except for this subchapter, any rule adopted pursuant to the Insurance Code.

§3.9708. Required Consumer Notices.

(a) If an application for an annuity contract or certificate is taken in a face-to-face meeting, the applicant shall be given at or before the time of application both a disclosure document and the appropriate buyer's guide specified in §3.9710 of this subchapter (relating to Buyer’s Guide).

(b) If the application is taken by means other than in a face-to-face meeting the applicant shall be sent not later than the fifth business day after the date on which the completed application is received by the insurer both a disclosure document and the appropriate buyer's guide specified in §3.9710 of this subchapter.

(c) If the insurer receives the application as a result of a direct solicitation through the mail, the insurer’s providing the appropriate buyer's guide and a disclosure document in a mailing inviting prospective applicants to apply for an annuity contract or certificate satisfies the requirement in subsection (b) of this section that the appropriate buyer's guide and the disclosure document be provided not later than the fifth business day after the date of receipt of the application.

(d) If the application is received through the Internet, the insurer must take reasonable steps to ensure that the appropriate buyer's guide and a disclosure document are available for viewing and printing on the insurer's website and opened or

acknowledged by the prospective applicant in order to satisfy the requirement that the appropriate buyer's guide and the disclosure document be provided not later than the fifth business day after the date of receipt of the application.

(e) A solicitation for an annuity contract that is provided in a manner other than a face-to-face meeting must include a statement that the proposed applicant may contact the insurer for a free annuity buyer's guide.

§3.9709. Disclosure Document.

(a) At a minimum, the following information must be included in the disclosure document required to be provided under this subchapter:

(1) the generic name of the contract, the insurer product name, if different from the generic name, the product's form number, and a statement of the fact that the contract is an annuity;

(2) the insurer's name and address;

(3) a description of the contract and the benefits provided under the contract; the description must emphasize the long-term nature of the contract and include examples of the long-term nature as appropriate;

(4) the guaranteed, non-guaranteed, and determinable elements of the contract, any limitations of those elements, and an explanation of how those elements operate;

(5) an explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the initial crediting rate, and the fact that rates may change from time to time and are not guaranteed;

(6) periodic income options, both on a guaranteed and non-guaranteed basis;

(7) any value reductions caused by withdrawals from or surrender of the contract;

(8) how values in the contract can be accessed;

(9) the death benefit, if available, and how the death benefit is computed;

(10) a summary of:

(A) the federal tax status of the contract; and

(B) any penalties applicable on withdrawal of values from the contract;

(11) the impact of any rider, such as a long-term care rider;

(12) a list of the specific dollar amount or percentage charges and fees, with an explanation of how those charges and fees apply; and

(13) information about the current guaranteed rate for new contracts that contains a clear notice that is reasonably intelligible to the average consumer that the rate is subject to change.

(b) An insurer shall define terms used in the disclosure document in language that facilitates the understanding by a typical person within the segment of the public to which the disclosure document is directed.

(c) A disclosure document that complies with the Financial Industry Regulatory Authority (FINRA) Conduct Rules and the United States Securities and Exchange Commission (SEC) prospectus requirements satisfies the requirements of this section for disclosure documents. This subsection does not limit the commissioner's ability to

enforce the provisions of this section or require the use of a FINRA-approved disclosure document. This subsection provides a safe harbor under this subchapter for an annuity contract that is regulated by, and complies with, the FINRA Conduct Rules and the SEC prospectus requirements pertaining to disclosure.

§3.9710. Buyer's Guide. For the purposes of this subchapter, an appropriate buyer's guide is the latest version of the buyer's guide adopted by the NAIC that applies to the particular type of annuity (such as fixed deferred annuity, equity-indexed annuity, or variable annuity) that is the subject of the transaction. If the NAIC has not adopted a buyer's guide for the particular type of annuity that is the subject of the transaction, then the appropriate buyer's guide is Buyer's Guide to Fixed Deferred Annuities that has been most recently adopted by the NAIC.

§3.9711. Free Look Period.

(a) If the buyer's guide and the disclosure document required by this subchapter are not provided at or before the time of application, a free look period of at least 15 calendar days must be provided during which the applicant may return the contract without penalty.

(b) Notice of the free look period required under this section must be provided to consumers in a notice that is included on or attached to the cover page of the delivered annuity contract. The notice must prominently disclose the 15 day free-look period.

(c) The free look period shall begin on the date the consumer receives the annuity contract and shall run concurrently with any other free look period required

under the Texas Administrative Code, the Texas Insurance Code, or another law of this state.

(d) An unconditional refund without penalty for purposes of this section for variable or modified guaranteed annuity contracts shall mean a refund equal to the cash surrender value provided in the annuity contract, plus any fees or charges deducted from the premiums or imposed under the contract.

(e) The refund and free look period requirements in this subsection do not apply if the prospective owner is an accredited investor, as defined in Regulation D as adopted by the United States Securities and Exchange Commission.

§3.9712. Report to Contract Owners.

(a) For annuities in the payout period with changes in non-guaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract.

(b) The report must contain at least the following information:

(1) the beginning and ending dates of the current reporting period;

(2) the accumulation and cash surrender value, if any, at the end of:

(A) the previous reporting period; and

(B) the current reporting period;

(3) the total amounts, if any, that have been credited, charged to the contract or certificate value, or paid during the current reporting period; and

(4) the amount of any outstanding loans as of the end of the current reporting period.

10. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on _____, 2010.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

APPENDIX X

- *Projected Lifetime Income Benefits*, Texas Department of Insurance, Workers Compensation Research and Evaluation Group.
- *Projected Death Income Benefits*, Texas Department of Insurance, Workers Compensation Research and Evaluation Group.
- *Sustained Return-to-Work by Impairment Rating, Injury*, Texas Department of Insurance.

Projected Lifetime Income Benefits
With 10% incremental increases in the Max for New Recipients
Fiscal Years 2011 - 2015

Percentage of SAWW (% of recipients capped at each level)	**Current Annual LIBs Payments** Injury Years 1991 – 2010 (Approx 2,500 recipients)	**Projected New LIBs Payments FY2011** (110 recipients)	**Projected New LIBs Payments FY2012** (220 recipients)	**Projected New LIBs Payments FY2013** (330 recipients)	**Projected New LIBs Payments FY2014** (440 recipients)	**Projected New LIBs Payments FY2015** (550 recipients)
100% (22% capped)	$51,871,289	$2,708,932	$5,499,133	$8,425,671	$11,079,535	$13,869,736
110% (15% capped)	$51,871,289	$2,787,370	$5,658,361	$8,529,352	$11,400,343	$14,271,335
120% (13% capped)	$51,871,289	$2,849,853	$5,785,202	$8,720,551	$11,655,900	$14,591,249
130% (11% capped)	$51,871,289	$2,901,090	$5,889,213	$8,877,337	$11,865,460	$14,853,583
140% (9% capped)	$51,871,289	$2,946,424	$5,981,241	$9,016,059	$12,050,876	$15,085,693
150% (8% capped)	$51,871,289	$2,984,823	$6,059,192	$9,133,560	$12,207,929	$15,282,297
No Caps	$51,871,289	$4,148,768	$8,422,045	$12,695,311	$16,968,578	$21,241,844

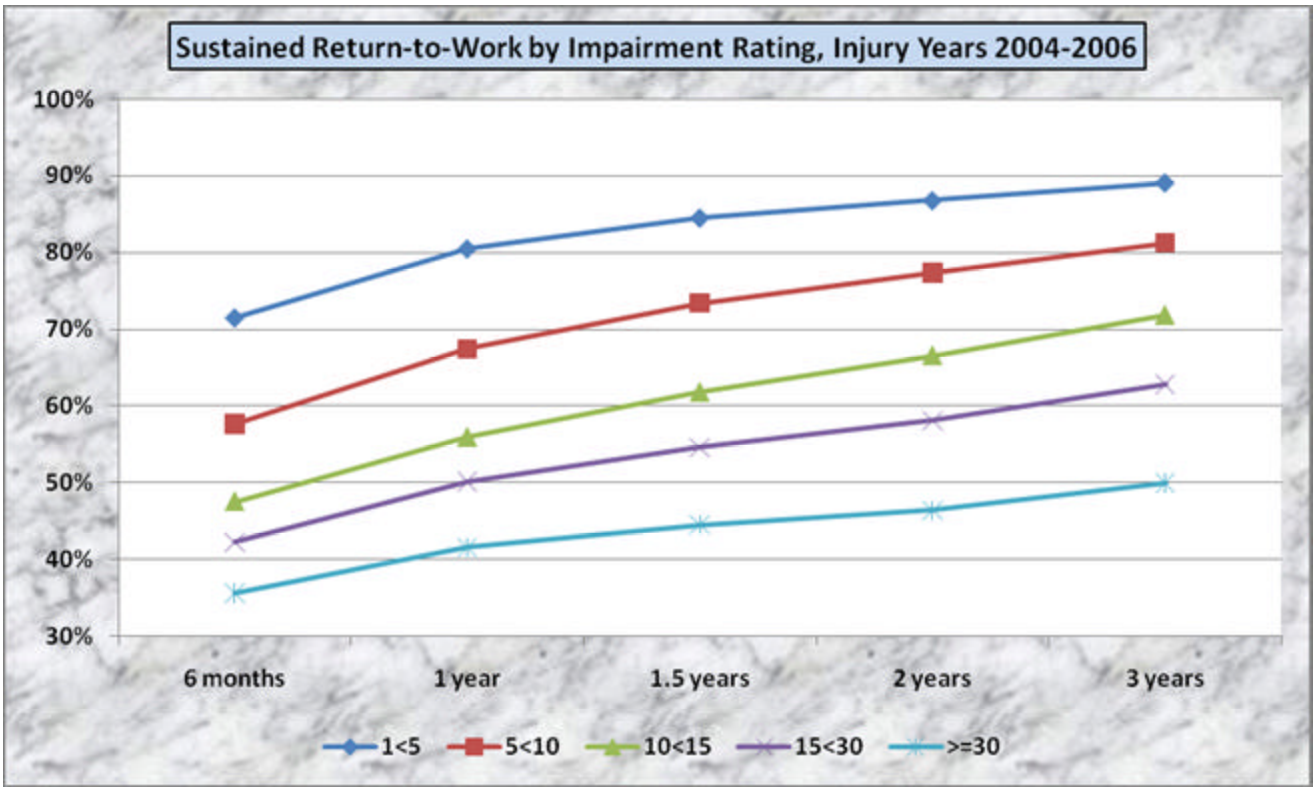
Source: TDI WC Research and Evaluation Group, 2010

Note: Projections based on most recent complete year of data, 2008 when 110 new injured workers qualified for LIBS. The projections assume an additional 110 new LIBs recipients each fiscal year. LIBs recipients receive a 3% annual increase each fiscal year after the first. Total payments for any given fiscal year, at any given capped level, is equal to the Current plus Projected New LIBS Payments.

Projected Death Income Benefits
With 10% incremental increases in the Max
Fiscal Years 2011 - 2015

Percentage of SAWW (% of recipients capped at each level)	**Current Annual DIBs Payments** Injury Years 1991 – 2009 (3962 Fatalities)	**Projected New DIBs Payments FY 2011 (150 cases)**	**Projected New DIBs Payments FY 2012 (140 cases)**	**Projected New DIBs Payments FY 2013 (130 cases)**	**Projected New DIBs Payments FY 2014 (120 cases)**	**Projected New DIBs Payments FY 2015 (110 cases)**
100% (31% Capped)	$46,338,477	$3,517,646	$6,800,781	$9,849,407	$12,663,524	$15,243,131
110% (25% Capped)	$46,338,477	$3,687,503	$7,129,172	$10,325,008	$13,275,010	$15,979,178
120% (19% Capped)	$46,338,477	$3,826,626	$7,398,144	$10,714,553	$13,775,854	$16,582,047
130% (15% Capped)	$46,338,477	$3,941,592	$7,620,411	$11,036,458	$14,189,732	$17,080,233
140% (13% Capped)	$46,338,477	$4,039,360	$7,809,429	$11,310,208	$14,541,695	$17,503,893
150% (10% Capped)	$46,338,477	$4,122,286	$7,969,753	$11,542,400	$14,840,229	$17,863,239
No Caps (0% Capped)	$46,338,477	$5,882,747	$11,373,310	$16,471,691	$21,177,888	$25,491,902

Current annual DIBs payments are the total benefits paid during 2009, regardless of injury year **Based initially on 150 injured workers.**
Each fiscal year beyond 2011 is reduced by 10 work-related fatalities.
A surviving spouse, minor children, dependent grandchildren, other dependents, and non-dependents (under certain conditions) of the deceased employee may be eligible to receive death benefits if certain requirements are met, and benefits end when they no longer apply. WCREG does not have access to information that allows WCREG to determine if those requirements continue to hold for DIBs recipients.
Projections are based on average weekly wage data from FY 2009.
Only cases with valid weekly wage, compensation rate, and final benefit amount are included.



Source: Texas Department of Insurance
Note: Only injured workers with valid impairment ratings are included.
Note: The last impairment rating is used if there are multiple ratings for the same injury.

APPENDIX XII

- *NASS Summary of the Military and Overseas Voter Empowerment Act (MOVE Act)*, National Association of Secretaries of State (NASS) (Nov. 6, 2009).
- UNIFORM MILITARY AND OVERSEAS VOTERS ACT (National Conference of Commissioners on Uniform State Laws 2010).

NASS
National Association of Secretaries of State

November 6, 2009

NASS Summary of the Military and Overseas Voter Empowerment Act (MOVE Act)
Passed by Congress on October 22nd, 2009
The President signed the bill on Wednesday, October 28, 2009

I. PROVISIONS CONCERNING STATES

A. Clarification of State Responsibilities (Sec. 576)

- States may delegate the responsibilities under the Act to jurisdictions within the State.

B. Transmitting Voter Registration Applications & Absentee Ballot Applications (Sec. 577)

- States must establish procedures that allow UOCAVA voters to request voter registration applications and absentee ballot applications by mail or electronically for general, special, primary, and runoff elections for Federal office. The procedures must include a means for the voter to designate how they want to receive the application – by mail or electronically.
- The State must transmit the voter registration application or absentee ballot application based on the preference selected by the voter. If the voter does not indicate a preference, the application must be delivered in accordance with State law. In the absence of any relevant State law, the application must be delivered by mail.
- To the extent practicable, the procedures must :(1) protect the security and integrity of the voter registration and absentee ballot application request process and (2) protect the privacy of the identity and personal data of the UOCAVA when the voter requests or is sent a voter registration application or absentee ballot application.
- **The above provisions apply with respect to the November 2010 General Election.**

C. Designating a Means of Electronic Communication (Sec. 577)

- Each State must designate at least one means of electronic communication for the following purposes: (1) for use by UOCAVA voters to request voter registration applications and absentee ballot applications; (2) for use by the States to send voter registration and absentee ballot applications to voters; and (3) for providing UOCAVA voters with election and voting information.
- In addition to the means of electronic communication designated by the State, the State may provide a means of electronic communication for jurisdictions within the State to communicate with UOCAVA voters.
- The State must include the designated means of electronic communication on all information and instructional materials that accompany balloting materials sent by the State to UOCAVA voters.
- **The above provisions apply with respect to the November 2010 General Election.**

D. Transmitting Blank Ballots (Sec. 578)

- The States must develop procedures for transmitting blank ballots to UOCAVA voters by mail and electronically for general, special, primary, and runoff elections for Federal office.
- The procedures must include a means for the voter to designate how they want to receive the blank ballot – by mail or electronically. The State must transmit the ballot based on the preference

selected by the voter. If the voter does not indicate a preference, the ballot must be delivered in accordance with State law. In the absence of any relevant State law, the ballot must be delivered by mail.

- To the extent practicable, the procedures must :(1) protect the security and integrity of absentee ballots and (2) protect the privacy of the identity and personal data of the UOCAVA voter throughout the transmission process
- **The above provisions apply with respect to the November 2010 General Election.**

E. Ballot Tracking Mechanism (Sec. 580(h))

- Each Chief State Election Official must work with local jurisdictions to develop a free access system that allows a UOCAVA voter to determine whether his/her absentee ballot was received by the appropriate State Election Official.
- **The above provision applies with respect to the November 2010 General Election.**

F. Accepting UOCAVA Ballot Materials (Sec. 581(a) & 582)

- Expands the use of the Federal Write-In Absentee Ballot (FWAB) to include all special, primary, and runoff elections for Federal office. **This requirement goes into effect on December 31, 2010.**
- Prohibits States from refusing to accept and process an otherwise valid voter registration application, absentee ballot application, voted ballot, or FWAB from an overseas voter due to notarization requirements, paper type, weight and size, or envelope type, weight and size. **These provisions apply with respect to the November 2010 General Election.**

G. Single Application for Multiple Elections (Sec. 585)

- Removes the UOCAVA requirement that a single absentee ballot request serve as a request to receive absentee ballots through the subsequent two Federal election cycles.

H. Ballot Transmittal Time (Sec. 579)

- Absentee ballots must be sent at least 45 days before the election to any UOCAVA voter who has submitted a request by that date. **Note**: In 2010, 45 days before the November 2nd Election is Saturday, September 18th.
- If the request is received less than 45 days before the election, the ballot may be sent in accordance with State law and, if practicable, in an expedited manner.
- A State may request a waiver from the 45 day transit time provision if the Chief State Election Official determines that the State cannot meet the requirements due to undue hardship. The undue hardship must be one of the following: (1) the date of the State primary; (2) a delay in generating ballots due to a legal contest; or (3) the State constitution prohibits the state from complying with the time frame requirements.
- The waiver request must include: (1) a recognition that the purpose of the 45 day transit time is to allow UOCAVA voters enough time to vote in Federal elections; (2) an explanation of why the State cannot meet the requirement; (3) the number of days prior to Federal elections that the State requires absentee ballots be sent to UOCAVA voters; and (4) a comprehensive plan to ensure that overseas voters are able to receive and submit an absentee ballot in time for it to be counted.
- If the undue hardship is based on either the State primary date or the State constitution, the waiver request must be submitted no later than 90 days before the upcoming election. **Note**: In 2010, 90 days before the November 2nd Election is Wednesday, August 4th. After consulting with the Attorney

General, the Department of Defense must grant the waiver request if the comprehensive plan is deemed sufficient. The Department of Defense must approve or deny a waiver request based on the State primary date or State constitution no later than 65 days before the Election. **Note**: In 2010, 65 days before the November 2nd Election is Sunday, August 29th.

- If a State requests a waiver based on a delay in generating ballots due to a legal contest, the request must be submitted as soon as practicable. The Department of Defense must approve or deny the request no later than 5 days after the waiver request is received.
- If a waiver request is granted, it is valid only for the Election for which the request was submitted.
- **The above provisions apply with respect to the November 2010 General Election.**

I. Runoff Election Plan (Sec. 579(b))

- If a State holds a runoff election, it must have a written plan to make absentee ballots available to UOCAVA voters with sufficient time to vote.
- **The above provision applies with respect to the November 2010 General Election.**

J. Requirements Payments (Sec. 588)

- Amends the Help America Vote Act (HAVA) by authorizing the appropriation of "such sums as necessary" for FY 2010 and beyond as requirements payments to the States specifically for implementing the MOVE Act. Any funds appropriated under this provision may only be used to carry out the requirements of the MOVE Act.
- Nothing in the MOVE Act prohibits the States from using existing HAVA funds (or those authorized by a future appropriations bill) to implement the MOVE Act.
- If a State receives a FY 2010 requirements payment specifically authorized for implementation of the MOVE Act, it has until the last day of the 2011 fiscal year to comply with the 5% match requirement.
- States must amend their State plans to indicate how they will comply with the requirements of the MOVE Act.

II. PROVISIONS CONCERNING THE DEPARTMENT OF DEFENSE/FVAP

A. Election Official Database (Sec. 577(e)(4))

- The Federal Voting Assistance Program (FVAP) must maintain a public online database that includes state contact information for Federal elections, including the single State office designated under UOCAVA and the designated means of electronic communication that each State has established to communicate with UOCAVA voters.
- **The above provision applies with respect to the November 2010 General Election.**

B. Ballot Collection/Delivery (Sec. 580)

- The Department of Defense must establish procedures for collecting and delivering the absentee ballots of voters who are overseas by reason of active duty or service. The procedures only apply to regularly scheduled general elections for Federal office.
- The Department of Defense must utilize the United States Postal Service expedited delivery service for mailing voted absentee ballots to the appropriate election official in time to be counted.
- The expedited service must be available for any ballot collected before noon on the seventh day preceding the date of the election. **Note**: In 2010, the seventh day before the general election is

Tuesday, October 26th. If the Department of Defense determines that that this deadline is not sufficient for timely delivery due to remoteness of location or other factors, the Department may establish an earlier deadline for those locations.

- No postage is required on the absentee ballots collected and delivered under these procedures.
- The ballots collected under these procedures are postmarked as of the date they are mailed.
- The Department of Defense must inform and educate uniformed service voters about the ballot collection and delivery procedures.
- The Department of Defense must take action to: (1) ensure the privacy of voters who cast ballots at Department of Defense locations or facilities and (2) protect the privacy of absentee ballots when the ballots are in the control or possession of the Department.
- **The above provisions apply with respect to the November 2010 General Election.**

C. Voter Registration Outreach (Sec. 583)

- The Federal Voting Assistance Program (FVAP) must develop online portals to inform absent uniformed service voters about voter registration and absentee ballot procedures.
- FVAP must establish a program to provide absent uniformed service voters with voter registration information and resources through the military Global Network. The information must be provided 90, 60, and 30 days prior to each Federal election.
- No later than 180 days after the MOVE Act is enacted, the Secretaries of each military department must designate an office on each installation to provide voter registration and absentee ballot information to uniformed service members and their family members. The Department of Defense must inform absent uniformed service members of the assistance available at the designated offices.
- The Secretary of Defense may authorize the Secretaries of the military departments to designate offices on military installations as voter registration agencies under the National Voter Registration Act.
- **The above provisions apply with respect to the November 2010 General Election.**

D. Reporting (Sec. 584 & 586)

- The Department of Defense must work with the Election Assistance Commission (EAC) and the Chief Election Official in each State to develop standards for the States to report on the number of ballots transmitted and received and other data as the Department determines appropriate.
- No later than 180 days after enactment of the MOVE Act, the Department of Defense must submit to Congress a report on (1) the status of implementing the ballot collection and delivery procedures; (2) an assessment of the effectiveness of the Voting Assistance Officer Program; and (3) a description of steps taken towards implementation of voter registration assistance on military installations.
- No later than March 31st of each year, the Department of Defense must submit to Congress a report containing: (1) an assessment of FVAP activities; (2) an assessment of voter registration and participation by absent uniformed service voter; (3) an assessment of voter registration and participation by overseas voters not affiliated with the uniformed services; (4) a description of the cooperation between States and the Federal Government; (5) a description of voter registration assistance programs implemented by each military department; (6) the number of absent uniformed service voters who utilized voter registration assistance provided at military installations; and (7) in the case of a report submitted in the years following a regularly scheduled Federal election, a

description of the procedures used to collect and deliver absentee ballots for expedited service, including the number of ballots collected and delivered, and the number of ballots which were not delivered by the time the polls closed on Election Day.

- **The above provisions apply with respect to the November 2010 General Election.**

E. Utilizing Technology (Sec. 581(b) & 589)

- Requires that the Department of Defense utilize technology to implement a system that allows a UOCAVA voter to enter his/her address or other information relevant to the local election jurisdiction and receive a list of all candidates for Federal office in that jurisdiction. The voter must also be able to print the FWAB with instructions for submitting it to the appropriate State election office, and the mailing address of the singe State office designated under UOCAVA. **This provision must be implemented by December 31st, 2011.**
- The Department of Defense may establish pilot programs to test technology that assists UOCAVA voters. Issues to be considered for any pilot program include: the secure electronic transmittal of voting materials; information security techniques; utilizing vote stations at military bases; and document delivery and upload systems.
- The Department of Defense must submit a report to Congress on the outcomes of any pilot program and recommendations for any additional programs.
- The EAC and the National Institute of Standards and Technology (NIST) must provide the Department of Defense with standards to support the pilot program(s). The standards must be in accordance with the electronic absentee voting guidelines established under the 2005 National Defense Authorization Act (which delayed the implementation of an electronic voting demonstration project until the EAC developed guidelines).
- If the EAC has not established electronic absentee voting guidelines required under the 2005 NDAA within 180 days of the enactment of the MOVE Act, the EAC must submit to Congress a report containing: (1) the reasons the guidelines have not been established by that date; (2) a detailed timeline for the establishment of the guidelines; and (3) a detailed explanation of the EAC's actions in establishing the guidelines since the date of enactment of the 2005 NDAA.

UNIFORM MILITARY AND OVERSEAS VOTERS ACT*

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT
IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS ONE-HUNDRED-AND-NINETEENTH YEAR
CHICAGO, ILLINOIS
JULY 9 - JULY 16, 2010

WITHOUT PREFATORY NOTE OR COMMENTS

July 15, 2010

*The following text is subject to revision by the Committee on Style of the National Conference of Commissioners on Uniform State Laws.

Support for this project was provided by a grant from The Pew Charitable Trusts' "Make Voting Work" project. The views expressed are those of the drafting committee and do not necessarily reflect the view of Make Voting Work or The Pew Charitable Trusts.

UNIFORM MILITARY AND OVERSEAS VOTERS ACT

SECTION 1. SHORT TITLE. This [act] may be cited as the Uniform Military and Overseas Voters Act.

SECTION 2. DEFINITIONS. In this [act]:

(1) "Covered voter" means:

(A) a uniformed-service voter or an overseas voter who is registered to vote in this state;

(B) a uniformed-service voter defined in paragraph (7)(A) whose voting residence is in this state and who otherwise satisfies this state's voter eligibility requirements;

(C) an overseas voter who, before leaving the United States, was last eligible to vote in this state and, except for a state residency requirement, otherwise satisfies this state's voter eligibility requirements;

(D) an overseas voter who, before leaving the United States, would have been last eligible to vote in this state had the voter then been of voting age and, except for a state residency requirement, otherwise satisfies this state's voter eligibility requirements; or

(E) an overseas voter who was born outside the United States, is not described in subparagraph (C) or (D), and, except for a state residency requirement, otherwise satisfies this state's voter eligibility requirements, if:

(i) the last place where a parent or legal guardian of the voter was, or under this [act] would have been, eligible to vote before leaving the United States is within this state; and

(ii) the voter has not previously registered to vote in any other state.

(2) “Dependent” means an individual recognized as a dependent by the applicable uniformed service.

(3) “Military-overseas ballot” means:

(A) a federal write-in absentee ballot described in the Uniformed and Overseas Citizens Absentee Voting Act, section 103, 42 U.S.C. Section 1973ff-2;

(B) a ballot specifically prepared or distributed for use by a covered voter in accordance with this [act]; or

(C) a ballot cast by a covered voter in accordance with this [act].

(4) “Overseas voter” means a United States citizen who is outside the United States.

(5) “State” means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands, or any territory or insular possession subject to the jurisdiction of the United States.

(6) “Uniformed service” means:

(A) active and reserve components of the Army, Navy, Air Force, Marine Corps, and Coast Guard of the United States;

(B) the Merchant Marine, the commissioned corps of the Public Health Service, and the commissioned corps of the National Oceanic and Atmospheric Administration of the United States; and

(C) the National Guard and state militia units.

(7) “Uniformed-service voter” means an individual who is qualified to vote and is:

(A) a member of the active or reserve components of the Army, Navy, Air Force, Marine Corps, or Coast Guard of the United States who is on active duty;

(B) a member of the Merchant Marine, the commissioned corps of the Public

Health Service, or the commissioned corps of the National Oceanic and Atmospheric Administration of the United States;

(C) a member of the National Guard or state militia unit who is on activated status; or

(D) a spouse or dependent of a member referred to in this paragraph.

(8) "United States", used in the territorial sense, means the several states, the District of Columbia, Puerto Rico, the United States Virgin Islands, and any territory or insular possession subject to the jurisdiction of the United States.

SECTION 3. ELECTIONS COVERED. The voting procedures in this [act] apply to:

(1) a general, special, [presidential preference,] [or] primary [, or runoff] election for federal office;

(2) a general, special, [recall,] [or] primary [, or runoff] election for statewide or state legislative office or state ballot measure; and

(3) a general, special, [recall,] [or] primary [, or runoff] election for local government office or local ballot measure conducted under [insert relevant state law] [for which absentee voting or voting by mail is available for other voters].

Legislative Note: *The bracketed language in paragraphs (1), (2), and (3) pertaining to presidential preference, recall, and runoff elections is only for states with such elections. In paragraph (3) the bracketed reference to "relevant state law" refers to the portion of the state election code or equivalent state statute that governs the conduct of local elections, to the extent that an enacting state wishes to include local elections in the coverage of this act.*

SECTION 4. ROLE OF [SECRETARY OF STATE].

(a) The [Secretary of State] is the state official responsible for implementing this [act] and the state's responsibilities under the Uniformed and Overseas Citizens Absentee Voting Act, 42 U.S.C. Section 1973ff et seq.

(b) The [Secretary of State] shall make available to covered voters information regarding voter registration procedures for covered voters and procedures for casting military-overseas ballots. The [Secretary of State] may delegate the responsibility under this subsection only to the state office designated in compliance with the Uniformed and Overseas Citizens Absentee Voting Act, section 102(b)(1), 42 U.S.C. Section 1973ff-1(b)(1).

(c) The [Secretary of State] shall establish an electronic transmission system through which covered voters may apply for and receive documents and other information under this [act].

(d) The [Secretary of State] shall develop standardized absentee-voting materials, including privacy and transmission envelopes and their electronic equivalents, authentication materials, and voting instructions, to be used with the military-overseas ballot of a voter authorized to vote in any jurisdiction in this state and, to the extent reasonably possible, shall do so in coordination with other states.

(e) The [Secretary of State] shall prescribe the form and content of a declaration for use by a covered voter to swear or affirm specific representations pertaining to the voter's identity, eligibility to vote, status as a covered voter, and timely and proper completion of an overseas-military ballot. The declaration must be based on the declaration prescribed to accompany a federal write-in absentee ballot under the Uniformed and Overseas Citizens Absentee Voting Act, section 103, 42 U.S.C. Section 1973ff-2, as modified to be consistent with this [act]. The [Secretary of State] shall ensure that a form for the execution of the declaration, including an indication of the date of execution of the declaration, is a prominent part of all balloting materials for which the declaration is required.

SECTION 5. OVERSEAS VOTER'S REGISTRATION ADDRESS. In registering

to vote, an overseas voter who is eligible to vote in this state shall use and must be assigned to the voting [precinct] [district] of the address of the last place of residence of the voter in this state[, or, in the case of a voter described by Section 2(1)(E), the address of the last place of residence in this state of the parent or legal guardian of the voter]. If that address is no longer a recognized residential address, the voter must be assigned an address for voting purposes.

SECTION 6. METHODS OF REGISTERING TO VOTE.

(a) In addition to any other approved method of registering to vote, a covered voter may use a federal post-card application, as prescribed under the Uniformed and Overseas Citizens Absentee Voting Act, section 101(b)(2), 42 U.S.C. Section 1973ff(b)(2), or the application's electronic equivalent, to apply to register to vote.

(b) A covered voter may use the declaration accompanying the federal write-in absentee ballot, as prescribed under the Uniformed and Overseas Citizens Absentee Voting Act, section 103, 42 U.S.C. Section 1973ff-2, to apply to register to vote simultaneously with the submission of the federal write-in absentee ballot[, if the declaration is received by [insert this state's voter registration deadline for that election]]. [If the declaration is received after that date, it must be treated as an application to register to vote for subsequent elections.]

(c) The [Secretary of State] shall ensure that the electronic transmission system described in Section 4(c) is capable of accepting both a federal post-card application and any other approved electronic registration application sent to the appropriate election official. The voter may use the electronic transmission system or any other approved method to register to vote.

SECTION 7. METHODS OF APPLYING FOR MILITARY-OVERSEAS BALLOT.

(a) A covered voter who is registered to vote in this state may apply for a military-

overseas ballot using either the regular [absentee ballot] application in use in the voter's jurisdiction under [reference state law on regular absentee ballots] or the federal post-card application, as prescribed under the Uniformed and Overseas Citizens Absentee Voting Act, section 101(b)(2), 42 U.S.C. Section 1973ff(b)(2), or the application's electronic equivalent.

(b) A covered voter who is not registered to vote in this state may use the federal post-card application or the application's electronic equivalent simultaneously to apply to register to vote under Section 6 and to apply for a military-overseas ballot.

(c) The [Secretary of State] shall ensure that the electronic transmission system described in Section 4(c) is capable of accepting the submission of both a federal post-card application and any other approved electronic military-overseas ballot application sent to the appropriate election official. The voter may use the electronic transmission system or any other approved method to apply for a military-overseas ballot.

(d) A covered voter may use the declaration accompanying the federal write-in absentee ballot, as prescribed under the Uniformed and Overseas Citizens Absentee Voting Act, section 103, 42 U.S.C. Section 1973ff-2, as an application for a military-overseas ballot simultaneously with the submission of the federal write-in absentee ballot, if the declaration is received by the appropriate election official by [insert the later of the fifth day before the election or the last day for other voters in this state to apply for an [absentee ballot] for that election].

(e) To receive the benefits of this [act], a covered voter must inform the appropriate election official that the voter is a covered voter. Methods of informing the appropriate election official that a voter is a covered voter include:

(1) the use of a federal post-card application or federal write-in absentee ballot;

(2) the use of an overseas address on an approved voter registration application or

ballot application; and

(3) the inclusion on an approved voter registration application or ballot application of other information sufficient to identify the voter as a covered voter.

[(f) This [act] does not preclude a covered voter from voting under [insert state law on regular absentee voting].]

SECTION 8. TIMELINESS AND SCOPE OF APPLICATION FOR MILITARY-OVERSEAS BALLOT. An application for a military-overseas ballot is timely if received by [insert the later of the fifth day before the election or the last day otherwise provided by law]. An application for a military-overseas ballot for a primary election, whether or not timely, is effective as an application for a military-overseas ballot for the general election. [An application for a military-overseas ballot is effective for a runoff election necessary to conclude the election for which the application was submitted.]

Legislative Note: *The bracketed language about a runoff election is only for states with runoff elections.*

SECTION 9. TRANSMISSION OF UNVOTED BALLOTS.

(a) For all covered elections for which this state has not received a waiver pursuant to the Military and Overseas Voter Empowerment Act, section 579, 42 U.S.C. 1973ff-1(g)(2), not later than 45 days before the election or, if the 45th day before the election is a weekend or holiday, not later than the business day preceding the 45th day, the election official in each jurisdiction charged with distributing a ballot and balloting materials shall transmit ballots and balloting materials to all covered voters who by that date submit a valid military-overseas ballot application.

(b) A covered voter who requests that a ballot and balloting materials be sent to the voter

by electronic transmission may choose facsimile transmission or electronic mail delivery, or, if offered by the voter's jurisdiction, Internet delivery. The election official in each jurisdiction charged with distributing a ballot and balloting materials shall transmit the ballot and balloting materials to the voter using the means of transmission chosen by the voter.

(c) If a ballot application from a covered voter arrives after the jurisdiction begins transmitting ballots and balloting materials to voters, the official charged with distributing a ballot and balloting materials shall transmit them to the voter not later than two business days after the application arrives.

SECTION 10. TIMELY CASTING OF BALLOT. To be valid a military-overseas ballot must be received by the appropriate local election official no later than the close of the polls, or the voter must submit the ballot for mailing[, electronic transmission,] or other authorized means of delivery not later than 12:01 a.m., at the place where the voter completes the ballot, on the date of the election.

SECTION 11. FEDERAL WRITE-IN ABSENTEE BALLOT. A covered voter may use the federal write-in absentee ballot, in accordance with the Uniformed and Overseas Citizens Absentee Voting Act, section 103, 42 U.S.C. Section 1973ff-2, to vote for all offices and ballot measures in a covered election.

SECTION 12. RECEIPT OF VOTED BALLOT.

(a) A valid military-overseas ballot cast in accordance with Section 10 must be counted if it is delivered by the end of business on the business day before [the latest deadline for completing the county canvass or other local tabulation used to determine the final official results] to the address that the appropriate state or local election office has specified.

(b) If, at the time of completing a military-overseas ballot and balloting materials, the

voter has affirmed under penalty of perjury, pursuant to Section 13, that the ballot was timely submitted, the ballot may not be rejected on the basis that it has a late postmark, an unreadable postmark, or no postmark.

Legislative Note: *Enacting states will need to ensure that the perjury laws of the enacting state cover the affirmation made by the voter under this section.*

SECTION 13. DECLARATION. Each military-overseas ballot must include or be accompanied by a declaration signed by the voter declaring that a material misstatement of fact in completing the document may be grounds for a conviction of perjury under the laws of the United States or this state.

Legislative Note: *Enacting states will need to ensure that the perjury laws of the enacting state cover the declaration made by the voter under this section.*

SECTION 14. CONFIRMATION OF RECEIPT OF APPLICATION AND VOTED BALLOT. The [Secretary of State], in coordination with local election officials, shall implement an electronic free-access system by which a covered voter may determine by telephone, electronic mail, or Internet access whether:

(1) the voter's federal post-card application or other registration or military-overseas ballot application has been received and accepted; and

(2) the voter's military-overseas ballot has been received and the current status of the ballot.

SECTION 15. USE OF VOTER'S ELECTRONIC-MAIL ADDRESS.

(a) The local election official shall request an electronic-mail address from each covered voter who registers to vote after [the effective date of this [act]]. An electronic-mail address provided by a covered voter shall not be publicly available and is exempt from disclosure under [the public records laws of this state]. An election official may not release a voter's electronic-

mail address to a third party. An election official may use the address only to communicate with the voter about the voting process, including transmitting military-overseas ballots and election materials if the voter has requested electronic transmission, and verifying the voter's mailing address and physical location, as needed. A request for an electronic-mail address under this section must describe the purpose for which the electronic-mail address will be used and state that any other use or disclosure is prohibited.

(b) A covered voter who provides an electronic-mail address may request that the voter's application for a military-overseas ballot be considered a standing request for electronic delivery of a ballot for all elections held through December 31 of the year following the calendar year of the date of the application or another shorter period the voter specifies[, including for any runoff elections that occur as a result of such elections]. An election official shall provide a military-overseas ballot to a voter who makes a request for each election to which the request is applicable. A covered voter entitled to receive a military-overseas ballot for a primary election under this subsection is also entitled to receive a military-overseas ballot for the general election.

Legislative Notes: *In connection with the bracketed language in subsection (a) concerning public records laws, some states require that exceptions to these laws also be specified in the public records law itself. In subsection (b), the bracketed language pertaining to runoff elections is only for states with runoff elections.*

SECTION 16. PUBLICATION OF ELECTION NOTICE.

(a) Not later than 100 days before a regularly scheduled election to which this [act] applies, and as soon as practicable in the case of an election not regularly scheduled, an official in each jurisdiction charged with printing and distributing ballots and balloting material shall prepare an election notice for that jurisdiction, to be used in conjunction with the federal write-in absentee ballot described in Section 11. The election notice must contain a list of all of the ballot

measures and federal, state, and local offices that as of that date the official expects to be on the ballot on the date of the election. The notice also must contain specific instructions for how a voter is to indicate on the federal write-in absentee ballot the voter's choice for each office to be filled and for each ballot measure to be contested.

(b) A covered voter may request a copy of an election notice. The official charged with preparing the election notice shall send the notice to the voter by facsimile, electronic mail, or regular mail, as the voter requests.

(c) As soon as [ballot styles are certified], and not later than the date ballots are required to be transmitted to voters under [insert state law on regular absentee voter authorization], the official charged with preparing the election notice shall update the notice with the certified candidates for each office and ballot measure questions and make the updated notice publicly available.

(d) A local election jurisdiction that maintains an Internet website shall make updated versions of its election notices regularly available on the website.

Legislative Note: *The bracketed language "[ballot styles are certified]" in subsection (c) is intended to cover the event when the final ballot for candidates (and issues, when applicable) is available.*

SECTION 17. PROHIBITION OF NONESSENTIAL REQUIREMENTS.

(a) If a voter's mistake or omission in the completion of a document under this [act] does not prevent determining whether a covered voter is eligible to vote, the mistake or omission does not invalidate the document. Failure to satisfy a nonessential requirement, such as using paper or envelopes of a specified size or weight, does not invalidate a document submitted under this [act]. In any write-in ballot authorized by this [act] [or in any vote for a write-in candidate on a regular ballot], if the intention of the voter is discernable under this state's uniform definition of

what constitutes a vote, as required by the Help America Vote Act, 42 U.S.C. Section 15481(a)(6), an abbreviation, misspelling, or other minor variation in the form of the name of a candidate or a political party must be accepted as a valid vote.

(b) Notarization is not required for the execution of a document under this [act]. An authentication, other than the declaration specified in section 13 or the declaration on the federal post-card application and federal write-in absentee ballot, is not required for execution of a document under this [act]. The declaration and any information in the declaration may be compared against information on file to ascertain the validity of the document.

SECTION 18. ISSUANCE OF INJUNCTION OR OTHER EQUITABLE RELIEF. A court may issue an injunction or grant other equitable relief appropriate to ensure substantial compliance with, or enforce, this [act] on application by:

(1) a covered voter alleging a grievance under this [act]; or

(2) an election official in this state.

SECTION 19. UNIFORMITY OF APPLICATION AND CONSTRUCTION. In applying and construing this uniform act, consideration must be given to the need to promote uniformity of the law with respect to its subject matter among states that enact it.

SECTION 20. RELATION TO ELECTRONIC SIGNATURES IN GLOBAL AND NATIONAL COMMERCE ACT. This [act] modifies, limits, and supersedes the federal Electronic Signatures in Global and National Commerce Act, 15 U.S.C. Section 7001, et seq., but does not modify, limit, or supersede Section 101(c) of that act, 15 U.S.C. Section 7001(c), or authorize electronic delivery of any of the notices described in Section 103(b) of that act, 15 U.S.C. Section 7003(b).

[SECTION 21. REPEALS.

The following are repealed:

(1) .....

(2) .....

(3) .....]

SECTION 22. EFFECTIVE DATE. This [act] takes effect . . . .

APPENDIX XIII

- *DRAFT Uniform Standards for Online Social Networking*, State of Michigan, Department of Technology, Management and Budget.

e-Michigan Web Development
Department of Technology, Management and Budget
State of Michigan

Uniform Standards for online social networking

Table of Contents

About This Document

The State Of Michigan believes in the importance of open exchange and learning—between our peers, business partners and constituents. The rapidly growing phenomenon of user-generated web content—blogging, social web-applications and networking also reffered to as social networking (or media) are emerging arenas the State Of Michigan must use to deliver quality service. We will continue to advocate State Of Michigan employees, partners and contractors responsible involvement in this rapidly growing space of relationship, learning and collaboration. However, this is also a new frontier for the SOM and with any other constituent facing application policies and standards that need to be in place.

The intention is to better serve users, whether they are general citizens or targeted constituents. More importantly, web Development Teams and Agencies need to read and understand the information contained within this manual. It includes important information about key, required presentation style elements for all State of Michigan on-line services. These include a consistent and common look and feel across all sites, and ease of use.

Below is the current and official State Of Michigan Social Netoworking Guidelines. These guidelines will detail specific Look & Feel Standards for each Social networking tool used by the SOM. Guidlelines and policies will change as do the Social networking tools offered.

No standards document can take into account every possible combination of social networking technology. Therefore, it is the responsibility of the IT Project Managers, Agencies or other responsible agents to contact EWD to inquire and receive the latest updates and specifications regarding information contained within this document. Additionally these standards are being authored post release of many agencies using existing Web 2.0 sites and it is the intention of this document to provide a framework for existing and future sites.

Based on the ease of use of starting a social networking site is imperative that contact with e-Michigan Web Development (EWD) be made as soon as possible, preferably at the Initiation Phase of a Web 2.0 solution. To schedule a review meeting, contact the EWD at (517) 241-5782 or thompsonj@michigan.gov.

State IT Development Teams, as well as third party development groups contracted or bidding on state IT initiatives, should use these standards.

Current social networking sites

The following sites are currently under the purview of these standards and represent the most widely used social networking sites. This document will be updated when new sites are adopted for use within the State of Michigan as deemed acceptable by the Online Social Communications Governance Board.

1. Facebook
2. Twitter
3. You Tube

Governance Board

The Online Social Communications Governance Board will be formed consisting of 5 members with representation from the following areas; The Online Social Communications Governance Board will be responsible for the authoring of the social networking Look and Feel Standards and any subsequent adoption or deletion of social networking sites used by the State Of Michigan.

1. Governors Office
2. e-Michigan
3. Agency PIO
4. Agency PIO
5. MDIT Office of Enterprise Security
6. Employee

All SOM "Pages", Channels and Twitter accounts must be approved by the "State of Michigan Online Communications Board"

SOMOCB will enforce the Uniform Standards for Online Social Networking policy

- New technology and online communication sites will be evaluated and approved by the board
- See governance section above for members information
- Board will develop a system to evaluate the effectiveness of the specific departments social networking sites

Copyright Information

All aspects of the Michigan.gov Brand as visualized in the banner header graphic in this document, either printed or electronic, are under the express control of the Department of Information Technology/e-Michigan Web Development Division. Attempts to modify or recreate the Michigan.gov brand image or graphic elements represented within this document are prohibited.

Requests for any Michigan.gov brand element should be made to the e-Michigan Web Development Division:

e-Michigan Web Development Division

Department of Information Technology

111 S. Capitol Avenue
Romney Building 9th Floor
Lansing, MI 48913

This document may be revised as needed to accommodate new standards or revise and edit existing standards.

Version 3.0

The State Of Michigan will refer to the following Policy and Act for guidance on how employees conduct themselves in the use of social communications applications. These are documented to ensure our conduct is always above reproach while guarding the confidentiality of our constituents.

1. **Acceptable Use Agreement POLICY 1460.00**

"This policy identifies acceptable use of State of Michigan Information Technology Resources, provides awareness of expected end-user behavior, and is also intended to safeguard IT data resources. This policy requires that end-users maintain respect for the privacy of protected citizen and employee information at all times. A cooperative effort from every employee is necessary to prevent misuse, eliminate the risk of liability to the State, and promote the efficient utilization of IT resources and information technology services."

To view the policy please go to; www.michigan.gov/XXXXX

2. STATE OF MICHIGAN, STATE ETHICS ACT, Standards of Conduct for Public Officers and Employees

"to prescribe standards of conduct for public officers and employees; to create a state board of ethics and prescribe its powers and duties; and to prescribe remedies and penalties."

To view the State Ethics Act go to: http://www.michigan.gov/mdcs/0,1607,7-147-6881_13592-26139--,00.html

Generally accepted uses of social networking sites by SOM agencies

- Market agency services to broader audience, reaching more users by social networking
- Promote current and future agency events
- Promote a "cause" for public awareness i.e. Children's Trust Fund
- Increase government transparency and help educate citizens on current issues
- Receive citizen input and stories (must be monitored closely), i.e. Building MI Future
- Make agencies more personable by conversation
- Use Social Media Sites to pull in the customer and then link them back to your Michigan.gov/xxx page to get the full story.
- Posting non-SOM content or linking to non SOM content needs to be relevant to the agency *"We realize there is a lot of good content available out side of the Mi.gov portal"*
- Posts must be made by the respective department's page. No personal accounts may be used to post official information.

Unacceptable uses of social communication sites

- Promoting personal business
- Advertising non-SOM services or products
- Posting off topic subject matter
- Discussing any SOM job or project related information
- Posting copywrited material (i.e. music in a Youtube video)
- Using "groups" to promote your agency
    - Allowing employees of your agency to network, both personally and professionally, in an open "official" Group

Facebook

Best Practices

- Use Facebook “Pages”only; no “Groups”
  - Pages = Business Networking, Groups = Personal Networking
  - Posts by administrators on a Page will appear to come from the Page

- Each agency Page should have at least two administrators within the agency
  - Use a common mailbox (agency “MI.gov” e-mail address) to establish a business account for your agency
  - In addition, each agency Page should also add contactmichigan@michigan.gov as administrator *"We will serve as a back up administrator to your agency"*

- Encourage engagement from fans
  - Must be monitored by your agency

- Page administrators should set their personal profiles (if any) to “private”
  - If an administrator lists their agency in their personal profile, he or she can be found in a search agency

Visual Uniform

- All SOM “Pages” must name their pages after their respective agency

- All SOM “Pages” must display there profile picture as their agency logo
  - Profile picture must also contain the E- Michigan approved Michigan.gov/xxx banner

- Pages content box’s must contain content that makes their agency easily identifiable
  - Content box must also include a link back to the agencies corresponding Michigan.gov
  - Text with a link directing visitors to their respective Michigan.gov site for “official” information.

- Content posted must be relevant to three areas
  - Content must be related to your agency directly
  - Content must be related to work and activities within your agencies
  - Third-party content must be related to your agencies work

    “ This is a judgment based condition that must be decided by moderator”

Content

- Content should contain links back to your agencies corresponding Michigan.gov/xxx
  - If content contains links to a third-party site, the site must contain information that is relevant to your agency or its work.
  - The third party site must be work appropriate and sensitive to cultural differences
  - Shortened links must be used through bit.ly service. The use Ow.ly is prohibited.
  - Post from third party sites must obey all copyright and licensing laws

  Reminder: Posts reflect directly on the agency, keep that in mind in when posting questionable content

- Posts must be work appropriate
  - Vulgar language and profanity is not allowed (When in doubt ask)
  - Be sensitive to cultural differences when posting or responding to a post or message.
  - Do not try and win an argument via posts. Don't engage to the point of making it a fight.

Twitter

Best Practices

- Each agency account should have at least two administrators within the agency
    - Use a common mailbox (agency "MI.gov" e-mail address) to establish a business account for your agency

- Encourage engagement from followers
    - Must be monitored by your agency
    - Respond to followers "@ replies" and direct messages

- Page administrators should keep their personal accounts (if any) separate from the agency account

Visual Uniform

- All SOM accounts must name their pages after their respective agency

- All SOM accounts must display there default picture as their agency logo

- All SOM accounts must use their agencies name as their Twitter handle
  "@departmentofmanagement&budget"

- SOM accounts Twitter Bio must contain content that makes their agency easily identifiable
    - Text with a link directing visitors to their respective Michigan.gov site for "official" information
    - Email address and or phone number to provide quick, easy assistance
    - Use relevant keywords to make your agencies Twitter account easy to search and find

- Include the agencies address in the location section

- Your agencies respective Michigan.gov website address should be listed in the web section

- Background wallpapers should reflect your Michigan.gov portals theme
    - This can include the exact wallpaper and or color theme

    - Be sensitive of those with disabilities when selecting colors *(i.e. colorblindness)*

Content

- Content posted must be relevant to three areas
  - Content must be related to your agency directly
  - Content must be related to work and activities within your agencies
  - Third-party content must be related to your agencies work

    " *This is a judgment based condition that must be decided by moderator*"

- Content should contain links back to your agencies corresponding Michigan.gov/xxx
  - If content contains links to a third-party site, the site must contain information that is relevant to your agency or its work.
  - The third party site must be work appropriate and sensitive to cultural differences
  - Shortened links must be used through bit.ly service. The use Ow.ly is prohibited.
- All images and videos are to be hosted on corresponding SOM accounts
  - No personal media storage accounts should host SOM content. *(i.e. twitpic, yfrog, tweetphote, etc)*
- Tweets must be work appropriate
  - Vulgar language and profanity is not allowed (When in doubt ask)
  - Be sensitive to cultural differences when posting or responding to an "@ reply" or message.
  - Do not try and win an argument via posts. Don't engage to the point of making it a fight.
  - Avoid trending topics
- Retweet when appropriate
  - Retweets must be relevant to the same areas original content is
  - Avoid retweeting an all ready retweeted post. (This confuses the reader)

Moderation

- Moderators must monitor all tweets
    - Contact the individual who posted the tweet and ask politely for them to delete or edit the reply if the content does not follow the "content" guidelines above
    - Do not ask for a tweet to be deleted because of a complaint or problem, work with the customer to resolve the issue
        - If the issue goes past 3 tweets, request to take the conversation to another venue (i.e. Phone, direct message or e-mail)
        - Be sure to tweet the resolution to the problem for other customers to see

- Respond timely to "@" replies and messages

- Tweets should be made everyday
    - Stagnant and dead accounts are damaging to your agency and the State of Michigan as a whole
    - A lapse in tweets greater than 10 days will be reviewed by
    - Look at your Twitter feed the same way you would your agencies "internet" site

- Tweet in moderation
    - Posting more then two tweets within a fifteen minute window is annoying to most followers
    - Multiple posts at one time increases your chances that your content will go unread in followers timelines

- Follow people back
    - Follow back the people that engage with your agencies account
    - Use judgment when following people, make sure that their name. picture and tweets reflect positively on your agency and the State of Michigan

Youtube

Best Practices

- Each agency account should have at least two administrators within the agency
    - Use a common mailbox (agency "MI.gov" e-mail address) to establish a business account for your agency

- Encourage comments and subscriptions from subscribers
    - Must be monitored by your agency
    - Respond to subscribers comments in a timely manner

- Account administrators should keep their personal channels (if any) separate from the agencies channel

Visual Uniform

- Each agency is encouraged to have a channel

- All SOM channels must name their pages after their respective agency

- All SOM channels must display there default picture as their agency logo

- SOM channels must contain content that makes their agency easily identifiable
    - Text with a link directing visitors to their respective Michigan.gov site for "official" information
    - Email address and or phone number to provide quick, easy assistance
    - Use relevant keywords to make your agencies channel easy to search and find

- Your agencies respective Michigan.gov website address should be listed in the web section

- Review your videos thumbnail
    - Default thumbnails can be unflattering and misleading to the videos actual content
    - Select a thumbnail image that best reflects the videos content

- Background wallpapers should reflect your Michigan.gov portals theme
    - This can include the exact wallper and or color theme
    - Be sensitive of those with disabilities when selecting colors *(i.e. colorblindness)*

- Keep video titles and descriptions relevant to the videos theme and content
    - Descriptions should be a summary of the video

- Use relevant keywords to tag your agencies videos
    - This makes it easier for the customer to search and find specific videos

Branding reflecting of Michigan.gov portal

Named after respective agency

Department logo

Department .gov website address

Appropriate thumbnail image

Information easily identifying the department

Content

- Videos posted must be relevant to three areas
    - Content must be related to your agency directly
    - Content must be related to work and activities within your agencies
    - Third-party content must be related to your agencies work

      " This is a judgment based condition that must be decided by moderator"

- Videos must obey all copyright and licensing laws (This includes music)

- Videos must be work appropriate
    - Vulgar language and profanity is not allowed (When in doubt ask)
    - Be sensitive to cultural differences when uploading a video
    - Do not try and win an argument via comments. Don't engage to the point of making it a fight.

Moderation

- Moderators must monitor all comments
    - Delete a comment if the content does not follow the "content" guidelines above
    - Do not delete a comment because of a complaint or problem, work with the customer to resolve the issue
        - If the issue goes past 3 tweets, request to take the conversation to another venue (i.e. Phone, direct message or e-mail)
        - Be sure to tweet the resolution to the problem for other customers to see

- Respond timely to comments

- Videos you favorite must follow the content guidelines

Tips

- Choose your “Page” name wisely; Facebook “Page” names cannot be changed

  “ Should be your agencies name”
- Setup your page to best suit your customer not you or your agency
- Avoid using jargon and acronyms
- Use your page as an extension of your agencies Michigan.gov/xxx site
- Encourage fan interaction; post content that starts conversation and is relevant
- Use as little text as possible; Use more media (i.e. pictures, video, audio)
- Make updates less than 140 characters so people can retweet you
- Be transparent, don’t act like your above the customer or behind closed doors
- When engaging and posting use a voice that puts a face on state government
- Discourage other employees from posting solutions to questions or problems from their personal accounts
- Avoid long periods of absence from posting
- Remind fans, followers and subscribers that they can contact your department at anytime
- Make your content dynamic, do not just regurgitate press releases
- Avoid retweeting a retweet
- Use common sense; Know what spam looks like

  "Take this free personality quiz"

*Remember everything you post online is public and ***WILL NEVER GO AWAY***. Be sure the content you post is appropriate now and into the future. Use common sense and be transparent!