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*June 17, 2024*

**Via Electronic Filing**
Open Records Division
Office of Honorable Ken Paxton
Attorney General of Texas
P.O. Box 12548
Austin, Texas 78711-2548

**RE: Opinion Request RQ-0539-KP**

Dear Attorney General Paxton:

Senator Charles Schwertner has asked for your opinion on the scope and reach of two recently enacted statutes, HB 1763 and HB 1919. HB 1763 regulates how "health benefit plans" and "pharmacy benefit managers" deal with the pharmacies and pharmacists that provide prescription drugs to the beneficiaries of those plans. HB 1919 restricts the ability of "health benefit plans" and "pharmacy benefit managers" to steer beneficiaries toward "affiliated providers" under the control of that health benefit plan or pharmacy benefit manager, or to confer preferential treatment on those "affiliated providers" vis-à-vis other in-network providers. Each of these laws was enacted in 2021, and they are now codified at Tex. Ins. Code §§ 1369.601–610 (HB 1763) and Tex. Ins. Code §§ 1369.551–555 (HB 1919).

Senator Schwertner has asked whether HB 1763 and HB 1919 are enforceable against health benefit plan issuers and pharmacy benefit managers subject to ERISA. Senator Schwertner is also asking whether HB 1763 and HB 1919 can be enforced against health benefit plans domiciled outside Texas if they provide coverage to Texas residents and use a pharmacy benefit manager that directly contracts with a network of providers that includes Texas pharmacy providers. We urge your office to clarify that these laws do not apply to self-funded and out-of-state plans. Senator Schwertner filed SB 1137 in the 88th Legislative Session, which demonstrates that he is likely aware that these laws do not apply. The bill, which would have applied these laws to self-funded and extraterritorial plans, was strongly opposed by stakeholders. The legislature rejected the proposal, clearly choosing not to apply these costly mandate bills to employers who take on the risk of paying claims for themselves. Further, even if such a bill were enacted, ERISA preempts any application of HB 1763 and

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HB 1919 to ERISA-covered plans,[1] and neither HB 1763 nor HB 1919 contains a clear statement needed to give extraterritorial application to state law.[2]

**1. The Legislature Has Already Considered and Rejected This Policy**

Senator Schwertner, who submitted the opinion request, introduced a bill that would have extended these state laws to self-funded plans, but the legislature resoundingly rejected the proposal after significant opposition. In 2023, Schwertner filed SB 1137, which would have extended the entirety of the Chapter 1369 pharmacy mandates, including HB 1763 and HB 1919, to plans not regulated by the state, such as self-funded ERISA plans. Substitutes laid out for both bills limited the applicability to impose only the mandates in HB 1763 and HB 1919. Schwertner publicly explained in his layout to the Senate Health & Human Services Committee that the passage of SB 1137 was needed to extend the state mandates created by HB 1763 and HB 1919 to self-funded plans.

Employers strongly opposed SB 1137 and its companion, and the legislature ultimately rejected the proposals. Over 35 different businesses, Chambers of Commerce, and associations opposed SB 1137, raising "serious concerns about any measure that erodes ERISA's protections." The diverse group, including oil and gas companies, airlines, and telecom providers, all asked for the legislature to "stand with the business community and preserve ERISA's protections." The legislature rejected both bills, leaving them pending in Committee and highlighting the importance of employer flexibility in benefit design.

The legislature knew that attempting to circumvent ERISA was bad public policy that would have cost employers and families millions of dollars. This policy would have a significant financial impact on employer-sponsored coverage. The Legislative Budget Board estimated that SB 1137 would have cost the state $79 million over a biennium to apply the provisions to the Teacher Retirement System alone. The bill was estimated to cost employers and families with commercial ERISA-exempt coverage $5.4 billion over 10 years.

Further, if these bills were to apply, Texas would be setting a precedent for a patchwork of regulations for multi-state employers. One of the major benefits of ERISA preemption and extraterritoriality limitations is that businesses can rely on one set of requirements for their health-benefit plans. If each state were to apply its own set of laws, it would undermine the rationale behind ERISA preemption, as businesses could be expected

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[1] *See* 29 U.S.C. § 1144(a)

[2] *See Coca-Cola Co. v. Harmar Bottling Co.*, 218 S.W.3d 671, 682 (Tex. 2006) ("[A] statute will not be given extraterritorial effect by implication but only when such intent is clear.").

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to comply with 50 different sets of regulations. This type of legal uncertainty makes benefit administration extremely complicated and expensive, and the resulting costs are ultimately passed on to businesses and families.

**2. ERISA Preempts HB 1763 and HB 1919 With Respect to Self-Insured, ERISA-Covered Group Health Plans**

Senator Schwertner acknowledges that HB 1763 and HB 1919 cannot apply to ERISA-covered plans if ERISA preempts the application of those statutes to ERISA-covered plans. *See* Schwertner Letter, RQ-0539-KP, at 2 ("[B]arring some specific principle of federal preemption, both HB 1763 and HB 1919 should be enforceable against an ERISA health benefit plan issuer or a pharmacy benefit manager administering the pharmacy benefits of such ERISA health benefit plan."). But his opinion request contains no analysis of the preemption issue. As it happens, ERISA indisputably preempts any effort to extend HB 1763 or HB 1919 to ERISA-covered plans.

**ERISA's Broad Express-Preemption Provision Bars States from Regulating Self-Insured Group Health Plans**. ERISA expressly preempts any state law that "relates to" an ERISA-covered employee benefit plan.[3] As recognized by the Supreme Court of the United States, a central purpose of ERISA's broad preemption provision is to allow for the uniform administration of ERISA plans.[4] In *Egelhoff*, the Court reaffirmed the longstanding rule that a state law "relates to" an ERISA plan "if it has a connection with or reference to such a plan."[5]

The Supreme Court clarified two main categories of state law that ERISA preempts: (1) "where a state's law acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation" and (2) where there is "an impermissible connection with ERISA plans [which] govern a central matter of plan administration."[6] A state law may also be preempted if its economic effects force an ERISA plan to adopt certain coverage or restrict its choice of insurers.[7]

The Supreme Court addressed ERISA preemption in the context of state rate regulation, and the Court specifically affirmed both *Egelhoff* and *Gobeille* when reviewing a

[3] 29 U.S.C. § 1144(a).
[4] *See, e.g., Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (holding that ERISA preempted a state statute governing beneficiaries under an ERISA plan).
[5] *Id.* at 147 (internal quotations and citations omitted).
[6] *Gobeille v. Liberty Mut. Ins. Co*., 577 U.S. 312, 319–20 (2016) (internal quotations and citations omitted).
[7] *See id.* at 320.

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state law that regulates the reimbursement amounts pharmacy benefit managers pay pharmacies for drugs covered by prescription drug plans.[8] In holding that the Arkansas state laws at issue in *Rutledge* were not preempted, the Court focused heavily on whether the mandated payment rates effectively bound the group health plans to specific design choices, or whether they merely altered the incentives associated with the administration of the plan.[9] Although the Court held that the Arkansas statutes at issue merely altered incentives, the unanimous opinion of the Court was clear that prior precedent outside the context of indirect cost regulation remained intact and that the decision did not address state laws governing a "central matter of plan administration" or forcing plans to adopt certain rules for coverage.[10]

More recently, the Tenth Circuit applied *Rutledge* consistent with the narrowly tailored approach taken by the Supreme Court. In *Mulready*, the Tenth Circuit held that an Oklahoma law that regulated PBMs and their pharmacy networks was not saved from preemption under *Rutledge*, but rather was preempted under the binding case law that survived *Rutledge*.[11] Much like the statutes at issue in Texas, the state law included four key provisions that subjected PBMs to certain rules, including pharmacy access network standards and restrictions on the incentives given to individuals who fill prescriptions at in-network and affiliated pharmacies.[12] The court found that these provisions mandated certain benefit structures related to a key benefit design (*i.e.* the scope and differentiation of the plan's pharmacy network benefit), and thus had an impermissible connection with ERISA-covered group health plans.[13] Additionally, the court found that the Oklahoma law was an attempt by the State to "govern[ ] a central matter of plan administration" and "interfere[ ] with nationally uniform plan administration."[14] The result of these impermissible connections was that the state laws were held preempted to the extent they applied directly or indirectly to ERISA-covered group health plans.

The Court in *Mulready* relied heavily on a similar Fifth Circuit decision which held that Louisiana's any-willing-provider statute was preempted. In *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana ex rel. Ieyoub*,[15] the Fifth Circuit determined that the

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[8] *Rutledge v. Pharm. Care Mgt. Ass'n*, 592 U.S. 80, 86 (2020).
[9] *See id*. at 81.
[10] *Id* at 80; *Gobeille* at 320.
[11] *Pharm. Care Mgt. Ass'n. v. Mulready*, 78 F.4th 1183, 1190 (10th Cir. 2023).
[12] *Id.* at 1190-1191.
[13] *Id*. at 1199-1200.
[14] *Id*. at 1200.
[15] 82 F.3d 642 (5th Cir. 1996)

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any-willing-provider law mandated plans to adopt certain benefit structures, *i.e.*, network designs.[16] The Court's view that state regulation of provider network composition impermissibly implicates plan design is equally applicable, if not more so, to pharmacy benefits where plans make a number of plan design choices to develop their pharmacy benefit, including network composition, formulary design, and cost-sharing structures. Like Louisiana's any-willing-provider law at issue in *CIGNA*, the application of HB 1763 and HB 1919 would eliminate flexibility in network design to the extent plans would elect to use benefit designs that rely heavily on PBM-affiliated pharmacies, including mail-order and specialty pharmacies. Furthermore, the prohibition on offering incentives for the use of certain pharmacies would require that plans amend their cost-sharing structures to meet the requirements of the Texas law, a type of benefit regulation that *Rutledge* made clear was impermissible. As a result, these types of limitations have an impermissible connection with ERISA-covered plans because they bind plans to specific benefit designs and thus are preempted under ERISA.

HB 1763 and HB 1919 would also upset nationally uniform plan administration because ERISA-covered group health plans would have to modify the way their pharmacy benefits are communicated to participants in Texas. Plans, through their PBM service providers, would be barred from steering or encouraging the use of lower cost pharmacy alternatives to meet the strictures of the state laws in Texas. Under *Gobeille*, state laws that impede on central matters of plan administration, like claims adjudication, are preempted. Applying the Texas statutes to self-insured group health plans would require plans to provide separate plan communications to Texas residents than are provided to participants in the other 49 states because of the different benefit designs mandated under the Texas statutes. Under *Gobeille*, ERISA does not allow for this type of parallel or conflicting regulation by the states, and thus these requirements are preempted for impermissibly interfering with nationally uniform plan administration and the implications on central matters of plan administration.[17]

The Fifth Circuit has applied *Gobeille* in holding that Tennessee's assignment-of-benefits statute "relate[s] to" ERISA plans because it impacts a "central matter of plan administration" and "interferes with nationally uniform plan administration."[18] The Fifth Circuit rejected the lower court's "conclusion that the Supreme Court's decision in *Gobeille*,

[16] *Id.* at 648.
[17] *See Gobeille*, 577 U.S. at 326–27.
[18] *Dialysis Newco, Inc. v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 259 (5th Cir. 2019).

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which dealt with duplicative reporting requirements, is inapposite to this case because the text of ERISA is 'silent' on assignments. The Supreme Court, this court, and other courts have long held that state laws can intrude upon central matters of plan administration or interfere with nationally uniform plan administration even when the text of ERISA itself does not mention the particular aspect in question."[19] Accordingly, even though ERISA itself does not specify certain network arrangements for pharmacy benefits, the Texas statutes should be preempted because they interfere with nationally uniform plan administration.

For the foregoing reasons, we respectfully request that the Attorney General, consistent with ERISA jurisprudence from the Supreme Court and the Fifth Circuit, among other courts, hold that the provisions of HB 1763 and HB 1919 cannot apply to ERISA-covered, self-insured group health plans, and that they cannot be enforced against pharmacy benefit managers with respect to their ERISA-covered business or against the plans themselves. The result that these courts came to rightfully protects employers' ability to offer and manage benefit plans that have a uniform set of requirements across states. The Attorney General should continue to prioritize Texas' business-friendly environment, aligning with the courts and the legislature on this issue.

**HB 1763 and HB 1919 regulate plan design, and are therefore preempted.** HB 1763 and HB 1919 impose standards on "health benefit plan issuers," as well as pharmacy benefit managers ("PBMs") acting on behalf of those "health benefit plans." HB 1763 and HB 1919 particularly focus on the manner in which those plans build their networks of participating pharmacies and the plan designs that employers adopt to ensure that their employees receive efficient and effective health-care coverage. By regulating the pharmacy benefit manager acting on behalf of its ERISA-plan clients, HB 1763 would limit a self-insured group health plan's use of certain pharmacies (*i.e.*, affiliated pharmacies) by prohibiting a health benefit plan issuer or pharmacy benefit manager from: (1) imposing accreditation standards or recertification requirements that differ from federal and state requirements; and (2) prohibiting a pharmacy from dispensing any drug that may be dispensed under the pharmacy's license unless otherwise prohibited. *See* Tex. Ins. Code § 1369.608.

HB 1919 has similar effects on plan design by preventing pharmacy benefit managers from steering or directing patients to affiliated pharmacies. *See* Tex. Ins. Code § 1369.554. More importantly, pharmacy benefit managers may not administer plans that provide a less

[19] *Id.*

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generous level of benefits (i.e., impose higher cost shares) for the failure to use an affiliated pharmacy. *See* Tex. Ins. Code § 1369.555(a). This steering prohibition includes requirements or inducements for a patient to use an affiliated provider, including by providing for reduced cost-sharing if the patient uses the affiliated provider. *See* Tex. Ins. Code § 1369.555(b).

Applying these requirements to self-funded group health plans prevents these plans from developing their networks of participating pharmacies and designing and administering their drug benefit design, *e.g.*, regarding drug benefit cost-shares, without interference from state regulation. As a result, the provisions of these statutes go well beyond mere regulation of the pharmacy benefit managers as state-licensed entities and impose specific plan-design requirements on the underlying self-funded group health plan clients of the pharmacy benefit manager. As described above, these laws are preempted to the extent they apply to ERISA-covered, self-insured group health plans.

**3. HB 1763 and HB 1919 Should Not be Granted Extraterritorial Effect**

**Choice-of-law clauses in contracts typically control which state's law governs a contract.** Applying HB 1763 and HB 1919 to insurance contracts between entities located outside Texas would negate industry-standard choice-of-law clauses. It is settled law that Texas courts apply the most-significant-relationship test, which weighs specific factors to consider which law governs a particular contract, *except* in cases where the contract contains a valid choice-of-law clause.[20] The preferred status of choice-of-law clauses in Texas law is in line with "[t]he most basic policy of contract law [which] is the protection of the justified expectations of the parties."[21] The parties' choice of law will control unless the chosen state has no substantial relationship to the parties or transaction, or applying the law would be contrary to the interest of another state with a greater interest.[22] Overturning the parties' expectation regarding a choice-of-law clause is typically a high bar, with the locus of signing and performance having been found to create a substantial relationship and a mere difference in law or even a difference in outcome having been found *not* to be sufficient to make the law contrary to the interest of the other state.[23]

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[20] *Duncan v. Cessna Aircraft Co.*, 665 S.W.2d 414, 421 (Tex. 1984) ("[I]in all choice of law cases, except those contract cases in which the parties have agreed to a valid choice of law clause, the law of the state with the most significant relationship to the particular substantive issue will be applied to resolve that issue.").
[21] *Chase Manhattan Bank, N.A. v. Greenbriar N. Section II*, 835 S.W.2d 720, 723 (Tex. App.—Houston [1st Dist.] 1992, no writ) (citing *DeSantis v. Wackenhut Corp.*, 793 S.W.2d 670, 677 (Tex. 1990)).
[22] *Nexen Inc. v. Gulf Interstate Eng'g Co*., 224 S.W.3d 412, 419–20 (Tex. App.—Houston [1st Dist.] 2006, no pet.) (citing Restatement (Second) of Conflict of Laws § 187).
[23] *Id*. at 421–22.

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Thus, applying HB 1763 and HB 1919 to insurance contracts where the contract was entered into out of state and is between two out-of-state entities would interfere with those contracts in a manner that would likely run counter to well-established Texas law. Further, as we discuss in detail below, it would also run counter to statutory language and statements made by the Insurance Commissioner itself when it previously addressed this issue.

**Texas law also recognizes a presumption against extraterritoriality.** The Texas legislature must clearly express its intent to extend a statute beyond the territorial limits of the state. The Texas Supreme Court has stated this presumption as follows:

> Unless the intention to have a statute operate beyond the limits of the state or country is clearly expressed or indicated by its language, purpose, subject matter, or history, no legislation is presumed to be intended to operate outside the territorial jurisdiction of the state or country enacting it. To the contrary, the presumption is that the statute is intended to have no extraterritorial effect, but to apply only within the territorial jurisdiction of the state or country enacting it, and it is generally so construed. An extraterritorial effect is not to be given statutes by implication.[24]

"Determining if the extraterritorial reach [of a statute] is 'clearly expressed' or otherwise 'indicated by its language, purpose, subject matter, or history' begins with the language of the provision."[25]

Neither HB 1763 nor HB 1919 contains language demonstrating—or even *hinting* at—an intent to apply to contracts entered into outside Texas. While Senator Schwertner assumes that language which does not explicitly bar application to entities outside Texas means that the statute intended to be applicable outside Texas, the opposite is true: given that neither HB 1763 nor HB 1919 contains language or any intimation that they were to extend to contracts entered into by parties outside Texas, they are presumed to have no extraterritorial effect. Indeed, had the legislature wanted either HB 1763 or HB 1919 to apply to out-of-state entities, they could have easily done so by using language that appears in other sections of the Texas Insurance Code.[26]

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[24] *Marmon v. Mustang Aviation, Inc.*, 430 S.W.2d 182, 187 (Tex. 1968).
[25] *Citizens Ins. Co. of Am. v. Daccach*, 217 S.W.3d 430, 444 (Tex. 2007).
[26] *See* Tex. Ins. Code § 841.001(5) (defining a "Foreign company" to mean "a life, accident, or health insurance company organized under the laws of another state").

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**The plain language of HB 1763 and HB 1919 and related sections precludes their application to out-of-state plans.** The text of HB 1763 and HB 1919 makes clear that extraterritorial application was not intended. HB 1763 and HB 1919 and their follow-on bills created subchapters "L" and "M" in Chapter 1369 of the Texas Insurance Code. HB 1763 and HB 1919 apply to a number of different types of entities offering health and related benefits, the lists of which overlap significantly with each other. But the types of entities to which HB 1763 and HB 1919 apply are restricted to entities that are regulated by and operating within Texas.

For example, both HB 1763 and HB 1919 apply to "health maintenance organization[s] operating under Chapter 843." Put simply, a Health Maintenance Organization (HMO) that offers a plan out of state is not "operating under Chapter 843," the Texas Health Maintenance Organization Act. They may be otherwise authorized to offer plans in this state pursuant to that chapter, but they are not "operating under" the chapter when issuing an out-of-state policy. Indeed, Chapter 843 requires an annual report with details about specific plans.[27] If Chapter 843 applied to all out-of-state plans offered by licensed entities, health-insurance issuers would have to track the movement of each employee in an out-of-state plan, and then begin filing annual reports for that plan if a single employee moved to Texas. This would be an absurd result. The same absurdity arises from a number of the other entities subject to both HB 1763 and HB 1919: Specifically:

- "group hospital service corporation[s] operating under Chapter 842" are required to submit annual statements[28]
- "multiple employer welfare arrangement[s] that hold[] a certificate of authority under Chapter 846" are required to submit a number of yearly filings to the Insurance Commissioner.[29]
- "small employer health benefit plan[s] subject to Chapter 1501" are required to submit yearly actuarial statements to the Insurance Commissioner.[30]
- HB 1763 is applicable to "standard health benefit plan[s] issued under Chapter 1507," which are required to include specific verbatim notices in their plan documents.[31]

[27] Tex. Ins. Code § 843.155.
[28] Tex. Ins. Code § 842.201.
[29] Tex. Ins. Code § 846.153.
[30] Tex. Ins. Code § 1501.215.
[31] Tex. Ins. Code § 1507.005.

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The specifics of each of the sections discussed above should control as compared to more-general statements in other statutes under both the Code Construction Act[32] and over a century of court precedent.[33] As one Texas court has said: "[t]he special provision is regarded as though it were an exception or proviso, removing something from the operation of general law.[34]

**Art. 21.42 cannot be applied extraterritorially.** While the more specific rules discussed above should be found to control, analysis of legal precedent related to Art. 21.42—the applicability language for the entire Texas Insurance Code—reveals that it too cannot apply extraterritorially. On its face, Art. 21.42 applies Texas insurance law to "[a]ny contract of insurance payable to any citizen or inhabitant of this State by any insurance company or corporation doing business within this State."[35] However, the United States Supreme Court has determined that the law is "incapable of being constitutionally applied [outside Texas] since the effect of such application would be to regulate business outside the state of Texas and control contracts made by citizens of other states in disregard of their laws."[36]

Texas courts analyzing Art. 21.42 have come to the same conclusion as the Supreme Court. The Texas Supreme Court stated: "Our Texas statute, Article 21.42, was upheld as constitutional in *International Brotherhood of B.M.I.S. v. Huval*, 140 Tex. 21, 166 S.W.2d 107 (1942); however, the statute cannot be given extraterritorial effect."[37] "For [Art. 21.42] to apply, the insurance proceeds must be payable to a Texas citizen, the policy must be issued by a company doing business in Texas, *and* the policy must arise in the course of the insurance company's Texas business."[38] But where a Texas resident sought to recover against an out-of-state insurer that had issued a policy to an out-of-state resident, the court found that the insurer was "not doing business within Texas, and [the] contract does not arise

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[32] Tex. Gov't Code § 311.026.
[33] *Lufkin v. City of Galveston*, 63 Tex. 437, 439 (1885). *Serv. Life & Cas. Ins. Co. v. Montemayor*, 150 S.W.3d 649, 651 (Tex. App.—Austin 2004, pet. denied). *In re A.A.G.*, 303 S.W.3d 739, 740 (Tex. App.—Waco 2009, no pet.).
[34] *Tex. Gen. Indem. Co. v. Tex. Workers' Comp. Comm'n*, 36 S.W.3d 635, 641 (Tex. App.—Austin 2000, no pet.) citing *Trinity Universal Ins. Co. v. McLaughlin*, 373 S.W.2d 66, 69 (Tex. Civ. App.—Austin 1963, writ ref'd n.r.e.).
[35] Tex. Ins. Code § 21.42.
[36] *Aetna Life Ins. Co. v. Dunken*, 266 U.S. 389, 399 (1924). *See also Austin Bldg. Co. v. Nat'l Union Fire Ins. Co.*, 432 S.W.2d 697, 701 (Tex. 1968) (same).
[37] *Austin Bldg. Co.*, 432 S.W.2d at 701.
[38] *Hefner v. Republic Indem. Co. of Am.*, 773 F. Supp. 11, 13 (S.D. Tex. 1991) (emphasis added) .

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in the course of in-state business" and consequently, Art. 21.42 was not applicable to mandates that Texas law would apply.[39]

Prior to 1937, Texas courts consistently held that when a group insurer issued and delivered the group policy to a Texas beneficiary, the acts of issuance and delivery were "doing business" in Texas, and that Art. 21.42 was therefore applicable. Then, in *Boseman v. Connecticut General Life Insurance Co.*, 301 U.S. 196 (1937), the United State Supreme Court rejected that policy as unconstitutional. In an effort to replace the pre-1937 theory for group policies, the Texas Supreme Court proposed the *Wann* rule, which essentially does away with the third prong of the general Art. 21.42 test.[40] In other words, if the insured can show that the insurer does any business in Texas, then Texas laws apply. However, given the holding in *Boseman*, issuance and delivery will clearly not satisfy the "doing business" test.

The *Wann* decision has rightly been called into question. Significantly, it remains an open question whether the truncated test in *Wann* would suffer the same or similar fate as *Dunken* did before the Supreme Court if applied too broadly. Given Texas' courts' acknowledgment that Art. 21.42 cannot be given extraterritorial effect, it seems unlikely Texas could use Art. 21.42 essentially to rewrite another state's mandates for policies issued to group policyholders in that other state. Indeed, the last case to cite *Wann*—which did so in 1999—also cited *Austin Building Co.*'s warning that "Article 21.42 may not be given extraterritorial effect so as 'to regulate business outside the state of Texas.'"[41]

Moreover, Texas courts in modern cases recognize that when a policy covers risks in several jurisdictions, "the place of contracting, place of negotiation, and the domicile of incorporation, and place of the business become the primary factors to determine which law applies."[42] Further, when the insured risks under a policy are not located in a single jurisdiction, neither the location of the insured risk nor the location of payment on that risk is of any consequence under the Restatement provisions adopted by Texas courts. The rationale is that it would be inappropriate to subject an insurer to multiple potentially

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[39] *Id.*
[40] *Metro. Life Ins. Co. v. Wann*, 109 S.W.2d 470, 472 (Comm'n App. 1937) (stating that the issuance and delivery of a certificate in this state constituted doing business in the state).
[41] *Houston Cas. Co. v. Certain Underwriters at Lloyd's London*, 51 F. Supp. 2d 789, 796 (S.D. Tex. 1999), aff'd sub nom. *Houston Cas. Co. v. Certain Underwriters at Lloyd's*, 252 F.3d 1357 (5th Cir. 2001).
[42] *Reddy Ice Corp. v. Travelers Lloyds Ins. Co.*, 145 S.W.3d 337, 346 (Tex. App.—Houston [14th Dist.] 2004, pet. denied).

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conflicting state laws under one contract, when that issue is more appropriately determined uniformly by the state under whose laws the policy was issued.

In contrast, applying *Wann*'s truncated approach too broadly would require essentially all group-policy issuers to conform all group policies issued to employers outside this state to Texas law on the chance that a single employee might become a Texas resident, or else seek to exclude coverage for any such individuals. Such a broad rule would defy the interests of out-of-state regulators approving group policy forms in their own jurisdictions, ignore the reasonable expectations of the insurer underwriting premiums and the out-of-state employer-policyholder, and disregard the principles of the Restatement (Second) of Conflict of Laws, § 188, especially if the parties included a choice-of-law provision, as set forth in section 187.

**The Insurance Commissioner's written decision demonstrates that it agrees with the law as stated above**. On July 16, 2009, the Insurance Commissioner resolved a matter concerning whether Blue Cross Blue Shield of Texas and Blue Cross Blue Shield of Alabama were doing business in Texas by issuing coverage to out-of-state companies that had employees in Texas.[43] The Insurance Commissioner's decision was clear in its findings:

> Respondents' administration of group insurance contracts initiated outside of Texas that affect Texas residents after the contracts were made (such as the issuance of a group certificates, making coverage determinations, responding to complaints and issuing explanations of benefits to enrollees after claims have been paid) does not constitute entering into a contract within this state or doing business within this state for the purposes of [Art. 21.42].
>
> [and]
>
> When an out-of-state insurance company issues a group policy to a non-Texas employer and the contract is entered into in another state, the law of the other state applies unless at the time it was issued the insurance company was otherwise doing business in Texas.[44]

Thus, the insurance commissioner agrees both that the mere issuance of a certificate of insurance is not doing business in the state of Texas, and that the law of the state in which the contract was entered would apply.[45] Moreover, the Insurance Commissioner specifically

[43] Order of the Insurance Commissioner No. 09-0569 (July 16, 2009) (attached hereto as Exhibit 1).
[44] Exhibit 1 at 7.
[45] *Id*.

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cites *Wann* in making that finding, which indicates that *Wann* is compatible with a finding that out-of-state plans are not subject to Texas regulation.[46]

**Practical issues also militate for a finding that HB 1763 and HB 1919 do not apply extraterritorially**. Many states have comparable state-law protections to those provided in HB 1763 and HB 1919. Applying HB 1763 and HB 1919 to policies issued out of state would put insurers in an impossible position of having to choose between which law to obey and which law to violate.

Consider a carrier that issues a group insurance policy in Arkansas. The group has employees who reside in ten states, including Texas. The policyholder is the employer in Arkansas and the certificate of coverage is issued in Arkansas. Assume, for sake of this example, that Arkansas also has regulations requiring that services provided under Arkansas-issued plans must meet its accreditation standards, which are more stringent that Texas' requirements. For its few Texas residents, the issuer of the group medical policy would be required to comply with both Arkansas law and Texas law. Unless those two laws are identical, a conflict will arise. This would subject the policy to two different sets of notice requirements, two different resolution processes, and two different appeals procedures — a result that not only creates massive inefficiency in policy administration, but also undermines the contractual bargain to which the parties agreed when they entered into the contract in Arkansas.

Similarly, Texas-regulated health insurance plans are required to include a notation on their member ID cards indicating that they are regulated by the Department.[47] Providers and members use this notation to determine if they are subject to various Texas statutory and regulatory requirements. Individuals insured under policies issued out of state would not include the "TDI" or "DOI" notation. Applying HB 1763 and HB 1919 to out-of-state policies would confuse providers who rely on insurance ID cards to understand the extent of applicable health-care coverage. Without further guidance, it is unclear whether TDI anticipates special ID cards to be issued to Texas residents covered by out-of-state policies such that providers could determine if the member is subject to HB 1763 and HB 1919.

In sum, this unnecessary, extraterritorial application of Texas laws—without any consumer protection benefit—to group policies issued out-of-state to employers domiciled outside of Texas is likely to result in member confusion and related disputes. For these

[46] *Id.*
[47] 28 Tex. Amin. Code § 21.2820.

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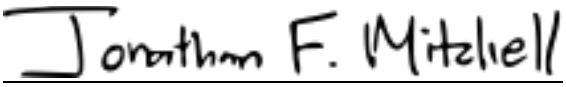
reasons and those explained above, TAHP requests that your office answer the question presented regarding extraterritorial application of HB 1763 and HB 1919 in the negative. Moreover, we respectfully request that your office both acknowledge the weight of existing jurisprudence and the practical results of an expansive view of the reach of the two statutes at issue—both of which make clear the inappropriateness of extraterritorial application of HB 1763 and HB 1919.

**4. The Attorney General Should Side with Texas Businesses and Reject This Attempt by Senator Schwertner to Circumvent the Legislature**

Senator Schwertner's SB 1137, which would have extended HB 1763 and HB 1919 to self-funded and extraterritorial plans, faced united opposition from the Texas business community. The Legislature concluded that the bills raised significant preemption concerns, and as a result, neither of these proposals advanced from committee. Enforcing these laws against pharmacy benefit managers, health plans, or third-party administrators will directly harm Texas businesses who rely on ERISA preemption to offer affordable, cost-effective employee health benefits. Senator Schwertner, in his layout of SB 1137, publicly acknowledged that it would take an act of the legislature to apply these laws to plans that are not currently regulated by the state, and we ask that this office not circumvent the legislature's decision.

Respectfully submitted,



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