By: Zerwas H.B. No. 636

A BILL TO BE ENTITLED

1 AN ACT

2 relating to creation of the Texas Health Insurance Connector.

3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

4 SECTION 1. The legislature finds that:

5 (1) the small employer and individual health benefit
6 plan markets in this state are a fundamental and integral component
7 of the economy of this state that create significant employment and
8 business opportunity, including enabling more than 1.5 million
9 individuals, and 110,000 small businesses with more than 650,000
10 employees, to obtain health benefit plan coverage in 2009;

11 (2) the United States Congress exceeded its
12 constitutional authority by passing the Patient Protection and
13 Affordable Care Act, which contained a number of provisions that
14 have the potential to significantly undermine the operations of the
15 small employer and individual health benefit plan markets in this
16 state;

17 (3) the Patient Protection and Affordable Care Act
18 includes an option for a state to create a health insurance exchange
19 to facilitate the purchase of individual and small group health
20 coverage and to provide assistance with enrollment of eligible
21 individuals in qualified health plans in lieu of the federal
22 government operating a health insurance exchange in the state for
23 that purpose;

24 (4) the federal government operating a health

1 insurance exchange in this state would significantly hinder the
2 operation of the small employer and individual health benefit plan
3 markets in this state so as to cause significant economic harm
4 throughout the state, to a greater extent than would be the case
5 under a health insurance exchange administered in or by this state;
6 (5) a federal health insurance exchange operating in
7 this state would infringe on powers reserved to this state under the
8 Tenth Amendment to the United States Constitution; and
9 (6) it is in the best interest of the citizens of this
10 state that the State of Texas create a health insurance exchange,
11 the Texas Health Insurance Connector, to facilitate, and make
12 transparent the purchase of, small employer and individual health
13 benefit plan coverage in this state, to provide assistance with
14 enrollment of eligible individuals in qualified health plans, and
15 to protect the economy of and the insurance markets in this state.
16 SECTION 2. Subtitle G, Title 8, Insurance Code, is amended
17 by adding Chapter 1509 to read as follows:
18 CHAPTER 1509. TEXAS HEALTH INSURANCE CONNECTOR
19 SUBCHAPTER A. GENERAL PROVISIONS
20 Sec. 1509.001. DEFINITIONS. In this chapter:
21 (1) "Board" means the board of directors of the
22 connector.
23 (2) "Connector" means the Texas Health Insurance
24 Connector.
25 (3) "Enrollee" means an individual who is enrolled in
26 a qualified health plan.
27 (4) "Executive commissioner" means the executive

1 commissioner of the Health and Human Services Commission.
2 (5) "Qualified health plan" means a health benefit
3 plan that the board has certified under Section 1509.108.
4 (6) "Qualified individual" means an individual who is
5 eligible to become an enrollee in accordance with the criteria
6 adopted by the board under Section 1509.109.
7 (7) "Secretary" means the secretary of the United
8 States Department of Health and Human Services.
9 (8) "Small employer" has the meaning assigned by
10 Section 1501.002, except that the term does not include
11 governmental entities described by that section.
12 Sec. 1509.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In
13 this chapter, "health benefit plan" means an insurance policy,
14 insurance agreement, evidence of coverage, or other similar
15 coverage document that provides coverage for medical or surgical
16 expenses incurred as a result of a health condition, accident, or
17 sickness that is issued by:
18 (1) an insurance company;
19 (2) a group hospital service corporation operating
20 under Chapter 842;
21 (3) a fraternal benefit society operating under
22 Chapter 885;
23 (4) a stipulated premium company operating under
24 Chapter 884;
25 (5) an exchange operating under Chapter 942;
26 (6) a health maintenance organization operating under
27 Chapter 843;

(7) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846; or

(8) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844.

(b) In this chapter, "health benefit plan" does not include:

(1) a plan that provides coverage:

(A) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury;

(B) as a supplement to a liability insurance policy;

(C) for credit insurance;

(D) only for vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

(2) a Medicare supplemental policy as defined by Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

(3) a workers' compensation insurance policy; or

(4) medical payment insurance coverage provided under a motor vehicle insurance policy.

Sec. 1509.003. RULES. (a) The board may adopt rules necessary and proper to implement this chapter.

(b) The board may adopt rules necessary to implement state responsibility in compliance with a federal law or regulation or action of a federal court relating to a person or activity under the purview of the connector if:

(1) the federal law, regulation, or action of the

1 federal court requires:
2 (A) a state to adopt the rules; or
3 (B) action by a state to ensure protection of the
4 citizens of the state;
5 (2) the rules will avoid federal preemption of state
6 insurance regulation; or
7 (3) the rules will prevent the loss of federal funds to
8 this state.
9 (c) The board may adopt a rule under Subsection (b) only if
10 the federal action requiring the adoption of a rule occurs or takes
11 effect between sessions of the legislature or at such a time during
12 a session of a legislature that sufficient time does not remain to
13 permit the preparation of a recommendation for legislative action
14 or permit the legislature to act. A rule adopted under this section
15 remains in effect until the 30th day after the end of the first
16 regular session of the legislature that follows the adoption of the
17 rule unless a law is enacted that authorizes the subject matter of
18 the rule. If a law is enacted that authorizes the subject matter of
19 the rule, the rule continues in effect.
20 Sec. 1509.004. AGENCY COOPERATION. (a) The connector, the
21 department, and the Health and Human Services Commission shall
22 cooperate fully in performing their respective duties under this
23 code or another law of this state relating to the operation of the
24 connector.
25 (b) The connector and the department shall cooperate to
26 promote a stable health benefit plan market in this state.
27 Sec. 1509.005. SUNSET PROVISION. The connector is subject

1 to review under Chapter 325, Government Code (Texas Sunset Act).
2 Unless continued in existence as provided by that chapter, the
3 connector is abolished and this chapter expires September 1, 2019.
4 Sec. 1509.006. CONNECTOR NOT INSURER. The connector is not
5 an insurer or health maintenance organization and is not subject to
6 regulation by the department.
7 Sec. 1509.007. EXEMPTION FROM STATE TAXES AND FEES. The
8 connector is not subject to any state tax, regulatory fee, or
9 surcharge, including a premium or maintenance tax or fee.
10 Sec. 1509.008. COMPLIANCE WITH FEDERAL LAW. The connector
11 shall comply with all applicable federal law and regulations.
12 [Sections 1509.009-1509.050 reserved for expansion]
13 SUBCHAPTER B. ESTABLISHMENT AND GOVERNANCE
14 Sec. 1509.051. ESTABLISHMENT. The Texas Health Insurance
15 Connector is established as the American Health Benefit Exchange
16 and the Small Business Health Options Program (SHOP) Exchange
17 required by Section 1311, Patient Protection and Affordable Care
18 Act (Pub. L. No. 111-148).
19 Sec. 1509.052. GOVERNANCE OF CONNECTOR; BOARD MEMBERSHIP.
20 (a) The connector is governed by a board of directors.
21 (b) The board consists of seven members composed as follows:
22 (1) five members appointed by the governor:
23 (A) two of whom must be chosen from a list
24 submitted to the governor by the lieutenant governor; and
25 (B) two of whom must be chosen from a list
26 submitted to the governor by the speaker of the house of
27 representatives;

(2) the commissioner, as a nonvoting ex officio member; and

(3) the executive commissioner, as a nonvoting ex officio member.

(c) At least three of the five board members appointed by the governor must have experience in health care administration, health care economics, or health insurance or be knowledgeable concerning general business or actuarial principles. One of the board members appointed by the governor must represent the interests of health benefit plan consumers in this state, one must represent the interests of small employers in this state, and one must be an enrollee or be reasonably expected to qualify for coverage under a qualified health plan in this state.

(d) A person may not serve as a member of the board if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation related to the operation of the connector or the business of insurance in this state.

Sec. 1509.053. PRESIDING OFFICER. The governor shall designate one member of the board to serve as presiding officer at the pleasure of the governor.

Sec. 1509.054. TERMS; VACANCY. (a) Appointed members of the board serve staggered six-year terms.

(b) The governor shall fill a vacancy on the board by appointing, for the unexpired term, an individual who has the appropriate qualifications to fill that position.

Sec. 1509.055. CONFLICT OF INTEREST. (a) A board member,

1 or a member of a committee formed by the board, with a direct
2 interest in a matter before the board, personally or through an
3 employer, shall abstain from deliberations and actions on the
4 matter in which the conflict of interest arises, shall abstain from
5 any vote on the matter, and may not in any manner participate in a
6 decision on the matter.
7 (b) Each board member shall file a conflict of interest
8 statement and a statement of ownership interests with the board to
9 ensure disclosure of all existing and potential personal interests
10 related to board business.
11 Sec. 1509.056. REIMBURSEMENT. A member of the board is not
12 entitled to compensation but is entitled to reimbursement for
13 travel or other expenses incurred while performing duties as a
14 board member in the amount provided by the General Appropriations
15 Act for state officials.
16 Sec. 1509.057. MEMBER'S IMMUNITY. (a) A member of the
17 board is not liable for an act or omission made in good faith in the
18 performance of powers and duties under this chapter.
19 (b) A cause of action does not arise against a member of the
20 board for an act or omission described by Subsection (a).
21 Sec. 1509.058. OPEN RECORDS AND OPEN MEETINGS. (a) The
22 board is subject to Chapter 551, Government Code. The board may
23 meet in executive session in accordance with Chapter 551,
24 Government Code, to discuss confidential or proprietary
25 information, including contract decisions and qualified health
26 plan rates.
27 (b) The board is subject to Chapter 552, Government Code,

1 except that, notwithstanding any other law, documents that contain
2 proprietary information, relate to deliberative processes or
3 communications, relate to contracting decisions, or reveal work
4 product, plans, or strategy that would influence decisions in the
5 health benefit plan marketplace are not public information.
6 Sec. 1509.059. RECORDS. The board shall keep records of the
7 board's proceedings for at least seven years.
8 Sec. 1509.060. BIENNIAL REPORT. Not later than January 1 of
9 each odd-numbered year, the board shall provide a report to the
10 governor, the legislature, the commissioner, and the executive
11 commissioner. The report must include information regarding the
12 development and implementation of the connector, specifically
13 detailing progress made by the connector in implementing the
14 requirements of this chapter.
15 Sec. 1509.061. ADDITIONAL REPORT. (a) The board shall
16 issue a report that meets the requirements of Section 1509.060 to
17 the entities described by that section not later than January 1,
18 2014.
19 (b) This section expires January 31, 2014.
20 [Sections 1509.062-1509.100 reserved for expansion]
21 SUBCHAPTER C. POWERS AND DUTIES OF CONNECTOR
22 Sec. 1509.101. EMPLOYEES; COMMITTEES. (a) The board may
23 employ, and determine the compensation of, an executive director, a
24 chief fiscal officer, a general counsel, a technology officer, and
25 any other agent or employee the board considers necessary to assist
26 the connector in carrying out the connector's responsibilities and
27 functions.

1 (b) The connector may appoint appropriate legal, actuarial,
2 and other committees necessary to provide technical assistance in
3 operating the connector and performing any of the functions of the
4 connector.
5 Sec. 1509.102. CONTRACTS. The connector may enter into any
6 contract that the connector considers necessary to implement or
7 administer this chapter, including a contract with the department
8 or the Health and Human Services Commission for the department or
9 commission, in exchange for payment, to perform functions or
10 provide services in connection with the operation of the connector.
11 Sec. 1509.103. INFORMATION SHARING AND CONFIDENTIALITY.
12 The connector may enter into information-sharing agreements with
13 federal and state agencies to carry out the connector's
14 responsibilities under this chapter. An agreement entered into
15 under this section must include adequate protection with respect to
16 the confidentiality of any information shared and comply with all
17 applicable state and federal law.
18 Sec. 1509.104. MEMORANDUM OF UNDERSTANDING. The connector
19 shall enter into a memorandum of understanding with the department
20 and the Health and Human Services Commission regarding the exchange
21 of information and the division of regulatory functions among the
22 connector, the department, and the commission.
23 Sec. 1509.105. LEGAL ACTION. (a) The connector may sue or
24 be sued.
25 (b) The connector may take any legal action necessary to
26 recover or collect amounts due the connector, including:
27 (1) assessments due the connector;

(2) amounts erroneously or improperly paid by the connector; and

(3) amounts paid by the connector as a mistake of fact or law.

Sec. 1509.106. FUNCTIONS. The connector shall:

(1) by rule establish procedures consistent with federal law and regulations for the certification, recertification, and decertification of health benefit plans as qualified health plans;

(2) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(3) maintain an Internet website through which an enrollee or prospective enrollee may:

(A) obtain standardized, comparative information concerning qualified health plans issued in this state; and

(B) locate comparative coverage information concerning qualified health plans through a searchable database of diseases, disabilities, or other medical conditions;

(4) assign a rating to each qualified health plan certified by the connector based on criteria developed by the secretary;

(5) use a standard format for presenting information concerning qualified health plan options;

(6) inform individuals of the eligibility requirements for Medicaid, the state child health plan program, or any other similar federal, state, or local public health benefit program;

(7) if the connector determines that an individual is eligible for Medicaid, the state child health plan program, or any other similar federal, state, or local public health benefit program, coordinate with the Health and Human Services Commission to enroll the individual in the program for which the individual is eligible;

(8) establish, and make available electronically, a calculator to determine the actual cost of coverage after the application of any premium tax credit or cost-sharing subsidy available under federal law;

(9) as applicable, certify that an individual is exempt from the individual responsibility penalty under Section 5000A, Internal Revenue Code of 1986, and notify the secretary of the exemption;

(10) establish a navigator program as described by Section 1311(i), Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(11) provide for the processing of applications for coverage under a qualified health plan, the enrollment of persons in qualified health plans, and the disenrollment of enrollees from qualified health plans;

(12) establish billing and payment policies for issuers of qualified health plans;

(13) engage in marketing and outreach activities; and

(14) collect and maintain information concerning qualified health plans, including data concerning enrollment, disenrollment, claims, and claims denials.

1 Sec. 1509.107. TYPES OF PLANS. The connector shall, in a
2 manner consistent with federal law, establish certification
3 requirements for at least six different types of qualified health
4 plans, at least two of which must include a health savings account
5 described by Section 223, Internal Revenue Code of 1986, at least
6 one of which must offer benchmark coverage or benchmark equivalent
7 coverage described by Section 1937(b), Social Security Act (42
8 U.S.C. Section 1396u-7), and at least one of which must offer
9 limited scope dental benefits either separately or in conjunction
10 with another type of plan.
11 Sec. 1509.108. CERTIFICATION OF PLAN. The board shall
12 certify a health benefit plan as a qualified health plan if the
13 health benefit plan meets the requirements for certification set
14 forth by the secretary. The connector may not, as a condition of
15 certification, require a health benefit plan issuer to:
16 (1) participate in both the individual and small
17 employer markets; or
18 (2) offer benefit levels that exceed benefit levels
19 required under federal law.
20 Sec. 1509.109. QUALIFICATION OF INDIVIDUALS. The board by
21 rule shall establish criteria for eligibility for a potential
22 enrollee to be considered a qualified individual. At a minimum, the
23 criteria must require that the individual:
24 (1) seek to enroll in a qualified health plan in the
25 individual health benefit plan market offered through the
26 connector;
27 (2) reside in and be a citizen or lawful resident of

1 this state, except as provided by Section 1312, Patient Protection
2 and Affordable Care Act (Pub. L. No. 111-148); and
3 (3) at the time of enrollment, not be incarcerated,
4 other than being incarcerated pending the disposition of any
5 criminal charges.
6 Sec. 1509.110. PREMIUM COLLECTION AND AGGREGATION. The
7 board by rule shall establish a mechanism for the collection and
8 aggregation of premium payments directly or indirectly from
9 enrollees and the payment of premiums to issuers of qualified
10 health plans. Rules adopted under this section must include rules
11 regarding an employer's authority to withhold premium payments from
12 an enrollee's paycheck and to submit those premium payments to
13 issuers of qualified health plans.
14 Sec. 1509.111. PREMIUM INCREASE JUSTIFICATION. (a) The
15 connector shall require an issuer of a qualified health plan to file
16 with the connector an explanation of any premium increase before
17 implementation of the increase.
18 (b) A health benefit plan issuer shall prominently display
19 the explanation of any premium increase on the health benefit plan
20 issuer's Internet website.
21 [Sections 1509.112-1509.150 reserved for expansion]
22 SUBCHAPTER D. COVERAGE REQUIREMENTS OR LIMITATIONS
23 Sec. 1509.151. PROHIBITED COVERAGE THROUGH CONNECTOR. A
24 qualified health plan offered through the connector may not provide
25 coverage for an abortion, as defined by Section 171.002, Health and
26 Safety Code.
27 [Sections 1509.152-1509.200 reserved for expansion]

SUBCHAPTER E. ASSESSMENTS FOR OPERATION OF CONNECTOR

Sec. 1509.201. ASSESSMENTS; PENALTY FOR NONPAYMENT. (a) The connector may charge the issuers of qualified health plans and health benefit plans applying for certification as qualified health plans an assessment as reasonable and necessary for the connector's organizational and operating expenses.

(b) The connector may refuse to recertify or may decertify a health benefit plan as a qualified health plan if the issuer of the plan fails or refuses to pay an assessment under this section.

Sec. 1509.202. GRANTS AND FEDERAL FUNDS. (a) The connector may accept a grant from a public or private organization and may spend those funds to pay the costs of program administration and operations.

(b) The connector may accept federal funds and shall use those funds in compliance with applicable federal law, regulations, and guidelines.

Sec. 1509.203. USE OF CONNECTOR ASSETS; ANNUAL REPORT. (a) The assets of the connector may be used only to pay the costs of the administration and operation of the connector.

(b) The connector shall prepare annually a complete and detailed written report accounting for all funds received and disbursed by the connector during the preceding fiscal year. The report must meet any reporting requirements provided in the General Appropriations Act, regardless of whether the connector receives any funds under that Act. The connector shall submit the report to the governor, the legislature, the commissioner, and the executive commissioner not later than January 31 of each year.

[Sections 1509.204-1509.250 reserved for expansion]

SUBCHAPTER F. TRUST FUND

Sec. 1509.251. TRUST FUND. (a) The connector fund is established as a special trust fund outside of the state treasury in the custody of the comptroller separate and apart from all public money or funds of this state.

(b) The connector may deposit assessments, gifts or donations, and any federal funding obtained by the connector into the connector fund in accordance with procedures established by the comptroller.

(c) Interest or other income from the investment of the fund shall be deposited to the credit of the fund.

SECTION 3. (a) As soon as possible after the effective date of this Act, but not later than October 31, 2011, the governor shall appoint the initial members of the board of directors of the Texas Health Insurance Connector. In making the appointments, the governor shall designate two persons to terms expiring February 1, 2013, two persons to terms expiring February 1, 2015, and one person to a term expiring February 1, 2017.

(b) As soon as possible after the appointments required by Subsection (a) of this section are made, but not later than November 30, 2011, the board of directors of the Texas Health Insurance Connector shall hold a special meeting to discuss the adoption of rules and procedures necessary to implement Chapter 1509, Insurance Code, as added by this Act.

(c) As soon as possible after the effective date of this Act, but not later than January 31, 2012, the board of directors of

1 the Texas Health Insurance Connector shall adopt rules and
2 procedures necessary to implement Chapter 1509, Insurance Code, as
3 added by this Act.

4 SECTION 4. This Act takes effect immediately if it receives
5 a vote of two-thirds of all the members elected to each house, as
6 provided by Section 39, Article III, Texas Constitution. If this
7 Act does not receive the vote necessary for immediate effect, this
8 Act takes effect September 1, 2011.