

By: Perry

H.B. No. 2165

A BILL TO BE ENTITLED

1 AN ACT

2 relating to the establishment of a medical reinsurance system and  
3 to certain insurance reforms necessary to the efficient operation  
4 of that system; providing an administrative penalty.

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

6 SECTION 1. The heading to Subtitle F, Title 4, Insurance  
7 Code, is amended to read as follows:

8 SUBTITLE F. REINSURANCE; STOP-LOSS INSURANCE

9 SECTION 2. Subtitle F, Title 4, Insurance Code, is amended  
10 by adding Chapter 495 to read as follows:

11 CHAPTER 495. STOP-LOSS INSURANCE FOR CERTAIN SELF-FUNDED ENTITIES

12 Sec. 495.001. DEFINITIONS. In this chapter:

13 (1) "Aggregate stop-loss insurance" means stop-loss  
14 insurance in which the issuer responds after a self-funded health  
15 benefit plan has covered:

16 (A) claims that total a specified dollar amount;

17 or

18 (B) a specified percentage of expected claims,  
19 which may be modified to account for any applicable individual  
20 stop-loss insurance coverage.

21 (2) "Health benefit plan" means a plan that provides  
22 benefits for hospital, medical, surgical, or other treatment  
23 expenses incurred as a result of a health condition, an accident, or  
24 sickness, including a group health insurance policy, a group

1 hospital service contract, a group evidence of coverage, or any  
2 other similar coverage document that:

3 (A) is issued, entered into, or provided by:

4 (i) an insurance company;

5 (ii) a group hospital service corporation  
6 operating under Chapter 842;

7 (iii) a health maintenance organization  
8 operating under Chapter 843;

9 (iv) a multiple employer welfare  
10 arrangement that holds a certificate of authority under Chapter  
11 846; or

12 (v) an employer, union, association,  
13 trustee, or other self-funded or self-insured welfare or benefit  
14 plan, program, or arrangement; and

15 (B) is not limited in scope to only one or more of  
16 the following types of coverage:

17 (i) accident-only or disability income  
18 insurance coverage or a combination of accident-only and disability  
19 income insurance coverage;

20 (ii) credit-only insurance coverage;

21 (iii) disability insurance coverage;

22 (iv) coverage only for a specified disease  
23 or illness;

24 (v) Medicare services under a federal  
25 contract;

26 (vi) Medicare supplement and Medicare  
27 Select policies regulated in accordance with federal law;

1                   (vii) long-term care coverage or benefits,  
2 nursing home care coverage or benefits, home health care coverage  
3 or benefits, community-based care coverage or benefits, or any  
4 combination of those coverages or benefits;

5                   (viii) coverage that provides  
6 limited-scope dental or vision benefits;

7                   (ix) coverage for an on-site medical  
8 clinic;

9                   (x) liability insurance coverage,  
10 including general liability insurance coverage, automobile  
11 liability insurance coverage, and coverage issued as a supplement  
12 to liability insurance coverage;

13                   (xi) workers' compensation insurance  
14 coverage or similar insurance coverage;

15                   (xii) automobile medical payment insurance  
16 coverage, including coverage issued as a supplement to automobile  
17 medical payment insurance coverage; or

18                   (xiii) hospital indemnity or other fixed  
19 indemnity insurance coverage.

20                   (3) "Individual stop-loss deductible" means the  
21 dollar amount of claims that a self-funded health benefit plan must  
22 cover before the issuer of an individual stop-loss insurance policy  
23 begins to reimburse the health benefit plan for additional covered  
24 claims for the remainder of a policy period.

25                   (4) "Individual stop-loss insurance" means stop-loss  
26 insurance in which the issuer responds when the self-funded health  
27 benefit plan covered by the insurance has covered claims that

1 exceed the applicable individual stop-loss deductible for one  
2 enrollee in the health benefit plan.

3 (5) "Reinsurance" means a contractual arrangement  
4 between a ceding insurer and an assuming insurer in accordance with  
5 Chapter 492.

6 (6) "Self-funded health benefit plan" means a health  
7 benefit plan that:

8 (A) is established as an employee welfare benefit  
9 plan under the Employee Retirement Income Security Act of 1974 (29  
10 U.S.C. Section 1001 et seq.) or offered by an entity, agency, or  
11 political subdivision of this state under Subtitle H, Title 8;

12 (B) holds the initial obligation to pay claims  
13 under the plan; and

14 (C) is exempt under state or federal law from the  
15 licensing requirements of this code.

16 (7) "Stop-loss insurance" means an insurance policy  
17 covering a self-funded health benefit plan. The term includes  
18 aggregate stop-loss insurance and individual stop-loss insurance.

19 Sec. 495.002. REINSURANCE PROHIBITED; STOP-LOSS INSURANCE  
20 REQUIRED. (a) An insurer authorized to write reinsurance in this  
21 state may not issue a reinsurance policy covering a self-funded  
22 health benefit plan.

23 (b) Subject to Section 495.003, an insurer authorized to  
24 write stop-loss insurance in this state may issue a stop-loss  
25 insurance policy covering a self-funded health benefit plan.

26 Sec. 495.003. PRIOR APPROVAL OF POLICIES. (a) An insurer  
27 authorized to write stop-loss insurance in this state may not issue

1 or issue for delivery a stop-loss insurance policy in this state  
2 until the policy has been filed with the department and approved by  
3 the commissioner. The commissioner may not approve an individual  
4 stop-loss insurance policy filed under this section if the  
5 individual stop-loss deductible is less than \$5,000 or exceeds  
6 \$100,000.

7 (b) The commissioner shall adopt rules under Section 37.001  
8 to govern the approval of policies filed under this section.

9 (c) If the commissioner disapproves a policy filed under  
10 this section, the disapproval is subject to judicial review under  
11 Subchapter D, Chapter 36.

12 (d) In the commissioner's order approving or disapproving a  
13 policy filed under this section, the commissioner shall state  
14 whether the stop-loss policy is subject to Chapters 1675 and 1676.

15 Sec. 495.004. REPORTS CONCERNING INDIVIDUAL STOP-LOSS  
16 INSURANCE. An insurer that issues individual stop-loss insurance  
17 in this state shall annually file with the department a report that  
18 contains the annualized gross premium and annual individual  
19 stop-loss deductible for each individual stop-loss insurance  
20 policy issued in this state.

21 SECTION 3. Title 8, Insurance Code, is amended by adding  
22 Subtitle K to read as follows:

23 SUBTITLE K. TEXAS MEDICAL REINSURANCE SYSTEM

24 CHAPTER 1675. TEXAS MEDICAL REINSURANCE SYSTEM

25 Sec. 1675.001. DEFINITIONS. In this chapter:

26 (1) "Affiliate" means a person or entity classified as  
27 an affiliate under Section 823.003.

1           (2) "Aggregate stop-loss insurance" has the meaning  
2 assigned by Section 495.001.

3           (3) "Board" means the board of directors of the Texas  
4 Medical Reinsurance System.

5           (4) "Health benefit plan" has the meaning assigned by  
6 Section 495.001.

7           (5) "Health benefit plan issuer" means an entity that  
8 issues a health benefit plan.

9           (6) "Independent auditor" means the auditor with whom  
10 the board contracts under Section 1675.006 to audit the  
11 administration, management, and operation of the system.

12           (7) "Individual stop-loss insurance" has the meaning  
13 assigned by Section 495.001.

14           (8) "Management company" means the entity with whom  
15 the board contracts under Section 1675.006 to administer, manage,  
16 and operate the system.

17           (9) "Plan of operation" means the plan of operation of  
18 the system established under Section 1675.007.

19           (10) "Self-funded health benefit plan" has the meaning  
20 assigned by Section 495.001.

21           (11) "Stop-loss insurance" has the meaning assigned by  
22 Section 495.001.

23           (12) "Subsidiary" means a person classified as a  
24 subsidiary under Section 823.003.

25           (13) "System" means the Texas Medical Reinsurance  
26 System established under this chapter.

27           Sec. 1675.002. TEXAS MEDICAL REINSURANCE SYSTEM. The Texas

1 Medical Reinsurance System is an entity that is:

2 (1) administered by a board of directors and  
3 management company in accordance with this chapter; and

4 (2) subject to the supervision and control of the  
5 commissioner.

6 Sec. 1675.003. SYSTEM BOARD OF DIRECTORS. (a) The board of  
7 directors of the system is composed of the following nine members:

8 (1) one member appointed by the governor, selected  
9 from a list of candidates prepared by the lieutenant governor;

10 (2) one member appointed by the governor, selected  
11 from a list of candidates prepared by the speaker of the house of  
12 representatives;

13 (3) one member appointed by the governor who is a small  
14 employer, as defined by Section 1501.002;

15 (4) one member appointed by the governor who is a large  
16 employer, as defined by Section 1501.002;

17 (5) one member appointed by the governor who  
18 represents the interests of political subdivisions of this state;

19 (6) one member appointed by the governor who  
20 represents the interests of physicians in this state;

21 (7) one member appointed by the governor who  
22 represents the interests of hospitals in this state;

23 (8) one member who is the executive director of the  
24 Employees Retirement System of Texas or that executive director's  
25 designee; and

26 (9) one member who is the executive director of the  
27 Teacher Retirement System of Texas or that executive director's

1 designee.

2 (b) A board member may not:

3 (1) be an officer, director, or employee of a health  
4 benefit plan issuer or an affiliate or subsidiary of a health  
5 benefit plan issuer;

6 (2) be a person required to register under Chapter  
7 305, Government Code; or

8 (3) be related to a person described by Subdivision  
9 (1) or (2) within the second degree by affinity or consanguinity.

10 (c) Members of the board appointed by the governor serve  
11 two-year terms expiring December 31 of each odd-numbered year. A  
12 member's term continues until a successor is appointed.

13 (d) A member of the board may not be compensated for serving  
14 on the board but is entitled to reimbursement for actual expenses  
15 incurred in performing functions as a member of the board as  
16 provided by the General Appropriations Act.

17 Sec. 1675.004. OPEN MEETINGS; PUBLIC INFORMATION. The  
18 board is subject to:

19 (1) the open meetings law, Chapter 551, Government  
20 Code; and

21 (2) the public information law, Chapter 552,  
22 Government Code.

23 Sec. 1675.005. BOARD MEMBER IMMUNITY. (a) A member of the  
24 board is not liable for an act performed, or omission made, in good  
25 faith in the performance of powers and duties under this chapter.

26 (b) A cause of action does not arise against a member of the  
27 board for an act or omission described by Subsection (a).



1       Sec. 1675.006. SELECTION OF MANAGEMENT COMPANY AND  
2 INDEPENDENT AUDITOR. (a) The board shall contract with:

3               (1) an entity that is qualified to administer, manage,  
4 and operate the system; and

5               (2) an entity that is qualified to audit the manner in  
6 which the entity described by Subdivision (1) performs its duties.

7       (b) An entity with whom the board contracts under Subsection  
8 (a) may not be a health benefit plan issuer or an affiliate or  
9 subsidiary of a health benefit plan issuer.

10       (c) A management company with whom the board contracts under  
11 Subsection (a)(1) must have the capability to gather, compile, and  
12 securely store information received from health benefit plan  
13 issuers and health care providers with whom health benefit plan  
14 issuers contract in a manner that allows the management company to  
15 prepare reports as requested by the board.

16       Sec. 1675.007. SYSTEM PLAN OF OPERATION. (a) The  
17 management company shall submit to the commissioner a plan of  
18 operation and any amendments to that plan necessary or suitable to  
19 ensure the fair, reasonable, and equitable administration of the  
20 system.

21       (b) The commissioner, after notice and hearing, may approve  
22 the plan of operation if the commissioner determines the plan:

23               (1) is suitable to ensure the fair, reasonable, and  
24 equitable administration of the system; and

25               (2) provides for the sharing of system gains or losses  
26 on an equitable and proportionate basis in accordance with this  
27 chapter.

1       (c) The plan of operation is effective on the written  
2 approval of the commissioner.

3       Sec. 1675.008. SYSTEM POWERS AND DUTIES. (a) The system,  
4 through the board and the management company, has the general  
5 powers and authority granted under state law to an insurer or a  
6 health maintenance organization authorized to engage in business,  
7 except that the system may not directly issue a health benefit plan.

8       (b) The system may:

9           (1) enter into contracts necessary or proper to  
10 implement this chapter, including, with the commissioner's  
11 approval, contracts with similar programs of other states for the  
12 joint performance of common functions or with persons or other  
13 organizations for the performance of administrative functions;

14           (2) sue or be sued, including taking legal action  
15 necessary or proper to recover assessments and penalties for, on  
16 behalf of, or against the system or a reinsured health benefit plan  
17 issuer;

18           (3) take legal action necessary to avoid the payment  
19 of improper claims against the system;

20           (4) issue reinsurance contracts in accordance with  
21 this chapter;

22           (5) establish guidelines, conditions, and procedures  
23 for reinsuring risks under the plan of operation;

24           (6) establish actuarial and underwriting functions as  
25 appropriate for the operation of the system;

26           (7) appoint appropriate legal, actuarial, and other  
27 committees necessary to provide technical assistance in:

1           (A) the operation of the system;  
2           (B) policy and other contract design; and  
3           (C) any other function within the authority of  
4 the system; and

5           (8) assess health benefit plan issuers and stop-loss  
6 insurers in accordance with Section 1675.012.

7           Sec. 1675.009. SYSTEM AUDIT; INDEPENDENT AUDIT AND STATE  
8 AUDIT. (a) The transactions of the system are subject to audit by  
9 the state auditor in accordance with Chapter 321, Government Code.  
10 The state auditor shall report the cost of each audit conducted  
11 under this subsection to the board, the management company, and the  
12 comptroller, and the board shall remit that amount to the  
13 comptroller.

14           (b) The independent auditor shall annually audit the  
15 transactions of the system and the manner in which the management  
16 company is performing the management company's duties. The  
17 independent auditor shall deliver to the board the results of an  
18 audit conducted under this subsection. An independent audit  
19 conducted under this subsection must include a budgetary and  
20 accounting analysis of the system's operation.

21           Sec. 1675.010. REINSURANCE REQUIRED; AMOUNT REQUIRED FOR  
22 STOP-LOSS INSURANCE. (a) The following entities shall purchase  
23 from the system reinsurance for the following types of health  
24 benefit plans:

25           (1) a health benefit plan issuer, for each health  
26 benefit plan issued; and

27           (2) an insurer that is authorized to write stop-loss

1 insurance in this state, for each individual stop-loss policy  
2 covering a self-funded health benefit plan.

3 (b) A health benefit plan issuer required to purchase  
4 reinsurance under Subsection (a)(1) is not required to and may not  
5 purchase reinsurance for a health benefit plan issued that covers  
6 exclusively Medicare services or is a Medicare supplement policy,  
7 as applicable and as determined by federal law.

8 (c) An insurer required to purchase reinsurance under  
9 Subsection (a)(2) must purchase reinsurance on each health benefit  
10 plan and each individual stop-loss insurance policy in a manner and  
11 amount consistent with Section 1676.002.

12 Sec. 1675.011. PREMIUM RATES FOR REINSURANCE. (a) As part  
13 of the plan of operation, the management company shall adopt a  
14 method to determine premium rates to be charged by the system for  
15 reinsurance contracts issued under this chapter.

16 (b) The method adopted must:

17 (1) allow premium rate variations based on:

18 (A) demographic and geographic factors; and

19 (B) the level of benefits provided under a  
20 reinsured health benefit plan;

21 (2) be actuarially justifiable and approved by the  
22 commissioner under Section 1675.007 as part of the system plan of  
23 operation; and

24 (3) provide for the sharing, on an equitable and  
25 proportionate basis, of system gains or losses among health benefit  
26 plan issuers and stop-loss insurers required to purchase  
27 reinsurance from the system under Section 1675.010.

1       Sec. 1675.012. ASSESSMENTS; DEFERMENT OF ASSESSMENTS. (a)

2 The board shall recover any net loss of the system by assessing each  
3 reinsured health benefit plan issuer or stop-loss insurer required  
4 to purchase reinsurance through the system under Section 1675.010  
5 an amount determined annually by the board based on information in  
6 annual statements and other reports required by and filed with the  
7 board.

8       (b) The board shall establish, as part of the plan of  
9 operation, a formula by which to make assessments that are made  
10 under Subsection (a). With the approval of the commissioner, the  
11 board may periodically change the assessment formula as  
12 appropriate. The board shall base the assessment formula on each  
13 reinsured health benefit plan issuer's or stop-loss insurer's share  
14 of the total premiums earned in the preceding calendar year from  
15 health benefit plans and policies of individual stop-loss insurance  
16 described by Section 1675.010.

17       (c) A reinsured health benefit plan issuer or stop-loss  
18 insurer may petition the commissioner for a deferment in whole or in  
19 part of an assessment imposed by the board.

20       (d) The commissioner may defer all or part of the assessment  
21 if the commissioner determines that payment of the assessment would  
22 endanger the ability of the reinsured health benefit plan issuer or  
23 stop-loss insurer to fulfill its contractual obligations.

24       (e) The board shall assess the amount of any deferred  
25 assessment against other reinsured health benefit plan issuers and  
26 stop-loss insurers in a manner consistent with the basis for  
27 assessment established by this chapter.

1       Sec. 1675.013. EFFECT OF DEFERRAL. A reinsured health  
2 benefit plan issuer or stop-loss insurer that receives a deferral  
3 under Section 1675.012(d):

4           (1) remains liable to the system for the amount  
5 deferred; and

6           (2) until the deferred assessment is paid, may not  
7 advertise, market, deliver, or issue for delivery:

8                   (A) a health benefit plan or insurance policy of  
9 the type for which the deferral is received; or

10                   (B) any other health benefit plan or insurance  
11 policy subject to this chapter.

12       Sec. 1675.014. RULES. The commissioner may adopt rules  
13 necessary to implement this chapter.

14       CHAPTER 1676. CERTAIN HEALTH SERVICES AND SUPPLIES PROVIDED UNDER  
15                   REINSURED PLANS AND POLICIES

16       Sec. 1676.001. DEFINITIONS. (a) In this chapter:

17           (1) "Health benefit plan claim" means a claim  
18 reimbursable under a reinsured plan or policy.

19           (2) "Health care provider" means a practitioner,  
20 institutional provider, or other person or organization that  
21 furnishes health care services or supplies and that is licensed or  
22 otherwise authorized to practice in this state. The term includes a  
23 physician.

24           (3) "Hospital" means a licensed public or private  
25 institution as defined by Chapter 241, Health and Safety Code, or  
26 Subtitle C, Title 7, Health and Safety Code.

27           (4) "Institutional provider" means a hospital,

1 nursing home, or other medical or health-related service facility  
2 that provides care for the sick or injured or other care that may be  
3 covered in a reinsured plan or policy.

4 (5) "Plan claim administrator" means the individual or  
5 entity responsible for paying claims under a reinsured plan or  
6 policy.

7 (6) "Policy period" means the period during which a  
8 reinsured plan or policy provides coverage.

9 (7) "Practitioner" means an individual who practices a  
10 healing art. The term includes a practitioner described by Section  
11 1451.001 or 1451.101.

12 (8) "Qualified health benefit plan claim" means a  
13 health benefit plan claim that has been repriced and adjusted by the  
14 plan claim administrator under Section 1676.003(b).

15 (9) "Reinsurance attachment point" means the point at  
16 which the system begins to reimburse a reinsured plan or policy  
17 under Section 1676.002.

18 (10) "Reinsurance extension period" means the  
19 applicable period in which the system provides reinsurance coverage  
20 for a reinsured plan or policy under Section 1676.006.

21 (11) "Reinsured entity" means:

22 (A) for a health benefit plan claim under a plan  
23 that is insured, the health benefit plan issuer; or

24 (B) for a health benefit plan claim under a  
25 self-funded health benefit plan that is self-insured, the insurer  
26 issuing the stop-loss insurance covering the plan.

27 (12) "Reinsured plan or policy" means a health benefit

1 plan or individual stop-loss insurance policy that is reinsured  
2 under the system as provided by Section 1675.010.

3 (13) "Repricing schedule" means the schedule  
4 established by the system under Section 1676.004 for the purpose of  
5 determining whether a health benefit plan claim is a qualified  
6 health benefit plan claim and, if applicable, the amount of  
7 reimbursement to which a reinsured entity may be entitled.

8 (b) In this chapter, "board," "management company," and  
9 "system" have the meanings assigned by Section 1675.001.

10 Sec. 1676.002. REINSURANCE ATTACHMENT POINT. (a) The  
11 board of the system, after consulting with the management company,  
12 shall annually establish the aggregated dollar amount of qualified  
13 health benefit claims at which the system begins to reimburse a  
14 reinsured entity.

15 (b) The system shall submit the reinsurance attachment  
16 point to the commissioner as an amendment to the system plan of  
17 operation for approval under Section 1675.007.

18 (c) The reinsurance attachment point may not be less than:

19 (1) \$50,000 per enrollee in a policy period, if the  
20 reinsured plan or policy is not described by Subdivision (2); and

21 (2) \$50,000 above the individual stop-loss deductible  
22 of an individual stop-loss insurance policy in a policy period.

23 Sec. 1676.003. DETERMINATION THAT CLAIM IS REINSURED;  
24 NOTICE TO SYSTEM. (a) A plan claim administrator shall determine,  
25 at the time of receipt of a claim under a reinsured plan or policy,  
26 whether the claim is potentially a reinsured claim.

27 (b) On receipt of a potentially reinsured claim, the plan



1 claim administrator shall adjust the amount of the claim to the  
2 lesser of:

3 (1) the amount charged for the service by the health  
4 care provider;

5 (2) the amount payable for the claim, without regard  
6 to whether it is a reinsured claim, under the reinsured plan or  
7 policy in accordance with any contract entered into by the health  
8 care provider; or

9 (3) the amount payable for the claim under the  
10 repricing schedule established under Section 1676.004.

11 (c) At the end of a policy period during which a health  
12 benefit plan claim occurs, the plan claim administrator shall  
13 calculate the total dollar amount of qualified health benefit plan  
14 claims for an individual.

15 (d) If a plan claim administrator determines that the total  
16 dollar amount of qualified health benefit plan claims for an  
17 individual exceeds the applicable reinsurance attachment point,  
18 the plan claim administrator, not later than the 30th day after the  
19 last day of the policy period, shall notify the system in writing of  
20 that determination and submit the claim to the system.

21 Sec. 1676.004. REPRICING SCHEDULE. (a) The system shall  
22 establish and maintain a repricing schedule for reinsured claims in  
23 accordance with the plan of operation and this section.

24 (b) The repricing schedule established under Subsection (a)  
25 must provide for certain reimbursement rates as follows:

26 (1) for a practitioner, a rate that is not less than  
27 110 percent of Medicare reimbursement rates for the practitioner;

1 and

2 (2) for an institutional provider, a rate that is not  
3 less than 140 percent of Medicare reimbursement rates for the  
4 institutional provider.

5 Sec. 1676.005. AMOUNT OF REINSURANCE; REINSURANCE  
6 REIMBURSEMENT. The system must provide for the reimbursement of  
7 aggregated qualified health benefit plan claims that exceed the  
8 reinsurance attachment point and that are originally submitted to  
9 the system under Section 1676.003(d), or during any applicable  
10 reinsurance extension period, as follows:

11 (1) for a reinsured health benefit plan, an amount  
12 that is equal to the lesser of:

13 (A) 95 percent of the aggregated dollar amount of  
14 health benefit plan claims that exceed the reinsurance attachment  
15 point for the respective period, before those claims have been  
16 repriced and adjusted under Section 1676.003(b); or

17 (B) the aggregated dollar amount of qualified  
18 health benefit plan claims that were submitted to the system under  
19 Section 1676.003(d) that exceed the reinsurance attachment point  
20 for the respective period; and

21 (2) for a reinsured stop-loss insurance policy, an  
22 amount that is equal to the lesser of:

23 (A) 95 percent of the aggregated dollar amount of  
24 health benefit plan claims that exceed the applicable reinsurance  
25 attachment point for the respective period and for which the  
26 reinsured entity is responsible under the individual stop-loss  
27 insurance policy, before those claims have been repriced and

1 adjusted under Section 1676.003(b); or

2 (B) the aggregated dollar amount of qualified  
3 health benefit plan claims that were submitted to the system under  
4 Section 1676.003(d) for the respective period and for which the  
5 insurer issuing the individual stop-loss insurance is responsible.

6 Sec. 1676.006. PERIOD OF REINSURANCE COVERAGE; CLAIMS  
7 BASIS. (a) The reinsurance policy issued by the system shall cover  
8 a reinsured plan or policy for:

9 (1) subject to Subsection (b), a period that is  
10 concomitant with the policy period of the reinsured plan or policy;  
11 and

12 (2) a claims basis that is consistent with the claims  
13 basis of the reinsured plan or policy, regardless of whether the  
14 reinsured plan or policy is an insured plan or a self-funded plan.

15 (b) A reinsurance policy issued by the system may not  
16 provide coverage for an initial period that exceeds 12 months.

17 Sec. 1676.007. REINSURANCE EXTENSION PERIOD. (a) The  
18 policy period that immediately follows the initial policy period  
19 during which the aggregated dollar amount of qualified reinsurance  
20 claims exceeds the reinsurance attachment point is the first  
21 reinsurance extension period. A reinsurance extension period under  
22 this subsection is automatic and applies regardless of whether a  
23 different health benefit plan issuer is responsible for the  
24 reinsured claims or a different stop-loss insurance carrier is  
25 responsible for the stop-loss insurance policy.

26 (b) If, during the first reinsurance extension period  
27 described by Subsection (a), the system reimburses a reinsured

1 entity for qualified health benefit claims that, if submitted  
2 during the initial policy period would have exceeded the  
3 reinsurance attachment point, the system shall extend reinsurance  
4 coverage from the first dollar of claims to the reinsured entity for  
5 a second reinsurance extension period.

6 (c) A reinsured entity may not receive a third or subsequent  
7 reinsurance extension period, and the period following the first  
8 reinsurance extension period is considered a new initial policy  
9 period.

10 Sec. 1676.008. DATA CALL FOR REIMBURSEMENT SCHEDULE. (a)  
11 The commissioner shall provide the system the information required  
12 by the system to establish and maintain the repricing schedule  
13 under Section 1676.004.

14 (b) The commissioner may request information necessary to  
15 comply with this section from any individual or entity that holds a  
16 license or certificate of authority under this code.

17 (c) An individual or entity that fails to comply with a  
18 request for information under this section violates this code and  
19 is subject to sanctions under Chapters 82, 83, and 84.

20 (d) Information that is obtained by the commissioner under  
21 this section and that is exempt from disclosure under Chapter 552,  
22 Government Code, including information exempt from disclosure  
23 under Section 552.104 or 552.110, Government Code:

24 (1) may be disclosed by the commissioner only to the  
25 system for the purposes of the reimbursement schedule; and

26 (2) may not be disclosed by the commissioner or the  
27 system to any other individual or entity.

1 SECTION 4. Effective September 1, 2014, Subchapter G,  
2 Chapter 1501, Insurance Code, is repealed.

3 SECTION 5. As soon as practicable after the effective date  
4 of this Act, the commissioner of insurance by rule shall develop a  
5 transition plan for implementation of Chapters 1675 and 1676,  
6 Insurance Code, as added by this Act, and for the orderly  
7 termination of the Texas Health Reinsurance System established  
8 under Subchapter G, Chapter 1501, Insurance Code. The transition  
9 plan must include a timetable with specific steps and deadlines  
10 needed to fully implement Chapters 1675 and 1676, Insurance Code.  
11 The transition plan must ensure that Chapters 1675 and 1676,  
12 Insurance Code, are fully implemented not later than September 1,  
13 2012.

14 SECTION 6. (a) The governor shall make the appointments  
15 described by Section 1675.003, Insurance Code, as added by this  
16 Act, as soon as possible after the effective date of this Act, and  
17 in no event later than April 1, 2012.

18 (b) The lieutenant governor and the speaker of the house of  
19 representatives shall submit the lists of candidates described by  
20 Sections 1675.003(a)(1) and (2), Insurance Code, as added by this  
21 Act, to the governor not later than January 1, 2012.

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