By: Coleman H.B. No. 3402

A BILL TO BE ENTITLED

AN ACT

relating to regulation of health benefit plan issuers in this state.

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

ARTICLE 1. CREATION OF THE TEXAS HEALTH INSURANCE EXCHANGE

SECTION 1.01. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1509 to read as follows:

CHAPTER 1509. TEXAS HEALTH INSURANCE EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1509.001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors of the exchange.

(2) "Catastrophic plan" has the meaning assigned by Section 1302(e), Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

(3) "Educated health care consumer" means an individual who is knowledgeable about the health care system and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(4) "Enrollee" means an individual who is enrolled in a qualified health plan.

(5) "Exchange" means the Texas Health Insurance Exchange.

(6) "Executive commissioner" means the executive

commissioner of the Health and Human Services Commission.

(7) "Qualified employer" means an employer that elects to make all of its full-time employees eligible for one or more qualified health plans offered through the exchange and, at the option of the employer, some or all of its part-time employees and:

(A) has its principal place of business in this state and elects to provide coverage through the exchange to all of its eligible employees, wherever employed; or

(B) elects to provide coverage through the exchange to all of its eligible employees who are principally employed in this state and who are eligible to participate in a qualified health plan.

(8) "Qualified health plan" means a health benefit plan that has been certified by the board as meeting the criteria specified by Section 1311(c), Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

(9) "Qualified individual" means an individual, including a minor, who:

(A) seeks to enroll in a qualified health plan offered to individuals through the exchange;

(B) resides in this state;

(C) at the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(D) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United

States.

(10) "Secretary" means the secretary of the United States Department of Health and Human Services.

(11) "SHOP Exchange" means a Small Business Health Options Program as defined by Section 1311(b)(1)(B), Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

Sec. 1509.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means an insurance policy, insurance agreement, evidence of coverage, or other similar coverage document that provides coverage for medical or surgical expenses incurred as a result of a health condition, accident, or sickness that is issued by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) an exchange operating under Chapter 942;

(6) a health maintenance organization operating under 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. DEFINITION OF SMALL EMPLOYER. (a) For purposes of this chapter, "small employer" means a person who employed at least two, and an average of not more than 50 employees during the preceding calendar year. This subsection expires December 31, 2013.

(b) All persons treated as a single employer under Section 414(b), (c), (m), or (o), Internal Revenue Code of 1986, are single employers for purposes of this chapter.

(c) An employer and any predecessor employer are a single employer for purposes of this chapter.

(d) In determining the number of employees of an employer under this section, the number of employees:

(1) includes part-time employees and employees who are not eligible for coverage through the employer; and

(2) for an employer that did not have employees during the entire preceding calendar year, is the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

(e) A small employer that makes enrollment in qualified health benefit plans available to its employees through the exchange and ceases to be a small employer by reason of an increase in the number of its employees continues to be a small employer for purposes of this chapter as long as it continuously makes enrollment through the exchange available to its employees.

Sec. 1509.004. RULEMAKING AUTHORITY. The board may adopt rules necessary and proper to implement this chapter. Rules adopted under this section may not conflict with or prevent the application of regulations promulgated by the secretary under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

Sec. 1509.005. AGENCY COOPERATION. (a) The exchange, the department, and the Health and Human Services Commission shall cooperate fully in performing their respective duties under this code or another law of this state relating to the operation of the exchange.

(b) The exchange and the Health and Human Services Commission shall cooperate fully to:

(1) ensure that the development of eligibility and enrollment systems for the exchange and its tax credits are fully integrated with the planning and development of the Health and

Human Services Commission's eligibility systems modernization efforts;

(2) ensure full and seamless interoperability and minimize duplication of cost and effort;

(3) develop and administer transition procedures that:

(A) address the needs of individuals and families who experience a change in income that results in a change in the source of coverage, with a particular emphasis on children and adults with special health care needs and chronic illnesses, conditions, and disabilities, as well as all individuals who are also enrolled in Medicare; and

(B) to the extent practicable under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), provide for the coordination of payments to Medicaid managed care organizations and qualified health plans that experience changes in enrollment resulting from changes in eligibility for Medicaid during an enrollment period;

(4) ensure consistent methods and standards, including formulas and verification methods, for prompt calculation of income based on individuals' modified adjusted gross incomes in order to guard against lapses in coverage and inconsistent eligibility determinations and procedures;

(5) ensure maximum access to federal data sources for the purpose of verifying income eligibility for Medicaid, the state child health plan program, premium tax credits, and cost-sharing reductions;

(6) ensure the prompt processing of applications and enrollment in the correct state subsidy program, regardless of whether the program is Medicaid, the state child health plan program, premium tax credits, or cost-sharing reductions;

(7) ensure procedures for transitioning individuals between Medicaid and tax-credit-based subsidies that protect individuals against delays in eligibility and plan enrollment;

(8) ensure rapid resolution of inconsistent information affecting eligibility and dissemination of clear and understandable information to applicants regarding the resolution process and any interim assistance that may be available while resolution is pending and procedures to assure that individuals are meaningfully informed of:

(A) the potential existence of overpayments of advance tax credits;

(B) procedures for reconciling enrollee liability for repayment in the event that an advance tax credit is subsequently proved to be an overpayment;

(C) procedures by which individuals can report a change in income that may affect the subsequent level of advance tax payment or the availability of a safe harbor; and

(D) information regarding safe harbors against overpayment liability or recoupment that may exist under federal or state law; and

(9) develop cross-market participation by:

(A) encouraging the development of common provider networks, network performance standards for health

benefit plans that participate in the exchange, Medicaid, and the state child health plan program, and developing coverage terms and quality standards in order to ensure maximum continuity and quality of care;

(B) promoting participation by health benefit plans that satisfy both qualified health plan and Medicaid managed care plan criteria, in order to minimize disruption in care as a result of enrollment shifts between subsidy sources;

(C) developing incentives, including quality ratings, default enrollment preferences, and other approaches, in order to encourage health benefit plans to participate in both Medicaid and the exchange; and

(D) coordinating health benefit plan payments and timely adjustments in all markets that may result from enrollment changes.

Sec. 1509.006. EXEMPTION FROM STATE TAXES AND FEES. The exchange is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Sec. 1509.007. COMPLIANCE WITH FEDERAL LAW. The exchange shall comply with all applicable federal law and regulations.

Sec. 1509.008. TEMPORARY EXEMPTION FROM STATE PURCHASING PROCEDURES. (a) The exchange is not subject to state purchasing or procurement requirements under Subtitle D, Title 10, Government Code, or any other law.

(b) This section expires January 1, 2016.

[Sections 1509.009-1509.050 reserved for expansion]

SUBCHAPTER B. ESTABLISHMENT AND GOVERNANCE

Sec. 1509.051. ESTABLISHMENT. The Texas Health Insurance Exchange is established as the American Health Benefit Exchange and the Small Business Health Options Program (SHOP) Exchange authorized and required by Section 1311, Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

Sec. 1509.052. GOVERNANCE OF EXCHANGE; BOARD MEMBERSHIP. (a) The exchange is governed by a board of directors.

(b) The board consists of seven members as follows:

(1) five appointed members:

(A) one of whom is appointed by the governor;

(B) two of whom are appointed by the lieutenant governor; and

(C) two of whom are appointed by the speaker of the house of representatives;

(2) the commissioner as an ex officio voting member; and

(3) the executive commissioner as an ex officio voting member.

(c) Each of the five board members appointed under Subsection (b)(1) must have demonstrated experience in at least two of the following areas:

(1) individual health care coverage;

(2) small employer health care coverage;

(3) health benefit plan administration;

(4) health care finance or economics;

(5) actuarial science;

(6) administration of a public or private health care delivery system; and

(7) purchasing health plan coverage.

(d) The board must include members who are health care consumers or small business owners.

(e) In making appointments under this section, the governor, lieutenant governor, and speaker of the house of representatives shall attempt to make appointments that increase the board's diversity of expertise.

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

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

(b) The appropriate appointing authority 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) Any board member or a member of a committee formed by the board with a direct interest in a matter, personally or through an employer, before the board shall abstain from deliberations and actions on the matter in which the conflict of interest arises and shall further abstain from any vote on the matter, and may not otherwise participate in a decision on the matter.

(b) Each board member shall file a conflict of interest statement and a statement of ownership interests with the board to ensure disclosure of all existing and potential personal interests

related to board business.

(c) A member of the board or of the staff of the exchange may not be employed by, affiliated with, a consultant to, a member of the board of directors of, or otherwise a representative of an issuer or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic while serving on the board or on the staff of the exchange.

(d) A member of the board or of the staff of the exchange may not be a member, a board member, or an employee of a trade association of issuers, health facilities, health clinics, or health care providers while serving on the board or on the staff of the exchange.

(e) A member of the board or of the staff of the exchange may not be a health care provider unless the member receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.

Sec. 1509.056. GENERAL DUTIES OF BOARD MEMBERS. (a) Each board member has the responsibility and duty to meet the requirements of this title and applicable state and federal laws and regulations, to serve the public interest of the individuals and small businesses seeking health care coverage through the exchange, and to ensure the operational well-being and fiscal solvency of the exchange.

(b) A member of the board may not make, participate in making, or in any way attempt to use the board member's official position to influence the making of any decision that the board

member knows or has reason to know will have a material financial effect, distinguishable from its effect on the public generally, on the board member or the board member's immediate family, or on:

(1) any source of income, other than gifts and loans by a commercial lending institution in the regular course of business on terms available to the public generally, aggregating $250 or more in value, provided or promised to the member within the 12 months immediately preceding the date the decision is made; or

(2) any business entity in which the member is a director, officer, partner, trustee, or employee, or holds any position of management.

Sec. 1509.057. REIMBURSEMENT. A member of the board is not entitled to compensation but is entitled to reimbursement for travel or other expenses incurred while performing duties as a board member in the amount provided by the General Appropriations Act for state officials.

Sec. 1509.058. MEMBER'S IMMUNITY. (a) A member of the board is not liable for an act or omission made in good faith in the performance of powers and duties under this chapter.

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

Sec. 1509.059. OPEN RECORDS AND OPEN MEETINGS. The board is subject to Chapters 551 and 552, Government Code.

Sec. 1509.060. RECORDS. The board shall keep records of the board's proceedings for at least seven years.

[Sections 1509.061-1509.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF EXCHANGE

Sec. 1509.101. EMPLOYEES; COMMITTEES. (a) The board may employ an executive director, a chief fiscal officer, a chief operations officer, a director of health plan contracting, a chief technology and information officer, a general counsel, and any other agents and employees that the board considers necessary to assist the exchange in carrying out its responsibilities and functions.

(b) The executive director shall organize, administer, and manage the operations of the exchange. The executive director may hire other employees as necessary to carry out the responsibilities of the exchange.

(c) The exchange may appoint appropriate legal, actuarial, and other committees necessary to provide technical assistance in operating the exchange and performing any of the functions of the exchange.

(d) The board shall set the salary for an agent or employee position under this section in an amount reasonably necessary to attract and retain individuals of superior qualifications. In determining the compensation for these positions, the board shall conduct, through the use of independent outside advisors, salary surveys of both other state and federal health insurance exchanges that are most comparable to the exchange and other relevant labor pools.

(e) The salaries established by the board under this section may not exceed the highest comparable salary for a position of that type, as determined by the salary surveys in Subsection (d).

(f) The board shall publish the salaries under this section in the board's annual budget and post the budget on an Internet website maintained by the exchange.

Sec. 1509.102. ADVISORY COMMITTEE. The board shall appoint an advisory committee to allow for the involvement of the health care and health insurance industries and other stakeholders in the operation of the exchange. The advisory committee may provide expertise and recommendations to the board but may not adopt rules or enter into contracts on behalf of the exchange.

Sec. 1509.103. CONTRACTS. (a) Except as provided by Subsection (b), the exchange may enter into any contract that the exchange considers necessary to implement or administer this chapter, including a contract with the Health and Human Services Commission or an entity that has experience in individual and small group health insurance, benefit administration, or other experience relevant to the responsibilities assumed by the entity, to perform functions or provide services in connection with the operation of the exchange.

(b) This exchange may not enter into a contract with a health benefit plan issuer under this section.

Sec. 1509.104. INFORMATION SHARING AND CONFIDENTIALITY. The exchange may enter into information-sharing agreements with federal and state agencies to carry out the exchange's responsibilities under this chapter. An agreement entered into under this section must include adequate protection with respect to the confidentiality of any information shared and comply with all applicable state and federal law.

Sec. 1509.105. MEMORANDUM OF UNDERSTANDING. The exchange shall enter into a memorandum of understanding with the department and the Health and Human Services Commission regarding the exchange of information and the division of regulatory functions among the exchange, the department, and the commission.

Sec. 1509.106. LEGAL ACTION. (a) The exchange may sue or be sued.

(b) The exchange may take any legal action necessary to recover or collect amounts due the exchange, including:

(1) assessments due the exchange;

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

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

Sec. 1509.107. FUNCTIONS. (a) The exchange shall make qualified health plans available to qualified individuals and qualified employers.

(b) The exchange may not make available any health benefit plan that is not a qualified health plan.

(c) The exchange may allow a health benefit plan issuer to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A), Internal Revenue Code of 1986, through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J), Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

(d) The exchange, or an issuer offering a health benefit

plan through the exchange, may not charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of Section 36B(c)(2)(C), Internal Revenue Code of 1986.

(e) In implementing the requirements of this section, the exchange 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, utilizing staff that is trained to provide assistance in a culturally and linguistically appropriate manner;

(3) provide oral interpretation services in any language for individuals seeking coverage through the exchange and make available a toll-free telephone number for the hearing and speech impaired;

(4) maintain an Internet website through which an enrollee or prospective enrollee may obtain standardized comparative information on a qualified health plan's premiums, coverage, cost-sharing, ratings, enrollee satisfaction, quality measures, and other relevant information;

(5) use a standardized format for presenting health benefit options in the exchange, including the use of the uniform

outline of coverage established under Section 2715, Public Health Service Act (42 U.S.C. Section 300gg-51);

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

(7) ensure that written information made available by the exchange is presented in a plainly worded, easily understandable format and made available in prevalent languages;

(8) determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under Section 1302(d)(2)(A), Patient Protection and Affordable Care Act (Pub. L. No. 111-148); and

(9) in accordance with federal law and regulations, inform individuals of eligibility requirements for Medicaid, the state child health plan program, or any applicable state or local public program and if through screening of the application by the exchange, the exchange determines that an individual is eligible for such program, enroll the individual in the program.

(f) In addition to performing the duties described by Subsection (e), and consistent with Section 1413, Patient Protection and Affordable Care Act (Pub. L. No. 111-148), the exchange shall:

(1) enter into data-sharing agreements with relevant state and federal agencies to facilitate eligibility determinations and enrollment;

(2) provide enrollment information and other relevant data, consistent with federal and state privacy rules, to the

qualified health plan in which a qualified individual or qualified small employer is enrolled;

(3) conduct redeterminations of eligibility for subsidies and assist in reenrollment as necessary, if an individual experiences changes in income or circumstances;

(4) inform individuals of the potential for overpayments of advance premium tax credits and of procedures by which individuals can report a change of income that may affect the subsequent level of premium tax credits, including the availability of any safe harbor from recoupment of any overpayment, to the extent permitted by that Act or any federal regulations promulgated under that Act;

(5) establish, and make available electronically, a calculator designed to:

(A) enable consumers to determine the actual cost of coverage after the application of any premium tax credit or cost-sharing subsidy available under federal law; and

(B) provide consumers with information on out-of-pocket costs for in-network and, if feasible, out-of-network services, taking into account any cost-sharing reductions;

(6) establish capability through which qualified employers may access coverage for their employees, and which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the exchange at the specified level of coverage;

(7) subject to Section 1411, Patient Protection and

Affordable Care Act (Pub. L. No. 111-148), grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A, Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(A) there is no affordable qualified health plan available through the exchange, or the individual's employer, covering the individual; or

(B) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(8) transfer to the United States secretary of the treasury the following:

(A) a list of the individuals who are issued a certification under Subdivision (7), including the name and taxpayer identification number of each individual;

(B) the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B, Internal Revenue Code of 1986, because the employer did not provide minimum essential coverage, or the employer provided the minimum essential coverage, but it was determined under Section 36B(c)(2)(C) of that code to be either unaffordable to the employee or not provide the required minimum actuarial value; and

(C) the name and taxpayer identification number of each individual who notifies the exchange under Section 1411(b)(4), Patient Protection and Affordable Care Act (Pub. L. No.

111-148), that he or she has changed employers and each individual who ceases coverage under a qualified health plan during a plan year, and the effective date of that cessation;

(9) provide to each employer the name of each employee of the employer described above who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(10) perform duties required of the exchange by the secretary or the United States secretary of the treasury related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

(11) select entities qualified to serve as Navigators in accordance with Section 1311(i), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and standards developed by the secretary; and

(12) award grants to enable Navigators to:

(A) conduct public education activities to raise awareness of the availability of qualified health plans;

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B, Internal Revenue Code of 1986, and cost-sharing reductions under Section 1402, Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(C) facilitate enrollment in qualified health plans;

(D) provide referrals to any applicable office of

health insurance consumer assistance or health insurance ombudsman established under Section 2793, Public Health Service Act (42 U.S.C. Section 300gg-93), or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan or coverage or a determination under that plan or coverage;

(E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange; and

(F) counsel exchange participants about the exchange, Medicaid, and the state child health plan program markets, including selection of plans and transition procedures for transitioning among Medicaid, the state child health plan program, exchange plans, and other coverage;

(13) ensure that there is a sufficient number of Navigators that possess the experience and capacity to serve disadvantaged, hard-to-reach, and culturally or linguistically isolated populations;

(14) certify Navigators as able to carry out the duties required by Section 1311(i)(3), Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(15) review the rate of premium growth within the exchange and outside the exchange and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

(16) credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is

enrolled, in accordance with Section 10108, Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and collect the amount credited from the offering employer;

(17) consult with stakeholders relevant to carrying out the activities required under this chapter, including:

(A) educated health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) the Health and Human Services Commission; and

(E) advocates for enrolling hard-to-reach populations;

(18) meet the following financial integrity requirements:

(A) keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the secretary, the governor, the commissioner, and the legislature a report concerning such accountings; and

(B) fully cooperate with any investigation conducted by the secretary pursuant to the secretary's authority under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and allow the secretary, in coordination with the inspector general of the United States Department of Health and Human Services, to investigate the affairs of the exchange, examine the books and records of the exchange, and require periodic reports

in relation to the activities undertaken by the exchange;

(19) use a single application for enrollment in Medicaid, the state child health plan program, and health benefit plans offered in the exchange, including establishing eligibility for premium tax credits and cost-sharing reductions, that may be:

(A) the single application form developed by the secretary under Section 1413(b), Patient Protection and Affordable Care Act (Pub. L. No. 111-148); or

(B) an application form developed in cooperation with the Health and Human Services Commission for that purpose;

(20) undertake activities necessary to market and publicize the availability of health care coverage and federal subsidies through the exchange;

(21) undertake outreach and enrollment activities that seek to assist enrollees and potential enrollees with enrolling and reenrolling in the exchange in the least burdensome manner, including populations that may experience barriers to enrollment, such as the disabled and those with limited English language proficiency;

(22) provide for:

(A) the processing of applications for coverage under a qualified health plan;

(B) the enrollment of persons in qualified health plans;

(C) the disenrollment of enrollees from qualified health plans; and

(D) for individual coverage, the collection of

premiums and assistance in the administration of subsidies, as the board considers appropriate; and

(23) for small employers, collect and aggregate premiums and administer all other necessary and related tasks, including enrollment and plan payment, in order to make the offering of employee plan choice as simple as possible for qualified small employers.

Sec. 1509.108. CERTIFICATION OF PLAN. The exchange shall certify a health benefit plan as a qualified health plan if:

(1) the plan provides the essential health benefits package described by Section 1302(a), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, if:

(A) the exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(B) the issuer makes prominent disclosure at the time it offers the plan, in a form approved by the exchange, that the plan does not provide the full range of essential pediatric benefits and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the exchange;

(2) the premium rates and contract language have been approved by the commissioner;

(3) the plan provides at least a bronze level of coverage, as described by Section 1302(d), Patient Protection and

Affordable Care Act (Pub. L. No. 111-148), unless the plan is a catastrophic plan and is offered only to individuals eligible for catastrophic coverage;

(4) the plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and if the plan is offered to small employers, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of that Act;

(5) the health benefit plan issuer offering the plan:

(A) is licensed and in good standing to offer health insurance coverage in this state;

(B) offers at least one qualified health plan in the silver level and at least one plan in the gold level as described by Section 1302(d), Patient Protection and Affordable Care Act (Pub L. No. 111-148);

(C) charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the exchange and without regard to whether the plan is offered directly from the issuer or through an insurance producer; and

(D) complies with the regulations developed by the secretary under Section 1311(d), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and other requirements the exchange establishes;

(6) the plan meets the requirements of certification under this chapter and any rules promulgated by the secretary under Section 1311(c), Patient Protection and Affordable Care Act (Pub.

L. No. 111-148), including minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health benefit plan performance; and

(7) the exchange determines that making the plan available through the exchange is in the interest of qualified individuals and qualified employers in this state.

Sec. 1509.109. PROHIBITED BASES FOR DENIAL OF CERTIFICATION. The exchange may not deny certification to a health benefit plan on the ground that the plan:

(1) is a fee-for-service plan; or

(2) provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

Sec. 1509.110. PREREQUISITES TO CERTIFICATION. (a) The exchange shall require each health benefit plan issuer seeking certification of a plan as a qualified health plan to:

(1) submit a justification for any premium increase before implementation of that increase;

(2) prominently display the justification for any premium increase on the health benefit plan issuer's Internet website;

(3) make available to the public, in plain language as that term is defined in Section 1311(e)(3)(B), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and submit to the

exchange, the secretary, and the commissioner, accurate and timely disclosure of:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment;

(D) data on disenrollment;

(E) data on the number of claims that are denied;

(F) data on rating practices;

(G) information on cost-sharing and payments with respect to any out-of-network coverage;

(H) information on enrollee and participant rights under Title I, Patient Protection and Affordable Care Act (Pub. L. No. 111-148); and

(I) other information as determined appropriate by the secretary;

(4) on request, inform an individual of the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider;

(5) make the information required to be disclosed under Subdivision (4) made available to the individual on an Internet website and by other means for individuals without access to the Internet;

(6) promptly notify affected individuals of price and benefit changes or other changes in circumstance that could materially impact enrollment or coverage;

(7) make available to the exchange and regularly update an electronic directory of contracting health care providers so that individuals seeking coverage through the exchange can search by health care provider name to determine which health plans in the exchange include that health care provider in their network; and

(8) as the board considers necessary, provide regularly updated information to the exchange as to whether a health care provider is accepting new patients for a particular health plan.

(b) In determining whether to certify an issuer, the exchange shall consider premium increase justification information obtained under Subsection (a), together with information and recommendations provided by the commissioner under Section 2794(b), Public Health Service Act (42 U.S.C. Section 300gg-94(b)).

Sec. 1509.111. ADDITIONAL REQUIREMENTS RELATING TO RULEMAKING BY BOARD. In adopting rules under this chapter, the board shall:

(1) standardize benefits and cost-sharing within tiers for products to be offered through the exchange;

(2) establish and use a competitive process, which is not required to comply with Chapter 2151, Government Code, to select participating health benefit plan issuers;

(3) determine the minimum requirements an issuer must meet to be considered for participation in the exchange and the standards and criteria for selecting qualified health plans to be offered through the exchange that are in the best interests of

qualified individuals and qualified small employers;

(4) consistently and uniformly apply any requirements, standards, and criteria under this chapter to all issuers;

(5) in the course of selectively contracting for health care coverage offered to qualified individuals and qualified small employers through the exchange, seek to contract with issuers to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service;

(6) ensure, in each region of the state, a choice of qualified health plans at each of the five tiers of coverage contained in Sections 1302(d) and (e), Patient Protection and Affordable Care Act (Pub. L. No. 111-148);

(7) require issuers, as a condition of participation in the exchange, to fairly and affirmatively offer, market, and sell in the exchange at least one product within each of the five levels of coverage described by Sections 1302(d) and (e), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and, as the board considers necessary, to offer additional products within each of the five levels of coverage described by Section 1302(d) of that Act; and

(8) require, as a condition of participation in the exchange, issuers that sell any products outside the exchange to fairly and affirmatively offer, market, and sell:

(A) all products made available to individuals in the exchange to individuals purchasing coverage outside the exchange; or

(B) all products made available to small employers in the exchange to small employers purchasing coverage outside the exchange.

Sec. 1509.112. EXEMPTION FROM STANDARDS PROHIBITED. (a) The exchange may not exempt any health benefit plan issuer seeking certification of a qualified health plan, regardless of the type or size of the issuer, from state licensing or solvency requirements.

(b) The exchange shall apply the criteria of this section in a manner that assures a fair competitive market between or among health benefit plan issuers participating in the exchange.

Sec. 1509.113. DENTAL PLANS. (a) This chapter applies to dental plans as provided in this section.

(b) A health benefit plan issuer may be certified to offer dental coverage, without being certified to offer other health coverages.

(c) A plan may be limited to dental and oral health benefits without substantially duplicating the benefits typically offered by health benefit plans that do not offer dental coverage.

(d) To be certified under this chapter, a dental plan must include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to Section 1302(b)(1)(J), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), and any other dental benefits the exchange or the secretary specifies by regulation.

(e) An issuer may offer jointly with another issuer a comprehensive plan through the exchange in which dental benefits are provided by an issuer through a qualified dental plan and the

other benefits are provided by an issuer through a qualified health plan. Plans offered under this subsection must be priced separately and made available for purchase separately at the same price at which they are offered together.

Sec. 1509.114. (a) The exchange may provide an integrated and uniform consumer directory of health care providers indicating which health benefit plan issuers the providers contract with and whether the providers are currently accepting new patients.

(b) The exchange may establish methods by which health care providers may transmit relevant information directly to the exchange, rather than through an issuer.

[Sections 1509.115-1509.150 reserved for expansion]

SUBCHAPTER D. ASSESSMENTS FOR OPERATION OF EXCHANGE

Sec. 1509.151. ASSESSMENTS; PENALTY FOR NONPAYMENT. (a) The exchange may charge the issuers of health benefit plans in this state, including qualified health plans, an assessment as reasonable and necessary for the exchange's organizational and operating expenses. Assessments must be determined annually. The exchange may charge interest for late assessments.

(b) The exchange 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.

(c) The commissioner shall adopt rules to implement and enforce the assessment of health benefit plan issuers under this section.

Sec. 1509.152. GRANTS AND FEDERAL FUNDS. (a) The exchange 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 exchange may accept federal funds and shall use those funds in compliance with applicable federal law, regulations, and guidelines.

Sec. 1509.153. USE OF EXCHANGE ASSETS; ANNUAL REPORT. (a) The assets of the exchange may be used only to pay the costs of the administration and operation of the exchange.

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

(c) General revenue may not be appropriated for the exchange.

Sec. 1509.154. PUBLICATION OF FINANCIAL INFORMATION. The exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, and the administrative costs of the exchange, on an Internet website to educate consumers on those costs. This information must include information on losses due to waste, fraud, and abuse.

[Sections 1509.155-1509.200 reserved for expansion]

SUBCHAPTER E. TRUST FUND

Sec. 1509.201. TRUST FUND. (a) The exchange 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 exchange may deposit assessments, gifts or donations, and any federal funding obtained by the exchange in the exchange 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.

[Sections 1509.202-1509.250 reserved for expansion]

SUBCHAPTER F. LEVEL PLAYING FIELD

Sec. 1509.251. LEVEL PLAYING FIELD. (a) The commissioner shall adopt rules to ensure a level playing field and a fair competitive market environment among issuers that offer qualified health plans through the exchange and issuers that offer health benefit plans or other health insurance coverage outside of the exchange. Notwithstanding any other law, the rules shall, to the extent practicable, ensure against adverse selection either in favor of or against exchange-participating issuers.

(b) To discourage adverse selection or steering of enrollees to or from the exchange, if the board opts to pay agents helping people enroll in exchange-participating, qualified plans a fee, instead of using existing compensation structures directly from issuers, the exchange shall survey the market outside of the exchange to determine prevailing agent commission rates and set exchange fees in a manner that is consistent with prevailing rates in the market outside of the exchange. This section does not

prohibit the exchange from paying a per member per month fee or using another fee structure if:

(1) prevailing rates in the market outside of the exchange are paid a percentage of premiums; and

(2) the total fee amounts earned are reasonably expected to be similar.

(c) The department shall coordinate with the exchange as necessary to survey the market on commission rates and identify prevailing practices. Agent fees paid inside or outside of the exchange must be fully transparent and clearly disclosed to the purchaser.

SECTION 1.02. Effective January 1, 2014, Section 1509.004, Insurance Code, as added by this Act, is amended by adding Subsection (a-1) to read as follows:

(a-1) For purposes of this chapter, "small employer" means a person who employed an average of not more than 100 employees during the preceding calendar year.

SECTION 1.03. (a) As soon as practicable after the effective date of this Act, but not later than October 31, 2011, the governor, lieutenant governor, and speaker of the house of representatives shall appoint the initial members of the board of directors of the Texas Health Insurance Exchange.

(b) As soon as practicable 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 Exchange 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 practicable after the effective date of this Act, but not later than January 31, 2012, the board of directors of the Texas Health Insurance Exchange shall adopt rules and procedures necessary to implement Chapter 1509, Insurance Code, as added by this Act.

(d) Not later than January 1, 2017, the board shall issue a report to the 85th Legislature recommending whether to adopt the option in Section 1312(c), Patient Protection and Affordable Care Act (Pub. L. No. 111-148), to merge the individual and small employer markets. In the report, the board shall provide information, based on at least two years of data from the exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained.

(e) If, after the effective date of this Act but before the initial members of the board of directors of the Texas Health Insurance Exchange have been appointed as required by Subsection (a), the Texas Department of Insurance becomes aware of any planning and establishment grants as described by Section 1311, Patient Protection and Affordable Care Act (Pub. L. No. 111-148), or any other public or private funding source, the department may apply for funding from that source.

(f) The exchange may not begin operations without adequate funding.

(g) The board of directors of the Texas Health Insurance

Exchange may adopt rules on an emergency basis in accordance with Section 2001.034, Government Code. Notwithstanding Section 2001.034(c), Government Code, a rule adopted under this subsection may remain in effect until January 1, 2015. Rules adopted under this subsection shall be deemed necessary for the immediate preservation of the public peace, health, safety, and general welfare and an additional finding under Sections 2001.034(a)(1) and (2), Government Code, is not required. The authority to adopt rules under this subsection expires January 1, 2015.

ARTICLE 2. EMERGENCY COVERAGE UNDER CERTAIN MANAGED CARE PLANS

SECTION 2.01. Section 843.107, Insurance Code, is amended to read as follows:

Sec. 843.107. INDEMNITY BENEFITS; POINT-OF-SERVICE PROVISIONS. (a) A health maintenance organization may offer:

(1) indemnity benefits covering out-of-area emergency care;

(2) indemnity benefits, in addition to those relating to out-of-area and emergency care, provided through an insurer or group hospital service corporation;

(3) a point-of-service plan under Subchapter A, Chapter 1273; or

(4) a point-of-service rider under Section 843.108.

(b) A health maintenance organization that offers indemnity benefits covering out-of-area emergency care under this section shall apply the same cost-sharing requirement to the emergency care as it applies to emergency care provided in-area.

SECTION 2.02. Section 843.348, Insurance Code, is amended

by adding Subsection (k) to read as follows:

(k) A health maintenance organization may not require preauthorization for emergency care.

SECTION 2.03. Sections 1271.155(a) and (b), Insurance Code, are amended to read as follows:

(a) A health maintenance organization shall pay for emergency care performed by non-network physicians or providers at the same rate the health maintenance organization pays for emergency care performed by network physicians or providers [~~at the usual and customary rate or at an agreed rate~~].

(b) A health care plan of a health maintenance organization must provide the following coverage of emergency care:

(1) a medical screening examination or other evaluation required by state or federal law necessary to determine whether an emergency medical condition exists shall be provided to covered enrollees in a hospital emergency facility or comparable facility;

(2) necessary emergency care shall be provided to covered enrollees, including the treatment and stabilization of an emergency medical condition; [~~and~~]

(3) services originated in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility following treatment or stabilization of an emergency medical condition shall be provided to covered enrollees as approved by the health maintenance organization, subject to Subsections (c) and (d); and

(4) as required by Section 1867, Social Security Act

(42 U.S.C. Section 1395dd), medical screening examinations that are within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the patient's condition and any further medical examination and treatment necessary to stabilize the patient within the capabilities of the staff and facilities available at the hospital shall be provided to covered enrollees.

SECTION 2.04. Section 1273.004, Insurance Code, is amended to read as follows:

Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING PROVISIONS. (a) Indemnity benefits and services provided under a point-of-service plan may be limited to those services described by the blended contract and may be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits may be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing may be imposed only when the enrollee obtains benefits or services outside the health maintenance organization delivery network.

(b) Notwithstanding Subsection (a), indemnity benefits and services provided under a point-of-service plan that covers emergency care may not be subject to different cost-sharing provisions. The cost-sharing provisions for indemnity benefits related to emergency care may not be higher than the cost-sharing provisions for in-network health maintenance organization coverage. For an enrollee in a limited provider network, higher cost-sharing provisions may not be imposed when the enrollee

obtains emergency care outside the health maintenance organization delivery network.

SECTION 2.05. Section 1301.135, Insurance Code, is amended by adding Subsection (i) to read as follows:

(i) An insurer that uses a preauthorization process for medical care and health care services may not require preauthorization for emergency care.

SECTION 2.06. Section 1301.155(b), Insurance Code, is amended to read as follows:

(b) If an insured cannot reasonably reach a preferred provider, an insurer shall provide reimbursement for the following emergency care services at the preferred level of benefits until the insured can reasonably be expected to transfer to a preferred provider:

(1) a medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a hospital that is necessary to determine whether a medical emergency condition exists;

(2) necessary emergency care services, including the treatment and stabilization of an emergency medical condition; [~~and~~]

(3) services originating in a hospital emergency facility or freestanding emergency medical care facility following treatment or stabilization of an emergency medical condition; and

(4) as required by Section 1867, Social Security Act (42 U.S.C. Section 1395dd), medical screening examinations that are within the capability of the emergency department of a hospital,

including ancillary services routinely available to the emergency department to evaluate the patient's condition and any further medical examination and treatment necessary to stabilize the patient within the capabilities of the staff and facilities available at the hospital.

SECTION 2.07. The changes in law made by this article apply only to a health insurance policy or contract or health maintenance organization contract or agreement that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health insurance policy or contract or health maintenance organization contract or agreement that is delivered, issued for delivery, or renewed before January 1, 2012, is covered by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 3. SELECTION OF PRIMARY CARE PHYSICIANS AND PROVIDERS UNDER PREFERRED PROVIDER BENEFIT PLANS AND HEALTH MAINTENANCE ORGANIZATIONS

SECTION 3.01. Section 843.203, Insurance Code, is amended by amending Subsection (b) and adding Subsections (d) and (e) to read as follows:

(b) An enrollee shall at all times have the right to select or change a primary care physician or primary care provider within the health maintenance organization network of available primary care physicians and primary care providers[~~, except that a health maintenance organization may limit an enrollee's request to change physicians or providers to not more than four changes in a 12-month period~~]. An enrollee may designate any participating primary care

physician or primary care provider who is available to accept the individual.

(d) For an enrollee who is a child, the health maintenance organization must allow the child's parent or guardian to designate as the child's primary care physician or primary care provider a participating physician who specializes in pediatrics.

(e) A health maintenance organization shall notify each enrollee of the enrollee's rights under Subsections (b) and (d).

SECTION 3.02. Subchapter D, Chapter 1301, Insurance Code, is amended by adding Section 1301.164 to read as follows:

Sec. 1301.164. SELECTION OF PRIMARY CARE PHYSICIAN OR PROVIDER. (a) If a preferred provider benefit plan requires or provides for designation by an insured of a participating primary care physician or primary care provider, the insurer shall allow an insured to designate any participating primary care physician or primary care provider who is available to accept the individual.

(b) For an enrollee who is a child, the insurer must allow the child's parent or guardian to designate as the child's primary care physician or primary care provider a participating physician who specializes in pediatrics.

(c) An insurer shall notify each insured of the insured's rights under this section.

SECTION 3.03. The change in law made by this article applies only to a health insurance policy or contract or health maintenance organization contract or agreement that is delivered or issued for delivery on or after January 1, 2012. An insurance policy or contract or health maintenance organization contract or agreement

that is delivered or issued for delivery before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 4. HEALTH BENEFIT PLAN COVERAGE OF CERTAIN DEPENDENTS

SECTION 4.01. Section 846.260, Insurance Code, is amended to read as follows:

Sec. 846.260. LIMITING AGE APPLICABLE TO UNMARRIED CHILD. If children are eligible for coverage under the terms of a multiple employer welfare arrangement's plan document, any limiting age applicable to an unmarried child of an enrollee is 26 [~~25~~] years of age.

SECTION 4.02. Section 1201.053(b), Insurance Code, is amended to read as follows:

(b) On the application of an adult member of a family, an individual accident and health insurance policy may, at the time of original issuance or by subsequent amendment, insure two or more eligible members of the adult's family, including a spouse, unmarried children younger than 26 [~~25~~] years of age, including a grandchild of the adult as described by Section 1201.062(a)(1), a child the adult is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court in this state, a foster child, a stepchild, a child of a domestic partner if the domestic partner is eligible to be insured and is insured under the policy, and any other individual dependent on the adult.

SECTION 4.03. Section 1201.062(a), Insurance Code, is

amended to read as follows:

(a) An individual or group accident and health insurance policy that is delivered, issued for delivery, or renewed in this state, including a policy issued by a corporation operating under Chapter 842, or a self-funded or self-insured welfare or benefit plan or program, to the extent that regulation of the plan or program is not preempted by federal law, that provides coverage for a child of an insured or group member, on payment of a premium, must provide coverage for:

(1) each grandchild of the insured or group member if the grandchild is:

(A) unmarried;

(B) younger than 26 [~~25~~] years of age; and

(C) a dependent of the insured or group member for federal income tax purposes at the time application for coverage of the grandchild is made; and

(2) each child for whom the insured or group member must provide medical support under an order issued under Chapter 154, Family Code, or enforceable by a court in this state.

SECTION 4.04. Section 1201.065(a), Insurance Code, is amended to read as follows:

(a) An individual or group accident and health insurance policy may contain criteria relating to a maximum age or enrollment in school to establish continued eligibility for coverage of a child 26 [~~25~~] years of age or older.

SECTION 4.05. Section 1251.151(a), Insurance Code, is amended to read as follows:

(a) A group policy or contract of insurance for hospital, surgical, or medical expenses incurred as a result of accident or sickness, including a group contract issued by a group hospital service corporation, that provides coverage under the policy or contract for a child of an insured must, on payment of a premium, provide coverage for any grandchild of the insured if the grandchild is:

(1) unmarried;

(2) younger than 26 [~~25~~] years of age; and

(3) a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

SECTION 4.06. Section 1251.152(a), Insurance Code, is amended to read as follows:

(a) For purposes of this section:

(1) "Child," with respect to an individual, includes the individual's stepchild or foster child or a child of the individual's domestic partner if the domestic partner is eligible for coverage and is covered under the group policy or contract.

(2) "Dependent" [~~, "dependent"~~] includes:

(A) [~~(1)~~] a child of an employee or member who is:

(i) [~~(A)~~] unmarried; and

(ii) [~~(B)~~] younger than 26 [~~25~~] years of age; and

(B) [~~(2)~~] a grandchild of an employee or member who is:

(i) [~~(A)~~] unmarried;

(ii) [~~(B)~~] younger than 26 [~~25~~] years of age; and

(iii) [~~(C)~~] a dependent of the insured for federal income tax purposes at the time the application for coverage of the grandchild is made.

SECTION 4.07. Section 1271.006(a), Insurance Code, is amended to read as follows:

(a) If children are eligible for coverage under the terms of an evidence of coverage, any limiting age applicable to an unmarried child of an enrollee, including an unmarried grandchild of an enrollee, a stepchild of an enrollee, a child of an enrollee's domestic partner if the domestic partner is eligible to be enrolled and is enrolled, an adopted child of an enrollee, and a foster child of an enrollee, is 26 [~~25~~] years of age. The limiting age applicable to a child must be stated in the evidence of coverage.

SECTION 4.08. Section 1501.002(2), Insurance Code, is amended to read as follows:

(2) "Dependent" means:

(A) a spouse;

(B) a child younger than 26 [~~25~~] years of age, including a newborn child;

(C) a child of any age who is:

(i) medically certified as disabled; and

(ii) dependent on the parent;

(D) an individual who must be covered under:

(i) Section 1251.154; or

(ii) Section 1201.062; and

(E) any other child eligible under an employer's health benefit plan, including a child described by Section 1503.003, a stepchild, a child of an employee's domestic partner if the domestic partner is eligible to receive and does receive coverage under the plan, or a foster child.

SECTION 4.09. Section 1501.609(b), Insurance Code, is amended to read as follows:

(b) Any limiting age applicable under a large employer health benefit plan to an unmarried child of an enrollee is 26 [~~25~~] years of age.

SECTION 4.10. Sections 1503.003(a) and (b), Insurance Code, are amended to read as follows:

(a) A health benefit plan may not condition coverage for a child younger than 26 [~~25~~] years of age on the child's being enrolled at an educational institution.

(b) A health benefit plan that requires as a condition of coverage for a child 26 [~~25~~] years of age or older that the child be a full-time student at an educational institution must provide the coverage:

(1) for the entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child's academic status to less than that of a full-time student; and

(2) continuously until the 10th day of instruction of the subsequent academic term, on which date the health benefit plan

may terminate coverage for the child if the child does not return to full-time student status before that date.

SECTION 4.11. Section 1506.003, Insurance Code, is amended to read as follows:

Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter:

(1) "Child," with respect to an individual, includes the individual's stepchild or foster child.

(2) "Dependent" [~~, "dependent"~~] means:

(A) [~~(1)~~] a resident spouse or unmarried child younger than 26 [~~25~~] years of age; or

(B) [~~(2)~~] a child who is:

(i) [~~(A)~~] a full-time student younger than 26 [~~25~~] years of age who is financially dependent on the parent;

(ii) [~~(B)~~] 18 years of age or older and is an individual for whom a person may be obligated to pay child support; or

(iii) [~~(C)~~] disabled and dependent on the parent regardless of the age of the child.

SECTION 4.12. Section 1506.158(a), Insurance Code, is amended to read as follows:

(a) An individual's pool coverage ends:

(1) on the date the individual ceases to be a legally domiciled resident of this state, unless the individual:

(A) is a student younger than 26 [~~25~~] years of age and is financially dependent on a parent covered by the pool;

(B) is a child for whom an individual covered by the pool may be obligated to pay child support; or

(C) is a child who is disabled and dependent on a parent covered by the pool, regardless of the age of the child;

(2) on the first day of the month following the date the individual requests coverage to end;

(3) on the date the individual covered by the pool dies;

(4) on the date state law requires cancellation of the coverage;

(5) at the option of the pool, on the 31st day after the date the pool sends to the individual any inquiry concerning the individual's eligibility, including an inquiry concerning the individual's residence, to which the individual does not reply;

(6) on the 31st day after the date a premium payment for pool coverage becomes due if the payment is not made before that day;

(7) on the date the individual is 65 years of age and eligible for coverage under Medicare, unless the coverage received from the pool is Medicare supplement coverage issued by the pool; or

(8) at the time the individual ceases to meet the eligibility requirements for coverage.

SECTION 4.13. Section 1551.004(a), Insurance Code, is amended to read as follows:

(a) In this chapter, "dependent" with respect to an individual eligible to participate in the group benefits program under Section 1551.101 or 1551.102 means the individual's:

(1) spouse;

(2) unmarried child younger than 26 [~~25~~] years of age;

(3) child of any age who the board of trustees determines lives with or has the child's care provided by the individual on a regular basis if:

(A) the child is mentally retarded or physically incapacitated to the extent that the child is dependent on the individual for care or support, as determined by the board of trustees;

(B) the child's coverage under this chapter has not lapsed; and

(C) the child is at least 26 [~~25~~] years old and was enrolled as a participant in the health benefits coverage under the group benefits program on the date of the child's 26th [~~25th~~] birthday;

(4) child of any age who is unmarried, for purposes of health benefit coverage under this chapter, on expiration of the child's continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) and its subsequent amendments; and

(5) ward, as that term is defined by Section 601, Texas Probate Code.

SECTION 4.14. Section 1551.158(a), Insurance Code, is amended to read as follows:

(a) A dependent child who is unmarried and whose coverage under this chapter ends when the child becomes 26 [~~25~~] years of age may, on expiration of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272), reinstate health benefit plan coverage under this chapter if the

child, or the child's participating parent or guardian, pays the full cost of the health benefit plan coverage.

SECTION 4.15. Section 1575.003(1), Insurance Code, is amended to read as follows:

(1) "Dependent" means:

(A) the spouse of a retiree;

(B) an unmarried child of a retiree or deceased active member if the child is younger than 26 [~~25~~] years of age, including:

(i) an adopted child;

(ii) a foster child, stepchild, or other child who is in a regular parent-child relationship; or

(iii) a recognized natural child;

(C) a retiree's recognized natural child, adopted child, foster child, stepchild, or other child who is in a regular parent-child relationship and who lives with or has his or her care provided by the retiree or surviving spouse on a regular basis regardless of the child's age, if the child is mentally retarded or physically incapacitated to an extent that the child is dependent on the retiree or surviving spouse for care or support, as determined by the trustee; or

(D) a deceased active member's recognized natural child, adopted child, foster child, stepchild, or other child who is in a regular parent-child relationship, without regard to the age of the child, if, while the active member was alive, the child:

(i) lived with or had the child's care

provided by the active member on a regular basis; and

(ii) was mentally retarded or physically incapacitated to an extent that the child was dependent on the active member or surviving spouse for care or support, as determined by the trustee.

SECTION 4.16. Section 1579.004, Insurance Code, is amended to read as follows:

Sec. 1579.004. DEFINITION OF DEPENDENT. In this chapter, "dependent" means:

(1) a spouse of a full-time employee or part-time employee;

(2) an unmarried child of a full-time or part-time employee if the child is younger than 26 [~~25~~] years of age, including:

(A) an adopted child;

(B) a foster child, stepchild, or other child who is in a regular parent-child relationship; and

(C) a recognized natural child;

(3) a full-time or part-time employee's recognized natural child, adopted child, foster child, stepchild, or other child who is in a regular parent-child relationship and who lives with or has his or her care provided by the employee or the surviving spouse on a regular basis, regardless of the child's age, if the child is mentally retarded or physically incapacitated to an extent that the child is dependent on the employee or surviving spouse for care or support, as determined by the board of trustees; and

(4) notwithstanding any other provision of this code, any other dependent of a full-time or part-time employee specified by rules adopted by the board of trustees.

SECTION 4.17. Section 1601.004(a), Insurance Code, is amended to read as follows:

(a) In this chapter, "dependent," with respect to an individual eligible to participate in the uniform program under Section 1601.101 or 1601.102, means the individual's:

(1) spouse;

(2) unmarried child younger than 26 [~~25~~] years of age; and

(3) child of any age who lives with or has the child's care provided by the individual on a regular basis if the child is mentally retarded or physically incapacitated to the extent that the child is dependent on the individual for care or support, as determined by the system.

SECTION 4.18. The changes in law made by this article apply only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2012, is covered by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 5. RESCISSION OF HEALTH BENEFIT PLAN

SECTION 5.01. Chapter 1202, Insurance Code, is amended by adding Subchapter C to read as follows:

SUBCHAPTER C. RESCISSION OF HEALTH BENEFIT PLAN

Sec. 1202.101. DEFINITION. In this subchapter, "rescission" means the termination of an insurance agreement, contract, evidence of coverage, insurance policy, or other similar coverage document in which the health benefit plan issuer, as applicable, refunds premium payments or demands the recoupment of any benefit already paid under the plan.

Sec. 1202.102. APPLICABILITY. (a) This subchapter applies only to a health benefit plan, including a small or large employer health benefit plan written under Chapter 1501, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) a reciprocal exchange operating under Chapter 942;

(6) a Lloyd's plan operating under Chapter 941;

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

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

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

(b) This subchapter does not apply to:

(1) a health benefit plan that provides coverage:

(A) only for a specified disease or for another limited benefit other than an accident policy;

(B) only for accidental death or dismemberment;

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

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

(E) for credit insurance;

(F) only for dental or vision care;

(G) only for hospital expenses; or

(H) 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), as amended;

(3) a workers' compensation insurance policy;

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

(5) a long-term care insurance policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so

comprehensive that the policy is a health benefit plan described by Subsection (a);

(6) a Medicaid managed care plan offered under Chapter 533, Government Code;

(7) any policy or contract of insurance with a state agency, department, or board providing health services to eligible individuals under Chapter 32, Human Resources Code; or

(8) a child health plan offered under Chapter 62, Health and Safety Code, or a health benefits plan offered under Chapter 63, Health and Safety Code.

Sec. 1202.103. RESCISSION PROHIBITED; EXCEPTION. (a) Notwithstanding any other law, except as provided by Subsection (b), a health benefit plan issuer may not rescind coverage under a health benefit plan with respect to an enrollee in the plan.

(b) A health benefit plan issuer may rescind coverage under a health benefit plan with respect to an enrollee if the enrollee engages in conduct that constitutes fraud or makes an intentional misrepresentation of a material fact.

Sec. 1202.104. NOTICE OF INTENT TO RESCIND. (a) A health benefit plan issuer may not rescind a health benefit plan on the basis of a material misrepresentation without first notifying the affected enrollee in writing of the issuer's intent to rescind the health benefit plan.

(b) The notice required under Subsection (a) must include, as applicable:

(1) the principal reasons for the decision to rescind the health benefit plan;

(2) the date on which the rescission is effective and the prior date to which the rescission retroactively reaches;

(3) an itemized list of any pending or paid claims the health benefit plan issuer intends to recoup following the rescission;

(4) an explanation of how the enrollee may obtain any documentation used by the health benefit plan issuer to justify the rescission;

(5) a statement that the enrollee is entitled to appeal a rescission decision to an independent review organization and that the health benefit plan issuer bears the burden of proof on appeal;

(6) an explanation of any time limit with which the enrollee must comply to appeal the rescission decision to an independent review organization, and a description of the consequences of failure to appeal within that time limit; and

(7) a statement that there is no cost to the individual to appeal the rescission decision to an independent review organization.

Sec. 1202.105. INDEPENDENT REVIEW PROCESS; PAYMENT OF CLAIMS. (a) An enrollee may appeal a health benefit plan issuer's rescission decision to an independent review organization in the manner prescribed by the commissioner by rule.

(b) A health benefit plan issuer shall comply with all requests for information made by the independent review organization and with the independent review organization's determination regarding the appropriateness of the issuer's

decision to rescind.

(c) A health benefit plan issuer shall pay all otherwise valid medical claims under an individual's plan until the later of:

(1) the date on which an independent review organization determines that the decision to rescind is appropriate; or

(2) the time to appeal to an independent review organization has expired without an affected individual initiating an appeal.

(d) The commissioner shall adopt rules necessary to implement and enforce this section, including rules establishing certification standards for independent review organizations for purposes of this chapter.

Sec. 1202.106. BURDEN OF PROOF. In an appeal to an independent review organization under Section 1202.105 or an enforcement action or cause of action based on a violation of this subchapter by a health benefit plan issuer, the health benefit plan issuer must prove that the issuer did not violate this subchapter.

SECTION 5.02. The change in law made by this article applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 6. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN CHILDREN

SECTION 6.01. Subtitle G, Title 8, Insurance Code, is

amended by adding Chapter 1521 to read as follows:

CHAPTER 1521. COVERAGE FOR CHILDREN; PREEXISTING CONDITIONS; ENROLLMENT IN PLANS

Sec. 1521.001. DEFINITION. In this chapter, "preexisting condition" means a condition present before the effective date of an individual's coverage under a health benefit plan.

Sec. 1521.002. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) an exchange operating under Chapter 942;

(6) a health maintenance organization operating under 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) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this chapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(e) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small or large employer health benefit plan subject to Chapter 1501.

(f) Notwithstanding Section 1507.003 or 1507.053, this chapter applies to a standard health benefit plan provided under Chapter 1507.

Sec. 1521.003. EXCEPTION. This chapter does not apply to:

(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 dental or 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;

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

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1521.002.

Sec. 1521.004. PREEXISTING CONDITION PROVISION PROHIBITED. A health benefit plan issuer may not, with respect to an individual younger than 19 years of age:

(1) deny the individual's application for coverage due to a preexisting condition;

(2) limit or deny coverage under the health benefit plan to the individual on the basis that the benefits requested are required to treat a preexisting condition; or

(3) charge the individual a premium in an amount that is more than two times the premium charged by the health benefit plan issuer to an individual younger than 19 years of age who does not have a preexisting condition, if the individual enrolls in a health benefit plan described by Section 1521.006 during an enrollment period described by Section 1521.006.

Sec. 1521.005. COVERAGE FOR CERTAIN DEPENDENTS REQUIRED. If a health benefit plan includes dependent coverage, the health benefit plan issuer shall approve the enrollment of an individual who is the minor child of an enrollee in the health benefit plan.

Sec. 1521.006. CHILD-ONLY PLANS REQUIRED; PENALTY. (a) A health benefit plan issuer shall offer, market, and sell health benefit plans in this state that exclusively cover individuals younger than 19 years of age.

(b) A health benefit plan issuer that does not comply with Subsection (a) may not issue new individual health benefit plans of any nature in this state.

(c) The department by rule shall require a health benefit plan issuer to have, and shall adopt rules concerning, enrollment periods for applicants described by Subsection (a). A health benefit plan issuer must have at least two enrollment periods per year of at least 60 days each.

(d) During a required enrollment period, a health benefit plan issuer must issue individual health benefit plan coverage on a guaranteed issue basis to an applicant younger than 19 years of age and may not issue a health benefit plan with a preexisting condition exclusion rider or endorsement described by Section 1521.004.

(e) The department by rule shall adopt standard special enrollment procedures in which an applicant described by Subsection (a) may enroll in an individual health benefit plan under this section on a guaranteed issue basis during a period other than an enrollment period under Subsection (c) if the applicant or a parent, managing conservator, or legal guardian of the applicant

experiences a qualifying event under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

Sec. 1521.007. CONFLICT WITH OTHER LAW. If this chapter conflicts with another law relating to coverage provided by a health benefit plan to an individual who is younger than 19 years of age, including a provision of Chapter 846, 1201, 1251, 1252, 1501, 1504, 1507, 1508, 1575, 1579, 1625, 1651, or 1652, this chapter controls.

SECTION 6.02. Each health benefit plan issuer required to issue individual health benefit plan coverage under Section 1521.005, Insurance Code, as added by this article, shall offer an initial enrollment period satisfying the requirements of Section 1521.006(d), Insurance Code, as added by this article, beginning not later than March 1, 2012. Notwithstanding Section 1521.005, Insurance Code, as added by this article, the initial enrollment period required by this section must be at least 90 days.

SECTION 6.03. This article applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 7. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN PREVENTIVE CARE SERVICES

SECTION 7.01. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1522 to read as follows:

CHAPTER 1522. PREVENTIVE CARE SERVICES

Sec. 1522.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) an exchange operating under Chapter 942;

(6) a health maintenance organization operating under 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) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this chapter applies to health and accident

coverage provided by a risk pool created under Chapter 172, Local Government Code.

(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(e) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small or large employer health benefit plan subject to Chapter 1501.

(f) Notwithstanding Section 1507.003 or 1507.053, this chapter applies to a standard health benefit plan provided under Chapter 1507.

Sec. 1522.002. EXCEPTION. This chapter does not apply to:

(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 dental or 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;

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

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1522.001.

Sec. 1522.003. CERTAIN COST-SHARING PROVISIONS PROHIBITED. A health benefit plan issuer may not impose a deductible, copayment, coinsurance, or other cost-sharing provision applicable to benefits for:

(1) a preventive item or service that has in effect a rating of "A" or "B" in the most recent recommendations of the United States Preventive Services Task Force;

(2) an immunization recommended for routine use in the most recent immunization schedules published by the United States Centers for Disease Control and Prevention of the United States Public Health Service; or

(3) preventive care and screenings supported by the most recent comprehensive guidelines adopted by the United States Health Resources and Services Administration.

Sec. 1522.004. CONFLICT WITH OTHER LAW. If this chapter conflicts with another law relating to the imposition of a deductible, copayment, coinsurance, or other cost-sharing provision, this chapter controls.

SECTION 7.02. This article applies only to a health benefit

plan that is delivered or issued for delivery on or after January 1, 2012. A health benefit plan that is delivered or issued for delivery before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 8. CERTAIN LIFETIME AND ANNUAL LIMITATIONS ON HEALTH BENEFIT PLAN COVERAGE

SECTION 8.01. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1523 to read as follows:

CHAPTER 1523. CERTAIN LIFETIME AND ANNUAL LIMITATIONS ON COVERAGE PROHIBITED

Sec. 1523.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a fraternal benefit society operating under Chapter 885;

(4) a stipulated premium company operating under Chapter 884;

(5) an exchange operating under Chapter 942;

(6) a health maintenance organization operating under

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) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004, Education Code.

(c) Notwithstanding Section 172.014, Local Government Code, or any other law, this chapter applies to health and accident coverage provided by a risk pool created under Chapter 172, Local Government Code.

(d) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(e) Notwithstanding Section 1501.251 or any other law, this chapter applies to coverage under a small or large employer health benefit plan subject to Chapter 1501.

(f) Notwithstanding Section 1507.003 or 1507.053, this chapter applies to a standard health benefit plan provided under Chapter 1507.

Sec. 1523.002. EXCEPTION. This chapter does not apply to:

(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 dental or 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;

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

(5) a long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy is a health benefit plan as described by Section 1523.001.

Sec. 1523.003. CERTAIN ANNUAL AND LIFETIME LIMITS PROHIBITED; REENROLLMENT REQUIRED. A health benefit plan issuer may not establish:

(1) a lifetime or annual benefit amount for an enrollee in relation to essential health benefits listed in 42 U.S.C. Section 18022(b)(1) and other benefits identified by the United States secretary of health and human services as essential health benefits; or

(2) an annual limit on the services for which the

health benefit plan will provide coverage, including an annual limit on an enrollee's number of:

(A) visits to a physician;

(B) days of inpatient or outpatient treatment; or

(C) prescription refills.

Sec. 1523.004. REINSTATEMENT OF COVERAGE. (a) A health benefit plan issuer, with relation to a former enrollee whose participation in or benefits under a health benefit plan terminated by reason of the enrollee exceeding a lifetime maximum benefit, shall:

(1) notify the former enrollee:

(A) that the lifetime maximum benefit no longer applies to the former enrollee; and

(B) that the former enrollee is eligible to reenroll in a health benefit plan issued by the health benefit plan issuer; and

(2) on request of the former enrollee, enroll the former enrollee in a health benefit plan that is identical or substantially similar to the enrollee's former health benefit plan.

(b) The notice required by Subsection (a) must be mailed to the former enrollee at the enrollee's last known address as shown in the records of the health benefit plan issuer.

Sec. 1523.005. CONFLICT WITH OTHER LAW. If this chapter conflicts with another law relating to lifetime or annual benefit limits or annual limits for specified services under a health benefit plan, this chapter controls.

SECTION 8.02. Each health benefit plan issuer required to

offer to former enrollees reenrollment in a health benefit plan under Section 1523.004, Insurance Code, as added by this article, shall send to each former enrollee entitled to a notice under that section the notice required by that section not later than December 1, 2011.

SECTION 8.03. (a) Except as provided by Subsection (b) of this section, this article applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2012. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2012, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

(b) The change in law made by Section 1523.004, Insurance Code, as added by this article, applies to a health benefit plan that is delivered, issued for delivery, or renewed before, on, or after January 1, 2012.

ARTICLE 9. EFFECTIVE DATE

SECTION 9.01. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2011.