By: West S.B. No. 1510

A BILL TO BE ENTITLED

AN ACT

relating to creation of the Texas Health Insurance Connector.

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0655 to read as follows:

Sec. 531.0655. COOPERATION WITH HEALTH INSURANCE CONNECTOR. To the extent practicable, the commission shall enter into agreements with the Texas Health Insurance Connector established under Chapter 1509, Insurance Code, to facilitate access for individuals to:

(1) health benefit plan coverage and other services offered by or through the Texas Health Insurance Connector; or

(2) Medicaid, the state child health plan program, or any other similar federal, state, or local public health benefit plan program.

SECTION 2. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1509 to read as follows:

CHAPTER 1509. TEXAS HEALTH INSURANCE CONNECTOR

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1509.001. DEFINITIONS. In this chapter:

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

(2) "Connector" means the Texas Health Insurance Connector.

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

(4) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(5) "Qualified health plan" means a health benefit plan that the board has certified under Section 1509.107.

(6) "Qualified individual" means an individual who is eligible to become an enrollee in accordance with the criteria adopted by the board under Section 1509.108.

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

(8) "Small employer" has the meaning assigned by Section 1501.002, except that the term does not include governmental entities described by that section.

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. ADOPTION OF PLAN OF OPERATION. (a) With the advice of the board, the commissioner by rule shall adopt a plan of operation to implement and govern the connector.

(b) The commissioner may adopt rules necessary to implement

state responsibility in compliance with a federal law or regulation or action of a federal court relating to a person or activity under the purview of the connector if:

(1) the federal law, regulation, or action of the federal court requires:

(A) a state to adopt the rules; or

(B) action by a state to ensure protection of the citizens of the state;

(2) the rules will avoid federal preemption of state insurance regulation; or

(3) the rules will prevent the loss of federal funds to this state.

Sec. 1509.004. AGENCY COOPERATION. (a) The connector and the Health and Human Services Commission shall cooperate fully with the department in performing their respective duties under this code or another law of this state relating to the operation of the connector.

(b) The connector shall cooperate with the department to promote a stable health benefit plan market in this state.

Sec. 1509.005. SUNSET PROVISION. The connector is subject to review under Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the connector is abolished and this chapter expires September 1, 2019.

Sec. 1509.006. REGULATION OF CONNECTOR. The connector is subject to regulation by the commissioner and the department.

Sec. 1509.007. EXEMPTION FROM STATE TAXES AND FEES. The connector is not subject to any state tax, regulatory fee, or

surcharge, including a premium or maintenance tax or fee.

Sec. 1509.008. COMPLIANCE WITH FEDERAL LAW. The connector shall comply with all applicable federal law and regulations.

[Sections 1509.009-1509.050 reserved for expansion]

SUBCHAPTER B. ESTABLISHMENT AND GOVERNANCE

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

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

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

(1) five members appointed by the governor:

(A) two of whom must be chosen from a list submitted to the governor by the lieutenant governor; and

(B) two of whom must be chosen from a list submitted to the governor by the speaker of the house of representatives;

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

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

(c) At least three of the five board members appointed by the governor must have experience in health care administration, health care economics, or health insurance or be knowledgeable concerning general business or actuarial principles. One of the

board members appointed by the governor must represent the interests of health benefit plan consumers in this state, one must represent the interests of small employers in this state, and one must be an enrollee or be reasonably expected to qualify for coverage under a qualified health plan in this state.

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

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

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

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

Sec. 1509.055. CONFLICT OF INTEREST. (a) A board member, or a member of a committee formed by the board, with a direct interest in a matter before the board, personally or through an employer, shall abstain from deliberations and actions on the matter in which the conflict of interest arises, shall abstain from any vote on the matter, and may not in any manner 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.

Sec. 1509.056. 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. 1509.057. 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. 1509.058. OPEN RECORDS AND OPEN MEETINGS. (a) The board is subject to Chapter 551, Government Code. The board may meet in executive session in accordance with Chapter 551, Government Code, to discuss confidential or proprietary information, including contract decisions and qualified health plan rates.

(b) The board is subject to Chapter 552, Government Code, except that, notwithstanding any other law, documents that contain proprietary information, relate to deliberative processes or communications, relate to contracting decisions, or reveal work product, plans, or strategy that would influence decisions in the health benefit plan marketplace are not public information.

Sec. 1509.059. RECORDS. The board shall keep records of the board's proceedings for at least seven years.

Sec. 1509.060. BIENNIAL REPORT. Not later than January 1 of

each odd-numbered year, the board shall provide a report to the governor, the legislature, the commissioner, and the executive commissioner. The report must include information regarding the development and implementation of the connector, specifically detailing progress made by the connector in implementing the requirements of this chapter.

Sec. 1509.061. ADDITIONAL REPORT. (a) The board shall issue a report that meets the requirements of Section 1509.060 to the entities described by that section not later than January 1, 2014.

(b) This section expires January 31, 2014.

[Sections 1509.062-1509.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF CONNECTOR

Sec. 1509.101. EMPLOYEES; COMMITTEES. (a) The board may employ, and determine the compensation of, an executive director, a chief fiscal officer, a general counsel, a technology officer, and any other agent or employee the board considers necessary to assist the connector in carrying out the connector's responsibilities and functions.

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

(c) The board may delegate to the executive director the authority to hire employees under this section.

Sec. 1509.102. CONTRACTS. (a) The connector may enter into any contract for the performance of functions or the provision of

services in connection with the operation of the connector that the connector considers necessary to implement or administer this chapter.

(b) The board shall evaluate the cost of contracting with the Health and Human Services Commission to determine eligibility for federal premium tax credits, cost-sharing subsidies, and exemptions from the individual mandate, and shall enter into a contract with the commission for those services if the board determines the contract to be cost-effective.

Sec. 1509.103. INFORMATION SHARING AND CONFIDENTIALITY. The connector may enter into information-sharing agreements with federal and state agencies to carry out the connector'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. 1509.104. MEMORANDUM OF UNDERSTANDING. (a) The department shall enter into a memorandum of understanding with the Health and Human Services Commission regarding the exchange of information and the division of regulatory functions among the connector, the department, and the commission.

(b) The connector may enter into a memorandum of understanding with the Health and Human Services Commission to provide that the Health and Human Services Commission or an appropriate health and human services agency will determine or assist in determining whether an individual is eligible for Medicaid, the state child health plan program, or any other similar

federal, state, or local public health benefit program.

Sec. 1509.105. LEGAL ACTION. (a) The connector may sue or be sued.

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

(1) assessments due the connector;

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

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

Sec. 1509.106. FUNCTIONS. The connector shall:

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

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

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

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

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

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

(5) use a standard format for presenting information

concerning qualified health plan options;

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

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

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

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

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

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

(12) establish billing and payment policies for

issuers of qualified health plans;

(13) engage in marketing and outreach activities; and

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

Sec. 1509.107. CERTIFICATION OF PLAN. The board shall certify a health benefit plan as a qualified health plan if the health benefit plan meets the requirements for certification set forth by the secretary or the board. The connector may not, as a condition of certification, require a health benefit plan issuer to:

(1) participate in both the individual and small employer markets; or

(2) offer benefit levels that exceed benefit levels required under state or federal law.

Sec. 1509.108. QUALIFICATION OF INDIVIDUALS. The plan of operation adopted under Section 1509.003 must establish criteria for eligibility for a potential enrollee to be considered a qualified individual. At a minimum, the criteria must require that the individual:

(1) seek to enroll in a qualified health plan in the individual health benefit plan market offered through the connector;

(2) reside in and be a citizen or lawful resident of this state, except as provided by Section 1312, Patient Protection and Affordable Care Act (Pub. L. No. 111-148); and

(3) at the time of enrollment, not be incarcerated,

other than being incarcerated pending the disposition of any criminal charges.

Sec. 1509.109. PREMIUM COLLECTION AND AGGREGATION. With the advice of the board, the commissioner by rule shall establish a mechanism for the collection and aggregation of premium payments directly or indirectly from enrollees and the payment of premiums to issuers of qualified health plans. The mechanism established under this section must address an employer's authority to withhold premium payments from an enrollee's paycheck and to submit those premium payments to issuers of qualified health plans.

Sec. 1509.110. PREMIUM INCREASE JUSTIFICATION. (a) The connector shall require an issuer of a qualified health plan to file with the connector an explanation of any premium increase before implementation of the increase.

(b) A health benefit plan issuer shall prominently display the explanation of any premium increase on the health benefit plan issuer's Internet website.

[Sections 1509.111-1509.150 reserved for expansion]

SUBCHAPTER D. ASSESSMENTS FOR OPERATION OF CONNECTOR

Sec. 1509.151. ASSESSMENTS; PENALTY FOR NONPAYMENT. (a) The department may charge the issuers of health benefit plans in this state, including issuers of qualified health plans, an assessment as reasonable and necessary for the connector's organizational and operating expenses.

(b) The assessment under this section must be based on each health benefit plan issuer's proportionate share of the total extended coverage and other premium received by all health benefit

plan issuers in this state.

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

(d) 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 connector may accept a grant from a public or private organization and may spend those funds to pay the costs of program administration and operations.

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

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

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

[Sections 1509.154-1509.200 reserved for expansion]

SUBCHAPTER E. TRUST FUND

Sec. 1509.201. TRUST FUND. (a) The connector fund is established as a special trust fund outside of the state treasury in the custody of the comptroller separate and apart from all public money or funds of this state.

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

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

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

(b) As soon as 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 Connector shall hold a special meeting to discuss the adoption of rules and procedures necessary to implement Chapter 1509, Insurance Code, as added by this Act.

(c) As soon as practicable after the effective date of this Act, but not later than January 31, 2012, the commissioner of insurance shall adopt rules and procedures necessary to implement

Chapter 1509, Insurance Code, as added by this Act.

SECTION 4. 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.