By: Ogden S.B. No. 1586

A BILL TO BE ENTITLED

AN ACT

relating to state fiscal matters related to certain regulatory agencies.

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

ARTICLE 1. REDUCTION OF EXPENDITURES AND IMPOSITION OF CHARGES GENERALLY

SECTION 1.01. This article applies to any state agency that receives an appropriation under Article VIII of the General Appropriations Act.

SECTION 1.02. Notwithstanding any other statute of this state, each state agency to which this article applies is authorized to reduce or recover expenditures by:

(1) consolidating any reports or publications the agency is required to make and filing or delivering any of those reports or publications exclusively by electronic means;

(2) extending the effective period of any license, permit, or registration the agency grants or administers;

(3) entering into a contract with another governmental entity or with a private vendor to carry out any of the agency's duties;

(4) adopting additional eligibility requirements for persons who receive benefits under any law the agency administers to ensure that those benefits are received by the most deserving persons consistent with the purposes for which the benefits are

provided;

(5) providing that any communication between the agency and another person and any document required to be delivered to or by the agency, including any application, notice, billing statement, receipt, or certificate, may be made or delivered by e-mail or through the Internet; and

(6) adopting and collecting fees or charges to cover any costs the agency incurs in performing its lawful functions.

ARTICLE 2. FISCAL MATTERS REGARDING REGULATION OF INSURERS

SECTION 2.01. Section 463.160, Insurance Code, is amended to read as follows:

Sec. 463.160. PREMIUM TAX CREDIT FOR CLASS A ASSESSMENT. The amount of a Class A assessment paid by a member insurer in each taxable year shall be allowed as a credit on the amount of premium taxes due [~~in the same manner as a credit is allowed under Section 401.151(e)~~].

SECTION 2.02. Sections 221.006, 222.007, 223.009, 401.151(e), and 401.154, Insurance Code, are repealed.

SECTION 2.03. This article takes effect immediately if this Act 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 article takes effect September 1, 2011.

ARTICLE 3. FISCAL MATTERS REGARDING HEALTH CARE DELIVERY

SECTION 3.01. Subtitle A, Title 2, Insurance Code, is amended by adding Chapter 41 to read as follows:

CHAPTER 41. HEALTH CARE PAYMENT AND DELIVERY SYSTEM REFORM

SUBCHAPTER A. HEALTH CARE PAYMENT AND DELIVERY SYSTEM REFORM COMMITTEE

Sec. 41.001. DEFINITION. In this chapter, "committee" means the Health Care Payment and Delivery System Reform Committee.

Sec. 41.002. ESTABLISHMENT; PURPOSE; ADMINISTRATIVE SUPPORT. (a) The Health Care Payment and Delivery System Reform Committee is established to identify priority outcomes for cost containment and quality improvement in health benefit coverage and health care services in this state.

(b) The committee is administratively attached to the department. The department shall provide administrative support and resources to the committee as necessary for the committee to perform its duties.

Sec. 41.003. COMPOSITION OF COMMITTEE. The committee is composed of:

(1) the following voting members:

(A) a representative of the Health and Human Services Commission, appointed by the executive commissioner of the Health and Human Services Commission;

(B) a representative of the Employees Retirement System of Texas, appointed by the executive director of the system;

(C) two representatives of the Teacher Retirement System of Texas, appointed by the executive director of the system:

(i) one of whom has specialized knowledge of basic plans under Chapter 1575; and

(ii) one of whom has specialized knowledge

of the catastrophic care coverage plan and the primary care coverage plan under Chapter 1579;

(D) a representative of The Texas A&M University System, appointed by the governing board of the system; and

(E) a representative of The University of Texas System, appointed by the governing board of the system; and

(2) the following nonvoting members:

(A) a representative of the speaker of the house of representatives, appointed by the speaker;

(B) a representative of the office of the lieutenant governor, appointed by the lieutenant governor;

(C) a representative of the House Public Health Committee or its successor, appointed by the chair of the committee; and

(D) a representative of the Senate Health and Human Services Committee or its successor, appointed by the chair of the committee.

Sec. 41.004. TERMS; REMOVAL. (a) Voting members of the committee serve staggered two-year terms, with the terms of three members expiring on February 1 of each year. The members shall draw lots at the first committee meeting to determine the length of each member's initial term and which members' terms expire each year.

(b) The terms of the nonvoting members of the committee expire February 1 of each even-numbered year.

(c) A member of the committee may be removed by the commissioner with cause stated in writing. The appropriate person or entity shall appoint in the manner provided by Section 41.003 a

replacement for a member who leaves or is removed from the committee.

Sec. 41.005. DUTIES. The committee shall:

(1) develop a plan to identify priority outcomes for cost containment and quality improvement in health insurance and health care services in this state;

(2) coordinate initiatives for reform of health care payment and delivery systems among state health payors;

(3) review pilot program proposals submitted to the committee under Section 41.051(a) and recommend to the commissioner for approval pilot programs the committee determines to be consistent with purposes described by Section 41.002;

(4) review funding proposals submitted to the committee under Section 41.051(b) and recommend to the commissioner pilot programs the committee determines to be eligible for funding under the rules adopted by the commissioner under Section 41.053; and

(5) determine outcomes to be measured in evaluating the effectiveness of each program approved by the commissioner under Section 41.052.

Sec. 41.006. SUBMISSION AND POSTING OF PRIORITY OUTCOME PLAN. Not later than September 1 of each even-numbered year, the committee shall:

(1) update the priority outcome plan developed under Section 41.005(1) as necessary;

(2) submit the priority outcome plan to:

(A) the governor; and

(B) the Legislative Budget Board; and

(3) make the priority outcome plan available to the public on the Internet website maintained by the department.

Sec. 41.007. EXPIRATION OF CHAPTER. This chapter expires September 1, 2021.

[Sections 41.008-41.050 reserved for expansion]

SUBCHAPTER B. HEALTH CARE PAYMENT AND DELIVERY SYSTEM REFORM PILOT PROGRAMS

Sec. 41.051. PROPOSAL OF PILOT PROGRAMS BY PROVIDERS OF HEALTH CARE SERVICES. (a) An individual or entity that provides health care services in this state may submit to the committee a proposal for a pilot program to design and implement a new health care payment or delivery system.

(b) An individual or entity that submits a pilot program proposal under Subsection (a) may submit to the committee an application for funding for the pilot program. An application may be submitted under this subsection:

(1) in conjunction with a pilot program proposal; or

(2) after a pilot program proposal is approved by the commissioner under Section 41.052.

Sec. 41.052. APPROVAL BY COMMISSIONER; PILOT PROGRAM PROPOSAL AND FUNDING. (a) On recommendation of the committee, the commissioner may approve:

(1) a pilot program proposal submitted to the committee under Section 41.051(a), if the commissioner finds that the pilot program:

(A) adequately protects the interests of

patients and consumers; and

(B) may demonstrate improved economy and efficiency for health care payment or delivery; or

(2) an application for funding for a pilot program submitted to the committee under Section 41.051(b).

(b) The commissioner may approve an application under Subsection (a)(2) only to the extent that sufficient appropriations have been received by the department to fund the proposed pilot program.

Sec. 41.053. RULES. The commissioner shall adopt rules necessary to implement this subchapter, including rules that establish a procedure through which a pilot program proposal or an application for funding for a pilot program may be submitted to, and approved by, the commissioner.

SECTION 3.02. Chapter 162, Occupations Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. PARTICIPATION IN PILOT PROGRAM TO PROMOTE HEALTH CARE PAYMENT AND DELIVERY SYSTEM REFORM

Sec. 162.301. EMPLOYMENT OF PHYSICIANS. (a) A person, including a partnership, trust, association, or corporation, operating a pilot program approved by the Health Care Payment and Delivery System Reform Committee under Chapter 41, Insurance Code, may employ a physician:

(1) for the purposes of the pilot program; and

(2) for the duration of the pilot program, as approved.

(b) A person that employs a physician under this section

does not violate Section 164.052(a)(13) or (17) or 165.156, or any other law that prohibits the practice of medicine by a person other than a physician, to the extent that the physician is performing services for the purpose of the pilot program.

(c) This section does not authorize a person to supervise or control the practice of medicine or permit the unauthorized practice of medicine as prohibited by this subtitle.

Sec. 162.302. EXPIRATION OF SUBCHAPTER. This subchapter expires September 1, 2021.

SECTION 3.03. Notwithstanding Section 41.006, Insurance Code, as added by this article, not later than February 1, 2012, the Health Care Payment and Delivery System Reform Committee shall develop the first plan required by Section 41.005(1), Insurance Code, as added by this article, submit the plan to the governor and Legislative Budget Board, and make the plan available to the public on the Texas Department of Insurance's Internet website.

SECTION 3.04. This article takes effect September 1, 2011.

ARTICLE 4. TEXAS HEALTH INSURANCE CONNECTOR

SECTION 4.01. 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 1509.108.

(6) "Qualified individual" means an individual who is eligible to become an enrollee in accordance with the criteria adopted by the board under Section 1509.109.

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

(b) The board may adopt rules necessary to implement state responsibility in compliance with a federal law or regulation or

action of a federal court relating to a person or activity under the purview of the connector if:

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

(c) The board may adopt a rule under Subsection (b) only if the federal action requiring the adoption of a rule occurs or takes effect between sessions of the legislature or at such a time during a session of a legislature that sufficient time does not remain to permit the preparation of a recommendation for legislative action or permit the legislature to act. A rule adopted under this section remains in effect until the 30th day after the end of the first regular session of the legislature that follows the adoption of the rule unless a law is enacted that authorizes the subject matter of the rule. If a law is enacted that authorizes the subject matter of the rule, the rule continues in effect.

Sec. 1509.004. AGENCY COOPERATION. (a) The connector, 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 connector.

(b) The connector and the department shall cooperate 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. CONNECTOR NOT INSURER. The connector is not an insurer or health maintenance organization and is not subject to regulation by 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.

Sec. 1509.102. CONTRACTS. The connector may enter into any contract that the connector considers necessary to implement or administer this chapter, including a contract with the department or the Health and Human Services Commission for the department or commission, in exchange for payment, to perform functions or provide services in connection with the operation of the connector.

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. The connector 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 connector, the department, and the commission.

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

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

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

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

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

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

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

(6) inform individuals of the eligibility

requirements for Medicaid, the state child health plan program, or any other similar federal, state, or local public health benefit program;

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

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

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

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

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

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

(13) engage in marketing and outreach activities; and

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

Sec. 1509.107. TYPES OF PLANS. The connector shall, in a manner consistent with federal law, establish certification requirements for at least six different types of qualified health plans, at least two of which must include a health savings account described by Section 223, Internal Revenue Code of 1986, at least one of which must offer benchmark coverage or benchmark equivalent coverage described by Section 1937(b), Social Security Act (42 U.S.C. Section 1396u-7), and at least one of which must offer limited scope dental benefits either separately or in conjunction with another type of plan.

Sec. 1509.108. 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. 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 federal law.

Sec. 1509.109. QUALIFICATION OF INDIVIDUALS. The board by rule shall 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. 1509.110. PREMIUM COLLECTION AND AGGREGATION. The board 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. Rules adopted under this section must include rules regarding 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. 1509.111. 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 1509.112-1509.150 reserved for expansion]

SUBCHAPTER D. COVERAGE REQUIREMENTS OR LIMITATIONS

Sec. 1509.151. PROHIBITED COVERAGE THROUGH CONNECTOR. A qualified health plan offered through the connector may not provide

coverage for an abortion, as defined by Section 171.002, Health and Safety Code.

[Sections 1509.152-1509.200 reserved for expansion]

SUBCHAPTER E. ASSESSMENTS FOR OPERATION OF CONNECTOR

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

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

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

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

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

(b) The connector shall prepare annually a complete and detailed written report accounting for all funds received and disbursed by the connector during the preceding fiscal year. The report must meet any reporting requirements provided in the General Appropriations Act, regardless of whether the connector receives

any funds under that Act. The connector shall submit the report to the governor, the legislature, the commissioner, and the executive commissioner not later than January 31 of each year.

[Sections 1509.204-1509.250 reserved for expansion]

SUBCHAPTER F. TRUST FUND

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

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

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

SECTION 4.02. (a) As soon as possible after the effective date of this article, but not later than October 31, 2011, the governor shall appoint the initial members of the board of directors of the Texas Health Insurance Connector. In making the appointments, the governor shall designate two persons to terms expiring February 1, 2013, two persons to terms expiring February 1, 2015, and one person to a term expiring February 1, 2017.

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

Code, as added by this Act.

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

SECTION 4.03. This article takes effect immediately if this Act 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 article takes effect September 1, 2011.