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By:  Johnson S.B. No. 1807

A BILL TO BE ENTITLED

AN ACT

relating to the creation of the Texas Health Insurance Exchange and an exchange reinsurance program.

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

SECTION 1.  Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1511 to read as follows:

CHAPTER 1511. TEXAS HEALTH INSURANCE EXCHANGE AND REINSURANCE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1511.001.  DEFINITIONS. In this chapter:

(1)  "Attachment point" means the threshold amount of claim costs that an eligible health benefit plan issuer must incur for an enrollee's covered benefits during a plan year above which the claim costs for benefits are eligible for reinsurance payments under the reinsurance program.

(2)  "Board" means the board of directors of the Texas Health Insurance Exchange Authority.

(3)  "Coinsurance rate" means the percentage rate at which the reinsurance program reimburses an eligible health benefit plan issuer for claim costs incurred above the attachment point and below the reinsurance cap for an enrollee's covered benefits during a plan year.

(4)  "Eligible health benefit plan issuer" means a health benefit plan issuer offering health benefit plans eligible for the reinsurance program to individuals in this state.

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

(6)  "Exchange" means the Texas Health Insurance Exchange established under this chapter.

(7)  "Exchange assister" means an individual or organization, including a navigator, who provides public education or assists consumers on behalf of the exchange. The term does not include a licensed insurance agent.

(8)  "Exchange authority" means the Texas Health Insurance Exchange Authority established under this chapter.

(9)  "Exchange fund" means the exchange revolving fund established under Section 1511.251.

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

(11)  "Navigator" means an individual or entity performing the activities and duties of a navigator as described by 42 U.S.C. Section 18031 or any regulation enacted under that section.

(12)  "Plan year" means the calendar year during which an eligible health benefit plan issuer provides coverage through a health benefit plan.

(13)  "Qualified health plan" has the meaning assigned by Section 1301(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18021).

(14)  "Reinsurance cap" means the maximum amount of claim costs incurred by an eligible health benefit plan issuer for an enrollee's covered benefits during a plan year above which the claim costs are no longer eligible for reinsurance payments under the reinsurance program.

(15)  "Reinsurance fund" means the reinsurance program revolving fund established under Section 1511.316.

(16)  "Reinsurance payment" means an amount paid to an eligible health benefit plan issuer under the reinsurance program.

(17)  "Reinsurance program" means the exchange reinsurance program established under this chapter.

Sec. 1511.002.  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 health maintenance organization operating under Chapter 843;

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

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

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

(7)  a fraternal benefit society operating under Chapter 885; or

(8)  an exchange operating under Chapter 942.

(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(g)(1));

(3)  a workers' compensation insurance policy;

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

(5)  an individual health benefit plan issued on or before March 23, 2010, that has not had any significant changes since that date that reduce benefits or increase costs to the individual.

Sec. 1511.003.  RULEMAKING AUTHORITY. The department and 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 United States secretary of health and human services under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

Sec. 1511.004.  AGENCY COOPERATION. (a) The exchange authority, 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 authority 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 related premium 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; and

(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.

Sec. 1511.005.  CONFIDENTIALITY OF RECORDS. (a) Except as otherwise provided by this chapter, documents, materials, or other information, including a disclosure, in the possession or control of the department or the exchange authority that is obtained by, created by, or disclosed to the commissioner or any other person under this chapter is confidential and privileged and is:

(1)  not subject to disclosure under Chapter 552, Government Code;

(2)  not subject to subpoena; and

(3)  not subject to discovery or admissible in evidence in any private civil action.

(b)  Except as otherwise provided by this chapter, documents, materials, or other information, including a disclosure, in the possession or control of the department or the exchange authority that is obtained by, created by, or disclosed to the commissioner or any other person under this chapter is recognized by this state as being proprietary and to contain trade secrets.

Sec. 1511.006.  PERSONAL HEALTH AND FINANCIAL INFORMATION CONFIDENTIAL. The department and the exchange authority shall protect all personally identifiable health and financial information in accordance with all applicable federal and state laws, including the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), and the Health Information Technology for Economic and Clinical Health Act (Pub. L. No. 111-5), enacted under the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5), and any regulations promulgated under those laws.

Sec. 1511.007.  INFORMATION SHARING AND CONFIDENTIALITY. (a) The department or the exchange authority may enter into information-sharing agreements with each other to carry out the department's or exchange authority's responsibilities under this chapter or with:

(1)  federal and state agencies; and

(2)  an eligible health benefit plan issuer.

(b)  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. 1511.008.  IMMUNITY. The following persons are not liable, and a cause of action does not arise against any of the following persons, for a good faith act or omission in exercising powers and performing duties under this chapter:

(1)  the board, the department, or the exchange authority;

(2)  a board member or member of the advisory committee established in Section 1511.152; or

(3)  an officer or employee of an entity listed in Subdivision (1).

Sec. 1511.009.  COMPLIANCE WITH FEDERAL LAW. The exchange authority and the reinsurance program shall comply with all applicable federal law and regulations, including all federal reporting requirements.

Sec. 1511.010.  NO ENTITLEMENT. Nothing in this chapter constitutes an entitlement or a claim on any money of the state.

Sec. 1511.011.  EXPIRATION OF CHAPTER. If any provision of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), integral to the operation of the exchange authority or reinsurance program established under this chapter is repealed, defunded, or invalidated, the commissioner shall notify the exchange authority or the department to initiate steps to cease operations of the exchange or reinsurance program and to cease operations not later than 15 months after notification is received under this section.

SUBCHAPTER B. EXCHANGE ESTABLISHMENT AND PURPOSE

Sec. 1511.051.  EXCHANGE AUTHORITY ESTABLISHED. This chapter establishes the Texas Health Insurance Exchange Authority to implement the Texas Health Insurance Exchange as an American Health Benefit Exchange authorized by Section 1311, Patient Protection and Affordable Care Act (42 U.S.C. Section 18031).

Sec. 1511.052.  PURPOSE. The purpose of the exchange authority is to create, manage, and maintain the exchange in order to:

(1)  benefit the state health insurance market and individuals enrolling in health benefit plans;

(2)  facilitate or assist in facilitating the purchasing of qualified health plans on the exchange by qualified enrollees in the individual market or the individual and small group markets; and

(3)  reduce or eliminate barriers to enrollment in qualified health plans offered on the exchange by:

(A)  simplifying the process to resolve data matching issues;

(B)  reducing circumstances under which documentation must be submitted;

(C)  simplifying the process for consumers to submit documentation;

(D)  streamlining special enrollment periods; and

(E)  making the Internet website for the exchange more user-friendly and mobile-friendly.

SUBCHAPTER C. GOVERNANCE OF EXCHANGE

Sec. 1511.101.  GOVERNANCE OF EXCHANGE AUTHORITY; BOARD MEMBERSHIP. The exchange authority is governed by a board of nine directors, with the advice and consent of the senate, as follows:

(1)  seven members appointed by the governor:

(A)  four of whom are health benefit plan issuers that offer health benefit plans through the exchange;

(B)  two of whom are individuals with experience in health care public education and consumer assistance activities who do not have a conflict of interest as provided by Section 1511.106; and

(C)  one of whom is a consumer advocate;

(2)  the commissioner, or the commissioner's designee, as an ex officio voting member; and

(3)  the executive commissioner, or the executive commissioner's designee, as an ex officio voting member.

Sec. 1511.102.  PRESIDING OFFICER. The commissioner, or the commissioner's designee, shall serve as the presiding officer.

Sec. 1511.103.  TERMS; VACANCY. (a) Appointed members of the board serve six-year staggered terms, with two or three of the members' terms expiring February 1 of each odd-numbered year.

(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. 1511.104.  MEETINGS; QUORUM. (a) The board shall meet at the call of the presiding officer or as provided in the bylaws of the board, but not less frequently than quarterly.

(b)  A majority of the appointed members of the board constitutes a quorum. If a quorum is present, the board by majority vote may act on any matter within the board's jurisdiction.

(c)  Meetings of the board are subject to Chapter 551, Government Code.

Sec. 1511.105.  BOARD MEMBER COMPENSATION. (a) A board member may not receive compensation but is entitled to reimbursement of the travel expenses incurred by the board member while conducting board business, subject to the availability of money.

(b)  Reimbursement under Subsection (a) shall be paid from the exchange fund.

Sec. 1511.106.  CONFLICTS OF INTEREST; RELEVANT EXPERIENCE. The board shall ensure compliance with the standards described by 42 U.S.C. Section 18041 and all applicable federal regulations promulgated under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) regarding conflicts of interest and relevant experience.

SUBCHAPTER D. POWERS AND DUTIES OF EXCHANGE

Sec. 1511.151.  EMPLOYEES; COMMITTEES. (a) The board may employ an executive director and any other agents and employees that the board considers necessary to assist the exchange authority in carrying out its responsibilities and functions. An employee of the exchange authority is a state employee.

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

(c)  The executive director shall attend all meetings of the board, but is not a member of the board, and may not vote or be counted for purposes of establishing a quorum.

(d)  The exchange authority 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 or exchange authority.

Sec. 1511.152.  ADVISORY COMMITTEE. (a) An advisory committee is established to advise the board on:

(1)  initial operational decisions;

(2)  ongoing financing decisions; and

(3)  any other decisions considered appropriate by the board.

(b)  The advisory committee is composed of eight members appointed or selected as follows:

(1)  four consumer representatives, including:

(A)  two persons appointed by the governor, one of whom must be a registered insurance exchange navigator or assister;

(B)  one person appointed by the speaker of the house of representatives; and

(C)  one person appointed by the lieutenant governor;

(2)  one representative selected by the Texas Hospital Association;

(3)  one representative selected by the Texas Medical Association;

(4)  one representative selected by the Texas Chamber of Commerce Executives from a small employer, as that term is defined by Section 1501.002; and

(5)  one representative selected by the Texas Association of Health Underwriters.

(c)  Advisory committee members serve staggered four-year terms, with two of the members' terms expiring February 1 of each odd-numbered year. A member may be reappointed for a second term. If a vacancy occurs on the committee, the appropriate appointing authority shall appoint a successor, in the same manner as the original appointment, to serve for the remainder of the unexpired term.

(d)  A majority of the members of the advisory committee constitutes a quorum. If a quorum is present, the advisory committee by majority vote may act on any matter within the committee's jurisdiction.

(e)  The advisory committee shall meet at least twice per year, with each meeting being held before a meeting of the board. Additional meetings may be held on reasonable notice of the time and location of the meeting selected by the board. The advisory committee shall meet at the call of the presiding officer or on written request of three members of the committee. A meeting of the committee is subject to Chapter 551, Government Code.

(f)  The executive director of the exchange authority, or the executive director's designee, shall attend each meeting of the advisory committee.

(g)  The members of the advisory committee shall determine the dates of each meeting by majority vote or by the call of the presiding officer on seven days' notice to all members.

(h)  The advisory committee must post a notice, including the date, time, and place, of a committee meeting on the exchange authority's Internet website not less than five days before each meeting. The notice must state that the meeting is open to the public. All actions taken by the committee must be taken in open session and on a majority vote of the members present.

(i)  A member of the advisory committee may not receive compensation but is entitled to reimbursement of the travel expenses incurred by the member while conducting committee business, subject to the availability of money. Reimbursement under this subsection shall be paid from the exchange fund.

Sec. 1511.153.  ADMINISTRATIVE POWERS AND DUTIES OF EXCHANGE AUTHORITY. (a) The exchange authority shall exercise all powers and duties necessary and appropriate to carry out the authority's purpose, including:

(1)  adopting bylaws;

(2)  employing staff;

(3)  making, executing, and delivering contracts;

(4)  applying for, soliciting, and receiving money from any source consistent with the purposes of this chapter;

(5)  establishing priorities for and allocating and distributing money received by the exchange authority;

(6)  submitting the exchange authority's budget annually and the exchange authority's budget request, including amounts to be appropriated out of the exchange fund necessary to administer the provisions of this chapter and the transfer of money to the reinsurance fund, biennially to the governor and the chairs of the standing committees of the senate and house of representatives with primary jurisdiction over appropriations;

(7)  establishing travel reimbursement policies for the exchange authority, the board, and the advisory committee;

(8)  coordinating with the appropriate federal and state agencies to seek waivers from statutory or regulatory requirements as necessary to carry out the purposes of this chapter;

(9)  entering into other arrangements, including interagency agreements with federal agencies and state agencies, as necessary;

(10)  giving reasonable public notice of any policies and procedures the exchange authority may implement to operate the exchange authority;

(11)  ensuring that there is a sufficient number of navigators and exchange assisters by awarding grants to navigators and exchange assisters at a yearly average number that exceeds the yearly average number of grants awarded from 2013 through 2016;

(12)  providing centralized training, support, and technical assistance for navigators and exchange assisters;

(13)  spending money on marketing and advertisements for the exchange in an amount that exceeds the amount of money spent in this state annually on marketing and advertisements in relation to the federally facilitated marketplace from 2013 to 2016;

(14)  coordinating innovative marketing and outreach campaigns, including by working with and supporting local enrollment coalitions, agents, and stakeholders;

(15)  ensuring a sufficient amount of money is spent on customer support services, including call centers, web support, and navigator and agent support, to provide high-quality services, including by:

(A)  creating a special team with knowledge and authority to resolve difficult eligibility and enrollment challenges;

(B)  ensuring call center staff are able to access and share information specific to a consumer's application;

(C)  investing in services and systems to improve information for consumers with limited English proficiency;

(D)  making the exchange Internet website and application process mobile-friendly; and

(E)  ensuring consumers can easily submit documentation, when needed; and

(16)  performing any other operational activities necessary or appropriate under this chapter.

(b)  The board must consider the advice of the advisory committee established under Section 1511.152.

Sec. 1511.154.  FUNCTIONS OF THE EXCHANGE AUTHORITY. (a) In carrying out the purposes of this chapter, the exchange authority shall:

(1)  educate consumers, including through outreach, a navigator program, and post-enrollment support;

(2)  assist individuals in accessing income-based assistance for which the individual may be eligible, including premium tax credits, cost-sharing reductions, and government programs;

(3)  consider the need for consumer choice in rural, urban, and suburban areas of the state;

(4)  negotiate premium rates with health benefit plan issuers on the exchange;

(5)  contract selectively with health benefit plan issuers to drive value and promote improvement in the delivery system;

(6)  standardize health benefit plan designs and cost-sharing;

(7)  leverage quality improvement and delivery system reforms by encouraging participating health benefit plans to implement strategies to promote the delivery of better coordinated, more efficient health care services;

(8)  align with other large purchasers of health benefit plans, including the state Medicaid program, the child health plan program under Chapter 62, Health and Safety Code, the Teacher Retirement System of Texas, and the Employees Retirement System of Texas, to send consistent purchasing signals to health benefit plan issuers and providers;

(9)  recruit new health benefit plan issuers to areas with less competition;

(10)  leverage consumer decision-making through better information and web-based decision-making tools;

(11)  subject to Subsection (b), assess and collect fees from health benefit plan issuers on the exchange to support the operation of the exchange and the reinsurance program under this chapter; and

(12)  distribute collected fees, including to benefit the reinsurance program.

(b)  The exchange authority may not assess or collect any costs or fees under Subsection (a)(11) other than an exchange user fee on total monthly premiums for health benefit plans on the exchange. The fee may not exceed three percent unless approved by unanimous consent of the board, and in no circumstance may the fee exceed 3.5 percent. The exchange authority shall set aside a percentage of the exchange user fee to increase subsidies for health benefit plans.

Sec. 1511.155.  ENFORCEMENT AND STATE SOVEREIGNTY. The exchange authority shall ensure that the exchange complies with the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and its subsequent amendments and any federal regulations promulgated under that act in a manner that maintains state sovereignty over the health insurance market in this state. Enforcement responsibilities shall be delegated to the appropriate state agencies and must be sufficient to prevent a determination by the United States secretary of health and human services that the state has failed to substantially enforce any provision of the Patient Protection and Affordable Care Act.

SUBCHAPTER E. REPORTING REQUIREMENTS FOR EXCHANGE AUTHORITY

Sec. 1511.201.  ANNUAL AUDIT. (a) The exchange authority shall have an examination and audit of the exchange authority conducted annually by an independent certified public accounting firm. The audit must:

(1)  assess compliance with the requirements of this chapter; and

(2)  identify any material weaknesses or significant deficiencies and identify and implement solutions to correct those weaknesses or deficiencies.

(b)  Not later than December 31 of each year, the exchange authority shall:

(1)  post on the exchange authority's Internet website:

(A)  the audit for the preceding year; and

(B)  a summary of the audit, including any identified material weaknesses or significant deficiencies and the department's proposed solution for those weaknesses or deficiencies; and

(2)  provide to the secretary of the senate and the chief clerk of the house of representatives and the department an electronic link to the web page on which the audit information in Subdivision (1) is posted.

(c)  The exchange authority shall pay for the cost of the annual audit under Subsection (a) with money from the exchange fund.

Sec. 1511.202.  ANNUAL REPORTS. (a) The exchange authority shall prepare an annual report regarding the activities of the exchange authority for the preceding year.

(b)  The exchange authority shall:

(1)  electronically submit the report required under this section to the governor, the lieutenant governor, the speaker of the house of representatives, and the chairs of the standing committees of the senate and house of representatives with primary jurisdiction over appropriations and insurance;

(2)  post the report on the exchange authority's Internet website; and

(3)  provide a copy of the electronic link to the posted report under Subdivision (2) to the department.

SUBCHAPTER F. EXCHANGE FUND

Sec. 1511.251.  EXCHANGE FUND. (a) The exchange fund is established as a revolving fund in the state treasury outside the general revenue fund.

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

(c)  The exchange fund shall be administered by the exchange authority for the purposes of the exchange established under this chapter, including the deposit of federal money available for the exchange and all other money received under or distributed in accordance with this subchapter.

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

SUBCHAPTER G. REINSURANCE PROGRAM

Sec. 1511.301.  APPLICATION FOR STATE INNOVATION WAIVER. (a) The department shall apply to the United States secretary of health and human services to obtain a waiver under 42 U.S.C. Section 18052 to:

(1)  waive any applicable provisions of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) with respect to health benefit plan coverage in this state;

(2)  establish a reinsurance program in accordance with an approved waiver; and

(3)  maximize federal funding for the reinsurance program for plan years beginning on or after the effective date of the implementation of the program.

(b)  The department may amend the waiver application as necessary to carry out the provisions of this chapter.

(c)  The department shall promptly notify the chairs of the standing committees of the senate and house of representatives with primary jurisdiction over appropriations and insurance of any amendment to the waiver application and any federal actions taken regarding the application.

(d)  Not later than February 1, 2022, the department shall make a draft of the application for the waiver under Subsection (a) available for a public review and comment period of not less than 30 days. The department shall consider any comments in submitting the final application. This subsection expires September 1, 2022.

Sec. 1511.302.  IMPLEMENTATION OF WAIVER AND ESTABLISHMENT OF REINSURANCE PROGRAM. (a) On approval by the United States secretary of health and human services of the department's application for a waiver under Section 1511.301, the department shall establish and implement a reinsurance program for the purposes of:

(1)  stabilizing rates and premiums for health benefit plans in the individual market; and

(2)  providing greater financial certainty to consumers of health benefit plans in this state.

(b)  The reinsurance program under this subchapter is considered to be a reinsurance entity for carrying out a reinsurance program under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and its subsequent amendments.

Sec. 1511.303.  OPERATION OF REINSURANCE PROGRAM. (a) The department shall perform all appropriate and necessary functions to operate the reinsurance program and effectuate the purposes for which the reinsurance program was established in accordance with the approved waiver under Section 1511.301. The functions may include:

(1)  establishing procedures for and performing administrative and accounting operations of the reinsurance program;

(2)  seeking and receiving funding and maximizing federal funding for the reinsurance program, including funding from:

(A)  the exchange authority;

(B)  federal funding that is or may become available to states to support the administration and implementation of state-based reinsurance programs; and

(C)  any other available sources;

(3)  collecting data submissions and reinsurance payment requests from eligible health benefit plan issuers;

(4)  making reinsurance payments to eligible health benefit plan issuers;

(5)  resolving disputes related to the amount of reinsurance payments;

(6)  suing or being sued, including taking any legal action necessary or proper to recover money for reinsurance payments; and

(7)  submitting invoices or other requests for money as necessary or appropriate under the waiver.

(b)  Except as prohibited under applicable federal law or regulations, the department may, as may be necessary or appropriate to carry out department duties, administer the reinsurance program directly or through:

(1)  a federal agency, an agency of another state, or another state agency; or

(2)  a contracted person or entity, including with a legal, actuarial, or economic third-party administrator or other person or entity, as the department determines appropriate, to provide consultation services and technical assistance.

(c)  A contracted person or entity under Subsection (b)(2) shall submit regular reports to the department regarding the person's or entity's performance, in the form and manner prescribed by the department.

Sec. 1511.304.  COORDINATION WITH EXCHANGE AUTHORITY. The department shall coordinate with the exchange authority as necessary to fund and operate the reinsurance program.

Sec. 1511.305.  REINSURANCE PROGRAM TERMS. (a) After consultation with all health benefit plan issuers participating in the exchange, but not less than 60 days before the date on which final rate filings for health benefit plans are required to be submitted each year under Section 1511.309, the department shall determine and adopt the attachment point, reinsurance cap, and coinsurance rate applicable to the reinsurance program for the following year.

(b)  In determining the attachment point, reinsurance cap, and coinsurance rate under Subsection (a), the department shall seek to:

(1)  manage the program within the total amount of funding available to the department for the reinsurance program; and

(2)  with respect to the individual market:

(A)  mitigate the impact of high-cost claims on premium rates;

(B)  stabilize or reduce premium rates; and

(C)  increase participation in the market.

(c)  The department shall, with respect to the adopted attachment point, reinsurance cap, and coinsurance rate:

(1)  publish notice of the terms:

(A)  in the Texas Register; and

(B)  on the department's Internet website; and

(2)  electronically send notice of the terms to:

(A)  the chairs of the standing committees of the senate and house of representatives with primary jurisdiction over appropriations and insurance; and

(B)  each participating health benefit plan issuer through a contact person or by e-mail, as identified by the plan issuer.

(d)  Not later than 10 business days after publication of notice in the Texas Register, a health benefit plan issuer may challenge and request a review of the department's determination of the attachment point, reinsurance cap, and coinsurance rate.

(e)  After the department has adopted the attachment point, reinsurance cap, and coinsurance rate under Subsection (a), the department may not, before or during the plan year for which those terms are in effect, change the attachment point, reinsurance cap, or coinsurance rate in a manner that is less favorable to the health benefit plan issuers participating in the exchange at the time of adoption.

Sec. 1511.306.  REINSURANCE PAYMENTS. (a) A health benefit plan issuer is eligible for a reinsurance payment if:

(1)  the claims costs for an enrollee's covered benefits during a plan year exceed the attachment point;

(2)  the eligible health benefit plan issuer has implemented and documented reasonable care management practices for enrollees who are the subject of reinsurance claims through the reinsurance program;

(3)  the eligible health benefit plan issuer makes a request for reinsurance payments in accordance with any requirements established by the department, including requirements regarding the format, structure, and timing for submission of claims for reinsurance payments; and

(4)  the eligible health benefit plan issuer participated in the exchange, or is affiliated with an entity that participated in the exchange, during the plan year in which the claims costs for which a reinsurance payment is requested were incurred.

(b)  In calculating reinsurance payments due to a health benefit plan issuer, the department must deduct from the relevant claim costs all other available insurance payments applicable to a claim, including insurance accessible through subrogation or coordination of benefits.

(c)  Payments to health benefit plan issuers must be calculated and made on a pro rata basis.

Sec. 1511.307.  REPORTING TO DEPARTMENT. A health benefit plan issuer that requests a reinsurance payment under this chapter must report to the department, in the form and manner prescribed by the department, any information regarding enrollees covered by the health benefit plan issuer necessary for the department to calculate reinsurance payments.

Sec. 1511.308.  REINSURANCE PAYMENT CLAIMS CONFIDENTIAL. A claim for a reinsurance payment under this subchapter is confidential and not subject to disclosure under Chapter 552, Government Code.

Sec. 1511.309.  EXCHANGE RATE FILINGS. A health benefit plan issuer must identify and include the impact of reinsurance payments under this subchapter in an annual rate filing for a health benefit plan to be offered through the exchange. The rate filing shall be submitted in the time and in the form and manner required by the department.

Sec. 1511.310.  RULES. The department may adopt any necessary and appropriate rules to establish processes for the settlement of reinsurance coverage claims and disbursement of reinsurance payments.

Sec. 1511.311.  REVIEW OF REINSURANCE PAYMENTS. A health benefit plan issuer may request an administrative review of the department's determination regarding the amount of a reinsurance payment due to the issuer.

Sec. 1511.312.  REINSURANCE PAYMENTS FROM FEDERAL MONEY. Notwithstanding any other provision of this subchapter, the department is not required to pay a reinsurance payment that would be payable with federal money if the federal government does not provide sufficient money for the reinsurance fund to fully reimburse the amount of the reinsurance payment.

Sec. 1511.313.  ANNUAL AUDIT. (a) The department shall have an examination and audit of the reinsurance program conducted annually by an independent certified public accounting firm. The audit must:

(1)  assess compliance with the requirements of this subchapter; and

(2)  identify any material weaknesses or significant deficiencies and identify and implement solutions to correct those weaknesses or deficiencies.

(b)  Not later than December 31 of each year, the department shall:

(1)  post on the department's Internet website:

(A)  the audit for the preceding year; and

(B)  a summary of the audit, including any identified material weaknesses or significant deficiencies and the department's proposed solution for those weaknesses or deficiencies; and

(2)  provide to the secretary of the senate and the chief clerk of the house of representatives an electronic link to the web page on which the audit information in Subdivision (1) is posted.

(c)  The department shall pay for the cost of the annual examination and audit under Subsection (a) with money from the reinsurance fund.

Sec. 1511.314.  ANNUAL REPORTS. (a) Not later than November 1 of the year following a plan year or 60 days after the final distribution of reinsurance payments for the applicable plan year, whichever is later, the department shall prepare a financial report regarding the previous plan year. The report must include:

(1)  the amount of money deposited into the reinsurance fund;

(2)  requests for reinsurance payments received from eligible health benefit plan issuers;

(3)  reinsurance payments made to eligible health benefit plan issuers; and

(4)  administrative and operational expenses incurred for the reinsurance program.

(b)  Not later than 60 days after rate filings required by Section 1511.309 for the individual market are submitted, the department shall prepare a report summarizing the quantifiable impact of the reinsurance program on individual market rates for the following plan year.

(c)  The department shall:

(1)  electronically submit the reports required under this section to the lieutenant governor, the speaker of the house of representatives, and the chairs of the standing committees of the senate and house of representatives with primary jurisdiction over appropriations and insurance; and

(2)  post the reports on the department's Internet website.

Sec. 1511.315.  REPORTING BY HEALTH BENEFIT PLAN ISSUERS. (a) A health benefit plan issuer must report information and provide access to records requested by the department as the department determines necessary for purposes of:

(1)  preparing the state innovation waiver application under Section 1511.301;

(2)  determining reinsurance program terms under Section 1511.305;

(3)  determining the amount of reinsurance payments due to a health benefit plan issuer;

(4)  monitoring costs and revenue associated with the reinsurance program;

(5)  administering the reinsurance program; and

(6)  ensuring compliance with all applicable federal and state laws with respect to the reinsurance program.

(b)  A health benefit plan issuer must provide information or records requested under Subsection (a) by the department not later than 30 days after the date that the plan issuer receives the request or, if necessary for the department to comply with a request from a federal or state agency, an earlier date as specified in the request.

(c)  Information and records provided to the department under this section:

(1)  may only be used by the department for the purposes described by Subsection (a); and

(2)  are confidential and not subject to disclosure under Chapter 552, Government Code.

Sec. 1511.316.  REINSURANCE FUND. (a) The reinsurance fund is established as a revolving fund in the state treasury outside the general revenue fund.

(b)  The fund shall be administered by the department for the purpose of the reinsurance program under this subchapter, including the deposit of federal money available for the reinsurance program and all other money received under or distributed in accordance with this subchapter.

(c)  Money from the fund may be used to:

(1)  implement and operate the reinsurance program; and

(2)  make reinsurance payments to eligible health benefit plan issuers under the reinsurance program.

(d)  In spending money from the fund, available federal money must be used first.

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

Sec. 1511.317.  REINSURANCE PROGRAM EXPENDITURES. (a) All costs and expenses incurred from the reinsurance program must be paid from the reinsurance fund, including compensation of employees and independent contractors or consultants hired by the department for purposes of operating the reinsurance program.

(b)  Each fiscal year, the total amount of annual expenditures from the reinsurance fund, including administrative and consulting expenses, may not exceed the total amount of federal money and money from other sources expected to be allocated to the reinsurance fund for that fiscal year.

Sec. 1511.318.  TEMPORARY EXEMPTION FROM STATE PURCHASING PROCEDURES. (a) For purposes of implementing and operating the reinsurance program under this subchapter, the department is not subject to state purchasing or procurement requirements under Subtitle D, Title 10, Government Code, or any other law. A contract or agreement entered into before the expiration of this section may not be for a term of more than five years.

(b)  This section expires January 1, 2023.

SUBCHAPTER H. ENFORCEMENT

Sec. 1511.351.  ENFORCEMENT REMEDIES. (a) On satisfactory evidence of a violation of this chapter by a health benefit plan issuer or other person, the commissioner may, at the commissioner's discretion, impose any of the following enforcement remedies:

(1)  suspension or revocation of the person's license or certificate of authority;

(2)  refusal to issue a new license or certificate of authority to the person, for a period not to exceed one year; or

(3)  a fine not to exceed $5,000 for each violation, except that the fine may be up to $10,000 if the violation was intentional.

(b)  Fines imposed by the commissioner against an individual health benefit plan issuer may not exceed an aggregate amount of $500,000 during a single calendar year.

(c)  Fines imposed against a person not described by Subsection (b) may not exceed an aggregate amount of $100,000 during a single calendar year.

(d)  The enforcement remedies under Subsection (a) are in addition to any other remedies or penalties that may be imposed under other law.

SUBCHAPTER I. TRANSITION PERIOD FOR ESTABLISHMENT OF EXCHANGE

Sec. 1511.401.  BUDGET FOR EXCHANGE. (a) In developing the exchange, the exchange authority, in coordination with the department, shall create a budget to fully implement the purposes and functions of the exchange authority and the exchange under this chapter.

(b)  The exchange authority shall conduct a fiscal analysis to determine ways in which the exchange authority can achieve the purposes of this chapter while spending less on exchange user fees than was spent for the federally facilitated exchange. The exchange authority must include in the fiscal analysis any funding sources available for specific purposes or functions under this chapter, including federal Medicaid matching funds.

Sec. 1511.402.  ENROLLMENT INCREASE TARGETS. (a) For the period of transition during which the exchange is being established and for the following five years, the department shall establish clearly stated numeric targets of increased enrollment in the exchange, the state Medicaid program, and the child health plan program under Chapter 62, Health and Safety Code.

(b)  The department shall take immediate steps to increase enrollment, including by lengthening open enrollment periods and streamlining special enrollment periods.

Sec. 1511.403.  INCREASED ENROLLMENT ADVISORY COMMITTEE. (a) The department shall create an advisory committee to:

(1)  study ways to increase enrollment in this state; and

(2)  help develop the five-year plan to reach the numeric targets established under Section 1511.402.

(b)  The department shall provide funding to the advisory committee for the purpose of employing staff and contracting with a person or entity to provide expertise, actuarial services, or other services as needed.

(c)  The advisory committee shall provide recommendations to the department and the exchange authority regarding strategies for increasing enrollment, including recommending the percentage of the exchange user fee imposed on premiums for health benefit plans on the exchange that the exchange authority should set aside to enhance subsidies for health benefit plans.

Sec. 1511.404.  EXPIRATION OF SUBCHAPTER. This subchapter expires September 1, 2027.

SECTION 2.  (a) As soon as practicable after the effective date of this Act, but not later than October 1, 2021, the governor shall appoint the initial members of the board of directors of the Texas Health Insurance Exchange Authority. The initial board members shall draw lots to achieve staggered terms, with two of the directors serving a term expiring February 1, 2023, two of the directors serving a term expiring February 1, 2025, and three of the directors serving a term expiring February 1, 2027.

(b)  As soon as practicable after the effective date of this Act, but not later than March 1, 2022, the board of directors of the Texas Health Insurance Exchange Authority shall adopt rules and procedures necessary to implement Chapter 1511, Insurance Code, as added by this Act.

(c)  Until the board of directors of the Texas Health Insurance Exchange Authority adopts rules under Subsection (b) of this section, the exchange authority shall operate the exchange in accordance with:

(1)  any applicable federal rules, regulations, or guidance; or

(2)  interim state guidelines consistent with Chapter 1511, Insurance Code, as added by this Act.

SECTION 3.  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, 2021.