

By: Ellis

S. B. No. 1782

A BILL TO BE ENTITLED

1 AN ACT

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

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

5 ARTICLE 1. CREATION OF THE TEXAS HEALTH INSURANCE EXCHANGE

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

CHAPTER 1509. TEXAS HEALTH INSURANCE EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1509.001. DEFINITIONS. In this chapter:

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

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

24 (6) "Executive commissioner" means the executive

1 commissioner of the Health and Human Services Commission.

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

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

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

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

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

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

21 (B) resides in this state;

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

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

1 States.

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

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

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

13 (1) an insurance company;

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

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

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

20 (5) an exchange operating under Chapter 942;

21 (6) a health maintenance organization operating under
22 Chapter 843;

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

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

27 (b) In this chapter, "health benefit plan" does not include:

1 (1) a plan that provides coverage:

2 (A) for wages or payments in lieu of wages for a

3 period during which an employee is absent from work because of

4 sickness or injury;

5 (B) as a supplement to a liability insurance

6 policy;

7 (C) for credit insurance;

8 (D) only for vision care;

9 (E) only for hospital expenses; or

10 (F) only for indemnity for hospital confinement;

11 (2) a Medicare supplemental policy as defined by

12 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

13 (3) a workers' compensation insurance policy; or

14 (4) medical payment insurance coverage provided under

15 a motor vehicle insurance policy.

16 Sec. 1509.003. DEFINITION OF SMALL EMPLOYER. (a) For

17 purposes of this chapter, "small employer" means a person who

18 employed at least two, and an average of not more than 50 employees

19 during the preceding calendar year. This subsection expires

20 December 31, 2013.

21 (b) All persons treated as a single employer under Section

22 414(b), (c), (m), or (o), Internal Revenue Code of 1986, are single

23 employers for purposes of this chapter.

24 (c) An employer and any predecessor employer are a single

25 employer for purposes of this chapter.

26 (d) In determining the number of employees of an employer

27 under this section, the number of employees:

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

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

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

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

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

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

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

1 Human Services Commission's eligibility systems modernization
2 efforts;

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

5 (3) develop and administer transition procedures
6 that:

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

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

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

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

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

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

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

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

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

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

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

25 (9) develop cross-market participation by:

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

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

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

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

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

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

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

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

25 (b) This section expires January 1, 2016.

26 [Sections 1509.009-1509.050 reserved for expansion]

1 SUBCHAPTER B. ESTABLISHMENT AND GOVERNANCE

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

7 Sec. 1509.052. GOVERNANCE OF EXCHANGE; BOARD MEMBERSHIP.

8 (a) The exchange is governed by a board of directors.

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

10 (1) five appointed members:

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

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

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

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

17 and

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

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

23 (1) individual health care coverage;

24 (2) small employer health care coverage;

25 (3) health benefit plan administration;

26 (4) health care finance or economics;

27 (5) actuarial science;

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

3 (7) purchasing health plan coverage.

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

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

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

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

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

18 Sec. 1509.055. CONFLICT OF INTEREST. (a) Any board member
19 or a member of a committee formed by the board with a direct
20 interest in a matter, personally or through an employer, before the
21 board shall abstain from deliberations and actions on the matter in
22 which the conflict of interest arises and shall further abstain
23 from any vote on the matter, and may not otherwise participate in a
24 decision on the matter.

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

1 related to board business.

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

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

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

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

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

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1 member knows or has reason to know will have a material financial
2 effect, distinguishable from its effect on the public generally, on
3 the board member or the board member's immediate family, or on:
4 (1) any source of income, other than gifts and loans by
5 a commercial lending institution in the regular course of business
6 on terms available to the public generally, aggregating \$250 or
7 more in value, provided or promised to the member within the 12
8 months immediately preceding the date the decision is made; or
9 (2) any business entity in which the member is a
10 director, officer, partner, trustee, or employee, or holds any
11 position of management.

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

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

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

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

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

26 [Sections 1509.061-1509.100 reserved for expansion]

1 SUBCHAPTER C. POWERS AND DUTIES OF EXCHANGE

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (1) assessments due the exchange;
11 (2) amounts erroneously or improperly paid by the
12 exchange; and
13 (3) amounts paid by the exchange as a mistake of fact
14 or law.

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

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

20 (c) The exchange may allow a health benefit plan issuer to
21 offer a plan that provides limited scope dental benefits meeting
22 the requirements of Section 9832(c)(2)(A), Internal Revenue Code of
23 1986, through the exchange, either separately or in conjunction
24 with a qualified health plan, if the plan provides pediatric dental
25 benefits meeting the requirements of Section 1302(b)(1)(J),
26 Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

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

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

7 (e) In implementing the requirements of this section, the
8 exchange shall:

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

13 (2) provide for the operation of a toll-free telephone
14 hotline to respond to requests for assistance, utilizing staff that
15 is trained to provide assistance in a culturally and linguistically
16 appropriate manner;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 (7) subject to Section 1411, Patient Protection and

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

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

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

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

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

17 (B) the name and taxpayer identification number
18 of each individual who was an employee of an employer but who was
19 determined to be eligible for the premium tax credit under Section
20 36B, Internal Revenue Code of 1986, because the employer did not
21 provide minimum essential coverage, or the employer provided the
22 minimum essential coverage, but it was determined under Section
23 36B(c)(2)(C) of that code to be either unaffordable to the employee
24 or not provide the required minimum actuarial value; and

25 (C) the name and taxpayer identification number
26 of each individual who notifies the exchange under Section
27 1411(b)(4), Patient Protection and Affordable Care Act (Pub. L. No.

1 111-148), that he or she has changed employers and each individual
2 who ceases coverage under a qualified health plan during a plan
3 year, and the effective date of that cessation;

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

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

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

16 (12) award grants to enable Navigators to:

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

19 (B) distribute fair and impartial information
20 concerning enrollment in qualified health plans, and the
21 availability of premium tax credits under Section 36B, Internal
22 Revenue Code of 1986, and cost-sharing reductions under Section
23 1402, Patient Protection and Affordable Care Act (Pub. L. No.
24 111-148);

25 (C) facilitate enrollment in qualified health
26 plans;

27 (D) provide referrals to any applicable office of

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

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

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

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

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

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

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

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

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

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

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

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

12 (D) the Health and Human Services Commission; and

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

15 (18) meet the following financial integrity
16 requirements:

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

21 (B) fully cooperate with any investigation
22 conducted by the secretary pursuant to the secretary's authority
23 under the Patient Protection and Affordable Care Act (Pub. L. No.
24 111-148) and allow the secretary, in coordination with the
25 inspector general of the United States Department of Health and
26 Human Services, to investigate the affairs of the exchange, examine
27 the books and records of the exchange, and require periodic reports

1 in relation to the activities undertaken by the exchange;

2 (19) use a single application for enrollment in

3 Medicaid, the state child health plan program, and health benefit

4 plans offered in the exchange, including establishing eligibility

5 for premium tax credits and cost-sharing reductions, that may be:

6 (A) the single application form developed by the

7 secretary under Section 1413(b), Patient Protection and Affordable

8 Care Act (Pub. L. No. 111-148); or

9 (B) an application form developed in cooperation

10 with the Health and Human Services Commission for that purpose;

11 (20) undertake activities necessary to market and

12 publicize the availability of health care coverage and federal

13 subsidies through the exchange;

14 (21) undertake outreach and enrollment activities

15 that seek to assist enrollees and potential enrollees with

16 enrolling and reenrolling in the exchange in the least burdensome

17 manner, including populations that may experience barriers to

18 enrollment, such as the disabled and those with limited English

19 language proficiency;

20 (22) provide for:

21 (A) the processing of applications for coverage

22 under a qualified health plan;

23 (B) the enrollment of persons in qualified health

24 plans;

25 (C) the disenrollment of enrollees from

26 qualified health plans; and

27 (D) for individual coverage, the collection of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (1) is a fee-for-service plan; or
14 (2) provides treatments necessary to prevent patients'
15 deaths in circumstances the exchange determines are inappropriate
16 or too costly.

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

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

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

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

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

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrolment;

(D) data on disenrollment;

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

(F) data on rating practices;

(G) information on cost-sharing and payments

10 with respect to any out-of-network coverage;

(H) information on enrollee and participant

12 rights under Title I, Patient Protection and Affordable Care Act

13 (Pub. L. No. 111-148); and

(I) other information as determined appropriate

15 by the secretary;

16 (4) on request, inform an individual of the amount of

17 cost-sharing, including deductibles, copayments, and coinsurance,

18 under the individual's plan or coverage that the individual would

19 be responsible for paying with respect to the fu

20 specific item or service by a participating provider;

21 (5) make the information required to be disclosed

22 under Subdivision (4) made available to the individual on an

23 Internet website and by other means for individuals without access

24 to the Internet;

25 (6) promptly notify affected individuals of price and

26 benefit changes or other changes in circumstance that could

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

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

11 (b) In determining whether to certify an issuer, the
12 exchange shall consider premium increase justification information
13 obtained under Subsection (a), together with information and
14 recommendations provided by the commissioner under Section
15 2794(b), Public Health Service Act (42 U.S.C. Section 300gg-94(b)).

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

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

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

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

1 qualified individuals and qualified small employers;
2 (4) consistently and uniformly apply any
3 requirements, standards, and criteria under this chapter to all
4 issuers;

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Sec. 1509.112. EXEMPTION FROM STANDARDS PROHIBITED. (a)

5 The exchange may not exempt any health benefit plan issuer seeking
6 certification of a qualified health plan, regardless of the type or
7 size of the issuer, from state licensing or solvency requirements.

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

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

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

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

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

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

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

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

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

12 [Sections 1509.115-1509.150 reserved for expansion]

13 SUBCHAPTER D. ASSESSMENTS FOR OPERATION OF EXCHANGE

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

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

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

26 Sec. 1509.152. GRANTS AND FEDERAL FUNDS. (a) The exchange
27 may accept a grant from a public or private organization and may

1 spend those funds to pay the costs of program administration and
2 operations.

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

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

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

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

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

25 [Sections 1509.155-1509.200 reserved for expansion]

26 SUBCHAPTER E. TRUST FUND

27 Sec. 1509.201. TRUST FUND. (a) The exchange fund is

1 established as a special trust fund outside of the state treasury in
2 the custody of the comptroller separate and apart from all public
3 money or funds of this state.

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

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

10 [Sections 1509.202-1509.250 reserved for expansion]

11 SUBCHAPTER F. LEVEL PLAYING FIELD

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

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

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

3 (1) prevailing rates in the market outside of the
4 exchange are paid a percentage of premiums; and
5 (2) the total fee amounts earned are reasonably
6 expected to be similar.

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

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

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

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

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

1 1509, Insurance Code, as added by this Act.

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

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

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

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

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

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1 Exchange may adopt rules on an emergency basis in accordance with
2 Section 2001.034, Government Code. Notwithstanding Section
3 2001.034(c), Government Code, a rule adopted under this subsection
4 may remain in effect until January 1, 2015. Rules adopted under
5 this subsection shall be deemed necessary for the immediate
6 preservation of the public peace, health, safety, and general
7 welfare and an additional finding under Sections 2001.034(a)(1) and
8 (2), Government Code, is not required. The authority to adopt rules
9 under this subsection expires January 1, 2015.

10 ARTICLE 2. EMERGENCY COVERAGE UNDER CERTAIN MANAGED CARE PLANS

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

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

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

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

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

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

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

27 SECTION 2.02. Section 843.348, Insurance Code, is amended

1 by adding Subsection (k) to read as follows:

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

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

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

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

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

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

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

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

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1 (42 U.S.C. Section 1395dd), medical screening examinations that are
2 within the capability of the emergency department of a hospital,
3 including ancillary services routinely available to the emergency
4 department to evaluate the patient's condition and any further
5 medical examination and treatment necessary to stabilize the
6 patient within the capabilities of the staff and facilities
7 available at the hospital shall be provided to covered enrollees.

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

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

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

1 obtains emergency care outside the health maintenance organization
2 delivery network.

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

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

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

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

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

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

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

25 (4) as required by Section 1867, Social Security Act
26 (42 U.S.C. Section 1395dd), medical screening examinations that are
27 within the capability of the emergency department of a hospital,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 ARTICLE 4. HEALTH BENEFIT PLAN COVERAGE OF CERTAIN DEPENDENTS

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

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

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

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

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

1 amended to read as follows:

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

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

12 (A) unmarried;
13 (B) younger than 26 [25] years of age; and
14 (C) a dependent of the insured or group member
15 for federal income tax purposes at the time application for
16 coverage of the grandchild is made; and

17 (2) each child for whom the insured or group member
18 must provide medical support under an order issued under Chapter
19 154, Family Code, or enforceable by a court in this state.

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

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

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

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8 (1) unmarried;

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

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

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

15 (a) For purposes of this section:

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

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

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

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

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

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

19 (2) "Dependent" means:

20 (A) a spouse;

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

22 including a newborn child;

23 (C) a child of any age who is:

24 (i) medically certified as disabled; and

25 (ii) dependent on the parent;

26 (D) an individual who must be covered under:

27 (i) Section 1251.154; or

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

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

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

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

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

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

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

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

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

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

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

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

12 (i) [~~(A)~~] a full-time student younger than
13 26 ~~[25]~~ years of age who is financially dependent on the parent;

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

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

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

21 (a) An individual's pool coverage ends:

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

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

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

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

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

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

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

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

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

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

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

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

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

26 (1) spouse;

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

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

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

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

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

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

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

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

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

5 (1) "Dependent" means:

6 (A) the spouse of a retiree;

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

10 (i) an adopted child;

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

13 (iii) a recognized natural child;

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

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

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

1 provided by the active member on a regular basis; and
2 (ii) was mentally retarded or physically
3 incapacitated to an extent that the child was dependent on the
4 active member or surviving spouse for care or support, as
5 determined by the trustee.

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

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

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

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

15 (A) an adopted child;

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

18 (C) a recognized natural child;

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

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

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

9 (1) spouse;

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

11 and

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

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

ARTICLE 5. RESCISSION OF HEALTH BENEFIT PLAN

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

1 SUBCHAPTER C. RESCISSION OF HEALTH BENEFIT PLAN

2 Sec. 1202.101. DEFINITION. In this subchapter,

3 "rescission" means the termination of an insurance agreement,

4 contract, evidence of coverage, insurance policy, or other similar

5 coverage document in which the health benefit plan issuer, as

6 applicable, refunds premium payments or demands the recoupment of

7 any benefit already paid under the plan.

8 Sec. 1202.102. APPLICABILITY. (a) This subchapter applies

9 only to a health benefit plan, including a small or large employer

10 health benefit plan written under Chapter 1501, that provides

11 benefits for medical or surgical expenses incurred as a result of a

12 health condition, accident, or sickness, including an individual,

13 group, blanket, or franchise insurance policy or insurance

14 agreement, a group hospital service contract, or an individual or

15 group evidence of coverage or similar coverage document that is

16 offered by:

17 (1) an insurance company;

18 (2) a group hospital service corporation operating

19 under Chapter 842;

20 (3) a fraternal benefit society operating under

21 Chapter 885;

22 (4) a stipulated premium company operating under

23 Chapter 884;

24 (5) a reciprocal exchange operating under Chapter 942;

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

26 (7) a health maintenance organization operating under

27 Chapter 843;

1 (8) a multiple employer welfare arrangement that holds
2 a certificate of authority under Chapter 846; or
3 (9) an approved nonprofit health corporation that
4 holds a certificate of authority under Chapter 844.

5 (b) This subchapter does not apply to:

6 (1) a health benefit plan that provides coverage:
7 (A) only for a specified disease or for another
8 limited benefit other than an accident policy;
9 (B) only for accidental death or dismemberment;
10 (C) for wages or payments in lieu of wages for a
11 period during which an employee is absent from work because of
12 sickness or injury;
13 (D) as a supplement to a liability insurance
14 policy;

15 (E) for credit insurance;
16 (F) only for dental or vision care;
17 (G) only for hospital expenses; or
18 (H) only for indemnity for hospital confinement;

19 (2) a Medicare supplemental policy as defined by
20 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
21 as amended;

22 (3) a workers' compensation insurance policy;
23 (4) medical payment insurance coverage provided under
24 a motor vehicle insurance policy;

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

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

3 (6) a Medicaid managed care plan offered under Chapter
4 533, Government Code;

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

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

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

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

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

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

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

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

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

1 decision to rescind.

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

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

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

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

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

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

26 ARTICLE 6. HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN CHILDREN

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

1 amended by adding Chapter 1521 to read as follows:

2 CHAPTER 1521. COVERAGE FOR CHILDREN; PREEXISTING CONDITIONS;

3 ENROLLMENT IN PLANS

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

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

14 (1) an insurance company;

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

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

19 (4) a stipulated premium company operating under
20 Chapter 844;

21 (5) an exchange operating under Chapter 942;

22 (6) a health maintenance organization operating under
23 Chapter 843;

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

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

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

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

8 (d) Notwithstanding any provision in Chapter 1551, 1575,
9 1579, or 1601 or any other law, this chapter applies to:

10 (1) a basic coverage plan under Chapter 1551;
11 (2) a basic plan under Chapter 1575;
12 (3) a primary care coverage plan under Chapter 1579;
13 and
14 (4) basic coverage under Chapter 1601.

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

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

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

22 (1) a plan that provides coverage:
23 (A) for wages or payments in lieu of wages for a
24 period during which an employee is absent from work because of
25 sickness or injury;
26 (B) as a supplement to a liability insurance
27 policy;

1 Sec. 1521.005. COVERAGE FOR CERTAIN DEPENDENTS REQUIRED.

2 If a health benefit plan includes dependent coverage, the health
3 benefit plan issuer shall approve the enrollment of an individual
4 who is the minor child of an enrollee in the health benefit plan.

5 Sec. 1521.006. CHILD-ONLY PLANS REQUIRED; PENALTY. (a) A

6 health benefit plan issuer shall offer, market, and sell health
7 benefit plans in this state that exclusively cover individuals
8 younger than 19 years of age.

9 (b) A health benefit plan issuer that does not comply with

10 Subsection (a) may not issue new individual health benefit plans of
11 any nature in this state.

12 (c) The department by rule shall require a health benefit

13 plan issuer to have, and shall adopt rules concerning, enrollment
14 periods for applicants described by Subsection (a). A health
15 benefit plan issuer must have at least two enrollment periods per
16 year of at least 60 days each.

17 (d) During a required enrollment period, a health benefit

18 plan issuer must issue individual health benefit plan coverage on a
19 guaranteed issue basis to an applicant younger than 19 years of age
20 and may not issue a health benefit plan with a preexisting condition
21 exclusion rider or endorsement described by Section 1521.004.

22 (e) The department by rule shall adopt standard special

23 enrollment procedures in which an applicant described by Subsection
24 (a) may enroll in an individual health benefit plan under this
25 section on a guaranteed issue basis during a period other than an
26 enrollment period under Subsection (c) if the applicant or a
27 parent, managing conservator, or legal guardian of the applicant

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

4 Sec. 1521.007. CONFLICT WITH OTHER LAW. If this chapter
5 conflicts with another law relating to coverage provided by a
6 health benefit plan to an individual who is younger than 19 years of
7 age, including a provision of Chapter 846, 1201, 1251, 1252, 1501,
8 1504, 1507, 1508, 1575, 1579, 1625, 1651, or 1652, this chapter
9 controls.

10 SECTION 6.02. Each health benefit plan issuer required to
11 issue individual health benefit plan coverage under Section
12 1521.005, Insurance Code, as added by this article, shall offer an
13 initial enrollment period satisfying the requirements of Section
14 1521.006(d), Insurance Code, as added by this article, beginning
15 not later than March 1, 2012. Notwithstanding Section 1521.005,
16 Insurance Code, as added by this article, the initial enrollment
17 period required by this section must be at least 90 days.

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

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

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

1 CHAPTER 1522. PREVENTIVE CARE SERVICES

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

9 (1) an insurance company;

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

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

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

16 (5) an exchange operating under Chapter 942;

17 (6) a health maintenance organization operating under
18 Chapter 843;

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

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

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

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

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

3 (d) Notwithstanding any provision in Chapter 1551, 1575,
4 1579, or 1601 or any other law, this chapter applies to:

5 (1) a basic coverage plan under Chapter 1551;
6 (2) a basic plan under Chapter 1575;
7 (3) a primary care coverage plan under Chapter 1579;

8 and

9 (4) basic coverage under Chapter 1601.

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

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

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

17 (1) a plan that provides coverage:

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

21 (B) as a supplement to a liability insurance
22 policy;

23 (C) for credit insurance;

24 (D) only for dental or vision care;

25 (E) only for hospital expenses; or

26 (F) only for indemnity for hospital confinement;

27 (2) a Medicare supplemental policy as defined by

1 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
2 (3) a workers' compensation insurance policy;
3 (4) medical payment insurance coverage provided under
4 a motor vehicle insurance policy; or
5 (5) a long-term care policy, including a nursing home
6 fixed indemnity policy, unless the commissioner determines that the
7 policy provides benefit coverage so comprehensive that the policy
8 is a health benefit plan as described by Section 1522.001.

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

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

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

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

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

27 SECTION 7.02. This article applies only to a health benefit

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1 plan that is delivered or issued for delivery on or after January 1,
2 2012. A health benefit plan that is delivered or issued for
3 delivery before January 1, 2012, is governed by the law as it
4 existed immediately before the effective date of this Act, and that
5 law is continued in effect for that purpose.

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

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

10 CHAPTER 1523. CERTAIN LIFETIME AND ANNUAL LIMITATIONS ON COVERAGE
11 PROHIBITED

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

19 (1) an insurance company;

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

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

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

26 (5) an exchange operating under Chapter 942;

27 (6) a health maintenance organization operating under

1 Chapter 843;

2 (7) a multiple employer welfare arrangement that holds
3 a certificate of authority under Chapter 846; or
4 (8) an approved nonprofit health corporation that
5 holds a certificate of authority under Chapter 844.

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

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

13 (d) Notwithstanding any provision in Chapter 1551, 1575,
14 1579, or 1601 or any other law, this chapter applies to:

15 (1) a basic coverage plan under Chapter 1551;
16 (2) a basic plan under Chapter 1575;
17 (3) a primary care coverage plan under Chapter 1579;

18 and

19 (4) basic coverage under Chapter 1601.

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

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

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

27 (1) a plan that provides coverage:

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4 (B) as a supplement to a liability insurance
5 policy;

6 (c) for credit insurance;

12 (3) a workers' compensation insurance policy;

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

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

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

3 (A) visits to a physician;
4 (B) days of inpatient or outpatient treatment; or
5 (C) prescription refills.

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

11 (1) notify the former enrollee:
12 (A) that the lifetime maximum benefit no longer
13 applies to the former enrollee; and
14 (B) that the former enrollee is eligible to
15 reenroll in a health benefit plan issued by the health benefit plan
16 issuer; and

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

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

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

27 SECTION 8.02. Each health benefit plan issuer required to

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1 offer to former enrollees reenrollment in a health benefit plan
2 under Section 1523.004, Insurance Code, as added by this article,
3 shall send to each former enrollee entitled to a notice under that
4 section the notice required by that section not later than December
5 1, 2011.

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

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

17 ARTICLE 9. EFFECTIVE DATE

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