By: Johnson H.B. No. 1002

A BILL TO BE ENTITLED

AN ACT

relating to creation of the Texas Health Insurance Exchange.

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

SECTION 1. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1509 to read as follows:

CHAPTER 1509. TEXAS HEALTH INSURANCE EXCHANGE

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1509.001. DEFINITIONS. In this chapter:

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

(2) "Catastrophic plan" has the meaning described by Section 1302(e), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022).

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

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

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

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

(7) "Qualified employer" means an employer that elects

to make all of its full-time employees eligible for one or more qualified health plans offered through the exchange and, at the option of the employer, some or all of its part-time employees and:

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

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

(8) "Qualified health plan" means a health benefit plan that has been certified by the board as meeting the criteria specified by Section 1311(c), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(c)).

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

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

(B) resides in this state;

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

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

(10) "Secretary" means the secretary of the United

States Department of Health and Human Services.

(11) "SHOP Exchange" means a Small Business Health Options Program as described by Section 1311(b)(1)(B), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(b)(1)(B)).

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

(1) an insurance company;

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

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

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

(5) an exchange operating under Chapter 942;

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

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

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

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

(1) a plan that provides coverage:

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

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

(C) for credit insurance;

(D) only for vision care;

(E) only for hospital expenses; or

(F) only for indemnity for hospital confinement;

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

(3) a workers' compensation insurance policy; or

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

Sec. 1509.003. TREATMENT OF EMPLOYERS. (a) For purposes of this chapter, "small employer" means a person who employed at least two, and an average of not more than 50 employees during the preceding calendar year. This subsection expires December 31, 2015.

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

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

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

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

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

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

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

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

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

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

Human Services Commission's eligibility systems modernization efforts;

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

(3) develop and administer transition procedures that:

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

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

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

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

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

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

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

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

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

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

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

(9) develop cross-market participation by:

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

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

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

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

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

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

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

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

(b) This section expires January 1, 2016.

[Sections 1509.009-1509.050 reserved for expansion]

SUBCHAPTER B. ESTABLISHMENT AND GOVERNANCE

Sec. 1509.051. ESTABLISHMENT. The Texas Health Insurance Exchange is established as an American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange authorized and required by Section 1311, Patient Protection and Affordable Care Act (42 U.S.C. Section 18031).

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

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

(1) five appointed members:

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

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

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

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

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

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

(1) individual health care coverage;

(2) small employer health care coverage;

(3) health benefit plan administration;

(4) health care finance or economics;

(5) actuarial science;

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

(7) purchasing health plan coverage.

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

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

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

Sec. 1509.054. TERMS; VACANCY. (a) Appointed members of the board serve six-year staggered terms, with either one or two of the members' terms expiring February 1 of each odd-numbered year.

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

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

(b) Each board member shall file a conflict of interest statement and a statement of ownership interests with the board to

ensure disclosure of all existing and potential personal interests related to board business.

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

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

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

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

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

position to influence the making of any decision that the board member knows or has reason to know will have a material financial effect, distinguishable from its effect on the public generally, on the board member or the board member's immediate family, or on:

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

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

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

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

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

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

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

[Sections 1509.061-1509.100 reserved for expansion]

SUBCHAPTER C. POWERS AND DUTIES OF EXCHANGE

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) assessments due the exchange;

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

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

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

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

(c) The exchange may allow a health benefit plan issuer to offer a plan that provides limited scope dental benefits meeting the requirements of Section 9832(c)(2)(A), Internal Revenue Code of 1986, through the exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022(b)(1)(J)).

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

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

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

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

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

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

(5) use a standardized format for presenting health

benefit options in the exchange, including the use of the uniform outline of coverage established under Section 2715, Public Health Service Act (42 U.S.C. Section 300gg-15);

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

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

(8) determine each qualified health plan's level of coverage in accordance with regulations issued by the secretary under Section 1302(d)(2)(A), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022(d)(2)(A)); and

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

(f) In addition to performing the duties described by Subsection (e), and consistent with Section 1413, Patient Protection and Affordable Care Act (42 U.S.C. Section 18083), the exchange shall:

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

(2) provide enrollment information and other relevant

data, consistent with federal and state privacy rules, to the qualified health plan in which a qualified individual or qualified small employer is enrolled;

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

(4) inform individuals of the potential for overpayments of advance premium tax credits and of procedures by which individuals can report a change of income that may affect the subsequent level of premium tax credits, including the availability of any safe harbor from recoupment of any overpayment, to the extent permitted by the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) or any federal regulations promulgated under that Act;

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

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

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

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

through the exchange at the specified level of coverage;

(7) subject to Section 1411, Patient Protection and Affordable Care Act (42 U.S.C. Section 18081), grant a certification attesting that, for purposes of the individual responsibility penalty under Section 5000A, Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

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

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

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

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

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

(C) the name and taxpayer identification number

of each individual who notifies the exchange under Section 1411(b)(4), Patient Protection and Affordable Care Act (42 U.S.C. Section 18081(b)(4)), that he or she has changed employers and each individual who ceases coverage under a qualified health plan during a plan year, and the effective date of that cessation;

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

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

(11) select entities qualified to serve as Navigators in accordance with Section 1311(i), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(i)), and standards developed by the secretary;

(12) award grants to enable Navigators to:

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

(B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under Section 36B, Internal Revenue Code of 1986, and cost-sharing reductions under Section 1402, Patient Protection and Affordable Care Act (42 U.S.C. Section 18071);

(C) facilitate enrollment in qualified health

plans;

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

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

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

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

(14) certify Navigators as able to carry out the duties required by Section 1311(i)(3), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(i)(3));

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

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

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

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

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

(D) the Health and Human Services Commission; and

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

(17) meet the following financial integrity requirements:

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

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

(18) use a single application for enrollment in Medicaid, the state child health plan program, and health benefit

plans offered in the exchange, including establishing eligibility for premium tax credits and cost-sharing reductions, that may be:

(A) the single application form developed by the secretary under Section 1413(b), Patient Protection and Affordable Care Act (42 U.S.C. Section 18083(b)); or

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

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

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

(21) provide for:

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

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

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

(D) for individual coverage, the collection of premiums and assistance in the administration of subsidies, as the board considers appropriate; and

(22) for small employers, collect and aggregate

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

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

(1) the plan provides the essential health benefits package described by Section 1302(a), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022(a)), except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, if:

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

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

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

(3) the plan provides at least a bronze level of coverage, as described by Section 1302(d), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022(d)), unless the plan is a catastrophic plan and is offered only to individuals eligible for catastrophic coverage;

(4) the plan's cost-sharing requirements do not exceed the limits established under Section 1302(c)(1), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022(c)(1)), and if the plan is offered to small employers, the plan's deductible does not exceed the limits established under Section 1302(c)(2) of that Act (42 U.S.C. Section 18022(c)(2));

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

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

(B) offers at least one qualified health plan in the silver level and at least one plan in the gold level as described by Section 1302(d), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022(d));

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

(D) complies with the regulations developed by the secretary under Section 1311(d), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(d)), and other requirements the exchange establishes;

(6) the plan meets the requirements of certification under this chapter and any rules promulgated by the secretary under Section 1311(c), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(c)), including minimum standards in the areas of marketing practices, network adequacy, essential community

providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage, and information on quality measures for health benefit plan performance; and

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

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

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

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

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

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

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

(3) make available to the public, in plain language as that term is defined in Section 1311(e)(3)(B), Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(e)(3)(B)), and submit to the exchange, the secretary, and the commissioner, accurate and timely disclosure of:

(A) claims payment policies and practices;

(B) periodic financial disclosures;

(C) data on enrollment;

(D) data on disenrollment;

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

(F) data on rating practices;

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

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

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

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

(5) make the information required to be disclosed under Subdivision (4) available to the individual:

(A) on an Internet website; and

(B) by means other than an Internet website for individuals without access to the Internet;

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

(7) make available to the exchange and regularly

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

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

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

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

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

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

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

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

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

(6) ensure, in each region of the state, a choice of qualified health plans at each of the five tiers of coverage contained in Sections 1302(d) and (e), Patient Protection and Affordable Care Act (42 U.S.C. Sections 18022(d) and (e));

(7) require issuers, as a condition of participation in the exchange, to fairly and affirmatively offer, market, and sell in the exchange at least one product within each of the five levels of coverage described by Sections 1302(d) and (e), Patient Protection and Affordable Care Act (42 U.S.C. Sections 18022(d) and (e)), and, as the board considers necessary, to offer additional products within each of the five levels of coverage described by Section 1302(d) of that Act (42 U.S.C. Section 18022(d)); and

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

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

(B) all products made available to small

employers in the exchange to small employers purchasing coverage outside the exchange.

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

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

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

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

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

(d) To be certified under this chapter, a dental plan must include, at a minimum, the essential pediatric dental benefits prescribed by the secretary pursuant to Section 1302(b)(1)(J), Patient Protection and Affordable Care Act (42 U.S.C. Section 18022(b)(1)(J)), and any other dental benefits the exchange or the secretary specifies by regulation.

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

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

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

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

[Sections 1509.115-1509.150 reserved for expansion]

SUBCHAPTER D. ASSESSMENTS FOR OPERATION OF EXCHANGE

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

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

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

Sec. 1509.152. GRANTS AND FEDERAL FUNDS. (a) The exchange

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

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

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

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

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

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

[Sections 1509.155-1509.200 reserved for expansion]

SUBCHAPTER E. TRUST FUND

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

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

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

[Sections 1509.202-1509.250 reserved for expansion]

SUBCHAPTER F. LEVEL PLAYING FIELD

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

(b) To discourage adverse selection or steering of enrollees to or from the exchange, if the board opts to pay agents helping people enroll in exchange-participating, qualified plans a fee, instead of using existing compensation structures directly from issuers, the exchange shall survey the market outside of the exchange to determine prevailing agent commission rates and set

exchange fees in a manner that is consistent with prevailing rates in the market outside of the exchange. This section does not prohibit the exchange from paying a per member per month fee or using another fee structure if:

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

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

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

SECTION 2. Effective January 1, 2016, Section 1509.003, Insurance Code, as added by this Act, is amended by adding Subsection (a-1) to read as follows:

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

SECTION 3. (a) As soon as practicable after the effective date of this Act, but not later than October 31, 2013, the governor, lieutenant governor, and speaker of the house of representatives shall appoint the initial members of the board of directors of the Texas Health Insurance Exchange as follows:

(1) the governor shall appoint one person to a term expiring February 1, 2019;

(2) the lieutenant governor shall appoint one person

to a term expiring February 1, 2015, and one person to a term expiring February 1, 2017; and

(3) the speaker of the house of representatives shall appoint one person to a term expiring February 1, 2015, and one person to a term expiring February 1, 2017.

(b) As soon as practicable after the appointments required by Subsection (a) of this section are made, but not later than November 30, 2013, the board of directors of the Texas Health Insurance Exchange shall hold a special meeting to discuss the adoption of rules and procedures necessary to implement Chapter 1509, Insurance Code, as added by this Act.

(c) As soon as practicable after the effective date of this Act, but not later than January 31, 2014, the board of directors of the Texas Health Insurance Exchange shall adopt rules and procedures necessary to implement Chapter 1509, Insurance Code, as added by this Act.

(d) Not later than January 1, 2019, the board shall issue a report to the 86th Legislature recommending whether to adopt the option in Section 1312(c), Patient Protection and Affordable Care Act (42 U.S.C. Section 18032(c)), to merge the individual and small employer markets. In the report, the board shall provide information, based on at least two years of data from the exchange, on the potential impact on rates paid by individuals and by small employers in a merged individual and small employer market, as compared to the rates paid by individuals and small employers if a separate individual and small employer market is maintained.

(e) If, after the effective date of this Act but before the

initial members of the board of directors of the Texas Health Insurance Exchange have been appointed as required by Subsection (a) of this section, the Texas Department of Insurance becomes aware of any planning and establishment grants as described by Section 1311, Patient Protection and Affordable Care Act (42 U.S.C. Section 18031), or any other public or private funding source, the department may apply for funding from that source.

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

(g) The board of directors of the Texas Health Insurance Exchange may adopt rules on an emergency basis in accordance with Section 2001.034, Government Code. Notwithstanding Section 2001.034(c), Government Code, a rule adopted under this subsection may remain in effect until January 1, 2017. Rules adopted under this subsection shall be deemed necessary for the immediate preservation of the public peace, health, safety, and general welfare and an additional finding under Sections 2001.034(a)(1) and (2), Government Code, is not required. The authority to adopt rules under this subsection expires January 1, 2017.

SECTION 4. Except as otherwise provided by this Act, this Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2013.