BILL ANALYSIS

Senate Research Center
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S.B. 1586
By: Ogden
Finance
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

This bill amends the Insurance and Occupations Codes relating to state fiscal matters related to certain regulatory agencies.

Sections 1.01 and 1.02 of this bill authorize state agencies to reduce or recover expenditures by taking action to consolidate reports, extend license, permit or registration periods, enter into contracts to carry out an agency's duties, adopt additional eligibility requirements for benefits, provide for electronic communication, and adopt and collect fees or charges to recover costs incurred by an agency.

Sections 2.01 and 2.02 of this bill repeal insurance premium tax credits for examination fees, implement a recommendation from the report, "End the Use of General Revenue Funds to Pay for Insurance Company Examinations," in the Legislative Budget Board's (LBB) *Government Effectiveness and Efficiency Report* submitted to the 82nd Legislature, 2011. Article 2 would take effect immediately upon receiving a two-thirds majority vote in each house. If the bill does not receive a two-thirds vote in each house, Article 2 would take effect September 1, 2011.

Sections 3.01 through 3.03 establish a Health Care Payment and Delivery System Reform Committee (committee) and attaches it to the Texas Department of Insurance (TDI). The committee consists of six appointees from state agencies that purchase health care and four non-voting members representing the legislature. The committee is required to develop a plan to identify priority outcomes for cost containment and quality improvement, coordinate initiatives for reform across state health payors, review pilot program proposals and funding requests submitted to the committee, and make recommendations to the commissioner of insurance (commissioner). The commissioner is required to adopt rules relating to funding of pilot programs and may approve a pilot program and/or award funding based on the recommendation of the committee. This bill amends the Occupations Code to permit a person, including a partnership, trust, association, or corporation operating an approved pilot program to employ a physician without violating Sections 164.052(a)(13) or (17) or 165.156 of the Occupations Code. These recommendations are contained in the Legislative Budget Board's 2011 Government Effectiveness and Efficiency Report entitled “Reform Healthcare Payment and Delivery Systems to Reduce State Expenditures." This section takes effect September 1, 2011.

Sections 4.01 through 4.03 establish a Health Insurance Connector (connector) in Texas as the vehicle for a health insurance exchange as required by the federal Patient Protection and Affordable Care Act of 2010 (ACA). The connector operates under the direction of a seven-member board of directors, which would be authorized to adopt rules when time does not permit legislative action. The board has the authority to hire employees and determine their compensation.

This bill requires the connector to perform all duties required of a health insurance exchange under ACA. This bill allows the connector to enter into contracts necessary to implement or administer its functions, including contracts with the TDI or HHSC to provide services in exchange for payment. This bill requires the connector to enter into a memorandum of understanding with TDI and HHSC regarding the exchange of information and the division of regulatory functions among the three entities. This bill allows the connector to take legal action to recover or collect amounts due the connector and to be sued.

This bill allows the connector to charge an assessment on the issuers of qualified health plans and health benefit plans applying for certification. This bill also allows the connector to accept and use federal funds and grants from public or private organizations. The connector is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee. This bill establishes a special trust fund outside of the state treasury into which the connector can deposit revenues. The trust fund is in the custody of the comptroller of public accounts and is separate and apart from all public money or funds of the state.

As proposed, S.B. 1586 amends current law relating to state fiscal matters related to certain regulatory agencies.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 4.01 (Section 41.053, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the board of directors of the Texas Health Insurance Connector in SECTION 4.01 (Sections 1509.003, 1509.109, and 1509.110, Insurance Code) of this bill.

Rulemaking authority is expressly granted to the Texas Health Insurance Connector in SECTION 4.01 (Section 1509.106, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

ARTICLE 1. REDUCTION OF EXPENDITURES AND IMPOSITION OF CHARGES GENERALLY

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

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

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

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

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

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

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

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

ARTICLE 2. FISCAL MATTERS REGARDING REGULATION OF INSURERS

SECTION 2.01. Amends Section 463.160, Insurance Code, as follows:

Sec. 463.160. PREMIUM TAX CREDIT FOR CLASS A ASSESSMENT. Requires that the amount of a Class A assessment paid by a member insurer in each taxable year be allowed as a credit on the amount of premium taxes due, rather than on the amount of premium taxes due in the same manner as a credit is allowed under Section 401.151(e) (requiring that the amount of all examination and evaluation fees paid to the state by an insurer in each taxable year be allowed as a credit on the amount of premium taxes due).

SECTION 2.02. Repealers: Sections 221.006 (Credit for Fees Paid), 222.007 (Failure to Pay Taxes), 223.009 (Credit for Fees Paid), 401.151(e) (requiring that the amount of all examination and evaluation fees paid to the state by an insurer in each taxable year be allowed as a credit on the amount of premium taxes due), and 401.154 (Tax Credit Authorized), Insurance Code.

SECTION 2.03. Effective date, this article: upon passage or September 1, 2011.

ARTICLE 3. FISCAL MATTERS REGARDING HEALTH CARE DELIVERY

SECTION 3.01. Amends Subtitle A, Title 2, Insurance Code, by adding Chapter 41, as follows:

CHAPTER 41. HEALTH CARE PAYMENT AND DELIVERY SYSTEM REFORM

SUBCHAPTER A. HEALTH CARE PAYMENT AND DELIVERY SYSTEM REFORM COMMITTEE

Sec. 41.001. DEFINITION. Defines, in this chapter, "committee."

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

(b) Provides that the committee is administratively attached to the Texas Department of Insurance (TDI). Requires TDI to provide administrative support and resources to the committee as necessary for the committee to perform its duties.

Sec. 41.003. COMPOSITION OF COMMITTEE. Provides that the committee is composed of certain voting members and certain nonvoting members. Sets forth the composition of the committee.

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

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

(c) Authorizes a member of the committee to be removed by the commissioner of insurance (commissioner) with cause stated in writing. Requires the appropriate person or entity to appoint in the manner provided by Section 41.003 a replacement for a member who leaves or is removed from the committee.

Sec. 41.005. DUTIES. Requires the committee to:

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

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

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

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

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

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

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

(2) submit the priority outcome plan to:

(A) the governor; and

(B) the Legislative Budget Board (LBB); and

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

Sec. 41.007. EXPIRATION OF CHAPTER. Provides that this chapter expires September 1, 2021.

[Reserves Sections 41.008-41.050 for expansion.]

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

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

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

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

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

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

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

(A) adequately protects the interests of patients and consumers; and

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

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

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

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

SECTION 3.02. Amends Chapter 162, Occupations Code, by adding Subchapter F, as follows:

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

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

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

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

(b) Provides that a person that employs a physician under this section does not violate Section 164.052(a)(13) (relating to impersonating a physician or permitting another to use the person's license or certificate to practice medicine in this state) or (17) (relating to directly or indirectly aiding or abeting the practice of medicine by a person, partnership, association, or corporation that is not licensed to practice medicine) or 165.156 (Misrepresentation Regarding Entitlement to Practice Medicine), or any other law that prohibits the practice of medicine by a person other than a physician, to the extent that the physician is performing services for the purpose of the pilot program.

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

Sec. 162.302. EXPIRATION OF SUBCHAPTER. Provides that this subchapter expires September 1, 2021.

SECTION 3.03. Requires the committee, notwithstanding Section 41.006, Insurance Code, as added by this article, not later than February 1, 2012, to develop the first plan required by Section 41.005(1), Insurance Code, as added by this article, submit the plan to the governor and TDI, and make the plan available to the public on TDI's Internet website.

SECTION 3.04. Effective date: September 1, 2011.

ARTICLE 4. TEXAS HEALTH INSURANCE CONNECTOR

SECTION 4.01. Amends Subtitle G, Title 8, Insurance Code, by adding Chapter 1509, as follows:

CHAPTER 1509. TEXAS HEALTH INSURANCE CONNECTOR

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1509.001. DEFINITIONS. Defines, in this chapter, "board," "connector," "enrollee," "executive commissioner," "qualified health plan," "qualified individual," "secretary," and "small employer."

Sec. 1509.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) Defines, in this chapter, "health benefit plan."

Sec. 1509.003. RULES. (a) Authorizes the board of directors of the Texas Health Insurance Connector (board; connector) to adopt rules necessary and proper to implement this chapter.

(b) Authorizes the board to adopt rules necessary to implement state responsibility in compliance with a federal law or regulation or action of a federal court relating to a person or activity under the purview of the connector if:

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

(A) a state to adopt the rules; or

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

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

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

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

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

(b) Requires the connector and TDI to cooperate to promote a stable health benefit plan market in this state.

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

Sec. 1509.006. CONNECTOR NOT INSURER. Provides that the connector is not an insurer or health maintenance organization and is not subject to regulation by TDI.

Sec. 1509.007. EXEMPTION FROM STATE TAXES AND FEES. Provides that the connector is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Sec. 1509.008. COMPLIANCE WITH FEDERAL LAW. Requires the connector to comply with all applicable federal law and regulations.

[Reserves Sections 1509.009-1509.050 for expansion.]

SUBCHAPTER B. ESTABLISHMENT AND GOVERNANCE

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

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

(b) Provides that the board consists of seven members. Sets forth the composition of the board.

(c) Requires at least three of the five board members appointed by the governor to have experience in health care administration, health care economics, or health insurance or be knowledgeable concerning general business or actuarial principles. Requires one of the board members appointed by the governor to represent the interests of health benefit plan consumers in this state; requires one to represent the interests of small employers in this state; and requires one to be an enrollee or be reasonably expected to qualify for coverage under a qualified health plan in this state.

(d) Prohibits a person from serving as a member of the board if the person is required to register as a lobbyist under Chapter 305 (Registration of Lobbyists), Government Code, because of the person's activities for compensation related to the operation of the connector or the business of insurance in this state.

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

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

(b) Requires the governor to 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) Requires a board member, or a member of a committee formed by the board, with a direct interest in a matter before the board, personally or through an employer, to abstain from deliberations and actions on the matter in which the conflict of interest arises; abstain from any vote on the matter; and not in any manner participate in a decision on the matter.

(b) Requires each board member to file a conflict of interest statement and a statement of ownership interests with the board to ensure disclosure of all existing and potential personal interests related to board business.

Sec. 1509.056. REIMBURSEMENT. Provides that a member of the board is not entitled to compensation but is entitled to reimbursement for travel or other expenses incurred while performing duties as a board member in the amount provided by the General Appropriations Act for state officials.

Sec. 1509.057. MEMBER'S IMMUNITY. (a) Provides that 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) Provides that a cause of action does not arise against a member of the board for an act or omission described by Subsection (a).

Sec. 1509.058. OPEN RECORDS AND OPEN MEETINGS. (a) Provides that the board is subject to Chapter 551 (Open Meetings), Government Code. Authorizes the board to meet in executive session in accordance with Chapter 551, Government Code, to discuss confidential or proprietary information, including contract decisions and qualified health plan rates.

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

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

Sec. 1509.060. BIENNIAL REPORT. Requires the board, not later than January 1 of each odd-numbered year, to provide a report to the governor, the legislature, the commissioner, and the executive commissioner of HHSC (executive commissioner). Requires that the report include information regarding the development and implementation of the connector, specifically detailing progress made by the connector in implementing the requirements of this chapter.

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

(b) Provides that this section expires January 31, 2014.

[Reserves Sections 1509.062-1509.100 for expansion.]

SUBCHAPTER C. POWERS AND DUTIES OF CONNECTOR

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

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

Sec. 1509.102. CONTRACTS. Authorizes the connector to enter into any contract that the connector considers necessary to implement or administer this chapter, including a contract with TDI or HHSC for TDI or HHSC, in exchange for payment, to perform functions or provide services in connection with the operation of the connector.

Sec. 1509.103. INFORMATION SHARING AND CONFIDENTIALITY. Authorizes the connector to enter into information-sharing agreements with federal and state agencies to carry out the connector's responsibilities under this chapter. Requires that an agreement entered into under this section include adequate protection with respect to the confidentiality of any information shared and comply with all applicable state and federal law.

Sec. 1509.104. MEMORANDUM OF UNDERSTANDING. Requires the connector to enter into a memorandum of understanding with TDI and HHSC regarding the exchange of information and the division of regulatory functions among the connector, TDI, and HHSC.

Sec. 1509.105. LEGAL ACTION. (a) Authorizes the connector to sue or be sued.

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

(1) assessments due the connector;

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

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

Sec. 1509.106. FUNCTIONS. Requires the connector to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) engage in marketing and outreach activities; and

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

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

Sec. 1509.108. CERTIFICATION OF PLAN. Requires the board to certify a health benefit plan as a qualified health plan if the health benefit plan meets the requirements for certification set forth by the secretary. Prohibits the connector from, as a condition of certification, requiring a health benefit plan issuer to:

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

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

Sec. 1509.109. QUALIFICATION OF INDIVIDUALS. Requires the board by rule to establish criteria for eligibility for a potential enrollee to be considered a qualified individual. Requires that the criteria, at a minimum, require that the individual:

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

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

(3) at the time of enrollment, not be incarcerated, other than being incarcerated pending the disposition of any criminal charges.

Sec. 1509.110. PREMIUM COLLECTION AND AGGREGATION. Requires the board by rule to establish a mechanism for the collection and aggregation of premium payments directly or indirectly from enrollees and the payment of premiums to issuers of qualified health plans. Requires that rules adopted under this section include rules regarding an employer's authority to withhold premium payments from an enrollee's paycheck and to submit those premium payments to issuers of qualified health plans.

Sec. 1509.111. PREMIUM INCREASE JUSTIFICATION. (a) Requires the connector to require an issuer of a qualified health plan to file with the connector an explanation of any premium increase before implementation of the increase.

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

[Reserves Sections 1509.112-1509.150 for expansion.]

SUBCHAPTER D. COVERAGE REQUIREMENTS OR LIMITATIONS

Sec. 1509.151. PROHIBITED COVERAGE THROUGH CONNECTOR. Prohibits a qualified health plan offered through the connector from providing coverage for an abortion, as defined by Section 171.002 (Definition), Health and Safety Code.

[Reserves Sections 1509.152-1509.200 for expansion.]

SUBCHAPTER E. ASSESSMENTS FOR OPERATION OF CONNECTOR

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

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

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

(b) Authorizes the connector to accept federal funds and requires the connector to use those funds in compliance with applicable federal law, regulations, and guidelines.

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

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

[Reserves Sections 1509.204-1509.250 for expansion.]

SUBCHAPTER F. TRUST FUND

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

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

(c) Requires that interest or other income from the investment of the fund be deposited to the credit of the fund.

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

(b) Requires the board, as soon as possible after the appointments required by Subsection (a) of this section are made, but not later than November 30, 2011, to 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) Requires the board, as soon as possible after the effective date of this article, but not later than January 31, 2012, to adopt rules and procedures necessary to implement Chapter 1509, Insurance Code, as added by this article.

SECTION 4.03. Effective date: upon passage or September 1, 2011.