

R E S O L U T I O N

1 BE IT RESOLVED by the House of Representatives of the State of
2 Texas, 81st Legislature, Regular Session, 2009, That House Rule 13,
3 Section 9(a), be suspended in part as provided by House Rule 13,
4 Section 9(f), to enable the conference committee appointed to
5 resolve the differences on Senate Bill 78, relating to promoting
6 awareness and education about the purchase and availability of
7 health coverage, to consider and take action on the following
8 matter:

9 House Rule 13, Section 9(a)(4), is suspended to permit the
10 committee to add text that is not in disagreement to Subtitle G,
11 Title 8, Insurance Code, by adding Chapter 1508 to read as follows:

12 ARTICLE 2. HEALTHY TEXAS PROGRAM

13 SECTION 2.01. Subtitle G, Title 8, Insurance Code, is
14 amended by adding Chapter 1508 to read as follows:

15 CHAPTER 1508. HEALTHY TEXAS PROGRAM

16 SUBCHAPTER A. GENERAL PROVISIONS

17 Sec. 1508.001. PURPOSE. (a) The purposes of the Healthy
18 Texas Program are to:

19 (1) provide access to quality small employer health
20 benefit plans at an affordable price;

21 (2) encourage small employers to offer health benefit
22 plan coverage to employees and the dependents of employees; and

23 (3) maximize reliance on proven managed care
24 strategies and procedures.

1 (b) The Healthy Texas Program is not intended to diminish
2 the availability of traditional small employer health benefit plan
3 coverage under Chapter 1501.

4 Sec. 1508.002. DEFINITIONS. In this chapter:

5 (1) "Dependent" has the meaning assigned by Section
6 1501.002(2).

7 (2) "Eligible employee" has the meaning assigned by
8 Section 1501.002(3).

9 (3) "Fund" means the healthy Texas small employer
10 premium stabilization fund established under Subchapter F.

11 (4) "Health benefit plan" and "health benefit plan
12 issuer" have the meanings assigned by Sections 1501.002(5) and
13 1501.002(6), respectively.

14 (5) "Program" means the Healthy Texas Program
15 established under this chapter.

16 (6) "Qualifying health benefit plan" means a health
17 benefit plan that provides benefits for health care services in the
18 manner described by this chapter.

19 (7) "Small employer" has the meaning assigned by
20 Section 1501.002(14).

21 Sec. 1508.003. RULES. The commissioner may adopt rules as
22 necessary to implement this chapter.

23 [Sections 1508.004-1508.050 reserved for expansion]

24 SUBCHAPTER B. EMPLOYER ELIGIBILITY; CONTRIBUTIONS

25 Sec. 1508.051. EMPLOYER ELIGIBILITY TO PARTICIPATE. (a) A
26 small employer may participate in the program if:

27 (1) during the 12-month period immediately preceding

1 the date of application for a qualifying health benefit plan, the
2 small employer does not offer employees group health benefits on an
3 expense-reimbursed or prepaid basis; and

4 (2) at least 30 percent of the small employer's
5 eligible employees receive annual wages from the employer in an
6 amount that is equal to or less than 300 percent of the poverty
7 guidelines for an individual, as defined and updated annually by
8 the United States Department of Health and Human Services.

9 (b) A small employer ceases to be eligible to participate in
10 the program if any health benefit plan that provides employee
11 benefits on an expense-reimbursed or prepaid basis, other than
12 another qualifying health benefit plan, is purchased or otherwise
13 takes effect after the purchase of a qualifying health benefit
14 plan.

15 Sec. 1508.052. COMMISSIONER ADJUSTMENTS AUTHORIZED.

16 (a) The commissioner by rule may adjust the 12-month period
17 described by Section 1508.051(a)(1) to an 18-month period if the
18 commissioner determines that the 12-month period is insufficient to
19 prevent inappropriate substitution of other health benefit plans
20 for qualifying health benefit plan coverage under this chapter.

21 (b) The commissioner by rule may adjust the percentage of
22 the poverty guidelines described by Section 1508.051(a)(2) to a
23 higher or lower percentage if the commissioner determines that the
24 adjustment is necessary to fulfill the purposes of this chapter. An
25 adjustment made by the commissioner under this subsection takes
26 effect on the first July 1 following the adjustment.

27 Sec. 1508.053. MINIMUM EMPLOYER PARTICIPATION

1 REQUIREMENTS. A small employer that meets the eligibility
2 requirements described by Section 1508.051(a) may apply to purchase
3 a qualifying health benefit plan if 60 percent or more of the
4 employer's eligible employees elect to participate in the plan.

5 Sec. 1508.054. EMPLOYER CONTRIBUTION REQUIREMENTS. (a) A
6 small employer that purchases a qualifying health benefit plan
7 must:

8 (1) pay 50 percent or more of the premium for each
9 employee covered under the qualifying health benefit plan;

10 (2) offer coverage to all eligible employees receiving
11 annual wages from the employer in an amount described by Section
12 1508.051(a)(2) or 1508.052(b), as applicable; and

13 (3) contribute the same percentage of premium for each
14 covered employee.

15 (b) A small employer that purchases a qualifying health
16 benefit plan under the program may elect to pay, but is not required
17 to pay, all or any portion of the premium paid for dependent
18 coverage under the qualifying health benefit plan.

19 [Sections 1508.055-1508.100 reserved for expansion]

20 SUBCHAPTER C. PROGRAM PARTICIPATION; REQUIRED COVERAGE AND
21 BENEFITS

22 Sec. 1508.101. PARTICIPATING PLAN ISSUERS. (a) Subject to
23 Subsection (b), any health benefit plan issuer may participate in
24 the program.

25 (b) The commissioner by rule may limit which health benefit
26 plan issuers may participate in the program if the commissioner
27 determines that the limitation is necessary to achieve the purposes

1 of this chapter.

2 (c) If the commissioner limits participation in the program
3 under Subsection (b), the commissioner shall contract on a
4 competitive procurement basis with one or more health benefit plan
5 issuers to provide qualifying health benefit plan coverage under
6 the program.

7 (d) Nothing in this chapter prohibits a regional or local
8 health care program described by Chapter 75, Health and Safety
9 Code, from participating in the program. The commissioner by rule
10 shall establish participation requirements applicable to regional
11 and local health care programs that consider the unique plan
12 designs, benefit levels, and participation criteria of each
13 program.

14 Sec. 1508.102. PREEXISTING CONDITION PROVISION REQUIRED. A
15 health benefit plan offered under the program must include a
16 preexisting condition provision that meets the requirements
17 described by Section 1501.102.

18 Sec. 1508.103. EXCEPTION FROM MANDATED BENEFIT
19 REQUIREMENTS. Except as expressly provided by this chapter, a
20 small employer health benefit plan issued under the program is not
21 subject to a law of this state that requires coverage or the offer
22 of coverage of a health care service or benefit.

23 Sec. 1508.104. CERTAIN COVERAGE PROHIBITED OR REQUIRED.

24 (a) A qualifying health benefit plan may only provide coverage for
25 in-plan services and benefits, except for:

26 (1) emergency care; or

27 (2) other services not available through a plan

1 provider.

2 (b) In-plan services and benefits provided under a
3 qualifying health benefit plan must include the following:

4 (1) inpatient hospital services;

5 (2) outpatient hospital services;

6 (3) physician services; and

7 (4) prescription drug benefits.

8 (c) The commissioner may approve in-plan benefits other
9 than those required under Subsection (b) or emergency care or other
10 services not available through a plan provider if the commissioner
11 determines the inclusion to be essential to achieve the purposes of
12 this chapter.

13 (d) The commissioner may, with respect to the categories of
14 services and benefits described by Subsections (b) and (c):

15 (1) prepare specifications for a coverage provided
16 under this chapter;

17 (2) determine the methods and procedures of claims
18 administration;

19 (3) establish procedures to decide contested cases
20 arising from coverage provided under this chapter;

21 (4) study, on an ongoing basis, the operation of all
22 coverages provided under this chapter, including gross and net
23 costs, administration costs, benefits, utilization of benefits,
24 and claims administration;

25 (5) administer the healthy Texas small employer
26 premium stabilization fund established under Subchapter F;

27 (6) provide the beginning and ending dates of

1 coverages for enrollees in a qualifying health benefit plan;

2 (7) develop basic group coverage plans applicable to
3 all individuals eligible to participate in the program;

4 (8) provide for optional group coverage plans in
5 addition to the basic group coverage plans described by Subdivision
6 (7);

7 (9) provide, as determined to be appropriate by the
8 commissioner, additional statewide optional coverage plans;

9 (10) develop specific health benefit plans that permit
10 access to high-quality, cost-effective health care;

11 (11) design, implement, and monitor health benefit
12 plan features intended to discourage excessive utilization,
13 promote efficiency, and contain costs for qualifying health benefit
14 plans;

15 (12) develop and refine, on an ongoing basis, a health
16 benefit strategy for the program that is consistent with evolving
17 benefits delivery systems;

18 (13) develop a funding strategy that efficiently uses
19 employer contributions to achieve the purposes of this chapter; and

20 (14) modify the copayment and deductible amounts for
21 prescription drug benefits under a qualifying health benefit plan,
22 if the commissioner determines that the modification is necessary
23 to achieve the purposes of this chapter.

24 [Sections 1508.105-1508.150 reserved for expansion]

25 SUBCHAPTER D. PROGRAM ADMINISTRATION

26 Sec. 1508.151. EMPLOYER CERTIFICATION. (a) At the time of
27 initial application, a health benefit plan issuer shall obtain from

1 a small employer that seeks to purchase a qualifying health benefit
2 plan a written certification that the employer meets the
3 eligibility requirements described by Section 1508.051 and the
4 minimum employer participation requirements described by Section
5 1508.053.

6 (b) Not later than the 90th day before the renewal date of a
7 qualifying health benefit plan, a health benefit plan issuer shall
8 obtain from the small employer that purchased the qualifying health
9 benefit plan a written certification that the employer continues to
10 meet the eligibility requirements described by Section 1508.051 and
11 the minimum employer participation requirements described by
12 Section 1508.053.

13 (c) A participating health benefit plan issuer may require a
14 small employer to submit appropriate documentation in support of a
15 certification described by Subsection (a) or (b).

16 Sec. 1508.152. APPLICATION PROCESS. (a) Subject to
17 Subsection (b), a health benefit plan issuer shall accept
18 applications for qualifying health benefit plan coverage from small
19 employers at all times throughout the calendar year.

20 (b) The commissioner may limit the dates on which a health
21 benefit plan issuer must accept applications for qualifying health
22 benefit plan coverage if the commissioner determines the limitation
23 to be necessary to achieve the purposes of this chapter.

24 Sec. 1508.153. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) A
25 qualifying health benefit plan must provide employees with an
26 initial enrollment period that is 31 days or longer, and annually at
27 least one open enrollment period that is 31 days or longer. The

1 commissioner by rule may require an additional open enrollment
2 period if the commissioner determines that the additional open
3 enrollment period is necessary to achieve the purposes of this
4 chapter.

5 (b) A small employer may establish a waiting period for
6 employees during which an employee is not eligible for coverage
7 under a qualifying health benefit plan. The last day of a waiting
8 period established under this subsection may not be later than the
9 90th day after the date on which the employee begins employment with
10 the small employer.

11 (c) A health benefit plan issuer may not deny coverage under
12 a qualifying health benefit plan to a new employee of a small
13 employer that purchased the qualifying health benefit plan if the
14 health benefit plan issuer receives an application for coverage
15 from the employee not later than the 31st day after the latter of:

- 16 (1) the first day of the employee's employment; or
17 (2) the first day after the expiration of a waiting
18 period established under Subsection (b).

19 (d) Subject to Subsection (e), a health benefit plan issuer
20 may deny coverage under a qualifying health benefit plan to an
21 employee of a small employer who applies for coverage after the
22 period described by Subsection (c).

23 (e) A health benefit plan issuer that denies an employee
24 coverage under Subsection (d):

- 25 (1) may only deny the employee coverage until the next
26 open enrollment period; and

- 27 (2) may subject the enrollee to a one-year preexisting

1 condition provision, as described by Section 1508.102, if the
2 period during which the preexisting condition provision applies
3 does not exceed 18 months from the date of the initial application
4 for coverage under the qualifying health benefit plan.

5 Sec. 1508.154. REPORTS. A health benefit plan issuer that
6 participates in the program shall submit reports to the department
7 in the form and at the time the commissioner prescribes.

8 [Sections 1508.155-1508.200 reserved for expansion]

9 SUBCHAPTER E. RATING OF QUALIFIED HEALTH BENEFIT PLANS

10 Sec. 1508.201. RATING; PREMIUM PRACTICES IN GENERAL.

11 (a) A health benefit plan issuer participating in the program
12 must:

13 (1) use rating practices for qualifying health benefit
14 plans that are consistent with the purposes of this chapter; and

15 (2) in setting premiums for qualifying health benefit
16 plans, consider the availability of reimbursement from the fund.

17 (b) A health benefit plan issuer participating in the
18 program shall apply rating factors consistently with respect to all
19 small employers in a class of business.

20 (c) Differences in premium rates charged for qualifying
21 health benefit plans must be reasonable and reflect objective
22 differences in plan design.

23 Sec. 1508.202. PREMIUM RATE DEVELOPMENT AND CALCULATION.

24 (a) Rating factors used to underwrite qualifying health benefit
25 plans must produce premium rates for identical groups that:

26 (1) differ only by the amounts attributable to health
27 benefit plan design; and

1 (2) do not reflect differences because of the nature
2 of the groups assumed to select a particular health benefit plan.

3 (b) A health benefit plan issuer shall treat each qualifying
4 health benefit plan that is issued or renewed in a calendar month as
5 having the same rating period.

6 (c) A health benefit plan issuer may use only age and gender
7 as case characteristics, as defined by Section 1501.201(2), in
8 setting premium rates for a qualifying health benefit plan.

9 (d) The commissioner by rule may establish additional
10 rating criteria and requirements for qualifying health benefit
11 plans if the commissioner determines that the criteria and
12 requirements are necessary to achieve the purposes of this chapter.

13 Sec. 1508.203. FILING; APPROVAL. (a) A health benefit
14 plan issuer shall file with the department, for review and approval
15 by the commissioner, premium rates to be charged for qualifying
16 health benefit plans.

17 (b) If the commissioner limits health benefit plan issuer
18 participation in the program under Section 1508.101(b), premium
19 rates proposed to be charged for each qualifying health benefit
20 plan will be considered as an element in the contract procurement
21 process required under that section.

22 [Sections 1508.204-1508.250 reserved for expansion]

23 SUBCHAPTER F. HEALTHY TEXAS SMALL EMPLOYER PREMIUM STABILIZATION

24 FUND

25 Sec. 1508.251. ESTABLISHMENT OF FUND. (a) To the extent
26 that funds appropriated to the department are available for this
27 purpose, the commissioner shall establish a fund from which health

1 benefit plan issuers may receive reimbursement for claims paid by
2 the health benefit plan issuers for individuals covered under
3 qualifying group health plans.

4 (b) The fund established under this section shall be known
5 as the healthy Texas small employer premium stabilization fund.

6 (c) The commissioner shall adopt rules necessary to
7 implement and administer the fund, including rules that set out the
8 procedures for operation of the fund and distribution of money from
9 the fund.

10 Sec. 1508.252. OPERATION OF FUND; CLAIM ELIGIBILITY.

11 (a) A health benefit plan issuer is eligible to receive
12 reimbursement in an amount that is equal to 80 percent of the dollar
13 amount of claims paid between \$5,000 and \$75,000 in a calendar year
14 for an enrollee in a qualifying health benefit plan.

15 (b) A health benefit plan issuer is eligible for
16 reimbursement from the fund only for the calendar year in which
17 claims are paid.

18 (c) Once the dollar amount of claims paid on behalf of a
19 covered individual reaches or exceeds \$75,000 in a given calendar
20 year, a health benefit plan issuer may not receive reimbursement
21 for any other claims paid on behalf of the individual in that
22 calendar year.

23 Sec. 1508.253. REIMBURSEMENT REQUEST SUBMISSION. (a) A
24 health benefit plan issuer seeking reimbursement from the fund
25 shall submit a request for reimbursement in the form prescribed by
26 the commissioner by rule.

27 (b) A health benefit plan issuer must request reimbursement

1 from the fund annually, not later than the date determined by the
2 commissioner, following the end of the calendar year for which the
3 reimbursement requests are made.

4 (c) The commissioner may require a health benefit plan
5 issuer participating in the program to submit claims data in
6 connection with reimbursement requests as the commissioner
7 determines to be necessary to ensure appropriate distribution of
8 reimbursement funds and oversee the operation of the fund. The
9 commissioner may require that the data be submitted on a per covered
10 individual, aggregate, or categorical basis.

11 Sec. 1508.254. FUND AVAILABILITY. (a) The commissioner
12 shall compute the total claims reimbursement amount for all health
13 benefit plan issuers participating in the program for the calendar
14 year for which claims are reported and reimbursement requested.

15 (b) If the total amount requested by health benefit plan
16 issuers participating in the program for reimbursement for a
17 calendar year exceeds the amount of funds available for
18 distribution for claims paid during that same calendar year, the
19 commissioner shall provide for the pro rata distribution of any
20 available funds. A health benefit plan issuer participating in the
21 program is eligible to receive a proportional amount of any
22 available funds that is equal to the proportion of total eligible
23 claims paid by all participating health benefit plan issuers that
24 the requesting health benefit plan issuer paid.

25 (c) If the amount of funds available for distribution for
26 claims paid by all health benefit plan issuers participating in the
27 program during a calendar year exceeds the total amount requested

1 for reimbursement by all participating health benefit plan issuers
2 during that calendar year, the commissioner shall carry forward any
3 excess funds and make those excess funds available for distribution
4 in the next calendar year. Excess funds carried over under this
5 section are added to the fund in addition to any other money
6 appropriated for the fund for the calendar year into which the funds
7 are carried forward.

8 Sec. 1508.255. PROGRAM REPORTING. (a) Each health benefit
9 plan issuer participating in the program shall provide the
10 department, in the form prescribed by the commissioner, monthly
11 reports of total enrollment under qualifying health benefit plans.

12 (b) On the request of the commissioner, each health benefit
13 plan issuer participating in the program shall furnish to the
14 department, in the form prescribed by the commissioner, data other
15 than data described by Subsection (a) that the commissioner
16 determines necessary to oversee the operation of the fund.

17 Sec. 1508.256. CLAIMS EXPERIENCE DATA. (a) Based on
18 available data and appropriate actuarial assumptions, the
19 commissioner shall separately estimate the per covered individual
20 annual cost of total claims reimbursement from the fund for
21 qualifying health benefit plans.

22 (b) On request, a health benefit plan issuer participating
23 in the program shall furnish to the department claims experience
24 data for use in the estimates described by Subsection (a).

25 Sec. 1508.257. TOTAL ELIGIBLE ENROLLMENT DETERMINATION.

26 (a) The commissioner shall determine total eligible enrollment
27 under qualifying health benefit plans by dividing the total funds

1 available for distribution from the fund by the estimated per
2 covered individual annual cost of total claims reimbursement from
3 the fund.

4 (b) At the end of the first year of enrollment and annually
5 thereafter, the commissioner shall submit a report to the governor
6 and the legislature regarding enrollment for the previous year and
7 limitations on future enrollment that ensure that the Healthy Texas
8 Program does not necessitate a substantial increase in funding to
9 continue the program, as consistent with Section 1508.001.

10 Sec. 1508.258. EVALUATION AND PROTECTION OF FUND; EMPLOYER
11 ENROLLMENT SUSPENSION. (a) The commissioner shall suspend the
12 enrollment of new employers in qualifying health benefit plans if
13 the commissioner determines that the total enrollment reported by
14 all health benefit plan issuers under qualifying health benefit
15 plans exceeds the total eligible enrollment determined under
16 Section 1508.257 and is likely to result in anticipated annual
17 expenditures from the fund in excess of the total funds available
18 for distribution from the fund.

19 (b) The commissioner shall provide a health benefit plan
20 issuer participating in the program with notification of any
21 enrollment suspension under Subsection (a) as soon as practicable
22 after:

23 (1) receipt of all enrollment data; and

24 (2) determination of the need to suspend enrollment.

25 (c) A suspension of issuance of qualifying health benefit
26 plans to employers under Subsection (a) does not preclude the
27 addition of new employees of an employer already covered under a

1 qualifying health benefit plan or new dependents of employees
2 already covered under a qualifying health benefit plan.

3 Sec. 1508.259. EMPLOYER ENROLLMENT REACTIVATION. If, at
4 any point during a suspension of enrollment under Section 1508.258,
5 the commissioner determines that funds are sufficient to provide
6 for the addition of new enrollments, the commissioner:

7 (1) may reactivate new enrollments; and

8 (2) shall notify all participating group health
9 benefit plan issuers that enrollment of new employers may be
10 resumed.

11 Sec. 1508.260. FUND ADMINISTRATOR. (a) The commissioner
12 may obtain the services of an independent organization to
13 administer the fund.

14 (b) The commissioner shall establish guidelines for the
15 submission of proposals by organizations for the purposes of
16 administering the fund and may approve, disapprove, or recommend
17 modification to the proposal of an applicant to administer the
18 fund.

19 (c) An organization approved to administer the fund shall
20 submit reports to the commissioner, in the form and at the times
21 required by the commissioner, as necessary to facilitate evaluation
22 and ensure orderly operation of the fund, including an annual
23 report of the affairs and operations of the fund. The annual report
24 must also be delivered to the governor, the lieutenant governor,
25 and the speaker of the house of representatives.

26 (d) An organization approved to administer the fund shall
27 maintain records in the form prescribed by the commissioner and

1 make those records available for inspection by or at the request of
2 the commissioner.

3 (e) The commissioner shall determine the amount of
4 compensation to be allocated to an approved organization as payment
5 for fund administration. Compensation is payable only from the
6 fund.

7 (f) The commissioner may remove an organization approved to
8 administer the fund from fund administration. An organization
9 removed from fund administration under this subsection must
10 cooperate in the orderly transition of services to another approved
11 organization or to the commissioner.

12 Sec. 1508.261. STOP-LOSS INSURANCE; REINSURANCE. (a) The
13 administrator of the fund, on behalf of and with the prior approval
14 of the commissioner, may purchase stop-loss insurance or
15 reinsurance from an insurance company licensed to write that
16 coverage in this state.

17 (b) Stop-loss insurance or reinsurance may be purchased to
18 the extent that the commissioner determines funds are available for
19 the purchase of that insurance.

20 Sec. 1508.262. PUBLIC EDUCATION AND OUTREACH. (a) The
21 commissioner may use an amount of the fund, not to exceed eight
22 percent of the annual amount of the fund, for purposes of developing
23 and implementing public education, outreach, and facilitated
24 enrollment strategies targeted to small employers who do not
25 provide health insurance.

26 (b) The commissioner shall solicit and accept
27 recommendations concerning the development and implementation of

1 education, outreach, and enrollment strategies under Subsection
2 (a) from agents licensed under Title 13 to write health benefit
3 plans in this state.

4 (c) The commissioner may contract with marketing
5 organizations to perform or provide assistance with education,
6 outreach, and enrollment strategies described by Subsection (a).

7 SECTION 2.02. The commissioner of insurance shall adopt any
8 rules necessary to implement the change in law made by Chapter 1508,
9 Insurance Code, as added by this article, not later than January 4,
10 2010.

11 SECTION 2.03. (a) The commissioner of insurance shall make
12 an initial determination concerning limitation of health benefit
13 plan issuer participation in the program established under Chapter
14 1508, Insurance Code, as added by this article, not later than
15 January 18, 2010. If the commissioner determines that limited
16 participation is necessary to achieve the purposes of Chapter 1508,
17 Insurance Code, as added by this article, the commissioner shall
18 issue a request for proposal from health benefit plan issuers to
19 participate in the program not later than May 1, 2010.

20 (b) The commissioner of insurance shall ensure that the
21 Healthy Texas Program is fully operational in a manner that allows
22 health benefit plan issuers participating in the program to make
23 the first annual request for reimbursement on January 1, 2011.

24 SECTION 2.04. This Act does not make an appropriation. This
25 Act takes effect only if a specific appropriation for the
26 implementation of the Act is provided in a general appropriations
27 act of the 81st Legislature.

H.R. No. 2992

1 Explanation: This addition is necessary to authorize the
2 creation of the Healthy Texas Program to enhance the availability
3 of health coverage.

Smithee

H.R. No. 2992

Speaker of the House

I certify that H.R. No. 2992 was adopted by the House on May 31, 2009, by the following vote: Yeas 145, Nays 0, 1 present, not voting.

Chief Clerk of the House