

By: Duncan, Nelson

S.B. No. 6

A BILL TO BE ENTITLED

AN ACT

relating to the creation of the Healthy Texas Program.

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

SECTION 1. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1508 to read as follows:

CHAPTER 1508. HEALTHY TEXAS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

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

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

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

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

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

Sec. 1508.002. DEFINITIONS. In this chapter:

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

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

(3) "Fund" means the healthy Texas small employer

1 premium stabilization fund established under Subchapter F.

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

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

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

10 (7) "Small employer" has the meaning assigned by  
11 Section 1501.002(14).

12 Sec. 1508.003. RULES. The commissioner may adopt rules as  
13 necessary to implement this chapter.

14 [Sections 1508.004-1508.050 reserved for expansion]

15 SUBCHAPTER B. EMPLOYER ELIGIBILITY; CONTRIBUTIONS

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

18 (1) during the 12-month period immediately preceding  
19 the date of application for a qualifying health benefit plan, the  
20 small employer does not offer employees group health benefits on an  
21 expense-reimbursed or prepaid basis; and

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

27 (b) A small employer ceases to be eligible to participate in

1 the program if any health benefit plan that provides employee  
2 benefits on an expense-reimbursed or prepaid basis, other than  
3 another qualifying health benefit plan, is purchased or otherwise  
4 takes effect after the purchase of a qualifying health benefit  
5 plan.

6 Sec. 1508.052. COMMISSIONER ADJUSTMENTS AUTHORIZED.

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

12 (b) The commissioner by rule may adjust the percentage of  
13 the poverty guidelines described by Section 1508.051(a)(2) to a  
14 higher or lower percentage if the commissioner determines that the  
15 adjustment is necessary to fulfill the purposes of this chapter. An  
16 adjustment made by the commissioner under this subsection takes  
17 effect on the first July 1 following the adjustment.

18 Sec. 1508.053. MINIMUM EMPLOYER PARTICIPATION  
19 REQUIREMENTS. A small employer that meets the eligibility  
20 requirements described by Section 1508.051(a) may apply to purchase  
21 a qualifying health benefit plan if 60 percent or more of the  
22 employer's eligible employees elect to participate in the plan.

23 Sec. 1508.054. EMPLOYER CONTRIBUTION REQUIREMENTS. (a) A  
24 small employer that purchases a qualifying health benefit plan  
25 must:

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



1 shall establish participation requirements applicable to regional  
2 and local health care programs that consider the unique plan  
3 designs, benefit levels, and participation criteria of each  
4 program.

5 Sec. 1508.102. PREEXISTING CONDITION PROVISION REQUIRED. A  
6 health benefit plan offered under the program must include a  
7 preexisting condition provision that meets the requirements  
8 described by Section 1501.102.

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

14 Sec. 1508.104. CERTAIN COVERAGE PROHIBITED OR REQUIRED.

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

- 17 (1) emergency care; or  
18 (2) other services not available through a plan  
19 provider.

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

- 22 (1) inpatient hospital services;  
23 (2) outpatient hospital services;  
24 (3) physician services; and  
25 (4) prescription drug benefits.

26 (c) The commissioner may approve in-plan benefits other  
27 than those required under Subsection (b) or emergency care or other

1 services not available through a plan provider if the commissioner  
2 determines the inclusion to be essential to achieve the purposes of  
3 this chapter.

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

6 (1) prepare specifications for a coverage provided  
7 under this chapter;

8 (2) determine the methods and procedures of claims  
9 administration;

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

12 (4) study, on an ongoing basis, the operation of all  
13 coverages provided under this chapter, including gross and net  
14 costs, administration costs, benefits, utilization of benefits,  
15 and claims administration;

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

18 (6) provide the beginning and ending dates of  
19 coverages for enrollees in a qualifying health benefit plan;

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

22 (8) provide for optional group coverage plans in  
23 addition to the basic group coverage plans described by Subdivision  
24 (7);

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

27 (10) develop specific health benefit plans that permit

1 access to high-quality, cost-effective health care;

2 (11) design, implement, and monitor health benefit  
3 plan features intended to discourage excessive utilization,  
4 promote efficiency, and contain costs for qualifying health benefit  
5 plans;

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

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

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

15 [Sections 1508.105-1508.150 reserved for expansion]

16 SUBCHAPTER D. PROGRAM ADMINISTRATION

17 Sec. 1508.151. EMPLOYER CERTIFICATION. (a) At the time of  
18 initial application, a health benefit plan issuer shall obtain from  
19 a small employer that seeks to purchase a qualifying health benefit  
20 plan a written certification that the employer meets the  
21 eligibility requirements described by Section 1508.051 and the  
22 minimum employer participation requirements described by Section  
23 1508.053.

24 (b) Not later than the 90th day before the renewal date of a  
25 qualifying health benefit plan, a health benefit plan issuer shall  
26 obtain from the small employer that purchased the qualifying health  
27 benefit plan a written certification that the employer continues to

1 meet the eligibility requirements described by Section 1508.051 and  
2 the minimum employer participation requirements described by  
3 Section 1508.053.

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

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

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

15 Sec. 1508.153. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) A  
16 qualifying health benefit plan must provide employees with an  
17 initial enrollment period that is 31 days or longer, and annually at  
18 least one open enrollment period that is 31 days or longer. The  
19 commissioner by rule may require an additional open enrollment  
20 period if the commissioner determines that the additional open  
21 enrollment period is necessary to achieve the purposes of this  
22 chapter.

23 (b) A small employer may establish a waiting period for  
24 employees during which an employee is not eligible for coverage  
25 under a qualifying health benefit plan. The last day of a waiting  
26 period established under this subsection may not be later than the  
27 90th day after the date on which the employee begins employment with

1 the small employer.

2 (c) A health benefit plan issuer may not deny coverage under  
3 a qualifying health benefit plan to a new employee of a small  
4 employer that purchased the qualifying health benefit plan if the  
5 health benefit plan issuer receives an application for coverage  
6 from the employee not later than the 31st day after the latter of:

7 (1) the first day of the employee's employment; or

8 (2) the first day after the expiration of a waiting  
9 period established under Subsection (b).

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

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

16 (1) may only deny the employee coverage until the next  
17 open enrollment period; and

18 (2) may subject the enrollee to a one-year preexisting  
19 condition provision, as described by Section 1508.102, if the  
20 period during which the preexisting condition provision applies  
21 does not exceed 18 months from the date of the initial application  
22 for coverage under the qualifying health benefit plan.

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

26 [Sections 1508.155-1508.200 reserved for expansion]

1 SUBCHAPTER E. RATING OF QUALIFIED HEALTH BENEFIT PLANS

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

3 (a) A health benefit plan issuer participating in the program  
4 must:

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

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

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

12 (c) Differences in premium rates charged for qualifying  
13 health benefit plans must be reasonable and reflect objective  
14 differences in plan design.

15 Sec. 1508.202. PREMIUM RATE DEVELOPMENT AND CALCULATION.

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

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

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

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

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

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

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

9 (b) If the commissioner limits health benefit plan issuer  
10 participation in the program under Section 1508.101(b), premium  
11 rates proposed to be charged for each qualifying health benefit  
12 plan will be considered as an element in the contract procurement  
13 process required under that section.

14 [Sections 1508.204-1508.250 reserved for expansion]

15 SUBCHAPTER F. HEALTHY TEXAS SMALL EMPLOYER PREMIUM STABILIZATION

16 FUND

17 Sec. 1508.251. ESTABLISHMENT OF FUND. (a) To the extent  
18 that funds appropriated to the department are available for this  
19 purpose, the commissioner shall establish a fund from which health  
20 benefit plan issuers may receive reimbursement for claims paid by  
21 the health benefit plan issuers for individuals covered under  
22 qualifying group health plans.

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

25 (c) The commissioner shall adopt rules necessary to  
26 implement and administer the fund, including rules that set out the  
27 procedures for operation of the fund and distribution of money from

1 the fund.

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

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

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

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

15 Sec. 1508.253. REIMBURSEMENT REQUEST SUBMISSION. (a) A  
16 health benefit plan issuer seeking reimbursement from the fund  
17 shall submit a request for reimbursement in the form prescribed by  
18 the commissioner by rule.

19 (b) A health benefit plan issuer must request reimbursement  
20 from the fund annually, not later than the date determined by the  
21 commissioner, following the end of the calendar year for which the  
22 reimbursement requests are made.

23 (c) The commissioner may require a health benefit plan  
24 issuer participating in the program to submit claims data in  
25 connection with reimbursement requests as the commissioner  
26 determines to be necessary to ensure appropriate distribution of  
27 reimbursement funds and oversee the operation of the fund. The

1 commissioner may require that the data be submitted on a per covered  
2 individual, aggregate, or categorical basis.

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

7 (b) If the total amount requested by health benefit plan  
8 issuers participating in the program for reimbursement for a  
9 calendar year exceeds the amount of funds available for  
10 distribution for claims paid during that same calendar year, the  
11 commissioner shall provide for the pro rata distribution of any  
12 available funds. A health benefit plan issuer participating in the  
13 program is eligible to receive a proportional amount of any  
14 available funds that is equal to the proportion of total eligible  
15 claims paid by all participating health benefit plan issuers that  
16 the requesting health benefit plan issuer paid.

17 (c) If the amount of funds available for distribution for  
18 claims paid by all health benefit plan issuers participating in the  
19 program during a calendar year exceeds the total amount requested  
20 for reimbursement by all participating health benefit plan issuers  
21 during that calendar year, the commissioner shall carry forward any  
22 excess funds and make those excess funds available for distribution  
23 in the next calendar year. Excess funds carried over under this  
24 section are added to the fund in addition to any other money  
25 appropriated for the fund for the calendar year into which the funds  
26 are carried forward.

27 Sec. 1508.255. PROGRAM REPORTING. (a) Each health benefit

1 plan issuer participating in the program shall provide the  
2 department, in the form prescribed by the commissioner, monthly  
3 reports of total enrollment under qualifying health benefit plans.

4 (b) On the request of the commissioner, each health benefit  
5 plan issuer participating in the program shall furnish to the  
6 department, in the form prescribed by the commissioner, data other  
7 than data described by Subsection (a) that the commissioner  
8 determines necessary to oversee the operation of the fund.

9 Sec. 1508.256. CLAIMS EXPERIENCE DATA. (a) Based on  
10 available data and appropriate actuarial assumptions, the  
11 commissioner shall separately estimate the per covered individual  
12 annual cost of total claims reimbursement from the fund for  
13 qualifying health benefit plans.

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

17 Sec. 1508.257. TOTAL ELIGIBLE ENROLLMENT DETERMINATION.  
18 The commissioner shall determine total eligible enrollment under  
19 qualifying health benefit plans by dividing the total funds  
20 available for distribution from the fund by the estimated per  
21 covered individual annual cost of total claims reimbursement from  
22 the fund.

23 Sec. 1508.258. EVALUATION AND PROTECTION OF FUND; EMPLOYER  
24 ENROLLMENT SUSPENSION. (a) The commissioner shall suspend the  
25 enrollment of new employers in qualifying health benefit plans if  
26 the commissioner determines that the total enrollment reported by  
27 all health benefit plan issuers under qualifying health benefit

1 plans exceeds the total eligible enrollment determined under  
2 Section 1508.257 and is likely to result in anticipated annual  
3 expenditures from the fund in excess of the total funds available  
4 for distribution from the fund.

5 (b) The commissioner shall provide a health benefit plan  
6 issuer participating in the program with notification of any  
7 enrollment suspension under Subsection (a) as soon as practicable  
8 after:

9 (1) receipt of all enrollment data; and

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

11 (c) A suspension of issuance of qualifying health benefit  
12 plans to employers under Subsection (a) does not preclude the  
13 addition of new employees of an employer already covered under a  
14 qualifying health benefit plan or new dependents of employees  
15 already covered under a qualifying health benefit plan.

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

20 (1) may reactivate new enrollments; and

21 (2) shall notify all participating group health  
22 benefit plan issuers that enrollment of new employers may be  
23 resumed.

24 Sec. 1508.260. FUND ADMINISTRATOR. (a) The commissioner  
25 may obtain the services of an independent organization to  
26 administer the fund.

27 (b) The commissioner shall establish guidelines for the

1 submission of proposals by organizations for the purposes of  
2 administering the fund and may approve, disapprove, or recommend  
3 modification to the proposal of an applicant to administer the  
4 fund.

5 (c) An organization approved to administer the fund shall  
6 submit reports to the commissioner, in the form and at the times  
7 required by the commissioner, as necessary to facilitate evaluation  
8 and ensure orderly operation of the fund, including an annual  
9 report of the affairs and operations of the fund. The annual report  
10 must also be delivered to the governor, the lieutenant governor,  
11 and the speaker of the house of representatives.

12 (d) An organization approved to administer the fund shall  
13 maintain records in the form prescribed by the commissioner and  
14 make those records available for inspection by or at the request of  
15 the commissioner.

16 (e) The commissioner shall determine the amount of  
17 compensation to be allocated to an approved organization as payment  
18 for fund administration. Compensation is payable only from the  
19 fund.

20 (f) The commissioner may remove an organization approved to  
21 administer the fund from fund administration. An organization  
22 removed from fund administration under this subsection must  
23 cooperate in the orderly transition of services to another approved  
24 organization or to the commissioner.

25 Sec. 1508.261. STOP-LOSS INSURANCE; REINSURANCE. (a) The  
26 administrator of the fund, on behalf of and with the prior approval  
27 of the commissioner, may purchase stop-loss insurance or

1 reinsurance from an insurance company licensed to write that  
2 coverage in this state.

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

6 Sec. 1508.262. PUBLIC EDUCATION AND OUTREACH. (a) The  
7 commissioner may use an amount of the fund, not to exceed eight  
8 percent of the annual amount of the fund, for purposes of developing  
9 and implementing public education, outreach, and facilitated  
10 enrollment strategies targeted to small employers who do not  
11 provide health insurance.

12 (b) The commissioner shall solicit and accept  
13 recommendations concerning the development and implementation of  
14 education, outreach, and enrollment strategies under Subsection  
15 (a) from agents licensed under Title 13 to write health benefit  
16 plans in this state.

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

20 SECTION 2. The commissioner of insurance shall adopt any  
21 rules necessary to implement the change in law made by this Act not  
22 later than January 4, 2010.

23 SECTION 3. (a) The commissioner of insurance shall make an  
24 initial determination concerning limitation of health benefit plan  
25 issuer participation in the program established under Chapter 1508,  
26 Insurance Code, as added by this Act, not later than January 18,  
27 2010. If the commissioner determines that limited participation is

1 necessary to achieve the purposes of Chapter 1508, Insurance Code,  
2 as added by this Act, the commissioner shall issue a request for  
3 proposal from health benefit plan issuers to participate in the  
4 program not later than May 1, 2010.

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

9 SECTION 4. This Act does not make an appropriation. This  
10 Act takes effect only if a specific appropriation for the  
11 implementation of the Act is provided in a general appropriations  
12 act of the 81st Legislature.

13 SECTION 5. This Act takes effect September 1, 2009.