1-1 By: Duncan, Nelson S.B. No. 6
1-2 (In the Senate - Filed March 12, 2009; March 18, 2009, read
1-3 first time and referred to Committee on State Affairs;
1-4 April 6, 2009, reported adversely, with favorable Committee
1-5 Substitute by the following vote: Yeas 8, Nays 0; April 6, 2009,
1-6 sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR S.B. No. 6 By: Duncan

1-8 A BILL TO BE ENTITLED
1-9 AN ACT

1-10 relating to the creation of the Healthy Texas Program.
1-11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-12 SECTION 1. Subtitle G, Title 8, Insurance Code, is amended
1-13 by adding Chapter 1508 to read as follows:
1-14 CHAPTER 1508. HEALTHY TEXAS PROGRAM
1-15 SUBCHAPTER A. GENERAL PROVISIONS
1-16 Sec. 1508.001. PURPOSE. (a) The purposes of the Healthy
1-17 Texas Program are to:
1-18 (1) provide access to quality small employer health
1-19 benefit plans at an affordable price;
1-20 (2) encourage small employers to offer health benefit
1-21 plan coverage to employees and the dependents of employees; and
1-22 (3) maximize reliance on proven managed care
1-23 strategies and procedures.
1-24 (b) The Healthy Texas Program is not intended to diminish
1-25 the availability of traditional small employer health benefit plan
1-26 coverage under Chapter 1501.
1-27 Sec. 1508.002. DEFINITIONS. In this chapter:
1-28 (1) "Dependent" has the meaning assigned by Section
1-29 1501.002(2).
1-30 (2) "Eligible employee" has the meaning assigned by
1-31 Section 1501.002(3).
1-32 (3) "Fund" means the healthy Texas small employer
1-33 premium stabilization fund established under Subchapter F.
1-34 (4) "Health benefit plan" and "health benefit plan
1-35 issuer" have the meanings assigned by Sections 1501.002(5) and
1-36 1501.002(6), respectively.
1-37 (5) "Program" means the Healthy Texas Program
1-38 established under this chapter.
1-39 (6) "Qualifying health benefit plan" means a health
1-40 benefit plan that provides benefits for health care services in the
1-41 manner described by this chapter.
1-42 (7) "Small employer" has the meaning assigned by
1-43 Section 1501.002(14).
1-44 Sec. 1508.003. RULES. The commissioner may adopt rules as
1-45 necessary to implement this chapter.
1-46 [Sections 1508.004-1508.050 reserved for expansion]
1-47 SUBCHAPTER B. EMPLOYER ELIGIBILITY; CONTRIBUTIONS
1-48 Sec. 1508.051. EMPLOYER ELIGIBILITY TO PARTICIPATE. (a) A
1-49 small employer may participate in the program if:
1-50 (1) during the 12-month period immediately preceding
1-51 the date of application for a qualifying health benefit plan, the
1-52 small employer does not offer employees group health benefits on an
1-53 expense-reimbursed or prepaid basis; and
1-54 (2) at least 30 percent of the small employer's
1-55 eligible employees receive annual wages from the employer in an
1-56 amount that is equal to or less than 300 percent of the poverty
1-57 guidelines for an individual, as defined and updated annually by
1-58 the United States Department of Health and Human Services.
1-59 (b) A small employer ceases to be eligible to participate in
1-60 the program if any health benefit plan that provides employee
1-61 benefits on an expense-reimbursed or prepaid basis, other than
1-62 another qualifying health benefit plan, is purchased or otherwise
1-63 takes effect after the purchase of a qualifying health benefit

2-1 plan.
2-2 Sec. 1508.052. COMMISSIONER ADJUSTMENTS AUTHORIZED.
2-3 (a) The commissioner by rule may adjust the 12-month period
2-4 described by Section 1508.051(a)(1) to an 18-month period if the
2-5 commissioner determines that the 12-month period is insufficient to
2-6 prevent inappropriate substitution of other health benefit plans
2-7 for qualifying health benefit plan coverage under this chapter.
2-8 (b) The commissioner by rule may adjust the percentage of
2-9 the poverty guidelines described by Section 1508.051(a)(2) to a
2-10 higher or lower percentage if the commissioner determines that the
2-11 adjustment is necessary to fulfill the purposes of this chapter. An
2-12 adjustment made by the commissioner under this subsection takes
2-13 effect on the first July 1 following the adjustment.
2-14 Sec. 1508.053. MINIMUM EMPLOYER PARTICIPATION
2-15 REQUIREMENTS. A small employer that meets the eligibility
2-16 requirements described by Section 1508.051(a) may apply to purchase
2-17 a qualifying health benefit plan if 60 percent or more of the
2-18 employer's eligible employees elect to participate in the plan.
2-19 Sec. 1508.054. EMPLOYER CONTRIBUTION REQUIREMENTS. (a) A
2-20 small employer that purchases a qualifying health benefit plan
2-21 must:
2-22 (1) pay 50 percent or more of the premium for each
2-23 employee covered under the qualifying health benefit plan;
2-24 (2) offer coverage to all eligible employees receiving
2-25 annual wages from the employer in an amount described by Section
2-26 1508.051(a)(2) or 1508.052(b), as applicable; and
2-27 (3) contribute the same percentage of premium for each
2-28 covered employee.
2-29 (b) A small employer that purchases a qualifying health
2-30 benefit plan under the program may elect to pay, but is not required
2-31 to pay, all or any portion of the premium paid for dependent
2-32 coverage under the qualifying health benefit plan.
2-33 [Sections 1508.055-1508.100 reserved for expansion]
2-34 SUBCHAPTER C. PROGRAM PARTICIPATION; REQUIRED COVERAGE AND
2-35 BENEFITS
2-36 Sec. 1508.101. PARTICIPATING PLAN ISSUERS. (a) Subject to
2-37 Subsection (b), any health benefit plan issuer may participate in
2-38 the program.
2-39 (b) The commissioner by rule may limit which health benefit
2-40 plan issuers may participate in the program if the commissioner
2-41 determines that the limitation is necessary to achieve the purposes
2-42 of this chapter.
2-43 (c) If the commissioner limits participation in the program
2-44 under Subsection (b), the commissioner shall contract on a
2-45 competitive procurement basis with one or more health benefit plan
2-46 issuers to provide qualifying health benefit plan coverage under
2-47 the program.
2-48 (d) Nothing in this chapter prohibits a regional or local
2-49 health care program described by Chapter 75, Health and Safety
2-50 Code, from participating in the program. The commissioner by rule
2-51 shall establish participation requirements applicable to regional
2-52 and local health care programs that consider the unique plan
2-53 designs, benefit levels, and participation criteria of each
2-54 program.
2-55 Sec. 1508.102. PREEXISTING CONDITION PROVISION REQUIRED. A
2-56 health benefit plan offered under the program must include a
2-57 preexisting condition provision that meets the requirements
2-58 described by Section 1501.102.
2-59 Sec. 1508.103. EXCEPTION FROM MANDATED BENEFIT
2-60 REQUIREMENTS. Except as expressly provided by this chapter, a
2-61 small employer health benefit plan issued under the program is not
2-62 subject to a law of this state that requires coverage or the offer
2-63 of coverage of a health care service or benefit.
2-64 Sec. 1508.104. CERTAIN COVERAGE PROHIBITED OR REQUIRED.
2-65 (a) A qualifying health benefit plan may only provide coverage for
2-66 in-plan services and benefits, except for:
2-67 (1) emergency care; or
2-68 (2) other services not available through a plan
2-69 provider.

3-1 (b) In-plan services and benefits provided under a
3-2 qualifying health benefit plan must include the following:
3-3 (1) inpatient hospital services;
3-4 (2) outpatient hospital services;
3-5 (3) physician services; and
3-6 (4) prescription drug benefits.
3-7 (c) The commissioner may approve in-plan benefits other
3-8 than those required under Subsection (b) or emergency care or other
3-9 services not available through a plan provider if the commissioner
3-10 determines the inclusion to be essential to achieve the purposes of
3-11 this chapter.
3-12 (d) The commissioner may, with respect to the categories of
3-13 services and benefits described by Subsections (b) and (c):
3-14 (1) prepare specifications for a coverage provided
3-15 under this chapter;
3-16 (2) determine the methods and procedures of claims
3-17 administration;
3-18 (3) establish procedures to decide contested cases
3-19 arising from coverage provided under this chapter;
3-20 (4) study, on an ongoing basis, the operation of all
3-21 coverages provided under this chapter, including gross and net
3-22 costs, administration costs, benefits, utilization of benefits,
3-23 and claims administration;
3-24 (5) administer the healthy Texas small employer
3-25 premium stabilization fund established under Subchapter F;
3-26 (6) provide the beginning and ending dates of
3-27 coverages for enrollees in a qualifying health benefit plan;
3-28 (7) develop basic group coverage plans applicable to
3-29 all individuals eligible to participate in the program;
3-30 (8) provide for optional group coverage plans in
3-31 addition to the basic group coverage plans described by Subdivision
3-32 (7);
3-33 (9) provide, as determined to be appropriate by the
3-34 commissioner, additional statewide optional coverage plans;
3-35 (10) develop specific health benefit plans that permit
3-36 access to high-quality, cost-effective health care;
3-37 (11) design, implement, and monitor health benefit
3-38 plan features intended to discourage excessive utilization,
3-39 promote efficiency, and contain costs for qualifying health benefit
3-40 plans;
3-41 (12) develop and refine, on an ongoing basis, a health
3-42 benefit strategy for the program that is consistent with evolving
3-43 benefits delivery systems;
3-44 (13) develop a funding strategy that efficiently uses
3-45 employer contributions to achieve the purposes of this chapter; and
3-46 (14) modify the copayment and deductible amounts for
3-47 prescription drug benefits under a qualifying health benefit plan,
3-48 if the commissioner determines that the modification is necessary
3-49 to achieve the purposes of this chapter.
3-50 [Sections 1508.105-1508.150 reserved for expansion]
3-51 SUBCHAPTER D. PROGRAM ADMINISTRATION
3-52 Sec. 1508.151. EMPLOYER CERTIFICATION. (a) At the time of
3-53 initial application, a health benefit plan issuer shall obtain from
3-54 a small employer that seeks to purchase a qualifying health benefit
3-55 plan a written certification that the employer meets the
3-56 eligibility requirements described by Section 1508.051 and the
3-57 minimum employer participation requirements described by Section
3-58 1508.053.
3-59 (b) Not later than the 90th day before the renewal date of a
3-60 qualifying health benefit plan, a health benefit plan issuer shall
3-61 obtain from the small employer that purchased the qualifying health
3-62 benefit plan a written certification that the employer continues to
3-63 meet the eligibility requirements described by Section 1508.051 and
3-64 the minimum employer participation requirements described by
3-65 Section 1508.053.
3-66 (c) A participating health benefit plan issuer may require a
3-67 small employer to submit appropriate documentation in support of a
3-68 certification described by Subsection (a) or (b).
3-69 Sec. 1508.152. APPLICATION PROCESS. (a) Subject to

4-1 Subsection (b), a health benefit plan issuer shall accept
4-2 applications for qualifying health benefit plan coverage from small
4-3 employers at all times throughout the calendar year.
4-4 (b) The commissioner may limit the dates on which a health
4-5 benefit plan issuer must accept applications for qualifying health
4-6 benefit plan coverage if the commissioner determines the limitation
4-7 to be necessary to achieve the purposes of this chapter.
4-8 Sec. 1508.153. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) A
4-9 qualifying health benefit plan must provide employees with an
4-10 initial enrollment period that is 31 days or longer, and annually at
4-11 least one open enrollment period that is 31 days or longer. The
4-12 commissioner by rule may require an additional open enrollment
4-13 period if the commissioner determines that the additional open
4-14 enrollment period is necessary to achieve the purposes of this
4-15 chapter.
4-16 (b) A small employer may establish a waiting period for
4-17 employees during which an employee is not eligible for coverage
4-18 under a qualifying health benefit plan. The last day of a waiting
4-19 period established under this subsection may not be later than the
4-20 90th day after the date on which the employee begins employment with
4-21 the small employer.
4-22 (c) A health benefit plan issuer may not deny coverage under
4-23 a qualifying health benefit plan to a new employee of a small
4-24 employer that purchased the qualifying health benefit plan if the
4-25 health benefit plan issuer receives an application for coverage
4-26 from the employee not later than the 31st day after the latter of:
4-27 (1) the first day of the employee's employment; or
4-28 (2) the first day after the expiration of a waiting
4-29 period established under Subsection (b).
4-30 (d) Subject to Subsection (e), a health benefit plan issuer
4-31 may deny coverage under a qualifying health benefit plan to an
4-32 employee of a small employer who applies for coverage after the
4-33 period described by Subsection (c).
4-34 (e) A health benefit plan issuer that denies an employee
4-35 coverage under Subsection (d):
4-36 (1) may only deny the employee coverage until the next
4-37 open enrollment period; and
4-38 (2) may subject the enrollee to a one-year preexisting
4-39 condition provision, as described by Section 1508.102, if the
4-40 period during which the preexisting condition provision applies
4-41 does not exceed 18 months from the date of the initial application
4-42 for coverage under the qualifying health benefit plan.
4-43 Sec. 1508.154. REPORTS. A health benefit plan issuer that
4-44 participates in the program shall submit reports to the department
4-45 in the form and at the time the commissioner prescribes.
4-46 [Sections 1508.155-1508.200 reserved for expansion]
4-47 SUBCHAPTER E. RATING OF QUALIFIED HEALTH BENEFIT PLANS
4-48 Sec. 1508.201. RATING; PREMIUM PRACTICES IN GENERAL.
4-49 (a) A health benefit plan issuer participating in the program
4-50 must:
4-51 (1) use rating practices for qualifying health benefit
4-52 plans that are consistent with the purposes of this chapter; and
4-53 (2) in setting premiums for qualifying health benefit
4-54 plans, consider the availability of reimbursement from the fund.
4-55 (b) A health benefit plan issuer participating in the
4-56 program shall apply rating factors consistently with respect to all
4-57 small employers in a class of business.
4-58 (c) Differences in premium rates charged for qualifying
4-59 health benefit plans must be reasonable and reflect objective
4-60 differences in plan design.
4-61 Sec. 1508.202. PREMIUM RATE DEVELOPMENT AND CALCULATION.
4-62 (a) Rating factors used to underwrite qualifying health benefit
4-63 plans must produce premium rates for identical groups that:
4-64 (1) differ only by the amounts attributable to health
4-65 benefit plan design; and
4-66 (2) do not reflect differences because of the nature
4-67 of the groups assumed to select a particular health benefit plan.
4-68 (b) A health benefit plan issuer shall treat each qualifying
4-69 health benefit plan that is issued or renewed in a calendar month as

5-1 having the same rating period.
5-2 (c) A health benefit plan issuer may use only age and gender
5-3 as case characteristics, as defined by Section 1501.201(2), in
5-4 setting premium rates for a qualifying health benefit plan.
5-5 (d) The commissioner by rule may establish additional
5-6 rating criteria and requirements for qualifying health benefit
5-7 plans if the commissioner determines that the criteria and
5-8 requirements are necessary to achieve the purposes of this chapter.
5-9 Sec. 1508.203. FILING; APPROVAL. (a) A health benefit
5-10 plan issuer shall file with the department, for review and approval
5-11 by the commissioner, premium rates to be charged for qualifying
5-12 health benefit plans.
5-13 (b) If the commissioner limits health benefit plan issuer
5-14 participation in the program under Section 1508.101(b), premium
5-15 rates proposed to be charged for each qualifying health benefit
5-16 plan will be considered as an element in the contract procurement
5-17 process required under that section.
5-18 [Sections 1508.204-1508.250 reserved for expansion]
5-19 SUBCHAPTER F. HEALTHY TEXAS SMALL EMPLOYER PREMIUM STABILIZATION
5-20 FUND
5-21 Sec. 1508.251. ESTABLISHMENT OF FUND. (a) To the extent
5-22 that funds appropriated to the department are available for this
5-23 purpose, the commissioner shall establish a fund from which health
5-24 benefit plan issuers may receive reimbursement for claims paid by
5-25 the health benefit plan issuers for individuals covered under
5-26 qualifying group health plans.
5-27 (b) The fund established under this section shall be known
5-28 as the healthy Texas small employer premium stabilization fund.
5-29 (c) The commissioner shall adopt rules necessary to
5-30 implement and administer the fund, including rules that set out the
5-31 procedures for operation of the fund and distribution of money from
5-32 the fund.
5-33 Sec. 1508.252. OPERATION OF FUND; CLAIM ELIGIBILITY.
5-34 (a) A health benefit plan issuer is eligible to receive
5-35 reimbursement in an amount that is equal to 80 percent of the dollar
5-36 amount of claims paid between $5,000 and $75,000 in a calendar year
5-37 for an enrollee in a qualifying health benefit plan.
5-38 (b) A health benefit plan issuer is eligible for
5-39 reimbursement from the fund only for the calendar year in which
5-40 claims are paid.
5-41 (c) Once the dollar amount of claims paid on behalf of a
5-42 covered individual reaches or exceeds $75,000 in a given calendar
5-43 year, a health benefit plan issuer may not receive reimbursement
5-44 for any other claims paid on behalf of the individual in that
5-45 calendar year.
5-46 Sec. 1508.253. REIMBURSEMENT REQUEST SUBMISSION. (a) A
5-47 health benefit plan issuer seeking reimbursement from the fund
5-48 shall submit a request for reimbursement in the form prescribed by
5-49 the commissioner by rule.
5-50 (b) A health benefit plan issuer must request reimbursement
5-51 from the fund annually, not later than the date determined by the
5-52 commissioner, following the end of the calendar year for which the
5-53 reimbursement requests are made.
5-54 (c) The commissioner may require a health benefit plan
5-55 issuer participating in the program to submit claims data in
5-56 connection with reimbursement requests as the commissioner
5-57 determines to be necessary to ensure appropriate distribution of
5-58 reimbursement funds and oversee the operation of the fund. The
5-59 commissioner may require that the data be submitted on a per covered
5-60 individual, aggregate, or categorical basis.
5-61 Sec. 1508.254. FUND AVAILABILITY. (a) The commissioner
5-62 shall compute the total claims reimbursement amount for all health
5-63 benefit plan issuers participating in the program for the calendar
5-64 year for which claims are reported and reimbursement requested.
5-65 (b) If the total amount requested by health benefit plan
5-66 issuers participating in the program for reimbursement for a
5-67 calendar year exceeds the amount of funds available for
5-68 distribution for claims paid during that same calendar year, the
5-69 commissioner shall provide for the pro rata distribution of any

6-1 available funds. A health benefit plan issuer participating in the
6-2 program is eligible to receive a proportional amount of any
6-3 available funds that is equal to the proportion of total eligible
6-4 claims paid by all participating health benefit plan issuers that
6-5 the requesting health benefit plan issuer paid.
6-6 (c) If the amount of funds available for distribution for
6-7 claims paid by all health benefit plan issuers participating in the
6-8 program during a calendar year exceeds the total amount requested
6-9 for reimbursement by all participating health benefit plan issuers
6-10 during that calendar year, the commissioner shall carry forward any
6-11 excess funds and make those excess funds available for distribution
6-12 in the next calendar year. Excess funds carried over under this
6-13 section are added to the fund in addition to any other money
6-14 appropriated for the fund for the calendar year into which the funds
6-15 are carried forward.
6-16 Sec. 1508.255. PROGRAM REPORTING. (a) Each health benefit
6-17 plan issuer participating in the program shall provide the
6-18 department, in the form prescribed by the commissioner, monthly
6-19 reports of total enrollment under qualifying health benefit plans.
6-20 (b) On the request of the commissioner, each health benefit
6-21 plan issuer participating in the program shall furnish to the
6-22 department, in the form prescribed by the commissioner, data other
6-23 than data described by Subsection (a) that the commissioner
6-24 determines necessary to oversee the operation of the fund.
6-25 Sec. 1508.256. CLAIMS EXPERIENCE DATA. (a) Based on
6-26 available data and appropriate actuarial assumptions, the
6-27 commissioner shall separately estimate the per covered individual
6-28 annual cost of total claims reimbursement from the fund for
6-29 qualifying health benefit plans.
6-30 (b) On request, a health benefit plan issuer participating
6-31 in the program shall furnish to the department claims experience
6-32 data for use in the estimates described by Subsection (a).
6-33 Sec. 1508.257. TOTAL ELIGIBLE ENROLLMENT DETERMINATION.
6-34 The commissioner shall determine total eligible enrollment under
6-35 qualifying health benefit plans by dividing the total funds
6-36 available for distribution from the fund by the estimated per
6-37 covered individual annual cost of total claims reimbursement from
6-38 the fund.
6-39 Sec. 1508.258. EVALUATION AND PROTECTION OF FUND; EMPLOYER
6-40 ENROLLMENT SUSPENSION. (a) The commissioner shall suspend the
6-41 enrollment of new employers in qualifying health benefit plans if
6-42 the commissioner determines that the total enrollment reported by
6-43 all health benefit plan issuers under qualifying health benefit
6-44 plans exceeds the total eligible enrollment determined under
6-45 Section 1508.257 and is likely to result in anticipated annual
6-46 expenditures from the fund in excess of the total funds available
6-47 for distribution from the fund.
6-48 (b) The commissioner shall provide a health benefit plan
6-49 issuer participating in the program with notification of any
6-50 enrollment suspension under Subsection (a) as soon as practicable
6-51 after:
6-52 (1) receipt of all enrollment data; and
6-53 (2) determination of the need to suspend enrollment.
6-54 (c) A suspension of issuance of qualifying health benefit
6-55 plans to employers under Subsection (a) does not preclude the
6-56 addition of new employees of an employer already covered under a
6-57 qualifying health benefit plan or new dependents of employees
6-58 already covered under a qualifying health benefit plan.
6-59 Sec. 1508.259. EMPLOYER ENROLLMENT REACTIVATION. If, at
6-60 any point during a suspension of enrollment under Section 1508.258,
6-61 the commissioner determines that funds are sufficient to provide
6-62 for the addition of new enrollments, the commissioner:
6-63 (1) may reactivate new enrollments; and
6-64 (2) shall notify all participating group health
6-65 benefit plan issuers that enrollment of new employers may be
6-66 resumed.
6-67 Sec. 1508.260. FUND ADMINISTRATOR. (a) The commissioner
6-68 may obtain the services of an independent organization to
6-69 administer the fund.

7-1 (b) The commissioner shall establish guidelines for the
7-2 submission of proposals by organizations for the purposes of
7-3 administering the fund and may approve, disapprove, or recommend
7-4 modification to the proposal of an applicant to administer the
7-5 fund.
7-6 (c) An organization approved to administer the fund shall
7-7 submit reports to the commissioner, in the form and at the times
7-8 required by the commissioner, as necessary to facilitate evaluation
7-9 and ensure orderly operation of the fund, including an annual
7-10 report of the affairs and operations of the fund. The annual report
7-11 must also be delivered to the governor, the lieutenant governor,
7-12 and the speaker of the house of representatives.
7-13 (d) An organization approved to administer the fund shall
7-14 maintain records in the form prescribed by the commissioner and
7-15 make those records available for inspection by or at the request of
7-16 the commissioner.
7-17 (e) The commissioner shall determine the amount of
7-18 compensation to be allocated to an approved organization as payment
7-19 for fund administration. Compensation is payable only from the
7-20 fund.
7-21 (f) The commissioner may remove an organization approved to
7-22 administer the fund from fund administration. An organization
7-23 removed from fund administration under this subsection must
7-24 cooperate in the orderly transition of services to another approved
7-25 organization or to the commissioner.
7-26 Sec. 1508.261. STOP-LOSS INSURANCE; REINSURANCE. (a) The
7-27 administrator of the fund, on behalf of and with the prior approval
7-28 of the commissioner, may purchase stop-loss insurance or
7-29 reinsurance from an insurance company licensed to write that
7-30 coverage in this state.
7-31 (b) Stop-loss insurance or reinsurance may be purchased to
7-32 the extent that the commissioner determines funds are available for
7-33 the purchase of that insurance.
7-34 Sec. 1508.262. PUBLIC EDUCATION AND OUTREACH. (a) The
7-35 commissioner may use an amount of the fund, not to exceed eight
7-36 percent of the annual amount of the fund, for purposes of developing
7-37 and implementing public education, outreach, and facilitated
7-38 enrollment strategies targeted to small employers who do not
7-39 provide health insurance.
7-40 (b) The commissioner shall solicit and accept
7-41 recommendations concerning the development and implementation of
7-42 education, outreach, and enrollment strategies under Subsection
7-43 (a) from agents licensed under Title 13 to write health benefit
7-44 plans in this state.
7-45 (c) The commissioner may contract with marketing
7-46 organizations to perform or provide assistance with education,
7-47 outreach, and enrollment strategies described by Subsection (a).
7-48 SECTION 2. The commissioner of insurance shall adopt any
7-49 rules necessary to implement the change in law made by this Act not
7-50 later than January 4, 2010.
7-51 SECTION 3. (a) The commissioner of insurance shall make an
7-52 initial determination concerning limitation of health benefit plan
7-53 issuer participation in the program established under Chapter 1508,
7-54 Insurance Code, as added by this Act, not later than January 18,
7-55 2010. If the commissioner determines that limited participation is
7-56 necessary to achieve the purposes of Chapter 1508, Insurance Code,
7-57 as added by this Act, the commissioner shall issue a request for
7-58 proposal from health benefit plan issuers to participate in the
7-59 program not later than May 1, 2010.
7-60 (b) The commissioner of insurance shall ensure that the
7-61 Healthy Texas Program is fully operational in a manner that allows
7-62 health benefit plan issuers participating in the program to make
7-63 the first annual request for reimbursement on January 1, 2011.
7-64 SECTION 4. This Act takes effect September 1, 2009.

7-65 * * * * *