By: Ellis S.B. No. 107

A BILL TO BE ENTITLED

AN ACT

relating to the creation of the Texas Health Benefit Plan Security 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 1510 to read as follows:

CHAPTER 1510. TEXAS HEALTH BENEFIT PLAN SECURITY ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1510.001. SHORT TITLE. This chapter may be cited as the Texas Health Benefit Plan Security Act.

Sec. 1510.002. DEFINITIONS. In this chapter:

(1) "Dependent" means:

(A) a spouse of an enrollee;

(B) an unmarried child who is under 19 years of age and is the child of an enrollee;

(C) a child who is a student under 23 years of age, is the child of an enrollee, and is financially dependent on the enrollee; or

(D) a child of any age who is the child of an enrollee, is disabled, and is dependent on the enrollee.

(2) "Eligible employee" means an individual employed by a small employer who works at least 20 hours per week for that employer. The term does not include an employee who works on a temporary or substitute basis or who works fewer than 26 weeks

annually.

(3) "Eligible individual" means:

(A) a self-employed individual who works and resides in this state and is organized as a sole proprietorship or in any other legally recognized manner in which a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

(B) an individual who does not work more than 20 hours a week for any single employer; or

(C) an individual employed by a small employer who does not offer health benefit plan coverage.

(4) "Employer" includes the owner or responsible agent of an employing business who is authorized to sign contracts on behalf of the business.

(5) "Enrollee" means an eligible individual or eligible employee who enrolls in the program.

(6) "Health benefit plan" has the meaning assigned by Section 1501.002(5).

(7) "Health benefit plan issuer" means any of the following entities, if the entity issues a health benefit plan in this state:

(A) an insurance company;

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

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

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

(E) a reciprocal exchange operating under Chapter 942;

(F) a Lloyd's plan operating under Chapter 941;

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

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

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

(8) "Participating employer" means a small employer who contracts with the department through the program.

(9) "Program" means the Health Benefit Plan Security Program established and operated under this chapter.

(10) "Provider" means any person, organization, corporation, or association who provides health care services and products and is authorized to provide those services and products under the laws of this state.

(11) "Small employer" has the meaning assigned by Section 1501.002(14). The commissioner, on or after September 1, 2011, by rule may expand the definition of "small employer" for the purposes of this chapter to include other employers not described by Section 1501.002(14).

(12) "Third-party administrator" means an administrator regulated under Chapter 4151.

Sec. 1510.003. DISCLOSURE OF CERTAIN INFORMATION IN

CONTRACT NEGOTIATIONS. During any negotiation with a health benefit plan issuer relating to a provider's reimbursement agreement with that issuer, the provider shall provide data relating to any reduction in or avoidance of bad debt or charity care costs by the provider as a result of the operation of the program.

Sec. 1510.004. CONSTRUCTION WITH OTHER LAW. (a) Notwithstanding any other law, including any otherwise applicable provision of Chapter 552, Government Code, any personally identifiable financial information, supporting data, or tax return of any individual obtained by the department under this chapter is confidential and not open to public inspection.

(b) Any health information obtained by the department under this chapter that is covered by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.) or Chapter 181, Health and Safety Code, is confidential and not open to public inspection.

Sec. 1510.005. RULES. The commissioner shall adopt rules as necessary to implement this chapter, including rules relating to criteria for small employer and enrollee participation in the program.

SUBCHAPTER B. PROGRAM ESTABLISHMENT AND OPERATION

Sec. 1510.051. PROGRAM ESTABLISHED; PURPOSE OF PROGRAM. (a) The Health Benefit Plan Security Program is established in the department.

(b) The purpose of the program is to provide comprehensive, affordable health care coverage to eligible individuals and

employees of small employers, and the dependents of eligible individuals and employees, on a voluntary basis.

Sec. 1510.052. DEPARTMENT PROGRAM POWERS AND DUTIES. (a) The department shall:

(1) determine the comprehensive services and benefits to be included by the program and develop the specifications for the health benefit plan coverage provided through the program;

(2) establish administrative and accounting procedures as recommended by the comptroller for the operation of the program;

(3) develop and implement a plan to publicize the existence of the program, including program eligibility requirements and enrollment procedures;

(4) arrange for the provision of health benefit plan coverage to eligible individuals and eligible employees through contracts with one or more qualified health benefit plan issuers; and

(5) develop a high-risk pool for enrollees in accordance with Section 1510.102.

(b) The department may:

(1) enter into contracts with qualified third parties, both private and public, for any service necessary to implement and operate the program;

(2) take any legal actions necessary to:

(A) avoid the payment of improper claims against the coverage provided by the program;

(B) recover any amounts erroneously or

improperly paid by the program;

(C) recover any amounts paid by the program as a result of mistake of fact or law;

(D) recover or collect savings offset payments due to the program under Subchapter F for the proper administration of the program; and

(E) recover other amounts due the program;

(3) establish and administer a revolving loan fund to assist providers in the purchase of computer hardware and software necessary to implement any program requirements relating to the electronic submission of claims and solicit matching contributions to the fund from each health benefit plan issuer;

(4) apply for and receive funds, grants, or contracts from public and private sources; and

(5) conduct studies and analyses related to the provision of health care, health care costs, and quality.

Sec. 1510.053. PROGRAM AUDIT. The state auditor shall annually audit the program and provide a written copy of the audit to the commissioner and the legislative committees having primary jurisdiction over the department.

SUBCHAPTER C. COVERAGE PROVIDED BY PROGRAM; REQUIREMENTS FOR HEALTH BENEFIT PLAN ISSUERS

Sec. 1510.101. PROVISION OF HEALTH BENEFIT PLAN COVERAGE. (a) The department, through the program, shall provide health benefit plan coverage through one or more health benefit plan issuers not later than September 1, 2010, by:

(1) issuing requests for proposals from health benefit

plan issuers;

(2) requiring health benefit plan issuers that wish to participate in the program to offer at least one health benefit plan that complies with the program's minimum requirements; and

(3) making payments to health benefit plan issuers that provide health benefit plan coverage to enrollees.

(b) The department, in order to provide health benefit plan coverage through the program, may:

(1) notwithstanding any other provision of this code, set allowable rates for administration and underwriting gains for health benefit plan issuers;

(2) require quality improvement, disease prevention, disease management, and cost-containment provisions in the contracts with participating health benefit plan issuers or may arrange for the provision of those services through contracts with other entities;

(3) administer continuation benefits for eligible individuals from employers with 20 or more employees who have purchased health benefit plan coverage through the program for the duration of their eligibility periods for continuation benefits under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.); and

(4) administer or contract to administer plans under Section 125, Internal Revenue Code of 1986, for employers and employees participating in the program, including medical expense reimbursement accounts and dependent care reimbursement accounts.

Sec. 1510.102. HEALTH HIGH-RISK POOL. (a) The department

shall establish a health high-risk pool for enrollees.

(b) An enrollee must be included in the high-risk pool if:

(1) the total cost of health care services for the enrollee exceeds $100,000 in any 12-month period; or

(2) the enrollee has been diagnosed with acquired immune deficiency syndrome (HIV/AIDS), angina pectoris, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open-heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia, or Wilson's disease.

(c) The department shall develop appropriate disease management protocols, develop procedures for implementing those protocols, and determine the manner in which disease management must be provided to enrollees in the high-risk pool. The program may include disease management in its contract with health benefit plan issuers participating in the program, contract separately with another entity for disease management services, or provide disease management services directly through the program.

Sec. 1510.103. REQUIREMENTS FOR HEALTH BENEFIT PLAN ISSUERS. In order to participate in the program as a health benefit plan issuer, a health benefit plan issuer must:

(1) provide the health services and benefits as determined by the department, including a standard benefit package

that meets the requirements for mandated coverage for specific health services, for specific diseases, and for providers of health services under the Medicaid program, and any supplemental benefits the department requires;

(2) ensure that providers contracting with a health benefit plan issuer participating in the program do not charge enrollees or third parties for covered health care services in excess of the amount allowed by the contract, except for applicable copayments, deductibles, or coinsurance;

(3) ensure that providers contracting with a health benefit plan issuer participating in the program do not refuse to provide coverage to an enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, sexual orientation, disability, or marital status; and

(4) ensure that a provider contracting with a health benefit plan issuer participating in the program is reimbursed at the rate negotiated between the health benefit plan issuer and the contracting provider.

SUBCHAPTER D. PARTICIPATION BY SMALL EMPLOYERS AND ELIGIBLE INDIVIDUALS

Sec. 1510.151. PARTICIPATION BY SMALL EMPLOYERS AND ELIGIBLE INDIVIDUALS. (a) The department, through the program, shall contract with small employers to provide for health benefit coverage for employees and the dependents of employees.

(b) The department, through the program, may permit eligible individuals to purchase the program's benefit plan

coverage for themselves and their dependents.

Sec. 1510.152. PREMIUMS, COSTS, AND CONTRIBUTIONS. (a) The program shall collect payments from small employers with whom the department has contracted under Section 1510.151(a) and enrollees, including eligible individuals who have purchased health benefit plan coverage from the program under Section 1510.151(b), to cover the costs of:

(1) health benefit plan coverage for enrollees and the dependents of enrollees in contribution amounts determined by the department;

(2) quality assurance, disease prevention, disease management, and cost-containment programs;

(3) administrative services; and

(4) other health promotion costs.

(b) The commissioner shall establish the minimum required contribution levels to be paid by a small employer toward the employer's aggregate payment for the cost of coverage of the small employer's employees. The minimum required contribution level to be paid by a small employer:

(1) may not exceed 60 percent; and

(2) must be prorated for employees who work less than the number of hours of a full-time equivalent employee.

(c) The commissioner may establish a separate minimum contribution level to be paid by a small employer toward the employer's aggregate payment for the cost of coverage of the dependents of a small employer's employees.

Sec. 1510.153. CERTIFICATIONS. (a) The department shall

require small employers with whom the department has contracted under Section 1510.151(a) to certify that:

(1) at least 75 percent of the employer's employees who work 30 hours or more per week and who do not have other creditable coverage are enrolled in a health benefit plan provided through the program; and

(2) the small employer and each enrollee employed by the employer otherwise meet the requirements of this chapter.

(b) The department may require an eligible individual to certify that all of the individual's dependents are covered under a health benefit plan issued by the program or another health benefit plan that offers creditable coverage as defined by Section 1205.004(a) or 1501.102(a).

(c) The department may require an eligible individual who is employed by a small employer who does not offer health benefit coverage to certify that the employer did not provide access to an employer-sponsored health benefit plan in the 12-month period immediately preceding the eligible individual's application to the program.

Sec. 1510.154. EFFECT OF SUBSIDIES. (a) The program shall reduce the payment amounts for enrollees and eligible individuals who are eligible for a subsidy.

(b) The program shall require small employers with whom the department has contracted under Section 1510.151(a) to pass on any subsidy to the enrollee qualifying for the subsidy, up to the full amount of payments made by the enrollee.

SUBCHAPTER E. SUBSIDIES

Sec. 1510.201. ESTABLISHMENT OF SUBSIDIES. (a) The department shall establish sliding-scale subsidies for the purchase of insurance paid by enrollees whose income is less than 300 percent of the federal poverty level and who are not eligible for coverage under the Medicaid program.

(b) The program may establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than 50 employees whose income is less than 300 percent of the federal poverty level and who are not eligible for coverage under the Medicaid program.

Sec. 1510.202. ELIGIBILITY REQUIREMENTS FOR SUBSIDY. To be eligible for a subsidy established under Section 1510.201, an enrollee must:

(1) have an income that is less than 300 percent of the federal poverty level, be a resident of this state, be ineligible for coverage under the Medicaid program, and be enrolled in a health benefit plan provided by the program; or

(2) be enrolled in a health benefit plan of an employer with more than 50 employees that meets any criteria established by the department, including any additional eligibility criteria.

Sec. 1510.203. LIMITATIONS ON SUBSIDIES. (a) The department shall limit the availability of subsidies to reflect limitations of available funds.

(b) The department may limit a subsidy to 40 percent of the payment made by an individual described by Section 1510.202(2) to more closely parallel the subsidy received by enrollees under

Section 1510.202(1).

(c) A subsidy granted to an enrollee who is an eligible individual who is not employed by a small employer may not exceed the maximum subsidy level available to enrollees who are employed by a small employer.

SUBCHAPTER F. SAVINGS OFFSET PAYMENTS

Sec. 1510.251. DETERMINATION OF COST SAVINGS. After notice and a hearing, the commissioner shall determine annually:

(1) the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs, to providers in this state as a result of the operation of the program; and

(2) any increased coverage in the Medicaid program or the state child health plan that is funded through the program.

Sec. 1510.252. ESTABLISHMENT OF OFFSET RATE AND AMOUNT. (a) The commissioner shall establish annually, at a rate that does not exceed the cost savings determined under Section 1510.251, a savings offset amount, to be paid quarterly during the 12-month period following the establishment of the offset amount by health benefit plan issuers, employee benefit excess insurance carriers, and third-party administrators other than health benefit plan issuers and administrators for accidental injury, specified disease, hospital indemnity, dental, vision, disability, income, long-term care, Medicare supplement, or other limited benefit health insurance.

(b) The commissioner shall make reasonable efforts to ensure that premium revenue, or claims plus any administrative

expenses and fees with respect to third-party administrators, is counted only once in any savings offset payment.

(c) The commissioner shall allow a health benefit plan issuer to exclude from the issuer's gross premium revenue reinsurance premiums that have been counted by the primary insurer for the purpose of determining its savings offset payment. The program shall allow each employee benefit excess insurance carrier to exclude from its gross premium revenue the amount of claims that have been counted by a third-party administrator for the purpose of determining its savings offset payment.

(d) The program may verify each health benefit plan issuer, employee benefit excess insurance carrier, and third-party administrator's savings offset payment based on annual statements and other reports.

Sec. 1510.253. PAYMENT OF OFFSET AMOUNT. (a) Each health benefit plan issuer and employee benefit excess insurance carrier shall pay a savings offset in an amount determined by the commissioner, not to exceed four percent of annual health insurance premiums and employee benefit excess insurance premiums on policies that insure residents of this state. The savings offset payment may not exceed the aggregate measurable cost savings under Section 1510.251.

(b) A health benefit plan issuer shall pay the first savings offset amount on September 1, 2011, and subsequently each quarter.

(c) The quarterly savings offset payments are due 30 days after written notice to the health benefit plan issuers, employee benefit excess insurance carriers, and third-party administrators

of the amount due, and accrue interest at 12 percent annually on or after that due date.

Sec. 1510.254. ANNUAL RECONCILIATION. The department shall annually reconcile the aggregate amount of annual offset payments paid by health benefit plan issuers to determine whether unused payments may be returned to health benefit plan issuers, employee benefit excess insurance carriers, and third-party administrators.

Sec. 1510.255. HEALTH BENEFIT PLAN ISSUER OBLIGATIONS. (a) Each health benefit plan issuer and health care provider shall demonstrate that best efforts have been made to ensure that an issuer has recovered savings offset payments made in accordance with this subchapter through negotiated reimbursement rates that reflect providers' reductions or stabilization in the cost of bad debt and charity care as a result of the operation of the program.

(b) A health benefit plan issuer shall use best efforts to ensure health benefit plan premiums reflect any recovery of savings offset payments as those savings offset payments are reflected through incurred claims experience.

Sec. 1510.256. DEPOSIT AND USE OF OFFSET PAYMENTS. (a) Savings offset payments collected under this subchapter shall be deposited in the state treasury to the credit of the Texas Department of Insurance operating account.

(b) Savings offset payments may be used only to fund the subsidies authorized by Subchapter E and may not exceed savings from reductions in growth of the state's health care spending and bad debt and charity care.

SECTION 2. (a) The commissioner of insurance shall adopt

the rules necessary to implement Chapter 1510, Insurance Code, as added by this Act, not later than January 1, 2010.

(b) The Texas Department of Insurance shall have the Texas Health Benefit Plan Security Program established under Chapter 1510, Insurance Code, as added by this Act, fully operational and able to provide health benefit coverage not later than September 1, 2010.

SECTION 3. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2009.