By: Shapleigh S.B. No. 2383

A BILL TO BE ENTITLED

AN ACT

relating to universal health coverage for Texans.

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

ARTICLE 1. HEALTH COVERAGE PROGRAM

SECTION 1.01. The Health and Safety Code is amended by adding Title 13 to read as follows:

TITLE 13. UNIVERSAL HEALTH COVERAGE FOR TEXANS

SUBTITLE A. GOVERNANCE OF HEALTH COVERAGE PROGRAM

CHAPTER 2001. GENERAL PROVISIONS

Sec. 2001.001. DEFINITIONS. In this title:

(1) "Agency" means the Texas Health Coverage Agency.

(2) "Commissioner" means the commissioner of health coverage.

(3) "Finance director" means the finance director of the system.

(4) "Health care facility" means a public or private hospital, skilled nursing facility, intermediate care facility, ambulatory surgical facility, family planning clinic that performs ambulatory surgical procedures, rural or urban health initiative clinic, kidney disease treatment facility, inpatient rehabilitation facility, and any other facility designated a health care facility by federal law. The term does not include the offices of physicians or health care providers practicing individually or in groups.

(5) "Health care provider" means an individual who is licensed, certified, or otherwise authorized to provide or render health care in the ordinary course of business or practice of a profession.

(6) "Integrated health care system" has the meaning assigned by Section 281.0517.

(7) "Premium commission" means the health care premium commission.

(8) "System" means the Texas Health Coverage System.

CHAPTER 2002. GOVERNANCE OF TEXAS HEALTH COVERAGE AGENCY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2002.001. DUTIES OF AGENCY. The Texas Health Coverage Agency administers the Texas Health Coverage System under this title.

Sec. 2002.002. SUNSET PROVISION. The agency is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the agency is abolished September 1, 2019.

Sec. 2002.003. GRANTS; FEDERAL FUNDING. The agency may accept gifts, grants, and donations, including grants from the federal government, to administer this title and provide health coverage through the system.

[Sections 2002.004-2002.050 reserved for expansion]

SUBCHAPTER B. COMMISSIONER

Sec. 2002.051. COMMISSIONER. (a) The commissioner of health coverage is appointed by the governor with the advice and consent of the senate.

(b) The commissioner shall be appointed without regard to race, color, disability, sex, religion, age, or national origin.

Sec. 2002.052. TERM. The commissioner serves a two-year term expiring on February 1 of each odd-numbered year.

Sec. 2002.053. ELIGIBILITY FOR SERVICE. (a) In this section, "Texas trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) A person is not eligible to serve as commissioner if, at any time within two years before the date on which service as commissioner begins:

(1) the person is an officer, employee, or paid consultant of a business or Texas trade association in the field of health insurance, pharmaceuticals, or medical equipment; or

(2) the person's spouse is an officer, employee, or paid consultant of a business or Texas trade association in the field of health insurance, pharmaceuticals, or medical equipment.

(c) A person may not serve as commissioner if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation on behalf of a profession related to the operation of the agency.

(d) A person appointed to serve as commissioner may not serve as an officer, employee, or paid consultant of a business or Texas trade association in the field of health insurance,

pharmaceuticals, or medical equipment for a period of two years after the person's appointment as commissioner ends.

Sec. 2002.054. POWERS AND DUTIES OF COMMISSIONER. (a) The commissioner is the executive officer of the agency and is responsible for administering the agency and the system.

(b) The commissioner may:

(1) set rates for payments by and to the system, including premium payments owed to the system, and establish the budget for the system;

(2) establish system objectives, priorities, and standards;

(3) employ agency personnel;

(4) allocate system resources in accordance with this title; and

(5) oversee the establishment and administration of the following:

(A) the health coverage policy board;

(B) the health coverage advisory committee;

(C) the office of patient advocacy;

(D) the office of health care planning;

(E) the office of health care quality;

(F) the health coverage fund;

(G) the payments board; and

(H) partnerships for health.

(c) The commissioner may adopt rules to administer the system and implement this title in accordance with Subchapter B, Chapter 2001, Government Code.

(d) The commissioner shall oversee the establishment of locally based integrated service networks, including physicians in fee-for-service, solo, and group practice and essential community and ancillary care providers and facilities, in order to pool and assign resources, form interdisciplinary teams that share responsibility and accountability for patient care, and provide a continuum of coordinated high-quality primary to tertiary care to residents of this state while preserving patient choice.

Sec. 2002.055. SYSTEM OFFICERS. The commissioner shall appoint the following system officers:

(1) the deputy commissioner;

(2) the finance director;

(3) the patient advocate for the office of patient advocacy;

(4) the inspector general;

(5) the director of the office of health care planning;

(6) the chief medical officer;

(7) the payments board director;

(8) the director for the partnerships for health;

(9) a regional director for each health care planning region;

(10) a chief enforcement counsel; and

(11) legal counsel, as determined by the commissioner.

[Sections 2002.056-2002.100 reserved for expansion]

SUBCHAPTER C. HEALTH COVERAGE POLICY BOARD AND HEALTH COVERAGE ADVISORY COMMITTEE

Sec. 2002.101. HEALTH COVERAGE POLICY BOARD. (a) The health coverage policy board establishes policy for the system and advises the commissioner concerning the operation of the system. The board assists the commissioner to establish:

(1) system objectives, priorities, and standards, including research and capital investment priorities;

(2) the scope of services provided by the system;

(3) guidelines for evaluating the performance of the system; and

(4) guidelines for ensuring public input.

(b) The health coverage policy board is composed of the following 11 members:

(1) the commissioner;

(2) the deputy commissioner;

(3) the finance director;

(4) the patient advocate;

(5) the chief medical officer;

(6) the director of the office of health care planning;

(7) the director of partnerships for health;

(8) the director of the payments board;

(9) one member of the health coverage advisory committee, to be determined by the health coverage advisory committee; and

(10) two representatives from regional planning

boards.

(b) The commissioner serves as the presiding officer of the board.

(c) The members of the health coverage policy board designated under Subsections (a)(9) and (10) serve two-year terms.

Sec. 2002.102. HEALTH COVERAGE ADVISORY COMMITTEE. (a) The health coverage advisory committee advises the commissioner and the health coverage policy board concerning implementation of the system.

(b) The commissioner shall appoint the following members to the health coverage advisory committee:

(1) four physicians, at least one of whom must be a psychiatrist;

(2) one registered nurse;

(3) one licensed vocational nurse;

(4) one licensed allied health practitioner;

(5) one mental health care provider;

(6) one dentist;

(7) one representative of private hospitals;

(8) one representative of public hospitals;

(9) one representative of an integrated health care delivery system;

(10) four consumers of health care, at least one of whom is disabled and at least one of whom is at least 65 years of age;

(11) one representative of organized labor;

(12) one representative of a health care facility that

serves low-income residents;

(13) one union member;

(14) one representative of an employer who employs more than 50 employees;

(15) one representative of an employer who employs fewer than 50 employees; and

(16) one pharmacist.

(c) In making appointments, the commissioner shall attempt to reflect the geographic and cultural diversity of this state.

(d) Members of the health coverage advisory committee serve two-year terms.

Sec. 2002.103. DISCRIMINATION PROHIBITED. The members of the health coverage policy board and health coverage advisory committee shall be appointed without regard to race, color, disability, sex, religion, age, or national origin.

Sec. 2002.104. ELIGIBILITY. (a) It is a ground for removal from the health coverage policy board or health coverage advisory committee that a member:

(1) is ineligible for membership under this subchapter;

(2) cannot, because of illness or disability, discharge the member's duties for a substantial part of the member's term; or

(3) is absent from more than half of the regularly scheduled board or committee meetings that the member is eligible to attend during a calendar year without an excuse approved by a majority vote of the board or committee, as applicable.

(b) A person may not serve as a member of the health coverage policy board or health coverage advisory committee if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation on behalf of a profession related to the operation of the agency.

(c) If the commissioner has knowledge that a potential ground for removal exists, the commissioner shall notify the presiding officer of the board or committee, as applicable, of the potential ground. The presiding officer shall then notify the governor and the attorney general that a potential ground for removal exists. If the potential ground for removal involves the presiding officer, the commissioner shall notify the next highest ranking officer of the board or committee, as applicable, who shall then notify the governor and the attorney general that a potential ground for removal exists.

Sec. 2002.105. TRAINING. (a) A person who is appointed to and qualifies for office as a member of the health coverage policy board or health coverage advisory committee may not vote, deliberate, or be counted as a member in attendance at a meeting of the board or committee until the person completes a training program that complies with this section.

(b) The training program must provide the person with information regarding:

(1) this title;

(2) the programs, functions, rules, and budget of the agency;

(3) the results of the most recent formal audit of the

agency;

(4) the requirements of laws relating to open meetings, public information, administrative procedure, and conflicts of interest; and

(5) any applicable ethics policies adopted by the agency or the Texas Ethics Commission.

(c) A person appointed to the health coverage policy board or health coverage advisory committee is entitled to reimbursement, as provided by the General Appropriations Act, for the travel expenses incurred in attending the training program regardless of whether the attendance at the program occurs before or after the person qualifies for office.

Sec. 2002.106. COMPENSATION; REIMBURSEMENT. A person appointed to the health coverage policy board or health coverage advisory committee is not entitled to compensation for service on the board or committee but is entitled to reimbursement, as provided by the General Appropriations Act, for the expenses incurred in attending board or committee meetings or performing other official functions of the board or committee.

Sec. 2002.107. APPLICABILITY OF OTHER LAW. Chapter 2110, Government Code, does not apply to the health coverage advisory committee.

[Sections 2002.108-2002.150 reserved for expansion]

SUBCHAPTER D. OFFICE OF PATIENT ADVOCACY

Sec. 2002.151. OFFICE ESTABLISHED. The office of patient advocacy is within the agency and is operated under the direction of the patient advocate.

Sec. 2002.152. DUTIES OF OFFICE. The office:

(1) represents the interests of the public and consumers of health care;

(2) assists patients in obtaining health care services and benefits through the system;

(3) acts as an advocate for patients receiving services and benefits through the system; and

(4) responds to complaints made to the agency.

Sec. 2002.153. PATIENT ADVOCATE. (a) The commissioner shall appoint a patient advocate to administer the office.

(b) The patient advocate shall:

(1) oversee the establishment and maintenance of a grievance process;

(2) participate in the grievance process under Subdivision (1) and an independent medical review system on behalf of consumers;

(3) receive, evaluate, and respond to consumer complaints;

(4) receive recommendations from the public regarding methods to improve the system and hold public hearings at least annually;

(5) develop educational and informational guidelines for consumers describing consumer rights and responsibilities and informing consumers about effective ways to exercise the right to secure health care services and participate in the system;

(6) establish a toll-free telephone number to receive complaints;

(7) report annually to the public, the commissioner, and the legislature regarding consumer perspective on system performance, including recommendations for needed improvements; and

(8) establish an independent medical review system to provide timely examination of disputed health care services and coverage decisions to ensure the system provides efficient, appropriate services and responds to enrollee disputes.

[Sections 2002.154-2002.200 reserved for expansion]

SUBCHAPTER E. INSPECTOR GENERAL FOR HEALTH COVERAGE

Sec. 2002.201. INSPECTOR GENERAL APPOINTED. The inspector general for health coverage is appointed by the commissioner.

Sec. 2002.202. DUTIES OF INSPECTOR GENERAL. (a) The inspector general for health coverage shall:

(1) investigate, audit, and review the financial and business records of entities that provide services or products to the system;

(2) investigate allegations of misconduct by an agency employee or appointee or by a provider of health care services reimbursed by the system and report any findings of misconduct to the attorney general;

(3) investigate patterns of medical practice that may indicate fraud or abuse of power related to inappropriate utilization of medical products and services;

(4) arrange for the collection and analysis of data needed to investigate inappropriate utilization of products and services under the system;

(5) conduct additional reviews or investigations when requested by the governor or a member of the legislature and report findings of the review to the governor, lieutenant governor, and legislature; and

(6) establish a telephone hotline for anonymous reporting of allegations of failure to make health insurance premium payments established by the commission.

(b) The inspector general may refer any matter to the attorney general, an appropriate prosecuting attorney, or a regulatory agency of this state for criminal prosecution or disciplinary action in accordance with law.

[Sections 2002.203-2002.250 reserved for expansion]

SUBCHAPTER F. OFFICE OF HEALTH CARE PLANNING

Sec. 2002.251. OFFICE. The office of health care planning is within the agency and operates under the direction of the director of the office.

Sec. 2002.252. DUTIES OF OFFICE. (a) The office of health care planning shall assist the commissioner in planning for the short-term and long-term health care needs of eligible residents of this state in accordance with this title and the policies established by the commissioner.

(b) The office of health care planning shall evaluate the health care workforce and facility needs of this state, identify medically underserved areas of this state, and develop plans to provide services within those areas.

(c) The office of health care planning shall assist the commissioner in developing performance criteria applicable to

health care goals.

Sec. 2002.253. DIRECTOR. The director of the office of health care planning shall:

(1) establish performance criteria for health care goals;

(2) evaluate the effectiveness of performance criteria in measuring quality of care, administration, and planning;

(3) assist the health care planning regions in developing operating and capital requests;

(4) estimate the health care workforce needed to meet the needs of the population and the cost to the state of that workforce;

(5) estimate the number, types, and costs of facilities required to meet the health care needs of this state; and

(6) appoint a technology advisory group to advise the office regarding technological advances that streamline costs and improve efficiency of the system.

[Sections 2002.254-2002.300 reserved for expansion]

SUBCHAPTER G. OFFICE OF HEALTH CARE QUALITY

Sec. 2002.301. ADMINISTRATION. The office of health care quality is within the agency and operates under the direction of the chief medical officer.

Sec. 2002.302. DUTIES OF OFFICE. The office of health care quality shall assist the commissioner in supporting the delivery of high-quality, efficient health care, monitoring the quality of care delivered through the system, and promoting patient satisfaction

and shall assist the regional directors in the development and evaluation of regional operating and capital budget requests.

Sec. 2002.303. CHIEF MEDICAL OFFICER. The chief medical officer shall:

(1) collaborate with regional medical officers, regional directors, and other necessary personnel to develop community-based networks of providers to offer comprehensive, multidisciplinary, coordinated services to patients;

(2) establish standards of care, based on best practices, to serve as guidelines for providers;

(3) measure and monitor the quality of care throughout the system;

(4) support health care providers in correcting quality of care problems;

(5) identify medical errors and their causes and develop plans to prevent errors; and

(6) provide information and assistance to the commissioner regarding all aspects of quality of health care delivered through the system.

[Sections 2002.304-2002.350 reserved for expansion]

SUBCHAPTER H. PARTNERSHIPS FOR HEALTH

Sec. 2002.351. PARTNERSHIPS FOR HEALTH. Partnerships for health is a program within the agency that improves health through community health initiatives, supports innovative methods to improve health care quality, promotes efficient delivery of health care, and educates the public.

Sec. 2002.352. DIRECTOR. The director of partnerships for

health is responsible for administration of the program.

Sec. 2002.353. ROLE OF PATIENT ADVOCATE. The patient advocate shall work with community and health care providers to propose partnerships for health projects.

[Sections 2002.354-2002.400 reserved for expansion]

SUBCHAPTER I. HEALTH CARE PLANNING REGIONS

Sec. 2002.401. HEALTH CARE PLANNING REGIONS ESTABLISHED. (a) The commissioner, in consultation with the director of the office of health care planning, shall establish geographically contiguous health care planning regions for the state on the basis of:

(1) patterns of usage of health care services;

(2) health care resources, including health care workforce resources;

(3) health care needs, including public health needs;

(4) geography;

(5) population and demographic characteristics; and

(6) other considerations as determined by the commissioner.

(b) To the extent consistent with Subsection (a), the commissioner may designate as health care planning regions the public health regions established by the Department of State Health Services under Chapter 121.

Sec. 2002.402. REGIONAL DIRECTOR. (a) The commissioner shall appoint a regional director for each health care planning region. The regional director directs the health care planning region and establishes health policy for the region.

(b) A regional director serves at the pleasure of the commissioner and may serve not more than eight two-year terms.

Sec. 2002.403. DUTIES OF REGIONAL DIRECTOR. The regional director shall:

(1) direct the region;

(2) reside in the region in which the director serves;

(3) establish and administer a regional office of the commission, including an office of patient advocacy, an office of health care planning, an office of health care quality, and an office of partnerships for health;

(4) appoint a regional planning board and serve as the executive director of the board;

(5) identify and prioritize regional health care needs and goals, in collaboration with the regional medical officer, regional health care providers, regional planning board, and regional director of partnerships for health;

(6) assess projected revenue and expenditures to ensure fiscal solvency of the regional planning system and advise the commissioner regarding potential revenue shortfalls and the possible need for cost containment measures;

(7) assure that regional administrative costs meet standards established by the agency and seek innovative ways to lower administrative costs;

(8) plan for the delivery of, and equal access to, high-quality and culturally and linguistically sensitive health care, including care to disabled persons;

(9) seek innovative and systemic methods to improve

health care quality and efficiency and to achieve system access for all state residents;

(10) make needed revenue sharing arrangements so that regionalization does not limit a patient's choice of provider;

(11) implement dispute resolution procedures;

(12) implement methods for public comment;

(13) report at regular intervals to the public and the commissioner regarding the status of the regional planning system, including evaluating access to care, quality of care, provider performance, and other issues related to regional health care needs;

(14) establish guidelines for providers to identify, maintain, and provide to the regional director inventories of regional health care assets;

(15) establish and maintain regional health care databases that are coordinated with other regional and statewide databases;

(16) in collaboration with the regional medical officer, enforce reporting requirements established by the system;

(17) establish and implement a regional capital management plan under the capital management plan established by the commissioner for the system;

(18) implement standards and formats established by the commissioner for the development and submission of operating and capital budget requests and make recommendations to the commissioner and the director of the office of health planning for needed changes;

(19) support regional providers in developing operating and capital budget requests;

(20) receive, evaluate, and prioritize provider operating and capital budget requests under standards and criteria established by the commissioner;

(21) prepare a three-year regional operating and capital budget request that meets the health care needs of the region under this division for submission to the commissioner; and

(22) establish a comprehensive three-year regional planning budget using funds allocated to the region by the commissioner.

Sec. 2002.404. REGIONAL MEDICAL OFFICER. (a) Each regional director shall appoint a regional medical officer for each health care planning region.

(b) A regional medical officer shall:

(1) administer all aspects of the regional office of health care quality;

(2) serve as a member of the regional planning board;

(3) oversee the establishment of integrated service networks that:

(A) include physicians in fee-for-service, solo, and group practice, essential community and ancillary care providers, and facilities;

(B) pool and align resources and form interdisciplinary teams to share responsibility and accountability for patient care; and

(C) provide a continuum of coordinated

high-quality primary to tertiary care to all residents of the region;

(4) assure the evaluation and measurement of the quality of health care delivered in the region, including assessment of the performance of individual providers under standards established by the chief medical officer, to ensure a single standard of high-quality care is delivered to all state residents;

(5) in collaboration with the chief medical officer and regional providers, evaluate standards of care in use at the time the system becomes operative;

(6) ensure a smooth transition toward use of standards based on clinical efficacy that guide clinical decision-making;

(7) support the development and distribution of user-friendly software for use by providers in order to support the delivery of high-quality health care;

(8) provide feedback to, and support and supervision of, health care providers to ensure the delivery of high-quality care under standards established by the system;

(9) collaborate with the regional partnerships for health to develop patient education to assist consumers in evaluating and appropriately utilizing health care providers and facilities;

(10) collaborate with regional public health officers to establish regional health policies that support the public health;

(11) establish a regional program to monitor and

decrease medical errors and their causes using standards and methods established by the chief medical officer;

(12) support the development and implementation of innovative means to provide high-quality care and assist providers in securing funds for innovative demonstration projects that seek to improve care quality;

(13) establish means to assess the impact of the system's policies intended to assure the delivery of high-quality care;

(14) collaborate with the chief medical officer, the director of the office of health care planning, the regional director, and health care providers in the development and maintenance of regional health care databases;

(15) ensure the enforcement of, and recommend needed changes to, the system's reporting requirements;

(16) support providers in developing regional budget requests; and

(17) annually report to the commissioner, the public, the regional planning board, and the chief medical officer on the status of regional health care programs, needed improvements, and plans to implement and evaluate delivery of care improvements.

Sec. 2002.405. REGIONAL PLANNING BOARD. The commissioner shall appoint a regional planning board for each health care planning region. The regional planning board shall advise the regional director concerning health policy for the region.

Sec. 2002.406. COMPOSITION OF REGIONAL PLANNING BOARD. (a) A regional director shall appoint 13 members to a regional planning

board.

(b) Members serve two-year terms that coincide with the term of the regional director and may be reappointed for not more than eight terms.

(c) Regional planning board members must have resided for at least two years in the region in which they serve before appointment to the board.

(d) Regional planning board members shall reside in the region they serve while on the board.

(e) The board consists of the following members:

(1) the regional director;

(2) the regional medical officer;

(3) the regional director of partnerships for health;

(4) a public health officer from one of the counties in the region, rotating among the county public health officers on a timetable to be established by each regional planning board;

(5) a representative from the office of patient advocacy;

(6) one expert in health care financing;

(7) one expert in health care planning;

(8) two members who are direct care providers in the region, one of whom is a registered nurse;

(9) one member who represents ancillary health care workers in the region;

(10) one member who represents hospitals in the region;

(11) one member who represents essential community

providers in the region; and

(12) one member representing the public.

(f) The regional director serves as chair of the board.

(g) The regional planning board shall advise and make recommendations to the regional director on all aspects of regional health policy.

[Sections 2002.407-2002.450 reserved for expansion]

SUBCHAPTER J. OFFICE OF TRANSITION ASSISTANCE

Sec. 2002.451. TRANSITION ASSISTANCE. The office of transition assistance is within the agency and operates under the direction of the commissioner.

Sec. 2002.452. TRANSITION ADVISORY COMMITTEE. The commissioner shall appoint a transition advisory group composed of the following members:

(1) the commissioner;

(2) the patient advocate;

(3) the chief medical officer;

(4) the director of the office of health care planning;

(5) the finance director;

(6) experts in health care financing and health care administration;

(7) direct care providers;

(8) representatives of retirement boards;

(9) employer and employee representatives;

(10) representatives of hospitals, integrated health care delivery systems, and other health care facilities;

(11) representatives of state health and human services agencies;

(12) representatives of counties; and

(13) health care consumers.

Sec. 2002.453. DUTIES OF OFFICE. The office of transition assistance shall:

(1) provide assistance to individuals who lose employment, directly or indirectly, as a result of the implementation of the system, including job training and job placement;

(2) advise the commission regarding the implementation of the system;

(3) make recommendations to the commissioner regarding the integration of health care delivery; and

(4) make recommendations to the governor, lieutenant governor, and legislature regarding research needed to support transition to the system.

Sec. 2002.454. EXPIRATION. This subchapter expires December 31, 2014.

CHAPTER 2003. FISCAL MANAGEMENT

SUBCHAPTER A. HEALTH COVERAGE FUND

Sec. 2003.001. FUND. The health coverage fund is a fund in the state treasury. The fund is composed of:

(1) all funds collected from health care;

(2) federal funds allocated to the fund; and

(3) other money allocated to the fund under law.

Sec. 2003.002. ADMINISTRATION OF FUND. (a) The finance

director administers the fund under the supervision and direction of the commissioner.

(b) The finance director may employ actuaries, accountants, and other experts as necessary to perform the finance director's duties under law.

Sec. 2003.003. ACCOUNTS IN FUND. The finance director shall establish the following accounts in the fund:

(1) a system account to provide for all annual state expenditures for health care; and

(2) a reserve account.

Sec. 2003.004. PREMIUMS SUFFICIENT TO COVER COSTS. Premiums collected each year under this title shall be sufficient to cover that year's projected costs.

Sec. 2003.005. USE OF FUND. (a) Money in the fund may be used in accordance with the General Appropriations Act to pay claims for health care services provided through the system and the administrative costs of the system.

(b) Not more than five percent of the money in the fund may be used for administrative costs of the system.

(c) Notwithstanding Subsection (b), not more than 10 percent of the money in the fund may be used for administrative costs of the system. This subsection expires August 31, 2022.

Sec. 2003.006. LEGISLATIVE APPROPRIATION REQUEST. (a) Not later than November 1 of each even-numbered year, the commissioner, in consultation with the finance director, shall submit to the Legislative Budget Board:

(1) an estimate of projected system revenues under

this title;

(2) an estimate of projected system liabilities for the succeeding fiscal biennium; and

(3) a legislative appropriation request for the succeeding fiscal biennium.

(b) The legislative appropriation request shall specify amounts to be allocated to the health care planning regions for health care services in those regions.

(c) The legislative appropriation request must include amounts necessary to provide transition assistance to individuals who lose employment, directly or indirectly, as a result of the implementation of the system. This subsection expires December 31, 2014.

Sec. 2003.007. RESERVES FOR FUTURE SYSTEM LIABILITY. (a) The comptroller, at the direction of the finance director, shall establish one or more separate accounts for system reserves against future liability.

(b) The commissioner shall work with the Department of Insurance, the Health and Human Services Commission, and other experts to determine an appropriate level of reserves for the system for the first year and future years of the system's operation.

(c) Funds held in reserve by state health programs and federal money for health care shall be transferred to the reserve account at the time the state assumes financial responsibility for health care.

Sec. 2003.008. SELF-INSURED SYSTEM. The commissioner may

implement a program to self-insure the system against unforeseen expenditures or revenue shortfalls not covered by reserves or may borrow funds to cover temporary revenue shortfalls not covered by system reserves, including the issuance of revenue bonds payable from the premiums received by the system for this purpose, whichever is more cost effective.

Sec. 2003.009. DUTY TO MONITOR SYSTEM SOLVENCY; NOTICE TO LEGISLATURE. The finance director shall monitor the solvency of the system. If the finance director determines that system liabilities may exceed system revenue in any year, the finance director shall notify the commissioner, the health coverage policy board, the governor, the lieutenant governor, and the speaker of the house of representatives.

Sec. 2003.010. COST CONTAINMENT. (a) After receiving notice under Section 2003.009, the commissioner, in consultation with the finance director and the health coverage policy board, may implement cost containment measures and may require each regional planning board to impose cost containment measures within the region subject to the board's jurisdiction.

(b) Cost containment measures may include:

(1) changes in the system or health facility administration that improve efficiency;

(2) changes in the delivery of health care services that improve efficiency and quality of care;

(3) postponement of introduction of new benefits or benefit improvements;

(4) the seeking of statutory authority for a temporary

decrease in benefits;

(5) postponement of planned capital expenditures;

(6) adjustments of health care provider payments to correct for deficiencies in quality of care and failure to meet compensation contract performance goals;

(7) adjustments to compensation of managerial employees and upper-level managers under contract with the system to correct for deficiencies in management and failure to meet contract performance goals;

(8) limitations on reimbursement budgets of the system's providers and upper-level managers whose compensation is determined by the payments board;

(9) limitations on aggregate reimbursements to manufacturers of pharmaceutical and durable and nondurable medical equipment;

(10) deferred funding of the reserve account;

(11) imposition of copayments or deductible payments except where prohibited by federal law and as determined by federal law for persons with low income; and

(12) imposition of an eligibility waiting period and other means if the commissioner determines that many individuals are emigrating to the state for the purpose of obtaining health care through the system.

(c) Nothing in this section shall be construed to diminish the benefits that an individual has under a collective bargaining agreement.

(d) Nothing in this section shall preclude an employee from

receiving benefits available to the employee under a collective bargaining agreement or other employee-employer agreement or a statute that are superior to benefits under this section.

(e) Cost containment measures implemented under this section must remain in place until the commissioner and the health coverage policy board determine that the cause of a revenue shortfall has been corrected.

(f) If the health coverage policy board determines that cost containment measures implemented under this section are not sufficient to meet a revenue shortfall, the commissioner shall report to the legislature and the public on the causes of the shortfall and the reasons for the failure of cost containment measures and shall recommend measures to correct the shortfall, including an increase in premium payments to the system.

Sec. 2003.011. REGIONAL COST CONTAINMENT. (a) If the commissioner or a regional director determines that regional revenue and expenditure trends indicate a need for regional cost containment measures, the regional director shall convene the regional planning board to discuss the possible need for cost containment measures and make a recommendation about appropriate measures to control costs.

(b) Cost containment measures under this section may include any of the following:

(1) changes in the administration of the system or in health facility administration that improve efficiency;

(2) changes in the delivery of health care services and health system management that improve efficiency or quality of

care;

(3) postponement of planned regional capital expenditures;

(4) adjustment of payments to health care providers to reflect deficiencies in quality of care and failure to meet compensation contract performance goals and payments to upper-level managers to reflect deficiencies in management and failure to meet compensation contract performance goals;

(5) adjustment of payments to health care providers and upper-level managers above a specified amount of aggregate billing; and

(6) adjustment of payments to pharmaceutical and medical equipment manufacturers and others selling goods and services to the system above a specified amount of aggregate billing.

(c) Cost containment measures shall remain in place in a region until the regional director and the commissioner determine that the cause of a revenue shortfall has been corrected.

[Sections 2003.012-2003.050 reserved for expansion]

SUBCHAPTER B. FEDERAL FUNDING

Sec. 2003.051. APPLICATION FOR FEDERAL FUNDING. The commissioner, through applications for appropriate waivers from the Centers for Medicare and Medicaid Services or another appropriate funding source, shall seek federal funding for the operation of the system.

[Sections 2003.052-2003.100 reserved for expansion]

SUBCHAPTER C. BUDGET

Sec. 2003.101. SYSTEM BUDGET. The budget for the system shall include each of the following:

(1) a transition budget;

(2) a providers and managers budget;

(3) a capitated operating budget;

(4) a noncapitated operating budget;

(5) a capital investment budget;

(6) a purchasing budget, including prescription drugs and durable and nondurable medical equipment;

(7) a research and innovation budget;

(8) a workforce training and development budget;

(9) a system administration budget; and

(10) regional budgets.

Sec. 2003.102. BUDGET CONSIDERATIONS. In establishing a budget under this section, the commissioner shall consider the following:

(1) the costs of transition to the new system;

(2) projections regarding the health care services anticipated to be used by residents of this state;

(3) differences in the costs of living between regions, including the overhead costs of maintaining medical practices;

(4) the health risk of enrollees;

(5) the scope of services provided;

(6) innovative programs that improve health care quality, administrative efficiency, and workplace safety;

(7) the unrecovered costs of providing care to persons who are not enrolled in the system;

(8) the costs of workforce training and development;

(9) the costs of corrective health outcome disparities and the unmet needs of previously uninsured and underinsured enrollees;

(10) relative usage of different health care providers;

(11) needed improvements in access to care;

(12) projected savings in administrative costs;

(13) projected savings due to provision of primary and preventive care to the population, including savings from decreases in preventable emergency room visits and hospitalizations;

(14) projected savings from improvements in quality of care;

(15) projected savings from decreases in medical errors;

(16) projected savings from system-wide management of capital expenditures;

(17) the cost of incentives and bonuses to support the delivery of high-quality health care, including incentives and bonuses needed to recruit and retain an adequate number of needed providers and managers and to attract health care providers to medically underserved areas;

(18) the costs of treating complex illnesses, including disease management programs;

(19) the cost of implementing standards of health care

coordination;

(20) the cost of electronic medical records and other electronic initiatives; and

(21) the costs of new technology, including research and development costs.

[Sections 2003.103-2003.150 reserved for expansion]

SUBCHAPTER D. PAYMENTS BOARD

Sec. 2003.151. PAYMENTS BOARD. (a) The commissioner shall establish the payments board and shall appoint a director and members of the board.

(b) The payments board is composed of:

(1) experts in health care finance and insurance systems;

(2) a designated representative of the commissioner;

(3) a designated representative of the health coverage fund; and

(4) a representative of the regional directors.

(c) The position of regional representative shall rotate among the directors of the regional planning boards every two years.

Sec. 2003.152. COMPENSATION PLAN. (a) The payments board shall establish and supervise a uniform payments system for health care providers and managers and shall maintain a compensation plan for each of the following health care providers and managers under the providers and managers budget established by the commissioner:

(1) upper-level managers employed by, or under contract with, private health care facilities;

(2) managers and officers of the system; and

(3) health care providers, including physicians, osteopathic physicians, dentists, podiatrists, optometrists, nurse practitioners, physician assistants, chiropractors, acupuncturists, psychologists, social workers, marriage, family, and child counselors, and other professional health care providers who are licensed to practice in this state and who provide services under the system.

(b) Health care providers licensed and accredited to provide services in this state may choose to be compensated for their services either by the system or by a person to whom they provide services.

(c) Health care providers who elect to receive compensation from the system shall enter into a contract with the system.

(d) Health care providers who elect to receive compensation by individuals to whom they provide services instead of by the system may establish charges for their services.

(e) A health care provider who accepts payment from the system under this section may not bill a patient for any covered service, except as authorized by the commissioner.

(f) A health care provider who receives compensation from the system may choose to be compensated as a fee-for-service provider or a provider employed by, or under contract with, a health care system that provides comprehensive, coordinated services.

(g) Nothing in this section restricts the right of a supervising health care provider to enter into a contractual arrangement that provides for salaried compensation for employees

who must be supervised by a physician.

(h) The compensation plan must include the following:

(1) actuarially sound payments that include a just and fair return for health care providers in the fee-for-service sector and for health care providers working in health systems where comprehensive and coordinated services are provided, including the actuarial basis for the payment;

(2) payment schedules that are in effect for three years; and

(3) bonus and incentive payments.

(i) A health care provider shall be paid for each service provided, including care provided to an individual subsequently determined to be ineligible for the system.

(j) A health care provider who delivers services that are not covered under the system may establish rates and charge patients for those services.

(k) Reimbursement to health care providers and compensation to managers may not exceed the amount allocated by the commissioner to provider and manager annual budgets.

Sec. 2003.153. REIMBURSEMENT FOR FEE-FOR-SERVICE PROVIDERS. (a) Fee-for-service health care providers shall choose representatives of their specialties to negotiate reimbursement rates with the payments board on their behalf.

(b) The payments board shall establish a uniform system of payments for all services provided.

(c) Payment schedules must be available to health care providers in printed and electronic format.

(d) Payment schedules are in effect for three years. Payment adjustments may be made at the discretion of the payments board to meet the goals of the system.

(e) In establishing a uniform system of payments, the payments board shall collaborate with regional directors and health care providers and consider regional differences in the cost of living and the need to recruit and retain skilled health care providers in the region.

(f) Fee-for-service health care providers shall submit claims electronically to the health coverage fund and shall be paid not later than the 30th business day after the date the claim is received.

[Sections 2003.154-2003.200 reserved for expansion]

SUBCHAPTER E. CAPITAL MANAGEMENT

Sec. 2003.201. CAPITAL MANAGEMENT PLAN. (a) The commissioner shall develop a capital management plan that governs all capital investments and acquisitions.

(b) The commissioner shall develop and maintain a capital inventory for each region and establish a process for each region to prepare a business plan that includes proposed investments and acquisitions.

Sec. 2003.202. COMPETITIVE BIDDING PROCESS. (a) The commissioner shall establish a competitive bidding process for the development of capital management plans.

(b) The system may fund all or part of capital projects.

Sec. 2003.203. NO INVESTMENTS FROM OPERATING BUDGETS. A capital investment may not be funded by money set aside in a

regional or system-wide operating budget.

Sec. 2003.204. REGIONAL CAPITAL INVESTMENT PLANS. Each regional director shall submit to the commissioner a regional capital management plan that is based on the capital management plan developed by the commissioner under Section 2003.201.

[Sections 2003.205-2003.250 reserved for expansion]

SUBCHAPTER F. PREMIUM COMMISSION

Sec. 2003.251. HEALTH CARE PREMIUM COMMISSION. (a) The health care premium commission is composed of 14 members, appointed as follows:

(1) three health economists with experience relevant to the duties of the commission, one of whom is appointed by the governor, one of whom is appointed by the lieutenant governor, and one of whom is appointed by the governor from a list submitted by the speaker of the house of representatives;

(2) a representative of the business community, other than the small business community, appointed by the governor;

(3) a representative of the small business community, appointed by the lieutenant governor;

(4) two representatives of employees in this state, one of whom is appointed by the lieutenant governor and one of whom is appointed by the governor from a list submitted by the speaker of the house of representatives;

(5) two representatives of nonprofit organizations interested in the establishment of a system of universal health care in this state, one of whom is appointed by the lieutenant governor and one of whom is appointed by the governor from a list

submitted by the speaker of the house of representatives;

(6) one representative of a nonprofit advocacy organization concerned with taxation policy and sustainable funding for public infrastructure, appointed by the governor from a list submitted by the speaker of the house of representatives;

(7) the comptroller, or the comptroller's designee;

(8) the director of the division of workforce development of the Texas Workforce Commission;

(9) the executive commissioner of the Health and Human Services Commission, or the executive commissioner's designee; and

(10) the lieutenant governor.

(b) The lieutenant governor and the speaker of the house of representatives shall designate a member of the senate and the house of representatives, respectively, to advise the premium commission.

(c) The appointed members of the premium commission serve for staggered terms of six years, with as near as possible to one-third of the members' terms expiring every February 1 of each odd-numbered year.

Sec. 2003.252. PREMIUM COMMISSION FUNCTIONS. The premium commission shall perform the following functions:

(1) determine the aggregate costs of providing health care coverage to residents of this state; and

(2) develop an equitable and affordable premium structure that will generate adequate revenue for the health coverage fund established under Subchapter A and ensure stable and actuarially sound funding for the system.

Sec. 2003.253. PREMIUM STRUCTURE. (a) The premium structure developed by the premium commission shall satisfy the following criteria:

(1) be means-based and generate adequate revenue to implement the system;

(2) to the greatest extent possible, ensure that all income earners and all employers contribute a premium amount that is affordable and consistent with existing funding sources for health care in this state;

(3) maintain the current ratio for aggregate health care contributions among the traditional health care funding sources, including employers, individuals, government, and other sources;

(4) provide a fair distribution of monetary savings achieved from the establishment of a universal health coverage system;

(5) coordinate with existing, ongoing funding sources from federal and state programs;

(6) be consistent with state and federal requirements governing financial contributions for persons eligible for existing public programs;

(7) comply with federal requirements; and

(8) include an exemption for employers and employees who are subject to a collective bargaining agreement.

(b) The premium commission shall seek expert and legal advice regarding the best method to structure premium payments consistent with existing employer-employee health care financing

structures.

Sec. 2003.254. POWERS AND DUTIES. The premium commission may:

(1) obtain grants from and contract with individuals and private, local, state, and federal agencies, organizations, and institutions;

(2) receive gifts, grants, and donations; and

(3) seek structured input from representatives of stakeholder organizations, policy institutes, and other persons with expertise in health care, health care financing, or universal health care models.

Sec. 2003.255. REPORT TO LEGISLATURE. On or before November 1 of each even-numbered year, the premium commission shall submit to the governor, the lieutenant governor, and both houses of the legislature a detailed recommendation for a premium structure.

[Sections 2003.256-2003.300 reserved for expansion]

SUBCHAPTER G. GOVERNMENTAL PAYMENTS

Sec. 2003.301. PAYMENTS FROM FEDERAL GOVERNMENT. (a) The commission shall seek any waivers, exemptions, agreements, or legislation necessary to ensure that all federal payments to the state for health care services are paid directly to the system. The system shall assume responsibility for all benefits and services previously paid by the federal government with those funds.

(b) In obtaining the waivers, exemptions, agreements, or legislation under Subsection (a), the commissioner shall seek from the federal government a contribution for health care services that does not decrease in relation to the contribution to other states as

a result of the waivers, exemptions, agreements, or legislation.

Sec. 2003.302. PAYMENTS FROM STATE GOVERNMENTS. (a) The commission shall seek any waivers, exemptions, agreements, or legislation necessary to ensure that all state payments for health care services are paid directly to the system. The system shall assume responsibility for all benefits and services previously paid by this state.

(b) The commissioner shall establish formulas for equitable contributions to the system from each county in this state and other local governmental entities.

Sec. 2003.303. AGREEMENT WITH ENTITIES CONTRIBUTING TO FUND. In order to minimize the administrative burden of maintaining eligibility records for programs transferred to the system, the commissioner shall attempt to reach an agreement with federal, state, and local governments in which contributions to the health coverage fund are fixed to the rate of change of the state gross domestic product, the size and age of population, and the number of residents living below the federal poverty level.

Sec. 2003.304. PAYMENTS THROUGH THE MEDICAL ASSISTANCE PROGRAM. To the extent that federal law allows the transfer of funding for the medical assistance program under Chapter 31, Human Resources Code, to the system, the commissioner shall pay from the health coverage fund all premiums, deductible payments, and coinsurance for eligible recipients of health benefits under the medical assistance program under Chapter 31, Human Resources Code.

Sec. 2003.305. MEDICARE PAYMENTS. To the extent that the commissioner obtains authorization to incorporate Medicare

revenues into the health coverage fund, Medicare Part B payments that previously were made by individuals or the state shall be paid by the system for all individuals eligible for both the system and the Medicare program.

[Sections 2003.306-2003.350 reserved for expansion]

SUBCHAPTER H. FEDERAL PREEMPTION

Sec. 2003.351. WAIVER FOR FEDERAL PREEMPTION. The commissioner shall pursue all reasonable means to secure a repeal or a waiver of any provision of federal law that preempts any provision of this title.

Sec. 2003.352. EMPLOYMENT CONTRACT. (a) To the extent permitted by federal law, an employee entitled to health or related benefits under a contract or plan that, under federal law, preempts provisions of this title, shall first seek benefits under that contract or plan before receiving benefits from the system.

(b) A benefit may not be denied under the system unless the employee has failed to take reasonable steps to secure similar benefits from the contract or plan, if those benefits are available.

(c) Nothing in this section precludes a person from receiving benefits from the system that are superior to benefits available to the person under an existing contract or plan.

(d) This title may not be construed to discourage recourse to contracts or plans that are protected by federal law.

(e) To the extent permitted by federal law, a health care provider shall first seek payment from the contract or plan before submitting a bill to the system.

[Sections 2003.353-2003.400 reserved for expansion]

SUBCHAPTER I. SUBROGATION

Sec. 2003.401. PURPOSE. (a) In this subchapter, "collateral source" means:

(1) an insurance policy written by an insurer, including the medical components of automobile, homeowners, and other forms of insurance;

(2) health care service plans and pension plans;

(3) employers;

(4) employee benefit contracts;

(5) government benefit programs;

(6) a judgment for damages for personal injury; or

(7) a third party who is or may be liable to an individual for health care services or costs.

(b) Until the role of all other payers for health care services has been terminated, costs for health care services may be collected from collateral sources whenever health care services provided to an individual are covered services under a policy of insurance, health care service plan, or other collateral source available to that individual, or for which the individual has a right of action for compensation to the extent permitted by law.

(c) A collateral source under this section does not include a contract or plan subject to federal preemption or a governmental unit, agency, or service. A contract or relationship with a governmental unit, agency, or service does not exclude an entity from the obligations of this section.

(d) The commissioner shall attempt to negotiate waivers,

seek federal legislation, or make other arrangements to incorporate collateral sources in this state into the system.

Sec. 2003.402. NOTIFICATION OF COVERAGE BY COLLATERAL SOURCE. (a) If an individual receives health care services under the system and is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, the individual shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information.

(b) The health care provider shall forward the information provided in Subsection (a) to the commissioner. The individual who receives services under Subsection (a) and who is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the commissioner.

Sec. 2003.403. SYSTEM REIMBURSEMENT. The system shall seek reimbursement from the collateral source for services provided to the individual under Section 2003.402(a) and may institute appropriate action, including filing suit, to recover the reimbursement. Upon demand, the collateral source shall pay to the health coverage fund the sums the collateral source would have paid or expended on behalf of the individual for the health care services provided by the system.

Sec. 2003.404. EXEMPT FROM SUBROGATION. If a collateral source is exempt from subrogation or the obligation to reimburse the system as provided by this subchapter, the commissioner may require that an individual who is entitled to health care services

from the source first seek those services from that source before seeking those services from the system.

SUBTITLE B. TEXAS HEALTH COVERAGE SYSTEM

CHAPTER 2101. ELIGIBILITY

SUBCHAPTER A. GENERAL ELIGIBILITY REQUIREMENTS

Sec. 2101.001. RESIDENTS AND CERTAIN EMPLOYEES ELIGIBLE. Except as otherwise provided by this chapter, each resident of this state is eligible for health coverage provided through the system. Residency is based on physical presence in the state with the intent to reside.

Sec. 2101.002. UNAUTHORIZED ALIEN INELIGIBLE. (a) A person who is not lawfully admitted for residence in the United States is not eligible for health coverage provided through the system.

(b) To the extent required by federal law, the system shall provide emergency services to a person otherwise ineligible for health coverage through the system under this section.

Sec. 2101.003. MILITARY PERSONNEL. United States military personnel are not eligible for health coverage provided through the system.

Sec. 2101.004. CERTAIN INMATES. A person covered by a managed health care plan for persons confined under the jurisdiction of the Texas Department of Criminal Justice is not eligible for health coverage provided through the system.

Sec. 2101.005. WORKERS' COMPENSATION. Coverage is not provided through the system for services covered under a program of workers' compensation insurance.

[Sections 2101.006-2101.050 reserved for expansion]

SUBCHAPTER B. ELIGIBILITY DETERMINATIONS

Sec. 2101.051. VERIFICATION OF ELIGIBILITY. The commissioner by rule shall adopt procedures for verifying residence as necessary to establish eligibility for health coverage provided through the system.

Sec. 2101.052. RESIDENCE OF MINOR. For purposes of this chapter, and except as provided by rules of the commissioner, an unmarried, unemancipated minor has the same residency status as the minor's parent or managing conservator.

Sec. 2101.053. EVIDENCE OF COVERAGE. The system may issue an identification card or other evidence of coverage to be used by an eligible resident to show proof that the resident is eligible for health coverage provided through the system.

Sec. 2101.054. PRESUMPTION APPLICABLE TO CERTAIN INDIVIDUALS. A health care facility is entitled to presume that a person who arrives at the facility and who is unable to provide proof of eligibility because the person is unconscious, is in need of emergency services, or is in need of acute psychiatric care is an eligible resident.

[Sections 2101.055-2101.100 reserved for expansion]

SUBCHAPTER C. SERVICES PROVIDED TO NONRESIDENTS

Sec. 2101.101. PAYMENT OF CLAIMS AUTHORIZED. The system may, in accordance with rules adopted by the commissioner, pay a claim for health care services provided to a nonresident who is temporarily in this state. The nonresident remains liable for the cost of all services provided to the nonresident through the

system.

CHAPTER 2102. HEALTH CARE SERVICES

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 2102.001. COVERAGE FOR HEALTH CARE SERVICES. The system must provide coverage for medically necessary health care services for an eligible resident at at least the level at which those services were provided under the state acute care Medicaid program, as that program existed on January 1, 2009.

Sec. 2102.002. LONG-TERM CARE. Notwithstanding Section 2102.001, the system may not provide coverage for long-term care services.

[Sections 2102.003-2102.050 reserved for expansion]

SUBCHAPTER B. OUT-OF-STATE BENEFITS

Sec. 2102.051. TEMPORARY BENEFITS. The system must provide health coverage for medically necessary health care services provided to an eligible resident who is out of this state for a temporary period not to exceed 90 days.

Sec. 2102.052. ELIGIBILITY. The commissioner by rule shall establish procedures for verifying eligibility for health coverage provided through the system under this subchapter.

Sec. 2102.053. EMERGENCY SERVICES. The system shall pay a claim for emergency services under this subchapter at the usual and customary rate for those services at the place at which the services are provided.

Sec. 2102.054. CLAIMS FOR SERVICES OTHER THAN EMERGENCY SERVICES. The system shall pay a claim for services not under this subchapter, other than emergency services, at a rate established by

the commissioner.

CHAPTER 2103. BENEFITS

Sec. 2103.001. MEDICAID. A resident who is eligible for medical assistance program benefits under Chapter 31, Human Resources Code, is entitled to all benefits available under that chapter.

Sec. 2103.002. COVERED BENEFITS. (a) Covered benefits under this chapter include all medical care determined appropriate by an individual's health care provider, except as provided in Subsection (c).

(b) Covered benefits under this section include:

(1) inpatient and outpatient health facility services;

(2) inpatient and outpatient professional health care provider services by licensed health care professionals;

(3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(4) durable medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, hearing aids, and repair;

(5) rehabilitative care;

(6) emergency transportation and necessary transportation for health care services for disabled and indigent persons;

(7) language interpretation and translation for health care services, including sign language for those unable to speak or hear, or who are language impaired, and Braille

translation or other services for those with no or low vision;

(8) child and adult immunizations and preventive care;

(9) health education;

(10) hospice care;

(11) home health care;

(12) prescription drugs listed on the system's preferred drug list;

(13) nonformulary prescription drugs if standards and criteria established by the commissioner are met;

(14) mental and behavioral health care;

(15) dental care;

(16) podiatric care;

(17) chiropractic care;

(18) acupuncture;

(19) blood and blood products;

(20) emergency care services;

(21) vision care;

(22) adult day care;

(23) case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting;

(24) substance abuse treatment;

(25) care of not more than 100 days in a skilled nursing facility following hospitalization;

(26) dialysis;

(27) benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing

entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization;

(28) chronic disease management;

(29) family planning services and supplies, except services related to an abortion; and

(30) early and periodic screening, diagnosis, and treatment services, as defined in 42 U.S.C. Section 1396d(r), for patients younger than 21 years of age, regardless of whether those services are covered benefits for persons who are at least 21 years of age.

(c) The following health care services are not covered benefits under the system:

(1) health care services determined to have no medical indication by the commissioner and the chief medical officer;

(2) surgery, dermatology, orthodontia, prescription drugs, or other procedures intended primarily for cosmetic purposes, unless required to correct a congenital defect, restore or correct a part of the body altered because of injury, disease, or surgery, or determined by a health care provider to be medically necessary;

(3) a private room in an inpatient facility if a non-private room is available, unless determined to be medically necessary; and

(4) services of a health care provider or facility that is not licensed by this state, except for services provided to a resident who is temporarily out of the state under Section

2102.051.

CHAPTER 2104. COST SHARING

Sec. 2104.001. COPAYMENTS REQUIRED. The finance director, with the approval of the commissioner, shall establish copayment amounts to be paid at the point of service by an eligible resident receiving health care services for which coverage is provided through the system.

Sec. 2104.002. DEDUCTIBLE AMOUNTS. The finance director, with the approval of the commissioner, shall establish deductible amounts that an eligible resident receiving health care services is responsible to pay before coverage is provided through the system.

Sec. 2104.003. LIMITS ON COPAYMENTS AND DEDUCTIBLES. The total amount payable for services provided through the system with respect to an eligible resident, including copayment and deductible amounts paid under this chapter, may not exceed five percent of the eligible resident's family income, as determined under rules of the commissioner.

CHAPTER 2105. HEALTH CARE PROVIDERS

Sec. 2105.001. ANY WILLING PROVIDER. (a) An eligible resident may select any physician, health care practitioner, or health care facility to provide medically necessary services within the scope of the license or other authorization of the physician, practitioner, or facility if the physician, practitioner, or facility agrees to accept payment for claims from the system subject to the terms imposed in accordance with this title.

(b) A physician, health care practitioner, or health care facility is subject to credentialing under the system in the same

manner as the physician, practitioner, or facility is subject to the credentialing requirements applicable under the state Medicaid program as that program existed on January 1, 2009.

Sec. 2105.002. PRIMARY CARE PROVIDER; REQUIRED REFERRAL. The commissioner by rule shall establish requirements under which an eligible resident must designate a primary care provider and must obtain a referral from that provider to obtain coverage for specialty care services. The system shall use the same methodology for primary care case management and referral as applicable under the state Medicaid program as that program existed on January 1, 2009.

ARTICLE 2. CONFORMING AMENDMENTS

SECTION 2.01. Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.0001 to read as follows:

Sec. 531.0001. COORDINATION WITH TEXAS HEALTH COVERAGE SYSTEM. (a) Notwithstanding any provision of this chapter or any other law of this state, on and after January 1, 2012, the Texas Health Coverage System is responsible for administering the system for providing health coverage and health care services in this state.

(b) The Health and Human Services Commission and each health and human services agency remain responsible for safety and licensing functions within the jurisdiction of the commission or the agency before January 1, 2012, but except as provided by Subsection (c), functions of the commission or agency relating to the provision of health coverage or health care services are transferred to the Texas Health Coverage Agency in accordance with

Title 13, Health and Safety Code.

(c) The Health and Human Services Commission and each health and human services agency remain responsible for long-term care services provided under the state Medicaid program.

SECTION 2.02. Chapter 30, Insurance Code, is amended by adding Section 30.005 to read as follows:

Sec. 30.005. COORDINATION WITH TEXAS HEALTH COVERAGE SYSTEM. Notwithstanding any provision of this code or any other law of this state, on and after January 1, 2012, an insurer, health maintenance organization, or other entity may not offer a health benefits plan in this state to the extent that plan duplicates coverage provided under the Texas Health Coverage System.

ARTICLE 3. TRANSITION PLAN

SECTION 3.01. Not later than October 1, 2009, the governor shall appoint the commissioner of health coverage in accordance with Chapter 2002, Health and Safety Code, as added by this Act.

SECTION 3.02. (a) Not later than January 1, 2010, the commissioner of health coverage shall appoint a transition advisory group. The transition advisory group must include representatives of the public, the health care industry, and issuers of health benefit plans and other experts identified by the commissioner.

(b) In consultation with the transition advisory group, the commissioner of health coverage shall develop a plan for the orderly implementation of Title 13, Health and Safety Code, as added by this Act. The plan must include provisions to assist individuals who lose employment, directly or indirectly, as a result of the implementation of the system.

SECTION 3.03. The Texas Health Coverage System shall become effective to provide coverage in accordance with Title 13, Health and Safety Code, as added by this Act, not later than January 1, 2012.

SECTION 3.04. (a) In this section, "affected state agency" means:

(1) the Health and Human Services Commission;

(2) the Texas Department of Insurance;

(3) the Department of State Health Services;

(4) the Department of Assistive and Rehabilitative Services;

(5) the Department of Aging and Disability Services;

(6) the Department of Family and Protective Services;

(7) the Employees Retirement System of Texas;

(8) the Teacher Retirement System of Texas;

(9) The Texas A&M University System; and

(10) The University of Texas System.

(b) Effective January 1, 2012, or on an earlier date specified by the commissioner of health coverage:

(1) the property and records of each affected state agency related to the administration of health coverage, health benefits, or health care services within the jurisdiction of the Texas Health Coverage Agency are transferred to the Texas Health Coverage Agency to assist that agency in beginning to administer Title 13, Health and Safety Code, as added by this Act, as efficiently as practicable;

(2) all powers, duties, functions, activities,

obligations, rights, contracts, records, property, and appropriations or other money of the affected state agency related to the administration of health coverage, health benefits, or health care services within the jurisdiction of the Texas Health Coverage Agency are transferred to the Texas Health Coverage Agency;

(3) a rule or form adopted by each affected state agency related to the administration of health coverage, health benefits, or health care services within the jurisdiction of the Texas Health Coverage Agency is a rule or form of the Texas Health Coverage Agency and remains in effect until altered by that agency; and

(4) a reference in law or an administrative rule to an affected state agency that relates to the administration of health coverage, health benefits, or health care services within the jurisdiction of the Texas Health Coverage Agency means the Texas Health Coverage Agency.

(c) An employee of an affected state agency employed on the effective date of this Act who performs a function that relates to the administration of health coverage, health benefits, or health care services within the jurisdiction of the Texas Health Coverage Agency does not automatically become an employee of the Texas Health Coverage Agency. To become an employee of the Texas Health Coverage Agency, a person must apply for a position at the Texas Health Coverage Agency. In establishing the Texas Health Coverage Agency in accordance with the transition plan developed under Section 3.02 of this Act, the Texas Health Coverage Agency shall

give preference in employment to employees described by this subsection who have the necessary qualifications for employment with the Texas Health Coverage Agency.

(d) Until the date of the transfer specified by Subsection (b) of this section, and subject to the transition plan developed under Section 3.02 of this Act, each affected state agency shall continue to exercise the powers and perform the duties assigned to the state agency under the law as it existed immediately before the effective date of this Act or as modified by another Act of the 81st Legislature, Regular Session, 2009, that becomes law, and the former law is continued in effect for that purpose.

ARTICLE 4. EFFECTIVE DATE

SECTION 4.01. 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.