Suspending limitations on conference committee jurisdiction, S.B. No. 78 (Nelson/Smithee)

By: Nelson S.R. No. 1101

R E S O L U T I O N

BE IT RESOLVED by the Senate of the State of Texas, 81st Legislature, Regular Session, 2009, That Senate Rule 12.03 be suspended in part as provided by Senate Rule 12.08 to enable the conference committee appointed to resolve the differences on Senate Bill 78, relating to promoting awareness and education about the purchase and availability of health coverage, to consider and take action on the following matter:

Senate Rule 12.03(4) is suspended to permit the committee, to add text that is not in disagreement to Subtitle G, Title 8, Insurance Code, by adding Chapter 1508 to read as follows:

ARTICLE 2. HEALTHY TEXAS PROGRAM

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

CHAPTER 1508. HEALTHY TEXAS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

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

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

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

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

(b) The Healthy Texas Program is not intended to diminish

the availability of traditional small employer health benefit plan coverage under Chapter 1501.

Sec. 1508.002. DEFINITIONS. In this chapter:

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

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

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

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

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

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

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

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

[Sections 1508.004-1508.050 reserved for expansion]

SUBCHAPTER B. EMPLOYER ELIGIBILITY; CONTRIBUTIONS

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

(1) during the 12-month period immediately preceding the date of application for a qualifying health benefit plan, the

small employer does not offer employees group health benefits on an expense-reimbursed or prepaid basis; and

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

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

Sec. 1508.052. COMMISSIONER ADJUSTMENTS AUTHORIZED. (a) The commissioner by rule may adjust the 12-month period described by Section 1508.051(a)(1) to an 18-month period if the commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other health benefit plans for qualifying health benefit plan coverage under this chapter.

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

Sec. 1508.053. MINIMUM EMPLOYER PARTICIPATION REQUIREMENTS. A small employer that meets the eligibility

requirements described by Section 1508.051(a) may apply to purchase a qualifying health benefit plan if 60 percent or more of the employer's eligible employees elect to participate in the plan.

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

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

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

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

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

[Sections 1508.055-1508.100 reserved for expansion]

SUBCHAPTER C. PROGRAM PARTICIPATION; REQUIRED COVERAGE AND BENEFITS

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

(b) The commissioner by rule may limit which health benefit plan issuers may participate in the program if the commissioner determines that the limitation is necessary to achieve the purposes of this chapter.

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

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

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

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

Sec. 1508.104. CERTAIN COVERAGE PROHIBITED OR REQUIRED. (a) A qualifying health benefit plan may only provide coverage for in-plan services and benefits, except for:

(1) emergency care; or

(2) other services not available through a plan provider.

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

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) physician services; and

(4) prescription drug benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[Sections 1508.105-1508.150 reserved for expansion]

SUBCHAPTER D. PROGRAM ADMINISTRATION

Sec. 1508.151. EMPLOYER CERTIFICATION. (a) At the time of initial application, a health benefit plan issuer shall obtain from a small employer that seeks to purchase a qualifying health benefit

plan a written certification that the employer meets the eligibility requirements described by Section 1508.051 and the minimum employer participation requirements described by Section 1508.053.

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

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

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

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

Sec. 1508.153. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) A qualifying health benefit plan must provide employees with an initial enrollment period that is 31 days or longer, and annually at least one open enrollment period that is 31 days or longer. The commissioner by rule may require an additional open enrollment

period if the commissioner determines that the additional open enrollment period is necessary to achieve the purposes of this chapter.

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

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

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

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

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

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

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

(2) may subject the enrollee to a one-year preexisting condition provision, as described by Section 1508.102, if the

period during which the preexisting condition provision applies does not exceed 18 months from the date of the initial application for coverage under the qualifying health benefit plan.

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

[Sections 1508.155-1508.200 reserved for expansion]

SUBCHAPTER E. RATING OF QUALIFIED HEALTH BENEFIT PLANS

Sec. 1508.201. RATING; PREMIUM PRACTICES IN GENERAL. (a) A health benefit plan issuer participating in the program must:

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

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

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

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

Sec. 1508.202. PREMIUM RATE DEVELOPMENT AND CALCULATION. (a) Rating factors used to underwrite qualifying health benefit plans must produce premium rates for identical groups that:

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

(2) do not reflect differences because of the nature

of the groups assumed to select a particular health benefit plan.

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

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

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

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

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

[Sections 1508.204-1508.250 reserved for expansion]

SUBCHAPTER F. HEALTHY TEXAS SMALL EMPLOYER PREMIUM STABILIZATION FUND

Sec. 1508.251. ESTABLISHMENT OF FUND. (a) To the extent that funds appropriated to the department are available for this purpose, the commissioner shall establish a fund from which health benefit plan issuers may receive reimbursement for claims paid by

the health benefit plan issuers for individuals covered under qualifying group health plans.

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

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

Sec. 1508.252. OPERATION OF FUND; CLAIM ELIGIBILITY. (a) A health benefit plan issuer is eligible to receive reimbursement in an amount that is equal to 80 percent of the dollar amount of claims paid between $5,000 and $75,000 in a calendar year for an enrollee in a qualifying health benefit plan.

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

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

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

(b) A health benefit plan issuer must request reimbursement from the fund annually, not later than the date determined by the

commissioner, following the end of the calendar year for which the reimbursement requests are made.

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

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

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

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

during that calendar year, the commissioner shall carry forward any excess funds and make those excess funds available for distribution in the next calendar year. Excess funds carried over under this section are added to the fund in addition to any other money appropriated for the fund for the calendar year into which the funds are carried forward.

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

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

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

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

Sec. 1508.257. TOTAL ELIGIBLE ENROLLMENT DETERMINATION. (a) The commissioner shall determine total eligible enrollment under qualifying health benefit plans by dividing the total funds available for distribution from the fund by the estimated per

covered individual annual cost of total claims reimbursement from the fund.

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

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

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

(1) receipt of all enrollment data; and

(2) determination of the need to suspend enrollment.

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

already covered under a qualifying health benefit plan.

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

(1) may reactivate new enrollments; and

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

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

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

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

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

the commissioner.

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

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

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

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

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

(b) The commissioner shall solicit and accept recommendations concerning the development and implementation of education, outreach, and enrollment strategies under Subsection

(a) from agents licensed under Title 13 to write health benefit plans in this state.

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

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

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

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

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

Explanation: This addition is necessary to authorize the

creation of the Healthy Texas Program to enhance the availability of health coverage.