By: Johnson S.B. No. 41

A BILL TO BE ENTITLED

AN ACT

relating to the development and implementation of the Live Well Texas program to provide health benefit coverage to certain individuals; imposing penalties.

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

SECTION 1. Subtitle I, Title 4, Government Code, is amended by adding Chapter 537A to read as follows:

CHAPTER 537A. LIVE WELL TEXAS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 537A.0001. DEFINITIONS. In this chapter:

(1) "Basic plan" means the program health benefit plan described by Section 537A.0202.

(2) "Eligible individual" means an individual who is eligible to participate in the program.

(3) "Participant" means an individual who is:

(A) enrolled in a program health benefit plan; or

(B) receiving health care financial assistance under Subchapter H.

(4) "Plus plan" means the program health benefit plan described by Section 537A.0203.

(5) "POWER account" means a personal wellness and responsibility account established for a participant under Section 537A.0251.

(6) "Program" means the Live Well Texas program

1 established under this chapter.

2 (7) "Program health benefit plan" includes:

3 (A) the basic plan; and

4 (B) the plus plan.

5 (8) "Program health benefit plan provider" means a
6 health benefit plan provider that contracts with the commission
7 under Section 537A.0107 to arrange for the provision of health care
8 services through a program health benefit plan.

9 SUBCHAPTER B. FEDERAL WAIVER FOR LIVE WELL TEXAS PROGRAM

10 Sec. 537A.0051. FEDERAL AUTHORIZATION FOR PROGRAM. (a)
11 Notwithstanding any other law, the executive commissioner shall
12 develop and seek a waiver under Section 1115 of the Social Security
13 Act (42 U.S.C. Section 1315) to the state Medicaid plan to implement
14 the Live Well Texas program to assist individuals in obtaining
15 health benefit coverage through a program health benefit plan or
16 health care financial assistance.

17 (b) The terms of a waiver the executive commissioner seeks
18 under this section must:

19 (1) be designed to:

20 (A) provide health benefit coverage options for
21 eligible individuals;

22 (B) produce better health outcomes for
23 participants;

24 (C) create incentives for participants to
25 transition from receiving public assistance benefits to achieving
26 stable employment;

27 (D) promote personal responsibility and engage

participants in making decisions regarding health care based on cost and quality;

(E) support participants' self-sufficiency by requiring unemployed participants to be referred to work search and job training programs;

(F) support participants who become ineligible to participate in a program health benefit plan in transitioning to private health benefit coverage;

(G) leverage enhanced federal medical assistance percentage funding to minimize or eliminate the need for a program enrollment cap; and

(H) leverage available federal medical assistance percentage funding, including funding available under the American Rescue Plan Act of 2021 (Pub. L. No. 117-2); and

(2) allow for the operation of the program consistent with the requirements of this chapter, except to the extent deviation from the requirements is necessary to obtain federal authorization of the waiver.

Sec. 537A.0052. FUNDING. Subject to approval of the waiver described by Section 537A.0051, the commission shall implement the program using federal funding available for that purpose, including enhanced federal medical assistance percentage funding available under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152).

Sec. 537A.0053. NOT AN ENTITLEMENT; TERMINATION OF PROGRAM. (a) This chapter does not establish an entitlement to health

benefit coverage or health care financial assistance under the program for eligible individuals.

(b) The program terminates at the time federal funding terminates under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), unless a successor program providing federal funding is created.

SUBCHAPTER C. PROGRAM ADMINISTRATION

Sec. 537A.0101. PROGRAM OBJECTIVE. The principal objective of the program is to provide primary and preventative health care through high deductible program health benefit plans to eligible individuals.

Sec. 537A.0102. PROGRAM PROMOTION. The commission shall promote and provide information about the program to individuals who:

(1) are potentially eligible to participate in the program; and

(2) live in medically underserved areas of this state.

Sec. 537A.0103. COMMISSION'S AUTHORITY RELATED TO HEALTH BENEFIT PLAN PROVIDER CONTRACTS. The commission may:

(1) enter into contracts with health benefit plan providers under Section 537A.0107;

(2) monitor program health benefit plan providers through reporting requirements and other means to ensure contract performance and quality delivery of services;

(3) monitor the quality of services delivered to participants through outcome measurements; and

1 (4) provide payment under the contracts to program
2 health benefit plan providers.
3 Sec. 537A.0104. COMMISSION'S AUTHORITY RELATED TO
4 ELIGIBILITY AND MEDICAID COORDINATION. The commission may:
5 (1) accept applications for health benefit coverage
6 under the program and implement program eligibility screening and
7 enrollment procedures;
8 (2) resolve grievances related to eligibility
9 determinations; and
10 (3) to the extent possible, coordinate the program
11 with Medicaid.
12 Sec. 537A.0105. THIRD-PARTY ADMINISTRATOR CONTRACT FOR
13 PROGRAM IMPLEMENTATION. (a) In administering the program, the
14 commission may contract with a third-party administrator to provide
15 enrollment and related services.
16 (b) If the commission contracts with a third-party
17 administrator under this section, the commission may:
18 (1) monitor the third-party administrator through
19 reporting requirements and other means to ensure contract
20 performance and quality delivery of services; and
21 (2) provide payment under the contract to the
22 third-party administrator.
23 (c) The executive commissioner shall retain all
24 policymaking authority over the program.
25 (d) The commission shall procure each contract with a
26 third-party administrator, as applicable, through a competitive
27 procurement process that complies with all federal and state laws.

Sec. 537A.0106. TEXAS DEPARTMENT OF INSURANCE DUTIES. (a) At the commission's request, the Texas Department of Insurance shall provide any necessary assistance with the program. The department shall monitor the quality of the services provided by program health benefit plan providers and resolve grievances related to those providers.

(b) The commission and the Texas Department of Insurance may adopt a memorandum of understanding that addresses the responsibilities of each agency with respect to the program.

(c) The Texas Department of Insurance, in consultation with the commission, shall adopt rules as necessary to implement this section.

Sec. 537A.0107. HEALTH BENEFIT PLAN PROVIDER CONTRACTS. The commission shall select through a competitive procurement process that complies with all federal and state laws and contract with health benefit plan providers to provide health care services under the program. To be eligible for a contract under this section, an entity must:

(1) be a Medicaid managed care organization;

(2) hold a certificate of authority issued by the Texas Department of Insurance that authorizes the entity to provide the types of health care services offered under the program; and

(3) satisfy, except as provided by this chapter, any applicable requirement of the Insurance Code or another insurance law of this state.

Sec. 537A.0108. HEALTH CARE PROVIDERS. (a) A health care provider who provides health care services under the program must

1 meet certification and licensure requirements required by
2 commission rules and other law.
3 (b) In adopting rules governing the program, the executive
4 commissioner shall ensure that a health care provider who provides
5 health care services under the program is reimbursed at a rate that
6 is at least equal to the rate paid under Medicare for the provision
7 of the same or substantially similar services.
8 Sec. 537A.0109. PROHIBITION ON CERTAIN HEALTH CARE
9 PROVIDERS. The executive commissioner shall adopt rules that
10 prohibit a health care provider from providing health care services
11 under the program for a reasonable period, as determined by the
12 executive commissioner, if the health care provider:
13 (1) fails to repay overpayments made under the
14 program; or
15 (2) owns, controls, manages, or is otherwise
16 affiliated with and has financial, managerial, or administrative
17 influence over a health care provider who has been suspended or
18 prohibited from providing health care services under the program.
19 SUBCHAPTER D. ELIGIBILITY FOR PROGRAM HEALTH BENEFIT COVERAGE
20 Sec. 537A.0151. ELIGIBILITY REQUIREMENTS. (a) An
21 individual is eligible to enroll in a program health benefit plan
22 if:
23 (1) the individual is a resident of this state;
24 (2) the individual is 19 years of age or older but
25 younger than 65 years of age;
26 (3) applying the eligibility criteria in effect in
27 this state on December 31, 2020, the individual is not eligible for

1 Medicaid; and

2 (4) federal matching funds are available under the
3 Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as
4 amended by the Health Care and Education Reconciliation Act of 2010
5 (Pub. L. No. 111-152) or other successor law to provide benefits to
6 the individual under the federal medical assistance program
7 established under Title XIX, Social Security Act (42 U.S.C. Section
8 1396 et seq.).

9 (b) An individual who is a parent or caretaker relative to
10 whom 42 C.F.R. Section 435.110 applies is eligible to enroll in a
11 program health benefit plan.

12 (c) In determining eligibility for the program, the
13 commission shall apply the same eligibility criteria regarding
14 residency and citizenship in effect for Medicaid in this state on
15 December 31, 2020.

16 Sec. 537A.0152. CONTINUOUS COVERAGE. The commission shall
17 ensure that an individual who is initially determined or
18 redetermined to be eligible to participate in the program and
19 enroll in a program health benefit plan will remain eligible for
20 coverage under the plan for a period of 12 months beginning on the
21 first day of the month following the date eligibility was
22 determined or redetermined, subject to Section 537A.0252(f).

23 Sec. 537A.0153. APPLICATION FORM AND PROCEDURES. (a) The
24 executive commissioner shall adopt an application form and
25 application procedures for the program. The form and procedures
26 must be coordinated with forms and procedures under Medicaid to
27 ensure that there is a single consolidated application process to

1 seek health benefit coverage under the program or Medicaid.
2 (b) To the extent possible, the commission shall make the
3 application form available in languages other than English.
4 (c) The executive commissioner may permit an individual to
5 apply by mail, over the telephone, or through the Internet.
6 Sec. 537A.0154. ELIGIBILITY SCREENING AND ENROLLMENT. (a)
7 The executive commissioner shall adopt eligibility screening and
8 enrollment procedures or use the Texas Integrated Enrollment
9 Services eligibility determination system or a compatible system to
10 screen individuals and enroll eligible individuals in the program.
11 (b) The eligibility screening and enrollment procedures
12 must ensure that an individual applying for the program who appears
13 eligible for Medicaid is identified and assisted with obtaining
14 Medicaid coverage. If the individual is denied Medicaid coverage
15 but is determined eligible to enroll in a program health benefit
16 plan, the commission shall enroll the individual in a program
17 health benefit plan of the individual's choosing and for which the
18 individual is eligible without further application or
19 qualification.
20 (c) Not later than the 30th day after the date an individual
21 submits a complete application form and unless the individual is
22 identified and assisted with obtaining Medicaid coverage under
23 Subsection (b), the commission shall ensure that the individual's
24 eligibility to participate in the program is determined and that
25 the individual is provided with information on program health
26 benefit plans and program health benefit plan providers. The
27 commission shall enroll the individual in the program health

1 benefit plan and with the program health benefit plan provider of
2 the individual's choosing in a timely manner, as determined by the
3 commission.
4 (d) The executive commissioner may establish enrollment
5 periods for the program.
6 Sec. 537A.0155. ELIGIBILITY REDETERMINATION PROCESS;
7 DISENROLLMENT. (a) Not later than the 90th day before the
8 expiration of a participant's coverage period, the commission shall
9 notify the participant regarding the eligibility redetermination
10 process and request documentation necessary to redetermine the
11 participant's eligibility.
12 (b) The commission shall provide written notice of
13 termination of eligibility to a participant not later than the 30th
14 day before the date the participant's eligibility will terminate.
15 The commission shall disenroll the participant from the program if:
16 (1) the participant does not submit the requested
17 eligibility redetermination documentation before the last day of
18 the participant's coverage period; or
19 (2) the commission, based on the submitted
20 documentation, determines the participant is no longer eligible for
21 the program, subject to Subchapter H.
22 (c) An individual may submit the requested eligibility
23 redetermination documentation not later than the 90th day after the
24 date the individual is disenrolled from the program. If the
25 commission determines that the individual continues to meet program
26 eligibility requirements, the commission shall reenroll the
27 individual in the program without any additional application

1 requirements.

2 (d) An individual who does not complete the eligibility
3 redetermination process in accordance with this section and who is
4 disenrolled from the program may not participate in the program for
5 a period of 180 days beginning on the date of disenrollment. This
6 subsection does not apply to an individual described by Section
7 537A.0206 or 537A.0208 or an individual who is pregnant or is
8 younger than 21 years of age.

9 (e) At the time a participant is disenrolled from the
10 program under this section, the commission shall provide to the
11 participant:

12 (1) notice that the participant may be eligible to
13 receive health care financial assistance under Subchapter H in
14 transitioning to private health benefit coverage; and

15 (2) information on and the eligibility requirements
16 for that financial assistance.

17 SUBCHAPTER E. BASIC AND PLUS PLANS

18 Sec. 537A.0201. BASIC AND PLUS PLAN COVERAGE GENERALLY.
19 (a) The basic and plus plans offered under the program must:

20 (1) comply with this subchapter and coverage
21 requirements prescribed by other law; and

22 (2) at a minimum, provide coverage for essential
23 health benefits required under 42 U.S.C. Section 18022(b).

24 (b) In modifying covered health benefits under the basic and
25 plus plans, the executive commissioner shall consider the health
26 care needs of healthy individuals and individuals with special
27 health care needs.

(c) The basic and plus plans must allow a participant with a chronic, disabling, or life-threatening illness to select an appropriate specialist as the participant's primary care physician.

Sec. 537A.0202. BASIC PLAN: COVERAGE AND INCOME ELIGIBILITY. (a) The program must include a basic plan that is sufficient to meet the basic health care needs of individuals who enroll in the plan.

(b) The covered health benefits under the basic plan must include:

(1) primary care physician services;

(2) prenatal and postpartum care;

(3) specialty care physician visits;

(4) home health services, not to exceed 100 visits per year;

(5) outpatient surgery;

(6) allergy testing;

(7) chemotherapy;

(8) intravenous infusion services;

(9) radiation therapy;

(10) dialysis;

(11) emergency care hospital services;

(12) emergency transportation, including ambulance and air ambulance;

(13) urgent care clinic services;

(14) hospitalization, including for:

(A) general inpatient hospital care;

1 (B) inpatient physician services;
2 (C) inpatient surgical services;
3 (D) non-cosmetic reconstructive surgery;
4 (E) a transplant;
5 (F) treatment for a congenital abnormality;
6 (G) anesthesia;
7 (H) hospice care; and
8 (I) care in a skilled nursing facility for a
9 period not to exceed 100 days per occurrence;
10 (15) inpatient and outpatient behavioral health
11 services;
12 (16) inpatient, outpatient, and residential substance
13 use treatment;
14 (17) prescription drugs, including tobacco cessation
15 drugs;
16 (18) inpatient and outpatient rehabilitative and
17 habilitative care, including physical, occupational, and speech
18 therapy, not to exceed 60 combined visits per year;
19 (19) medical equipment, appliances, and assistive
20 technology, including prosthetics and hearing aids, and the repair,
21 technical support, and customization needed for individual use;
22 (20) laboratory and pathology tests and services;
23 (21) diagnostic imaging, including x-rays, magnetic
24 resonance imaging, computed tomography, and positron emission
25 tomography;
26 (22) preventative care services as described by
27 Section 537A.0204; and

(23) services under the early and periodic screening, diagnostic, and treatment program for participants who are younger than 21 years of age.

(c) To be eligible for health care benefits under the basic plan, an individual who is eligible for the program must have an annual household income that is equal to or less than 100 percent of the federal poverty level.

Sec. 537A.0203. PLUS PLAN: COVERAGE AND INCOME ELIGIBILITY. (a) The program must include a plus plan that includes the covered health benefits listed in Section 537A.0202 and the following additional enhanced health benefits:

(1) services related to the treatment of conditions affecting the temporomandibular joint;

(2) dental care;

(3) vision care;

(4) notwithstanding Section 537A.0202(b)(18), inpatient and outpatient rehabilitative and habilitative care, including physical, occupational, and speech therapy, not to exceed 75 combined visits per year;

(5) bariatric surgery; and

(6) other services the commission considers appropriate.

(b) An individual who is eligible for the program and whose annual household income exceeds 100 percent of the federal poverty level will automatically be enrolled in and receive health benefits under the plus plan. An individual who is eligible for the program and whose annual household income is equal to or less than 100

1 percent of the federal poverty level may choose to enroll in the
2 plus plan.
3 (c) A participant enrolled in the plus plan is required to
4 make POWER account contributions in accordance with Section
5 537A.0252.
6 Sec. 537A.0204. PREVENTATIVE CARE SERVICES. (a) The
7 commission shall provide to each participant a list of health care
8 services that qualify as preventative care services based on the
9 age, gender, and preexisting conditions of the participant. In
10 developing the list, the commission shall consult with the federal
11 Centers for Disease Control and Prevention.
12 (b) A program health benefit plan shall, at no cost to the
13 participant, provide coverage for:
14 (1) preventative care services described by 42 U.S.C.
15 Section 300gg-13; and
16 (2) a maximum of $500 per year of preventative care
17 services other than those described by Subdivision (1).
18 (c) A participant who receives preventative care services
19 not described by Subsection (b) that are covered under the
20 participant's program health benefit plan is subject to deductible
21 and copayment requirements for the services in accordance with the
22 terms of the plan.
23 Sec. 537A.0205. COPAYMENTS. (a) A participant enrolled in
24 the basic plan shall pay a copayment for each covered health benefit
25 except for a preventative care or family planning service. The
26 executive commissioner by rule shall adopt a copayment schedule for
27 basic plan services, subject to Subsection (c).

(b) Except as provided by Subsection (c), a participant enrolled in the plus plan may not be required to pay a copayment for a covered service.

(c) A participant enrolled in the basic or plus plan shall pay a copayment in an amount set by commission rule not to exceed $25 for nonemergency use of hospital emergency department services unless:

(1) the participant has met the cost-sharing maximum for the calendar quarter, as prescribed by commission rule;

(2) the participant is referred to the hospital emergency department by a health care provider;

(3) the visit is a true emergency, as defined by commission rule; or

(4) the participant is pregnant.

Sec. 537A.0206. CERTAIN PARTICIPANTS ELIGIBLE FOR STATE MEDICAID PLAN BENEFITS. (a) A participant described by 42 C.F.R. Section 440.315 who is enrolled in the basic or plus plan is entitled to receive under the program all health benefits that would be available under the state Medicaid plan.

(b) A participant to which this section applies is subject to the cost-sharing requirements, including copayment and POWER account contribution requirements, of the program health benefit plan in which the participant is enrolled.

(c) The commission shall develop screening measures to identify participants to which this section applies.

Sec. 537A.0207. PREGNANT PARTICIPANTS. (a) A participant who becomes pregnant while enrolled in the program and who meets the

eligibility requirements for Medicaid may choose to remain in the program or enroll in Medicaid.

(b) A pregnant participant described by Subsection (a) who is enrolled in the basic or plus plan and who remains in the program is:

(1) notwithstanding Section 537A.0205, not subject to any cost-sharing requirements, including copayment and POWER account contribution requirements, of the program health benefit plan in which the participant is enrolled until the expiration of the second month following the month in which the pregnancy ends;

(2) entitled to receive as a Medicaid wrap-around benefit all Medicaid services a pregnant woman enrolled in Medicaid is entitled to receive, including a pharmacy benefit, when the participant exceeds coverage limits under the participant's program health benefit plan or if a service is not covered by the plan; and

(3) eligible for additional vision and dental care benefits.

Sec. 537A.0208. PARENTS AND CARETAKER RELATIVES. (a) A parent or caretaker relative to whom 42 C.F.R. Section 435.110 applies is entitled to receive as a Medicaid wrap-around benefit all Medicaid services to which the individual would be entitled under the state Medicaid plan that are not covered under the individual's program health benefit plan or exceed the plan's coverage limits.

(b) An individual described by Subsection (a) who chooses to participate in the program is subject to the cost-sharing

1 requirements, including copayment and POWER account contribution
2 requirements, of the program health benefit plan in which the
3 individual is enrolled.
4 SUBCHAPTER F. PERSONAL WELLNESS AND RESPONSIBILITY (POWER)
5 ACCOUNTS
6 Sec. 537A.0251. ESTABLISHMENT AND OPERATION OF POWER
7 ACCOUNTS. (a) The commission shall establish a personal wellness
8 and responsibility (POWER) account for each participant who is
9 enrolled in a program health benefit plan that is funded with money
10 contributed in accordance with this subchapter.
11 (b) The commission shall enable each participant to access
12 and manage money in and information regarding the participant's
13 POWER account through an electronic system. The commission may
14 contract with an entity that has appropriate experience and
15 expertise to establish, implement, or administer the electronic
16 system.
17 (c) Except as otherwise provided by Section 537A.0252, the
18 commission shall require each participant to contribute to the
19 participant's POWER account in amounts described by that section.
20 Sec. 537A.0252. POWER ACCOUNT CONTRIBUTIONS; DEDUCTIBLE.
21 (a) The executive commissioner by rule shall establish an annual
22 universal deductible for each participant enrolled in the basic or
23 plus plan.
24 (b) To ensure each participant's POWER account contains a
25 sufficient amount of money at the beginning of a coverage period,
26 the commission shall, before the beginning of that period, fund
27 each account with the following amounts:

(1) for a participant enrolled in the basic plan, the annual universal deductible amount; and

(2) for a participant enrolled in the plus plan, the difference between the annual universal deductible amount and the participant's required annual contribution as determined by the schedule established under Subsection (c).

(c) The executive commissioner by rule shall establish a graduated annual POWER account contribution schedule for participants enrolled in the plus plan that:

(1) is based on a participant's annual household income, with participants whose annual household incomes are less than the federal poverty level paying progressively less and participants whose annual household incomes are equal to or greater than the federal poverty level paying progressively more; and

(2) may not require a participant to contribute more than a total of five percent of the participant's annual household income to the participant's POWER account.

(d) A participant's employer may contribute on behalf of the participant any amount of the participant's annual POWER account contribution. A nonprofit organization may contribute on behalf of a participant any amount of the participant's annual POWER account contribution.

(e) Subject to the contribution cap described by Subsection (c)(2) and not before the expiration of the participant's first coverage period, the commission shall require a participant who uses one or more tobacco products to contribute to the participant's POWER account an annual POWER account contribution

1 amount that is one percent more than the participant would
2 otherwise be required to contribute under the schedule established
3 under Subsection (c).
4 (f) An annual POWER account contribution must be paid by or
5 on behalf of a participant monthly in installments that are at least
6 equal to one-twelfth of the total required contribution. The
7 coverage period for a participant whose annual household income
8 exceeds 100 percent of the federal poverty level may not begin until
9 the first day of the first month following the month in which the
10 first monthly installment is received.
11 Sec. 537A.0253. USE OF POWER ACCOUNT MONEY. A participant
12 may use money in the participant's POWER account to pay copayments
13 and deductible costs required under the participant's program
14 health benefit plan. The commission shall issue to each
15 participant an electronic payment card that allows the participant
16 to use the card to pay the program health benefit plan costs.
17 Sec. 537A.0254. PROGRAM HEALTH BENEFIT PLAN PROVIDER
18 REWARDS PROGRAM FOR ENGAGEMENT IN CERTAIN HEALTHY BEHAVIORS;
19 SMOKING CESSATION INITIATIVE. (a) A program health benefit plan
20 provider shall establish a rewards program through which a
21 participant receiving health care through a program health benefit
22 plan offered by the program health benefit plan provider may earn
23 money to be contributed to the participant's POWER account.
24 (b) Under a rewards program, a program health benefit plan
25 provider shall contribute money to a participant's POWER account if
26 the participant engages in certain healthy behaviors. The
27 executive commissioner by rule shall determine:

1 (1) the behaviors in which a participant must engage
2 to receive a contribution, which must include behaviors related to:
3 (A) completion of a health risk assessment;
4 (B) smoking cessation; and
5 (C) as applicable, chronic disease management;
6 and
7 (2) the amount of money a program health benefit plan
8 provider shall contribute for each behavior described by
9 Subdivision (1).
10 (c) Subsection (b) does not prevent a program health benefit
11 plan provider from contributing money to a participant's POWER
12 account if the participant engages in a behavior not specified by
13 that subsection or a rule adopted in accordance with that
14 subsection. If a program health benefit plan provider chooses to
15 contribute money under this subsection, the program health benefit
16 plan provider shall determine the amount of money to be contributed
17 for the behavior.
18 (d) A participant may use contributions a program health
19 benefit plan provider makes under a rewards program to offset a
20 maximum of 50 percent of the participant's required annual POWER
21 account contribution established under Section 537A.0252.
22 (e) Contributions a program health benefit plan provider
23 makes under a rewards program that result in a participant's POWER
24 account balance exceeding the participant's required annual POWER
25 account contribution may be rolled over into the next coverage
26 period in accordance with Section 537A.0256.
27 (f) During the first coverage period of a participant who

uses one or more tobacco products, a program health benefit plan provider shall actively attempt to engage the participant in and provide educational materials to the participant on:

(1) smoking cessation activities for which the participant may receive a monetary contribution under this section; and

(2) other smoking cessation programs or resources available to the participant.

Sec. 537A.0255. MONTHLY STATEMENTS. The commission shall distribute to each participant with a POWER account a monthly statement that includes information on:

(1) the participant's POWER account activity during the preceding month, including information on the cost of health care services delivered to the participant during that month;

(2) the balance of money available in the POWER account at the time the statement is issued; and

(3) the amount of any contributions due from the participant.

Sec. 537A.0256. POWER ACCOUNT ROLLOVER. (a) The executive commissioner by rule shall establish a process in accordance with this section to roll over money in a participant's POWER account to the succeeding coverage period. The commission shall calculate the amount to be rolled over at the time the participant's program eligibility is redetermined.

(b) For a participant enrolled in the basic plan, the commission shall calculate the amount to be rolled over to a subsequent coverage period POWER account from the participant's

1 current coverage period POWER account based on:

2 (1) the amount of money remaining in the participant's

3 POWER account from the current coverage period; and

4 (2) whether the participant received recommended

5 preventative care services during the current coverage period.

6 (c) For a participant enrolled in the plus plan who, as

7 determined by the commission, timely makes POWER account

8 contributions in accordance with this subchapter, the commission

9 shall calculate the amount to be rolled over to a subsequent

10 coverage period POWER account from the participant's current

11 coverage period POWER account based on:

12 (1) the amount of money remaining in the participant's

13 POWER account from the current coverage period;

14 (2) the total amount of money the participant

15 contributed to the participant's POWER account during the current

16 coverage period; and

17 (3) whether the participant received recommended

18 preventative care services during the current coverage period.

19 (d) Except as provided by Subsection (e), a participant may

20 use money rolled over into the participant's POWER account for the

21 succeeding coverage period to offset required annual POWER account

22 contributions, as applicable, during that coverage period.

23 (e) A participant enrolled in the basic plan who rolls over

24 money into the participant's POWER account for the succeeding

25 coverage period and who chooses to enroll in the plus plan for that

26 coverage period may use the money rolled over to offset a maximum of

27 50 percent of the required annual POWER account contributions for

that coverage period.

Sec. 537A.0257. REFUND. If at the end of a participant's coverage period the participant chooses to cease participating in a program health benefit plan or is no longer eligible to participate in a program health benefit plan, or if a participant is terminated from the program health benefit plan under Section 537A.0258 for failure to pay required contributions, the commission shall refund to the participant any money the participant contributed that remains in the participant's POWER account at the end of the coverage period or on the termination date.

Sec. 537A.0258. PENALTIES FOR FAILURE TO MAKE POWER ACCOUNT CONTRIBUTIONS. (a) For a participant whose annual household income exceeds 100 percent of the federal poverty level and who fails to make a contribution in accordance with Section 537A.0252, the commission shall provide a 60-day grace period during which the participant may make the contribution without penalty. If the participant fails to make the contribution during the grace period, the participant will be disenrolled from the program health benefit plan in which the participant is enrolled and may not reenroll in a program health benefit plan until:

(1) the 181st day after the date the participant is disenrolled; and

(2) the participant pays any debt accrued due to the participant's failure to make the contribution.

(b) For a participant enrolled in the plus plan whose annual household income is equal to or less than 100 percent of the federal poverty level and who fails to make a contribution in accordance

1 with Section 537A.0252, the commission shall disenroll the
2 participant from the plus plan and enroll the participant in the
3 basic plan. A participant enrolled in the basic plan under this
4 subsection may not change enrollment to the plus plan until the
5 participant's program eligibility is redetermined.
6 SUBCHAPTER G. EMPLOYMENT INITIATIVE
7 Sec. 537A.0301. GATEWAY TO WORK PROGRAM. (a) The
8 commission shall develop and implement a gateway to work program
9 to:
10 (1) integrate existing job training and job search
11 programs available in this state through the Texas Workforce
12 Commission or other appropriate state agencies with the Live Well
13 Texas program; and
14 (2) provide each participant with general information
15 on the job training and job search programs.
16 (b) Under the gateway to work program, the commission shall
17 refer each participant who is unemployed or working less than 20
18 hours a week to available job search and job training programs.
19 SUBCHAPTER H. HEALTH CARE FINANCIAL ASSISTANCE FOR CERTAIN
20 PARTICIPANTS
21 Sec. 537A.0351. HEALTH CARE FINANCIAL ASSISTANCE FOR
22 CONTINUITY OF CARE. (a) The commission shall ensure continuity of
23 care by providing health care financial assistance in accordance
24 with and in the manner described by this subchapter for a
25 participant who:
26 (1) is disenrolled from a program health benefit plan
27 in accordance with Section 537A.0155 because the participant's

1 annual household income exceeds the income eligibility
2 requirements for enrollment in a program health benefit plan; and
3 (2) seeks and obtains private health benefit coverage
4 within 12 months following the date of disenrollment.
5 (b) To receive health care financial assistance under this
6 subchapter, a participant must provide to the commission, in the
7 form and manner required by the commission, documentation showing
8 the participant has obtained or is actively seeking private health
9 benefit coverage.
10 (c) The commission may not impose an upper income
11 eligibility limit on a participant to receive health care financial
12 assistance under this subchapter.
13 Sec. 537A.0352. DURATION AND AMOUNT OF HEALTH CARE
14 FINANCIAL ASSISTANCE. (a) A participant described by Section
15 537A.0351 may receive health care financial assistance under this
16 subchapter until the first anniversary of the date the participant
17 was disenrolled from a program health benefit plan.
18 (b) Health care financial assistance made available to a
19 participant under this subchapter:
20 (1) may not exceed the amount described by Section
21 537A.0353; and
22 (2) is limited to payment for eligible services
23 described by Section 537A.0354.
24 Sec. 537A.0353. BRIDGE ACCOUNT; FUNDING. (a) The
25 commission shall establish a bridge account for each participant
26 eligible to receive health care financial assistance under Section
27 537A.0351. The account is funded with money the commission

1 contributes in accordance with this section.

2 (b) The commission shall enable each participant for whom a
3 bridge account is established to access and manage money in and
4 information regarding the participant's account through an
5 electronic system. The commission may contract with the same
6 entity described by Section 537A.0251(b) or another entity with
7 appropriate experience and expertise to establish, implement, or
8 administer the electronic system.

9 (c) The commission shall fund each bridge account in an
10 amount equal to $1,000 using money the commission retains or
11 recoups during the rollover process described by Section 537A.0256
12 or following the issuance of a refund as described by Section
13 537A.0257.

14 (d) The commission may not require a participant to
15 contribute money to the participant's bridge account.

16 (e) The commission shall retain or recoup any unexpended
17 money in a participant's bridge account at the end of the period for
18 which the participant is eligible to receive health care financial
19 assistance under this subchapter for the purpose of funding another
20 participant's POWER account under Subchapter F or bridge account
21 under this subchapter.

22 Sec. 537A.0354. USE OF BRIDGE ACCOUNT MONEY. (a) The
23 commission shall issue to each participant for whom a bridge
24 account is established an electronic payment card that allows the
25 participant to use the card to pay costs for eligible services
26 described by Subsection (b).

27 (b) A participant may use money in the participant's bridge

account to pay:

(1) premium costs incurred during the private health benefit coverage enrollment process and coverage period; and

(2) copayments, deductible costs, and coinsurance associated with the private health benefit coverage obtained by the participant for health care services that would otherwise be reimbursable under Medicaid.

(c) Costs described by Subsection (b)(2) associated with eligible services delivered to a participant may be paid by:

(1) a participant using the electronic payment card issued under Subsection (a); or

(2) a health care provider directly charging and receiving payment from the participant's bridge account.

Sec. 537A.0355. ENROLLMENT COUNSELING. The commission shall provide enrollment counseling to an individual who is seeking private health benefit coverage and who is otherwise eligible to receive health care financial assistance under this subchapter.

SECTION 2. (a) The Health and Human Services Commission shall conduct a study on the development and implementation of the Live Well Texas program under Chapter 537A, Government Code, as added by this Act, including potential sources of funding for the state's share of costs associated with implementing the program. The study must:

(1) consider the feasibility of using funding from the following sources to fund the program:

(A) rebates collected under the Medicaid vendor drug program; and

1 (B) managed care state premium tax revenue;
2 (2) evaluate the anticipated savings to this state
3 resulting from the reduction or elimination of:
4 (A) health care-related benefits that a program
5 participant would otherwise be eligible to receive under other
6 programs administered by the commission or another health and human
7 services agency, including:
8 (i) the kidney health care program;
9 (ii) the Healthy Texas Women program; and
10 (iii) other programs that provide benefits:
11 (a) to pregnant women;
12 (b) for treating breast and cervical
13 cancer;
14 (c) to support community health
15 treatment;
16 (d) for substance use treatment; and
17 (e) for treatment of HIV infection;
18 and
19 (B) health care expenses incurred by the Texas
20 Department of Criminal Justice for inpatient hospital stays of more
21 than 24 hours in a freestanding hospital; and
22 (3) based on the evaluation under Subdivision (2) of
23 this subsection, determine the extent to which savings offset or
24 eliminate the state's share of costs associated with implementing
25 the program.
26 (b) Not later than November 30, 2022, the Health and Human
27 Services Commission shall prepare and submit to the legislature a

1 written report that:

2 (1) summarizes the results of the study conducted
3 under Subsection (a) of this section; and

4 (2) includes legislative recommendations, as
5 applicable.

6 SECTION 3. As soon as practicable after the effective date
7 of this Act, the executive commissioner of the Health and Human
8 Services Commission shall apply for and actively pursue from the
9 federal Centers for Medicare and Medicaid Services or another
10 appropriate federal agency the waiver as required by Section
11 537A.0051, Government Code, as added by this Act. The commission
12 may delay implementing this Act until the waiver applied for under
13 that section is granted.

14 SECTION 4. This Act takes effect January 1, 2023, but only
15 if the constitutional amendment proposed by the 87th Legislature,
16 3rd Called Session, 2021, requiring the state to develop and seek
17 appropriate authorization under the federal Medicaid program to
18 implement the Live Well Texas program to provide health benefit
19 coverage to certain individuals is approved by the voters. If that
20 amendment is not approved by the voters, this Act has no effect.