By: Johnson S.B. No. 1751

A BILL TO BE ENTITLED

AN ACT

relating to improvements to access to health care in this state, including increased access to and scope of coverage under health benefit plans and Medicaid, and to improvements in health outcomes; authorizing an assessment; imposing penalties.

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

ARTICLE 1. HEALTH BENEFIT PLAN AVAILABILITY AND SCOPE OF COVERAGE

SECTION 1.01. (a) 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) "MyHealth account" means a personal wellness and responsibility account established for a participant under Section 537A.0251.

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

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

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

(5) "Plus plan" means the program health benefit plan

1 described by Section 537A.0203.
2 (6) "Program" means the Live Well Texas program
3 established under this chapter.
4 (7) "Program health benefit plan" includes:
5 (A) the basic plan; and
6 (B) the plus plan.
7 (8) "Program health benefit plan provider" means a
8 health benefit plan provider that contracts with the commission
9 under Section 537A.0107 to arrange for the provision of health care
10 services through a program health benefit plan.
11 SUBCHAPTER B. FEDERAL WAIVER FOR LIVE WELL TEXAS PROGRAM
12 Sec. 537A.0051. FEDERAL AUTHORIZATION FOR PROGRAM. (a)
13 Notwithstanding any other law, the executive commissioner shall
14 develop and seek a waiver under Section 1115 of the Social Security
15 Act (42 U.S.C. Section 1315) to the state Medicaid plan to implement
16 the Live Well Texas program to assist individuals in obtaining
17 health benefit coverage through a program health benefit plan or
18 health care financial assistance.
19 (b) The terms of a waiver the executive commissioner seeks
20 under this section must:
21 (1) be designed to:
22 (A) provide health benefit coverage options for
23 eligible individuals;
24 (B) produce better health outcomes for
25 participants;
26 (C) create incentives for participants to
27 transition from receiving public assistance benefits to achieving

1 stable employment;
2 (D) promote personal responsibility and engage
3 participants in making decisions regarding health care based on
4 cost and quality;
5 (E) support participants' self-sufficiency by
6 requiring unemployed participants to be referred to work search and
7 job training programs;
8 (F) support participants who become ineligible
9 to participate in a program health benefit plan in transitioning to
10 private health benefit coverage; and
11 (G) leverage enhanced federal medical assistance
12 percentage funding to minimize or eliminate the need for a program
13 enrollment cap; and
14 (2) allow for the operation of the program consistent
15 with the requirements of this chapter, except to the extent
16 deviation from the requirements is necessary to obtain federal
17 authorization of the waiver.
18 Sec. 537A.0052. FUNDING. Subject to approval of the waiver
19 described by Section 537A.0051, the commission shall implement the
20 program using enhanced federal medical assistance percentage
21 funding available under the Patient Protection and Affordable Care
22 Act (Pub. L. No. 111-148) as amended by the Health Care and
23 Education Reconciliation Act of 2010 (Pub. L. No. 111-152).
24 Sec. 537A.0053. NOT AN ENTITLEMENT; TERMINATION OF PROGRAM.
25 (a) This chapter does not establish an entitlement to health
26 benefit coverage or health care financial assistance under the
27 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

(4) provide payment under the contracts to program health benefit plan providers.

1 Sec. 537A.0104. COMMISSION'S AUTHORITY RELATED TO
2 ELIGIBILITY AND MEDICAID COORDINATION. The commission may:
3 (1) accept applications for health benefit coverage
4 under the program and implement program eligibility screening and
5 enrollment procedures;
6 (2) resolve grievances related to eligibility
7 determinations; and
8 (3) to the extent possible, coordinate the program
9 with Medicaid.
10 Sec. 537A.0105. THIRD-PARTY ADMINISTRATOR CONTRACT FOR
11 PROGRAM IMPLEMENTATION. (a) In administering the program, the
12 commission may contract with a third-party administrator to provide
13 enrollment and related services.
14 (b) If the commission contracts with a third-party
15 administrator under this section, the commission may:
16 (1) monitor the third-party administrator through
17 reporting requirements and other means to ensure contract
18 performance and quality delivery of services; and
19 (2) provide payment under the contract to the
20 third-party administrator.
21 (c) The executive commissioner shall retain all
22 policymaking authority over the program.
23 (d) The commission shall procure each contract with a
24 third-party administrator, as applicable, through a competitive
25 procurement process that complies with all federal and state laws.
26 Sec. 537A.0106. TEXAS DEPARTMENT OF INSURANCE DUTIES. (a)
27 At the commission's request, the Texas Department of Insurance

1 shall provide any necessary assistance with the program. The
2 department shall monitor the quality of the services provided by
3 program health benefit plan providers and resolve grievances
4 related to those providers.
5 (b) The commission and the Texas Department of Insurance may
6 adopt a memorandum of understanding that addresses the
7 responsibilities of each agency with respect to the program.
8 (c) The Texas Department of Insurance, in consultation with
9 the commission, shall adopt rules as necessary to implement this
10 section.
11 Sec. 537A.0107. HEALTH BENEFIT PLAN PROVIDER CONTRACTS.
12 The commission shall select through a competitive procurement
13 process that complies with all federal and state laws and contract
14 with health benefit plan providers to provide health care services
15 under the program. To be eligible for a contract under this section,
16 an entity must:
17 (1) be a Medicaid managed care organization;
18 (2) hold a certificate of authority issued by the
19 Texas Department of Insurance that authorizes the entity to provide
20 the types of health care services offered under the program; and
21 (3) satisfy, except as provided by this chapter, any
22 applicable requirement of the Insurance Code or another insurance
23 law of this state.
24 Sec. 537A.0108. HEALTH CARE PROVIDERS. (a) A health care
25 provider who provides health care services under the program must
26 meet certification and licensure requirements required by
27 commission rules and other law.

(b) In adopting rules governing the program, the executive commissioner shall ensure that a health care provider who provides health care services under the program is reimbursed at a rate that is at least equal to the rate paid under Medicare for the provision of the same or substantially similar services.

Sec. 537A.0109. PROHIBITION ON CERTAIN HEALTH CARE PROVIDERS. The executive commissioner shall adopt rules that prohibit a health care provider from providing health care services under the program for a reasonable period, as determined by the executive commissioner, if the health care provider:

(1) fails to repay overpayments made under the program; or

(2) owns, controls, manages, or is otherwise affiliated with and has financial, managerial, or administrative influence over a health care provider who has been suspended or prohibited from providing health care services under the program.

SUBCHAPTER D. ELIGIBILITY FOR PROGRAM HEALTH BENEFIT COVERAGE

Sec. 537A.0151. ELIGIBILITY REQUIREMENTS. (a) An individual is eligible to enroll in a program health benefit plan if:

(1) the individual is:

(A) a resident of this state; and

(B) a citizen of the United States or is otherwise legally authorized to be present in the United States;

(2) the individual is 19 years of age or older but younger than 65 years of age;

(3) applying the eligibility criteria in effect in

1 this state on December 31, 2020, the individual is not eligible for
2 Medicaid; and
3 (4) federal matching funds are available under the
4 Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as
5 amended by the Health Care and Education Reconciliation Act of 2010
6 (Pub. L. No. 111-152) to provide benefits to the individual under
7 the federal medical assistance program established under Title XIX,
8 Social Security Act (42 U.S.C. Section 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 Sec. 537A.0152. CONTINUOUS COVERAGE. The commission shall
13 ensure that an individual who is initially determined or
14 redetermined to be eligible to participate in the program and
15 enroll in a program health benefit plan will remain eligible for
16 coverage under the plan for a period of 12 months beginning on the
17 first day of the month following the date eligibility was
18 determined or redetermined, subject to Section 537A.0252(f).
19 Sec. 537A.0153. APPLICATION FORM AND PROCEDURES. (a) The
20 executive commissioner shall adopt an application form and
21 application procedures for the program. The form and procedures
22 must be coordinated with forms and procedures under Medicaid to
23 ensure that there is a single consolidated application process to
24 seek health benefit coverage under the program or Medicaid.
25 (b) To the extent possible, the commission shall make the
26 application form available in languages other than English.
27 (c) The executive commissioner may permit an individual to

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

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

a period of 180 days beginning on the date of disenrollment. This subsection does not apply to an individual described by Section 537A.0206 or 537A.0208 or an individual who is pregnant or is younger than 21 years of age.

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

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

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

SUBCHAPTER E. BASIC AND PLUS PLANS

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

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

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

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

(B) inpatient physician services;

(C) inpatient surgical services;

(D) non-cosmetic reconstructive surgery;

(E) a transplant;

(F) treatment for a congenital abnormality;

(G) anesthesia;

(H) hospice care; and

(I) care in a skilled nursing facility for a period not to exceed 100 days per occurrence;

(15) inpatient and outpatient behavioral health services;

(16) inpatient, outpatient, and residential substance use treatment;

(17) prescription drugs, including tobacco cessation drugs;

(18) inpatient and outpatient rehabilitative and habilitative care, including physical, occupational, and speech therapy, not to exceed 60 combined visits per year;

(19) medical equipment, appliances, and assistive technology, including prosthetics and hearing aids, and the repair, technical support, and customization needed for individual use;

(20) laboratory and pathology tests and services;

(21) diagnostic imaging, including x-rays, magnetic resonance imaging, computed tomography, and positron emission tomography;

(22) preventative care services as described by 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

1 plan, an individual who is eligible for the program must have an
2 annual household income that is equal to or less than 100 percent of
3 the federal poverty level.
4 Sec. 537A.0203. PLUS PLAN: COVERAGE AND INCOME ELIGIBILITY.
5 (a) The program must include a plus plan that includes the covered
6 health benefits listed in Section 537A.0202 and the following
7 additional enhanced health benefits:
8 (1) services related to the treatment of conditions
9 affecting the temporomandibular joint;
10 (2) dental care;
11 (3) vision care;
12 (4) notwithstanding Section 537A.0202(b)(18),
13 inpatient and outpatient rehabilitative and habilitative care,
14 including physical, occupational, and speech therapy, not to exceed
15 75 combined visits per year;
16 (5) bariatric surgery; and
17 (6) other services the commission considers
18 appropriate.
19 (b) An individual who is eligible for the program and whose
20 annual household income exceeds 100 percent of the federal poverty
21 level will automatically be enrolled in and receive health benefits
22 under the plus plan. An individual who is eligible for the program
23 and whose annual household income is equal to or less than 100
24 percent of the federal poverty level may choose to enroll in the
25 plus plan.
26 (c) A participant enrolled in the plus plan is required to
27 make MyHealth account contributions in accordance with Section

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

1 is:
2 (1) notwithstanding Section 537A.0205, not subject to
3 any cost-sharing requirements, including copayment and MyHealth
4 account contribution requirements, of the program health benefit
5 plan in which the participant is enrolled until the expiration of
6 the second month following the month in which the pregnancy ends;
7 (2) entitled to receive as a Medicaid wrap-around
8 benefit all Medicaid services a pregnant woman enrolled in Medicaid
9 is entitled to receive, including a pharmacy benefit, when the
10 participant exceeds coverage limits under the participant's
11 program health benefit plan or if a service is not covered by the
12 plan; and
13 (3) eligible for additional vision and dental care
14 benefits.
15 Sec. 537A.0208. PARENTS AND CARETAKER RELATIVES. (a) A
16 parent or caretaker relative to whom 42 C.F.R. Section 435.110
17 applies is entitled to receive as a Medicaid wrap-around benefit
18 all Medicaid services to which the individual would be entitled
19 under the state Medicaid plan that are not covered under the
20 individual's program health benefit plan or exceed the plan's
21 coverage limits.
22 (b) An individual described by Subsection (a) who chooses to
23 participate in the program is subject to the cost-sharing
24 requirements, including copayment and MyHealth account
25 contribution requirements, of the program health benefit plan in
26 which the individual is enrolled.

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

1 difference between the annual universal deductible amount and the
2 participant's required annual contribution as determined by the
3 schedule established under Subsection (c).
4 (c) The executive commissioner by rule shall establish a
5 graduated annual MyHealth account contribution schedule for
6 participants enrolled in the plus plan that:
7 (1) is based on a participant's annual household
8 income, with participants whose annual household incomes are less
9 than the federal poverty level paying progressively less and
10 participants whose annual household incomes are equal to or greater
11 than the federal poverty level paying progressively more; and
12 (2) may not require a participant to contribute more
13 than a total of five percent of the participant's annual household
14 income to the participant's MyHealth account.
15 (d) A participant's employer may contribute on behalf of the
16 participant any amount of the participant's annual MyHealth account
17 contribution. A nonprofit organization may contribute on behalf of
18 a participant any amount of the participant's annual MyHealth
19 account contribution.
20 (e) Subject to the contribution cap described by Subsection
21 (c)(2) and not before the expiration of the participant's first
22 coverage period, the commission shall require a participant who
23 uses one or more tobacco products to contribute to the
24 participant's MyHealth account an annual MyHealth account
25 contribution amount that is one percent more than the participant
26 would otherwise be required to contribute under the schedule
27 established under Subsection (c).

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

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

1 provide educational materials to the participant on:
2 (1) smoking cessation activities for which the
3 participant may receive a monetary contribution under this section;
4 and
5 (2) other smoking cessation programs or resources
6 available to the participant.
7 Sec. 537A.0255. MONTHLY STATEMENTS. The commission shall
8 distribute to each participant with a MyHealth account a monthly
9 statement that includes information on:
10 (1) the participant's MyHealth account activity during
11 the preceding month, including information on the cost of health
12 care services delivered to the participant during that month;
13 (2) the balance of money available in the MyHealth
14 account at the time the statement is issued; and
15 (3) the amount of any contributions due from the
16 participant.
17 Sec. 537A.0256. MYHEALTH ACCOUNT ROLL OVER. (a) The
18 executive commissioner by rule shall establish a process in
19 accordance with this section to roll over money in a participant's
20 MyHealth account to the succeeding coverage period. The commission
21 shall calculate the amount to be rolled over at the time the
22 participant's program eligibility is redetermined.
23 (b) For a participant enrolled in the basic plan, the
24 commission shall calculate the amount to be rolled over to a
25 subsequent coverage period MyHealth account from the participant's
26 current coverage period MyHealth account based on:
27 (1) the amount of money remaining in the participant's

MyHealth account from the current coverage period; and

(2) whether the participant received recommended preventative care services during the current coverage period.

(c) For a participant enrolled in the plus plan who, as determined by the commission, timely makes MyHealth account contributions in accordance with this subchapter, the commission shall calculate the amount to be rolled over to a subsequent coverage period MyHealth account from the participant's current coverage period MyHealth account based on:

(1) the amount of money remaining in the participant's MyHealth account from the current coverage period;

(2) the total amount of money the participant contributed to the participant's MyHealth account during the current coverage period; and

(3) whether the participant received recommended preventative care services during the current coverage period.

(d) Except as provided by Subsection (e), a participant may use money rolled over into the participant's MyHealth account for the succeeding coverage period to offset required annual MyHealth account contributions, as applicable, during that coverage period.

(e) A participant enrolled in the basic plan who rolls over money into the participant's MyHealth account for the succeeding coverage period and who chooses to enroll in the plus plan for that coverage period may use the money rolled over to offset a maximum of 50 percent of the required annual MyHealth 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 MyHealth account at the end of the coverage period or on the termination date.

Sec. 537A.0258. PENALTIES FOR FAILURE TO MAKE MYHEALTH 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 with Section 537A.0252, the commission shall disenroll the participant from the plus plan and enroll the participant in the

basic plan. A participant enrolled in the basic plan under this subsection may not change enrollment to the plus plan until the participant's program eligibility is redetermined.

SUBCHAPTER G. EMPLOYMENT INITIATIVE

Sec. 537A.0301. GATEWAY TO WORK PROGRAM. (a) The commission shall develop and implement a gateway to work program to:

(1) integrate existing job training and job search programs available in this state through the Texas Workforce Commission or other appropriate state agencies with the Live Well Texas program; and

(2) provide each participant with general information on the job training and job search programs.

(b) Under the gateway to work program, the commission shall refer each participant who is unemployed or working less than 20 hours a week to available job search and job training programs.

SUBCHAPTER H. HEALTH CARE FINANCIAL ASSISTANCE FOR CERTAIN PARTICIPANTS

Sec. 537A.0351. HEALTH CARE FINANCIAL ASSISTANCE FOR CONTINUITY OF CARE. (a) The commission shall ensure continuity of care by providing health care financial assistance in accordance with and in the manner described by this subchapter for a participant who:

(1) is disenrolled from a program health benefit plan in accordance with Section 537A.0155 because the participant's annual household income exceeds the income eligibility requirements for enrollment in a program health benefit plan; and

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

bridge account is established to access and manage money in and information regarding the participant's account through an electronic system. The commission may contract with the same entity described by Section 537A.0251(b) or another entity with appropriate experience and expertise to establish, implement, or administer the electronic system.

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

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

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

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

(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.

(b) As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall apply for and actively pursue from the appropriate federal agency the waiver as required by Section 537A.0051, Government Code, as added by this section. The commission may delay implementing this section until the waiver applied for under Section 537.0051 is granted, subject to Subsection (c) of this section.

(c) To maximize budget savings, not later than the 90th day after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall seek from the appropriate federal agency an amendment to the state Medicaid plan

to implement the provisions of this section that the commission would otherwise be authorized to implement under the state Medicaid plan without the waiver described by Subsection (b) of this section. The commission shall implement the provisions described by this subsection as soon as practicable after the state Medicaid plan amendment is approved.

SECTION 1.02. (a) Subtitle E, Title 8, Insurance Code, is amended by adding Chapter 1380 to read as follows:

CHAPTER 1380. COVERAGE OF ESSENTIAL HEALTH BENEFITS

Sec. 1380.001. APPLICABILITY OF CHAPTER. (a) This chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is issued by:

(1) an insurance company;

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

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

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

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

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

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

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

(9) an exchange operating under Chapter 942.

(b) Notwithstanding any other law, this chapter applies to:

(1) a small employer health benefit plan subject to Chapter 1501, including coverage provided through a health group cooperative under Subchapter B of that chapter;

(2) a standard health benefit plan issued under Chapter 1507;

(3) a basic coverage plan under Chapter 1551;

(4) a basic plan under Chapter 1575;

(5) a primary care coverage plan under Chapter 1579;

(6) a plan providing basic coverage under Chapter 1601;

(7) health benefits provided by or through a church benefits board under Subchapter I, Chapter 22, Business Organizations Code;

(8) group health coverage made available by a school district in accordance with Section 22.004, Education Code;

(9) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533, Government Code;

(10) the child health plan program under Chapter 62, Health and Safety Code;

(11) a regional or local health care program operated under Section 75.104, Health and Safety Code;

(12) a self-funded health benefit plan sponsored by a

1 professional employer organization under Chapter 91, Labor Code;
2 (13) county employee group health benefits provided
3 under Chapter 157, Local Government Code; and
4 (14) health and accident coverage provided by a risk
5 pool created under Chapter 172, Local Government Code.
6 (c) This chapter applies to coverage under a group health
7 benefit plan provided to a resident of this state regardless of
8 whether the group policy, agreement, or contract is delivered,
9 issued for delivery, or renewed in this state.
10 Sec. 1380.002. EXCEPTION. This chapter does not apply to an
11 individual health benefit plan issued on or before March 23, 2010,
12 that has not had any significant changes since that date that reduce
13 benefits or increase costs to the individual.
14 Sec. 1380.003. REQUIRED COVERAGE FOR ESSENTIAL HEALTH
15 BENEFITS. (a) In this section:
16 (1) "Individual health benefit plan" means:
17 (A) an individual accident and health insurance
18 policy to which Chapter 1201 applies; or
19 (B) individual health maintenance organization
20 coverage.
21 (2) "Small employer health benefit plan" has the
22 meaning assigned by Section 1501.002.
23 (b) An individual or small employer health benefit plan must
24 provide coverage for the essential health benefits listed in 42
25 U.S.C. Section 18022(b)(1), as that section existed on January 1,
26 2017, and other benefits identified by the United States secretary
27 of health and human services as essential health benefits as of that

1 date.

2 Sec. 1380.004. CERTAIN ANNUAL AND LIFETIME LIMITS
3 PROHIBITED. A health benefit plan issuer may not establish an
4 annual or lifetime benefit amount for an enrollee in relation to
5 essential health benefits listed in 42 U.S.C. Section 18022(b)(1),
6 as that section existed on January 1, 2017, and other benefits
7 identified by the United States secretary of health and human
8 services as essential health benefits as of that date.

9 Sec. 1380.005. LIMITATIONS ON COST-SHARING. A health
10 benefit plan issuer may not impose cost-sharing requirements that
11 exceed the limits established in 42 U.S.C. Section 18022(c)(1) in
12 relation to essential health benefits listed in 42 U.S.C. Section
13 18022(b)(1), as those sections existed on January 1, 2017, and
14 other benefits identified by the United States secretary of health
15 and human services as essential health benefits as of that date.

16 Sec. 1380.006. RULES. (a) Subject to Subsection (b), the
17 commissioner may adopt rules as necessary to implement this
18 chapter.

19 (b) Rules adopted by the commissioner to implement this
20 chapter must be consistent with the Patient Protection and
21 Affordable Care Act (Pub. L. No. 111-148), as that Act existed on
22 January 1, 2017.

23 (b) Subtitle G, Title 8, Insurance Code, is amended by
24 adding Chapter 1512 to read as follows:

25 CHAPTER 1512. HEALTH BENEFIT COVERAGE AVAILABILITY

26 SUBCHAPTER A. GENERAL PROVISIONS

27 Sec. 1512.001. APPLICABILITY OF CHAPTER. (a) Except as

1 otherwise provided by this chapter, this chapter applies only to a
2 health benefit plan that provides benefits for medical or surgical
3 expenses incurred as a result of a health condition, accident, or
4 sickness, including an individual, group, blanket, or franchise
5 insurance policy or insurance agreement, a group hospital service
6 contract, or an individual or group evidence of coverage or similar
7 coverage document that is issued by:
8 (1) an insurance company;
9 (2) a group hospital service corporation operating
10 under Chapter 842;
11 (3) a health maintenance organization operating under
12 Chapter 843;
13 (4) an approved nonprofit health corporation that
14 holds a certificate of authority under Chapter 844;
15 (5) a multiple employer welfare arrangement that holds
16 a certificate of authority under Chapter 846;
17 (6) a stipulated premium company operating under
18 Chapter 884;
19 (7) a fraternal benefit society operating under
20 Chapter 885;
21 (8) a Lloyd's plan operating under Chapter 941; or
22 (9) an exchange operating under Chapter 942.
23 (b) Notwithstanding any other law, this chapter applies to:
24 (1) a small employer health benefit plan subject to
25 Chapter 1501, including coverage provided through a health group
26 cooperative under Subchapter B of that chapter; and
27 (2) a standard health benefit plan issued under

1 Chapter 1507.

2 (c) This chapter applies to coverage under a group health
3 benefit plan provided to a resident of this state regardless of
4 whether the group policy, agreement, or contract is delivered,
5 issued for delivery, or renewed in this state.

6 Sec. 1512.002. EXCEPTIONS. (a) This chapter does not apply
7 to:

8 (1) a plan that provides coverage:

9 (A) for wages or payments in lieu of wages for a
10 period during which an employee is absent from work because of
11 sickness or injury;

12 (B) as a supplement to a liability insurance
13 policy;

14 (C) for credit insurance;

15 (D) only for dental or vision care;

16 (E) only for a specified disease or for another
17 limited benefit; or

18 (F) only for accidental death or dismemberment;

19 (2) a Medicare supplemental policy as defined by
20 Section 1882(g)(1), Social Security Act (42 U.S.C. Section
21 1395ss(g)(1));

22 (3) a workers' compensation insurance policy;

23 (4) medical payment insurance coverage provided under
24 a motor vehicle insurance policy; or

25 (5) a long-term care policy, including a nursing home
26 fixed indemnity policy, unless the commissioner determines that the
27 policy provides benefit coverage so comprehensive that the policy

is a health benefit plan as described by Section 1512.001.

(b) This chapter does not apply to an individual health benefit plan issued on or before March 23, 2010, that has not had any significant changes since that date that reduce benefits or increase costs to the individual.

Sec. 1512.003. CONFLICT WITH OTHER LAW. If there is a conflict between this chapter and other law, this chapter prevails.

Sec. 1512.004. RULES. (a) Subject to Subsection (b), the commissioner may adopt rules as necessary to implement this chapter.

(b) Rules adopted by the commissioner to implement this chapter must be consistent with the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as that Act existed on January 1, 2017.

SUBCHAPTER B. GUARANTEED ISSUE AND RENEWABILITY

Sec. 1512.051. GUARANTEED ISSUE. A health benefit plan issuer shall issue a group or individual health benefit plan chosen by a group plan sponsor or individual to each group plan sponsor or individual that elects to be covered under the plan and agrees to satisfy the requirements of the plan.

Sec. 1512.052. RENEWABILITY AND CONTINUATION OF HEALTH BENEFIT PLANS. (a) Except as provided by Subsection (b), a health benefit plan issuer shall renew or continue a group or individual health benefit plan at the option of the group plan sponsor or individual, as applicable.

(b) A health benefit plan issuer may decline to renew or continue a group or individual health benefit plan:

(1) for failure to pay a premium or contribution in accordance with the terms of the plan;

(2) for fraud or intentional misrepresentation;

(3) because the issuer is ceasing to offer coverage in the relevant market in accordance with rules adopted by the commissioner;

(4) with respect to an individual plan, because an individual no longer resides, lives, or works in an area in which the issuer is authorized to provide coverage, but only if all plans are not renewed or not continued under this subdivision uniformly without regard to any health status related factor of covered individuals; or

(5) in accordance with federal law, including regulations.

Sec. 1512.053. OPEN AND SPECIAL ENROLLMENT PERIODS. (a) A health benefit plan issuer issuing an individual health benefit plan may restrict enrollment in coverage to an annual open enrollment period and special enrollment periods.

(b) An individual or an individual's dependent qualified to enroll in an individual health benefit plan may enroll anytime during the open enrollment period or during a special enrollment period designated by the commissioner.

(c) A health benefit plan issuer issuing a group health benefit plan may not limit enrollment to an open or special enrollment period.

(d) The commissioner shall adopt rules as necessary to administer this section, including rules designating enrollment

1 periods.

2 SUBCHAPTER C. PREEXISTING CONDITIONS AND HEALTH STATUS

3 Sec. 1512.101. DEFINITIONS. In this subchapter:

4 (1) "Dependent" has the meaning assigned by Section
5 1501.002.

6 (2) "Health status related factor" has the meaning
7 assigned by Section 1501.002.

8 (3) "Preexisting condition" means a condition present
9 before the effective date of an individual's coverage under a
10 health benefit plan.

11 Sec. 1512.102. APPLICABILITY OF SUBCHAPTER.
12 Notwithstanding any other law, in addition to a health benefit plan
13 to which this chapter applies under Subchapter A, this subchapter
14 applies to:

15 (1) a basic coverage plan under Chapter 1551;

16 (2) a basic plan under Chapter 1575;

17 (3) a primary care coverage plan under Chapter 1579;

18 (4) a plan providing basic coverage under Chapter
19 1601;

20 (5) health benefits provided by or through a church
21 benefits board under Subchapter I, Chapter 22, Business
22 Organizations Code;

23 (6) group health coverage made available by a school
24 district in accordance with Section 22.004, Education Code;

25 (7) the state Medicaid program, including the Medicaid
26 managed care program operated under Chapter 533, Government Code;

27 (8) the child health plan program under Chapter 62,

1 Health and Safety Code;

2 (9) a regional or local health care program operated
3 under Section 75.104, Health and Safety Code;

4 (10) a self-funded health benefit plan sponsored by a
5 professional employer organization under Chapter 91, Labor Code;

6 (11) county employee group health benefits provided
7 under Chapter 157, Local Government Code; and

8 (12) health and accident coverage provided by a risk
9 pool created under Chapter 172, Local Government Code.

10 Sec. 1512.103. PREEXISTING CONDITION AND HEALTH STATUS
11 RESTRICTIONS PROHIBITED. Notwithstanding any other law, a health
12 benefit plan issuer may not:

13 (1) deny coverage to or refuse to enroll a group, an
14 individual, or an individual's dependent in a health benefit plan
15 on the basis of a preexisting condition or health status related
16 factor;

17 (2) limit or exclude, or require a waiting period for,
18 coverage under the health benefit plan for treatment of a
19 preexisting condition otherwise covered under the plan; or

20 (3) charge a group, individual, or dependent more for
21 coverage than the health benefit plan issuer charges a group,
22 individual, or dependent who does not have a preexisting condition
23 or health status related factor.

24 SUBCHAPTER D. PROHIBITED DISCRIMINATION

25 Sec. 1512.151. DISCRIMINATORY BENEFIT DESIGN PROHIBITED.
26 (a) A health benefit plan issuer may not, through the plan's
27 benefit design, discriminate against an enrollee on the basis of

race, color, national origin, age, sex, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition.

(b) A health benefit plan issuer may not use a health benefit design that will have the effect of discouraging the enrollment of individuals with significant health needs in the health benefit plan.

(c) This section may not be construed to prevent a health benefit plan issuer from appropriately utilizing reasonable medical management techniques.

Sec. 1512.152. DISCRIMINATORY MARKETING PROHIBITED. A health benefit plan issuer may not use a marketing practice that will have the effect of discouraging the enrollment of individuals with significant health needs in the health benefit plan or that discriminates on the basis of race, color, national origin, age, sex, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition.

(c) Section 841.002, Insurance Code, is amended to read as follows:

Sec. 841.002. APPLICABILITY OF CHAPTER AND OTHER LAW. Except as otherwise expressly provided by this code, each insurance company incorporated or engaging in business in this state as a life insurance company, an accident insurance company, a life and accident insurance company, a health and accident insurance company, or a life, health, and accident insurance company is subject to:

(1) this chapter;

(2) Chapter 3;

(3) Chapters 425 and 493;

(4) Title 7;

(5) Sections [~~1202.051,~~] 1204.151, 1204.153, and 1204.154;

(6) Subchapter A, Chapter 1202, Subchapters A and F, Chapter 1204, Subchapter A, Chapter 1273, Subchapters A, B, and D, Chapter 1355, and Subchapter A, Chapter 1366;

(7) Subchapter A, Chapter 1507;

(8) Chapters 1203, 1210, 1251-1254, 1301, 1351, 1354, 1359, 1364, 1368, 1505, 1651, 1652, and 1701; and

(9) Chapter 177, Local Government Code.

(d) Section 1201.005, Insurance Code, is amended to read as follows:

Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a reference to this chapter includes a reference to:

(1) [~~Section 1202.052;~~

~~(2)~~] Section 1271.005(a), to the extent that the subsection relates to the applicability of Section 1201.105, and Sections 1271.005(d) and (e);

(2) [~~(3)~~] Chapter 1351;

(3) [~~(4)~~] Subchapters C and E, Chapter 1355;

(4) [~~(5)~~] Chapter 1356;

(5) [~~(6)~~] Chapter 1365;

(6) [~~(7)~~] Subchapter A, Chapter 1367;

(7) Subchapter B, Chapter 1512; and

1 (8) Subchapters A, B, and G, Chapter 1451.

2 (e) Section 1507.003(b), Insurance Code, is amended to read
3 as follows:

4 (b) For purposes of this subchapter, "state-mandated health
5 benefits" does not include benefits that are mandated by federal
6 law or standard provisions or rights required under this code or
7 other laws of this state to be provided in an individual, blanket,
8 or group policy for accident and health insurance that are
9 unrelated to a specific health illness, injury, or condition of an
10 insured, including provisions related to:

11 (1) continuation of coverage under:

12 (A) Subchapters F and G, Chapter 1251;

13 (B) Section 1201.059; and

14 (C) Subchapter B, Chapter 1253;

15 (2) termination of coverage under Sections [~~1202.051~~
16 ~~and~~] 1501.108 and 1512.052;

17 (3) preexisting conditions under Subchapter D,
18 Chapter 1201, and Sections 1501.102-1501.105;

19 (4) coverage of children, including newborn or adopted
20 children, under:

21 (A) Subchapter D, Chapter 1251;

22 (B) Sections 1201.053, 1201.061,
23 1201.063-1201.065, and Subchapter A, Chapter 1367;

24 (C) Chapter 1504;

25 (D) Chapter 1503;

26 (E) Section 1501.157;

27 (F) Section 1501.158; and

(G) Sections 1501.607-1501.609;

(5) services of practitioners under:

(A) Subchapters A, B, and C, Chapter 1451; or

(B) Section 1301.052;

(6) supplies and services associated with the treatment of diabetes under Subchapter B, Chapter 1358;

(7) coverage for serious mental illness under Subchapter A, Chapter 1355;

(8) coverage for childhood immunizations and hearing screening as required by Subchapters B and C, Chapter 1367, other than Section 1367.053(c) and Chapter 1353;

(9) coverage for reconstructive surgery for certain craniofacial abnormalities of children as required by Subchapter D, Chapter 1367;

(10) coverage for the dietary treatment of phenylketonuria as required by Chapter 1359;

(11) coverage for referral to a non-network physician or provider when medically necessary covered services are not available through network physicians or providers, as required by Section 1271.055; and

(12) coverage for cancer screenings under:

(A) Chapter 1356;

(B) Chapter 1362;

(C) Chapter 1363; and

(D) Chapter 1370.

(f) Section 1507.053(b), Insurance Code, is amended to read as follows:

(b) For purposes of this subchapter, "state-mandated health benefits" does not include coverage that is mandated by federal law or standard provisions or rights required under this code or other laws of this state to be provided in an evidence of coverage that are unrelated to a specific health illness, injury, or condition of an enrollee, including provisions related to:

(1) continuation of coverage under Subchapter G, Chapter 1251;

(2) termination of coverage under Sections [~~1202.051 and~~] 1501.108 and 1512.052;

(3) preexisting conditions under Subchapter D, Chapter 1201, and Sections 1501.102-1501.105;

(4) coverage of children, including newborn or adopted children, under:

(A) Chapter 1504;

(B) Chapter 1503;

(C) Section 1501.157;

(D) Section 1501.158; and

(E) Sections 1501.607-1501.609;

(5) services of providers under Section 843.304;

(6) coverage for serious mental health illness under Subchapter A, Chapter 1355; and

(7) coverage for cancer screenings under:

(A) Chapter 1356;

(B) Chapter 1362;

(C) Chapter 1363; and

(D) Chapter 1370.

(g) Section 1501.602(a), Insurance Code, is amended to read as follows:

(a) A large employer health benefit plan issuer[~~:~~

[~~(1) may refuse to provide coverage to a large employer in accordance with the issuer's underwriting standards and criteria;~~

[~~(2) shall accept or reject the entire group of individuals who meet the participation criteria and choose coverage; and~~

[~~(3)~~] may exclude only those employees or dependents who decline coverage.

(h) Subchapter B, Chapter 1202, Insurance Code, is repealed.

(i) The change in law made by this section applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2022. A health benefit plan that is delivered, issued for delivery, or renewed before January 1, 2022, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 2. TEXAS HEALTH INSURANCE EXCHANGE AUTHORITY AND REINSURANCE PROGRAM

SECTION 2.01. (a) This section establishes the Texas Health Insurance Exchange Authority governed by a board of directors to implement the Texas Health Insurance Exchange as an American Health Benefit Exchange authorized by Section 1311, Patient Protection and Affordable Care Act (42 U.S.C. Section

18031).

(b) The purpose of the Texas Health Insurance Exchange Authority created under this section is to create, manage, and maintain the exchange in order to:

(1) benefit the state health insurance market and individuals enrolling in health benefit plans; and

(2) facilitate or assist in facilitating the purchasing of qualified plans on the exchange by qualified enrollees in the individual market or the individual and small group markets.

(c) In carrying out the purposes of this section, the Texas Health Exchange Authority shall:

(1) educate consumers, including through outreach, a navigator program, and postenrollment support;

(2) assist individuals in accessing income-based assistance for which the individual may be eligible, including premium tax credits, cost-sharing reductions, and government programs;

(3) negotiate premium rates with health benefit plan issuers on the exchange;

(4) contract selectively with health benefit plan issuers to drive value and promote improvement in the delivery system;

(5) standardize health benefit plan designs and cost-sharing;

(6) leverage quality improvement and delivery system reforms by encouraging participating health benefit plans to

1 implement strategies to promote the delivery of better coordinated,
2 more efficient health care services;
3 (7) consider the need for consumer choice in rural,
4 urban, and suburban areas of the state;
5 (8) assess and collect fees from health benefit plan
6 issuers on the Texas Health Insurance Exchange to support the
7 operation of the exchange and the reinsurance program; and
8 (9) distribute receipted fees, including to benefit
9 the reinsurance program.
10 (d) As soon as practicable after the effective date of this
11 Act, the board of directors of the Texas Health Insurance Exchange
12 Authority shall adopt rules and procedures necessary to implement
13 this section.
14 SECTION 2.02. (a) The Texas Department of Insurance may
15 apply to the United States secretary of health and human services to
16 obtain a waiver under 42 U.S.C. Section 18052 to:
17 (1) waive any applicable provisions of the Patient
18 Protection and Affordable Care Act (Pub. L. No. 111-148) with
19 respect to health benefit plan coverage in this state;
20 (2) establish a reinsurance program in accordance with
21 an approved waiver; and
22 (3) maximize federal funding for the reinsurance
23 program for plan years beginning on or after the effective date of
24 the implementation of the program.
25 (b) On approval by the United States secretary of health and
26 human services of the Texas Department of Insurance's application
27 waiver under Subsection (a) of this section, the department shall

1 establish and implement a reinsurance program for the purposes of:
2 (1) stabilizing rates and premiums for health benefit
3 plans in the individual market; and
4 (2) providing greater financial certainty to
5 consumers of health benefit plans in this state.
6 ARTICLE 3. HEALTH BENEFIT PLAN RATES
7 SECTION 3.01. Title 8, Insurance Code, is amended by adding
8 Subtitle N to read as follows:
9 SUBTITLE N. RATES
10 CHAPTER 1698. RATES FOR CERTAIN COVERAGE
11 SUBCHAPTER A. GENERAL PROVISIONS
12 Sec. 1698.001. APPLICABILITY OF CHAPTER. This chapter
13 applies only to rates for the following health benefit plans:
14 (1) an individual major medical expense insurance
15 policy to which Chapter 1201 applies;
16 (2) individual health maintenance organization
17 coverage;
18 (3) a group accident and health insurance policy
19 issued to an association under Section 1251.052;
20 (4) a blanket accident and health insurance policy
21 issued to an association under Section 1251.358;
22 (5) group health maintenance organization coverage
23 issued to an association described by Section 1251.052 or 1251.358;
24 or
25 (6) a small employer health benefit plan provided
26 under Chapter 1501.
27 Sec. 1698.002. APPLICABILITY OF OTHER LAWS GOVERNING RATES.

The requirements of this chapter are in addition to any other provision of this code governing health benefit plan rates. Except as otherwise provided by this chapter, in the case of a conflict between this chapter and another provision of this code, this chapter controls.

SUBCHAPTER B. RATE STANDARDS

Sec. 1698.051. EXCESSIVE, INADEQUATE, AND UNFAIRLY DISCRIMINATORY RATES. (a) A rate is excessive, inadequate, or unfairly discriminatory for purposes of this chapter as provided by this section.

(b) A rate is excessive if the rate is likely to produce a long-term profit that is unreasonably high in relation to the health benefit plan coverage provided.

(c) A rate is inadequate if:

(1) the rate is insufficient to sustain projected losses and expenses to which the rate applies; and

(2) continued use of the rate:

(A) endangers the solvency of a health benefit plan issuer using the rate; or

(B) has the effect of substantially lessening competition or creating a monopoly in a market.

(d) A rate is unfairly discriminatory if the rate:

(1) is not based on sound actuarial principles;

(2) does not bear a reasonable relationship to the expected loss and expense experience among risks or is based on unreasonable administrative expenses; or

(3) is based wholly or partly on the race, creed,

1 color, ethnicity, or national origin of an individual or group
2 sponsoring coverage under or covered by the health benefit plan.

3 SUBCHAPTER C. DISAPPROVAL OF RATES

4 Sec. 1698.101. REVIEW OF PREMIUM RATES. (a) In this
5 section:
6 (1) "Individual health benefit plan" means:
7 (A) an individual accident and health insurance
8 policy to which Chapter 1201 applies; or
9 (B) individual health maintenance organization
10 coverage.
11 (2) "Small employer health benefit plan" has the
12 meaning assigned by Section 1501.002.
13 (b) The commissioner by rule shall establish a process under
14 which the commissioner:
15 (1) reviews health benefit plan rates and rate changes
16 for compliance with this chapter and other applicable law; and
17 (2) disapproves rates that do not comply with this
18 chapter not later than the 60th day after the date the department
19 receives a complete filing.
20 (c) The rules must:
21 (1) require an individual or small employer health
22 benefit plan issuer to:
23 (A) submit to the commissioner a justification
24 for a rate increase that results in an increase equal to or greater
25 than 10 percent; and
26 (B) post information regarding the rate increase
27 on the health benefit plan issuer's Internet website;

1 (2) require the commissioner to make available to the
2 public information on rate increases and justifications submitted
3 by health benefit plan issuers under Subdivision (1);
4 (3) provide a mechanism for receiving public comment
5 on proposed rate increases; and
6 (4) provide for the results of rate reviews to be
7 reported to the Centers for Medicare and Medicaid Services.
8 Sec. 1698.102. DISAPPROVAL OF RATE CHANGE AUTHORIZED. (a)
9 In this section, "qualified health plan" has the meaning assigned
10 by Section 1301(a), Patient Protection and Affordable Care Act (42
11 U.S.C. Section 18021).
12 (b) The commissioner may disapprove a rate or rate change
13 filed with the department by a health benefit plan issuer not later
14 than the 60th day after the date the department receives a complete
15 filing if:
16 (1) the commissioner determines that the proposed rate
17 is excessive, inadequate, or unfairly discriminatory; or
18 (2) the required rate filing is incomplete.
19 (c) In making a determination under this section, the
20 commissioner shall consider the following factors:
21 (1) the reasonableness and soundness of the actuarial
22 assumptions, calculations, projections, and other factors used by
23 the plan issuer to arrive at the proposed rate or rate change;
24 (2) the historical trends for medical claims
25 experienced by the plan issuer;
26 (3) the reasonableness of the plan issuer's historical
27 and projected administrative expenses;

(4) the plan issuer's compliance with medical loss ratio standards applicable under state or federal law;

(5) whether the rate applies to an open or closed block of business;

(6) whether the plan issuer has complied with all requirements for pooling risk and participating in risk adjustment programs in effect under state or federal law;

(7) the financial condition of the plan issuer for at least the previous five years, or for the plan issuer's time in existence, if less than five years, including profitability, surplus, reserves, investment income, reinsurance, dividends, and transfers of funds to affiliates or parent companies;

(8) for a rate change, the financial performance for at least the previous five years of the block of business subject to the proposed rate change, or for the block's time in existence, if less than five years, including past and projected profits, surplus, reserves, investment income, and reinsurance applicable to the block;

(9) the covered benefits or health benefit plan design or, for a rate change, any changes to the benefits or design;

(10) the allowable variations for case characteristics, risk classifications, and participation in programs promoting wellness;

(11) whether the proposed rate is necessary to maintain the plan issuer's solvency or maintain rate stability and prevent excessive rate increases in the future; and

(12) any other factor listed in 45 C.F.R. Section

1 154.301(a)(4) to the extent applicable.
2 (d) In making a determination under this section regarding a
3 proposed rate for a qualified health plan, the commissioner shall
4 consider, in addition to the factors under Subsection (c), the
5 following factors:
6 (1) the purchasing power of consumers who are eligible
7 for a premium subsidy under the Patient Protection and Affordable
8 Care Act (Pub. L. No. 111-148);
9 (2) if the plan is in the silver level, as described by
10 42 U.S.C. Section 18022(d), whether the rate is appropriate for the
11 plan in relation to the rates charged for qualified health plans
12 offering different levels of coverage, taking into account lack of
13 funding for cost-sharing reductions and the covered benefits for
14 each level of coverage; and
15 (3) whether the plan issuer utilized the induced
16 demand factors developed by the Centers for Medicare and Medicaid
17 Services for the risk adjustment program established under 42
18 U.S.C. Section 18063 for the level of coverage offered by the plan,
19 and, if the plan did not utilize those factors, whether the plan
20 issuer provided objective evidence showing why those factors are
21 inappropriate for the rate.
22 (e) In making a determination under this section, the
23 commissioner may consider the following factors:
24 (1) if the commissioner determines appropriate for
25 comparison purposes, medical claims trends reported by plan issuers
26 in this state or in a region of this country or the country as a
27 whole; and

(2) inflation indexes.

Sec. 1698.103. DISPUTE RESOLUTION. The commissioner by rule shall establish a method for a health benefit plan issuer to dispute the disapproval of a rate under this subchapter, which may include an informal method for the plan issuer and the commissioner to reach an agreement about an appropriate rate.

Sec. 1698.104. USE OF DISAPPROVED RATE PENDING DISPUTE RESOLUTION. (a) If the commissioner disapproves a rate under this subchapter and the plan issuer objects to the disapproval, the plan issuer may use the disapproved rate pending the completion of:

(1) the dispute resolution process established under this subchapter; and

(2) any other appeal of the disapproval authorized by law and pursued by the plan issuer.

(b) The commissioner shall adopt rules establishing the conditions under which any excess premiums will be refunded or credited to the persons who paid the premiums if the plan issuer uses a disapproved rate while an appeal is pending and the rate dispute is not resolved in the plan issuer's favor.

Sec. 1698.105. FEDERAL FUNDING. The commissioner shall seek all available federal funding to cover the cost to the department of reviewing rates and resolving rate disputes under this subchapter.

SECTION 3.02. Subtitle N, Title 8, Insurance Code, as added by this article, applies only to rates for health benefit plan coverage delivered, issued for delivery, or renewed on or after January 1, 2022. Rates for health benefit plan coverage delivered,

issued for delivery, or renewed before January 1, 2022, are governed by the law in effect immediately before the effective date of this Act, and that law is continued in effect for that purpose.

ARTICLE 4. HEALTH INSURANCE RISK POOL

SECTION 4.01. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1511 to read as follows:

CHAPTER 1511. HEALTH INSURANCE RISK POOL

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1511.0001. DEFINITIONS. In this chapter:

(1) "Board" means the board of directors appointed under this chapter.

(2) "Pool" means a health insurance risk pool established under this chapter and administered by the board.

Sec. 1511.0002. WAIVER. The commissioner shall:

(1) apply to the United States secretary of health and human services under 42 U.S.C. Section 18052 for a waiver of Section 1312(c)(1) of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and any applicable regulations or guidance beginning with the 2022 plan year;

(2) take any action the commissioner considers appropriate to make an application under Subdivision (1); and

(3) implement a state plan that meets the requirements of a waiver granted in response to an application under Subdivision (1) if the plan is:

(A) consistent with state and federal law; and

(B) approved by the United States secretary of health and human services.

1 Sec. 1511.0003. EXEMPTION FROM STATE TAXES AND FEES.
2 Notwithstanding any other law, a program created under this chapter
3 is not subject to any state tax, regulatory fee, or surcharge,
4 including a premium or maintenance tax or fee.
5 Sec. 1511.0004. NOTICE AND COMMENT. Following the grant of
6 a waiver under Section 1511.0002 and before the commissioner
7 implements a state plan under that section, the commissioner shall
8 hold a public hearing to solicit stakeholder comments regarding the
9 establishment of a health insurance risk pool under this chapter.
10 SUBCHAPTER B. ESTABLISHMENT AND PURPOSE
11 Sec. 1511.0051. ESTABLISHMENT OF HEALTH INSURANCE RISK
12 POOL. To the extent that federal money is available and only if the
13 United States secretary of health and human services grants the
14 waiver application submitted under Section 1511.0002, the
15 commissioner shall:
16 (1) apply for the federal money;
17 (2) use the federal money to establish a pool for the
18 purpose of this chapter; and
19 (3) authorize the board to use the federal money to
20 administer a pool for the purpose of this chapter.
21 Sec. 1511.0052. PURPOSE OF POOL. The purpose of the pool is
22 to provide a reinsurance mechanism to:
23 (1) meaningfully reduce health benefit plan premiums
24 in the individual market by mitigating the impact of high-risk
25 individuals on rates;
26 (2) maximize available federal money to assist
27 residents of this state to obtain guaranteed issue health benefit

1 coverage without increasing the federal deficit; and
2 (3) increase enrollment in guaranteed issue,
3 individual market health benefit plans that provide benefits and
4 coverage and cost-sharing protections against out-of-pocket costs
5 comparable to and as comprehensive as health benefit plans that
6 would be available without the pool.
7 SUBCHAPTER C. ADMINISTRATION
8 Sec. 1511.0101. BOARD OF DIRECTORS. (a) The pool is
9 governed by a board of directors.
10 (b) The board consists of nine members appointed by the
11 commissioner as follows:
12 (1) at least two, but not more than four, members must
13 be individuals who are affiliated with a health benefit plan issuer
14 authorized to write health benefit plans in this state;
15 (2) at least two members must be:
16 (A) individuals or the parents of individuals who
17 are covered by the pool or are reasonably expected to qualify for
18 coverage by the pool; or
19 (B) individuals who work as advocates for
20 individuals described by Paragraph (A); and
21 (3) the other members may be selected from individuals
22 such as:
23 (A) a physician licensed to practice in this
24 state by the Texas State Board of Medical Examiners;
25 (B) a hospital administrator;
26 (C) an advanced nurse practitioner; or
27 (D) a representative of the public who is not:

1 (i) employed by or affiliated with an
2 insurance company or insurance plan, group hospital service
3 corporation, or health maintenance organization;
4 (ii) related within the first degree of
5 consanguinity or affinity to an individual described by
6 Subparagraph (i); or
7 (iii) licensed as, employed by, or
8 affiliated with a physician, hospital, or other health care
9 provider.
10 (c) For purposes of Subsection (b), an individual who is
11 required to register under Chapter 305, Government Code, because of
12 the individual's activities with respect to health benefit
13 plan-related matters is affiliated with a health benefit plan
14 issuer.
15 (d) An individual is not disqualified under Subsection
16 (b)(3)(D)(i) from representing the public if the individual's only
17 affiliation with an insurance company or insurance plan, group
18 hospital service corporation, or health maintenance organization
19 is as an insured or as an individual who has coverage through a plan
20 provided by the corporation or organization.
21 Sec. 1511.0102. TERMS; VACANCY. (a) Board members serve
22 staggered six-year terms.
23 (b) The commissioner shall fill a vacancy on the board by
24 appointing, for the unexpired term, an individual who has the
25 appropriate qualifications to fill that position.
26 Sec. 1511.0103. PRESIDING OFFICER. The commissioner shall
27 designate one board member to serve as presiding officer at the

1 pleasure of the commissioner.
2 Sec. 1511.0104. PER DIEM; REIMBURSEMENT. A board member is
3 not entitled to compensation for service on the board but is
4 entitled to:
5 (1) a per diem in the amount provided by the General
6 Appropriations Act for state officials for each day the member
7 performs duties as a board member; and
8 (2) reimbursement of expenses incurred while
9 performing duties as a board member in the amount provided by the
10 General Appropriations Act for state officials.
11 Sec. 1511.0105. MEMBER'S IMMUNITY. (a) A board member is
12 not liable for an act or omission made in good faith in the
13 performance of powers and duties under this chapter.
14 (b) A cause of action does not arise against a board member
15 for an act or omission described by Subsection (a).
16 Sec. 1511.0106. ADDITIONAL POWERS AND DUTIES. The
17 commissioner by rule may establish powers and duties of the board in
18 addition to those provided by this chapter.
19 Sec. 1511.0107. PLAN OF OPERATION. (a) Operation and
20 management of the pool are governed by a plan of operation adopted
21 by the board and approved by the commissioner. The plan of
22 operation includes the articles, bylaws, and operating rules of the
23 pool.
24 (b) The plan of operation must ensure the fair, reasonable,
25 and equitable administration of the pool.
26 (c) The board shall amend the plan of operation as necessary
27 to carry out this chapter. An amendment to the plan of operation

must be approved by the commissioner before the board may adopt the amendment.

SUBCHAPTER D. POWERS AND DUTIES

Sec. 1511.0151. METHODS TO REDUCE PREMIUM IN INDIVIDUAL MARKET. Subject to any requirements to obtain federal money for the pool, the board may use pool money to achieve lower enrollee premium rates by establishing a reinsurance mechanism for health benefit plan issuers writing comprehensive, guaranteed issue coverage in the individual market.

Sec. 1511.0152. INCREASED ACCESS TO GUARANTEED ISSUE COVERAGE. The board shall use pool money to increase enrollment in guaranteed issue coverage in the individual market in a manner that ensures that the benefits and cost-sharing protections available in the individual market are maintained in the same manner the benefits and protections would be maintained without the waiver described by Section 1511.0002.

Sec. 1511.0153. CONTRACTS AND AGREEMENTS. The board may enter into a contract or agreement that the board determines is appropriate to carry out this chapter, including a contract or agreement with:

(1) a similar pool in another state for the joint performance of common administrative functions;

(2) another organization for the performance of administrative functions; or

(3) a federal agency.

Sec. 1511.0154. RULES. The commissioner and board may adopt rules necessary to implement this chapter, including rules to

1 administer the pool and distribute pool money.
2 Sec. 1511.0155. PROCEDURES, CRITERIA, AND FORMS. The board
3 by rule shall provide the procedures, criteria, and forms necessary
4 to implement, collect, and deposit assessments under Subchapter E.
5 Sec. 1511.0156. PUBLIC EDUCATION AND OUTREACH. (a) The
6 board may develop and implement public education, outreach, and
7 facilitated enrollment strategies under this chapter.
8 (b) The board may contract with marketing organizations to
9 perform or provide assistance with the strategies described by
10 Subsection (a).
11 Sec. 1511.0157. AUTHORITY TO ACT AS REINSURER. In addition
12 to the powers granted to the board under this chapter, the board may
13 exercise any authority that may be exercised under the law of this
14 state by a reinsurer.
15 SUBCHAPTER E. FUNDING
16 Sec. 1511.0201. FUNDING. The commissioner may use money
17 appropriated to the department to:
18 (1) apply for federal money and grants; and
19 (2) implement this chapter.
20 Sec. 1511.0202. ASSESSMENTS. (a) The board may assess
21 health benefit plan issuers, including making advance interim
22 assessments, as reasonable and necessary for the pool's
23 organizational and interim operating expenses.
24 (b) The board shall credit an interim assessment as an
25 offset against any regular assessment that is due after the end of
26 the fiscal year.
27 (c) The regular assessment is the amount calculated under

1 Section 1511.0204.
2 (d) The board shall deposit money from the interim and
3 regular assessments described by this section in an account
4 established outside the treasury and administered by the board.
5 Money in the account may be spent without an appropriation and may
6 be used only for purposes authorized by this chapter.
7 Sec. 1511.0203. DETERMINATION OF POOL FUNDING
8 REQUIREMENTS. After the end of each fiscal year, the board shall
9 determine for the next calendar year the amount of money required by
10 the pool to reduce enrollee premiums in accordance with this
11 chapter after applying the federal money obtained under this
12 chapter.
13 Sec. 1511.0204. ASSESSMENTS TO COVER POOL FUNDING
14 REQUIREMENTS. (a) The board shall recover an amount equal to the
15 funding required as determined under Section 1511.0203 by assessing
16 each health benefit plan issuer an amount determined annually by
17 the board based on information in annual statements, the health
18 benefit plan issuer's annual report to the board under Sections
19 1511.0251 and 1511.0252, and any other reports required by and
20 filed with the board.
21 (b) The board shall use the total number of enrolled
22 individuals reported by all health benefit plan issuers under
23 Section 1511.0252 as of the preceding December 31 to compute the
24 amount of a health benefit plan issuer's assessment, if any, in
25 accordance with this subsection. The board shall allocate the
26 total amount to be assessed based on the total number of enrolled
27 individuals covered by excess loss, stop-loss, or reinsurance

1 policies and on the total number of other enrolled individuals as
2 determined under Section 1511.0252. To compute the amount of a
3 health benefit plan issuer's assessment:
4 (1) for the issuer's enrolled individuals covered by
5 an excess loss, stop-loss, or reinsurance policy, the board shall:
6 (A) divide the allocated amount to be assessed by
7 the total number of enrolled individuals covered by excess loss,
8 stop-loss, or reinsurance policies, as determined under Section
9 1511.0252, to determine the per capita amount; and
10 (B) multiply the number of a health benefit plan
11 issuer's enrolled individuals covered by an excess loss, stop-loss,
12 or reinsurance policy, as determined under Section 1511.0252, by
13 the per capita amount to determine the amount assessed to that
14 health benefit plan issuer; and
15 (2) for the issuer's enrolled individuals not covered
16 by excess loss, stop-loss, or reinsurance policies, the board,
17 using the gross health benefit plan premiums reported for the
18 preceding calendar year by health benefit plan issuers under
19 Section 1511.0253, shall:
20 (A) divide the gross premium collected by a
21 health benefit plan issuer by the gross premium collected by all
22 health benefit plan issuers; and
23 (B) multiply the allocated amount to be assessed
24 by the fraction computed under Paragraph (A) to determine the
25 amount assessed to that health benefit plan issuer.
26 (c) A small employer health benefit plan described by
27 Chapter 1501 is not subject to an assessment under this section.

Sec. 1511.0205. ASSESSMENT DUE DATE; INTEREST. (a) An assessment is due on the date specified by the board that is not earlier than the 30th day after the date written notice of the assessment is transmitted to the health benefit plan issuer.

(b) Interest accrues on the unpaid amount of an assessment at a rate equal to the prime lending rate, as published in the most recent issue of the Wall Street Journal and determined as of the first day of each month during which the assessment is delinquent, plus three percent.

Sec. 1511.0206. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A health benefit plan issuer may petition the board for an abatement or deferment of all or part of an assessment imposed by the board. The board may abate or defer all or part of the assessment if the board determines that payment of the assessment would endanger the ability of the health benefit plan issuer to fulfill its contractual obligations.

(b) If all or part of an assessment against a health benefit plan issuer is abated or deferred, the amount of the abatement or deferment shall be assessed against the other health benefit plan issuers in a manner consistent with the method for computing assessments under this chapter.

(c) A health benefit plan issuer receiving an abatement or deferment under this section remains liable to the pool for the deficiency.

Sec. 1511.0207. USE OF EXCESS FROM ASSESSMENTS. If the total amount of the assessments exceeds the pool's actual losses and administrative expenses, the board shall credit each health

1 benefit plan issuer with the excess in an amount proportionate to
2 the amount the health benefit plan issuer paid in assessments. The
3 credit may be paid to the health benefit plan issuer or applied to
4 future assessments under this chapter.
5 Sec. 1511.0208. COLLECTION OF ASSESSMENTS. The pool may
6 recover or collect assessments made under this subchapter.
7 SUBCHAPTER F. REPORTING
8 Sec. 1511.0251. ANNUAL ISSUER REPORT TO BOARD: REQUESTED
9 INFORMATION. Each health benefit plan issuer shall report to the
10 board the information requested by the board, as of December 31 of
11 the preceding year.
12 Sec. 1511.0252. ANNUAL ISSUER REPORT TO BOARD: ENROLLED
13 INDIVIDUALS. (a) Each health benefit plan issuer shall report to
14 the board the number of residents of this state enrolled, as of
15 December 31 of the preceding year, in the issuer's health benefit
16 plans providing coverage for residents in this state, as:
17 (1) an employee under a group health benefit plan; or
18 (2) an individual policyholder or subscriber.
19 (b) In determining the number of individuals to report under
20 Subsection (a)(1), the health benefit plan issuer shall include
21 each employee for whom a premium is paid and coverage is provided
22 under an excess loss, stop-loss, or reinsurance policy issued by
23 the issuer to an employer or group health benefit plan providing
24 coverage for employees in this state. A health benefit plan issuer
25 providing excess loss insurance, stop-loss insurance, or
26 reinsurance, as described by this subsection, for a primary health
27 benefit plan issuer may not report individuals reported by the

primary health benefit plan issuer.

(c) Ten employees covered by a health benefit plan issuer under a policy of excess loss insurance, stop-loss insurance, or reinsurance count as one employee for purposes of determining that health benefit plan issuer's assessment.

(d) In determining the number of individuals to report under this section, the health benefit plan issuer shall exclude:

(1) the dependents of the employee or an individual policyholder or subscriber; and

(2) individuals who are covered by the health benefit plan issuer under a Medicare supplement benefit plan subject to Chapter 1652.

(e) In determining the number of enrolled individuals to report under this section, the health benefit plan issuer shall exclude individuals who are retired employees 65 years of age or older.

Sec. 1511.0253. ANNUAL ISSUER REPORT TO BOARD: GROSS PREMIUMS. (a) Each health benefit plan issuer shall report to the board the gross premiums collected for the preceding calendar year for health benefit plans.

(b) For purposes of this section, gross health benefit plan premiums do not include premiums collected for:

(1) coverage under a Medicare supplement benefit plan subject to Chapter 1652;

(2) coverage under a small employer health benefit plan subject to Chapter 1501;

(3) coverage:

1 (A) for wages or payments in lieu of wages for a
2 period during which an employee is absent from work because of
3 accident or disability;
4 (B) as a supplement to a liability insurance
5 policy;
6 (C) for credit insurance;
7 (D) only for dental or vision care; or
8 (E) only for a specified disease or illness;
9 (4) a workers' compensation insurance policy;
10 (5) medical payment insurance coverage provided under
11 a motor vehicle insurance policy;
12 (6) a long-term care policy, including a nursing home
13 fixed indemnity policy, unless the commissioner determines that the
14 policy provides comprehensive health benefit plan coverage;
15 (7) liability insurance coverage, including general
16 liability insurance and automobile liability insurance;
17 (8) coverage for on-site medical clinics;
18 (9) insurance coverage under which benefits are
19 payable with or without regard to fault and that is statutorily
20 required to be contained in a liability insurance policy or
21 equivalent self-insurance; or
22 (10) other similar insurance coverage, as specified by
23 federal regulations issued under the Health Insurance Portability
24 and Accountability Act of 1996 (Pub. L. No. 104-191), under which
25 benefits for medical care are secondary or incidental to other
26 insurance benefits.
27 Sec. 1511.0254. ANNUAL BOARD REPORT OF POOL ACTIVITIES.

1 (a) Beginning June 1, 2022, not later than June 1 of each year, the
2 board shall submit a report to the governor, lieutenant governor,
3 and speaker of the house of representatives.
4 (b) The report submitted under Subsection (a) must include:
5 (1) a summary of the activities conducted under this
6 chapter in the calendar year preceding the year in which the report
7 is submitted;
8 (2) the average amount by which health benefit plan
9 premiums were reduced in this state and in each rating region;
10 (3) the average change in each rating region in the
11 amount of health benefit plan premiums paid by individuals who
12 receive a premium subsidy under the Patient Protection and
13 Affordable Care Act (Pub. L. No. 111-148); and
14 (4) an estimate of the change in each rating region in
15 enrollment in health benefit plans due to the reduction in
16 premiums.
17 SEC. 4.02. Notwithstanding Section 1511.0002(1), Insurance
18 Code, as added by this article, the commissioner of insurance may
19 not apply for the waiver as required by that subdivision until the
20 commissioner determines that the commissioner has completed a
21 review under Chapter 1698, Insurance Code, as added by this Act, of
22 all health benefit plan rates in effect for compliance with that
23 chapter and other applicable law.
24 ARTICLE 5. ADMINISTRATION OF, ELIGIBILITY FOR, AND BENEFITS
25 PROVIDED UNDER MEDICAID
26 SECTION 5.01. Section 533.001, Government Code, is amended
27 by adding Subdivision (6-a) to read as follows:

1 (6-a) "Social determinants of health" means the
2 environmental conditions in which a person is born, lives, learns,
3 works, plays, worships, and ages that affect a range of health,
4 functional, and quality of life outcomes and risks.
5 SECTION 5.02. (a) Section 533.003(a), Government Code, is
6 amended to read as follows:
7 (a) In awarding contracts to managed care organizations,
8 the commission shall:
9 (1) give preference to organizations that have
10 significant participation in the organization's provider network
11 from each health care provider in the region who has traditionally
12 provided care to Medicaid and charity care patients;
13 (2) give extra consideration to organizations that
14 agree to assure continuity of care for at least three months beyond
15 the period of Medicaid eligibility for recipients;
16 (3) consider the need to use different managed care
17 plans to meet the needs of different populations;
18 (4) consider the ability of organizations to process
19 Medicaid claims electronically; and
20 (5) give extra consideration to organizations that use
21 enriched data sets incorporating social determinants of health to
22 manage socially complex populations in a manner that achieves:
23 (A) cost savings through implementation of
24 appropriate interventions for those populations; and
25 (B) favorable health outcomes for those
26 populations by reducing preventable emergency room visits,
27 hospitalizations, and institutionalizations [~~in the initial~~

~~implementation of managed care in the South Texas service region, give extra consideration to an organization that either:~~

[~~(A) is locally owned, managed, and operated, if one exists; or~~

[~~(B) is in compliance with the requirements of Section 533.004~~].

(b) Section 533.003(a), Government Code, as amended by this section, applies to a contract entered into or renewed on or after the effective date of this Act. A contract entered into or renewed before that date is governed by the law in effect on the date the contract was entered into or renewed, and that law is continued in effect for that purpose.

SECTION 5.03. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.021 and 533.022 to read as follows:

Sec. 533.021. PROMOTORAS AND COMMUNITY HEALTH WORKERS. (a) In this section, "promotora" and "community health worker" have the meaning assigned by Section 48.001, Health and Safety Code.

(b) The commission shall allow each Medicaid managed care organization providing health care services under the STAR Medicaid managed care program to categorize services provided by a promotora or community health worker as a quality improvement cost, as authorized by federal law, instead of as an administrative expense.

Sec. 533.022. ANNUAL REPORT ON USE OF SOCIAL DETERMINANTS OF HEALTH. Each Medicaid managed care organization that uses enriched data sets described by Section 533.003(a)(5) shall submit to the commission an annual report that assesses any cost savings

1 and favorable health outcomes achieved by using those data sets.
2 SECTION 5.04. (a) Chapter 533, Government Code, is amended
3 by adding Subchapter F to read as follows:
4 SUBCHAPTER F. PILOT PROJECT TO ADDRESS CERTAIN SOCIAL DETERMINANTS
5 OF HEALTH
6 Sec. 533.101. DEFINITIONS. In this subchapter:
7 (1) "Pilot project" means the pilot project
8 established under Section 533.102.
9 (2) "Project participant" means an individual who
10 participates in the pilot project.
11 (3) "Social determinants of health" means the
12 environmental conditions in which an individual lives that affect
13 the individual's health and quality of life.
14 Sec. 533.102. PILOT PROJECT FOR PROVIDING ENHANCED CASE
15 MANAGEMENT AND OTHER SERVICES TO ADDRESS SOCIAL DETERMINANTS OF
16 HEALTH. (a) The executive commissioner shall seek a waiver under
17 Section 1115 of the federal Social Security Act (42 U.S.C. Section
18 1315) to the state Medicaid plan to develop and implement a
19 five-year pilot project to improve the health care outcomes of
20 Medicaid recipients and reduce associated health care costs by
21 providing enhanced case management and other coordinated,
22 evidence-based, nonmedical intervention services designed to
23 directly address recipient needs related to the following social
24 determinants of health:
25 (1) housing instability;
26 (2) food insecurity;
27 (3) transportation insecurity;

(4) interpersonal violence; and

(5) toxic stress.

(b) The commission shall develop and implement the pilot project with the assistance and involvement of Medicaid managed care organizations, public or private stakeholders, and other persons the commission determines appropriate.

(c) A pilot project established under this section shall be conducted in one or more regions of this state as selected by the commission.

Sec. 533.103. BENEFITS: CASE MANAGEMENT AND INTERVENTION SERVICES. (a) The pilot project must assign a case manager to each project participant. The case manager will determine, authorize, and coordinate individualized nonmedical intervention services for participants that directly address and improve the participants' quality of life respecting one or more of the social determinants of health described by Section 533.102.

(b) The commission shall prescribe the nonmedical intervention services that may be provided to project participants, which may include:

(1) the following services to address housing instability:

(A) tenancy support and sustaining services;

(B) housing quality and safety improvement services;

(C) legal assistance with connecting participants to community resources to address legal issues, other than providing legal representation or paying for legal

1 representation;
2 (D) one-time financial assistance to secure
3 housing; and
4 (E) short-term post-hospitalization housing;
5 (2) the following services to address food insecurity:
6 (A) assistance applying for benefits under the
7 supplemental nutrition assistance program or the federal special
8 supplemental nutrition program for women, infants, and children
9 administered by 42 U.S.C. Section 1786;
10 (B) assistance accessing school-based meal
11 programs;
12 (C) assistance locating and accessing food banks
13 or community-based summer and after-school food programs;
14 (D) nutrition counseling; and
15 (E) financial assistance for targeted nutritious
16 food or meal delivery services for individuals with medically
17 related special dietary needs if funding cannot be obtained through
18 other sources;
19 (3) the following services to address transportation
20 insecurity:
21 (A) educational assistance to gain access to
22 public and private forms of transportation, including
23 ride-sharing; and
24 (B) financial assistance for public
25 transportation or, if public transportation is not available,
26 private transportation to support participants' ability to access
27 pilot project services; and

1 (4) the following services to address interpersonal
2 violence and toxic stress:
3 (A) assistance with locating and accessing
4 community-based social services and mental health agencies with
5 expertise in addressing interpersonal violence;
6 (B) assistance with locating and accessing
7 high-quality child-care and after-school programs;
8 (C) assistance with locating and accessing
9 community engagement activities;
10 (D) navigational services focused on identifying
11 and improving existing factors posing a risk to the safety and
12 health of victims transitioning from traumatic situations,
13 including:
14 (i) obtaining a new phone number or mailing
15 address;
16 (ii) securing immediate shelter and
17 long-term housing;
18 (iii) making school arrangements to
19 minimize disruption of school schedules; and
20 (iv) connecting participants to
21 medical-legal partnerships to address overlap between health care
22 and legal needs;
23 (E) legal assistance for interpersonal
24 violence-related issues, including assistance securing a
25 protection order, other than providing legal representation or
26 paying for legal representation;
27 (F) assistance accessing evidence-based

1 parenting support; and

2 (G) assistance accessing evidence-based

3 maternal, infant, and early home visiting services.

4 Sec. 533.104. PARTICIPANT ELIGIBILITY. An individual is

5 eligible to participate in the pilot project if the individual:

6 (1) is a Medicaid recipient and receives benefits

7 through a Medicaid managed care model or arrangement under this

8 chapter;

9 (2) resides in a region in which the pilot project is

10 implemented; and

11 (3) meets other eligibility criteria established by

12 the commission for project participation, including:

13 (A) having or being at a higher risk than the

14 general population of developing a chronic or serious health

15 condition; and

16 (B) experiencing at least one of the social

17 determinants of health described by Section 533.102.

18 Sec. 533.105. RULES. The executive commissioner may adopt

19 rules to implement this subchapter.

20 Sec. 533.106. REPORT. Not later than September 1 of each

21 even-numbered year, the commission shall submit to the legislature

22 a report on the pilot project. The report must include:

23 (1) an evaluation of the pilot project's success in

24 reducing or eliminating poor health outcomes and reducing

25 associated health care costs; and

26 (2) a recommendation on whether the pilot project

27 should be continued, expanded, or terminated.

Sec. 533.107. EXPIRATION. This subchapter expires September 1, 2027.

(b) As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall apply for and actively pursue a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan from the Centers for Medicare and Medicaid Services or any other federal agency to implement Subchapter F, Chapter 533, Government Code, as added by this section. The commission may delay implementing Subchapter F, Chapter 533, Government Code, as added by this section, until the waiver applied for under this subsection is granted.

SECTION 5.05. Section 32.024, Human Resources Code, is amended by adding Subsections (l-1) and (oo) to read as follows:

(l-1) The commission shall continue to provide medical assistance to a woman who is eligible for medical assistance for pregnant women for a period of not less than 12 months following the last month of the woman's pregnancy.

(oo) The commission shall provide medical assistance reimbursement to a treating health care provider who participates in Medicaid for the provision to a child or adult medical assistance recipient of behavioral health services that are classified by a Current Procedural Terminology code as collaborative care management services.

SECTION 5.06. (a) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.02472 to read as follows:

1 Sec. 32.02472. ELIGIBILITY OF CERTAIN PERSONS LAWFULLY
2 PRESENT IN THE UNITED STATES. (a) The commission shall provide
3 medical assistance in accordance with 8 U.S.C. Section 1612(b) to a
4 person who:
5 (1) is a qualified alien, as defined by 8 U.S.C.
6 Sections 1641(b) and (c);
7 (2) meets the eligibility requirements of the medical
8 assistance program;
9 (3) entered the United States on or after August 22,
10 1996; and
11 (4) has resided in the United States for a period of
12 five years after the date the person entered as a qualified alien.
13 (b) To the extent allowed by federal law, the commission
14 shall provide medical assistance for pregnant women to a person who
15 is pregnant and is lawfully present, or lawfully residing in the
16 United States as defined by the Centers for Medicare and Medicaid
17 Services, including a battered alien under 8 U.S.C. Section
18 1641(c), regardless of the date the person entered the United
19 States.
20 (b) Not later than October 1, 2021, the executive
21 commissioner of the Health and Human Services Commission shall seek
22 an amendment to the state Medicaid plan or a waiver or other
23 authorization from a federal agency as necessary to implement
24 Section 32.02472, Human Resources Code, as added by this section.
25 SECTION 5.07. Subchapter B, Chapter 32, Human Resources
26 Code, is amended by adding Section 32.02605 to read as follows:
27 Sec. 32.02605. PRESUMPTIVE ELIGIBILITY OF CERTAIN ELDERLY

1 INDIVIDUALS FOR HOME AND COMMUNITY-BASED SERVICES. (a) In this
2 section, "elderly" means an individual who is at least 65 years of
3 age.
4 (b) The executive commissioner shall by rule adopt a program
5 providing for:
6 (1) the determination and certification of
7 presumptive eligibility for medical assistance of an elderly
8 individual who requires a skilled level of nursing care; and
9 (2) the provision through the medical assistance
10 program to the individual of that care in a home or community-based
11 setting instead of in an institutional setting, provided the
12 individual applies for and meets the basic eligibility requirements
13 for medical assistance.
14 (c) The program established under this section must:
15 (1) provide medical assistance benefits under a
16 presumptive eligibility determination for a period of not more than
17 90 days;
18 (2) establish eligibility criteria and a process for
19 determining the entities authorized to make determinations of
20 presumptive eligibility under the program;
21 (3) provide a preliminary screening tool to entities
22 described by Subdivision (2) that will allow representatives of
23 those entities to:
24 (A) make a determination as to whether an
25 applicant is:
26 (i) functionally able to live at home or in
27 a community setting; and

(ii) likely to be financially eligible for medical assistance;

(B) make the determination under Paragraph (A)(ii) not later than the fourth day after the date a determination is made under Paragraph (A)(i); and

(C) initiate the provision of medical assistance benefits not later than the fifth day after the date an applicant is determined eligible under Paragraph (A)(i); and

(4) require an applicant to sign a written agreement:

(A) attesting to the accuracy of financial and other information the applicant provides and on which presumptive eligibility is based; and

(B) acknowledging that:

(i) state-funded services are subject to the period prescribed by Subdivision (1); and

(ii) the applicant is required to comply with Subsection (d).

(d) An applicant who is determined presumptively eligible for medical assistance under the program established by this section must complete an application for medical assistance not later than the 10th day after the date the applicant is screened for functional eligibility under Subsection (c)(3)(A)(i).

(e) Not later than the 45th day after the date the commission receives an application under Subsection (d), the commission shall make a final determination of eligibility for medical assistance.

(f) To the extent permitted by federal law, the commission

1 shall retroactively apply a final determination of eligibility for
2 medical assistance under Subsection (e) for a period that does not
3 precede the 90th day before the date the application was filed under
4 Subsection (d).
5 (g) The commission shall submit an annual report to the
6 standing committees of the senate and house of representatives
7 having jurisdiction over the medical assistance program that
8 details:
9 (1) the number of individuals determined
10 presumptively eligible for medical assistance under the program
11 established under this section;
12 (2) the savings to the state based on how much
13 institutional care would have cost for individuals determined
14 presumptively eligible for medical assistance under the program
15 established under this section who were later determined eligible
16 for medical assistance; and
17 (3) the number of individuals determined
18 presumptively eligible for medical assistance under the program
19 established under this section who were later determined not
20 eligible for medical assistance and the cost to the state to provide
21 those individuals with home or community-based services before the
22 final determination of eligibility for medical assistance.
23 (h) The report required under Subsection (g) may be combined
24 with any other report required by this chapter or other law.
25 SECTION 5.08. Section 32.0261, Human Resources Code, is
26 amended to read as follows:
27 Sec. 32.0261. CONTINUOUS ELIGIBILITY. The executive

1 commissioner shall adopt rules in accordance with 42 U.S.C. Section
2 1396a(e)(12), as amended, to provide for a period of continuous
3 eligibility for a child under 19 years of age who is determined to
4 be eligible for medical assistance under this chapter. The rules
5 shall provide that the child remains eligible for medical
6 assistance, without additional review by the commission and
7 regardless of changes in the child's resources or income, until the
8 earlier of:

9 (1) the first anniversary of [~~end of the six-month~~
10 ~~period following~~] the date on which the child's eligibility was
11 determined; or

12 (2) the child's 19th birthday.

13 ARTICLE 6. HEALTH LITERACY

14 SECTION 6.01. Section 104.002, Health and Safety Code, is
15 amended by adding Subdivision (6) to read as follows:

16 (6) "Health literacy" means the degree to which an
17 individual has the capacity to obtain and understand basic health
18 information and services to make appropriate health decisions.

19 SECTION 6.02. Subchapter B, Chapter 104, Health and Safety
20 Code, is amended by adding Section 104.0157 to read as follows:

21 Sec. 104.0157. HEALTH LITERACY ADVISORY COMMITTEE. (a)
22 The statewide health coordinating council shall establish an
23 advisory committee on health literacy composed of representatives
24 of relevant interest groups, including the academic community,
25 consumer groups, health plans, pharmacies, and associations of
26 physicians, dentists, hospitals, and nurses.

27 (b) Members of the advisory committee shall elect one member

as presiding officer.

(c) The advisory committee shall develop a long-range plan for improving health literacy in this state. The committee shall update the plan at least once every two years.

(d) In developing the long-range plan, the advisory committee shall study the economic impact low health literacy has on state health programs and health insurance coverage for residents of this state. The advisory committee shall:

(1) identify primary risk factors contributing to low health literacy;

(2) examine methods for health care practitioners, health care facilities, and others to address the health literacy of patients and the public;

(3) examine the effectiveness of using quality measures in state health programs to improve health literacy;

(4) identify strategies for expanding the use of plain language instructions for patients; and

(5) examine the impact improved health literacy has on enhancing patient safety, reducing preventable events, and increasing medication adherence to attain greater cost-effectiveness and better patient outcomes in the provision of health care.

(e) Not later than December 1 of each even-numbered year, the advisory committee shall submit the long-range plan developed or updated under this section to the governor, the lieutenant governor, the speaker of the house of representatives, and each member of the legislature.

(f) An advisory committee member serves without compensation but is entitled to reimbursement for the member's travel expenses as provided by Chapter 660, Government Code, and the General Appropriations Act.

(g) Sections 2110.002, 2110.003, and 2110.008, Government Code, do not apply to the advisory committee.

(h) Meetings of the advisory committee under this section are subject to Chapter 551, Government Code.

SECTION 6.03. Sections 104.022(e) and (f), Health and Safety Code, are amended to read as follows:

(e) The state health plan shall be developed and used in accordance with applicable state and federal law. The plan must identify:

(1) major statewide health concerns, including the prevalence of low health literacy among health care consumers;

(2) the availability and use of current health resources of the state, including resources associated with information technology and state-supported institutions of higher education; and

(3) future health service, information technology, and facility needs of the state.

(f) The state health plan must:

(1) propose strategies for the correction of major deficiencies in the service delivery system;

(2) propose strategies for improving health literacy to attain greater cost-effectiveness and better patient outcomes in the provision of health care;

1 (3) [(2)] propose strategies for incorporating
2 information technology in the service delivery system;
3 (4) [(3)] propose strategies for involving
4 state-supported institutions of higher education in providing
5 health services and for coordinating those efforts with health and
6 human services agencies in order to close gaps in services; and
7 (5) [(4)] provide direction for the state's
8 legislative and executive decision-making processes to implement
9 the strategies proposed by the plan.
10 ARTICLE 7. FEDERAL AUTHORIZATION AND EFFECTIVE DATE
11 SEC. 7.01. (a) Except as provided by Subsection (b) of this
12 section, if before implementing any provision of this Act a state
13 agency determines that a waiver or authorization from a federal
14 agency is necessary for implementation of that provision, the
15 agency affected by the provision shall request the waiver or
16 authorization and may delay implementing that provision until the
17 waiver or authorization is granted.
18 (b) Subsection (a) of this section does not apply to the
19 extent another provision of this Act specifically authorizes or
20 requires a state agency to seek a waiver, state Medicaid plan
21 amendment, or other authorization from a federal agency.
22 SEC. 7.02. This Act takes effect September 1, 2021.