

By: Johnson

S.B. No. 78

A BILL TO BE ENTITLED

AN ACT

1  
2 relating to the development and implementation of the Live Well  
3 Texas program and the expansion of Medicaid eligibility to provide  
4 health benefit coverage to certain individuals; imposing  
5 penalties.

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

7 SECTION 1. Subtitle I, Title 4, Government Code, is amended  
8 by adding Chapters 537A and 537B to read as follows:

9 CHAPTER 537A. LIVE WELL TEXAS PROGRAM

10 SUBCHAPTER A. GENERAL PROVISIONS

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

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

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

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

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

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

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

22 (5) "POWER account" means a personal wellness and  
23 responsibility account the commission establishes for a  
24 participant under Section 537A.0251.

1           (6) "Program" means the Live Well Texas program  
2 established under this chapter.

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

4                   (A) the basic plan; and

5                   (B) the plus plan.

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

10           SUBCHAPTER B. FEDERAL WAIVER FOR LIVE WELL TEXAS PROGRAM

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

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

20                   (1) be designed to:

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

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

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

1           (D) promote personal responsibility and engage  
2 participants in making decisions regarding health care based on  
3 cost and quality;

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

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

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

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

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

23          Sec. 537A.0053. NOT AN ENTITLEMENT; TERMINATION OF PROGRAM.

24          (a) This chapter does not establish an entitlement to health  
25 benefit coverage or health care financial assistance under the  
26 program for eligible individuals.

27          (b) The program terminates at the time the share of federal

1 funding for the program under the Patient Protection and Affordable  
2 Care Act (Pub. L. No. 111-148) as amended by the Health Care and  
3 Education Reconciliation Act of 2010 (Pub. L. No. 111-152) is  
4 reduced below 90 percent.

5 SUBCHAPTER C. PROGRAM ADMINISTRATION

6 Sec. 537A.0101. PROGRAM OBJECTIVE. The program's principal  
7 objective is to provide primary and preventative health care  
8 through high deductible program health benefit plans to eligible  
9 individuals.

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

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

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

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

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

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

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

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

27 Sec. 537A.0104. COMMISSION'S AUTHORITY RELATED TO

1 ELIGIBILITY AND MEDICAID COORDINATION. The commission may:

2 (1) accept applications for health benefit coverage  
3 under the program and implement program eligibility screening and  
4 enrollment procedures;

5 (2) resolve grievances related to eligibility  
6 determinations; and

7 (3) to the extent possible, coordinate the program  
8 with Medicaid.

9 Sec. 537A.0105. THIRD-PARTY ADMINISTRATOR CONTRACT FOR  
10 PROGRAM IMPLEMENTATION. (a) In administering the program, the  
11 commission may contract with a third-party administrator to provide  
12 enrollment and related services.

13 (b) If the commission contracts with a third-party  
14 administrator under this section, the commission may:

15 (1) monitor the third-party administrator through  
16 reporting requirements and other means to ensure contract  
17 performance and quality delivery of services; and

18 (2) provide payment under the contract to the  
19 third-party administrator.

20 (c) The executive commissioner shall retain all  
21 policymaking authority over the program.

22 (d) The commission shall procure each contract with a  
23 third-party administrator, as applicable, through a competitive  
24 procurement process that complies with all federal and state laws.

25 Sec. 537A.0106. TEXAS DEPARTMENT OF INSURANCE DUTIES. (a)  
26 At the commission's request, the Texas Department of Insurance  
27 shall provide any necessary assistance with the program. The

1 department shall monitor the quality of the services provided by  
2 program health benefit plan providers and resolve grievances  
3 related to those providers.

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

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

10 Sec. 537A.0107. HEALTH BENEFIT PLAN PROVIDER CONTRACTS.

11 The commission shall select through a competitive procurement  
12 process that complies with all federal and state laws and contract  
13 with health benefit plan providers to provide health care services  
14 under the program. To be eligible for a contract under this section,  
15 an entity must:

16 (1) be a Medicaid managed care organization;

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

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

23 Sec. 537A.0108. HEALTH CARE PROVIDERS. (a) A health care  
24 provider who provides health care services under the program must  
25 meet certification and licensure requirements required by  
26 commission rules and other law.

27 (b) In adopting rules governing the program, the executive

1 commissioner shall ensure that a health care provider who provides  
2 health care services under the program is reimbursed at a rate that  
3 is at least equal to the rate paid under Medicare for the provision  
4 of the same or substantially similar services.

5 Sec. 537A.0109. PROHIBITION ON CERTAIN HEALTHCARE  
6 PROVIDERS. The executive commissioner shall adopt rules that  
7 prohibit a health care provider from providing program health care  
8 services for a reasonable period, as determined by the executive  
9 commissioner, if the health care provider:

- 10 (1) fails to repay program overpayments; or  
11 (2) owns, controls, manages, or is otherwise  
12 affiliated with and has financial, managerial, or administrative  
13 influence over a health care provider who has been suspended or  
14 prohibited from providing program health care services.

15 SUBCHAPTER D. ELIGIBILITY FOR PROGRAM HEALTH BENEFIT COVERAGE

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

- 19 (1) the individual is a resident of this state;  
20 (2) the individual is 19 years of age or older but  
21 younger than 65 years of age;  
22 (3) applying the eligibility criteria in effect in  
23 this state on December 31, 2022, the individual is not eligible for  
24 Medicaid; and  
25 (4) federal matching funds are available under the  
26 Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as  
27 amended by the Health Care and Education Reconciliation Act of 2010

1 (Pub. L. No. 111-152) to provide benefits to the individual under  
2 the federal medical assistance program established under Title XIX,  
3 Social Security Act (42 U.S.C. Section 1396 et seq.).

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

7 (c) In determining eligibility for the program, the  
8 commission shall apply the same eligibility criteria regarding  
9 residency and citizenship in effect for Medicaid in this state on  
10 December 31, 2022.

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

18 Sec. 537A.0153. APPLICATION FORM AND PROCEDURES. (a) The  
19 executive commissioner shall adopt an application form and  
20 application procedures for the program. The form and procedures  
21 must be coordinated with forms and procedures under Medicaid to  
22 ensure that there is a single consolidated application process to  
23 seek health benefit coverage under the program or Medicaid.

24 (b) To the extent possible, the commission shall make the  
25 application form available in languages other than English.

26 (c) The executive commissioner may permit an individual to  
27 apply by mail, over the telephone, or through the Internet.

1       Sec. 537A.0154. ELIGIBILITY SCREENING AND ENROLLMENT. (a)

2       The executive commissioner shall adopt eligibility screening and  
3       enrollment procedures or use the Texas Integrated Enrollment  
4       Services eligibility determination system or a compatible system to  
5       screen individuals and enroll eligible individuals in the program.

6       (b) The eligibility screening and enrollment procedures  
7       must ensure that an individual applying for the program who appears  
8       eligible for Medicaid is identified and assisted with obtaining  
9       Medicaid coverage. If the individual is denied Medicaid coverage  
10       but is determined eligible to enroll in a program health benefit  
11       plan, the commission shall enroll the individual in a program  
12       health benefit plan of the individual's choosing and for which the  
13       individual is eligible without further application or  
14       qualification.

15       (c) Not later than the 30th day after the date an individual  
16       submits a complete application form and unless the individual is  
17       identified and assisted with obtaining Medicaid coverage under  
18       Subsection (b), the commission shall ensure that the individual's  
19       eligibility to participate in the program is determined and that  
20       the individual, if eligible, is provided with information on  
21       program health benefit plans and program health benefit plan  
22       providers. The commission shall enroll the individual in the  
23       program health benefit plan and with the program health benefit  
24       plan provider of the individual's choosing in a timely manner, as  
25       determined by the commission.

26       (d) The executive commissioner may establish enrollment  
27       periods for the program.

1       Sec. 537A.0155. ELIGIBILITY REDETERMINATION PROCESS;  
2 DISENROLLMENT. (a) Not later than the 90th day before a  
3 participant's coverage period expires, the commission shall notify  
4 the participant regarding the eligibility redetermination process  
5 and request documentation necessary to redetermine the  
6 participant's eligibility.

7       (b) The commission shall provide written notice of  
8 termination of eligibility to a participant not later than the 30th  
9 day before the date the participant's eligibility will terminate.

10 The commission shall disenroll the participant from the program if:

11       (1) the participant does not submit the requested  
12 eligibility redetermination documentation before the last day of  
13 the participant's coverage period; or

14       (2) the commission, based on the submitted  
15 documentation, determines the participant is no longer eligible for  
16 the program, subject to Subchapter H.

17       (c) An individual may submit the requested eligibility  
18 redetermination documentation not later than the 90th day after the  
19 date the commission disenrolls the individual from the program. If  
20 the commission determines that the individual continues to meet  
21 program eligibility requirements, the commission shall reenroll  
22 the individual in the program without any additional application  
23 requirements.

24       (d) An individual who does not complete the eligibility  
25 redetermination process in accordance with this section and who the  
26 commission disenrolls from the program may not participate in the  
27 program for a period of 180 days beginning on the date of

1 disenrollment. This subsection does not apply to an individual:

2 (1) described by Section 537A.0206 or 537A.0208; or

3 (2) who is:

4 (A) pregnant; or

5 (B) younger than 21 years of age.

6 (e) At the time the commission disenrolls a participant from  
7 the program, the commission shall provide to the participant:

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

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

13 SUBCHAPTER E. BASIC AND PLUS PLANS

14 Sec. 537A.0201. BASIC AND PLUS PLAN COVERAGE GENERALLY.

15 (a) The basic and plus plans offered under the program must:

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

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

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

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

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

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

- 7           (1) primary care physician services;
- 8           (2) prenatal and postpartum care;
- 9           (3) specialty care physician visits;
- 10          (4) home health services, not to exceed 100 visits per  
11 year;
- 12          (5) outpatient surgery;
- 13          (6) allergy testing;
- 14          (7) chemotherapy;
- 15          (8) intravenous infusion services;
- 16          (9) radiation therapy;
- 17          (10) dialysis;
- 18          (11) emergency care hospital services;
- 19          (12) emergency transportation, including ambulance  
20 and air ambulance;
- 21          (13) urgent care clinic services;
- 22          (14) hospitalization, including for:
  - 23               (A) general inpatient hospital care;
  - 24               (B) inpatient physician services;
  - 25               (C) inpatient surgical services;
  - 26               (D) non-cosmetic reconstructive surgery;
  - 27               (E) a transplant;

- 1                   (F) treatment for a congenital abnormality;  
2                   (G) anesthesia;  
3                   (H) hospice care; and  
4                   (I) care in a skilled nursing facility for a  
5 period not to exceed 100 days per occurrence;  
6                   (15) inpatient and outpatient behavioral health  
7 services;  
8                   (16) inpatient, outpatient, and residential substance  
9 use treatment;  
10                  (17) prescription drugs, including tobacco cessation  
11 drugs;  
12                  (18) inpatient and outpatient rehabilitative and  
13 habilitative care, including physical, occupational, and speech  
14 therapy, not to exceed 60 combined visits per year;  
15                  (19) medical equipment, appliances, and assistive  
16 technology, including prosthetics and hearing aids, and the repair,  
17 technical support, and customization needed for individual use;  
18                  (20) laboratory and pathology tests and services;  
19                  (21) diagnostic imaging, including x-rays, magnetic  
20 resonance imaging, computed tomography, and positron emission  
21 tomography;  
22                  (22) preventative care services as described by  
23 Section 537A.0204; and  
24                  (23) services under the early and periodic screening,  
25 diagnostic, and treatment program for participants who are younger  
26 than 21 years of age.  
27                  (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 POWER 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 participant's age, gender, and preexisting conditions. 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

1 pay a copayment in an amount set by commission rule not to exceed  
2 \$25 for nonemergency use of hospital emergency department services  
3 unless:

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

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

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

10 (4) the participant is pregnant.

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

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

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

22 Sec. 537A.0207. PREGNANT PARTICIPANTS. (a) A participant  
23 who becomes pregnant while enrolled in the program and who meets the  
24 eligibility requirements for Medicaid may choose to remain in the  
25 program or enroll in Medicaid.

26 (b) A pregnant participant described by Subsection (a) who  
27 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 POWER  
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 POWER account contribution  
25 requirements, of the program health benefit plan in which the  
26 individual is enrolled.

27 SUBCHAPTER F. PERSONAL WELLNESS AND RESPONSIBILITY (POWER)

ACCOUNTS

Sec. 537A.0251. ESTABLISHMENT AND OPERATION OF POWER ACCOUNTS. (a) The commission shall establish a personal wellness and responsibility (POWER) account for each participant who is enrolled in a program health benefit plan that is funded with money contributed in accordance with this subchapter.

(b) The commission shall enable each participant to access and manage money in and information regarding the participant's POWER account through an electronic system. The commission may contract with an entity that has appropriate experience and expertise to establish, implement, or administer the electronic system.

(c) Except as otherwise provided by Section 537A.0252, the commission shall require each participant to contribute to the participant's POWER account in amounts described by that section.

Sec. 537A.0252. POWER ACCOUNT CONTRIBUTIONS; DEDUCTIBLE.

(a) The executive commissioner by rule shall establish an annual universal deductible for each participant enrolled in the basic or plus plan.

(b) To ensure each participant's POWER account contains a sufficient amount of money at the beginning of a coverage period, the commission shall, before the beginning of that period, fund each account with the following amounts:

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

(2) for a participant enrolled in the plus plan, the difference between the annual universal deductible amount and the

1 participant's required annual contribution as determined by the  
2 schedule established under Subsection (c).

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

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

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

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

19 (e) Subject to the contribution cap described by Subsection  
20 (c)(2) and not before the expiration of the participant's first  
21 coverage period, the commission shall require a participant who  
22 uses one or more tobacco products to contribute to the  
23 participant's POWER account an annual POWER account contribution  
24 amount that is one percent more than the participant would  
25 otherwise be required to contribute under the schedule established  
26 under Subsection (c).

27 (f) An annual POWER account contribution must be paid by or

1 on behalf of a participant monthly in installments that are at least  
2 equal to one-twelfth of the total required contribution. The  
3 coverage period for a participant whose annual household income  
4 exceeds 100 percent of the federal poverty level may not begin until  
5 the first day of the first month following the month in which the  
6 first monthly installment is received.

7 Sec. 537A.0253. USE OF POWER ACCOUNT MONEY. A participant  
8 may use money in the participant's POWER account to pay copayments  
9 and deductible costs the participant's program health benefit plan  
10 requires. The commission shall issue to each participant an  
11 electronic payment card that allows the participant to use the card  
12 to pay the program health benefit plan costs.

13 Sec. 537A.0254. PROGRAM HEALTH BENEFIT PLAN PROVIDER  
14 REWARDS PROGRAM FOR ENGAGEMENT IN CERTAIN HEALTHY BEHAVIORS;  
15 SMOKING CESSATION INITIATIVE. (a) A program health benefit plan  
16 provider shall establish a rewards program through which a  
17 participant receiving health care through a program health benefit  
18 plan the program health benefit plan provider offers may earn money  
19 to be contributed to the participant's POWER account.

20 (b) Under a rewards program, a program health benefit plan  
21 provider shall contribute money to a participant's POWER account if  
22 the participant engages in certain healthy behaviors. The executive  
23 commissioner by rule shall determine:

24 (1) the behaviors in which a participant must engage  
25 to receive a contribution, which must include behaviors related to:

26 (A) completion of a health risk assessment;

27 (B) smoking cessation; and

1                   (C) as applicable, chronic disease management;  
2 and

3                   (2) the amount of money a program health benefit plan  
4 provider shall contribute for each behavior described by  
5 Subdivision (1).

6           (c) Subsection (b) does not prevent a program health benefit  
7 plan provider from contributing money to a participant's POWER  
8 account if the participant engages in a behavior not specified by  
9 that subsection or a rule the executive commissioner adopts in  
10 accordance with that subsection. If a program health benefit plan  
11 provider chooses to contribute money under this subsection, the  
12 program health benefit plan provider shall determine the amount of  
13 money to be contributed for the behavior.

14           (d) A participant may use contributions a program health  
15 benefit plan provider makes under a rewards program to offset a  
16 maximum of 50 percent of the participant's required annual POWER  
17 account contribution the executive commissioner establishes under  
18 Section 537A.0252.

19           (e) Contributions a program health benefit plan provider  
20 makes under a rewards program that result in a participant's POWER  
21 account balance exceeding the participant's required annual POWER  
22 account contribution may be rolled over into the next coverage  
23 period in accordance with Section 537A.0256.

24           (f) During the first coverage period of a participant who  
25 uses one or more tobacco products, a program health benefit plan  
26 provider shall actively attempt to engage the participant in and  
27 provide educational materials to the participant on:

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

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

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

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

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

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

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

22           (b) For a participant enrolled in the basic plan, the  
23 commission shall calculate the amount to be rolled over to a  
24 subsequent coverage period POWER account from the participant's  
25 current coverage period POWER account based on:

26           (1) the amount of money remaining in the participant's  
27 POWER account from the current coverage period; and

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

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

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

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

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

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

20           (e) A participant enrolled in the basic plan who rolls over  
21 money into the participant's POWER account for the succeeding  
22 coverage period and who chooses to enroll in the plus plan for that  
23 coverage period may use the money rolled over to offset a maximum of  
24 50 percent of the required annual POWER account contributions for  
25 that coverage period.

26           Sec. 537A.0257. REFUND. If at the end of a participant's  
27 coverage period the participant chooses to cease participating in a

1 program health benefit plan or is no longer eligible to participate  
2 in a program health benefit plan, or if the commission disenrolls a  
3 participant from the program health benefit plan under Section  
4 537A.0258 for failure to pay required contributions, the commission  
5 shall refund to the participant any money the participant  
6 contributed that remains in the participant's POWER account at the  
7 end of the coverage period or on the disenrollment date.

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

19 (1) the 181st day after the disenrollment date; and  
20 (2) the participant pays any debt accrued due to the  
21 participant's failure to make the contribution.

22 (b) For a participant enrolled in the plus plan whose annual  
23 household income is equal to or less than 100 percent of the federal  
24 poverty level and who fails to make a contribution in accordance  
25 with Section 537A.0252, the commission shall disenroll the  
26 participant from the plus plan and enroll the participant in the  
27 basic plan. A participant enrolled in the basic plan under this

1 subsection may not change enrollment to the plus plan until the  
2 participant's program eligibility is redetermined.

3 SUBCHAPTER G. EMPLOYMENT INITIATIVE

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

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

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

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

16 SUBCHAPTER H. HEALTH CARE FINANCIAL ASSISTANCE FOR CERTAIN  
17 PARTICIPANTS

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

23 (1) the commission disenrolls from a program health  
24 benefit plan in accordance with Section 537A.0155 because the  
25 participant's annual household income exceeds the income  
26 eligibility requirements for enrollment in a program health benefit  
27 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 the commission requires, documentation showing the  
6 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 commission  
15 disenrolled the participant from a program health benefit plan.

16           (b) Health care financial assistance the commission makes  
17 available to a participant under this subchapter:

18                   (1) may not exceed the amount described by Section  
19 537A.0353; and

20                   (2) may be used only to pay 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

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

7 (c) The commission shall fund each bridge account in an  
8 amount equal to \$1,000 using money the commission retains or  
9 recoups:

10 (1) during the roll over process described by Section  
11 537A.0256;

12 (2) following the issuance of a refund as described by  
13 Section 537A.0257; or

14 (3) under Subsection (e).

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

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

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

1       (b) A participant may use money in the participant's bridge  
2 account to pay:

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

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

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

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

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

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

19       CHAPTER 537B. EXPANDED MEDICAID ELIGIBILITY FOR CERTAIN  
20                               INDIVIDUALS

21       Sec. 537B.0001. APPLICABILITY. This chapter applies only  
22 to an individual who would be eligible to participate in the Live  
23 Well Texas program under Chapter 537A based on the eligibility  
24 requirements described by Section 537A.0151, if the commission were  
25 to establish the program.

26       Sec. 537B.0002. EXPANDED MEDICAID ELIGIBILITY UNDER  
27 PATIENT PROTECTION AND AFFORDABLE CARE ACT. (a) Except as provided

1 by Subsection (b) and notwithstanding any other law, the commission  
2 shall provide Medicaid benefits to all individuals who apply for  
3 those benefits and to whom this chapter applies.

4 (b) After the waiver described by Section 537A.0051 is  
5 approved and the commission implements the Live Well Texas program  
6 under Chapter 537A, the commission shall:

7 (1) provide health benefit coverage through that  
8 program in accordance with Chapter 537A to individuals to whom this  
9 chapter applies; and

10 (2) cease providing Medicaid benefits to those  
11 individuals, except as provided by Chapter 537A.

12 (c) The commission shall:

13 (1) continue to provide Medicaid benefits to  
14 individuals described by Subsection (a) if the waiver described by  
15 Section 537A.0051 is not approved; and

16 (2) resume providing Medicaid benefits to individuals  
17 described by Subsection (a) if the Live Well Texas program  
18 implemented under Chapter 537A terminates in accordance with  
19 Section 537A.0053(b).

20 (d) The executive commissioner shall adopt rules regarding  
21 the provision of Medicaid benefits as required by this section,  
22 including, as applicable, rules on transitioning individuals from  
23 receiving Medicaid benefits under this section to receiving health  
24 benefit coverage under the Live Well Texas program implemented  
25 under Chapter 537A.

26 SECTION 2. As soon as practicable after the effective date  
27 of this Act, the executive commissioner of the Health and Human

1 Services Commission shall apply for and actively pursue from the  
2 federal Centers for Medicare and Medicaid Services or another  
3 appropriate federal agency the waiver as required by Section  
4 537A.0051, Government Code, as added by this Act. The commission  
5 may delay implementing other provisions of Chapter 537A, Government  
6 Code, as added by this Act, until the waiver applied for under that  
7 section is granted.

8 SECTION 3. (a) Chapter 537B, Government Code, as added by  
9 this Act, applies only to an initial determination or  
10 recertification of an individual's Medicaid eligibility under  
11 Chapter 32, Human Resources Code, made on or after the  
12 implementation of Chapter 537B, regardless of the date the  
13 individual applied for Medicaid.

14 (b) As soon as practicable after the effective date of this  
15 Act, the executive commissioner of the Health and Human Services  
16 Commission shall take all necessary actions to expand Medicaid  
17 eligibility in accordance with Chapter 537B, Government Code, as  
18 added by this Act, including notifying appropriate federal agencies  
19 of that expanded eligibility. If before implementing Chapter 537B a  
20 state agency determines that any other waiver or authorization from  
21 a federal agency is necessary for implementation of that chapter,  
22 the agency affected by the chapter shall request the waiver or  
23 authorization and may delay implementing that chapter until the  
24 waiver or authorization is granted.

25 SECTION 4. This Act takes effect immediately if it receives  
26 a vote of two-thirds of all the members elected to each house, as  
27 provided by Section 39, Article III, Texas Constitution. If this

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1 Act does not receive the vote necessary for immediate effect, this  
2 Act takes effect on the 91st day after the last day of the  
3 legislative session.