By: Johnson, Blanco S.B. No. 195

A BILL TO BE ENTITLED

AN ACT

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

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

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

CHAPTER 537A. LIVE WELL TEXAS PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

(7) "Program health benefit plan" includes:

(A) the basic plan; and

(B) the plus plan.

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

SUBCHAPTER B. FEDERAL WAIVER FOR LIVE WELL TEXAS PROGRAM

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

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

(1) be designed to:

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

(B) produce better health outcomes for participants;

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

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

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

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

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

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

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

Sec. 537A.0053. NOT AN ENTITLEMENT; TERMINATION OF PROGRAM. (a) This chapter does not establish an entitlement to health benefit coverage or health care financial assistance under the program for eligible individuals.

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

funding for the program 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) is reduced below 90 percent.

SUBCHAPTER C. PROGRAM ADMINISTRATION

Sec. 537A.0101. PROGRAM OBJECTIVE. The program's principal objective 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.

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

ELIGIBILITY AND MEDICAID COORDINATION. The commission may:

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

(2) resolve grievances related to eligibility determinations; and

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

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

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

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

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

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

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

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

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

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

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

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

(1) be a Medicaid managed care organization;

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

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

Sec. 537A.0108. HEALTH CARE PROVIDERS. (a) A health care provider who provides health care services under the program must meet certification and licensure requirements required by 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 program health care services for a reasonable period, as determined by the executive commissioner, if the health care provider:

(1) fails to repay program overpayments; 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 program health care services.

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 resident of this state;

(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 this state on December 31, 2022, the individual is not eligible for Medicaid; and

(4) federal matching funds are available under the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010

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

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

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

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

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

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

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

Sec. 537A.0154. ELIGIBILITY SCREENING AND ENROLLMENT. (a) The executive commissioner shall adopt eligibility screening and enrollment procedures or use the Texas Integrated Enrollment Services eligibility determination system or a compatible system to screen individuals and enroll eligible individuals in the program.

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

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

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

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

(b) The commission shall provide written notice of termination of eligibility to a participant not later than the 30th day before the date the participant's eligibility will terminate. The commission shall disenroll the participant from the program if:

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

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

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

(d) An individual who does not complete the eligibility redetermination process in accordance with this section and who the commission disenrolls 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:

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

(2) who is:

(A) pregnant; or

(B) younger than 21 years of age.

(e) At the time the commission disenrolls a participant from the program, 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

plan, an individual who is eligible for the program must have an annual household income that is equal to or less than 100 percent of the federal poverty level.

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

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

(2) dental care;

(3) vision care;

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

(5) bariatric surgery; and

(6) other services the commission considers appropriate.

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

(c) A participant enrolled in the plus plan is required to make POWER account contributions in accordance with Section

537A.0252.

Sec. 537A.0204. PREVENTATIVE CARE SERVICES. (a) The commission shall provide to each participant a list of health care services that qualify as preventative care services based on the participant's age, gender, and preexisting conditions. In developing the list, the commission shall consult with the federal Centers for Disease Control and Prevention.

(b) A program health benefit plan shall, at no cost to the participant, provide coverage for:

(1) preventative care services described by 42 U.S.C. Section 300gg-13; and

(2) a maximum of $500 per year of preventative care services other than those described by Subdivision (1).

(c) A participant who receives preventative care services not described by Subsection (b) that are covered under the participant's program health benefit plan is subject to deductible and copayment requirements for the services in accordance with the terms of the plan.

Sec. 537A.0205. COPAYMENTS. (a) A participant enrolled in the basic plan shall pay a copayment for each covered health benefit except for a preventative care or family planning service. The executive commissioner by rule shall adopt a copayment schedule for basic plan services, subject to Subsection (c).

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

(c) A participant enrolled in the basic or plus plan shall

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

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

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

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

(4) the participant is pregnant.

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

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

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

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

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

is:

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

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

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

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

(b) An individual described by Subsection (a) who chooses to participate in the program is subject to the cost-sharing requirements, including copayment and POWER account contribution requirements, of the program health benefit plan in which the individual is enrolled.

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

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

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

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

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

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

(f) An annual POWER account contribution must be paid by or on behalf of a participant monthly in installments that are at least equal to one-twelfth of the total required contribution. The coverage period for a participant whose annual household income exceeds 100 percent of the federal poverty level may not begin until the first day of the first month following the month in which the first monthly installment is received.

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

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

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

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

(A) completion of a health risk assessment;

(B) smoking cessation; and

(C) as applicable, chronic disease management; and

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

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

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

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

(f) During the first coverage period of a participant who uses one or more tobacco products, a program health benefit plan provider shall actively attempt to engage the participant in and

provide educational materials to the participant on:

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

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

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

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

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

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

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

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

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

POWER 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 POWER account contributions in accordance with this subchapter, the commission shall calculate the amount to be rolled over to a subsequent coverage period POWER account from the participant's current coverage period POWER account based on:

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

(2) the total amount of money the participant contributed to the participant's POWER 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 POWER account for the succeeding coverage period to offset required annual POWER account contributions, as applicable, during that coverage period.

(e) A participant enrolled in the basic plan who rolls over money into the participant's POWER 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 POWER account contributions for that coverage period.

Sec. 537A.0257. REFUND. If at the end of a participant's

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

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

(1) the 181st day after the disenrollment date; 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) the commission disenrolls 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

(2) seeks and obtains private health benefit coverage within 12 months following the date of disenrollment.

(b) To receive health care financial assistance under this subchapter, a participant must provide to the commission, in the form and manner the commission requires, documentation showing the participant has obtained or is actively seeking private health benefit coverage.

(c) The commission may not impose an upper income eligibility limit on a participant to receive health care financial assistance under this subchapter.

Sec. 537A.0352. DURATION AND AMOUNT OF HEALTH CARE FINANCIAL ASSISTANCE. (a) A participant described by Section 537A.0351 may receive health care financial assistance under this subchapter until the first anniversary of the date the commission disenrolled the participant from a program health benefit plan.

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

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

(2) may be used only to pay for eligible services described by Section 537A.0354.

Sec. 537A.0353. BRIDGE ACCOUNT; FUNDING. (a) The commission shall establish a bridge account for each participant eligible to receive health care financial assistance under Section 537A.0351. The account is funded with money the commission contributes in accordance with this section.

(b) The commission shall enable each participant for whom the commission establishes a bridge account 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:

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

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

(3) under Subsection (e).

(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 POWER 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 the commission establishes a bridge account 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 the participant obtains 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.

CHAPTER 537B. EXPANDED MEDICAID ELIGIBILITY FOR CERTAIN INDIVIDUALS

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

Sec. 537B.0002. EXPANDED MEDICAID ELIGIBILITY UNDER

PATIENT PROTECTION AND AFFORDABLE CARE ACT. (a) Except as provided by Subsection (b) and notwithstanding any other law, the commission shall provide Medicaid benefits to all individuals who apply for those benefits and to whom this chapter applies.

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

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

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

(c) The commission shall:

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

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

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

SECTION 2. 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 federal Centers for Medicare and Medicaid Services or another appropriate federal agency the waiver as required by Section 537A.0051, Government Code, as added by this Act. The commission may delay implementing other provisions of Chapter 537A, Government Code, as added by this Act, until the waiver applied for under that section is granted.

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

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

SECTION 4. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as

provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2023.