

By: Delisi

H.B. No. 2404

A BILL TO BE ENTITLED

AN ACT

1
2 relating to the operation and financing of the medical assistance
3 program and other programs to provide health care benefits and
4 services to persons in this state.

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

6 SECTION 1. (a) Subchapter B, Chapter 531, Government Code,
7 is amended by adding Sections 531.094, 531.0941, 531.097, and
8 531.0971 to read as follows:

9 Sec. 531.094. PILOT PROGRAM TO PROMOTE HEALTHY LIFESTYLES.

10 (a) The commission shall develop and implement a pilot program in
11 one region of this state under which Medicaid recipients are
12 provided incentives to lead healthy lifestyles, including through
13 participating in certain health-related programs or engaging in
14 certain health-conscious behaviors, thereby resulting in better
15 health outcomes for those recipients.

16 (b) Except as provided by Subsection (c), in implementing
17 the pilot program, the commission may provide:

18 (1) expanded health care benefits or value-added
19 services for Medicaid recipients who participate in certain
20 programs, such as specified weight loss or smoking cessation
21 programs;

22 (2) individual health rewards accounts that allow
23 Medicaid recipients who follow certain disease management
24 protocols to receive money deposits into the accounts that may be

1 used to purchase health-related items specified by the commission
2 that are not covered by Medicaid; and

3 (3) any other incentive the commission determines
4 would promote healthy lifestyles and improve health outcomes for
5 Medicaid recipients.

6 (c) The commission shall consider similar incentive
7 programs implemented in other states to determine the most
8 cost-effective measures to implement in the pilot program under
9 this section.

10 (d) Not later than December 1, 2010, the commission shall
11 submit a report to the legislature that:

12 (1) describes the operation of the pilot program;

13 (2) analyzes the effect of the incentives provided
14 under the pilot program on the health of program participants; and

15 (3) makes recommendations regarding the continuation
16 or expansion of the pilot program.

17 (e) This section expires September 1, 2011.

18 Sec. 531.0941. MEDICAID HEALTH SAVINGS ACCOUNT PILOT
19 PROGRAM. If the commission determines that it is feasible, the
20 commission shall develop and implement a Medicaid health savings
21 account pilot program that is consistent with federal law to:

22 (1) encourage health care cost awareness and
23 sensitivity; and

24 (2) promote appropriate utilization of Medicaid
25 services by recipients.

26 Sec. 531.097. TAILORED BENEFIT PACKAGES FOR CERTAIN
27 CATEGORIES OF THE MEDICAID POPULATION. (a) The executive

1 commissioner may seek a waiver under Section 1115 of the federal
2 Social Security Act (42 U.S.C. Section 1315) to develop and
3 implement tailored benefit packages designed to:

4 (1) provide Medicaid benefits that are customized to
5 meet the health care needs of recipients within defined categories
6 of the Medicaid population through a defined system of care;

7 (2) improve health outcomes for those recipients;

8 (3) improve those recipients' access to services;

9 (4) achieve cost containment and efficiency; and

10 (5) reduce the administrative complexity of
11 delivering Medicaid benefits.

12 (b) Except as provided by Subsection (c) and subject to the
13 terms of the waiver authorized by this section, the commission has
14 broad discretion to develop the tailored benefit packages under
15 this section and determine the respective categories of Medicaid
16 recipients to which the packages apply in a manner that preserves
17 recipients' access to necessary services and is consistent with
18 federal requirements.

19 (c) Each tailored benefit package developed under this
20 section must include:

21 (1) a basic set of benefits that are provided under all
22 tailored benefit packages; and

23 (2) to the extent applicable to the category of
24 Medicaid recipients to which the package applies:

25 (A) a set of benefits customized to meet the
26 health care needs of recipients in that category; and

27 (B) services to integrate the management of a

1 recipient's acute and long-term care needs, to the extent feasible.

2 (d) A tailored benefit package developed under this section
3 may include any service available under the state Medicaid plan or
4 under any federal Medicaid waiver, including any preventive health
5 or wellness service.

6 (e) In developing the tailored benefit packages, the
7 commission shall consider similar benefit packages established in
8 other states as a guide.

9 (f) The executive commissioner, by rule, shall define each
10 category of recipients to which a tailored benefit package applies
11 and a mechanism for appropriately placing recipients in specific
12 categories. Recipient populations to which a package applies may
13 include:

- 14 (1) persons with disabilities or special health needs;
15 (2) elderly persons;
16 (3) children; and
17 (4) working-age parents and caretaker relatives.

18 Sec. 531.0971. TAILORED BENEFIT PACKAGES FOR NON-MEDICAID
19 POPULATIONS. (a) The commission shall identify state or federal
20 non-Medicaid programs that provide health care services to persons
21 whose health care needs could be met by providing customized
22 benefits through a system of care that is used under a
23 Medicaid-tailored benefit package implemented under Section
24 531.097.

25 (b) If the commission determines that it is feasible and to
26 the extent permitted by federal and state law, the commission
27 shall:

1 (1) provide the health care services for persons
2 identified under Subsection (a) through the applicable
3 Medicaid-tailored benefit package; and

4 (2) if appropriate or necessary to provide the
5 services as required by Subdivision (1), develop and implement a
6 system of blended funding methodologies to provide the services in
7 that manner.

8 (b) Not later than September 1, 2008, the Health and Human
9 Services Commission shall implement the pilot program under Section
10 531.094, Government Code, as added by this section.

11 SECTION 2. (a) Subchapter C, Chapter 531, Government Code,
12 is amended by adding Section 531.1112 to read as follows:

13 Sec. 531.1112. STUDY CONCERNING INCREASED USE OF TECHNOLOGY
14 TO STRENGTHEN FRAUD DETECTION AND DETERRENCE; IMPLEMENTATION. (a)
15 The commission and the commission's office of inspector general
16 shall jointly study the feasibility of increasing the use of
17 technology to strengthen the detection and deterrence of fraud in
18 the state Medicaid program. The study must include the
19 determination of the feasibility of using technology to verify a
20 person's citizenship and eligibility for coverage.

21 (b) The commission shall implement any methods the
22 commission and the commission's office of inspector general
23 determine are effective at strengthening fraud detection and
24 deterrence.

25 (b) Not later than December 1, 2008, the Health and Human
26 Services Commission shall submit to the legislature a report
27 detailing the findings of the study required by Section 531.1112,

1 Government Code, as added by this section. The report must include
2 a description of any method described by Section 531.1112(b),
3 Government Code, as added by this section, that the commission has
4 implemented or intends to implement.

5 SECTION 3. (a) Chapter 531, Government Code, is amended by
6 adding Subchapter N to read as follows:

7 SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL

8 Sec. 531.501. DIRECTION TO OBTAIN FEDERAL WAIVER FOR POOLED

9 FUNDS. (a) The executive commissioner may seek a waiver under
10 Section 1115 of the federal Social Security Act (42 U.S.C. Section
11 1315) to the state Medicaid plan to allow the commission to more
12 efficiently and effectively use federal money paid to this state
13 under various programs to defray costs associated with providing
14 uncompensated health care in this state by:

15 (1) depositing that federal money and, to the extent
16 necessary, state money, into a pooled fund established in the state
17 treasury outside the general revenue fund; and

18 (2) using the money for purposes consistent with this
19 subchapter.

20 (b) The federal money the executive commissioner may seek
21 approval to pool includes:

22 (1) money provided under the disproportionate share
23 hospitals and upper payment limit supplemental payment programs;

24 (2) money provided by the federal government in lieu
25 of some or all of the payments under those programs;

26 (3) any combination of funds described by Subdivisions
27 (1) and (2); and

1 (4) any other federal money available for that
2 purpose.

3 (c) The terms of a waiver approved under this section must:

4 (1) include safeguards to ensure that the total amount
5 of federal money in the pooled fund and any federal money provided
6 under the disproportionate share hospitals and upper payment limit
7 supplemental payment programs that is not included in the pooled
8 fund is, for a particular state fiscal year, at least equal to the
9 amount provided to this state under those supplemental payment
10 programs during state fiscal year 2007;

11 (2) allow for the development by this state of a
12 methodology for allocating money in the pooled fund to:

13 (A) offset, in part, the uncompensated health
14 care costs incurred by hospitals; and

15 (B) reduce the number of uninsured persons in
16 this state; and

17 (3) if possible, include an annual adjustment to the
18 amount of upper payment limit supplemental payment program money
19 provided to this state to account for inflation and population
20 growth.

21 (d) The executive commissioner shall seek to obtain in a
22 waiver under this section maximum flexibility with respect to using
23 the money in the pooled fund for purposes consistent with this
24 subchapter.

25 Sec. 531.502. ESTABLISHMENT OF TEXAS HEALTH OPPORTUNITY
26 POOL. Subject to approval of the waiver authorized by Section
27 531.501, the Texas health opportunity pool is established in

1 accordance with the terms of that waiver as an account in the state
2 treasury outside the general revenue fund. Money in the pool may be
3 used only for purposes consistent with this subchapter and the
4 terms of the waiver.

5 Sec. 531.503. USE OF TEXAS HEALTH OPPORTUNITY POOL IN
6 GENERAL; RULES FOR ALLOCATION. (a) Except as otherwise provided by
7 the terms of a waiver authorized by Section 531.501, money in the
8 Texas health opportunity pool may be used:

9 (1) subject to Section 531.504, to provide
10 reimbursements to health care providers that:

11 (A) are based on the providers' costs related to
12 providing uncompensated care; and

13 (B) compensate the providers for at least a
14 portion of those costs;

15 (2) to reduce the number of persons in this state who
16 do not have health benefits coverage;

17 (3) to reduce the need for uncompensated health care
18 provided by hospitals in this state; and

19 (4) for any other purpose specified by this subchapter
20 or the waiver.

21 (b) On approval of the waiver, the executive commissioner by
22 rule shall develop a methodology for allocating money in the pool.
23 The methodology must be consistent with the terms of the waiver.

24 Sec. 531.504. REIMBURSEMENTS FOR UNCOMPENSATED HEALTH CARE
25 COSTS. (a) Except as otherwise provided by the terms of a waiver
26 authorized by Section 531.501 and subject to Subsections (b) and
27 (c), money in the Texas health opportunity pool may be allocated to

1 hospitals and counties in this state to defray the costs of
2 providing uncompensated health care in this state.

3 (b) To be eligible for money from the pool under this
4 section, a hospital or county must use a portion of the money to
5 implement strategies that will reduce the need for uncompensated
6 inpatient and outpatient care, including care provided in a
7 hospital emergency room. Strategies that may be implemented by a
8 county or hospital, as applicable, include:

9 (1) fostering improved access for patients to primary
10 care systems or other programs that offer those patients medical
11 homes, including the following programs:

12 (A) three share or multiple share programs;

13 (B) programs to provide premium subsidies for
14 health benefits coverage; and

15 (C) other programs to increase access to health
16 benefits coverage; and

17 (2) creating health care systems efficiencies, such as
18 using electronic medical records systems.

19 (c) The allocation methodology adopted by the executive
20 commissioner under Section 531.503(b) must specify the percentage
21 of the money from the pool allocated to a hospital or county that
22 the hospital or county must use for strategies described by
23 Subsection (b).

24 Sec. 531.505. INCREASING ACCESS TO HEALTH BENEFITS
25 COVERAGE. (a) Except as otherwise provided by the terms of a
26 waiver authorized by Section 531.501, money in the Texas health
27 opportunity pool that is available to reduce the number of persons

1 in this state who do not have health benefits coverage or to reduce
2 the need for uncompensated health care provided by hospitals in
3 this state may be used for purposes relating to increasing access to
4 health benefits coverage for low-income persons, including:

5 (1) providing premium payment assistance to those
6 persons through a premium payment assistance program developed
7 under this section; and

8 (2) making contributions to health savings accounts
9 for those persons.

10 (b) The commission and the Texas Department of Insurance
11 shall jointly develop a premium payment assistance program designed
12 to assist persons described by Subsection (a) in obtaining and
13 maintaining health benefits coverage. The program may provide
14 assistance in the form of payments for all or part of the premiums
15 for that coverage. In developing the program, the executive
16 commissioner shall adopt rules establishing:

17 (1) eligibility criteria for the program;

18 (2) the amount of premium payment assistance that will
19 be provided under the program; and

20 (3) the process by which that assistance will be paid.

21 (c) The commission shall implement the premium payment
22 assistance program developed under Subsection (b), subject to
23 appropriations for that purpose.

24 Sec. 531.506. INFRASTRUCTURE IMPROVEMENTS. (a) Except as
25 otherwise provided by the terms of a waiver authorized by Section
26 531.501 and subject to Subsection (c), money in the Texas health
27 opportunity pool may be used for purposes related to developing and

1 implementing initiatives to improve the infrastructure of local
2 provider networks that provide services to Medicaid recipients and
3 low-income uninsured persons in this state.

4 (b) Infrastructure improvements under this section may
5 include developing and implementing a system for maintaining
6 medical records in an electronic format.

7 (c) Not more than 10 percent of the total amount of the money
8 in the pool used in a state fiscal year for purposes other than
9 providing reimbursements to hospitals for uncompensated health
10 care may be used for infrastructure improvements described by
11 Subsection (b).

12 (b) The Health and Human Services Commission shall:

13 (1) identify health care related state and local funds
14 and program expenditures that are not, on the effective date of this
15 Act, being matched with federal money; and

16 (2) explore the feasibility of certifying or otherwise
17 using those funds and expenditures as state expenditures for which
18 this state may receive federal payments under the disproportionate
19 share hospitals and upper payment limit supplemental payment
20 programs instead of using money received by this state through
21 intergovernmental transfers for that purpose.

22 SECTION 4. (a) Chapter 531, Government Code, is amended by
23 adding Subchapter O to read as follows:

24 SUBCHAPTER O. UNCOMPENSATED HOSPITAL CARE

25 Sec. 531.551. UNCOMPENSATED HOSPITAL CARE REPORTING AND
26 ANALYSIS. (a) The executive commissioner shall adopt rules
27 providing for:

1 (1) a standard definition of "uncompensated hospital
2 care";

3 (2) a methodology to be used by hospitals in this state
4 to compute the cost of that care that incorporates the standard set
5 of adjustments described by Section 531.552(g)(4); and

6 (3) procedures to be used by those hospitals to report
7 the cost of that care to the commission and to analyze that cost.

8 (b) The rules adopted by the executive commissioner under
9 Subsection (a)(3) may provide for procedures by which the
10 commission may periodically verify the completeness and accuracy of
11 the information reported by hospitals.

12 Sec. 531.552. WORK GROUP ON UNCOMPENSATED HOSPITAL
13 CARE. (a) In this section, "work group" means the work group on
14 uncompensated hospital care.

15 (b) The executive commissioner shall establish the work
16 group on uncompensated hospital care to assist the executive
17 commissioner in developing rules required by Section 531.551 by
18 performing the functions described by Subsection (g).

19 (c) The executive commissioner shall determine the number
20 of members of the work group. The executive commissioner shall
21 ensure that the work group includes representatives from the office
22 of the attorney general and the hospital industry. A member of the
23 work group serves at the will of the executive commissioner.

24 (d) The executive commissioner shall designate a member of
25 the work group to serve as presiding officer. The members of the
26 work group shall elect any other necessary officers.

27 (e) The work group shall meet at the call of the executive

1 commissioner.

2 (f) A member of the work group may not receive compensation
3 for serving on the work group but is entitled to reimbursement for
4 travel expenses incurred by the member while conducting the
5 business of the work group as provided by the General
6 Appropriations Act.

7 (g) The work group shall study and advise the executive
8 commissioner in:

9 (1) identifying the number of different reports
10 required to be submitted to the state that address uncompensated
11 hospital care, care for low-income uninsured persons in this state,
12 or both;

13 (2) standardizing the definitions used to determine
14 uncompensated hospital care for purposes of those reports;

15 (3) improving the tracking of hospital charges, costs,
16 and adjustments as those charges, costs, and adjustments relate to
17 identifying uncompensated hospital care and maintaining a
18 hospital's tax-exempt status;

19 (4) developing and applying a standard set of
20 adjustments to a hospital's initial computation of the cost of
21 uncompensated hospital care that account for all funding streams
22 that:

23 (A) are not patient-specific; and

24 (B) are used to offset the hospital's initially
25 computed amount of uncompensated care;

26 (5) developing a standard and comprehensive center for
27 data analysis and reporting with respect to uncompensated hospital

1 care; and

2 (6) analyzing the effect of the standardization of the
3 definition of uncompensated hospital care and the computation of
4 its cost, as determined in accordance with the rules adopted by the
5 executive commissioner, on the laws of this state, and analyzing
6 potential legislation to incorporate the changes made by the
7 standardization.

8 (b) The executive commissioner of the Health and Human
9 Services Commission shall:

10 (1) establish the work group on uncompensated hospital
11 care required by Section 531.552, Government Code, as added by this
12 section, not later than October 1, 2007; and

13 (2) adopt the rules required by Section 531.551,
14 Government Code, as added by this section, not later than March 1,
15 2008.

16 (c) The executive commissioner of the Health and Human
17 Services Commission shall review the methodology used under the
18 Medicaid disproportionate share hospitals supplemental payment
19 program to compute low-income utilization costs to ensure that
20 standardized adjustments to uncompensated care costs described by
21 Section 531.552(g)(4), Government Code, as added by this Act, and
22 adopted by the executive commissioner are consistent with that
23 methodology.

24 SECTION 5. (a) Subchapter A, Chapter 533, Government Code,
25 is amended by adding Section 533.019 to read as follows:

26 Sec. 533.019. VALUE-ADDED SERVICES. The commission shall
27 actively encourage managed care organizations that contract with

1 the commission to offer benefits, including health care services or
2 benefits or other types of services, that:

3 (1) are in addition to the services ordinarily covered
4 by the managed care plan offered by the managed care organization;
5 and

6 (2) have the potential to improve the health status of
7 enrollees in the plan.

8 (b) The changes in law made by Section 533.019, Government
9 Code, as added by this Act, apply to a contract between the Health
10 and Human Services Commission and a managed care organization under
11 Chapter 533, Government Code, that is entered into or renewed on or
12 after the effective date of this section. The commission shall seek
13 to amend contracts entered into with managed care organizations
14 under that chapter before the effective date of this Act to
15 authorize those managed care organizations to offer value-added
16 services to enrollees in accordance with Section 533.019,
17 Government Code, as added by this section.

18 SECTION 6. Section 32.0422, Human Resources Code, is
19 amended to read as follows:

20 Sec. 32.0422. HEALTH INSURANCE PREMIUM PAYMENT
21 REIMBURSEMENT PROGRAM FOR MEDICAL ASSISTANCE RECIPIENTS. (a) In
22 this section:

23 (1) "Commission" ["Department"] means the Health and
24 Human Services Commission [Texas Department of Health].

25 (2) "Executive commissioner" means the executive
26 commissioner of the Health and Human Services Commission.

27 (3) "Group health benefit plan" means a plan described

1 by Section 1207.001, Insurance Code.

2 (b) The commission [~~department~~] shall identify individuals,
3 otherwise entitled to medical assistance, who are eligible to
4 enroll in a group health benefit plan, but are not eligible for the
5 medical assistance opt-out program if that program is implemented
6 under Section 32.04221. The commission [~~department~~] must include
7 individuals eligible for or receiving health care services under a
8 Medicaid managed care delivery system.

9 (b-1) To assist the commission in identifying individuals
10 described by Subsection (b):

11 (1) the commission shall include on an application for
12 medical assistance and on a form for recertification of a
13 recipient's eligibility for medical assistance:

14 (A) an inquiry regarding whether the applicant or
15 recipient, as applicable, is eligible to enroll in a group health
16 benefit plan; and

17 (B) a statement informing the applicant or
18 recipient, as applicable, that reimbursements for required
19 premiums and cost-sharing obligations under the group health
20 benefit plan may be available to the applicant or recipient; and

21 (2) not later than the 15th day of each month, the
22 office of the attorney general shall provide to the commission the
23 name, address, and social security number of each newly hired
24 employee reported to the state directory of new hires operated
25 under Chapter 234, Family Code, during the previous calendar month.

26 (c) The commission [~~department~~] shall require an individual
27 requesting medical assistance or a recipient, during the

1 recipient's eligibility recertification review, to provide
2 information as necessary relating to any [~~the availability of a~~]
3 group health benefit plan that is available to the individual or
4 recipient through an employer of the individual or recipient or an
5 employer of the individual's or recipient's spouse or parent to
6 assist the commission in making the determination required by
7 Subsection (d).

8 (d) For an individual identified under Subsection (b), the
9 commission [~~department~~] shall determine whether it is
10 cost-effective to enroll the individual in the group health benefit
11 plan under this section.

12 (e) If the commission [~~department~~] determines that it is
13 cost-effective to enroll the individual in the group health benefit
14 plan, the commission [~~department~~] shall:

15 (1) require the individual to apply to enroll in the
16 group health benefit plan as a condition for eligibility under the
17 medical assistance program; and

18 (2) provide written notice to the issuer of the group
19 health benefit plan in accordance with Chapter 1207, Insurance
20 Code.

21 (e-1) This subsection applies only to an individual who is
22 identified under Subsection (b) as being eligible to enroll in a
23 group health benefit plan offered by the individual's employer. If
24 the commission determines under Subsection (d) that enrolling the
25 individual in the group health benefit plan is not cost-effective,
26 but the individual prefers to enroll in that plan instead of
27 receiving benefits and services under the medical assistance

1 program, the commission, if authorized by a waiver obtained under
2 federal law, shall:

3 (1) allow the individual to enroll in the plan;

4 (2) consider that individual to be a recipient of
5 medical assistance; and

6 (3) provide written notice to the issuer of the group
7 health benefit plan in accordance with Chapter 1207, Insurance
8 Code.

9 (f) Except as provided by Subsection (f-1), the commission
10 [The department] shall provide for payment of:

11 (1) the employee's share of required premiums for
12 coverage of an individual enrolled in the group health benefit
13 plan; and

14 (2) any deductible, copayment, coinsurance, or other
15 cost-sharing obligation imposed on the enrolled individual for an
16 item or service otherwise covered under the medical assistance
17 program.

18 (f-1) For an individual described by Subsection (e-1) who
19 enrolls in a group health benefit plan, the commission shall
20 provide for payment of the employee's share of the required
21 premiums, except that if the employee's share of the required
22 premiums exceeds the Medicaid premium rate for the individual, as
23 determined by the executive commissioner, the individual shall pay
24 the difference between the required premiums and the Medicaid
25 premium rate. In addition, subject to federal law, the individual
26 shall pay all deductibles, copayments, coinsurance, and other
27 cost-sharing obligations imposed on the individual under the group

1 health benefit plan.

2 (g) A payment made by the commission [~~department~~] under
3 Subsection (f) or (f-1) is considered to be a payment for medical
4 assistance.

5 (h) A payment of a premium for an individual who is a member
6 of the family of an individual enrolled in a group health benefit
7 plan under Subsection (e) [~~this section~~] and who is not eligible for
8 medical assistance is considered to be a payment for medical
9 assistance for an eligible individual if:

10 (1) enrollment of the family members who are eligible
11 for medical assistance is not possible under the plan without also
12 enrolling members who are not eligible; and

13 (2) the commission [~~department~~] determines it to be
14 cost-effective.

15 (i) A payment of any deductible, copayment, coinsurance, or
16 other cost-sharing obligation of a family member who is enrolled in
17 a group health benefit plan in accordance with Subsection (h) and
18 who is not eligible for medical assistance:

19 (1) may not be paid under this chapter; and

20 (2) is not considered to be a payment for medical
21 assistance for an eligible individual.

22 (i-1) The commission shall make every effort to expedite
23 payments made under this section, including by ensuring that those
24 payments are made through electronic transfers of money to the
25 recipient's account at a financial institution, if possible. In
26 lieu of reimbursing the individual enrolled in the group health
27 benefit plan for required premium or cost-sharing payments made by

1 the individual, the commission may, if feasible:

2 (1) make payments under this section for required
3 premiums directly to the employer providing the group health
4 benefit plan in which an individual is enrolled; or

5 (2) make payments under this section for required
6 premiums and cost-sharing obligations directly to the group health
7 benefit plan issuer.

8 (j) The commission [~~department~~] shall treat coverage under
9 the group health benefit plan as a third party liability to the
10 program. Enrollment of an individual in a group health benefit plan
11 under this section does not affect the individual's eligibility for
12 medical assistance benefits, except that the state is entitled to
13 payment under Sections 32.033 and 32.038.

14 (k) The commission [~~department~~] may not require or permit an
15 individual who is enrolled in a group health benefit plan under this
16 section to participate in the Medicaid managed care program under
17 Chapter 533, Government Code, or a Medicaid managed care
18 demonstration project under Section 32.041.

19 ~~(l) [The Texas Department of Human Services shall provide~~
20 ~~information and otherwise cooperate with the department as~~
21 ~~necessary to ensure the enrollment of eligible individuals in the~~
22 ~~group health benefit plan under this section.~~

23 ~~[(n)]~~ The executive commissioner [~~department~~] shall adopt
24 rules as necessary to implement this section.

25 SECTION 7. Subchapter B, Chapter 32, Human Resources Code,
26 is amended by adding Section 32.04221 to read as follows:

27 Sec. 32.04221. MEDICAL ASSISTANCE OPT-OUT PROGRAM. (a) In

1 this section:

2 (1) "Commission" means the Health and Human Services
3 Commission.

4 (2) "Executive commissioner" means the executive
5 commissioner of the Health and Human Services Commission.

6 (3) "Group health benefit plan" means a plan described
7 by Section 1207.001, Insurance Code.

8 (b) The commission shall seek a waiver from an appropriate
9 federal agency under which a person who is eligible for or is a
10 recipient of medical assistance and who is a member of a population
11 of recipients specified in the waiver may choose to opt out of
12 receiving services under the medical assistance program and instead
13 enroll in a group health benefit plan offered by an employer.

14 (c) The commission shall ensure that participation by a
15 person in the opt-out program is on a voluntary basis, and the
16 commission may not require any person to opt out of receiving
17 medical assistance services.

18 (d) Consistent with the terms of the waiver, for a
19 participant in the opt-out program who enrolls in a group health
20 benefit plan offered by an employer, the commission shall provide
21 for payment of the employee's share of the required premiums,
22 except that if the employee's share of the required premiums
23 exceeds the Medicaid premium rate for the participant, as
24 determined by the executive commissioner, the participant shall pay
25 the difference between the required premiums and the Medicaid
26 premium rate. In addition, the participant shall pay all
27 deductibles, copayments, coinsurance, and other cost-sharing

1 obligations imposed on the participant under the group health
2 benefit plan.

3 (e) Except as limited by the terms of the waiver, a
4 participant in the opt-out program is limited to the health
5 benefits coverage provided under the health benefits plan in which
6 the participant enrolls. The participant may not receive any
7 benefits or services under the medical assistance program other
8 than the premium payment as provided by Subsection (d).

9 (f) A person who is eligible for or is a recipient of medical
10 assistance and who is a member of a population of recipients who are
11 eligible for the opt-out program, as determined under the terms of
12 the waiver, is not eligible to participate in the health insurance
13 premium payment assistance program under Section 32.0422.

14 SECTION 8. Subchapter B, Chapter 32, Human Resources Code,
15 is amended by adding Section 32.0641 to read as follows:

16 Sec. 32.0641. COST SHARING FOR CERTAIN HIGH-COST MEDICAL
17 SERVICES. (a) If the department determines that it is feasible and
18 cost-effective, and to the extent permitted under Title XIX, Social
19 Security Act (42 U.S.C. Section 1396 et seq.) and any other
20 applicable law or regulation or under a federal waiver or other
21 authorization, the executive commissioner of the Health and Human
22 Services Commission shall adopt cost-sharing provisions that
23 require a recipient who chooses a high-cost medical service when a
24 medically acceptable, lower-cost medical service is available to
25 pay a copayment or premium payment for the high-cost medical
26 service.

27 (b) A medical service is considered a high-cost medical

1 service for purposes of this section if the service is provided
2 through a hospital emergency room. The executive commissioner by
3 rule shall determine other medical services that are high-cost
4 medical services for purposes of this section.

5 SECTION 9. (a) The heading to Subtitle C, Title 2, Health
6 and Safety Code, is amended to read as follows:

7 SUBTITLE C. PROGRAMS PROVIDING [~~INDIGENT~~] HEALTH CARE BENEFITS AND
8 SERVICES

9 (b) Subtitle C, Title 2, Health and Safety Code, is amended
10 by adding Chapter 76 to read as follows:

11 CHAPTER 76. MULTIPLE SHARE PROGRAM

12 SUBCHAPTER A. GENERAL PROVISIONS

13 Sec. 76.001. DEFINITIONS. In this chapter:

14 (1) "Commission" means the Health and Human Services
15 Commission.

16 (2) "Employee" means an individual who is employed by
17 an employer for compensation. The term includes a partner of a
18 partnership and the proprietor of a sole proprietorship.

19 (3) "Employer" means a person who employs one or more
20 employees.

21 (4) "Executive commissioner" means the executive
22 commissioner of the Health and Human Services Commission.

23 (5) "Multiple share program" means an
24 employer-sponsored commercial insurance product or noninsurance
25 health benefit plan funded by a combination of:

26 (A) employer contributions;

27 (B) employee cost sharing; and

1 (C) public or philanthropic funds.

2 (6) "Partnering entity" means a local entity that
3 partners with the commission to obtain funding for a multiple share
4 program.

5 (7) "Public share" means the portion of the cost of a
6 multiple share program comprised of public funds.

7 [Sections 76.002-76.050 reserved for expansion]

8 SUBCHAPTER B. AUTHORITY OF COMMISSION; METHODS OF FUNDING

9 Sec. 76.051. MULTIPLE SHARE PROGRAM. A local entity may
10 propose a multiple share program to the commission and may, subject
11 to rules adopted under Section 76.103, act as a partnering entity.

12 Sec. 76.052. FUNDING. The commission may seek a waiver from
13 the Centers for Medicare and Medicaid Services or another
14 appropriate federal agency to use Medicaid or child health plan
15 program funds to finance the public share of a multiple share
16 program. The commission may cooperate with a partnering entity to
17 finance the public share.

18 Sec. 76.053. AUTHORITY TO DETERMINE SCOPE. The commission
19 may determine if a multiple share program proposed by a partnering
20 entity should be local, regional, or statewide in scope. The
21 commission shall base this determination on:

22 (1) appropriate methods to meet the needs of the
23 uninsured community; and

24 (2) federal guidance.

25 Sec. 76.054. METHOD OF FINANCE. If the legislature does not
26 appropriate sufficient money from the general revenue to fund a
27 multiple share program, a partnering entity may use the following

1 types of funding to maximize this state's receipt of available
2 federal matching funds provided through Medicaid and the child
3 health plan:

4 (1) local funds made available to this state through
5 intergovernmental transfers from local governments; and

6 (2) certified public expenditures.

7 [Sections 76.055-76.100 reserved for expansion]

8 SUBCHAPTER C. COST OF PROGRAM; CONTRIBUTION OF SHARES

9 Sec. 76.101. CONTRIBUTION OF SHARES. A multiple share
10 program may require that:

11 (1) each participating employer contribute at least
12 one-third of the cost of coverage; and

13 (2) this state or a political subdivision of this
14 state contribute not more than one-third of the cost of coverage.

15 Sec. 76.102. COST SHARING. Subject to applicable federal
16 law, an employee who participates in a multiple share program may be
17 required to pay:

18 (1) a share of the premium;

19 (2) copayments;

20 (3) coinsurance; and

21 (4) deductibles.

22 Sec. 76.103. STANDARDS AND PROCEDURES. The executive
23 commissioner by rule shall:

24 (1) define the types of local entities that may be
25 partnering entities;

26 (2) determine eligibility criteria for participating
27 employers and employees;

1 (3) determine a minimum benefit package for multiple
2 share programs that offer noninsurance health benefit plans;

3 (4) determine methods for limiting substitution of
4 coverage in multiple share programs of partnering entities;

5 (5) determine methods for limiting adverse selection
6 in multiple share programs of partnering entities; and

7 (6) determine how a multiple share program participant
8 may continue program coverage if the participant leaves the
9 employment of a participating employer or becomes ineligible due to
10 income.

11 (c) Not later than January 1, 2008, the executive
12 commissioner of the Health and Human Services Commission shall
13 adopt rules and procedures necessary to implement the multiple
14 share program created by Chapter 76, Health and Safety Code, as
15 added by this section. In adopting the rules and procedures, the
16 executive commissioner may consult with the Texas Department of
17 Insurance.

18 (d) This section takes effect immediately if this Act
19 receives a vote of two-thirds of all the members elected to each
20 house, as provided by Section 39, Article III, Texas Constitution.
21 If this Act does not receive the vote necessary for this section to
22 have immediate effect, this section takes effect September 1, 2007.

23 SECTION 10. (a) In this section, "committee" means the
24 committee on health and long-term care insurance incentives.

25 (b) The committee on health and long-term care insurance
26 incentives is established to study and develop recommendations
27 regarding methods by which this state may reduce the need for

1 residents of this state to rely on the Medicaid program by providing
2 incentives for employers to provide health insurance, long-term
3 care insurance, or both, to their employees.

4 (c) The committee on health and long-term care insurance
5 incentives is composed of:

6 (1) the presiding officers of:

7 (A) the Senate Health and Human Services
8 Committee;

9 (B) the House Committee on Public Health;

10 (C) the Senate State Affairs Committee; and

11 (D) the House Committee on Insurance;

12 (2) three public members, appointed by the governor,
13 who collectively represent the diversity of businesses in this
14 state, including diversity with respect to:

15 (A) the geographic regions in which those
16 businesses are located;

17 (B) the types of industries in which those
18 businesses are engaged; and

19 (C) the sizes of those businesses, as determined
20 by number of employees; and

21 (3) the following ex officio members:

22 (A) the comptroller;

23 (B) the commissioner of insurance; and

24 (C) the executive commissioner of the Health and
25 Human Services Commission.

26 (d) The committee shall elect a presiding officer from the
27 committee members and shall meet at the call of the presiding

1 officer.

2 (e) The committee shall study and develop recommendations
3 regarding incentives this state may provide to employers to
4 encourage those employers to provide health insurance, long-term
5 care insurance, or both, to employees who would otherwise rely on
6 the Medicaid program to meet their health and long-term care needs.
7 In conducting the study, the committee shall:

8 (1) examine the feasibility and determine the cost of
9 providing incentives through:

10 (A) the franchise tax under Chapter 171, Tax
11 Code, including allowing exclusions from an employer's total
12 revenue of insurance premiums paid for employees, regardless of
13 whether the employer chooses under Section 171.101(a)(1)(B)(ii),
14 Tax Code, as effective January 1, 2008, to subtract cost of goods
15 sold or compensation for purposes of determining the employer's
16 taxable margin;

17 (B) deductions from or refunds of other taxes
18 imposed on the employer; and

19 (C) any other means, as determined by the
20 committee; and

21 (2) for each incentive the committee examines under
22 Subdivision (1) of this subsection, determine the impact that
23 implementing the incentive would have on reducing the number of
24 individuals in this state who do not have private health or
25 long-term care insurance coverage, including individuals who are
26 Medicaid recipients.

27 (f) Not later than September 1, 2008, the committee shall

1 submit to the Senate Health and Human Services Committee, the House
2 Committee on Public Health, the Senate State Affairs Committee, and
3 the House Committee on Insurance a report regarding the results of
4 the study required by this section. The report must include a
5 detailed description of each incentive the committee examined and
6 determined is feasible and, for each of those incentives, specify:

7 (1) the anticipated cost associated with providing
8 that incentive;

9 (2) any statutory changes needed to implement the
10 incentive; and

11 (3) the impact that implementing the incentive would
12 have on reducing:

13 (A) the number of individuals in this state who
14 do not have private health or long-term care insurance coverage;
15 and

16 (B) the number of individuals in this state who
17 are Medicaid recipients.

18 SECTION 11. (a) The Health and Human Services Commission
19 shall conduct a study regarding the feasibility and
20 cost-effectiveness of developing and implementing an integrated
21 Medicaid managed care model designed to improve the management of
22 care provided to Medicaid recipients who are aging, blind, or
23 disabled or have chronic health care needs and are not enrolled in a
24 managed care plan offered under a capitated Medicaid managed care
25 model, including recipients who reside in:

26 (1) rural areas of this state; or

27 (2) urban or surrounding areas in which the Medicaid

1 Star + Plus program or another capitated Medicaid managed care
2 model is not available.

3 (b) Not later than September 1, 2008, the commission shall
4 submit a report regarding the results of the study to the standing
5 committees of the senate and house of representatives having
6 primary jurisdiction over the Medicaid program.

7 SECTION 12. If before implementing any provision of this
8 Act a state agency determines that a waiver or authorization from a
9 federal agency is necessary for implementation of that provision,
10 the agency affected by the provision shall request the waiver or
11 authorization and may delay implementing that provision until the
12 waiver or authorization is granted.

13 SECTION 13. Except as otherwise provided by this Act, this
14 Act takes effect September 1, 2007.