By: Nelson S.B. No. 10

A BILL TO BE ENTITLED

AN ACT

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

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

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

Sec. 531.094. PILOT PROGRAM TO PROMOTE HEALTHY LIFESTYLES. (a) The commission shall develop and implement a pilot program in one region of this state under which Medicaid recipients are provided incentives to lead healthy lifestyles, including through participating in certain health-related programs or engaging in certain health-conscious behaviors, thereby resulting in better health outcomes for those recipients.

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

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

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

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

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

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

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

(1) describes the operation of the pilot program;

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

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

(e) This section expires September 1, 2011.

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

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

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

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

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

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

(2) improve health outcomes for those recipients;

(3) improve those recipients' access to services;

(4) achieve cost containment and efficiency; and

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

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

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

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

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

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

(B) services to integrate the management of a

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

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

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

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

(1) persons with disabilities or special health needs;

(2) elderly persons;

(3) children; and

(4) working-age parents and caretaker relatives.

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

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER N. TEXAS HEALTH OPPORTUNITY POOL

Sec. 531.501. DIRECTION TO OBTAIN FEDERAL WAIVER FOR POOLED FUNDS. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to the state Medicaid plan to allow the commission to more efficiently and effectively use federal money paid to this state under various programs to defray costs associated with providing uncompensated health care in this state by:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) three share or multiple share programs;

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

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

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

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

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

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

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

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

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

(1) eligibility criteria for the program;

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

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

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

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

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

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

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

(b) The Health and Human Services Commission shall:

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

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

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

SUBCHAPTER O. UNCOMPENSATED HOSPITAL CARE

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

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

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

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

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

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

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

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

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

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

commissioner.

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

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

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

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

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

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

(A) are not patient-specific; and

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

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

care; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

by Section 1207.001, Insurance Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

health benefit plan.

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

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

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

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

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

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

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

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

the individual, the commission may, if feasible:

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

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

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

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

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

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

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

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

this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 76. MULTIPLE SHARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 76.001. DEFINITIONS. In this chapter:

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

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

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

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

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

(A) employer contributions;

(B) employee cost sharing; and

(C) public or philanthropic funds.

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

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

[Sections 76.002-76.050 reserved for expansion]

SUBCHAPTER B. AUTHORITY OF COMMISSION; METHODS OF FUNDING

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

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

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

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

(2) federal guidance.

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

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

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

(2) certified public expenditures.

[Sections 76.055-76.100 reserved for expansion]

SUBCHAPTER C. COST OF PROGRAM; CONTRIBUTION OF SHARES

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

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

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

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

(1) a share of the premium;

(2) copayments;

(3) coinsurance; and

(4) deductibles.

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

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

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

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

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

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

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

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

(d) This section takes effect immediately if this Act 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 this section to have immediate effect, this section takes effect September 1, 2007.

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

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

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

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

(1) the presiding officers of:

(A) the Senate Health and Human Services Committee;

(B) the House Committee on Public Health;

(C) the Senate State Affairs Committee; and

(D) the House Committee on Insurance;

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

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

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

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

(3) the following ex officio members:

(A) the comptroller;

(B) the commissioner of insurance; and

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

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

officer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) rural areas of this state; or

(2) urban or surrounding areas in which the Medicaid

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

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

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

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