

**Report  
on  
Senate Bill 10, Section 25  
Eightieth Legislature, Regular Session**

**Healthy Texas  
Phase II Report**



**Submitted by the  
Texas Department of Insurance**

## **INTRODUCTION**

On June 1, 2009, the 81st Texas Legislature passed a bill to create Healthy Texas – a market-based program to assist commercial carriers in providing affordable health care coverage to working Texans and their families.<sup>1</sup>

Healthy Texas legislation was based on recommendations made by the Texas Department of Insurance (TDI) in the Healthy Texas Phase I Report submitted in November 2008. In the Phase I report<sup>2</sup>, the Department laid out a rationale and status report for Healthy Texas, building on six years of federally funded research at TDI to evaluate the health care and insurance coverage desires and concerns of Texas small employers and their employees. Preliminary recommendations were to:

- Enable the health insurance market to lower premium costs for certain small employers by creating a state-funded reinsurance system;
- Make reinsurance supported health insurance products available through other publicly supported programs aimed at lowering health insurance premiums, such as regional or local health care programs, Medicaid Health Opportunity Pool participants and any premium assistance programs that may be created; and
- Provide a comprehensive, sustainable program that creates a unique public/private partnership of insurers, providers, agents, employers, employees, local government and the state.

The following report describes the Healthy Texas program as defined by legislation and presents preliminary steps for the program to become open to enrollment in Summer 2010.

## **HEALTHY TEXAS**

Healthy Texas creates a new public/private health insurance initiative to provide lower-cost health insurance to uninsured Texans within the small employer market. It has the potential to provide insurance to a significant portion of the 5.9 million Texans currently without health insurance.

### ***Targets Small Employers Without Health Insurance***

For the past ten years, the state of Texas has had the highest uninsured rate in the nation – nearly 80 percent higher than the national average. In 2007, an estimated 5.9 million Texans had no insurance throughout the entire year. As shown in Figure 1, most uninsured adults (69 percent) in Texas are employed. Of the remaining uninsured, only five percent are considered unemployed (i.e., are not actively looking for work). The remaining 26 percent are not in the labor force, including parents who are taking care of children, early retirees who no longer work, non-working college students, adults caring

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<sup>1</sup>For text of Healthy Texas legislation see Appendix 1 or full Senate Bill (SB) 78 legislation online at: [www.legis.state.tx.us/tlodocs/81R/billtext/doc/sb00078f.doc](http://www.legis.state.tx.us/tlodocs/81R/billtext/doc/sb00078f.doc)

<sup>2</sup> <http://www.tdi.state.tx.us/reports/life/documents/hlthytxph1rpt08.pdf>

for aging parents, individuals who are disabled and unable to work and other adults who for various reasons are not working or looking for work.<sup>3</sup>

**Figure 1**

**Texas Uninsured Rates by Employment Status**

<b>Employment Status</b>	<b>% of Total Uninsured</b>
Employed	69%
Unemployed	5%
Not in Labor Force	26%

Source: US Census Bureau, Current Population Survey (Texas Sample), 2008.

Texas workers in small firms are more likely to be uninsured than employees working for larger firms (those with 100 or more employees). Nearly one-third (31 percent) of uninsured Texas adults are employed in firms of fewer than 10 workers; a total of 59 percent work in firms of fewer than 100 employees. While nearly all large firms offer insurance, a quarter of the uninsured adults are employed in firms with 500 or more workers. Many of these workers are not eligible for health insurance coverage because they work too few hours or are considered temporary.<sup>4</sup>

As in most other states, most Texans with health insurance have it through their employers. However, in Texas only 57 percent of the population has employer-sponsored insurance, compared to the national average of 68 percent. Although most states have experienced declining rates of employer-sponsored coverage in recent years, the decline in Texas is more pronounced: since 2001, the percentage of Texans with employer coverage has dropped from 59 percent to the current rate of 50 percent, a 16 percent decrease in 6 years. More recent economic events and tighter financial resources will further exacerbate this trend.<sup>5</sup>

***Reinsurance Maximizes State Funds, Provides Needed Financial Relief and Economic Development Opportunities for Small Employers***

Healthy Texas is targeted at those small employers not currently offering health insurance coverage to their employees, allowing the state to use limited public funds to increase health care coverage among workers who have not previously had the option to purchase employer-sponsored health insurance. This statewide program creates a state-funded reinsurance pool to pay for a portion of high enrollee costs.

The reinsurance model is based on the fact that a small percentage of people account for most health insurance claims costs. Reducing commercial insurers' responsibility for high-cost claims allows them to provide lower cost insurance for the large majority of enrollees who have low health care costs. This approach was implemented by New York State in 2001 for uninsured individuals and businesses and has been highly successful.

<sup>3</sup> US Census Bureau, Current Population Survey (Texas Sample), 2008.

<sup>4</sup> Agency for Healthcare Research and Quality, 2006 Medical Expenditure Panel Survey - Insurance Component.

<sup>5</sup> US Census Bureau, Current Population Survey (Texas Sample), 2008.

Like New York’s program, Healthy Texas enrollees will select from a variety of state-approved private market health plans. From the enrollee’s perspective, the health plan will operate like any private market plan. However, as shown in Figure 2, the state-funded Healthy Texas reinsurance program will pay for 80 percent of the claims costs if an individual’s total claims fall between \$5,000 and \$75,000 in a calendar year. The health plan will cover 100 percent of claims below the \$5,000 threshold and above \$75,000, up to the annual benefit limit. The health plan also covers the remaining 20 percent of costs between the \$5,000 and \$75,000 risk corridor.

**Figure 2**  
**Healthy Texas**

Per Person Annual Claims Costs	Responsibility
\$75,000+	Private insurer pays 100%
\$5,000-75,000	Healthy Texas pays 80% Private insurer pays 20%
\$0-\$5,000	Private insurer pays 100%

By reducing the insurer’s exposure to high-cost claims, reinsurance allows for a significant reduction (estimated to be about one-third) in Healthy Texas premium costs for currently uninsured small businesses and their workers. It will also protect insurers and small employers from the ruinous impact of catastrophic illness in small businesses. Healthy Texas will increase both the affordability and the availability of insurance as more insurers will be willing and able to offer affordable products to small employers. In addition, for an employer to qualify, Healthy Texas requires that only 60 percent of an employer’s eligible employees participate as opposed to the current standard of 75 percent participation. This change should make it easier for employers to obtain the minimum number of employees needed to qualify for participation.

A reinsurance approach allows the state to leverage both public and private funds. It minimizes additional administrative costs by building on the existing employer-based health insurance model. Healthy Texas will also foster economic development within the state by helping small employers attract better employees and enabling them to keep workers healthy by providing access to quality health plans at an affordable price.

**DEVELOPMENT OF HEALTHY TEXAS**

***Stakeholder Involvement***

The development and design of the Healthy Texas program, as it was finally adopted by the Texas Legislature, was greatly informed by input from a statewide group of stakeholders, including providers (such as the Texas Medical Association and the Texas Hospital Association), insurance carriers and health maintenance organizations (including

the Texas Association of Health Plans), insurance agents (such as the Texas Association of Health Underwriters), employers, local chambers of commerce across the state and various consumer organizations. (See Appendix 1 for a summary of stakeholder feedback from meetings held in November and December 2008.)

The continued support and involvement of these stakeholders and others will facilitate statewide implementation of Healthy Texas and ensure the program is successful in reaching its maximum enrollment potential.

### *Analysis*

To develop Healthy Texas as a flexible program to meet a diversity of needs, TDI solicited the input and ongoing involvement of a key working group, including representatives from the Governor's office, the Lieutenant Governor's office, the Speaker's office, other legislative offices, the Health and Human Services Commission (HHSC) and the University of Texas, Lyndon B. Johnson (LBJ) School of Public Affairs.

A rigorous analytic approach informed the development of the program. A summary of the major analytic milestones follows:

- In June 2007, the 80<sup>th</sup> Texas Legislature enacted Senate Bill (SB) 10, a comprehensive bill to evaluate critical changes to the health care system in Texas and to ultimately increase the number of Texans with access to primary and preventive care through health insurance coverage. Specifically, SB 10 directed the Department to issue a report that included recommendations for a program under which small employer health plan coverage would be offered.
- To begin the analysis laid out in the SB 10 Healthy Texas provision, the Department decided to build on six years of research conducted through the federally funded State Planning Grant (SPG), including small employer surveys and focus groups. The results of that study provided a starting point for development of recommendations to the Legislature.
- As a next step, the Department designed a benefit plan that took into consideration lessons learned through the SPG, HHSC's experience in designing a low-cost health benefit plan and input from regional programs.
- In addition, through analysis of other state programs to reduce the number of uninsured, the Department determined that publicly funded reinsurance would be an effective tool to accomplish the goal of lowering premiums through a market-based solution
- Next, the Department completed an actuarial analysis of various plan design options. Senate Bill 10 allowed the commissioner to contract with actuaries and other experts as necessary to conduct the study. Through the summer and fall of 2008, TDI and the LBJ School of Public Affairs worked together with the actuarial firm, Milliman, Inc., to develop and analyze options for the Healthy Texas proposal.

## **THE PROGRAM**

### ***Administration***

Healthy Texas was structured to require minimal administrative oversight to keep costs low. The Department is the state agency responsible for implementing and administering the program. TDI will oversee the reinsurance system and perform administrative operations while commercial carriers will provide the health plans.

### ***Benefit Design***

As required in legislation, the Healthy Texas benefit package must include:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Prescription drug benefits

Healthy Texas legislation gives TDI the authority to establish benefit design parameters for the program. The benefit package outlined in Appendix 3 was used for actuarial analysis conducted during program development. The actual benefit packaged offered through Healthy Texas may differ.

By law, Healthy Texas benefit plans are exempt from certain mandated benefit requirements. Consistent with current market requirements, a preexisting condition provision will be included in benefit plans offered through the program.

### ***Rating***

One of the purposes of Healthy Texas as outlined in legislation is to provide small employers with access to quality health benefit plans at an affordable price. To meet the goal of affordability, commercial insurers participating in Healthy Texas must agree to a modified community rating practice, wherein rates vary only according to the age and gender of the group participants. In addition, benefit plans offered by private insurers must be offered at a cost that reflects the reduced financial risk incurred as a result of the reinsurance funds. Healthy Texas premiums are subject to TDI approval.

### ***Employer Qualifications***

To ensure that the program reaches those employers and employees that are currently uninsured, eligibility for the program is limited according to the following parameters:

- The employer must qualify as a small business with between 2-50 employees
- An employer must not have provided group insurance 12 months prior to application to Healthy Texas
- At least 30 percent of employees must receive annual wages at or below 300 percent of the federal poverty level
- The employer must pay at least 50 percent of the premium cost for employees
- At least 60 percent of eligible employees must elect to participate in the program

As program experience is gained, Healthy Texas eligibility could be expanded to other groups. Specifically, it is possible that Healthy Texas may provide coverage for low

income Texans under the proposed Health Opportunity Pool (HOP) pending Centers for Medicare and Medicaid Services (CMS) approval. Healthy Texas may also be available to TexHealth Coalition three-share programs, individuals and sole-proprietors.

Applications from eligible small employers may be received throughout the year until maximum program enrollment levels are reached. The eligibility parameters described above are one way to limit enrollment and lower the overall cost of the program to the state. In addition, Healthy Texas may cap enrollment in the early years of the program to allow for some flexibility as experience is gained and to guard against unexpected losses.

Similar to the commercial small group market, once small employers become part of Healthy Texas, the initial enrollment period for their employees must be at least 31 days, with a 31-day open enrollment period provided at least once a year, subject to adjustment as needed.

### ***Funding***

The 81<sup>st</sup> Legislature provided \$17.4 million in annual reinsurance funding and \$171,000 for limited administrative, development and outreach funding over the biennium. The Department, in cooperation with HHSC, submitted an application for additional federal funding to further support the successful implementation of Healthy Texas.

### ***Implementation Date***

Efforts are currently underway to establish Healthy Texas. Enrollment is planned for the summer of 2010.

### ***Next Steps***

Throughout the summer and fall, TDI will be working with stakeholders and actuarial consultants to develop the health plan participation request for proposal (RFP). Ongoing stakeholder involvement is critical to the success of the RFP process. In mid-July, TDI will hold a meeting in Austin to solicit stakeholder input into implementation plans and development of the RFP. Future meetings will be scheduled periodically as needed to ensure continued stakeholder involvement and provide program updates.

# Appendix 1 - Healthy Texas Portion of Senate Bill 78

## ARTICLE 2. HEALTHY TEXAS PROGRAM

SECTION 2.01. Subtitle G, Title 8, Insurance Code, is amended by adding Chapter 1508 to read as follows:

### CHAPTER 1508. HEALTHY TEXAS PROGRAM

#### SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1508.001. PURPOSE. (a) The purposes of the Healthy Texas Program are to:

(1) provide access to quality small employer health benefit plans at an affordable price;

(2) encourage small employers to offer health benefit plan coverage to employees and the dependents of employees; and

(3) maximize reliance on proven managed care strategies and procedures.

(b) The Healthy Texas Program is not intended to diminish the availability of traditional small employer health benefit plan coverage under Chapter 1501.

Sec. 1508.002. DEFINITIONS. In this chapter:

(1) "Dependent" has the meaning assigned by Section 1501.002(2).

(2) "Eligible employee" has the meaning assigned by Section 1501.002(3).

(3) "Fund" means the healthy Texas small employer premium stabilization fund established under Subchapter F.

(4) "Health benefit plan" and "health benefit plan issuer" have the meanings assigned by Sections 1501.002(5) and 1501.002(6), respectively.

(5) "Program" means the Healthy Texas Program established under this chapter.

(6) "Qualifying health benefit plan" means a health benefit plan that provides benefits for health care services in the manner described by this chapter.

(7) "Small employer" has the meaning assigned by Section 1501.002(14).

Sec. 1508.003. RULES. The commissioner may adopt rules as necessary to implement this chapter.

[Sections 1508.004-1508.050 reserved for expansion]

#### SUBCHAPTER B. EMPLOYER ELIGIBILITY; CONTRIBUTIONS

Sec. 1508.051. EMPLOYER ELIGIBILITY TO PARTICIPATE. (a) A small employer may participate in the program if:

(1) during the 12-month period immediately preceding the date of application for a qualifying health benefit plan, the small employer does not offer employees group health benefits on an expense-reimbursed or prepaid basis; and

(2) at least 30 percent of the small employer's eligible employees receive annual wages from the employer in an amount that is equal to or less than 300 percent of the poverty guidelines for an individual, as defined and updated annually by the United States Department of Health and Human Services.

(b) A small employer ceases to be eligible to participate in the program if any health benefit plan that provides employee benefits on an expense-reimbursed or prepaid basis, other than another qualifying health benefit plan, is purchased or otherwise takes effect after the purchase of a qualifying health benefit plan.

Sec. 1508.052. COMMISSIONER ADJUSTMENTS AUTHORIZED. (a) The commissioner by rule may adjust the 12-month period described by Section 1508.051(a)(1) to an 18-month period if the commissioner determines that the 12-month period is insufficient to prevent inappropriate substitution of other health benefit plans for qualifying health benefit plan coverage under this chapter.

(b) The commissioner by rule may adjust the percentage of the poverty guidelines described by Section 1508.051(a)(2) to a higher or lower percentage if the commissioner determines that the adjustment is necessary to fulfill the purposes of this chapter. An adjustment made by the commissioner under this subsection takes effect on the first July 1 following the adjustment.

Sec. 1508.053. MINIMUM EMPLOYER PARTICIPATION REQUIREMENTS. A small employer that meets the eligibility requirements described by Section 1508.051(a) may apply to purchase a qualifying health benefit plan if 60 percent or more of the employer's eligible employees elect to participate in the plan.

Sec. 1508.054. EMPLOYER CONTRIBUTION REQUIREMENTS. (a) A small employer that purchases a qualifying health benefit plan must:

(1) pay 50 percent or more of the premium for each employee covered under the qualifying health benefit plan;

(2) offer coverage to all eligible employees receiving annual wages from the employer in an amount described by Section 1508.051(a)(2) or 1508.052(b), as applicable; and

(3) contribute the same percentage of premium for each covered employee.

(b) A small employer that purchases a qualifying health benefit plan under the program may elect to pay, but is not required to pay, all or any portion of the premium paid for dependent coverage under the qualifying health benefit plan.

[Sections 1508.055-1508.100 reserved for expansion]

SUBCHAPTER C. PROGRAM PARTICIPATION; REQUIRED COVERAGE AND BENEFITS

Sec. 1508.101. PARTICIPATING PLAN ISSUERS. (a) Subject to Subsection (b), any health benefit plan issuer may participate in the program.

(b) The commissioner by rule may limit which health benefit plan issuers may participate in the program if the commissioner determines that the limitation is necessary to achieve the purposes of this chapter.

(c) If the commissioner limits participation in the program under Subsection (b), the commissioner shall contract on a competitive procurement basis with one or more health benefit plan issuers to provide qualifying health benefit plan coverage under the program.

(d) Nothing in this chapter prohibits a regional or local health care program described by Chapter 75, Health and Safety Code, from participating in the program. The commissioner by rule shall establish participation requirements applicable to regional and local health care programs that consider the unique plan designs, benefit levels, and participation criteria of each program.

Sec. 1508.102. PREEXISTING CONDITION PROVISION REQUIRED. A health benefit plan offered under the program must include a preexisting condition provision that meets the requirements described by Section 1501.102.

Sec. 1508.103. EXCEPTION FROM MANDATED BENEFIT REQUIREMENTS. Except as expressly provided by this chapter, a small employer health benefit plan issued under the program is not subject to a law of this state that requires coverage or the offer of coverage of a health care service or benefit.

Sec. 1508.104. CERTAIN COVERAGE PROHIBITED OR REQUIRED. (a) A qualifying health benefit plan may only provide coverage for in-plan services and benefits, except for:

- (1) emergency care; or
- (2) other services not available through a plan provider.

(b) In-plan services and benefits provided under a qualifying health benefit plan must include the following:

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) physician services; and
- (4) prescription drug benefits.

(c) The commissioner may approve in-plan benefits other than those required under Subsection (b) or emergency care or other services not available through a plan provider if the commissioner determines the inclusion to be essential to achieve the purposes of this chapter.

(d) The commissioner may, with respect to the categories of services and benefits described by Subsections (b) and (c):

- (1) prepare specifications for a coverage provided under this chapter;
- (2) determine the methods and procedures of claims administration;

(3) establish procedures to decide contested cases arising from coverage provided under this chapter;

(4) study, on an ongoing basis, the operation of all coverages provided under this chapter, including gross and net costs, administration costs, benefits, utilization of benefits, and claims administration;

(5) administer the healthy Texas small employer premium stabilization fund established under Subchapter F;

(6) provide the beginning and ending dates of coverages for enrollees in a qualifying health benefit plan;

(7) develop basic group coverage plans applicable to all individuals eligible to participate in the program;

(8) provide for optional group coverage plans in addition to the basic group coverage plans described by Subdivision (7);

(9) provide, as determined to be appropriate by the commissioner, additional statewide optional coverage plans;

(10) develop specific health benefit plans that permit access to high-quality, cost-effective health care;

(11) design, implement, and monitor health benefit plan features intended to discourage excessive utilization, promote efficiency, and contain costs for qualifying health benefit plans;

(12) develop and refine, on an ongoing basis, a health benefit strategy for the program that is consistent with evolving benefits delivery systems;

(13) develop a funding strategy that efficiently uses employer contributions to achieve the purposes of this chapter; and

(14) modify the copayment and deductible amounts for prescription drug benefits under a qualifying health benefit plan, if the commissioner determines that the modification is necessary to achieve the purposes of this chapter.

[Sections 1508.105-1508.150 reserved for expansion]

#### SUBCHAPTER D. PROGRAM ADMINISTRATION

Sec. 1508.151. EMPLOYER CERTIFICATION. (a) At the time of initial application, a health benefit plan issuer shall obtain from a small employer that seeks to purchase a qualifying health benefit plan a written certification that the employer meets the eligibility requirements described by Section 1508.051 and the minimum employer participation requirements described by Section 1508.053.

(b) Not later than the 90th day before the renewal date of a qualifying health benefit plan, a health benefit plan issuer shall obtain from the small employer that purchased the qualifying health benefit plan a written certification that the employer continues to meet the eligibility requirements described by Section 1508.051 and the minimum employer participation requirements described by Section 1508.053.

(c) A participating health benefit plan issuer may require a small employer to submit appropriate documentation in support of a certification described by Subsection (a) or (b).

Sec. 1508.152. APPLICATION PROCESS. (a) Subject to Subsection (b), a health benefit plan issuer shall accept applications for qualifying health benefit plan coverage from small employers at all times throughout the calendar year.

(b) The commissioner may limit the dates on which a health benefit plan issuer must accept applications for qualifying health benefit plan coverage if the commissioner determines the limitation to be necessary to achieve the purposes of this chapter.

Sec. 1508.153. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a) A qualifying health benefit plan must provide employees with an initial enrollment period that is 31 days or longer, and annually at least one open enrollment period that is 31 days or longer. The commissioner by rule may require an additional open enrollment period if the commissioner determines that the additional open enrollment period is necessary to achieve the purposes of this chapter.

(b) A small employer may establish a waiting period for employees during which an employee is not eligible for coverage under a qualifying health benefit plan. The last day of a waiting period established under this subsection may not be later than the 90th day after the date on which the employee begins employment with the small employer.

(c) A health benefit plan issuer may not deny coverage under a qualifying health benefit plan to a new employee of a small employer that purchased the qualifying health benefit plan if the health benefit plan issuer receives an application for coverage from the employee not later than the 31st day after the latter of:

(1) the first day of the employee's employment; or

(2) the first day after the expiration of a waiting period established under Subsection (b).

(d) Subject to Subsection (e), a health benefit plan issuer may deny coverage under a qualifying health benefit plan to an employee of a small employer who applies for coverage after the period described by Subsection (c).

(e) A health benefit plan issuer that denies an employee coverage under Subsection (d):

(1) may only deny the employee coverage until the next open enrollment period; and

(2) may subject the enrollee to a one-year preexisting condition provision, as described by Section 1508.102, if the period during which the preexisting condition provision applies does not exceed 18 months from the date of the initial application for coverage under the qualifying health benefit plan.

Sec. 1508.154. REPORTS. A health benefit plan issuer that participates in the program shall submit reports to the department in the form and at the time the commissioner prescribes.

[Sections 1508.155-1508.200 reserved for expansion]

#### SUBCHAPTER E. RATING OF QUALIFIED HEALTH BENEFIT PLANS

Sec. 1508.201. RATING; PREMIUM PRACTICES IN GENERAL. (a) A health benefit plan issuer participating in the program must:

(1) use rating practices for qualifying health benefit plans that are consistent with the purposes of this chapter; and

(2) in setting premiums for qualifying health benefit plans, consider the availability of reimbursement from the fund.

(b) A health benefit plan issuer participating in the program shall apply rating factors consistently with respect to all small employers in a class of business.

(c) Differences in premium rates charged for qualifying health benefit plans must be reasonable and reflect objective differences in plan design.

Sec. 1508.202. PREMIUM RATE DEVELOPMENT AND CALCULATION.

(a) Rating factors used to underwrite qualifying health benefit plans must produce premium rates for identical groups that:

(1) differ only by the amounts attributable to health benefit plan design;

and

(2) do not reflect differences because of the nature of the groups assumed to select a particular health benefit plan.

(b) A health benefit plan issuer shall treat each qualifying health benefit plan that is issued or renewed in a calendar month as having the same rating period.

(c) A health benefit plan issuer may use only age and gender as case characteristics, as defined by Section 1501.201(2), in setting premium rates for a qualifying health benefit plan.

(d) The commissioner by rule may establish additional rating criteria and requirements for qualifying health benefit plans if the commissioner determines that the criteria and requirements are necessary to achieve the purposes of this chapter.

Sec. 1508.203. FILING; APPROVAL. (a) A health benefit plan issuer shall file with the department, for review and approval by the commissioner, premium rates to be charged for qualifying health benefit plans.

(b) If the commissioner limits health benefit plan issuer participation in the program under Section 1508.101(b), premium rates proposed to be charged for each qualifying health benefit plan will be considered as an element in the contract procurement process required under that section.

[Sections 1508.204-1508.250 reserved for expansion]

SUBCHAPTER F. HEALTHY TEXAS SMALL EMPLOYER PREMIUM

STABILIZATION FUND

Sec. 1508.251. ESTABLISHMENT OF FUND. (a) To the extent that funds appropriated to the department are available for this purpose, the commissioner shall establish a fund from which health benefit plan issuers may receive reimbursement for claims paid by the health benefit plan issuers for individuals covered under qualifying group health plans.

(b) The fund established under this section shall be known as the healthy Texas small employer premium stabilization fund.

(c) The commissioner shall adopt rules necessary to implement and administer the fund, including rules that set out the procedures for operation of the fund and distribution of money from the fund.

Sec. 1508.252. OPERATION OF FUND; CLAIM ELIGIBILITY. (a) A health benefit plan issuer is eligible to receive reimbursement in an amount that is equal to 80 percent of the dollar amount of claims paid between \$5,000 and \$75,000 in a calendar year for an enrollee in a qualifying health benefit plan.

(b) A health benefit plan issuer is eligible for reimbursement from the fund only for the calendar year in which claims are paid.

(c) Once the dollar amount of claims paid on behalf of a covered individual reaches or exceeds \$75,000 in a given calendar year, a health benefit plan issuer may not receive reimbursement for any other claims paid on behalf of the individual in that calendar year.

Sec. 1508.253. REIMBURSEMENT REQUEST SUBMISSION. (a) A health benefit plan issuer seeking reimbursement from the fund shall submit a request for reimbursement in the form prescribed by the commissioner by rule.

(b) A health benefit plan issuer must request reimbursement from the fund annually, not later than the date determined by the commissioner, following the end of the calendar year for which the reimbursement requests are made.

(c) The commissioner may require a health benefit plan issuer participating in the program to submit claims data in connection with reimbursement requests as the commissioner determines to be necessary to ensure appropriate distribution of reimbursement funds and oversee the operation of the fund. The commissioner may require that the data be submitted on a per covered individual, aggregate, or categorical basis.

Sec. 1508.254. FUND AVAILABILITY. (a) The commissioner shall compute the total claims reimbursement amount for all health benefit plan issuers participating in the program for the calendar year for which claims are reported and reimbursement requested.

(b) If the total amount requested by health benefit plan issuers participating in the program for reimbursement for a calendar year exceeds the amount of funds available for distribution for claims paid during that same calendar year, the commissioner shall provide for the pro rata distribution of any available funds. A health benefit plan issuer participating in the program is eligible to receive a proportional amount of any available funds that is equal to the proportion of total eligible claims paid by all participating health benefit plan issuers that the requesting health benefit plan issuer paid.

(c) If the amount of funds available for distribution for claims paid by all health benefit plan issuers participating in the program during a calendar year exceeds the total amount requested for reimbursement by all participating health benefit plan issuers during that calendar year, the commissioner shall carry forward any excess funds and make those excess funds available for distribution in the next calendar year. Excess funds carried over under this section are added to the fund in addition to any other money appropriated for the fund for the calendar year into which the funds are carried forward.

Sec. 1508.255. PROGRAM REPORTING. (a) Each health benefit plan issuer participating in the program shall provide the department, in the form prescribed by the commissioner, monthly reports of total enrollment under qualifying health benefit plans.

(b) On the request of the commissioner, each health benefit plan issuer participating in the program shall furnish to the department, in the form prescribed by the commissioner, data other than data described by Subsection (a) that the commissioner determines necessary to oversee the operation of the fund.

Sec. 1508.256. CLAIMS EXPERIENCE DATA. (a) Based on available data and appropriate actuarial assumptions, the commissioner shall separately estimate the per covered individual annual cost of total claims reimbursement from the fund for qualifying health benefit plans.

(b) On request, a health benefit plan issuer participating in the program shall furnish to the department claims experience data for use in the estimates described by Subsection (a).

Sec. 1508.257. TOTAL ELIGIBLE ENROLLMENT DETERMINATION.  
(a) The commissioner shall determine total eligible enrollment under qualifying health

benefit plans by dividing the total funds available for distribution from the fund by the estimated per covered individual annual cost of total claims reimbursement from the fund.

(b) At the end of the first year of enrollment and annually thereafter, the commissioner shall submit a report to the governor and the legislature regarding enrollment for the previous year and limitations on future enrollment that ensure that the program does not necessitate a substantial increase in funding to continue the program, as consistent with Section 1508.001.

Sec. 1508.258. EVALUATION AND PROTECTION OF FUND; EMPLOYER ENROLLMENT SUSPENSION. (a) The commissioner shall suspend the enrollment of new employers in qualifying health benefit plans if the commissioner determines that the total enrollment reported by all health benefit plan issuers under qualifying health benefit plans exceeds the total eligible enrollment determined under Section 1508.257 and is likely to result in anticipated annual expenditures from the fund in excess of the total funds available for distribution from the fund.

(b) The commissioner shall provide a health benefit plan issuer participating in the program with notification of any enrollment suspension under Subsection (a) as soon as practicable after:

(1) receipt of all enrollment data; and

(2) determination of the need to suspend enrollment.

(c) A suspension of issuance of qualifying health benefit plans to employers under Subsection (a) does not preclude the addition of new employees of an employer

already covered under a qualifying health benefit plan or new dependents of employees already covered under a qualifying health benefit plan.

Sec. 1508.259. EMPLOYER ENROLLMENT REACTIVATION. If, at any point during a suspension of enrollment under Section 1508.258, the commissioner determines that funds are sufficient to provide for the addition of new enrollments, the commissioner:

(1) may reactivate new enrollments; and

(2) shall notify all participating group health benefit plan issuers that enrollment of new employers may be resumed.

Sec. 1508.260. FUND ADMINISTRATOR. (a) The commissioner may obtain the services of an independent organization to administer the fund.

(b) The commissioner shall establish guidelines for the submission of proposals by organizations for the purposes of administering the fund and may approve, disapprove, or recommend modification to the proposal of an applicant to administer the fund.

(c) An organization approved to administer the fund shall submit reports to the commissioner, in the form and at the times required by the commissioner, as necessary to facilitate evaluation and ensure orderly operation of the fund, including an annual report of the affairs and operations of the fund. The annual report must also be delivered to the governor, the lieutenant governor, and the speaker of the house of representatives.

(d) An organization approved to administer the fund shall maintain records in the form prescribed by the commissioner and make those records available for inspection by or at the request of the commissioner.

(e) The commissioner shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation is payable only from the fund.

(f) The commissioner may remove an organization approved to administer the fund from fund administration. An organization removed from fund administration under this subsection must cooperate in the orderly transition of services to another approved organization or to the commissioner.

Sec. 1508.261. STOP-LOSS INSURANCE; REINSURANCE. (a) The administrator of the fund, on behalf of and with the prior approval of the commissioner, may purchase stop-loss insurance or reinsurance from an insurance company licensed to write that coverage in this state.

(b) Stop-loss insurance or reinsurance may be purchased to the extent that the commissioner determines funds are available for the purchase of that insurance.

Sec. 1508.262. PUBLIC EDUCATION AND OUTREACH. (a) The commissioner may use an amount of the fund, not to exceed eight percent of the annual amount of the fund, for purposes of developing and implementing public education, outreach, and facilitated enrollment strategies targeted to small employers who do not provide health insurance.

(b) The commissioner shall solicit and accept recommendations concerning the development and implementation of education, outreach, and enrollment strategies under Subsection (a) from agents licensed under Title 13 to write health benefit plans in this state.

(c) The commissioner may contract with marketing organizations to perform or provide assistance with education, outreach, and enrollment strategies described by Subsection (a).

SECTION 2.02. The commissioner of insurance shall adopt any rules necessary to implement the change in law made by Chapter 1508, Insurance Code, as added by this article, not later than January 4, 2010.

SECTION 2.03. (a) The commissioner of insurance shall make an initial determination concerning limitation of health benefit plan issuer participation in the program established under Chapter 1508, Insurance Code, as added by this article, not later than January 18, 2010. If the commissioner determines that limited participation is necessary to achieve the purposes of Chapter 1508, Insurance Code, as added by this article, the commissioner shall issue a request for proposal from health benefit plan issuers to participate in the program not later than May 1, 2010.

(b) The commissioner of insurance shall ensure that the Healthy Texas Program is fully operational in a manner that allows health benefit plan issuers participating in the program to make the first annual request for reimbursement on January 1, 2011.

SECTION 2.04. This Act does not make an appropriation. This Act takes effect only if a specific appropriation for the implementation of the Act is provided in a general appropriations act of the 81st Legislature.

### ARTICLE 3. EFFECTIVE DATE

SECTION 3.01. This Act takes effect September 1, 2009.

## Appendix 2

### **STAKEHOLDER FEEDBACK**

In November and December 2008, TDI held meetings with key stakeholder groups to solicit input on a proposal for Healthy Texas. Five meetings held with consumers, carriers, providers, small employers and agents provided the Department with useful input on many facets of the Healthy Texas program. A summary of the feedback from those meetings is included below.

#### ***Overall Approach***

Appreciate State's willingness to create and provide funding for Healthy Texas, believing it shows a commitment to reducing the number of uninsured, working Texans. Most stakeholders agreed that the proposed approach presents a viable model for making health insurance more affordable for Texas small businesses.

#### ***Program Design***

Agree that Healthy Texas should be offered only to small businesses, believing that uninsured employees provide an excellent opportunity for Texas to begin to address the uninsured problem.

Most support using reinsurance to lower the cost of coverage to affordable levels; suggest that reinsurance band be trended up over time to account for medical inflation.

Some in the carrier community believe that community rating could potentially lead to adverse selection. However, carriers also expressed the opinion that eligibility requirements built into the program design could mitigate this.

Overall support for the benefit design for Healthy Texas. Many like that the benefit package is built on a commercial plan design that has already been demonstrated to be successful in the market place. Some expressed the opinion that adhering to a standard plan design could reduce adverse selection in the program.

Suggest regularly evaluating benefit package to ensure it is meeting participants' needs and that it is still in alignment with small group plans being offered in the marketplace.

#### ***Operations/Program Administration***

Concerns about the potential for administrative complexity were raised by providers and carriers. Both groups suggested that efforts be made to minimize the program's administrative costs by, for example, limiting reporting requirements.

#### ***Implementation***

Some suggest full, state-wide implementation, while a majority suggest implementation of a pilot program with limited carriers by region.

## Appendix 3

### BENEFIT PLAN DESIGN

The Healthy Texas benefit package would include in-patient, out-patient, maternity, behavioral health benefits with modest deductibles and out-of-pocket expenses comparable to plans offered in the commercial market. Actuarial analysis is based on the following benefit plan design. As Healthy Texas is implemented, the actual benefit package offered may differ, but the following provides a baseline benefit package for the program.

	Healthy Texas
<b>Plan Basics</b>	
Annual Deductible	\$500 (3x for family)
Coinsurance	20%
Out of Pocket Maximum (Including Deductible)	\$2,000
Annual Maximum Benefit per Person	\$300,000
<b>Hospital Benefits</b>	
Inpatient Hospital Stay	• Subject to ded/coins
Outpatient Hospital Surgery	• Subject to ded/coins
Hospital Outpatient Rad/Path and Diagnostic Tests	• Subject to ded/coins
Emergency Room Visits	• \$75 copay + subject to ded/coins • 50% of U&C for Out-of-Area
Maternity	• Subject to ded/coins • Inpatient Hospital benefits include Skilled Nursing Facility.
<b>Physician Benefits in IP / OP Facility</b>	
Inpatient Hospital Care	• Subject to ded/coins
Outpatient Hospital Care	• Subject to ded/coins
Radiology, Pathology	• Subject to ded/coins
<b>Physician Benefits in Office</b>	
Physician Office Visit Limit and Copays*	• Adults: first 2 visits, \$25 copay only • Children: first 6 visits, \$25 copay only • All remaining visits subject to ded/coins
*Types of Visits Included	• Office/Home Visits • Urgent Care Visits • Well Baby Exams • Physical Exams • Hearing/Speech Exams • Consults • Physical Therapy
Maternity	• \$25 for initial prenatal visit
Immunizations	• Covered at 100%
Vision Exams	• Not Covered
Chiropractor	• Not Covered
Podiatrist	• Not Covered
Radiology and Pathology Performed in Office Setting	• Subject to ded/coins
Miscellaneous medical services, including therapeutic injections, allergy testing, allergy immunotherapy, cardiovascular and other	• Subject to ded/coins
<b>Psychiatric and Substance Abuse Services</b>	
Inpatient	• Subject to ded/coins • Limited to 20 days/year
Outpatient	• \$40 copay for first 2 visits • All other visits subject to ded/coins • Limited to 20 visits/year (including first 2 visits at \$40)
<b>Other Services</b>	
Prescription Drugs	• \$200 deductible • Generics: \$10 copay (2x for mail order) or 30% coins, whichever is less • Brand: 30% coins • Annual maximum: none • Generic penalty if brand available (waived if DAW)
Ambulance	• Subject to ded/coins
Private Duty Nursing & Home Healthcare	• Not Covered
Durable Medical Equipment & Medical Supplies/Prosthetics	• Not Covered
Dental	• Not Covered
<b>Other Exclusions</b>	
Pre-Existing Condition Limitation	• Glasses/Contacts 6/12 Pre-existing condition limitation
Out-of-Network Benefits	• Not covered

## Appendix 4

### KEY DECISIONS FOLLOW-UP

The Healthy Texas Phase I Report included a Key Decisions matrix in the appendix. Decisions on most of the elements in this matrix have been addressed throughout this report, but it is included again in this appendix with decisions highlighted.

Options for Consideration	Implications for Decisions
<b>Administrative Oversight</b>	
<i>Who will oversee the reinsurance system and perform administrative operations?</i>	
<b>Decision</b>	
Texas Department of Insurance will oversee the reinsurance system and perform administrative options.	
Texas Department of Insurance	<ul style="list-style-type: none"> <li>●Has insurance experience and data collection capabilities that will be critical to monitoring the experience of the program</li> <li>●Program could be established relatively quickly if administered internally</li> <li>●Is positioned to regulate and oversee the provision of private health insurance benefits through the reinsurance program</li> <li>●Would have to contract for claims reimbursement system</li> <li>●Has no experience with operating such a program</li> </ul>
Health and Human Services Commission/Medicaid	<ul style="list-style-type: none"> <li>●Has Medicaid experience, but limited private insurance expertise</li> <li>●Has data collection capabilities that will be critical to monitoring the experience of the program</li> <li>●Program could be established relatively quickly using existing contractors</li> <li>●May be able to use existing contractors for various administrative functions</li> </ul>
Texas Health Insurance Risk Pool (THIRP)	<ul style="list-style-type: none"> <li>●Program could be established relatively quickly building on existing administrative infrastructure</li> <li>●THIRP has experience with individual enrollment, but not group</li> <li>●May be able to use existing contractor for various administrative functions</li> </ul>
Newly created entity	<ul style="list-style-type: none"> <li>●Would require creation of an entirely new organization, which could delay implementation</li> <li>●Provides an opportunity to create a unique organization that is singularly focused on the creation and oversight of the reinsurance program</li> </ul>
<b>Eligibility</b>	
<i>Who will be allowed to enroll in the program?</i>	
<b>Decision</b>	
To begin, Healthy Texas will be available to <b>small employer groups</b> . To ensure that the program reaches employers and employees currently uninsured, eligibility is limited according to the following parameters:	
<ul style="list-style-type: none"> <li>● No group health insurance 12 months prior to application</li> </ul>	

<ul style="list-style-type: none"> <li>• At least 30 percent of eligible employees receiving annual wages at or below 300 percent of non-farm federal poverty level</li> <li>• Employer must pay at least 50 percent of employee premium; not required to contribute to premium for dependent coverage</li> <li>• At least 60 percent of small employer's eligible employees must elect to participate</li> </ul>	
Small Employer groups	<ul style="list-style-type: none"> <li>•Should income eligibility requirements be based on individual employee's salary? Family salary?</li> <li>•All small groups (2-50), or only smallest groups (2-10 or 2-25)</li> <li>•Limit to currently uninsured?</li> <li>•Must be in business for minimum time period (12 months?)</li> <li>•May require a certain percentage of eligible employees to participate in order to qualify for program</li> </ul>
Sole Proprietors/Individuals	<ul style="list-style-type: none"> <li>•May increase risk of adverse selection</li> <li>•Sole proprietors often have difficulty buying coverage. In the Healthy New York reinsurance system, they represent the largest enrollment category</li> </ul> <p><u>Note:</u> In Healthy New York, individual enrollees had a higher medical loss ratio (88.5%) than small group enrollees (67.1%); Percentage of members reaching stop-loss threshold: 5.7% of small employer enrollees, 7.6% of sole proprietors; 7.2% of individuals</p>
Individuals	<ul style="list-style-type: none"> <li>•Would be a problem for insurers if program is guaranteed issuance</li> <li>•Allowing individuals increases risk of adverse selection and likely would result in higher reinsurance claims costs</li> <li>•To guard against adverse selection, the state could restrict eligibility for individuals to those without access to ESI</li> <li>•Would provide a more affordable opportunity than the Risk Pool</li> </ul>
<p><b>Enrollment Period</b>  <i>How frequently will plan be available for enrollment?</i></p>	
<p><b>Decision</b>  Eligible employers may apply for Healthy Texas coverage throughout the year until maximum enrollment levels are reached. Employees must be provided with an initial enrollment period that is 31 days or longer and annually at least one open enrollment period that is 31 days or longer, subject to adjustment as needed.</p>	
Continuous enrollment	<ul style="list-style-type: none"> <li>•Would provide opportunities for individuals to enroll at any time</li> <li>•Would provide less predictability</li> <li>•Would provide opportunity for continual growth</li> </ul>
Limited enrollment	<ul style="list-style-type: none"> <li>•Provides more predictability both for insurers and for state funding purposes</li> <li>•Limits growth; will prevent some employers from participating who do not initially enroll</li> </ul>
<p><b>Crowd Out Protections</b>  <i>How will the plan discourage employers from dropping existing coverage and joining Healthy</i></p>	

<i>Texas program?</i>	
<b>Decision</b> Employers must have been without coverage for one year before enrolling in Healthy Texas.	
Limit eligibility to those groups/individuals who have been uninsured for 6 or 12 months	<ul style="list-style-type: none"> <li>●Would discourage employers with existing coverage from dropping coverage to join <i>Healthy Texas</i></li> <li>●Could be perceived as a “reward” for those employers who have not been offering insurance and a penalty for those who have</li> <li>●Would create an unfair economic advantage for employers who qualify for program compared to those who do not because they already offer insurance</li> </ul>
Limit enrollment to certain group sizes	<ul style="list-style-type: none"> <li>●Could limit eligibility to all groups of 10 or fewer since these groups are the most likely to be uninsured and insurers often prefer not to insure the smaller groups</li> <li>●Would prevent crowd-out among groups of 11 or more employees, who are more likely to already offer coverage than smaller groups</li> </ul>
Provide incentives for employers who already offer coverage to continue with existing plan	<ul style="list-style-type: none"> <li>●Offer tax credits to qualified small employers who offer insurance to offset economic disadvantage</li> <li>●Provide subsidies for qualified low-income workers, but only if employer maintains existing coverage</li> </ul>
<b>Benefit Plan</b> <i>What benefits must be offered?</i>	
<b>Decision</b> A benefit plan approved by the Commissioner will be offered. Out-of-network benefits will be available for emergencies only and will be covered at 50 percent of usual and customary reimbursement levels. Additional catastrophic benefit coverage could be purchased by enrollees/employers.	
Create one or more standard plans	<ul style="list-style-type: none"> <li>●Reinsurance pricing will be dependent on the benefit plan structure; providing standard plans will simplify pricing process</li> <li>●Employers have indicated they prefer standardized, state-approved plans</li> </ul>
Allow any plan that meets minimum standards	<ul style="list-style-type: none"> <li>●Allowing multiple plans will appeal to insurers and agents</li> <li>●Multiple plans will create challenges in pricing and predicting claims for reinsurance payments</li> </ul>
<b>Rate Oversight</b> <i>In exchange for reinsurance protection, what rating requirements should be implemented?</i>	
<b>Decision</b> Private insurers will offer approved benefit plans at a cost that is affordable for the target population and reflects the availability of reinsurance funds for high cost claims. Premiums will be subject to approval by the Department.	
Limits on annual rate increases and/or minimum loss ratio requirements	<ul style="list-style-type: none"> <li>●Provides rate stability and predictability for employers</li> <li>●May discourage some carriers from participating</li> </ul>
<b>Insurer Participation</b> <i>How many and which insurers will participate in the program?</i>	

<b>Decision</b> Any licensed health benefit plan issuer that complies with the program participation requirements may participate in the program.	
Require participation of all insurers and/or HMOs that meet certain financial thresholds	<ul style="list-style-type: none"> <li>●Participants could be assigned randomly to insurer</li> <li>●Participants could choose which insurer they prefer</li> </ul>
Limit participation to a few selected insurers, based on bidding process	<ul style="list-style-type: none"> <li>●Insurers prefer large numbers – may increase support for program if only a few insurers are guaranteed a minimum enrollment and voluntary participation</li> <li>●Limiting the number of insurers will simplify operation of program</li> <li>●Limiting participation may discourage support/encourage opposition from some insurers</li> </ul>
<b>Agent Participation</b> <i>What role will insurance agents have in the program?</i>	
<b>Decision</b> Insurance agents will participate in the marketing and sale of Healthy Texas benefit plans.	
Include agents	<ul style="list-style-type: none"> <li>●Pay a commission based on percentage of premium or fixed fee per person</li> <li>●Provides an infrastructure for marketing, outreach and enrollment</li> <li>●Increases cost based on price of commission</li> </ul>
Exclude agents	<ul style="list-style-type: none"> <li>●May impact enrollment if agents are not involved in outreach</li> <li>●Will likely draw opposition from agents</li> <li>●Will save money normally paid for commissions</li> <li>●In surveys, employers have indicated they prefer to avoid agent and enroll directly on-line if possible</li> <li>●Agents play a valuable role in education, but may prefer to delegate that responsibility to the entity overseeing the program</li> </ul>
<b>Funding</b> <i>How will the reinsurance pool reserves be funded?</i>	
<b>Decision</b> The reinsurance fund is financed by General Revenue appropriations.	
General Revenue (GR)	<ul style="list-style-type: none"> <li>●GR appropriations could be used to establish the initial funding and continued thereafter or could be phased out over a pre-determined time period</li> </ul>
Premium Payments	<ul style="list-style-type: none"> <li>●Premiums for the purchase of reinsurance benefit plans will include partial funding for reinsurance coverage, subsidized with other funds to keep premiums affordable</li> </ul>
HOP contributions/participation	<ul style="list-style-type: none"> <li>●HOP funds could be used to provide reinsurance for HOP-eligible enrollees.</li> </ul>
Insurer payments	<ul style="list-style-type: none"> <li>●All insurers could be charged a reinsurance support fee based on a formula that reflects the insurers' profits or medical loss ratio. Fees would be deductible from premium tax payments</li> </ul>

Provider assessments	<ul style="list-style-type: none"> <li>● Providers – all types or specific types – could be required to pay a reinsurance support fee</li> </ul>
State-issued bonds	<ul style="list-style-type: none"> <li>● Structured similarly to the workers' compensation system when created, the state could issue bonds that would be paid back as reserve funds grow through investments</li> <li>● The risk of high claims and low yield investments may limit the ability of the reinsurance system to pay back bonds</li> </ul>