HEALTH AND SAFETY CODE

TITLE 2. HEALTH

SUBTITLE C. PROGRAMS PROVIDING HEALTH CARE BENEFITS AND SERVICES

CHAPTER 62. CHILD HEALTH PLAN FOR CERTAIN LOW-INCOME CHILDREN

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 62.001. OBJECTIVE OF THE STATE CHILD HEALTH PLAN. The principal objective of the state child health plan is to provide primary and preventative health care to low-income, uninsured children of this state, including children with special health care needs, who are not served by or eligible for other state assisted health insurance programs.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.002. DEFINITIONS. In this chapter:

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

(2) "Commissioner" means the commissioner of health and human services.

(3) "Health plan provider" means an insurance company, health maintenance organization, or other entity that provides health benefits coverage under the child health plan program. The term includes a primary care case management provider network.

(4) "Net family income" means the amount of income established for a family after reduction for offsets for child care expenses, in accordance with standards applicable under the Medicaid program.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.45, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1353, Sec. 1, eff. June 15, 2007.

Sec. 62.003. NOT AN ENTITLEMENT; TERMINATION OF PROGRAM.

(a) This chapter does not establish an entitlement to assistance in obtaining health benefits for a child.

(b) The program established under this chapter terminates at the time that federal funding terminates under Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, unless a successor program providing federal funding for a state-designed child health plan program is created.

(c) Unless the legislature authorizes the expenditure of other revenue for the program established under this chapter, the program terminates on the date that money obtained by the state as a result of the Comprehensive Settlement Agreement and Release filed in the case styled The State of Texas v. The American Tobacco Co., et al., No. 5-96CV-91, in the United States District Court, Eastern District of Texas, is no longer available to provide state funding for the program.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.004. FEDERAL LAW AND REGULATIONS. The commissioner shall monitor federal legislation affecting Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.) and changes to the federal regulations implementing that law. If the commissioner determines that a change to Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.) or the federal regulations implementing that law conflicts with this chapter, the commissioner shall report the changes to the governor, lieutenant governor, and speaker of the house of representatives, with recommendations for legislation necessary to implement the federal law or regulations, seek a waiver, or withdraw from participation.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

SUBCHAPTER B. ADMINISTRATION OF CHILD HEALTH PLAN PROGRAM

Sec. 62.051. DUTIES OF COMMISSION. (a) The commission shall develop a state-designed child health plan program to obtain health benefits coverage for children in low-income families. The commission shall ensure that the child health plan program is designed and administered in a manner that qualifies for federal funding under Title XXI of the Social Security Act (42 U.S.C.

Section 1397aa et seq.), as amended, and any other applicable law or regulations.

(b) The commission is the agency responsible for making policy for the child health plan program, including policy related to covered benefits provided under the child health plan. The commission may not delegate this duty to another agency or entity.

(c) The commission shall oversee the implementation of the child health plan program and coordinate the activities of each agency necessary to the implementation of the program, including the Texas Department of Health, Texas Department of Human Services, and Texas Department of Insurance.

(d) The commission shall adopt rules as necessary to implement this chapter. The commission may require the Texas Department of Health, the Texas Department of Human Services, or any other health and human services agency to adopt, with the approval of the commission, any rules that may be necessary to implement the program. With the consent of another agency, including the Texas Department of Insurance, the commission may delegate to that agency the authority to adopt, with the approval of the commission, any rules that may be necessary to implement the program.

(e) The commission shall conduct a review of each entity that enters into a contract under Section 62.055 or Section 62.155, to ensure that the entity is available, prepared, and able to fulfill the entity's obligations under the contract in compliance with the contract, this chapter, and rules adopted under this chapter.

(f) The commission shall ensure that the amounts spent for administration of the child health plan program do not exceed any limit on those expenditures imposed by federal law.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.052. DUTIES OF TEXAS DEPARTMENT OF HEALTH. (a) The commission may direct the Texas Department of Health to:

(1) implement contracts with health plan providers under Section 62.155;

(2) monitor the health plan providers, through

reporting requirements and other means, to ensure performance under the contracts and quality delivery of services;

(3) monitor the quality of services delivered to enrollees through outcome measurements including:

(A) rate of hospitalization for ambulatory sensitive conditions, including asthma, diabetes, epilepsy, dehydration, gastroenteritis, pneumonia, and UTI/kidney infection;

(B) rate of hospitalization for injuries;

(C) percent of enrolled adolescents reporting risky health behavior such as injuries, tobacco use, alcohol/drug use, dietary behavior, physical activity, or other health related behaviors; and

(D) percent of adolescents reporting attempted suicide; and

(4) provide payment under the contracts to the health plan providers.

(b) The commission, or the Texas Department of Health under the direction of and in consultation with the commission, shall adopt rules as necessary to implement this section.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.053. DUTIES OF TEXAS DEPARTMENT OF HUMAN SERVICES. (a) Under the direction of the commission, the Texas Department of Human Services may:

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

(2) resolve grievances relating to eligibility determinations; and

(3) coordinate the child health plan program with the Medicaid program.

(b) If the commission contracts with a third party administrator under Section 62.055, the commission may direct the Texas Department of Human Services to:

(1) implement the contract;

(2) monitor the third party administrator, through reporting requirements and other means, to ensure performance under

the contract and quality delivery of services; and

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

(c) The commission, or the Texas Department of Human Services under the direction of and in consultation with the commission, shall adopt rules as necessary to implement this section.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.054. DUTIES OF TEXAS DEPARTMENT OF INSURANCE. (a) At the request of the commission, the Texas Department of Insurance shall provide any necessary assistance with the development of the child health plan. The department shall monitor the quality of the services provided by health plan providers and resolve grievances relating to the health plan providers.

(b) The commission and the Texas Department of Insurance may adopt a memorandum of understanding that addresses the responsibilities of each agency in developing the plan.

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

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.055. CONTRACTS FOR IMPLEMENTATION OF CHILD HEALTH PLAN. (a) It is the intent of the legislature that the commission maximize the use of private resources in administering the child health plan created under this chapter. In administering the child health plan, the commission may contract with a third party administrator to provide enrollment and related services under the state child health plan.

(b), (c) Repealed by Acts 2003, 78th Leg., ch. 198, Sec. 2.156(a)(1).

(d) A third party administrator may perform tasks under the contract that would otherwise be performed by the Texas Department of Health or Texas Department of Human Services under this chapter.

(e) The commission shall:

(1) retain all policymaking authority over the state

child health plan;

(2) procure all contracts with a third party administrator through a competitive procurement process in compliance with all applicable federal and state laws or regulations; and

(3) ensure that all contracts with child health plan providers under Section 62.155 are procured through a competitive procurement process in compliance with all applicable federal and state laws or regulations.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.43, 2.156(a)(1), eff. Sept. 1, 2003.

Sec. 62.056. COMMUNITY OUTREACH CAMPAIGN; TOLL-FREE HOTLINE. (a) The commission shall conduct a community outreach and education campaign to provide information relating to the availability of health benefits for children under this chapter. The commission shall conduct the campaign in a manner that promotes enrollment in, and minimizes duplication of effort among, all state-administered child health programs.

(b) The community outreach campaign must include:

(1) outreach efforts that involve school-based health clinics;

(2) a toll-free telephone number through which families may obtain information about health benefits coverage for children; and

(3) information regarding the importance of each conservator of a child promptly informing the other conservator of the child about the child's health benefits coverage.

(c) The commission shall contract with community-based organizations or coalitions of community-based organizations to implement the community outreach campaign and shall also promote and encourage voluntary efforts to implement the community outreach campaign. The commission shall procure the contracts through a process designed by the commission to encourage broad participation of organizations, including organizations that target population groups with high levels of uninsured children.

(d) The commission may direct that the Department of State Health Services perform all or part of the community outreach campaign.

(e) The commission shall ensure that information provided under this section is available in both English and Spanish.

Added by Acts 2007, 80th Leg., R.S., Ch. 1353, Sec. 2, eff. June 15, 2007.

Sec. 62.058. FRAUD PREVENTION. The commission shall develop and implement rules for the prevention and detection of fraud in the child health plan program.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.0582. THIRD-PARTY BILLING VENDORS. (a) A third-party billing vendor may not submit a claim with the commission for payment on behalf of a health plan provider under the program unless the vendor has entered into a contract with the commission authorizing that activity.

(b) To the extent practical, the contract shall contain provisions comparable to the provisions contained in contracts between the commission and health plan providers, with an emphasis on provisions designed to prevent fraud or abuse under the program. At a minimum, the contract must require the third-party billing vendor to:

(1) provide documentation of the vendor's authority to bill on behalf of each provider for whom the vendor submits claims;

(2) submit a claim in a manner that permits the commission to identify and verify the vendor, any computer or telephone line used in submitting the claim, any relevant user password used in submitting the claim, and any provider number referenced in the claim; and

(3) subject to any confidentiality requirements imposed by federal law, provide the commission, the office of the attorney general, or authorized representatives with:

(A) access to any records maintained by the vendor, including original records and records maintained by the vendor on behalf of a provider, relevant to an audit or

investigation of the vendor's services or another function of the commission or office of attorney general relating to the vendor; and

(B) if requested, copies of any records described by Paragraph (A) at no charge to the commission, the office of the attorney general, or authorized representatives.

(c) On receipt of a claim submitted by a third-party billing vendor, the commission shall send a remittance notice directly to the provider referenced in the claim. The notice must include detailed information regarding the claim submitted on behalf of the provider.

(d) The commission shall take all action necessary, including any modifications of the commission's claims processing system, to enable the commission to identify and verify a third-party billing vendor submitting a claim for payment under the program, including identification and verification of any computer or telephone line used in submitting the claim, any relevant user password used in submitting the claim, and any provider number referenced in the claim.

(e) The commission shall audit each third-party billing vendor subject to this section at least annually to prevent fraud and abuse under the program.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.44(a), eff. Jan. 1, 2006.

Sec. 62.059. HEALTH INSURANCE PREMIUM ASSISTANCE PROGRAM FOR CHILDREN ELIGIBLE FOR CHILD HEALTH PLAN. (a) In this section, "group health benefit plan" means a plan described by Section 1207.001, Insurance Code.

(b) The commission shall identify children, otherwise eligible to enroll in the state child health plan under this chapter, who are eligible to enroll in a group health benefit plan.

(c) For a child identified under Subsection (b), the commission shall determine whether it is cost-effective to enroll the child in the group health benefit plan under this section. The commission may determine cost-effectiveness on an aggregate basis for the premium assistance program as a whole.

(d) If the commission determines that it is cost-effective to enroll the child in the group health benefit plan, the commission shall:

(1) inform the child and the child's parent or guardian of the availability of the premium assistance program under this section;

(2) offer, as an optional alternative to enrollment in the commission's state child health plan program, a premium assistance payment to assist with the employee's or member's share of the required premiums for the group health benefit plan that is available to the child; and

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

(e) The commission shall determine the amount of the premium assistance payment. The premium assistance payment shall be paid only for the reimbursement of the employee's or member's share of required premiums for coverage of a child enrolled in the group health benefit plan.

(f) The premium assistance payment paid under Subsection (e) may provide assistance for the payment of a group health benefit plan premium that includes the child's parent or other individuals who are members of the child's family.

(g) The commission may not provide for the payment of any deductible, copayment, coinsurance, or other cost-sharing obligation for the child or another individual enrolled in a group health benefit plan under Subsection (f).

(h) Repealed by Acts 2003, 78th Leg., ch. 198, Sec. 2.07(b).

(i) Redesignated as subsec. (h) by Acts 2003, 78th Leg., ch. 11, Sec. 1.

Added by Acts 2001, 77th Leg., ch. 1165, Sec. 1, eff. Aug. 31, 2001. Amended by Acts 2003, 78th Leg., ch. 11, Sec. 1, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 198, Sec. 2.07(b), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 728, Sec. 11.125, eff. September 1, 2005.

SUBCHAPTER C. ELIGIBILITY FOR COVERAGE UNDER CHILD HEALTH PLAN

Sec. 62.101. ELIGIBILITY. (a) A child is eligible for health benefits coverage under the child health plan if the child:

(1) is younger than 19 years of age;

(2) is not eligible for medical assistance under the Medicaid program;

(3) is not covered by a health benefits plan offering adequate benefits, as determined by the commission;

(4) has a family income that is less than or equal to the income eligibility level established under Subsection (b); and

(5) satisfies any other eligibility standard imposed under the child health plan program in accordance with 42 U.S.C. Section 1397bb, as amended, and any other applicable law or regulations.

(b) The commission shall establish income eligibility levels consistent with Title XXI, Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, and subject to the availability of appropriated money, so that a child who is younger than 19 years of age and whose net family income is at or below 200 percent of the federal poverty level is eligible for health benefits coverage under the program. In addition, the commission may establish eligibility standards regarding the amount and types of allowable assets for a family whose net family income is above 150 percent of the federal poverty level.

(b-1) The eligibility standards adopted under Subsection (b) related to allowable assets:

(1) must allow a family to own at least $10,000 in allowable assets; and

(2) may not in calculating the amount of allowable assets under Subdivision (1) consider:

(A) the value of one vehicle that qualifies for an exemption under commission rule based on its use;

(B) the value of a second or subsequent vehicle that qualifies for an exemption under commission rule based on its use if:

(i) the vehicle is worth $18,000 or less; or

(ii) the vehicle has been modified to provide transportation for a household member with a disability;

(C) if no vehicle qualifies for an exemption based on its use under commission rule, the first $18,000 of value of the highest valued vehicle; or

(D) the first $7,500 of value of any vehicle not described by Paragraph (A), (B), or (C).

(c) The commissioner shall evaluate enrollment levels and program impact every six months during the first 12 months of implementation and at least annually thereafter and shall submit a finding of fact to the Legislative Budget Board and the Governor's Office of Budget and Planning as to the adequacy of funding and the ability of the program to sustain enrollment at the eligibility level established by Subsection (b). In the event that appropriated money is insufficient to sustain enrollment at the authorized eligibility level, the commissioner shall:

(1) suspend enrollment in the child health plan;

(2) establish a waiting list for applicants for coverage; and

(3) establish a process for periodic or continued enrollment of applicants in the child health plan program as the availability of money allows.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.46, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1353, Sec. 3, eff. June 15, 2007.

Sec. 62.1011. VERIFICATION OF INCOME. The commission shall continue employing methods of verifying the net income of the individuals considered in the calculation of an applicant's net family income. The commission shall verify income under this section unless the applicant reports a net family income that exceeds the income eligibility level established under Section 62.101(b).

Added by Acts 2007, 80th Leg., R.S., Ch. 1353, Sec. 4, eff. June 15,

2007.

Sec. 62.1015. ELIGIBILITY OF CERTAIN CHILDREN; DISALLOWANCE OF MATCHING FUNDS. (a) In this section, "charter school," "employee," and "regional education service center" have the meanings assigned by Section 2, Article 3.50-7, Insurance Code.

(b) A child of an employee of a charter school, school district, other educational district whose employees are members of the Teacher Retirement System of Texas, or regional education service center may be enrolled in health benefits coverage under the child health plan. A child enrolled in the child health plan under this section:

(1) participates in the same manner as any other child enrolled in the child health plan; and

(2) is subject to the same requirements and restrictions relating to income eligibility, continuous coverage, and enrollment, including applicable waiting periods, as any other child enrolled in the child health plan.

(c) The cost of health benefits coverage for children enrolled in the child health plan under this section shall be paid as provided in the General Appropriations Act. Expenditures made to provide health benefits coverage under this section may not be included for the purpose of determining the state children's health insurance expenditures, as that term is defined by 42 U.S.C. Section 1397ee(d)(2)(B), as amended, unless the Health and Human Services Commission, after consultation with the appropriate federal agencies, determines that the expenditures may be included without adversely affecting federal matching funding for the child health plan provided under this chapter.

Added by Acts 2001, 77th Leg., ch. 1187, Sec. 1.04, eff. Sept. 1, 2001. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.47, eff. Sept. 1, 2003.

Sec. 62.102. CONTINUOUS COVERAGE. (a) Subject to a review under Subsection (b), the commission shall provide that an individual who is determined to be eligible for coverage under the child health plan remains eligible for those benefits until the

earlier of:

(1) the end of a period not to exceed 12 months, beginning the first day of the month following the date of the eligibility determination; or

(2) the individual's 19th birthday.

(b) During the sixth month following the date of initial enrollment or reenrollment of an individual whose net family income exceeds 185 percent of the federal poverty level, the commission shall:

(1) review the individual's net family income and may use electronic technology if available and appropriate; and

(2) continue to provide coverage if the individual's net family income does not exceed the income eligibility limits prescribed by this chapter.

(c) If, during the review required under Subsection (b), the commission determines that the individual's net family income exceeds the income eligibility limits prescribed by this chapter, the commission may not disenroll the individual until:

(1) the commission has provided the family an opportunity to demonstrate that the family's net family income is within the income eligibility limits prescribed by this chapter; and

(2) the family fails to demonstrate such eligibility.

(d) The commission shall provide written notice of termination of eligibility to the individual not later than the 30th day before the date the individual's eligibility terminates.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.48, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 899, Sec. 3.01, eff. August 29, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1353, Sec. 5, eff. June 15, 2007.

Sec. 62.103. APPLICATION FORM AND PROCEDURES. (a) The commission, or the Texas Department of Human Services at the

direction of and in consultation with the commission, shall adopt an application form and application procedures for requesting child health plan coverage under this chapter.

(b) The form and procedures must be coordinated with forms and procedures under the Medicaid program to ensure that there is a single consolidated application to seek assistance under this chapter or the Medicaid program.

(c) To the extent possible, the application form shall be made available in languages other than English.

(d) The commission may permit application to be made by mail, over the telephone, or through the Internet.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2001, 77th Leg., ch. 584, Sec. 1.

Sec. 62.104. ELIGIBILITY SCREENING AND ENROLLMENT. (a) The commission, or the Texas Department of Human Services at the direction of and in consultation with the commission, shall develop eligibility screening and enrollment procedures for children that comply with the requirements of 42 U.S.C. Section 1397bb, as amended, and any other applicable law or regulations. The procedures shall ensure that Medicaid-eligible children are identified and referred to the Medicaid program.

(b) The Texas Integrated Enrollment Services eligibility determination system or a compatible system may be used to screen and enroll children under the child health plan.

(c) The eligibility screening and enrollment procedures shall ensure that children who appear to be Medicaid-eligible are identified and that their families are assisted in applying for Medicaid coverage.

(d) A child who applies for enrollment in the child health plan, who is denied Medicaid coverage after completion of a Medicaid application under Subsection (c), but who is eligible for enrollment in the child health plan, shall be enrolled in the child health plan without further application or qualification.

(e) The commission shall report semi-annually to the committees of both houses of the legislature with jurisdiction over the child health plan:

(1) the number of individuals referred for Medicaid application under this section who are enrolled in the Medicaid program; and

(2) the number of individuals who are denied coverage under the Medicaid program because they failed to complete the application process.

(f) A determination of whether a child is eligible for child health plan coverage under the program and the enrollment of an eligible child with a health plan provider must be completed, and information on the family's available choice of health plan providers must be provided, in a timely manner, as determined by the commission. The commission must require that the determination be made and the information be provided not later than the 30th day after the date a complete application is submitted on behalf of the child, unless the child is referred for Medicaid application under this section.

(g) In the first year of implementation of the child health plan, enrollment shall be open. Thereafter, the commission may establish enrollment periods.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.105. COVERAGE FOR QUALIFIED ALIENS. The commission shall provide coverage under the state Medicaid program and under the program established under this chapter to a child who is a qualified alien, as that term is defined by 8 U.S.C. Section 1641(b), if the federal government authorizes the state to provide that coverage. The commission shall comply with any prerequisite imposed under the federal law to providing that coverage.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

SUBCHAPTER D. CHILD HEALTH PLAN

Sec. 62.151. CHILD HEALTH PLAN COVERAGE. (a) The child health plan must comply with this chapter and the coverage requirements prescribed by 42 U.S.C. Section 1397cc, as amended, and any other applicable law or regulations.

(b) In developing the covered benefits, the commission shall consider the health care needs of healthy children and

children with special health care needs.

(c) In developing the plan, the commission shall ensure that primary and preventive health benefits do not include reproductive services, other than prenatal care and care related to diseases, illnesses, or abnormalities related to the reproductive system.

(d) The child health plan must allow an enrolled child with a chronic, disabling, or life-threatening illness to select an appropriate specialist as a primary care physician.

(e) In developing the covered benefits, the commission shall seek input from the Public Assistance Health Benefit Review and Design Committee established under Section 531.067, Government Code.

(f) The commission, if it determines the policy to be cost-effective, may ensure that an enrolled child does not, unless authorized by the commission in consultation with the child's attending physician or advanced practice nurse, receive under the child health plan:

(1) more than four different outpatient brand-name prescription drugs during a month; or

(2) more than a 34-day supply of a brand-name prescription drug at any one time.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.49, eff. Sept. 1, 2003.

Sec. 62.152. APPLICATION OF INSURANCE LAW. To provide the flexibility necessary to satisfy the requirements of Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, the child health plan is not subject to a law that requires:

(1) coverage or the offer of coverage of a health care service or benefit;

(2) coverage or the offer of coverage for the provision of services by a particular health care services provider, except as provided by Section 62.155(b); or

(3) the use of a particular policy or contract form or of particular language in a policy or contract form.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.153. COST SHARING. (a) To the extent permitted under 42 U.S.C. Section 1397cc, as amended, and any other applicable law or regulations, the commission shall require enrollees to share the cost of the child health plan, including provisions requiring enrollees under the child health plan to pay:

(1) a copayment for services provided under the plan;

(2) an enrollment fee; or

(3) a portion of the plan premium.

(b) Subject to Subsection (d), cost-sharing provisions adopted under this section shall ensure that families with higher levels of income are required to pay progressively higher percentages of the cost of the plan.

(c) If cost-sharing provisions imposed under Subsection (a) include requirements that enrollees pay a portion of the plan premium, the commission shall specify the manner in which the premium is paid. The commission may require that the premium be paid to the Texas Department of Health, the Texas Department of Human Services, or the health plan provider.

(d) Cost-sharing provisions adopted under this section may be determined based on the maximum level authorized under federal law and applied to income levels in a manner that minimizes administrative costs.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.50, eff. Sept. 1, 2003.

Sec. 62.154. WAITING PERIOD; CROWD OUT. (a) To the extent permitted under Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, the child health plan must include a waiting period and may include copayments and other provisions intended to discourage:

(1) employers and other persons from electing to discontinue offering coverage for children under employee or other group health benefit plans; and

(2) individuals with access to adequate health benefit plan coverage, other than coverage under the child health plan, from electing not to obtain or to discontinue that coverage for a child.

(b) A child is not subject to a waiting period adopted under Subsection (a) if:

(1) the family lost coverage for the child as a result of:

(A) termination of employment because of a layoff or business closing;

(B) termination of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272);

(C) change in marital status of a parent of the child;

(D) termination of the child's Medicaid eligibility because:

(i) the child's family's earnings or resources increased; or

(ii) the child reached an age at which Medicaid coverage is not available; or

(E) a similar circumstance resulting in the involuntary loss of coverage;

(2) the family terminated health benefits plan coverage for the child because the cost to the child's family for the coverage exceeded 10 percent of the family's net income;

(3) the child has access to group-based health benefits plan coverage and is required to participate in the health insurance premium payment reimbursement program administered by the commission; or

(4) the commission has determined that other grounds exist for a good cause exception.

(c) A child described by Subsection (b) may enroll in the child health plan program at any time, without regard to any open enrollment period established under the enrollment procedures.

(d) The waiting period required by Subsection (a) must:

(1) extend for a period of 90 days after the last date

on which the applicant was covered under a health benefits plan; and

(2) apply to a child who was covered by a health benefits plan at any time during the 90 days before the date of application for coverage under the child health plan.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.51(a), (b), eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1353, Sec. 6, eff. June 15, 2007.

Sec. 62.155. HEALTH PLAN PROVIDERS. (a) The commission, or the Texas Department of Health at the direction of and in consultation with the commission, shall select the health plan providers under the program through a competitive procurement process. A health plan provider, other than a state administered primary care case management network, must hold a certificate of authority or other appropriate license issued by the Texas Department of Insurance that authorizes the health plan provider to provide the type of child health plan offered and must satisfy, except as provided by this chapter, any applicable requirement of the Insurance Code or another insurance law of this state.

(b) A managed care organization or other entity shall seek to obtain, in the organization's or entity's provider network, the participation of significant traditional providers, as defined by commission rule, if that organization or entity:

(1) contracts with the commission or with another agency or entity to operate a part of the child health plan under this chapter; and

(2) uses a provider network to provide or arrange for health care services under the child health plan.

(c) In selecting a health plan provider, the commission:

(1) may give preference to a person who provides similar coverage under the Medicaid program; and

(2) shall provide for a choice of at least two health plan providers in each service area.

(d) The commissioner may authorize an exception to

Subsection (c)(2) if there is only one acceptable applicant to become a health plan provider in the service area.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.52, eff. Sept. 1, 2003.

Sec. 62.156. HEALTH CARE PROVIDERS. Health care providers who provide health care services under the child health plan must satisfy certification and licensure requirements, as required by the commission, consistent with law.

Added by Acts 1999, 76th Leg., ch. 235, Sec. 1, eff. Aug. 30, 1999.

Sec. 62.157. TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

Text of section as added by Acts 2001, 77th Leg., ch. 959, Sec. 5

(a) In providing covered benefits to a child with special health care needs, a health plan provider must permit benefits to be provided through telemedicine medical services and telehealth services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services and telehealth services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services and telehealth services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single telemedicine medical services and telehealth services session, if the commission determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services and telehealth services, including the costs of transportation and lodging and other direct costs.

(c) In developing the policies required by Subsection (a),

the commission shall consult with:

(1) The University of Texas Medical Branch at Galveston;

(2) Texas Tech University Health Sciences Center;

(3) the Texas Department of Health;

(4) providers of telemedicine hub sites in this state;

(5) providers of services to children with special health care needs; and

(6) representatives of consumer or disability groups affected by changes to services for children with special health care needs.

Added by Acts 2001, 77th Leg., ch. 959, Sec. 5, eff. June 14, 2001.

Sec. 62.157. TELEMEDICINE MEDICAL SERVICES.

Text of section as added by Acts 2001, 77th Leg., ch. 1255, Sec. 4

(a) In providing covered benefits to a child, a health plan provider must permit benefits to be provided through telemedicine medical services in accordance with policies developed by the commission.

(b) The policies must provide for:

(1) the availability of covered benefits appropriately provided through telemedicine medical services that are comparable to the same types of covered benefits provided without the use of telemedicine medical services; and

(2) the availability of covered benefits for different services performed by multiple health care providers during a single session of telemedicine medical services, if the commission determines that delivery of the covered benefits in that manner is cost-effective in comparison to the costs that would be involved in obtaining the services from providers without the use of telemedicine medical services, including the costs of transportation and lodging and other direct costs.

(c) In developing the policies required by Subsection (a), the commission shall consult with the telemedicine advisory committee.

(d) In this section, "telemedicine medical service" has the meaning assigned by Section 57.042, Utilities Code.

Added by Acts 2001, 77th Leg., ch. 1255, Sec. 4, eff. June 15, 2001.

Sec. 62.158. STATE TAXES. The commission shall ensure that any experience rebate or profit-sharing for health plan providers under the child health plan is calculated by treating premium, maintenance, and other taxes under the Insurance Code and any other taxes payable to this state as allowable expenses for purposes of determining the amount of the experience rebate or profit-sharing.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.53, eff. Sept. 1, 2003.

Sec. 62.159. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist a child manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the commission identifies populations for which disease management would be cost-effective.

(b) The child health plan must provide disease management services or coverage for disease management services in the manner required by the commission, including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care.

Added by Acts 2003, 78th Leg., ch. 589, Sec. 1, eff. June 20, 2003.