By: Martinez Fischer H.B. No. 4054

A BILL TO BE ENTITLED

AN ACT

relating to a "Texas solution" to reforming and addressing issues related to the Medicaid program, including the creation of an alternative program designed to ensure health benefit plan coverage to certain low-income individuals through the private marketplace; authorizing a fee.

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

ARTICLE 1. BLOCK GRANT FUNDING SYSTEM FOR STATE MEDICAID PROGRAM

SECTION 1.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 540 to read as follows:

CHAPTER 540. BLOCK GRANT FUNDING SYSTEM FOR STATE MEDICAID PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 540.001. DEFINITIONS. In this chapter:

(1) "Health benefit exchange" means an American Health Benefit Exchange administered by the federal government or an exchange created under Section 1311(b) of the Patient Protection and Affordable Care Act (42 U.S.C. Section 18031(b)).

(2) "Medicaid program" means the medical assistance program established and operated under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.).

(3) "State Medicaid program" means the medical assistance program provided by this state under the Medicaid program.

Sec. 540.002. FEDERAL AUTHORIZATION TO REFORM MEDICAID

REQUIRED. If the federal government establishes, through conversion or otherwise, a block grant funding system for the Medicaid program or otherwise authorizes the state Medicaid program to operate under a block grant funding system, including under a Medicaid program waiver, the commission, in cooperation with applicable health and human services agencies, shall, subject to Section 540.003, administer and operate the state Medicaid program in accordance with this chapter.

Sec. 540.003. CONFLICT WITH OTHER LAW. To the extent of a conflict between a provision of this chapter and:

(1) another provision of state law, the provision of this chapter controls, subject to Section 540.002(b); and

(2) a provision of federal law or any authorization described under Section 540.002, the federal law or authorization controls.

Sec. 540.004. ESTABLISHMENT OF REFORMED STATE MEDICAID PROGRAM. The commission shall establish a state Medicaid program that provides benefits under a risk-based Medicaid managed care model.

Sec. 540.005. RULES. The executive commissioner shall adopt rules necessary to implement this chapter.

SUBCHAPTER B. ACUTE CARE

Sec. 540.051. ELIGIBILITY FOR MEDICAID ACUTE CARE. (a) An individual is eligible to receive acute care benefits under the state Medicaid program if the individual:

(1) has a household income at or below 100 percent of the federal poverty level;

(2) is under 19 years of age and:

(A) is receiving Supplemental Security Income (SSI) under 42 U.S.C. Section 1381 et seq.; or

(B) is in foster care or resides in another residential care setting under the conservatorship of the Department of Family and Protective Services; or

(3) meets the eligibility requirements that were in effect on September 1, 2015.

(b) The commission shall provide acute care benefits under the state Medicaid program to each individual eligible under this section through the most cost-effective means, as determined by the commission.

(c) If an individual is not eligible for the state Medicaid program under Subsection (a), the commission shall refer the individual to the program established under Chapter 541 that helps connect eligible residents with health benefit plan coverage through private market solutions, a health benefit exchange, or any other resource the commission determines appropriate.

Sec. 540.052. MEDICAID SLIDING SCALE SUBSIDIES. (a) An individual who is eligible for the state Medicaid program under Section 540.051 may receive a Medicaid sliding scale subsidy to purchase a health benefit plan from an authorized health benefit plan issuer.

(b) A sliding scale subsidy provided to an individual under this section must:

(1) be based on:

(A) the average premium in the market; and

(B) a realistic assessment of the individual's ability to pay a portion of the premium; and

(2) include an enhancement for individuals who choose a high deductible health plan with a health savings account.

(c) The commission shall ensure that counselors are made available to individuals receiving a subsidy to advise the individuals on selecting a health benefit plan that meets the individuals' needs.

(d) An individual receiving a subsidy under this section is responsible for paying:

(1) any difference between the premium costs associated with the purchase of a health benefit plan and the amount of the individual's subsidy under this section; and

(2) any copayments associated with the health benefit plan.

(e) If the amount of a subsidy received by an individual under this section exceeds the premium costs associated with the individual's purchase of a health benefit plan, the individual may deposit the excess amount in a health savings account that may be used only in the manner described by Section 540.054(b).

Sec. 540.053. ADDITIONAL COST-SHARING SUBSIDIES. In addition to providing a subsidy to an individual under Section 540.052, the commission shall provide additional subsidies for coinsurance payments, copayments, deductibles, and other cost-sharing requirements associated with the individual's health benefit plan. The commission shall provide the additional subsidies on a sliding scale based on income.

Sec. 540.054. DELIVERY OF SUBSIDIES; HEALTH SAVINGS ACCOUNTS. (a) The commission shall determine the most appropriate manner for delivering and administering subsidies provided under Sections 540.052 and 540.053. In determining the most appropriate manner, the commission shall consider depositing subsidy amounts for an individual in a health savings account established for that individual.

(b) A health savings account established under this section may be used only to:

(1) pay health benefit plan premiums and cost-sharing amounts; and

(2) if appropriate, purchase health care-related goods and services.

Sec. 540.055. MEDICAID HEALTH BENEFIT PLAN ISSUERS AND MINIMUM COVERAGE. The commission shall allow any health benefit plan issuer authorized to write health benefit plans in this state to participate in the state Medicaid program. The commission in consultation with the commissioner of insurance shall establish minimum coverage requirements for a health benefit plan to be eligible for purchase under the state Medicaid program, subject to the requirements specified by this chapter.

Sec. 540.056. REINSURANCE FOR PARTICIPATING HEALTH BENEFIT PLAN ISSUERS. (a) The commission in consultation with the commissioner of insurance shall study a reinsurance program to reinsure participating health benefit plan issuers.

(b) In examining options for a reinsurance program, the commission and commissioner of insurance shall consider a plan

design under which:

(1) a participating health benefit plan is not charged a premium for the reinsurance; and

(2) the health benefit plan issuer retains risk on a sliding scale.

SUBCHAPTER C. LONG-TERM SERVICES AND SUPPORTS

Sec. 540.101. PLAN TO REFORM DELIVERY OF LONG-TERM SERVICES AND SUPPORTS. The commission shall develop a comprehensive plan to reform the delivery of long-term services and supports that is designed to achieve the following objectives under the state Medicaid program or any other program created as an alternative to the state Medicaid program:

(1) encourage consumer direction;

(2) simplify and streamline the provision of services;

(3) provide flexibility to design benefits packages that meet the needs of individuals receiving long-term services and supports under the program;

(4) improve the cost-effectiveness and sustainability of the provision of long-term services and supports;

(5) reduce reliance on institutional settings; and

(6) encourage cost sharing by family members when appropriate.

ARTICLE 2. IMMEDIATE REFORM: PROGRAM TO ENSURE HEALTH BENEFIT COVERAGE FOR CERTAIN INDIVIDUALS THROUGH PRIVATE MARKETPLACE

SECTION 2.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 541 to read as follows:

CHAPTER 541. PROGRAM TO ENSURE HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN INDIVIDUALS THROUGH PRIVATE MARKET SOLUTIONS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 541.001. DEFINITION. In this chapter, "medical assistance program" means the program established under Chapter 32, Human Resources Code.

Sec. 541.002. CONFLICT WITH OTHER LAW. (a) Except as provided by Subsection (b), to the extent of a conflict between a provision of this chapter and:

(1) another provision of state law, the provision of this chapter controls; and

(2) a provision of federal law or any authorization described under Subchapter B, the federal law or authorization controls.

(b) The program operated under this chapter is in addition to any medical assistance program operated under a block grant funding system under Chapter 540.

Sec. 541.003. PROGRAM FOR HEALTH BENEFIT PLAN COVERAGE THROUGH PRIVATE MARKET SOLUTIONS. Subject to the requirements of this chapter, the commission in consultation with the Texas Department of Insurance shall develop and implement a program that helps connect certain low-income residents of this state with health benefit plan coverage through private market solutions.

Sec. 541.004. NOT AN ENTITLEMENT. This chapter does not establish an entitlement to assistance in obtaining health benefit plan coverage.

Sec. 541.005. RULES. The executive commissioner shall

adopt rules necessary to implement this chapter.

SUBCHAPTER B. FEDERAL AUTHORIZATION

Sec. 541.051. FEDERAL AUTHORIZATION FOR FLEXIBILITY TO ESTABLISH PROGRAM. (a) The commission in consultation with the Texas Department of Insurance shall negotiate with the United States secretary of health and human services, the federal Centers for Medicare and Medicaid Services, and other appropriate persons for purposes of seeking a waiver or other authorization necessary to obtain the flexibility to use federal matching funds to help provide, in accordance with Subchapter C, health benefit plan coverage to certain low-income individuals through private market solutions.

(b) Any agreement reached under this section must:

(1) create a program that is made cost neutral to this state by:

(A) leveraging premium tax revenues; and

(B) achieving cost savings through offsets to general revenue health care costs or the implementation of other cost savings mechanisms;

(2) create more efficient health benefit plan coverage options for eligible individuals through:

(A) program changes that may be made without the need for additional federal approval; and

(B) program changes that require additional federal approval;

(3) require the commission to achieve efficiency and reduce unnecessary utilization, including duplication, of health

care services;

(4) be designed with the goals of:

(A) relieving local tax burdens;

(B) reducing general revenue reliance so as to make general revenue available for other state priorities; and

(C) minimizing the impact of any federal health care laws on Texas-based businesses; and

(5) afford this state the opportunity to develop a state-specific solution with benefits that specifically meet the unique needs of this state's population.

(c) An agreement reached under this section may be:

(1) limited in duration; and

(2) contingent on continued funding by the federal government.

SUBCHAPTER C. PROGRAM REQUIREMENTS

Sec. 541.101. ENROLLMENT ELIGIBILITY. (a) Subject to Subsection (b), an individual may be eligible to enroll in a program designed and established under this chapter if the person:

(1) is younger than 65;

(2) has a household income at or below 133 percent of the federal poverty level; and

(3) is not otherwise eligible to receive benefits under the medical assistance program, including through a program operated under Chapter 540 through a block grant funding system or a waiver, other than one granted under this chapter, to the program.

(b) The executive commissioner may amend or further define the eligibility requirements of this section if the commission

determines it necessary to reach an agreement under Subchapter B.

Sec. 541.102. MINIMUM PROGRAM REQUIREMENTS. A program designed and established under this chapter must:

(1) if cost-effective for this state, provide premium assistance to purchase health benefit plan coverage in the private market, including health benefit plan coverage offered through a managed care delivery model;

(2) provide enrollees with access to health benefits, including benefits provided through a managed care delivery model, that:

(A) are tailored to the enrollees;

(B) provide levels of coverage that are customized to meet health care needs of individuals within defined categories of the enrolled population; and

(C) emphasize personal responsibility and accountability through flexible and meaningful cost sharing requirements and wellness initiatives, including through incentives for compliance with health, wellness, and treatment strategies and disincentives for noncompliance;

(3) include pay-for-performance initiatives for private health benefit plan issuers that participate in the program;

(4) use technology to maximize the efficiency with which the commission and any health benefit plan issuer, health care provider, or managed care organization participating in the program manages enrollee participation;

(5) allow recipients under the medical assistance

program to enroll in the program to receive premium assistance as an alternative to the medical assistance program;

(6) encourage eligible individuals to enroll in other private or employer-sponsored health benefit plan coverage, if available and appropriate;

(7) encourage the utilization of health care services in the most appropriate low-cost settings; and

(8) establish health savings accounts for enrollees, as appropriate.

SECTION 2.02. The Health and Human Services Commission in consultation with the Texas Department of Insurance and the Medicaid Reform Task Force shall actively develop a proposal for the authorization from the appropriate federal entity as required by Subchapter B, Chapter 541, Government Code, as added by this article. As soon as possible after the effective date of this Act, the Health and Human Services Commission shall request and actively pursue obtaining the authorization from the appropriate federal entity.

ARTICLE 3. MEDICAID: INCREMENTAL REFORM

SECTION 3.01. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0974 to read as follows:

Sec. 531.0974. CUSTOMIZED BENEFITS PACKAGE. The commission shall, for individuals receiving home and community-based services and supports instead of institutional long-term services and supports, develop and implement customized benefits packages that are designed to prevent the overutilization of services. Customized benefits packages under this section must be based on an

individualized needs assessment administered at a single point of entry.

SECTION 3.02. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Sections 32.0501, 32.0642, and 32.077 to read as follows:

Sec. 32.0501. DUAL ELIGIBLE INTEGRATED CARE DEMONSTRATION PROJECT. (a) In this section:

(1) "ICF-IDD" has the meaning assigned to "ICF-MR" by Section 531.002, Health and Safety Code.

(2) "Nursing facility" has the meaning assigned by Section 531.912, Government Code.

(3) "State supported living center" has the meaning assigned by Section 531.002, Health and Safety Code.

(b) Subject to Subsection (c), the department shall establish a dual eligible integrated care demonstration project that would allow appropriate individuals described by Section 32.050(a), as determined by the department, to receive long-term services and supports under both the medical assistance program and the Medicare program through a single managed care plan.

(c) An individual who is a resident of a nursing facility, ICF-IDD, or state supported living center is exempt from participation in the demonstration project.

Sec. 32.0642. PARENTAL FEE PROGRAM. (a) To the extent allowed by federal law, the department shall establish a parental fee program that requires the parent or legal guardian of a child receiving institutional long-term services and supports or home and community-based services and supports under the medical assistance

program established under this chapter to pay a fee that:

(1) correlates with the services and supports provided; and

(2) takes into consideration the child's household income.

(b) Failure to pay a fee under this section may not affect a child's eligibility for benefits under the medical assistance program.

(c) The executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement this section.

Sec. 32.077. HOUSING BENEFITS FOR CERTAIN RECIPIENTS. To the extent allowed by federal law, the department shall provide housing payment assistance for recipients receiving home and community-based services and supports under the medical assistance program established under this chapter.

SECTION 3.03. (a) The Health and Human Services Commission shall conduct a study to examine the estate recovery program implemented by this state under 42 U.S.C. Section 1396p(b)(1) and determine options the state has to improve recovery under and increase the efficacy of the program.

(b) Not later than December 1, 2016, the commission shall submit a written report containing the findings of the study conducted under this section together with the commission's recommendations to the governor, the lieutenant governor, and the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program.

SECTION 3.04. (a) The Health and Human Services Commission shall conduct a study on imposing alternative income and asset limits for purposes of determining eligibility for long-term services and supports under the medical assistance program under Chapter 32, Human Resources Code. The commission shall consider:

(1) imposing greater restrictions on exempt assets;

(2) limiting the amount of income that an individual may transfer into a qualified trust under 42 U.S.C. Section 1396p(d)(4)(B) to an amount equal to the average cost of nursing home care; and

(3) reducing the income eligibility limit to qualify for Medicaid institutional long-term services and supports or home and community-based waiver services under the medical assistance program under Chapter 32, Human Resources Code.

(b) Not later than December 1, 2016, the commission shall submit a written report containing the findings of the study conducted under this section together with the commission's recommendations to the governor, the lieutenant governor, and the standing committees of the senate and house of representatives having primary jurisdiction over the Medicaid program.

ARTICLE 4. MEDICAID REFORM TASK FORCE

SECTION 4.01. (a) In this section:

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

(2) "Medicaid program" and "state Medicaid program" have the meanings assigned by Section 540.001, Government Code, as added by this Act.

(3) "Task force" means the Medicaid Reform Task Force established under this section.

(b) The Medicaid Reform Task Force is established for purposes of advising the commission in designing a state Medicaid plan and program and a program for ensuring health benefit plan coverage for low-income individuals that are:

(1) consistent with Articles 2 and 3 of this Act; and

(2) if the federal government establishes a block grant funding system in accordance with Section 540.002, Government Code, as added by this Act, consistent with Article 1 of this Act.

(c) The task force consists of 12 members appointed as follows:

(1) one member appointed by the governor;

(2) two members of the senate appointed by the lieutenant governor;

(3) two members of the house of representatives appointed by the speaker of the house of representatives;

(4) one member from the Senate Committee on Finance, appointed by the presiding officer;

(5) one member from the House Appropriations Committee, appointed by the presiding officer;

(6) one member of the Senate Committee on Health and Human Services, appointed by the presiding officer;

(7) one member of the House Public Health Committee, appointed by the presiding officer;

(8) the executive commissioner of the commission or the executive commissioner's designee;

(9) the commissioner of insurance or the commissioner's designee to represent the Texas Department of Insurance; and

(10) the director of the Legislative Budget Board or the director's designee.

(d) The lieutenant governor and the speaker of the house of representatives shall each appoint a member of the task force to act as co-presiding officers.

(e) A member of the task force serves without compensation.

(f) Not later than January 1, 2016, the appropriate appointing officers shall appoint the members of the task force.

(g) Not later than December 1, 2016, the task force shall submit a report to the legislature regarding its activities under this section.

(h) This section expires September 1, 2017.

ARTICLE 5. FEDERAL AUTHORIZATION AND EFFECTIVE DATE

SECTION 5.01. Subject to Section 2.02 of this Act, if before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 5.02. This Act takes effect September 1, 2015.