SUBJECT: Obtaining a Medicaid reform waiver and federal funding changes

COMMITTEE: Appropriations — favorable, without amendment

VOTE: 17 ayes — Pitts, Aycock, Button, Chisum, Crownover, Darby, Eiland, Gooden, S. King, Margo, D. Miller, Morrison, Otto, Schwertner, Shelton, Torres, Zerwas

2 nays — Turner, Giddings

8 absent — Dukes, Hochberg, Johnson, Martinez, McClendon, Patrick, Riddle, Villarreal

WITNESSES: For — Arlene Wohlgemuth, Texas Public Policy Foundation

Against — Anne Dunkelberg, Center for Public Policy Priorities

On — Billy Millwee and Thomas Suehs, Health and Human Services Commission; Carolyn Bardin

BACKGROUND: Medicaid is a health benefit program that serves certain low-income individuals, primarily children and disabled or elderly people. State Medicaid expenditures are matched by federal funding, and state Medicaid programs must comply with federal requirements regarding eligibility and benefits in order to qualify for federal matching funds. Federal funding formulas are modified every year and take into account the relative per-capita wealth of each state.

The federal regulating agency, the Centers for Medicare and Medicaid Services (CMS), also allows states under certain conditions to petition for waivers from federal requirements.

DIGEST: HB 13 would require the Texas Health and Human Services Commission (HHSC) to seek a waiver from federal Medicaid requirements and modifications in the federal funding formula. The objectives of the waiver would be to:

- provide flexibility in income eligibility and benefit design;
- encourage the use of private versus public health benefits;

- create a culture of shared financial responsibility by establishing copayments for eligible people and by promoting the use of health savings accounts and vouchers;
- consolidate related federal funding streams, including funds from the disproportionate share hospitals and the upper payment limit supplemental payment programs;
- allow flexibility in the use of state funds to draw federal matching funds;
- empower uninsured people to purchase health coverage by promoting cost-effective models using a sliding scale and fees for service; and
- allow the redesign of long-term care services and supports to increase access to patient-centered care.

In pursuing federal funding modifications, the bill would require HHSC to work with the Texas delegation to the U.S. Congress and CMS and other federal agencies to achieve a federal match formula that accounted for population size and growth and the percentage of people below the federal poverty level. The commission also would have to try to obtain additional federal Medicaid funding for services for illegal immigrants.

The bill also would create an eight-member Medicaid Reform Waiver Legislative Oversight Committee to facilitate the waiver design and a smooth transition from the existing system to the new one. The committee would have to submit a report to the lieutenant governor and the speaker by November 15, 2012, that identified the issues related to the transition and to the effectiveness and impact of recommended Medicaid changes. The bill would abolish the committee and the requirement to seek federal funding modifications on September 1, 2013.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect on the 91st day after the last day of the legislative session.

SUPPORTERS SAY:

HB 13 would help to maintain health care coverage for needy Texans by requesting a waiver to allow Medicaid funds to be used most efficiently and comprehensively. Medicaid is the fastest-growing item in the budget. If the program is not fixed, the state will have to impose a significant tax hike or make deeper cuts to provider rates to compensate for the escalating costs. Many states, including Rhode Island, Vermont, and Washington

state, have requested waivers to deliver care in ways that best fit their states' needs. HB 13 would allow Texas to join their ranks.

The bill would direct HHSC to apply for a federal waiver giving the state five years to demonstrate a successful transition to a block grant system that would allow more flexibility in the operation of the Texas Medicaid program. The waiver would provide the state with more control over program design and encourage the uninsured to seek coverage in the private market through subsidies. It would improve Medicaid and prevent waste by introducing copayments and creating a culture of personal responsibility and accountability.

HB 13 would encourage greater provider participation for low-income Texans because more people would be served in the private health insurance market. The state currently lacks enough doctors willing to accept patients under Medicaid because the reimbursement rate for Medicaid providers is too low. Reimbursement rates would be higher in the private market, and this should increase the number of participating physicians. Many Texans are enrolled in Medicaid because of low income, not because of chronic illness, and they could be better served in the private market. By transitioning individuals to a private health insurance model, recipients would have greater access to care and experience better health outcomes.

The language contained in the bill is deliberately broad to provide the state congressional delegation greater negotiating power with the federal government to ensure that the state received the best deal possible. Fears that the state could deny coverage or reduce the income threshold are baseless because the federal guidelines for eligibility and maintenance of effort still would apply to any waiver negotiated.

OPPONENTS SAY:

The bill as written contains overly general language that would not provide any guarantees or protections for the level of care provided to low-income and chronically ill Texans. If the Medicaid program in Texas received the necessary federal waiver, the state would receive a fixed amount of funding for five years that would not increase based on inflation or population growth in the state. There would be no assurance that the state would receive additional funds to cover increased caseloads if an economic downturn or natural disaster occurred.

HB 13 could dramatically reduce the populations covered under the Texas Medicaid program. Since the federal government does not currently require a waiver for Texas to change the eligibility criteria to increase coverage for the state's nearly 6.5 million uninsured people, it can only be assumed that any waiver would seek to lower the income threshold and deny coverage to Texans for some programs and services.

HB 13 would burden poor families and the chronically ill with additional health care expenses, delay treatment, and increase costs. Medicaid and the Children's Health Insurance Program (CHIP) provide health care services for children and very low-income people who often have another medical condition, including pregnant women, the elderly, and people with disabilities. The federal government established guidelines to prevent the denial of coverage or imposition of copayments for enrollees below the poverty threshold ($22,350 per year for a family of four). This provision ensures access to care for people to prevent major illnesses and high health care expenditures. The bill could discourage these recipients from seeking care until it was urgently needed.

HB 13 would place chronically ill and very low-income Texans at the mercy of the unregulated individual insurance market. The costs for health coverage and treatment are escalating faster in the private market than in Medicaid. The premiums for individual insurance plans typically are more expensive than employer-based coverage, and customers commonly experience sharp rate hikes from year to year. Pushing Medicaid recipients onto a voucher system would not guarantee that the coverage could be purchased or that the private insurance plan would meet their health care needs. Given that most Medicaid recipients in Texas receive care through a managed care organization, which is effectively a private health insurance model, this provision seems unnecessary and redundant.

NOTES:

HB 13 is similar to HB 13 by Kolkhorst, 82nd Legislature, regular session, which passed the House by 112-28 on May 11, but died in the Senate after being reported favorably, as substituted, by the Senate Health and Human Services Committee on May 20.

During second-reading consideration yesterday of SB 7 by Nelson, the House adopted an amendment by Rep. Kolkhorst that is identical to HB 13.