BILL ANALYSIS

C.S.H.B. 2368
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Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Texas residents covered by private health insurance plans are asked to contribute to the cost of their medical services through a copayment. Interested parties contend that, because a copayment for physician visits or out-patient health services is significantly lower than copayments for other services, this financial contribution encourages the use of preventative health services and creates an incentive to appear at a scheduled doctor's visit. They further assert that copayments can help deter any abuse of free medical services, like those provided by Medicaid, that may occur if the patient has no responsibility for a portion of the financial cost. C.S.H.B. 2368 seeks to require certain Medicaid recipients to pay a small part of the cost for some medical services and to require the executive commissioner of the Health and Human Services Commission to adopt cost-sharing provisions, such as copayments, that encourage personal accountability and appropriate utilization of health services.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 2368 amends the Human Resources Code to require the executive commissioner of the Health and Human Services Commission (HHSC), to the extent permitted under federal law and subject to certain bill provisions relating to the adoption of copayments, to adopt cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services and removes a provision conditioning that requirement on a determination by HHSC that the adoption of such cost-sharing provisions is feasible and cost-effective.

C.S.H.B. 2368 requires the executive commissioner to adopt a cost-sharing provision that requires a Medicaid recipient who chooses to receive a nonemergency medical service through a hospital emergency room to pay a copayment or other cost-sharing payment for such a service under certain circumstances. The bill removes language requiring the executive commissioner to adopt cost-sharing provisions that require a Medicaid recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a copayment, premium payment, or other cost-sharing payment for the high-cost medical service under certain conditions and makes conforming changes. The bill specifies that a Medicaid recipient is required to pay a copayment or other cost-sharing payment for the receipt of a nonemergency medical service through a hospital emergency room if, after receiving certain information from the hospital relating to appropriate medical service options for nonemergency medical conditions, the recipient chooses to obtain medical services through the hospital emergency room despite having access to appropriate and medically acceptable medical services. The bill removes language conditioning that requirement on the recipient's access to medically acceptable, lower-cost medical services.

C.S.H.B. 2368 requires the executive commissioner, if the executive commissioner adopts copayments for certain health care services, to require a Medicaid recipient to pay copayments in

an amount of not more than $5 for each hospital outpatient visit at the time of the visit, other than a visit for a nonemergency medical service provided through a hospital emergency room; not more than $5 for each medical visit with a physician at the time of the visit; and not more than $7.50 per prescription drug. The bill removes a provision prohibiting HHSC, if the executive commissioner adopts a copayment or other cost-sharing payment for certain health services, from reducing hospital payments to reflect the potential receipt of a copayment or other payment from a recipient receiving medical services provided through a hospital emergency room. The bill specifies that its provisions establishing the amounts of certain copayments do not require a medical assistance provider to bill or collect from a recipient a copayment required or authorized under such provisions.

C.S.H.B. 2368 makes conforming changes to provisions of law relating to the adoption of provisions requiring Medicaid recipients to share the cost of medical assistance. The bill requires a state agency that is affected by a provision of the bill to request a federal waiver or authorization if the agency determines that a waiver or authorization is necessary for the implementation of the provision, and it authorizes the agency to delay implementation until the federal waiver or authorization is obtained.

EFFECTIVE DATE

September 1, 2011.

COMPARISON OF ORIGINAL AND SUBSTITUTE

C.S.H.B. 2368 differs from the original by removing statutory language conditioning the requirement that the executive commissioner of the Health and Human Services Commission (HHSC) adopt certain cost-sharing provisions on a determination by HHSC that the adoption of such cost-sharing provisions is feasible and cost-effective, whereas the original retains that statutory language. The substitute differs from the original by specifying that the executive commissioner is required to adopt cost-sharing provisions that encourage personal accountability and appropriate utilization of health care services, whereas the original contains no such specification.

C.S.H.B. 2368 differs from the original by requiring the executive commissioner to adopt a cost-sharing provision that requires a Medicaid recipient who chooses to receive a nonemergency medical service through a hospital emergency room to pay a copayment or other cost-sharing payment for such a service under certain circumstances, whereas the original requires the executive commissioner to adopt cost-sharing provisions that require a recipient who chooses a high-cost medical service provided through a hospital emergency room to pay a premium payment or other cost sharing payment other than a copayment for the high-cost medical service under certain circumstances. The substitute differs from the original by requiring the cost-sharing provision adopted by the executive commissioner to require a Medicaid recipient who chooses to receive a nonemergency medical service through a hospital emergency room to pay a copayment or other cost-sharing payment for such a service if, after receiving certain information relating to appropriate medical service options for nonemergency medical conditions from the hospital, the recipient chooses to obtain the medical service through the hospital emergency room despite having access to appropriate and medically acceptable medical services and by removing the statutory language conditioning that requirement on the recipient's access to medically acceptable, lower-cost medical services, whereas the original retains the statutory provisions.

C.S.H.B. 2368 differs from the original by removing statutory language prohibiting HHSC, if the executive commissioner adopts a copayment or other cost-sharing payment for certain health services, from reducing hospital payments to reflect the potential receipt of a copayment or other payment from a recipient receiving medical services provided through a hospital emergency room, whereas the original amends that statutory language to make conforming changes to

reflect the requirement that a Medicaid recipient who chooses a high-cost medical service provided through a hospital emergency room pay a cost-sharing payment other than a copayment for the medical service.

C.S.H.B. 2368 differs from the original by requiring the executive commissioner to require a Medicaid recipient to pay certain specified copayments, if the executive commissioner adopts copayments for those services, whereas the original requires HHSC to require a Medicaid recipient to pay certain specified nominal copayments. The substitute differs from the original, in a provision requiring the executive commissioner to require that a Medicaid recipient pay not more than $5 copayment for each hospital outpatient visit at the time of the visit, by specifying that a recipient is required to pay such a copayment for hospital outpatient visit other than a visit for a nonemergency medical service provided through a hospital emergency room, whereas the original contains no such specification. The substitute omits a provision included in the original requiring HHSC to require a Medicaid recipient to pay a copayment of up to five percent of the first $300 of the medical assistance reimbursement rate for an emergency room service at the time the service is provided. The substitute differs from the original by requiring the executive commissioner to require that a recipient pay not more than $7.50 per prescription drug, whereas the original requires the executive commissioner to require that a recipient pay 2.5 percent of the medical assistance reimbursement rate for a prescription drug at the time of receipt, not to exceed $7.50 per prescription drug.

C.S.H.B. 2368 omits provisions included in the original requiring HHSC, subject to applicable federal law, to require copayments for certain specified services under Medicaid and authorizing HHSC to establish copayments for a medical assistance service not specified in the original's provisions only if the copayment is specifically provided for in other law. The substitute omits provisions included in the original prohibiting HHSC from requiring copayments from certain specified recipients and from imposing more than one copayment for a single encounter with a recipient. The substitute omits a provision included in the original requiring HHSC to develop a mechanism by which Medicaid providers are able to identify recipients from whom a copayment is prohibited from being required. The substitute omits a provision included in the original requiring HHSC, if the provider chooses not to bill or collect a copayment from a recipient, to deduct the applicable copayment amount from the reimbursement payment made to the provider.

C.S.H.B. 2368 differs from the original in conforming and nonsubstantive ways.