

## **BILL ANALYSIS**

C.S.H.B. 3791  
By: Zerwas  
Appropriations  
Committee Report (Substituted)

### **BACKGROUND AND PURPOSE**

Interested parties contend that Texas entitlement programs as they presently exist are unsustainable. Many believe that the current network of hospitals, physicians, and other providers who care for the state's low-income population have reached a breaking point at which they can no longer welcome new clients under the existing models of coverage. It is possible that Texas stands to gain coverage for a significant number of uninsured residents through any health care expansion, but it is also possible that an expansion of Medicaid would result in an expansion of patient need. The parties contend that the state's existing system is broken and that adding more people to an already broken system sets the state up for a crisis.

Interested parties contend that any agreement reached for the expansion of Medicaid should allow the state to develop a tailored insurance product for the added population that can leverage private markets by building on a managed care model, have meaningful cost-sharing requirements, and provide benefits for Texas taxpayers that include tax relief at the local level. Many believe that any agreement also should benefit Texas taxpayers by providing appropriate health care coverage and should encourage appropriate health care utilization in low-cost settings, thereby reducing the cost of uncompensated care and increasing the amount of general revenue available to support other Texas priorities.

C.S.H.B. 3791 seeks to provide incremental reforms that will save costs and enhance the efficiency of the state Medicaid program and to provide for a plan that considers the particular needs, the economy, and the unique and growing population of Texas.

### **RULEMAKING AUTHORITY**

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 1.01, 2.01, and 3.02 of this bill.

### **ANALYSIS**

#### **Article 1. Block Grant Funding System for State Medicaid Program**

C.S.H.B. 3791 amends the Government Code to require the Health and Human Services Commission (HHSC), 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, to establish a state Medicaid program that provides benefits under a risk-based Medicaid managed care model and, in cooperation with applicable health and human services agencies, administer and operate the state Medicaid program in accordance with the bill's provisions. The bill establishes the extent to which the bill's provisions relating to the program control over other provisions of law. The bill requires the executive commissioner of HHSC to adopt rules necessary to implement the bill's provisions relating to the block grant funding system for the state Medicaid program.

C.S.H.B. 3791 sets out the eligibility requirements for an individual to receive acute care benefits under that state Medicaid program and requires HHSC to provide the benefits to each eligible individual through the most cost-effective means, as determined by HHSC. The bill requires HHSC, if an individual does not meet those eligibility requirements, to refer the individual to the program established under the bill's provisions that helps connect eligible residents with health benefit plan coverage through private market solutions, a health benefit exchange, or any other resource HHSC determines appropriate.

C.S.H.B. 3791 authorizes an individual who is eligible for Medicaid acute care benefits to receive a Medicaid sliding scale subsidy to purchase a health benefit plan from an authorized health benefit plan issuer and sets out the requirements for the sliding scale subsidy. The bill requires HHSC to 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. The bill establishes that an individual receiving such a subsidy is responsible for paying any difference between the premium costs associated with the purchase of a health benefit plan and the amount of the individual's subsidy and for paying any copayments associated with the health benefit plan. The bill authorizes the individual, if the amount of the subsidy exceeds the premium costs associated with the individual's purchase of a health benefit plan, to deposit the excess amount in a health savings account that may be used only in the manner described by the bill's provisions. The bill requires HHSC to provide specified additional subsidies on a sliding scale based on income.

C.S.H.B. 3791 requires HHSC to determine the most appropriate manner for delivering and administering the subsidies and, in determining the most appropriate manner, to consider depositing subsidy amounts for an individual in a health savings account established for that individual. The bill restricts the uses of such a health savings account to paying health benefit plan premiums and cost-sharing amounts and, if appropriate, purchasing health care-related goods and services.

C.S.H.B. 3791 requires HHSC to allow any health benefit plan issuer authorized to write health benefit plans in Texas to participate in the state Medicaid program and, in consultation with the commissioner of insurance, to 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 the bill's provisions. The bill requires HHSC, in consultation with the commissioner of insurance, to study a reinsurance program to reinsure participating health benefit plan issuers and requires HHSC and the commissioner of insurance, in examining options for a reinsurance program, to consider a plan design under which a participating health benefit plan is not charged a premium for the reinsurance and the health benefit plan issuer retains risk on a sliding scale. The bill requires HHSC to develop a comprehensive plan to reform the delivery of long-term services and supports that is designed to achieve certain specified objectives under the state Medicaid program or any other program created as an alternative to the state Medicaid program.

## **Article 2. Immediate Reform: Program to Ensure Health Benefit Coverage for Certain Individuals Through Private Marketplace**

C.S.H.B. 3791 amends the Government Code to require HHSC, in consultation with the Texas Department of Insurance (TDI), to develop and implement a program that helps connect certain low-income Texas residents with health benefit plan coverage through private market solutions. The bill establishes that the bill's provisions relating to the program do not establish an entitlement to assistance in obtaining health benefit plan coverage and that the program is in addition to any Medicaid program operated under a block grant funding system. The bill establishes the extent to which the bill's provisions relating to the program control over other provisions of law. The bill requires the executive commissioner of HHSC to adopt rules necessary to implement provisions relating to the program.

C.S.H.B. 3791 requires HHSC in consultation with TDI to 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 health benefit plan coverage to certain low-income individuals through private market solutions. The bill requires any such agreement to create a program that is made cost neutral to Texas through specified means, creates more efficient health benefit plan coverage options for eligible individuals through specified means, requires HHSC to achieve efficiency and reduce unnecessary utilization of health care services, be designed with certain specified goals, and afford Texas the opportunity to develop a state-specific solution with benefits that specifically meet the unique needs of the state's population. The bill authorizes such an agreement to be limited in duration and contingent on continued funding by the federal government.

C.S.H.B. 3791 sets out eligibility requirements for an individual to enroll in the program and authorizes the executive commissioner of HHSC to amend or further define the eligibility requirements if HHSC determines it necessary in order to reach an agreement with the federal government. The bill also sets out the minimum requirements for the program.

C.S.H.B. 3791 requires HHSC in consultation with TDI and the Medicaid Reform Task Force formed under the bill's provisions to actively develop a proposal for the authorization from the appropriate federal entity as required by the bill's provisions and requires HHSC, as soon as possible after the bill's effective date, to request and actively pursue obtaining the authorization from the appropriate federal entity.

### **Article 3. Medicaid: Incremental Reform**

C.S.H.B. 3791 amends the Government Code to require HHSC, for individuals receiving home and community-based services and supports instead of institutional long-term services and supports, to develop and implement customized benefits packages that are designed to prevent the overutilization of services. The bill requires such customized benefits packages to be based on an individualized needs assessment administered at a single point of entry.

C.S.H.B. 3791 amends the Human Resources Code to require HHSC to establish a dual eligible integrated care demonstration project that would allow individuals who are eligible to receive dual Medicaid and Medicare coverage, as determined by HHSC, to receive long-term services and supports under both the Medicaid program and the Medicare program through a single managed care plan. The bill exempts an individual who is a resident of a nursing facility, ICF-IDD, or state supported living center from participation in the demonstration project.

C.S.H.B. 3791 requires HHSC, to the extent allowed by federal law, to 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 Medicaid program to pay a fee that correlates with the services and supports provided and takes into consideration the child's household income. The bill prohibits failure to pay such a fee from affecting a child's eligibility for benefits under the Medicaid program. The bill requires the executive commissioner of HHSC to adopt rules necessary to implement the parental fee program.

C.S.H.B. 3791 requires HHSC, to the extent allowed by federal law, to provide housing payment assistance for recipients receiving home and community-based services and supports under the Medicaid program.

C.S.H.B. 3791 requires HHSC to conduct a study to examine the estate recovery program implemented by Texas under federal law and to determine options the state has to improve recovery under and increase the efficacy of the program. The bill requires HHSC to conduct a study on imposing alternative income and asset limits for purposes of determining eligibility for

long-term services and supports under the Medicaid program and sets out the elements that HHSC is required to consider in conducting the study. The bill requires HHSC, not later than December 1, 2014, to submit a written report containing the findings of each study together with the HHSC 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**

C.S.H.B. 3791 includes a temporary provision, set to expire September 1, 2015, establishing the Medicaid Reform Task Force for purposes of advising HHSC in designing a state Medicaid plan and program and a program for ensuring health benefit plan coverage for certain low-income individuals that are consistent with the bill's provisions. The bill sets out the composition of the task force, including members appointed by the governor, lieutenant governor, and speaker of the house of representatives, and establishes that a member of the task force serves without compensation. The bill requires the appropriate appointing officers to appoint the members of the task force not later than January 1, 2014, and requires the task force to submit a report to the legislature not later than December 1, 2014.

#### **Miscellaneous**

C.S.H.B. 3791 requires a state agency that determines that a waiver or authorization from a federal agency is necessary for implementation of any of the bill's provisions to request the waiver or authorization and authorizes the agency to delay implementing that provision until the waiver or authorization is granted.

#### **EFFECTIVE DATE**

September 1, 2013.

#### **COMPARISON OF ORIGINAL AND SUBSTITUTE**

While C.S.H.B. 3791 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

##### INTRODUCED

SECTION 1. The legislature finds that:

- a) Our current Texas Medicaid program has reached an unsustainable capacity;
- b) Texas stands to gain coverage for a significant number of now uninsured residents through any healthcare expansion; and
- c) The current Texas network of hospital and physician providers cannot endure an expansion of patient need without significant reform;
- d) It is in the best interest of this state that the Legislature and the Texas Health and Human Services Commission negotiate a plan that considers the particular needs of Texas, our economy, and unique population.

##### HOUSE COMMITTEE SUBSTITUTE

**No equivalent provision.**

SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02105 to read as follows:

Sec. 531.02105. FLEXIBILITY FROM FEDERAL REQUIREMENTS. (a) The commission 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 flexibility to adjust the operation of the Medicaid program without the necessity of receiving federal approval for all changes to the program. Any agreement reached must identify broad categories of:

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

(2) program changes that require additional federal approval;

(b) In reaching an agreement, the commission shall ensure that any agreement:

(1) allows the state flexibility from federal requirements to develop a tailor insurance product for low-income adults;

(2) allows any product to leverage private markets by building on a managed care model and maximizing premium assistance where cost effective to the state;

(3) allow the product to prioritize personal responsibility by meaningful cost sharing requirements;

(4) benefits Texas taxpayers by providing appropriate health care coverage, encourages appropriate health care utilization in low-cost settings, provides meaningful tax relief at the local level, and frees up general revenue to support other state priorities.

(c) An agreement under this section may be limited in duration and may be contingent on the continued funding obligations of the federal government.

SUBCHAPTER B. FEDERAL AUTHORIZATION

Sec. 540.051. 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.

No equivalent provision.

SECTION 3. Subtitle I, Title 4, Government Code, is amended by adding Chapter 539 to read as follows:

CHAPTER 539. ALTERNATIVE MEDICAID EXPANSION PROGRAMS

Sec. 539.001. FEDERAL AUTHORIZATION FOR ALTERNATIVE MEDICAID EXPANSION PROGRAMS.

In addition to the commission's ability to negotiate under Section 531,02105, The commission shall actively negotiate with the United States secretary of health and human services, the federal Centers for Medicare and Medicaid Services, and other appropriate persons for federal authorization for the state to operate the component of the state Medicaid program for providing program benefits to the Medicaid expansion population under an alternative Medicaid expansion plan, including a block grant funding system or state plan amendment.

Sec. 539.002. MINIMUM REQUIREMENTS OF FEDERAL AUTHORIZATION.

Federal authorization obtained under Section 539.001 must allow for providing state Medicaid program benefits to recipients in the Medicaid expansion population under the same terms and conditions as an agreement under

ARTICLE 1. BLOCK GRANT FUNDING SYSTEM FOR STATE MEDICAID PROGRAM

SECTION 1.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 539 to read as follows:

CHAPTER 539. BLOCK GRANT FUNDING SYSTEM FOR STATE MEDICAID PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 539.001. 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. 539.002. 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 539.003, administer and operate the state Medicaid program in accordance with this chapter.

Section 531.02105

No equivalent provision.

Sec. 539.003. IMPLEMENTATION OF ALTERNATIVE MEDICAID EXPANSION PLAN. If the commission receives the authorization described by Section 539.002, the commission shall develop and provide any appropriate state Medicaid program.

No equivalent provision.

Sec. 539.003. 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 539.002, the federal law or authorization controls.

Sec. 539.004. 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. 539.005. RULES. The executive commissioner shall adopt rules necessary to implement this chapter.

SUBCHAPTER B. ACUTE CARE

Sec. 539.051. 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, 2013.

(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 540 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.

No equivalent provision.

Sec. 539.052. MEDICAID SLIDING SCALE SUBSIDIES. (a) An individual who is eligible for the state Medicaid program under Section 539.051 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 539.054(b).

No equivalent provision.

Sec. 539.053. ADDITIONAL COST-SHARING SUBSIDIES. In addition to providing a subsidy to an individual under Section 539.052, 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.

No equivalent provision.

Sec. 539.054. DELIVERY OF SUBSIDIES; HEALTH SAVINGS ACCOUNTS. (a) The commission shall

determine the most appropriate manner for delivering and administering subsidies provided under Sections 539.052 and 539.053. 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.

No equivalent provision.

Sec. 539.055. 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.

No equivalent provision.

Sec. 539.056. 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.

No equivalent provision.

#### SUBCHAPTER C. LONG-TERM SERVICES AND SUPPORTS

Sec. 539.101. 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.

SECTION 4. The Health and Human Services Commission shall actively develop a proposal for the authorization from the appropriate federal entity as required by Section 531.02105 and Chapter 539, Government Code, as added by this Act. 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.

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 540, 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.

SECTION 5. (a) The Health and Human Services Commission, the Texas Department of Insurance, or the commission in conjunction with the department, shall negotiate with the appropriate federal entity for authorization to develop any appropriate alternative Medicaid expansion plan, including a state health benefit exchange. The negotiated authorization must allow the state health benefit exchange to be flexible, patient-friendly, tailored to the needs of the state, and be similar to the health benefit exchange described in the Patients' Choice Act, S.B. 516, 111th Congress (2009), or H.R. 2520, 111th Congress (2009).

(b) If the appropriate federal entity authorizes an alternative Medicaid expansion plan, including a state health benefit exchange described in Subsection (a) of this section, the Health and Human Services Commission, the Texas Department of Insurance, or the commission in

No equivalent provision.

conjunction with the department, shall develop and implement the health benefit exchange.

No equivalent provision.

SECTION 6. Not later than September 1, 2013, the Speaker of the House and the Lieutenant Governor shall each appoint a chair and four additional members of their respective houses to advise the Health and Human Services Commission and the Texas Department of Insurance on negotiations with the federal government regarding federal authorization for the state to operate the component of the state Medicaid program for providing program benefits to the Medicaid expansion population under an alternative Medicaid expansion plan, including a block grant funding system or state plan amendment.

#### 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 539.001, 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 539.002, 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, 2014, the appropriate appointing officers shall appoint the members of the task force.  
(g) Not later than December 1, 2014, the task force shall submit a report to the legislature regarding its activities under this section.  
(h) This section expires September 1, 2015.

No equivalent provision.

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

No equivalent provision.

SECTION 2.01. Subtitle I, Title 4, Government Code, is amended by adding Chapter 540 to read as follows:  
CHAPTER 540. PROGRAM TO ENSURE HEALTH BENEFIT PLAN COVERAGE FOR CERTAIN INDIVIDUALS THROUGH PRIVATE MARKET SOLUTIONS  
SUBCHAPTER A. GENERAL PROVISIONS

No equivalent provision.

Sec. 540.001. DEFINITION. In this chapter, "medical assistance program" means the program established under Chapter 32, Human Resources Code.

No equivalent provision.

Sec. 540.002. 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 539.

No equivalent provision.

Sec. 540.003. 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.

No equivalent provision.

Sec. 540.004. NOT AN ENTITLEMENT. This chapter does not establish an entitlement to assistance in obtaining health benefit plan coverage.

No equivalent provision.

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

No equivalent provision.

SUBCHAPTER C. PROGRAM REQUIREMENTS

Sec. 540.101. 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 539 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.

No equivalent provision.

Sec. 540.102. 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.

No equivalent provision.

ARTICLE 3. MEDICAID:  
INCREMENTAL REFORM

No equivalent provision.

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.

No equivalent provision.

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:

No equivalent provision.

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.

No equivalent provision.

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.

No equivalent provision.

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.

No equivalent provision.

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, 2014, 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.

No equivalent provision.

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, 2014, 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.

No equivalent provision.

ARTICLE 5. FEDERAL AUTHORIZATION AND EFFECTIVE DATE

No equivalent provision.

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 7. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2013.

SECTION 5.02. This Act takes effect September 1, 2013.