SUBJECT: Adopting the Interstate Health Care Compact

COMMITTEE: State Sovereignty, Select — committee substitute recommended

VOTE: 5 ayes — Creighton, Branch, Darby, S. Miller, Pitts

0 nays

2 absent — Martinez Fischer, Thompson

WITNESSES: For — Susanna Dokupil, Health Care Compact Alliance; Mario Loyola, Texas Public Policy Foundation; Susan Nawojski; Suzanne Rogers; Julie Turner; Peggy Venable, Americans for Prosperity (*Registered, but did not testify*: Kathy Barber, National Federation of Independent Business; Gareth Ellzey; Rebecca Forest; Andrew Kerr, Texans for Fiscal Responsibility; Maria Martinez; Dustin Matocha, Young Conservatives of Texas, Empower Texans; Lee Spiller, Citizens Commission on Human Rights; Arlene Wohlgemuth, Texas Public Policy Foundation; Thomas Wolfe, Texas Conservative Coalition)

Against — Trey Berndt, AARP; Anne Dunkelberg, Center for Public Policy Priorities; Laura Guerra-Cardus, Children's Defense Fund - TX; Melanie Lantrip; (*Registered, but did not testify*: Miryam Bujanda, Methodist Healthcare Ministries; Ashley Harris, Texans Care for Children; Bob Kafka, ADAPT of Texas; Jodie Smith, Texans Care for Children)

On — John Hawkins, Texas Hospital Association; Bee Moorhead, Texas Impact

BACKGROUND: The U.S. Constitution, Article 1, section. 10, clause 3 prohibits states, without the consent of Congress, from entering into agreements or compacts with other states or a foreign power.

DIGEST: CSHB 5 would amend the Insurance Code to place into law the provisions of an Interstate Health Care Compact and to direct Texas to join the compact with other states to secure from the federal government primary responsibility to regulate and improve health care by its own legislature. A "member state" would be a state that signed the compact and had

adopted it under its laws. The bill would define health care to include a wide range of services, including preventive, therapeutic, physical or mental health and functioning, pharmacy, and individual or group health plans, except for plans provided by the U.S. Department of Defense and U.S. Department of Veteran Affairs or for Native Americans.

The bill would authorize Texas, as a member state, to suspend by legislation the operation of all federal laws, rules, and regulations that were inconsistent with the state's health care laws and regulations. Federal laws and regulations would remain in effect unless suspended, and Texas would be responsible for funding any unsuspended federal health care law or rule in effect after the compact's effective date.

The bill would provide that Texas as a member state would have the right to federal money up to an amount equal to its federally funded mandatory health care spending in fiscal 2010 and adjusted by factors that took into account changes in the state's average population as determined by the U.S. Bureau of the Census and inflation as measured using a Total Gross Domestic Product Deflator determined by the U.S. Department of Commerce.

The bill would create the Interstate Advisory Health Care Commission, whose membership would be determined by each member state and would be funded as agreed by the member states. Texas, as a member state, could not appoint more than two members and could withdraw membership at any time. The commission would be required to collect information and data to assist member states in their health care regulation and to share their information with the member states' legislatures. The commission could study health care regulation issues and make non-binding recommendations. The commission could have other responsibilities and duties as conferred by the member states' legislatures.

Member states by unanimous agreement could amend the compact, and the amendment would remain in effect unless Congress disapproved the amendment within one year. Texas, as a member state, could withdraw from the compact by adopting a law, but the withdrawal could not take effect until six months after the governor had informed the other member states.

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 September 1, 2011.

The bill provides that Texas would agree that the compact's effective date would be the latter of the date the compact was adopted under Texas law or the date when the compact was adopted by at least two states and received consent of the U.S. Congress. The compact would not take effect if, in consenting to the compact, Congress altered the compact's fundamental purposes.

SUPPORTERS SAY:

Federal health care requirements are driving rising and unsustainable state expenditures that are "breaking the banks" of Texas and other states. Medicaid spending, in particular, has grown by more than 170 percent over the last decade. State spending will grow exponentially when federal health care reform takes effect and an additional 2.1 million Texans become eligible for Medicaid by 2019. Texas must wrest control of health care spending and chart its own course that better responds to its unique demographic, geographic, and economic characteristics. A health care compact between Texas and at least one other state would allow us to gain this control.

The U.S. Constitution authorizes interstate compacts, which take the place of federal law. More than 200 compacts now exist to help states meet a range of issues, including transportation, supervision of former prisoners, and low-level radioactive waste disposal, and offer unused potential for other activities, including health care. Congress would have to pass a law to give consent to the compact, but no other legislation would be needed. Its approval of the Washington Metropolitan Area Transit Authority compact shows precedent for approving a compact that provides for the suspension of certain federal laws.

An interstate compact would preserve federalism by allowing each member state to create a health care system that aligned with their needs. Texas needs to use all legal tools at its disposal to protect areas of authority traditionally reserved for states and the health care interests of Texans.

The bill would initiate the state's membership into a potential compact and not bind its participation. The state could withdraw at any time because the

controlling provisions on withdrawal would be entirely specified within the compact.

Texas' control of health care regulation and programs would mean the state could apply innovative approaches and tailor programs to meet specific state needs. Federal Medicaid requirements are a "one size fits all" kind of approach that leaves little room for innovation. Federal maintenance of effort requirements prohibit Texas from making changes that would tailor Medicaid eligibility or make other meaningful reforms.

The compact would allow Texas to choose which federal programs it wanted to suspend, and Texas could choose to keep in place programs that were popular, such as Medicare, if warranted. Seniors may have paid into Medicare through their payroll taxes, but Medicare also is funded by other tax revenue, and the compact would give Texas the flexibility and control to assure that all Medicare spending was appropriate and in the best interest of Texans. Among the options would be to contract with the federal agency that now administers Medicare to assure program continuity, if warranted. Additional controls on Medicare would help prevent the federal government from shifting to the states the entire cost of care for individuals who were both Medicare and Medicaid eligible, which are now being split among the programs. Appropriate and effective use of the state's authority under the compact would be further assured by the passage of HB 273, which would establish a committee to examine and make recommendations about the state's capability to assume regulatory authority over health care.

Making meaningful changes would not mean reducing eligibility to publicly funded health care services, but participation in the compact would allow the state to better evaluate and respond to priority needs and populations. By re-directing funds from less important services or overly restrictive or prescriptive regulatory requirements, we can meet current eligibility levels, improve provider rates, and build health care capacity in other areas.

CSHB 5 would ensure adequate federal funding to meet changing capacity and service needs because the compact appropriately would calibrate Texas' share of federal funding to account for population growth and inflation. By establishing 2010 as a baseline year, federal funding would be pegged to the year when Texas enjoyed its highest federal matching rate for Medicaid due to federal stimulus funding. It is uncertain whether

Texas in subsequent years would forgo additional funding related to federal health care reform because of the compact, since health care reform is being challenged by several states and entities and ultimately may be invalidated or repealed.

Congress is too distant and gridlocked to devise laws and regulations that respond to issues as personal as health care. These decisions should be made as close to home as possible, by Texans for Texans.

Fears of Texans having reduced access to safe, quality health care when compared to other states are unwarranted. The bill specifically states that member states would pledge to improve health care policy within their jurisdictions. The bill also would require states' federal funding to be audited by the U.S. Government Accountability Office.

The health care compact would be governance reform, not health care reform, and would leave health care policy decisions entirely in the hands of Texas. The compact would allow Texas to provide safe, high-quality health care in a way that was fiscally responsible under the control of state lawmakers who were more responsive, accountable and accessible to Texas citizenry and able to increase marketplace competition and options. Texas could set health care service standards other states may want to emulate.

Congress would have trouble saying no to a compact that was enacted by several states. Legislatures in many more states are now considering participation in the compact. The legislatures in Arizona and Georgia have already adopted this legislation. At the very least, enactment of this bill by Texas and other states would require Congress to better address states' demands for more state control. For example, state demands were critical in reforming welfare programs in the 1990s.

OPPONENTS SAY:

Rising state health care expenditures are largely related to population growth, health status, aging and the emergence of new technologies and therapies. Increased health spending in both the public and private sectors is nothing new, and it has typically outpaced economic growth since the 1960s. Since the interstate compact proposed by CSHB 5 could not slow these trends and Texas has continuously implemented reforms to contain Medicaid costs and incentivize innovation, the most likely result of Texas' participation in the compact would be kicking low-income, often aged or

unhealthy, and mentally, developmentally or physically disabled people off of much-needed, federally supported health care services.

The bill would not require Texas to build capacity to meet the needs of its population, and therefore would not guarantee that Texas would have a better health care system or would keep eligibility standards in place. Medicaid eligibility in Texas is among the lowest in the United States, and with 6.4 million uninsured people, many are now going without needed health care.

It is unrealistic to believe that under the compact's funding scheme, Texas would have the financial resources to be able to extend and improve services or keep eligibility levels. This session, the state is unable to create a budget for fiscal 2012-13 that meets current service levels on most health and human service programs, even with dramatic cuts in provider rates and cost-reducing improvements in program administration. Any increase in capacity would be financed solely by state dollars, since the compact would lock Texas' federal funds at a 2010 level that would adjust only for growth and inflation. Since Texas' current Medicaid expenditures are well below the national average, we would receive less initial funding relative to other states. Additionally, the funding formula would mean Texas would lose about $120 billion in new federal funds related to health care reform.

This bill could jeopardize Medicare, which is a crucial health care support for seniors of all income levels. Medicare is a program that people earned by paying into it during their working years, and should not be tampered with. Texas has no experience administering Medicare, and even if it kept federal Medicare laws and rules in place, it would still be responsible for running and funding it. Keeping Medicare a federally run and funded program also will help seniors maintain a similar level of quality care, regardless of where they moved or traveled within the United States. No serious federal proposals exist to pass onto states the entire cost of individuals called "dual eligibles," whose health care costs are now shared by Medicare and Medicaid. The only proposals recently considered have been to shift the entire cost of dual eligibles to the federal government.

It would be irresponsible of Texas legislators to agree to this unprecedented compact that could bind Texas to an unknown fate. The governor of Arizona wisely vetoed that state's compact bill on April 18, citing the likelihood that that the state's citizens, especially seniors, would

be penalized if the state assumed control of health care spending from the federal government.

Interstate compacts do not replace or nullify federal law, but are designed to facilitate states' interactions in common regulatory activities. An interstate compact has never been used for health care. Congress does not relinquish any powers by consenting to a compact. It is unclear whether Congress could consent to this compact without passing legislation authorizing states to suspend federal law and whether Texas could unilaterally withdraw from a Congress-approved compact without Congressional approval.

Suspending federal health care laws and regulations could endanger the health of Texans and create a lower level of health care for Texans when compared to residents of other states. Federal health care regulations provide the most equitable basis for health service access for all U.S. citizens and often are needed as a check and balance to lapses in state regulation or enforcement.

OTHER OPPONENTS SAY:

This bill is more a political and symbolic exercise against recent federal actions than a realistic way of addressing our health expenditures. The chances are slim that Congress would approve a compact that required them to give states money without directing its spending. The Texas Legislature directs all spending of state tax dollars because it is the prudent and fiscally responsible way to manage money, and Congress should be expected to act similarly. There is no reason to believe that state lawmakers would be more responsive or fiscally responsible than members of the U.S. House or Senate.

NOTES:

The committee substitute removed a statement that the preliminary estimate of Texas' base funding level is about $60.4 billion.

HB 273 by Zerwas, which would create a committee to study and make recommendations to the governor and the Legislature about the most efficient use of the authority provided by an interstate health care compact, was reported favorably, without amendment, by the Select Committee on State Sovereignty on April 14.