LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 81ST LEGISLATIVE REGULAR SESSION

March 19, 2009

TO: Honorable Patrick M. Rose, Chair, House Committee on Human Services

FROM: John S. O'Brien, Director, Legislative Budget Board

IN RE: **HB2962** by Coleman (Relating to eligibility for and administration of the child health plan and Medicaid programs.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for HB2962, As Introduced: a negative impact of ($589,300,568) through the biennium ending August 31, 2011.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2010	($148,672,647)
2011	($440,627,921)
2012	($654,040,835)
2013	($676,791,803)
2014	($698,543,203)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/ (Cost) from *GR Match For Medicaid* 758	Probable Savings/ (Cost) from *General Revenue Fund* 1	Probable Savings/ (Cost) from *GR Match For Title XXI* 8010	Probable Savings/ (Cost) from *Premium Co-payments* 3643
2010	($93,774,328)	($4,718,213)	($50,180,106)	($4,665,990)
2011	($343,334,918)	($8,500,377)	($88,792,626)	($12,291,450)
2012	($548,853,251)	($9,195,345)	($95,992,239)	($20,376,284)
2013	($570,787,863)	($9,270,879)	($96,733,061)	($20,807,817)
2014	($594,160,046)	($9,136,250)	($95,246,907)	($21,120,832)

Fiscal Year	Probable Savings/ (Cost) from *Experience Rebates-CHIP* 8054	Probable Savings/ (Cost) from *Vendor Drug Rebates-CHIP* 8070	Probable Savings/ (Cost) from *Vendor Drug Rebates-Medicaid* 706	Probable Savings/ (Cost) from *Federal Funds* 555
2010	($2,843,977)	($2,789,413)	($3,025,662)	($275,005,718)
2011	($5,124,099)	($4,996,595)	($6,944,006)	($749,082,987)
2012	($5,542,825)	($5,404,275)	($6,940,624)	($1,064,676,678)
2013	($5,589,159)	($5,451,267)	($6,940,624)	($1,098,251,657)
2014	($5,507,165)	($5,373,071)	($6,940,624)	($1,127,746,842)

Fiscal Year	Probable Revenue Gain from *Premium Co-payments* 3643	Probable Revenue Gain from *Experience Rebates-CHIP* 8054	Probable Revenue Gain from *Vendor Drug Rebates-CHIP* 8070	Probable Revenue Gain from *Vendor Drug Rebates-Medicaid* 706
2010	$4,665,990	$2,843,977	$2,789,413	$3,025,662
2011	$12,291,450	$5,124,099	$4,996,595	$6,944,006
2012	$20,376,284	$5,542,825	$5,404,275	$6,940,624
2013	$20,807,817	$5,589,159	$5,451,267	$6,940,624
2014	$21,120,832	$5,507,165	$5,373,071	$6,940,624

Fiscal Year	Change in Number of State Employees from FY 2009
2010	(150.0)
2011	(306.0)
2012	(306.0)
2013	(306.0)
2014	(306.0)

Fiscal Analysis

Section 1 requires the Health and Human Services Commission (HHSC) to take all necessary actions to modify or maintain enrollment and retention processes employed in the Children's Health Insurance Program (CHIP) and the Medicaid program to ensure receipt of certain federal performance bonus payments. The bill sets forth actions HHSC is required to take with regard to children younger than 19 years of age, including implementing or maintaining the following: 12 months continuous eligibility in CHIP and Medicaid (12 months continuous eligibility is proposed in Section 9 of the bill); liberalizing asset test requirements; eliminating personal interview requirements for determining eligibility; using the same forms and information verification process for determining eligibility for CHIP and Medicaid; using automatic administrative processes for recertifying eligibility; and using ex parte process with regard to personal interviews.

Section 2 would add work-related expenses to the expenses that are deducted from family income for the purpose of determining income eligibility for the Children's Health Insurance Program (CHIP).

Section 3 requires the Health and Human Services Commission (HHSC) to increase income eligibility for CHIP from at or below 200 percent of the federal poverty level (FPL) to at or below 300 percent of FPL.

Sections 3 and 10 would eliminate HHSC’s authority to establish eligibility standards regarding the amount and types of allowable assets for a family whose net family income is above 150 percent of FPL.

Sections 4 and 10 eliminate the review of income during the sixth month of enrollment currently required for families with income above 185 percent of FPL.

Section 5 requires CHIP to provide, at a minimum, the covered benefits as described in certain legislative interim reports and as provided under the plan on June 1, 2003.

Section 8 requires the executive commissioner of HHSC to develop and implement a CHIP buy-in option for children whose net family income exceeds 300 percent of FPL, but does not exceed 400 percent FPL. This option would require payment of 100 percent of the health benefits plan premium; fees to offset administrative costs; and additional deductibles, coinsurance, or other cost-sharing payments as determined by the executive commissioner. The buy-in option would also provide for a waiting period comparable to that for CHIP. The executive commissioner would be allowed to establish rules and procedures for the buy-in option that differ from those generally applicable to CHIP. To the extent allowed by federal law, the buy-in option would be required to include provisions designed to discourage crowd-out. Section 9 requires the executive commissioner, by November 1,

2010, to adopt rules as necessary to implement the buy-in option.

Section 9 establishes a period of continuous eligibility not to exceed 12 months for children under 19 years of age in Medicaid, replacing the current six months of eligibility.

Section 10 would also eliminate HHSC's authority to establish prescription drug limits in CHIP and eliminate the authorization for cost-sharing provisions to be based on the maximum level authorized under federal law and to be applied to income levels in a manner that minimizes administrative costs.

Section 12 provides that the changes in law made by the bill would apply to initial determination of eligibility or a recertification of eligibility for CHIP or the Medicaid program prospectively on or after September 1, 2009.

Section 13 requires state agencies to request any federal waiver or authorization necessary to implement any provisions of the bill and authorizes them to delay implementation until the waivers or authorizations are granted.

Methodology

Section 1: The agency assumes that to qualify for federal bonus payments under Section 2105(a)(3), Social Security Act, the Medicaid program would need to implement an auto reenrollment for clients and 12 months continuous eligibility (12 months continuous eligibility is addressed below in Section 9). The agency assumes client services as contemplated in this section, would begin September 1, 2010. The agency assumes the additional cost to the program from higher caseloads from auto enrollment would be $334.5 million All Funds, including $137.3 million in General Revenue Funds, in fiscal year 2011; $835.0 million All Funds, including $342.7 million in General Revenue Funds, in fiscal year 2012; $888.5 million All Funds, including $364.6 million in General Revenue Funds, in fiscal year 2013; and $945.4 million All Funds, including $388.0 million in General Revenue Funds, in fiscal year 2014. The agency estimates a cost of $4.0 million All Funds, including $2.0 million in General Revenue Funds, in fiscal year 2010 for one time changes to automated systems. The total net cost for the 2010-11 biennium for Section 1 would be $338.5 million All Funds, including $139.3 million in General Revenue Funds.

Sections 2-6, 10: It is assumed that beginning September 1, 2009 clients between 200 and 300 percent of FPL will begin enrolling in CHIP. It is assumed that annual enrollment fees will be established in the amount of $65 for families between 200 and 250 percent of FPL and $85 for families between 250 and 300 percent FPL. It is assumed that beginning September 1, 2009, income reviews during the sixth month of enrollment will be eliminated, the assets test will be eliminated, work-related expenses will be disregarded from income, and any required changes to benefits will be in place. All other costs and program policies are maintained at the level assumed for children at or below 200 percent of FPL.

Federal law currently caps income eligibility for CHIP at 50 percentage points above the highest limit for children enrolled in Medicaid; in Texas this cap would be 235 percent of FPL. HHSC indicates that the state may be allowed to "disregard" income above 235 percent of FPL. It is assumed that federal matching funds will be available for children above 235 percent FPL, but if the state does not get approval to enroll children above 235 percent FPL additional General Revenue Funds would be required to fund them.

It is estimated that the cumulative impact of all required changes contained in these sections would result in an additional 111,189 average monthly recipient months in fiscal year 2010; 199,933 in fiscal year 2011; 216,321 in fiscal year 2012; 218,202 in fiscal year 2013; and 215,071 in fiscal year 2014. There would also be additional administrative expenditures associated with the expanded program including one-time costs for system changes and policy implementation and ongoing costs for eligibility and enrollment broker services and postage.

The total cost of these sections is estimated to be $202.8 million All Funds, including $65.2 million in General Revenue Funds, in fiscal year 2010; $359.0 million All Funds, including $113.7 million in General Revenue Funds, in fiscal year 2011; $388.3 million All Funds, including $123.0 million in General Revenue Funds, in fiscal year 2012; $391.5 million All Funds, including $124.2 million in

General Revenue Funds, in fiscal year 2013; and $385.8 million All Funds, including $122.5 million in General Revenue Funds in fiscal year 2014. These General Revenue Funds amounts include expenditure of additional collections of Vendor Drug Rebates for CHIP, Experience Rebates, and Premium Copayments totaling $10.3 million in fiscal year 2010, $16.4 million in fiscal year 2011, $17.8 million in fiscal year 2012, $18.2 million in fiscal year 2013, and $18.2 million in fiscal year 2014. It is assumed that CHIP federal matching funds will be available; however, if the state exhausts its capped federal allotment, General Revenue Funds would be required in lieu of assumed Federal Funds.

Section 8: It is assumed that it will take a year for the agency to obtain the necessary waivers and authorizations and to perform required start-up activities. It is assumed that client services will begin September 1, 2010.

It is estimated that the buy-in program would take a year to reach full caseload resulting in 3,490 average monthly recipient months in fiscal year 2011; 7,848 in fiscal year 2012; 7,940 in fiscal year 2013; and 8,048 in fiscal year 2014. The average cost per recipient month is estimated to be $143.39 in each fiscal year. The client services cost of the project is estimated to be $6.0 million in fiscal year 2011, $13.5 million in fiscal year 2012, $13.7 million in fiscal year 2013, and $13.8 million in fiscal year 2014. It is assumed that the client services portion of the project will be funded entirely through collection of Premium Copayments.

There would also be administrative expenditures associated with the buy-in program estimated to be $1.8 million All Funds, including $0.9 million in General Revenue Funds, in fiscal year 2010; $0.4 million All Funds, including $0.2 million in General Revenue Funds, in fiscal year 2011 and $0.9 million All Funds, including $0.4 million in General Revenue Funds, in fiscal year 2012 and subsequent years. These amounts include one-time costs for system changes and policy implementation and ongoing costs for eligibility and enrollment broker services, postage, and collection of premiums. It is assumed that matching federal funds will be available at the Medicaid administrative 50/50 match.

The total cost of Section 8 is estimated to be $1.8 million All Funds, including $0.9 million in General Revenue Funds, in fiscal year 2010 rising to $14.8 million All Funds, including $14.3 million in General Revenue Funds, by fiscal year 2014. These General Revenue amounts include expenditure of collected Premium Copayments.

Section 9: It is assumed that beginning September 1, 2009 a period of 12 months continuous eligibility would replace the current six months of eligibility for all children enrolling in or renewing Medicaid on or after that date. It is assumed that children enrolled in the program prior to September 1, 2009 would receive six months of continuous eligibility until their next renewal. If the bill were implemented such that 12 months continuous eligibility would apply to all clients on September 1, 2009, including those already enrolled in the program, the cost of implementation would be higher.

It is estimated that 12 months continuous eligibility would result in an additional 113,917 average monthly recipient months in fiscal year 2010 and 258,385 in fiscal year 2011 and subsequent years. The average cost per recipient month is estimated to be $168.77 in fiscal year 2010 and $169.11 in fiscal year 2011 and beyond. The additional cost to the program from higher caseloads would be $230.7 million All Funds, including $95.1 million in General Revenue Funds, in fiscal year 2010 rising to $524.3 million All Funds, including $215.3 million in General Revenue Funds, in fiscal year 2011 and $524.3 million All Funds, including $215.2 million in General Revenue Funds, in fiscal year 2012 forward. These General Revenue Funds amounts include expenditure of additional collections of Vendor Drug Rebates for Medicaid totaling $3.0 million in fiscal year 2010 and $6.9 million in fiscal year 2011 and subsequent years.

There would be a net savings in administrative expenditures of $2.3 million All Funds (including $1.2 million in General Revenue Funds) in fiscal year 2010 and $5.1 million All Funds (including $2.5 million in General Revenue Funds) in fiscal year 2011 forward. This includes one-time costs for system changes and policy implementation; additional cost for enrollment broker services, outreach, and postage; and savings from FTE reductions. Savings from FTE reductions total $6.2 million All Funds from reduction of 150 FTEs in fiscal year 2010 and $12.7 million All Funds from reduction of

306 FTEs in fiscal year 2011 and beyond.

The total net cost of Section 9 is estimated to be $228.4 million All Funds, including $93.9 million in General Revenue Funds, in fiscal year 2010; $519.3 million All Funds, including $212.8 million in General Revenue Funds, in fiscal year 2011; and $519.3 million All Funds, including $212.7 million in General Revenue Funds, in fiscal year 2012 and subsequent years.

The total net cost of the bill is estimated to be $437.0 million All Funds, including $162.0 million in General Revenue Funds, in fiscal year 2010 increasing to $1,865.2 million All Funds, including $737.5 million in General Revenue Funds, by fiscal year 2014. State General Revenue cost for the 2010-11 biennium could be lower to the extent that federal stimulus improves the federal match for Medicaid client services.

Technology

Technology costs included above total $7.5 million All Funds, including $3.4 million in General Revenue Funds, in fiscal year 2010 for one-time costs associated with system changes.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission

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