LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

April 3, 2007

TO: Honorable Jane Nelson, Chair, Senate Committee on Health & Human Services

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

IN RE: **SB10** by Nelson (Relating to the operation and financing of the medical assistance program and other programs to provide health care benefits and services to persons in this state.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for SB10, As Introduced: a negative impact of ($391,134,690) through the biennium ending August 31, 2009.

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
2008	($6,547,065)
2009	($384,587,625)
2010	($382,173,317)
2011	($381,810,408)
2012	($381,227,807)

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue (Loss) from *GENERAL REVENUE FUND* 1	Probable Revenue Gain from *New Trust Fund outside Treasury*	Probable (Cost) from *GR MATCH FOR MEDICAID* 758	Probable (Cost) from *FEDERAL FUNDS* 555
2008	$0	$0	($6,547,065)	($7,680,403)
2009	($393,254,585)	$3,000,000,000	($10,320,693)	($14,381,241)
2010	($394,441,663)	$3,000,000,000	($9,737,010)	($13,514,339)
2011	($396,871,660)	$3,000,000,000	($9,968,645)	($13,861,744)
2012	($399,257,205)	$3,000,000,000	($10,228,491)	($14,251,513)

Fiscal Year	Probable Savings from *GR MATCH FOR MEDICAID* 758	Probable Savings from *FEDERAL FUNDS* 555	Change in Number of State Employees from FY 2007
2008	$0	$0	14.0
2009	$18,987,653	$29,342,779	57.0
2010	$22,005,356	$33,812,232	99.0
2011	$25,029,897	$38,350,128	182.0
2012	$28,257,889	$43,189,337	262.0

Fiscal Analysis

Section 1 (Sec.531.094) would require the Health and Human Services Commission (HHSC) to develop and implement a pilot program in one region of the state, which would establish incentives to encourage Medicaid recipients to lead healthy lifestyles. In establishing incentives HHSC could choose to provide expanded health benefits or value-added benefits, establish reward accounts for Medicaid recipients in disease management programs to be used to purchase health related items that are not covered by Medicaid, or implement other incentives as determined by HHSC. The bill would require HHSC to implement the pilot by September 1, 2008 and to provide a report to the legislature with the pilot analysis and recommendations regarding the continuation or expansion of the pilot no later than December 1, 2010. This section expires September 1, 2011.

Section 1 (Sec 531.0941) would require HHSC to develop and implement a Medicaid health savings account (HSA) pilot program consistent with the federal law, if HHSC determines that it is feasible. This pilot program is to encourage health care costs awareness and sensitivity among Medicaid recipients, and to promote appropriate utilization of Medicaid services.

Section 1 (Sec 531.097) would authorize HHSC to seek an 1115 Medicaid waiver to develop and implement tailored benefit packages designed to: (1) provide Medicaid benefits that are customized to meet the health care needs of recipients within defined categories of the Medicaid population; (2) improve health outcomes for recipients; (3) improve recipients access to services; (4) achieve cost savings and efficiency, and (5) reduce the administrative complexity of delivering Medicaid benefits. The bill gives the Executive Commissioner of HHSC broad discretion to develop the tailored benefit packages, specify certain benefit requirements for tailored benefit packages, and determine populations to which a benefit package could apply.

Section 1 (Sec 531.0971) would require HHSC to identify state or federal non-Medicaid programs that provide healthcare services, which could be provided under a Medicaid-tailored benefit package. HHSC would be required to implement tailored benefit packages for the identified populations, if determined to be feasible and as permitted by law, and if necessary implement a system of blended funding methodologies to provide those services.

Section 2 (Sec. 531.1112) would require HHSC and the Office of Inspector General to study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in the Medicaid program. Analysis must include feasibility determination of using technology for citizenship and eligibility verification. HHSC would be required to provide a report to the legislature detailing the findings and implementation plans by December 1, 2008.

Section 3 of the bill would amend Chapter 531, Government Code by adding Subchapter N. This section would authorize HHSC to seek a Medicaid waiver to implement the Texas Health Opportunity Pool (THOP). Federal Disproportionate Share Hospital (DSH) funds, Upper Payment Limit (UPL) funds, any other federal funds, and state funds as necessary would be deposited in the THOP. These pooled funds would be deposited into an account outside the General Revenue Fund. This section would require that THOP funds be distributed based on a methodology developed by the HHSC Executive Commissioner. THOP funds would be used to reduce the number of persons in Texas who do not have health insurance coverage, the need for uncompensated care provided by Texas hospitals, and for any other purpose specified by the waiver. To be eligible for THOP funds, hospitals and counties must use a portion of the funds to reduce the need for uncompensated hospital care. This section would authorize allocation of funds from the THOP to reduce the number of individuals without access to health benefit coverage or to reduce the need for uncompensated healthcare by (1) providing premium payments assistance to eligible individuals and (2) making contributions to health savings accounts for those individuals. This section would also require HHSC and the Texas Department of Insurance (TDI) to develop a premium payment assistance program for individuals without access to health coverage. HHSC would be required to implement this program subject to additional appropriations. This section would cap the maximum amount of THOP funds that can be used for infrastructure improvements of local provider networks that deliver services to Medicaid recipients and low-income uninsured individuals. This section would also require HHSC to identify state and local healthcare related program expenditures that are not matched with federal funds, and explore the feasibility of certifying or using these funds as state match for the DSH and UPL

programs.

Section 4 (Sec. 530.551-552) of the bill would amend Chapter 531, Government Code by adding Subchapter O to require the Executive Commissioner of HHSC to develop rules to adopt a standard definition of uncompensated hospital care, set a methodology to compute the cost of that care, and establish procedures for the reporting of the uncompensated care. The rules would include procedure for the review of the information reported by hospital for completeness and accuracy. The Executive Commissioner of HHSC is directed to establish a work group on uncompensated hospital care by October 1, 2007, and adopt the rules for standardization of uncompensated hospital care no later than March 1, 2008.

Section 5 (Sec. 530.019) would direct HHSC to actively encourage managed care organizations (MCOs) that contract with HHSC to provide benefits to include value-added services that are in addition to the services that are covered by the benefit plan and that have the potential to improve the health status of enrollees of the plan.

Section 6 (Sec. 32.0422) would establish tiers of participation in the Health Insurance Premium Payment (HIPP) program and make the program available only to individuals who are not eligible for the Medicaid opt-out program created by the bill. The bill would create two tiers of participation within HIPP. The first tier would be those individuals who are not eligible for Medicaid opt-out but are eligible for HIPP and are determined to be cost effective. This tier would receive current HIPP benefits.

The second tier would be those individuals who are not eligible for Medicaid opt-out and are identified as being eligible to enroll in a group health benefit plan offered by the individual's employer. The bill would require HHSC, if HHSC determines that enrolling certain individuals in a group health benefit plan is not cost-effective, but an individual prefers to enroll in that plan instead of receiving benefits and services through Medicaid and if authorized by a waiver obtained under federal law, to: allow the individual to enroll in the plan; consider that individual to be a recipient of Medicaid; and provide written notice to the issuer of the group health benefit plan in accordance with Chapter 1207, Insurance Code. The bill would require HHSC to pay the employee's share of the required premiums, except that if the employee's share of the required premiums exceeds the Medicaid premium rate for the individual, the individual would be required to pay the difference between the required premiums and the Medicaid premium rate. In addition, subject to federal law, the individual would be required to pay all deductibles, copayments, coinsurance, and other cost-sharing obligations imposed on the individual under the group health benefit plan.

Section 7 (Sec. 32.04221) would require HHSC to seek a federal waiver to allow a person eligible for or receiving Medicaid to voluntarily opt out of receiving services under Medicaid and enroll in a group health benefit plan offered by an employer. HHSC would pay the employee's share of the required premium, up to the Medicaid premium rate; participants would be required to pay the difference in the premium amount, as well as any deductibles, copayments, coinsurance and other cost-sharing obligations imposed by the plan. Persons, who opt out of Medicaid, would not be eligible for wrap-around services provided by Medicaid. Individuals eligible for opt-out option, who would chose not to participate in the employer-sponsored benefit plan and continue receiving services under Medicaid, would not be eligible to participate in HIPP.

Section 8 (Sec. 32.0641) would require HHSC to adopt cost-sharing provisions for high-cost medical services provided to the Medicaid recipients at the hospital emergency room (ER) departments when a lower-cost medical services is available, if HHSC determines that it is feasible and cost-effective and to the extent permitted under federal law or a federal waiver. HHSC would also be required to determine other medical services that are high-cost services.

Section 9 would amend Health and Safety Code to allow local entities to propose a multiple share program to HHSC, and authorize HHSC to seek a waiver to use Medicaid or Children's Health Insurance Program (CHIP) funds to finance the public share of a multiple share program. The section would authorize HHSC to determine the scope of multiple share programs, define funding options for the public share of the program, and set certain requirements for the contribution of shares by employer (at least one-third of the cost of coverage) and the state (not more than one-third). HHSC

would be given authority to define the types of local entities that would be able to participate in the program as a partnering entity, determine eligibility criteria for participating employers and employees, and determine a minimum benefit package for programs that offer non-insurance health benefit plan. HHSC would be required to adopt rules for the multiple share program implementation by January 1, 2008. This section would become effective immediately if it receives two-thirds of votes, otherwise it would take effect on September 1, 2007.

Section 10 would establish a committee on health and long-term care insurance incentives to study and develop recommendations regarding methods to reduce the need for the state's residents to rely on Medicaid by establishing incentives for employers to provide health insurance and/or long-term insurance. This committee would be required to submit a report with committee's recommendations to the various legislative committees by September 1, 2008.

Section 11 would require HHSC to conduct a study regarding the feasibility and cost-effectiveness of developing and implementing an integrated Medicaid managed care model designed to improve the management of care provided to Medicaid recipients who are aging, blind, disabled, or those who have chronic healthcare needs and those who are not enrolled in a capitated managed care. HHSC would be required to submit a report detailing results of the study to the standing legislative committees that have primary jurisdiction over Medicaid by September 1, 2008.

Section 12 would require HHSC to request a waiver or authorization from a federal agency if needed to implement the provisions.

Section 13 would set the effective date for the bill on September 1, 2007, unless otherwise specified by the bill.

Methodology

This analysis assumes that HHSC would be able to obtain necessary federal approvals in fiscal year 2008 and implement provisions of the bill in 2009.

Section 1

Sec. 531.0941 Medicaid Health Savings Account Pilot Program: HHSC estimates a cost of $1.4 million in All Funds, including $0.6 million in General Revenue Funds, for fiscal years 2009 and beyond to contract with a third party vendor who would provide customer assistance, maintain client accounts and enroll providers that currently do not contract with Medicaid. Since HHSC assumes that obtaining a federal approval to implement a health savings account (HSA) could take 12 months, all administrative costs are estimated starting in fiscal year 2009.

HHSC also estimates that in 2008-09 biennium there will be additional costs associated with changes to the claims payment system and eligibility and enrollment system, and increase in the number of calls from Medicaid recipients and program providers. These costs are estimated to be $4.9 million in All Funds, including $2.3 million in General Revenue Funds.

Sec. 531.097 Tailored Benefit Packages for Certain Categories of the Medicaid Population: HHSC indicates that tailored benefit packages could be done through healthcare management or more intensive healthcare management to specific Medicaid populations. HHSC also indicates that partnering with Medicare for clients that are eligible for Medicare and Medicaid could result in better client case management. HHSC assumes that there will be a decrease in the client costs for individuals that participate in tailored benefit packages in the amount of $51.4 million in All Funds, including $20.5 million in General Revenue Funds in fiscal year 2009. In the following years client costs would decline in the following manner: fiscal year 2010 - $58.2 million in All Funds, including $23.3 million in General Revenue Funds; fiscal year 2011 - $65.7 million in All Funds, including $26.3 million in General Revenue Funds; and in fiscal year 2012 - $73.7 million in All Funds, including $29.5 million in General Revenue Funds.

HHSC estimates that there would administrative costs in fiscal year 2008 related to the claims payment and eligibility and enrollment system changes necessary to implement provisions of the

section, in the amount of $1.9 million in All Funds, including $0.9 million in General Revenue Funds. In addition, starting in fiscal year 2009 and beyond HHSC assumes that there would be an increase in the enrollment broker fees in the amount of $3.2 million, including $1.6 million in General Revenue Funds. This estimate is based on the assumption that 67,000 Medicaid recipients would be receiving services via tailored benefit packages.

Section 3

Section 3 assumes both the THOP account and a premium payment program would be established in fiscal year 2009 and be funded using existing Medicaid DSH and UPL payments which total an estimated $3.0 billion in All Funds ($1.5 billion in DSH and $1.5 billion in UPL payments). This amount is shown above as a revenue gain to a new account outside the treasury. No other state funds are assumed to be included in the THOP account. It is assumed that local public hospitals and state-owned hospitals continue to provide intergovernmental transfers to draw federal funds for the THOP account. The THOP account would be used for the distribution of THOP funds, provider infrastructure, and the premium assistance program. It is estimated that HHSC's administrative costs of additional FTEs to determine eligibility and enroll uninsured clients into the premium payment assistance program would be funded by the THOP account ($1,744,230 for 40 in fiscal year 2009, $3,119,341 for 82 in fiscal year 2010, $6,276,724 for 165 in fiscal year 2011, and $9,319,984 for 245 in fiscal year 2012). The premium assistance program's All Funds cost is estimated at $5,973,839 in fiscal year 2009, $12,058,412 in fiscal year 2010, and $24,171,309 in fiscal year 2011, and $36,118,987 in fiscal year 2012. The remaining estimated $2.9 billion will be available to hospitals to implement Section 3 provisions related to reducing the number of uninsured individuals.

Approximately $288.8 million per year related to the DSH program and approximately $39.6 million per year from the UPL program are currently transferred to Unappropriated General Revenue, based on payments for state-owned hospitals. Section 3 provisions that include state revenue as necessary in the THOP could potentially have a significant negative impact on General Revenue if these transfers to unappropriated General Revenue were pooled into the THOP (total loss of $328.4 million each year). This amount is shown above as a loss to General Revenue. It is assumed that Section 3 would also have a negative impact on state-owned hospitals that receive DSH and/or UPL payments. Approximately, $541.1 million in All Funds that is currently distributed to only state-owned hospitals would be pooled and distributed using a methodology that may not distribute the same amount of funds to state-owned hospitals due to additional non-state-owned hospitals being eligible for THOP funds and funding the premium assistance program with THOP funds. Section 531.503 of the bill allows THOP funds to be distributed based on the providers' costs related to providing uncompensated care. Assuming state-owned hospitals provide 16 percent of the total uncompensated care (based on the 2005 Annual Survey of Hospitals); state-owned hospitals would receive approximately $476.2 million each year from the THOP, with a net loss of $64.9 million.

Section 6

HHSC assumes that changes related to the increased efforts to identify individuals eligible to enroll in a group health benefit plan would result in a 5 percent increase in the number of clients eligible for HIPP in fiscal year 2009, and 3.6 percent increase in each fiscal year beyond 2009. This percent increase would correspond to 650 additional individuals eligible for HIPP in fiscal year 2009, and based on the current saving trends in HIPP, the program could save Medicaid additional $840,627 in All Funds in the same year, including $335,915 in General Revenue Funds. Additional participation in HIPP could save $870,890 in All Funds in fiscal year 2010, $902,242 in fiscal year 2011 and $934,722 in fiscal year 2012.

The impact of the Medicaid opt-out program (Section 7 of the bill) is not considered in this saving estimate because eligibility criteria for the opt-out program are unknown.

Section 7

Depending on the design of the Medicaid opt-out waiver, there is a potential that the HIPP program would be eliminated. If individuals from all eligibility groups in Medicaid were eligible to participate in the opt-out, then none of these individuals could enroll in HIPP.

Based on the HHSC analysis, in fiscal year 2008 there will be additional administrative costs in the amount of $4.9 million in All Funds, including $2.1 million in General Revenue Funds. These costs would relate to the eligibility and claims processing systems changes, as well as printing expenses for the application forms. HHSC estimates that in fiscal year 2009, the Medicaid opt-out program would represent a cost of $16.8 million in All Funds, including $6.7 million in General Revenue Funds. This estimate is based on the assumption that individuals currently eligible for HIPP would no longer be able to participate in the program, and that these individuals would not switch to opt-out. There could be savings from the Medicaid recipients participating in the opt-out program, however, this participation is not estimated, since there is no available data to assist in determining the number of Medicaid recipients that would be interested to opt-out on voluntary basis.

Section 8. Cost-sharing for Certain High-Cost Medical Services: This analysis assumes that HHSC would establish ER cost-sharing requirements for the population with family income above 100 percent of the Federal Poverty Level (FPL). Individuals with income between 100 and 150 percent of FPL would be required to contribute $6 in cost-sharing, which represents a maximum allowable charge under federal Deficit Reduction Act (DRA). Medicaid recipients with income between 150 and 185 percent of FPL would have a co-payment of $25 for a non-emergent visit to ER. Individuals with income above 185 percent of FPL would have a $50 co-payment for each non-emergent visit. DRA does not set upper limit for each non-emergent visit for individuals with income about 150 percent of FPL, but states that total cost sharing cannot exceed five percent of the family's income. HHSC estimates that maximum revenue amount from the cost-sharing obligations collected at the ER departments could be $840,677. HHSC does not assume any cost-sharing obligations for individuals with income below 100 percent of FPL. Even though DRA did not prohibit states from establishing cost-sharing requirements for individuals in this income category, HHSC assumes that co-pay collection for these recipients cannot be enforced.

HHSC estimates that hospitals could incur additional cost to collect co-payments and meet certain requirements related to cost-sharing as set by the federal government. The HHSC analysis also assumes that cost-sharing revenue collected by the hospitals would not impact the hospital rates. If HHSC were to update the claims administrative system to track co-payments and reduce rates, the costs for these changes are estimated to be $2.6 million. HHSC estimates a cost of $368,400 in All Funds, including $184,200 in General Revenue Funds in Fiscal year 2008 to modify the eligibility and enrollment system and make changes to Medicaid ID Cards to identify Medicaid recipients eligible for cost-sharing requirements.

Section 9. Multiple share programs: This analysis assumes HHSC would partner with local entities to establish and finance multiple share programs. According to HHSC, multiple share programs could be funded with intergovernmental transfers or certified public expenditures used as a state match if General Revenue is not appropriated. HHSC did not determine how many local entities would apply for the program funding and how many individuals would be covered. HHSC assumes additional administrative expenses necessary to carry out provisions of this section: changes to the eligibility systems and interfaces are estimated to be $1.0 million in All Funds in fiscal year 2008, including $0.5 million in General Revenue Funds. HHSC also assumes contracting with the consultant to develop program standards at a biennial cost of $0.2 million in All Funds.

To implement multiple provisions of the bill (excluding Section 3), HHSC estimates that the agency would need 14 additional FTEs in fiscal year 2008 and 17 additional FTEs in fiscal year 2009 (above 2007 level).

Technology

To implement provisions of the bill, HHSC would incur in 2008-2009 biennium costs, which are estimated to be $15.1 million in All Funds, including $8.0 million in General Revenue Funds This includes a one-time system cost of $1.2 million in fiscal year 2008 to enable the current Medicaid eligibility infrastructure to determine client eligibility for the premium assistance program that would be implemented under Section 3.

Local Government Impact

Hospitals or counties would be eligible for funding for uncompensated health care or infrastructure improvements from the health opportunity pool established in Section 3 of the bill. The amount of funds awarded to a hospital or county would depend on the balance of the fund and the number of eligible applications received by the pool. The provisions of the bill relating to the THOP would have an impact on the transferring public hospitals that provide the state share for the non-state owned Disproportionate Share Hospital funds that are distributed to about 174 other hospitals. The current DSH program provides a mechanism to ensure that the transferring hospitals receive at least the same amount they transfer to draw the federal DSH funds. It is not known at this time if the THOP distribution methodology would hold harmless the hospitals that provide the state share to draw the THOP funds. In addition, public hospitals receiving UPL payments would also be impacted by the provisions of the bill relating to the THOP. These hospitals currently provide the state share and receive all the federal funds under federal UPL provisions. The THOP's distribution methodology may reduce the amount of UPL payments currently distributed to these hospitals. Hospital losses should be offset somewhat from reimbursement related to formerly uninsured clients, now covered by the premium assistance program. Other local costs for caring for the uninsured population should be offset as well for this population.

As for the implementation of Section 8, HHSC estimates that local governments that operate hospital facilities would likely incur costs to collect co-payments and coordinate provision of health services to the Medicaid clients at the alternative provider facility. Local governments would also gain additional revenue from the collection of cost-sharing obligations.

It is assumed that a local entity would propose a multiple share program as outlined in Section 9 of the bill only if sufficient funding is available.

Source Agencies: 302 Office of the Attorney General, 304 Comptroller of Public Accounts, 454 Department of Insurance, 529 Health and Human Services Commission, 720 The University of Texas System Administration

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