LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

April 25, 2007

TO: Honorable Dianne White Delisi, Chair, House Committee on Public Health

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

IN RE: **HB3284** by Laubenberg (Relating to implementing certain incentives and cost-sharing requirements under the Medicaid program.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated.

The bill is not expected to have a significant fiscal impact to the state.

The bill would require the Health and Human Services Commission (HHSC) to develop and implement incentives to encourage Medicaid recipients to engage in healthy behaviors, if HHSC determines that it is feasible and cost-effective. HHSC could choose between establishing enhanced benefit accounts, health opportunity accounts, health savings accounts and other reward accounts to allow Medicaid recipients who engage in prescribed heath-related activities to earn credits that could be used for obtaining additional benefits. The bill would require incentives implemented under the bill to provide positive rewards for healthy behaviors, and not punitive incentives.

HHSC would implement a pilot program and establish incentives for healthy behavior for Medicaid recipients in Managed Care Organizations (MCOs) starting in fiscal year 2008. HHSC assumes that MCOs would voluntarily participate in the pilot since many of these organizations implemented these concepts in other states. HHSC estimates no additional costs for these value-added services. HHSC assumes that savings could occur as the health of the Medicaid recipients improves and as the individuals have an opportunity to manage their reward accounts and make decisions related their health care expenditures. HHSC also estimates that these savings would eventually offset any initial costs associated with the incentives program. Savings and initial costs would be explored once it is determined how many clients and regions would be selected for the pilot.

The bill also authorizes HHSC to adopt cost-sharing provisions for high-cost medical services provided to the Medicaid recipients at the hospital emergency room (ER) departments to the extent permitted under federal law. Under these provisions, a Medicaid recipient would be required to pay a co-payment or a premium payment for the service if an individual does not have a condition that requires emergency medical services and prefers to receive treatment at the ER after hospital staff informs an individual about alternative provider availability who would provide the service without requiring a cost-sharing payment. Hospital representatives would need to provide the information about cost-sharing obligations at the ER, name and address of the alternative non-emergency Medicaid provider and offer assistance in scheduling the service with the alternative non-emergency provider. Hospitals may require payment of the cost-sharing obligations in advance.

In assessing the fiscal impact of this provision, HHSC assumed it 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 set upper limit for each non-emergent visit 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 would be $840,677.

HHSC does not assume any cost-sharing obligations for individuals with income below 100 percent of FPL. Even though the DRA does not prohibit states from establishing cost-sharing requirements for individuals in this income category, HHSC assumes that co-pay collection for these recipients could not be enforced.

HHSC estimates a cost of $368,400 in All 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. It is assumed this cost could be funded by the agency's existing resources. 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 provider rates, HHSC estimates the costs of these changes would be $2.6 million.

The bill requires HHSC to request a waiver or authorization from a federal agency if needed to implement these provisions. The bill prohibits any waiver applied for under the bill from being used to divert Medicaid recipients from receiving emergency care for emergencies, and from waiving any provision of a federal emergency medical treatment law. The bill would take effect September 1, 2007.

Local Government Impact

According to HHSC analysis, 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.

Source Agencies: 529 Health and Human Services Commission

LBB Staff: JOB, JJ, CL, JI, NB