LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 80TH LEGISLATIVE REGULAR SESSION

April 12, 2007

TO: Honorable Warren Chisum, Chair, House Committee on Appropriations

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

IN RE: **HB3465** by Delisi (Relating to the creation of a low-income pool using certain federal funds.), **As Introduced**

Estimated Two-year Net Impact to General Revenue Related Funds for HB3465, As Introduced: a negative impact of ($393,254,585) through the biennium ending August 31, 2009.

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2008	$0
2009	($393,254,585)
2010	($394,441,663)
2011	($396,871,660)
2012	($399,257,205)

All Funds, Five-Year Impact:

Fiscal Year	Probable Revenue (Loss) from *GENERAL REVENUE FUND* 1	Probable Revenue Gain from *Other- Low Income Pool*	Probable (Cost) from *Other- Low Income Pool*	Change in Number of State Employees from FY 2007
2008	$0	$1,020,000	($1,020,000)	0.0
2009	($393,254,585)	$2,998,980,000	($2,998,980,000)	40.0
2010	($394,441,663)	$3,000,000,000	($3,000,000,000)	82.0
2011	($396,871,660)	$3,000,000,000	($3,000,000,000)	165.0
2012	($399,257,205)	$3,000,000,000	($3,000,000,000)	245.0

Fiscal Analysis

The bill would amend Chapter 531, Government Code by adding Subchapter N. This section would authorize HHSC to seek a Medicaid waiver to implement a low-income pool fund. Federal Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) funds would be deposited in this low-income pool fund. This section would require that pooled funds be distributed based on a methodology developed by the HHSC Executive Commissioner. Pooled funds would be used to reimburse health care providers for providing uncompensated health care and to assist uninsured persons in obtaining health care coverage.

Methodology

This fiscal analysis assumes the low-income pool 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 as a revenue gain to a new account inside the treasury. No other state funds are assumed included the low-income pool.

It is assumed that local public hospitals and state-owned hospitals continue to provide intergovernmental transfers to draw federal funds for the low-income pool. The low-income pool account would be used for reimbursement to health care providers for providing uncompensated care and a premium assistance program. It is estimated that HHSC's administrative costs of additional personnel to determine eligibility and enroll uninsured clients into a premium payment assistance program would be funded by the low-income pool account ($1,744,230 for 40 additional personnel in fiscal year 2009, $3,119,341 for 82 additional personnel in fiscal year 2010, $6,276,724 for 165 additional personnel in fiscal year 2011, and $9,319,984 for 245 additional personnel 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 health care providers to implement 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. Pooling DSH and UPL payments to state-owned hospitals could potentially have a significant negative impact on General Revenue (total loss of $328.4 million each year). This amount is included as a loss to General Revenue. It is assumed that this bill 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 low-income pool funds. 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 low-income pool, with a net annual loss of $64.9 million.

Technology

This includes a one-time system cost of $1,020,000 in fiscal year 2008 funded from the low income pool to enable the current Medicaid eligibility infrastructure to determine client eligibility for the premium assistance program that would be implemented under this bill.

Local Government Impact

Hospitals or political subdivisions 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 political subdivision would depend on the balance of the fund and the number of eligible applications received by the pool. This bill 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 low-income pool distribution methodology would hold harmless the hospitals that provide the state share to draw the low-income pool funds. In addition, public hospitals receiving UPL payments would be impacted by the provisions of this bill relating to the low-income pool funds. These hospitals currently provide the state share and receive all the federal funds under federal UPL provisions. The low-income pool 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 subsidies funded by the low-income pool. Other local costs for caring for the uninsured population should be offset as well for this population.

Source Agencies: 304 Comptroller of Public Accounts, 529 Health and Human Services Commission, 537 State Health Services, Department of

LBB Staff: JOB, CT, KE, MH