LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

May 17, 2013

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

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: **HB2383** by Eiland (Relating to life settlement contracts for the payment of long-term care services and support and the consideration of a life insurance policy in determining eligibility for medical assistance.), **Committee Report 2nd House, Substituted**

The fiscal implications of the bill cannot be determined at this time. The number of individuals who might become eligible for Medicaid and the cost of providing services to those individuals are unknown.

The bill would allow the owner of a life insurance policy, in certain circumstances, to enter into a life settlement contract for the benefit of a recipient of Medicaid long-term-care services and support in exchange for direct payments to a health care provider or the state. The bill requires that the proceeds of the life settlement contract be used for the payment of Medicaid long-term-care services and support and establishes Medicaid as the secondary payor. The bill specifies that only the Medicaid recipient may choose the provider and type of services provided and paid for, and that any attempt to require the recipient to choose a specific provider is prohibited and constitutes an unfair method of competition or an unfair or deceptive act under the Insurance Code. HHSC would be required to educate applicants for Medicaid long-term-care services and support about options for life insurance policies, including options that do not allow a life insurance policy to be considered as an asset or resource in determining Medicaid eligibility. HHSC would also be required to ensure that eligibility and need for Medicaid are determined without considering the balance of proceeds from a life settlement contract. HHSC would be prohibited from implementing any of these provisions if HHSC determined implementation is not cost-effective or feasible. HHSC would be required to adopt rules necessary to implement the provisions of the bill by January 1, 2014 and the change would only apply to eligibility determinations made on or after January 1, 2014. The bill authorizes the Texas Department of Insurance to conduct periodic market examinations of each person who enters into a life settlement contract with an owner of a life insurance policy under the provisions of the bill. The bill would be effective immediately if it receives a vote of two-thirds of the members of each house; otherwise, the bill would be effective September 1, 2013.

The number of persons for whom Medicaid ineligibility was based solely on the value of a life insurance policy is not known. Further, it is not known how many persons with policies would be willing to enter into a life settlement contract under the conditions set forth in the bill in order to become eligible for Medicaid nor what the value of any offsetting payments to health care providers or the state might be. The average annual cost is approximately $40,000 for nursing facility care, $15,000 for Community Based Alternatives (CBA) waiver services, and approximately $27,000 for waiver-like services through the STAR+PLUS program with additional

costs associated with acute care services, prescription drugs, and Medicare premiums; services provided to persons not meeting the requirements for a nursing facility level of care would have a lower annual cost. Medicaid would continue to pay for services other than long-term-care services and support during the time a recipient's long-term-care services were being paid from life settlement contract proceeds and would begin paying for all services following the exhaustion of those proceeds.

Without significant offsets from payments under life settlement contracts, the cost to provide services to 25 clients could exceed $1 million in All Funds in each fiscal year. There would be additional costs related to tracking payments from the life settlement contracts and for systems modifications related to eligibility changes. Managed care is mandatory for many persons receiving long-term-care services through Medicaid, and it is unclear how those premiums would be set and paid if recipients were making direct payments to providers. Additionally, if recipients are allowed to select any provider and are not required to use a network provider under managed care or a Medicaid provider under fee-for-service, it is not known what fiscal impact that might have. Further, if recipients are allowed to select the type of services they receive, they may elect to receive higher cost services for which they do not meet the functional eligibility requirements, which could increase the fiscal impact.

The requirement that HHSC not implement any provision if determined that implementation is not cost-effective or feasible would make it unlikely that the department would be able to implement the provisions of the bill since they are likely to increase costs to the state.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission

LBB Staff: UP, CL, MB, LR, NB