**LEGISLATIVE BUDGET BOARD**
**Austin, Texas**

# FISCAL NOTE, 83RD LEGISLATIVE REGULAR SESSION

**April 29, 2013**

**TO:** Honorable Jim Pitts, Chair, House Committee on Appropriations

**FROM:** Ursula Parks, Director, Legislative Budget Board

**IN RE:** **HB3791** by Zerwas (relating to a "Texas solution" to reforming and addressing issues related to the Medicaid program, including the creation of an alternative program designed to ensure health benefit plan coverage to certain low-income individuals through the private marketplace; authorizing a fee.), **Committee Report 1st House, Substituted**

Since the fiscal implications of the bill largely depend on the results of discussions with federal agencies regarding possible changes to the state's administration of Medicaid and the implementation of an alternative health coverage program through the private marketplace, the fiscal impact cannot be determined at this time.

The bill would add Chapters 539 and 540 and a new section in Chapter 531 to the Government Code, as well as add new sections to Chapter 32 of the Human Resources Code, creating a Texas solution to issues with the Medicaid program.

Article I authorizes the Health and Human Services Commission (HHSC) to operate the state Medicaid program under a block grant system or waiver, if approved by federal authorities. The Medicaid block grant would apply to clients eligible under rules in effect on September 1, 2013, in addition to new clients with incomes up to 100% of the Federal Poverty Level (FPL). The bill directs HHSC to deliver acute care services in the most cost-effective means possible, under a risk-based managed care model, providing clients with subsidies to purchase a health benefit plan from an authorized health benefit plan issuer. Clients would be responsible for premium cost sharing and copays on a sliding scale basis, and would deposit any excess funds into a Health Savings Account. HHSC and the Department of Insurance (TDI) must examine the option of a reinsurance program for the participating health benefit plans. HHSC is also directed to develop a comprehensive plan to reform the delivery of long-term services and supports.

Article II would require HHSC and TDI to provide healthcare coverage in the private market to individuals under age 65 with incomes between 0-133% of FPL, if they are not eligible for the Medicaid program described in Article I. The coverage would not constitute an entitlement and must be cost neutral, leverage premium tax revenue, and achieve cost savings. HHSC and TDI would request flexibility from federal authorities to use federal matching funds to help implement the goals of the program. The program would be temporary and be contingent on continued funding by the federal government.

Article III would direct the agency to implement customized benefit packages to prevent over utilization of services by clients receiving home and community based services; establish a dual eligible integrated care demonstration project; implement a parental fee program; provide housing benefits for certain medical assistance recipients; and conduct two studies requiring reports due December 1, 2014. One study would look at the effects of an estate recovery program and the other study would examine the impact of imposing alternative income and asset limits for determining eligibility for long-term services and supports.

Article IV requires the creation of a 12-member Medicaid reform task force by January 1, 2014 to advise HHSC in designing the state Medicaid and health benefit plans in accordance with the bill. A report to the legislature regarding the task force's activities would be due by December 1, 2014 and this section of the bill would expire by September 1, 2015.

Although directed by the bill to be cost effective (Article I) or cost neutral (Article II), the cost to the state of implementing provisions of Articles I and II is largely unknown because it depends on decisions made as a result of negotiations with federal authorities and the subsequent details of program implementation. Some of the cost offsets to the state that may occur, however, can be estimated.

In the 82nd Legislative Session, TDI provided a fiscal estimate for House Bill 636, related to creating a state healthcare exchange. That analysis yielded an estimate of $334 million in All Funds to establish the exchange; assuming the use of existing infrastructure those costs are now estimated by TDI to be closer to $200 million in All Funds. Additionally, TDI indicates that operational costs may be funded with a 3.5 percent user fee assessed on all premium volume flowing through the exchange.

With more persons becoming insured through a Medicaid block grant and/or healthcare market solution, the state's need for programs serving uninsured persons administered through HHSC or the Department of State Health Services (DSHS) would decrease. According to its analysis conducted for provisions in the introduced version of this bill that are similar to provisions contained in this version, HHSC estimated that DSHS could experience a savings of $115.4 million in General Revenue (GR) over the 2014-2015 biennium due to reduced need in programs serving uninsured clients.

Depending on how Article I and II are implemented and the resulting increased number of people covered under health insurance, the state would see additional premium tax revenue. Based on previous Legislative Budget Board (LBB) analysis of Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) and applying that analysis to the system contemplated by this legislation, premium tax revenue for services and prescription drugs could result in an additional $28.6 million in GR for the 2014-2015 biennium and $270.5 million in GR for fiscal years 2014-2018.

The provision of the bill described in Article III to customize benefits packages for individuals receiving home and community-based services and supports would result in a cost to the state. In a fiscal note for SB 7, Eighty-third Texas Legislature, the LBB estimated a GR cost of $1.5 million to implement a similar program. Ultimately, savings could be achieved from diverting clients to less costly services and settings, but those savings cannot be determined at this time.

The fiscal impact of a parental fee program described in Article III cannot be determined because it is not known how many families could be subject to premiums or at what level. Additionally, the ACA makes such premium payments voluntary until the maintenance of eligibility for children expires at the end of September 2019. The fiscal impact of a dual eligible integrated care demonstration project and housing subsidies for certain beneficiaries, are unknown until more detail about their implementation is decided.

It is assumed that any costs associated with conducting the studies described in Article III and creating a task force described in Article IV would not be significant and could be absorbed within the available resources of HHSC and other involved agencies.

## Local Government Impact

Depending on how the provisions of the bill were implemented and the resulting reduction in the number of uninsured in the state, local government hospitals would likely see a decrease in uncompensated care (including charity care and bad debt). Previous LBB analysis on implementing Medicaid expansion under the ACA estimated that uncompensated care costs to local government hospitals could decrease by $1.6 billion for the 2014-15 biennium and $5.0 billion for fiscal years 2014-2018. Assuming the system contemplated by this legislation would yield similar net results, local government hospitals could realize a similar level of cost reduction. In addition, local hospitals may experience increased revenue due to a possible increase in healthcare utilization among people previously uninsured.

**Source Agencies:** 304 Comptroller of Public Accounts

**LBB Staff:** UP, KK, MB, JTe