

State Budget Impact of Providing Health Insurance to Low-Income Adults with 90% Federal Funding ¹

Background

Medicaid funding in Texas is a combination of federal, state, and local revenue. For every \$100 spent on the program to provide health benefits to children, pregnant women, individuals with disabilities, and the elderly, the federal government contributes just over \$60 (not counting a temporary increase related to the pandemic).

Texas has the opportunity to increase the federal contribution to 90% for a group of non-disabled adults who currently do not qualify for any other form of health insurance assistance. As shown by the experience of other states, such as Indiana, the state has flexibility in how to take advantage of that opportunity, including the creation of a plan that aligns with state priorities such as personal responsibility, budget certainty, and benefits more in line with the commercial market.

Because the state is responsible for the 10% share, how would that decision affect the state budget, particularly the programs in which state general revenue (“GR”) pays for health care services? Specifically, would new GR have to be allocated or would the program pay for itself or even generate a positive financial result?

In 2013, the state answered that question with this statement in a fiscal analysis: “...potential savings and revenues would more than offset the GR cost, resulting in a net positive fiscal impact.”²

The magnitude of this positive impact, and its underlying sources, has not yet been fully documented—until now. This document compares a fully operational 90% federally financed program with the state’s current budget and its state-funded health programs and commitments. It assumes a “normal” coverage environment rather than one marked by unusual activity, such as the unemployment spikes and health care delivery disruptions caused by the coronavirus pandemic, because it would take several years to implement a coverage expansion and, by then, the pandemic and its attendant recession are likely to be over.

Costs

This comparison begins by estimating the costs of a fully operational program. That, in turn, is based on two critical numbers: the number of eligible adults enrolled per month, and the average monthly premium (the actual premiums will vary based on a person’s age, gender, and county of residence).

The 2013 fiscal analysis estimated how many people would be enrolled once the program was fully operational and how much that health insurance would cost. When those numbers are updated to account for population growth, and reconciled with other more current estimates, the result is approximately 1 million total individuals enrolled, with some moving off the program while others take their place month-to-month, based on changes in employment status, family size, and other eligibility factors. That total amounts to a rolling average of two out of every

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² <https://capitol.texas.gov/tlodocs/83R/fiscalnotes/html/HB03376I.htm>

three eligible individuals, as estimated by the Kaiser Family Foundation, which is a reasonable participation or “take-up” rate based on the state’s experience with other health programs that have income-based eligibility requirements.

When the state made its estimates in 2013, it projected the monthly cost of coverage through a five-year period ending in 2018. When those numbers are compared to the current cost of buying health insurance through healthcare.gov, we have determined that \$525 per month is a reasonable average rate. **Applying that figure to 1 million enrollees produces an annual cost of \$6.3 billion. The total non-federal cost would be \$650 million (\$630 million match plus \$20 million for administrative, technology, and state employee costs).**

The state could pay the non-federal portion with existing GR or it could authorize an alternate approach that would increase the positive state budgetary impact. A number of states have done that with financing mechanisms that include premium or insurance taxes, provider assessments, lottery proceeds, and increased sales, cigarette, and alcohol taxes.

Positive Impacts

There are two general financial categories that explain how the state can spend \$650 million to cover 1 million Texans and still be in the black. The first is cost savings to existing health programs and the second is increased tax revenue directly attributable to the health insurance premiums paid to health plans to cover the eligible individuals.

Annual Cost Savings for Existing Medicaid Groups: \$106 million/yr

Two current Medicaid coverage groups could be partially transitioned to the enhanced funding category: pregnant women and women who need treatment for breast or cervical cancer. If that were to happen, the state’s general revenue (GR) contribution would be cut by about three-quarters (from a 38% match rate to 10%) for the period in which those women would be in the 90% federally funded program.

Estimating the cost savings involves taking into account different eligibility standards, the rules that govern when the enhanced rate is available compared to the traditional rate, and the number of women who are currently enrolled in those programs. When those factors are analyzed within the context of a coverage expansion, those programs would receive new federal funding of—and the Legislature could cut GR annual appropriations by—\$100 million for pregnant women and \$6.3 million for non-family-planning services delivered through the Healthy Texas Women program.

Annual Cost Savings for Health Programs Funded With General Revenue: \$488 million/yr

The largest positive impact of a coverage expansion would be reduction of state spending that is currently targeted to individuals who could get some or all of their services through new funding sources.

Inpatient care of incarcerated prisoners: \$251 million/yr

Individuals eligible for services under a coverage expansion include adult prisoners who are admitted to a hospital or other medical institution for more than 24 hours. The state pays for inpatient care of prisoners at the University of Texas Medical Branch (UTMB) and Texas Tech University Health Sciences Center. The appropriation for these hospital services in FY 2021 is \$251 million and that full amount would be saved under a coverage expansion.

Community Mental Health Services: \$200 million/yr

The appropriations bill allocates \$837 million in funding for community-based mental health services and locally operated or purchased psychiatric inpatient care delivered through local mental health authorities. Over \$700 million of this is from General Revenue, including maintenance-of-effort funding for the mental health block grant.

Nine out of ten uninsured adults receiving community mental health services have incomes that would qualify them for the coverage expansion. However, unlike other categorical health programs, it is more difficult to accurately determine the extent to which mental health GR investments could be saved by providing new coverage options to the tens of thousands of uninsured individuals with serious mental illness who are being served by community mental health resources.

The mental health service infrastructure is complex and multi-faceted. Making new coverage options more broadly available will help many adults with serious mental illness but may also pose risks to some or many mental health providers compared to the current mix of funding sources. GR investments will continue to be needed to support mental health authorities, hospitals, and individual providers. In addition, some level of GR match will be needed to protect the flow of federal funds that are tied to state maintenance of effort.

Given these various contingencies, a conservative and reasonable estimate of mental health GR savings for making new coverage options available to a cohort of the uninsured is \$200 million annually.

Substance Abuse Treatment Services: \$12 million/yr

The state administers a variety of substance abuse prevention, intervention, and treatment programs. While these services primarily help teenagers and young adults, the appropriations bill targets 10,500 adults for treatment services in FY 2021 at a cost of \$86 million.

Substance abuse treatment services are primarily paid for with federal funds with \$30 million in GR earmarked as matching funds in FY 2021. Based on the income demographics of adults receiving these services, at least \$12 million in GR could be saved if those individuals had their substance abuse treatment services paid by health insurance.

HIV Medication Assistance Program: \$16.5 million/yr

This program provides medications for Texans living with HIV who are uninsured or underinsured for prescribed medications and meet the income requirements. These federal funds have a matching requirement and GR allocated for that purpose in FY 2021 is \$23.5 million.

Demographic and financial data for each state's HIV medication program is published by HRSA, the federal agency that oversees those services. Based on those data, if qualifying individuals could receive their HIV medications through a coverage expansion rather than the current program, the state would save at least \$16.5 million in GR.

Kidney Health Care Program: \$8.4 million/yr

The Kidney Healthcare Program (KHP) assists with costs associated with end-stage renal disease (ESRD) for individuals who haven't yet qualified for Medicare.

The program's annual report includes demographic information that can be used to estimate the number of kidney health care program recipients who could receive their services at the 90% federal rate, meaning they would not need (or qualify for) KHP.

The annual appropriation for this program is \$18.7 million, almost all of which is general revenue. Based on age and income data published in the annual report, \$8.4 million of that could be saved if those individuals switched from KHP to a coverage expansion.

Additional Revenue: \$110 million/yr

According to the office of the Texas Comptroller, all health insurers and health maintenance organizations (HMOs) licensed by the Texas Department of Insurance must pay a 1.75% tax on gross premiums they collect annually. The amount of tax that would be due on \$6.3 billion in premiums at 1.75% is \$110 million, a credit to general revenue.

Total Positive Impact: \$704 million/yr

Compared to the \$650 million cost of expanding coverage, this is a positive difference of \$54 million per year or almost \$110 million for the biennial budget. If the state were to find a new funding source, then \$704 million annually or just over \$1.4 billion for the biennial budget could be redirected to other budgetary priorities.

These are conservative figures that do not include several items that cannot be easily quantified but that would yield additional savings and/or revenue:

- Individuals with disabilities who are currently receiving Medicaid services at the lower federal match rate but who could apply for expanded coverage at the 90% rate without seeking a disability determination (additional savings)
- State-funded community health programs that serve a variety of low-income and uninsured populations (additional savings)
- State reimbursement to certain counties for indigent health care expenses (additional savings)
- State administrative costs associated with overseeing and facilitating "safety net" programs financed with local provider and property tax revenues (additional savings)
- Co-pays or other cost-sharing paid by coverage recipients (additional revenue)
- Taxable economic activity associated with reducing the state's uninsured rate (additional revenue)

This analysis also does not estimate the impact of \$6.3 billion in new coverage funding that could replace or augment county and hospital district property tax collections currently targeted to indigent and uncompensated care as well as inpatient care for jail inmates.

For a more detailed breakdown of the impact on the state's general revenue, see Exhibit A.

Exhibit A

Impact on General Revenue of providing coverage to non-disabled adults ages 19-64 with 90% federal funding³

This document compares the current state budget to the budget that would exist if the state had previously authorized 90% federal funding to cover low-income adults.

This document does *not* estimate the positive effects on the budget of economic activity associated with reducing the state's uninsured rate,

Similarly, this document does *not* estimate the positive impact on homeowners and businesses if a portion of annual property tax payments collected for indigent and uncompensated care, as well as inpatient care for jail inmates, is replaced with federal dollars. Counties and hospital districts collect at least \$3 billion annually for these purposes today.

Background

Medicaid funding in Texas is a combination of federal and state/local funds. The Federal Medical Assistance Percentage (FMAP), the amount of funding provided by the federal government, was 62% before it was temporarily raised to 68% as a result of the pandemic (a situation that will end when the federal emergency ends). For the purpose of analyzing Medicaid financial impacts, the pre-pandemic FMAP is the appropriate reference point.

Texas has the opportunity to achieve a 90% FMAP by choosing to cover non-disabled adults ages 19-64 with incomes below 138% of the federal poverty level (FPL). The state has a variety of ways to do that—a traditional Medicaid expansion or a “Texas Plan” that aligns with state priorities such as personal responsibility, budget certainty, and benefits more in line with the commercial market.

While this enhanced funding would still obligate the state and/or local sources for the 10% match, it would create a net gain for state general revenue (GR), as this document demonstrates. That is the case whether the non-federal share is paid with GR or with some other form of revenue.

Assumptions

The most accurate way to estimate the financial impact of drawing down the 90% federal contribution is to compare a fully operational program with the state's current budget and its state-funded health programs and commitments. This estimate is going to be most useful and accurate if it assumes a “normal” coverage environment rather than one marked by unusual activity, such as the unemployment spikes and health care delivery disruptions caused by the coronavirus pandemic.

This comparison begins by estimating the coverage costs of a fully operational 90% FMAP program. That, in turn, is based on two critical numbers: the number of individuals enrolled per

³ Prepared by Randy Fritz, John R. Pitts and John R. Pitts, Jr. for the Episcopal Health Foundation

month; and the average (or “blended”) monthly premium across all enrollees (the actual premiums will vary based on a person’s age, gender, and county of residence).

There are two useful reference points for estimating enrollment: the implementation of the Children’s Health Insurance Program (CHIP), which is the last time the state rolled out a new major coverage program; and the fiscal note for the only Medicaid expansion bill that has received a committee hearing to date.

When CHIP was implemented twenty years ago, the state embarked on a major outreach and social marketing program to maximize enrollment. Even with this effort, the percentage of eligible children who actually enrolled (also known as the “take-up rate”) ranged between 75 and 80 percent.

The fiscal note for HB 3376 (2013 session) estimated full enrollment to be 883,000 adults per month. Given that the state’s population has grown 15 percent since the last Census, it is reasonable to assume that enrollment would now be approximately 1 million individuals based on the HHSC estimate from 2013. That would yield a take-up rate of about 67% based on multiple estimates of the eligible population, which is reasonable for a program that will not be marketed or promoted in the same way as CHIP.

There are two Texas-specific reference points for estimating the average monthly Medicaid premium for adults ages 19-64:

- Medicaid premiums for parents in very low-income families, as stipulated in the 2020-21 appropriations bill: \$390
- Gold-level premiums in the Marketplace as blended across cohorts defined by geography, age, gender, and smoking/non-smoking status: \$633

The Medicaid premiums are too low because they undercount the oldest and most expensive demographic (ages 55-64); but the gold-level premiums are too high because they assume provider reimbursement rates that are closer to commercial rates than Medicaid. Given these considerations, this analysis assumes a blended rate of \$525/month compared to a Medicaid rate of \$390 and Marketplace gold-level blended rate of \$633.

The HB 3376 fiscal note also estimated a blended rate of \$525 for FY 2018. This figure is consistent with CMS actuarial findings that show Medicaid costs for non-disabled adults to be on a downward trajectory (<https://www.macpac.gov/subtopic/state-and-federal-spending-under-the-aca/>).

Based on these assumptions and findings, the annual cost of covering 1 million low-income adults at a blended rate of \$525/month is \$6.3 billion. The total non-federal cost would be \$650 million (\$630 million match plus \$20 million for administrative, technology, and HHSC personnel costs).

Revenue and cost impacts

The following are the positive revenue and cost impacts against which \$650M in annual non-federal costs should be evaluated (underlying details follow in the next sections):

- General revenue impact for existing Medicaid groups that could be transitioned to the 90% FMAP: +\$106 million/yr

- Pregnant women: +\$100 million/yr – see below p. 8
- Healthy Texas Women non-family-planning services: +\$6.3 million/yr – see below p. 9
- General revenue impact for state-funded health programs and activities:
 - Inpatient hospital and clinical care for incarcerated prisoners: +\$251 million/yr – see below p. 9
 - Community-based mental health services: +\$200 million/yr – see below p. 9 and 10
 - Substance abuse treatment for adults: +\$12 million/yr – see below p. 10
 - HIV Medication Assistance Program: +\$16.5 million/yr – see below p. 10
 - Kidney Healthcare Program: +\$8.4 million/yr – see below p. 10 and 11
- Additional tax revenue from health insurance providers: +\$110 million/yr – see below p. 11
- **Total savings/additional revenue: +\$704 million annually (+\$1.4 billion for the biennium)**

This analysis does not include several items that cannot be reasonably quantified but that would yield additional savings and/or revenue above the \$704 million annually (or \$1.4 billion for the biennium):

- Individuals with disabilities who are currently receiving Medicaid services at the lower federal match rate but who could apply for expanded coverage at the 90% rate without seeking a disability determination (additional savings)
- State-funded community health programs that serve a variety of low-income and uninsured populations
- State reimbursement to certain counties for indigent health care expenses
- State administrative costs associated with overseeing and facilitating Medicaid “safety net” programs financed with local provider and property tax revenues
- Co-pays or other cost-sharing paid by coverage recipients

Net difference compared to current budget if the non-federal cost of \$650 million was paid with GR: +\$54 million annually (+\$108 million for the biennium)

Net difference compared to current budget if the state were to find a new funding source for the non-federal cost: +\$704 million annually (+\$1.4 billion for the biennium)

Backup calculations

General revenue impact on existing Medicaid groups

Two current Medicaid coverage groups include women ages 19-64 that could be partially transitioned to the enhanced funding category. When that happens, the state’s general revenue (GR) contribution will be cut by about three-quarters (from a 38% match rate to 10%).

Both of these groups—pregnant women and women who need treatment for breast or cervical cancer—have income criteria higher than the 138% FPL limit for the 90% match. The upper limit for pregnant women is 185%; it is 200% for the breast and cervical cancer program.

The U.S. Census Bureau publishes data regarding uninsured Texans according to several categories including income level. They estimate twice as many uninsured Texans fall into the <138% FPL category as the 138%-200% FPL category. Extrapolating from that, one can reasonably assume there are three times as many uninsured Texans in the <138% FPL category compared to those with incomes between 138% and 185% FPL.

Besides these income distributions, there are several additional complications in estimating GR savings for those two Medicaid groups. First, the 90% FMAP is only available for women who were already enrolled in that coverage at the time they either became pregnant or their cancer was diagnosed. Second, a woman who becomes pregnant while enrolled in the 90% FMAP program must transfer to the traditional FMAP program when she goes through the periodic eligibility renewal process. For some women, this could occur early in their pregnancy; for others, it would occur late in their pregnancy or after they've given birth; for others, it would never occur.

Since this analysis assumes a less-than-75% take-up rate for overall enrollment, it will also be applied to these two groups—meaning that no more than three-quarters of eligible women with incomes <138% FPL are assumed to be enrolled in the 90% FMAP group when they become pregnant or receive a relevant cancer diagnosis.

Medicaid Pregnant Women Program

The estimated savings are based on cost and enrollment information from the recent appropriations bill for FY 2021. Page references are to the appropriations bill.

Current budget:

- FY 2021 enrollment (p. II-40): 138,454
- FY 2021 spending (p. II-36): \$1.058 billion
- State match (at 38%): \$402 million

Comparative budget that includes 90% FMAP population:

- Women in the <138% FPL category: 103,840
- Women who are enrolled at the time of their pregnancy/diagnosis: 77,880
- Cost of covering 77,880 women under existing spending and matching assumptions: \$595 million
- State match (at 10%): \$59.5 million
- Cost of covering the remaining 60,573 women: \$463 million
- State match (at 38%): \$176 million
- Total state match: \$235 million
- **Difference between current \$402M match and the \$235M comparative match: \$167 million**
- **Estimated GR savings: \$100 million (explanation below)**

The \$167 million savings would occur if there were no transfers to the traditional program during pregnancy. But, as noted above, women who report a pregnancy during periodic renewal

must be transferred to the traditional FMAP program. Assuming a one-year eligibility period, it is reasonable to assume that at least 60% of the potential \$167 million GR savings will be achieved based on the various times that individuals go through renewal (\$100 million).

Healthy Texas Women non-family-planning services (primarily breast and cervical cancer)

Funding for the breast and cervical cancer program is incorporated into the Healthy Texas Women program waiver. While that is the main non-family-planning component of the waiver, the waiver also includes other services for which the state must pay the 38% FMAP rather than the lower match rate available for family planning services.

The estimated savings for FY 2021 are based on cost information from the Healthy Texas Waiver approval letter.

Current budget:

- FY 2021 state match (at 38%): \$11.3 million

Comparative budget that includes 90% FMAP population:

- State match (at 38%) attributable to women with incomes in the 138%-200% FPL category: \$3.7 million
- State match attributable to women with incomes in the <138% FPL who are enrolled in the 90% FMAP group prior diagnosis: \$600K
- State match (at 38%) attributable to women with incomes in the <138% FPL who are enrolled after diagnosis: \$700K
- Total state match: 5.0 million
- **Estimated GR savings (current \$11.3M match minus \$5M comparative match): \$6.3 million**

General revenue savings for state-funded health programs and activities

Texas Department of Criminal Justice (TDCJ)

The 90% FMAP funding may be used to pay for the costs of medical care for prisoners (ages 19-64) who are admitted to a hospital or other medical institution for more than 24 hours.

The state uses general revenue to pay for inpatient care for TDCJ prisoners at the University of Texas Medical Branch (UTMB) and Texas Tech University Health Sciences Center. **The appropriation for these hospital and clinical services in FY 2021 is \$251 million. This total amount will be saved if Medicaid reimburses those services at the 90% FMAP rate.**

Community Mental Health Services (HHSC)

The appropriations bill allocates \$837 million in funding for community-based mental health services and locally operated or purchased psychiatric inpatient care delivered through local authorities. Approximately \$715 million of this is from General Revenue, including maintenance-of-effort funding for the mental health block grant.

More than 90 percent of uninsured adults receiving community mental health services have incomes below 138% FPL. However, unlike other categorical health programs, it is much more

difficult to accurately determine the extent to which mental health GR investments could be saved by providing 90% FMAP coverage to the tens of thousands of uninsured individuals with serious mental illness who are being served by community mental health resources.

The mental health service infrastructure is complex and multi-faceted. Making Medicaid more broadly available will help many adults with serious mental illness but may also pose risks to some or many mental health providers compared to the current mix of GR, DSRIP, and block grant funding. GR investments will continue to be needed to support mental health authorities, hospitals, and individual providers. In addition, some level of GR match will be needed to maintain the flow of federal funds that are tied to state maintenance of effort.

Given these various contingencies, a conservative and reasonable estimate of mental health GR savings for making Medicaid available to a cohort of the uninsured is \$200 million annually. This figure may evolve as further analysis occurs regarding the extent to which a portion of GR funding targeted to mental health can be reallocated to produce the most cost-effective and resilient system of mental health care in Texas.

Substance Abuse Treatment Services (HHSC)

HHSC administers a variety of substance abuse prevention, intervention, and treatment programs. While these services are primarily targeted at teenagers and young adults, the appropriations bill targets 10,500 adults for treatment services in FY 2021 at a cost of \$86 million (\$680 average monthly cost).

Substance abuse treatment services are primarily paid for with federal funds. \$30 million in GR was requested for FY 2021 in the HHSC Legislative Appropriations Request to draw down these federal funds.

Data on the income demographics of Texas adults receiving substance abuse treatment services could not be found. However, it is reasonable to assume that most individuals receiving these services are uninsured. According to 2018 Census Bureau data, almost 40% of uninsured adults in Texas have incomes <138% FPL. Therefore, it is reasonable to assume that at least 40 percent of the money being spent by HHSC on adult substance abuse treatment services is targeted to individuals in that income group. **Accordingly, an estimated \$12 million in GR could be saved if those individuals had their substance abuse treatment services paid by Medicaid. The GR savings could easily be higher if a larger proportion of adults receiving substance abuse treatment services are poor or nearly poor.**

HIV Medication Assistance Program (DSHS)

This program provides medications for Texans living with HIV who are uninsured or underinsured for prescribed medications and have incomes less than 200% FPL. Its primary source of funding is Part B of the federal Ryan White legislation. These federal funds have a matching requirement and GR allocated for that purpose in FY 2021 is \$23.5 million.

Demographic and financial data for each state's Part B program is published by HRSA, the federal agency that oversees the Ryan White program. For the most recent year for which data is available for Texas (FY 2018), 70% of program recipients had incomes <138% FPL. **If the 90% FMAP funding was available in Texas, those individuals could receive their HIV medications through Medicaid, saving an estimated \$16.5 million in GR.**

Kidney Health Care Program (HHSC)

The Kidney Healthcare program (KHP) assists with costs associated with end-stage renal disease (ESRD) that Medicare doesn't cover.

For individuals to be eligible for KHP, they must be Texas residents, have ESRD, be receiving chronic renal dialysis or have a kidney transplant, have incomes less than \$60,000 per year, meet the Medicare ESRD criteria, and not be eligible for Medicaid based on age, income, and/or disability. There is no age limitation, meaning some recipients are over age 65. These eligibility policies are established under state law.

The program's annual report includes demographic information that can be used to estimate the number of kidney health care program recipients who could receive their services under Medicaid at the 90% FMAP rate, meaning they would not need (or qualify for) KHP.

The FY 2018 annual report states that almost 60 percent of recipients had annual incomes below \$20,000 and 78 percent had incomes below \$30,000. The same report showed that one in three recipients were over 64 years of age. Age and income were not cross-referenced. Based on this information, it is reasonable to assume that at least 45 percent of KHP recipients could receive their non-Medicare-financed services through Medicaid at the 90% FMAP rate.

The appropriation for this program is \$18.7 million, almost all of which is general revenue. **If 45 percent of program recipients are under age 65 and have incomes below 138% of the poverty line, then the savings to GR of moving those individuals to Medicaid from KHP would be an estimated \$8.4 million.**

Increase in general revenue

Health insurance premium tax

According to the Comptroller's website, all health insurers and health maintenance organizations (HMOs) licensed by the Texas Department of Insurance must pay a 1.75% tax on gross premiums they collect annually.

The amount of tax that would be due on \$6.3 billion in premiums at 1.75% is \$110 million. This would be a credit to general revenue.