PREPARED BY: Liz Hruska
DATE PREPARED: March 11, 2014
PHONE: 471-0053

LB 887

Revision: 03

FISCAL NOTE

LEGISLATIVE FISCAL ANALYST ESTIMATE

Revised to provide new information

ESTIMATE OF FISCAL IMPACT – STATE AGENCIES **(See narrative for political subdivision estimates)**

	FY 2014-15		FY 2015-16	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	(2,595,782)		(2,926,625)	
CASH FUNDS	264,500	86,000	264,500	86,000
FEDERAL FUNDS	291,713,766		374,534,165	
OTHER FUNDS				
TOTAL FUNDS	289,382,483	86,000	371,872,040	86,000

Any Fiscal Notes received from state agencies and political subdivisions are attached following the Legislative Fiscal Analyst Estimate.

Bill Summary

This bill requires the Department of Health and Human Services to submit, not later than 30 days after the effective date of the bill, a state plan amendment to cover the new Medicaid adult group, commonly referred to as Medicaid Expansion. The bill directs the Department to apply for a benchmark benefit package for Secretary-approved coverage to include full Medicaid coverage and other coverage required by the Affordable Care Act (ACA) and services covered by the federal Paul Wellstone and Pete Domenici Mental Health Parity Act of 2008. This bill establishes the Wellness in Nebraska (WIN) Act. The state plan amendment would be in effect until enactment of waivers implementing the WIN Act. The Department is required to apply for any waivers or state plan amendments to implement the Wellness in Nebraska plan beginning January 1, 2015, or as soon after that date that the waivers are enacted.

The WIN Act has two components: WIN Medicaid Coverage and WIN Marketplace Coverage. WIN Medicaid Coverage is for: a) those with income at or below 100% of the Federal Poverty Level (FPL), or b) those who are medically fragile or those with exceptional medical conditions with incomes at or below 133% of FPL. WIN Marketplace Coverage is for those with incomes above 100% of FPL and at or below 133%. They would be eligible for premiums paid by the Department to purchase: a) qualified health plans on the health benefit exchange, or b) employer-sponsored health insurance. The Department shall pay all co-payments, co-insurance, deductibles and wrap-around benefits. The Department shall pay premiums directly to the qualified health plans issuer. Wrap-around benefits include non-emergency transportation, early and periodic screening (EPSDT), diagnostic and treatment program for those under age 21, a fee-for-service dental plan.

Beginning January 1, 2016, all newly eligible individuals enrolled in WIN shall be enrolled in patient-centered medical homes, where available. If patient-centered medical homes are not available for all WIN clients, the Department with the WIN Oversight Committee will develop plans for increasing the number of patient-centered medical homes or developing alternative integrated care models and pilot projects. By January 1, 2016, the Department in conjunction with the WIN Oversight Committee shall recommend a reimbursement methodology and incentives for participation in the patient-centered medical home and health home systems to ensure that providers enter into and continue to participate in the system.

Beginning January 1, 2016, the WIN participants with incomes at or above 50 percent of FPL shall contribute two percent of their monthly income towards their coverage. For members who complete the required preventative care services and wellness activities, the monthly contributions will be waived during each subsequent year until the member fails to complete the required activities. Total monthly contributions plus cost-sharing each quarter shall be limited to one quarter of five percent of the yearly income. The policy shall include guidelines for hardship exemptions. Individuals are eligible for covered benefits for 12 months.

The Department shall conduct an annual review of eligibility. The WIN Oversight Committee is created. It consists of nine members of the Legislature appointed by the Executive Committee. The WIN Oversight Committee shall oversee and monitor the WIN Act. The committee has the authority to hire a consultant. The bill states that if the Federal Financial Participation Rate (FMAP) falls below 90%, the Legislature shall affirm, amend or repeal the Medicaid Expansion coverage. The bill has the emergency clause.

Implementation Assumptions

In this fiscal note, it is assumed that implementation of the Medicaid Expansion would begin on August 1, 2014. The bill also directs the Department to apply for a waiver to establish the WIN Program by January 1, 2015 or as soon thereafter as the waiver is enacted. The Department estimates that the waiver would begin on July 1, 2015. For a Medicaid waiver to be approved, the costs must be budget neutral. This means the waiver cannot cost the federal government more than what would have otherwise been spent absent the waiver over the length of the waiver. An actuarial study is required for the waiver application to determine cost neutrality. For purposes of this fiscal note, the costs are assumed to be the same if implemented with or without a waiver.

There is a great degree of uncertainty in projecting the cost of this bill. Medicaid Expansion covers a population that previously has never been covered by Medicaid. The pool of those potentially eligible coupled with assumptions regarding their behavior as to whether or not to participate and when, their health status and their decisions with regard to continuing insurance coverage or opting for Medicaid all make the impact difficult to project.

Administration

Non-waiver administrative costs were calculated at $200 per estimated enrollee, the same as in the Milliman Report. Those costs are $10,800,000 ($5,400,000 GF and FF) in FY 15 and $14,000,000 ($7,000,000 GF and FF) in FY 16. The waiver application costs are $616,405 (261,459 GF and $354,946 FF) in FY 15. Since the budget neutrality requirement applies to the waiver over the length of the waiver, the first year of waiver administrative costs are recognized in this fiscal note with the assumption that there would be offsetting savings over the duration of the waiver The first year implementation costs combined with the health care delivery system redesign costs are $3,483,843 ($1,519,241 GF and $1,964,602 FF) in FY 16. The salary and benefits for these staff are those identified in the Department's fiscal note. The non-personnel costs differ, however. The Department estimates indirect costs at 46% of salary and benefits. In this fiscal note non-personnel costs are estimated to be $7,500 per person per year.

Additionally, there will be contractual costs associated with the waiver and health care delivery system changes. Those projected costs are $698,000 ($349,000 GF and FF) in FY 15 and $160,000 ($80,000 GF and FF). IT costs are estimated to be $419,000 ($41,900 GF and $377,100 FF) in FY 15. Most administrative costs are 50% General and 50% federal, with some costs matched at a 75% federal rate. IT costs are at a 10-90% split with the federal government paying the higher percent.

Aid

The Federal Medical Assistance Percentage (FMAP) is the percentage paid by the federal government for the aid costs of Medicaid. Initially the aid costs are fully funded by the federal government and are gradually phased down to 90% in 2020. The chart on the following page shows the federal match rates for the calendar years 2014 to 2020:

Calendar Year	Fed. Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and after	90%

This fiscal note shows projected costs through 2020. The projections beyond the next biennium are shown because of the changes in the FMAP and due to the assumption that participation will increase over time.

In 2010, the Department of Health and Human Services contracted with Milliman to project the costs of implementing the Affordable Care Act. Milliman provided a revised report in January 2013. Milliman provided two projection scenarios, full participation and what they call mid-range participation. The full participation projection assumes 80% of all eligible persons will apply for and utilize the services. The mid-range participation rates range from 56% to 64% for childless adults and parents and 38% to 56% for the category of "insured switchers." Although Milliman provided the full participation scenario, in their report they state: "While we provided a full participation scenario, we do not expect full enrollment to occur. Rather, we have provided the full enrollment scenario to indicate an endpoint for reference and discussion." The fiscal note of the Department of Health and Human Services uses the mid-point between full and mid-range enrollment for a Milliman Report they commission in January 2014.

The Legislative Fiscal Office (LFO) also studied the impacts of the ACA and included their projections in a report released in November 2012. The participation rate in this report is 60%; except for the category of "insured switchers" which is at 25% in the first year. By the fourth year, the participation rate is anticipated to reach 75%; except for the "insured switchers" who remain at 25%.

In this fiscal note, the aid costs are the midpoint between the mid-range estimates from the 2013 Milliman Report and the LFO projections. Although the Fiscal Office and Milliman used the same reference, the American Census Surveys, to estimate the total eligible population, the figures on which participation rates were based are not the same. The LFO population numbers are lower than Milliman's. The blended enrollment estimate when full enrollment is achieved is 65,000 individuals.

The aid costs by fund source are shown in the chart below along with the projected number of enrollees:

Fiscal Year	State	Federal	Total	# of Enrollees
FY 2014-15	0	276,532,720	276,532,720	53,640
FY 2015-16	0	354,205,813	354,205,813	63,091
FY 2016-17	9,192,190	358,495,396	367,687,585	64,824
FY 2017-18	20,854,444	358,317,261	379,171,705	65,209
FY 2018-19	25,418,368	365,633,443	391,051,811	65,597
FY 2019-20	34,280,970	369,024,561	403,305,531	65,989
Total	89,745,971	2,082,209,193	2,171,955,165	

The Department of Health and Human Services did not include an estimate of the costs for providing EPSDT or habilitative services nor has the LFO calculated the impact of those services. Those services likely will result in additional costs but additional study of the impact is needed to determine those costs.

Primary Care Rates

In calendar year 2013 and 2014, the ACA requires states to pay primary care rates at the Medicare rates. The federal government is paying the full costs. After the expiration of the mandate, it is assumed the state would continue to pay at the higher rate. The impact of continuing those rates are included in this fiscal note. The FY 15 and FY 16 costs are $3,100,000 FF. Beginning in FY 17, match rates will be the enhanced Medicaid Expansion match rates.

Managed Care Tax

The ACA established a new tax on insurers. The tax applies to managed care plans. Since the state contracts for managed care, it is anticipated that the cost of the contract will increase. The cost in FY 15 is $5,600,000 FF and $6,800,000 FF in FY 16. Beginning in FY 17, match rates will be enhanced Medicaid expansion match rates.

2014 Milliman Report

The Department of Health and Human Services contracted with Milliman in 2014 to assess the fiscal impact of LB 887. In the prior reports, Milliman provided two scenarios, full and mid-range. In the 2014 report at the direction of the Department, Milliman provided only one scenario, the mid-point between full and mid-range scenarios. The mid-point enrollment figures in the 2014 report are significantly above the mid-range enrollment numbers in the 2013. The mid-range figures in the 2013 report are 76,500 once maximum enrollment is achieved. In the 2014 report, the Department directed Milliman to report only the mid-point figures, which are an estimated 95,000 enrollees. Elsewhere in the 2014 report, Milliman states, “An additional 4% of Nebraska resident are projected to enroll as part of the Medicaid expansion, should Nebraska choose to increase eligibility to 138% of FPL.” This would equate to 74,200 enrollees and is consistent with the mid-range figures in the prior year report, but far below 95,000 estimate. Due to the lack of comparable information, the 2013 Milliman mid-range report is used in this fiscal note.

Health Care System Redesign

The bill contains provisions requiring the use of patient-centered medical homes and accountable care organizations. This has the potential to reduce costs through more efficient and appropriate utilization of services and produce improved outcomes. No cost savings have been projected. The savings would not occur until the years beyond the biennium and additional study is needed to determine the extent of the savings. The waiver provision has a wellness component which in the private sector insurance market has shown to reduce medical costs. No savings are projected for the wellness component, but those savings would be available to offset the ongoing costs of the administration of the waiver.

Program Savings

The State Disability Program will be eliminated if Medicaid is expanded per this bill. The State Disability Medical Program covers individuals whose disability is expected to last not less than six month up through 12 months. After twelve months, if the disability continues Social Security and Medicare coverage begins. Although persons eligible under this program are considered disabled under the state’s definition, they are not considered disabled under federal law, so their medical care would be covered under the Medicaid expansion.

Savings in FY 15 would be $7,583,333 and $9,100,000 in FY 16. FY 15 costs assume a two-month lag in payments.

The state currently provides coverage for prescription drugs for low-income individuals who are HIV positive or have AIDS. These individuals would be eligible for drug coverage under the provision of this bill, so the state drug program will no longer be utilized. Savings in FY 15 would be $750,000 and $900,000 in FY 16. There is also a two-month lag in payments assumed in these savings in FY 15.

The state provides behavioral health funding to the mental health regions to cover individuals who are not insured and services that not covered by insurance or Medicaid. Estimated savings, net of the costs that would not be covered by Medicaid, are up to $6 million annually for those who would be covered by Medicaid expansion. However, to avoid a disruption in services, the savings will be gradually captured**.** In FY 16 the appropriation will be reduced by $1 million; in FY 17, by $2 million and in FY 18, by $3 million. In FY 19 and thereafter, the savings are anticipated to be $4 million.

Corrections

Inmates of correctional facilities are not eligible for Medicaid; however, if inmates are hospitalized outside of the correctional facility, they are eligible for Medicaid for the services provided while in the hospital. Estimated savings of $364,808 are anticipated in FY 15 and full year savings would be $729,616. These savings are less than total inpatient hospital expenses due to the following reasons: some inmates may not be legal residents, some may not cooperate with the application process or the service provider may not accept Medicaid.

Counties

Counties would see a reduction in costs currently spent on covering individuals through General Assistance. The savings would vary from county to county; however county by county information is not available. The state's two largest counties Douglas and Lancaster provided projected cost savings. Douglas County estimates savings of $1,650,000 annually in reduced reimbursements to medical providers and $300,000 in payments for prescription drugs. They could have additional savings of $1,869,000, if their Primary Health Care Clinic is closed. Lancaster County projects savings of $2,500,000 annually in their General Assistance Program. Savings in FY 15 would be approximately one quarter of estimated annual savings.

As noted above, inmates of correctional facilities are eligible for Medicaid coverage for inpatient hospital services. Counties will have savings for inpatient hospital services for jail inmates, but as with General Assistance, those costs would vary from county to county. No estimate is available at this time.

Insurance

The Department of Insurance indicates that five additional staff will be needed. The Department is solely cash funded. The total cost would be $264,500 in FY 15 and FY 16. Additional revenue of $86,000 annually is also anticipated.

WIN Oversight Committee

The WIN Oversight Committee has the authority to hire a consultant. The cost would be $50,000 in FY 15 and FY 16.

Fiscal Impact Summary

The chart on the next page shows the fiscal impact of the Medicaid expansion through FY 2019-20:

	Summary							
1		FY14-15	FY15-16	FY16-17	FY17-18	FY18-19	FY19-20	Total All Years
2	Aid Costs New Eligibles							
3	General	0	0	9,192,190	20,854,444	25,418,368	34,280,970	89,745,971
4	Federal	276,532,720	354,205,813	358,495,396	358,317,261	365,633,443	369,024,561	2,082,209,193
5	Total	276,532,720	354,205,813	367,687,585	379,171,705	391,051,811	403,305,531	2,171,955,165
6								
7	Primary Care to Medicare							
8	General	0	0	77,500	170,500	201,500	263,500	713,000
9	Federal	3,100,000	3,100,000	3,022,500	2,929,500	2,898,500	2,836,500	17,887,000
10	Total	3,100,000	3,100,000	3,100,000	3,100,000	3,100,000	3,100,000	18,600,000
11								
12	Administration							
13	General	5,400,000	7,000,000	7,150,000	7,550,000	8,000,000	8,400,000	43,500,000
14	Federal	5,400,000	7,000,000	7,150,000	7,550,000	8,000,000	8,400,000	43,500,000
15	Total	10,800,000	14,000,000	14,300,000	15,100,000	16,000,000	16,800,000	87,000,000
16								
17	Waiver							
18	General	261,459	1,519,241					1,780,700
19	Federal	354,946	1,964,602					2,319,548
20	Total	616,405	3,483,843					4,100,248
21								
22	Contracts							
23	General	349,000	80,000					429,000
24	Federal	349,000	80,000					429,000
25	Total	698,000	160,000					858,000
26	IT							
27	General	41,900	153,750					195,650
28	Federal	377,100	1,383,750					1,760,850
29	Total	419,000	1,537,500					1,956,500
30								
31	ACA Managed Care Fee							
32	General	0	0	136,000	350,000	432,000	584,000	1,502,000
33	Federal	5,600,000	6,800,000	6,664,000	6,650,000	6,768,000	6,716,000	39,198,000
34	Total	5,600,000	6,800,000	6,800,000	7,000,000	7,200,000	7,300,000	40,700,000
35								
36	Program Savings (All General)							
37	State Disability	(7,583,333)	(9,100,000)	(9,100,000)	(9,100,000)	(9,100,000)	(9,100,000)	(53,083,333)
38	AIDS Drugs	(750,000)	(900,000)	(900,000)	(900,000)	(900,000)	(900,000)	(5,250,000)
39	Behavioral Health		(1,000,000)	(2,000,000)	(3,000,000)	(4,000,000)	(4,000,000)	(14,000,000)
40	Total	(8,333,333)	(11,000,000)	(12,000,000)	(13,000,000)	(14,000,000)	(14,000,000)	(72,333,333)
41								
42	Corrections							
43	General	(364,808)	(729,616)	(729,616)	(729,616)	(729,616)	(729,616)	(4,012,888)
44								
45	Department of Insurance							
46	Cash	264,500	264,500					529,000
47	WIN Oversight							
48	General	50,000	50,000					100,000
49								
50	Grand Total							
51	General	(2,595,782)	(2,926,625)	3,826,074	15,195,328	19,322,252	28,798,854	61,620,100
52	Cash	264,500	264,500					529,000
53	Federal	291,713,766	374,534,165	375,331,896	375,446,761	383,299,943	386,977,061	2,187,303,591
54	Total	289,382,483	371,872,040	379,157,969	390,642,089	402,622,195	415,775,915	2,249,452,691

ADMINISTRATIVE SERVICES-STATE BUDGET DIVISION: REVIEW OF AGENCY & POLT. SUB. RESPONSES			
LB: 887	AM: Revised	AGENCY/POLT. SUB: Health and Human Services (HHS)	
REVIEWED BY: Elton Larson		DATE: 1/30/2014	PHONE: 471-4173
COMMENTS: Revised HHS revised fiscal estimates based on new available information appear reasonable.			

ADMINISTRATIVE SERVICES-STATE BUDGET DIVISION: REVIEW OF AGENCY & POLT. SUB. RESPONSES			
LB: 887	AM:	AGENCY/POLT. SUB: Department of Insurance (DOI)	
REVIEWED BY: Elton Larson		DATE: 1/28/2013	PHONE: 471-4173
COMMENTS: DOI analysis and estimate of fiscal impact appear reasonable.			

LB(1) 887 FISCAL NOTE 2014

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

State Agency or Political Subdivision Name:(2) Department of Health and Human Services

Prepared by: (3) Steve Shively | Date Prepared:(4) 1-14-14 | Phone: (5) 471-0676

	FY 2014-2015		FY 2015-2016	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	-$2,494,554*		$1,401,792*	
CASH FUNDS				
FEDERAL FUNDS	$290,871,841*		$469,318,019*	
OTHER FUNDS				
TOTAL FUNDS	$288,377,287*		$470,719,811*	

Return by date specified or 72 hours prior to public hearing, whichever is earlier.

Explanation of Estimate:

The Nebraska Medicaid program currently provides coverage for low-income individuals in specified categories: children to age 19, their qualifying caretaker relatives, pregnant women, the aged, and the disabled. The program provides a wide variety of medical services, as well as non-medical services designed to help the aged and disabled live in the community. In Fiscal Year 2013, Nebraska Medicaid covered a monthly average of 240,639 individuals, at a total annual cost of more than $1.8 billion.

In 2010, President Obama signed the Patient Protection and Accountable Care Act (hereinafter the ACA), creating an individual mandate to have health insurance and establishing health insurance exchanges. In June 2012, the Supreme Court ruled the expansion of Medicaid to a new adult group could not be mandated but rather was voluntary for states. In order to get assistance in estimating the impact of the ACA to the Nebraska Medicaid program, the Nebraska Department of Health and Human Services retained Milliman, Inc., an international actuarial and consulting firm with expertise in Medicaid and the private health insurance market. The additional appropriation necessary to implement the required provisions of ACA were included in LB 195 for SFY14 and SFY15, the mainline budget bill.

Optional Medicaid Expansion of the Affordable Care Act

LB 887 seeks to implement the optional Medicaid expansion in Nebraska providing Medicaid services to the optional adult group not previously covered. The Department estimates that the expansion under LB 887 will result in enrollment of an additional 113,410 new individuals in Medicaid by Fiscal Year 2020. The average annual costs for the optional population are based on Milliman's analysis which was originally drafted in November, 2010, and updated January 27, 2014. The analysis relied on contracted managed care data on capitation rates, Nebraska Medicaid service costs, the Medicaid Statistical Information System (MSIS) State Summary Datamart, and Medicaid expansion data from other states. The estimates are based on expenditures for current adult Medicaid enrollees. The annual estimates assume a 2.5% growth for capitated expenditures and a 3.5% growth for Fee-for-Service expenditures. Expenditures for benefits are estimated at $3.28 billion through Fiscal Year 2020. Implementation of LB 887 is estimated for 7-1-14 assuming the timely approval of State Plan Amendments (SPAs). WIN Nebraska is projected to begin 7-1-15 assuming 1115 waivers are approved. Due to the complex and rigorous SPA and 1115 waiver approval processes, the implementation dates could be delayed. The year-by-year analysis and breakdown by State Funds and Federal Funds is set out in the Cost of Benefits table below.

In order to handle the additional 113,410 individuals estimated to enroll in the optional program created by LB 887, the Department would need 338 additional baseline staff by State Fiscal Year 2020. This staff is necessary in order to determine eligibility, process claims, and administer Medicaid requirements such as contract management, program integrity, legal, financial, human resources and data analysis. Additional staff

expenditures are estimated at $118.6 million through Fiscal Year 2020. The year-by-year analysis and breakdown by State Funds and Federal Funds is set out in the Administrative Costs table below.

Medicaid Expansion	New Enrollees	Staff Positions
SFY15	59,668	177
SFY16	86,567	258
SFY17	110,074	328
SFY18	111,175	331
SFY19	112,287	335
SFY20	113,410	338

Cost of Benefits	Total	State Funds	Federal Funds
SFY15	$274,400,000	-$9,200,000	$283,600,000
SFY16	$447,300,000	-$9,500,000	$456,800,000
SFY17	$592,200,000	$5,400,000	$586,800,000
SFY18	$619,000,000	$25,000,000	$594,000,000
SFY19	$655,100,000	$33,300,000	$621,800,000
SFY20	$693,800,000	$49,900,000	$643,900,000
Total	**$3,281,800,000**	**$94,900,000**	**$3,186,900,000**

Administrative Costs	Total	State Funds	Federal Funds
SFY15	$11,900,000	$5,900,000	$6,000,000
SFY16	$17,300,000	$8,600,000	$8,700,000
SFY17	$22,000,000	$11,000,000	$11,000,000
SFY18	$22,200,000	$11,100,000	$11,100,000
SFY19	$22,500,000	$11,200,000	$11,300,000
SFY20	$22,700,000	$11,300,000	$11,400,000
Total	**$118,600,000**	**$59,100,000**	**$59,500,000**

Additionally, LB 887 requires benefits to provide habilitative services and coverage of chronic disease management to an undefined population under the State Plan Amendment and WIN Medicaid. It is impossible for the Department to estimate what the costs would be, but they would be in addition to the costs of benefits referenced above. The 1115 waiver for premium assistance ends 12/31/2016, and the cost of the state innovation waiver required after this date is not included in the expenditure estimates.*

In addition, computer changes would be necessary to meet business requirements for processing the optional population. The cost of the necessary computer changes are estimated at $1,956,500 total ($195,000 GF, $1,760,850 FF) through SFY20. Computer changes are reflected in the table below.

Computer Changes	Total	State Funds	Federal Funds
SFY15	$419,000	$41,900	$377,100
SFY16	$1,537,500	$153,750	$1,383,750
SFY17	$0	$0	$0
SFY18	$0	$0	$0
SFY19	$0	$0	$0
SFY20	$0	$0	$0
Total	**$1,956,500**	**$195,650**	**$1,760,850**

A contract at the estimated cost of $150,000 ($75,000 GF, $75,000 FF) would be needed in SFY15 to apply for a State Plan Amendments to cover the newly eligible individuals within 30 days after LB 887 is passed. Additional contract(s) would be necessary to prepare the required 1115 waiver(s) and assist the Department with the development, procurement, and implementation of WIN Marketplace at a cost of $325,000 ($162,500 GF, $162,500 FF) in SFY15 and $70,000 ($35,000 GF, $35,000 FF) in SFY16.

In addition to the baseline staff identified above, 12 additional staff members in SFY15 and 52 additional staff members in SFY16 will be needed to administer the various requirements of the Wellness in Nebraska (WIN) programs. A total of 64 additional staff members with be needed through SFY20. Additional staff and all contracts are reflected in the tables below and are required for the following:

- Medical Team – 1 dedicated full-time Medical Director beginning 7-1-14 to assist in the development of the Alternative Benefit Plan State Plan Amendment and to determine the criteria for the "Medically Frail" population defined in section 24 of LB 887; 3 Nurses and 1 Staff Assistant beginning 7-1-15 to assist in the identification of the "Medically Frail" population.
- Financial Team (Marketplace/HIPP) – 1 Administrator I beginning 1-1-15; 2 Unit Managers, 1 Staff Assistant, and 20 Payment Reviewers starting 7-1-15 to process payments of premiums for persons buying into the Exchange, and to process Employer Sponsored insurance premiums for qualified individuals.
- Financial Team (2% Contribution) – 1 Administrator I beginning 7-1-15; 1 Accountant I, 1 Staff Assistant, and 10 Accounting Clerk II positions starting 1-1-16 to facilitate the collection of the 2% contributions by clients as defined in Section 43 of LB 887, to document when wellness quality measures are met and the contribution is waived, and track total contributions.
- Eligibility Team – 1 Program Specialist starting 7-1-14 to assist in the development and administration of the 1115 waiver; 2 Statistical Analyst II positions starting 7-1-14 for data collection for the 1115 waiver application and establishing data quality metrics; 1 Business Analyst and 1 Unit Manager beginning 1-1-15 to assist in the identification, design and development of computer changes due to the 1115 waiver; 1 Program Accuracy Specialist, 2 Statistical Analyst II, 1 Staff Assistant, 1 Quality Program Specialist starting 7-1-15 to facilitate quality measurement development, gathering, and additional reporting.
- SIU Team – 2 Quality Control Specialist starting 7-1-15 to investigate possible abuse and fraud in WIN Marketplace.
- Managed Care Team – 2 Program Quality Specialists starting 7-1-14 for quality and financial oversight of the WIN Medicaid Program; 4 Program Quality Specialists beginning 1-1-16 to manage and oversee the WIN Marketplace and WIN Medicaid contracts.
- Program Team – 2 Program Specialists beginning 1-1-15 to develop, implement, and evaluate the incentives for providers and clients, as well as develop plans and manage Health Home and Accountable Care Organizations.
- CMS 64 Reporting – 1 Program Analyst starting 1-1-15 for additional CMS 64 reporting requirements associated with the 1115 waivers.
- Actuarial Annual Update Contract – To set initial rates and update annually.
- Wellness Contract – Monitor compliance with wellness contract by clients.

Contracts	Total	State Funds	Federal Funds
SFY15	$698,000	$349,000	$349,000
SFY16	$314,000	$157,000	$157,000
SFY17	$369,000	$184,500	$184,500
SFY18	$369,000	$184,500	$184,500
SFY19	$369,000	$184,500	$184,500
SFY20	$369,000	$184,500	$184,500
Total	**$1,012,000**	**$506,000**	**$506,000**

Additional Staff	Total	State Funds	Federal Funds
SFY15	$960,287	$414,546	$545,741

SFY16	$4,268,311	$1,991,042	$2,277,269
SFY17	$4,777,855	$2,245,814	$2,532,041
SFY18	$4,777,855	$2,245,814	$2,532,041
SFY19	$4,777,855	$2,245,814	$2,532,041
SFY20	$4,777,855	$2,245,814	$2,532,041
Total	**$24,340,018**	**$11,388,844**	**$12,951,174**

Total of all Medicaid Expansion / Provisions that can be estimated*

Total	Total	State Funds	Federal Funds
SFY2015	$288,377,287	-$2,494,554	$290,871,841
SFY2016	$470,719,811	$1,401,792	$469,318,019
SFY2017	$619,346,855	$18,830,314	$600,516,541
SFY2018	$646,346,855	$38,530,314	$607,816,541
SFY2019	$682,746,855	$46,930,314	$635,816,541
SFY2020	$721,646,855	$63,630,314	$658,016,541
Total	**$3,429,184,518**	**$166,828,494**	**$3,262,356,024**

MAJOR OBJECTS OF EXPENDITURE

PERSONAL SERVICES:

POSITION TITLE	NUMBER OF POSITIONS 14-15	NUMBER OF POSITIONS 15-16	2014-2015 EXPENDITURES	2015-2016 EXPENDITURES
Administration/Staff	189	322	$12,860,287*	$21,568,311*
Benefits				
Operating			$698,000*	$314,000*
Travel				
Capital Outlay			$419,000*	$1,537,500*
Aid			$274,400,000*	$447,300,000*
Capital Improvements				
TOTAL			$288,377,287*	$470,719,811*

*Does not include the estimated impact for the provisions of LB 887 requiring expanded coverage of habilitative services, coverage of chronic disease management, and the state innovation waiver.

Please complete ALL (5) blanks in the first three lines. **2014**

LB(1) 887 FISCAL NOTE

State Agency OR Political Subdivision Name: (2) Nebraska Department of Insurance

Prepared by: (3) Krystle Ledvina Garcia Date Prepared: (4) 1/21/2014 Phone: (5) (402) 471-4637

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

	FY 2014-15		FY 2015-16	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	$178,500		$170,000	
CASH FUNDS	$86,000	$86,000	$88,000	$88,000
FEDERAL FUNDS				
OTHER FUNDS				
TOTAL FUNDS	$264,500	$86,000	$258,000	$88,000

Explanation of Estimate:

LB887 creates the Wellness in Nebraska Act. This bill will require substantial additional resources to be created within the Department of Insurance. Specifically, new positions in the Examination, Legal, Life and Health, Consumer Affairs, and the Market Conduct Divisions will necessarily be required due to this proposed legislation. This will result in the addition of four and a half FTEs.

The bill adds several additional duties upon the Department of Insurance which in turn requires new resources for the Department. The bill requires the inclusion of Accountable Care Organizations or ACOs into an insurer's provider network if an ACO is available. The Department does not currently have a licensing procedure for ACOs. This bill would require the Department to implement a licensing procedure for ACOs, monitor the solvency of the ACO, and assure compliance with state and federal law for these new entities. An Analyst II would be needed within the examination division to monitor the solvency of the ACOs and to compile the actuarial data and reports.

The bill also imposes a requirement that the Department of Insurance provide the proposed WIN legislative committee with any reports, data, analysis, including actuarial data and reports, or other information upon which the departments utilize for implementing the act. In addition, the Bill requires the Director of the Department of Insurance to participate in quarterly meetings with the Committee. These meetings will require the preparation of additional reports and data. The bill also requires the Department to promote a regulatory environment where price-competitive choices exist and to promote at least two qualified health plans. These are duties that are not currently imposed upon the staff and would create additional duties which would require the hiring of additional FTEs.

Additionally, the bill requires the Department to review very specific and unfamiliar Medicaid requirements that would be imposed into insurance plans. As such, an Analyst II would be needed in the Life and Health Division to review these new requirements and assure that the newly created networks are adequate which is also required under this bill. An additional Attorney II would be needed to assist in the preparation of reports, assist the Director with information for quarterly meetings, and provide the required regulation and enforcement components of the bill.

The Department also anticipates the need for an additional Consumer Affairs Investigator II. Given the new plan options and the increased number of new and additional insured individuals, the Department anticipates that consumers will have additional questions and complaints. The bill also mandates that the Department promotes at least two qualified health plans. Although the Department is unclear as to what this particular provision means within the context of the bill, if the Department is required to promote these plans, we have determined that a consumer affairs investigator would be the most appropriate individual in the Department to handle this task.

Finally, the Department anticipates that it will need to hire an additional Market Conduct Examiner II at .5 FTE.

This additional employee will be needed to assist in examinations of the additional and newly created requirements placed upon insurers to assure compliance with this bill.

Because most of these new duties are not billable to the insurers, the majority of the funding must be appropriated from the General Fund. Cash funds may be used to pay the costs associated with the Market Conduct Examiner II and Examination Analyst II as these are costs that are billed back to the insurers. This bill will take effect when passed and as such, would require these additional employees be hired immediately.

BREAKDOWN BY MAJOR OBJECTS OF EXPENDITURE

Personal Services:

POSITION TITLE	NUMBER OF POSITIONS 14-15	NUMBER OF POSITIONS 15-16	2014-15 EXPENDITURES	2015-16 EXPENDITURES
Examination Analyst II	1	1	$48,000	$50,000
Attorney II	1	1	$50,000	$52,000
Life and Health Analyst II	1	1	$38,000	$39,000
Consumer Affairs Investigator II	1	1	$41,000	$42,000
Market Conduct Examiner II (.5FTE)	1	1	$21,000	$21,000
Benefits……			$54,000	$54,000
Operating……..……			$12,500	
Travel……..				
Capital outlay……..……..				
Aid……...				
Capital improvements……...				
TOTAL…….…..			$264,500	$258,000