PREPARED BY: Liz Hruska
DATE PREPARED: February 23, 2015
PHONE: 471-0053

LB 472

Revision: 00

FISCAL NOTE

LEGISLATIVE FISCAL ANALYST ESTIMATE

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

	FY 2015-16		FY 2016-17	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	(2,614,649)		5,929,383	(7,000,000)
CASH FUNDS	116,776		149,326	
FEDERAL FUNDS	448,157,186		448,024,417	
OTHER FUNDS				
TOTAL FUNDS	445,659,312		454,103,127	(7,000,000)

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

This bill establishes the Medicaid Redesign Act. 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. The state plan amendment would be in effect until the Medicaid demonstration waiver the department is required develop is approved by the federal Centers for Medicare and Medicaid. The Medicaid Redesign Task Force is created. The Task Force will conduct a comprehensive review of the Medicaid Program and make recommendations on: 1) programs that result in cost savings; 2) opportunities that strengthen the health care delivery system and finances; 3) approaches that identify best practices and maximize efficiencies; 4) improved quality measurement, 5) targeted interventions for super utilizers and individuals with exceptional medical conditions and 6) the effectiveness of managed care. The Department in consultation with the task force shall contract by October 1, 2015, with an independent organization with expertise in fiscal analysis, claims and clinical data analysis; options for health care delivery and experience with managed care organizations. The task force shall provide a report on December 15th of each year to the Governor and the Legislature.

The Department is required to develop and submit a Medicaid demonstration waiver within 12 months after the effective date of this act. Each newly eligible participant whose income is above 50% of the Federal Poverty Level (FPL) will be required to make monthly contributions up to two percent of their income. The first year of demonstration waiver no contributions will be assessed. A participant who completes a program of required preventative care services and wellness activities will have their contributions waived in the subsequent year of participation. Failure to make the monthly contributions will not impact eligibility but will constitute a debt to the state. The waiver shall include a private premium assistance program for persons with incomes between 100% and 133% of FPL. Those with incomes below 100% of FPL and medically frail individuals, super utilizers and individuals with exceptional medical conditions under 133% of FPL will be covered under the Medicaid Program. The waiver shall include patient-centered medical homes for all participants and value-based payments that may include a paid-care coordinator fee on a per-member, per-month basis plus measure value created by provider and payer on a risk-adjusted basis on absolute payment and performance. Medically frail individuals, super utilizers and special populations would have health homes that provide intensive care management and patient navigation services by a multidisciplinary team.

The bill changes the distribution of the Comprehensive Health Insurance Pool Distributive Fund beginning no later than May 1, 2017. The Director of the Department of Insurance shall transmit the money remaining in the fund to the State Treasurer for credit to the following funds: 50% to the Insurance Tax Fund; 16.5% to the General Fund; 10% to the Mutual Finance Assistive Fund and 23.5% to the Health Care Access Fund and

Support Fund. The Health Care Access and Support Fund is created. The fund will be used to support the Medicaid Program. The bill states that if the Federal Financial Participation Rate (FMAP) falls below 90%, the coverage for newly eligible individuals shall terminate as of the date the federal funding falls below that level. The bill has the emergency clause.

Implementation Assumptions

In this fiscal note, it is assumed that implementation of the Medicaid Expansion 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. A review of Medicaid Expansion states showed mixed results. Of the 29 states that expanded coverage, 12 had higher than expected participation rates and 17 had lower rates.

Comprehensive Health Insurance Pool

Currently 40% of the funding from the Comprehensive Distributive Fund is transferred to the General Fund. The bill directs 23.5% of this amount to the newly created Health Care Access and Support Fund. The money is the Health Care Access and Support Fund is to be used to as the part of the state match for Medicaid. Since the fund can be used to pay the state match for Medicaid, in this fiscal note, it is assumed to be used for the Medicaid Expansion match. The amount that would be deposited into the fund in FY 17 is approximately $7 million. This is also the amount of the General Fund loss of revenue.

Administration

The Department estimates that the non-waiver administrative costs would be $18,500,000 ($5,500,000 GF and $13,000,000 FF) in FY 16 and $21,500,000 ($6,450,000 GF and $15,100,000 FF) in FY 17. The cost to support the Medicaid Redesign Task Force and prepare and develop the waiver would be $1,518,489 ($613,234 GF and $905,255 FF) in FY 16 and $2,213,370 ($1,033,680 GF and $1,179,691 FF in FY 17).

Additionally, there will be contractual costs associated with the waiver application and the Medicaid Redesign Task Force. Those projected costs are $2,586,332 ($1,293,166 GF and FF) in FY 16 and $264,000 ($132,000 GF and FF). IT costs are estimated to be $460,900 ($41,900 GF and $419,000 FF) in FY 16; $1,553,250 ($15,750 GF and $1,537,500 FF) in FY 17. In FY 18, IT costs are projected to drop to $247,500 ($22,500 GF and $225,000 FF). Administrative costs are a mix of 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 2015 to 2020:

Calendar Year	Fed. Match
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." In the 2014 and 2015 reports, Milliman at the direction of the Department provided only the mid-point of the mid-range and full participation; with 90% being used for the full participation figure. By directing Milliman to use an average of the higher full participation estimates which they stated in prior reports that they do not expect to occur with their the mid-range estimates, their projections are skewed to the high end. 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 and was released February 2015.

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 estimated enrollment is the mid-point between Milliman's 2013 figures and the LFO estimates. Similarly, the cost per person is the mid-point between Milliman and LFO. The Milliman enrollment estimates were higher than LFO's but the costs per person were lower than LFO's.

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 2015-16	0	432,539,764	432,539,764	76,502
FY 2016-17	11,027,570	430,075,227	441,102,797	77,264
FY 2017-18	24,772,170	425,630,916	450,403,086	78,033
FY 2018-19	29,226,146	420,406,862	449,633,008	78,809
FY 2019-20	40,486,452	435,824,744	476,311,196	79,593
Total	105,512,337	2,144,477,513	2,249,989,850	

Health Care System Redesign

The bill contains provisions requiring the use of innovated and proven efficiency methods of health care delivery such as health homes for the medically frail 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 16 would be $7,583,333 and $9,100,000 in FY 17. FY 16 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 16 would be $750,000 and $900,000 in FY 17. There is also a two-month lag in payments assumed in these savings in FY 16.

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. A report by the Nebraska Association of Regional Administrators states that 85.9% of the persons served by the Behavioral Health Regions are under 138% of FPL. Estimated savings, net of the costs that would not be covered by Medicaid, are up to $8 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; by $2 million and in FY 17, by $4 million in FY 19. In FY 20 and thereafter, the savings are anticipated to be $8 million.

Insurance

The Department of Insurance indicates that one and half additional staff will be needed. The Department is solely cash funded. The total cost would be $116,776 in FY 16 and $149,326 FY 17.

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 16 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. In the past, 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 16 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.

Fiscal Impact Summary

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

Summary						
	FY15-16	FY16-17	FY17-18	FY18-19	FY19-20	Total All Years
Aid Costs New Eligibles						
General	0	11,027,570	24,772,170	29,226,146	40,486,452	105,512,337
Federal	432,539,764	430,075,227	425,630,916	420,406,862	435,824,744	2,144,477,513
Total	432,539,764	441,102,797	450,403,086	449,633,008	476,311,196	2,249,989,850
Administration						
General	5,500,000	6,450,000	7,500,000	7,600,000	7,600,000	34,650,000
Federal	13,000,000	15,100,000	17,400,000	17,600,000	17,800,000	80,900,000
Total	15,300,310	15,452,770	15,606,560	15,761,760	15,918,650	115,550,000
Waiver						
General	613,234	1,033,680				1,646,914
Federal	905,255	1,179,691				2,084,946
Total	1,518,489	2,213,370				3,731,859
Contracts						
General	1,293,166	132,000				1,425,166
Federal	1,293,167	132,000				1,425,167
Total						
IT						
General	41,900	15,750	22,500			80,150
Federal	419,000	1,537,500	225,000			2,181,500
Total	460,900	1,553,250	247,500			2,261,650
Program Savings (All General)						
State Disability	(7,583,333)	(9,100,000)	(9,100,000)	(9,100,000)	(9,100,000)	(43,983,333)
AIDS Drugs	(750,000)	(900,000)	(900,000)	(900,000)	(900,000)	(4,350,000)
Behavioral Health	(1,000,000)	(2,000,000)	(4,000,000)	(6,000,000)	(8,000,000)	(21,000,000)
Total	(9,333,333)	(12,000,000)	(14,000,000)	(16,000,000)	(18,000,000)	(69,333,333)
Corrections						
General	(729,616)	(729,616)	(729,616)	(729,616)	(729,616)	(3,648,080)
Insurance	116,776	149,326				266,102
Grand Total						
General	(2,614,649)	5,929,383	10,565,054	13,096,530	22,356,836	70,333,153
Cash	116,776	149,326	7,000,000	7,000,000	7,000,000	21,266,102
Federal	448,157,186	448,024,417	443,255,916	438,006,862	453,624,744	2,231,069,125
Total	445,659,312	454,103,127	460,820,970	458,103,392	482,981,580	2,322,668,380

ADMINISTRATIVE SERVICES-STATE BUDGET DIVISION: REVIEW OF AGENCY & POLT. SUB. RESPONSES			
LB: 472	AM:	AGENCY/POLT. SUB: HHS	
REVIEWED BY: Elton Larson		DATE: 2/24/2015	PHONE: 471-4173
COMMENTS: HHS analysis and estimate of fiscal impact appear reasonable. FY17 Cash Fund revenue and expenditure estimates are from Department of Insurance estimate of revenue accruing to the Health Care Access and Support Fund.			

ADMINISTRATIVE SERVICES-STATE BUDGET DIVISION: REVIEW OF AGENCY & POLT. SUB. RESPONSES			
LB: 472	AM:	AGENCY/POLT. SUB: Department of Insurance	
REVIEWED BY: Elton Larson		DATE: 2/23/2015	PHONE: 471-4173
COMMENTS: DOI analysis and estimate of fiscal impact appear reasonable.			

LB(1) 472 FISCAL NOTE 2015

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

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

Prepared by: (3) Mike Mason | Date Prepared:(4) 2-23-15 | Phone: (5) 471-0676

	FY 2015-2016		FY 2016-2017	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	-$1,951,700		$5,911,334	
CASH FUNDS			$7,041,775	$7,041,775
FEDERAL FUNDS	$459,375,522		$555,875,131	
OTHER FUNDS				
TOTAL FUNDS	$457,423,822		$568,828,240	$7,041,775

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

Explanation of Estimate:

In 2010, President Obama signed the Patient Protection and Affordable Care Act (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 and was voluntary for states. In order to get assistance in estimating the impact of the optional adult group 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.

LB 472 seeks to implement the optional Medicaid expansion in Nebraska providing Medicaid services to the optional adult group not previously covered. Implementation of LB 472 is estimated for July 1, 2015 assuming the timely approval of State Plan Amendments (SPAs). The waivers serving as a demonstration pilot project for redesign of Medicaid are projected to begin January 1, 2017 assuming the Section 1115 Demonstration Waivers are approved. Due to the complex and rigorous SPA and Section 1115 Demonstration Waiver approval procedures, the implementation dates could be delayed.

The estimated new enrollees and average annual costs for the optional population are based on Milliman's analysis, which was updated February 23, 2015. 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. Expenditures for benefits are estimated at $3.1 billion through State Fiscal Year 2020. The Department estimates that the expansion under LB 472 will result in enrollment of an additional 127,029 new individuals in Medicaid by State Fiscal Year 2020. The year-by-year analysis and breakdown by State Funds and Federal Funds is set out in the Benefits & Enrollment table below.

Benefits & Enrollment	Total Funds	State Funds	Federal Funds	New Enrollees
SFY16	$434,400,000	-$9,400,000	$443,800,000	92,340
SFY17	$541,050,000	$4,150,000	$536,900,000	107,759
SFY18	$689,000,000	$28,450,000	$660,550,000	124,526
SFY19	$715,000,000	$36,800,000	$678,200,000	125,771
SFY20	$754,400,000	$54,400,000	$700,000,000	127,029
Total	**$3,133,850,000**	**$114,400,000**	**$3,019,450,000**	

In order to handle the additional 127,029 individuals estimated to enroll in the optional expansion program created by LB 472, the Department would need 371 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 $115.6 million through State Fiscal Year 2020. The year-by-year analysis and breakdown by State Funds and Federal Funds is detailed in the Administration table below.

Administration	Total Funds	State Funds	Federal Funds	Staff Positions
SFY16	$18,500,000	$5,500,000	$13,000,000	270
SFY17	$21,550,000	$6,450,000	$15,100,000	315
SFY18	$24,900,000	$7,500,000	$17,400,000	364
SFY19	$25,200,000	$7,600,000	$17,600,000	368
SFY20	$25,400,000	$7,600,000	$17,800,000	371
Total	**$115,550,000**	**$34,650,000**	**$80,900,000**	

Additionally, LB 472 requires benefits to provide habilitative services and coverage of chronic-disease management to an undefined population under the Medicaid Resign Act. 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.*

IS&T changes would be necessary to meet business requirements for processing the optional population. The cost of the necessary computer changes are estimated at $2,181,500 total funds through SFY20. IS&T changes are reflected in the table below.

IS&T Changes	Total Funds	State Funds	Federal Funds
SFY16	$419,000	$41,900	$377,100
SFY17	$1,537,500	$153,750	$1,383,750
SFY18	$225,000	$22,500	$202,500
SFY19	$0	$0	$0
SFY20	$0	$0	$0
Total	**$2,181,500**	**$218,150**	**$1,963,350**

In addition to the baseline staff identified above, 16 additional staff members in SFY16 and 48 additional staff members in SFY17 will be needed to administer the various requirements of the Medicaid Redesign Act. A total of 64 additional staff members with be needed through SFY20. Additional staff are shown in the table below and are required for the following:

- Medical Team – 1 Medical Director beginning 7-1-15 to assist in the development of the Alternative Benefit Plan SPA and to determine the criteria for the medically frail population defined in Section 4 of LB 472; 3 Nurses and 1 Staff Assistant II beginning 7-1-15 would also assist in the identification of the medically frail population. The Medical Director and Nursing Staff would be contract positions in the first two years.
- Financial Team (Premium Assistance) – 1 Administrator I beginning 1-1-16; 2 Office Managers, 1 Staff Assistant I, and 20 Payment Reviewers starting 7-1-16 to process payments for the premium assistance program.
- Financial Team (2% Client Contribution) – 1 Administrator I beginning 7-1-16; 1 Accountant I, 1 Staff Assistant I, 10 Accounting Clerk II positions, and 1 Hearing Officer all starting 1-1-17 to facilitate the collection of the 2% contributions by clients as defined in Section 12 of LB 472, to document when wellness quality measures are met and the contribution is waived, and to track total contributions.
- Eligibility / Data Analytics Team – 1 Program Specialist starting 7-1-15 to assist in the development and administration of the 1115 waiver(s); 2 Statistical Analyst II positions starting 7-1-15 for data collection for the 1115 waiver application and establishing data quality metrics; 1 Business Analyst and 1 Office Manager beginning 1-1-16 to assist in the identification, design, and development of IS&T changes due to the 1115 waiver(s); 1 Program Accuracy Specialist, 2 Statistical Analyst II, 1 Staff Assistant I, and 1

Program Specialist starting 7-1-16 to facilitate quality measurement development, gathering, and additional reporting.

- SIU Team – 1 Quality Control Specialist and 1 Fraud Investigator starting 7-1-16 to investigate possible abuse and fraud.
- Program Team – 1 Program Manager II starting 7-1-15 to manage the staff developing, submitting, and administering the 1115 demonstration waiver(s) and health homes; 1 Program Coordinator starting 7-1-15 to develop and oversee the health home model under the 1115 demonstration waiver(s) for the medically frail, super utilizers, and special needs populations; 1 Program Specialist starting 7-1-15 to complete the Managed Care SPA and 1915(b) waiver work for the newly eligible to be enrolled in managed care before the approval and implementation of the 1115 demonstration waiver(s), then applying for and overseeing the 1115 demonstration waiver(s); 2 Program Specialists starting 7-1-15 for quality and financial oversight of the Managed Care Organization (MCO) vendors in relation to the newly eligible population; 3 Program Specialists starting 7-1-16 to manage additional MCO and health home contracts for the newly eligible population and for the additional financial oversight of additional MCO and health home vendors.
- CMS 64 Reporting – 1 Program Analyst starting 7-1-16 for additional CMS 64 reporting requirements associated with the 1115 waiver(s).

Additional Staff	Total Funds	State Funds	Federal Funds
SFY16	$1,518,489	$613,234	$905,255
SFY17	$4,426,740	$2,067,359	$2,359,381
SFY18	$4,809,086	$2,258,532	$2,550,554
SFY19	$4,809,086	$2,258,532	$2,550,554
SFY20	$4,809,086	$2,258,532	$2,550,554
Total	**$20,372,487**	**$9,456,189**	**$10,916,298**

A contract at an estimated cost of $1,093,333 total funds beginning 10-1-15 in SFY16 would be needed for a contractor to support the Medicaid Redesign Task Force, complete a comprehensive review, and make recommendations. In order to apply for SPAs to cover the newly eligible individuals within 30 days after LB 472 is passed and to prepare the required 1115 waiver(s) and assist the Department with the development, procurement, and implementation of the Medicaid Redesign Act, a contract will be needed at an estimated cost of $1,250,000 total funds in SFY16. Additional contracts are also needed to update the capitation rates annually through an actuarial contract, review the Managed Care Organizations yearly through an External Quality Review Organization, and maintain the wellness program and health homes. Annual analysis of contracts costs are represented in the Contracts table below.

Contracts	Total Funds	State Funds	Federal Funds
SFY16	$2,586,333	$1,293,166	$1,293,167
SFY17	$264,000	$132,000	$132,000
SFY18	$369,000	$184,500	$184,500
SFY19	$435,000	$217,500	$217,500
SFY20	$369,000	$184,500	$184,500
Total	**$4,023,333**	**$2,011,666**	**$2,011,667**

Section 16 of LB 472 redirects general funds from the Comprehensive Health Insurance Pool Distributive Fund to the Health Care Access and Support Fund. This additional revenue is estimated at $7,041,775 cash funds annually beginning in SFY17, which offsets the general fund need.

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

Total	Total Funds	State Funds	Federal Funds
SFY16	$457,423,822	-$1,951,700	$459,375,522
SFY17	$568,828,240	$12,953,109	$555,875,131
SFY18	$719,303,086	$38,415,532	$680,887,554
SFY19	$745,444,086	$46,876,032	$698,568,054
SFY20	$784,978,086	$64,443,032	$720,535,054
Total	**$3,275,977,320**	**$160,736,005**	**$3,115,241,315**

MAJOR OBJECTS OF EXPENDITURE

PERSONAL SERVICES:

POSITION TITLE	NUMBER OF POSITIONS 15-16	16-17	2015-2016 EXPENDITURES	2016-2017 EXPENDITURES
Administration and Additional Staff	286	363	$10,164,936	$13,192,269

Benefits	$3,527,601	$4,575,680
Operating	$9,331,285	$10,010,291
Travel		
Capital Outlay		
Aid	$434,400,000	$541,050,000
Capital Improvements		
TOTAL	$457,423,822	$568,828,240

*Does not include the estimated impact for the provisions of LB 472 requiring expanded coverage of habilitative services or coverage of chronic-disease management.

Please complete ALL (5) blanks in the first three lines. **2015**

LB(1) 472 **FISCAL NOTE**

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

Prepared by: (3) Robert M. Bell Date Prepared: (4) 2/23/2015 Phone: (5) 402-471-4650

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

	FY 2015-16		FY 2016-17	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS				($7,041,775)
CASH FUNDS	$116,776		$149,326	
FEDERAL FUNDS				
OTHER FUNDS				
TOTAL FUNDS	$116,776		$149,326	($7,041,775)

Explanation of Estimate:

LB 472 adopts the Medicaid Redesign Act. The Department of Insurance would require the addition of two additional employees to implement the provisions of LB 472. Additionally, LB 472 redirects excess funding from the Comprehensive Health Insurance Pool (CHIP) Distributive Fund that currently flows to the General Fund to the newly created Health Care Access and Support Fund.

Section 5 of LB 472 creates the Medicaid Redesign Task Force, which the Director of Insurance would become a member. Section 6 creates the duties of the Task Force which include, among many items; review of a variety of matters related to health care delivery systems, recommendations related a Medicaid demonstration waiver, and engagement with stakeholders. Section 6 also places a duty on state agencies to provide the task force with requested data in a timely manner and useable format. Section 14 requires the Task Force to issue an annual report. It is likely that the Task Force will require the preparation of additional reports and data not currently performed by the Department.

Section 9 of the bill requires the Department of Health and Human Services to apply for a medicaid demonstration waiver. The waiver is to include a private premium assistance program for persons with incomes between one hundred percent and one hundred thirty three percent of the federal poverty level to participate in the private insurance marketplace. Currently, individuals in this category are eligible to receive premium assistance from the federal government. The federal assistance is paid directly to the insurer when the insured purchases health insurance off of the federally facilitated marketplace. It appears the Nebraska Department of Health and Human Services would instead direct these payments under LB 472.

Because the LB 472 contains an emergency clause, an Attorney II would be needed immediately to assist in the preparation of reports, the gathering and analysis of data, respond to Task Force data requests, to assist the Director with Task Force meetings, and to provide regulation of insurers and coordination with DHHS related to the implementation of the private premium assistance program for persons in the one hundred percent and one hundred thirty three percent of the federal poverty level category. Additionally, the Department anticipates the need of a Consumer Affairs Investigator II to handle the increase in the number of consumer questions and complaints from participants in the one hundred percent and one hundred thirty three percent of the federal poverty level category when the program begins, presumably January 1, 2016.

Section 16 of the bill redirects the excess from the CHIP Distributive Fund from the General Fund to the Health Care Access and Support Fund. Current law provides that after funding of the net loss from the operation of CHIP, any excess is to be distributed pursuant to Neb. Rev. Stat. § 77-912, which distributes to excess in the following manner: 40% to the General Fund, 10% to the Mutual Assistance Fund, and 50% to the Insurance Tax Fund. Section 16 provides that beginning May 1, 2017, the distribution is to be as follows: 16.5% to the General Fund, 23.5% to the Health Care Access and Support Fund, 10% to the Mutual Assistance Fund, and 50% to the Insurance Tax Fund.

The CHIP Distributive Fund is funded by premium tax and any related retaliatory taxes paid by insurers writing health insurance in this state. It is difficult to estimate the precise amount of revenue generated for the fund and the impending liquidation of CoOportunity Health will lower the amount of revenue actually collected. The Nebraska Life and Health Guaranty Association is the entity under the law responsible to provide limited protection to Nebraska residents who are holders of CoOportunity Health policies. The Association can issue assessments to insurers to provide funding for protection in the case of insolvency. Insurers are then able to offset against its premium and related retaliatory tax liability the assessment in an amount equal to 20% of the assessment annually beginning the first calendar year after the year of assessment through the fifth calendar year. It is possible that the Association will issue further assessments in the future related to the CoOportunity Health.

The Association has issued a $46,800,000 assessment in 2015 due to the impending liquidation of CoOportunity Health. Presuming that health insurers take the full off set available, CHIP Distributive Fund revenue will decrease $9,360,000 beginning in calendar year 2016. The Department estimates that $43,000,000 will be due to the fund in 2017, but taking into account the offset this estimate is lowered to $33,640,000.

Since the adoption of the Affordable Care Act, participation in CHIP had dropped significantly but a small number policyholders, who are extremely high utilizers, still exist. Based upon current utilization, the Department estimates that CHIP will utilize $3,675,000 in 2017, though this number could change considerably depending enrollment increases due to CoOportunity Health Liquidation and a pending United States Supreme Court, *King v. Burwell*. Given these uncertainties the Department's best estimate is that approximately $29,965,500 will be eligible for excess for distribution in 2017.

Section 16 of LB 472 will redirect 23.5% of the excess CHIP revenue from the General Fund to the Health Care Access and Support Fund. Assuming that all relevant pre-payments made in 2016 will distributed pursuant to the new language in Section 16, this will result in a $7,041,775 reduction in General Funds beginning FY2016-2017.

BREAKDOWN BY MAJOR OBJECTS OF EXPENDITURE

Personal Services:

POSITION TITLE	NUMBER OF POSITIONS 15-16	NUMBER OF POSITIONS 16-17	2015-16 EXPENDITURES	2016-17 EXPENDITURES
Attorney II	1.0	1.0	$52,140	$53,391
Consumer Affairs Investigator II	.5	1.0	$20,645	$42,280
Benefits			$38,991	$52,655
Operating			$5,000	$1,000
Travel				
Capital outlay				
Aid				
Capital improvements				
TOTAL			$116,776	$149,326