

LEGISLATIVE FISCAL OFFICE
Fiscal Note



Fiscal Note On: **HCR 3** HLS 15RS 419
 Bill Text Version: **ORIGINAL**
 Opp. Chamb. Action:
 Proposed Amd.:
 Sub. Bill For.: **REVISED**

Date:	Author: EDWARDS
Dept./Agy.: DHH/Medicaid	Analyst: Shawn Hotstream
Subject: Medicaid Expansion	

HEALTH CARE OR DECREASE GF EX See Note Page 1 of 2
 Amends administrative rules to cause La. Medicaid eligibility standards to conform to those established in the Affordable Care Act

Proposed resolution amends the Louisiana Administrative Code (LAC 50:III.501) related to Medicaid eligibility standards to provide the Louisiana Medicaid eligibility standards conform to the standards established under the Affordable Care Act.

Proposed resolution requires the secretary of the Department of Health and Hospitals to submit to the Centers for Medicare and Medicaid on or before September 1, 2015, any state plan amendments or waiver as may be necessary to implement the provisions of the resolution.

EXPENDITURES	2015-16	2016-17	2017-18	2018-19	2019-20	5 -YEAR TOTAL
State Gen. Fd.	DECREASE	DECREASE	DECREASE	DECREASE	INCREASE	
Agy. Self-Gen.	\$0	\$0	\$0	\$0	\$0	\$0
Ded./Other	\$0	\$0	\$0	\$0	\$0	\$0
Federal Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Local Funds	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	\$0
Annual Total						

REVENUES	2015-16	2016-17	2017-18	2018-19	2019-20	5 -YEAR TOTAL
State Gen. Fd.	\$0	\$0	\$0	\$0	\$0	\$0
Agy. Self-Gen.	\$0	\$0	\$0	\$0	\$0	\$0
Ded./Other	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Federal Funds	INCREASE	INCREASE	INCREASE	INCREASE	INCREASE	
Local Funds	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>	\$0
Annual Total						

EXPENDITURE EXPLANATION

Expanding Medicaid Eligibility in Louisiana as authorized under the Patient Protection and Affordable Care Act is projected to free up approximately \$52 M in State General Funds in FY 16, and significantly decrease State General Fund cumulative expenditures over 5 years and increase total Medicaid programmatic expenditures over the same time period. Net State General Fund costs are projected starting in year 5 (2020). The State General Fund and programmatic impact is projected as a range, and is based on multiple cost and SGF offset factors. The range of SGF expenditure impact over 5 years is projected to be a cumulative decrease between \$102 M and \$165 M. The range is modeled on differences in the take up rate of new eligible enrollees and an average cost per new enrollee, or a Moderate take up rate model and a High Take up rate model. Note: The significant changes from the prior year analysis includes an increase in the per member per month capitation rate (new rate provided by DHH rate actuary), adjusted FMAP (loss of 2 years receiving 100% federal match for new eligibles), reduction in Crowd Out estimates, updated inmate care spending data, and the elimination of the woodwork category.

The High take up rate model contemplates a more aggressive take up rate (90%), and a \$453.01 per member per month cost per enrollee for FY 16. This model reflects an increase in total programmatic expenditures of \$378 M (\$52 M SGF savings) in FY 16, and \$8.0 B total programmatic expenditures (\$165 M SGF savings) over 5 years. This model reflects a net SGF cost to the state beginning in year 5 (FY 20). The Moderate Take up rate model contemplates a less aggressive take up rate (75%) and a \$453.01 PMPM cost per enrollee. This model reflects an increase in total programmatic expenditures of \$323 M (\$52 M SGF savings) in FY 16, and \$7.1 B total programmatic expenditures (\$102 M SGF savings over 5 years). This model reflects a net SGF cost to the state beginning in year 5 (FY 20).

The fiscal note considered multiple factors that resulted in a net projected State General Fund cost or offset (savings) to Medicaid. These factors include an estimate of the different populations that will be eligible under Medicaid expansion, participation rate (take up rate) of these eligibles, administrative costs, the enhanced Federal Medical Assistance Percentage (FMAP) applied each year, the impact of Disproportionate Share Hospital (DSH) funding, and impact on inpatient prisoner care funding. Listed below are the specific assumptions used in determining the net impact to Medicaid.

- 298,000 uninsured between ages 19 to 64 to 138% of the federal poverty level (childless adults and parents of Medicaid eligible children)
- All new eligibles placed in Bayou Health full risk prepaid Medicaid managed care health plan (not fee for service Medicaid)
- Fiscal note assumes a fiscal impact range, based on variances in take up rates

REVENUE EXPLANATION

The fiscal note assumes all new eligibles will be enrolled in Bayou Health full risk plans. Based on this assumption, additional premium tax revenues are anticipated to be generated and deposited into the Medical Assistance Trust Fund (MATF). R.S. 22:842 imposes a 2.25% premium tax on insurance premiums (gross annual premiums) related to life, health, and accident. However, the net impact of these revenues are indeterminable as every insurance company is entitled to a corporate income tax offset (R.S. 47:227) in the amount of any premium taxes paid. Based on the assumptions in this expansion model, total premium tax earnings are estimated to be \$186 M over 5 years.

Senate	<u>Dual Referral Rules</u>	House	<input checked="" type="checkbox"/> 6.8(F)(1) >= \$100,000 SGF Fiscal Cost {H & S}	 John D. Carpenter Legislative Fiscal Officer
<input checked="" type="checkbox"/> 13.5.1 >= \$100,000 Annual Fiscal Cost {S&H}			<input type="checkbox"/> 6.8(F)(2) >= \$500,000 Rev. Red. to State {H & S}	
<input type="checkbox"/> 13.5.2 >= \$500,000 Annual Tax or Fee Change {S&H}			<input type="checkbox"/> 6.8(G) >= \$500,000 Tax or Fee Increase or a Net Fee Decrease {S}	

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CONTINUED EXPLANATION from page one:

- 4) New eligible enrollee cost based on a Per Member Per Month rate of \$453.01 estimated by DHH's rate actuary (Mercer) for FY 16. The FY 16 rate includes Full Medicaid Pricing for the expansion population.
- 5) FMAP rate under PPACA: 100% FMAP through FY 16 (one year), 95% - FY 17, 94%- FY 18, 93% - FY 19, and 90% in FY 20 and future fiscal years
- 6) DSH reduction based on implementation of Health Insurance Exchanges and Medicaid Expansion, 60,000 childless adults projected to remain uninsured beyond 400% of the federal poverty level (Louisiana Health Insurance Survey, 2013)
- 7) Assume benefits received for new eligibles are the same as current Medicaid benefits and not a minimum package
- 8) Crowd out assumption based on Department of Insurance actuarial analysis (approximately 30% to 40% take up rate over 10 years)
- 9) Fiscal note does not assume any provider rate increase for physicians or hospitals, only adjustments to the PMPM costs annually
- 10) Medicaid expansion model is based on review of various analysis models, including Kaiser, Urban Institute Health Policy Center, other state's individual actuarial analysis and expansion experience, DHH analysis, and Congressional Budget Office Assumptions.

Expenditure Factors

New Eligible Adults - (298,000 previously uninsured): Expanding Medicaid eligibility to individuals (childless adults and parents) up to 138% of the federal poverty level will increase SGF Medicaid PMPM costs beginning in FY 17 as a result of offering coverage for currently uninsured newly eligible individuals (uninsured adults between the age of 19-64 and certain parents). Based on the PMPM of \$453.01 for FY 16 in the Moderate Take up rate model, total spending is projected to increase by \$4.9 B (\$358 M SGF) over 5 years. Based on the same PMPM in the High take up rate model, total spending is projected to increase by \$5.6 B (\$417 M SGF) over 5 years. This is based on a 90% take up rate (CMS-Office of the Actuary-2012).

New Eligible (Crowd Out): Approximately 224,000 with either insurance privately purchased on the individual market (50,186) or (ESI) employer sponsored insurance (173,826) are projected eligible for Medicaid to 138% of the federal poverty level (LSU Public Policy Research Lab). Crowd out, or those individuals that would drop private insurance or ESI and enroll in Medicaid based on eligibility, is estimated to be approximately 67,000 phased in the Moderate take up rate model, and approximately 89,600 phased in the High take up rate model. These individuals are considered new eligibles for the purpose of enhanced federal match, and are anticipated to increase SGF Medicaid payment costs beginning in FY 17. The Moderate take up rate model reflects total Medicaid spending increasing by \$922 M(\$67.7 M SGF) over 5 years. This is based on a 30% of individuals eligible under the expansion (Department of Insurance Actuary). The High take up rate model reflects total Medicaid spending increasing by \$1.3 B (\$99 M SGF) over 5 years. This is based on 40% of the individuals with ESI or private insurance transitioning to Medicaid (Department of Insurance Actuary, updated estimate for 2016).

Currently Eligible, not enrolled (Woodwork): Approximately 36,000 are projected to be currently eligible for Medicaid, but not enrolled (DHH estimate). These individuals are likely parents of Medicaid eligible children. Woodwork represents individuals currently eligible/not enrolled that would sign up for Medicaid as a result of initial PPACA media exposure. The expansion analysis for FY 16 removes the estimated impact of the woodwork effect (cost to the model). This reduction is based on data from the DHH that indicates a nominal percentage (.3%) of those projected eligible actually enrolled since 2013.

Medicaid Administration: Medicaid administration costs are based on hiring additional Medicaid Analyst personnel for processing eligibility applications, renewal applications, case management, processing change request (change in income or health circumstance), payment to the fiscal intermediary and enrollment broker. The estimated impact is \$29 M SGF over 5 years.

Transitioned Eligibles (currently enrolled, new eligibles): Current Medicaid enrollees that receive limited benefits/specific services are considered new eligibles under a Medicaid expansion, and are eligible to receive enhanced federal match under PPACA. The fiscal note assumes these populations (100%) will receive full benefits under an expansion. These populations/categories include individuals that are covered under a Medicaid eligibility category limited to a specific service (family planning waiver) or limited to a specific disease (breast and cervical cancer), individuals served under the Medically Needy category (only qualify after these individuals spend down resources in order to qualify), Provisional Medicaid enrollees, and children aging out of foster care. Both models anticipate decreasing SGF match by over \$41.2 M over 5 years. In calculating the effect of covering these populations, costs were trended forward 5 years without expansion (under standard match). These expenditures are compared to the cost of these populations receiving full benefits under Medicaid as new eligibles (with enhanced match). This comparison of SGF spending resulted in the savings in SGF discussed above. Total programmatic spending is anticipated to increase as these populations will receive full Medicaid benefits. Spending under expansion is built on PMPM cost associated with each population category (individually priced out) provided by Mercer (DHH actuary).

Disproportionate Share Hospital (DSH) payments for uninsured (safety net population): Based on the Louisiana Health Insurance Survey (LHIS) of 2013, approximately 562,2858 (90%) of Louisiana's 622,033 total uninsured adults are estimated to fall below 400% of the FPL, leaving an additional 59,748 adults still estimated uninsured (10%). The majority of uninsured under 400% of the FPL that are anticipated to be eligible in Medicaid or Health Insurance Exchanges have likely historically been covered with DSH reimbursement for uncompensated care costs. Total DSH funding is not eliminated in this analysis. The fiscal note assumes a 75% reduction in DSH payments by FY 2020 as a result of both health insurance exchanges and Medicaid expansion, or a state general fund match reduction from \$321 M (appropriated for FY 15) to \$80 M. The first year DSH reduction estimate is based on actual hospital experiences in certain expansion states as referenced

in a report from ASPE Office of Health Policy, U.S. Department of Health and Human Services.

Correction Care Spending: For FY 15, approximately \$42 M is appropriated for off site inmate healthcare. This expenditure is 100% State General Fund, and is used for hospital inpatient care and specialty care. As the expansion removes the categorically eligible requirement for this population for certain inpatient services, it is anticipated that the majority of inmates will be Medicaid eligible for inpatient health services, and the state will be able to leverage enhanced federal dollars under the expansion FMAP. Based on projected inpatient spending for FY 15, the fiscal note assumes approximately \$18 M in SGF savings over 5 years.

The table below reflects the 5 year impact of both models.

Category	Moderate Take-up rate model	High Take-up rate model
	Cumulative Estimate	Cumulative Estimate
	5 year SGF Total	5 year SGF Total
New Eligible	\$358,312,950	\$417,050,356
Crowd Out	\$67,695,325	\$99,141,574
Administration	\$29,088,975	\$29,088,975
Transitioned Eligibles	(\$41,179,997)	(\$41,179,997)
Uninsured (DSH)	(\$498,462,018)	(\$651,216,508)
Correction Health Care	(\$18,424,358)	(\$18,424,358)
Total	(\$102,969,123)	(\$165,539,958)

Senate Dual Referral Rules House 6.8(F)(1) >= \$100,000 SGF Fiscal Cost {H & S}

13.5.1 >= \$100,000 Annual Fiscal Cost {S&H} 6.8(F)(2) >= \$500,000 Rev. Red. to State {H & S}

13.5.2 >= \$500,000 Annual Tax or Fee Change {S&H} 6.8(G) >= \$500,000 Tax or Fee Increase or a Net Fee Decrease {S}

John D. Carpenter
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