PREPARED BY: Sandy Sostad
DATE PREPARED: February 23, 2016
PHONE: 471-0054

LB 706

Revision: 01

Revised on 2/23/16 to reflect alternate method of calculating fiscal impact using insured population in Nebraska

FISCAL NOTE

LEGISLATIVE FISCAL ANALYST ESTIMATE

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

	FY 2016-17		FY 2017-18	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	$296,100		$888,300	
CASH FUNDS				
FEDERAL FUNDS				
OTHER FUNDS				
TOTAL FUNDS	$296,100		$888,300	

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

LB 706 defines habilitative services for purposes of Chapter 44 which pertains to insurance. Habilitative services for the purposes of insurance are defined to be health care services that help a person keep, learn, or improve skills and functioning for daily living, including applied behavior analysis (ABA).

State Responsibility for Mandated Benefits that are not in the Benchmark Plan: The Department of Insurance (DOI) indicates the bill will have a general fund fiscal impact for the state to pay for the cost of habilitative services for the following reasons. The bill provides for the coverage of ABA as a habilitative service in insurance plans. Habilitative services are included as one of the essential benefits the Affordable Care Act (ACA) requires in every health insurance plan. However, the DOI indicates the benchmark plan selected by Nebraska does not specifically include ABA as a covered service. If a state mandates coverage for a service that is not included in its benchmark plan as an essential benefit, then the state must pay the costs for such services.

The fiscal note prepared by the DOI discusses recent federal guidance in reference to defining habilitative services. DOI was provided informal guidance that the state would not have to defray costs if "reasonable" additional habilitative services were included beyond those in the benchmark plan. However, a federal official advised the state of Tennessee that providing habilitative services in addition to those included in the benchmark plan would mean the state has to pay the insurance costs for such benefits.

DOI indicates that federal guidance on the issue could change again in the future, but, at the present time the department believes the state would be responsible to defray the costs for habilitative services, specifically for ABA.

Estimated Fiscal Impact of LB 706 to Cover ABA: The revised fiscal note by the DOI discusses the qualified health insurance plans which will be subject to having the costs of ABA paid by the state pursuant to the bill. DOI indicates that individual and small group plans are considered to be qualified health insurance plans under the ACA. Some of these plans are currently grandfathered. Others are deemed to be transitional which allows individuals to keep the plan until 2017. Plans which are grandfathered or transitional are estimated to make up 50% of the individual and small group market.

A recent actuarial study to examine the uninsured population in the state estimates that 313,329 people have individual or small group coverage in 2017. About 50% of the plans are estimated to be grandfathered or transitional per the ACA. So, 156,660 people are projected to have plans that the bill will require the state to pay ABA claim costs for in 2017. In 2018, it is assumed the number will increase to about 235,000 individuals when transitional plans are no longer allowed per the ACA. A report by the Missouri Department of Insurance, in February of 2016, about a similar mandate shows the average claim cost per month for ABA was $.30 per member. Assuming a January 1, 2017 operative date is added to the bill, the estimated general fund fiscal impact to pay ABA claims for persons with individual or small group coverage is about $282,000 in FY17 and $846,000 in FY18.

The state does not regulate plans provided by self-insured groups per ERISA. The DOI estimates there may be some attrition to qualified health plans by persons with ERISA plans who need coverage for ABA. The department estimates claims may increase by 5% for persons switching coverage which would increase the estimated fiscal impact of the bill by an additional $14,100 in FY17 and $42,300 in FY18. If the switch in insurance occurs, then the total fiscal impact of the bill will be $296,100 in FY17 and $888,300 in FY18 and thereafter.

Additional Unknown Costs: There is also a proposed rule by the federal government which will require states to be responsible for any insurance mandates, on a retroactive basis, even if the mandate only applies to plans which are currently not required to include essential benefits. If this becomes the final rule, then the bill will have a higher fiscal impact to cover ABA claims in grandfathered and transitional plans.

General Fund Impact: If is assumed the cost to provide insurance benefits to persons for habilitative services pursuant to LB 706 will be funded with general funds rather than cash funds from the Department of Insurance Cash Fund because the expenditure of funds for insurance benefits for individuals would not be a permissible use of the department cash fund.

No Fiscal Impact for HHS: The bill will not have a fiscal impact for the Department of Health and Human Services (HHS) because the provisions in Chapter 44 applying to insurance have been interpreted by the DOI and the HHS to not apply to Medicaid or Medicaid managed care.

ADMINISTRATIVE SERVICES-STATE BUDGET DIVISION: REVIEW OF AGENCY & POLT. SUB. RESPONSES			
LB: 706	AM:	AGENCY/POLT. SUB: Department of Health & Human Services	
REVIEWED BY: Robin Kilgore		DATE: 1-28-16	PHONE: 471-4180
COMMENTS: No basis to disagree with agency estimate of fiscal impact.			

ADMINISTRATIVE SERVICES-STATE BUDGET DIVISION: REVIEW OF AGENCY & POLT. SUB. RESPONSES			
LB:706 Revised	AM:	AGENCY/POLT. SUB: Department of Insurance	
REVIEWED BY: Robin Kilgore		DATE: 2-22-16	PHONE: 471-4180
COMMENTS: No basis to disagree with agency estimate of fiscal impact.			

Please complete ALL (5) blanks in the first three lines. **2016**

LB(1) 706 Revised **FISCAL NOTE**

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

Prepared by: (3) Robert M. Bell Date Prepared: (4) Revised 2/22/16 Phone: (5) 402-471-4650

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

	FY 2016-17		FY 2017-18	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	296,095		888,287	
CASH FUNDS				
FEDERAL FUNDS				
OTHER FUNDS				
TOTAL FUNDS	296,095		888,287	

Explanation of Estimate:

Legislative Bill 706 defines habilitative services for the purposes of Chapter 44. The definition includes applied behavior analysis, which is a service provided to individuals with autism. Section 1311(d)(3)(B) of the federal Patient Protection and Affordable Care Act provides that beginning January 1, 2014, if a state law mandates insurers cover benefits on a health insurance exchange that are not included in the final United States Health and Human Services "essential benefits" list, the state will pay any additional costs for those benefits for enrollees for any individual or small group plan issued on or after January 1, 2014. The method by which states "will pay any additional costs" has not yet been determined. In the proposed federal essential health benefits rule the cost of additional benefits is as determined by the insurer alone.

Habilitative services are one of the ten essential health benefits the Affordable Care Act requires in every qualified health plan (individual and small group plans). From 2014 to 2016, plans in Nebraska used the habilitative services definition found in the Blue Cross Blue Shield small employer plan which was the default benchmark plan selected for Nebraska by the federal Secretary of Health and Human Services. For plan year 2017, the benchmark plan selected for Nebraska was a plan in existence in 2014 meaning the definition of habilitative services remained the same. The definition in the benchmark plan does not include the specific inclusion of applied behavioral analysis contained in LB 706.

A new federal regulation suggested that a state may define habilitative services after the selection of a benchmark plan without creating a mandated benefit. However, specific guidance from the federal government on whether or not a state would have to defray the costs of the insurers if the state defines habilitative services that provides more services than in the benchmark plan has been elusive at best.

Late last year, the Department was provided informal guidance that the Nebraska would not have to defray costs if the definition was "reasonable," however on January 15, 2016, Kevin Counihan, the federal official in charge of the exchanges, stated to the Tennessee Insurance Commissioner Julie Mix McPeak that if a state legislature requires an insurer to "provide habilitative services in addition to those already included in the base-benchmark plan [it] would be considered imposing a state-required additional benefit, and the state would be required to defray the cost of qualified health plans' providing such benefits." The letter indicates that if a state has already made a benchmark plan selection for 2017 and the state legislature subsequently expands the definition, the state would be responsible to the insurers to defray the increased costs of the insurer related to the new definition because it would be a mandated benefit.

Though the guidance from the federal government may change yet again, the best information available to the Department is that the State of Nebraska would be responsible to defray the costs associated with this mandate. A 2016 report from the Missouri Department of Insurance, Financial Institutions and Professional Registration states that a similar mandate became effective in Missouri in 2014 for all plans regulated by the Missouri DOI. The Missouri

estimates a $0.30 per member per month cost.

Similar to Missouri, the Nebraska Department regulates plans purchased from private insurers. Regulated plans do not include self-insured groups, government plans, or Medicaid/CHIP coverage. Regulated plans include policies sold on and off the exchange for individual and small group coverage and large group plans. The ACA's cost defrayment provisions only apply to QHPs. Individual and small group plans must be QHPs under the ACA, but if an individual or small group plan is grandfathered or transitional, insureds are allowed to "keep their plan" even though it is not a QHP. The federal government has only allowed transitional plans to continue until 2017, and grandfathered plans can continue into the future if they make no substantial changes.

The Department commissioned an actuarial study to examine the effect of the ACA on Nebraska's uninsured population. Numbers from that study estimates that for 2017, 200,619 people will have individual coverage and 112,710 people will have small group coverage, for a total of 313,329 covered lives

From 2016 marketplace enrollment numbers, the Department estimates that grandfathered/transitional plans make up 50% of the individual and small group market, however the transitional plans are scheduled to phase out in 2017 which the Department estimates will halve this percentage and increase cost in FY2017-18. As a result, the cost defrayment will apply to 156,665 lives for the last half of FY2016-2017 and 234,997 lives in FY2017-18.

Applying the Missouri per member per month cost of $0.30 for six months to 156,665 lives for FY2016-2017 the cost would be $281,996, and for twelve months to 234,997 lives in FY2017-2018 for a cost of $845,988.

Finally, members in ERISA plans that do not cover applied behavioral analysis may leave their plans to join qualified health plans that cover applied behavioral analysis if the services are needed. This could increase claims in qualified health plans by 5%, providing a final estimated fiscal impact of $296,095 for FY2016-2017 and a fiscal impact of $888,287 for FY2017-18.

Additionally, the federal government has also given notice through a proposed rule that states would be responsible, retroactively, for any insurance mandates even if the mandate only applied to plans not required to include essential health benefits. If this proposed rule does not change when it becomes final, it could significantly increase the fiscal impact of LB 706.

This note presumes that plans would not start coverage until January 1, 2017. The identified fiscal impact will be to the State of Nebraska as an entity and will not impact the Department of Insurance's budget.

BREAKDOWN BY MAJOR OBJECTS OF EXPENDITURE

Personal Services:

POSITION TITLE	NUMBER OF POSITIONS 16-17	NUMBER OF POSITIONS 17-18	2016-17 EXPENDITURES	2017-18 EXPENDITURES
Benefits				
Operating				
Travel				
Capital outlay			296,095	888,287
Aid				
Capital improvements				
TOTAL			296,095	888,287

LB(1) 706 FISCAL NOTE 2016

ESTIMATE PROVIDED BY STATE AGENCY OR POLITICAL SUBDIVISION

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

Prepared by: (3) Pat Weber | Date Prepared:(4) 1-21-16 | Phone: (5) 471-6351

	FY 2016-2017		FY 2017-2018	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS				
CASH FUNDS				
FEDERAL FUNDS				
OTHER FUNDS				
TOTAL FUNDS	$0	$0	$0	$0

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

Explanation of Estimate:

This bill will have no impact to Medicaid because the provisions of Title 44 have been interpreted by DHHS in consultation with Department of Insurance not to apply to Medicaid or Medicaid managed care. Therefore, there is no Fiscal Impact to the Department of Health and Human Services.

MAJOR OBJECTS OF EXPENDITURE

PERSONAL SERVICES:

POSITION TITLE	NUMBER OF POSITIONS 16-17	17-18	2016-2017 EXPENDITURES	2017-2018 EXPENDITURES
Benefits				
Operating				
Travel				
Capital Outlay				
Aid				
Capital Improvements				
TOTAL			$0	$0