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DATE PREPARED: March 16, 2015
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LB 518

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				
CASH FUNDS				
FEDERAL FUNDS				
OTHER FUNDS				
TOTAL FUNDS	See Below		See Below	

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

This bill establishes the Nebraska Health Savings Account Plan within the Medicaid Program. The bill states legislative intent to make changes to the Medicaid Program effective January 1, 2016 in order to: (a) provide incentives to recipients of benefits under the program through free market qualified health care services; (b) spend no additional General Funds; (c) accommodate more residents of Nebraska in the program; and (d) Implement cost-efficient incentives. The health savings accounts would be provided to eligible recipients under Medicaid. There would be three options based on income levels: 1) Option A – 100% coverage for those with incomes up to 100% of the federal poverty limit (FPL); 2) Option B – 70% coverage for those with incomes from 100% to 133% of FPL and 3) Option C – 40% coverage for those whose income is 133% to 200% of FPL. The Department of Health and Human Services will administer the program. If funding for an individual is insufficient, reviewing agents employed by the department will approve modifications. The determination may be appealed. An array of services are allowed to be paid for by the plan.

Funding for the Nebraska Health Savings Plan is from Medicaid funding. A waiver would have to be obtained. Waivers must be cost neutral to the federal government over the course of the waiver which is generally five years. Approval of the waiver is unlikely. The services covered by the health savings account differ from mandatory and optional services required and allowed by federal law. The income eligibility is higher than current coverage for adults eligible for Medicaid who are not elderly or disabled, so there would not be current funding to offset the costs of covering an expanded population.

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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) 3-17-15 | Phone: (5) 471-0676

	FY 2015-2016		FY 2016-2017	
	EXPENDITURES	REVENUE	EXPENDITURES	REVENUE
GENERAL FUNDS	$1,486,886		$755,886	
CASH FUNDS				
FEDERAL FUNDS	$1,620,738		$889,738	
OTHER FUNDS				
TOTAL FUNDS	$3,107,624		$1,645,624	

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

Explanation of Estimate:

LB 518 requires a review of the Medical Assistance Program and the implementation of a Health Savings Account (HSA) Plan effective January 1, 2016. The HSA Plan shall create health savings accounts for recipients of Medicaid benefits, their spouses, and dependents. The HSA Plan creates three plan options at different funding levels, each providing preventative services, telemedicine services, and other qualified medical services identified in the bill.

The bill does not specify if the HSA Plan is a Medicaid replacement plan or an additional one where recipients are able to opt out of traditional Medicaid and into an HSA Plan. LB 518 requires many changes to Medicaid and it is difficult to accurately determine how the proposed HSA's will fit into the current structure of the program. If this is a replacement plan, then the anticipated costs would be the same as the current Medicaid healthcare delivery model plus the additional expenses to transition to the new model.

Also, at this time it is not known whether any of the activities described in LB 518 will be eligible for Federal Financial Participation (FFP) either through a State Plan Amendment (SPA) or Waiver. It is anticipated that based on the description of the eligibility categories, and the scope of services to be included in the HSA Plan, both a SPA and a waiver will be rejected by the Centers for Medicare and Medicaid Services (CMS).

If the HSA Plan cannot be implemented through a SPA or Waiver, it would need to be funded with 100% State Funds. One of the established purposes of LB 518 is to spend no additional General Fund dollars. It is anticipated that achieving the goal of budget neutrality could only be achieved through savings achieved on existing Medicaid beneficiaries; however, this bill does not contain any explanation of a methodology for capturing savings. Any savings would be offset by the need for additional contractors, staffing, system needs, and a Fiscal Agent.

In addition to the time constraints associated with developing a waiver, it is important to note that MLTC does not have a current system capable of implementing the HSA Plan. Significant system changes would be required in addition to creating a new network, fee schedules, and processing guidelines. Extensive system changes would be necessary to ensure that the operation of the HSAs/debit cards could properly interface with NFocus, the eligibility and enrollment system, and the MMIS system. Because of the unique requirements, the HSA Plan would have to be implemented as a standalone program, independent from the current Nebraska Medicaid program, and likely administered by a Fiscal Agent. LB 518 would, at a minimum, require the following changes to current practices within MLTC:

IT changes are needed for technical and business requirements to add a new program with three new eligibility categories at an approximate cost of $1,432,000 total funds in SFY16.

A contract and resources to research and develop SPAs, waivers, amendments, requests for proposals, and to update rules & regulations would require a team of 10 additional Program Specialists at a cost of $872,263 total funds annually. Hiring a licensed physician who is trained as a primary care physician as a Medical Director would cost approximately $267,704 total funds annually. Hiring a Chief Information Officer would cost approximately $255,656 total funds annually.

A contract for ongoing and periodic audits of the HSA Plan (clinical, customer service, financial, and likely, HSA compliance audit, etc.) is estimated at $200,000 total funds annually. An actuarial contract would be required at an estimated minimum cost of $80,000 total funds in SFY16 and $50,000 total funds in SFY17.

The bill does not specify if this is a Medicaid-replacement plan or if recipients are able to opt out of Medicaid and into the HSA. As a result, the scope of enrollment is unknown. In either type of plan, future recipient behaviors and choices cannot be predicted, resulting in unknown costs dependent upon utilization rates. Estimates for the scope of work for a Fiscal Agent, the size of staffing required for the volume of recipients, the estimated needs for contracting and other personnel, as well as hotlines, are dependent on utilization rates and undeterminable. The following resources are needed for LB 518 and are indeterminable in cost:

- A contract with a Fiscal Agent for HSA plan administration based on scope of program needs.
- Employ reviewing agents, additional hearing officers, and eligibility & enrollment staff based on client volume.
- A contract with nursing personnel and/or a telemedicine contractor.
- Establish and maintain a consumer hotline, and employ or contract for call center resources and associated equipment. This would include storage and retrieval capabilities for both the medical calls and hotline.
- Employ credentialing staff or vendor based on client volume.
- Operations staff is needed for plan funding, debit-card processing and oversight, reconciliation of accounts, collections, and tax reporting.
- Purchasing a contract for establishing a fund for reinsurance or catastrophic losses by recipients a reinsurance contract, in addition to staff for administration, submitting claims to the carrier, etc.
- Additional program integrity staff to detect potential fraud, waste, and abuse.
- Additional staffing for the fee schedule and provider network development.

The Department is also unable to determine the impact to existing contracts that rely on per-member per-month (PMPM) fees, membership levels for profit and sustainability, or medical review arrangements that were based on case load estimates.

LB 518 indicates that changes will be made effective 1/1/16. An undertaking of this size would require multiple years to implement. Besides regulation changes, time is needed for the above-mentioned expertise to be hired, contracts would need to be procured, system changes made, and a stand-alone operations created.

MAJOR OBJECTS OF EXPENDITURE

PERSONAL SERVICES:

POSITION TITLE	NUMBER OF POSITIONS 15-16	NUMBER OF POSITIONS 16-17	2015-2016 EXPENDITURES	2016-2017 EXPENDITURES
Program Specialist	10	10	$442,915	$442,915
Medical Director	1	1	$135,935	$135,935
Chief Information Officer	1	1	$131,250	$131,250

	2015-2016	2016-2017
Benefits	$244,499	$244,499
Operating	$2,153,025	$691,025
Travel		
Capital Outlay		
Aid		
Capital Improvements		
TOTAL	$3,107,624	$1,645,624