Analysis; Fiscal Impact of Initiative 427

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Introduction

Initiative 427 is a proposal to expand the Medicaid program to cover childless adults, 19 to 64 years of age, under the provisions of the Patient Protection and Affordable Care Act of 2010 (the ACA). This ballot initiative is similar to several bills that have been proposed in the unicameral over the past six years – all failing to pass into law.

Numerous stakeholders, including state legislators, have asked the Nebraska Division of Medicaid and Long-Term Care (MLTC), what the cost to MLTC would be if the ballot initiative passes. Building upon numerous analyses of the past legislative proposals, and the experience of other states that have opted into the ACA Medicaid Expansion, MLTC has determined that the complete fiscal impact to the Department of Health and Human Services that can be estimated through state fiscal year (SFY) 2029 will increase expenditures by $5.5 billion, $669.89 million of that amount state funds. However, there is the potential to offset some of the state general fund amount with additional federal funding, leaving the state impact to $591.19 million. MLTC estimates that over ten years there will be 93,036 new people enrolled in Nebraska Medicaid if Initiative 427 passes. These estimates are based upon current economic data. If there is an economic downturn, more individuals will become Medicaid-eligible, and the cost of the expansion population will increase. For example, if enrollment grows an additional 3% beginning in SFY 2021, it would result in the total number of eligible individuals to grow to 112,110 enrolled by 2029, resulting in a total aid cost of $6.3 billion over ten years, of which $736 million would be new state costs. Considering potential offsets, the total cost would be $6.35 billion, of which $689.6 million would be state general funds. The assumptions made are detailed below.

Nebraska Medicaid

Medicaid, established in 1965, is a federal-state program that pays for health care for persons with disabilities, the aged, and low-income children and families. Certain services and populations are mandatory for states to cover if a state opts-into Medicaid. Other populations and services are optional as shown below.

Table 1. Federal Mandatory and Optional Medicaid Eligibility Groups

Mandatory eligibility groups	Optional eligibility groups
Poverty-related infants, children, and pregnant women and deemed newborns	Low-income children, pregnant women, and parents above federal minimum standards
Low-income families (with income below the state's 1996 Aid to Families with Dependent Children limit)	Elderly and disabled individuals with incomes above federal minimum standards or who receive long-term services and supports in the community
Families receiving transitional medical assistance	Medically needy
Children with Title IV-E adoption assistance, foster care, or guardianship care and children aging out of foster care	Adults without dependent children (the ACA Medicaid Expansion Group)
Elderly and disabled individuals receiving Supplemental Security Income (SSI) and aged, blind, and disabled individuals in 209(b) states	Home and Community-Based Services and Section 1115 waiver enrollees
Certain working individuals with disabilities	Enrollees covered only for specific diseases or services, such as breast and cervical cancer or family planning services
Certain low-income Medicare enrollees	

Source: MACPAC, 2017, analysis of the Social Security Act and the *Code of Federal Regulations*.

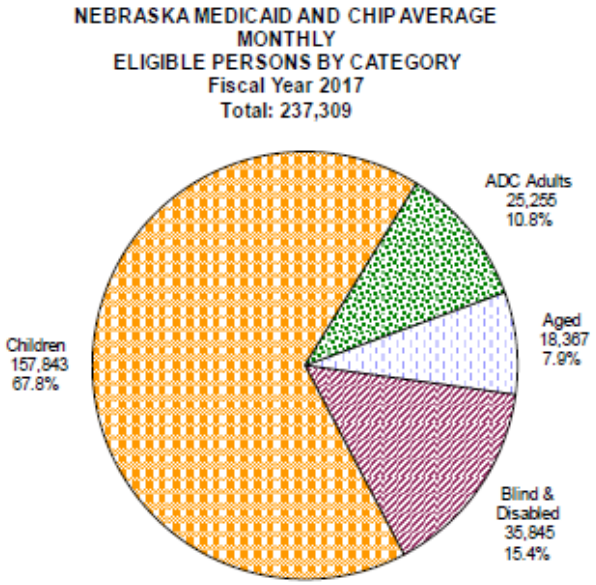
Table 2. Nebraska Mandatory and Optional Medicaid Services

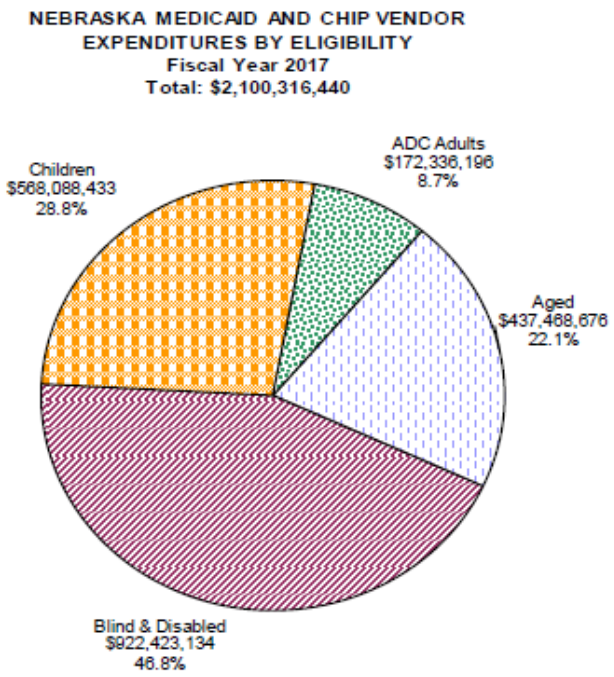
Mandatory Services	
Inpatient and outpatient hospital services	Medical and surgical services of a dentist
Laboratory and x-ray services	Nurse practitioner services
Nursing facility services	Nurse midwife services
Home health services	Pregnancy-related services
Nursing services	Medical supplies
Clinic services	Early and periodic screening and diagnostic treatment (EPSDT) for children
Physician services	

Optional Services	
Prescribed drugs	Physical therapy services
Intermediate care facilities for the developmentally disabled (ICF/DD)	Hearing screening services for newborn and infant children
Home and community based services (HCBS)	Occupational therapy services
Dental services	Optometric services
Rehabilitation services	Podiatric services
Personal care services	Hospice services
Durable medical equipment	Mental health and substance use disorder services
Medical transportation services	Chiropractic services
Vision-related services	School-based administrative services
Speech therapy services	

Source: 2017 Nebraska Medicaid Annual Report

The current focus of Nebraska's Medicaid program is on children, low income families, and persons with disabilities. Percentages of people eligible and their cost by those categories are shown below.





Source: 2017 Nebraska Medicaid Annual Report

Medicaid is jointly funded by the federal government and the states. Both states and the federal government have been dedicating a greater amount of their state budgets to Medicaid over the past fifty years. Nationally, Medicaid is the largest state expenditure. In 2008, Medicaid was 20.5% of total state spending. In 2017, it was 29%. Fifty-five percent of spending growth in states since 2012 is due to increased Medicaid expenditures. The annual spending growth from Medicaid has averaged 8.1% since 2012 compared with other programs of 2.2% annual growth. Of general fund expenditures, in federal fiscal year 2016, 36.5% went to elementary and secondary education, 19.7% went to Medicaid, and 9.7% to higher education.[i] From 2015 to 2016, the annual general fund percentage change in Nebraska Medicaid expenditures was 7.8%.

Table 3. Nebraska State Spending by Function, as a Percentage of Total State Expenditures, Fiscal 2016

Function	Percentage
Elementary & Secondary Education	14.2%
Higher Education	23.9%
Public Assistance	0.4%
Medicaid	17.1%
Corrections	2.9%
Transportation	8.3%
All Other	33.2%
Total	**100%**

Source: "State Expenditure Report: Examining Fiscal 2015-2017 State Spending," National Association of State Budget Officers. Available at: https://bit.ly/2PKLkmO

Table 4. Nebraska Medicaid Expenditures, as a Percent of Total Expenditures, FFY 15-17

FFY 2015	FFY 2016	FFY 2017
16.9%	17.1%	17.5%

Source: "State Expenditure Report: Examining Fiscal 2015-2017 State Spending," National Association of State Budget Officers. Available at: https://bit.ly/2PKLkmO

The ACA and Medicaid Expansion

Signed into law on March 23, 2010, the ACA was a comprehensive piece of legislation fundamentally changing the American health care system, addressing private insurance, Medicaid, Medicare, the Indian Health Service, and long-term care. Two of the most significant issues faced by states following the passage of the law were the implementation of state health insurance exchanges (later known as the health insurance marketplace) and the addition of previously ineligible adults into the Medicaid program (expansion eligible). Both programs were given January 1, 2014, effective dates.

The exchange would serve as a portal for individuals and small businesses to purchase health insurance coverage. If an individual or family had a certain income from 100% to 400% of the federal poverty level (FPL), they had available certain federal subsidies to help purchase health insurance coverage. The law, as written, gave states the option to establish their own health insurance exchanges or to opt-into the federal exchange. Most states, including Nebraska, declined to establish an ACA exchange. Today, about 88,000 Nebraskans have exchange coverage.

The ACA mandated states to expand existing Medicaid programs to cover otherwise able-bodied, non-disabled adults aged 19 to 64 years of age. Following the law's passage, there were numerous legal challenges to its provisions, three of which reached the United States Supreme Court. In the first case, *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), the Supreme Court upheld the law, but found that the mandate for states to expand their Medicaid programs or lose federal funding for their existing programs was unconstitutionally coercive. The Court gave individual states the option to expand their own Medicaid programs.

Since 2014, 33 states and the District of Columbia have expanded their Medicaid programs through the ACA. The most recent state to implement the expansion program was Louisiana in July 2016. In Maine, voters approved expanding Medicaid by ballot initiative in 2017. The Virginia General Assembly approved of Medicaid expansion in May 2018. The program is set to begin on January 1, 2019.

Assumptions and the Fiscal Impact of Initiative 427

MLTC has built off the fiscal estimates of previous Medicaid expansion proposals introduced over the past six years, updated assumptions, and incorporated current data, e.g. the population estimate due to the availability of the American Community Survey for 2017 and changes to the estimated capitation rates since the implementation of Heritage Health. Additional years of Medicaid expansion, as well as more research of a broader range of other states' experiences, helped to inform the reasonableness of the assumptions used in these new estimates.

Effective Date

Initiative 427, if approved, has no effective date for the coverage to begin. The only deadline is to submit documents seeking approval of the program to the federal government by April 1, 2019. However, the drafting and submission of documents like a state plan amendment (SPA) or a waiver amendment is only one part of implementing a Medicaid program. As described below, other considerations include:

- contract amendments with every existing managed care entity;
- changes to state regulation;
- hiring and training of staff; and
- changes to existing information technology systems.

To put the timeline in perspective, it took several years to prepare for the implementation of the Heritage Health managed care program, including drafting of the request for proposal, receiving the necessary federal authorities, promulgating regulations, and making changes to the information technology systems. Even after contracts were signed, implementation still took eight months. Taking the above considerations into account, it is assumed the full implementation of this program will be no earlier than January 1, 2020.

Federal Authorities

In order to utilize federal funding for Medicaid, any change to the program, including deciding to cover adults under the ACA, requires federal approval. Federal approval can be gained through an amendment to the Medicaid state plan (SPA), through a waiver, or a combination of both.

The Medicaid state plan is the contract a state has with the federal government on how the Medicaid program is administered. An amendment is achieved through the state submitting a SPA, starting a 90-day negotiation period with the federal government. During the 90-day period, the federal government may send to a state a request for additional information (RAI). A formal RAI stops the 90-day clock until the state responds. When the state responds, it begins a new 90-day clock that ends with the approval or disapproval of the SPA. Other requirements, prior to the submission of a SPA, include public notice (if there is a rate or methodology change for a service) and tribal notice (30 to 60 days prior to the SPA submission).

Medicaid waivers allow states to administer programs without certain requirements of the Social Security Act. Nebraska currently has five waivers, four for its home and community-based services (Section 1915(c) waivers) and one for its managed care program, Heritage Health (a Section 1915(b) waiver). Other states have expanded their Medicaid programs using Section 1115 demonstration waivers. Depending upon the type of waiver, certain public notice requirements must be met prior to submission and the entire development and approval of a waiver can take nearly a year.

To implement the provisions of Initiative 427, MLTC must develop and submit a SPA and an amendment to its 1915(b) waiver to enroll this expanded population into managed care.

Heritage Health

On January 1, 2017, MLTC launched Heritage Health, an integrated Medicaid managed care program combining physical, behavioral, and pharmacy services. Three plans are contracted with the state to

deliver Heritage Health services to most Medicaid members: Nebraska Total Care (Centene), United Health Care Community Plan, and WellCare of Nebraska. Dental benefits are provided separately by Managed Care of North America (MCNA). Heritage Health is not only is focused on the quality of services provided to Medicaid members, but also on the costs. Better coordination of care slows the cost growth of the Medicaid program. Most states expanding eligibility through the ACA have covered the expanded population in their managed care programs.[ii] If Initiative 427 passes, the expansion eligible group will also be enrolled in managed care.

In addition to the Section 1915(b) amendment mentioned above, in order to enroll these expansion eligible adults into managed care, MLTC will have to negotiate contract amendments with the four health plans. These amendments will also include rates that must be developed by MLTC's actuary and possible risk-sharing arrangements due to the uncertainty of the cost in covering this expansion population.[iii] Both the rates and the contract amendments must be approved by CMS prior to the program's implementation.[iv]

Regulatory Changes

Medicaid eligibility is governed both by state legislation and regulations promulgated by MLTC. The regulatory process takes considerable time and required a public hearing and approval by the attorney general's office. If Initiative 427 passes, Title 477 of the Nebraska Administrative Code must be amended to include the new eligibility category.

Matching Rates

Medicaid is funded jointly by federal and state governments. The most a state has to contribute for eligible costs is 50%. The match rate for those considered in the expansion population under the ACA is higher than the match rate for most other populations covered by Medicaid. From January 1, 2020, onwards, the match rate for this population is 90/10. That is, the federal government will contribute 90% of the cost of the new population while the state will pay 10%. The 10% matching rate is only available for medical services to the expanded population and IT development. Other administrative costs are matched at 75/25 or 50/50. MLTC's fiscal analysis assumes a continuation of the 90% matching rate. However, there is always the possibility that Congress may change the match rate, as has been seen recently with the elimination of the 23% enhancement for the children's health insurance program (CHIP) earlier this year.

States are funding the 10% match in a variety of ways, as listed in the table below.

Table 5. How states fund the ACA Medicaid Expansion Program

State	Source of Funding
Arizona	Hospital Tax
Arkansas	Work Requirements, Premiums
California	Cigarette Taxes, Hospital Tax
Colorado	Hospital Tax
Indiana	Cigarette Taxes, Hospital Tax, Work Requirements, Premiums
Kentucky	Work Requirements, Premiums
Louisiana	Tax on HMO
Minnesota	Provider Tax
Montana	Cigarette Taxes (Proposed)
New Hampshire	Liquor Taxes, Work Requirements
North Dakota	Provider Reimbursement Cut
Oregon	Tax on Hospitals and Health Insurance Plans
Virginia	Provider Tax

Source: Quinn, Mattie, "As Federal Medicaid Money Fades, How Are States Funding Expansion?" Governing, available at: https://bit.ly/2QlWLCe

Population Size

On September 13, 2018, the United States Census Bureau released its 2017 American Community Survey, the best sources for information on Nebraska's uninsured population and those who would be covered through the ACA Medicaid expansion.[v] While this is the best information available, there are still some data limitations. The 2017 data showed:

Table 6. Uninsured population in Nebraska

Group	Population
Total Population	1,891,453
Total Uninsured	156,784
Total Uninsured under 19	25,713
Total Uninsured between 19 and 64	91,875
Total Uninsured 65 or older	1,881
Total Uninsured Citizens	122,919
Total Uninsured Aliens	33,865
Total Population below 138% FPL	326,637
Total Insured Below 138% FPL	263,857
Total with Private Insurance Below 138% FPL	128,140
Total with Public Coverage* Below 138% FPL	168,189
Total Uninsured Below 138% FPL	62,780

*Medicare, Medicaid, VA
Source: 2018 American Community Survey

The number of individuals below 138% FPL also includes individuals who are covered and receive premium assistance on the health insurance marketplace. The Nebraska Department of Insurance estimates this number to be a little over 16,000. If the state opts-into the ACA Medicaid expansion, these individuals cannot maintain their private plans with premium assistance and must enroll in

Medicaid.[vi] The Department of Insurance also estimates that the impact on the general fund will be a reduction of $712,727 by 2020 as the private insurance carriers currently pay a premium tax on the lives they cover.[vii] It is unknown what impact this will have on the continued viability of the exchange (it has a current enrollment of about 88,000).

Also of note is that many states initially underestimated the number of individuals who would enroll in Medicaid as expansion eligible.[viii] For example, Arkansas initially predicted 215,000 enrollees prior to implementation. In 18 months, enrollment was nearly 300,000.[ix]

Crowd-out

Those who are shown as currently insured, but below the threshold to be covered by the ACA Medicaid expansion, might still qualify if they decide to drop their insurance coverage or if their employer drops coverage. Individuals and families who currently purchase their health insurance coverage on the individual market or through their employer might chose to have Medicaid coverage instead. Employers, especially those who employ a large number of low-income individuals, may find it more economically advantageous to have Medicaid provide coverage to their employees instead of providing it themselves.

Woodwork

The woodwork effect refers to those individuals currently eligible for Medicaid coverage who enroll based upon the increased outreach around Medicaid expansion. One study found a clear woodwork effect with the enrollment of previously eligible children.[x] However, due to the existing outreach and the focus on insurance coverage since the passage of the ACA, it is assumed that this number will be low, approximately 865 per year.

Growth rate

Based upon experience from other states, and analysis of population trends in Nebraska, it is estimated approximately 65% of those eligible for Medicaid benefits under this proposed expansion ballot initiative would actually enroll with Medicaid in year one. By year two, it is estimated that this percentage of eligible persons actually enrolled would grow to 80%, and MLTC assumes by year three all potentially eligible individuals who chose to enroll would be enrolled in Medicaid.

Since eligibility for the ACA expansion group is income-based, if there is an economic downturn the growth rate will increase, as will the cost of the expansion population. For example, if enrollment grows an additional 3% beginning in SFY 2021, it would result in the total number of eligible persons to grow to an 112,110 individuals. This would result in an estimated total cost to $6.3 billion, increasing the state aid cost to $736 million.

Table 7. Estimated increase in enrollment (and associated aid costs) if Initiative 427 is approved assuming stable economic conditions

State Fiscal Year	Estimated Expansion Population by Year	State Funds	Federal Funds	Total Aid Cost
FY20 (Half a Year)	57,592	$19,826,774	$149,351,013	$169,177,787
FY21	70,882	$49,269,837	$371,139,560	$420,409,397
FY22	88,602	$62,416,513	$470,170,776	$532,587,289
FY23	89,223	$64,833,312	$488,376,023	$553,209,335
FY24	89,847	$67,343,690	$507,286,187	$574,629,877
FY25	90,476	$69,951,271	$526,928,562	$596,879,833
FY26	91,109	$72,659,820	$547,331,499	$619,991,319
FY27	91,747	$75,473,244	$568,524,449	$643,997,693
FY28	92,389	$78,395,606	$590,538,000	$668,933,606
FY29	93,036	$81,431,123	$613,403,926	$694,835,049
FY20 to FY29		**$641,601,190**	**$4,833,049,996**	**$5,474,651,186**

Table 8. Estimated increase in enrollment (and associated aid cost) if Initiative 427 is approved and enrollment grows an additional 3% per year

State Fiscal Year	Estimated Expansion Population by Year	State Funds	Federal Funds	Total Aid Cost
FY20 (Half a Year)	57,592	$19,826,774	$149,351,013	$169,177,787
FY21	73,008	$50,747,932	$382,273,747	$433,021,679
FY22	91,260	$64,289,009	$484,275,899	$548,564,908
FY23	94,774	$68,949,962	$519,385,902	$588,335,864
FY24	98,423	$73,948,834	$557,041,380	$630,990,214
FY25	102,212	$79,310,124	$597,426,880	$676,737,004
FY26	106,147	$85,060,109	$640,740,328	$725,800,437
FY27	110,234	$91,226,966	$687,194,002	$778,420,969
FY28	114,478	$97,840,921	$737,015,567	$834,856,489
FY29	118,885	$104,934,388	$790,449,196	$895,383,584
FY20 to FY29		**$736,135,019**	**$5,545,153,915**	**$6,281,288,934**

Capitation rates

Since the adult expansion population will receive services through the state's managed care entities, the plans will be paid a per member, per month rate for all of their services. This is known as a capitation payment. For purposes of this fiscal analysis, it is assumed that the expansion population will receive the same services as the existing Medicaid population, including optional services like dental care and chiropractic services.

The capitation rates in this analysis are a blended average rate for the expected categories of aid that the expansion populations are expected to fall into under the current Medicaid eligibility groups. The

majority of the individuals in the expansion population will be eligible in the lower cost "family" category of aid eligibility groups, with a small number of other individuals (from the woodwork population) that are anticipated to fall into the more costly aged, blind, and disabled category of aid. The capitation rates in this analysis are inclusive of all eligible services (physical health, behavioral health, pharmacy, and dental benefits). If Initiative 427 is approved, the state will work with its actuary to determine the actual capitation rate for the expansion population.

States expanding their Medicaid programs have found that the costs for this expansion category are initially higher than other Medicaid eligible adults. State that have expanded their Medicaid programs have seen pent-up demand in the new population based upon previously unmet health care needs, leading to costs above their initial projections.[xi] These demands tend to decrease as the program matures.[xii]

Additionally, the increase of eligible Medicaid members will require a robust provider network to meet the population's health needs. While some adults are currently enrolled in Medicaid, the provider network today primarily serves children. In order to increase the provider networks to serve the expansion population, it is assumed provider rates must be increased. This increase is factored into the capitation rates.

Table 9. Estimated average capitation rates, ACA expansion population

State Fiscal Year	Per Member, Per Month Estimate
FY20	$489.59
FY21	$494.26
FY22	$500.91
FY23	$516.69
FY24	$532.97
FY25	$549.76
FY26	$567.08
FY27	$584.94
FY28	$603.36
FY29	$622.37

Staffing

The requirements of Initiative 427, if approved, will require a significant increase in staff for MLTC. Not only will additional staff be required to handle the additionally regulatory requirements of this new Medicaid population, but staff also will must be hired to handle eligibility determinations and questions regarding benefits from the public. The recruitment and training of this additional staff must be factored into the timeline for implementing Initiative 427.

For the eligibility field staff (those employees who will process applications and determine eligibility for the expansion population), it is estimated 36 additional staff will have to be in place on the implementation date. It will take six months to recruit and train this staff. Additional eligibility staff will be hired in the first year and thereafter as enrollment increases.

In addition to the eligibility staff, three program specialists will be hired in the regulatory compliance unit to assist in the drafting and development of the SPA, regulations, training, changes to eligibility system rules in addition to providing field support and working on quality measurements and reporting. The MLTC data and analytics team will require two statistical analysts and one staff assistant to facilitate quality measurement development, data gathering, and additional reporting. The MLTC delivery systems unit will require five new program specialists for oversight of the managed care entities in the delivery of services to this new population. The MLTC finance unit will require an additional budget analyst to comply with additional federal financial reporting.

There will be additional staff required as the expansion population grows. By SFY 2029, it is estimated 95 additional staff will be required if the state's economic condition remains stable. The general fund estimated cost to be $26,036,313 for the full ten year analysis. The total fund cost will be $52,072,627. If there is an increase in enrollment, there will be a greater enrollment staff needed.

Table 10. Staffing estimate to support Initiative 427 implementation assuming stable economic conditions

State Fiscal Year	Total Funds	State Funds	Federal Funds	Positions
FY20	$2,698,294	$1,349,147	$1,349,147	53
FY21	$4,163,084	$2,081,542	$2,081,542	59
FY22	$4,704,292	$2,352,146	$2,352,146	67
FY23	$4,974,896	$2,487,448	$2,487,448	71
FY24	$5,245,500	$2,622,750	$2,622,750	75
FY25	$5,516,104	$2,758,052	$2,758,052	79
FY26	$5,786,708	$2,893,354	$2,893,354	83
FY27	$6,057,312	$3,028,656	$3,028,656	87
FY28	$6,327,916	$3,163,958	$3,163,958	91
FY29	$6,598,520	$3,299,260	$3,299,260	95
Total	**$52,072,627**	**$26,036,313**	**$26,036,313**	

Table 11. Staffing estimate to support Initiative 427 implementation with 3% enrollment growth

State Fiscal Year	Total Funds	State Funds	Federal Funds	Positions
FY20	$3,645,407	$1,822,703	$1,822,703	55
FY21	$4,636,641	$2,318,321	$2,318,321	66
FY22	$5,719,057	$2,859,529	$2,859,529	82
FY23	$5,922,010	$2,961,005	$2,961,005	85
FY24	$6,057,312	$3,028,656	$3,028,656	87
FY25	$6,260,265	$3,130,133	$3,130,133	90
FY26	$6,463,218	$3,231,609	$3,231,609	93
FY27	$6,666,171	$3,333,086	$3,333,086	96
FY28	$6,869,124	$3,434,562	$3,434,562	99
FY29	$7,072,077	$3,536,039	$3,536,039	102
Total	**$59,311,283**	**$29,655,641**	**$29,655,641**	

Information Technology Changes

There are significant changes that must occur in the many different information technology (IT) systems administered by DHHS. Systems determining eligibility and paying claims will have to be modified to accommodate the new eligibility category. Many of these systems are decades old and take significant time and resources to modify. These changes must be factored into the timeline for implementation.

Below are the estimated cost for the IT changes needed:

- initial changes to MMIS $43,500 TF ($4,350 GF);
- NFOCUS changes $247,820 in TF ($24,782 in GF);
- $1.5 Million TF change order to DMA system ($150K in GF);
- $4,800 TF cost to change Access Nebraska Portal ($480 GF cost); and
- ongoing additional costs anticipated at $600K per year TF ($60K per year in GF).

Table 12. IT costs to support Initiative 427 implementation

State Fiscal Year	Total Funds	State Funds	Federal Funds
FY20	$1,796,120	$179,612	$1,616,508
FY21	$600,000	$60,000	$540,000
FY22	$600,000	$60,000	$540,000
FY23	$600,000	$60,000	$540,000
FY24	$600,000	$60,000	$540,000
FY25	$600,000	$60,000	$540,000
FY26	$600,000	$60,000	$540,000
FY27	$600,000	$60,000	$540,000
FY28	$600,000	$60,000	$540,000
FY29	$600,000	$60,000	$540,000
Total	**$7,196,120**	**$719,612**	**$6,476,508**

Not factored into these costs are the change orders necessary for the other IT projects the Department currently has underway. The replacement of the state's Medicaid management information system (MMIS) is underway, as are procurement activities for the enrollment and eligibility solution, electronic visit verification, and case management for long-term care services. All of these projects will face delays with the resources needed to implement the ACA Medicaid expansion and it is unknown what costs will be incurred if the timelines for these projects change.

Enrollment Broker

There will also have to be a contract change for the enrollment broker, which facilitates members' enrollment into the managed care organizations. The enrollment broker is paid based upon the number of members enrolled, so if enrollment increases, costs will increase. These costs are detailed below:

Table 13. Enrollment broker costs assuming stable economic conditions, Initiative 427 implementation

State Fiscal Year	Total Funds	State Funds	Federal Funds
FY20	$93,298	$46,649	$46,649
FY21	$229,657	$114,829	$114,829
FY22	$297,704	$148,852	$148,852
FY23	$310,495	$155,248	$155,248
FY24	$323,450	$161,725	$161,725
FY25	$336,571	$168,286	$168,286
FY26	$349,860	$174,930	$174,930
FY27	$363,319	$181,660	$181,660
FY28	$376,949	$188,475	$188,475
FY29	$390,752	$195,376	$195,376
Total	**$3,072,055**	**$1,536,028**	**$1,536,028**

Table 14. Enrollment broker costs with 3% enrollment growth, Initiative 427 implementation

State Fiscal Year	Total Funds	State Funds	Federal Funds
FY20	$93,298	$93,299	$93,300
FY21	$236,548	$118,274	$118,274
FY22	$306,635	$153,318	$153,318
FY23	$330,056	$165,028	$165,028
FY24	$354,810	$177,405	$177,405
FY25	$380,712	$190,356	$190,356
FY26	$407,742	$203,871	$203,871
FY27	$436,692	$218,346	$218,346
FY28	$467,260	$233,630	$233,630
FY29	$499,034	$249,517	$249,517
Total	**$3,512,787**	**$1,803,043**	**$1,803,044**

Public Outreach

Not factored into the cost estimate for expansion is public outreach. Other states that opted into the ACA Medicaid expansion have done significant outreach both to potential members but also to providers. Funding will have to be provided if similar outreach is to take place in Nebraska.

Potential General Fund Cost Offsets

With the ACA Medicaid expansion, there is the potential for the state to offset some general fund expenditures by moving costs to the federal government. This can come by moving state-only costs to Medicaid or by an increased federal match for existing Medicaid populations that would now be determined to be expansion eligible under the ACA's provisions. Those potential offsets are discussed below.

Behavioral health

In states that expanded Medicaid, there remains a percentage of individuals who chose to not enroll or were unaware that they qualified for Medicaid and did not enroll. These individuals are in addition to Nebraskans not eligible for Medicaid, but unable to afford insurance who seek assistance from the Division of Behavioral Health (BH). In some states the transition time necessitated adjustments to original budget assumptions, such that the magnitude of the offsets grew over time as the transition progressed rather than immediate offsets. It is therefore important to be conservative in estimates and provide for a period of transition.

This percentage of Medicaid "churning" (the exit and re-entry of beneficiaries as their eligibility changes) and coverage transitions varied across states. Estimates based on data from 2004-2008 indicate that more than 30 percent of eligible individuals lose eligibility within 6 months of enrollment and about half within 12 months. Causes of churn/coverage transition:

- Income or household changes, i.e. individuals may experience changes in income, marital status, and household size. Seasonal employment and overtime can also impact income.
- Administrative disenrollment, i.e. incomplete re-enrollment paperwork or coverage renewals.
- Obtaining employer-sponsored insurance coverage, or change due to failure to make timely premium payments.

A critical consideration in calculating any potential offsets and impact on the state is the potential penalty and loss of federal block grant funding should BH not maintain state expenditures levels for behavioral health services. Both the substance abuse prevention and treatment block grant and the mental health block grant (MHBG) funding contain maintenance of effort (MOE) provisions that requires states to maintain behavioral health funding through the BH at the level of the two year period prior to the receipt of the grant. These levels were initially determined when state funding for MLTC Medicaid rehabilitation option and substance abuse waivers services were provided by BH, thus included in the MOE amounts. Moving funding to MLTC to pay for the expansion eligible, at a lower state match rate, will result in BH not maintaining its MOE levels and thus risk loss of federal block grant funding.

The block grant funding supports a variety of services outside of those that are supported with MLTC funding. These services are recovery and prevention in focus and support individuals in either not needing higher levels, more costly services or extending lengths of time between crises. Loss of these services will directly impact the frequency and severity of intervention necessary for MLTC recipients as well as decrease availability of affordable services for non-MLTC eligible enrolled persons. As such a portion of any offset may be needed to restore these services should federal block grant funding be lost. This is estimated to be up to $5.1 million for SAPTBG and $3.1 million for the MHBG annually.

Services may further be impacted by reductions in statutory match of general funds. Presently Nebraska Revised Statute 71-808 requires a significant portion of general funds to be matched, with $1 of local funds for every $3 of general funds. The match dollars consist of 40% county funds and 60% in non-federal, non-county sources. A reduction of $5.8 million will result in a corresponding reduction in matching funds of $1.8 million.

State disability program

While Medicaid currently provides Medicaid for individuals determined to be disabled by the Social Security Administration, there are some individuals who might meet those disability requirements except for the length of time they have been disabled (duration). These individuals under 100% of the federal poverty level are currently provided services through the state disability program paid for through state general funds. If Initiative 427 passes, these individuals would be deemed expansion eligible for Medicaid and be covered at the 90/10 match rate.

Pregnant women

Nebraska provides Medicaid coverage for pregnant women up to 194% of the federal poverty level. This eligibility category receives the traditional state match. However, it is assumed that many of these women, whose incomes fall below 138% of the FPL, would be in the expansion category. If so, there is the potential for general fund offsets.

However, since the passage of the ACA, the federal government has provided clarification regarding coverage of pregnant women. While when they are not pregnant, they do qualify as expansion eligible, if they report their pregnancy to the state, they are moved to the pregnant women category and are only eligible for the traditional match rate. Because of this additional guidance, potential offsets achieved by shifting pregnant women to the expansion category are not included in this analysis.[xiii]

Corrections

Longstanding federal guidance prohibits states from using Medicaid funding for incarcerated individuals. However, if an incarcerated person is receiving inpatient services in a medical institution for a stay of 24 hours or more), Medicaid funding is available.[xiv] Some general fund savings can be expected by the Department of Corrections in shifting some cost of prisoner care to Medicaid, but it is unknown what amount of offsets can be anticipated.

Table 15. Total estimated general fund offsets

SFY	Division of Behavioral Health	State Disability Program	Women with Cancer Program	Total Offsets by Year
SFY20	($1,885,000)	($556,366)	($535,302)	($2,976,668)
SFY21	($4,640,000)	($1,112,732)	($1,070,604)	($6,823,336)
SFY22	($5,800,000)	($1,134,987)	($1,092,016)	($8,027,003)
SFY23	($5,916,000)	($1,157,686)	($1,113,856)	($8,187,543)
SFY24	($6,034,320)	($1,180,840)	($1,136,134)	($8,351,294)
SFY25	($6,155,006)	($1,204,457)	($1,158,856)	($8,518,320)
SFY26	($6,278,107)	($1,228,546)	($1,182,033)	($8,688,686)
SFY27	($6,403,669)	($1,253,117)	($1,205,674)	($8,862,460)
SFY28	($6,531,742)	($1,278,179)	($1,229,787)	($9,039,709)
SFY29	($6,662,377)	($1,303,743)	($1,254,383)	($9,220,503)
Total	**($56,306,220)**	**($11,410,653)**	**($10,978,646)**	**($78,695,520)**

Conclusion

MLTC's analysis concludes that at the conclusion of FY29, the expansion population will be 93,036 Nebraskans and that expanding Medicaid to cover previously ineligible adults will be a significant investment by the state, both financially and in human resources. Below is the total estimated cost to the state if Initiative 427 is approved under two scenarios— stable economic conditions and with a 3% growth in the expansion population.

Table 16. Total estimated cost if Initiative 427 is approved is approved assuming stable economic conditions

SFY	Total Funds	State Funds	Federal Funds
FY20*	$173,765,498	$21,402,181	$152,363,317
FY21	$425,402,139	$51,526,208	$373,875,931
FY22	$538,189,285	$64,977,511	$473,211,774
FY23	$559,094,726	$67,536,007	$491,558,719
FY24	$580,798,827	$70,188,165	$510,610,662
FY25	$603,332,509	$72,937,609	$530,394,900
FY26	$626,727,887	$75,788,104	$550,939,783
FY27	$651,018,324	$78,743,560	$572,274,764
FY28	$676,238,471	$81,808,039	$594,430,432
FY29	$702,424,321	$84,985,759	$617,438,562
Total	**$5,536,991,988**	**$669,893,143**	**$4,867,098,845**

***Assuming 1/1/2020 Implementation

Table 17. Total estimated cost if Initiative 427 is approved assuming stable economic conditions, offsets considered

SFY	Total Funds	State Funds	Federal Funds
FY20*	$173,765,498	$18,425,513	$155,339,985
FY21	$425,402,139	$44,702,872	$380,699,267
FY22	$538,189,285	$56,950,509	$481,238,777
FY23	$559,094,726	$59,348,465	$499,746,262
FY24	$580,798,827	$61,836,872	$518,961,956
FY25	$603,332,509	$64,419,290	$538,913,219
FY26	$626,727,887	$67,099,418	$559,628,469
FY27	$651,018,324	$69,881,100	$581,137,224
FY28	$676,238,471	$72,768,330	$603,470,141
FY29	$702,424,321	$75,765,256	$626,659,065
Total	**$5,536,991,988**	**$591,197,623**	**$4,945,794,365**

***Assuming 1/1/2020 Implementation

Table 18. Total estimated cost if Initiative 427 is approved is approved and enrollment grows an additional 3% per year

SFY	Total Funds	State Funds	Federal Funds
FY20*	$174,712,611	$21,875,738	$152,836,874
FY21	$438,494,868	$53,244,526	$385,250,342
FY22	$555,190,600	$67,361,855	$487,828,745
FY23	$595,187,930	$72,135,995	$523,051,935
FY24	$638,002,336	$77,214,895	$560,787,441
FY25	$683,977,981	$82,690,613	$601,287,368
FY26	$733,271,397	$88,555,589	$644,715,809
FY27	$786,123,832	$94,838,398	$691,285,434
FY28	$842,792,873	$101,569,114	$741,223,760
FY29	$903,554,695	$108,779,944	$794,774,752
Total	**$6,351,309,123**	**$768,266,665**	**$5,583,042,458**

***Assuming 1/1/2020 Implementation

Table 19. Total estimated cost if Initiative 427 is approved and enrollment grows an additional 3% per year, offsets considered

SFY	Total Funds	State Funds	Federal Funds
FY20*	$174,712,611	$18,899,070	$155,813,542
FY21	$438,494,868	$46,421,190	$392,073,678
FY22	$555,190,600	$59,334,852	$495,855,748
FY23	$595,187,930	$63,948,452	$531,239,478
FY24	$638,002,336	$68,863,602	$569,138,735
FY25	$683,977,981	$74,172,293	$609,805,688
FY26	$733,271,397	$79,866,903	$653,404,494
FY27	$786,123,832	$85,975,938	$700,147,893
FY28	$842,792,873	$92,529,405	$750,263,468
FY29	$903,554,695	$99,559,441	$803,995,255
Total	**$6,351,309,123**	**$689,571,146**	**$5,661,737,978**

***Assuming 1/1/2020 Implementation

[i] "State Expenditure Report: Examining Fiscal 2015-2017 State Spending," National Association of State Budget Officers. Available at: https://bit.ly/2PKLkmO.

[ii] See "2016 Actuarial Report on the Financial Outlook for Medicaid," available at: https://go.cms.gov/2jxva0j. "Most States covered newly eligible adults through managed care programs and used risk mitigation strategies to offset the risks that the costs of the newly eligible adults were greater, or less, than projected."

[iii] See "2016 Actuarial Report on the Financial Outlook for Medicaid," available at: https://go.cms.gov/2jxva0j. Given the uncertainty inherent in covering a large new population in Medicaid (many of whom were expected to have been previously uninsured), most States that implemented the eligibility expansion included risk-sharing arrangements in their contracts with managed care plans for newly eligible adults in 2014 and 2015, and some States continued these arrangements into 2016.

[iv] According to the Federal Administrative Accountability Dashboard, the mean number of days it took to review and approve states' managed care base capitation rates and capitation rate amendments in calendar year 2016 was 137. (https://bit.ly/2MPH03G).

[v] The information is available at https://bit.ly/2dmQmHD.

[vi] See "Canceling a Marketplace plan when you get Medicaid or Chip," available at https://bit.ly/2xwxVb4.

"Once you get a final determination that you're eligible for Medicaid or the Children's Health Insurance Program (CHIP) that counts as qualifying health coverage (or "minimum essential coverage"):

- You're no longer eligible for a Marketplace plan with advance payments of the premium tax credit and savings on out-of-pocket costs
- You should IMMEDIATELY end Marketplace coverage with premium tax credits or other cost savings for anyone in your household who is determined eligible for or already enrolled in Medicaid or CHIP that counts as qualifying health coverage

If you still want a Marketplace plan after you're found eligible for Medicaid or CHIP, you will have to pay full price for your share of the Marketplace plan without premium tax credits or other cost savings"

[vii] See Nebraska Revised Statute 77-908. The decline in premium tax revenue is not included in MLTC's fiscal impact amount.

[viii] See "2016 Actuarial Report on the Financial Outlook for Medicaid," available at: https://go.cms.gov/2jxva0j. "[N]ewly eligible adult enrollment is projected to be 6.2 percent higher in 2016 than previously projected (11.2 million as opposed to 10.5 million projected in the previous report) and to reach 13.1 million by 2024 (10.8 percent higher than the 11.8 million projected in the previous report)."

[ix] See "Estimated Medicaid-related impact of the ACA with expansion: Updated November 13, 2012," Arkansas Department of Human Services, available at https://bit.ly/2DlNdoF.

[x] Hudson, Julie and Moriya, Asako, "Medicaid Expansion for Adults Had Measureable 'Welcome Mat' Effects on Their Children," Health Affairs, 36 no. 9 (September 2017), https://bit.ly/2PSYfTO.

[xi] See "2016 Actuarial Report on the Financial Outlook for Medicaid," available at: https://go.cms.gov/2jxva0j. "The average per enrollee costs for newly eligible adults grew from $5,511 in 2014 to $6,365 in 2015 (an increase of 15.5 percent). These per enrollee costs were notably higher than those for non-newly eligible adults, as many States included adjustments to reflect a higher level of acuity or morbidity. In most States, these adjustments were positive, and in some cases the adjustments were substantial. States also included other adjustments in the capitation rates for newly eligible adults; many projected increased costs due to pent-up demand, expecting that a number of the newly eligible would have been previously uninsured and would use additional services in the first several months of coverage. Finally, some States also included adjustments for adverse selection with the anticipation that the persons who were most likely to enroll in the first year would be those with the greatest health care needs."

[xii] See "2016 Actuarial Report on the Financial Outlook for Medicaid," available at: https://go.cms.gov/2jxva0j "Per enrollee costs for newly eligible adults are estimated to have decreased from $6,365 in 2015 to $5,926 in 2016 (6.9 percent). These per enrollee costs are expected to continue to further decrease by 6.3 percent in 2017 and 3.3 percent in 2018, at which point newly eligible adult costs are projected to be less than that of the non-newly eligible adults ($5,370 and $5,764, respectively). Newly eligible adult per enrollee costs were 27.7 percent higher than those for other Medicaid adults in 2015, and are estimated to be 13.6 percent higher in 2016."

[xiii] See "Medicaid/CHIP Affordable Care Act Implementation: Answers to Frequently Asked Questions," May 22, 2012, available at https://bit.ly/2DkbeMQ

"Q3: If a woman indicates on the application she is pregnant, do States need to enroll her as a pregnant woman if she is otherwise eligible for the adult group? Would there be a need to track pregnancy if the benefits for both groups are the same?

A: If a woman indicates on the application that she is pregnant, she should be enrolled in Medicaid coverage as a pregnant woman. The Affordable Care Act specifies that pregnant women are not eligible for the new adult group. As mentioned above, if a woman enrolled in the adult group later becomes pregnant, she will have the option to stay enrolled in the adult group or request that the State move her to a pregnancy-related eligibility group."

[xiv] See "Re: To Facilitate successful re-entry for individuals transitioning from incarceration to their communities," State Health Official letter #16-007, April 28, 2016, available at https://bit.ly/26x4hNw.