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DEPT. OF HEALTH AND HUMAN SERVICES

Health and Human Services Committee
LB 956
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Good afternoon, Senator Riepe, and members of the Health and Human Services Committee. My name is Thomas "Rocky" Thompson (T-H-O-M-A-S R-O-C-K-Y T-H-O-M-P-S-O-N), and I am the Interim Director of the Division of Medicaid and Long-Term Care (MLTC) in the Department of Health and Human Services (DHHS). I am here to testify in opposition of LB 956.

LB 956 would require the Department to create a new state government-sponsored health insurance program delivered in the same manner and with the same benefits as Nebraska Medicaid. All residents of the state not otherwise eligible for Medicaid would be allowed to participate. Unlike our current Medicaid program, federal funds would be unavailable and unable to be used for this new insurance product, both according to this bill and federal law. Since federal authority is not needed to establish this new insurance product under the Social Security Act, a Section 1115 waiver is not necessary.

As written, LB 956 directs the Department to use previous expenditures by the Nebraska Medicaid program as a financial basis for determining the premium that should be set for participants in this new insurance program. The legislation also caps the premium amount. This would impose a significant financial risk on the state budget. Before I detail those risks, I will give a brief background on how rates are developed within the Medicaid program.

The development of capitation rates is a complex exercise involving a comprehensive review of medical claims and a projection of the likely utilization of Medicaid services in the future. Nebraska Medicaid contracts with an actuarial consultant to develop capitation rates in consultation with the Department's finance and accounting units. Capitation rates are developed for specific categories of Medicaid recipients, including children, pregnant women, the elderly, and individuals with physical and developmental disabilities. These capitation rates are required by federal regulation to be actuarially sound. That means the Department must certify that the rates are not set too low, thus risking the financial viability of the health plan, nor so high that overpayment to plans from the state would result.

As written, LB 956 does not allow the Department to set premiums using an actuarially-sound process that anticipates the use of medical services by the population the program would likely serve. The legislation instead sets the premium at one hundred fifty (150) percent of the median expenditure paid on behalf of a current Medicaid beneficiary. The failure to utilize an actuarially-sound process could result in a premium that does not accurately anticipate the utilization of benefits by this new population.

LB 956 will pose a significant financial risk to the state, as the premium it requires would be based on previous expenditures for traditional Medicaid populations that may be very different from the population the program would likely serve. Any cost overruns resulting from the failure of the premium to accurately anticipate costs will be born entirely by the state.

To understand the financial risk, it may be instructive to look at the experience of health plans on the federal health insurance marketplace, as those plans serve a population similar to the population likely to participate in the LB 956 program. The Nebraska Department of Insurance has reported that premiums for health plans in the individual market have increased 153% from 2013 to 2017 as insurers have struggled to accurately anticipate the costs associated with covering this population. For some plans that have participated in the ACA Marketplace, cost overruns due to insufficient premiums have resulted in financial losses that run to the tens of millions of dollars per year. Should current Medicaid health plans be required to participate in the LB 956 program, the financial stability of those health plans could be jeopardized.

LB 956 would grow government by requiring the Department to hire numerous new employees to administer this health insurance program. In order to ensure that participants in the LB 956 program are not otherwise eligible for Medicaid, as required by the bill, each applicant for the new program would have to undergo a Medicaid-eligibility determination. As the Department illustrated in its fiscal note, should a population of 129,000 individuals choose to participate in the new program, nearly 100 additional personnel would be required just to process the eligibility determinations. Additional staff would be required to manage the program and develop policies and regulations.

Furthermore, this bill does not prohibit participation by individuals with access to employer-provided health insurance. As written, the legislation may encourage some employers to cease offering health coverage and attempt to transfer employees to the LB 956 program. Regardless of whether program participants move from the individual market or from employer-provided insurance, LB 956 would transfer the financial risk of covering these individuals from private insurers to the state of Nebraska.

The creation and launch of this program would also require the time and attention of current Department employees and leadership which may result in reduced oversight of the current Medicaid program. Remember that the Medicaid program serves some of Nebraska's most vulnerable residents, including the elderly, persons with disabilities, and low-income mothers and children. Resources dedicated to this mission would be taken away to administer this new insurance product to a population who may already have the resources to purchase health insurance either on the individual or group markets.

We believe that finite government resources and Department personnel are best utilized to oversee those programs already entrusted to us on behalf of the state's most economically-disadvantaged and medically-fragile individuals. While I am proud of the quality of care offered by our Heritage Health plans to the most vulnerable in our state, we should not divert from our mission to provide the best health services to low-income families and persons with disabilities to create a new insurance product for a population who already have the ability to purchase health care coverage in the existing market. For these reasons I oppose LB 956.

Thank you for the opportunity to testify before you today. I am happy to answer any questions you may have.