



Nebraska ACA Fiscal Impact Estimate

Updated to Reflect Legislative Bill 887

State of Nebraska, Department of Health and Human Services

Prepared for:

Ms. Vivianne Chaumont

Director, Division of Medicaid and Long Term Care
Department of Health and Human Services
State of Nebraska

Prepared by:

Mr. Robert M. Damler

FSA, MAAA
Principal and Consulting Actuary

111 Monument Circle
Suite 601
Indianapolis, IN 46024-5126
USA

Tel +1 317 639-1000
Fax +1 317 639-1001

milliman.com

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BACKGROUND

The legislature of Nebraska has introduced a plan to expand Medicaid under Section 2001 of the Affordable Care Act of 2010 (ACA). Legislative Bill 887, the “Wellness in Nebraska Act” (WIN), provides for an immediate state plan amendment (SPA) to expand Medicaid under the current Medicaid program. This is to be followed by development of waivers to customize Nebraska’s program to allow for the following:

- Premium support for those who have access to employer sponsored insurance (ESI),
- Exchange coverage for those between 100% FPL and 138% FPL who are without access to employer coverage,
- Incorporate patient-centered medical homes in the WIN Medicaid program and WIN Marketplace,
- Options for the medically frail to allow them to opt in to the WIN Medicaid program, and
- Monthly contributions of 2% of income for those with income at or above 50% FPL.

The Nebraska Department of Health and Human Services, Division of Medicaid and Long Term Care (DHHS), has requested Milliman update the newly eligible portion of the prior fiscal impact estimate, provided January 8, 2013, in order to reflect the program proposed in LB 887. This report does not update any other section of the prior report.

This report primarily concerns costs for SFY 2015 and SFY 2016. The enclosures and Table 2 also include projections through SFY 2020.

This report replaces the first version of the 2014 update, provided January 28, 2014.

SUMMARY OF RESULTS

PATIENT PROTECTION AND AFFORDABLE CARE ACT – FISCAL IMPACT ESTIMATE

Milliman has updated estimates of the enrollment and fiscal impact associated with the newly eligible population under a Medicaid expansion in order to reflect Legislative Bill (LB) 887, known as the Wellness in Nebraska Act (WIN). Estimates in Table 1 illustrate the projected fiscal impact for state fiscal years (SFY) 2015 and 2016 and for the biennium in total.

Table 1 Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care Patient Protection and Affordable Care Act - Medicaid Expansion Estimated Fiscal Impact: Current Biennium (Values illustrated in \$millions)			
State Dollar Impact	SFY 2015 SPA Program	SFY 2016 With Waivers	Biennium
Population, by SFY 2016 Program			
WIN ESI Premium Support			
Medically Frail	\$ 0.0	\$ 0.0	\$ 0.0
Healthy, with income below 100% FPL	\$ 0.0	\$ 0.0	\$ 0.0
Healthy, with income between 100% FPL and 138% FPL	\$ 0.0	\$ 0.0	\$ 0.0
WIN Medicaid Coverage			
Medically Frail, with no ESI	\$ 0.0	\$ 0.0	\$ 0.0
Healthy, with income below 100% FPL and no ESI	\$ 0.0	\$ 0.0	\$ 0.0
WIN Marketplace Coverage, 100% to 138% FPL and no ESI	\$ 0.0	\$ 0.0	\$ 0.0
State Disability Program, Shift to Medicaid as Newly Eligible	(\$ 9.2)	(\$ 9.4)	(\$ 18.6)
Administrative Cost for enrollees in all programs	\$ 3.6	\$ 5.0	\$ 8.6
Total	(\$ 5.6)	(\$ 4.4)	(\$ 10.0)
State and Federal Impact	SFY 2015 SPA Program	SFY 2016 With Waivers	Biennium
Population, by SFY 2016 Program			
WIN ESI Premium Support			
Medically Frail	\$ 18.9	\$ 19.3	\$ 38.2
Healthy, with income below 100% FPL	\$ 17.6	\$ 56.6	\$ 74.2
Healthy, with income between 100% FPL and 138% FPL	\$ 17.3	\$ 56.3	\$ 73.6
WIN Medicaid Coverage			
Medically Frail, with no ESI	\$ 78.2	\$ 87.5	\$ 165.7
Healthy, with income below 100% FPL and no ESI	\$ 86.4	\$ 97.8	\$ 184.2
WIN Marketplace Coverage, 100% to 138% FPL and no ESI	\$ 63.3	\$ 130.5	\$ 193.8
State Disability Program, Shift to Medicaid as Newly Eligible	\$ 3.3	\$ 3.4	\$ 6.7
Administrative Cost for enrollees in all programs	\$ 11.9	\$ 16.7	\$ 28.6
Total	\$ 296.9	\$ 468.1	\$ 765.0

Note: For comparison purposes, populations are stratified by ultimate eligibility category under the waivers. During SFY 2015, all are to be enrolled under the Medicaid SPA.

For the initial stage of the Medicaid expansion, LB 887 requests DHHS to apply for a state plan amendment (SPA) that will expand enrollment under the Medicaid state plan for all newly eligible individuals. For purposes of estimating a fiscal impact, we have assumed the SPA is approved without delay, allowing implementation under the Medicaid State Plan as of July 1, 2014 (the beginning of SFY 2015).

Other programs authorized by LB 887, including WIN Marketplace coverage, and WIN ESI premium support, will require waivers to be written and approved by CMS. In addition, DHHS will have to implement system changes, hire new vendors, and develop and train staff on new administrative processes. For purposes of this report, it is estimated that this will require an additional year, with implementation on July 2015.

Consequently, SFY 2015 costs reflect Medicaid State Plan enrollment for all populations, while SFY 2016 costs reflect implementation of the following additional programs specified in LB 887:

- WIN ESI premium support for newly eligible enrollees with access to cost effective employer sponsored insurance (ESI). Medically Frail enrollees can opt out of this program
- WIN Medicaid coverage for healthy enrollees with incomes below 100% FPL who also do not have access to cost effective ESI and for medically frail enrollees
- WIN Marketplace Coverage for healthy enrollees with incomes between 100% FPL and 138% FPL who also do not have access to cost effective ESI
- Monthly contributions for those over 50% FPL who do not receive recommended wellness services

Table 2 provides an estimate for the cost of each of the major waiver programs listed above.

Enclosures 1 and 2 provide additional details for the fiscal impact results of the Affordable Care Act. Results are presented by state fiscal year, with both State dollar and State and Federal impacts illustrated.

Enclosure 1 illustrates the fiscal impact estimate of the Medicaid expansion based on the current program structure, as will initially occur under the State Plan Amendment.

Enclosure 2 illustrates the fiscal impact estimate after all waivers have been implemented. DHHS may interpolate between the two to adjust the estimate to reflect the projected date for implementation of various waiver provisions, as this date is difficult to predict with certainty.

Table 2 Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care Patient Protection and Affordable Care Act State Budget Fiscal Impact: Through SFY 2020 (Values illustrated in \$millions)		
Component – Estimated Cost through SFY 2020	State Budget Cost	State and Federal Cost
WIN Medicaid coverage for all	\$ 76.9	\$ 2,515.2
Additional cost of WIN ESI premium program	\$ 25.2	\$ 412.1
Additional cost of WIN exchange program	\$ 26.7	\$ 502.5
Savings from premiums charged to those over 50% FPL	(\$ 0.6)	(\$ 12.0)
Total	\$ 128.2	\$ 3,417.8

ESTIMATED ACA ENROLLMENT IMPACT

Table 3 illustrates the projected newly eligible Medicaid enrollment for SFY 2015 and SFY 2016.

Table 3 Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care Patient Protection and Affordable Care Act Estimated Enrollment Impact – Average Monthly Enrollment		
Population, by SFY 2016 program	SFY 2015	SFY 2016
WIN ESI Premium Support		
Medically Frail	1,785	4,270
Healthy, with income below 100% FPL	5,128	12,497
Healthy, with income between 100% FPL and 138% FPL	5,281	12,483
WIN Medicaid Coverage		
Medically Frail	6,780	7,722
Healthy, with income below 100% FPL	23,644	27,285
WIN Marketplace Coverage, 100% to 138% FPL and no ESI	16,895	19,001
State Disability Plan	154	154
Total	59,668	83,412

Data

We updated projected newly eligible enrollment using a combination of the 2012 American Community Survey (2012 ACS) data from the U.S. Census Bureau collected in 2012 (representing 2012 insurance and income data) as well as Medicaid enrollment data provided by DHHS.

This data was summarized to estimate the total population eligible for the Medicaid expansion, stratified by income band, insurance coverage, and parent/non-parent status. We used 138% FPL as the upper income limit, which reflects the 133% FPL indicated in the Affordable Care Act with the required MAGI 5% income disregard allowance. We excluded college and graduate students from the ACS data because it was determined that they were not appropriately grouped with their parents, causing an inappropriate match between income level and insurance coverage. The newly eligible population was defined as ages 19 through 64. WIN Medicaid and WIN Marketplace enrollment includes the uninsured population along with those identified as being enrolled in the Individual Insurance market within the 2012 ACS data. The population assumed to be eligible for the WIN ESI Premium Support program includes those listed as being covered under employer sponsored insurance (ESI).

Methodology and Participation Assumptions

The total number eligible was reduced to reflect estimated participation rates. Participation rates used for this report are similar to midpoint participation estimates from the final LB 577 fiscal estimate projections, provided January 8, 2013 (the average between the mid-range participation scenario and the full participation scenario illustrated in the 2013 report). As in the 2013 report, participation assumptions included a considerable amount of actuarial judgment and varied by income level, parent status, and current source of insurance coverage (ESI, Individual Insurance, and Uninsured).

The participation scenarios are described individually below:

Full participation: Within a reasonable range of participation rates, the full participation scenario reflects the conservative or high end of the range, to be used for reference and discussion. It does not reflect participation of all eligible individuals; as illustrated in Table 4, it represents 75% participation by eligible individuals identified in the 2012 ACS census information.

Mid-Range participation: Within a reasonable range of participation rates, the mid-range participation is a lower estimate, corresponding to less available information and less efficient enrollment processes.

Average participation: This represents the arithmetic average of the full participation and mid-range participation scenarios. This set of participation assumptions was used in the January 8, 2013 report.

With Waiver: Adjustments have been made to the assumptions in the prior report to reflect the WIN ESI Premium support program, projected to be effective SFY 2016. Under previous projections, we had assumed that newly eligible individuals who were already enrolled in ESI plans would be less likely to enroll in Medicaid than the uninsured. During SFY 2015, we continue to use lower participation assumptions for those who are already enrolled in employer plans. However, when the WIN ESI premium support program becomes available, we have assumed that many of the individuals who chose to stay with their employer plan will now enroll in the program in order to begin receiving premium payment and cost sharing support from Medicaid. After approval of the WIN ESI premium support waiver, participation rates for those who are covered by employer sponsored insurance are projected to increase to 80%.

Table 4 illustrates ultimate participation rates by SFY 2016 program under each of the scenarios outlined.

Table 4 Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care Patient Protection and Affordable Care Act State Budget Enrollment Impact Ultimate Participation Rates				
Population, by SFY 2016 Program	Full Participation	Mid-Range (SPA)	Average (SPA)	With Waiver
WIN ESI Premium Support				
Medically Frail	70%	43%	56%	80%
Healthy, with income below 100% FPL	70%	41%	55%	80%
Healthy, with income between 100% FPL and 138% FPL	70%	44%	57%	80%
WIN Medicaid Coverage				
Medically Frail	77%	59%	68%	68%
Healthy, with income below 100% FPL	74%	56%	65%	65%
WIN Marketplace Coverage, 100% to 138% FPL and no ESI	82%	65%	73%	73%
Total	75%	53%	64%	72%

Please note that the only difference between the Average participation scenario used for expansion under the State Plan Amendment and the With Waiver participation scenario is higher rates of participation from those who are currently enrolled in employer plans.

As in the January 8, 2013 report, we assumed participation would be lower in the initial years of the Medicaid expansion resulting from the Affordable Care Act. Participation is projected to reach its ultimate level during SFY 2017. Table 5 outlines participation ramp up during the first three years of the Medicaid expansion. After Year 1, ramp up is illustrated under two scenarios: the State Plan Amendment (top section) and after approval of the waivers (bottom section). The two scenarios begin to vary in year 2 under the Waiver, as additional enrollment is assumed for the population currently enrolled in ESI coverage due to the WIN ESI Premium Support program.

Table 5 Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care Patient Protection and Affordable Care Act State Budget Enrollment Impact Participation Ramp Up			
Participation Assumptions: Medicaid Expansion under State Plan Amendment			
Population, by SFY 2016 Program	Year 1	Year 2	Year 3
WIN ESI Premium Support			
Medically Frail	24%	40%	56%
Healthy, with income below 100% FPL	24%	40%	55%
Healthy, with income between 100% FPL and 138% FPL	24%	41%	57%
WIN Medicaid Coverage			
Medically Frail	51%	57%	68%
Healthy, with income below 100% FPL	46%	53%	65%
WIN Marketplace Coverage, 100% to 138% FPL and no ESI	56%	62%	73%
Total	41%	51%	64%
Participation Assumptions: Medicaid Expansion with Waiver			
Population, by SFY 2016 Program	Year 1	Year 2	Year 3
WIN ESI Premium Support			
Medically Frail	24%	57%	80%
Healthy, with income below 100% FPL	24%	57%	80%
Healthy, with income between 100% FPL and 138% FPL	24%	57%	80%
WIN Medicaid Coverage			
Medically Frail	51%	57%	68%
Healthy, with income below 100% FPL	46%	53%	65%
WIN Marketplace Coverage, 100% to 138% FPL and no ESI	56%	62%	73%
Total	41%	57%	72%

For this preliminary report, we have assumed that all newly eligible enrollees who are currently enrolled in an employer sponsored health plan will enroll in the WIN ESI premium support program at the beginning of SFY 2016, although the medically frail with employer insurance will have an option to select the Medicaid state plan instead. As for those who are uninsured or are insured in the individual market, we have assumed those who are medically frail or have income under 100% FPL will enroll in WIN Medicaid coverage, while those with income at or above 100% FPL and are not medically frail are enrolled in WIN Marketplace Coverage.

Please note that one issue that has not yet been addressed in this report is that many of the uninsured have access to employer insurance. Approximately one third to one half of the uninsured population appears to be working full time for an employer with 50 or more employees, and likely a large percentage of these individuals have access to employer insurance. Survey data shows that many healthy low income enrollees choose not to enroll in employer plans because they are unable or unwilling to pay the employee share of the premium. To the extent that uninsured individuals choose to enroll in their employer plans now that Medicaid is supporting premium payments and cost sharing, this may shift individuals currently illustrated as enrolling in the WIN Marketplace program to the WIN ESI premium support program.

Medically Frail

The percentage of the population that qualifies as medically frail was estimated using the definition in Section 24 of LB 887. This definition appears broader than required by CMS, but this is explicitly allowed by regulations under 42 CFR 440.315, which specify that states may add other categories of individuals to the definition.

The legislation includes individuals with two chronic conditions or who have one chronic condition and are at risk of a second chronic condition. From claims data for adult enrollees from other state Medicaid TANF programs with similar eligibility (excluding the ABD population), it appears that approximately 25% of TANF enrollees would meet this criteria, with rates varying by age. This prevalence was reduced to approximately 15% to reflect lower morbidity in the newly eligible population.

Percentage Increase in Medicaid in Relation to the Total Number of Nebraskans

- Calendar Year 2012 Nebraska Census Estimate 1,855,000
- Currently, 13% of Nebraska residents are enrolled in Medicaid
- An additional 2% of Nebraska residents are projected to enroll due to the woodwork effect and required ACA provisions such as the foster child expansion
- An additional 4% of Nebraska residents are projected to enroll as part of the Medicaid expansion, should Nebraska choose to increase Medicaid eligibility to 138% of FPL

Final expected participation in the Medicaid program would be to 19%, or approximately 1 in 5 Nebraskans.

The remainder of this letter discusses development of the fiscal estimates for each of the populations listed in Table 1.

ANNUAL COST PER ENROLLEE

The fiscal impact associated with the Medicaid expansion to 138% FPL includes both currently insured and uninsured individuals with income below 138% FPL. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance under MAGI. The analysis presented in this report reflects estimated participation. The participation assumptions by population are presented in Tables 4 and 5. The assumed SFY 2016 average annual cost per enrollee is provided by population in Table 6.

Table 6 Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care Patient Protection and Affordable Care Act Average Annual Cost per Enrollee		
Population, by SFY 2016 program	SFY 2015 Annual Cost Under State Plan	SFY 2016 Annual Cost With Waivers
WIN ESI Premium Support		
Medically Frail	\$10,587	\$4,518
Healthy, with income below 100% FPL	\$3,423	\$4,527
Healthy, with income between 100% FPL and 138% FPL	\$3,282	\$4,508
WIN Medicaid Coverage		
Medically Frail	\$11,539	\$11,328
Healthy, with income below 100% FPL	\$3,655	\$3,583
WIN Marketplace Coverage, 100% to 138% FPL and no ESI	\$3,747	\$6,868

Medicaid State Plan Cost

Medicaid program cost estimates were developed from a combination of the 2014 contracted managed care capitation rates, the *Nebraska Medicaid Reform Annual Report* dated December 1, 2013, the Medicaid Statistical Information System (MSIS) State Summary Datamart, and other Medicaid expansion programs. Projected capitation rates reflect continuation of the ACA PCP reimbursement increase and have been loaded to reflect estimated Health insurer assessment fees and related taxes (estimated at 2.4% of rates). Other costs included in the Medicaid state plan cost include behavioral health capitation costs, and costs for services that have been carved out of the capitation costs, such as pharmacy and dental services.

The values in Table 4 reflect the age/gender mix of each population based upon the 2012 ACS census data. For example, the populations with income between 100% and 138% FPL has a different age/gender distribution than the corresponding population below 100% FPL, and this impacts expected average cost. The Medically Frail cost was estimated using adult claims data from other Medicaid TANF programs (excluding ABD population). The cost differential between Medically Frail and healthy reflects the cost differential between the TANF subpopulation that suffers from chronic illness and the remainder who do not.

WIN Exchange Cost

The estimated cost to cover enrollees on the Exchange is estimated to be higher than under the Medicaid State Plan. Primarily this is due to higher provider reimbursement on the exchange (commercial reimbursement rather than Medicaid rates). We have also assumed Medicaid pharmacy rebates will not be collected for exchange enrollees.

Actual silver plan cost: To develop the WIN Exchange cost estimate, Milliman started by researching actual silver plan costs on the Nebraska health exchange, stratified by county, age and gender. The average cost was developed for each stratification, then a composite (weighted average) was developed to reflect the county, age and gender distribution of the population of uninsured Nebraska adults with income between 100% FPL and 138% FPL.

100% Cost sharing: Silver plans are designed to have actuarial value of approximately 70%. This means that on average, the premium covers 70% of health care costs, and the other 30% is funded through member cost sharing such as deductibles, copayments, and coinsurance. Since the WIN exchange plans will cover all cost sharing, the silver plan price was increased to reflect 100% cost sharing. In performing this adjustment, it was assumed that 15% of the exchange premium was related to administration, profit, and contingency.

Induced Utilization: Silver plans are priced assuming that cost sharing encourages members to be wiser consumers, to ask questions before undergoing additional testing or elective surgery, to use primary care or urgent care instead of the emergency room, and to stay up to date on preventive services. In the absence of financial consequences, there is significant data showing that people tend to use more services. CMS' risk adjustment methodology for exchange plans adds 12% induced utilization for low income members who are eligible for cost sharing reductions on the exchange. The cost of induced utilization for WIN Exchange enrollees will be spread across all those who purchase a silver plan on the exchange. As a result, Milliman only increased the average cost of the WIN Exchange program by 1.5% for induced utilization. Please note that the WIN Exchange program is expected to increase the cost of all silver plans on Nebraska's exchange by 1.5%.

Additional Benefits: WIN Exchange plans will separately provide Medicaid benefits not normally provided on the exchange, such as dental benefits, EPSDT, and non-emergency transportation. Milliman estimated that the current cost of these benefits for adults is approximately \$30 per member per month.

Monthly Contributions: LB 887 provides for monthly contributions of 2% of income from WIN exchange enrollees who did not receive recommended wellness services during the prior year. Starting with the second year of the program, the average annual cost was reduced assuming approximately 10% of enrollees pay these premiums. The cost of monitoring compliance with wellness programs and collecting premiums is an administrative cost that is not estimated in this report.

WIN Employer Sponsored Insurance Premium Support Program Cost

The cost to cover enrollees through the WIN ESI Premium Support program is estimated to be lower than on the exchange, but in most cases higher than under the Medicaid State Plan. As with WIN Exchange enrollees, the base cost is higher due primarily to provider reimbursement (commercial reimbursement rather than Medicaid rates), but for the WIN ESI premium support program, this cost is offset by the amount contributed by the employer. We have also assumed Medicaid pharmacy rebates will not be collected for WIN ESI Premium Support enrollees.

Premium Cost: The WIN Employer Sponsored Insurance (ESI) Premium Support program will pay the employee portion of premium costs. This was estimated based on actual employer costs in the State of Nebraska, as sampled in the 2012 Medical Expenditure Panel Survey (MEPS). The survey provided average premiums and average employee contributions for single (employee only) coverage. The information was stratified by wage quartile, allowing Milliman to make adjustments to reflect a lower income employee population, with the employee share of the premium averaging 30%. (Please note that the WIN ESI premium support program is not limited to employees, but will also cover individuals who have access to employer sponsored insurance through a family member. Single (employee only) coverage was used to develop premium costs because the premium for family coverage generally applies to two or more individuals and we wished to develop a one-person premium cost.)

Cost Sharing: In addition to paying the employees' share of the premium, Medicaid will cover employee cost sharing. To estimate this, we assumed the average plan covered 70% of total allowed costs (roughly a silver plan) and included a 15% margin for administration, profit, and contingency.

Additional Benefits: As with the WIN Exchange enrollees, Medicaid will also pay for wraparound dental, EPSDT, and non-emergency transportation benefits.

Monthly Contributions: Average annual costs were reduced to reflect 10% of enrollees making contributions of 2% of income, beginning in the second year of the program.

Cost Effectiveness: Section 38 of Legislative Bill 887 stipulates that the WIN ESI Premium Support program is only available in cases where the department has determined that it is cost effective. Criteria for cost effectiveness has not been fully clarified in the legislation, and is difficult to evaluate for individuals on a prospective basis. This is mainly because the cost sharing and additional benefit component costs are unknown and depend on service utilization during the coming year. For those who do not utilize medical services or only have a preventive service visit, these components may be \$0. For this analysis, the cost effectiveness evaluation has been assumed to compare the employee share of premium under WIN ESI to the alternative program cost (WIN Exchange or WIN Medicaid). However, if the determination of cost effectiveness were to include the *average* cost of employee cost sharing and additional benefits, we have estimated that the WIN ESI premium support program will generally be cost effective for those over 100% FPL (cost will compare favorably to WIN Marketplace), but not be cost effective for those under 100% FPL (cost will compare unfavorably to WIN Medicaid).

Monthly Contributions for Medicaid Enrollees Above 50% FPL

Section 43(2) of LB 887 also provides for contributions of 2% of income for expansion enrollees in the regular Medicaid program with income above 50% FPL, to the extent that they did not receive required preventive care services and wellness activities during the prior year. Although there are no enforceable consequences for enrollees who fail to make contributions, we have assumed that approximately 70% comply – 60% by receiving required services, and 10% by making contributions of 2% of income. Starting with the second year of the program, the average annual cost was reduced to reflect this.

Trend

We assumed annual expenditure trends consistent with DHHS budget projections through SFY 2013, with growth in all other years of 2.5% for capitated expenditures and 3.5% for FFS expenditures. The expansion population enrolled under the Medicaid state plan is expected to enroll in the Medicaid managed care program, including managed behavioral health. However dental and pharmacy services for these individuals are assumed to continue being delivered through FFS.

Federal Medical Assistance Percentage

The Affordable Care Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

For simplicity, it was assumed that the enhanced FMAPs above apply to all of the newly eligible. We anticipate it will apply to almost all of the newly eligible, all but a few low income disabled individuals who meet the current income standard but do not meet the resource requirement.

Administration

In addition to the expenditures associated with providing medical services, Nebraska is expected to incur additional administrative expenditures related to implementation of the Affordable Care Act. On-going costs for the coverage of the additional Medicaid expansion enrollees were developed assuming approximately \$200 per recipient per year, or approximately 5.8% of total expected medical expenditures. Based on our experience with Medicaid programs, state Medicaid administrative costs range from 3.5% to 6.0% of total medical costs. The administrative expenses were assumed to be incurred beginning in SFY2015.

The Federal Financial Participation (FFP) for these administrative services was assumed to be 75% for 80% of the cost, and 50% for the remaining 20% of the administrative cost. This results in a weighted average FFP of 70%.

Administrative services related to IT systems improvement or additional costs for implementing and maintaining the WIN waiver programs were not included in this analysis.

ACA Health Insurer Assessment Fee

Effective 2014, the ACA requires an excise tax, called the health insurer assessment fee, based on health plan market share of premium. Milliman prepared a report for the Medicaid Health Plans of America which estimated the impact of this fee for Medicaid managed care plans by state. The impact includes both the impact of the expected fee that will be assessed to Medicaid MCOs as well as the additional impact to account for the fact that plans will be receiving additional taxable income. Managed care capitation rates will need to increase in order to fund these additional amounts. We assumed Nebraska's capitation rates would increase by 2.4% to adequately fund the health insurer assessment fee.

This report is focused solely on the expansion population and does not illustrate the cost of the health insurer assessment fee related to existing Medicaid populations or the woodwork population. However, per member per year values developed for the expansion population have been adjusted, where appropriate, to reflect this required fee.

Physician Fee Schedule Increase to Medicare Rates

In November 2010, we conducted an analysis of the Nebraska Medicaid program's physician fees in comparison to the Medicare fee schedule. The results of this analysis included the observation that the SFY 2011 Nebraska Medicaid fee schedule reimbursement was approximately 71.7% of the Medicare fee schedule for affected service categories. The Affordable Care Act requires an increase in the Medicaid physician fee schedule for all Evaluation and Management (E&M) preventive care services to 100% of the Medicare physician fee schedule. 100% federal funding is available for calendar years 2013 and 2014. No additional funding is available for other physician services.

We have assumed that DHHS will increase the fee schedule for the required services for primary care providers only and will continue the increased fee schedule after calendar year 2014 to assure continued member access to physician care.

The portion of the cost for the newly eligible population related to enhanced reimbursement for primary care physicians is estimated to be approximately \$5.6 million (State and Federal) for SFY 2015, and \$3.1 million for SFY 2016 after implementation of the waivers. The per member per year values already reflect this cost. Please note that the cost is lower after implementation of the waivers because the physician fee schedule increase only impacts costs for those under the WIN Medicaid program.

State Disability Shift to Medicaid Newly Eligible

The State of Nebraska currently covers the State Disability Program (SDP) population to 100% FPL with 100% state funds. We utilized FFY 2014 DHHS expenditures estimates for the State Disability population, assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.38/1.33 to reflect expansion to the 138% FPL level. The additional enrollment from expansion of the SDP has been offset in the Medically Frail population without employer insurance, to avoid double counting.

After the Medicaid expansion, SDP enrollees will qualify for Medicaid as newly eligible, and will receive enhanced federal funding. This is illustrated as a savings to the state.

Impact of Twelve Month Continuous Eligibility or a Twelve Month Renewal Period

Section 44 of LB 887 states that "Following initial enrollment, a member is eligible for covered benefits for twelve months, subject to program termination and other limitations specified by the Department."

For purposes of other sections of this report, projections reflect the assumption that "other limitations specified by the department" describes a process that does not differ substantively from current processes applied to Medicaid parents.

Under the current process, eligibility renewals occur once each year, but participants are required to report a change that might affect eligibility, such as a change in income or family structure.

An alternative interpretation of Section 44 is that this is legislative direction to provide 12 months of continuous eligibility for the new adult group. Under continuous eligibility, after an individual is determined eligible and enters the program, the individual is guaranteed coverage for 12 full months, regardless of whether a later change in circumstances (such as increased income) would make him or her ineligible.

If the state were to adopt continuous eligibility for the new adult group, we may anticipate the following qualitative changes:

- Additional months of coverage
- Average monthly cost per enrollee might decline slightly

These will be separately discussed in more detail below.

Additional months of coverage

Under the current Nebraska Medicaid program, parents retain Medicaid coverage for an average of 8.5 months after initial eligibility determination. Continuous eligibility would increase average coverage to 12 months, increasing coverage months by more than 40%.

Income fluctuations are not expected to have as significant an impact for the new adult group because the income standard (138% FPL) will be higher than the current parent standard, but based on an analysis of the children, who have a comparable income standard, we estimate a covered month increase of approximately 20% to 25%.

Average Monthly Cost for Additional Months of Coverage

The average for additional months of coverage may decline due to lower utilization during the additional months. Because individuals often enroll in Medicaid when they have a medical need, initial utilization tends to be highest. After initial needs are met, utilization tends to stabilize. Based on a series of analyses of Medicare Expenditure Panel Survey (MEPS), Ku et al provides estimates for how the average monthly cost of adult Medicaid coverage varies by duration of enrollment. Milliman has used this data to estimate a 50% reduction in utilization for additional months of coverage.

Under WIN Medicaid for the State Plan Amendment, the reduced utilization will translate into reduced cost. However, for those enrolled in WIN ESI or WIN marketplace, reduced utilization would be spread over the whole employer or exchange market, and the change would be too small to affect overall premiums.

Table 7 provides a high level summary of the estimated impact of 12-month of continuous eligibility. These values represent a reasonable range for the expected cost of converting to 12-month continuous eligibility for the new adult group, by type of program. The total estimated state and federal cost is between \$520 million and \$690 million during the period SFY 2015 to SFY 2020.

Table 7 Nebraska Department of Health and Human Services Division of Medicaid and Long Term Care Patient Protection and Affordable Care Act Estimated Impact of 12-month Continuous Eligibility (SFY 2015 to SFY 2020)		
Population	WIN Medicaid Population	WIN Marketplace and WIN ESI Premium Support
Change to Coverage Months	+20% to 25%	+20% to 25%
Change to Average Monthly Cost for Additional Coverage	(40%) to (50%)	Negligible
Overall Change to Cost	+10% to 15%	+20% to 25%
Overall Net Impact (State and Federal, \$ millions)	\$140 to \$210	\$380 to \$480

CMS has proposed a 94% FMAP for providing continuous eligibility to the new adult group, with a 2.6% adjustment accounting for those individuals who may not have been eligible for the entirety of the eligibility period.

In addition to the direct cost, there may ultimately be an indirect cost from upgrading continuous coverage for children and others who are currently eligible for Medicaid.

The estimates in Table 7 assume no change to administrative costs. Although more coverage months are anticipated, continuous eligibility entails certain administrative simplifications, such as less frequent renewals and verification activity.

OTHER COSTS NOT ITEMIZED IN THIS REPORT

This report addresses solely the Medicaid expansion population (newly eligible) and the fiscal impact of programs proposed under the Wellness in Nebraska Act (LB 887). This report attempts to quantify the cost for major programs proposed in the bill. However, there are some portions of the bill that have not been addressed in this report, but which have the potential to result in either additional cost or savings to the state. These include, but are not limited to, the following:

- Potential savings from wider use of patient-centered medical homes and ACOs: These innovations have the potential to both improve outcomes and reduce cost. However, we have not quantified potential savings in this report for several reasons. For one, savings documented in the published studies varies widely, and appears to rely heavily on implementation details which have not been clearly specified in the legislation. Second, the implementation date is delayed, phased in, and not clearly specified in the legislation. And finally, during initial years of implementation, set-up and training costs will likely offset savings until the program is functioning smoothly.
- Potential savings from increased competition among carriers and price pressure on providers was estimated to save 5% of cost for the Arkansas private option. The rationale is that since providers will be spending less time on uncompensated care, they will have the capacity to lower reimbursement, and competitive insurance companies will provide the needed pressure. This may ultimately emerge, but at the present time, the market power of providers seems to outweigh that of insurers. We would prefer to wait until this begins to emerge before providing an estimate.

Aside from the Medicaid expansion population (newly eligible), the Affordable Care Act includes many other mandates or state options for most of which Milliman has previously provided estimated fiscal impacts. Other impacts not addressed in this report include, but are not limited to, the following:

- Additional woodwork/welcome mat enrollment from those who are currently eligible but un-enrolled
- Expansion of coverage for former foster care children to age 26
- The cost of enhanced physician reimbursement for the current Medicaid population after 2014
- ACA Health Insurer Fee on managed care provided to the current Medicaid population (the ACA Health Insurer Fee applicable to the expansion population has been included in the annual costs in this report)
- DSH Reduction
- CHIP FMAP increase (savings to the State)
- Potential elimination of the Breast and Cervical Cancer program after the expansion (savings to the State)
- Potential elimination of the Transitional Medical Assistance program after the expansion (savings to the State)

REFORM ESTIMATE MODELING UPDATES

We updated estimates through SFY 2020 in this report. In developing this updated report, we used sources of data and information that have emerged since the last report. This information resulted in significant changes in the fiscal impact estimates. The following items can be identified as key sources underlying these changes.

- **Nebraska Medicaid managed care capitation rates.** The per member per month costs under the Medicaid program were developed using the January 1, 2014 through December 31, 2014 Medicaid physical managed care capitation rates, 2013 increases for enhanced primary care physician reimbursement (trended to 2014), and the September 2013 through June 2014 behavioral managed care rates. These rates represent the average costs of a population with characteristics similar to that of the individuals who will be enrolling in Medicaid with the Affordable Care Act expansion. We added components of cost to represent pharmacy and dental services since these are not included in the capitation rates.
- **December 2013 Nebraska Medicaid Annual Report.** Emerging Medicaid experience in the State of Nebraska is lower in recent years than previous budget projections had estimated.
- **2012 American Community Census data.** We have worked to develop algorithms for ACS census information to help us better stratify segments of the population. We have applied a more refined calculation of income level than is available in sources used previously for this purpose. Having these more detailed data has allowed us to develop better estimates of the population which will be eligible for the Medicaid expansion, including the characteristics we used to estimate behavior in the reform environment. We developed average monthly eligible population estimates for each segment of interest and applied participation assumptions to determine average monthly enrolled population estimates.
- **Silver Plan Exchange Costs.** These were developed by requesting online quotes from all carriers for individuals in all counties and age and gender groups. An average cost was developed for each age/gender group. A final weighted average cost was then developed to reflect the age and gender makeup of the population eligible for the WIN exchange program.
- **Affordable Care Act clarifications and research reports.** CMS has released certain proposed and final rules for the Affordable Care Act which provide clarification and subsequently change how certain elements of the reform should be estimated. Additionally, research papers are continuously being published containing analysis for various elements of the Affordable Care Act. These analyses have allowed us to estimate fiscal impacts for Nebraska which were not previously accessible. We have updated the report to reflect these sources for the following items.
 - Medicaid rate increase to the Medicare physician fee schedule for evaluation and management (E&M) services provided by primary care providers. Our updated analysis reflects actual 2013 payments made for this reimbursement increase.

LIMITATIONS

The information contained in this report has been prepared for the State of Nebraska, Department of Health and Human Services (DHHS), Division of Medicaid and Long Term Care, to assist with estimating the fiscal impact of the Medicaid expansion under the Affordable Care Act (ACA). The data and information presented may not be appropriate for any other purpose.

The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by DHHS, as well as enrollment and expenditure data obtained from the Medicaid Statistical Information System (MSIS) State Summary Datamart and the Nebraska Medicaid Annual Report dated December 1, 2013. Milliman has also relied on Nebraska data from the U.S. Census Bureau's American Community Survey. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

The projections in this report are based on our understanding of the ACA, its associated regulations issued to date, and Nebraska LB 887. Forthcoming ACA-related regulations may materially impact the values in this report. Similarly, to the extent that the plan design proposed in LB 887 is modified during negotiations with CMS, the changes may also materially impact the values in this report. For this reason, this report should be considered time-sensitive material which may change as new information becomes available.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and DHHS, as amended December 30, 2013.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The author of this report, Mr. Robert M. Damler, is a principal and consulting actuary in the Indianapolis office of Milliman. He is also a member of the American Academy of Actuaries, and meets the qualification standards for performing the analyses in this report.

Enclosure 1

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Participation: Average of Mid-Range and Full Participation Scenarios - Under State Plan

EXPENDITURES	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2015 - SFY 2020
SPA Medicaid Coverage - Current Employer Sponsored Insurance							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	1,785	3,005	4,249	4,292	4,335	4,378	
Annual Per-Person Cost Estimate	\$ 10,587	\$ 10,515	\$ 10,541	\$ 10,618	\$ 10,804	\$ 10,992	\$ 10,697
Total Funds Estimate (State and Federal)	\$ 18,900,000	\$ 31,600,000	\$ 44,800,000	\$ 45,600,000	\$ 46,800,000	\$ 48,100,000	\$ 235,800,000
Federal Funds Estimate	\$ 18,900,000	\$ 31,600,000	\$ 43,700,000	\$ 43,100,000	\$ 43,800,000	\$ 44,000,000	\$ 225,100,000
State Funds Estimate	\$ 0	\$ 0	\$ 1,100,000	\$ 2,500,000	\$ 3,000,000	\$ 4,100,000	\$ 10,700,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	5,128	8,633	12,207	12,329	12,452	12,577	
Annual Per-Person Cost Estimate	\$ 3,423	\$ 3,400	\$ 3,408	\$ 3,433	\$ 3,493	\$ 3,554	\$ 3,459
Total Funds Estimate (State and Federal)	\$ 17,600,000	\$ 29,300,000	\$ 41,600,000	\$ 42,300,000	\$ 43,500,000	\$ 44,700,000	\$ 219,000,000
Federal Funds Estimate	\$ 17,600,000	\$ 29,300,000	\$ 40,600,000	\$ 40,000,000	\$ 40,700,000	\$ 40,900,000	\$ 209,100,000
State Funds Estimate	\$ 0	\$ 0	\$ 1,000,000	\$ 2,300,000	\$ 2,800,000	\$ 3,800,000	\$ 9,900,000
Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	5,281	8,890	12,571	12,697	12,824	12,952	
Annual Per-Person Cost Estimate	\$ 3,282	\$ 3,260	\$ 3,268	\$ 3,292	\$ 3,350	\$ 3,408	\$ 3,317
Total Funds Estimate (State and Federal)	\$ 17,300,000	\$ 29,000,000	\$ 41,100,000	\$ 41,800,000	\$ 43,000,000	\$ 44,100,000	\$ 216,300,000
Federal Funds Estimate	\$ 17,300,000	\$ 29,000,000	\$ 40,100,000	\$ 39,500,000	\$ 40,200,000	\$ 40,400,000	\$ 206,500,000
State Funds Estimate	\$ 0	\$ 0	\$ 1,000,000	\$ 2,300,000	\$ 2,800,000	\$ 3,700,000	\$ 9,800,000
SPA Medicaid Coverage - Current Individual Insured or Uninsured							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	6,780	7,722	9,358	9,453	9,549	9,646	
Annual Per-Person Cost Estimate	\$ 11,539	\$ 11,350	\$ 11,204	\$ 10,920	\$ 11,111	\$ 11,305	\$ 11,219
Total Funds Estimate (State and Federal)	\$ 78,200,000	\$ 87,600,000	\$ 104,800,000	\$ 103,200,000	\$ 106,100,000	\$ 109,000,000	\$ 588,900,000
Federal Funds Estimate	\$ 78,200,000	\$ 87,600,000	\$ 102,200,000	\$ 97,500,000	\$ 99,200,000	\$ 99,700,000	\$ 564,400,000
State Funds Estimate	\$ 0	\$ 0	\$ 2,600,000	\$ 5,700,000	\$ 6,900,000	\$ 9,300,000	\$ 24,500,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	23,644	27,285	33,931	34,270	34,613	34,959	
Annual Per-Person Cost Estimate	\$ 3,655	\$ 3,596	\$ 3,546	\$ 3,459	\$ 3,520	\$ 3,581	\$ 3,553
Total Funds Estimate (State and Federal)	\$ 86,400,000	\$ 98,100,000	\$ 120,300,000	\$ 118,600,000	\$ 121,800,000	\$ 125,200,000	\$ 670,400,000
Federal Funds Estimate	\$ 86,400,000	\$ 98,100,000	\$ 117,300,000	\$ 112,100,000	\$ 113,900,000	\$ 114,600,000	\$ 642,400,000
State Funds Estimate	\$ 0	\$ 0	\$ 3,000,000	\$ 6,500,000	\$ 7,900,000	\$ 10,600,000	\$ 28,000,000

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Participation: Average of Mid-Range and Full Participation Scenarios - Under State Plan

EXPENDITURES	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2015 - SFY 2020
SPA Medicaid Coverage - Current Individual Insured or Uninsured Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	16,895	19,001	22,550	22,776	23,004	23,234	
Annual Per-Person Cost Estimate	\$ 3,747	\$ 3,667	\$ 3,589	\$ 3,491	\$ 3,552	\$ 3,614	\$ 3,602
Total Funds Estimate (State and Federal)	\$ 63,300,000	\$ 69,700,000	\$ 80,900,000	\$ 79,500,000	\$ 81,700,000	\$ 84,000,000	\$ 459,100,000
Federal Funds Estimate	\$ 63,300,000	\$ 69,700,000	\$ 78,900,000	\$ 75,100,000	\$ 76,400,000	\$ 76,900,000	\$ 440,300,000
State Funds Estimate	\$ 0	\$ 0	\$ 2,000,000	\$ 4,400,000	\$ 5,300,000	\$ 7,100,000	\$ 18,800,000
State Disability Program - Shift to Medicaid as Newly Eligible							
Population Estimate	154	154	154	154	154	154	
Annual Per-Person Cost Estimate	\$ 21,748	\$ 22,400	\$ 23,072	\$ 23,765	\$ 24,477	\$ 25,212	\$ 23,446
Total Funds Estimate (State and Federal)	\$ 3,300,000	\$ 3,400,000	\$ 3,600,000	\$ 3,700,000	\$ 3,800,000	\$ 3,900,000	\$ 21,700,000
Federal Funds Estimate	\$ 12,500,000	\$ 12,900,000	\$ 12,900,000	\$ 12,900,000	\$ 13,200,000	\$ 13,300,000	\$ 77,700,000
State Funds Estimate	\$ (9,200,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (9,300,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (56,100,000)
Administrative Expenses For New Enrollment							
Population Estimate	59,668	74,690	95,020	95,970	96,930	97,899	
Annual Per-Person Cost Estimate	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200
Total Funds Estimate (State and Federal)	\$ 11,900,000	\$ 14,900,000	\$ 19,000,000	\$ 19,200,000	\$ 19,400,000	\$ 19,600,000	\$ 104,000,000
Federal Funds Estimate	\$ 8,300,000	\$ 10,400,000	\$ 13,300,000	\$ 13,400,000	\$ 13,600,000	\$ 13,700,000	\$ 72,700,000
State Funds Estimate	\$ 3,600,000	\$ 4,500,000	\$ 5,700,000	\$ 5,800,000	\$ 5,800,000	\$ 5,900,000	\$ 31,300,000
Total Change to Budget Due to Medicaid Expansion							
Population Estimate	59,668	74,690	95,020	95,970	96,930	97,899	
Total (State and Federal)	\$ 296,900,000	\$ 363,600,000	\$ 456,100,000	\$ 453,900,000	\$ 466,100,000	\$ 478,600,000	\$ 2,515,200,000
Federal Funds	\$ 302,500,000	\$ 368,600,000	\$ 449,000,000	\$ 433,600,000	\$ 441,000,000	\$ 443,500,000	\$ 2,438,200,000
State Funds	\$ (5,600,000)	\$ (4,900,000)	\$ 7,000,000	\$ 20,200,000	\$ 25,100,000	\$ 35,100,000	\$ 76,900,000

Enclosure 2

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Participation: Average of Mid-Range and Full Participation Scenarios - With Waivers

EXPENDITURES	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2015 - SFY 2020
WIN ESI Premium Support							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	2,537	4,270	6,038	6,099	6,160	6,221	
Annual Per-Person Cost Estimate	\$ 4,285	\$ 4,518	\$ 4,790	\$ 5,078	\$ 5,384	\$ 5,708	\$ 5,067
Total Funds Estimate (State and Federal)	\$ 10,900,000	\$ 19,300,000	\$ 28,900,000	\$ 31,000,000	\$ 33,200,000	\$ 35,500,000	\$ 158,800,000
Federal Funds Estimate	\$ 10,900,000	\$ 19,300,000	\$ 28,200,000	\$ 29,300,000	\$ 31,000,000	\$ 32,500,000	\$ 151,200,000
State Funds Estimate	\$ 0	\$ 0	\$ 700,000	\$ 1,700,000	\$ 2,200,000	\$ 3,000,000	\$ 7,600,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	7,424	12,497	17,670	17,847	18,025	18,206	
Annual Per-Person Cost Estimate	\$ 4,285	\$ 4,527	\$ 4,799	\$ 5,088	\$ 5,394	\$ 5,718	\$ 5,076
Total Funds Estimate (State and Federal)	\$ 31,800,000	\$ 56,600,000	\$ 84,800,000	\$ 90,800,000	\$ 97,200,000	\$ 104,100,000	\$ 465,300,000
Federal Funds Estimate	\$ 31,800,000	\$ 56,600,000	\$ 82,700,000	\$ 85,800,000	\$ 90,900,000	\$ 95,300,000	\$ 443,100,000
State Funds Estimate	\$ 0	\$ 0	\$ 2,100,000	\$ 5,000,000	\$ 6,300,000	\$ 8,800,000	\$ 22,200,000
Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	7,416	12,483	17,651	17,828	18,006	18,186	
Annual Per-Person Cost Estimate	\$ 4,285	\$ 4,508	\$ 4,780	\$ 5,068	\$ 5,374	\$ 5,698	\$ 5,058
Total Funds Estimate (State and Federal)	\$ 31,800,000	\$ 56,300,000	\$ 84,400,000	\$ 90,400,000	\$ 96,800,000	\$ 103,600,000	\$ 463,300,000
Federal Funds Estimate	\$ 31,800,000	\$ 56,300,000	\$ 82,300,000	\$ 85,400,000	\$ 90,500,000	\$ 94,800,000	\$ 441,100,000
State Funds Estimate	\$ 0	\$ 0	\$ 2,100,000	\$ 5,000,000	\$ 6,300,000	\$ 8,800,000	\$ 22,200,000
WIN Medicaid Coverage							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	6,780	7,722	9,358	9,453	9,549	9,646	
Annual Per-Person Cost Estimate	\$ 11,539	\$ 11,328	\$ 11,182	\$ 10,898	\$ 11,088	\$ 11,281	\$ 11,200
Total Funds Estimate (State and Federal)	\$ 78,200,000	\$ 87,500,000	\$ 104,600,000	\$ 103,000,000	\$ 105,900,000	\$ 108,800,000	\$ 588,000,000
Federal Funds Estimate	\$ 78,200,000	\$ 87,500,000	\$ 102,000,000	\$ 97,300,000	\$ 99,000,000	\$ 99,600,000	\$ 563,600,000
State Funds Estimate	\$ 0	\$ 0	\$ 2,600,000	\$ 5,700,000	\$ 6,900,000	\$ 9,200,000	\$ 24,400,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	23,644	27,285	33,931	34,270	34,613	34,959	
Annual Per-Person Cost Estimate	\$ 3,655	\$ 3,583	\$ 3,532	\$ 3,446	\$ 3,506	\$ 3,567	\$ 3,541
Total Funds Estimate (State and Federal)	\$ 86,400,000	\$ 97,800,000	\$ 119,900,000	\$ 118,100,000	\$ 121,400,000	\$ 124,700,000	\$ 668,300,000
Federal Funds Estimate	\$ 86,400,000	\$ 97,800,000	\$ 116,900,000	\$ 111,600,000	\$ 113,500,000	\$ 114,100,000	\$ 640,300,000
State Funds Estimate	\$ 0	\$ 0	\$ 3,000,000	\$ 6,500,000	\$ 7,900,000	\$ 10,600,000	\$ 28,000,000

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Participation: Average of Mid-Range and Full Participation Scenarios - With Waivers

EXPENDITURES	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2015 - SFY 2020
WIN Marketplace Coverage							
Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	16,895	19,001	22,550	22,776	23,004	23,234	
Annual Per-Person Cost Estimate	\$ 6,201	\$ 6,868	\$ 7,563	\$ 8,092	\$ 8,579	\$ 9,095	\$ 7,836
Total Funds Estimate (State and Federal)	\$ 104,800,000	\$ 130,500,000	\$ 170,600,000	\$ 184,300,000	\$ 197,300,000	\$ 211,300,000	\$ 998,800,000
Federal Funds Estimate	\$ 104,800,000	\$ 130,500,000	\$ 166,300,000	\$ 174,200,000	\$ 184,500,000	\$ 193,300,000	\$ 953,600,000
State Funds Estimate	\$ 0	\$ 0	\$ 4,300,000	\$ 10,100,000	\$ 12,800,000	\$ 18,000,000	\$ 45,200,000
State Disability Program - Shift to Medicaid as Newly Eligible							
Population Estimate	154	154	154	154	154	154	
Annual Per-Person Cost Estimate	\$ 21,748	\$ 22,400	\$ 23,072	\$ 23,765	\$ 24,477	\$ 25,212	\$ 23,446
Total Funds Estimate (State and Federal)	\$ 3,300,000	\$ 3,400,000	\$ 3,600,000	\$ 3,700,000	\$ 3,800,000	\$ 3,900,000	\$ 21,700,000
Federal Funds Estimate	\$ 12,500,000	\$ 12,900,000	\$ 12,900,000	\$ 12,900,000	\$ 13,200,000	\$ 13,300,000	\$ 77,700,000
State Funds Estimate	\$ (9,200,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (9,300,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (56,100,000)
Administrative Expenses For New Enrollment							
Population Estimate	64,849	83,412	107,353	108,426	109,510	110,605	
Annual Per-Person Cost Estimate	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200
Total Funds Estimate (State and Federal)	\$ 13,000,000	\$ 16,700,000	\$ 21,500,000	\$ 21,700,000	\$ 21,900,000	\$ 22,100,000	\$ 116,900,000
Federal Funds Estimate	\$ 9,100,000	\$ 11,700,000	\$ 15,100,000	\$ 15,200,000	\$ 15,300,000	\$ 15,500,000	\$ 81,900,000
State Funds Estimate	\$ 3,900,000	\$ 5,000,000	\$ 6,400,000	\$ 6,500,000	\$ 6,600,000	\$ 6,600,000	\$ 35,000,000
Total Change to Budget Due to Medicaid Expansion							
Population Estimate	64,849	83,412	107,353	108,426	109,510	110,605	
Total (State and Federal)	\$ 360,200,000	\$ 468,100,000	\$ 618,300,000	\$ 643,000,000	\$ 677,500,000	\$ 714,000,000	\$ 3,481,100,000
Federal Funds	\$ 365,500,000	\$ 472,600,000	\$ 606,400,000	\$ 611,700,000	\$ 637,900,000	\$ 658,400,000	\$ 3,352,500,000
State Funds	\$ (5,300,000)	\$ (4,400,000)	\$ 11,800,000	\$ 31,200,000	\$ 39,600,000	\$ 55,600,000	\$ 128,500,000