



Nebraska ACA Fiscal Impact Estimate

Updated to Reflect Legislative Bill 472

State of Nebraska, Department of Health and Human Services

Prepared for:
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

Mr. Jason A. Clarkson
FSA, MAAA
Actuary

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

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

milliman.com

Table of Contents

BACKGROUND	2
SUMMARY OF RESULTS	3
Patient Protection and Affordable Care Act – Fiscal Impact estimate	3
Estimated ACA Enrollment Impact.....	5
Data	5
Methodology and Participation Assumptions	6
Medically Frail	8
Annual Cost per Enrollee	8
Medicaid State Plan Cost.....	9
Exchange Cost.....	10
Employer Sponsored Insurance Premium Support Program Cost.....	10
Monthly Contributions for Medicaid Enrollees Above 50% FPL	11
Trend	11
Federal Medical Assistance Percentage	12
Administration	12
State Disability Shift to Medicaid Newly Eligible.....	12
Other Costs Not Itemized in this Report.....	12
Reform Estimate Modeling Updates	14
LIMITATIONS	15

Enclosure 1: Fiscal impact detail by SFY and population – Medicaid State Plan Amendment

Enclosure 2: Fiscal impact detail by SFY and population – With Approved Waivers

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 472 (LB472), the “Medicaid Redesign Act” (MRA), 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 by the Medicaid Redesign Task Force within 12 months of the implementation of the bill.

It is assumed that the waivers developed will customize Nebraska’s program in a similar manner to what was outlined under Legislative Bill 887, including 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;
- Incorporation of innovative models including patient-centered medical homes, health homes for newly eligible superutilizers, and value-based payments;
- Options for the medically frail to allow them to opt in to the 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 prior fiscal impact estimate, provided February 25, 2014, in order to reflect the program proposed in LB472.

This report primarily concerns costs for SFY 2016 through SFY 2018. The enclosures and Table 2 also include projections through SFY 2021.

The scope of this report is limited to a projection of the financial impact of LB472, as it relates to Medicaid expansion, on Nebraska state and federal Medicaid expenditures. The report is not a total economic analysis of LB472 on other state agencies or state revenues. DHHS can use the results of this report, along with its own determination of the potential benefits of expanding Medicaid coverage, as it considers whether or not to expand Medicaid eligibility under LB472.

SUMMARY OF RESULTS

PATIENT PROTECTION AND AFFORDABLE CARE ACT – FISCAL IMPACT ESTIMATE

We have updated estimates of the enrollment and fiscal impact associated with the newly eligible population under a Medicaid expansion in order to reflect LB472, known as the Medicaid Redesign Act (MRA). These estimates also reflect updated data sources and assumptions based on emerging experience from states that expanded Medicaid during 2014. Estimates in Table 1 illustrate the projected fiscal impact for state fiscal years (SFY) 2016 through 2018.

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: SFY 2016 through SFY 2018 (Values illustrated in \$millions)			
STATE IMPACT			
Population, by Waiver Program	SFY 2016 Under SPA	SFY 2017 Transition	SFY 2018 With Waiver
ESI Premium Support			
Medically Frail	\$ 0.0	\$ 0.9	\$ 1.6
Healthy, with income below 100% FPL	\$ 0.0	\$ 1.6	\$ 5.1
Healthy, with income between 100% FPL and 138% FPL	\$ 0.0	\$ 1.6	\$ 4.9
Medicaid Coverage			
Medically Frail, with no ESI	\$ 0.0	\$ 2.6	\$ 6.2
Healthy, with income below 100% FPL and no ESI	\$ 0.0	\$ 3.5	\$ 8.2
Marketplace Coverage, 100% to 138% FPL and no ESI	\$ 0.0	\$ 3.5	\$ 11.7
State Disability Program, Shift to Medicaid as Newly Eligible	(\$ 9.4)	(\$ 9.4)	(\$ 9.3)
Administrative Cost for enrollees in all programs	\$ 5.5	\$ 6.5	\$ 7.5
Total	(\$ 3.9)	\$ 10.6	\$ 35.9

STATE AND FEDERAL IMPACT			
Population, by Waiver Program	SFY 2016 Under SPA	SFY 2017 Transition	SFY 2018 With Waiver
ESI Premium Support			
Medically Frail	\$ 37.1	\$ 33.1	\$ 28.3
Healthy, with income below 100% FPL	\$ 40.9	\$ 61.7	\$ 92.1
Healthy, with income between 100% FPL and 138% FPL	\$ 41.3	\$ 60.9	\$ 89.7
Medicaid Coverage			
Medically Frail, with no ESI	\$ 96.2	\$ 104.7	\$ 112.8
Healthy, with income below 100% FPL and no ESI	\$ 127.8	\$ 139.1	\$ 149.7
Marketplace Coverage, 100% to 138% FPL and no ESI	\$ 87.7	\$ 138.1	\$ 212.7
State Disability Program, Shift to Medicaid as Newly Eligible	\$ 3.4	\$ 3.6	\$ 3.7
Administrative Cost for enrollees in all programs	\$ 18.5	\$ 21.6	\$ 24.9
Total	\$ 452.9	\$ 562.6	\$ 713.9

Note: For comparison purposes, populations are stratified by ultimate eligibility category under the waivers. During SFY 2016, all are to be enrolled under the Medicaid State Plan. It was assumed that the waiver will be implemented midway through SFY 2017, on January 1, 2017.

For the initial stage of the Medicaid expansion, LB472 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, 2015 (the beginning of SFY 2016).

The SPA is to be followed by the development of waivers by the Medicaid Redesign Task Force within 12 months of the implementation of the bill. It is assumed that the waivers developed will customize Nebraska's program in a similar manner to what was outlined under Legislative Bill 887, which will require approval by CMS. To accomplish this, 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 was assumed that the waiver will be implemented midway through SFY 2017, on January 1, 2017.

Consequently, SFY 2016 costs reflect Medicaid State Plan enrollment for all populations. SFY 2017 reflects implementation of the waivers on January 1, 2017. SFY 2018 costs reflect full implementation of the following additional programs:

- 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.
- 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.
- Marketplace coverage for healthy enrollees with incomes between 100% FPL and 138% FPL who do not have access to cost effective ESI.
- Monthly contributions from 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 and total (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 Estimated Fiscal Impact: Through SFY 2021 (Values illustrated in \$millions)		
Component – Estimated Cost through SFY 2021	State Budget	State and Federal
Medicaid coverage for all	\$ 158.0	\$ 3,184.8
Additional cost of ESI premium program	\$ 25.7	\$ 312.3
Additional cost of exchange program	\$ 43.7	\$ 587.6
Savings from premiums charged to those over 50% FPL	(\$ 1.0)	(\$ 13.2)
Total	\$ 226.5	\$ 4,071.4

ESTIMATED ACA ENROLLMENT IMPACT

Table 3 illustrates the projected newly eligible Medicaid enrollment for SFY 2016 through SFY 2018.

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 Waiver Program	SFY 2016	SFY 2017	SFY 2018
ESI Premium Support			
Medically Frail	3,648	4,783	6,083
Healthy, with income below 100% FPL	11,771	15,498	19,778
Healthy, with income between 100% FPL and 138% FPL	11,820	15,336	19,345
Medicaid Coverage			
Medically Frail	8,697	9,691	10,704
Healthy, with income below 100% FPL	33,400	37,166	41,005
Marketplace Coverage, 100% to 138% FPL and no ESI	22,849	25,131	27,457
State Disability Plan	154	154	154
Total	92,340	107,759	124,526

Note: For comparison purposes, populations are stratified by ultimate eligibility category under the waivers. During SFY 2016, all are to be enrolled under the Medicaid State Plan. It was assumed that the waiver will be implemented midway through SFY 2017, on January 1, 2017.

Data

We updated projected newly eligible enrollment using three years of American Community Survey (ACS) data from the U.S. Census Bureau. Data collected in 2011 through 2013 was averaged in order to improve the credibility of the data and to minimize observed fluctuation in survey data between years. In aggregating data for multiple years, a population growth assumption of 1% per year was assumed.

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. Medicaid and Marketplace enrollment includes the uninsured population along with those identified as being enrolled in the Individual Insurance market within the ACS data. The population assumed to be eligible for ESI Premium Support includes those listed as being covered under employer sponsored insurance (ESI).

Methodology and Participation Assumptions

The total eligible population was reduced to reflect estimated participation rates. Participation rates used for this report reflect the average between a mid-range participation scenario and a full participation scenario, similar to what was illustrated in the 2013¹ and 2014² reports. The Centers for Medicare & Medicaid Services (CMS) produces publically available reports on Medicaid and CHIP monthly applications³. For states that implemented Medicaid expansions during 2014, these and other available data sources provide insight on observed participation rates. We have updated our participation assumptions to reflect this new information. Consistent with prior reports, 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 over 90% participation by eligible individuals identified in the ACS data.

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, which results in a participation rate of approximately 80% under the SPA.

With Waiver: After the ESI premium support program becomes available, we have assumed that many of the individuals who initially elect to stay with their employer plan will enroll in the program to receive premium payment and cost sharing support from Medicaid. After approval of the ESI premium support waiver, participation rates for those who are covered by employer sponsored insurance are projected to increase to just over 90%.

Table 4 illustrates ultimate participation rates by waiver 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 Waiver Program	Full Participation	Mid-Range (SPA)	Average (SPA)	With Waiver
ESI Premium Support				
Medically Frail	91%	54%	72%	91%
Healthy, with income below 100% FPL	91%	53%	72%	91%
Healthy, with income between 100% FPL and 138% FPL	91%	56%	74%	91%
Medicaid Coverage				
Medically Frail	94%	72%	83%	83%
Healthy, with income below 100% FPL	92%	70%	81%	81%
Marketplace Coverage, 100% to 138% FPL and no ESI	96%	76%	86%	86%
Total	93%	66%	80%	86%

¹ <http://dhhs.ne.gov/medicaid/Documents/AffordableCareActFiscalAnalysis2013.pdf>

² <http://dhhs.ne.gov/medicaid/Documents/AffordableCareActMedicaidExpansionFINAL.pdf>

³ <http://www.medicare.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html>

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 previous reports, 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 2018. 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, as additional enrollment is assumed for the population currently enrolled in ESI coverage due to the ESI Premium Support program, which is assumed to be implemented midway through SFY 2017.

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 Waiver Program	Year 1	Year 2	Year 3
ESI Premium Support			
Medically Frail	56%	64%	72%
Healthy, with income below 100% FPL	55%	64%	72%
Healthy, with income between 100% FPL and 138% FPL	57%	65%	74%
Medicaid Coverage			
Medically Frail	69%	76%	83%
Healthy, with income below 100% FPL	68%	74%	81%
Marketplace Coverage, 100% to 138% FPL and no ESI	73%	80%	86%
Total	65%	72%	80%

PARTICIPATION ASSUMPTIONS: Medicaid Expansion with Waiver			
Population, by Waiver Program	Year 1	Year 2	Year 3
ESI Premium Support			
Medically Frail	56%	72%	91%
Healthy, with income below 100% FPL	55%	72%	91%
Healthy, with income between 100% FPL and 138% FPL	57%	73%	91%
Medicaid Coverage			
Medically Frail	69%	76%	83%
Healthy, with income below 100% FPL	68%	74%	81%
Marketplace Coverage, 100% to 138% FPL and no ESI	73%	80%	86%
Total	65%	78%	86%

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 ESI premium support program beginning January 1, 2017, although the waiver will likely include a provision for the medically frail with employer insurance 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 Medicaid coverage, while those with income at or above 100% FPL and are not medically frail are enrolled in 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, yet elect to waive coverage. 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. This information suggests 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 once Medicaid is supporting premium payments and cost sharing, this may shift individuals currently shown as enrolling in the Marketplace to the ESI premium support program.

Medically Frail

The percentage of the population that qualifies as medically frail was estimated using the information provided in Section 4 of LB472. This definition appears broader than required by CMS, but this is explicitly allowed by regulations under 42 CFR 440.315, which specifies 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. We have estimated that 13.5% of the population would meet this criteria, with varying rates by age. This prevalence rate was developed by reviewing claims data for adult enrollees from other state Medicaid programs. The prevalence rates observed from these programs was adjusted to reflect lower morbidity in the newly eligible population. There is a great deal of uncertainty related to the actual percentage of the population that will meet this criteria, and these estimates required a considerable amount of actuarial judgment.

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 rates. The participation assumptions by population are presented in Tables 4 and 5. The assumed SFY 2017 average annual cost per enrollee is provided by population in Table 6. This table includes average annual costs under the Medicaid State Plan and assuming the waivers are implemented for the entirety of SFY 2017.

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: SFY 2017		
Population, by Waiver program	Annual Cost Under SPA	Annual Cost With Waiver
ESI Premium Support		
Medically Frail	\$10,110	\$4,383
Healthy, with income below 100% FPL	\$3,453	\$4,392
Healthy, with income between 100% FPL and 138% FPL	\$3,473	\$4,373
Medicaid Coverage		
Medically Frail	\$10,817	\$10,796
Healthy, with income below 100% FPL	\$3,748	\$3,734
Marketplace Coverage, 100% to 138% FPL and no ESI	\$3,751	\$7,234

Table 6 offers the following observations:

- **Cost of medically frail vs. healthy population** - The medically frail population’s annual cost is estimated to be almost three times that of the health population under the SPA. However, the average annual cost of ESI Premium Support is not estimated to vary greatly between the medically fail and healthy populations under the waiver. This is because required premium contributions under employer sponsored plans do not differ based on the health status of employees.
- **Impact of monthly contributions** - For the portion of the population receiving Medicaid coverage under both the SPA and waiver, estimated annual costs are slightly lower under the waiver due to the monthly contributions for enrollees above 50% FPL.
- **Cost of marketplace coverage** - Based on publically available exchange premiums, the estimated cost of purchasing coverage for the healthy population through the marketplace is almost twice the estimated annual cost for the same population under the SPA. This variation in cost is likely driven by morbidity and provider reimbursement differences between the Medicaid and exchange markets.

Medicaid State Plan Cost

Medicaid program cost estimates were developed from a combination of the 2015 contracted managed care capitation rates, the *Nebraska Medicaid Reform Annual Reports* dated December 1, 2014, 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 Health insurer assessment fees and related taxes, as reflected in the 2015 contracted managed care capitation rates. Medicaid program cost estimates reflect assumed levels of pent-up demand for the newly eligible population in SFY 2016 through SFY 2018. This results in reductions to the annual per-person cost estimates for the SPA in subsequent years, as illustrated in Enclosure 1. Additionally, we assumed that the ultimate morbidity of the expansion population will be favorable to that of the existing eligible population by 5%. 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. Medicaid program costs do not include any maternity expenses as it is assumed the newly eligible population will not be pregnant, consistent with the definition in Section 4(4) of LB472.

The values in Table 4 reflect the age/gender mix of each population based upon the ACS census data. For example, the populations with income between 100% and 138% FPL have a different age/gender distribution than the corresponding population below 100% FPL, and this impacts expected average cost. The cost differential between Medically Frail and healthy reflects the assumed cost difference between the subpopulation that suffers from chronic illness and the remainder who do not, which was developed using adult claims data from other Medicaid programs. There is a great deal of uncertainty related to the actual cost difference between the Medically Frail and healthy populations, and these estimates required a considerable amount of actuarial judgment.

Exchange Cost

The estimated cost to cover enrollees on the exchange is estimated to be higher than under the Medicaid State Plan. This is primarily 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. Exchange costs were developed excluding plans offered by CoOpportunity Health, which is in the process of being liquidated⁴.

Actual silver plan cost: To develop the exchange cost estimate, we 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. In developing the average cost, premiums for silver plans offered by CoOpportunity Health were excluded.

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. We assumed that Medicaid will cover all cost sharing for eligible individuals, so the silver plan price was increased to reflect 100% cost sharing accordingly. 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 efficient 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 Medicaid exchange enrollees will be spread across all those who purchase a silver plan on the exchange. As a result, we only increased the average waiver exchange program cost by 1.5% for induced utilization. Please note that the waiver is expected to increase the cost of all silver plans on Nebraska's exchange by 1.5%.

Additional Benefits: It is assumed that Medicaid benefits not normally provided on the exchange, such as dental benefits, EPSDT for individuals under 21, and non-emergency transportation, will be provided to eligible individuals. We estimated that the current cost of these benefits for adults is approximately \$31.80 per member per month, and have included this amount in the exchange cost estimates.

Monthly Contributions: LB472 provides for monthly contributions of 2% of income from exchange enrollees who do not receive recommended wellness services during the prior year. Once the waiver is implemented, the average annual cost is 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.*

Employer Sponsored Insurance Premium Support Program Cost

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

⁴ <http://nebraskaradionetwork.com/2015/02/10/collapse-of-coopportunity-health-has-nebraskans-seeking-answers-alternatives/>

Premium Cost: The 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 Medical Expenditure Panel Survey (MEPS). MEPS data from 2011 through 2013 was averaged in order to improve the credibility of the data and to minimize observed fluctuation in data between years. In aggregating data for multiple years, an annualized premium trend assumption of 6% was assumed.

The MEPS survey provided average premiums and average employee contributions for single (employee only) coverage. The information was stratified by wage quartile, allowing us to make adjustments to reflect a lower income employee population, with the employee share of the premium averaging 30%. (Please note that we assumed the ESI premium support program would not be 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, we assumed 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 exchange enrollees, we assumed Medicaid will also pay for wraparound dental, EPSDT, and non-emergency transportation benefits. The estimated value of these items is included in the illustrated ESI costs.

Monthly Contributions: Average annual costs were reduced to reflect 10% of enrollees making contributions of 2% of income, which is assumed to begin once the waiver is implemented.

Cost Effectiveness: It is likely that the waiver would be structured to limit ESI premium support to situations where the department has determined that the premium support is cost effective to traditional Medicaid. Since the criteria for cost effectiveness has not been developed, it 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 the purpose of this analysis, we have assumed that ESI coverage would meet any developed cost effectiveness criteria.*

Monthly Contributions for Medicaid Enrollees Above 50% FPL

Section 12 of LB472 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. Beginning with the waiver implementation on January 1, 2017, the average annual cost was reduced to reflect this. We have assumed that the presence of monthly contributions does not impact the participation rates of the eligible population.

Trend

We assumed annual Medicaid expenditure trends of 1.5% for capitated expenditures and 2.5% 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. We have assumed an ESI and Exchange annualized trend rate of 6.0%. Additionally, Exchange premiums are assumed to experience growth in addition to normal trend in early years as the federal transitional reinsurance program is phased out and the risk corridor program terminated.

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, except for 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, consistent with the report dated February 25, 2014. These administrative expenses were assumed to be incurred beginning in SFY 2016 and remain at the same level through SFY 2021.

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 waiver programs were not included in this analysis.

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. Consistent with the prior report, 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 approximately 1.04 (1.38 *divided by* 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.

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 Medicaid Redesign Act (LB472). 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 use of patient-centered medical homes, health homes for newly eligible super-utilizers, and value-based payments: These innovations have the potential to both improve outcomes and reduce cost. However, we have not quantified potential savings in this report. 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. Additionally, 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: The rationale for these savings 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 also has the potential to occur if new entrants emerge in the commercial markets with previous experience in Medicaid managed care. We would prefer to wait until data supporting this emerges 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 we 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;
- 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); and,
- Potential elimination of the Transitional Medical Assistance program after the expansion (savings to the State).

REFORM ESTIMATE MODELING UPDATES

We updated estimates through SFY 2021 in this report. In developing this updated report, we used sources of data and information that have emerged since the prior reports. This information resulted in changes in the fiscal impact estimates. The following items can be identified as key sources underlying these changes.

- **Comparison to Prior Reports.** The scope of this report is limited to a projection of the financial impact of LB472, as it relates to Medicaid expansion, on Nebraska state and federal Medicaid expenditures. This excludes more broadly related ACA expenditures, which may have been reflected in prior reports.
- **Projection Period.** State and federal expenditures are projected from SFY 2016 through SFY 2021. The projection period of the prior report dated February 25, 2014 was SFY 2015 through SFY 2020. When comparing figures between these reports, it should be noted that while the projection period is of equal length we have excluded a year with a 100% FMAP (SFY 2015) and included an additional year with a 90% FMAP (SFY 2021).
- **Nebraska Medicaid Managed Care Capitation Rates.** The per member per month costs under the Medicaid program were developed using the July 2014 through June 2015 Medicaid physical managed care capitation rates and the July through December 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, and adjusted the costs for assumed morbidity differences between the populations.
- **2011 through 2013 American Community Census (ACS) data.** We have worked to develop algorithms for ACS census information to help us better stratify segments of the population. For this report, data collected in 2011 through 2013 was averaged in order to improve the credibility of the data and to minimize observed fluctuation in survey data between years. In aggregating data for multiple years, a population growth assumption of 1% per year was assumed.
- **Medicaid Expansion Participation Rates.** The Centers for Medicare & Medicaid Services (CMS) produces publically available reports on Medicaid and CHIP monthly applications. For states that implemented Medicaid expansions during 2014, these and other available data sources provide insight on observed participation rates. We have updated our participation assumptions to reflect this new information.
- **2015 Silver Plan Exchange Costs.** To develop the exchange cost estimate, we researched 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. In developing the average cost, premiums for silver plans offered by CoOpportunity Health were excluded.
- **Employer Sponsored Insurance Premium Support Program Cost.** ESI cost was estimated based on actual employer costs in the State of Nebraska, as sampled in the Medical Expenditure Panel Survey (MEPS). MEPS data from 2011 through 2013 was averaged in order to improve the credibility of the data and to minimize observed fluctuation in data between years. In aggregating data for multiple years, an annualized premium trend assumption of 6% was assumed.

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, 2014. Milliman has also relied on Nebraska data from the U.S. Census Bureau's American Community Survey, publically available marketplace premium data, and Nebraska data from the Medical Expenditure Panel Survey (MEPS). 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 LB472. Forthcoming ACA-related regulations may materially impact the values in this report. Similarly, to the extent that LB472 is modified these 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 dated January 2015.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet 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	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2016 - SFY2021
SPA Medicaid Coverage - Current Employer Sponsored Insurance							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	3,648	4,238	4,838	4,887	4,936	4,985	
Annual Per-Person Cost Estimate	\$ 10,180	\$ 10,110	\$ 10,134	\$ 10,207	\$ 10,384	\$ 10,564	\$ 10,272
Total Funds Estimate (State and Federal)	\$ 37,100,000	\$ 42,800,000	\$ 49,000,000	\$ 49,900,000	\$ 51,200,000	\$ 52,700,000	\$ 282,700,000
Federal Funds Estimate	\$ 37,100,000	\$ 41,700,000	\$ 46,300,000	\$ 46,700,000	\$ 46,800,000	\$ 47,400,000	\$ 266,000,000
State Funds Estimate	\$ 0	\$ 1,100,000	\$ 2,700,000	\$ 3,200,000	\$ 4,400,000	\$ 5,300,000	\$ 16,700,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	11,771	13,673	15,610	15,767	15,924	16,084	
Annual Per-Person Cost Estimate	\$ 3,474	\$ 3,453	\$ 3,464	\$ 3,491	\$ 3,555	\$ 3,619	\$ 3,513
Total Funds Estimate (State and Federal)	\$ 40,900,000	\$ 47,200,000	\$ 54,100,000	\$ 55,000,000	\$ 56,600,000	\$ 58,200,000	\$ 312,000,000
Federal Funds Estimate	\$ 40,900,000	\$ 46,000,000	\$ 51,100,000	\$ 51,400,000	\$ 51,800,000	\$ 52,400,000	\$ 293,600,000
State Funds Estimate	\$ 0	\$ 1,200,000	\$ 3,000,000	\$ 3,600,000	\$ 4,800,000	\$ 5,800,000	\$ 18,400,000
Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	11,820	13,729	15,675	15,832	15,990	16,150	
Annual Per-Person Cost Estimate	\$ 3,495	\$ 3,473	\$ 3,484	\$ 3,512	\$ 3,576	\$ 3,641	\$ 3,534
Total Funds Estimate (State and Federal)	\$ 41,300,000	\$ 47,700,000	\$ 54,600,000	\$ 55,600,000	\$ 57,200,000	\$ 58,800,000	\$ 315,200,000
Federal Funds Estimate	\$ 41,300,000	\$ 46,500,000	\$ 51,600,000	\$ 52,000,000	\$ 52,300,000	\$ 52,900,000	\$ 296,600,000
State Funds Estimate	\$ 0	\$ 1,200,000	\$ 3,000,000	\$ 3,600,000	\$ 4,900,000	\$ 5,900,000	\$ 18,600,000
SPA Medicaid Coverage - Current Individual Insured or Uninsured							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	8,697	9,691	10,704	10,812	10,922	11,033	
Annual Per-Person Cost Estimate	\$ 11,065	\$ 10,817	\$ 10,562	\$ 10,290	\$ 10,468	\$ 10,650	\$ 10,624
Total Funds Estimate (State and Federal)	\$ 96,200,000	\$ 104,800,000	\$ 113,100,000	\$ 111,300,000	\$ 114,300,000	\$ 117,500,000	\$ 657,200,000
Federal Funds Estimate	\$ 96,200,000	\$ 102,200,000	\$ 106,900,000	\$ 104,100,000	\$ 104,600,000	\$ 105,800,000	\$ 619,800,000
State Funds Estimate	\$ 0	\$ 2,600,000	\$ 6,200,000	\$ 7,200,000	\$ 9,700,000	\$ 11,700,000	\$ 37,400,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	33,400	37,166	41,005	41,415	41,829	42,247	
Annual Per-Person Cost Estimate	\$ 3,828	\$ 3,748	\$ 3,665	\$ 3,574	\$ 3,639	\$ 3,706	\$ 3,688
Total Funds Estimate (State and Federal)	\$ 127,800,000	\$ 139,300,000	\$ 150,300,000	\$ 148,000,000	\$ 152,200,000	\$ 156,500,000	\$ 874,100,000
Federal Funds Estimate	\$ 127,800,000	\$ 135,800,000	\$ 142,000,000	\$ 138,400,000	\$ 139,300,000	\$ 140,900,000	\$ 824,200,000
State Funds Estimate	\$ 0	\$ 3,500,000	\$ 8,300,000	\$ 9,600,000	\$ 12,900,000	\$ 15,600,000	\$ 49,900,000

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	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2016 - SFY2021
SPA Medicaid Coverage - Current Individual Insured or Uninsured							
Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	22,849	25,131	27,457	27,731	28,009	28,289	
Annual Per-Person Cost Estimate	\$ 3,839	\$ 3,751	\$ 3,662	\$ 3,569	\$ 3,633	\$ 3,699	\$ 3,687
Total Funds Estimate (State and Federal)	\$ 87,700,000	\$ 94,300,000	\$ 100,600,000	\$ 99,000,000	\$ 101,800,000	\$ 104,700,000	\$ 588,100,000
Federal Funds Estimate	\$ 87,700,000	\$ 91,900,000	\$ 95,100,000	\$ 92,600,000	\$ 93,100,000	\$ 94,200,000	\$ 554,600,000
State Funds Estimate	\$ 0	\$ 2,400,000	\$ 5,500,000	\$ 6,400,000	\$ 8,700,000	\$ 10,500,000	\$ 33,500,000
State Disability Program - Shift to Medicaid as Newly Eligible							
Population Estimate	154	154	154	154	154	154	
Annual Per-Person Cost Estimate	\$ 22,400	\$ 23,072	\$ 23,765	\$ 24,477	\$ 25,212	\$ 25,968	\$ 24,149
Total Funds Estimate (State and Federal)	\$ 3,400,000	\$ 3,600,000	\$ 3,700,000	\$ 3,800,000	\$ 3,900,000	\$ 4,000,000	\$ 22,400,000
Federal Funds Estimate	\$ 12,900,000	\$ 12,900,000	\$ 12,900,000	\$ 13,200,000	\$ 13,300,000	\$ 13,400,000	\$ 78,600,000
State Funds Estimate	\$ (9,400,000)	\$ (9,400,000)	\$ (9,300,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (56,300,000)
Administrative Expenses For New Enrollment							
Population Estimate	92,340	103,782	115,444	116,598	117,764	118,942	
Annual Per-Person Cost Estimate	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200
Total Funds Estimate (State and Federal)	\$ 18,500,000	\$ 20,800,000	\$ 23,100,000	\$ 23,300,000	\$ 23,600,000	\$ 23,800,000	\$ 133,100,000
Federal Funds Estimate	\$ 13,000,000	\$ 14,600,000	\$ 16,200,000	\$ 16,300,000	\$ 16,500,000	\$ 16,700,000	\$ 93,300,000
State Funds Estimate	\$ 5,500,000	\$ 6,200,000	\$ 6,900,000	\$ 7,000,000	\$ 7,100,000	\$ 7,100,000	\$ 39,800,000
Total Change to Budget Due to Medicaid Expansion							
Population Estimate	92,340	103,782	115,444	116,598	117,764	118,942	
Total (State and Federal)	\$ 452,900,000	\$ 500,500,000	\$ 548,500,000	\$ 545,900,000	\$ 560,800,000	\$ 576,200,000	\$ 3,184,800,000
Federal Funds	\$ 456,900,000	\$ 491,600,000	\$ 522,100,000	\$ 514,700,000	\$ 517,700,000	\$ 523,700,000	\$ 3,026,700,000
State Funds	\$ (3,900,000)	\$ 8,800,000	\$ 26,300,000	\$ 31,200,000	\$ 43,100,000	\$ 52,500,000	\$ 158,000,000

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	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2016 - SFY2021
ESI Premium Support							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	4,587	5,327	6,083	6,143	6,205	6,267	
Annual Per-Person Cost Estimate	\$ 4,134	\$ 4,383	\$ 4,648	\$ 4,928	\$ 5,224	\$ 5,539	\$ 4,853
Total Funds Estimate (State and Federal)	\$ 19,000,000	\$ 23,400,000	\$ 28,300,000	\$ 30,300,000	\$ 32,400,000	\$ 34,700,000	\$ 168,100,000
Federal Funds Estimate	\$ 19,000,000	\$ 22,800,000	\$ 26,700,000	\$ 28,300,000	\$ 29,600,000	\$ 31,200,000	\$ 157,600,000
State Funds Estimate	\$ 0	\$ 600,000	\$ 1,600,000	\$ 2,000,000	\$ 2,800,000	\$ 3,500,000	\$ 10,500,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	14,914	17,323	19,778	19,976	20,176	20,378	
Annual Per-Person Cost Estimate	\$ 4,143	\$ 4,392	\$ 4,656	\$ 4,936	\$ 5,233	\$ 5,548	\$ 4,862
Total Funds Estimate (State and Federal)	\$ 61,800,000	\$ 76,100,000	\$ 92,100,000	\$ 98,600,000	\$ 105,600,000	\$ 113,000,000	\$ 547,200,000
Federal Funds Estimate	\$ 61,800,000	\$ 74,200,000	\$ 87,000,000	\$ 92,200,000	\$ 96,600,000	\$ 101,700,000	\$ 513,500,000
State Funds Estimate	\$ 0	\$ 1,900,000	\$ 5,100,000	\$ 6,400,000	\$ 9,000,000	\$ 11,300,000	\$ 33,700,000
Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	14,588	16,943	19,345	19,538	19,734	19,931	
Annual Per-Person Cost Estimate	\$ 4,124	\$ 4,373	\$ 4,637	\$ 4,917	\$ 5,214	\$ 5,528	\$ 4,843
Total Funds Estimate (State and Federal)	\$ 60,200,000	\$ 74,100,000	\$ 89,700,000	\$ 96,100,000	\$ 102,900,000	\$ 110,200,000	\$ 533,200,000
Federal Funds Estimate	\$ 60,200,000	\$ 72,200,000	\$ 84,800,000	\$ 89,900,000	\$ 94,200,000	\$ 99,200,000	\$ 500,500,000
State Funds Estimate	\$ 0	\$ 1,900,000	\$ 4,900,000	\$ 6,200,000	\$ 8,700,000	\$ 11,000,000	\$ 32,700,000
Medicaid Coverage							
Adults and Parents - Medically Frail - Under 138% FPL							
Population Estimate	8,697	9,691	10,704	10,812	10,922	11,033	
Annual Per-Person Cost Estimate	\$ 11,044	\$ 10,796	\$ 10,541	\$ 10,269	\$ 10,447	\$ 10,628	\$ 10,603
Total Funds Estimate (State and Federal)	\$ 96,100,000	\$ 104,600,000	\$ 112,800,000	\$ 111,000,000	\$ 114,100,000	\$ 117,300,000	\$ 655,900,000
Federal Funds Estimate	\$ 96,100,000	\$ 102,000,000	\$ 106,600,000	\$ 103,800,000	\$ 104,400,000	\$ 105,600,000	\$ 618,500,000
State Funds Estimate	\$ 0	\$ 2,600,000	\$ 6,200,000	\$ 7,200,000	\$ 9,700,000	\$ 11,700,000	\$ 37,400,000
Adults and Parents - Healthy - Under 100%							
Population Estimate	33,400	37,166	41,005	41,415	41,829	42,247	
Annual Per-Person Cost Estimate	\$ 3,814	\$ 3,734	\$ 3,651	\$ 3,560	\$ 3,625	\$ 3,691	\$ 3,674
Total Funds Estimate (State and Federal)	\$ 127,400,000	\$ 138,800,000	\$ 149,700,000	\$ 147,400,000	\$ 151,600,000	\$ 155,900,000	\$ 870,800,000
Federal Funds Estimate	\$ 127,400,000	\$ 135,300,000	\$ 141,500,000	\$ 137,800,000	\$ 138,700,000	\$ 140,300,000	\$ 821,000,000
State Funds Estimate	\$ 0	\$ 3,500,000	\$ 8,200,000	\$ 9,600,000	\$ 12,900,000	\$ 15,600,000	\$ 49,800,000

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	SFY2016	SFY2017	SFY2018	SFY2019	SFY2020	SFY2021	SFY2016 - SFY 2021
Marketplace Coverage							
Adults and Parents - Healthy - 100% to 138% FPL							
Population Estimate	22,849	25,131	27,457	27,731	28,009	28,289	
Annual Per-Person Cost Estimate	\$ 6,601	\$ 7,234	\$ 7,748	\$ 8,214	\$ 8,709	\$ 9,233	\$ 8,016
Total Funds Estimate (State and Federal)	\$ 150,800,000	\$ 181,800,000	\$ 212,700,000	\$ 227,800,000	\$ 243,900,000	\$ 261,200,000	\$ 1,278,200,000
Federal Funds Estimate	\$ 150,800,000	\$ 177,300,000	\$ 201,000,000	\$ 213,000,000	\$ 223,200,000	\$ 235,100,000	\$ 1,200,400,000
State Funds Estimate	\$ 0	\$ 4,500,000	\$ 11,700,000	\$ 14,800,000	\$ 20,700,000	\$ 26,100,000	\$ 77,800,000
State Disability Program - Shift to Medicaid as Newly Eligible							
Population Estimate	154	154	154	154	154	154	
Annual Per-Person Cost Estimate	\$ 22,400	\$ 23,072	\$ 23,765	\$ 24,477	\$ 25,212	\$ 25,968	\$ 24,149
Total Funds Estimate (State and Federal)	\$ 3,400,000	\$ 3,600,000	\$ 3,700,000	\$ 3,800,000	\$ 3,900,000	\$ 4,000,000	\$ 22,400,000
Federal Funds Estimate	\$ 12,900,000	\$ 12,900,000	\$ 12,900,000	\$ 13,200,000	\$ 13,300,000	\$ 13,400,000	\$ 78,600,000
State Funds Estimate	\$ (9,400,000)	\$ (9,400,000)	\$ (9,300,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (9,400,000)	\$ (56,300,000)
Administrative Expenses For New Enrollment							
Population Estimate	99,188	111,737	124,526	125,771	127,029	128,299	
Annual Per-Person Cost Estimate	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200	\$ 200
Total Funds Estimate (State and Federal)	\$ 19,800,000	\$ 22,300,000	\$ 24,900,000	\$ 25,200,000	\$ 25,400,000	\$ 25,700,000	\$ 143,300,000
Federal Funds Estimate	\$ 13,900,000	\$ 15,600,000	\$ 17,400,000	\$ 17,600,000	\$ 17,800,000	\$ 18,000,000	\$ 100,300,000
State Funds Estimate	\$ 5,900,000	\$ 6,700,000	\$ 7,500,000	\$ 7,600,000	\$ 7,600,000	\$ 7,700,000	\$ 43,000,000
Total Change to Budget Due to Medicaid Expansion							
Population Estimate	99,188	111,737	124,526	125,771	127,029	128,299	
Total (State and Federal)	\$ 538,500,000	\$ 624,700,000	\$ 713,900,000	\$ 740,200,000	\$ 779,800,000	\$ 822,000,000	\$ 4,219,100,000
Federal Funds	\$ 542,100,000	\$ 612,300,000	\$ 677,900,000	\$ 695,800,000	\$ 717,800,000	\$ 744,500,000	\$ 3,990,400,000
State Funds	\$ (3,500,000)	\$ 12,300,000	\$ 35,900,000	\$ 44,400,000	\$ 62,000,000	\$ 77,500,000	\$ 228,600,000