

State of Nebraska

Medicaid Expansion Cost Estimate

Ten Year Cost Analysis of LB1032





February 8, 2016

Mr. Calder Lynch
Medicaid Director
Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68509

Subject: Analysis of LB1032 Proposal to Expand Medicaid Eligibility

Dear Mr. Lynch:

In partnership with the Department of Health and Human Services (DHHS), **Optumas** developed an estimate of costs associated with the Medicaid Expansion plan as outlined in LB1032. This report provides an overview of the methodology, sources, and assumptions used in developing the cost estimate.

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1. Background

Legislative Bill (LB) 1032 creates a Medicaid Expansion program that utilizes the Health Insurance Exchange (HIX), Employer-sponsored Insurance (ESI), and the existing Medicaid managed care framework to increase Medicaid eligibility up to 138% of the Federal Poverty Level (FPL). The proposed legislation expands Medicaid through three different programs:

1. Premium Assistance to purchase Qualified Health Plans (QHPs) on the HIX
2. Premium Assistance to subsidize the employee's share of ESI premiums
3. Medicaid managed care enrollment for individuals deemed to be Medically Frail

Other facets of the proposed legislation include a premium of 2% of household income for expansion-eligible individuals over 50% FPL, provision of wrap-around, non-Essential Health Benefits, and stipulations regarding allowed cost sharing. **Optumas** analyzed the number of enrollees and cost of each aspect of Medicaid Expansion proposed in LB1032. The methodology, sources, and final values for enrollment and expenditures associated with LB1032 for State Fiscal Years (SFYs) 2018 – 2027 are summarized in the following report.

2. Executive Summary

Legislative Bill 1032 proposes an expansion of Medicaid through three different avenues: Qualified Health Plans (QHPs); premium assistance through Employer Sponsored Insurance (ESI); and Medically Frail population coverage via Medicaid managed care. In addition to these three expansion populations, it is anticipated that individuals eligible for Medicaid prior to expansion will present and enroll. Each of these populations was analyzed by **Optumas** as part of a 10-year projection of the costs associated with LB1032.

Using publicly available survey data and take-up rate experience from similar states, **Optumas** projects the QHP expansion population will be 74,206 individuals as of June 2019 (full program ramp-in). The cost of this population was estimated based on current Health Insurance Exchange premiums and potential changes commercial insurers might make due to the influx of a Medicaid Expansion population. The results of this analysis indicates a Calendar Year 2018 (CY18) cost of \$738 per member per month (PMPM) for QHP services. This was supplemented with anticipated wrap-around service benefit costs of \$6 PMPM.

Survey data was used to determine the potential size of the Medicaid Expansion ESI population. Available data led **Optumas** to project that the fully-ramped in population size would be 34,662 individuals enrolled in ESI Expansion. Data regarding group insurance premiums was used to project a CY18 cost of \$392 PMPM. Similar to the QHP Expansion, this commercial insurance premium amount was supplemented with \$6 PMPM of wrap-around benefits.

The Medically Frail carve-out was assumed to represent 10% of the expansion-eligible population based on experience of other states. This results in 15,121 individuals being determined as Medically Frail, at a CY18 PMPM of \$1,303. The PMPM is developed using Medicaid data for currently eligible populations.

Optumas reviewed the experience of states that expanded Medicaid in 2014 to project a woodwork population of 2,870 for Nebraska. **Optumas** applied a reduction of 10% to recent analyses of the non-disabled adult rate to develop a PMPM cost of \$464 for the woodwork population.

The Federal and State share of the spend over the 10 Fiscal Years of this analysis are shown in the subsequent table.

	State Fiscal Year	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Ten Year Total
Benefits	Total Spend	\$312	\$883	\$1,213	\$1,343	\$1,469	\$1,607	\$1,758	\$1,924	\$2,106	\$2,305	\$14,921
	Federal Share -Benefits	\$291	\$819	\$1,101	\$1,202	\$1,315	\$1,438	\$1,574	\$1,723	\$1,886	\$2,064	\$13,413
	Federal Share - Transitional	\$33	\$33	\$32	\$32	\$32	\$33	\$34	\$34	\$35	\$36	\$333
	State Share - Benefits	\$21	\$64	\$111	\$141	\$154	\$169	\$184	\$201	\$220	\$241	\$1,507
	State Share - Transitional	-\$33	-\$33	-\$32	-\$32	-\$32	-\$33	-\$34	-\$34	-\$35	-\$36	-\$333
	State Share - Mem. Contributions	-\$7	-\$20	-\$26	-\$27	-\$27	-\$28	-\$28	-\$29	-\$29	-\$30	-\$249
	Net State Share	-\$19	\$12	\$53	\$83	\$95	\$108	\$123	\$139	\$156	\$175	\$926
Admin	Total Spend	\$11	\$10	\$11	\$11	\$11	\$11	\$11	\$11	\$11	\$11	\$110
	Federal Share	\$7	\$5	\$6	\$6	\$6	\$6	\$6	\$6	\$6	\$6	\$57
	State Share	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$5	\$52
Net Spend	Total Spend	\$316	\$873	\$1,198	\$1,328	\$1,453	\$1,591	\$1,741	\$1,907	\$2,088	\$2,286	\$14,781
	Federal Share	\$331	\$857	\$1,139	\$1,239	\$1,353	\$1,477	\$1,613	\$1,763	\$1,926	\$2,106	\$13,803
	State Share	-\$14	\$17	\$59	\$89	\$101	\$114	\$128	\$144	\$161	\$181	\$978

Dollar figures represent millions of dollars

3. Methodology

Medicaid Expansion will have three unique, non-overlapping avenues for newly-eligible individuals to receive Medicaid coverage under the proposed legislation of LB1032. These three avenues are enrollment in the private insurance market via QHP, premium assistance to supplement existing ESI coverage, and enrollment of individuals deemed Medically Frail into the existing Medicaid managed care framework. The population size and cost associated with each of these aspects of Medicaid Expansion were analyzed by **Optumas**. Publicly available survey data, Nebraska Medicaid data, QHP premiums, and Medicaid Expansion experiences from other states are incorporated to create a robust projection of potential enrollment levels and anticipated costs. Projections of initial experience were projected forward from State Fiscal Year (SFY) 2018 to 2027. Outer year projects are reliant on current expense trend information and anticipate population growth. Due to the compounding necessary to obtain 2027 projections, estimates should be understood to contain a reasonable amount of projection error.

In addition to costs directly associated with Medicaid Expansion, **Optumas** reviewed the potential for a woodwork effect on the currently eligible population. The woodwork effect is when individuals who are eligible for Medicaid prior to expansion but for various reasons have not enrolled decide to enroll after Medicaid expands eligibility criteria. States frequently experience a growth in traditionally-eligible cohorts when Medicaid eligibility is expanded, and experience of other states that expanded Medicaid in 2014 was used to estimate the impact of the woodwork effect for Nebraska.

Each component of the analysis of costs associated with Medicaid Expansion as proposed by LB1032, including data sources, methodological approach, and assumptions, is explained in further detail in the following sections.

3.1 QHP Expansion

Per LB1032, individuals newly eligible for Medicaid due to expansion without a credible offer of ESI and without a Medically Frail determination will be eligible for enrollment into a QHP through the State's premium assistance program. **Optumas** used publicly available survey data from the American Community Survey (ACS) and the Current Population Survey (CPS) to determine the potential size of this population. Five-year survey data from the ACS was compared to CPS. While differences existed in the two survey data sources, the larger survey sample size of ACS and more granular regional data made it the preferred source of data¹. Survey data was aggregated by county, income, age, gender, and health insurance coverage status to determine the number of individuals potentially eligible for QHP Expansion.²

¹ <https://www.census.gov/hhes/www/poverty/about/datasources/factsheet.html>

² <http://factfinder.census.gov/>

The potential individuals eligible for Medicaid Expansion were the uninsured population under 138% FPL and the privately insured population under 138% FPL. Additionally, each population was limited to individuals between the ages of 19 and 64. This resulted in a total potential population size of 142,086 individuals potentially eligible for Medicaid Expansion (survey time period-basis).³ This figure was projected forward at 1% annual membership growth to the program ramp-in time period (January 2018 through June 2019), resulting in a total population of 151,206. As discussed later, 10% of the population is considered to be Medically Frail. Additionally, 65% of the remaining privately insured population under 138% FPL is assumed to receive insurance through the ESI premium assistance program. This assumption is based on the survey data results showing the portion of privately insured individuals purchasing individual insurance and a modicum of people who will choose to leave ESI in favor of enrolling with a QHP and not having insurance tied to their employment.⁴ Lastly, **Optumas** reviewed take-up rate information from multiple states that expanded Medicaid programs in 2014 to determine an ultimate penetration rate. A mountain region state and a southern plains state both showed a post-expansion take-up rate of 80% of the eligible population after sufficient time had elapsed for full penetration to the newly-eligible population to occur. **Optumas** used these experience points to assume Nebraska will achieve an 80% take up rate 18 months after implementing Medicaid Expansion. Survey data population sizes were trended forward at 1% annual enrollment growth. Aggregating the previously discussed data points results in a fully-ramped in QHP Expansion enrollment of 74,206 individuals as of June 2019. See Appendix I for a summary table of the assumed population sizes and movements.

To determine the cost of this population **Optumas** reviewed the current HIX premiums and modeled changes commercial insurers might make due to the influx of a Medicaid Expansion program into the HIX. Exchange enrollment reports provided the distribution of Exchange enrollees by county and age band.⁵ To complete the analysis of current exchange costs, **Optumas** conducted a hypothetical modeling exercise placing all current Exchange enrollees in Silver Premium Plans.⁶ When completing this modeling, **Optumas** was not able to precisely determine which individuals would be enrolled in a tobacco-plan compared to a non-tobacco plan. **Optumas** conducted a sensitivity analysis to determine the impact of various assumptions regarding the smoking rate. These checks showed that slight changes in the smoker rate did not produce a material change in the final results. With this information in mind, **Optumas** used an assumption that 10% of current enrollees selected that they are tobacco users. Due to the self-reported nature of this information it was determined most reasonable to select a lower tobacco use value than is actually prevalent in the community. The distribution of current Exchange enrollees by age and county assuming a hypothetical enrollment in a silver plan resulted in a PMPM of \$687.

³ The 5 year ACS survey represents CY10 – CY14 data

⁴ http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_B27016&prodType=table

⁵ <https://aspe.hhs.gov/report/plan-selections-county-health-insurance-marketplace-july-2015-updated>

⁶ <https://www.healthcare.gov/see-plans/#/>

The PMPM paid by the State for QHP Expansion enrollees will be the aggregate of current QHP enrollee risk and the new risk of Medicaid Expansion individuals. The Medicaid Expansion risk was modeled using Medicaid data for the current Family M&F 21+ rating cohort. Based on **Optumas'** experience in other states this cohort was deemed to be the most similar to the non-frail expansion enrollees. The projected managed care medical PMPM for CY17 was adjusted for the acuity of the expansion population using reference State information. The adjustment was made separately for the Childless Adult and the Parent sub-cohorts of the expansion population.⁷ Other adjustments, including trend to CY18 at prevalent Medicaid trend rates, incorporation of additional delivery costs for the expansion population, and pent-up demand adjustments, were used to adjust the Family 21+ M&F rate to be appropriate for the expansion population. In aggregate, these rate adjustments represent a 22.3% increase to the expected CY17 medical costs.

An additional consideration in projecting forward the expansion population's expense under the QHP Expansion scenario is reimbursement level. Since this aspect of the cost projection is built on Medicaid data, inherent in that is Medicaid reimbursement levels. However, under QHP Expansion the state will pay commercial reimbursement for the newly eligible population. **Optumas** converted the reimbursement from Medicaid to commercial levels using a report produced by the Centers for Medicare and Medicaid Services (CMS).⁸ The report specifically discusses Hospital and Physician reimbursement; **Optumas** discussed Pharmacy reimbursement with the State and decided that no adjustment was necessary to convert Medicaid Fee-for-Service (FFS) reimbursement to commercial reimbursement. Since this report was published the State has changed policy to pay primary care services at Medicare rates. Due to this change the Medicare-to-Commercial fee ratio was used for primary care services to adjust reimbursement to commercial values. The aggregate impact of the reimbursement adjustment is a 37.3% increase to the projected PMPM.

At this point in the rate development all experience has been converted to be consistent with a commercial product. Consistent with that approach **Optumas** applied a non-medical load to that rate of 15% of premium to create the final projected CY18 experience. This created a final loaded rate of \$835.48 PMPM.

To develop the total cost of the QHP Expansion, the projected cost for the Medicaid Expansion individuals was combined with the demographic-based analysis of current Exchange enrollees. These two populations were blended together, and the final, weighted-average rate will be paid for each member on the Exchange, regardless of whether they are Medicaid or private-pay. The expected blending weights change over time as the Medicaid population enrolls in larger

⁷ <http://www.census.gov/cps/data/cpstablecreator.html>

⁸ <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/2015TRAlternativeScenario.pdf>

numbers over time. The initial blending conducted for CY18 results in an expected QHP rate of \$738 PMPM. A table of the blending process for the program ramp-in years has been provided in Appendix II.

The State will need to provide wrap-around benefits for individuals enrolled in the QHP Expansion. These benefits represent services covered by the Medicaid plan, but not offered as part of the Essential Health Benefits covered by QHPs. These services are anticipated to be: Non-Emergent Medical Transportation (NEMT); Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for 19 and 20 year olds; and Vision services. Nebraska's existing Medicaid experience was used to determine the anticipated costs of these services. It is expected that wrap-around benefits will be provided via Medicaid managed care, so changes in reimbursement are not necessary. Wrap-around benefits were trended at 4% annually to project from the base period to the analysis time-frame. The anticipated expense for the wrap-around benefits in CY18 is \$6.07 PMPM. Wrap-around benefit expenses for CY18 are itemized in Appendix III.

3.2 ESI Expansion

Individuals who become newly-eligible for Medicaid Expansion that already have insurance through their employer will be eligible for an ESI premium assistance program under LB1032. The program will pay the employee's share of the ESI premium, as well as cost sharing amounts the employee would incur under their employer's insurance plan. The same survey data used to project the QHP Expansion population was used to model the size of the ESI Expansion.⁹ The uninsured individuals under 138% FPL were assumed to have no access to credible ESI, so a 0% take up rate of ESI expansion was incorporated. For individuals under 138% FPL currently with Private insurance, it was assumed that 65% would use the ESI premium assistance program to remain on their employer plan but have their premium and out of pocket costs paid by the State. This assumption is based on the survey data results showing the portion of privately insured individuals purchasing individual insurance and a modicum of people who will choose to leave ESI in favor of enrolling with a QHP and not having insurance tied to their employment.¹⁰ In addition, **Optumas** reviewed available information on the portion of low-wage employees with ESI where the employer pays more than 50% of the premium.¹¹ This, along with an analysis of Nebraska's group insurance premiums, indicates that the overwhelming majority of current group plans will be cost-effective from the State's perspective (i.e. cost the State less than enrolling the individual in a QHP with the State paying 100% of the cost). Because of this, the main component in determining whether a person with ESI will remain on ESI and use the State's premium assistance or will enroll in a QHP is member

⁹ <http://factfinder.census.gov/>

¹⁰ http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_14_1YR_B27016&prodType=table

¹¹ <http://kff.org/report-section/ehbs-2014-summary-of-findings/>

choice. Additionally, **Optumas** assumed that at full program implementation 80% of individuals under 138% FPL with private insurance will take up some form of Medicaid Expansion. This is the same assumption that was used for the Uninsured population. While it is intuitive to expect a higher portion of the privately insured individuals to take up Medicaid since they will have a direct cost savings, inconsistencies in elements of the survey data prevented **Optumas** from incorporating this level of precision. Instead, take-up rates were looked at in aggregate and the same take-up rate was applied to both the uninsured and the privately insured sub-populations. See Appendix I for a table depicting the population sizes and movements.

Costs for this component of Medicaid Expansion were developed using available data around group insurance premiums and employer contribution rates. The Medical Expenditure Panel Survey (MEPS) collects data by state, firm type, firm size, and wage quartile. Data collected included employee premiums, employer premiums, and plan type.¹² **Optumas** limited each of these data sources to be specific to Nebraska and to the lowest wage quartile. While the lowest quartile will not be an exact match to the individuals under 138% FPL on employer insurance, it was the most reasonable available proxy. This data served as the basis for projecting potential ESI expenses, and is summarized in Appendix IV. Additionally, **Optumas** assumed the State will not purchase family plans under ESI. The children enrolled in any family plans should be eligible for Medicaid prior to expansion, so **Optumas** assumed the State would move those children to traditional Medicaid and provide premium assistance for an Employee Plus One plan for the newly eligible adults.

Optumas conducted research on the benefit design of the average group insurance plan, but was unable to find useful information about the expected out of pocket costs associated with Nebraska's group insurance plans. Due to this, **Optumas** assumed that the average group insurance plan covered 80% of anticipated medical expenses via premium payments, with the other 20% remaining as out-of-pocket cost sharing payments. **Optumas** grossed up total premiums (employer plus employee) to reflect total plan costs, and then subtracted the employer premium contributions to arrive at the payments expected to be made by the State under ESI premium assistance. Expenses were trended forward at 9% annually to project the CY14 base experience throughout the analysis timeframe. The annual trend rate of 9% is in line with recent commercial PMPM increases. This results in a CY18 cost of \$392 PMPM.

Similar to the QHP Expansion, the State is expected to provide wrap-around benefits for individuals enrolled in ESI Expansion. The exact wrap-around benefits may vary based on the specific plan design for each individual recipient, but it is anticipated it will be comparable to the QHP Expansion wrap-around benefits. **Optumas** modeled these services consistent with the process described under QHP Expansion, resulting in the same \$6 PMPM cost of wrap-around benefits for CY18.

¹² <http://meps.ahrq.gov/mepsweb/>

3.3 Medically Frail Population

Optumas reviewed the Medically Frail criteria established in LB1032 to determine the potential population size and costs associated with the highest-need individuals who will become newly eligible for Medicaid. States that have implemented similar Medically Frail population carve-outs have experience around 10% of the expansion-eligible population receive a determination of Medically Frail. Applying a similar assumption to the previously-mentioned ACS and CPS data results in 15,121 individuals being determined as Medically Frail. **Optumas** assumes these individuals will come equally from the privately insured under 138% FPL and the uninsured under 138% FPL populations. Please see Appendix I for a table depicting population movements.

To develop the cost for this population **Optumas** utilized the State's Medicaid data. **Optumas** also reviewed experience for other states that have implemented a Medically Frail carve-out, and compared the Medically Frail population to historically eligible populations. This comparison showed that the Medically Frail population experienced medical expenses 30% lower than the historically eligible disabled adult population. Based on this result, **Optumas** summarized the anticipated CY17 experience for Nebraska's AABD 21+ M&F population. Adjustments were made as necessary, including adding in expenses to cover anticipated delivery costs for the Medically Frail population and trending forward to CY18. No reimbursement adjustment was made to this population. It was assumed that the State would be able to meet the necessary access to care requirements at the current reimbursement rates. **Optumas** did not conduct an access to care analysis, choosing to rely on feedback from the State instead. It is important to note that if a reimbursement change was necessary to create a sufficiently broad provider network, it is possible that reimbursement rates would change for more than just the Medically Frail Expansion population. Applying these modeling assumptions to the Nebraska data results in a CY18 PMPM of \$1,303 for the Medically Frail population. This PMPM is trended forward at 6% annually throughout the analysis time period. A lower trend is used for the Medically Frail population because it will remain in a Medicaid managed care delivery system, rather than being enrolled in a commercial product. This distinction necessitates the use of traditional Medicaid managed care trend rates, the most recent of which are around 6% annually for a high-need population.

3.4 Woodwork Effect

The concept of the woodwork effect is that people who were eligible for Medicaid prior to expansion but had never enrolled will sign up for Medicaid after expansion. There are various potential reasons for this, including increased publicity for the Medicaid program or confusion around eligibility thresholds that are simplified post-expansion. Since woodwork individuals are eligible for Medicaid prior to the expansion of eligibility criteria, they receive the standard

Federal Medical Assistance Percentage (FMAP) rather than the enhanced rate. The individuals are anticipated to be enrolled in to Medicaid managed care.

To quantify the size of this population **Optumas** reviewed data for states that expanded Medicaid in 2014. Enrollment by month was analyzed to determine if there was a change in growth rates in non-expansion cohorts that could be attributed to the timing of Medicaid Expansion. Applying an anticipated enrollment growth change derived from this analysis to Nebraska enrollment levels results in a woodwork population of 2,870 once all anticipated woodwork individuals have presented.

Woodwork is considered to be time limited. If a person joins traditional Medicaid years after expansion, it is unreasonable to attribute their decision to join Medicaid to the increased publicity and awareness created by Medicaid Expansion. For the purposes of this analysis, **Optumas** assumed that individuals can only be attributed to the woodwork effect for 12 months. Additionally, based on review of other states' experience **Optumas** halved the impact of woodwork after 6 months. For the first 6 months of CY18, traditional Medicaid populations are projected to grow at 2%: 1% is traditional growth, and 1% is attributed to woodwork. For the next 6 months, the population grows at 1.5%: 1% traditional and 0.5% attributed to woodwork. These growth rate differentials, applied to the current TANF 21+ M&F population size, result the full woodwork population of 2,870 mentioned previously.

The woodwork population is not subject to the 1% annual growth rate the other populations receive. As mentioned previously, the woodwork effect is time-limited, so the woodwork population will not continuously grow during the projection period.

The cost of this population is based on the current cost for non-disabled adults. Woodwork individuals are expected to be comparable to this population demographically. However, due to the fact that they have not previously enrolled in Medicaid it can be expected for the woodwork population to be lower cost than the currently enrollment non-disabled adult population. **Optumas** applied a reduction of 10% to recent analyses of the non-disabled adult rate to develop a PMPM cost of \$464 for the woodwork population. The PMPM is trended forward at 6% annually, consistent with the most recent Medicaid managed care trends.

3.5 Member Contributions

Expansion individuals with incomes over 50% FPL are charged a premium per LB 1032. The premium is charged on an individual basis as 2% of household income, however the total premiums paid for a given household may not exceed 5% of the household's income. **Optumas** used CPS and ACS data to determine the distribution of the potential expansion enrollees by FPL band. Family size data from the publicly available survey sources was also incorporated. This data, in conjunction with the established FPL tables, provides the possible payment

amounts for each individual enrolled in Medicaid Expansion.¹³ **Optumas** trended this amount forward from year to year at the recent historical growth in the poverty level threshold.¹⁴ This results in an anticipated PMPM premium of \$294 in CY18. The trend rate to project this value through the remainder of the 10-year projection period is slightly less than 1%.

The 5% per household maximum contribution was deemed a de minimis impact to the premium collection amount.

The proposed legislation states that failure to pay a premium will result in individuals incurring a debt to the State. Resulting from a discussion with the State regarding this aspect of the legislation, **Optumas** modeled a collection rate of 70% of premiums for individuals over 50% of the poverty level. This is meant to represent both the premiums actually paid and the debt incurred for non-payment. As such, the figures listed for member contributions should be considered to be on the high end of potential experience.

3.5 Other Costs

In addition to costs incurred for benefits related to the previously mentioned populations, the State will incur expenses administering the expansion program. The State provided **Optumas** with a summary of Staffing, Information Technology, and Contracting expenses by fiscal year. These have been included in the analysis, and are itemized in Appendix V.

Additionally, the State will experience changes in expenditures by transitioning populations and services that were previously State-fund only to the Medicaid Expansion cohort via the change in eligibility criteria. This is anticipated to be a neutral transition from a total spend perspective, but expenditures will shift from State funds to Federal funds.

¹³ <https://aspe.hhs.gov/poverty-guidelines>

¹⁴ <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/downloads/2015-federal-poverty-level-charts.pdf>

4. Cost Projection Notes

4.1 Limitations

Due to the scope and timeframe for this analysis **Optumas** had to make several assumptions that were unable to be fully validated through data or research. These assumptions, as well as other methodological limitations are discussed below.

Pharmacy Reimbursement

In order to convert the existing Medicaid experience to a reasonable projection of potential costs incurred by QHPs under LB1032's proposed expansion, **Optumas** converted Medicaid reimbursement levels to commercial reimbursement. The reimbursement adjustment for pharmacy has limited support. In **Optumas'** experience with reimbursement analyses it is common for Medicaid to pay significantly less than commercial reimbursement for professional and facility services, but typically pharmacy services are much closer to a uniform reimbursement level across payors. **Optumas** discussed the reimbursement adjustment with the State, and through the course of that discussion the State suggested that no change was necessary to convert Medicaid reimbursement to commercial reimbursement. Since this change is consistent with **Optumas'** experience it was incorporated into the model.

Medicaid Reimbursement Amount

When analyzing the potential cost of the Medically Frail population, **Optumas** assumed the State could achieve necessary access to care standards without increasing reimbursement rates. This would require the current provider network (or new providers contracting for similar rates) to be able to accommodate the medical needs of roughly 15,000 more individuals. If this is not possible, the State may need to increase reimbursement. Some states have received authorization from CMS to pay different rates for different populations, but if Nebraska is not able to receive that authorization the increased reimbursement could apply to the entire Medicaid program. This would represent a substantial increase in costs over what is shown in this analysis.

Assumed Commercial Carrier Response

Costs incurred by the State under QHP expansion will be dependent on the premiums set by commercial carriers operating in Nebraska's HIX. **Optumas** has estimated the price changes commercial carriers might implement using existing rates and projections of the Medicaid Expansion population expense. However, commercial carriers may not have access to the same information, and could estimate the necessary rate change differently.

External Impacts of Expansion

Medicaid Expansion can have many impacts outside of the direct cost paid for services provided to newly eligible individuals. Reductions in uncompensated care could result in less cost-shifting towards commercial payors. Paying higher, commercial levels of reimbursement for the newly-eligible population could further reduce the cost shift dynamic. The influx of a large number of lives into the HIX could help stabilize premiums by providing a larger base of lives, and could also entice additional carriers to compete for business in Nebraska. Impacts such as these have not been incorporated as part of this analysis. The focus has been limited to direct impacts of Medicaid Expansion as proposed by LB1032.

Member Premium Collection

Premium collection from a low income population is typically a difficult task for any state to accomplish. As mentioned in the methodology section of this narrative, **Optumas** has assumed a 70% collection rate, either through actual payments or debts to the state. This should be considered to be a maximum possible collection. While larger collection amounts are theoretically possible (either through an income distribution different than the assumed distribution or a higher collection rate), **Optumas** believes the values used in this report should be treated as a maximum.

Survey Data Reliance

The primary data source underlying the count of people eligible for Medicaid Expansion and the characteristics of those people is survey data. **Optumas** has taken measures to ensure the survey data is used in a reasonable manner, but it remains survey data extrapolated from a smaller population to represent the entire Nebraska population. Due to this extrapolation and the potential for individuals to inaccurately respond to survey questions, it is possible for variance between the survey results and the actual population.

10 Year Projections

Cost estimates have been projected out for 10 years, to SFY2027. Projecting expenditure levels that many years to a future time period drastically increases the potential for projection error. The trends utilized in the analysis are recent trends and very reasonable for the initial years of the projection period, but due to the possibility of unforeseen reforms or interventions they may not be representative of the actual cost growth experienced for the outer years.

Reimbursement Differences

The study on reimbursement differentials between Medicaid, Medicare, and commercial reimbursement relies on national data. The reimbursement differentials specific to Nebraska

may not match what is stated in the referenced report. **Optumas** feels the reimbursement differential is a reasonable estimate and constitutes an appropriate assumption value, but since it is not a State-specific value it could be improved upon via a formal and comprehensive reimbursement analysis.

5. Appendices

5.1 Appendix I – Population Modeling

	Expansion Eligible	Projected to Analysis Period*	Med. Frail Carve Out	Remaining Non-Frail	Ultimate Take-up	Expansion Enrolled	QHP Enrollment Rate	QHP Enrolled	ESI Enrollment Rate	ESI Enrollment
Private	69,597	74,064	10%	66,658	80%	53,326	35%	18,664	65%	34,662
Uninsured	72,489	77,141	10%	69,427	80%	55,542	100%	55,542	0%	-
Total	142,086	151,206	15,121	136,085	27,217	108,868		74,206		34,662

*January 2018 – June 2019, representing the projected enrollment ramp-in period.

5.2 Appendix II – QHP Expansion Blending Process

	CY18		CY19		CY20	
	Enrollment	PMPM	Enrollment	PMPM	Enrollment	PMPM
Private-pay Exchange Enrollment	889,692	\$687	898,589	\$748.49	907,575	\$815.86
QHP Expansion Exchange Enrollment	464,382	\$835	861,186	\$867.30	899,754	\$945.36
Total QHP Cost	1,354,074	\$738	1,759,775	\$806.64	1,807,329	\$880.33

5.3 Appendix III – Wrap-around Benefit Costs

Benefit	CY18 PMPM
NEMT	\$1.25
EPSDT	\$0.01
Vision	\$4.81

5.4 Appendix IV – ESI Premium Details

Year	Individual Plan			Employee +1 Plan		
	Employee	Firm	Total	Employee	Firm	Total
2012	\$1,846	\$3,348	\$5,194	\$2,910	\$7,778	\$10,688
2013	\$1,206	\$4,148	\$5,354	\$2,371	\$6,171	\$8,542
2014	\$1,699	\$4,196	\$5,895	\$4,371	\$6,450	\$10,821

5.5 Appendix V – Administrative Spend by Component and SFY

SFY	Staffing			Information Technology			Contracts		
	Total Funds	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds	Total Funds	State Funds	Federal Funds
SFY17	\$1,572,233	\$635,220	\$937,013	\$1,825,393	\$182,539	\$1,642,854	\$1,723,000	\$861,500	\$861,500
SFY18	\$8,488,732	\$4,093,470	\$4,395,262	\$2,595,132	\$259,513	\$2,335,619	\$369,000	\$184,500	\$184,500
SFY19	\$9,406,623	\$4,552,415	\$4,854,208	\$0	\$0	\$0	\$369,000	\$184,500	\$184,500
SFY20	\$10,465,728	\$5,081,968	\$5,383,760	\$0	\$0	\$0	\$435,000	\$217,500	\$217,500
SFY21	\$10,536,335	\$5,117,271	\$5,419,064	\$0	\$0	\$0	\$369,000	\$184,500	\$184,500
SFY22	\$10,606,942	\$5,152,575	\$5,454,367	\$0	\$0	\$0	\$369,000	\$184,500	\$184,500
SFY23	\$10,677,549	\$5,187,878	\$5,489,671	\$0	\$0	\$0	\$435,000	\$217,500	\$217,500
SFY24	\$10,677,549	\$5,187,878	\$5,489,671	\$0	\$0	\$0	\$369,000	\$184,500	\$184,500
SFY25	\$10,748,156	\$5,223,182	\$5,524,974	\$0	\$0	\$0	\$369,000	\$184,500	\$184,500
SFY26	\$10,818,763	\$5,258,485	\$5,560,278	\$0	\$0	\$0	\$435,000	\$217,500	\$217,500
SFY27	\$10,818,763	\$5,258,485	\$5,560,278	\$0	\$0	\$0	\$369,000	\$184,500	\$184,500
Total	\$104,817,373	\$50,748,827	\$54,068,546	\$4,420,525	\$442,052	\$3,978,473	\$5,611,000	\$2,805,500	\$2,805,500