GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2013

Legislative Fiscal Note

BILL NUMBER: Senate Bill 730 (First Edition)

SHORT TITLE: Expand Medicaid to Include All Below 133% FPL.

SPONSOR(S): Senators Clark and Robinson

FISCAL IMPACT

($ in millions)

☑ **Yes** ☐ **No** ☐ **No Estimate Available**

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
State Impact					
General Fund Revenues:	$ 719.7	$ 2,713.6	$ 2,761.2	$ 2,854.9	$ 2,976.8
General Fund Expenditures	$ 694.5	$ 2,658.5	$ 2,801.5	$ 2,952.1	$ 3,110.6
Special Fund Revenues:					
Special Fund Expenditures:					
State Positions:					
NET STATE IMPACT	**$25.2**	**$ 55.1**	**$ (40.3)**	**$ (97.2)**	**$ (133.8)**
Local Impact					
Revenues:					
Expenditures:					
NET LOCAL IMPACT	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:
Division of Medicial Assistance, Department of Corrections, Division of Public Health and the Division of Mental Health,

EFFECTIVE DATE: January 1, 2015

TECHNICAL CONSIDERATIONS:
Yes - See Technical Considerations Section

BILL SUMMARY:

Expand eligibility for the Medicaid program to include all people under age 65 who have incomes equal to or below 133% of the Federal Poverty Level. Appropriate funds for the administrative costs associated with the expansion and to account for the savings to other State programs from the expansion.

ASSUMPTIONS AND METHODOLOGY:

The Affordable Care Act (ACA) provides enhanced federal match (FMAP) for state's that elect to expand Medicaid eligibility to persons whose income is at or below 133% of the federal poverty level (FPL). North Carolina chose not to expand at the initial effective date of January 1, 2014. This analysis provides the impact of a decision to expand effective January 1, 2015.

Expansion of Medicaid effective January 1, 2015 would allow North Carolina to receive a 100% FMAP for the expanded population through September 30, 2017. In order to determine the impact of expanding Medicaid, the first step is estimating the number of people that would be enrolled in Medicaid if the minimum eligibility guidelines are changed from 100% FPL to 133% FPL.

Utilizing the US Census Bureau data on poverty from 2012[1] and applying uptake assumptions for the percentage of the eligible population that would actually enroll in Medicaid, it is estimated that the following number of individuals would represent the 2014 base population for the newly enrolled in Medicaid:

	Uninsured Uptake	Insured Uptake	TOTAL UPTAKE
Aged	2,417	34,270	36,686
Blind	12	170	182
Disabled	2,099	29,768	31,867
Families and Children	227,886	143,830	371,716
Children	15,949	34,154	50,103
Family Planning	-	-	-
TOTALS	248,363	242,192	490,554

Assuming that the growth rate for this population is consistent with the estimates used for the SFY 2014-15 rebase from the 2011 CMS report from the Office of the Actuary, the expanded enrollment in subsequent years would be as follows:

	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
ENROLLMENT	495,950	501,406	506,921	512,497	518,135	523,834	529,596

The process for estimating the increased enrollment for expansion involved 1) determining the potential population that would be eligible for enrollment, 2) separating the insured population from the uninsured population using North Carolina percentages for the appropriate FPL range[2] and 3) applying "uptake" factors to the insured and uninsured populations.

[1]http://www.census.gov/hhes/www/cpstables/032013/pov/pov46_001_185200.htm
[2] http://www.census.gov/hhes/www/cpstables/032013/health/toc.htm; http://www.nciom.org/wp-content/uploads/2010/08/Uninsured-Snapshot_1-28-13.pdf

The uptake factor for the uninsured population was 57%[3], which is the enrollment rate cited in the Pennsylvania Law Project. The insured population uptake was assumed at 25%, consistent with the previous analysis.

In order to quantify the spending impact the year to date claims spending through February 2014[4] for the populations identified for expansion was calculated on a per member per month (PMPM) basis.

The following chart presents the base PMPM's for the expanded populations:

	Aged	Blind	Disabled	Families	Children
Hospital	$ 15.49	$ 124.87	$ 211.57	$ 104.52	$ 42.35
Physician	$ 41.46	$ 95.53	$ 107.93	$ 71.53	$ 47.32
Dental	$ 8.64	$ 11.48	$ 17.19	$ 22.16	$ 16.78
Drugs	$ 2.98	$ 135.63	$ 210.73	$ 80.72	$ 30.15
Nursing Home	$ 627.82	$ 126.70	$ 64.45	$ 0.06	$ 0.00
Mental Health	$ 75.67	$ 525.70	$ 522.78	$ 86.36	$ 38.68
Other	$ 315.71	$ 231.73	$ 190.26	$ 23.30	$ 11.71
PMPM	$ 1,087.77	$ 1,251.63	$ 1,324.90	$ 388.65	$ 187.01

These PMPM's were adjusted to reflect the cost of the minimum essential benefits package which would exclude dental and nursing home services.

The analysis assumed that the first year would be a transition year for both the uninsured and insured populations. During that year, recipients would gain an understanding of what is covered and access services that either had previously not be available to them or participate in the enhanced benefits available under Medicaid compared to most insurance policies.

The following table presents the assumptions regarding the percentage of a long term Medicaid recipient that an enrollee under the expansion would consume in services in the first year under the expansion:

YR 1 Utilization	Uninsured	Insured
Hospital	50%	50%
Physician	75%	50%
Dental	100%	100%
Drugs	50%	100%
Nursing Home	100%	100%
Mental Health	100%	100%
Other	25%	25%

[3] http://www.phlp.org/wp-content/uploads/2012/09/A-Yardstick-for-Medicaid-Costs.pdf

[4] Truven Data Warehouse extract provided by DHHS

Further it was assumed that there would be an average 45 day lag in claims from the time the service is provided to the time the claim is submitted for payment for the newly enrolled in the first year.

The other factors that were considered included the increase in administrative costs for claims adjudication and prior authorization of services (such as drugs and personal care), increased drug rebate collections, reduced costs in other State agencies with higher eligibility standards and finally the impact on the general economy with more federal cash being infused into the economy from the increased Medicaid enrollment.

The following table (Attachment 1) presents the overall fiscal impact on the State from expanding Medicaid on January 1, 2015:

TOTAL COST OF EXPANSION (Federal and State Dollars)-Minimum Essential Benefits

	2015	2016	2017	2018	2019	2020	2021	Cumulative
Aged	$ 80,942,779	$ 303,648,719	$ 319,742,101	$ 336,688,432	$ 354,532,919	$ 373,323,164	$ 372,254,414	
Blind	832,854	3,034,113	3,194,921	3,364,252	3,542,557	3,730,312	3,928,019	
Disabled	153,612,498	561,774,546	591,548,597	622,900,673	655,914,409	690,677,872	727,283,800	
Families and Children	445,570,663	1,716,383,471	1,807,351,795	1,903,141,440	2,004,007,936	2,110,220,357	2,207,937,192	
Children	27,445,772	107,912,290	113,631,642	119,654,119	125,995,787	132,673,564	138,555,523	
TOTAL CLAIMS	$ 708,404,565	$ 2,692,753,139	$ 2,835,469,055	$ 2,985,748,915	$ 3,143,993,608	$ 3,310,625,269	$ 3,449,958,948	$ 18,445,265,569
Administration	17,081,915	27,729,794	28,034,821	28,343,204	28,654,980	28,970,184	29,288,856	187,940,276
TOTAL REQUIREMENTS	$ 725,486,480	$ 2,720,482,932	$ 2,863,503,877	$ 3,014,092,119	$ 3,172,648,587	$ 3,339,595,453	$ 3,479,247,804	$ 18,633,205,845
GEN FUND APPROP	$ 5,830,817	$ 6,932,448	$ 113,338,795	$ 178,766,364	$ 219,383,313	$ 313,475,383	$ 352,318,109	$ 1,190,045,230
Net Rebates	-	-	(11,065,610)	(19,529,286)	(23,553,541)	(32,188,891)	(36,659,215)	(122,996,543)
DHHS Impact	$ 5,830,817	$ 6,932,448	$ 102,273,185	$ 159,237,077	$ 195,829,773	$ 281,286,492	$ 315,658,894	$ 1,067,048,687
Other State Dept Impact	(30,994,620)	(61,989,239)	(61,989,239)	(61,989,239)	(61,989,239)	(61,989,239)	(61,989,239)	(402,930,054)
State Spending Impact	**$(25,163,802)**	**$(55,056,791)**	**$ 40,283,946**	**$ 97,247,838**	**$ 133,840,534**	**$ 219,297,253**	**$ 253,669,655**	**$ 664,118,634**
New Federal Funds	$ 691,219,361	$ 2,550,209,831	$ 2,466,271,716	$ 2,515,340,602	$ 2,628,004,168	$ 2,710,449,042	$ 2,797,126,265	$ 16,358,620,986

The "Other State Dept Impact" reflects reduced state spending as a result of the expanded population covered by Medicaid in the Department of Public Safety for prisoners in the correction system, Division of Mental Health, Developmental Disabilities and Substance Abuse and the AIDS Drug Assistance Program[5].

The FMAP percentages included in the federal ACA legislation were applied to service expenditures to determine the State share of the expenditures, assuming the following blended rates presented on a state fiscal year basis:

	2015	2016	2017	2018	2019	2020	2021
FMAP	100.0%	100.0%	96.3%	94.3%	93.3%	90.8%	90.0%

Growth rate for the new analysis is consistent with the SFY 2014-15 rebase estimate, which is using CMS' projection for growth in Medicaid enrollment and spending without expansion.

[5] Information prepared by the DHHS Budget and Analysis Section for the 2012 Expansion Analysis

SOURCES OF DATA:

Footnotes are provided with the assumptions and methodology section. In general information was obtained from the US Census Bureau, North Carolina OSBM population projections, DHHS analysis of the impact of Medicaid expansion prepared in 2012, the DMA Truven data warehouse, Pennsylvania Health Law Project and the North Carolina Institute of Medicine.

TECHNICAL CONSIDERATIONS:

This analysis was prepared assuming that the minimum essential benefits would be the coverage for the expanded population. Another consideration is using Medicaid coverage as it exists for other Medicaid enrollees as the benefits package for the expanded population.

There are numerous assumptions that were used to develop this estimate. Critical assumptions have been footnoted throughout the memorandum. Of particular note, service utilization for the expanded population was based on the current Medicaid population use rates, with an adjustment in the first year to account for a "ramping up" of access to services and a lag for provider billing.

There have been significant challenges in obtaining enrollment and expenditure data with the implementation of the new NC Tracks and NC FAST systems through FY 2013-14. Fiscal staff will revise the estimates included in this memorandum if the future data provided by these systems significantly impacts the analysis.

Finally this analysis was prepared by the Fiscal Research Division based on available data and information. The Department was contacted to provide an update to the analysis it prepared in 2012, but as of the date of this Fiscal Memorandum had not responded.

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ATTACHMENT 1

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DATE: May 19, 2014

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