DEPARTMENT OF AUDITS AND ACCOUNTS

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December 21, 2016

Honorable Jason Spencer
State Representative
501-D Coverdell Legislative Office Building
Atlanta, GA 30334

SUBJECT: Fiscal Note
House Bill (LC 33 6665)

Dear Representative Spencer:

This bill would allow Medicaid funds to be used to enroll eligible individuals in a qualified health plan (QHP) through a state, federal, or partnership health insurance exchange or marketplace. Eligible individuals are U.S. citizens or documented qualified aliens, 19 to 65 years of age, who have incomes less than 100% of federal poverty level and are ineligible for coverage through other health care assistance programs. The Georgia Department of Community Health (DCH) would pay health insurance premiums and supplemental subsidies directly to QHP providers on behalf of enrollees. Enrollees would be responsible for paying a personal responsibility premium. The program would terminate if the federal medical assistance percentages (FMAP) dropped below certain levels each year. In addition to premium assistance, this bill calls for the development and execution of a pilot to test the viability of a health savings account (HSA) for eligible members.

DCH provided estimates of the enrollees, costs, and revenue that would result from the premium assistance program. As shown in **Exhibit 1**, in fiscal year 2021, state costs are estimated between $255.5 million and $338.8 million ($752 to $756 per new enrollee), while $9.9 million to $12.7 million in additional revenue would be collected. Potential costs associated with the HSA pilot are shown on page 5. The program is expected to take two years to reach full enrollment.

Cost savings for state agencies that currently spend state funds on health services to the uninsured are likely to occur. These agencies include the Department of Community Health, the Department of Public Health (DPH), Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia Department of Corrections (GDC). Savings from these agencies are estimated to be $51.8 million in fiscal year 2019 and $47.4 million in fiscal year 2021, with the

decrease attributable to reductions in federal matching percentages for the newly eligible and enrolled clients.

Exhibit 1: Estimate of Financial Impact, State Fiscal Years 2019 to 2021

($ in Millions)	FY2019 Low	FY2019 High	FY2020 Low	FY2020 High	FY2021 Low	FY2021 High
Estimated Enrollment						
Newly Eligible	259,223	331,626	288,526	373,328	290,963	376,480
Currently Eligible (Woodwork)	33,315	52,685	48,585	71,441	48,746	71,673
Total Estimated Enrollment	**292,538**	**384,310**	**337,111**	**444,768**	**339,709**	**448,154**
Ongoing State Costs						
Newly Eligible	$112.4	$143.8	$168.2	$217.6	$205.1	$265.3
Currently Eligible (Woodwork)	$27.2	$43.4	$41.2	$60.9	$43.1	$62.8
Administration(1)	$6.1	$8.6	$7.3	$10.6	$7.3	$10.6
Total State Costs	**$145.7**	**$195.8**	**$217.2**	**$289.1**	**$255.5**	**$338.8**
State Costs/Enrollee(2)	$498	$509	$644	$650	$752	$756
Additional Revenue						
Net State Insurance Premium	$8.5	$11.0	$9.6	$12.4	$9.9	$12.7
	FY2019		**FY2020**		**FY2021**	
Cost Savings(3)						
Dept. Community Health	$0.0	$21.3	$0.0	$18.9	$0.0	$16.5
Dept. Public Health	$1.6	$2.1	$1.7	$2.2	$1.7	$2.2
Dept. Behavioral Health	$9.5	$12.1	$10.2	$13.1	$10.2	$13.0
Dept. Corrections	$15.3	$16.3	$15.0	$15.9	$14.7	$15.7
Total Cost Savings	**$26.4**	**$51.8**	**$26.9**	**$50.1**	**$26.6**	**$47.4**

(1) Administration will require startup funding in SFY 2018 of $2.4 million to $4.1 million in state funds.
(2) Amounts based on a combination of newly eligible and currently eligible enrollees, which have different federal matching rates.
(3) Agency spending for uninsured or number of uninsured served is on page 6.

Totals may not sum due to rounding.

Estimated Enrollment

The bill would result in additional Medicaid enrollees in two categories: those newly eligible and those already eligible that would enroll after seeking coverage due to the bill. DCH estimated the population of each for fiscal years 2019-2021 and assumed that it would take two years to reach full participation. Each category and subcategory included a low and high participation rate, leading to a range of estimates. Enrollment estimates are included in **Exhibit 2** and are discussed in more detail below.

Exhibit 2: Projected Enrollment, State Fiscal Years 2019 to 2021

	FY2019		FY2020		FY2021	
Enrollment Population	**Low**	**High**	**Low**	**High**	**Low**	**High**
Newly Eligible Adults	259,223	331,626	288,526	373,328	290,963	376,480
Woodwork Effect	33,315	52,685	48,585	71,441	48,746	71,673
Total Enrollment	**292,538**	**384,310**	**337,111**	**444,768**	**339,709**	**448,154**

- *Newly Eligible* – This category includes uninsured adults living below 100% of the Federal Poverty Level (FPL), but it also includes adults living below 100% FPL and currently insured by their employer and adults living below 100% FPL and currently insured through the Federal Health Insurance Exchange.
    - *Currently Uninsured* – The estimated population was obtained from U.S. Census Bureau's 2015 Current Population Survey. Participation rates of 75% and 95% were used for state fiscal year 2021. The participation rates would equate to an estimated enrollment of 267,180 to 338,428. A relatively high level of participation from this population is expected because these individuals are currently uninsured.
    - *Currently Insured through Employer* – The estimated population was obtained from U.S. Census Bureau's 2015 Current Population Survey. It was estimated that 25% and 40% would choose the coverage offered through the bill by FY 2021. This would equate to 23,783 to 38,052 adults. A percentage of this population will opt for Medicaid coverage due to lower costs than their current employer-based coverage.
- *Currently Eligible (Woodwork Effect)* – This category includes uninsured adults and children that already qualify for Medicaid coverage but are not enrolled. As a result of seeking coverage through the new program, they will be identified and enrolled in the existing Georgia Families Care Management Organization (CMO) Program. The population estimated to be currently eligible but uninsured was obtained from U.S. Census Bureau's 2015 Current Population Survey. Approximately 25% to 40% was deemed likely to enroll, resulting in 48,746 to 71,673 enrollees by state fiscal year 2021.

Total and State Costs

The bill's costs are estimated for three categories: premium assistance/cost sharing subsidy for new enrollees; payments to CMOs for those resulting from the woodwork effect, and program administration. Each amount for each category is dependent on the enrollments above; therefore, a range is included for each year. The FMAP for the category and year was applied to determine state costs. Total costs and state costs are shown in **Exhibit 3** and are discussed below.

Exhibit 3: Projected Total and State Cost, State Fiscal Years 2019 to 2021

TOTAL COSTS						
	FY2019		FY2020		FY2021	
($ in Millions)	Low	High	Low	High	Low	High
Newly Eligible	$1,729.8	$2,213.0	$1,978.7	$2,560.3	$2,050.7	$2,653.5
Woodwork Effect	$85.9	$137.1	$132.0	$192.3	$136.2	$198.4
Administration(1)	$21.1	$28.8	$24.8	$34.5	$24.9	$34.7
Admin. FTEs	162	210	186	244	187	245
Total Costs	**$1,836.8**	**$2,378.9**	**$2,135.5**	**$2,787.1**	**$2,211.8**	**$2,886.5**
Cost/Enrollee(2)	**$6,279**	**$6,190**	**$6,335**	**$6,266**	**$6,511**	**$6,441**

STATE COSTS ONLY						
	FY2019		FY2020		FY2021	
($ in Millions)	Low	High	Low	High	Low	High
Newly Eligible	$112.4	$143.8	$168.2	$217.6	$205.1	$265.3
Woodwork Effect	$27.2	$43.4	$41.8	$60.9	$43.1	$62.8
Administration(1)	$6.1	$8.6	$7.3	$10.6	$7.3	$10.6
State Costs	**$145.7**	**$195.8**	**$217.2**	**$289.1**	**$255.5**	**$338.8**
Cost/Enrollee(2)	**$498**	**$509**	**$644**	**$650**	**$752**	**$756**

(1) Administration includes FY 2018 startup costs of $7.4 million to $11.4 million, with the state share estimated at $2.4 million to $4.1 million.
(2) Cost per enrollee within each year varies because the woodwork effect comprises a different percentage of enrollees within the low and high ranges. The newly eligible and woodwork populations have different FMAPs, which affects the state cost per enrollee.

Totals may not sum due to rounding.

- *Newly Eligible (Premium Assistance and Cost Sharing Subsidy)* – Total costs in fiscal year 2021 for this population are estimated to be $2.1 billion to $2.7 billion, with a state share of $205.1 million to $265.3 million. DCH applied an FMAP rate of 93% for federal fiscal year 2019 and a 90% for federal fiscal year 2020 and 2021.

  The cost of the premium assistance and cost sharing subsidies was calculated using the cost of silver level plans for Georgia found on the 2016 federal health insurance exchange and adjusted for inflation. Each year includes a high and low cost estimate, dependent on projected enrollment. The projected aggregate per member per month (PMPM) is $550.36 in CY 2019 and $581.61 by CY 2021. This is higher than exchange plan premiums because the state must pay any cost-sharing requirements (e.g., deductible, copays) that exceed 5% of an enrollee's household income and must fund other Medicaid services not required by qualified health plans (e.g., non-emergency transportation, access to federally qualified and rural health centers). DCH also offset the premium costs based on revenues generated by the Personal Responsibility Premiums paid by members.

- *Previously Eligible for Medicaid (i.e., Woodwork Effect)* – Total costs in fiscal year 2021 are an estimated $136.2 million to $198.4 million. State costs are $43.1 million to $62.8 million. While the total costs per CMO enrollee is lower than those newly eligible, the state costs per enrollee are higher due to a lower FMAP for this category. The current FMAP rate for Georgia is approximately 68%. The cost to cover newly enrolled Medicaid participants was calculated using low income Medicaid rates for children and adults enrolled in the Georgia Families Care Management Organization (CMO) Program. The

Georgia Families adult PMPMs range by age and gender from $285.39 to $572.44. These participants will be approximately 85% children and 15% adults dependent upon the size of the population. The costs also include the $5.73 PMPM charge for non-emergency transportation.

- *Administration* – Total administrative costs are estimated to be $24.9 million to $34.7 million in fiscal year 2021, with a state share of $7.3 million to $10.6 million. In fiscal year 2018, startup costs are included. DCH estimated administrative costs using its historical costs for Medicaid administration. The state share is based on a compilation of FMAP rates for various Medicaid-related activities. The aggregate administrative FMAP ranges from 69% to 71% depending on the fiscal year and low to high level scenarios. Depending on the activity, Medicaid administrative FMAP ranges from 75% for eligibility-related functions and claims processing to 50% for program development, oversight, compliance and reporting.

Health Savings Account Pilot

The bill provides limited guidance for designing the Health Savings Account (HSA) pilot. For the purposes of the fiscal note, it is assumed that these individuals would be covered by one of the silver level qualified health plans.

The cost of the HSA pilot is dependent on the plan design and the number of enrollees. Projected costs are presented in **Exhibit 4** presuming a 10% participation level. In the absence of prescriptive language in the bill, DCH modeled scenarios similar to Indiana's HSA program. The analysis assumes the 2% Personal Responsibility Premium is deposited into the HSA, with an assumed average annual income of 75% FPL. It also assumes that the amount deposited into the account is spent in the same year. Administrative costs are set at amounts similar to the monthly fees assessed on private HSAs ($4.50/month), though actual costs would likely depend on a number of factors such as procurement, member churn, and the number of participants. The maintenance cost is split evenly between state and federal funds. The FMAP rate for the premium assistance program is applied to the cost of the HSA contributions. However, the maintenance costs are covered by the administrative FMAP rate at roughly 50%.

Exhibit 4: Projected Cost of Health Savings Account Pilot, State Fiscal Years 2019-2021

	2019		2020		2021	
($ in millions)	Low	High	Low	High	Low	High
State Contribution	$4.6	$5.9	$6.5	$8.4	$7.5	$9.8
Federal Contribution	$57.0	$72.9	$62.1	$80.3	$61.6	$79.7
Total Contribution	$61.6	$78.8	$68.5	$88.7	$69.1	$89.4
Totals may not sum due to rounding.						

Additional State Revenue

The program will generate additional state revenue through the State Insurance Premium Tax and the Hospital Medicaid Financing Program. The bill is expected to generate additional State Insurance Premium Tax revenue of $8.5 million to $11.0 million in fiscal year 2019, with the amount increasing over the next two years (**Exhibit 5**). The premium tax is paid on all health

insurance plans operating in Georgia, which would include those plans resulting from the bill. Regarding the Hospital Medicaid Financing Program, a lag between hospital revenues and the payment of the program fee means that additional revenue would not be collected until fiscal year 2022 (three years after hospitals' 2019 revenue). It should be noted that this program is only authorized through June 30, 2017. If the program is not re-authorized, the state revenue will not be realized. We did not attempt to calculate the subsequent effect that the bill would have on individual income tax or sales tax.

Exhibit 5: Projected Additional State Revenue

($ in Millions)	FY2019		FY2020		FY2021	
	Low	High	Low	High	Low	High
State Insurance Premium Tax	$8.5	$11.0	$9.6	$12.4	$9.9	$12.7
	FY 2022		FY 2023		FY 2024	
Hospital Medicaid Financing Program Fee (if re-authorized at current fee level)	$6.2	$7.9	$7.0	$8.9	$7.2	$9.2

Potential Cost Savings

By expanding Medicaid eligibility, the bill would likely result in cost savings to existing Medicaid programs and other state health programs that serve the uninsured. The amount of these savings is dependent on Medicaid policy decisions, the amount of uninsured care provided by agencies that is reimbursable under Medicaid, and a continued need to fund an infrastructure in those agencies.

- *DCH Medicaid Programs* – DCH currently provides Medicaid coverage to certain categories of individuals, a portion of which would be eligible under the bill's provisions. Individuals who meet the eligibility requirements under the bill (most notably the FPL requirement) could be placed in the newly eligible category, which has a higher FMAP and lower state costs than the current categories under which these individuals qualify for coverage. While there are policy considerations beyond costs related to a transition, DCH identified the categories as the Medically Needy Program, the Breast and Cervical Cancer Waiver, and the Family Planning Waiver. DCH provided a "high level estimate" of potential state savings of $21.3 million in fiscal year 2019, $18.9 million in fiscal year 2020, and $16.5 million in fiscal year 2021.

  The Robert Wood Johnson Foundation (RWJF) issued a report in March 2016[1] examining the budget impact of Medicaid expansion in eleven states: Arkansas, California, Colorado, Kentucky, Maryland, Michigan, New Mexico, Oregon, Pennsylvania, Washington, and West Virginia. Pregnant women, medically needy, disabled adults, breast and cervical cancer program, and family planning were identified as savings categories. However, not all states expected savings in every category.

- *Other Healthcare Programs* – The state provides funding to multiple state agencies that provide health care to individuals who would become Medicaid eligible under the bill. As uninsured individuals enroll in Medicaid, a portion of state funding would be replaced with

[1] *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, Robert Wood Johnson Foundation Issue Brief: March 2016

federal Medicaid funds. We collected client and service counts from the Departments of Behavioral Health and Developmental Disabilities, Public Health, and Corrections and estimated cost savings to the state as described below.

- *Behavioral Health* – Under a Medicaid expansion, some DBHDD services would be covered by Medicaid (e.g., physicians, prescriptions, therapy), but other services would not be (e.g., housing, supported employment, crisis services). DBHDD indicated that it provided care for 53,233 uninsured individuals during fiscal year 2016 and that Medicaid applicable services totaled $1,019 per recipient during the period. We estimate that implementation of this bill will result in approximately 10,200 to 13,074 currently uninsured DBHDD clients becoming insured (including both woodwork and newly eligible clients). As a result, the state would receive federal funding of approximately $9.5 million to $12.1 million for FY2019.

  Five states reviewed by RWJF (AR, CO, KY, MI, WA) reported actual or expected savings of state funds for mental/behavioral health spending.

- *Public Health* – DPH provides some health care services in the community via county health departments. Like DBHDD, county health departments provide services that would be reimbursable under Medicaid, while providing others that would not. DPH reportedly served 520,369 Medicaid clients and 531,519 non-Medicaid clients in fiscal year 2016.[2] We estimate implementation of this bill will result in approximately 101,847 to 130,545 currently uninsured DPH clients becoming insured (including both woodwork and newly eligible clients). As a result, the state would receive federal funding of approximately $1.6 million to $2.1 million for FY2019.

  Two states reviewed by RWJF (AR, WA) expected to replace some state public health spending with federal funds.

- *Corrections* – According to the RWJF report, "Medicaid will cover services provided to an inmate during an inpatient stay of at least 24 hours in a medical institution such as an acute care facility. To qualify, the inmate must be otherwise Medicaid-eligible." GDC reported 947 individual inmates accounting for 1,263 inpatient hospitalizations and 7,082 inpatient bed days greater than 24 hours in fiscal year 2016. While it is difficult to know the percentage of inmates eligible under the bill, we expect a majority to meet the income requirements. If 75% to 80% are eligible, this bill will result in approximately 710 to 758 offenders becoming insured. As a result, the state would receive federal funding of approximately $15.3 million to $16.3 million for FY2019.

  Four states reviewed by RWJF (AR, CO, MI, WA) expected to save state funds related to inmate hospitalization.

[2] Includes some clients with private insurance and some as uninsured or "self-pay."

DBHDD and DPH have fixed costs and are required to operate a statewide infrastructure. State funding would be necessary to ensure that the agencies maintain the capacity to serve those without insurance or to provide those services that are not reimbursable.

Sincerely,

Greg S. Griffin
State Auditor

Teresa A. MacCartney, Director
Office of Planning and Budget

GSG/TAM/ct