Ohio Legislative Service Commission

Wendy Risner

Fiscal Note & Local Impact Statement

Bill: H.B. 176 of the 130th G.A. **Date**: October 15, 2013

Status: As Re-referred to House Health and Aging **Sponsor**: Rep. Sears

Local Impact Statement Procedure Required: No

Contents: To implement Medicaid reforms, permit the coverage of additional groups under certain circumstances, and to revise the duties of the Joint Legislative Committee on Medicaid Technology and Reform

State Fiscal Highlights

- **Medicaid reform**. There could be a decrease in Medicaid expenditures depending on the extent that the Ohio Department of Medicaid (ODM) is able to achieve the reform objectives detailed in the bill. Any decrease in Medicaid expenditures would result in a loss of federal Medicaid reimbursement.
- **Medicaid expansion**. Mercer, the state's current contracted actuarial firm, estimated the fiscal impact of providing Medicaid services to the expansion population is approximately $2.6 billion over the FY 2014-FY 2015 biennium, all of which will be paid by the federal government. Currently, some individuals qualify for Medicaid at income levels above 138% of the federal poverty line as a result of income disregards, transitional medical assistance, and other exceptions. There could be state savings if these individuals receive tax credits on the Health Insurance Exchange instead of receiving services through the Medicaid Program.
- **Medicaid expansion**. There will be a gain in revenue from the sales and use tax on Medicaid managed care organizations (MCOs). A portion of the sales and use tax revenue is transferred to the Public Library Fund and the Local Government Fund.
- **Medicaid expansion**. As a result of the Medicaid expansion, the state could realize savings if Ohioans who are covered by other programs move onto Medicaid.

Local Fiscal Highlights

- **Medicaid expansion**. As a result of the Medicaid expansion, local governments could see savings if Ohioans who are covered under locally funded programs move onto Medicaid. Additionally, public hospitals and other local government entities providing health care services will realize an increase in service costs and a corresponding gain in Medicaid payments due to the expansion population.
- **Medicaid expansion**. There will be a gain in revenue for counties from the sales and use tax on Medicaid MCOs since county add-on sales tax also apply to MCOs.

Detailed Fiscal Analysis

Medicaid reforms

The bill, subject to any necessary federal approval, requires the Medicaid Assistance Director to implement reforms that do all of the following: (1) improve the health of recipients while reducing the cost of health care and uncompensated health care costs, (2) control expenditures and reduce the rate of expenditures, (3) enroll at least 80% of recipients in a care management system, group health plan, Medicaid component that provides premium assistance for qualified employer-sponsored coverage to Medicaid recipients under age 19 and their parents, a Medicaid component that provides payments for insurance premiums for certain individuals, or a Medicaid waiver component that provides premium assistance for Medicaid recipients to purchase qualified health plans through a Health Benefits Exchange, (4) require recipients to assume greater personal responsibility under both cost-sharing programs and a Medicaid component that incorporates the objectives of health savings accounts through value insurance designs, (5) ensure that Medicaid recipients who abuse narcotics receive proper treatment and are unable to access narcotics through the health care system, (6) promote employment-related services and job training available under Medicaid and other programs to lower Medicaid caseloads, (7) make the program more efficient, and (8) support health care payment innovations in the private sector by assisting other purchasers of health care services and health care providers by leveraging the Medicaid Program's purchasing power.

There would be decreases in Medicaid expenditures depending on the extent that the Director is able to achieve the objectives specified in the bill. Any decrease in Medicaid expenditures would result in a corresponding loss of federal Medicaid reimbursement. Generally, the federal government reimburses Ohio about 64% for Medicaid medical services expenditures and about 50% for administrative expenditures. Most Medicaid payments for services are made from GRF line item 651525, Medicaid/Health Care Services, by the Ohio Department of Medicaid (ODM). However, other non-GRF and federally funded line items are also used for Medicaid expenditures.

While ODM is currently implementing certain cost-saving utilization and payment reforms and is able to adjust provider rates for hospitals, physicians, and other community providers through the agency rule-making process, there are certain constraints in the Medicaid Program. Payment rates to managed care companies must be set each year by a certified actuary. Payments to nursing facilities and intermediate care facilities are established in state law. Also, Aged, Blind, and Disabled caseloads are projected to increase due to Ohio's aging population, and since Medicaid is an entitlement program, individuals who are categorically eligible to receive services are entitled to receive those services.

Federal approval

The bill requires the Medicaid Assistance Director to seek federal approval for applicable reforms. However, the bill prohibits any reform from being implemented until this approval is granted, unless federal law allows implementation to begin prior to approval. Medicaid reforms generally require federal approval. Thus, the provision would have no fiscal effect.

Reporting requirement

The Director is required to prepare reports on the progress being made in implementing the reforms. The annual report is to be submitted to the General Assembly. ODM would realize a minimal increase in administrative costs for preparing these annual reports.

Medicaid expansion

Beginning January 1, 2014, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred to collectively as the Affordable Care Act (ACA)) require states to expand their Medicaid programs. However, the Supreme Court made this expansion optional. The expansion would include individuals who are: (1) under 65 years of age, (2) not pregnant, (3) not entitled to or enrolled for benefits under Medicare Part A, (4) not enrolled for benefits under Medicare Part B, (5) not otherwise eligible for Medicaid, and (6) have incomes not exceeding 133% of the federal poverty line (138% after 5% income disregard and using individuals' modified adjusted gross incomes (MAGI)). The bill permits the Medicaid Program to cover the expansion group or one or more subgroups of the group if the following apply: (1) the federal match for the expenditures for Medicaid services provided to the group or subgroup is at least the amount specified in federal law on March 30, 2010, and (2) the Medicaid Program is able to cover the group or subgroup in a manner that causes per recipient Medicaid expenditures to be reduced.

The federal government will reimburse 100% of costs associated with the expansion group for calendar years (CY) 2014, 2015, and 2016, 95% of costs for CY 2017, 94% of costs for CY 2018, 93% of costs for CY 2019, and 90% of cost for subsequent years. If federal reimbursements fall below these amounts, the bill specifies that coverage to the expansion group and any subgroup must stop. An individual's disenrollment from Medicaid is not subject to appeal under these circumstances.

Mercer, the state's current contracted actuarial firm, estimated the fiscal impact of providing Medicaid services to the expansion population to be approximately $2.6 billion over the FY 2014-FY 2015 biennium, all of which will be paid by the federal government. Currently, some individuals qualify for Medicaid at income levels above 138% of the federal poverty line as a result of income disregards, transitional medical assistance, and other exceptions. There could be state savings if these individuals receive tax credits on the Health Insurance Exchange instead of receiving services through the Medicaid Program. Additionally, in some cases, state and local

governments could see savings result when Ohioans who are covered by other programs move onto Medicaid. For example, the Ohio Department of Rehabilitation and Correction could realize savings for prisoner inpatient hospital costs and the county community mental health and addiction services system could realize a savings for locally funded services that are shifted to Medicaid. Additionally, public hospitals and other local government entities providing health care services will realize an increase in service costs and a corresponding gain in Medicaid payments due to the expansion population.

Ohio has a sales and use tax on Medicaid managed care organizations (MCOs) and this tax will be impacted by the bill. Revenues collected from this tax are deposited into the GRF. A small portion of the sales and use tax revenue is transferred to the Public Library Fund and the Local Government Fund. County add-on sales tax also apply to MCOs. The sales tax rate applies to payments from the state to the MCOs. As a result of the Medicaid expansion, a gain in sales and use tax revenue is expected.

Ohio Medicaid Reform Fund

The bill creates the Ohio Medicaid Reform Fund and specifies that the fund is to consist of funds the state receives for the federal share of Medicaid expenditures for the expansion group or subgroups. The fund is to be used as the federal share of Medicaid expenditures for the expansion group or subgroups. Additionally, the bill allows the Director of Budget and Management to create any necessary accounts or line items for the Ohio Medicaid Reform Fund and specifies that any money deposited into the fund during FY 2014 and FY 2015 is appropriated.

Joint Legislative Committee on Medicaid Technology and Reform

The bill revises the law governing the existing Joint Legislative Committee on Medicaid Technology and Reform. The Committee currently consists of five members appointed by the Speaker of the House of Representatives and five members appointed by the Senate President. The bill specifies that the Speaker and President are to each appoint three members from the majority party and two members from the minority party. The bill requires the Speaker and the President to each designate one of the members from the majority party to serve as co-chairperson.

The Committee is permitted by continuing law to study any matter it considers relevant to Medicaid Program operations; however, priority is given to the study or review of mechanisms to enhance the program's effectiveness through improved technology systems and program reform. The bill specifies that the reforms that are to receive priority are the reforms that are to be implemented under the bill.

The bill requires the Committee to meet at least once each quarter and specifies that the co-chairpersons are to arrange for the Medical Assistance Director to testify periodically. The co-chairpersons are permitted to request assistance and staff support from the Legislative Service Commission.

Since the Committee is already established and consists of the same number of members, presumably there would be no fiscal impact.

HB0176RH.docx/jc