



**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID BUSINESS AND POLICY**

Nicholas A. Toumpas
Commissioner

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Kathleen A. Dunn
Associate Commissioner

March 10, 2015

Representative Richard Barry, Chairman
House Finance, Division III
Legislative Office Building
33 North State Street, Room 209
Concord, NH 03301

Subject: Request for Additional Information – DHHS Office of Medicaid Business and Policy

Dear Representative Barry:

Thank you for providing the opportunity for the Department of Health and Human Services, Office of Medicaid Business and Policy to provide an overview of the Medicaid program as an introduction to our SFY16-17 budget. During our work-session on March 3, 2015, requests were made for additional information, which we are providing to you below.

1) Representative Rosenwald requested more current dashboard information related to long-term-care (LTC) caseloads.

See Attachment #1, DHHS Dashboard, SFY15 Data thru January 2015, Table H

2) Representative McGuire requested a comparison of eligibility requirements for pre- and post- ACA.

Response to be submitted separately

3) Representative Kurk requested a list of optional Medicaid services and associated costs.

See Attachment #2

4) Representative Barry requested DHHS provide the rate ranges, as determined by the actuary, which could be paid to MCOs.

Milliman does not produce a rate range. This was completed at the beginning of the program to establish a baseline. Since then, rates are set based on claims experience, and applying actuarial assumptions about the impact of care management on utilization of services. The original actuarial rate ranges produced by Milliman in February 2012 was \$276.97 low end to \$308.77 high end, however, this is no longer a part of the MCO rate setting process.

5) Explanation of why we should not reduce MCO Admin fee more than 2%

The administrative expense allowance included in the MCM capitation rates is \$29.12 PMPM or 8.98% for the January 2015 – June 2015 time period. The actuarial research shows that the 50th percentile administrative cost is 11.0%, with the 25th percentile at 8.3%. Based on that information, it appears that the administrative expense allowance included in the MCM capitation rates is already at the low end nationally. Please note, some MCOs cover LTC services while those services are currently not part of the NH MCM program. The administrative allowance for those services may skew the direct comparison of this assumption to national results.

The actuary has recently received financial information from one of the MCOs which shows an average administrative expense of 12.1% over their first year of operation. It is the actuary's recommendation that the administrative allowance not be decreased until the program is more mature and the MCOs have had a chance to become more efficient.

6) Representative Kurk requested detailed information showing how much we have spent (state and federal funds) for administration on the New Hampshire Health Protection Program (NHHPP).

DHHS Est NHHPP Admin and Contract Costs

Figures Rounded to \$000

| | SFY15 | | | SFY16 | | | SFY17 | | |
|---------------------------------|------------------|------------------|-----------------|------------------|------------------|----------------|------------------|------------------|----------------|
| | General Funds | Federal Funds | Total Funds | General Funds | Federal Funds | Total Funds | General Funds | Federal Funds | Total Funds |
| Personnel | \$1,412 | \$1,725 | \$3,137 | \$1,633 | \$2,089 | \$3,722 | \$1,702 | \$2,177 | \$3,879 |
| Equipment | \$52 | \$0 | \$116 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Current expense | \$130 | \$0 | \$288 | \$130 | \$158 | \$288 | \$130 | \$158 | \$288 |
| HIPP Contractor (HMS) | \$0 | \$0 | \$3,401 | \$1,651 | \$1,651 | \$3,302 | \$1,651 | \$1,651 | \$3,302 |
| Maximus contract (enrollment) | \$125 | \$0 | \$250 | \$125 | \$125 | \$250 | \$125 | \$125 | \$250 |
| Karno (communications) | \$366 | \$0 | \$731 | \$150 | \$150 | \$300 | \$0 | \$0 | \$0 |
| Manatt (NHHPP policy & program) | \$918 | \$0 | \$1,836 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Deloitte: Development costs | \$276 | \$2,487 | \$2,764 | \$96 | \$864 | \$960 | \$27 | \$246 | \$274 |
| Xerox: development costs | \$213 | \$1,919 | \$2,133 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Xerox: software | \$197 | \$593 | \$790 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Xerox: license fees and support | \$72 | \$216 | \$288 | \$157 | \$472 | \$630 | \$157 | \$472 | \$630 |
| Xerox: staffing | \$54 | \$160 | \$214 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| TOTAL | \$3,814 | \$7,100 | \$15,948 | \$3,942 | \$5,509 | \$9,452 | \$3,792 | \$4,829 | \$8,623 |

7) Representative McGuire requested a side-by-side comparison document of the qualification requirements for someone in traditional Medicaid and the NH Health Protection Plan.

Response to be submitted separately

8) Corrected copy of the "NHHPP Summary 03-03-15" spreadsheet.

See Attachment #3

9) Copy of most recent Dr Gittell Enrollment Forecast Report

See Attachment #4

10) Representative Barry requested the Lewin Executive Summary

See Attachments:

- #5 Lewin Executive Summary Phase I November 2012
- #6 Lewin Executive Summary Phase II January 2013
- #7 Lewin Executive Summary Phase III Final Report September 2013

11) Representative McGuire requested a copy of SB 413

See Attachment #8

12) Rep. McGuire requested a copy of the Premium Assistance Waiver

See Attachment #9 Premium Assistance Waiver and Attachment #10 Premium Assistance Approval letter

13) Premium Assistance program co-pays

See Attachment #11

14) Agency 047 C1101 Costs

Agy 047: OMBP Budget Summary

Class Title: C1 101 Medical Payments to Providers

Figures Rounded to \$000

| Approp | FY14 Actual | FY15 Adj Auth | FY15 Reclassified | FY15 Revised | FY16 Governor | FY17 Governor |
|--------------------------------|----------------|------------------|----------------------|----------------|------------------|------------------|
| 7937 Medicaid Admin | 221 | 401 | - | 401 | 400 | 400 |
| 7945 Electronic Health Records | 5,436 | 6,178 | - | 6,178 | 2,718 | 1,929 |
| 7946 Affordable Care Act (ACA) | 14,227 | 9,717 | - | 9,717 | - | - |
| 7940; 7948;7941 and 7942 | 178,748 | 236,794 | 192,705 | 673,236 | 613,985 | 609,045 |
| TOTAL | 198,631 | 253,090 | 192,705 | 689,533 | 617,102 | 611,374 |

7937 Medicaid Admin – funds in this account are made either to a vendor or to a client. Application Assistors payments are made to vendors (mostly hospitals) that have been authorized by the Department to assist clients with submitting a complete Application for Assistance document. Client reimbursements are made to Medicaid clients that have other insurance that are required to receive their maintenance prescriptions through mail-order pharmacies. NH Medicaid reimburses the client for out of pocket expenses instead of incurring the full cost of the prescription. Clients are reimbursed from this account as determined from a Fair Hearing.

7945 Electronic Health Records Incentive Payments – funds in this account support incentive payments to eligible health care providers as part of the New Hampshire Medicaid Electronic Health Records Incentive Program. The incentive payments are processed based on New Hampshire's State Medicaid Health Information

Technology Plan based on Centers for Medicare and Medicaid Services approval. These payments are funded 100% federal funds.

7946 Affordable Care Act (ACA) Payments under Section 1202 of the Affordable Care Act, which requires increase primary care reimbursement to parity with Medicare for calendar years 2013 and 2014. The Affordable Care Act implements Medicaid payment for primary care services furnished by certain physicians in calendar years 2013 and 2014 at rates not less than the Medicare rates in effect in those calendar years. These payments are not part of the FY16/17 budget and are reported in the above table for historical reference only for FY14/15.

7940 Provider Payments; 7948 Medicaid Care Management; 7941 BCC Program and 7942 Family Planning Services – includes costs associated for fee-for service; prescription drugs, outpatient hospital and monthly care management premium payments.

Please feel free to contact us with any further questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Sh L Rock", is written over a light blue circular stamp.

Sheri L. Rockburn, CPA
DHHS Chief Financial Officer

cc: Nicholas Toumpas, Commissioner

Attachment 1 DHHS Dashboard SFY15 Elderly LTC
Attachment 2 List of optional Medicaid services and associated costs
Attachment 3 Corrected copy of the NHHPP Summary 03-03-15
Attachment 4 Dr. Gittell Enrollment Forecast Report
Attachment 5 Lewin Executive Summary Phase I November 2012
Attachment 6 Lewin Executive Summary Phase II January 2013
Attachment 7 Lewin Executive Summary Phase III Final Report September 2013
Attachment 8 SB413
Attachment 9 Premium Assistance Waiver Special Terms and Conditions
Attachment 10 Premium Assistance Approval letter
Attachment #11 Premium Assistance program co-pays

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N |
|----|---|--|---------------|------------------------|---------------------|----------------------|--------------------------|---------------|------------------|----------------------------|--------------------------|---------------------------|------------------------|-----|
| 1 | Table H | | | | | | | | | | | | | |
| 2 | Department of Health and Human Services | | | | | | | | | | | | | |
| 3 | Operating Statistics | | | | | | | | | | | | | |
| 4 | Elderly & Adult Long Term Care | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | |
| 6 | | Total Nursing Clients | | CFI Home Health | CFI Midlevel | Other Nursing | Nursing Home Beds | | Pct In NF | APS Clients Assmnts | APS Cases Ongoing | SSBG AIHC Waitlist | Total SSBG AIHC | |
| 7 | | Actual | Budget | | | Note 1 | 3 mo. Avg | Budget | | | | | | |
| 8 | | | | | | | | | | | | | | |
| 44 | Jul-12 | 7,225 | 7,578 | 2,401 | 444 | 34 | 4,380 | 4,422 | 60.6% | 238 | 1,096 | 9 | | |
| 45 | Aug-12 | 7,448 | 7,578 | 2,468 | 471 | 39 | 4,509 | 4,422 | 60.5% | 251 | 1,087 | 5 | | |
| 46 | Sep-12 | 7,281 | 7,578 | 2,454 | 462 | 37 | 4,365 | 4,422 | 60.0% | 209 | 1,092 | 6 | 518 | YTD |
| 47 | Oct-12 | 7,293 | 7,578 | 2,475 | 464 | 35 | 4,354 | 4,422 | 59.7% | 243 | 1,137 | 1 | | |
| 48 | Nov-12 | 7,254 | 7,578 | 2,478 | 482 | 34 | 4,294 | 4,422 | 59.2% | 200 | 1,203 | 1 | | |
| 49 | Dec-12 | 7,253 | 7,578 | 2,433 | 484 | 35 | 4,336 | 4,422 | 59.8% | 178 | 1,186 | 1 | 635 | YTD |
| 50 | Jan-13 | 7,194 | 7,578 | 2,421 | 461 | 37 | 4,312 | 4,422 | 59.9% | 255 | 1,201 | 1 | | |
| 51 | Feb-13 | 7,092 | 7,578 | 2,415 | 443 | 33 | 4,234 | 4,422 | 59.7% | 159 | 1,202 | 1 | | |
| 52 | Mar-13 | 7,052 | 7,578 | 2,487 | 438 | 38 | 4,127 | 4,422 | 58.5% | 220 | 1,196 | 1 | 705 | YTD |
| 53 | Apr-13 | 6,658 | 7,578 | 2,390 | 238 | 9 | 4,030 | 4,422 | 60.5% | 205 | 1,228 | 1 | | |
| 54 | May-13 | 7,037 | 7,578 | 2,511 | 362 | 11 | 4,164 | 4,422 | 59.2% | 174 | 1,206 | 1 | | |
| 55 | Jun-13 | 7,038 | 7,578 | 2,405 | 421 | 10 | 4,212 | 4,422 | 59.8% | 194 | 1,224 | 1 | 769 | YTD |
| 56 | Jul-13 | 7,153 | 7,356 | 2,452 | 421 | 72 | 4,280 | 4,380 | 59.8% | 276 | 1,230 | 1 | | |
| 57 | Aug-13 | 7,284 | 7,356 | 2,532 | 439 | 25 | 4,313 | 4,380 | 59.2% | 263 | 1,225 | 1 | | |
| 58 | Sep-13 | 7,145 | 7,356 | 2,480 | 449 | 20 | 4,216 | 4,380 | 59.0% | 264 | 1,247 | 1 | 474 | YTD |
| 59 | Oct-13 | 7,290 | 7,356 | 2,435 | 459 | 24 | 4,396 | 4,380 | 60.3% | 291 | 1,255 | 1 | | |
| 60 | Nov-13 | 7,264 | 7,356 | 2,422 | 488 | 36 | 4,354 | 4,380 | 59.9% | 224 | 1,242 | 6 | | |
| 61 | Dec-13 | 7,342 | 7,356 | 2,417 | 454 | 27 | 4,471 | 4,380 | 60.9% | 255 | 1,267 | 3 | 573 | YTD |
| 62 | Jan-14 | 7,265 | 7,356 | 2,428 | 481 | 27 | 4,356 | 4,380 | 60.0% | 319 | 1,269 | 3 | | |
| 63 | Feb-14 | 7,041 | 7,356 | 2,372 | 449 | 37 | 4,220 | 4,380 | 59.9% | 258 | 1,270 | 0 | | |
| 64 | Mar-14 | 7,121 | 7,356 | 2,366 | 455 | 27 | 4,300 | 4,380 | 60.4% | 283 | 1,266 | 0 | 652 | YTD |
| 65 | Apr-14 | 7,125 | 7,356 | 2,317 | 493 | 24 | 4,315 | 4,380 | 60.6% | 298 | 1,238 | 0 | | |
| 66 | May-14 | 7,439 | 7,356 | 2,418 | 477 | 24 | 4,544 | 4,380 | 61.1% | 312 | 1,265 | 0 | | |
| 67 | Jun-14 | 7,271 | 7,356 | 2,356 | 475 | 32 | 4,440 | 4,380 | 61.1% | 282 | 1,216 | 0 | 675 | YTD |
| 68 | Jul-14 | 7,337 | 7,421 | 2,431 | 444 | 44 | 4,462 | 4,380 | 60.8% | 363 | 801 | 0 | | |
| 69 | Aug-14 | 7,094 | 7,421 | 2,403 | 439 | 44 | 4,252 | 4,380 | 59.9% | 276 | 786 | 0 | | |
| 70 | Sep-14 | 7,088 | 7,421 | 2,428 | 431 | 37 | 4,229 | 4,380 | 59.7% | 270 | 794 | 0 | 1439 | YTD |
| 71 | Oct-14 | 7,242 | 7,421 | 2,453 | 492 | 36 | 4,297 | 4,380 | 59.3% | 301 | 757 | 0 | | |
| 72 | Nov-14 | 7,160 | 7,421 | 2,422 | 460 | 36 | 4,278 | 4,380 | 59.7% | 212 | 752 | 0 | | |
| 73 | Dec-14 | 7,181 | 7,421 | 2,431 | 469 | 35 | 4,281 | 4,380 | 59.6% | 263 | 764 | 0 | 1889 | YTD |
| 75 | Feb-15 | | | | | | | | | | | | | |
| 76 | Mar-15 | | | | | | | | | | | | | |
| 77 | Apr-15 | | | | | | | | | | | | | |
| 78 | May-15 | | | | | | | | | | | | | |
| 79 | Jun-15 | | | | | | | | | | | | | |
| 80 | ANNUAL AVERAGE | | | | | | | | | | | | | |
| 81 | SFY11 | 7,188 | 7,740 | 2,513 | 399 | 33 | 4,277 | 4,063 | 59.5% | 212 | 1,071 | 3 | 620 | |
| 82 | SFY12 | 7,237 | 7,515 | 2,426 | 440 | 33 | 4,370 | 4,400 | 60.4% | 226 | 1,084 | 6 | 681 | |
| 83 | SFY13 | 7,152 | 7,578 | 2,445 | 431 | 29 | 4,276 | 4,422 | 59.8% | 211 | 1,172 | 2 | 657 | |
| 84 | SFY14 | 7,228 | 7,356 | 2,416 | 462 | 31 | 4,350 | 4,380 | 60.2% | 277 | 1,249 | 1 | 594 | |
| 85 | | | | | | | | | | | | | | |
| 86 | Note 1: These clients are also captured under OMBP Provider Payments | | | | | | | | | | | | | |
| 87 | Note : CFI Home Health = CFI Home Support and Home Health Care Waiver Services | | | | | | | | | | | | | |
| 88 | Source of Data | | | | | | | | | | | | | |
| 89 | Columns | | | | | | | | | | | | | |
| 90 | | | | | | | | | | | | | | |
| 91 | D-F | MDSS monthly client counts | | | | | | | | | | | | |
| 92 | G | 3 month Avg of the number of paid bed days in the month/days in prior month | | | | | | | | | | | | |
| 93 | | by the number of days in the previous month. MDSS | | | | | | | | | | | | |
| 94 | J | Options Monthly Protective Reports | | | | | | | | | | | | |
| 95 | K | Options Monthly Activity Report | | | | | | | | | | | | |
| 96 | L | SSBG Adult In-Home Care verbal report from Adult Protective Services Administrator | | | | | | | | | | | | |
| 97 | M | Quarterly Options Paid Claims from Business Systems Unit Manager | | | | | | | | | | | | |

Unique Members With Medicaid Benefits at Some Point in SFY 13

170,771

| Category of Service | Distinct Members Using Service in SFY13 | Claims Payments | Mandatory vs Optional |
|--|---|-----------------|--------------------------|
| Mandatory (State or Federal) Service Categories | | | |
| 001 - Inpatient Hospital General | 17,097 | \$66,470,412 | M |
| 007 - Outpatient Hospital General | 95,874 | \$94,093,235 | M |
| 011 - SNF Nursing Home | 3,280 | \$11,179,352 | M |
| 012 - ICF Nursing Home | 6,323 | \$196,466,432 | M |
| 013 - Swing SNF I/P Hospital | 91 | \$291,206 | M |
| 014 - Swing ICF I/P Hospital | 34 | \$155,492 | M |
| 015 - Atypical SNF | 68 | \$6,718,576 | M |
| 016 - Atypical ICF | 87 | \$4,213,864 | M |
| 023 - Laboratory | 10,461 | \$1,346,881 | M |
| 024 - X-Ray Services | 4,563 | \$579,118 | M |
| 025 - Clinical Services | 13,279 | \$28,974,340 | M |
| 026 - Home Health | 2,755 | \$13,418,214 | M |
| 027 - Family Planning Services | 3,125 | \$1,042,134 | M |
| 032 - Medical Supplies / DME | 23,774 | \$23,361,212 | M |
| 043 - Physician Svcs. | 135,066 | \$74,389,363 | M |
| 044 - ARNP | 31,530 | \$5,173,671 | M |
| 045 - Dental Svcs. | 66,062 | \$23,119,743 | M |
| 065 - HCBC-DI | 4,849 | \$226,730,138 | M* |
| 066 - HCBC-ECI | 3,690 | \$53,325,075 | M* |
| 069 - BIRTHING CENTERS | 25 | \$19,887 | M |
| 080 - Rural Health Clinics | 24,872 | \$13,594,915 | M |
| 081 - FQHC | 2,169 | \$185,737 | M |
| 110 - Disability Determination Svc. | 5,606 | \$479,049 | M |
| 113 - SNF Ancillary Services | 144 | \$316,234 | M |
| 114 - ICF Ancillary Services | 17 | \$51,559 | M |
| 880 - NURSING FACILITY SUPPLEMENTAL PA | 4,953 | \$20,935,179 | M |
| Nursing Facility MQIP Payout | NA | \$26,989,788 | M |
| Optional Service Categories | | | |
| 003 - Inpatient Hospital Mental | 110 | \$725,777 | O |
| 008 - Outpatient Hospital Mental | 10 | \$476 | O |
| 017 - Mental Health Ctr. | 22,106 | \$96,994,608 | O |
| 030 - Disp. Pres. Drugs ** | 105,456 | \$66,956,882 | O |
| 037 - Ambulance Services | 10,341 | \$3,013,682 | O |
| 039 - Wheelchair Van | 3,055 | \$2,933,441 | O |
| 042 - Audiology Svcs. | 2,530 | \$418,642 | O |
| 046 - Certified Midwife (Non-nurse) | 145 | \$139,844 | O |
| 047 - Optometric Svcs. | 25,503 | \$2,915,507 | O |
| 048 - Psychology | 10,720 | \$7,731,555 | O |
| 049 - Private Duty Nursing | 115 | \$9,567,729 | O |
| 051 - Physical Therapy | 2,829 | \$1,813,749 | O |
| 053 - Speech Therapy | 937 | \$963,304 | O |
| 054 - Occupational Therapy | 877 | \$974,357 | O |
| 055 - Podiatrist Svcs. | 4,782 | \$345,714 | O |
| 056 - Medical Svcs. Clinic (mostly methadone) | 1,935 | \$3,143,018 | O |
| 057 - Personal Care | 189 | \$7,485,053 | O |
| 060 - Early Intervention Services | 2,996 | \$10,299,106 | O |
| 063 - Adult Medical Daycare | 230 | \$1,086,263 | O |

| Category of Service | Distinct Members Using Service in SFY13 | Claims Payments | Mandatory vs Optional |
|---|---|-----------------|--------------------------|
| 072 - Crisis Intervention (DCYF) | 17 | \$253,479 | O |
| 073 - Intensive Home and Community (DCYF) | 222 | \$1,705,771 | O |
| 074 - Child Health Support Svcs. (DCYF) | 338 | \$1,429,703 | O |
| 076 - Home Based Therapy (DCYF) | 229 | \$945,783 | O |
| 077 - Placement Svcs. (DCYF) | 138 | \$2,212,715 | O |
| 078 - Private Non-Medical Institutions (DCYF) | 703 | \$13,107,731 | O |
| 102 - ICF Svcs. For the Mentally Retarded | 39 | \$3,774,593 | O |
| 103 - Psych. Svcs. Under Age 21 | 318 | \$4,196,249 | O |
| 112 - Target Case Management | 1,080 | \$732,291 | O |

* Delivered to comply with NH RSA mandate for home and community based care

** Claims costs less rebates

Data Source: NH MMIS as of 3/9/15; dollars with missing categories of services were imputed proportionally based on dollars in each category of service

| | A | B | C | D | E | F | G | H | I | J | K |
|----|--|---|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|----------------------------|------------------------------------|
| 1 | NHHPP Summary | | | | | | | | | | |
| 2 | | | SFY 2014 | SFY 2015 | SFY 2016 | SFY 2017 | SFY 2018 | SFY 2019 | SFY 2020 | SFY 2021 and Beyond | SFY2014-SFY2021 (7.5 Years) |
| 3 | Block A: NHHPP Newly Eligibles, effective August 15, 2014 | | | | | | | | | | |
| 4 | NHHPP Enrollment | | | | | | | | | | |
| 5 | Eligibles | | 0 | 46,679 | 55,000 | 55,000 | 55,000 | 55,000 | 55,000 | 55,000 | |
| 6 | PMPY Cost | | \$0 | \$9,253 | \$9,253 | \$8,783 | \$8,783 | \$8,783 | \$8,783 | \$8,783 | |
| 7 | FMAP Rate | | 100% | 100% | 100% | 95% | 94% | 93% | 90% | 90% | |
| 8 | FF \$\$ | | \$0 | \$229,233,825 | \$508,936,000 | \$470,966,925 | \$456,475,635 | \$451,645,205 | \$441,984,345 | \$434,738,700 | \$2,993,980,635 |
| 9 | GF \$\$ | | \$0 | \$0 | \$0 | \$12,076,075 | \$26,567,365 | \$31,397,795 | \$41,058,655 | \$48,304,300 | \$159,404,190 |
| 10 | Block B: NHHPP Expansion Cost Offsets | | | | | | | | | | |
| 11 | Substance Use Disorder Benefit Costs and Savings | | | | | | | | | | |
| 12 | Eligibles | | 0 | 46,679 | 55,000 | 55,000 | 55,000 | 55,000 | 55,000 | 55,000 | |
| 13 | PMPY Cost | | \$0 | \$460 | \$690 | \$690 | \$690 | \$690 | \$690 | \$690 | |
| 14 | TF Investment | | \$0 | \$21,472,340 | \$37,950,000 | \$37,950,000 | \$37,950,000 | \$37,950,000 | \$37,950,000 | \$37,950,000 | \$249,172,340 |
| 15 | FMAP Rate | | 100% | 100% | 100% | 95.0% | 94.0% | 93.0% | 90.0% | 90% | |
| 16 | FF \$\$ | | \$0 | \$21,472,340 | \$37,950,000 | \$37,001,250 | \$35,862,750 | \$35,559,150 | \$34,724,250 | \$34,155,000 | \$236,724,740 |
| 17 | GF \$\$ | | \$0 | \$0 | \$0 | \$948,750 | \$2,087,250 | \$2,390,850 | \$3,225,750 | \$3,795,000 | \$12,447,600 |
| 18 | Savings @ 1.45 ROI, 5 year ramp to full savings | | 0% | 0% | 0.17% | 0.45% | 1.12% | 1.16% | 1.31% | 1.45% | |
| 19 | TF Savings | | \$0 | \$0 | (\$6,451,500) | (\$17,077,500) | (\$42,371,175) | (\$44,022,000) | (\$49,524,750) | (\$55,027,500) | (\$214,474,425) |
| 20 | FMAP Rate | | 100% | 100% | 100% | 95% | 94% | 93% | 90% | 90% | |
| 21 | FF \$\$ | | \$0 | \$0 | (\$6,451,500) | (\$16,650,563) | (\$40,040,760) | (\$41,160,570) | (\$45,315,146) | (\$49,524,750) | (\$199,143,289) |
| 22 | GF \$\$ | | \$0 | \$0 | \$0 | (\$426,938) | (\$2,330,415) | (\$2,861,430) | (\$4,209,604) | (\$5,502,750) | (\$15,331,136) |
| 23 | SUD NET TF \$\$ | | \$0 | \$21,472,340 | \$31,498,500 | \$20,872,500 | (\$4,421,175) | (\$6,072,000) | (\$11,574,750) | (\$17,077,500) | \$34,697,915 |
| 24 | SUD NET FF \$\$ | | \$0 | \$21,472,340 | \$31,498,500 | \$20,350,688 | (\$4,178,010) | (\$5,601,420) | (\$10,590,896) | (\$15,369,750) | \$37,581,451 |
| 25 | SUD NET GF \$\$ | | \$0 | \$0 | \$0 | \$521,813 | (\$243,165) | (\$470,580) | (\$983,854) | (\$1,707,750) | (\$2,883,536) |
| 26 | Health Insurance Payment Program (HIPP) Expansion | | | | | | | | | | |
| 27 | Eligibles | | 0 | (158) | (250) | (250) | (250) | (250) | (250) | (250) | |
| 28 | FF \$\$ | | \$0 | (\$580,650) | (\$741,965) | (\$252,457) | (\$251,162) | (\$249,867) | (\$245,984) | (\$233,037) | (\$2,555,122) |
| 29 | GF \$\$ | | \$0 | \$0 | \$0 | (\$6,473) | (\$7,768) | (\$9,063) | (\$12,947) | (\$25,893) | (\$62,144) |
| 30 | Elimination of BCCP Eligibility Pathway for New Members Pending CMS SPA Approval (SB413 provision) | | | | | | | | | | |
| 31 | Eligibles | | 0 | 0 | (220) | (80) | (165) | (188) | (202) | (202) | |
| 32 | PMPY Cost | | \$7,954 | \$18,964 | \$18,964 | \$18,964 | \$18,964 | \$18,964 | \$18,964 | \$18,964 | |
| 33 | FMAP Rate | | 100% | 100% | 100% | 95.0% | 94.0% | 93.0% | 90.0% | 90.0% | |
| 34 | FF \$\$ | | \$0 | \$0 | \$1,460,253 | (\$1,479,217) | (\$2,957,012) | (\$3,333,548) | (\$3,505,175) | (\$3,447,713) | (\$13,262,413) |
| 35 | GF \$\$ | | \$0 | \$0 | (\$1,460,253) | (\$1,479,217) | (\$3,035,240) | (\$3,440,507) | (\$3,639,253) | (\$3,639,253) | (\$16,693,723) |
| 36 | Subtotal NHHPP Cost Offsets | | | | | | | | | | |
| 37 | Eligibles | | 0 | 46,521 | 54,530 | 54,670 | 54,585 | 54,562 | 54,548 | 54,548 | |
| 38 | FF \$\$ | | \$0 | \$20,891,690 | \$32,216,788 | \$18,619,014 | (\$7,386,184) | (\$9,184,835) | (\$14,342,056) | (\$19,050,500) | \$21,763,916 |
| 39 | GF \$\$ | | \$0 | \$0 | (\$1,460,253) | (\$963,878) | (\$3,286,172) | (\$3,920,150) | (\$4,636,054) | (\$5,372,896) | (\$19,639,403) |
| 40 | Block C: Total: NHHPP Impacts = (Medicaid Expansion Expenditures + Medicaid Expansion Cost Offsets) | | | | | | | | | | |
| 41 | Total | | | | | | | | | | |
| 42 | Net FF \$\$ | | \$0 | \$250,125,515 | \$541,152,788 | \$489,585,939 | \$449,089,451 | \$442,460,370 | \$427,642,289 | \$415,688,200 | \$3,015,744,551 |
| 43 | Net GF \$\$ | | \$0 | \$0 | (\$1,460,253) | \$11,112,197 | \$23,281,193 | \$27,477,645 | \$36,422,601 | \$42,931,404 | \$139,764,787 |
| 44 | | | | | | | | | | | |
| 45 | Block D: PLACEHOLDER - Additional Impacts to NH Healthcare System | | | | | | | | | | |
| 46 | State and County Corrections | | \$0 | \$0 | \$0 | TBD | TBD | TBD | TBD | TBD | TBD |
| 47 | New premium revenue from increased Medicaid enrollment | | \$0 | TBD | TBD | TBD | TBD | TBD | TBD | TBD | TBD |
| 48 | New MET revenue from increased Medicaid enrollment | | \$0 | \$0 | TBD | TBD | TBD | TBD | TBD | TBD | TBD |
| 49 | Reduction Hosp Uncompensated Care Critical Access Hosp | | \$0 | \$0 | TBD | TBD | TBD | TBD | TBD | TBD | TBD |
| 50 | Reduction Hosp Uncompensated Care Other Hosp | | \$0 | \$0 | TBD | TBD | TBD | TBD | TBD | TBD | TBD |
| 51 | Reduction FQHC Uncompensated Care | | \$0 | \$0 | TBD | TBD | TBD | TBD | TBD | TBD | TBD |
| 52 | Reduction CMHC Uncompensated Care | | \$0 | \$0 | TBD | TBD | TBD | TBD | TBD | TBD | TBD |
| 53 | | | | | | | | | | | |
| 54 | | | | | | | | | | | |

| | A | B | C | D | E | F | G | H | I | J | K |
|----|--|---|---|---|---|---|---|---|---|---|---|
| 1 | NHHPP Summary | | | | | | | | | | |
| 55 | Footnotes: | | | | | | | | | | |
| 56 | Line 3: Data reflects actual new eligibles for Medicaid to present date. SFY 2014 reflects only 6 months as eff 1/1/2015. SFY15 based upon actual case load growth of 5.5%. SFY16 base projection is then adjusted per Dr. Ross Gittell's December 2014 Medicaid caseload report that indicates reduction in SFY 2016 and 2017 of 1.4% each year. Dec 2014 152,639 -150,441 = 2,198 or -1.4%. SFY15 11k is then reduced by 2,198 =8,802 to calculate SFY16 base projection. SFY 2018 - 2021 reflect Lewin's original estimates of a 2% caseload growth. The numbers will need adjusting during SFY 2016 and 2017 when caseload projections are updated by Dr. Gittell. | | | | | | | | | | |
| 57 | Line 5: Enrollment based upon 50,000 NHHPP and 5,000 medically frail remaining in Medicaid. FY15 Weighted avg PMPM \$769.85; FY16 six mos @ \$769.85 and six mos @ \$683.54 based on Demonstration waiver rate eff 1/1/16. FY17 and forward \$683.54. Assumes 0% caseload growth for SFY16-SFY21. SFY18 and forward applied 0.00% rate trend. SFY18-SFY21 PMPM assumptions will need to be restated | | | | | | | | | | |
| 58 | Line 6: SFY14/15: Cost is based on weighted avg (by sub-populations showing enrollment increase) of MCM rates, incl. adding maternity kickpayments for additional preg women pop. Applied 0.00% trend factor for FY16/17 based on Gov Budget. SFY18 and forward applied 0.00% rate trend. SFY18-SFY21 PMPM assumptions will need to be restated. | | | | | | | | | | |
| 59 | Line 7: As provided in 42 USC Sec. 1396d(y)(1), the Federal medical assistance percentage for a State that is one of the 50 States or the District of Columbia, with respect to amounts expended by such State for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to: "(A) 100 percent for calendar quarters in 2014, 2015, and 2016; "(B) 95 percent for calendar quarters in 2017; "(C) 94 percent for calendar quarters in 2018; "(D) 93 percent for calendar quarters in 2019; and "(E) 90 percent for calendar quarters in 2020 and each year thereafter. 138% FPL = \$15,856 for family of one, \$27,916 for family of four. | | | | | | | | | | |
| 60 | Line 23: Cost is based on weighted (by sub-population in NHHPP as of 12/1/14) average of MCM per member per month. Eff 1/1/16 lower rates are based on Demonstration waiver. Assumes 0% growth in enrollment and 0% rates per Governor's budget through SFY 2021. PMPM rate assumptions will need to be restated once actual rates are known. | | | | | | | | | | |
| 61 | Line 12: Eligibles based upon projected case load at end of SFY 2015. Costs of benefit spread across all covered lives. | | | | | | | | | | |
| 62 | Line 13: Cost of SUD benefit for NHHPP extrapolated from PMPY above in Line 23. Thus DO NOT add the SUD costs to the cost of the NHHPP program. Use to demonstrate ROI potential only. | | | | | | | | | | |
| 63 | Line 13: SUD benefit phasing in. Current PMPM does not include all of the SUD services. For purposes of this model, assumed PMPM will double in cost when all benefits implemented. Ramp up of provider network with subsequent increased utilization. Assumes benefit fully phased in by end of SFY17. 0% growth in caseload and PMPY consistent with Governor's budget. | | | | | | | | | | |
| 64 | Line 18: Due to phase in of benefit, ROI moved from SFY15 to SFY16. | | | | | | | | | | |
| 65 | Line 22: Reduction in General fund is due to cost avoidance not savings | | | | | | | | | | |
| 66 | Line 26: HIPP eligibles are based on cases versus individuals | | | | | | | | | | |
| 67 | Line 27: HIPP Orig proj based on 36% of the NHHPP pop. being employed w/access to ESI (employer sponsored insurance). Review of the current NHHPP pop. only 4.8% are employed w/access to ESI. Original Lewin projections based on national data. NH did not fit into the national avg as anticipated. | | | | | | | | | | |
| 68 | Line 30: Requires CMS approval to phase out eligibility category. Assumes 7/1/15 effective date. Estimates beyond SFY17 need updating to reflect current screening, diagnosis and treatment modalities. | | | | | | | | | | |
| 69 | Line 32: SFY16 increase due to implementation of new policy eliminating BCCP Medicaid eligibility pathway. Accounted for difference between ACA FMAP and 65% current FMAP match for BCCP. | | | | | | | | | | |
| 70 | Lines 46 -53: Impacts to other state agencies, premium and MET revenue and uncompensated care based upon point in time Lewin Group Estimate and a different NHHPP model than what was finally passed by NH Legislature. AS MORE INFORMATION BECOMES AVAILABLE, THESE LINES WILL BE UPDATED. | | | | | | | | | | |

New Hampshire Medicaid Program Enrollment Forecast

SFY 2015 to SFY 2017

Prepared for the NH Department of Health and Human Services
December 2014

Contents

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1. Executive Summary

Total average annual Medicaid enrollment increased by 3,500 or 2.5 percent, from 139,900 in State Fiscal Year (SFY) 2013 to 143,300 in SFY 2014. Average annual enrollment is projected to increase 6.5 percent to 152,600 in SFY 2015; to decrease -1.4 percent to 150,400 in SFY 2016; and decrease -1.3 percent to 148,600 in SFY 2017.

A strengthening economy is expected to reduce low-income enrollment by 5,900 through the forecast period from SFY 2015 to SFY 2017. Enrollment for the disabled, elderly and miscellaneous enrollment categories is expected to stabilize around current levels over the forecast period. Enrollment in Medicare Savings Programs is expected to expand by 2,100 through the forecast period. This forecast does not include enrollment in the New Hampshire Health Protection Program which began in 2014 as a result of changes in state law related to the Affordable Care Act(ACA).

Through 2014, there was a significant increase in enrollment in low-income and Medicare savings programs (9 percent and 19 percent respectively in 2014 Q3 from 2013 Q3). This increase is believed to be related to factors associated with the commencement of the ACA in January 2014. A combination of new federal process and policy requirements for income calculation and the "woodwork" effect are believed to be the primary factors causing the increase. The newly implemented family planning category also increased enrollment in the miscellaneous category by 90 percent in 2014 Q3.

Significant factors in this forecast:

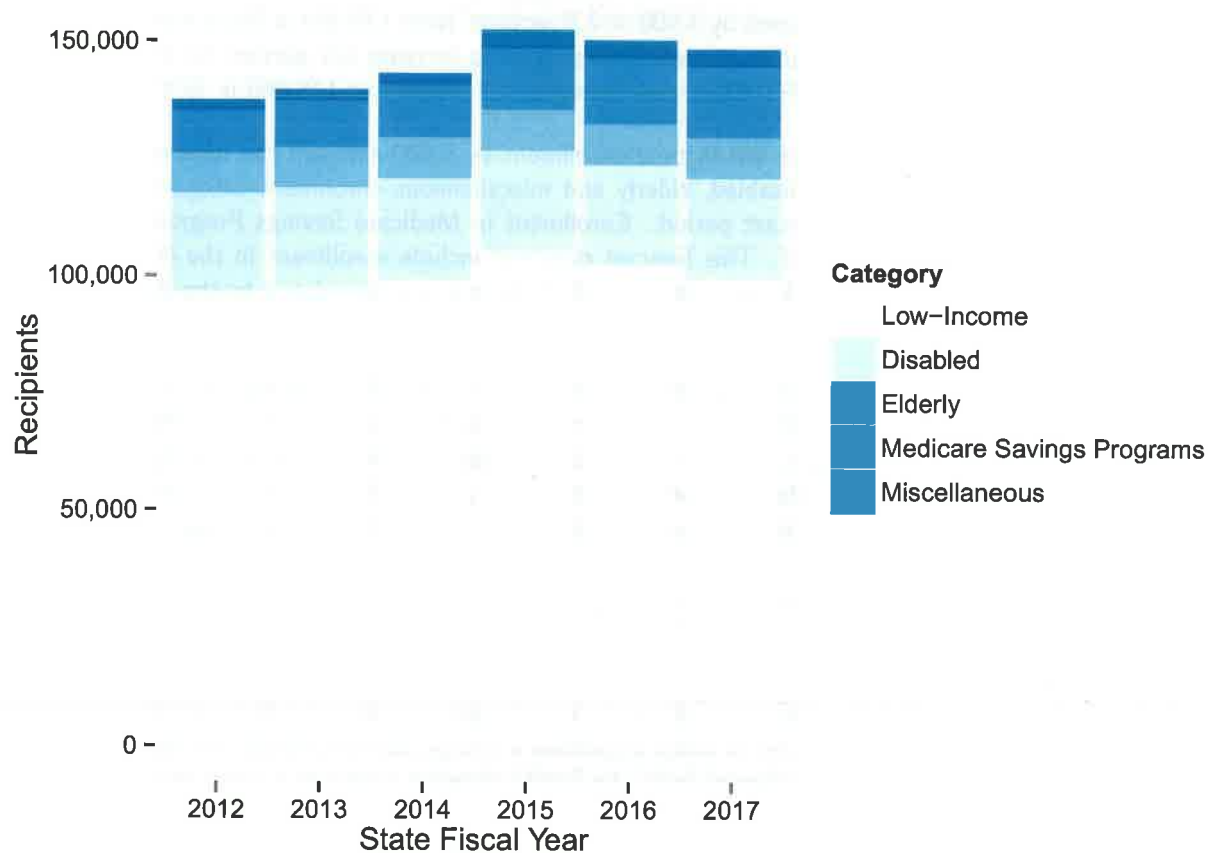
1. The rate of annual increase in low-income and Medicare Savings programs has ended or is very close to ending and the annual rate of change in enrollment in these populations is expected to decrease through the forecast period. The increased annual rate of enrollment from the family planning category is expected to drop-off by mid-2015.
2. The NH unemployment rate is expected to decrease at an average annual rate of -18 percent. This is expected to put downward pressure on low-income enrollment. It may also put some downward pressure on elderly and disabled enrollment. In general, programs are expected to return to the trends of enrollment observed between 2013 and 2014 before the ACA began to impact enrollment.

Table 1: Average annual enrollment projections by major category by State Fiscal Year (does not include the New Hampshire Health Protection Program)

| Category | 2012* | 2013* | 2014* | 2015 | 2016 | 2017 |
|------------------------------|-------------|-------------|-------------|-------------|--------------|--------------|
| Low-Income | 96,883 | 97,658 | 99,217 | 105,488 | 102,722 | 99,640 |
| Disabled | 20,911 | 21,307 | 21,749 | 21,504 | 21,235 | 21,399 |
| Elderly | 8,430 | 8,598 | 8,725 | 8,691 | 8,647 | 8,718 |
| Medicare Savings Programs | 9,036 | 9,928 | 11,248 | 13,011 | 14,036 | 15,142 |
| Miscellaneous | 2,307 | 2,359 | 2,388 | 3,945 | 3,802 | 3,658 |
| Total | 137,565 | 139,850 | 143,327 | 152,639 | 150,441 | 148,557 |
| Total % Annual Change | 1.4% | 1.7% | 2.5% | 6.5% | -1.4% | -1.3% |

*Actual enrollment

Figure 1: Average annual enrollment by State Fiscal Year (does not include the New Hampshire Health Protection Program)



In the figure, SFY 2012-2014 are actual enrollment, and SFY 2015-2017 are forecast enrollment

2. Background

Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965. Medicaid is administered as a federal-state partnership providing low-income and disabled Americans with access to medical and health services. All of the states, the District of Columbia, and the U.S. territories have established Medicaid programs. Medicaid provides health coverage to nearly 60 million low-income people and is one of the largest payers for health care in the United States.¹

The federal government partially funds Medicaid and establishes mandatory and optional program characteristics for operation of the states' Medicaid programs. The States provide the remaining program funding, choose which program options that they wish to implement, and administer the Medicaid program within their state. This results in variations in Medicaid coverage across the country.

Separately, the Children's Health Insurance program (CHIP) provide coverage to children otherwise not eligible for Medicaid.² This program is administered in some states—including New Hampshire—as a Medicaid Expansion.

The Patient Protection and Affordable Care Act (PPACA)—commonly called the Affordable Care Act (ACA)—signed into law by President Barack Obama on March 23, 2010 represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. Beginning in 2014, the Affordable Care Act provided states with the authority to expand Medicaid eligibility to currently ineligible adults age 19 to 64 in households with incomes below 133 percent of the Federal Poverty Level (FPL) and standardizes the rules for determining eligibility and benefits through Medicaid, CHIP, and the health insurance marketplace.

The New Hampshire Department of Health and Human Services (DHHS) is the single State agency that administers the New Hampshire Medicaid program. New Hampshire Medicaid provided health care coverage, fully or in part, to nearly 174,000 people during State Fiscal Year 2012 at a cost of \$1.3 billion.³ In this forecast, three primary factors were identified that will drive Medicaid enrollment in NH over the next several years: 1) economic and employment activity (with the closely related employer-sponsored health insurance availability); 2) Medicaid/health care policy at the state and federal level; and 3) demographics.

¹Klees, B.S., and Wolfe. "Brief Summaries Of Medicare & Medicaid Title XVIII and Title XIX of the Social Security Act as of November 1, 2013", Office of the Actuary, Centers for Medicare & Medicaid Services, Department of Health & Human Services. Available online at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/SummaryMedicareMedicaid.html>

²Title XXI of the Social Security Act in the Balanced Budget Act of 1997

³"Monitoring Access to Care in New Hampshire's Medicaid Program: Review of Key Indicators May 2013," Office of Medicaid Business & Policy, New Hampshire Department of Health & Human Services, May 15, 2013. Available on-line at <http://www.dhhs.nh.gov/ombp/documents/medicaid-report-may2013.pdf>

3. The New Hampshire Economy & Economic Outlook

The NH economy is improving along with the national economy. Nationally, there are indicators that the economy is on a stronger economic foundation and job growth trajectory. These indicators include increasing levels of monthly job growth and now, after long stagnation, wage growth.

While economic conditions in the U.S. and NH have improved, there continues to be significant downside risk with economic projections. The prospects for reoccurring recession in Europe negatively impacts the export prospects to a major market for U.S., New England and NH companies and weakens a key source of foreign direct investment in NH and the region. In addition, global political conditions and national security concerns can adversely impact the investment climate and consumer confidence and threaten sustained growth nationally and in NH.

The forecast for New England is for continuation of growth rates below the national average and below what would typically be associated with strong growth. The New England Economic Partnership (NEEP) forecast is that total employment growth in the region will average 1.3 percent per year and overall growth 2.7 percent per year through the forecast period, or out to 2018. NH and all the states in the region are projected to have employment growth below the national average over the forecast period. Demographic factors including aging population and lower labor force growth than the U.S. average continue to contribute to slower employment growth than the national average across the region and lower unemployment in NH than might be anticipated with slow employment growth.

NH along with Massachusetts, and Vermont are expected to continue to have the strongest economies in New England over the forecast period. Massachusetts has already recovered the jobs lost in the recession and Vermont, and New Hampshire are expected to soon follow. Within the New England region, Vermont is expected to have the highest average annual growth in employment on a percent change basis over the forecast period as seen in *figure 2*. Average annual employment growth in Vermont is expected to be 1.5 percent, followed close behind by New Hampshire at 1.4 percent, and Massachusetts at 1.3 percent. All of the New England states are expected to continue to have below the U.S. average of 1.7 percent annual employment growth, with Maine and Connecticut having the lowest forecast annualized growth rate over the forecast period at 1.0 percent.

In October 2014, NH at 4.2 percent had the lowest unemployment rate in the region followed by Vermont at 4.4 percent. This was the 7th lowest in the nation. NH's unemployment rate continued to be well below the U.S. rate of 5.8 percent and has declined from the 5.2 percent unemployment rate observed in the previous year in October. NH and Vermont are expected to continue to have the lowest unemployment rates in the region and among the lowest in the nation through the forecast period.

Table 2: Historical NH seasonal unemployment rate by quarter

| | 2013 | | | | 2014 | | |
|-----------------------|------|-------|-------|-------|--------|--------|--------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 |
| NH Unemployment Rate | 5.4% | 5.2% | 5.3% | 5.2% | 4.7% | 4.4% | 4.4% |
| Total % Annual Change | 1.9% | -4.3% | -6.0% | -6.0% | -13.0% | -15.9% | -17.1% |

Table 3: NH unemployment forecast by quarter

| | 2015 | | | | 2016 | | | | 2017 | |
|-----------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| NH Unemployment Rate | 3.7% | 3.5% | 3.4% | 3.2% | 3.0% | 2.9% | 2.8% | 2.6% | 2.4% | 2.2% |
| Total % Annual Change | -12.3% | -19.2% | -16.9% | -17.2% | -17.5% | -17.4% | -17.3% | -17.9% | -19.9% | -23.4% |

Figure 2: Total employment average annual percent change: U.S. and New England from 2014 Q2 to 2018 Q1

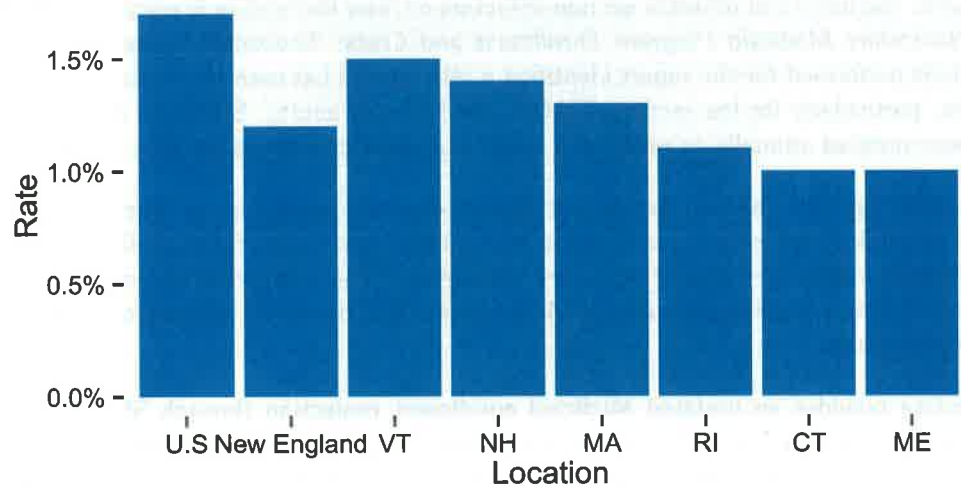
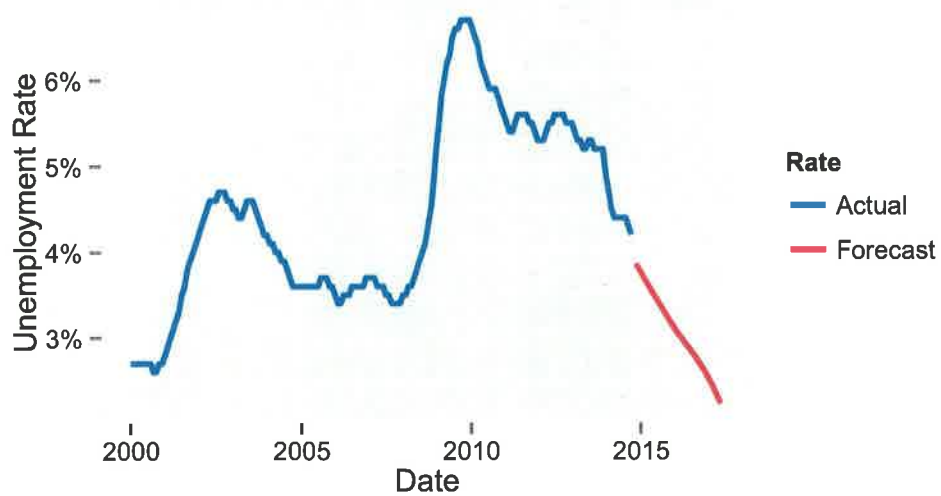


Figure 3: NH seasonally-adjusted unemployment rate



4. Forecast Background

In the spring of 2008, Professor Ross Gittel and Matthew Magnusson of the University of New Hampshire Whittemore School of Business and Economics, at the request of the New Hampshire Department of Health and Human Services (NH DHHS), evaluated the impact of different economic factors on New Hampshire Medicaid enrollment in the report *Forecasting New Hampshire Medicaid Program Enrollment and Costs: Economic Indicators for the NH Medicaid Program*. The analysis performed for the report identified a relationship between the States unemployment rate and Medicaid enrollment, particularly for low-income (TANF) children and adults. Since the initial analysis, enrollment projections have been updated annually to reflect the latest economic conditions for New Hampshire.

Since 2008, the methodology has involved forecasting distinct eligibility categories of Medicaid enrollment based on forecasts of the NH unemployment rate in combination with longer-term trends for that eligibility category. This has proven to be an effective method for projecting future enrollment. The categories analyzed changed slightly when NH DHHS implemented a new reporting system for Medicaid in 2013; this is the second forecast to incorporate data from the new reporting system.

This enrollment update provides an updated Medicaid enrollment projection through SFY 2017. This projection includes the most current economic outlook and unemployment forecast for New Hampshire. This forecast does not include enrollment in the New Hampshire Health Protection Program which began in 2014 as a result of changes in state law related to the Affordable Care Act.

5. Methodology

This forecast is based off of the NH unemployment rate projected by the New Hampshire Economic Partnership (NEEP) in their fall 2014 forecast. To assist with developing the forecast, a data extract is provided by DHHS which contains age, gender, county of residence and category of enrollment as of the last day of the month. This data does not include personally identifiable information for recipients. For this forecast, DHHS provided the research team with de-identified individual enrollment data from January 2004 through November 2014.

The end of month report is reported to result in 10,000-15,000 fewer enrollees than the data provided in the previous report that maintained a running monthly count of enrollment that included retroactive and partial month enrollments.⁴ Therefore, this forecast would be expected to under-report total enrollees but it does so consistently and is useful for measuring and projecting changes in enrollment over time.

The forecast is based on reviewing the trends in enrollment for aggregated categories of medicaid enrollment. The analysis categories are: 1) low-income; 2) disabled; 3) elderly; 4) Medicare savings programs; and 5) miscellaneous. In *table 4* there is a mapping of Medicaid eligibility categories to the analysis categories used in this forecast.

Table 4: Mapping of Medicaid eligibility categories to analysis categories

| Analysis Category | NH Medicaid Category Code | Category Name |
|---------------------------|---------------------------|--------------------------------|
| Disabled | DI | Disabled |
| | DIM | Disabled MEAD |
| Elderly | EL | Elderly |
| Low-Income | LI | Low-Income |
| | LIC | Low-income Expanded - CHIP |
| | LIP | Low-Income Pregnant |
| Medicare Savings Programs | QDWI | QDWI |
| | QMB | QMB |
| | SLM1 | SLM1 |
| | SLMB | SLMB |
| Miscellaneous | AL | Alien |
| | BC | BCCP |
| | FC | Foster Care - Adoption Subsidy |
| | FP | Family Planning |
| | RE | Refugee |
| | | |

This forecast does not include enrollment in the New Hampshire Health Protection Program which began in 2014 as a result of changes in state law related to the Affordable Care Act

⁴This is based on discussions with DHHS between 2008 and the present. The difference between an end-of-month count versus a running monthly count has not been evaluated by the research team to verify the 10 to 15 thousand enrollment difference assumption between the two methods

Methodology Updates

- December 2014

1. The family planning category (category code: FP) was included in this forecast as part of the miscellaneous analysis category. The family planning category was first observed in enrollment records starting in April 2014.
2. Uncertainty intervals were added around the forecast annual rate of change for each analysis category. This is based on observed variability in the categories and a six-month lead and lag. In this forecast, they were only included in forecast figures—*figures 7, 8, 9, 10, 11* starting on page 15—to indicate the expected range of variability for each category over the forecast period. The uncertainty intervals will be monitored over time and upper and lower bounds for enrollment estimates may be added into future forecasts.
3. Monthly, quarterly, and annual enrollment figures were adjusted so that the end of month enrollment was "shifted" to represent the enrollment in the following month. For example, in the previous forecast, January 31, 2013 was estimated to represent enrollment for January 1, 2013. In this forecast, it is now representing enrollment for February 1, 2013. This will most likely be refined further in future forecasts. This is believed to provide a more accurate estimate of enrollment, but does result in some slight changes from the enrollment figures stated in the previous forecast.
4. The monthly change in enrollment for the past year was added to the analysis section of the forecast. While the current monthly trend has always been part of the forecast analysis process, discussion of it has not typically been included in the actual written forecast. The inclusion of this information is to provide additional support for the predictions made in the forecast.

6. Past Enrollment

Factors related to the implementation of the Affordable Care Act appear to have boosted Medicaid enrollment through 2014 with the most significant increases observed in the low-income category. This increase was also evident in the Medicare savings programs category. The elderly and disabled category do not appear to have been impacted significantly by the ACA and may be experiencing a downward trend in enrollment due to the improving economy. The miscellaneous category experienced a significant increase in 2014 due to the addition of the family planning in 2014.

Figure 4: End of month enrollment January 2004 to November 2014

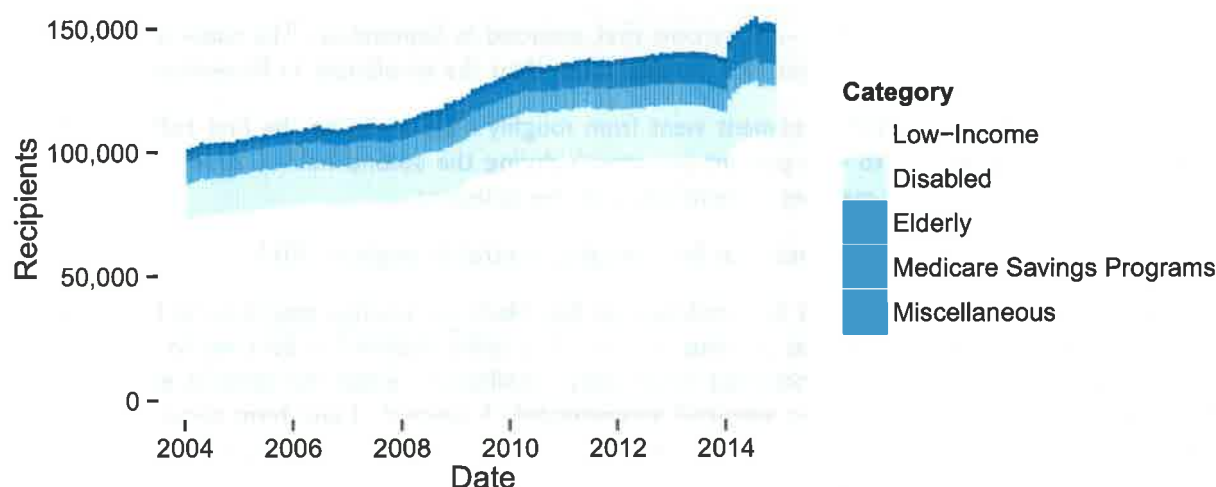


Table 5: Historical enrollment by analysis category by quarter

| | 2013 | | | | 2014 | | | |
|---------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Low-Income | 97,855 | 97,720 | 97,122 | 95,754 | 98,967 | 105,024 | 106,037 | 105,716 |
| Disabled | 21,341 | 21,464 | 21,717 | 21,703 | 21,737 | 21,838 | 21,879 | 21,374 |
| Elderly | 8,566 | 8,548 | 8,635 | 8,775 | 8,738 | 8,751 | 8,750 | 8,685 |
| Medicare Savings Programs | 10,061 | 10,316 | 10,435 | 10,574 | 11,679 | 12,305 | 12,440 | 12,584 |
| Miscellaneous | 2,378 | 2,350 | 2,287 | 2,303 | 2,320 | 2,642 | 4,315 | 3,985 |
| Total | 140,201 | 140,397 | 140,197 | 139,109 | 143,441 | 150,559 | 153,421 | 152,344 |

Table 6: Annualized change in enrollment by analysis category

| | 2013 | | | | 2014 | | | |
|---------------------------|-------------|-------------|-------------|--------------|-------------|-------------|-------------|-------------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Low-Income | 1.3% | 1% | -0.2% | -2% | 1.1% | 7.5% | 9.2% | 10.4% |
| Disabled | 1.4% | 1.4% | 2.4% | 2.3% | 1.9% | 1.7% | 0.8% | -1.5% |
| Elderly | 1.3% | 0% | 0.1% | 1.4% | 2% | 2.4% | 1.3% | -1% |
| Medicare Savings Programs | 8.3% | 9.1% | 8.8% | 8.5% | 16.1% | 19.3% | 19.2% | 19% |
| Miscellaneous | 2.9% | 1.3% | -1.5% | -3.5% | -2.4% | 12.4% | 88.7% | 73% |
| Total | 1.8% | 1.6% | 0.8% | -0.4% | 2.3% | 7.2% | 9.4% | 9.5% |

Monthly Trend in Enrollment

The monthly change in enrollment for each analysis category was determined for the past year.

Low-Income There were two occurrences of periods of monthly increases in enrollment over the past year in the low-income category. The first surge in enrollment occurred from February 2014 to June 2014 peaking at 5.3 percent in February. This surge is believed to be a result of a combination of new federal process and policy requirements for income calculation and the “woodwork” effect, both related to the ACA.

A second smaller surge occurred from July to October 2014, peaking at 0.8 percent in October. This second surge may be a “mini-woodwork” effect caused by the New Hampshire Health Protection Program which began around the same period of time.

There also was a sharp downward tick of -1.8 percent that occurred in September. The cause of the decrease is not known. Enrollment in December was -0.3 percent lower than the enrollment in November.

Disabled The monthly change in disabled enrollment went from roughly neutral during the first half of 2014 to a negative trend ranging from -0.5 to -1.3 percent per month during the second half of 2014. The improving economy may have put downward pressure on enrollment in this category.

Elderly The monthly change in elderly enrollment has been roughly neutral throughout 2014.

Medicare savings programs There was spike in enrollment in the Medicare savings programs in February 2014 showing a 14.2 percent increase from the previous month. This spike observed is believed to be due to the same factors related to the ACA that increased low-income enrollment. Since the spike in enrollment, the monthly growth rate for this category has averaged approximately 5 percent. Long term demographic trends of an aging population appear to be putting upward pressure on enrollment in this category.

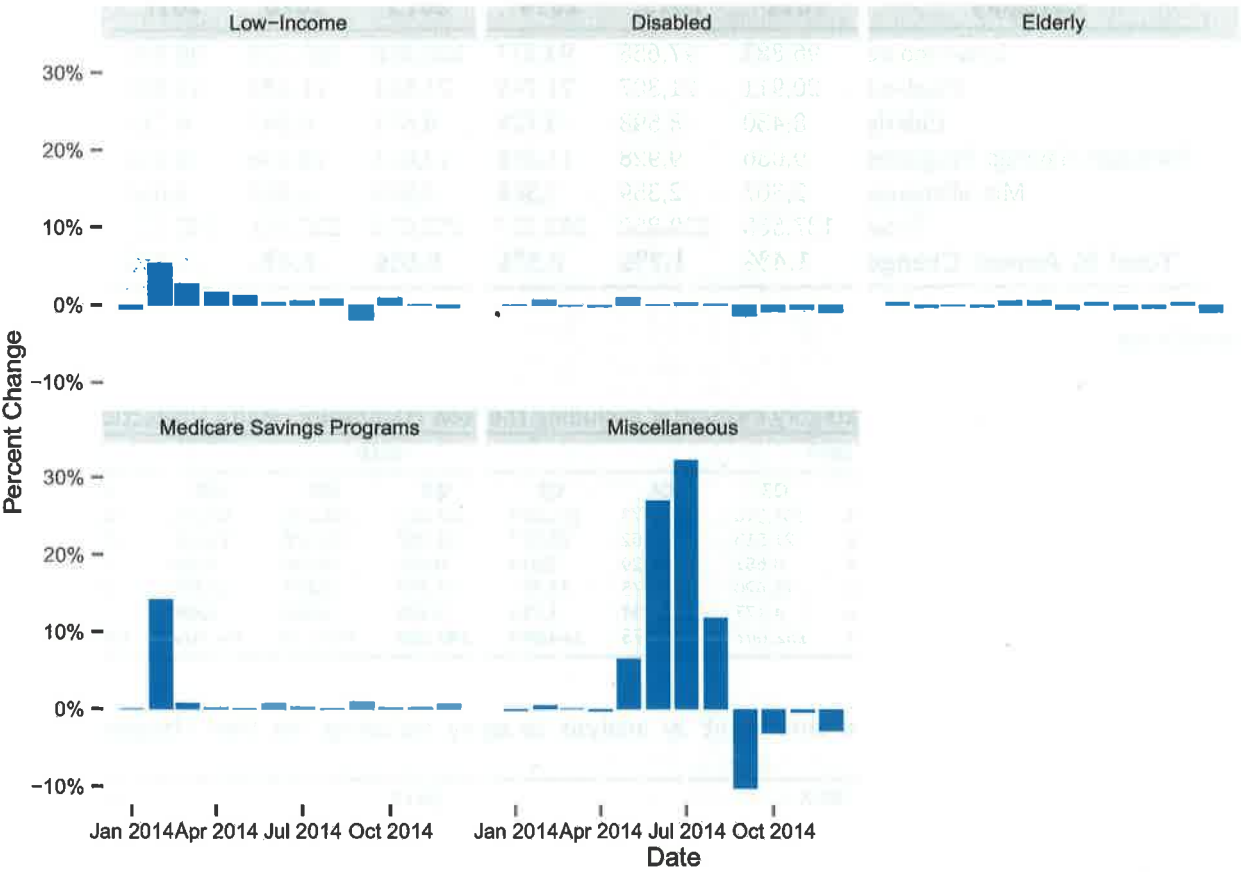
Miscellaneous There was a large surge in enrollment in the miscellaneous category due to the addition of the family planning category. Between May and August 2014, miscellaneous enrollment grew rapidly peaking at 32 percent in July 2014. After the surge in enrollment, the miscellaneous category entered into a slight downward trend in enrollment.

Table 7: Monthly change in enrollment by analysis category

| | Jan 2014 | Feb 2014 | Mar 2014 | Apr 2014 | May 2014 | Jun 2014 |
|---------------------------|----------|----------|----------|----------|----------|----------|
| Low-Income | -0.5% | 5.3% | 2.7% | 1.6% | 1.2% | 0.3% |
| Disabled | 0% | 0.6% | -0.1% | -0.2% | 0.9% | 0% |
| Elderly | 0.3% | -0.3% | -0.1% | -0.2% | 0.5% | 0.5% |
| Medicare Savings Programs | 0.1% | 14.2% | 0.8% | 0.2% | 0.1% | 0.7% |
| Miscellaneous | -0.2% | 0.5% | 0.1% | -0.3% | 6.5% | 27% |

| | Jul 2014 | Aug 2014 | Sep 2014 | Oct 2014 | Nov 2014 | Dec 2014 |
|---------------------------|----------|----------|----------|----------|----------|----------|
| Low-Income | 0.5% | 0.7% | -1.8% | 0.8% | 0% | -0.3% |
| Disabled | 0.3% | 0.1% | -1.3% | -0.8% | -0.5% | -0.9% |
| Elderly | -0.5% | 0.3% | -0.5% | -0.4% | 0.3% | -0.9% |
| Medicare Savings Programs | 0.3% | 0.1% | 0.9% | 0.2% | 0.2% | 0.6% |
| Miscellaneous | 32.2% | 11.8% | -10.3% | -3.1% | -0.4% | -2.8% |

Figure 5: Monthly change in enrollment by analysis category from January 2014 to December 2014



7. Forecast Enrollment

Medicaid enrollment is expected to expand by 6.5% in SFY 2015 and decrease between 1% to 2% in SFY 2016 and 2017. The primary drivers of enrollment change are expected to be: 1) a strengthening economy reducing enrollment in low-income; and 2) long-term demographic trends increasing enrollment in the Medicare savings programs. An improving economy is also expected to put downward pressure on enrollment in the elderly, disabled, and miscellaneous categories.

Table 8: Average annual enrollment projections by major category by State Fiscal Year (does not include the New Hampshire Health Protection Program)

| Category | 2012* | 2013* | 2014* | 2015 | 2016 | 2017 |
|------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
| Low-Income | 96,883 | 97,658 | 99,217 | 105,488 | 102,722 | 99,640 |
| Disabled | 20,911 | 21,307 | 21,749 | 21,504 | 21,235 | 21,399 |
| Elderly | 8,430 | 8,598 | 8,725 | 8,691 | 8,647 | 8,718 |
| Medicare Savings Programs | 9,036 | 9,928 | 11,248 | 13,011 | 14,036 | 15,142 |
| Miscellaneous | 2,307 | 2,359 | 2,388 | 3,945 | 3,802 | 3,658 |
| Total | 137,565 | 139,850 | 143,327 | 152,639 | 150,441 | 148,557 |
| Total % Annual Change | 1.4% | 1.7% | 2.5% | 6.5% | -1.4% | -1.3% |

*Actual enrollment

Table 9: Forecast enrollment by analysis category by quarter excluding the New Hampshire Health Protection Program

| Category | 2015 | | | | 2016 | | | | 2017 | |
|---------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| Low-Income | 105,026 | 105,173 | 104,216 | 102,773 | 101,879 | 102,018 | 101,090 | 99,689 | 98,823 | 98,957 |
| Disabled | 21,322 | 21,441 | 21,513 | 21,062 | 21,077 | 21,287 | 21,478 | 21,165 | 21,316 | 21,635 |
| Elderly | 8,656 | 8,674 | 8,681 | 8,629 | 8,618 | 8,660 | 8,699 | 8,684 | 8,709 | 8,781 |
| Medicare Savings Programs | 13,618 | 13,402 | 13,420 | 13,575 | 14,691 | 14,458 | 14,477 | 14,645 | 15,849 | 15,597 |
| Miscellaneous | 3,857 | 3,623 | 4,177 | 3,834 | 3,711 | 3,486 | 4,019 | 3,689 | 3,571 | 3,354 |
| Total | 152,479 | 152,313 | 152,007 | 149,873 | 149,976 | 149,909 | 149,763 | 147,872 | 148,268 | 148,324 |

Table 10: Forecast annualized change in enrollment by analysis category excluding the New Hampshire Health Protection Program

| Category | 2015 | | | | 2016 | | | | 2017 | |
|---------------------------|-------------|-------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 |
| Low-Income | 6.1% | 0.1% | -1.7% | -2.8% | -3% | -3% | -3% | -3% | -3% | -3% |
| Disabled | -1.9% | -1.8% | -1.7% | -1.5% | -1.1% | -0.7% | -0.2% | 0.5% | 1.1% | 1.6% |
| Elderly | -0.9% | -0.9% | -0.8% | -0.6% | -0.4% | -0.2% | 0.2% | 0.6% | 1.1% | 1.4% |
| Medicare Savings Programs | 16.6% | 8.9% | 7.9% | 7.9% | 7.9% | 7.9% | 7.9% | 7.9% | 7.9% | 7.9% |
| Miscellaneous | 66.3% | 37.2% | -3.2% | -3.8% | -3.8% | -3.8% | -3.8% | -3.8% | -3.8% | -3.8% |
| Total | 6.3% | 1.2% | -0.9% | -1.6% | -1.6% | -1.6% | -1.5% | -1.3% | -1.1% | -1.1% |

Figure 6: Analysis Category by SFY (historic & forecast)

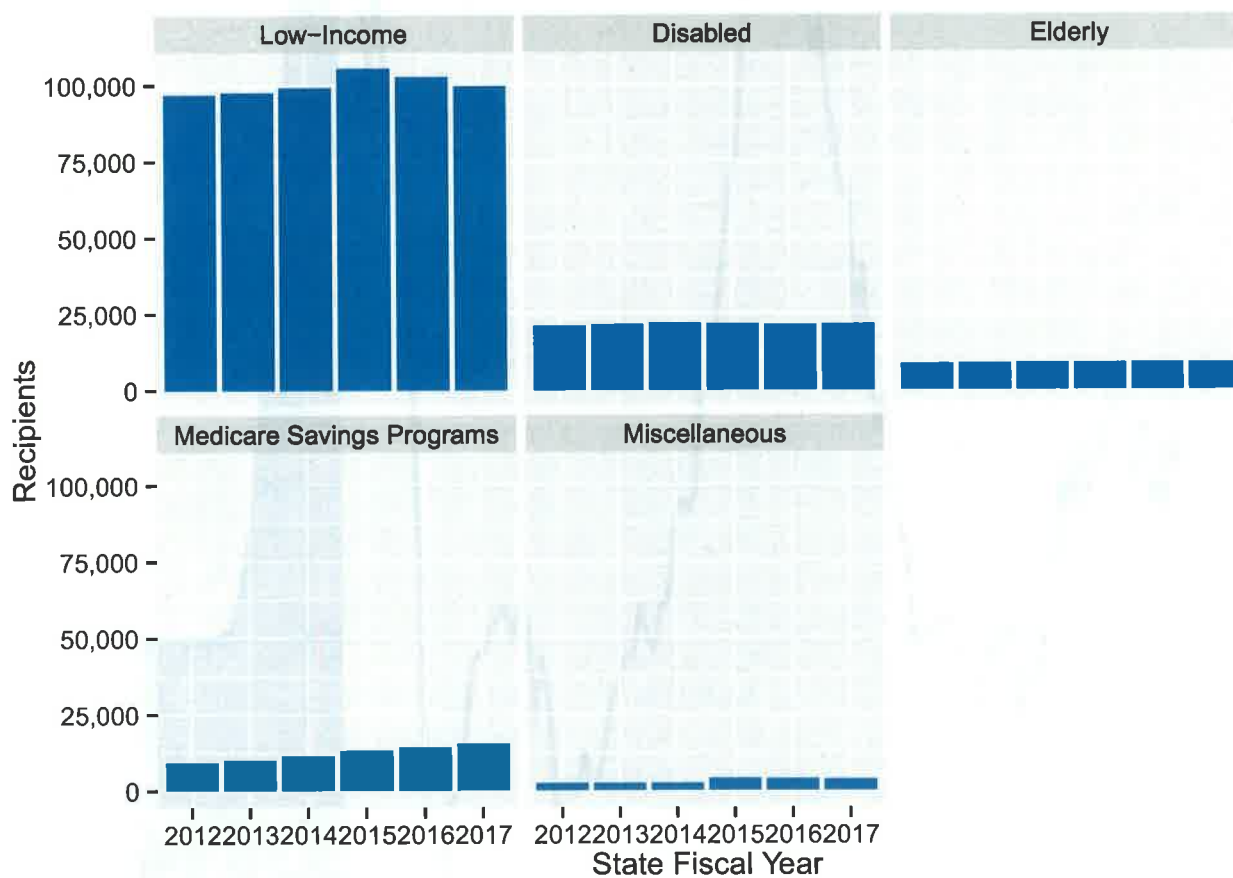


Figure 7: Annual change in low income analysis category enrollment (historic & forecast)

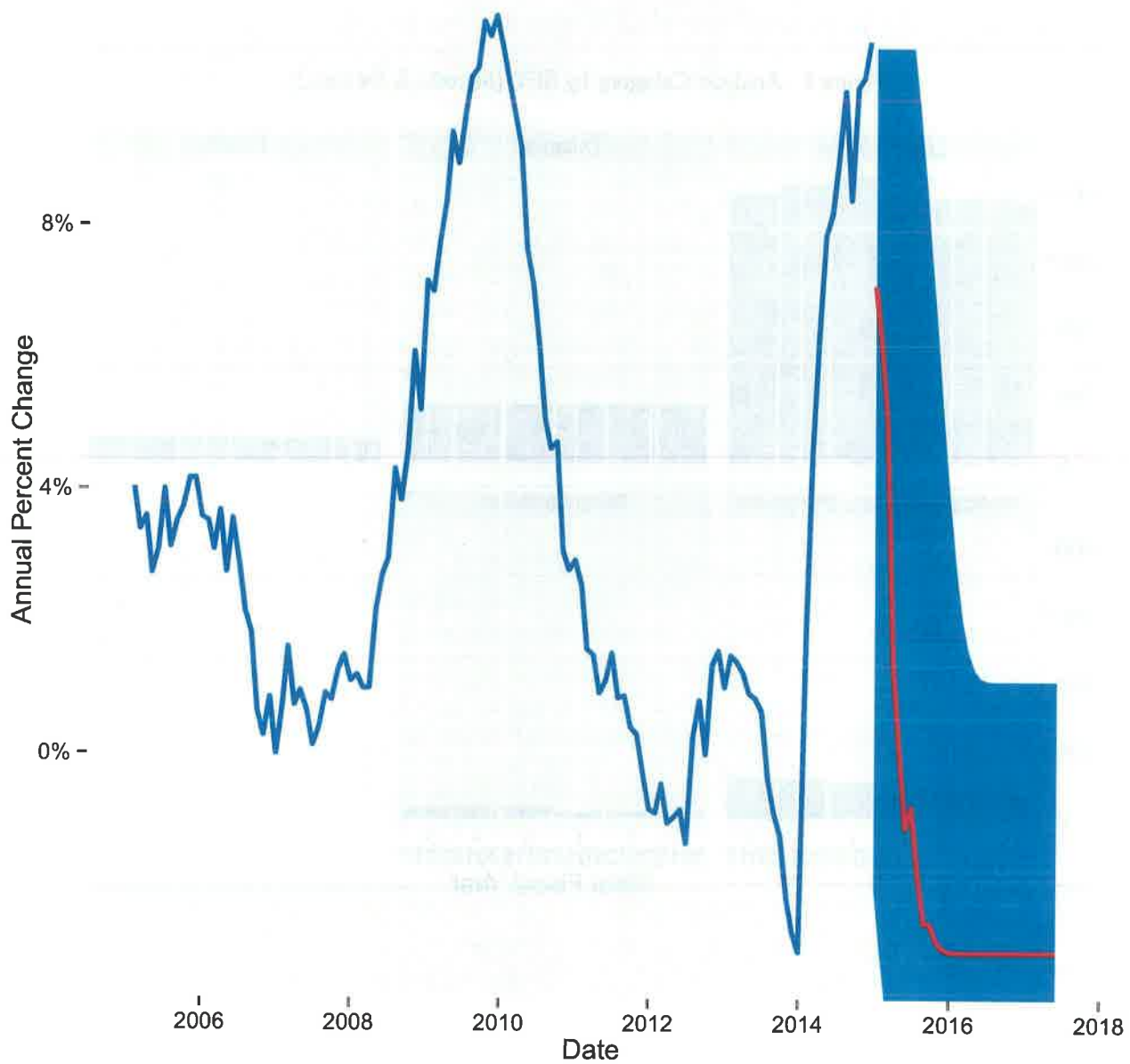


Figure 8: Annual change in disabled analysis category enrollment (historic & forecast)

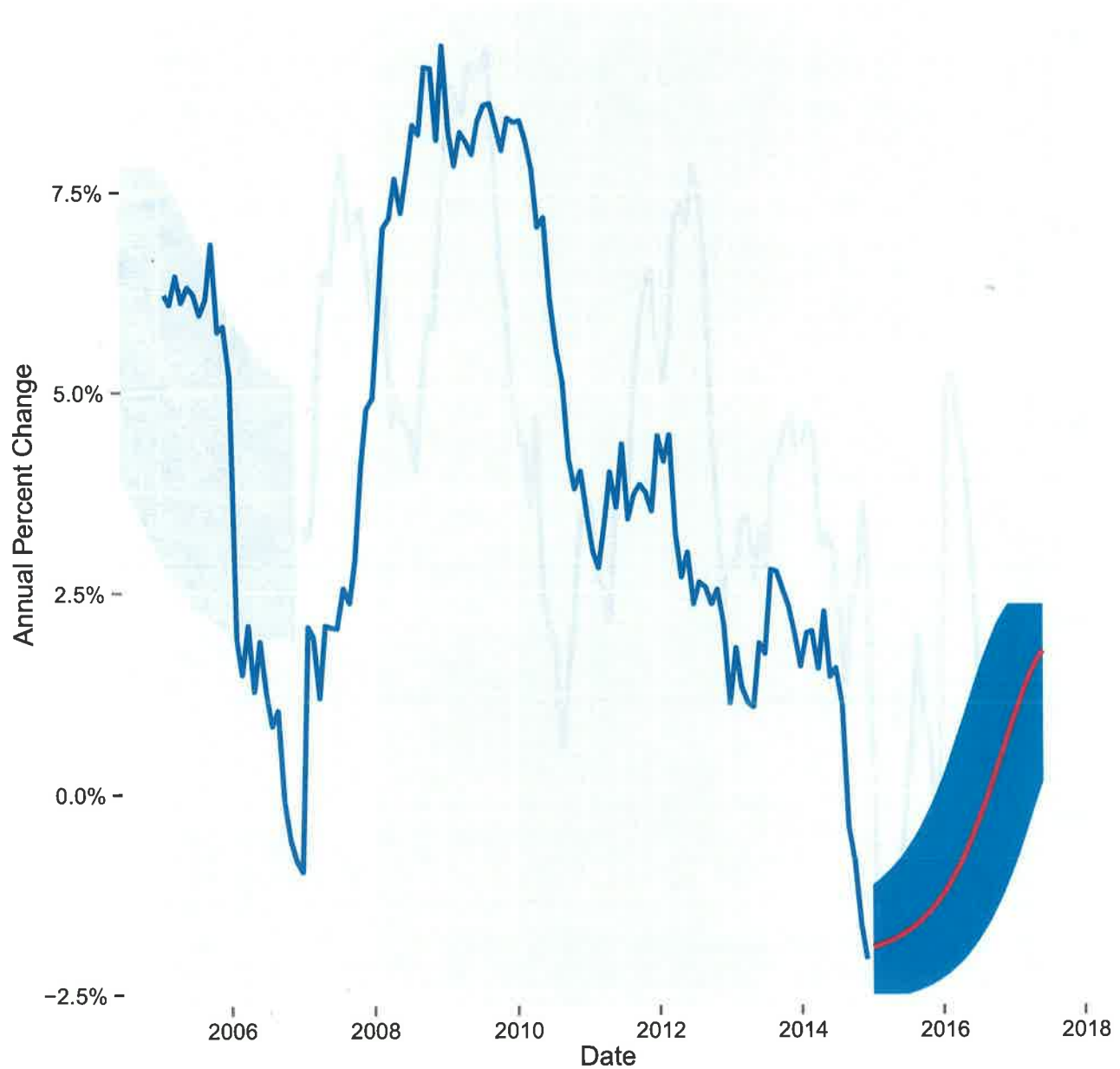


Figure 9: Annual change in elderly analysis category enrollment (historic & forecast)

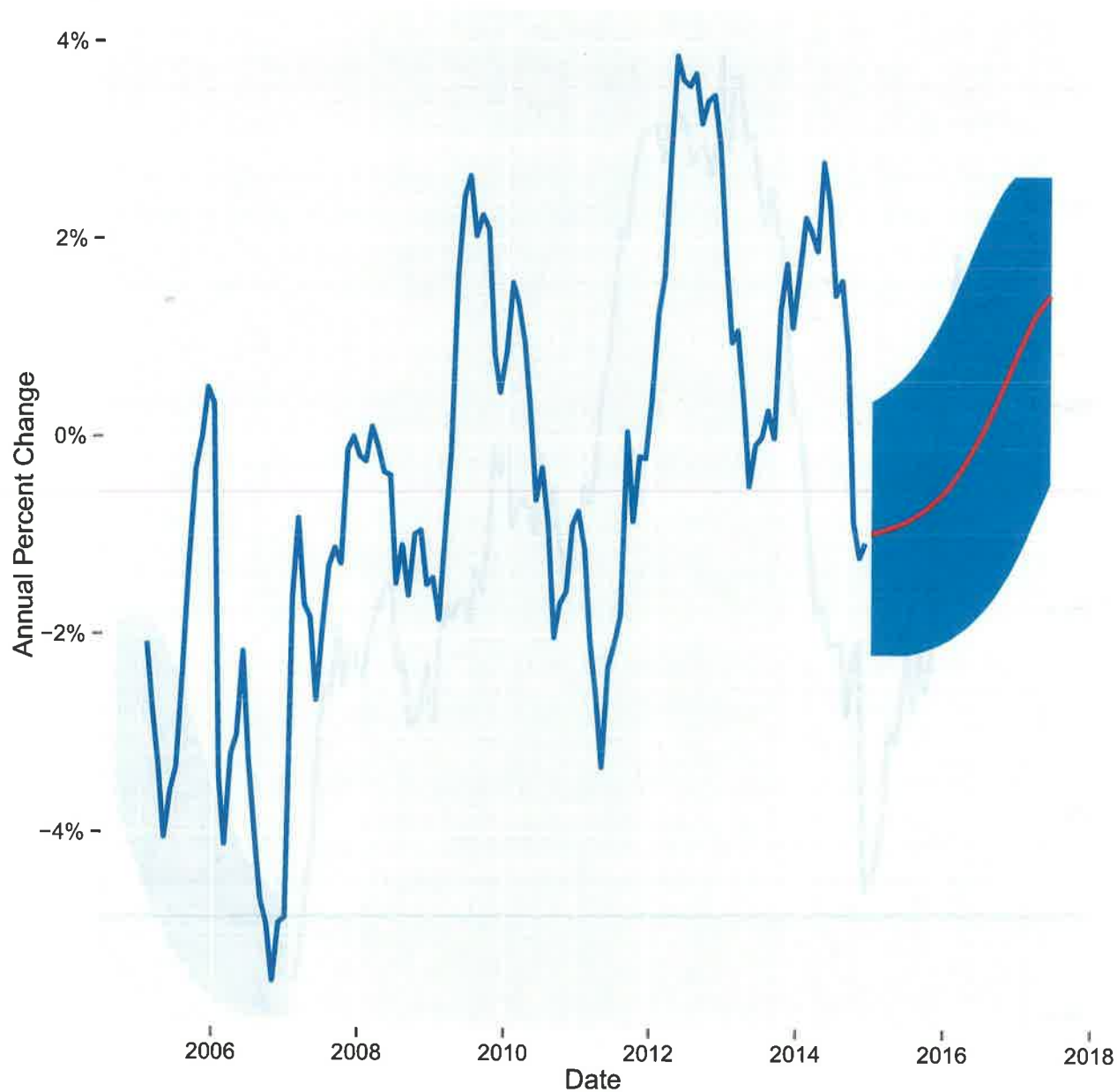


Figure 10: Annual change in Medicare savings programs analysis category enrollment (historic & forecast)

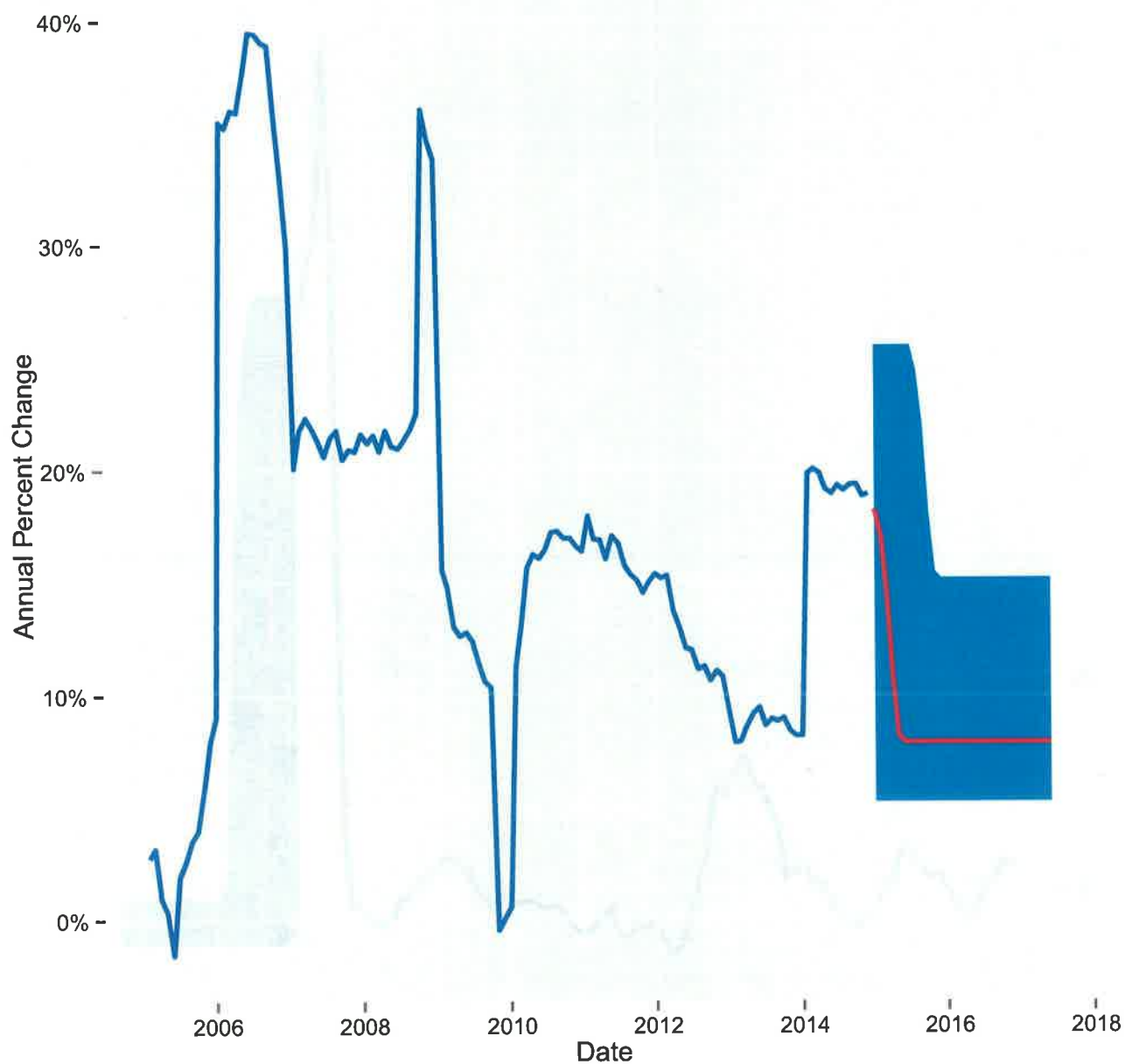
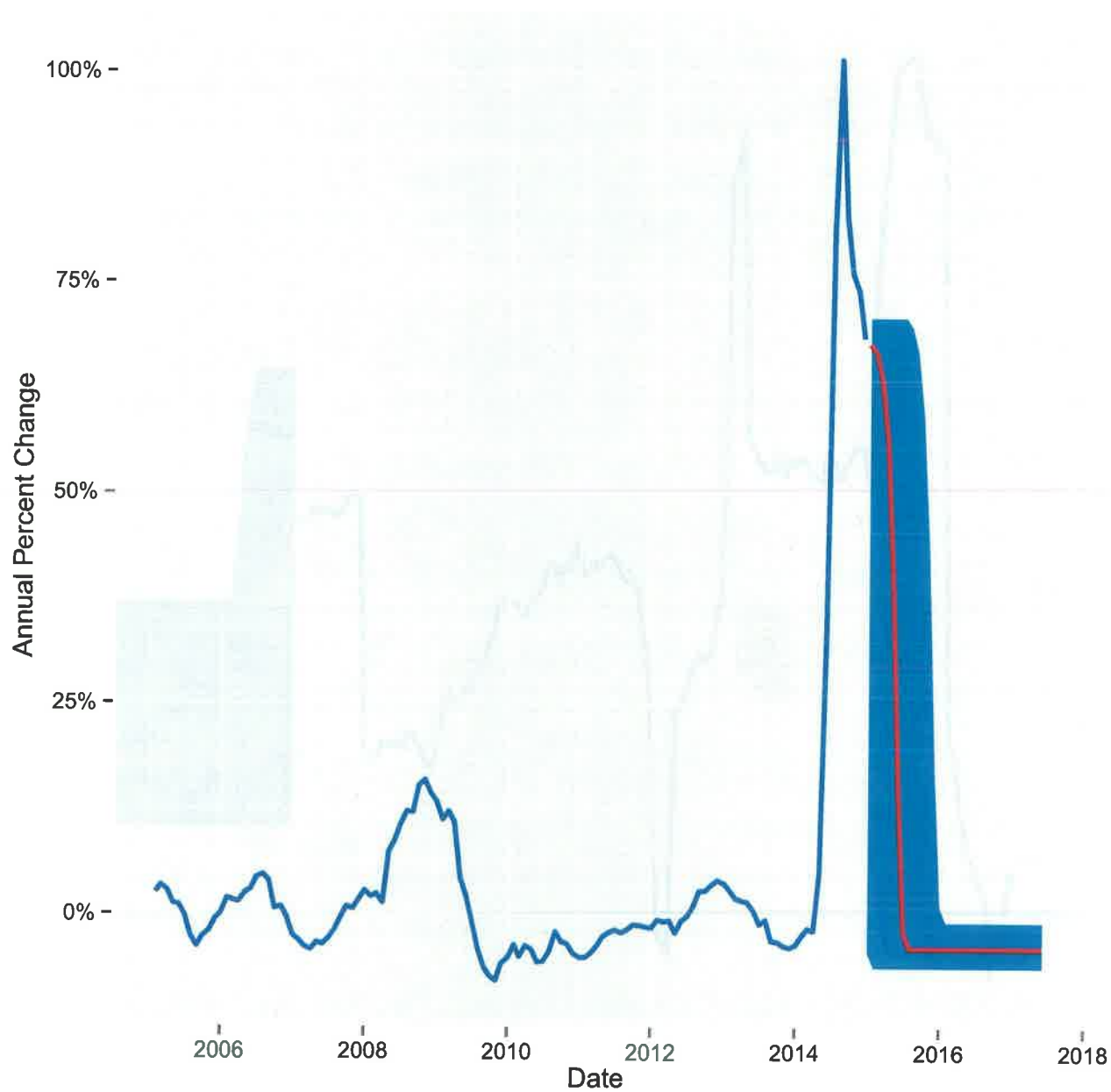


Figure 11: Annual change in miscellaneous analysis category enrollment (historic & forecast)



8. Conclusion

This enrollment update is in response to a request by the NH Department of Health & Human Services (NH DHHS) of Dr. Ross Gittell of the Community College System of New Hampshire and Matthew Magnusson to provide an updated Medicaid enrollment projection through the end of State Fiscal Year (SFY) 2017. This forecast includes the most current New England Economic Partnership economic outlook and unemployment forecast for New Hampshire.

Total average annual Medicaid enrollment increased by 3,500 or 2.5 percent, from 139,900 in State Fiscal Year (SFY) 2013 to 143,300 in SFY 2014. Average annual enrollment is projected to increase 6.5 percent to 152,600 in SFY 2015; to decrease -1.4 percent to 150,400 in SFY 2016; and decrease -1.3 percent to 148,600 in SFY 2017.

A combination of new federal process and policy requirements for income calculation and the "woodwork" effect—both related to the ACA—are believed to have resulted in an expected one-time step up in enrollment, specifically impacting low-income and Medicare savings programs. Annualized enrollment growth is expected to drop abruptly in 2015 as enrollment adjusts to the changes brought on by the ACA.

The strengthening economy in NH is expected to reduce net enrollment between SFY 2015 and SFY 2016 by 2,200 and by a further 1,900 between SFY 2016 to SFY 2017.

This forecast does not include enrollment in the New Hampshire Health Protection Program which began in 2014 as a result of changes in state law related to the Affordable Care Act

A. Enrollment by Analysis Category

| Report Date | Low-Income | Disabled | Elderly | Medicare Savings Programs | Miscellaneous | Total |
|-------------|------------|----------|---------|---------------------------|---------------|---------|
| 2014-11-30 | 105,510 | 21,206 | 8,641 | 12,642 | 3,906 | 151,905 |
| 2014-10-31 | 105,795 | 21,399 | 8,718 | 12,569 | 4,017 | 152,498 |
| 2014-09-30 | 105,842 | 21,517 | 8,696 | 12,541 | 4,032 | 152,628 |
| 2014-08-31 | 105,007 | 21,697 | 8,731 | 12,521 | 4,161 | 152,117 |
| 2014-07-31 | 106,912 | 21,980 | 8,773 | 12,404 | 4,637 | 154,706 |
| 2014-06-30 | 106,191 | 21,959 | 8,747 | 12,396 | 4,146 | 153,439 |
| 2014-05-31 | 105,665 | 21,901 | 8,795 | 12,363 | 3,137 | 151,861 |
| 2014-04-30 | 105,328 | 21,906 | 8,751 | 12,280 | 2,470 | 150,735 |
| 2014-03-31 | 104,078 | 21,706 | 8,706 | 12,272 | 2,319 | 149,081 |
| 2014-02-28 | 102,427 | 21,757 | 8,727 | 12,251 | 2,326 | 147,488 |
| 2014-01-31 | 99,738 | 21,787 | 8,733 | 12,149 | 2,323 | 144,730 |
| 2013-12-31 | 94,735 | 21,667 | 8,755 | 10,638 | 2,311 | 138,106 |
| 2013-11-30 | 95,200 | 21,657 | 8,733 | 10,632 | 2,316 | 138,538 |
| 2013-10-31 | 95,945 | 21,754 | 8,824 | 10,580 | 2,305 | 139,408 |
| 2013-09-30 | 96,118 | 21,697 | 8,769 | 10,510 | 2,287 | 139,381 |
| 2013-08-31 | 96,858 | 21,786 | 8,651 | 10,495 | 2,274 | 140,064 |
| 2013-07-31 | 97,129 | 21,741 | 8,634 | 10,417 | 2,298 | 140,219 |
| 2013-06-30 | 97,380 | 21,624 | 8,621 | 10,393 | 2,289 | 140,307 |
| 2013-05-31 | 97,670 | 21,591 | 8,588 | 10,396 | 2,336 | 140,581 |
| 2013-04-30 | 97,652 | 21,424 | 8,512 | 10,310 | 2,353 | 140,251 |
| 2013-03-31 | 97,837 | 21,377 | 8,543 | 10,241 | 2,361 | 140,359 |
| 2013-02-28 | 97,959 | 21,329 | 8,547 | 10,209 | 2,362 | 140,406 |
| 2013-01-31 | 97,941 | 21,363 | 8,541 | 10,141 | 2,378 | 140,364 |
| 2012-12-31 | 97,664 | 21,332 | 8,610 | 9,834 | 2,394 | 139,834 |
| 2012-11-30 | 97,828 | 21,237 | 8,635 | 9,828 | 2,407 | 139,935 |
| 2012-10-31 | 98,065 | 21,261 | 8,670 | 9,760 | 2,391 | 140,147 |
| 2012-09-30 | 97,306 | 21,160 | 8,655 | 9,645 | 2,360 | 139,126 |
| 2012-08-31 | 97,739 | 21,203 | 8,650 | 9,645 | 2,344 | 139,581 |
| 2012-07-31 | 97,478 | 21,156 | 8,609 | 9,564 | 2,309 | 139,116 |
| 2012-06-30 | 96,748 | 21,256 | 8,619 | 9,568 | 2,313 | 138,504 |
| 2012-05-31 | 96,837 | 21,197 | 8,593 | 9,500 | 2,323 | 138,450 |
| 2012-04-30 | 96,754 | 21,197 | 8,553 | 9,445 | 2,316 | 138,265 |
| 2012-03-31 | 96,634 | 21,139 | 8,510 | 9,429 | 2,320 | 138,032 |
| 2012-02-29 | 96,595 | 21,049 | 8,454 | 9,459 | 2,314 | 137,871 |
| 2012-01-31 | 96,490 | 20,986 | 8,458 | 9,400 | 2,310 | 137,644 |
| 2011-12-31 | 96,678 | 21,096 | 8,454 | 8,998 | 2,306 | 137,532 |
| 2011-11-30 | 96,313 | 20,798 | 8,384 | 8,870 | 2,311 | 136,676 |
| 2011-10-31 | 96,748 | 20,736 | 8,378 | 8,788 | 2,307 | 136,957 |
| 2011-09-30 | 97,304 | 20,674 | 8,368 | 8,718 | 2,293 | 137,357 |
| 2011-08-31 | 96,947 | 20,674 | 8,382 | 8,668 | 2,278 | 136,949 |
| 2011-07-31 | 97,225 | 20,616 | 8,301 | 8,606 | 2,283 | 137,031 |
| 2011-06-30 | 98,070 | 20,768 | 8,321 | 8,546 | 2,315 | 138,020 |
| 2011-05-31 | 97,659 | 20,582 | 8,291 | 8,477 | 2,338 | 137,347 |
| 2011-04-30 | 97,684 | 20,644 | 8,233 | 8,359 | 2,365 | 137,285 |
| 2011-03-31 | 97,651 | 20,480 | 8,270 | 8,293 | 2,335 | 137,029 |
| 2011-02-28 | 97,034 | 20,152 | 8,318 | 8,205 | 2,331 | 136,040 |
| 2011-01-31 | 97,353 | 20,156 | 8,353 | 8,162 | 2,322 | 136,346 |
| 2010-12-31 | 97,483 | 20,199 | 8,420 | 7,800 | 2,341 | 136,243 |
| 2010-11-30 | 96,570 | 20,094 | 8,401 | 7,713 | 2,343 | 135,121 |
| 2010-10-31 | 96,457 | 19,991 | 8,393 | 7,674 | 2,335 | 134,850 |

| Report Date | Low-Income | Disabled | Elderly | Medicare Savings Programs | Miscellaneous | Total |
|-------------|------------|----------|---------|---------------------------|---------------|---------|
| 2010-09-30 | 96,895 | 19,912 | 8,439 | 7,576 | 2,319 | 135,141 |
| 2010-08-31 | 96,093 | 19,935 | 8,376 | 7,517 | 2,317 | 134,238 |
| 2010-07-31 | 96,392 | 19,938 | 8,453 | 7,436 | 2,331 | 134,550 |
| 2010-06-30 | 96,592 | 19,904 | 8,499 | 7,321 | 2,356 | 134,672 |
| 2010-05-31 | 96,568 | 19,876 | 8,488 | 7,243 | 2,386 | 134,561 |
| 2010-04-30 | 96,786 | 19,851 | 8,517 | 7,205 | 2,426 | 134,785 |
| 2010-03-31 | 96,211 | 19,814 | 8,492 | 7,096 | 2,422 | 134,035 |
| 2010-02-28 | 95,518 | 19,604 | 8,492 | 7,018 | 2,440 | 133,072 |
| 2010-01-31 | 94,910 | 19,569 | 8,447 | 6,921 | 2,444 | 132,291 |
| 2009-12-31 | 94,702 | 19,524 | 8,483 | 6,703 | 2,464 | 131,876 |
| 2009-11-30 | 93,950 | 19,321 | 8,476 | 6,615 | 2,455 | 130,817 |
| 2009-10-31 | 93,564 | 19,263 | 8,525 | 6,562 | 2,418 | 130,332 |
| 2009-09-30 | 92,515 | 19,115 | 8,582 | 6,478 | 2,395 | 129,085 |
| 2009-08-31 | 91,841 | 18,962 | 8,549 | 6,411 | 2,363 | 128,126 |
| 2009-07-31 | 91,713 | 18,887 | 8,528 | 6,344 | 2,436 | 127,908 |
| 2009-06-30 | 90,908 | 18,750 | 8,525 | 6,287 | 2,493 | 126,963 |
| 2009-05-31 | 90,124 | 18,546 | 8,542 | 6,241 | 2,527 | 125,980 |
| 2009-04-30 | 89,879 | 18,543 | 8,491 | 6,199 | 2,529 | 125,641 |
| 2009-03-31 | 88,100 | 18,380 | 8,409 | 6,137 | 2,514 | 123,540 |
| 2009-02-28 | 87,050 | 18,127 | 8,376 | 6,205 | 2,567 | 122,325 |
| 2009-01-31 | 86,144 | 18,056 | 8,316 | 6,220 | 2,533 | 121,269 |
| 2008-12-31 | 85,515 | 18,017 | 8,411 | 6,665 | 2,595 | 121,203 |
| 2008-11-30 | 84,482 | 17,822 | 8,437 | 6,612 | 2,604 | 119,957 |
| 2008-10-31 | 84,368 | 17,835 | 8,452 | 6,593 | 2,622 | 119,870 |
| 2008-09-30 | 83,259 | 17,649 | 8,404 | 5,871 | 2,582 | 117,765 |
| 2008-08-31 | 83,173 | 17,460 | 8,360 | 5,797 | 2,519 | 117,309 |
| 2008-07-31 | 83,163 | 17,396 | 8,357 | 5,694 | 2,537 | 117,147 |
| 2008-06-30 | 82,886 | 17,302 | 8,304 | 5,594 | 2,511 | 116,597 |
| 2008-05-31 | 82,713 | 17,179 | 8,338 | 5,534 | 2,472 | 116,236 |
| 2008-04-30 | 82,126 | 17,151 | 8,353 | 5,505 | 2,421 | 115,556 |
| 2008-03-31 | 81,308 | 16,981 | 8,417 | 5,429 | 2,266 | 114,401 |
| 2008-02-29 | 80,827 | 16,812 | 8,461 | 5,407 | 2,287 | 113,794 |
| 2008-01-31 | 80,500 | 16,678 | 8,472 | 5,382 | 2,276 | 113,308 |
| 2007-12-31 | 79,797 | 16,481 | 8,532 | 4,980 | 2,289 | 112,079 |
| 2007-11-30 | 80,301 | 16,480 | 8,565 | 4,908 | 2,276 | 112,530 |
| 2007-10-31 | 79,515 | 16,356 | 8,532 | 4,846 | 2,261 | 111,510 |
| 2007-09-30 | 79,605 | 16,184 | 8,487 | 4,793 | 2,239 | 111,308 |
| 2007-08-31 | 80,094 | 16,135 | 8,496 | 4,759 | 2,247 | 111,731 |
| 2007-07-31 | 79,717 | 16,059 | 8,449 | 4,693 | 2,260 | 111,178 |
| 2007-06-30 | 80,500 | 16,061 | 8,429 | 4,626 | 2,267 | 111,883 |
| 2007-05-31 | 80,541 | 16,020 | 8,370 | 4,572 | 2,272 | 111,775 |
| 2007-04-30 | 80,385 | 15,931 | 8,382 | 4,522 | 2,254 | 111,474 |
| 2007-03-31 | 80,504 | 15,847 | 8,425 | 4,494 | 2,235 | 111,505 |
| 2007-02-28 | 80,023 | 15,707 | 8,452 | 4,449 | 2,232 | 110,863 |
| 2007-01-31 | 79,547 | 15,740 | 8,492 | 4,441 | 2,228 | 110,448 |
| 2006-12-31 | 78,918 | 15,710 | 8,548 | 4,096 | 2,226 | 109,498 |
| 2006-11-30 | 79,111 | 15,728 | 8,564 | 4,063 | 2,237 | 109,703 |
| 2006-10-31 | 78,512 | 15,721 | 8,542 | 4,009 | 2,246 | 109,030 |
| 2006-09-30 | 78,958 | 15,727 | 8,597 | 3,979 | 2,218 | 109,479 |
| 2006-08-31 | 79,364 | 15,761 | 8,592 | 3,909 | 2,255 | 109,881 |
| 2006-07-31 | 79,398 | 15,659 | 8,561 | 3,865 | 2,302 | 109,785 |
| 2006-06-30 | 80,392 | 15,738 | 8,594 | 3,836 | 2,334 | 110,894 |
| 2006-05-31 | 80,012 | 15,697 | 8,599 | 3,770 | 2,356 | 110,434 |
| 2006-04-30 | 79,621 | 15,605 | 8,537 | 3,711 | 2,332 | 109,806 |

| Report Date | Low-Income | Disabled | Elderly | Medicare Savings Programs | Miscellaneous | Total |
|-------------|------------|----------|---------|---------------------------|---------------|---------|
| 2006-03-31 | 79,909 | 15,661 | 8,570 | 3,675 | 2,332 | 110,147 |
| 2006-02-28 | 78,750 | 15,408 | 8,522 | 3,654 | 2,321 | 108,655 |
| 2006-01-31 | 78,979 | 15,421 | 8,633 | 3,699 | 2,298 | 109,030 |
| 2005-12-31 | 78,915 | 15,865 | 8,985 | 3,154 | 2,282 | 109,201 |
| 2005-11-30 | 78,433 | 15,862 | 9,006 | 3,052 | 2,245 | 108,598 |
| 2005-10-31 | 78,289 | 15,813 | 9,039 | 2,952 | 2,226 | 108,319 |
| 2005-09-30 | 78,437 | 15,739 | 9,041 | 2,864 | 2,203 | 108,284 |
| 2005-08-31 | 77,919 | 15,600 | 9,012 | 2,811 | 2,169 | 107,511 |
| 2005-07-31 | 77,708 | 15,529 | 8,916 | 2,772 | 2,199 | 107,124 |
| 2005-06-30 | 78,103 | 15,539 | 8,883 | 2,750 | 2,236 | 107,511 |
| 2005-05-31 | 77,263 | 15,406 | 8,790 | 2,740 | 2,289 | 106,488 |
| 2005-04-30 | 77,488 | 15,409 | 8,803 | 2,730 | 2,276 | 106,706 |
| 2005-03-31 | 77,074 | 15,341 | 8,855 | 2,702 | 2,299 | 106,271 |
| 2005-02-28 | 76,386 | 15,184 | 8,888 | 2,702 | 2,284 | 105,444 |
| 2005-01-31 | 76,297 | 15,129 | 8,941 | 2,730 | 2,256 | 105,353 |
| 2004-12-31 | 76,189 | 15,084 | 8,955 | 2,894 | 2,280 | 105,402 |
| 2004-11-30 | 75,290 | 14,989 | 8,961 | 2,830 | 2,259 | 104,329 |
| 2004-10-31 | 75,153 | 14,953 | 9,040 | 2,791 | 2,271 | 104,208 |
| 2004-09-30 | 75,606 | 14,730 | 9,072 | 2,755 | 2,262 | 104,425 |
| 2004-08-31 | 75,263 | 14,696 | 9,126 | 2,716 | 2,255 | 104,056 |
| 2004-07-31 | 75,352 | 14,655 | 9,132 | 2,702 | 2,258 | 104,099 |
| 2004-06-30 | 75,098 | 14,629 | 9,191 | 2,699 | 2,239 | 103,856 |
| 2004-05-31 | 74,955 | 14,492 | 9,117 | 2,784 | 2,265 | 103,613 |
| 2004-04-30 | 75,429 | 14,521 | 9,175 | 2,722 | 2,248 | 104,095 |
| 2004-03-31 | 74,400 | 14,411 | 9,158 | 2,677 | 2,236 | 102,882 |
| 2004-02-29 | 73,879 | 14,312 | 9,137 | 2,619 | 2,210 | 102,157 |
| 2004-01-31 | 73,340 | 14,243 | 9,131 | 2,657 | 2,201 | 101,572 |

B. Forecast Authors

Matthew Magnusson is a graduate of the University of New Hampshire's Whittemore School of Business and Economics with a Masters of Business Administration. He brings information technology skills in managing big data projects to provide analysis and report authorship, specifically in regards to economic data sets. Recent research while employed as a Research Scientist at the University of New Hampshire (UNH) includes economic modeling for a study sponsored by NRDC and Protect Our Winters "Climate Impacts on the Winter Tourism Economy in the United States," "New Hampshire's Green Economy and Industries: Current Employment and Future Opportunities" performed for the Rockingham Economic Development Committee (REDC), "Economic Impact of Granite Reliable Power Wind Power Project in Coos County, New Hampshire" performed for Granite Reliable Power, LLC and the economic analysis of policies proposed in "The New Hampshire Climate Action Plan" performed for the NH Climate Change Task Force.

Dr. Ross Gittell is a well-known authority in economic analysis and forecasting. Dr. Ross Gittell was appointed Chancellor of the Community College System of NH on February 1, 2012. With an extensive background in university teaching, strategic planning and management, Dr. Gittell's focus has been on applying economic, organizational and management theory to regional, state and community economic development issues. For many years, as a distinguished Professor at the University of New Hampshire's Peter T. Paul College of Business and Economics, Dr. Gittell has frequently been a resource for government, non-profit and business decision makers in New Hampshire and nationally on such issues as economic policy, workforce development, job creation strategies, community development and the business climate.

Dr. Gittell holds a Ph.D. in Public Policy from Harvard University, a Masters in Business Administration from the University of California, Berkeley, and a Bachelors degree in economics from the University of Chicago. Prior to his appointment as Chancellor at CCSNH, he was the James R. Carter Professor in the Department of Management at the Whittemore School of Business and Economics at the University of New Hampshire.

Dr. Gittell is active on numerous Boards and commissions. He is Vice President, forecast manager and board member of the New England Economic Partnership, a Director of the Exeter Trust Company, a board member of the NH Charitable Foundation, and a board member of Exeter Hospital



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

An Evaluation of the Impact of Medicaid Expansion in New Hampshire

Phase I Report

Prepared by: The Lewin Group

November 2012

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Executive Summary

Following the June 2012 United States Supreme Court ruling that the federal government could not require individual states to expand their Medicaid programs for adults and declared this part of the Affordable Care Act (ACA) unconstitutional, states now have the option to opt out of the Medicaid expansion provision of the ACA without compromising their current federal Medicaid funding.

As a result of this ruling, the New Hampshire Department of Health and Human Services contracted with The Lewin Group to explore the potential financial impacts of expanding or not expanding its Medicaid program. The purpose of this report, which represents the first of two project phases, is to estimate the impact of expanding versus not expanding Medicaid on New Hampshire's Medicaid program. However, this analysis does not capture the full effects of expanding or not expanding Medicaid and should only be used in the context of the effects on the New Hampshire Medicaid program only. A second report will follow in December, and will discuss the secondary effects on other state health programs, health care providers, commercial premiums, and the overall state economy.

This report provides estimates on Medicaid enrollment and costs under the option of not expanding Medicaid compared to the option of expanding the program under various program design options. We present the following options for the state's consideration as it continues to weigh the costs and benefits of implementing an expansion, not only on state and federal finances, but also as it considers the needs of state residents.

Option to Not Expand Medicaid

The ACA includes various coverage provisions that will affect New Hampshire's Medicaid program regardless of any changes made to the current program. These provisions include reforming the individual insurance markets by eliminating pre-existing condition exclusions, guaranteeing coverage and renewability of coverage, establishing Health Benefit Exchanges (HBE), an individual mandate, and subsidizing health insurance for people between 100 and 400 percent of FPL and a mandate for large employers to offer health insurance. The ACA also provides states with a 23 percentage point increase in their enhanced Federal Medical Assistance Percentage (FMAP) rate for CHIP beginning in federal fiscal year 2016, regardless of whether the state decides to expand Medicaid. We estimate that the state would save \$61 million from 2016 through 2019 assuming that the state would have continued the CHIP program in the absence of the ACA.

If the state decides not to expand Medicaid then we estimate the state would save between \$65.8 and \$113.7 million over the 2014 to 2020 period due to the other effects of the ACA and depending on options to reduce eligibility levels to 138 percent of FPL for adults beginning in 2014.

1. **No Expansion - Baseline:** maintenance of the current Medicaid program, without changes to Federal matching rates for Medicaid reimbursement, taking into account certain provisions of the Affordable Care Act that will affect the state's Medicaid program with or without expansion:

Cumulative State Cost (2014-2020): (\$65,780,000)
Cumulative Federal Cost (2014-2020): \$55,845,000
Change in Enrollment by 2020: 175

- 2. No Expansion and Moving Current Eligibles Above 138 percent of FPL to HBE:** capping certain eligibility categories (Medicaid for Employed Adults with Disabilities and poverty-level pregnant women) for adults at 138 percent of FPL and moving enrollees to the Exchange where they can obtain subsidized private health insurance coverage:

Cumulative State Cost (2014-2020): (\$113,691,000)
Cumulative Federal Cost (2014-2020): \$7,154,000 ¹
Change in Enrollment by 2020: (913)

Option to Expand Medicaid

Expanding Medicaid to all adults below 138 percent of FPL beginning January 2014 would result in an increase in state Medicaid spending of between \$38.0 and \$102.3 million over the 2014 through 2020 period depending on participation levels in the program. As a midpoint assumption, we estimate the cost to the state would be about \$85.5 million over this time period. However, the expansion would result in additional federal funding of between \$1.95 and \$2.71 billion over this same period.

- 1. Expansion – Baseline estimate:** implementing Medicaid expansion in 2014 under a fee for service system, for all adults in the state up to 138 percent of FPL

Cumulative State Cost (2014-2020): \$85,488,000
Cumulative Federal Cost (2014-2020): \$2,510,922,000
Change in Enrollment by 2020: 62,237

- 2. Expansion - Low-range Participation Assumption:** sensitivity analysis based on current Medicaid participation for adults in New Hampshire, representing a low take up rate scenario:

Cumulative State Cost (2014-2020): \$38,009,000
Cumulative Federal Cost (2014-2020): \$1,952,472,000
Change in Enrollment by 2020: 47,565

- 3. Expansion - High-range Participation Assumption:** sensitivity analysis based on Medicaid participation rates among eligible adults in Massachusetts, representing a high take up rate scenario:

Cumulative State Cost (2014-2020): \$102,333,000
Cumulative Federal Cost (2014-2020): \$2,709,058,000
Change in Enrollment by 2020: 67,443

¹ Federal cost does not include the cost of providing premium and cost sharing subsidies in the HBEs.

The state also has a variety of options it could consider in designing the expansion. If the expansion was implemented under a managed care arrangement (Care Management), we estimate the cost to the state would be about \$69.5 million over the 2014 through 2020 period, while increasing federal matching funds by \$2.5 billion.

4. Expansion Option –Managed Care Rates: estimate of the cost of the program under a managed care arrangement using managed care rates that were developed for this analysis

| | |
|---|------------------------|
| <i>Cumulative State Cost (2014-2020):</i> | <i>\$69,470,000</i> |
| <i>Cumulative Federal Cost (2014-2020):</i> | <i>\$2,501,073,000</i> |
| <i>Change in Enrollment by 2020:</i> | <i>62,237</i> |

New Hampshire also has the option to begin the expansion at any time after January 1, 2014, and still receive the enhanced federal match. However, 100 percent federal matching is only available from 2014 through 2016. If the state decides to delay the start of the program until after January 2014, then it will lose the ability to provide coverage to residents at full federal funding during that period.

Assuming the state delays implementation by one year, the cost to the state would be \$79.4 million over the 2014 to 2020 period which is a savings of about \$6.1 million compared to implementing the program in January 2014. However, the federal funding to the state would decline from \$2.5 to \$2.16 billion which would be a loss of \$340 million in federal funds over this period. Assuming the state delays implementation by two years, the state would save about \$14.3 million but lose \$713 million in federal funding compared to implementing the program in January 2014.

5. Expansion Option – Delay Implementation by One Year: estimate of the cost of the program in delaying implementation until January 1, 2015, under a fee-for-service program

| | |
|---|------------------------|
| <i>Cumulative State Cost (2014-2020):</i> | <i>\$79,384,000</i> |
| <i>Cumulative Federal Cost (2014-2020):</i> | <i>\$2,158,931,000</i> |
| <i>Change in Enrollment by 2020:</i> | <i>62,237</i> |

6. Expansion Option – Delay Implementation by Two Years: estimate of the cost of the program in delaying implementation until January 1, 2016, under a fee-for-service program

| | |
|---|------------------------|
| <i>Cumulative State Cost (2014-2020):</i> | <i>\$71,166,000</i> |
| <i>Cumulative Federal Cost (2014-2020):</i> | <i>\$1,797,367,000</i> |
| <i>Change in Enrollment by 2020:</i> | <i>62,237</i> |

New Hampshire also has the option to limit eligibility for current eligibility groups for adults to 138 percent of FPL beginning in 2014. Current eligibles above 138 percent of FPL could receive subsidized coverage in the HBE. Potential eligibility categories include the Medicaid for Employed Adults with Disabilities (MEAD) and poverty-level adult pregnant women. The state also has the option to transition certain adults out of certain eligibility categories, such as the

Breast and Cervical Cancer Program category, which would allow these current eligibles to become covered under the newly eligible group at the enhanced federal matching rates.

If the state expands Medicaid to 138 percent of FPL, then more adult women with incomes below 138 percent of FPL will have enrolled as a newly eligible adult through the Medicaid expansion prior to a pregnancy and thus the state would receive the enhanced federal matching rate for these eligibles. However, this may depend on future guidance from the Centers for Medicaid and Medicaid Services (CMS).

Under these various design options, the state could significantly reduce the cost of the Medicaid expansion while maintaining substantial federal funding. However, some of these scenarios may change depending in future guidance from CMS.

7. Expansion Option – Moving Current Eligibles Above 138 percent of FPL to HBE:

Cumulative State Cost (2014-2020): \$37,576,000
Cumulative Federal Cost (2014-2020): \$2,462,231,000
Change in Enrollment by 2020: 61,149

8. Expansion Option – Moving Current Eligibles Above 138 percent of FPL to HBE+ Transition Enrollees out of Breast and Cervical Cancer Program Eligibility Category:

Cumulative State Cost (2014-2020): \$24,021,000
Cumulative Federal Cost (2014-2020): \$2,475,786,000
Change in Enrollment by 2020: 61,149

9. Expansion Option - Moving Current Eligibles Above 138 percent of FPL to HBE + Transition Enrollees out of Breast and Cervical Cancer Program Eligibility Category + Transition of Pregnant Women Below 138 percent of FPL into “Newly Eligible” Category:

Cumulative State Cost (2014-2020): (\$26,182,000)
Cumulative Federal Cost (2014-2020): \$2,525,989,000
Change in Enrollment by 2020: 61,149

Detailed year by year cost estimates for state Medicaid spending are presented in *Figure ES-1* for each of the above Medicaid expansion scenarios. Federal Medicaid spending estimates are presented in *Figure ES-2*.

Figure 1: Summary of the State Cost and Enrollment of Various Options for Expanding Medicaid in New Hampshire by Year (in \$1000s)

| Scenario | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative (2014-2020) | Change in Enrollment by 2020 |
|--|----------|-----------|-----------|-----------|-----------|-----------|----------|---------------------------|------------------------------------|
| No Expansion | | | | | | | | | |
| 1. Baseline | -\$551 | -\$634 | -\$14,948 | -\$15,597 | -\$16,278 | -\$16,990 | -\$782 | -\$65,780 | 175 |
| 2. Moving Current Eligibles Above 138 Percent of FPL to HBE | -\$6,435 | -\$6,813 | -\$21,436 | -\$22,409 | -\$23,431 | -\$24,500 | -\$8,668 | -\$113,691 | (913) |
| Expansion | | | | | | | | | |
| 1. Baseline | \$3,603 | \$4,322 | -\$9,138 | \$9,143 | \$13,141 | \$17,371 | \$47,046 | \$85,488 | 62,237 |
| 2. Low-Range Participation Assumption | \$1,271 | \$1,532 | -\$12,420 | \$1,582 | \$4,455 | \$7,498 | \$34,091 | \$38,009 | 47,565 |
| 3. High-Range Participation Assumption | \$4,430 | \$5,312 | -\$7,973 | \$11,826 | \$16,222 | \$20,874 | \$51,642 | \$102,333 | 67,443 |
| 4. Managed Care Rates | \$2,493 | \$2,415 | -\$11,405 | \$6,760 | \$10,586 | \$14,619 | \$44,001 | \$69,470 | 62,237 |
| 5. Delay Implementation by One Year | -\$551 | \$3,363 | -\$10,129 | \$9,143 | \$13,141 | \$17,371 | \$47,046 | \$79,384 | 62,237 |
| 6. Delay Implementation by Two Years | -\$551 | -\$634 | -\$11,121 | \$5,913 | \$13,141 | \$17,371 | \$47,046 | \$71,166 | 62,237 |
| 7. Move Current Eligibles Above 138 Percent of FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | -\$2,282 | -\$1,857 | -\$15,625 | \$2,331 | \$5,988 | \$9,861 | \$39,160 | \$37,576 | 61,149 |
| 8. Option 7 + Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category | -\$4,105 | -\$3,771 | -\$17,636 | \$431 | \$4,038 | \$7,860 | \$37,205 | \$24,021 | 61,149 |
| 9. Option 8 + Transition of Pregnant Women Below 138 Percent of FPL into "Newly Eligible" Category | -\$9,531 | -\$10,346 | -\$25,459 | -\$6,962 | -\$3,553 | \$71 | \$29,598 | -\$26,182 | 61,149 |

Figure 2: Summary of the Federal Cost of Various Options for Expanding Medicaid in New Hampshire by Year (in \$1000s)

| Scenario | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative (2014-2020) |
|--|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---------------------------|
| No Expansion | | | | | | | | |
| 1. Baseline | -\$560 | -\$644 | \$13,488 | \$14,119 | \$14,775 | \$15,462 | -\$795 | \$55,845 |
| 2. Moving Current Eligibles Above 138 Percent FPL to HBE | -\$6,540 | -\$6,923 | \$6,894 | \$7,196 | \$7,506 | \$7,829 | -\$8,809 | \$7,154 |
| Expansion | | | | | | | | |
| 1. Baseline | \$264,869 | \$316,152 | \$385,000 | \$379,322 | \$388,136 | \$396,936 | \$380,507 | \$2,510,922 |
| 2. Low-Range Participation Assumption | \$204,591 | \$244,201 | \$300,611 | \$296,248 | \$303,165 | \$310,072 | \$293,584 | \$1,952,472 |
| 3. High-Range Participation Assumption | \$286,255 | \$341,680 | \$414,941 | \$408,796 | \$418,284 | \$427,755 | \$411,347 | \$2,709,058 |
| 4. Managed Care Rates | \$278,524 | \$314,933 | \$382,642 | \$375,934 | \$383,703 | \$391,416 | \$373,922 | \$2,501,073 |
| 5. Delay Implementation by One Year | -\$560 | \$273,610 | \$340,979 | \$379,322 | \$388,136 | \$396,936 | \$380,507 | \$2,158,931 |
| 6. Delay Implementation by Two Years | -\$560 | -\$644 | \$296,959 | \$336,033 | \$388,136 | \$396,936 | \$380,507 | \$1,797,367 |
| 7. Move Current Eligibles Above 138 Percent of FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | \$258,889 | \$309,873 | \$378,407 | \$372,399 | \$380,867 | \$389,304 | \$372,493 | \$2,462,231 |
| 8. Option 7 + Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category | \$260,712 | \$311,787 | \$380,417 | \$374,299 | \$382,818 | \$391,305 | \$374,448 | \$2,475,786 |
| 9. Option 8 + Transition Pregnant Women below 138 Percent of FPL Into "Newly Eligible" Category | \$266,139 | \$318,362 | \$388,240 | \$381,692 | \$390,408 | \$399,094 | \$382,055 | \$2,525,989 |

I. Introduction

In March 2010, the U.S. Congress passed the Patient Protection & Affordable Care Act (ACA), a sweeping piece of legislation designed to overhaul the country's health care system and extend health insurance to millions of uninsured Americans. The law included several approaches to accomplish this goal, including the establishment of Health Benefit Exchanges (HBE), insurance market reforms, an individual mandate, subsidized health insurance and a mandate for large employers to offer health insurance. One of the key provisions of the Act was an expansion of Medicaid in all 50 states and the District of Columbia.

As originally written, each state would be required to expand its Medicaid program to cover all adults under age 65 whose household incomes are less than or equal to 138 percent of the federal poverty level (FPL) or face losing all federal funding for their Medicaid programs. For these newly eligible individuals, the federal government would cover 100 percent of the health care costs between 2014 and 2016. This percentage would be gradually decreased from 100 percent to 90 percent between 2016 and 2020.

However, in June 2012, the United States Supreme Court ruled that the federal government could not require individual states to expand their Medicaid programs for adults and declared this part of the ACA unconstitutional. States will now have the option to opt out of the Medicaid expansion provision of the Act without compromising their current federal Medicaid funding.

As a result of this ruling, the New Hampshire Department of Health and Human Services contracted with the Lewin Group to explore the potential financial impacts of expanding or not expanding its Medicaid program. The purpose of this report, which represents the first of two project phases, is to estimate the impact of expanding versus not expanding Medicaid on New Hampshire's Medicaid program. A second report will follow in December, and will discuss the secondary effects on other state health programs, health care providers, commercial premiums, and the overall state economy.

To adequately address this question, we included the following considerations in our analysis:

- Estimates of newly eligible individuals and currently eligible but not enrolled who can be expected to enroll;
- Estimates of the short- and long-term costs of covering the newly eligible individuals in both a fee-for-service (FFS) and managed care environment;
- The impact of delayed implementation of an expansion of Medicaid;
- The administrative costs to DHHS associated with implementing the Medicaid expansion;
- The number of individuals currently eligible above 138 percent of FPL who may become 'newly eligible' and the increase in federal revenue associated therewith; and
- The impact on currently eligible individuals with incomes above 138 percent of FPL remaining on Medicaid or moving into the Health Benefit Exchange (HBE).

This report provides estimates on Medicaid enrollment and costs under the option of not expanding Medicaid compared to the option of expanding the program under various program design options. Detailed tables for each of the scenarios described in this report are presented in Appendix A.

II. Analysis and Results

The following sections present our estimates of the impact on state and federal Medicaid spending under various options for expanding and not expanding Medicaid in New Hampshire.

A. Impact of Expanding Medicaid under the ACA on the Uninsured in New Hampshire

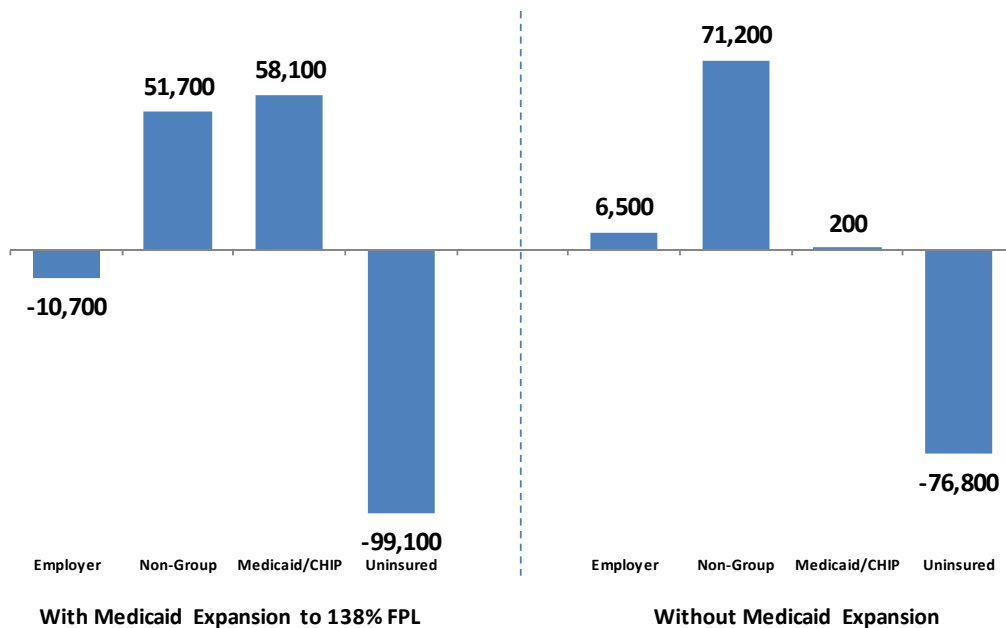
The coverage provisions in the ACA will dramatically change health insurance coverage in New Hampshire when it is fully implemented in 2014. These provisions include reforming the individual insurance markets by eliminating pre-existing condition exclusions, guaranteeing coverage and renewability of coverage, establishing health benefit Exchanges, an individual mandate, and subsidizing health insurance for people between 100 and 400 percent of FPL and a mandate for large employers to offer health insurance.²

As originally written, New Hampshire was required to expand its Medicaid program to cover adults with incomes below 138 percent of FPL, and those above that income level but below 400 percent of FPL without an offer of affordable employer coverage would be eligible for subsidized coverage through the Exchange. The Supreme Court ruling now makes the Medicaid expansion optional for the state. If the state decides to expand Medicaid coverage as originally designed under the Act then all state residents below 400 percent of FPL will have access to subsidized coverage. However, if the state does not expand Medicaid, many of the lowest income adults (below 100 percent of FPL) will not have access to subsidized coverage because premium subsidies through the Exchange are only available for individuals between 100 and 400 percent of FPL.

We estimate that there will be about 170,000 uninsured in New Hampshire in 2014 in the absence of the ACA. Taking into account all other provisions of the ACA, our estimates show that if the state expands Medicaid, the number of uninsured would be reduced by 99,000 (*Figure 3*). However, if the state decides not to expand Medicaid then the ACA will have a lesser impact on the number of uninsured.

² Under the ACA, states have the option of establishing a fully state-based exchange, a state-federal partnership exchange, or default into a federally-facilitated exchange. In June, 2012, NH passed HB 1297, which prohibits the state from establishing a state-based exchange. Given this, the federal government will run the exchange in New Hampshire.

Figure 3. Change in Coverage under the ACA in New Hampshire (in 1,000s)



The uninsured that would primarily be affected under the decision to expand Medicaid will be individuals below 138 percent of FPL. Those remaining uninsured will continue to strain the finances of other public health programs and safety net providers for their care, while likely forgoing or reducing necessary care and risking a drain to personal finances.

B. Impact on the New Hampshire Medicaid Program of Not Expanding

As described above, the state has the option of not expanding Medicaid as originally required under the ACA without facing a financial penalty. However, other aspects of the ACA will affect New Hampshire's Medicaid program regardless of any changes made to the current program. These other provisions include the following:

- The ACA requires all U.S. citizens to obtain health insurance coverage or pay a penalty. By 2016 the penalty will be the greater of \$695 per person (capped at \$2,085 per family) or 2.5 percent of income. However, exemptions apply to people below the federal tax filing threshold and to families where coverage is unaffordable (i.e., premiums that exceed 8 percent of family income). Most New Hampshire residents with incomes below 138 percent of FPL will be exempt from the penalty. However, the mere existence of the individual mandate may incent some people who are currently eligible to obtain Medicaid or CHIP coverage to satisfy the mandate. We estimate there will be 12,900 children and adults in New Hampshire that are eligible for Medicaid but not enrolled and 2,900 will enroll to satisfy the mandate.
- The ACA requires states to simplify their Medicaid eligibility procedures, which is unaffected by the Supreme Court's decision. Beginning in 2014, the state will be required to use Modified Adjusted Gross Income (MAGI) to determine financial eligibility and use streamlined application and enrollment procedures, such as eliminating asset tests. Experience in states that have eliminated asset tests showed increased enrollment of

between 3 and 10 percent for the affected populations.^{3,4} Based on these results, we estimate 850 adults will be newly enrolled in Medicaid, who had not previously been enrolled due to eligibility procedures.

- The ACA requires all large employers with more than 50 workers to offer qualified health insurance or pay a penalty. The Act also provides certain small employers with tax credits to incentivize offering coverage to their employees. We estimate that some employers will begin to offer coverage due to these provisions, which may become available to lower wage workers and their dependents that are currently enrolled in Medicaid. We assume that some of these workers will decide to take the employer's offer of coverage, which will reduce Medicaid enrollment. We estimate that about 3,600 adults and children will leave Medicaid for these new options under the ACA.
- As an incentive for states to retain their CHIP programs through 2019, the ACA provides states with a 23 percentage point increase in their enhanced Federal Medical Assistance Percentage (FMAP) rate for CHIP beginning in federal fiscal year 2016, regardless of whether the state decides to expand Medicaid. We estimate that the state would save \$61 million from 2016 through 2019 assuming that the state would have continued the CHIP program in the absence of the ACA.

We estimate that these provisions required by the ACA will result in a net increase in Medicaid enrollment of 175 individuals by 2020 (*Figure 4*). However, the cost of those leaving the program for an offer of private coverage will be slightly higher than the costs for the new enrollees, which will result in significant savings to the state between 2014 and 2020. Coupled with the savings from the increased federal CHIP funding, we estimate the state would save about \$66 million over this period. The federal government will only contribute an estimated \$56 million to New Hampshire's Medicaid program over this period, if the state chooses to forgo Medicaid expansion.

³ Utah Department of Health, "Medicaid Asset Limit Study", October 2005.

⁴ National Academy for State Health Policy, "Maximizing Kids' Enrollment in Medicaid and SCHIP", February 2009.

Figure 4: Impact on New Hampshire Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|---------------------------------|----------|----------|-----------|-----------|-----------|-----------|----------|-----------|
| Change in Enrollment | 133 | 153 | 172 | 172 | 173 | 175 | 175 | |
| Total Costs (in \$1000s) | | | | | | | | |
| State Share | -\$551 | -\$634 | -\$14,948 | -\$15,597 | -\$16,278 | -\$16,990 | -\$782 | -\$65,779 |
| Federal Share | -\$559 | -\$644 | \$13,488 | \$14,119 | \$14,775 | \$15,462 | -\$795 | \$55,845 |
| Total | -\$1,110 | -\$1,278 | -\$1,461 | -\$1,478 | -\$1,503 | -\$1,528 | -\$1,577 | -\$9,935 |

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-1 for further detail.

As an option, the state could examine the impact of capping certain eligibility categories for adults at 138 percent of FPL and moving enrollees to the HBE where they can obtain subsidized private health insurance coverage and under which they would be guaranteed coverage and renewability for that coverage in the future. For illustrative purposes, we assumed that the state caps eligibility at 138 percent of FPL for the Medicaid for Employed Adults with Disabilities (MEAD) and poverty-level pregnant women eligibility categories. The MEAD eligibility category currently covers working disabled individuals to 450 percent of FPL. Poverty level pregnant women are currently eligible through 185 percent of FPL.

This option would result in moving 805 enrollees to the HBE in 2014. If the state decided to implement this option, the state's share of Medicaid savings would be nearly \$114 million over this period.

Figure 5: Impact on New Hampshire Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020) and Capping Certain Eligibility Categories for Adults at 138 Percent of FPL

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|
| Change in Enrollment | (805) | (808) | (813) | (837) | (862) | (886) | (913) | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | -\$6,435 | -\$6,813 | -\$21,436 | -\$22,409 | -\$23,431 | -\$24,500 | -\$8,668 | -\$113,691 |
| Federal Share | -\$6,540 | -\$6,923 | \$6,894 | \$7,196 | \$7,506 | \$7,829 | -\$8,809 | \$7,154 |
| Total | -\$12,975 | -\$13,736 | -\$14,541 | -\$15,213 | -\$15,925 | -\$16,671 | -\$17,477 | -\$106,537 |

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-2 for further detail.

We show that the federal government would also share in the savings to Medicaid resulting from capping eligibility for these two eligibility categories and moving individuals into the HBE since the federal government currently pays 50 percent of the cost for these individuals. Under these circumstances, the federal government will save an estimated \$7 million between 2014 and 2020. However, we do not show the new federal cost for providing premium and cost-sharing subsidies for these individuals.

This analysis does not quantify the additional cost to enrollees moved to the HBE who would be required to pay a portion of the premium that would range from 3 percent of income for those at 138 percent of FPL to 9.5 percent of income for those at 400 percent of FPL. Also, individuals that are working full-time for an employer that offers affordable coverage would be ineligible for subsidized coverage through the Exchange and would be required to enroll in the employer's health plan⁵. Health benefit plans offered in the Exchange or by the employer may also require these individuals to pay deductibles and copayments that may exceed their current cost-sharing requirements under Medicaid.

C. Impact on the New Hampshire Medicaid Program of Expanding Under Various Design Options

We estimated the impact on Medicaid enrollment and state spending under the option that the state expands Medicaid to all adults in the state up to 138 percent of FPL beginning in 2014. In 2014, we estimate there will be about 100,700 adult legal residents below 138 percent of FPL who would be newly eligible for the expansion. Of these, 49,500 would be uninsured and 51,100 would have some form of health insurance (*Figure 6*). In addition, we estimate there are 12,900 children and adults who are currently eligible for Medicaid or CHIP but are uninsured and may potentially enroll to satisfy the individual mandate.

Figure 6: Estimate of Individuals Eligible and Who Will Enroll in a Medicaid Expansion to 138 Percent of FPL in New Hampshire in 2014 ^{1/}

| | Eligible | Enroll | Participation Rate |
|---|----------|--------|--------------------|
| Newly Eligible - Previously Uninsured | 49,518 | 37,919 | 76.6% |
| Newly Eligible - Previously Insured | 51,143 | 20,513 | 40.1% |
| Currently Eligible but Uninsured | 12,915 | 2,888 | 22.4% |
| Leave Medicaid for New Offer of Employer Coverage | n/a | 3,561 | n/a |
| Net Change in Medicaid Enrollment | n/a | 57,760 | n/a |

1/Assumes full implementation and ultimate enrollment in 2014

As described in our methodology below, we estimate that about 76 percent of the uninsured will ultimately enroll in a Medicaid expansion and about 40 percent of those that would have had private insurance in the absence of the expansion would also enroll. Due to the individual mandate and parents enrolling in Medicaid, we estimate that about 22 percent of the currently eligible but uninsured will ultimately enroll. It may take up to 2 years to reach this ultimate enrollment level as people learn about the program and their eligibility over time. Based on national estimates produced by the Congressional Budget Office (CBO), we assume that the program will reach 76 percent of ultimate enrollment in the first year, 88 percent in the second, and 100 by the third year. As described in the section above, we estimate that about 3,600 adults and children will leave Medicaid for newly offered employer coverage due to the employer related provisions of the ACA.

⁵ An affordable employer plan must have an actuarial value of at least 60%, and enrollees' share of premium must not exceed 9.5% of income.

Expanding Medicaid to all adults below 138 percent of FPL would result in a net increase in Medicaid enrollment of 62,237 individuals by 2020 (*Figure 7*). Total Medicaid costs, including health care and administration, would increase by \$2.6 billion from 2014 through 2020. The federal government will pay 100 percent of the health care costs for newly eligible adults from 2014 through 2016. By 2020, the percent paid by the federal government will drop to 90 percent. However, the state will only receive the current federal matching rate for health care costs for new enrollees that are eligible under current Medicaid eligibility criteria. The additional cost of administering Medicaid eligibility and coverage for these new enrollees will be matched by the federal government at the current matching rate for program administration.

Figure 7: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Baseline ACA Analysis ^{1/}

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 44,169 | 51,548 | 59,157 | 59,895 | 60,674 | 61,455 | 62,237 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | \$3,603 | \$4,322 | -\$9,138 | \$9,143 | \$13,141 | \$17,371 | \$47,046 | \$85,488 |
| Federal Share | \$264,869 | \$316,152 | \$385,000 | \$379,322 | \$388,136 | \$396,936 | \$380,507 | \$2,510,922 |
| Total | \$268,472 | \$320,474 | \$375,862 | \$388,465 | \$401,277 | \$414,308 | \$427,553 | \$2,596,410 |

1/ Assumes fee-for-service program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-3 for further detail.

Based on the federal matching methods for these new enrollees, we estimate that the state's share of the cost between 2014 and 2020 would be about \$85million, which would be about 3.3 percent of the total cost of expanding Medicaid. This includes a 23 percentage point increase in their enhanced FMAP rate for CHIP beginning in federal fiscal year 2016, which we estimate that the state would save \$60 million over this period. The federal government, on the other hand, will spend an estimated \$2.5 billion between 2014 and 2020, to cover the cost of the increased federal matching rates for the newly eligible enrollees.

1. Sensitivity Analysis - Take up Rate Assumptions for Newly Eligible Group

The estimates presented in this report are dependent on the accuracy of the survey data used to estimate the number of newly eligible individuals in New Hampshire that are below 138 percent of FPL as well as being sensitive to assumptions used to estimate participation by those newly eligible for the expansion. Our model for this analysis was based on multiple surveys, imputations for under-reporting Medicaid coverage, and simulation of monthly income and assets. Therefore, it is difficult to calculate a confidence interval to account for survey sampling error based on this method.

However, to provide a range of potential enrollment estimates we performed a sensitivity analysis around the participation assumptions used to produce our results. Medicaid

participation rates for adults ages 19 to 64 vary dramatically across states, ranging from 44 to 83 percent.⁶ Some of the reasons linked to higher take up include lower cost sharing, more generous benefits, and greater use of managed care. For example, Massachusetts's health reform, which includes an individual mandate, was associated with a 10 percentage point increase in participation.

We replicated the methodology used in this study using Current Population Survey (CPS) data from 2008 through 2010. Our analysis showed that Medicaid participation among non-disabled adults was 66 percent nationally. Based on the Sommers et al. study finding on the effects of Massachusetts health reform, we adjusted the national rate to 76 percent as a mid-range participation assumption for the study. We found an 83 percent Medicaid participation rate in Massachusetts, the highest among all states, and used that rate for a high-end assumption. Medicaid participation among eligible adults in New Hampshire was 50 percent. We adjusted the New Hampshire rate to 60 percent to account for the effects of ACA and used this as a low-range participation assumption. *Figure 8* presents the impact of the various participation assumptions on potential Medicaid enrollment under the expansion.

Assuming the low-range participation assumption, Medicaid enrollment will be approximately 24% lower by 2020 compared to 62,237 under the baseline assumption (*Figure 9*). The cost of the Medicaid expansion to the state would be \$38 million— over \$47 million lower than costs under the medium-range participation assumption. The federal government share of costs is also proportionally lower under a low-range participation assumption; its costs would total approximately \$1.9 billion, compared to nearly \$2.5 billion under an assumption of medium-range participation.

⁶ Sommers, Tomasi, Swartz and Epstein, "Reasons for the Wide Variation in Medicaid Participation Rates Among States Holds Lessons for Coverage Expansions in 2014", *Health Affairs*, May 2012.

Figure 8: Participation Assumptions for Sensitivity Analysis ^{1/}

| | Low-Range Assumption | Mid-Range Assumption (Baseline) | High-Range Assumption |
|--|----------------------|---------------------------------|-----------------------|
| Newly Eligible - Previously Uninsured | | | |
| Eligible | 49,518 | 49,518 | 49,518 |
| Enroll | 29,512 | 37,919 | 40,902 |
| Participation | 60% | 77% | 83% |
| Newly Eligible - Previously Insured | | | |
| Eligible | 51,143 | 51,143 | 51,143 |
| Enroll | 15,965 | 20,513 | 22,126 |
| Participation | 31% | 40% | 43% |
| Currently Eligible but Uninsured | | | |
| Eligible | 12,915 | 12,915 | 12,915 |
| Enroll | 2,248 | 2,888 | 3,115 |
| Participation | 17% | 22% | 24% |
| Leave Medicaid for New Offer of Employer Coverage | | | |
| Leave Medicaid | 3,561 | 3,561 | 3,561 |
| Net Change in Medicaid Enrollment | | | |
| Net Change | 44,165 | 57,760 | 62,583 |

1/ Assumes that all provisions are fully implemented and ultimate enrollment is reached in 2014.

Figure 9: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Sensitivity Analysis - Low-Range Participation Assumption^{1/}

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 33,773 | 39,413 | 45,228 | 45,788 | 46,380 | 46,973 | 47,565 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | \$1,271 | \$1,532 | -\$12,420 | \$1,582 | \$4,455 | \$7,498 | \$34,091 | \$38,009 |
| Federal Share | \$204,591 | \$244,201 | \$300,611 | \$296,248 | \$303,165 | \$310,072 | \$293,584 | \$1,952,472 |
| Total | \$205,863 | \$245,732 | \$288,191 | \$297,831 | \$307,619 | \$317,570 | \$327,675 | \$1,990,481 |

1/ Assumes fee-for-service program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-4 for further detail.

Assuming the high-range participation assumption, Medicaid enrollment would increase by 67,443 compared to 62,237 under the baseline assumption (*Figure 10*). Thus, the cost of the Medicaid expansion to the state would be about \$102 million compared to \$85million under the baseline assumption. The federal government would be responsible for an additional \$198 million of costs under the high-range participation assumption; its share of total cost would be nearly \$2.7 billion between 2014 and 2020.

Figure 10: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Sensitivity Analysis - High-Range Participation Assumption^{1/}

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 47,857 | 55,854 | 64,099 | 64,900 | 65,746 | 66,594 | 67,443 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | \$4,430 | \$5,312 | -\$7,973 | \$11,826 | \$16,222 | \$20,874 | \$51,642 | \$102,333 |
| Federal Share | \$286,255 | \$341,680 | \$414,941 | \$408,796 | \$418,284 | \$427,755 | \$411,347 | \$2,709,058 |
| Total | \$290,685 | \$346,992 | \$406,967 | \$420,622 | \$434,506 | \$448,630 | \$462,989 | \$2,811,391 |

1/ Assumes fee-for-service program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-5 for further detail.

These sensitivity analyses present a range of possible enrollment impacts and the associated costs to the program. Actual participation in the Medicaid expansion program will depend on a variety of factors, including the level of outreach activities to increase awareness of the program and enrollment simplification to ease the enrollment process for applicants.

2. Alternative Design Option - Managed Care (Care Management) for Newly Eligible Group

The New Hampshire legislature enacted changes in the law in 2011 to implement a managed care system for its Medicaid program. Implementing the Medicaid expansion under a managed care program could provide a substantial increase in the number of Medicaid eligibles that could be enrolled in managed care. The additional members could make the program financially viable for plans and help attract to participate in the program.

For this analysis, we estimated the cost of the program using the managed care rates that we develop, which are described in the methodology section below. Due to the short history of the Medicaid managed care system in the state, these rates may not fully reflect true costs of the hypothetical newly eligible population under expansion. Additionally, our managed care rates do not reflect the exclusion of certain services from the state's Medicaid managed care program, such as long-term supports and services and dental services. **Figure 11** presents the impact of administering the Medicaid expansion under a managed care arrangement.

Under a managed care environment, the cost to the state would be \$69 million compared to our estimate of \$85 million under a fee-for-service program over the seven-year period.

Figure 11: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Sensitivity Analysis - Managed Care Model Assumption

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 44,169 | 51,548 | 59,157 | 59,895 | 60,674 | 61,455 | 62,237 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | \$2,493 | \$2,415 | -\$11,405 | \$6,760 | \$10,586 | \$14,619 | \$44,001 | \$69,470 |
| Federal Share | \$278,524 | \$314,933 | \$382,642 | \$375,934 | \$383,703 | \$391,416 | \$373,922 | \$2,501,073 |
| Total | \$281,017 | \$317,348 | \$371,237 | \$382,693 | \$394,289 | \$406,035 | \$417,923 | \$2,570,544 |

1/ Assumes managed care program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-6 for further detail.

Under a managed care model, the health plans would perform many of the administrative functions for which the state is currently responsible, such as claims processing, managing appeals and grievances, and utilization review. These administrative costs for the plans are included in the payment rates that we developed for this analysis. The state will incur new costs for plan oversight, quality reporting and actuarial services among others. However, based on various studies of state administrative costs under a managed care program compared to a fee for service program, we estimate that state administrative costs would be reduced from 5.5 percent of spending to 4.0 percent.⁷

3. Alternative Design Option - Delayed Program Implementation

Beginning January 1, 2014, New Hampshire could expand Medicaid to all adults below 138 percent of FPL and receive enhanced federal matching. However, CMS has stated that states may “decide whether and when to expand, and if a state covers the expansion group, it may later drop the coverage”.⁸ Therefore, New Hampshire has the option to begin the expansion at any time after January 1, 2014, and still receive the enhanced federal match. However, 100 percent federal matching is only available from 2014 through 2016. If the state decides to delay the start of the program until after January 2014, then it will lose the ability to provide coverage to residents at full federal funding during that period.

Another state concern is that the federal government may reduce the level of funding for the expansion in the future due to budget pressures or that future cost of the program will place pressure on state budgets. In any case, states could discontinue eligibility for the expansion at any time without penalty.

⁷ Policy and Research Unit on Medicaid and Medicare, USC Institute for Families in Society, Medicaid Health Care Performance CY 2010, September 2011 and America’s Health Insurance Plans, “Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies”, Updated March 2009

⁸ Presentation by Cindy Mann, CMS Deputy Administrator to the National Conference of State Legislators, “Medicaid and CHIP: Today and Moving Forward”, August 6, 2012.

To illustrate the impact of this option, we estimated the cost to the state of delaying implementation of the Medicaid expansion until January 1, 2015. We assume that the state will still be required to meet eligibility simplification requirements and interface with the Exchange beginning in 2014. However, the program will still experience increased enrollment from people currently eligible who enroll to satisfy the mandate and those that become newly eligible through the enrollment simplification processes. The program will also see people leaving Medicaid for the other coverage options that become available under the ACA.

Delaying implementation of the program to 2015 would only reduce the cost to the state by \$6.1 million between 2014 and 2020 compared to the cost of implementing the program starting in 2014 (*Figure 12*). The program would cover 44,000 fewer people in 2014 under a delayed implementation. This is due to the fact that the federal government pays the full cost for the newly eligible group for the first three years of the program. With a one-year delay in expansion of implementation for New Hampshire, the federal government will save over \$350 million, largely due to the absence of the newly eligible enrollees for which the state would have received 100% FMAP funding during 2014.

Similarly, delaying implementation of the program until 2016 would only reduce the cost to the state by \$14.3 million between 2014 and 2020 compared to the cost of implementing the program in 2014 (*Figure 12*). Under these circumstances, federal contributions will be nearly \$720 million less over the seven-year period, when compared to implementing the program in January 2014.

Figure 12: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Delayed Implementation until January 2015

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 133 | 44,595 | 52,115 | 59,895 | 60,674 | 61,455 | 62,237 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | -\$551 | \$3,363 | -\$10,129 | \$9,143 | \$13,141 | \$17,371 | \$47,046 | \$79,384 |
| Federal Share | -\$560 | \$273,610 | \$340,979 | \$379,322 | \$388,136 | \$396,936 | \$380,507 | \$2,158,931 |
| Total | -\$1,110 | \$276,973 | \$330,850 | \$388,465 | \$401,277 | \$414,308 | \$427,553 | \$2,238,315 |

1/ Assumes fee-for-service program, implementation January 1, 2015, current Medicaid eligible above 138% FPL remain in the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-7 for further detail.

Figure 13: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Delayed Implementation Until January 2016

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|----------|----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 133 | 153 | 45,073 | 52,765 | 60,674 | 61,455 | 62,237 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | -\$551 | -\$634 | -\$11,121 | \$5,913 | \$13,141 | \$17,371 | \$47,046 | \$71,166 |
| Federal Share | -\$560 | -\$644 | \$296,959 | \$336,033 | \$388,136 | \$396,936 | \$380,507 | \$1,797,367 |
| Total | -\$1,110 | -\$1,278 | \$285,837 | \$341,946 | \$401,277 | \$414,308 | \$427,553 | \$1,868,533 |

1/ Assumes fee-for-service program, implementation January 1, 2016, current Medicaid eligible above 138% FPL remain on the program and all current eligibility categories are retained.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-8 for further detail.

4. Alternative Design Option 7 - Move Current Eligibles Above 138% FPL to Exchange (MEAD and Pregnant Women Eligibility Categories)

Beginning in 2014 when the Medicaid maintenance of effort requirement for adults expires, New Hampshire will have the option of moving currently eligible enrollees of certain subgroups, who are above 138 percent of FPL, into the health benefit Exchange. This will involve capping Medicaid income eligibility for these groups at 138 percent of FPL and allowing those enrollees to purchase coverage through the HBE with premium and cost-sharing subsidies, which will be paid in full by the federal government. In doing so, New Hampshire will no longer be responsible for funding 50 percent of the cost for these individuals.

Potential eligibility groups that could be moved to the Exchange include the Medicaid for Employed Adults with Disabilities (MEAD) eligibility category, which currently covers working disabled individuals to 450 percent of FPL, and poverty level pregnant women, who are currently eligible through 185 percent of FPL.

For this analysis, we used historical Medicaid enrollment and paid claims obtained from DHHS from 2009 through 2011. These data included enrollee's family income as a percent of FPL. Enrollee counts and paid claims amounts were summarized by eligibility category, age, gender, poverty level, and month. We trended these data to 2020 using 2.5 percent enrollment growth and 5 percent health care cost growth.

By reducing income eligibility for these eligibility categories and moving these individuals to the Exchanges, the Medicaid program would no longer bear the cost for these individuals and the state and federal government would share the savings. However, the cost of providing premium and cost-sharing subsidies through the Exchange would be paid by the federal government. Those individuals moved to the Exchanges would be required to pay a portion of the premium, ranging from 3 percent of income for those at 138 percent of FPL to 9.5 percent of income for those at 400 percent of FPL.

This option would result in moving over 900 enrollees to the Exchanges in 2014 and an additional savings to the state of about \$47.9 million between 2014 and 2020 over the baseline

(Figure 14). Thus, if the state decided to implement this option then the net cost of the Medicaid expansion to the state would be \$37.6 million between 2014 and 2020.

Figure 14: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option 7- Capping Certain Eligibility Categories for Adults at 138 Percent of FPL

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 43,231 | 50,587 | 58,172 | 58,886 | 59,639 | 60,394 | 61,149 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | -\$2,282 | -\$1,857 | -\$15,625 | \$2,331 | \$5,988 | \$9,861 | \$39,160 | \$37,576 |
| Federal Share | \$258,889 | \$309,873 | \$378,407 | \$372,399 | \$380,867 | \$389,304 | \$372,493 | \$2,462,231 |
| Total | \$256,607 | \$308,016 | \$362,781 | \$374,730 | \$386,855 | \$399,165 | \$411,653 | \$2,499,808 |

1/ Assumes fee-for-service program, implementation January 1, 2014, limit eligibility to 138% FPL remain for pregnant women and MEAD eligibility categories and all current eligibility categories are retained.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-9 for further detail.

We found that the federal government would also share in the savings to Medicaid resulting from capping eligibility for these two eligibility categories and moving individuals into the Exchange since the federal government currently pays 50 percent of the cost for these individuals. It would save an estimated \$49 million between 2014 and 2020, compared to baseline expansion conditions, in which costs would reach over \$2.5 billion in the timeframe. However, we did not show the new federal cost for providing premium and cost-sharing subsidies for these individuals. Also, this analysis does not quantify the additional cost to enrollees moved to the Exchanges who would be required to pay a portion of the premium ranging from 3 percent of income for those at 138 percent of FPL to 9.5 percent of income for those at 400 percent of FPL. Health benefit plans in the Exchange may also require these individuals to pay deductibles and copayments that well exceed cost-sharing requirements under Medicaid.

5. Alternative Design Option 8 - Option 7 + Transition Enrollees out of Breast and Cervical Cancer Program Eligibility Category

Beginning in 2014 when the Medicaid maintenance of effort requirement for adults expires, New Hampshire would have the option to transition enrollees out of the Breast and Cervical Cancer Program (BCCP) eligibility category. By doing so, current enrollees as well as individuals that could become eligible for these programs in the future could enroll as newly eligible adults if their income is below 138 percent of FPL. Those above 138 percent of FPL could receive premium and cost-sharing subsidies through the Exchange.

Due to the significantly enhanced FMAP rates under Medicaid expansion, New Hampshire would save most of the funds it had previously spent on covering enrollees in these eligibility categories. For enrollees below 138 percent of FPL the federal government would pay a larger share of the cost. The Medicaid program would no longer be responsible for the cost of

previously eligibles over 138 percent of FPL who would seek subsidized coverage in the Exchange, which would be fully paid by the federal government.

We estimate the cost of this option using trended Medicaid enrollment and paid claims for these groups. By evolving this current Medicaid program and allowing enrollees to take coverage under the newly eligible category or purchase subsidized health insurance through the Exchange depending on their income, the state could significantly reduce its share of the costs of the expansion. Nearly all of the costs for these individuals would become federally funded. In conjunction with moving current eligibles above 138 percent of FPL for the MEAD eligibility category and poverty-level pregnant women coverage discussed previously, this aggregate option would reduce the state's cost of the Medicaid expansion by \$61 million between 2014 and 2020 as compared to our baseline expansion estimates (*Figure 15*). Additionally, this would reduce costs for the federal government by \$35 million relative to our baseline estimate.

Figure 15: Impact on New Hampshire Medicaid Spending if Medicaid is expanded under the ACA (2014-2020) - Program Design Option 8- Option 7 plus Transition Enrollees out of Breast and Cervical Cancer Program Eligibility Category

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 43,231 | 50,587 | 58,172 | 58,886 | 59,639 | 60,394 | 61,149 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | -\$4,105 | -\$3,771 | -\$17,636 | \$431 | \$4,038 | \$7,860 | \$37,205 | \$24,021 |
| Federal Share | \$260,712 | \$311,787 | \$380,417 | \$374,299 | \$382,818 | \$391,305 | \$374,448 | \$2,475,786 |
| Total | \$256,607 | \$308,016 | \$362,781 | \$374,730 | \$386,855 | \$399,165 | \$411,653 | \$2,499,808 |

1/ Assumes fee-for-service program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and current enrollees in the MEAD and BCCP eligibility categories are transferred out.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-10 for further detail.

6. Alternative Design Option 9 - Option 8 + Transition of Pregnant Women Below 138 Percent of FPL to "Newly Eligible" Category

If the state expands Medicaid to 138 percent of FPL, then more adult women with incomes below 138 percent of FPL will have enrolled as a newly eligible adult through the Medicaid expansion prior to a pregnancy. Under this sensitivity analysis, we assume that the cost of Medicaid services for these women will be paid at the enhanced federal matching rate instead of requiring the state to recategorize these individuals into the current Medicaid poverty level category, for which the state receives only a 50 percent matching rate. However, this will depend on guidance from CMS.

Under this scenario, we estimate there will be 2,076 adult pregnant women below 138 percent of FPL in the Medicaid program in 2014. We assume that about 76 percent of these individuals would enroll in the Medicaid expansion, which is our average participation rate for uninsured individuals, prior to pregnancy. These women would be included in the newly eligible category when they become pregnant and thus pregnancy-related services would be covered with enhanced federal funding. We assume that the remaining 24 percent of current pregnant

women would have remained uninsured until their pregnancy, at which time they would apply for Medicaid coverage and become eligible based on the current poverty related eligibility category.

Figure 16 shows the change in enrollment and state spending for this scenario compared to the baseline ACA analysis presented above in order to show the impact of this specific assumption. We show no change in Medicaid enrollment or administrative costs because these individuals are simply categorized under a different eligibility category. However, health care costs for these individuals will now be matched at the enhanced matching rate for the expansion population. In conjunction with savings under the previous design options, the transition of pregnant women below 138 percent of FPL into the newly eligible category will lead to state a total savings of over \$26 million over the 2014-2020 period, saving the state over \$111 million beyond implementing the baseline expansion in 2014. This design option would cost the federal government an additional \$15 million beyond the baseline.

Figure 16: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option 9 - Option 8 + Transition of Pregnant Women Below 138 Percent of FPL to "Newly Eligible" Category^{1/}

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 43,231 | 50,587 | 58,172 | 58,886 | 59,639 | 60,394 | 61,149 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | -\$9,531 | -\$10,346 | -\$25,459 | -\$6,962 | -\$3,553 | \$71 | \$29,598 | -\$26,182 |
| Federal Share | \$266,139 | \$318,362 | \$388,240 | \$381,692 | \$390,408 | \$399,094 | \$382,055 | \$2,525,989 |
| Total | \$256,607 | \$308,016 | \$362,781 | \$374,730 | \$386,855 | \$399,165 | \$411,653 | \$2,499,808 |

1/ Assumes fee-for-service program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and current enrollees in the MEAD and BCCP eligibility categories are transferred out.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model. Please refer to Appendix A, Figure A-11 for further detail.

D. Summary

Figure 17 summarizes the cumulative total cost to the state of New Hampshire (2014-2020) under eleven simulations of various design options. Without expansion, the state would see savings ranging from \$65.8 to \$113.7 million, depending on the design of the program. Under Medicaid expansion, the state may encounter costs up to \$102 million, unless it elects to expand the program under certain combinations of program designs. Under the option where the state expands Medicaid while moving certain current eligible groups above 138 percent of FPL to the health benefit exchange, transitions enrollees out of the Breast and Cervical Cancer Program eligibility category, and assuming pregnant women below 138 percent of FPL will transition into the "newly eligible" category, the state could save over \$26 million while providing alternative options for covering these individuals.

However, under each of the expansion scenarios, the federal government would provide between \$1.8 and \$2.7 billion dollars in funding to the state that would be forfeited if the state does not expand Medicaid.

Figure 17: Summary of the State Cost of Various Options for Expanding Medicaid in New Hampshire (2014-2020)

| Scenario | Cost to State (2014-2020) in \$1,000s | Cost to Federal Government (2014- 2020) in \$1,000s |
|--|--|---|
| No Expansion: | | |
| 1. Baseline | -\$65,779.6 | \$55,845.0 |
| 2. Moving Current Eligibles Above 138 of Percent FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | -\$113,691.4 | \$7,154.1 |
| Expansion: | | |
| 1. Baseline | \$85,488.0 | \$2,510,922.3 |
| 2. Low-Range Participation Assumption | \$38,009.2 | \$1,952,472.0 |
| 3. High-Range Participation Assumption | \$102,333.2 | \$2,709,057.8 |
| 4. Managed Care Rates | \$69,470.2 | \$2,501,073.5 |
| 5. Delay Implementation by One Year | \$79,384.2 | \$2,158,931.0 |
| 6. Delay Implementation by Two Years | \$71,165.5 | \$1,797,367.2 |
| 7. Move Current Eligibles Above 138 of Percent FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | \$37,576.1 | \$2,462,231.5 |
| 8. Option 7 plus Transition Enrollees out of Breast and Cervical Cancer Program Eligibility Category | \$24,021.2 | \$2,475,786.4 |
| 9. Option 8 plus Transition of Pregnant Women Below 138 Percent of FPL into “Newly Eligible” Category | -\$26,181.6 | \$2,525,989.2 |

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model.

III. Methodology

This section describes the methodology used to produce the enrollment and cost estimates presented in this report.

We used the Lewin Group Health Benefits Simulation Model (HBSM) to estimate the number of people who would become newly eligible for Medicaid through the expansion in New Hampshire. To do this, we simulated the number of people eligible for the expansion in coverage using 3 years of Current Population Survey (CPS) data compiled by the Bureau of the Census (2008-2010). We use the CPS because these data include the detailed information required to simulate eligibility for the program, including income by source, employment, family characteristics, and state of residence. We pooled 3 years of CPS data in order to increase the sample size, which improves the accuracy of the estimates for narrowly defined population groups.

The first step in developing these estimates is to correct the CPS data for under-reporting of Medicaid coverage. As in most household surveys, some individuals fail to report whether they were enrolled in Medicaid and/or the various public assistance programs. In fact, the CPS reports up to 40 percent fewer Medicaid enrollees than program data show actually participate in the program. To correct for this problem, we identified people who appear to be eligible for Medicaid in these data and assigned a portion of them to Medicaid covered status. The resulting data replicate program control totals on enrollment by class of eligibility.

Using these data, we can estimate the number of program filing units (single individuals and related families living together) who meet the income eligibility requirements under the current program in their state of residence. The model also simulates the number of people who would be eligible under proposed increases in income eligibility. In particular, the model can estimate the number of non-custodial adults who are eligible under expansions affecting these groups.

The model simulates a wide variety of Medicaid policy changes, including changes in income eligibility levels for selected population groups such as children, parents, two-parent families, and childless adults. It also models changes in certification period rules, changes in the deprivation standard (i.e., hours worked limit) for two-parent families, “deeming” of income from people outside the immediate family unit, and other refinements in eligibility. It uses the actual income eligibility levels in each state. The model is also designed to simulate the unique features of the Medicaid program including month-by-month simulations of income eligibility and the unique family unit definitions used in the program.

A. Simulate Newly Eligible Population

The first step of the modeling was to simulate the current Medicaid eligibility rules for New Hampshire to identify people who currently meet the income and categorical eligible criteria for Medicaid in the state. We use the CPS data to simulate eligibility on a month-by-month basis. We do this by allocating reported weeks of employment across the 52 weeks of the year according to the number of jobs reported for the year. Reported weeks of unemployment and non-participation in the labor force are also allocated over the year. We then distribute wages across the weeks employed and distribute unemployment compensation over weeks unemployed. Workers compensation income over weeks not in labor force and other sources of

income are allocated across all 12 months of the year. Using the same methodology, we will simulate people who would become newly eligible for the expansion program under the ACA to 133 percent of FPL (plus the 5 percent income disregard).

The HBSM simulates enrollment among newly eligible people based on estimates of the percentage of people who are eligible for the current program who actually enroll. Not all eligible people are expected to enroll in Medicaid when they become eligible. We estimated the number of eligible people who enroll under the Medicaid expansion based on a multivariate model of enrollment among people across the country (i.e., national data) who are currently eligible under the existing Medicaid program, which varies with age, race, income, work status, and other factors affecting enrollment.

This participation model reflects differences in the percentage of eligible people who participate in Medicaid by age, income, self-reported health status, race/ethnicity, employment status, and coverage from other sources of insurance. This approach results in an average participation rate of about 70 percent among people who are currently uninsured and about 39 percent among eligible people who have coverage from some other source. Thus, the model simulates the number of privately insured people who would shift to public coverage (i.e., “crowd-out”).

B. Simulate Crowd-Out

“Crowd-out” is a major concern for policy makers in considering coverage expansions under public programs. Crowd-out is the process whereby publicly subsidized coverage is substituted for private insurance. Several studies have attempted to estimate the extent of crowd-out using data on enrollment under public and private coverage during periods where Medicaid eligibility for poverty level children was expanded.⁹ A review of the literature today reveals a range of crowd-out estimates from 0 to 60 percent for Medicaid and CHIP expansions using various data sources and analytical techniques. Thus, up to 60 percent of those taking coverage under these coverage expansions would have had private insurance in the absence of the program.

Our Medicaid participation model simulates the crowd-out that occurs as newly eligible people discontinue their private coverage and enroll in public coverage. As discussed above, we estimate that the participation rate for people with access to employer-sponsored insurance (ESI) is about 39 percent. We developed this estimate based upon CPS data showing the availability of employer-based coverage for children who are eligible under Medicaid or SCHIP. This provided a basis for estimating separate participation rates for children with and without access to ESI, thus enabling an estimate of crowd-out for public program expansion simulation.

⁹ Beginning in 1989, there were a series of Medicaid eligibility expansions for children and pregnant women. Children through age 5 and pregnant women are eligible through 133 percent of FPL. States also have the option of expanding eligibility for pregnant women to 185 percent of the FPL. Also, all children below the FPL who were born after September 30, 1983, are eligible for the program. Thus, all children below the FPL will be covered by 2001.

C. Simulate Enrollment for Currently Eligible but Not Enrolled Population

Changes in eligibility for the Medicaid expansion can lead to increased enrollment among those who are already eligible for the program. For example, we assume that currently eligible but uninsured children would become enrolled in cases where a newly eligible parent becomes enrolled under a coverage expansion. This is because eligibility for parents is determined on a family unit basis. Thus, uninsured children of parents who enroll in the program are assumed to be automatically enrolled.

We also estimate an increase in enrollment among the currently eligible but not enrolled population resulting from the eligibility expansions. We modeled the behavioral impact that the mandate for health insurance would have on enrollment for this group of people. The penalty for remaining uninsured under PPACA (\$695 per person per year, up to \$2,085 per family in 2016) is assumed to be an additional cost of being uninsured. We apply this assumption only to families that would face the penalty (i.e., with incomes above the federal tax filing threshold). We then estimate the increase in coverage for this group using a multivariate analysis of a broad range of factors affecting the level of insurance coverage, including the price paid for coverage, which includes the amount of the penalty.

D. Integrate Medicaid Expansion with HBSM

We integrate the Medicaid simulations developed with CPS data into MEPS data included in the HBSM. The MEPS data used in HBSM include all of the data required to simulate eligibility for the program except state of residence, which makes it difficult to use for Medicaid simulations. Our approach is to assign MEPS households to a state within the census region identified for the individual in proportion to the distribution of people by income (derived from the CPS). We then simulate eligibility and enrollment for MEPS households using exactly the same models and assumptions used to simulate Medicaid eligibility with the CPS. We then adjust participation function so that the MEPS-based enrollment estimates replicate the estimates developed with the CPS.

The MEPS data would actually be ideal for Medicaid simulations if they included a state of residence indicator. MEPS include month-by-month coverage and employment data which provide a basis for allocating reported income across months for each individual in these data. They also provide the family composition information required to identify family units.

This approach enables us to integrate the state-based Medicaid program analyses into the HBSM, where detailed health data are available to simulate costs and other aspects of health reform. It also allows us to integrate the simulation of Medicaid expansions together with other elements of health reform such as employer requirements and the effect of premium subsidies on coverage and spending.

The HBSM also simulates all the coverage options available under the ACA, including new offers of employer coverage due to the employer penalty and worker demand for coverage due to the individual mandate. Our model provides estimates of new employer coverage due to the ACA, which could lead to a new offer of employer coverage for people currently on Medicaid in New Hampshire. Our analysis assumes that a portion of those people will shift to employer coverage if offered.

Figure 18 shows our estimate of the number of New Hampshire residents that would be newly eligible and enroll in a Medicaid expansion up to 138 percent of FPL. The table also shows the number of people we estimate are eligible for the current Medicaid program but are not enrolled. Finally, the table shows our estimate of the number of current enrollees that would leave Medicaid for a new offer of employer coverage under the ACA.

Figure 18: Estimate of Number Eligible and Who Will Enroll in a Medicaid Expansion to 138 Percent FPL in New Hampshire in 2014

| Expansion to 138 Percent FPL | Newly Eligible - Previously Uninsured | | Newly Eligible - Previously Insured (Crowd-Out) | | Currently Eligible but Uninsured (Woodwork) | | Leave Medicaid for New Offer of Employer Coverage | Net Change in Medicaid Enrollment |
|------------------------------|---------------------------------------|--------|---|--------|---|--------|---|-----------------------------------|
| | Eligible | Enroll | Eligible | Enroll | Eligible | Enroll | | |
| Age/Sex Category | | | | | | | | |
| Under age 1 M&F | 0 | 0 | 0 | 0 | 930 | 169 | 102 | 68 |
| Age 1-5 M&F | 0 | 0 | 0 | 0 | 2,386 | 366 | 855 | (489) |
| Age 6-13 M&F | 0 | 0 | 0 | 0 | 3,978 | 758 | 1,245 | (487) |
| Age 14-20 M | 3,007 | 1,989 | 6,626 | 2,980 | 1,611 | 377 | 512 | 4,834 |
| Age 14-20 F | 2,960 | 2,375 | 7,450 | 2,908 | 1,212 | 268 | 370 | 5,182 |
| Age 21-44 M | 16,976 | 12,834 | 10,305 | 3,447 | 367 | 100 | 88 | 16,293 |
| Age 21-44 F | 13,343 | 9,544 | 9,364 | 3,778 | 2,015 | 812 | 317 | 13,818 |
| Age 45-64 M | 6,161 | 5,180 | 5,559 | 2,467 | 196 | 14 | 15 | 7,645 |
| Age 45-64 F | 7,069 | 5,996 | 11,840 | 4,933 | 220 | 25 | 57 | 10,896 |
| Age 65+ M | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Age 65+ F | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 49,518 | 37,919 | 51,143 | 20,513 | 12,915 | 2,888 | 3,561 | 57,760 |

1/ Assumes that all provisions are fully implemented and ultimate enrollment is reached in 2014.

Estimates of persons eligible and enrolling in the expansion were projected from 2014 through 2020 using age- and sex-specific population growth rates for New Hampshire, adjusted for potentially higher rate of growth among the demographic enrolled in Medicaid. The population growth rate for each age and sex category was derived using state-level data from the U.S. Census Bureau's *Interim State Projections of Population for Five-Year Age Groups and Selected Age Groups by Sex, 2005*. An annual adjustment factor of 1 percent was added to reflect the growth in the population in poverty.

E. Estimate Costs for the Newly Eligible Population

To understand the cost ramifications of the potential expansion to New Hampshire's Medicaid program under the ACA, OptumInsight compiled multiple data sources utilization and costs. The primary data source for the analysis was historical New Hampshire Fee-For-Service (FFS) Medicaid claims data. The data was provided by the New Hampshire DHHS and included claims and enrollment data by eligibility category, age, gender, dual enrollment status, federal poverty level categories, and pregnancy status. The data reflected experience from January 2009 to August 2012.

Given the lack of historical claims and enrollment data for the population who would be eligible for the expansion up to 138 percent of FPL under a Medicaid environment, OptumInsight relied on an average of current, non-Medicare Dual Temporary Assistance for Needy Families (TANF) enrollees and other supplemental sources. The other supplemental sources include the Health Benefits Simulation Model (HBSM), the Office of the Actuary's 2011 report, and a prior published New Hampshire study.

To develop baseline projections for 2014 to 2020, the historical FFS experience was trended forward to the appropriate time periods. Further documentation regarding the trend factor development is discussed later in this report.

Once the FFS data were projected forward to the respective time period, adjustments were applied to reflect state costs under a managed care Medicaid program. The adjustments were intended to capture the reduced service utilization due to a managed care organization's ability to implement care management strategies. The following adjustments were applied to the FFS claims data:

| Rate Cohort | Adjustment |
|-------------|------------|
| Adults | 0.867 |
| Children | 0.857 |
| Aged | 0.852 |
| Disabled | 0.839 |

While care management strategies under a managed Medicaid program affect utilization patterns, offsetting administrative expenses increases the overall cost of care. Therefore, to account for the increased expense associated with a managed Medicaid program, the results reflect the following administrative and premium tax loads:

| Aid Category | Administrative Expense | Premium Tax |
|---------------------------------|------------------------|-------------|
| TANF/Poverty Level | 12.0% | 2.0% |
| Foster Care | 9.2% | 2.0% |
| MEAD | 9.2% | 2.0% |
| Disabled HC, CSD, APTD, and ANB | 9.2% | 2.0% |
| BCCP | 9.2% | 2.0% |
| Old Age | 7.4% | 2.0% |

The results of the aforementioned methodology include projections for both current and expansion populations for the New Hampshire Medicaid program under both a FFS and a managed care environment.

F. Medical Cost Trend Development

Medical cost trend estimates were developed under a fee-for-service and managed care delivery system. The trends were used to project the baseline costs forward to calendar years 2014 – 2020. Several data sources were used to develop the trend estimates including:

- Actual New Hampshire Medicaid data from January 2009 – August 2012
- The State of New Hampshire July 2012 – June 2013 Capitation Rate Development, prepared by Milliman dated April 6, 2012
- The 2011 Actuarial Report on the Financial Outlook for Medicaid, prepared by the Office of the Actuary

The state of New Hampshire supplied data from the FFS Medicaid program for the period January 2009 - August 2012. The data was supplied by eligibility category, age, gender, dual eligibility status, pregnancy status, and by FPL groupings. The data was grouped into the following categories based on the member's basis of eligibility:

- Adults
- Children
- Disabled
- Aged

Once the data was grouped, we performed a trend analysis based on the historical per member per month (PMPM) paid claims data.

We reviewed FFS trend estimates contained in the State of New Hampshire July 2012 – June 2013 Capitation Rate Development. These trends were used to project costs from calendar year 2010 to the New Hampshire 2012/2013 state fiscal year.

Our final trend source was the 2011 Actuarial Report on the Financial Outlook for Medicaid. This report was prepared by the Office of the Actuary and is a national look at Medicaid trend levels extending to calendar year 2020. Recent historical New Hampshire FFS trends have been lower than national Medicaid trend levels; however, future New Hampshire trends may migrate toward the national level.

We blended the three trend estimates at the following levels to develop the trends used for this analysis:

- Actual New Hampshire Medicaid Data – 50%
- New Hampshire Capitation Development – 25%
- 2011 Actuarial Report – 25%

The following table provides the results of the blending and presents the annual trend assumptions:

| Population | FFS Annual Trend Rate |
|------------|-----------------------|
| Adults | 2.1% |
| Children | 3.2% |
| Aged | 3.6% |
| Disabled | 0.8% |

We estimated the impact of the Care Management program under a Medicaid managed care environment as described in the previous section. We also expect the care management program to reduce medical trend levels compared to a FFS program. We have assumed the Medicaid managed care program will reduce annual trends at a rate of 0.25 percent versus the FFS trend levels. Our final estimate of PMPM medical cost for an expansion population under a fee-for-service program is presented in *Figure 19*. *Figure 20* presents our estimate of monthly managed care capitation rates for the expansion population. As described, these rates include an assumption for medical cost, administration and premium tax.

Figure 19: Estimated Monthly Medical Cost for the Expansion Population in New Hampshire under a Fee-For-Service Model

| Age / Gender | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|--------------|------|------|------|------|------|------|------|
| Age 14-20 F | 292 | 301 | 311 | 321 | 331 | 341 | 352 |
| Age 14-20 M | 278 | 287 | 296 | 306 | 315 | 325 | 336 |
| Age 21-44 F | 427 | 436 | 445 | 454 | 463 | 473 | 483 |
| Age 21-44 M | 389 | 398 | 406 | 414 | 423 | 431 | 440 |
| Age 45-64 F | 664 | 677 | 691 | 706 | 720 | 735 | 750 |
| Age 45-64 M | 788 | 804 | 820 | 837 | 854 | 872 | 890 |

Figure 20: Estimated Monthly Capitation Rates for the Expansion Population in New Hampshire Under a Managed Care Model

| Age / Gender | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|--------------|------|------|------|------|------|------|------|
| Age 14-20 F | 307 | 299 | 308 | 317 | 326 | 336 | 346 |
| Age 14-20 M | 293 | 286 | 294 | 302 | 311 | 320 | 330 |
| Age 21-44 F | 453 | 438 | 446 | 454 | 463 | 471 | 479 |
| Age 21-44 M | 413 | 400 | 407 | 414 | 422 | 429 | 437 |
| Age 45-64 F | 703 | 681 | 694 | 706 | 719 | 732 | 745 |
| Age 45-64 M | 835 | 808 | 823 | 838 | 853 | 868 | 884 |

Due to the short history of the Medicaid managed care system in the state, these rates may not fully reflect true costs of the hypothetical newly eligible population under expansion. Additionally, our managed care rates do not reflect the exclusion of certain services from the

state's Medicaid managed care program, such as long-term supports and services and dental services.

Monthly cost estimates are multiplied by the estimated number of enrollees within each age and gender cell in order to compute total costs for the expansion population.

G. Administrative Costs

Total administrative costs were calculated as 5.5 percent of the annual medical cost of the Medicaid program for the fee for service options and as 4 percent of the annual medical cost for the managed care option. This was based on our analysis of the CMS 64 data from 2002 through 2011. The state and federal shares were found by applying the estimated Federal Medical Assistance Percentage (FMAP) rate for administrative costs (57.34 percent) to the total cost.

There is some concern among states that the Medicaid expansion will require a significant increase in administrative costs. As stated above, Medicaid administrative costs in New Hampshire account for about 5.5 percent of total Medicaid spending. The federal government matches administrative costs at 50%, although some functions are matched at higher rates.¹⁰

Medicaid expansion may require states to adopt new administrative roles, including enhancement of current systems to interface with the health benefit Exchange, increased time spent on enrollment of traditional and expansion populations, outreach to newly eligible populations, and upgrading and/or modifying current systems to interface with the new Exchanges. Though associated costs may increase, the State Health Reform Assistance Network proposes that increases may be offset by enhanced federal matching (e.g., 90% match for building the eligibility system, 75% match for systems operation).

Historically, administrative costs to the state in a fee-for-service system tend to be higher than those in a managed care environment, in which the managed care organization would be largely responsible for administrative tasks. If the state chooses to implement expansion under a fee or service system, it will likely experience a surge in staffing needs in order to accommodate the significant volume of new enrollment. The timely and successful provision of certain program maintenance functions (i.e. enrollee and provider appeals, case management and disease management for certain populations, program integrity, prior authorization and utilization management functions, call center operations, and claims processing) is dependent on adequate staffing. To accommodate significant new enrollment following Medicaid expansion under a fee-for-service system, DHHS may need to hire new staff to maintain adequate service levels (i.e. calls are answered within a certain number of seconds, appeals are handled within a certain number of days). In the initial stages of expansion implementation, DHHS may experience a surge in staffing needs in order to handle eligible determination and enrollment processing. This however, is contingent upon pending policy decisions regarding how eligibility is determined.

New state administrative roles may include the following:

¹⁰ Kaiser Commission on Medicaid and the Uninsured, "Medicaid Administration", 2002.

- **Update technology systems that support eligibility:** To be eligible for enhanced federal financial participation (FPP), or enhanced match, the state's Medicaid Management Information System (MMIS) must meet a minimum set of requirements for efficient and economical operation. Before approval will be granted, the system must: align with industry standards; use open interfaces; promote sharing of Medicaid technologies and systems; support accurate and timely processing of claims; produce data and reports that contribute to program evaluation, transparency, and accountability; and coordinate seamlessly with the Exchanges.¹¹
- **Review current eligibility categories and consider how existing and potential expanded Medicaid programs will interact with the Exchanges:** The addition of new eligibility categories may require additional administrative funds. Most existing categories can be collapsed into three groups: parents, pregnant women, and children under age 19. After January 2014, states can elect to include all non-pregnant individuals between the ages of 19 and 65 whose household incomes are at or below 133 percent of FPL. With or without Medicaid expansion, the state will need to interface with the health benefit Exchange. As previously mentioned, this will require enhancements to existing systems and possibly additional staff to facilitate operations.
- **Implement MAGI methodologies:** All state Medicaid agencies will be switching to a new standard for determining eligibility known as Modified Adjusted Gross Income (MAGI). Changing to MAGI eligibility standards will affect how income is counted and how households are defined. For example, MAGI excludes income from Veterans benefits, child-support income, and death benefits, but would include stepparent and grandparent income.¹²
- **Revise application processes:** The ACA requires states to use a single, streamlined application to facilitate Medicaid enrollment. In particular, the application must meet cultural competency and literacy standards to ensure access, and the online application should be tailored to the applicant based on responses to certain questions.¹³ Most states will use the federal application, but states are permitted to develop their own application if it meets the standards set forth by the Secretary.
- **Modify and streamline renewal processes to increase retention:** Several states have already created more flexible renewal processes, including online, telephone, and administrative renewals. By reducing inefficiencies in the renewal process, states can conserve administrative funds used for closing and reopening cases and eliminate the

¹¹ Centers for Medicare & Medicaid Services, "Enhanced Funding Requirements: Seven Conditions and Standards", April 2011.

¹² Kaiser Commission on Medicaid and the Uninsured, "Expanding Coverage to Adults Through Medicaid Under Health Reform", September 2010.

¹³ Centers for Medicare & Medicaid Services, "Supporting Statement for Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies", 2012.

gaps in coverage that result from individuals who “churn” on and off Medicaid over short periods of time.¹⁴

One promising avenue for decreasing costs is eliminating the income certification process and asset tests that many states use to prove an individual’s income. An asset test takes into consideration an individual’s resources beyond income, including savings accounts or vehicles, when considering eligibility for Medicaid. Many states have already dropped the asset test requirement, with additional states considering this possibility. For example, the state of Oklahoma reported spending \$3.5 million on administrative activities surrounding the asset test, which they reduced to \$2.5 million by removing the requirement.

Several studies suggest that introducing ‘self-certification’ of income would reduce the burden on both applicants and enrollment officers. The Medi-Cal Policy Institute found that income certification was estimated to be 2.5 percent of an eligibility worker’s time. Eliminating the requirement yielded a savings of approximately \$4.2 million state and federal dollars.

H. Children’s Health Insurance Program (CHIP)

Under the Affordable Care Act, states will receive a 23 percent increase in federal funding matching rate (from 65 percent to 88 percent) for the Children’s Health Insurance Program (CHIP), between federal fiscal year 2016 and 2019. State savings were calculated by comparing baseline annual state expenses without this ACA provision, to projected state expenses under the enhanced match rates. State expenses for both scenarios were found by multiplying total projected cost of CHIP operation for New Hampshire by the portion of costs for which the state is responsible. The federal share was calculated in the same manner (*Figure 21*).

Figure 21: Calculation of Impact on New Hampshire CHIP Funding Under the ACA (in \$1,000s)

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|-----------------------------|----------|----------|----------|----------|-----------|-----------|-----------|-----------|-----------|
| Total Computable | \$51,859 | \$54,193 | \$56,631 | \$59,180 | \$61,843 | \$64,626 | \$67,534 | \$70,573 | \$73,749 |
| Baseline | | | | | | | | | |
| Federal share | \$33,708 | \$35,225 | \$36,810 | \$38,467 | \$40,198 | \$42,007 | \$43,897 | \$45,872 | \$47,937 |
| State Share | \$18,151 | \$18,967 | \$19,821 | \$20,713 | \$21,645 | \$22,619 | \$23,637 | \$24,701 | \$25,812 |
| ACA | | | | | | | | | |
| Federal share | \$33,708 | \$35,225 | \$36,810 | \$38,467 | \$54,422 | \$56,871 | \$59,430 | \$62,104 | \$73,749 |
| State Share | \$18,151 | \$18,967 | \$19,821 | \$20,713 | \$7,421 | \$7,755 | \$8,104 | \$8,469 | \$0 |
| Difference under ACA | | | | | | | | | |
| Federal share | \$0 | \$0 | \$0 | \$0 | \$14,224 | \$14,864 | \$15,533 | \$16,232 | \$25,812 |
| State Share | \$0 | \$0 | \$0 | \$0 | -\$14,224 | -\$14,864 | -\$15,533 | -\$16,232 | -\$25,812 |

Source: Lewin Projections using CMS 64 data for CHIP

¹⁴ Kaiser Commission on Medicaid and the Uninsured, “Performing Under Pressure: Annual Findings of a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2011-2012”, January 2012.

I. Move Current Eligibles Above 138 Percent FPL to the HBE (MEAD and Pregnant Women Eligibility Categories)

To calculate state savings from moving currently eligible participants in the Medicaid for Employed Adults with Disabilities (MEAD) eligibility category who are above 138 percent of FPL, the state share of expenses without Medicaid expansion was compared to the state share of expenses for this eligibility category under Medicaid expansion to 138 percent of FPL. Since the state would no longer be responsible for expenses incurred by enrollees, it would save all of the funds it had previously devoted to covering this subgroup. By the same token, the federal government would save an equal amount as the state because it too would cease to be responsible for the remaining 50 percent of expenses. State savings for moving pregnant women above 138 percent of FPL was calculated in the same manner.

Total administrative costs were calculated as 5.5 percent of the annual total cost for each group. The state and federal shares were found by applying the estimated FMAP rate for administrative costs (57.34 percent) to the total cost.

| Moving Current Eligibles above 138% of FPL to Health Benefit Exchange | | | | | | | |
|--|-------------|-------------|--------------|--------------|--------------|--------------|--------------|
| Medicaid for Employed Adults with Disabilities (MEAD) | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Number of Enrollees above 138% of FPL | 705 | 723 | 741 | 759 | 778 | 798 | 818 |
| Total cost | \$9,450,967 | \$9,923,515 | \$10,419,691 | \$10,940,676 | \$11,487,709 | \$12,062,095 | \$12,665,200 |
| Traditional Medicaid | | | | | | | |
| State share of total cost | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 |
| Federal share of total cost | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 |
| When moved to HBE | | | | | | | |
| State share of total cost | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| State savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 |
| Federal share of total cost | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 |
| Federal savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 |
| State and federal share of total cost, without Medicaid expansion, is based on Federal Medical Assistance Percentage (FMAP) of 50% | | | | | | | |

| Moving Current Eligibles above 138% of FPL to Health Benefit Exchange | | | | | | | |
|--|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Adult Pregnant Women | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Number of Enrollees above 138% of FPL | 233 | 238 | 244 | 250 | 257 | 263 | 270 |
| Total cost | \$1,795,215 | \$1,884,976 | \$1,979,224 | \$2,078,186 | \$2,182,095 | \$2,291,200 | \$2,405,760 |
| Traditional Medicaid | | | | | | | |
| State share of total cost | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 |
| Federal share of total cost | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 |
| When moved to HBE | | | | | | | |
| State share of total cost | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| State savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 |
| Federal share of total cost | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Federal savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 |
| State and federal share of total cost, without Medicaid expansion, is based on Federal Medical Assistance Percentage (FMAP) of 50% | | | | | | | |

J. Transition of Enrollees Out of Breast and Cervical Cancer Program Eligibility Category

One option available to New Hampshire is to move those who are currently enrolled in the Breast and Cervical Cancer Program (BCCP) eligibility category out of the current Medicaid program, and into the expanded program and Health Benefit Exchange for 2014 through 2020. To calculate the savings for the state in doing so, state savings for each income subgroup under Medicaid expansion was calculated. Due to the significantly enhanced FMAP rates under Medicaid expansion, New Hampshire would save most of the funds it had previously spent on covering enrollees in this eligibility category. Enrollees below 138 percent of FPL would enroll in the expanded Medicaid program as “new eligibles.” Because the federal government would need to recoup the loss of coverage by the state for those below 138 percent of FPL, the savings to the state would be transferred as costs to the federal government. Those over 138 percent of FPL would seek coverage in the health benefit Exchange, thereby saving the federal government its share of expenses.

There would be no additional administrative costs associated with modifying these eligibility categories for enrollees below 138 percent of FPL, because these enrollees would become a part of the “newly eligible” group. Administrative costs for enrollees above 138 percent of FPL would be calculated as 5.5 percent of the annual total cost of the program. The state and federal shares were found by applying the estimated FMAP rate for administrative costs (57.34 percent) to the total cost.

| Transition of Enrollees out of Certain Eligibility Categories | | | | | | | |
|---|------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| Breast and Cervical Cancer Program (BCCP) | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Baseline | | | | | | | |
| <i>Under 100% FPL</i> | | | | | | | |
| Number of Enrollees | 245 | 251 | 257 | 264 | 270 | 277 | 284 |
| Total Cost | \$3,646,895.00 | \$3,829,239.75 | \$4,020,701.74 | \$4,221,736.83 | \$4,432,823.67 | \$4,654,464.85 | \$4,887,188.09 |
| State share of total cost | \$1,823,447.50 | \$1,914,619.88 | \$2,010,350.87 | \$2,110,868.41 | \$2,216,411.83 | \$2,327,232.43 | \$2,443,594.05 |
| Federal share of total cost | \$1,823,447.50 | \$1,914,619.88 | \$2,010,350.87 | \$2,110,868.41 | \$2,216,411.83 | \$2,327,232.43 | \$2,443,594.05 |
| <i>100-138% FPL</i> | | | | | | | |
| Number of Enrollees | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Total Cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| State share of total cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Federal share of total cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| <i>Above 138% FPL</i> | | | | | | | |
| Number of Enrollees | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Total Cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| State share of total cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Federal share of total cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Sum of total costs | | | | | | | |
| State share of total cost | \$1,823,447.50 | \$1,914,619.88 | \$2,010,350.87 | \$2,110,868.41 | \$2,216,411.83 | \$2,327,232.43 | \$2,443,594.05 |
| Federal share of total cost | \$1,823,447.50 | \$1,914,619.88 | \$2,010,350.87 | \$2,110,868.41 | \$2,216,411.83 | \$2,327,232.43 | \$2,443,594.05 |
| Eligibility Category Modification | | | | | | | |
| <i>Under 138% FPL - "Newly Eligible"</i> | | | | | | | |
| Number of enrollees | 245 | 251 | 257 | 264 | 270 | 277 | 284 |
| Total cost | \$3,646,895.00 | \$3,829,239.75 | \$4,020,701.74 | \$4,221,736.83 | \$4,432,823.67 | \$4,654,464.85 | \$4,887,188.09 |
| State share of total cost | \$0.00 | \$0.00 | \$0.00 | \$211,086.84 | \$265,969.42 | \$325,812.54 | \$488,718.81 |
| State savings, from transition | \$1,823,447.50 | \$1,914,619.88 | \$2,010,350.87 | \$1,899,781.57 | \$1,950,442.41 | \$2,001,419.89 | \$1,954,875.24 |
| Federal share of total cost | \$3,646,895.00 | \$3,829,239.75 | \$4,020,701.74 | \$4,010,649.98 | \$4,166,854.25 | \$4,328,652.31 | \$4,398,469.28 |
| Federal savings, from elimination | (\$1,823,447.50) | (\$1,914,619.88) | (\$2,010,350.87) | (\$1,899,781.57) | (\$1,950,442.41) | (\$2,001,419.89) | (\$1,954,875.24) |
| <i>Above 138% FPL - Move to HBE</i> | | | | | | | |
| Number of enrollees | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Total cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| State share of total cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| State savings, from transition | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Federal share of total cost | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Federal savings, from transition | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Sum of total savings, from transition | | | | | | | |
| State share of total savings | \$1,823,447.50 | \$1,914,619.88 | \$2,010,350.87 | \$1,899,781.57 | \$1,950,442.41 | \$2,001,419.89 | \$1,954,875.24 |
| Federal share of total savings | (\$1,823,447.50) | (\$1,914,619.88) | (\$2,010,350.87) | (\$1,899,781.57) | (\$1,950,442.41) | (\$2,001,419.89) | (\$1,954,875.24) |

K. Transition of Pregnant Women Below 138 Percent of FPL into “Newly Eligible” Category

If the state expands Medicaid to 138 percent of FPL, then more adult women with incomes below 138 percent of FPL will have enrolled as a newly eligible adult through the Medicaid expansion prior to a pregnancy. Under this sensitivity analysis, we assume that the cost of Medicaid services for these women will be paid at the enhanced federal matching rate instead of requiring the state to re-categorize these individuals into the current Medicaid poverty level category, for which the state receives only a 50 percent matching rate. However, this will depend on guidance from CMS.

For this subgroup, the total savings to the state were calculated by multiplying projected state savings under the expansion by the product of the lag rate and the expected take up rate.

There would be no additional administrative costs associated with modifying these eligibility categories for enrollees below 138 percent of FPL, because these enrollees would become a part of the “newly eligible” group.

| Transition of Adult Pregnant Women Below 138 Percent of FPL | | | | | | | |
|---|-----------------------|-----------------------|------------------------|------------------------|------------------------|------------------------|------------------------|
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Baseline | | | | | | | |
| <i>Under 100% FPL</i> | | | | | | | |
| Number of Enrollees | 1784 | 1828 | 1874 | 1921 | 1969 | 2018 | 2068 |
| Total Cost | \$16,593,222 | \$17,422,883 | \$18,294,027 | \$19,208,728 | \$20,169,165 | \$21,177,623 | \$22,236,504 |
| State share of total cost | \$8,296,611 | \$8,711,441 | \$9,147,014 | \$9,604,364 | \$10,084,582 | \$10,588,812 | \$11,118,252 |
| <i>100-138% FPL</i> | | | | | | | |
| Number of Enrollees | 293 | 300 | 308 | 315 | 323 | 331 | 339 |
| Total Cost | \$2,329,283 | \$2,445,747 | \$2,568,034 | \$2,696,436 | \$2,831,258 | \$2,972,820 | \$3,121,461 |
| State share of total cost | \$1,164,641 | \$1,222,873 | \$1,284,017 | \$1,348,218 | \$1,415,629 | \$1,486,410 | \$1,560,731 |
| Sum of total costs | | | | | | | |
| State share of total cost | \$9,461,252.20 | \$9,934,314.81 | \$10,431,030.55 | \$10,952,582.08 | \$11,500,211.18 | \$12,075,221.74 | \$12,678,982.83 |
| Transition | | | | | | | |
| <i>Under 138% FPL - "Newly Eligible"</i> | | | | | | | |
| Number of enrollees | 2076 | 2128 | 2181 | 2236 | 2292 | 2349 | 2408 |
| Lag factor | 0.5735 | 0.6618 | 0.75 | 0.75 | 0.75 | 0.75 | 0.75 |
| Total cost | \$18,922,504 | \$19,868,630 | \$20,862,061 | \$21,905,164 | \$23,000,422 | \$24,150,443 | \$25,357,966 |
| State share of total cost | \$0 | \$0 | \$0 | \$1,095,258 | \$1,380,025 | \$1,690,531 | \$2,535,797 |
| State savings, from transition | \$5,426,306 | \$6,574,179 | \$7,823,273 | \$7,392,993 | \$7,590,139 | \$7,788,518 | \$7,607,390 |
| Sum of total savings, from transition | | | | | | | |
| State share of total savings | \$5,426,306 | \$6,574,179 | \$7,823,273 | \$7,392,993 | \$7,590,139 | \$7,788,518 | \$7,607,390 |

Appendix A. Detailed Tables

Figure A-1: Impact on New Hampshire Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020)

| No Medicaid Expansion | | | | | | | | |
|---|--------------|--------------|---------------|---------------|---------------|---------------|--------------|---------------|
| FFS rates | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 13761 | 13968 | 14192 | 14430 | 14685 | 14946 | 15216 | |
| Take Up Rate | 27% | 27% | 27% | 27% | 27% | 27% | 27% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2855.64 | 3341.60 | 3844.72 | 3907.32 | 3975.78 | 4046.60 | 4118.68 | |
| PMPY Cost | \$4,258 | \$4,364 | \$4,471 | \$4,580 | \$4,692 | \$4,806 | \$4,922 | |
| Total Cost | \$12,159,666 | \$14,581,093 | \$17,189,243 | \$17,896,081 | \$18,653,097 | \$19,447,784 | \$20,272,882 | \$120,199,845 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$6,079,833 | \$7,290,546 | \$8,594,621 | \$8,948,040 | \$9,326,549 | \$9,723,892 | \$10,136,441 | \$60,099,923 |
| Subtotal - Federal Cost | \$6,079,833 | \$7,290,546 | \$8,594,621 | \$8,948,040 | \$9,326,549 | \$9,723,892 | \$10,136,441 | \$60,099,923 |
| 2. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2723 | 3189 | 3673 | 3735 | 3803 | 3871 | 3943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 3. CHIP | | | | | | | | |
| State Savings | - | - | -\$14,223,849 | -\$14,863,922 | -\$15,532,799 | -\$16,231,775 | - | -\$60,852,345 |
| Federal Savings | - | - | \$14,223,849 | \$14,863,922 | \$15,532,799 | \$16,231,775 | - | \$60,852,345 |
| 4. Net Impact | | | | | | | | |
| Change in Enrollment | 133 | 153 | 172 | 172 | 173 | 175 | 175 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$526,148 | -\$605,663 | -\$14,916,078 | -\$15,564,229 | -\$16,245,117 | -\$16,956,044 | -\$747,397 | -\$65,560,676 |
| Federal Cost | -\$526,148 | -\$605,663 | \$13,531,620 | \$14,163,615 | \$14,820,480 | \$15,507,506 | -\$747,397 | \$56,144,014 |
| Subtotal | -\$1,052,296 | -\$1,211,327 | -\$1,384,458 | -\$1,400,614 | -\$1,424,637 | -\$1,448,538 | -\$1,494,793 | -\$9,416,663 |
| Administrative Costs | | | | | | | | |
| State Share | -\$24,462 | -\$28,159 | -\$32,183 | -\$32,559 | -\$33,117 | -\$33,673 | -\$34,748 | -\$218,901 |
| Federal Share | -\$33,414 | -\$38,464 | -\$43,962 | -\$44,475 | -\$45,238 | -\$45,997 | -\$47,465 | -\$299,015 |
| Subtotal | -\$57,876 | -\$66,623 | -\$76,145 | -\$77,034 | -\$78,355 | -\$79,670 | -\$82,214 | -\$517,916 |
| Total | | | | | | | | |
| State Share | -\$550,610 | -\$633,822 | -\$14,948,262 | -\$15,596,788 | -\$16,278,235 | -\$16,989,717 | -\$782,145 | -\$65,779,578 |
| Federal Share | -\$559,562 | -\$644,128 | \$13,487,658 | \$14,119,140 | \$14,775,243 | \$15,461,509 | -\$794,862 | \$55,844,998 |
| Total | -\$1,110,172 | -\$1,277,950 | -\$1,460,604 | -\$1,477,648 | -\$1,502,992 | -\$1,528,207 | -\$1,577,007 | -\$9,934,579 |

Figure A-2: Impact on New Hampshire Medicaid Spending if Medicaid is Not Expanded Under the ACA (2014-2020) and Capping Certain Eligibility Categories for Adults at 138 Percent of FPL

| No Medicaid Expansion | | | | | | | | |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|-----------------------|
| | FFS rates | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 13,761 | 13,968 | 14,192 | 14,430 | 14,685 | 14,946 | 15,216 | |
| Take Up Rate | 27% | 27% | 27% | 27% | 27% | 27% | 27% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,856 | 3,342 | 3,845 | 3,907 | 3,976 | 4,047 | 4,119 | |
| PMPY Cost | \$4,258 | \$4,364 | \$4,471 | \$4,580 | \$4,692 | \$4,806 | \$4,922 | |
| Total Cost | \$12,159,666 | \$14,581,093 | \$17,189,243 | \$17,896,081 | \$18,653,097 | \$19,447,784 | \$20,272,882 | \$120,199,845 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$6,079,833 | \$7,290,546 | \$8,594,621 | \$8,948,040 | \$9,326,549 | \$9,723,892 | \$10,136,441 | \$60,099,923 |
| Subtotal - Federal Cost | \$6,079,833 | \$7,290,546 | \$8,594,621 | \$8,948,040 | \$9,326,549 | \$9,723,892 | \$10,136,441 | \$60,099,923 |
| 2. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 3. CHIP | | | | | | | | |
| State savings | - | - | -\$14,223,849 | -\$14,863,922 | -\$15,532,799 | -\$16,231,775 | - | (60,852,345) |
| Federal Savings | - | - | \$14,223,849 | \$14,863,922 | \$15,532,799 | \$16,231,775 | - | 60,852,345 |
| 4. Moving Current Eligibles above 138% to Health Benefit Exchange | | | | | | | | |
| MEAD | | | | | | | | |
| Enrollees | 705 | 723 | 741 | 759 | 778 | 798 | 818 | |
| State Savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Federal Savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Pregnant Women | | | | | | | | |
| Enrollees | 233 | 238 | 244 | 250 | 257 | 263 | 270 | |
| State Savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| Federal Savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| 5. Net Impact | | | | | | | | |
| Change in Enrollment | (805) | (808) | (813) | (837) | (862) | (886) | (913) | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$6,149,239 | -\$6,509,909 | -\$21,115,536 | -\$22,073,660 | -\$23,080,019 | -\$24,132,691 | -\$8,282,876 | -\$111,343,930 |
| Federal Cost | -\$6,149,239 | -\$6,509,909 | \$7,332,162 | \$7,654,185 | \$7,985,578 | \$8,330,859 | -\$8,282,876 | \$10,360,760 |
| Subtotal | -\$12,298,478 | -\$13,019,818 | -\$13,783,374 | -\$14,419,475 | -\$15,094,441 | -\$15,801,832 | -\$16,565,752 | -\$100,983,170 |
| Administrative Costs | | | | | | | | |
| State Share | -\$285,892 | -\$302,661 | -\$320,411 | -\$335,197 | -\$350,888 | -\$367,332 | -\$385,090 | -\$2,347,471 |
| Federal Share | -\$390,524 | -\$413,429 | -\$437,675 | -\$457,874 | -\$479,306 | -\$501,769 | -\$526,026 | -\$3,206,603 |
| Subtotal | -\$676,416 | -\$716,090 | -\$758,086 | -\$793,071 | -\$830,194 | -\$869,101 | -\$911,116 | -\$5,554,074 |
| Total | | | | | | | | |
| State Share | -\$6,435,131 | -\$6,812,570 | -\$21,435,947 | -\$22,408,857 | -\$23,430,907 | -\$24,500,023 | -\$8,667,966 | -\$113,691,401 |
| Federal Share | -\$6,539,763 | -\$6,923,338 | \$6,894,487 | \$7,196,311 | \$7,506,272 | \$7,829,090 | -\$8,808,902 | \$7,154,157 |
| Total | -\$12,974,894 | -\$13,735,908 | -\$14,541,459 | -\$15,212,547 | -\$15,924,635 | -\$16,670,933 | -\$17,476,869 | -\$106,537,244 |

Figure A-3: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Baseline ACA Analysis

| Expansion up to 138% of FPL | | | | | | | | |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|
| FFS rates | | | | | | | | |
| Mid-range participation assumption | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth + 1% Poverty growth | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | 100,661 | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 58% | 58% | 58% | 58% | 58% | 58% | 58% | |
| Enrollment Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 44,683 | 52,153 | 59,856 | 60,607 | 61,400 | 62,193 | 62,989 | |
| PMPY Cost | \$5,799 | \$5,930 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$374,798,027 | \$387,152,140 | \$399,721,474 | \$412,516,868 | \$2,505,194,267 |
| FMAP | 100% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$18,739,901 | \$23,229,128 | \$27,980,503 | \$41,251,687 | \$111,201,220 |
| Subtotal - Federal Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$356,058,125 | \$363,923,012 | \$371,740,971 | \$371,265,181 | \$2,393,993,047 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth + 1% Poverty growth | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 22% | 22% | 22% | 22% | 22% | 22% | 22% | |
| Enrollment Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,209 | 2,584 | 2,974 | 3,023 | 3,077 | 3,133 | 3,191 | |
| PMPY Cost | \$3,888 | \$3,991 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$8,586,402 | \$10,313,351 | \$12,182,342 | \$12,712,000 | \$13,282,655 | \$13,883,497 | \$14,514,395 | \$85,474,641 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| Subtotal - Federal Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. Increased CHIP match rate | | | | | | | | |
| State Savings | - | - | (14,223,849) | (14,863,922) | (15,532,799) | (16,231,775) | - | (60,852,345) |
| Federal Savings | - | - | 14,223,849 | 14,863,922 | 15,532,799 | 16,231,775 | - | 60,852,345 |
| 5. Net Impact | | | | | | | | |
| Change in Enrollment | 44,169 | 51,548 | 59,157 | 59,895 | 60,674 | 61,455 | 62,237 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$2,312,780 | -\$2,739,534 | -\$17,419,529 | \$583,631 | \$4,298,790 | \$8,242,316 | \$37,625,047 | \$28,277,941 |
| Federal Cost | \$256,788,448 | \$306,506,228 | \$373,686,938 | \$367,629,700 | \$376,058,271 | \$384,466,334 | \$367,638,541 | \$2,432,774,459 |
| Subtotal | \$254,475,668 | \$303,766,693 | \$356,267,409 | \$368,213,332 | \$380,357,061 | \$392,708,650 | \$405,263,588 | \$2,461,052,400 |
| Administrative Costs | | | | | | | | |
| State Share | \$5,915,583 | \$7,061,410 | \$8,281,850 | \$8,559,547 | \$8,841,842 | \$9,128,969 | \$9,420,823 | \$57,210,025 |
| Federal Share | \$8,080,579 | \$9,645,758 | \$11,312,857 | \$11,692,186 | \$12,077,796 | \$12,470,007 | \$12,868,674 | \$78,147,857 |
| Subtotal | \$13,996,162 | \$16,707,168 | \$19,594,707 | \$20,251,733 | \$20,919,638 | \$21,598,976 | \$22,289,497 | \$135,357,882 |
| Total | | | | | | | | |
| State Share | \$3,602,803 | \$4,321,876 | -\$9,137,679 | \$9,143,179 | \$13,140,632 | \$17,371,285 | \$47,045,870 | \$85,487,966 |
| Federal Share | \$264,869,026 | \$316,151,986 | \$384,999,795 | \$379,321,886 | \$388,136,067 | \$396,936,340 | \$380,507,215 | \$2,510,922,316 |
| Total | \$268,471,829 | \$320,473,862 | \$375,862,116 | \$388,465,065 | \$401,276,700 | \$414,307,625 | \$427,553,085 | \$2,596,410,282 |

Figure A-4: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020)
- Sensitivity Analysis - Low-Range Participation Assumption

| Expansion to 138% of FPL | | | | | | | | |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|
| FFS rates | | | | | | | | |
| Low-range participation assumption | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth rate | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | 100,661 | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 45% | 45% | 45% | 45% | 45% | 45% | 45% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 34,777 | 40,591 | 46,586 | 47,171 | 47,788 | 48,405 | 49,025 | |
| PMPY Cost | \$5,799 | \$5,930 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$201,659,587 | \$240,687,291 | \$282,258,861 | \$291,706,898 | \$301,322,157 | \$311,104,923 | \$321,063,632 | \$1,949,803,349 |
| FMAP | 100% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$14,585,345 | \$18,079,329 | \$21,777,345 | \$32,106,363 | \$86,548,382 |
| Subtotal - Federal Cost | \$201,659,587 | \$240,687,291 | \$282,258,861 | \$277,121,553 | \$283,242,827 | \$289,327,578 | \$288,957,269 | \$1,863,254,967 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 17% | 17% | 17% | 17% | 17% | 17% | 17% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 1,719 | 2,011 | 2,315 | 2,353 | 2,395 | 2,439 | 2,484 | |
| PMPY Cost | \$3,888 | \$3,991 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$6,682,833 | \$8,026,925 | \$9,481,568 | \$9,893,803 | \$10,337,947 | \$10,805,584 | \$11,296,615 | \$66,525,277 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$3,341,416 | \$4,013,463 | \$4,740,784 | \$4,946,902 | \$5,168,974 | \$5,402,792 | \$5,648,308 | \$33,262,638 |
| Subtotal - Federal Cost | \$3,341,416 | \$4,013,463 | \$4,740,784 | \$4,946,902 | \$5,168,974 | \$5,402,792 | \$5,648,308 | \$33,262,638 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. CHIP | | | | | | | | |
| State Savings | - | - | -\$14,223,849 | -\$14,863,922 | -\$15,532,799 | -\$16,231,775 | - | -\$60,852,345 |
| Federal Savings | - | - | \$14,223,849 | \$14,863,922 | \$15,532,799 | \$16,231,775 | - | \$60,852,345 |
| 5. Net Impact | | | | | | | | |
| Change in Enrollment | 33,773 | 39,413 | 45,228 | 45,788 | 46,380 | 46,973 | 47,565 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$3,264,564 | -\$3,882,747 | -\$18,769,916 | -\$4,980,023 | -\$2,323,363 | \$500,201 | \$26,870,833 | -\$5,849,579 |
| Federal Cost | \$198,395,023 | \$236,804,544 | \$291,936,644 | \$287,284,029 | \$293,905,733 | \$300,513,985 | \$283,721,739 | \$1,892,561,696 |
| Subtotal | \$195,130,458 | \$232,921,797 | \$273,166,728 | \$282,304,006 | \$291,582,370 | \$301,014,186 | \$310,592,572 | \$1,886,712,117 |
| Administrative Costs | | | | | | | | |
| State Share | \$4,536,034 | \$5,414,538 | \$6,350,078 | \$6,562,485 | \$6,778,171 | \$6,997,425 | \$7,220,085 | \$43,858,817 |
| Federal Share | \$6,196,141 | \$7,396,161 | \$8,674,092 | \$8,964,235 | \$9,258,859 | \$9,558,355 | \$9,862,506 | \$59,910,349 |
| Subtotal | \$10,732,175 | \$12,810,699 | \$15,024,170 | \$15,526,720 | \$16,037,030 | \$16,555,780 | \$17,082,591 | \$103,769,166 |
| Total | | | | | | | | |
| State Share | \$1,271,470 | \$1,531,791 | -\$12,419,837 | \$1,582,462 | \$4,454,808 | \$7,497,626 | \$34,090,919 | \$38,009,239 |
| Federal Share | \$204,591,163 | \$244,200,705 | \$300,610,736 | \$296,248,265 | \$303,164,592 | \$310,072,340 | \$293,584,245 | \$1,952,472,045 |
| Total | \$205,862,634 | \$245,732,495 | \$288,190,898 | \$297,830,727 | \$307,619,400 | \$317,569,966 | \$327,675,164 | \$1,990,481,284 |

Figure A-5: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Sensitivity Analysis - High-Range Participation Assumption

| Expansion to 138% of FPL | | | | | | | | |
|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| FFS rates | | | | | | | | |
| High-range participation assumption | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth rate | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | 100,661 | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 63% | 63% | 63% | 63% | 63% | 63% | 63% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 48,198 | 56,255 | 64,564 | 65,374 | 66,229 | 67,085 | 67,944 | |
| PMPY Cost | \$5,799 | \$5,930 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$279,481,239 | \$333,569,971 | \$391,184,261 | \$404,278,351 | \$417,604,197 | \$431,162,192 | \$444,964,027 | \$2,702,244,238 |
| FMAP | 100% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$20,213,918 | \$25,056,252 | \$30,181,353 | \$44,496,403 | \$119,947,926 |
| Subtotal - Federal Cost | \$279,481,239 | \$333,569,971 | \$391,184,261 | \$384,064,434 | \$392,547,945 | \$400,980,838 | \$400,467,624 | \$2,582,296,313 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 24% | 24% | 24% | 24% | 24% | 24% | 24% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,382 | 2,788 | 3,208 | 3,261 | 3,319 | 3,380 | 3,442 | |
| PMPY Cost | \$3,888 | \$3,991 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$9,261,778 | \$11,124,564 | \$13,140,563 | \$13,711,882 | \$14,327,423 | \$14,975,525 | \$15,656,048 | \$92,197,783 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$4,630,889 | \$5,562,282 | \$6,570,281 | \$6,855,941 | \$7,163,712 | \$7,487,762 | \$7,828,024 | \$46,098,891 |
| Subtotal - Federal Cost | \$4,630,889 | \$5,562,282 | \$6,570,281 | \$6,855,941 | \$7,163,712 | \$7,487,762 | \$7,828,024 | \$46,098,891 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. CHIP | | | | | | | | |
| State Savings | - | - | -\$14,223,849 | -\$14,863,922 | -\$15,532,799 | -\$16,231,775 | - | -\$60,852,345 |
| Federal Savings | - | - | \$14,223,849 | \$14,863,922 | \$15,532,799 | \$16,231,775 | - | \$60,852,345 |
| 5. Net Impact | | | | | | | | |
| Change in Enrollment | 47,857 | 55,854 | 64,099 | 64,900 | 65,746 | 66,594 | 67,443 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$1,975,091 | -\$2,333,928 | -\$16,940,418 | \$2,557,589 | \$6,648,298 | \$10,989,180 | \$41,440,589 | \$40,386,218 |
| Federal Cost | \$277,506,148 | \$331,236,043 | \$402,691,541 | \$396,135,950 | \$405,205,589 | \$414,252,215 | \$397,411,810 | \$2,624,439,295 |
| Total | \$275,531,057 | \$328,902,115 | \$385,751,122 | \$398,693,538 | \$411,853,886 | \$425,241,395 | \$438,852,399 | \$2,664,825,513 |
| Administrative Costs | | | | | | | | |
| State Share | \$6,405,040 | \$7,645,712 | \$8,967,233 | \$9,268,095 | \$9,574,022 | \$9,885,231 | \$10,201,634 | \$61,946,968 |
| Federal Share | \$8,749,168 | \$10,443,904 | \$12,249,078 | \$12,660,050 | \$13,077,941 | \$13,503,046 | \$13,935,248 | \$84,618,436 |
| Total | \$15,154,208 | \$18,089,616 | \$21,216,312 | \$21,928,145 | \$22,651,964 | \$23,388,277 | \$24,136,882 | \$146,565,403 |
| Total | | | | | | | | |
| State Share | \$4,429,948 | \$5,311,784 | -\$7,973,185 | \$11,825,684 | \$16,222,320 | \$20,874,411 | \$51,642,223 | \$102,333,186 |
| Federal Share | \$286,255,316 | \$341,679,947 | \$414,940,619 | \$408,795,999 | \$418,283,530 | \$427,755,261 | \$411,347,058 | \$2,709,057,730 |
| Total | \$290,685,265 | \$346,991,731 | \$406,967,434 | \$420,621,683 | \$434,505,850 | \$448,629,672 | \$462,989,281 | \$2,811,390,916 |

Figure A-6: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Sensitivity Analysis - Managed Care Model Assumption

| Expansion to 138% of FPL | | | | | | | | |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|
| MCO rates - expansion group | | | | | | | | |
| Mid-range participation assumption | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth rate | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number | 100,661 | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 58% | 58% | 58% | 58% | 58% | 58% | 58% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 44,683 | 52,153 | 59,856 | 60,607 | 61,400 | 62,193 | 62,989 | |
| PMPY Cost | \$6,140 | \$5,956 | \$6,071 | \$6,181 | \$6,287 | \$6,393 | \$6,498 | |
| Total Cost | \$274,358,782 | \$310,630,285 | \$363,390,294 | \$374,632,194 | \$386,028,246 | \$397,579,211 | \$409,292,583 | \$2,515,911,594 |
| FMAP | 100% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$18,731,610 | \$23,161,695 | \$27,830,545 | \$40,929,258 | \$110,653,108 |
| Subtotal - Federal Cost | \$274,358,782 | \$310,630,285 | \$363,390,294 | \$355,900,584 | \$362,866,551 | \$369,748,666 | \$368,363,325 | \$2,405,258,486 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Un | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 22% | 22% | 22% | 22% | 22% | 22% | 22% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,209 | 2,584 | 2,974 | 3,023 | 3,077 | 3,133 | 3,191 | |
| PMPY Cost | \$4,103 | \$3,987 | \$4,083 | \$4,181 | \$4,281 | \$4,384 | \$4,488 | |
| Total Cost | \$9,061,736 | \$10,304,851 | \$12,142,266 | \$12,638,920 | \$13,173,714 | \$13,735,674 | \$14,324,352 | \$85,381,514 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$4,530,868 | \$5,152,426 | \$6,071,133 | \$6,319,460 | \$6,586,857 | \$6,867,837 | \$7,162,176 | \$42,690,757 |
| Subtotal - Federal Cost | \$4,530,868 | \$5,152,426 | \$6,071,133 | \$6,319,460 | \$6,586,857 | \$6,867,837 | \$7,162,176 | \$42,690,757 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Saving | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. CHIP | | | | | | | | |
| State Savings | - | - | -\$14,223,849 | -\$14,863,922 | -\$15,532,799 | -\$16,231,775 | - | -\$60,852,345 |
| Federal Savings | - | - | \$14,223,849 | \$14,863,922 | \$15,532,799 | \$16,231,775 | - | \$60,852,345 |
| 5. Net Impact | | | | | | | | |
| Change in Enrollment | 44,169 | 51,548 | 59,157 | 59,895 | 60,674 | 61,455 | 62,237 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$2,075,113 | -\$2,743,784 | -\$17,439,567 | \$538,800 | \$4,176,886 | \$8,018,446 | \$37,207,597 | \$27,683,266 |
| Federal Cost | \$272,283,669 | \$307,886,500 | \$374,398,425 | \$367,435,619 | \$374,947,340 | \$382,400,117 | \$364,641,663 | \$2,443,993,334 |
| Subtotal | \$270,208,557 | \$305,142,716 | \$356,958,859 | \$367,974,419 | \$379,124,226 | \$390,418,564 | \$401,849,260 | \$2,471,676,600 |
| Administrative Costs | | | | | | | | |
| State Share | \$4,568,227 | \$5,158,834 | \$6,034,854 | \$6,221,086 | \$6,409,588 | \$6,600,533 | \$6,793,784 | \$41,786,907 |
| Federal Share | \$6,240,115 | \$7,046,874 | \$8,243,501 | \$8,497,891 | \$8,755,381 | \$9,016,209 | \$9,280,186 | \$57,080,157 |
| Subtotal | \$10,808,342 | \$12,205,709 | \$14,278,354 | \$14,718,977 | \$15,164,969 | \$15,616,743 | \$16,073,970 | \$98,867,064 |
| Total | | | | | | | | |
| State Share | \$2,493,114 | \$2,415,050 | -\$11,404,713 | \$6,759,886 | \$10,586,474 | \$14,618,980 | \$44,001,381 | \$69,470,172 |
| Federal Share | \$278,523,785 | \$314,933,375 | \$382,641,926 | \$375,933,510 | \$383,702,721 | \$391,416,326 | \$373,921,849 | \$2,501,073,492 |
| Total | \$281,016,899 | \$317,348,425 | \$371,237,213 | \$382,693,396 | \$394,289,195 | \$406,035,306 | \$417,923,230 | \$2,570,543,664 |

Figure A-7: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Delayed Implementation until January 2015

| Expansion up to 138% of FPL | | | | | | | | |
|---|--------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| FFS rates | | | | | | | | |
| Mid-range participation assumption | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth + 1% Poverty growth | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | - | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 0% | 58% | 58% | 58% | 58% | 58% | 58% | |
| Enrollment Lag Rate | 0% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | - | 52,153 | 59,856 | 60,607 | 61,400 | 62,193 | 62,989 | |
| PMPY Cost | \$0 | \$5,930 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$0 | \$268,012,994 | \$319,993,031 | \$374,798,027 | \$387,152,140 | \$399,721,474 | \$412,516,868 | \$2,162,194,534 |
| FMAP | 0% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$18,739,901 | \$23,229,128 | \$27,980,503 | \$41,251,687 | \$111,201,220 |
| Subtotal - Federal Cost | \$0 | \$268,012,994 | \$319,993,031 | \$356,058,125 | \$363,923,012 | \$371,740,971 | \$371,265,181 | \$2,050,993,314 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth + 1% Poverty growth | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 22% | 22% | 22% | 22% | 22% | 22% | 22% | |
| Enrollment Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,209 | 2,584 | 2,974 | 3,023 | 3,077 | 3,133 | 3,191 | |
| PMPY Cost | \$3,888 | \$3,991 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$12,159,666 | \$10,313,351 | \$12,182,342 | \$12,712,000 | \$13,282,655 | \$13,883,497 | \$14,514,395 | \$89,047,906 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$6,079,833 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$44,523,953 |
| Subtotal - Federal Cost | \$6,079,833 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$44,523,953 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. Increased CHIP match rate | | | | | | | | |
| State Savings | - | - | (14,223,849) | (14,863,922) | (15,532,799) | (16,231,775) | - | (60,852,345) |
| Federal Savings | - | - | 14,223,849 | 14,863,922 | 15,532,799 | 16,231,775 | - | 60,852,345 |
| 5. Net Impact | | | | | | | | |
| Change in Enrollment | 133 | 44,595 | 52,115 | 59,895 | 60,674 | 61,455 | 62,237 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$526,148 | -\$2,739,534 | -\$17,419,529 | \$583,631 | \$4,298,790 | \$8,242,316 | \$37,625,047 | \$30,064,573 |
| Federal Cost | -\$526,148 | \$265,273,459 | \$331,021,200 | \$367,629,700 | \$376,058,271 | \$384,466,334 | \$367,638,541 | \$2,091,561,358 |
| Subtotal | -\$1,052,296 | \$262,533,925 | \$313,601,671 | \$368,213,332 | \$380,357,061 | \$392,708,650 | \$405,263,588 | \$2,121,625,931 |
| Administrative Costs | | | | | | | | |
| State Share | -\$24,462 | \$6,102,906 | \$7,290,036 | \$8,559,547 | \$8,841,842 | \$9,128,969 | \$9,420,823 | \$49,319,662 |
| Federal Share | -\$33,414 | \$8,336,460 | \$9,958,056 | \$11,692,186 | \$12,077,796 | \$12,470,007 | \$12,868,674 | \$67,369,764 |
| Subtotal | -\$57,876 | \$14,439,366 | \$17,248,092 | \$20,251,733 | \$20,919,638 | \$21,598,976 | \$22,289,497 | \$116,689,426 |
| Total | | | | | | | | |
| State Share | -\$550,610 | \$3,363,372 | -\$10,129,493 | \$9,143,178 | \$13,140,633 | \$17,371,285 | \$47,045,870 | \$79,384,235 |
| Federal Share | -\$559,562 | \$273,609,919 | \$340,979,256 | \$379,321,887 | \$388,136,067 | \$396,936,340 | \$380,507,215 | \$2,158,931,122 |
| Total | -\$1,110,172 | \$276,973,291 | \$330,849,763 | \$388,465,065 | \$401,276,700 | \$414,307,625 | \$427,553,085 | \$2,238,315,357 |

Figure A-8: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Delayed Implementation Until January 2016

| Expansion to 138% FPL | | | | | | | | |
|---|--------------|--------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| FFS rates | | | | | | | | |
| Medium-range participation | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth rate | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | - | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 0% | 58% | 58% | 58% | 58% | 58% | 58% | |
| Lag Rate | 0% | 0% | 76% | 88% | 100% | 100% | 100% | |
| Enrollment | - | - | 45,772 | 53,477 | 61,400 | 62,193 | 62,989 | |
| PMPY Cost | \$0 | \$0 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$0 | \$0 | \$277,327,294 | \$330,704,141 | \$387,152,140 | \$399,721,474 | \$412,516,868 | \$1,807,421,917 |
| FMAP | 0% | 0% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$16,535,207 | \$23,229,128 | \$27,980,503 | \$41,251,687 | \$108,996,525 |
| Subtotal - Federal Cost | \$0 | \$0 | \$277,327,294 | \$314,168,934 | \$363,923,012 | \$371,740,971 | \$371,265,181 | \$1,698,425,392 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 13,761 | 13,968 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 27% | 27% | 22% | 22% | 22% | 22% | 22% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,856 | 3,342 | 2,974 | 3,023 | 3,077 | 3,133 | 3,191 | |
| PMPY Cost | \$4,258 | \$4,364 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$12,159,666 | \$14,581,093 | \$12,182,342 | \$12,712,000 | \$13,282,655 | \$13,883,497 | \$14,514,395 | \$93,315,647 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$6,079,833 | \$7,290,546 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$46,657,823 |
| Subtotal - Federal Cost | \$6,079,833 | \$7,290,546 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$46,657,823 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. CHIP | | | | | | | | |
| State cost | - | - | -\$14,223,849 | -\$14,863,922 | -\$15,532,799 | -\$16,231,775 | - | -\$60,852,345 |
| Federal cost | - | - | \$14,223,849 | \$14,863,922 | \$15,532,799 | \$16,231,775 | - | \$60,852,345 |
| 5. Net Impact | | | | | | | | |
| Change in Enrollment | 133 | 153 | 45,073 | 52,765 | 60,674 | 61,455 | 62,237 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$526,148 | -\$605,663 | -\$17,419,529 | -\$1,621,063 | \$4,298,790 | \$8,242,316 | \$37,625,047 | \$29,993,750 |
| Federal Cost | -\$526,148 | -\$605,663 | \$288,355,463 | \$325,740,509 | \$376,058,271 | \$384,466,334 | \$367,638,541 | \$1,741,127,306 |
| Subtotal | -\$1,052,296 | -\$1,211,327 | \$270,935,934 | \$324,119,446 | \$380,357,061 | \$392,708,650 | \$405,263,588 | \$1,771,121,056 |
| Administrative Costs | | | | | | | | |
| State Share | -\$24,462 | -\$28,159 | \$6,298,221 | \$7,534,533 | \$8,841,842 | \$9,128,969 | \$9,420,823 | \$41,171,768 |
| Federal Share | -\$33,414 | -\$38,464 | \$8,603,256 | \$10,292,036 | \$12,077,796 | \$12,470,007 | \$12,868,674 | \$56,239,890 |
| Subtotal | -\$57,876 | -\$66,623 | \$14,901,476 | \$17,826,570 | \$20,919,638 | \$21,598,976 | \$22,289,497 | \$97,411,658 |
| Total | | | | | | | | |
| State Share | -\$550,610 | -\$633,822 | -\$11,121,308 | \$5,913,470 | \$13,140,633 | \$17,371,285 | \$47,045,870 | \$71,165,518 |
| Federal Share | -\$559,562 | -\$644,128 | \$296,958,718 | \$336,032,545 | \$388,136,067 | \$396,936,340 | \$380,507,215 | \$1,797,367,196 |
| Total | -\$1,110,172 | -\$1,277,950 | \$285,837,410 | \$341,946,016 | \$401,276,700 | \$414,307,625 | \$427,553,085 | \$1,868,532,714 |

Figure A-9: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020) - Program Design Option - Moving Current Eligibles Above 138 Percent FPL to HBE (MEAD and Pregnant Women Eligibility Categories)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth rate | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | 100,661 | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 58% | 58% | 58% | 58% | 58% | 58% | 58% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 44,683 | 52,153 | 59,856 | 60,607 | 61,400 | 62,193 | 62,989 | |
| PMPY Cost | \$5,799 | \$5,930 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$374,798,027 | \$387,152,140 | \$399,721,474 | \$412,516,868 | \$2,505,194,267 |
| FMAP | 100% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$18,739,901 | \$23,229,128 | \$27,980,503 | \$41,251,687 | \$111,201,220 |
| Subtotal - Federal Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$356,058,125 | \$363,923,012 | \$371,740,971 | \$371,265,181 | \$2,393,993,047 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 22% | 22% | 22% | 22% | 22% | 22% | 22% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,209 | 2,584 | 2,974 | 3,023 | 3,077 | 3,133 | 3,191 | |
| PMPY Cost | \$3,888 | \$3,991 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$8,586,402 | \$10,313,351 | \$12,182,342 | \$12,712,000 | \$13,282,655 | \$13,883,497 | \$14,514,395 | \$85,474,641 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| Subtotal - Federal Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. CHIP | | | | | | | | |
| State Savings | - | - | -\$14,223,849 | -\$14,863,922 | -\$15,532,799 | -\$16,231,775 | - | -\$60,852,345 |
| Federal Savings | - | - | \$14,223,849 | \$14,863,922 | \$15,532,799 | \$16,231,775 | - | \$60,852,345 |
| 5. Moving Current Eligibles above 138% to Exchange | | | | | | | | |
| MEAD | | | | | | | | |
| Enrollees | 705 | 723 | 741 | 759 | 778 | 798 | 818 | |
| State savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Federal Savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Pregnant Women | | | | | | | | |
| Enrollees | 233 | 238 | 244 | 250 | 257 | 263 | 270 | |
| State savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| Federal Savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| 6. Net Impact | | | | | | | | |
| Change in Enrollment | 43,231 | 50,587 | 58,172 | 58,886 | 59,639 | 60,394 | 61,149 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$7,935,871 | -\$8,643,780 | -\$23,618,987 | -\$5,925,799 | -\$2,536,112 | \$1,065,669 | \$30,089,567 | -\$17,505,312 |
| Federal Cost | \$251,165,357 | \$300,601,982 | \$367,487,480 | \$361,120,269 | \$369,223,369 | \$377,289,686 | \$360,103,061 | \$2,386,991,205 |
| Subtotal | \$243,229,486 | \$291,958,203 | \$343,868,494 | \$355,194,470 | \$366,687,257 | \$378,355,355 | \$390,192,629 | \$2,369,485,893 |
| Administrative Costs | | | | | | | | |
| State Share | \$5,654,152 | \$6,786,908 | \$7,993,623 | \$8,256,908 | \$8,524,072 | \$8,795,310 | \$9,070,481 | \$55,081,455 |
| Federal Share | \$7,723,469 | \$9,270,793 | \$10,919,144 | \$11,278,787 | \$11,643,727 | \$12,014,234 | \$12,390,113 | \$75,240,269 |
| Subtotal | \$13,377,622 | \$16,057,701 | \$18,912,767 | \$19,535,696 | \$20,167,799 | \$20,809,545 | \$21,460,595 | \$130,321,724 |
| Total | | | | | | | | |
| State Share | -\$2,281,719 | -\$1,856,872 | -\$15,625,364 | \$2,331,109 | \$5,987,960 | \$9,860,979 | \$39,160,048 | \$37,576,143 |
| Federal Share | \$258,888,826 | \$309,872,775 | \$378,406,624 | \$372,399,057 | \$380,867,096 | \$389,303,921 | \$372,493,175 | \$2,462,231,475 |
| Subtotal | \$256,607,108 | \$308,015,904 | \$362,781,261 | \$374,730,166 | \$386,855,056 | \$399,164,900 | \$411,653,223 | \$2,499,807,617 |

Figure A-10: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020)
- Program Design Option - Option 7 + Transition Enrollees Out of Breast and Cervical Cancer Program Eligibility Category

| Expansion to 138% FPL | | | | | | | | |
|--|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|------------------------|
| FFS rates | | | | | | | | |
| Medium-range participation assumption | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth rate | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | 100,661 | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 58% | 58% | 58% | 58% | 58% | 58% | 58% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 44,683 | 52,153 | 59,856 | 60,607 | 61,400 | 62,193 | 62,989 | |
| PMPY Cost | \$5,799 | \$5,930 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$374,798,027 | \$387,152,140 | \$399,721,474 | \$412,516,868 | \$2,505,194,267 |
| FMAP | 100% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$18,739,901 | \$23,229,128 | \$27,980,503 | \$41,251,687 | \$111,201,220 |
| Subtotal - Federal Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$356,058,125 | \$363,923,012 | \$371,740,971 | \$371,265,181 | \$2,393,993,047 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 22% | 22% | 22% | 22% | 22% | 22% | 22% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,209 | 2,584 | 2,974 | 3,023 | 3,077 | 3,133 | 3,191 | |
| PMPY Cost | \$3,888 | \$3,991 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$8,586,402 | \$10,313,351 | \$12,182,342 | \$12,712,000 | \$13,282,655 | \$13,883,497 | \$14,514,395 | \$85,474,641 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| Subtotal - Federal Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. CHIP | | | | | | | | |
| State cost | - | - | -\$5,984,443 | -\$6,328,922 | -\$6,673,346 | -\$7,017,713 | - | -\$26,004,424 |
| Federal cost | - | - | \$5,984,443 | \$6,328,922 | \$6,673,346 | \$7,017,713 | - | \$26,004,424 |
| 5. Moving Currently Eligibles Above 138 Percent of FPL to HBE | | | | | | | | |
| MEAD | | | | | | | | |
| Enrollees | 705 | 723 | 741 | 759 | 778 | 798 | 818 | |
| State Savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Federal Savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Pregnant Women | | | | | | | | |
| Enrollees | 233 | 238 | 244 | 250 | 257 | 263 | 270 | |
| State Savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| Federal Savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| 6. Transition Enrollees Out of BCCP Eligibility Category | | | | | | | | |
| Enrollees | 245 | 251 | 257 | 264 | 270 | 277 | 284 | |
| State savings | \$1,823,448 | \$1,914,620 | \$2,010,351 | \$1,899,782 | \$1,950,442 | \$2,001,420 | \$1,954,875 | \$13,554,937 |
| Federal Savings | -\$1,823,448 | -\$1,914,620 | -\$2,010,351 | -\$1,899,782 | -\$1,950,442 | -\$2,001,420 | -\$1,954,875 | -\$13,554,937 |
| 7. Net Impact | | | | | | | | |
| Change in Enrollment | | | | | | | | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$9,759,318 | -\$10,558,400 | -\$25,629,337 | -\$7,825,581 | -\$4,486,554 | -\$935,751 | \$28,134,692 | -\$31,060,249 |
| Federal Cost | \$252,988,804 | \$302,516,602 | \$369,497,831 | \$363,020,051 | \$371,173,811 | \$379,291,106 | \$362,057,937 | \$2,400,546,143 |
| Subtotal | \$243,229,486 | \$291,958,203 | \$343,868,494 | \$355,194,470 | \$366,687,257 | \$378,355,355 | \$390,192,629 | \$2,369,485,893 |
| Administrative Costs | | | | | | | | |
| State Share | \$5,654,152 | \$6,786,908 | \$7,993,623 | \$8,256,908 | \$8,524,072 | \$8,795,310 | \$9,070,481 | \$55,081,455 |
| Federal Share | \$7,723,469 | \$9,270,793 | \$10,919,144 | \$11,278,787 | \$11,643,727 | \$12,014,234 | \$12,390,113 | \$75,240,269 |
| Subtotal | \$13,377,622 | \$16,057,701 | \$18,912,767 | \$19,535,696 | \$20,167,799 | \$20,809,545 | \$21,460,595 | \$130,321,724 |
| Total | | | | | | | | |
| State Share | -\$4,105,166 | -\$3,771,492 | -\$17,635,714 | \$431,328 | \$4,037,517 | \$7,859,559 | \$37,205,173 | \$24,021,205 |
| Federal Share | \$260,712,274 | \$311,787,395 | \$380,416,975 | \$374,298,838 | \$382,817,539 | \$391,305,341 | \$374,448,050 | \$2,475,786,412 |
| Total | \$256,607,108 | \$308,015,904 | \$362,781,261 | \$374,730,166 | \$386,855,056 | \$399,164,900 | \$411,653,223 | \$2,499,807,617 |

Figure A-11: Impact on New Hampshire Medicaid Spending if Medicaid is Expanded Under the ACA (2014-2020)
- Program Design Option - Option 8 plus Transition of Pregnant Women Below 138 Percent of FPL into "Newly Eligible" Category

| Expansion to 138% FPL | | | | | | | | |
|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|-----------------|
| FFS rates | | | | | | | | |
| Medium-range participation assumption | | | | | | | | |
| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
| 1. Cost of Newly Eligibles | | | | | | | | |
| Population growth rate | | 1.1% | 1.2% | 1.2% | 1.3% | 1.3% | 1.3% | |
| Projected Total Number of Newly Eligibles | 100,661 | 101,782 | 103,051 | 104,337 | 105,710 | 107,089 | 108,487 | |
| Take Up Rate | 58% | 58% | 58% | 58% | 58% | 58% | 58% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 44,683 | 52,153 | 59,856 | 60,607 | 61,400 | 62,193 | 62,989 | |
| PMPY Cost | \$5,799 | \$5,930 | \$6,059 | \$6,184 | \$6,305 | \$6,427 | \$6,549 | |
| Total Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$374,798,027 | \$387,152,140 | \$399,721,474 | \$412,516,868 | \$2,505,194,267 |
| FMAP | 100% | 100% | 100% | 95% | 94% | 93% | 90% | |
| Subtotal - State Cost | \$0 | \$0 | \$0 | \$18,739,901 | \$23,229,128 | \$27,980,503 | \$41,251,687 | \$111,201,220 |
| Subtotal - Federal Cost | \$259,101,227 | \$309,245,762 | \$362,658,768 | \$356,058,125 | \$363,923,012 | \$371,740,971 | \$371,265,181 | \$2,393,993,047 |
| 2. Cost of Currently Eligible but Not Enrolled | | | | | | | | |
| Population growth rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.8% | |
| Currently Eligible but Uninsured - Eligible | 12,915 | 13,110 | 13,321 | 13,546 | 13,787 | 14,033 | 14,288 | |
| Take Up Rate | 22% | 22% | 22% | 22% | 22% | 22% | 22% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Enrollment | 2,209 | 2,584 | 2,974 | 3,023 | 3,077 | 3,133 | 3,191 | |
| PMPY Cost | \$3,888 | \$3,991 | \$4,096 | \$4,205 | \$4,316 | \$4,431 | \$4,548 | |
| Total Cost | \$8,586,402 | \$10,313,351 | \$12,182,342 | \$12,712,000 | \$13,282,655 | \$13,883,497 | \$14,514,395 | \$85,474,641 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| Subtotal - Federal Cost | \$4,293,201 | \$5,156,676 | \$6,091,171 | \$6,356,000 | \$6,641,328 | \$6,941,748 | \$7,257,198 | \$42,737,321 |
| 3. Leave Medicaid for New Offer of Employer Coverage | | | | | | | | |
| Population Growth Rate | | 1.5% | 1.6% | 1.7% | 1.8% | 1.8% | 1.9% | |
| Lag Rate | 76% | 88% | 100% | 100% | 100% | 100% | 100% | |
| Disenrollment | 2,723 | 3,189 | 3,673 | 3,735 | 3,803 | 3,871 | 3,943 | |
| PMPY Cost | \$4,852 | \$4,952 | \$5,057 | \$5,166 | \$5,280 | \$5,398 | \$5,520 | |
| Total Savings | \$13,211,961 | \$15,792,420 | \$18,573,701 | \$19,296,695 | \$20,077,734 | \$20,896,321 | \$21,767,675 | \$129,616,508 |
| FMAP | 50% | 50% | 50% | 50% | 50% | 50% | 50% | |
| Subtotal - State Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| Subtotal - Federal Savings | \$6,605,981 | \$7,896,210 | \$9,286,851 | \$9,648,347 | \$10,038,867 | \$10,448,161 | \$10,883,838 | \$64,808,254 |
| 4. CHIP | | | | | | | | |
| State Savings | - | - | -\$5,984,443 | -\$6,328,922 | -\$6,673,346 | -\$7,017,713 | - | -\$26,004,424 |
| Federal Savings | - | - | \$5,984,443 | \$6,328,922 | \$6,673,346 | \$7,017,713 | - | \$26,004,424 |
| 5. Moving Current Eligibles Above 138 Percent of FPL to HBE | | | | | | | | |
| MEAD | | | | | | | | |
| Enrollees | 705 | 723 | 741 | 759 | 778 | 798 | 818 | |
| State Savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Federal Savings | \$4,725,483 | \$4,961,758 | \$5,209,846 | \$5,470,338 | \$5,743,855 | \$6,031,047 | \$6,332,600 | \$38,474,927 |
| Pregnant Women | | | | | | | | |
| Enrollees | 233 | 238 | 244 | 250 | 257 | 263 | 270 | |
| State Savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| Federal Savings | \$897,607 | \$942,488 | \$989,612 | \$1,039,093 | \$1,091,047 | \$1,145,600 | \$1,202,880 | \$7,308,327 |
| 6. Transition of Enrollees Out of BCCP Eligibility Category | | | | | | | | |
| Enrollees | 245 | 251 | 257 | 264 | 270 | 277 | 284 | |
| State savings | \$1,823,448 | \$1,914,620 | \$2,010,351 | \$1,899,782 | \$1,950,442 | \$2,001,420 | \$1,954,875 | \$13,554,937 |
| Federal Savings | -\$1,823,448 | -\$1,914,620 | -\$2,010,351 | -\$1,899,782 | -\$1,950,442 | -\$2,001,420 | -\$1,954,875 | -\$13,554,937 |
| 7. Attrition of Adult Pregnant Women Below 138 percent of FPL into "Newly Eligible" Category | | | | | | | | |
| Enrollees | 2,076 | 2,128 | 2,181 | 2,236 | 2,292 | 2,349 | 2,408 | |
| State Savings | \$5,426,306 | \$6,574,179 | \$7,823,273 | \$7,392,993 | \$7,590,139 | \$7,788,518 | \$7,607,390 | \$50,202,798 |
| Federal Savings | -\$5,426,306 | -\$6,574,179 | -\$7,823,273 | -\$7,392,993 | -\$7,590,139 | -\$7,788,518 | -\$7,607,390 | -\$50,202,798 |
| 8. Net Impact | | | | | | | | |
| Change in Enrollment | 40,910 | 40,829 | 40,746 | 40,660 | 40,572 | 40,482 | 40,389 | |
| Health Care Costs | | | | | | | | |
| State Cost | -\$15,185,625 | -\$17,132,578 | -\$33,452,610 | -\$15,218,574 | -\$12,076,694 | -\$8,724,269 | \$20,527,302 | -\$81,263,048 |
| Federal Cost | \$258,415,111 | \$309,090,781 | \$377,321,104 | \$370,413,044 | \$378,763,951 | \$387,079,624 | \$369,665,326 | \$2,450,748,941 |
| Subtotal | \$243,229,486 | \$291,958,203 | \$343,868,494 | \$355,194,470 | \$366,687,257 | \$378,355,355 | \$390,192,629 | \$2,369,485,893 |
| Administrative Costs | | | | | | | | |
| State Share | \$5,654,152 | \$6,786,908 | \$7,993,623 | \$8,256,908 | \$8,524,072 | \$8,795,310 | \$9,070,481 | \$55,081,455 |
| Federal Share | \$7,723,469 | \$9,270,793 | \$10,919,144 | \$11,278,787 | \$11,643,727 | \$12,014,234 | \$12,390,113 | \$75,240,269 |
| Subtotal | \$13,377,622 | \$16,057,701 | \$18,912,767 | \$19,535,696 | \$20,167,799 | \$20,809,545 | \$21,460,595 | \$130,321,724 |
| Total | | | | | | | | |
| State Share | -\$9,531,472 | -\$10,345,671 | -\$25,458,987 | -\$6,961,665 | -\$3,552,622 | \$71,041 | \$29,597,784 | -\$26,181,593 |
| Federal Share | \$266,138,580 | \$318,361,574 | \$388,240,248 | \$381,691,831 | \$390,407,678 | \$399,093,859 | \$382,055,440 | \$2,525,989,210 |
| Total | \$256,607,108 | \$308,015,904 | \$362,781,261 | \$374,730,166 | \$386,855,056 | \$399,164,900 | \$411,653,223 | \$2,499,807,617 |



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

An Evaluation of the Impact of Medicaid Expansion in New Hampshire

Phase II Report

Prepared by:

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The Lewin Group

January 2013

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- Bi-State Primary Care Association
- DHHS State Office of Rural Health
- New Hampshire Department of Corrections
- New Futures, Inc.
- New Hampshire Bureau of Behavioral Health
- New Hampshire Community Behavioral Health Association
- New Hampshire Hospital
- New Hampshire Insurance Department
- New Hampshire Medical Society

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Executive Summary

Following the June 2012 United States Supreme Court ruling on the Affordable Care Act (ACA), states now have the option to opt out of the Medicaid expansion provision of the ACA without compromising their current federal Medicaid funding. As a result of this ruling, The Lewin Group is working with the New Hampshire Department of Health and Human Services to explore the potential impacts of expanding versus not expanding its Medicaid program.

Phase I of the analysis, released in November 2012, provides estimates on Medicaid enrollment and costs under the option of not expanding Medicaid compared to the option of expanding Medicaid under various program design options. This report presents Phase II of the study, in which we estimate the impact of Medicaid expansion in areas outside of Medicaid, including other state programs, the uninsured, providers, the state economy, and the commercial health insurance market.

Summary of Phase I Analysis

In Phase I of this study, under a no expansion option, we estimate the state would save between \$65.8 and \$113.7 million between 2014 and 2020 due to effects of the ACA and depending on options to reduce eligibility levels to 138 percent of FPL for adults beginning in 2014, compared to pre-ACA projections. Under the expansion option, we estimate a cumulative increase in state Medicaid spending between \$38.0 and \$102.3 million between 2014 and 2020, depending on participation levels in the program, compared to projected pre-ACA spending.

The baseline assumptions that we use in Phase II of the study are outlined in *Figure E-1*, below. Without Medicaid expansion, we project \$65.8 million in savings to the state and \$55.8 million in cost to the federal government from 2014 to 2020. Total enrollment would increase by 175 in 2020. Under Medicaid expansion, we estimate an \$85.5 million cost to the state and a \$2.5 billion cost to the federal government from 2014 to 2020. Total enrollment would increase by about 62,200 by 2020. For both scenarios, it is important to note that additional federal spending becomes designated revenue for the state. These federal dollars will be used to cover the cost of implementing ACA provisions in New Hampshire, and will cover the full cost of insuring the newly eligible population through 2016 under Medicaid expansion.

Figure E-1. Summary of Phase I Baseline Scenarios, 2014-2020, in \$1000s

| Scenario | Cost to State (2014-2020) in \$1,000s | Cost to Federal Government (2014- 2020) in \$1,000s | Total Change in Enrollment (2020) |
|--------------|--|---|---|
| No Expansion | (\$65,779.6) | \$55,845.0 | 175 |
| Expansion | \$85,488.0 | \$2,510,922.3 | 62,237 |

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model.

Impact on Other State Programs

Collectively, the total savings realized to other state programs under Medicaid expansion, such as the current state high risk pool and the state corrections department, would equate to \$67.1 million over the 2014 to 2020 period, assuming a fee-for-service (FFS) program. Under a managed care program, a Premium Assessment tax totaling \$49.4 million from 2014 to 2020 would serve as revenue to the State General Fund. These savings are summarized in **Figure E-2** below. Using our baseline assumptions provided in Phase I and our estimated offsets in Phase II, under a FFS program, the cumulative state cost of expanding Medicaid would total \$18.4 million from 2014 to 2020, compared to pre-ACA projections (**Figure E-3**); however, costs could be further reduced under alternative design options. If the state opts to expand Medicaid under a managed care program, then the premium assessment tax would add an additional \$49.4 million in offsets to the State General Fund, for a total offset of \$116.6 million over this period.

Figure E-2. Summary of Total Offsets within Other State Programs Due to Medicaid Expansion, in \$1,000s (2014-2020)

| | Total Offset |
|--|---------------------|
| State Employee Health Benefits | \$27,429 |
| State High Risk Pool | \$0 |
| State Corrections Department | \$21,782 |
| State Funding for Cypress Center | \$4,725 |
| Increased State Revenue ^{1/} | \$13,200 |
| Total Offsets Under FFS | \$67,136 |
| Premium Assessment ^{2/} | \$49,434 |
| Total Offset Under Managed Care | \$116,570 |

1/ See "State Economic Impact" section for detailed analysis and explanation

2/ Premium Assessment only applicable if Medicaid expansion is implemented within a managed care program

Figure E-3. Summary of Total Cost of Expansion with Offsets, in \$1,000s (2014-2020)^{1/}

| Scenario | Cost to Federal Government (2014-2020) in \$1,000s | Cost to State (2014-2020) in \$1,000s | Offsets to State Costs (2014-2020) in \$1,000s | Net Cost to State (2014-2020) in \$1,000s |
|-----------------|---|--|---|--|
| No Expansion | \$55,845.0 | (\$65,779.6) | \$0 | (\$65,779.6) |
| Expansion | \$2,510,922.3 | \$85,488.0 | \$67,136.0 | \$18,352.0 |

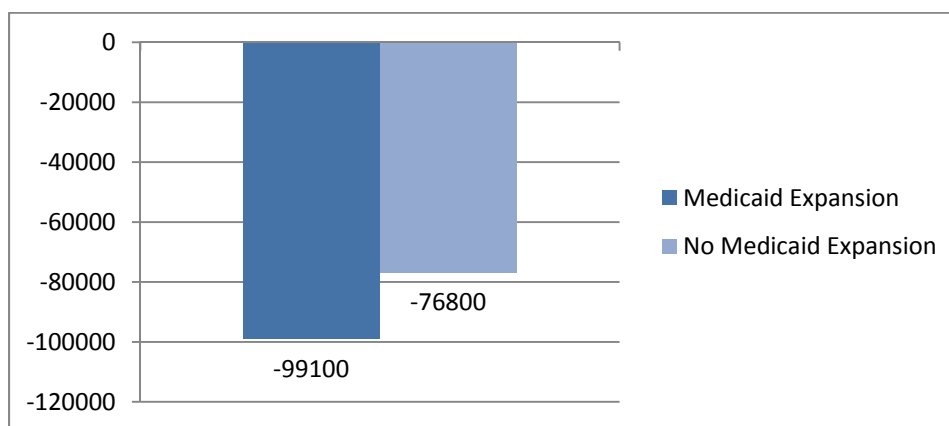
Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model

1/Assumes a FFS program

Impact on the Uninsured

In considering whether or not to expand the state's Medicaid program, it is important to consider the impact that expanding or not expanding Medicaid may have on individuals and families. Taking into account all other provisions of the ACA, our estimates show that if the state expands Medicaid, the number of uninsured would be reduced by 99,100 (*Figure E-4*) compared to pre-ACA uninsurance rates. Thus, the number of uninsured in New Hampshire would be approximately 71,000 with Medicaid expansion. Absent an expansion, the number of uninsured would be reduced by 76,800 (*Figure E-4*) compared to pre-ACA uninsurance rates, bringing the number of uninsured in New Hampshire to 93,200.

Figure E-4. Reduction in Number of Uninsured under the ACA in New Hampshire in 2014 ^{1/}

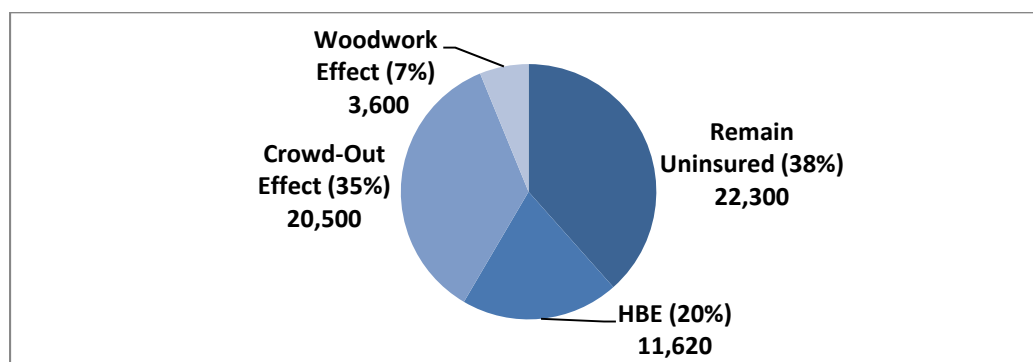


1/ Assumes all provisions of the ACA are fully implemented in 2014.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

Additionally, we estimate that under Medicaid expansion, approximately 58,000 individuals will enroll in Medicaid. In absence of Medicaid expansion, under the ACA, we estimate that 38 percent of these individuals would remain uninsured, 20 percent would go into the Health Benefits Exchange (HBE), 35 percent would remain under private coverage, and seven percent (who were previously eligible but unenrolled) would have enrolled in Medicaid due to the individual mandate (*Figure E-5*).

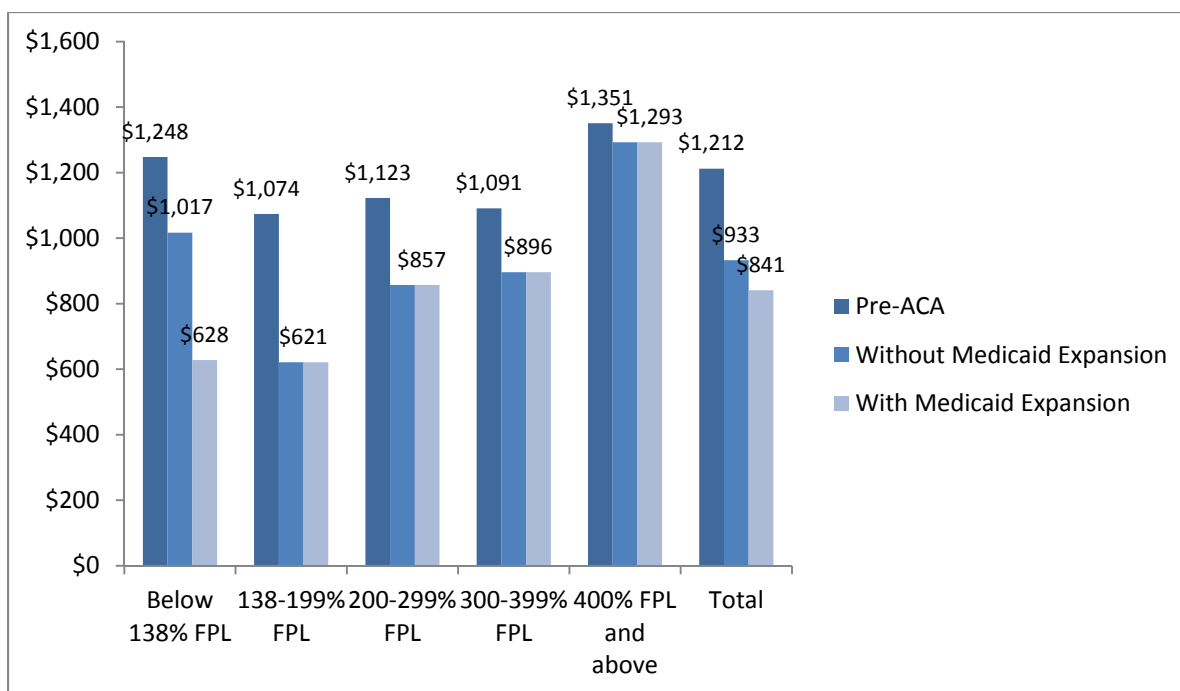
Figure E-5. Insurance Status of the 58,000 Individuals Who Would Enroll under Medicaid Expansion, in the Absence of Expansion (2014-2020)



Under Medicaid expansion, the reduction in number of uninsured will vary by geographic area. Hillsborough and Rockingham Counties will see the largest absolute reductions in the uninsured under Medicaid expansion.

Additionally, without expansion, those remaining uninsured will continue to strain the finances of other public health programs and safety net providers for their care, while likely forgoing or reducing necessary care and risking a drain on personal finances. With Medicaid expansion, the average out-of-pocket spending per uninsured person would decline by \$372 to a total of \$841, compared to a decline of \$219 for a total of \$993 under the ACA without Medicaid expansion. This out-of-pocket spending will vary based on family income, as shown in *Figure E-6*, below.

Figure E-6. Out-of-Pocket Health Spending for Uninsured in New Hampshire in 2014 ^{1/}



1/ Assumes all provisions of the ACA are fully implemented in 2014.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

Impact on Providers

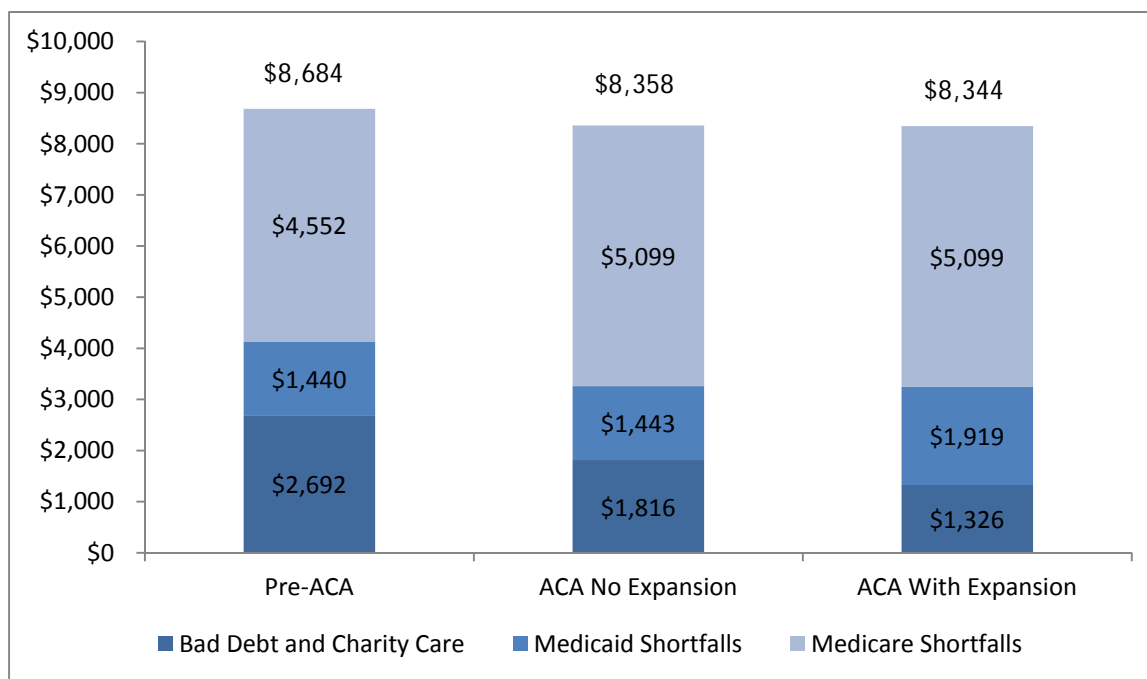
Expanding or not expanding Medicaid will have a measurable impact on a number of provider groups. Much of this will be reflective of reductions in uncompensated care as a result of more people having health coverage.

We estimate that by 2020, Medicaid hospital and Institute for Mental Disease DSH payments will total \$101.9 million, \$50.9 million of which will be federal funds. We estimate that New Hampshire's federal DSH allotment will drop to \$92.0 million in 2020. However, this will still be more than what is needed to match the uncompensated care pool (UCP). Thus, we estimate that

the ACA Medicaid DSH cuts will not affect the Medicaid DSH payments to New Hampshire hospitals assuming that the current payment methodology continues through 2020¹.

Using the Lewin Group Health Benefits Simulation Model for the state of New Hampshire and data provided by the New Hampshire Hospital Association (NHHA), we estimate uncompensated care (bad debt, charity care, and undercompensated care due to below-cost Medicare and Medicaid payments) for New Hampshire health systems, which include the hospital as well as other entities owned by the system, such as physician groups, skilled nursing facilities, freestanding surgical centers and home health agencies. Here, health systems in the state could see uncompensated care reduced by about \$340 million (4 percent) under the ACA with or without the Medicaid expansion (*Figure E-7*). This is due to the take-up of commercial coverage anticipated in reaction of the individual mandate.

Figure E-7. Total Uncompensated Care for New Hampshire Health System Under the ACA With and Without the Medicaid Expansion, in Millions (2014-2020)



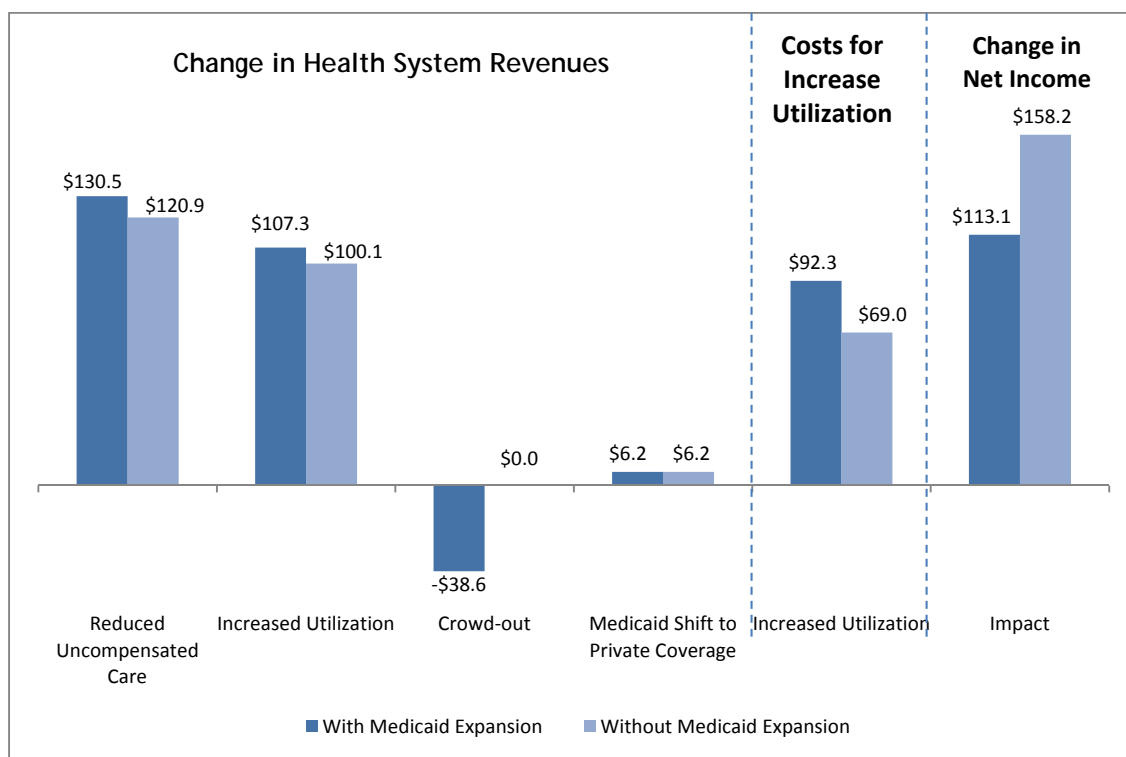
Source: Lewin Group analysis using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

As shown in *Figure E-8*, we estimate that health systems would see an increase in net income of about \$113.1 million under the Medicaid expansion assuming full implementation in 2014, which would represent a 28 percent increase from their current net income. However, due to more people being enrolled in private insurance in the absence of the expansion, we estimate

¹ Current methodology assumes continuation of the Medicaid Enhancement Tax (MET) assessed on net patient service revenue. Thirteen percent of the anticipated MET revenue is placed in the Uncompensated Care Fund (UCF), for which federal matching funds are drawn down up to the state's allotment. Payments from the UCF are distributed to New Hampshire hospitals, with priority given to Critical Access Hospitals.

that health system net income would increase by \$158.2 million. Under no Medicaid expansion, although health systems would see more of an improvement in their bottom line net income, they would provide a greater volume of uncompensated care than if Medicaid is expanded. This is under the assumption that current DSH distribution stays as-is.

Figure E-8. Impact on New Hampshire Health System Revenues Under the ACA With and Without the Medicaid Expansion

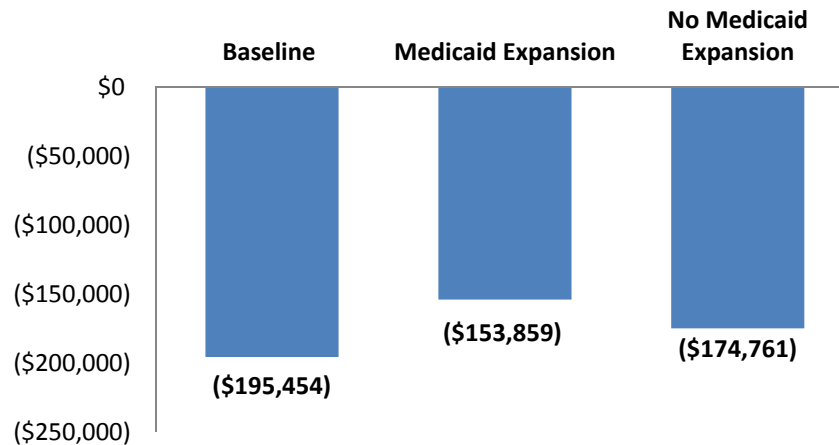


1/ Assumes that all provisions of the ACA are fully phased in, but illustrations in 2011 dollars.
Source: Lewin Group analysis using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Additionally, because we find that the ACA reductions in federal Medicaid DSH allotments will not affect DSH payments in New Hampshire over the next several years, additional state funds will not be needed to cover costs for the New Hampshire Hospital (NHH) – the primary Institute for Mental Disease (IMD) in the state.

In considering impact on federally qualified health centers (FQHCs), dramatic reductions in uncompensated care would occur with expansion (\$9 million reduction) and without expansion (\$6 million reduction), in 2011 dollars. From 2014 to 2020, cumulative FQHC shortfalls for uninsured recipients would drop from a baseline of \$104.6 million to \$26.4 million under the ACA with Medicaid expansion compared to \$50.8 million without expansion. Across all payer categories, from 2014 to 2020, cumulative FQHC shortfall would drop from a pre-ACA projected baseline of \$195.5 million to \$153.9 million under Medicaid expansion, while the shortfall would drop by a lesser amount (to \$174.8 million) under no expansion (*Figure E-9*).

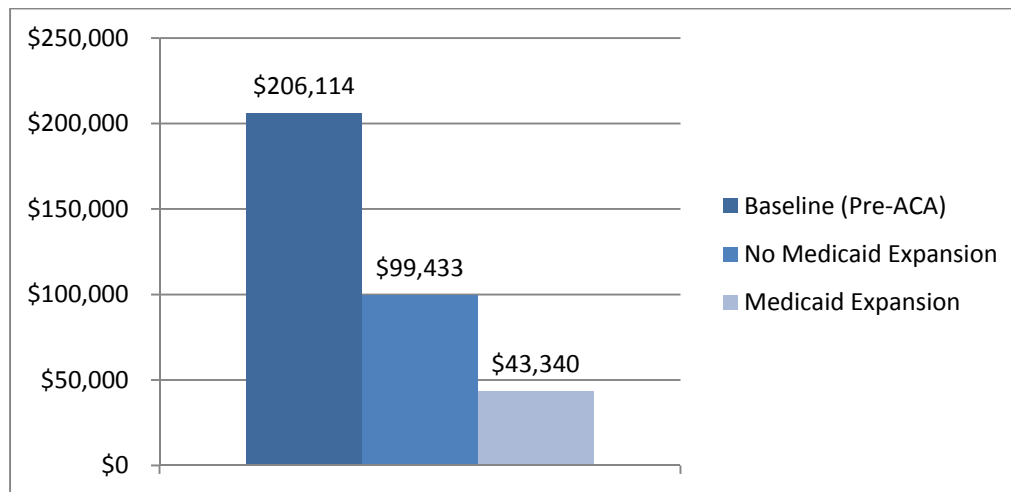
Figure E-9. Cumulative Shortfall for FQHCs Across All Payer Categories 2014-2020 (\$1,000s)



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM) and UDS data.

In considering the impact on the state's ten Community Mental Health Centers (CMHCs), we estimate that CMHCs would see a \$162.8 million reduction in uncompensated care during the 2014 to 2020 period (*Figure E-10*). Without an expansion, a smaller reduction (\$106.7 million) will occur, largely due to effects of other provisions of the ACA.

Figure E-10. Cumulative Uncompensated Care for CMHCs 2014-2020 (\$1,000s)



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

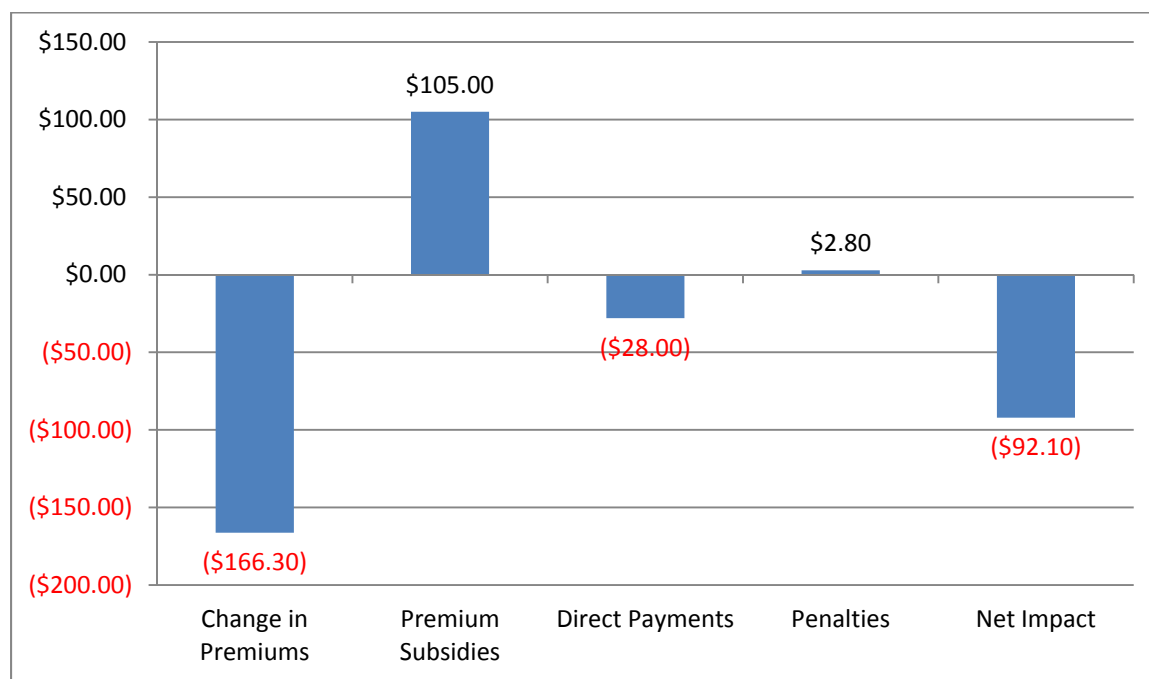
Economic Impact

Both the expansion and no expansion scenarios under the ACA will result in increased revenue for providers in the hospital, physician/clinic, and pharmacy sectors. For hospitals, providers will gain lesser revenue under expansion, while physician, clinic, and pharmacy providers will see greater gains under Medicaid expansion. In total, providers will experience an estimated \$3.5 billion gain in revenue under expansion and a \$3.3 billion gain in revenue under no

expansion from 2014 to 2020, compared to pre-ACA projections; here, compared to the expansion option, providers would lose \$158.3 million in revenue from 2014 to 2020 without expansion.

The decision to expand or not expand Medicaid will also affect household spending in New Hampshire. As shown in *Figure E-11*, under Medicaid expansion, households will spend less on premiums, but under no expansion, there will be higher subsidies as more individuals obtain coverage through the Health Benefits Exchange (HBE). Also, because private coverage will require higher cost-sharing than Medicaid, without expansion, households will spend more on direct payments to providers. In total, under Medicaid expansion, we estimate that New Hampshire households will save a total of \$92.1 million, or about \$145 per year, on average.

Figure E-11. Impact of Medicaid Expansion on Household Health Spending, compared to no Expansion (in millions)



Using these inputs, we estimate changes in total employment, gross state product (GSP), personal income, and state revenue under expansion and no expansion, compared to a pre-ACA projected baseline.

Over the 2014 to 2020 analysis period, New Hampshire gains an average of 5,100 jobs under Medicaid expansion compared to a 4,400 gain under no expansion; this translates to about 700 more jobs across all sectors under expansion, compared to no expansion.

Over the same 2014 to 2020 period, we estimate that under Medicaid expansion, the state will see a \$2.8 billion increase in GSP, compared to a \$2.5 billion increase under no expansion (*Figure E-12*). Personal income will also increase under both scenarios – an increase of \$2.3 billion under expansion and an increase of \$2.1 billion under no expansion, from 2014 to 2020. In 2014, gains in personal income translate to about \$102 per capita under expansion and \$91 per capita under

no expansion. Additionally, the state will gain new tax revenues under both scenarios, spurred by economic growth, but will see a greater increase under expansion compared to no expansion (\$127 million and \$114 million, respectively); this translates into an offset of \$13.2 million if the state elects to expand Medicaid.

Figure E-12. Cumulative Change in GSP, Personal Income, and State Revenue from baseline, 2014-2020, in millions

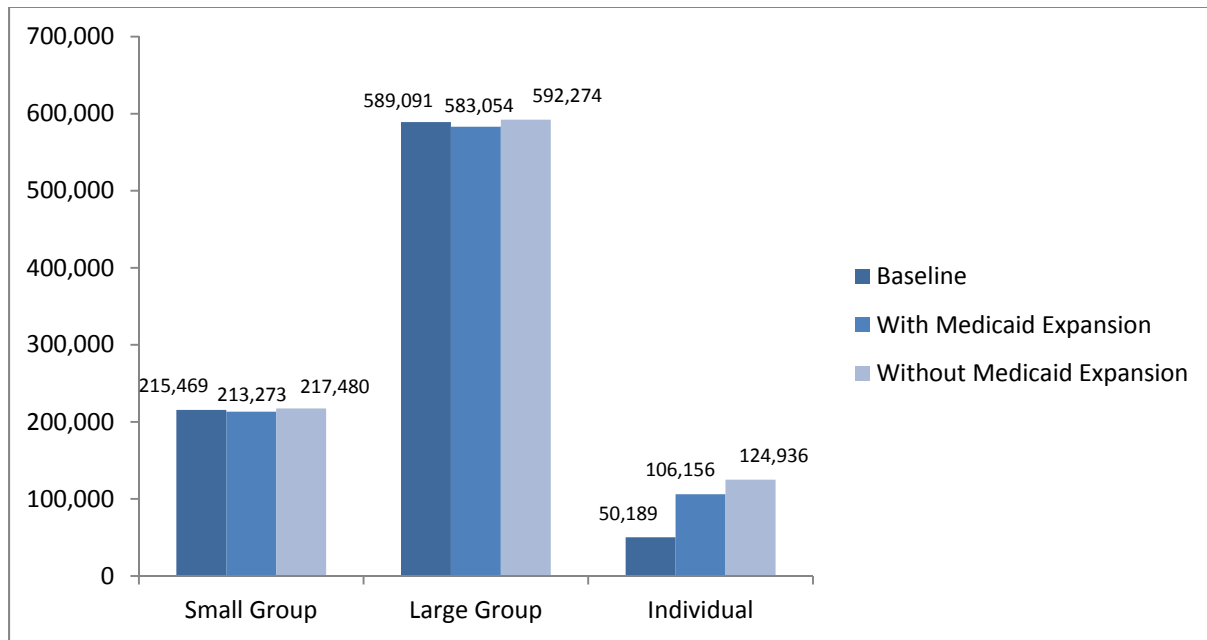
| | Change in GSP | Change in Personal Income | Change in State Revenue |
|---------------------|---------------|---------------------------|-------------------------|
| Expansion | \$2,839.05 | \$2,346.30 | \$127.32 |
| No Expansion | \$2,450.78 | \$2,069.38 | \$114.13 |
| Difference | \$388.27 | \$276.92 | \$13.20 |

Impact on Commercial Market

Providers must find financial support to cover costs when payment received for services falls short. This phenomenon is often referred to as “cost-shifting,” and represents an attempt by providers to offset a portion of unpaid costs of care from one patient population through above-cost charges and revenues from other patient populations. In response to higher charges by providers, insurers may, theoretically, shift a portion of the additional cost burden onto members, which is then reflected through increased premiums. Under either Medicaid expansion or no expansion, we estimate that reduced costs of uncompensated care and undercompensated care to be an insignificant portion of annual total premiums paid by private individual market and employer market insurance holders. Under the assumption that 50 percent of this reduced uncompensated and undercompensated care would have been cost-shifted to private insurance members in the form of an insurance premium increase, we estimate an approximate 0.37 percent decrease to private market premiums under Medicaid expansion. In the absence of expansion, we estimate the effect will even milder, a potential 0.34 percent decrease in private market premiums.

Source of coverage in the commercial market will also be affected by Medicaid expansion, as members shift from small group, large group, and individual coverage to other sources of coverage. Here, small group and large group coverage will see minimal reductions in enrollments under Medicaid expansion. The individual market will see significant growth in enrollment under Medicaid expansion, and even larger growth under no expansion, as fewer people who currently have individual coverage will leave for Medicaid and more uninsured will seek individual coverage since subsidies will be available for those between 100 and 138 percent of FPL.

Figure E-13. Commercial Market Enrollment in 2014 under ACA



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In the small and large group markets, average allowed costs will be reduced by small amounts under both Medicaid expansion and no expansion. In the individual market, however, average allowed costs would increase significantly under ACA, from \$339 in the current individual market, to \$464 under Medicaid expansion and \$471 under no expansion (*Figure E-13*).

In sum, expanding or not expanding Medicaid will have impacts beyond the state's Medicaid program itself. A decision to expand Medicaid will offset costs to other state programs, thus reducing the total state cost of implementing Medicaid expansion. The ACA and Medicaid expansion will also have measurable positive impacts on the state economy at large. Additionally, the impact on the uninsured, on providers, and on the commercial market should also be realized, as the decision to expand Medicaid affects these stakeholders and subgroups in very different ways.

I. Introduction

In March 2010, the United States Congress passed the Patient Protection and Affordable Care Act (ACA), a sweeping piece of legislation designed to overhaul the country's health care system and extend health insurance to millions of uninsured Americans. The law includes several approaches to accomplish this goal, including the establishment of Health Benefit Exchanges (HBEs), insurance market reforms, an individual mandate to obtain coverage, subsidized health insurance, and a mandate for large employers to offer health insurance. One of the key provisions of the Act was a mandatory expansion of Medicaid in all 50 states and the District of Columbia.

As originally written, each state was required to expand its Medicaid program to cover all adults under age 65 whose household incomes are less than or equal to 138 percent of the federal poverty level (FPL) or face losing all federal funding for their Medicaid programs. For these newly eligible individuals, the federal government would cover 100 percent of the health care costs between 2014 and 2016. This percentage would gradually decrease from 100 percent to 90 percent between 2017 and 2020.

However, in June 2012, the U.S. Supreme Court ruled that the federal government could not require individual states to expand their Medicaid programs for adults and declared this part of the ACA unconstitutional. States will now have the option to opt out of the Medicaid expansion provision of the Act without compromising their current federal Medicaid funding.

The New Hampshire Department of Health and Human Services contracted with The Lewin Group to explore the financial impacts of Medicaid expansion in the state of New Hampshire. In November, Lewin completed a Phase I report detailing the impact of expanding versus not expanding Medicaid on New Hampshire's Medicaid program and provided estimates on Medicaid enrollment and costs under various program design options.

This report, representing Phase II of The Lewin Group's analysis of Medicaid expansion in New Hampshire, will discuss the secondary effects on other state health programs, health care providers, commercial premiums, and the overall state economy. In particular, we will examine the following:

- ***Impact on State Health Programs:*** We will explore the ways in which Medicaid expansion will affect state employee health coverage, the state's high risk pool, the state corrections department, and indigent care funding for behavioral health. Offsets in these areas may reduce the total cost of expansion to the state.
- ***Impact on the Uninsured:*** We will explore changes in the numbers of uninsured individuals, including changes at the county-level, shifts in family health spending for the uninsured, and the potential impact on individual bankruptcies.
- ***Impact on Providers:*** We will look at the impact of the ACA on Disproportionate Share Hospital (DSH) payment reductions and the effects of expansion on hospitals and health systems, community health centers, community mental health centers, and institutions for mental disease.

- ***Economic Impact:*** We will discuss the broader economic impact of choosing to expand versus not expand Medicaid in the state, including the impact on jobs, gross state product (GSP), personal income, and tax revenue.
- ***Impact on Commercial Market:*** Lastly, we will explore the impact on commercial insurance markets in the state and the potential impact of cost shifting to private insurance.

The methodology used to produce these impact estimates is described in detail within the final section of the report.

II. Summary of Phase I Analysis

Phase I of this analysis offers details on the aspects of the ACA that will require changes to the state's current program, regardless of the decision to expand or not expand Medicaid, including reforms to the individual insurance markets by eliminating pre-existing condition exclusions, guarantees of coverage and renewability of coverage, the establishment of HBEs, an individual mandate, subsidized health insurance for people between 100 and 400 percent of FPL, and a mandate for large employers to offer health insurance. The ACA also provides states with a 23 percentage point increase to the enhanced Federal Medical Assistance Percentage (FMAP) rate for CHIP beginning in federal fiscal year 2016. We estimated the state would save \$61.0 million between 2016 and 2019, assuming that the state would have continued the CHIP program in the absence of the ACA. These savings are incorporated into both expansion and no expansion cost estimates.

Figure 1 provides a summary of the state and federal costs of 11 program design options. Under each scenario, the costs to the federal government largely translate to designated revenues for the state. Under a no expansion option, we estimate the state would save between \$65.8 and \$113.7 million between 2014 and 2020 due to the other effects of the ACA and depending on options to reduce eligibility levels to 138 percent of FPL for adults beginning in 2014. This is compared to projected spending in the absence of the ACA. Under no expansion, we estimate a baseline option, as well as an option to move those currently eligible above 138 percent of FPL in certain eligibility categories (Medicaid for Employed Adults with Disabilities and poverty-level pregnant women) to the HBE, where they will be eligible for subsidized private insurance coverage. Total enrollment under the latter option would decrease by 913 individuals by 2020, compared to pre-ACA enrollment projections.

Figure 1. Summary of the State and Federal Cost of Various Options for Expanding Medicaid in New Hampshire, Compared to No ACA (2014-2020)

| Scenario | Cost to State (2014-2020) in \$1,000s | Cost to Federal Government (2014- 2020) in \$1,000s | Total Change in Enrollment (2020) |
|--|--|---|---|
| No Expansion: | | | |
| 1. Baseline | (\$65,779.6) | \$55,845.0 | 175 |
| 2. Moving Current Eligibles Above 138 of Percent FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | (\$113,691.4) | \$7,154.1 | (913) |
| Expansion: | | | |
| 1. Baseline | \$85,488.0 | \$2,510,922.3 | 62,237 |
| 2. Low-Range Participation Assumption | \$38,009.2 | \$1,952,472.0 | 47,565 |
| 3. High-Range Participation Assumption | \$102,333.2 | \$2,709,057.8 | 67,443 |
| 4. Managed Care Rates | \$69,470.2 | \$2,501,073.5 | 62,237 |
| 5. Delay Implementation by One Year | \$79,384.2 | \$2,158,931.0 | 62,237 |
| 6. Delay Implementation by Two Years | \$71,165.5 | \$1,797,367.2 | 62,237 |

| Scenario | Cost to State (2014-2020) in \$1,000s | Cost to Federal Government (2014- 2020) in \$1,000s | Total Change in Enrollment (2020) |
|--|--|---|---|
| 7. Move Current Eligibles Above 138 of Percent FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | \$37,576.1 | \$2,462,231.5 | 61,149 |
| 8. Option 7 plus Transition Enrollees out of Breast and Cervical Cancer Program Eligibility Category | \$24,021.2 | \$2,475,786.4 | 61,149 |
| 9. Option 8 plus Transition of Pregnant Women Below 138 Percent of FPL into "Newly Eligible" Category | (\$26,181.6) | \$2,525,989.2 | 61,149 |

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model.

Under the expansion option, we estimate a cumulative increase in state Medicaid spending between \$38.0 and \$102.3 million between 2014 and 2020, depending on participation levels in the program, compared to projected pre-ACA spending. This assumes Medicaid is expanded to all adults below 138 percent of FPL beginning January 2014. The expansion would also result in additional federal funding between \$1.8 billion and \$2.7 billion over this period.

The report discusses baseline, low-range, and high-range participation assumptions. The baseline "midpoint" assumption is estimated to cost the state approximately \$85.5 million and result in an increase in enrollment of 62,237 by 2020. New Hampshire also has the option of implementing the expansion under a managed care arrangement, which would cost about \$69.5 million with the same increase in enrollment--\$16 million less than the baseline participation expansion option.

If the state decides to expand its Medicaid program, it can choose to delay implementation by one or two years and still be eligible for the enhanced federal match. However, 100 percent federal match rates will only be available between 2014 and 2016, and thus, the state would forgo significant federal revenue during this period of delay. By delaying implementation for one year (starting in 2015), the state would spend about \$79.4 million, a savings of approximately \$6.1 million compared to a January 2014 start date. Delaying implementation for two years (starting in 2016) would save the state about \$14.3 million compared to a January 2014 start date.

Finally, the Phase I report explored various options for limiting eligibility for current groups of adults who are above 138 percent of FPL, as these individuals will be eligible to receive subsidized coverage in the HBE. Potential categories include the Medicaid for Employed Adults with Disabilities (MEAD) program and poverty-level pregnant women. The state can also transition enrollees out of the Breast and Cervical Cancer Program, allowing these individuals to be covered under the newly eligible group at enhanced federal matching rates. Under these options, the cost to the state ranges from a savings of \$26.2 million to an additional cost of \$37.6 million, compared to pre-ACA projections.

III. Phase II Analysis and Results

In our Phase II analyses, we estimate the impact of expanding or not expanding Medicaid across five different areas: other state programs, the uninsured, providers, the state economy, and the commercial market. The results of our analyses are presented below.

A. Impact on Other State Programs

Currently, New Hampshire provides services and/or coverage to many low-income individuals who do not qualify for Medicaid under current eligibility criteria. Most of these individuals will be enrolled in the Medicaid expansion and the cost for these services will be paid by Medicaid, which are counted in Phase I. Thus, other state agencies will no longer need to pay for this care, which will result in a savings to the state and is counted as an offset to the state's cost of the Medicaid expansion.

Programs and areas where the state could see savings include state employee coverage, the state high-risk pool, the state Department of Corrections, and the Cypress Center. Under a managed care arrangement, a premium assessment tax would provide revenue to the State General Fund, which would serve as an offset to the state cost of expansion.

Furthermore, as individuals come forward to take advantage of new coverage opportunities created by the Affordable Care Act, some may learn in the process that they qualify for other public programs, such as the Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps) or child care assistance.² Although enrollment in such programs is not automatic, these programs may experience a boost in enrollment following implementation of a potential expansion as individuals elect to enroll themselves or family members. The fiscal effect of this dynamic, often referred to as the “woodwork effect” or “welcome mat effect,” will depend on the funding resources the programs draw upon and whether any additional state funding is required.

1. State Employee Coverage

Our analysis estimates that about 14,600 public and private sector employees and their dependents would become covered under the Medicaid expansion, who would have otherwise been covered by their employers in the absence of the expansion. This includes about 200 state employees who would have been covered under the state's employee health benefits plan. As these employees and their dependents become covered under Medicaid expansion, the state would no longer pay its share of the premium for these workers. As a result, we estimate a savings to the state of \$27.4 million between 2014 and 2020 (*Figure 2*).

² SNAP eligibility is dependent on general and financial requirements based on household income, household resources, and household expenses. SNAP is a predominantly federally-funded program. The state is only responsible for administrative expenses. Child care assistance (NH Child Care Scholarship) may be available to parents who are working, looking for work, or enrolled in a training program. Gross family income is used to determine eligibility, and may not exceed 250 percent of federal poverty guidelines for qualifying parents.

2. State High-Risk Pool

The New Hampshire Health Plan (NHHP) is a high-risk pool that provides health insurance coverage to about 2,800 residents who otherwise may have trouble obtaining insurance. In 2011, the average annual cost per member was \$9,800 and was funded through premiums paid by enrollees and assessments on health plans. In 2014, it is anticipated that NHHP members will be enrolled in private health plans in the HBE or in Medicaid expansion, depending on the member's family income. If Medicaid is not expanded, we assume that NHHP members with income below 100 percent of FPL would be enrolled in private health plans in the HBE at a community rated premium but without the aid of federal premium subsidies. This is assuming that this group of individuals will continue to need health insurance coverage, and are willing to acquire coverage at a relatively high cost with respect to income, as they had been prior to 2014. When enrolled in the HBE, however, these individuals will likely enjoy savings if the HBE community rated premiums are lower than in the NHHP. Since all NHHP members will be moved to another source of coverage with or without the Medicaid expansion, we estimate that savings will not be solely attributable to the expansion. .

3. State Corrections Department

In 1997, a federal rule was adopted that permits Medicaid to cover health care costs for inmates admitted to an inpatient facility overnight, assuming that inmate is otherwise eligible for Medicaid. However, few states have taken full advantage of this rule because most inmates, including those in New Hampshire, do not qualify for Medicaid under current eligibility criteria. Thus, these costs are currently endured by the state.

However, in 2014, if New Hampshire elects to expand Medicaid, inmates who leave the prison for over 24 hours and are admitted for inpatient services will become eligible for Medicaid under the new eligibility criteria and Medicaid will cover services for the duration of the inpatient stay. This applies to all inmates "admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility that is not part of the state or local correctional system."³ Additionally, as "newly eligibles," the federal government will pay for 100 percent of incurred inpatient costs through 2016, which would gradually decrease until leveling off at 90 percent in 2020 and all years to follow. This will result in significant savings to the state corrections department.

Using FY 2011 prison inmate medical expenditure data provided by the New Hampshire Department of Corrections, we estimate the state corrections department would save \$21.8 million over the 2014 to 2020 period as a result of Medicaid now covering these inpatient costs (*Figure 2*).

Also under expansion, as offenders transition out of the prison setting and into the community, former inmates would no longer struggle to gain access to coverage, as most would qualify for Medicaid immediately upon release as a "newly eligible." They then can avoid gaps in

³ NACO (2012 March). County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage. Retrieved from http://www.naco.org/programs/csd/Documents/Health%20Reform%20Implementation/County-Jails-HealthCare_WebVersion.pdf

coverage and care that are commonplace today upon release from incarceration, which can negatively impact successful transition into the community. Under the ACA, mental health and substance use disorder services, including behavioral health treatment, is considered an “essential health benefit,” meaning this must be covered under all health plans, including Medicaid for the expansion group. Given that the prison population faces a disproportionate burden of mental illness and substance abuse, access to these health care services may increase use of services and ultimately prevent individuals from future imprisonment. Here, research suggests that as a result of increased access to mental health and substance abuse services, New Hampshire may experience measurable reductions in recidivism as a result of Medicaid expansion and thus, reductions in costs associated with maintaining those prisoners. It is also likely that Medicaid expansion will result in savings from individuals who avert imprisonment all together.

4. State Spending for Behavioral Health

The New Hampshire Bureau of Behavioral Health cited that an annual sum of \$675,000 is contributed by the state towards providing indigent care for patients at the Cypress Center, a short-term crisis stabilization facility run by The Mental Health Center of Greater Manchester. These funds are contributed towards providing uncompensated ad hoc and medical services for patients at the facility, and may potentially be eliminated if covered under provisions of the ACA. Assuming that the state will no longer need to contribute this annual allotment between 2014 and 2020, it will save an additional \$4.7 million, as shown in *Figure 2*.

5. Additional Offsets

A two percent premium assessment will be levied on all participating health plans contracted under the state’s Medicaid managed care program, if the state chooses to implement Medicaid expansion under a managed care arrangement (Care Management). The premium assessment will be an assessed fee of two percent on premiums borne by the federal government and the state. All revenue from this tax would be paid to the State General Fund, and thus, would serve as an additional offset to the state under Medicaid expansion. *Figure 2* summarizes the total additional revenues from the two percent premium assessment under Medicaid expansion, assuming a managed care arrangement, compared to no expansion. From 2014 to 2020, these revenues would equate to a total of \$49.4 million.

Additionally, a premium assessment may also be applied to participating health plans in the Health Benefit Exchange. This would be an assessed fee on all commercial premiums and would become a source of incoming revenue for the state Insurance Department regardless of whether the state decides to expand. However, these are not estimated for this report.

6. Total Offsets to State

Collectively, the total savings realized for other state programs under Medicaid expansion would equate to \$67.1 million over the 2014 to 2020 period, assuming a fee-for-service program. Under a managed care program, offsets under Medicaid expansion would total \$116.6 million when premium assessment tax revenue is included. These savings are summarized in *Figure 2* below.

Figure 2. Summary of Total Offsets Within Other State Programs Due to Medicaid Expansion, in \$1,000s (2014-2020)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|---|----------|----------|----------|----------|----------|----------|----------|-----------|
| State Employee Health Benefits | \$2,597 | \$3,188 | \$3,840 | \$4,070 | \$4,314 | \$4,573 | \$4,847 | \$27,429 |
| State High Risk Pool | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| State Corrections Department | \$2,714 | \$2,877 | \$3,050 | \$3,072 | \$3,222 | \$3,379 | \$3,467 | \$21,782 |
| State Funding for Cypress Center | \$675 | \$675 | \$675 | \$675 | \$675 | \$675 | \$675 | \$4,725 |
| Increased Tax Revenue | \$670 | \$1,540 | \$1,940 | \$2,180 | \$2,250 | \$2,280 | \$2,340 | \$13,200 |
| Total Offsets Under FFS | \$6,656 | \$8,280 | \$9,505 | \$9,997 | \$10,461 | \$10,907 | \$11,329 | \$67,136 |
| Premium Assessment^{1/} | \$5,404 | \$6,103 | \$7,139 | \$7,359 | \$7,582 | \$7,808 | \$8,037 | \$49,434 |
| Total Offsets Under Managed Care | \$12,060 | \$14,383 | \$16,644 | \$17,356 | \$18,043 | \$18,715 | \$19,366 | \$116,570 |

1/ Premium Assessment only applicable if Medicaid expansion is implemented within a managed care program.

The combined results of the Phase I and Phase II analyses show that the net savings to the state without Medicaid expansion will range from a \$65.8 million to \$113.7 million, depending on the design option. Under expansion, inclusive of Phase II offsets, the state may see savings of up to \$93.3 million or may contribute up to \$35.4 million towards the cost of expansion, depending on the design option it selects (*Figure 3*).

Figure 3. Summary of Total Offsets Within Other State Programs Due to Medicaid Expansion, in \$1,000s (2014-2020)

| Scenario | Cost to Federal Government (2014-2020) in \$1,000s | Cost to State (2014-2020) in \$1,000s | Offsets to State Costs (2014-2020) in \$1,000s ^{1/} | Net Cost to State (2014-2020) in \$1,000s |
|--|--|---------------------------------------|--|---|
| No Expansion: | | | | |
| 1. Baseline | \$55,845.0 | (\$65,779.6) | \$0 | (\$65,779.6) |
| 2. Moving Current Eligibles Above 138 of Percent FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | \$7,154.1 | (\$113,691.4) | \$0 | (\$113,691.4) |
| Expansion: | | | | |
| 1. Baseline | \$2,510,922.3 | \$85,488.0 | \$67,136.0 | \$18,352.0 |
| 2. Low-Range Participation Assumption | \$1,952,472.0 | \$38,009.2 | \$67,136.0 | (\$29,126.8) |
| 3. High-Range Participation | \$2,709,057.8 | \$102,333.2 | \$67,136.0 | \$35,197.2 |

| Scenario | Cost to Federal Government (2014-2020) in \$1,000s | Cost to State (2014-2020) in \$1,000s | Offsets to State Costs (2014-2020) in \$1,000s ^{1/} | Net Cost to State (2014-2020) in \$1,000s |
|--|--|---------------------------------------|--|---|
| Assumption | | | | |
| 4. Managed Care Rates | \$2,501,073.5 | \$69,470.2 | \$116,570.0 ⁴ | (\$47,100) |
| 5. Delay Implementation by One Year | \$2,158,931.0 | \$79,384.2 | \$44,028.0 | \$35,356.2 |
| 6. Delay Implementation by Two Years | \$1,797,367.2 | \$71,165.5 | \$37,925.0 | \$33,240.5 |
| 7. Move Current Eligibles Above 138 of Percent FPL to HBE (MEAD and Pregnant Women Eligibility Categories) | \$2,462,231.5 | \$37,576.1 | \$67,136.0 | (\$29,559.9) |
| 8. Option 7 plus Transition Enrollees out of Breast and Cervical Cancer Program Eligibility Category | \$2,475,786.4 | \$24,021.2 | \$67,136.0 | (\$43,114.8) |
| 9. Option 8 plus Transition of Pregnant Women Below 138 Percent of FPL into "Newly Eligible" Category | \$2,525,989.2 | (\$26,181.6) | \$67,136.0 | (\$93,317.6) |

1/ Equal offsets are applied across all design options, except for the Delayed Implementation options. However, offsets may vary slightly by scenario.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

B. Impact on the Uninsured

In considering whether or not to expand the state's Medicaid program, it is important to consider the impact that expanding or not expanding Medicaid may have on individuals and families. It will affect the number of individuals and families who remain uninsured, which will vary by geographic region. It will also affect individual and family spending on health care, particularly for those families who would be covered under the expansion option. Potential impact on individual bankruptcy is also a worthwhile consideration, though we find the impact under expansion to be limited.

1. Change in Number of Uninsured

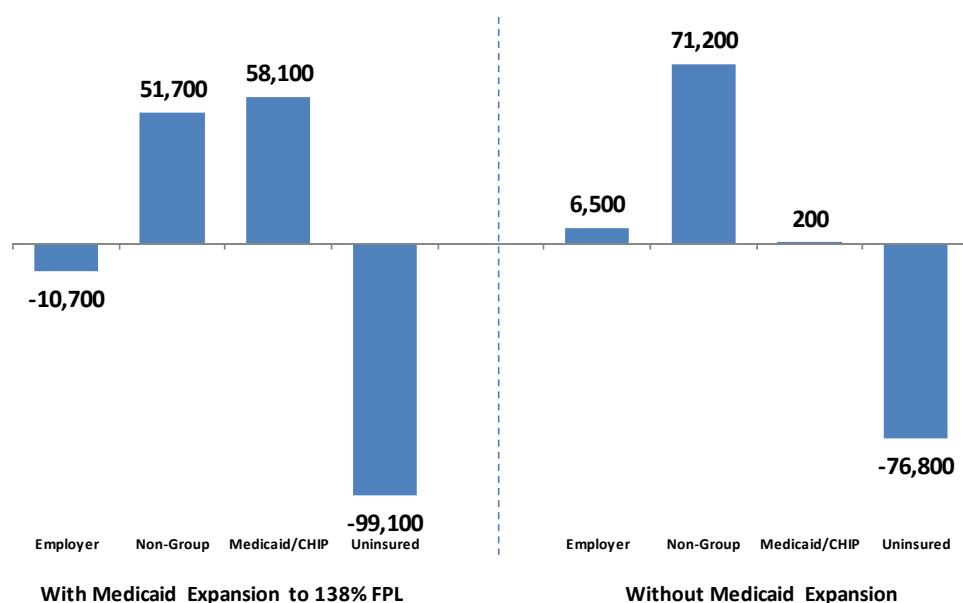
The coverage provisions in the ACA will dramatically change health insurance coverage in New Hampshire when it is fully implemented in 2014. These provisions include reforming the individual insurance markets by eliminating pre-existing condition exclusions, guaranteeing coverage and renewability of coverage, establishing Health Benefit Exchanges, an individual

⁴ Includes premium assessment tax revenues, paid to the State General Fund (\$49.4 million)

coverage mandate, subsidizing health insurance for individuals between 100 and 400 percent of FPL, and a mandate for large employers to offer health insurance.⁵

We estimate that there will be about 170,000 uninsured in New Hampshire in 2014 in the absence of the ACA. Taking into account all other provisions of the ACA, our estimates show that if the state expands Medicaid, the number of uninsured would be reduced by 99,100 (*Figure 4*) compared to pre-ACA uninsurance rates. Thus, the number of uninsured in New Hampshire would be approximately 71,000 with Medicaid expansion (*Figure 5*). However, if the state decides not to expand Medicaid, then the ACA will have a lesser impact on the number of uninsured. Many of the lowest income adults (below 100 percent of FPL) will not have access to subsidized coverage because premium subsidies through the HBE are only available for individuals between 100 and 400 percent of FPL. Thus, the Medicaid expansion would cover an additional 22,300 people in New Hampshire who are below poverty, who would otherwise be uninsured without Medicaid expansion.

Figure 4. Change in Coverage Under the ACA in New Hampshire in 2014 ^{1/}

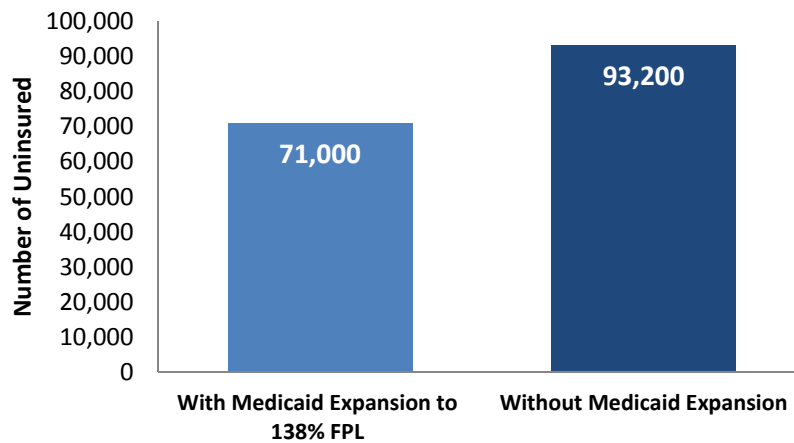


^{1/} Assumes all provisions of the ACA are fully implemented in 2014.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

⁵ Under the ACA, states have the option of establishing a fully state-based exchange, a state-federal partnership exchange, or default into a federally-facilitated exchange. In June, 2012, New Hampshire passed HB 1297, which prohibits the state from establishing a state-based exchange. Given this, the federal government will run the exchange in New Hampshire.

Figure 5. Number of Uninsured under ACA^{2/}

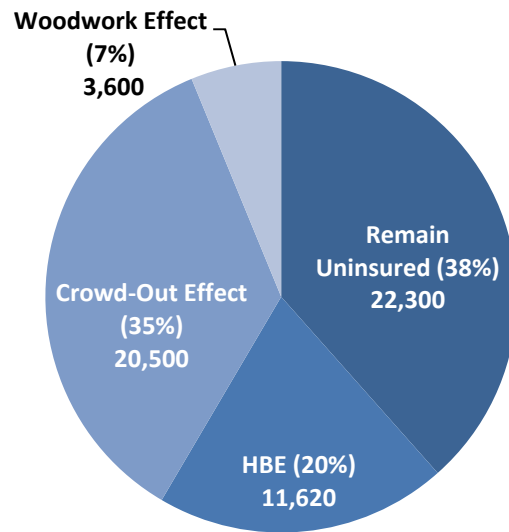


1/ Assumes all ACA provisions are fully implemented and reach ultimate enrollment in 2014

2/ Without Medicaid expansion assumes subsidized coverage in the Exchange is available for families between 100% and 400% of FPL

We estimate the net change in Medicaid enrollment to be 58,000 individuals under expansion. As depicted in *Figure 6*, we estimate that out of the 58,000 individuals who would have enrolled in Medicaid under expansion, 20,500 of these individuals would have enrolled due to a crowd-out effect, or the substitution of private coverage for Medicaid. Without a program expansion, this group would remain under private coverage. An estimated 11,620 individuals, who are between 100 percent and 138 percent of FPL, would seek subsidized coverage in the Health Benefits Exchange. Approximately 3,600 currently eligible individuals would have enrolled in Medicaid under an expansion, propelled by the requirements of the individual mandate. This is commonly referred to as the “woodwork effect.” Finally, this leaves about 22,300 individuals uninsured in the absence of an expansion, or 38 percent of the original 58,000 people who would have gained coverage under Medicaid expansion.

Figure 6. Insurance Status of the 58,000 Individuals Who Would Enroll under Medicaid Expansion, in the Absence of Expansion in 2014



1/ Assumes all provisions of the ACA are fully implemented in 2014

2. County-Level Impact on the Uninsured

Under expansion, the reduction in number of uninsured will vary by geographic area. As shown in *Figure 7*, Hillsborough and Rockingham Counties will see the largest absolute reductions in the uninsured under Medicaid expansion.

Figure 7. Change in the Number of Uninsured Coverage Under the ACA in New Hampshire ^{1/}

| County | Number Uninsured Pre-ACA | Change in Uninsured Post ACA | |
|---------------------|--------------------------|------------------------------|----------------------------|
| | | With Medicaid Expansion | Without Medicaid Expansion |
| Belknap County | 8,232 | -4,856 | -3,715 |
| Carroll County | 7,410 | -4,371 | -3,344 |
| Merrimack County | 16,962 | -10,007 | -7,655 |
| Cheshire County | 13,386 | -8,572 | -6,579 |
| Sullivan County | 7,540 | -4,828 | -3,705 |
| Coos County | 6,500 | -4,198 | -3,294 |
| Grafton County | 14,301 | -9,237 | -7,247 |
| Hillsborough County | 48,270 | -26,272 | -20,851 |
| Rockingham County | 33,814 | -18,404 | -14,606 |
| Strafford County | 13,901 | -8,340 | -5,800 |
| Total | 170,315 | -99,085 | -76,798 |

1/ Assumes all provisions of the ACA are fully implemented in 2014.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

3. Health Spending by the Uninsured

Without expansion, those remaining uninsured will continue to strain the finances of other public health programs and safety net providers for their care, while likely forgoing or reducing necessary care and risking a drain on personal finances. This is because single adults falling below poverty level may not have access to subsidized coverage via the HBE, nor would they be eligible for Medicaid.

We estimate that uninsured New Hampshire residents would have spent about \$1,212 annually per person out-of-pocket for health care in 2014 in the absence of the ACA (*Figure 8*). However, with Medicaid expansion, the average out-of-pocket spending per uninsured person would decline by \$372 to a total of \$841, compared to a decline of \$219 for a total of \$993 under the ACA without Medicaid expansion.

The change in out-of-pocket spending per uninsured person would be most dramatic for residents who are below 138 percent of FPL. We estimate that uninsured New Hampshire residents who are below 138 percent of FPL will likely spend about \$1,248 per person out-of-pocket for health care in 2014 in the absence of the ACA, representing a significant portion of their income. Under the ACA with the Medicaid expansion, the average out-of-pocket spending per uninsured person below 138 percent of FPL would decline by \$620 to a total of \$628, a nearly 50 percent reduction compared to pre-ACA spending. However, without the expansion, the average reduction for this group would only be \$230. Thus, on average, uninsured individuals below 138 percent of FPL would pay significantly more out-of-pocket for health care services than other lower- and middle-income individuals who were uninsured prior to the ACA. This analysis does not include the premium costs for newly insured individuals purchasing coverage in the HBE or through their employer's health plan.

Figure 8. Change in Out-of-Pocket Health Spending for Uninsured in New Hampshire in 2014 ^{1/}

| Family Income as a Percent of FPL | Out-of-Pocket Spending Per Person Pre-ACA | With Medicaid Expansion | | Without Medicaid Expansion | |
|-----------------------------------|---|--|----------------------|--|----------------------|
| | | Out-of-Pocket Spending Per Person Post-ACA | Change from Baseline | Out-of-Pocket Spending Per Person Post-ACA | Change from Baseline |
| Below 138% FPL | \$1,248 | \$628 | -\$620 | \$1,017 | -\$230 |
| 138-199% FPL | \$1,074 | \$621 | -\$452 | \$621 | -\$452 |
| 200-299% FPL | \$1,123 | \$857 | -\$267 | \$857 | -\$267 |
| 300-399% FPL | \$1,091 | \$896 | -\$195 | \$896 | -\$195 |
| 400% FPL and above | \$1,351 | \$1,293 | -\$57 | \$1,293 | -\$57 |
| Total | \$1,212 | \$841 | -\$372 | \$993 | -\$219 |

1/ Assumes all provisions of the ACA are fully implemented in 2014.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

4. Individual Bankruptcies

From 2007 to 2010, total individual bankruptcy filings for nonbusiness debts increased by 89 percent in New Hampshire, from about 2,650 in 2007 to about 5,000 in 2010.⁶ In 2011, total New Hampshire individual bankruptcy filings for nonbusiness debts began to decrease, for a total of about 4,300. At the time of filing, the median current monthly income for these individuals was \$3,696, equivalent to annual earnings of \$44,352.⁷ New Hampshire does not collect data on reasons for bankruptcy filing. However, recent research at Harvard suggests that about 62 percent of all bankruptcies are medically related, mostly due to unpaid medical bills.⁸ In New Hampshire, this would amount to about 2,666 medically-related individual bankruptcies in 2011. The majority (about 75 percent) of these individuals filing for medically-related bankruptcy have some health insurance. Gaps in coverage, including uncovered services and high levels of cost sharing, drive out-of-pocket expenses.⁹ This translates to about 667 uninsured New Hampshire residents who had medically-related bankruptcy filings in 2011. Though New Hampshire income data are unavailable, it is likely that many of these individuals would qualify for insurance subsidies in the Exchange, given the median income for this group. Some of these individuals would likely qualify for Medicaid under Medicaid expansion; however, that does not necessarily translate into averted bankruptcy. For instance, evidence from a 2008 Oregon health insurance experiment, in which a group of low-income adults were selected by lottery to receive Medicaid benefits, showed that enrolling in Medicaid did not have a statistically significant effect on bankruptcy, compared to a comparable group who was not selected for the lottery. However, the study did show a “decline in the probability of having any unpaid bills sent to collection,” about a 10 percent relative difference from the control mean.¹⁰ This implies that Medicaid expansion to all adults at or below 138 percent of FPL would have limited impact on medically-related bankruptcies.

C. Impact on Providers

Expanding or not expanding Medicaid will have a measurable impact on a number of provider groups. Much of this will be reflective of reductions in uncompensated care. Here, we first estimate the impact of the ACA on Medicaid DSH payments—a change that will occur with or without Medicaid expansion. We then compare the impact of expanding versus not expanding across four types of providers—health systems (including hospitals), Institutes for Mental Disease (IMD), Federally Qualified Health Centers, and Community Mental Health Centers. Our analyses are presented below.

1. DSH Reductions and Uncompensated Care

Disproportionate Share Hospital (DSH) payments, or DSH payments, are made to qualifying hospitals to offset costs associated with caring for a “disproportionate share” of uninsured and underinsured patients. The state receives federal matching funds for these payments to

⁶ American Bankruptcy Institute (2011). Annual Business and Non-business Filings by State (2007-11).

⁷ Administrative Office of the United States Courts (2012). 2011 Report of Statistics Required by the Bankruptcy Abuse Prevention and Consumer Protection Act of 2005. Washington, D.C.

⁸ Harvard CITATION Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/19501347>

⁹ Ibid.

¹⁰ Oregon study citation

hospitals and New Hampshire Hospital, an Institution for Mental Disease (IMD)¹¹. The maximum annual amount of federal matching funds that New Hampshire may use to make Medicaid DSH payments was capped at \$160.3 million in 2011¹², but the state has not utilized its full allotment, drawing only \$42.0 million in federal funding across its 26 hospitals and hospital systems and \$9.0 million to its state-operated psychiatric facility, New Hampshire Hospital, thus leaving \$109.0 million of its federal allotment unspent.

The ACA reduces federal funding for the Medicaid DSH program beginning in 2014. The reduction will occur over time and will be dependent upon whether the state is designated as a “high” or “low” DSH state.¹³ As a “high” DSH state, DSH allotments will be reduced by 51 percent.¹⁴ The methodology of implementing this reduction is currently being developed by the federal government. The rationale for reducing Medicaid DSH funding is that the new coverage options provided under the ACA will reduce the number of uninsured and in turn the amount of uncompensated care that hospitals currently provide to the uninsured. Medicaid DSH payments were used to help pay hospitals for a portion of the uncompensated care they provided. Thus, as uncompensated care levels decline under health reform, the ACA requires a reduction in DSH payments as the need for them goes down. However, without the Medicaid expansion as originally designed in the ACA, the policy rationale is blunted if the state does not expand Medicaid. This apparent schism has not been addressed in the wake of the Supreme Court decision that deemed Medicaid expansion optional for states.

The provisions in the ACA that specify federal reductions in DSH funding are separate from the Medicaid expansion provisions, and were untouched by the Supreme Court decision that concluded that the Medicaid expansion was optional for states. Thus, DSH funding will be reduced whether or not the state expands Medicaid. However, the reductions will be tied to the number of uninsured in the state and how the state treats hospitals with high Medicaid and uncompensated care levels.

Additionally, since 1991, New Hampshire, like other states, has levied a provider tax on hospitals to help fund its uncompensated care. This tax, known as the Medicaid Enhancement Tax (MET), is assessed at 5.5 percent of hospitals’ net patient service revenue.¹⁵

In 2010, however, significant changes to the state DSH methodology occurred in response to findings from an Office of Inspector General audit. The new methodology resulted in some non-Critical Access Hospitals receiving smaller DSH payments based upon a lesser amount of uncompensated care provided. During the SFY 2012 and 2013 budget process, the decision was made to significantly reduce the amount of MET revenue available for DSH payments. The

¹¹ Terminology used here is based on current federal terminology for the designation of these facilities.

¹² Kaiser Family Foundation State Health Facts

¹³ New Hampshire is designated as a “high” DSH state on the basis that DSH expenditures are above 3 percent of total (state and federal) Medicaid spending. According to the New Hampshire Department of Health and Human Services Office of Business Operations, in state fiscal year 2010, Disproportionate Share payments to general hospitals and New Hampshire Hospital comprised 16.6 percent of total Medicaid expenditures in the state.

¹⁴ HHS.gov/Recovery, “Disproportionate Share Hospital,” FY 2009, U.S. Department of Health and Human Services, available at www.hhs.gov/recovery/cms/dsh.html; and Kaiser Family Foundation, “Federal Medicaid DSH Allotments,” available at <http://www.statehealthfacts.org/comparetable.jsp?ind=185&cat=4>

¹⁵ New Hampshire Statutes, Chapter 84-A: Medicaid Enhancement Tax

decision resulted in non-Critical Access Hospitals not receiving DSH payments to offset the costs of providing uncompensated care in the last cycle.

Uncompensated care encompasses three components, all of which represent losses incurred by hospitals for a failure to collect payment for services delivered: charity care (also referred to as indigent care or community care), bad debt, and undercompensated care due to below-cost payment for services provided to Medicare and Medicaid patients. Charity care is defined in this report as care for which hospitals do not expect payment because of a determination of patients' inability to pay, while bad debt results from charges that the hospital is unable to collect.

The distinction between charity care and bad debt is not always clear. Different hospitals define and report these components in varying ways for accounting purposes. For example, one hospital may write off charges as bad debt, while another may designate such charges as charity care. Historically, the increase in both charity care and bad debt has been attributed to price increases, increasing insurance deductibles, and economic conditions.

2. Impact of ACA on Medicaid DSH Payments

Based on our methodology described below, we estimate that by 2020, Medicaid hospital and Institute for Mental Disease DSH payments will total \$101.9 million, of which \$50.9 million will be paid by the federal government (*Figure 9*). We also estimate the state's federal DSH allotment through 2020, assuming that New Hampshire is treated like an average state for treatment of the ACA Medicaid DSH reductions. Based on this assumption, we estimate that New Hampshire's federal DSH allotment will drop to \$92.0 million in 2020. However, this will still be more than what is needed to match the uncompensated care pool (UCP). Thus, we estimate that the ACA Medicaid DSH cuts will not affect the Medicaid DSH payments to New Hampshire hospitals assuming that the current payment methodology continues through 2020.

Figure 9. Medicaid DSH Payments and Federal DSH Allotments Under the ACA for New Hampshire (2010-2020)

| Year | Hospital DSH Payment ^{1/} | IMD DSH Payment ^{2/} | Total DSH Payment | Federal DSH Drawdown | Federal DSH Allotment Pre-ACA ^{3/} | Federal DSH Allotment Post-ACA ^{4/} | Amount (Under)/ Over Allotment |
|------|------------------------------------|-------------------------------|-------------------|----------------------|---|--|--------------------------------|
| 2010 | \$182.0 | \$18.5 | \$200.5 | \$100.3 | \$165.4 | \$165.4 | -\$65.2 |
| 2011 | \$205.8 | \$16.4 | \$222.2 | \$111.1 | \$160.3 | \$160.3 | -\$49.2 |
| 2012 | \$48.7 | \$9.2 | \$57.9 | \$29.0 | \$162.0 | \$162.0 | -\$133.0 |
| 2013 | \$57.2 | \$9.6 | \$66.8 | \$33.4 | \$165.4 | \$165.4 | -\$132.0 |
| 2014 | \$61.1 | \$10.2 | \$71.3 | \$35.6 | \$167.0 | \$158.5 | -\$122.9 |
| 2015 | \$64.5 | \$10.8 | \$75.3 | \$37.7 | \$170.4 | \$160.4 | -\$122.7 |
| 2016 | \$68.8 | \$11.5 | \$80.3 | \$40.1 | \$173.8 | \$163.7 | -\$123.6 |
| 2017 | \$72.8 | \$12.2 | \$84.9 | \$42.5 | \$177.2 | \$146.9 | -\$104.4 |
| 2018 | \$77.1 | \$12.9 | \$90.0 | \$45.0 | \$180.5 | \$96.2 | -\$51.3 |
| 2019 | \$81.9 | \$13.7 | \$95.6 | \$47.8 | \$183.9 | \$90.3 | -\$42.5 |
| 2020 | \$87.3 | \$14.6 | \$101.9 | \$50.9 | \$187.3 | \$92.0 | -\$41.0 |

- 1/ Assumes 13 percent of MET used to fund UCF and includes federal matching funds.
2/ Based on data reported by New Hampshire hospital for 2010 through 2012 and trended to 2020 based on projected hospital revenue growth for CMS Office of the Actuary.
3/ New Hampshire's DSH allotment for 2011 was trended to 2020 based on national projected federal DSH funding.
4/ Assumes DSH cuts for New Hampshire are made in proportion to national reduction specified in the ACA.

Source: Lewin Group estimates

3. *Health Systems*

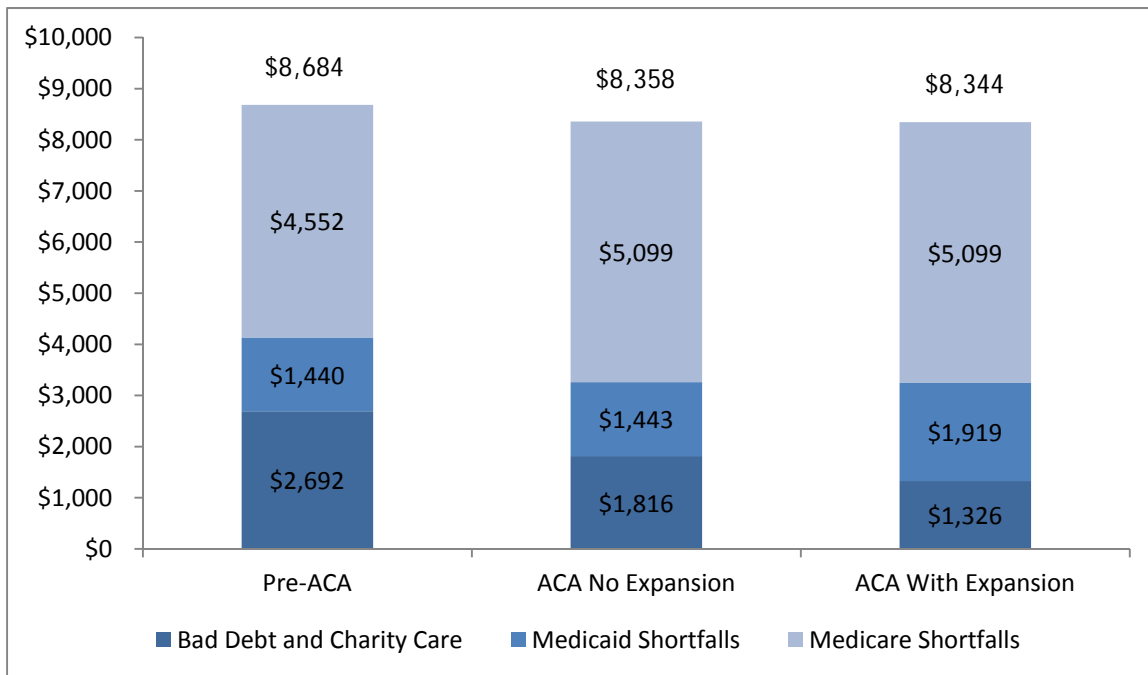
In our analysis, we examine the financial impact to New Hampshire's 26 hospitals and hospital systems, with and without an expansion of the Medicaid program. These hospitals fall into two categories, based on Medicare reimbursement methods from the Centers for Medicare & Medicaid Services (CMS). The 13 larger hospitals use a Prospective Payment System (PPS), while the remaining 13 hospitals are designated as Critical Access Hospitals (CAH). Medicaid reimbursement to New Hampshire hospitals differs significantly for PPS and CAH facilities, largely due to the discrepancies in how the state Medicaid program allots DSH adjustment payments. We emphasize that certain characteristics that are specific to New Hampshire make it difficult to apply national trends to New Hampshire provider systems.

Using the Lewin Group Health Benefits Simulation Model for the state of New Hampshire and data provided by the New Hampshire Hospital Association (NHHA), we estimate uncompensated care (bad debt, charity care, and undercompensated care ¹⁶) for New Hampshire health systems, which include the hospital as well as other entities owned by the system, such as physician groups, skilled nursing facilities, freestanding surgical centers and home health agencies.

We estimate bad debt and charity care to be about \$2.7 billion over the 2014 to 2020 period in the absence of the ACA. If the state expands Medicaid, this amount would be reduced by \$1.3 billion over this period, compared to an \$862.0 million reduction if the state does not expand Medicaid (*Figure 10*). However, because more people will be enrolled in Medicaid under the expansion and Medicaid payments are less than the cost of treating these patients, hospitals will experience greater Medicaid payment shortfalls. The ACA also includes Medicare payment reductions that will add to hospital payment shortfalls for Medicare patients, which were estimated by the American Hospital Association to be \$547 million over the 2014 to 2020 period. Overall, we estimate that health system uncompensated care will be reduced by about \$340 million (4 percent) under the ACA with or without the Medicaid expansion.

¹⁶ Which includes payment shortfalls for Medicare and Medicaid due to payments that are less than the cost of treating these patients.

Figure 10. Total Uncompensated Care for New Hampshire Health System Under the ACA With and Without the Medicaid Expansion, in Millions (2014-2020)



Source: Lewin Group analysis using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

To estimate the overall financial impact of the Medicaid expansion on New Hampshire health systems, we assume that previously uncompensated costs for patients covered by the Medicaid expansion will be reimbursed at Medicaid rates that are below cost. However, payments for patients newly covered by private insurance are assumed to be made at private payment levels, which are substantially above costs. We estimate there will be more people newly covered by private insurance if the state does not expand Medicaid since those between 100 and 138 percent of FPL will be eligible for subsidized private coverage in the HBE. Although there is a greater reduction in bad debt and charity care if the state expands Medicaid (\$131.3 million reduction) compared to not expanding Medicaid (\$85.9 million reduction), since hospitals would receive a much higher private payment rate compared to Medicaid, the revenues received by the hospital for this care under the expansion would be \$130.5 million with expansion compared to \$120.9 million without expansion if no other changes are made to the rate structure (*Figure 11*).

When reviewing these forecasts, it is important to consider the unique characteristics of New Hampshire's health care safety net that affect a Medicaid expansion's impact on hospitals. In particular, New Hampshire has a particularly low uninsured rate for the nonelderly, well below the national average.¹⁷ Additionally, Medicaid payment rates in the state are significantly lower than Medicare and commercial insurance rates and lower than the rates of other Medicaid

¹⁷ According to the Kaiser Family Foundation, the uninsured rate for nonelderly adults in 2011 was 15 percent in New Hampshire, compared to 21 percent nationally.

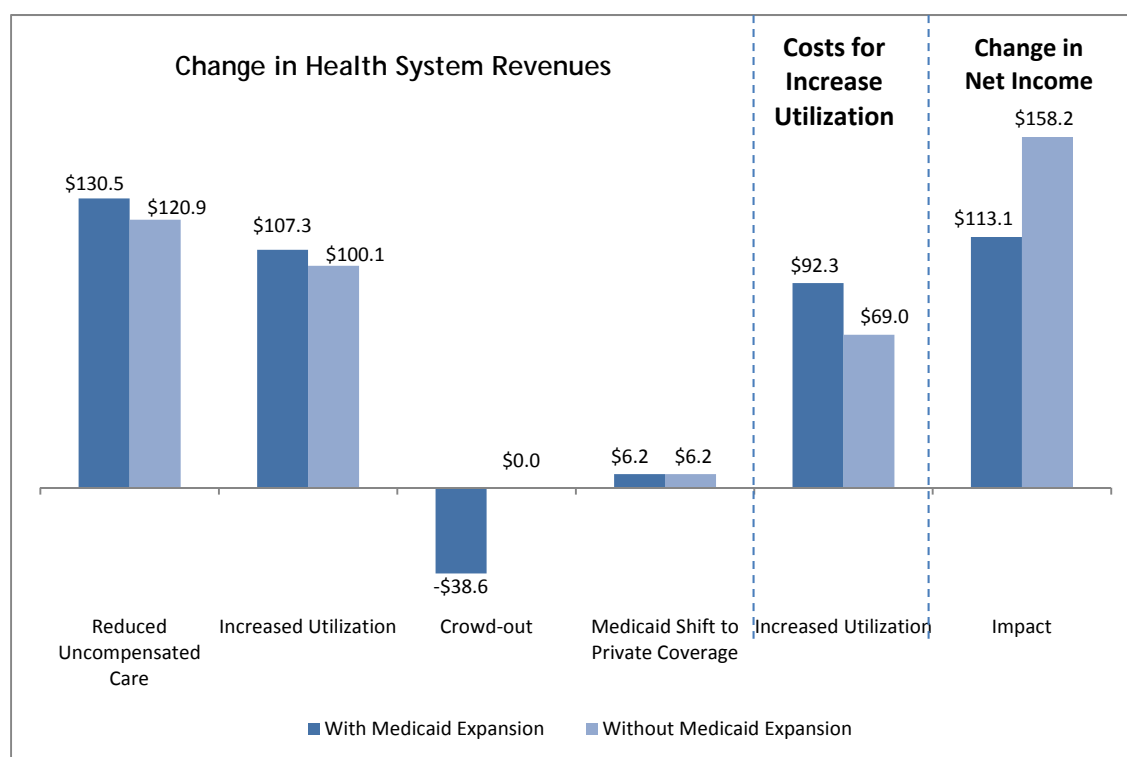
programs nationally¹⁸. In conjunction, these state-specific traits make it difficult to extrapolate trends for New Hampshire provider systems based on what is projected nationally or for other states.

Additionally, we assume that health system inpatient and outpatient utilization for newly insured people will increase to the same levels as insured people with similar demographic, income, and health status characteristics. If the state expands Medicaid, we estimate an increased utilization by the newly insured translating to \$92.3 million in costs, for which the hospital will receive about \$107.3 million in revenue due to the mix of Medicaid and commercial payments. Similarly, if the state does not expand Medicaid, we estimate an increase in utilization of \$69.0 million in costs with \$100.1 million in payments (*Figure 11*).

Our analysis shows that about 20,500 individuals who choose to enroll in the Medicaid expansion would have been covered by private insurance in the absence of the expansion (i.e., crowd out). Health systems would have received commercial payment rates for services provided to these people in the absence of the expansion, but will instead receive the lower Medicaid rates. Because of the lower Medicaid reimbursement, we estimate a loss to the health systems of \$38.6 million (*Figure 11*). We also estimate that 3,500 previous Medicaid enrollees would take private coverage as their employers begin to offer coverage. Conversely, hospitals would have received Medicaid payment rates for these people in the absence of the ACA, but will instead receive higher commercial rates. We estimate the net effect would be an increase in net income of about \$6.2 million, also shown in *Figure 10*.

¹⁸ Kaiser Family Foundation Medicaid-to-Medicare Fee Index, 2008

Figure 11. Impact on New Hampshire Health System Revenues Under the ACA With and Without the Medicaid Expansion^{1/}



1/ Assumes that all provisions of the ACA are fully phased in, but illustrations in 2011 dollars. Estimates do not include Medicare payment reductions scheduled under the ACA.
Source: Lewin Group analysis using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Overall, as shown in *Figure 11*, we estimate that health systems would see an increase in net income of about \$113.1 million under the Medicaid expansion assuming full implementation in 2014, which would represent a 28 percent increase in their current net income. However, due to more people being enrolled in private insurance in the absence of the expansion, we estimate that health system net income would increase by \$158.2 million. Under no Medicaid expansion, although health systems would see more of an improvement in their bottom line, they would need to provide a greater volume of uncompensated care.

4. Institutions for Mental Disease

Long-term adult psychiatric care does not receive federal funding through the Medicaid program. This provision, termed the Institutions for Mental Diseases (IMD) exclusion, prohibits Medicaid reimbursement for care delivered to individuals between 21 years and 65 years of age in psychiatric institutions. Although not required, the New Hampshire Medicaid program has elected to cover inpatient psychiatric care for persons under 21 years of age and those over 65 years of age, as optional services under its state Medicaid plan.

An IMD is defined as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases,

including medical attention, nursing care, and related services.”¹⁹ In the state of New Hampshire, the primary IMD is New Hampshire Hospital (NHH), a state-operated, publically-funded psychiatric hospital that provides inpatient psychiatric services to children, adolescents, adults, and elders with severe mental illness.

New Hampshire Hospital receives Disproportionate Share Hospital (DSH) payments from the state for serving a high number of low-income patients and for providing a large volume of uncompensated care. In state fiscal year 2012, total expenditures at NHH reached nearly \$58.7 million. The hospital received \$9.2 million in DSH payments, which represents 16 percent of its expenses. However, DSH payments for NH Hospital are not made from the state’s uncompensated care fund.

We find that the ACA reductions in federal Medicaid DSH allotments will not affect DSH payments in New Hampshire over the next several years. Since the ACA will have no impact on DSH funding in the state then there will be no need for additional state funds to cover costs for NHH.

5. Safety Net Providers

a. Community-Based Health Centers

Community-based health centers in the state are non-profit, locally-driven entities that focus on providing comprehensive primary care and other health services to communities and populations that would otherwise face significant barriers to accessing health care services and treat patients irrespective of their ability to pay for those services. Federally Qualified Health Centers (FQHCs) currently provide care to 12 percent of the Medicaid population, and it is uncertain how this may shift upon implementation of ACA provisions and the presumed increased demand for primary care services that may result.. We analyze the effects of Medicaid expansion one of the primary community-based clinic models: Federally-Qualified Health Centers.²⁰ These facilities currently receive enhanced reimbursement rates to partially offset the costs of providing care to the uninsured and the underinsured, and will continue to receive these rates under the ACA.

The 10 FQHCs in New Hampshire provide services at 52 sites in the state, and are primarily located in underserved areas confronted by high levels of poverty and a scarcity of physician practices. FQHCs are given cost-based reimbursement for services provided under Medicare, and are reimbursed under the Prospective Payment System (PPS) for services provided under Medicaid. Additionally, they are eligible to receive a variety of federal, state, and non-governmental grants. These grants include competitively awarded non-federal grants, which FQHCs must compete for on an intermittent basis. Past FQHC revenues have included a one-time American Recovery and Reinvestment Act Capital Improvement Projects and Facilities Improvement grant, which has since been discontinued.

¹⁹ 42 U.S.C. §1396d(i)

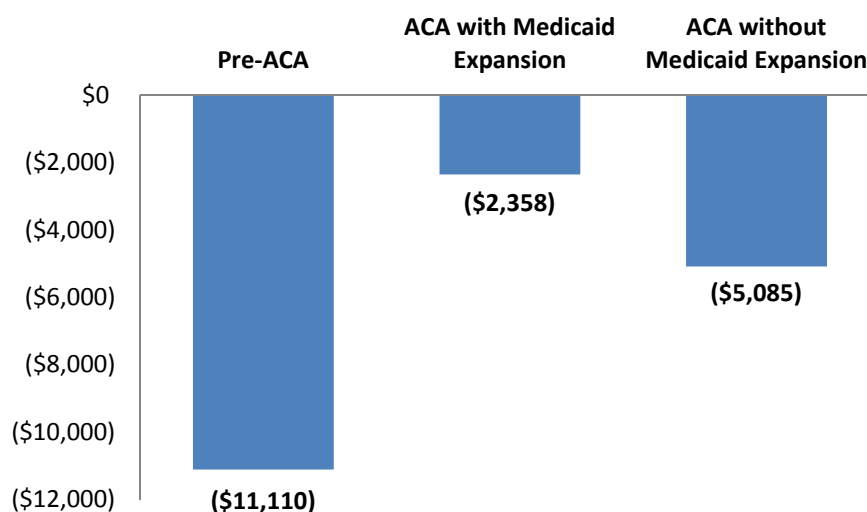
²⁰ While FQHC Look-Alikes perform similar functions as FQHCs, they do not receive federal health center grants. Our analysis does not include FQHC Look-Alikes. Consequently, projections may slightly underrepresent the true volume of care delivered in this capacity.

From the U.S. Department of Health and Human Services' Uniform Data System (UDS), we compiled five years (2007-2011) of aggregate annual financial and utilization data for New Hampshire's FQHCs. We simulated the transition of patients from their current source of coverage (Medicaid, Medicare, other public insurance, private coverage, and uninsured) to coverage under the ACA in proportion to the change in coverage for people below 200 percent of FPL in our simulation model. Using these assumptions, we estimated the impact on FQHCs with and without Medicaid expansion.

As shown in *Figure 12*, we model the reduction in FQHC shortfalls (costs less collections) from uninsured patients due to changes in coverage under the ACA, with and without the Medicaid expansion. For illustrative purposes, we show the impact on FQHCs (presented in 2011 dollars) assuming all ACA provisions are fully implemented. Aggregate uncompensated care across all 10 FQHCs for uninsured patients reached over \$11.0 million in 2011.

Under the ACA, FQHCs would see a dramatic reduction in uncompensated care, with or without the Medicaid expansion (*Figure 11*). If the state implements the Medicaid expansion, FQHCs would see uncompensated care reduced by nearly \$9.0 million to \$2.4 million. Without the Medicaid expansion, uncompensated care would fall by about \$6.0 million to \$5.1 million compared to pre-ACA estimates.

Figure 12. FQHC Uncompensated Care from Uninsured Recipients With and Without Medicaid Expansion in 2011 (\$1,000s)



1/ Assumes all provisions of the ACA are fully implemented and impacts illustrated in 2011 dollars.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM) and 2011 UDS data.

We also estimated total revenues, costs, and shortfalls for all FQHC patients. As uninsured patients become covered by Medicaid or private coverage, we assumed that FQHCs would receive payments for these patients at current Medicaid or private payment levels. We also assume that FQHCs would see increased utilization for newly insured patients, which we estimate will be about 70 percent above current utilization levels for uninsured patients.

Based on these assumptions, we estimate that FQHCs would see a substantial increase in revenues, from \$26.3 to \$38.6 million under the ACA with the Medicaid expansion compared to revenues of \$33.4 million without the expansion (*Figure 13*). The analysis also shows that FQHC losses for patient care would also drop from \$21.6 million to \$16.7 million under the ACA with the Medicaid expansion compared to \$19.5 million without the expansion.

Figure 13. Revenues, Costs, and Shortfalls for FQHCs from All Payers With and Without Medicaid Expansion in 2011

| | Total Cost | Revenue | Shortfall |
|--------------------------------|-------------------|----------------|------------------|
| Pre-ACA | \$47,514,259 | \$26,345,914 | \$21,168,345 |
| ACA with Medicaid Expansion | \$55,347,874 | \$38,609,318 | \$16,738,556 |
| ACA without Medicaid Expansion | \$52,924,012 | \$33,447,093 | \$19,476,919 |

1/ Assumes all provisions of the ACA are fully implemented and impacts illustrated in 2011 dollars.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM) and 2011 UDS data.

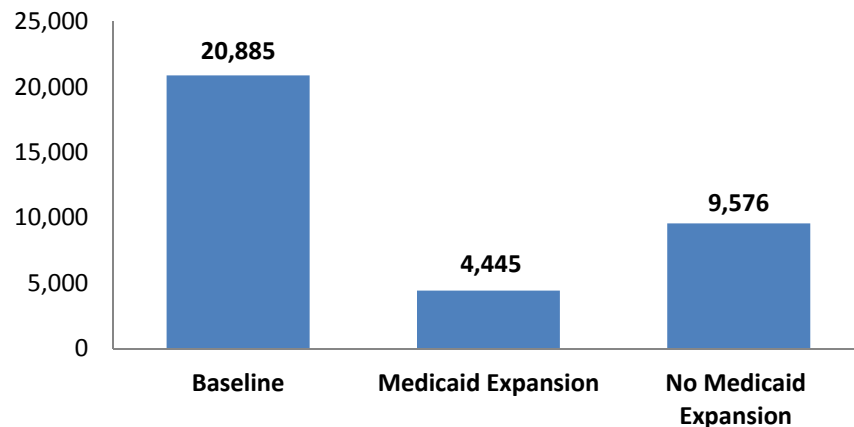
Historically, grant and other non-direct patient service revenue have accounted for a significant portion of FQHCs' total revenues. In 2011, they received \$31.1 million in combined grants, which accounted for nearly 42 percent of total revenues:

- Federal Bureau of Primary Health Care (BPHC) grants of \$8.9 million that contribute to the cost of operating the FQHC, including purchasing and leasing of buildings and equipment and training for staff;
- Federal American Recovery and Reinvestment Act (ARRA) grants of \$12.0 million for facility and capital improvement projects, which are discontinued after 2012; and
- State government grants of \$4.7 million and local government and private grants of \$4.6 million.

Of the combined grant total, 15 percent were from state government grants and contracts. While grant funding will help to offset the cost of providing uncompensated care, their usage may be restricted or earmarked for specific purposes. It is unclear whether New Hampshire will continue its current trajectory of state funding, thus it is uncertain whether Medicaid expansion will lead to clear savings for the state.

To illustrate the long-term impact of the ACA with and without the Medicaid expansion, we projected patient volume, revenues, and costs through 2020. As shown in *Figure 14* below, under the ACA, FQHCs will see a dramatic reduction in the number of uninsured FQHC patients in 2020 under the Medicaid expansion versus not expanding Medicaid.

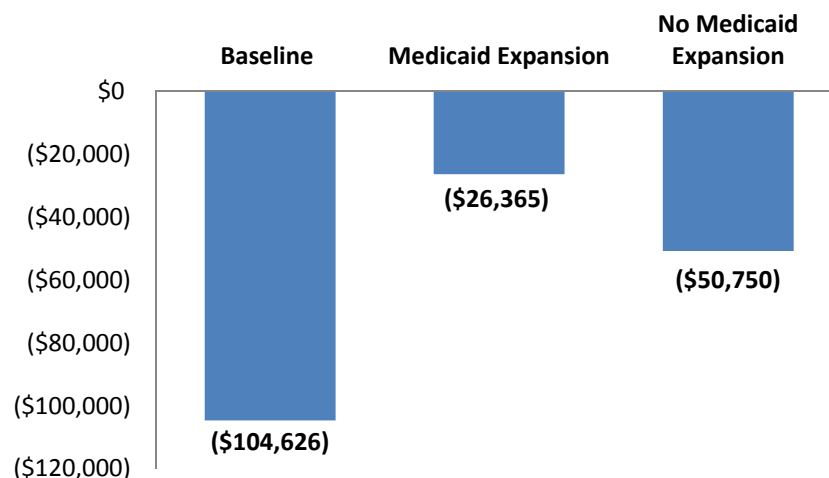
Figure 14. Number of Uninsured FQHC Patients Under Expansion versus No Expansion in 2020



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM) and UDS data.

In the absence of Medicaid expansion, the cumulative cost of treating the uninsured is projected to be \$65.9 million (or 51.5 percent) lower than under a projected pre-ACA scenario.²¹ With expansion, however, total costs for treating this group of recipients are expected to be nearly \$95.7 million lower (a 75 percent reduction), given there will be fewer uninsured in New Hampshire if Medicaid is expanded. Total annual shortfalls incurred by FQHCs for providing treatment to the uninsured will also diminish significantly. While this will occur with or without Medicaid expansion under the ACA, total annual and cumulative shortfalls over the period will be substantially lower under an expansion scenario (\$26.4 million) than under a no expansion scenario (\$50.8 million), as shown in *Figure 15*.

Figure 15. Cumulative Shortfall for FQHCs from Uninsured Recipients 2014-2020 (\$1,000s)

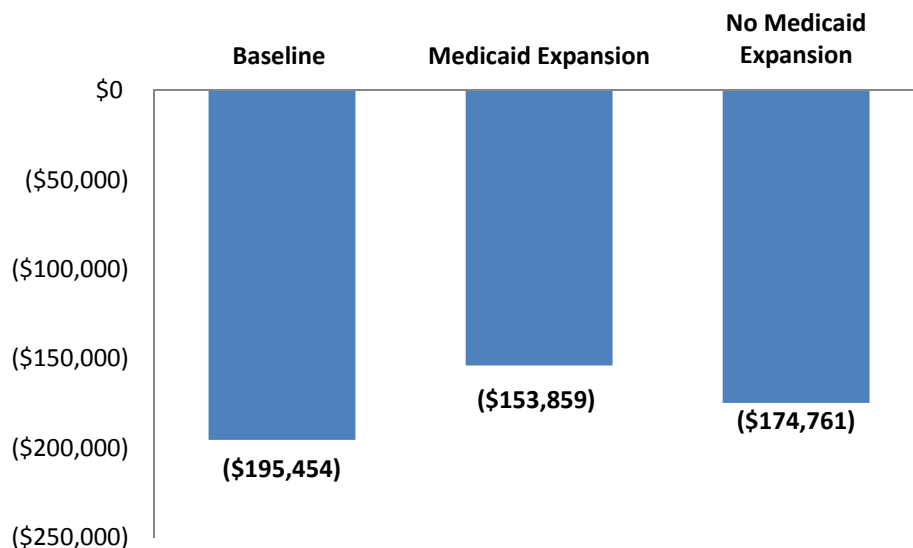


Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM) and UDS data.

²¹ Please refer to the Methodology section for further detail regarding the derivation of these figures.

Across all payer categories, from 2014 to 2020, we find that cumulative shortfall (costs less patient revenues) for FQHCs under the Medicaid expansion scenario (a total shortfall of \$153.9 million) to be \$41.6 million less than the projected shortfall under our baseline, pre-ACA scenario (a total shortfall of \$195.5 million). Though FQHCs will experience a reduced shortfall under the no expansion option (a total shortfall of \$174.8 million), the shortfall under no expansion is projected to be \$20.9 million more than the projected shortfall under expansion (Figure 16).

Figure 16. Cumulative Shortfall for FQHCs Across All Payer Categories, in \$1,000s (2014-2020)



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM) and UDS data.

In addition to the 10 FQHCs, there are also 12 Rural Health Clinics (RHCs) spread mainly throughout the remote regions of New Hampshire. Without adequate data to assess the impact of a potential Medicaid expansion upon these facilities, it is not possible to discuss them in detail at this time. However, we expect that projected trends observed for FQHCs, with regards to the reduction in uncompensated care and reduction in uninsured care recipients, will apply to RHCs as well. Because certain centers are a part of larger health care systems, the effects of Medicaid expansion has been largely accounted for in the hospital analysis of this report.

b. Community Mental Health Centers

Located throughout the state are 10 Community Mental Health Centers (CMHCs) serving individuals recovering from mental illness or emotional disorders. These Centers are non-profit organizations contracted annually by the state to participate in its network of regional behavioral health providers. In fiscal year 2009, the Centers provided behavioral health services to over 48,000 New Hampshire residents, one-fourth of whom were children.²²

²² Quarter 4 of Fiscal Year 2009, New Hampshire Department of Health & Human Services, Bureau of Behavioral Health

We analyze annual audited financial statement data from 2006 through 2009 to evaluate the financial sustainability of health centers in subsequent years, through 2020. Because CMHCs currently receive little or no funding from the state to offset the cost of providing treatment to uninsured or underinsured individuals, a potential Medicaid expansion will likely not generate savings to the state. However, it will have a significant impact on the financial viability of CMHCs.

In FY 2009, the combined revenue for all 10 Centers was approximately \$150.0 million. Notably, annual margins after accounting for operating expenses were low throughout the four year historical period. When the 2010 Medicaid payment reimbursement cuts are accounted for in projecting future revenues and expenses, the margin becomes negative. Because Medicaid payments account for such a substantial proportion of total revenue (nearly 75 percent of total revenue sources²³), the financial sustainability of CMHCs is highly dependent upon Medicaid policy and payment rates.

The CMHC also provide a substantial amount of uncompensated care to uninsured and underinsured patients. The New Hampshire Community Behavioral Health Association provided us with 2009 aggregate loss figures for the four largest categories of uncompensated care:

- Uncompensated emergency services (\$3.6 million);
- Spend down (\$5.7 million);
- Application of sliding fee schedule to self-pay patients (\$7.0 million); and
- Intake services (\$1.7 million).

In total, combined losses due to uncompensated care across the 10 CMHCs in 2009 represented nearly 12 percent of total operating expenditures. We then use the provided figures to estimate future losses due to uncompensated care, after adjusting for CMHC-observed trends in shortfalls.²⁴ Under a baseline scenario, assuming that historical trends will persist in the 2014 to 2020 period, total expected losses due to uncompensated care will reach upwards of \$206.0 million.

Using the Lewin Group's Health Benefits Simulation Model, we estimated the reduction in uncompensated care to the CMHCs due to currently uninsured persons gaining Medicaid coverage or private insurance coverage as a result of Affordable Care Act provisions with and without the Medicaid expansion. Under Medicaid expansion, the CMHCs may see a \$162.8 million reduction in uncompensated care during the 2014 to 2020 period (*Figure 17*). Without an expansion, a smaller reduction will occur, largely due to effects of other provisions of the ACA.

²³ Includes all patient service revenue, as well as grants and contracts.

²⁴ For example, CMHCs have historically been unable to recoup losses resulting from patients participating in spend down. The New Hampshire Community Behavioral Health Association estimates Medicaid expansion may reduce loss due to spend down by \$6.0 million to \$7.0 million annually.

Figure 17. Impact of Medicaid Expansion on CMHC Uncompensated Care (\$1,000s)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|--|----------|----------|----------|----------|----------|----------|----------|-----------|
| Baseline | \$24,388 | \$25,905 | \$27,517 | \$29,230 | \$31,050 | \$32,984 | \$35,039 | \$206,114 |
| Reduction in Uncompensated Care | | | | | | | | |
| Expansion | \$19,260 | \$20,458 | \$21,731 | \$23,084 | \$24,521 | \$26,048 | \$27,671 | \$162,774 |
| No Expansion | \$12,623 | \$13,408 | \$14,242 | \$15,129 | \$16,071 | \$17,072 | \$18,136 | \$106,681 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

In addition to the Community Mental Health Centers, a number of Peer Support Agencies for mental and behavioral health services are also located throughout the state. These facilities exhibit similarities to the CMHCs, but are counted as a separate line item in the state budget. Pending receipt of adequate data on these resources, analysis is not possible at this time.

D. Economic Impact

In order to estimate the overall impact of the Medicaid expansion in New Hampshire, we estimated net change in payments to New Hampshire providers due to all provisions of the ACA with and without the Medicaid expansion in order to isolate the effects of just the Medicaid expansion. Expected provider revenues without an expansion are compared to revenues with expansion, and is presented in the third column of *Figure 18*. As discussed previously, hospitals and hospital systems gain lower revenue over the period under an expansion, while physicians, clinics, and the prescription drug sectors gain higher revenue. In total, providers will experience an estimated \$158.3 million in lost revenue between 2014 and 2020 without Medicaid expansion.

Figure 18. Difference in Provider Revenue, by Sector (2014-2020) (in millions) ^{1/}

| | Change in Provider Payments with Medicaid Expansion | Change in Provider Payments without Medicaid Expansion | Difference in Provider Revenue with and without the Medicaid Expansion, |
|----------------------|---|--|---|
| Hospital1/ | \$1,193 | \$1,421 | (\$228) |
| Physicians/Clinics2/ | \$1,611 | \$1,405 | \$206 |
| Drugs3/ | \$696 | \$516 | \$181 |
| Total | \$3,500 | \$3,341 | \$158 |

1/Based on the Lewin Group's analysis of hospitals and health systems

In addition, we estimate the change in household health spending in New Hampshire under the ACA with and without the Medicaid expansion in order to isolate the effects of just the Medicaid expansion. As shown in *Figure 19*, without a Medicaid expansion, households will spend more on premiums, since more people will be covered under private insurance than with under Medicaid.²⁵ However, there will be higher subsidies, as more people obtain coverage through the

²⁵ All estimates were made under the assumption that Medicaid does not require a premium or cost-sharing charges. Although most individuals covered by Medicaid will not have a premium, the state has limited authority to impose cost-sharing charges and premiums for certain Medicaid beneficiaries under the Deficit reduction Act of 2005.

Health Benefits Exchange. Since private coverage will require higher cost-sharing for care than Medicaid, households will spend more on the direct payments to providers without the expansion. Additionally, a slightly higher proportion of the uninsured will remain uninsured without a program expansion, leading to higher amounts paid towards individual mandate penalties. Under Medicaid expansion, we estimate the New Hampshire households will save about \$145 per year on average.

Figure 19. Change in Household Health Spending in New Hampshire (in millions)

| | With Expansion | Without Expansion | Impact of Expansion |
|--------------------|-----------------------|--------------------------|----------------------------|
| Change in Premiums | \$273.7 | \$440.0 | -\$166.3 |
| Premium Subsidies | -\$237.6 | -\$342.6 | \$105.0 |
| Direct Payments | -\$2.0 | \$26.0 | -\$28.0 |
| Penalties | \$35.8 | \$38.6 | \$2.8 |
| Net Impact | \$69.9 | \$162.0 | -\$92.1 |

1/ Assumes all provisions of the ACA are fully implemented in 2014.

Using these inputs, The Lewin Group partnered with REMI to conduct an economic impact analysis of both the non-expansion and Medicaid expansion scenarios using REMI's proprietary Tax-Pi software. The model provides economic and fiscal impacts relative to the baseline scenario from 2014 to 2020. The baseline scenario assumes no major changes to New Hampshire's economy or policies, which means that the baseline forecast has no inherent understanding of the ACA's impact in the coming years. The REMI model compares the baseline scenario to the ACA without Medicaid expansion and to the ACA with Medicaid expansion. The results focus on fiscal and economic growth that would be created under each scenario.

As shown in *Figure 20*, in the non-expansion scenario, New Hampshire experiences an increase of about 3,700 jobs in 2014, compared to pre-ACA projections, or a 0.42 percent change. Employment peaks at just under 4,900 new jobs in 2016 and tapers down to an annual increase of roughly 4,300 in 2020. During the 2014 to 2020 period of analysis, new employment under no expansion averages approximately 4,400 jobs above the baseline forecast. By comparison, under Medicaid expansion, New Hampshire experiences an increase of about 4,300 jobs in 2014, or a 0.49 percent change – almost 600 more than under no expansion. Similar to the non-expansion scenario, the employment growth peaks in 2016 but with about 5,700 new jobs. Over the 2014 to 2020 analysis period, New Hampshire gains an average of 5,100 jobs under Medicaid expansion relative to the baseline scenario – 700 more jobs compared to no expansion.

Figure 20. Change in Total Employment from Baseline, 2014-2020

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---------------------|-------|-------|-------|-------|-------|-------|-------|
| Expansion | 4,304 | 4,995 | 5,672 | 5,501 | 5,287 | 5,073 | 4,943 |
| No Expansion | 3,730 | 4,310 | 4,898 | 4,747 | 4,571 | 4,391 | 4,279 |
| Difference | 574 | 685 | 773 | 754 | 717 | 682 | 664 |

Gains in employment under ACA will vary by sector. Employment gains by sector for the top five private non-agricultural and non-government sectors experiencing the most change during the 2014 to 2020 period are listed in *Figure 21*. Under both the expansion and no expansion scenarios, we anticipate that New Hampshire will enjoy a growth in the number of jobs in these five sectors, when compared to pre-ACA estimates. The ambulatory health care services sector experiences the greatest average number of added jobs—over 1,500 under expansion and about 1,300 without expansion. Most of these sectors experience greater job gains with expansion, while the hospital sector experiences a greater gain without expansion.

Figure 21. Average Change in Employment by Sector from Baseline, 2014-2020

| | With Expansion | Without Expansion | Difference, with Expansion |
|-------------------------------------|----------------|-------------------|----------------------------|
| Ambulatory health care services | 1,578 | 1,315 | 263 |
| Hospitals | 1,035 | 1,212 | -177 |
| Retail trade | 721 | 489 | 232 |
| Construction | 450 | 367 | 83 |
| Administrative and support services | 173 | 151 | 22 |

The ACA also impacts gross state product (GSP) in New Hampshire. GSP represents the total value of goods and services produced in New Hampshire. Under no expansion, the New Hampshire economy adds \$274 million in GSP in 2014, while it adds \$316 million under expansion. Increase in GSP peaks in 2016, at \$377million in new growth under no expansion and \$436 in new growth under expansion—a 0.44 percent increase and 0.51 percent increase, respectively, above the baseline’s forecasted GSP growth. From 2014 to 2020, New Hampshire’s economy accrues a total of \$2.5 billion in additional GSP growth under no expansion, compared to more than \$2.8 billion under expansion (*Figure 22*).

Figure 22. Change in Gross State Product from Baseline, 2014-2020 (in millions)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|---------------------|----------|----------|----------|----------|----------|----------|----------|------------|
| Expansion | \$316.09 | \$374.57 | \$436.17 | \$433.90 | \$429.16 | \$423.73 | \$425.44 | \$2,839.05 |
| No Expansion | \$274.26 | \$323.45 | \$376.65 | \$374.06 | \$370.23 | \$365.57 | \$366.57 | \$2,450.78 |
| Difference | \$41.83 | \$51.13 | \$59.52 | \$59.84 | \$58.93 | \$58.16 | \$58.87 | \$388.27 |

The ACA affects personal income as well, which indicates the total amount of income received by all residents of the state, inclusive of wages, salary, benefits, and dividends. Under no expansion, personal income experiences an initial increase of \$198 million in 2014 (0.29 percent increase), compared to baseline, while a larger increase of \$223 million (0.32 percent increase) is seen under Medicaid expansion in 2014 (*Figure 23*). This translates to a gain of about \$91 per capita under no expansion and \$102 per capita under expansion, in 2005 dollars. The percent increase in personal income peaks in 2016 and 2017 – a 0.39 percent increase under no expansion and a 0.44 percent increase under expansion, compared to the pre-ACA projected baseline. From 2014 to 2020, New Hampshire’s economy accrues \$2.1 billion in personal income under no expansion and over \$2.3 billion in personal income under expansion.

Figure 23. Change in Personal Income from Baseline, 2014-2020 (in millions)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|---------------------|----------|----------|----------|----------|----------|----------|----------|------------|
| Expansion | \$223.41 | \$282.81 | \$343.84 | \$359.59 | \$370.35 | \$377.79 | \$388.51 | \$2,346.30 |
| No Expansion | \$197.67 | \$249.03 | \$302.83 | \$316.48 | \$326.53 | \$333.60 | \$343.24 | \$2,069.38 |
| Difference | \$25.73 | \$33.78 | \$41.01 | \$43.12 | \$43.82 | \$44.19 | \$45.27 | \$276.92 |

The economic growth spurred by both the expansion and no expansion scenarios also stimulates new revenue generation. Economic growth drives tax revenue collection. As a state increases employment, income, and output, the pool of taxable dollars from which to draw increases, assuming no changes to the existing tax policy. For example, as business output grows in New Hampshire, the state’s business profits tax will generate additional revenue. The REMI model uses this concept to calculate total revenue generation in the state. REMI utilizes all tax and fee categories outlined in the 2011 Governor’s Operating Budget, including revenue sources such as the business profits and enterprise tax, tobacco tax, communications tax, state property tax, gasoline road toll, alcohol fund, Medicaid enhancement tax, and many others. The link between economic growth and the various revenue sources is utilized to forecast total revenue generation for the state in both the non-expansion and expansion scenarios.

Under the no expansion scenario, in 2014, New Hampshire’s state government gains approximately \$5.7 million in additional revenue, compared to the pre-ACA projected baseline (*Figure 24*). By comparison, Medicaid expansion would result in about \$6.4 million in additional revenue in 2014. Total new revenue peaks in 2020 – a 0.50 percent increase under no expansion and a 0.55 percent increase under expansion. From 2014 to 2020, New Hampshire collects \$114 million in new revenues under the no expansion scenario, compared to \$127 million in new revenues under the expansion scenario; this represents a \$13 million increase in revenue under expansion, compared to no expansion.

Figure 24. Change in State Revenue from Baseline, 2014-2020 (in millions)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|---------------------|--------|---------|---------|---------|---------|---------|---------|-----------|
| Expansion | \$6.39 | \$14.47 | \$18.05 | \$20.55 | \$21.64 | \$22.59 | \$23.64 | \$127.32 |
| No Expansion | \$5.72 | \$12.92 | \$16.12 | \$18.37 | \$19.39 | \$20.31 | \$21.30 | \$114.13 |
| Difference | \$0.67 | \$1.54 | \$1.94 | \$2.18 | \$2.25 | \$2.28 | \$2.34 | \$13.20 |

The aforementioned economic and fiscal indicators accumulate to modest differences between expansion and non-expansion over the 2014 to 2020 analysis period. Overall, the REMI model indicates a significant boost to New Hampshire's economy, revenues, and employment regardless of whether the expansion or non-expansion scenario is selected. However, the Medicaid expansion maximizes the economic, fiscal, and employment (for most sectors) impacts when compared to the no expansion scenario.

E. Impact on Commercial Market

1. Cost Shifting

Providers must find financial support to cover costs when payment received for services falls short. This phenomenon is often referred to as "cost-shifting," and represents an attempt by providers to offset a portion of unpaid costs of care from one patient population through above-cost charges and revenues from other patient populations. In response to higher charges by providers insurers may, theoretically, shift a portion of the additional cost burden onto members, which may then be reflected through increased premiums.

It is estimated that in 2009, the twenty-six New Hampshire Health Care Systems cost-shifted \$683 million, a direct reflection of the amount of the uncompensated and undercompensated care delivered in the state²⁶. It is unclear to what degree this sum translated to higher premiums for the privately insured. Cost shifting in the market from uncompensated care and underpayment by Medicare and Medicaid onto individual and employer market insurance premiums will not occur spontaneously under the ACA. Cost shifting may result if purchasers, such as employers, demand lower premiums based on the decrease in the number of uninsured, while insurers may demand lower payment rates from hospital systems because they will no longer need to cross-subsidize for the uninsured and underinsured.

Nationwide, speculation regarding the effect of impending DSH cuts on hospitals margins have prompted concern about whether the potential impact will be borne by the privately insured through increasing member premiums. We estimate that the ACA Medicaid DSH cuts will not impact Medicaid DSH payments to New Hampshire hospitals through 2020, assuming that the current payment methodology continues. Thus, the DSH reductions will have no impact on individual premiums. However, the reduction of uncompensated care under Medicaid expansion would potentially reduce cost-shifting, and could theoretically reduce premiums for those who are privately insured.

Under Medicaid expansion, we estimate that uncompensated and undercompensated care (inclusive of bad debt, charity care, and payment below cost from Medicaid and Medicare) will comprise an average of 0.7 percent of total annual private insurance premiums in the state (*Figure 25*). This includes single coverage premiums in the individual market, single and family coverage in the private-sector employer market, and single and family coverage in the public-sector employer market. This estimate also accounts for an estimated 56,000 additional

²⁶ Health System Cost-Shifting in NH." *New Hampshire Center for Public Policy* (2011)

members coming into the individual market beginning in 2014, who will be obtaining coverage through the Health Benefits Exchange. Research has indicated mixed consensus regarding the degree of cost-shifting by hospitals, with some estimates pointing to 50 percent of the costs of uncompensated and undercompensated care being shifted onto the private market²⁷.

Figure 25. Reduction in Private Insurance Premiums with Medicaid Expansion (in \$1000s)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Premium per Member | \$6.2 | \$6.5 | \$6.9 | \$7.3 | \$7.8 | \$8.3 | \$8.8 |
| Total Premiums | \$5,538,665 | \$5,886,382 | \$6,291,287 | \$6,668,341 | \$7,087,920 | \$7,555,270 | \$8,068,545 |
| Uncompensated and Undercompensated Care Reduced | \$41,600 | \$46,200 | \$59,200 | \$53,600 | \$49,500 | \$44,000 | \$46,100 |
| Percentage of Total Premiums | 0.8% | 0.8% | 0.9% | 0.8% | 0.7% | 0.6% | 0.6% |

Absent a program expansion, uncompensated and undercompensated care represents a slightly lower portion of total premiums, in part due to an additional 19,000 members obtaining coverage through the HBE when compared to an expansion scenario, contributing to higher total annual premiums (*Figure 26*).

Figure 26. Reduction in Private Insurance Premiums without Medicaid Expansion (in \$1000s)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| Premium per Member | \$6.1 | \$6.5 | \$6.9 | \$7.3 | \$7.7 | \$8.2 | \$8.8 |
| Total Premiums | \$5,594,126 | \$5,954,083 | \$6,372,914 | \$6,754,874 | \$7,179,899 | \$7,653,327 | \$8,173,277 |
| Uncompensated and Undercompensated Care Reduced | \$42,500 | \$46,200 | \$58,100 | \$51,500 | \$46,500 | \$40,100 | \$41,100 |
| Percentage of Total premiums | 0.8% | 0.8% | 0.9% | 0.8% | 0.6% | 0.5% | 0.5% |

2. Source of Coverage: Individual vs. Group Market

Using the Lewin Group's Health Benefits Simulation model (HBSM), we estimated the effects on the commercial insurance markets in New Hampshire under the ACA with and without a Medicaid expansion. This was performed for the small group market (for businesses with fewer than 100 employees), the large group market (for businesses with 100 or more employees), and for the individual market.

²⁷ Frakt, Austin, Ph.D. "How Much Do Hospitals Cost Shift? A Review of the Evidence." *The Milbank Quarterly* 89.1 (2011)

For each of the three markets, we model the effects of expanding and not expanding Medicaid on the number of members enrolled, as well as the effect on the average allowed cost, a measure of relative morbidity of the individuals transitioning in and out of the market. Average allowed cost effectively captures comprehensive individual-level spending within the market, as it includes both members' health care cost-sharing, as well as the share of expenses borne by insurers. However, these should not be used as estimates of premiums in the market.

Figure 27 shows member movement in and out of the small group market due to the ACA with and without the Medicaid expansion. Due to crowd out under the Medicaid expansion, we estimate there will be a small reduction in the number of people with small group employer coverage. However, we estimate a small increase in people covered in the small group market if Medicaid is not expanded. In either case the net change in the size of the small group risk pool is minimal, with or without the expansion. Likewise, a slight net decrease in average allowed costs occurs in both scenarios under the ACA, which would result in a minimum effect on premiums in the small group market.

Figure 27. Small Group Commercial Market: Members and Average Allowed Costs With and Without Medicaid Expansion (2014)

| | With Medicaid Expansion | | Without Medicaid Expansion | |
|--------------------------------------|-------------------------|-----------------------|----------------------------|-----------------------|
| | Members | Average Allowed Costs | Members | Average Allowed Costs |
| Current Small Group Market | 215,469 | \$504 | 215,469 | \$504 |
| Leave Small Group Market | 16,362 | \$551 | 13,322 | \$698 |
| To Medicaid | 4,054 | \$583 | 0 | \$0 |
| To Other Coverage | 12,308 | \$541 | 13,322 | \$698 |
| Retain Small Group Coverage | 199,108 | \$500 | 202,147 | \$491 |
| Leave Other Coverage for Small Group | 14,322 | \$425 | 15,488 | \$393 |
| From Uninsured | 10,556 | \$359 | 11,645 | \$328 |
| From Other Coverage | 3,766 | \$610 | 3,843 | \$592 |
| Small Group Under ACA | 213,273 | \$495 | 217,480 | \$493 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM)

As shown in *Figure 28*, the large group employer market will experience a more dramatic shift in the size of the risk pool if expansion occurs. The difference in size of the risk pool attributable to Medicaid expansion is substantial: under Medicaid expansion, there will be 9,200 fewer individuals in the risk pool, compared to no expansion. Due to the ACA, average costs for people in the large group market will drop under both expansion and no expansion scenarios. Average costs for people in the large group are similar regardless of the Medicaid expansion and thus would result in an insignificant effect on premiums.²⁸

²⁸ Premiums will be 0.5 percent lower under Medicaid expansion.

Figure 28. Large Group Commercial Market: Members and Average Allowed Costs With and Without Medicaid Expansion (2014)

| | With Medicaid Expansion | | Without Medicaid Expansion | |
|--------------------------------------|-------------------------|-----------------------|----------------------------|-----------------------|
| | Members | Average Allowed Costs | Members | Average Allowed Costs |
| Current Large Group Market | 589,091 | \$560 | 589,091 | \$560 |
| Leave Large Group Market | 24,324 | \$595 | 16,352 | \$749 |
| To Medicaid | 8,832 | \$322 | 0 | \$0 |
| To Other Coverage | 15,492 | \$751 | 16,352 | \$749 |
| Retain Large Group Coverage | 564,767 | \$558 | 572,739 | \$555 |
| Leave Other Coverage for Large Group | 18,643 | \$298 | 19,887 | \$297 |
| From Uninsured | 14,162 | \$256 | 15,213 | \$260 |
| From Other Coverage | 4,481 | \$431 | 4,673 | \$417 |
| Large Group Under ACA | 583,054 | \$550 | 592,274 | \$547 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

The most significant differences are seen when we study the individual market. Whether Medicaid expansion takes place or not, the size of the individual market risk pool will more than double under the ACA and allowed costs for people in the individual market will also increase dramatically. This will mostly be due to guaranteed issue of coverage, elimination of pre-existing condition exclusions, and moving the high-risk pool enrollees (including those in the temporary federal pool) into the market.

Notably, as shown in *Figure 29*, nearly 40 percent of the final individual market will be composed of those who were previously uninsured enrolling in the individual market. Enrollment in the individual market will be higher without the Medicaid expansion because fewer people who currently have individual coverage will leave for Medicaid. Also, more uninsured will take individual coverage since subsidies will be available for those between 100 and 138 percent of FPL. However, average costs for the group would be slightly lower if Medicaid is expanded, which would lead to slightly lower premiums in the individual market.

Figure 29. Individual Commercial Market: Members and Average Allowed Costs With and Without Medicaid Expansion (2014)

| | With Medicaid Expansion | | Without Medicaid Expansion | |
|-------------------------------------|-------------------------|-----------------------|----------------------------|-----------------------|
| | Members | Average Allowed Costs | Members | Average Allowed Costs |
| Current Individual Market | 50,189 | \$339 | 50,189 | \$339 |
| Leave Individual Market | 11,860 | \$243 | 8,187 | \$261 |
| To Medicaid | 3,947 | \$196 | 0 | \$0 |
| To Other Coverage | 7,913 | \$266 | 8,187 | \$261 |
| Retain Individual Market Coverage | 38,329 | \$369 | 42,002 | \$354 |
| Leave Other Coverage for Individual | 67,827 | \$518 | 82,934 | \$530 |
| From Uninsured | 40,417 | \$313 | 53,428 | \$307 |
| From High-Risk Pool | 3,329 | \$2,390 | 3,594 | \$2,689 |
| From Other Coverage | 24,080 | \$603 | 25,912 | \$692 |
| Individual Market Under ACA | 106,156 | \$464 | 124,936 | \$471 |

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

IV. Methodology

This section describes the methodology used to produce the enrollment and cost estimates presented in this report.

A. Impact of ACA on Medicaid DSH Payments

The ACA reduces federal funding for the Medicaid Disproportionate Share Hospital (DSH) program beginning in 2014. The rationale for reducing Medicaid DSH funding is that the new coverage options provided under the ACA will reduce the number of uninsured and in turn the amount of uncompensated care that hospitals currently provide to the uninsured. Medicaid DSH payments were used to help pay hospitals for a portion of the uncompensated care they provided. Thus, as uncompensated care levels decline, then so will DSH payments.

The provisions in the ACA that specify federal reductions in DSH funding are separate from the Medicaid expansion provisions. Thus, DSH funding will be reduced whether or not the state expands Medicaid. However, the reductions will be tied to the number of uninsured in the state and how the state treats hospitals with high Medicaid and uncompensated care levels.

In our analysis of the impact of the ACA on Medicaid DSH payments, we examined the New Hampshire Medicaid DSH program and estimated the amount of DSH payments, based on the state's current method, and compared that to the projected federal DSH allotment available to the state through 2020. We estimated the amount of the Medicaid Enhancement Tax (MET) that would be collected for each year assuming that the tax rate is 5.5 percent of hospital net patient service revenue. Thirteen percent of the anticipated MET revenue is placed in the Uncompensated Care Fund (UCF), for which federal matching funds are drawn down up to the state's allotment. Payments from the UCF are first paid to cover uncompensated care costs for Critical Access Hospitals. The remainder, if any, is then paid to acute care hospitals for a portion of their uncompensated care costs.

As shown in *Figure 30*, based on this methodology, we estimated the amount of Medicaid DSH payments that would be paid to hospitals plus the amount paid to New Hampshire Hospital (Institution for Mental Disease), which was \$9.2 million in 2012. We estimate that by 2020, Medicaid DSH payments will be \$101.9 million of which \$50.9 million will be paid by the federal government. We then estimated the state's federal DSH allotment through 2020 assuming that New Hampshire is treated like an average state for treatment of the ACA Medicaid DSH cuts. Based on these assumptions, we estimate that New Hampshire's federal DSH allotment will drop to \$92.0 million in 2020. However, this will still be more than what is needed to match the UCF. Thus, we estimate that the ACA Medicaid DSH cuts will not affect the Medicaid DSH payments to New Hampshire hospitals assuming that the current payment methodology continues through 2020.

Figure 30. Medicaid DSH Payments and Federal DSH Allotments Under the ACA for New Hampshire 2010-2020 ^{1/}

| Year | Hospital DSH Payment ^{1/} | IMD DSH Payment ^{2/} | Total DSH Payment | Federal DSH Drawdown | Federal DSH Allotment Pre-ACA ^{3/} | Federal DSH Allotment Post-ACA ^{4/} | Amount (Under)/ Over Allotment |
|------|------------------------------------|-------------------------------|-------------------|----------------------|---|--|--------------------------------|
| 2010 | \$182.0 | \$18.5 | \$200.5 | \$100.3 | \$165.4 | \$165.4 | -\$65.2 |
| 2011 | \$205.8 | \$16.4 | \$222.2 | \$111.1 | \$160.3 | \$160.3 | -\$49.2 |
| 2012 | \$48.7 | \$9.2 | \$57.9 | \$29.0 | \$162.0 | \$162.0 | -\$133.0 |
| 2013 | \$57.2 | \$9.6 | \$66.8 | \$33.4 | \$165.4 | \$165.4 | -\$132.0 |
| 2014 | \$61.1 | \$10.2 | \$71.3 | \$35.6 | \$167.0 | \$158.5 | -\$122.9 |
| 2015 | \$64.5 | \$10.8 | \$75.3 | \$37.7 | \$170.4 | \$160.4 | -\$122.7 |
| 2016 | \$68.8 | \$11.5 | \$80.3 | \$40.1 | \$173.8 | \$163.7 | -\$123.6 |
| 2017 | \$72.8 | \$12.2 | \$84.9 | \$42.5 | \$177.2 | \$146.9 | -\$104.4 |
| 2018 | \$77.1 | \$12.9 | \$90.0 | \$45.0 | \$180.5 | \$96.2 | -\$51.3 |
| 2019 | \$81.9 | \$13.7 | \$95.6 | \$47.8 | \$183.9 | \$90.3 | -\$42.5 |
| 2020 | \$87.3 | \$14.6 | \$101.9 | \$50.9 | \$187.3 | \$92.0 | -\$41.0 |

1/ Assumes 13 percent of MET used to fund UCP and includes federal matching funds.

2/ Based on data reported by New Hampshire hospital for 2010 through 2012 and trended to 2020 based on projected hospital revenue growth for CMS Office of the Actuary.

3/ New Hampshire's DSH allotment for 2011 was trended to 2020 based on national projected federal DSH funding.

4/ Assumes DSH cuts for New Hampshire is made in proportion to national reduction specified in the ACA.

Source: Lewin Group estimates.

B. Health Systems

For this analysis, we used the Lewin Group Health Benefits Simulation Model for the state of New Hampshire. Our HBSM model provides estimated impacts of the coverage expansions on major stakeholders including hospitals and physicians. The HBSM model of hospital impacts reflects reductions in uncompensated care resulting from expanded health insurance coverage to the uninsured. We combined the results of the HBSM simulations with audited financial statement data for New Hampshire health systems for 2010 and 2011 provided by the New Hampshire Hospital Association (NHHA). These data provided consolidated information on gross and net revenue by payer, operating expenses and bad debt and charity care for health systems in the state. Health systems include the hospital as well as other entities owned by the system, such as physician groups, skilled nursing facilities, freestanding surgical centers, and home health agencies. *Figure 31* presents the data used for the analysis for 2011.

Figure 31. New Hampshire Health System Revenues and Expenses for 2011

| Payer Group | Gross Revenue | Operating Expenses | Percent of Expenses | Net Revenue | Net Revenue as Percent of Expenses by Payer |
|------------------------|-------------------------|------------------------|---------------------|------------------------|---|
| Medicaid ^{1/} | \$979,194,385 | \$449,667,570 | 10% | \$295,193,568 | 66% |
| Medicare | \$3,976,493,652 | \$1,826,093,230 | 39% | \$1,337,714,941 | 73% |
| Commercial | \$4,355,425,872 | \$2,000,107,229 | 43% | \$2,947,601,749 | 147% |
| All Other | \$346,115,834 | \$158,943,994 | 3% | \$207,441,765 | 131% |
| Uncompensated care | \$550,255,307 | \$252,689,324 | 5% | \$0 | 0% |
| Other Operating | | | | \$303,115,201 | |
| Total | \$10,207,485,051 | \$4,687,501,347 | 100% | \$5,091,067,224 | 109% |

1/ We did not attempt to exclude Medicaid DSH payments from the data. Hospitals were not consistent in how they reported DSH payments. Some included DSH payments as other operating revenue while others included it as net Medicaid revenue. Also, we did not adjust Medicaid net revenues for retrospective settlements. Thus, this analysis yields higher Medicaid payment to cost ratios than other similar analyses have shown.

Source: Lewin Group analysis of data provided by the New Hampshire Hospital Association, derived from Audited Financial Statements for 2011.

The data show uncompensated care costs for bad debt and charity care of \$252.7 million in 2011. Data provided by the NHHA also showed that about 75 percent of uncompensated care was provided to uninsured, while 25 percent was provided to underinsured people, which is similar to other estimates. Using our HBSM model, we estimate that uncompensated care costs for the uninsured would be reduced by about 70 percent if the state expanded Medicaid and about 45 percent due to other coverage provisions if the state did not expand Medicaid. This is due to a high portion of uncompensated care (48 percent) being provided to people below poverty in hospitals and emergency departments. Based on this analysis, we estimate that bad debt and charity care for New Hampshire health systems would be about \$2.7 billion over the 2014 to 2020 period in the absence of the ACA. If the state expands Medicaid, this amount would be reduced by \$1.3 billion over this period compared to \$862.0 million if the state does not expand Medicaid (*Figure 32*). Thus, health systems in the state could see uncompensated care reduced by an additional \$456.0 million over this period if the state expands Medicaid under the ACA.

Figure 32. Reductions in Bad Debt and Charity Care for New Hampshire Health System, Under the ACA With and Without The Medicaid Expansion 2014-2020

| Year | Operating Expenses | Bad Debt and Charity Care as a Percent of Operating Expenses | Bad Debt and Charity Care Costs Pre-ACA | Reduced Bad Debt and Charity Care under the ACA | |
|-----------|--------------------|--|---|---|----------------------------|
| | | | | With Medicaid Expansion | Without Medicaid Expansion |
| 2014 | \$5,583 | 5.6% | \$310 | \$125 | \$80 |
| 2015 | \$5,918 | 5.6% | \$332 | \$155 | \$99 |
| 2016 | \$6,273 | 5.7% | \$356 | \$189 | \$121 |
| 2017 | \$6,649 | 5.7% | \$381 | \$202 | \$130 |
| 2018 | \$7,048 | 5.8% | \$408 | \$216 | \$139 |
| 2019 | \$7,471 | 5.8% | \$437 | \$232 | \$149 |
| 2020 | \$7,919 | 5.9% | \$468 | \$248 | \$159 |
| 2014-2020 | \$46,862 | 5.7% | \$2,692 | \$1,366 | \$877 |

Source: Lewin Group analysis using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

To estimate the overall financial impact of the Medicaid expansion on New Hampshire health systems, we provide an illustration of the impact on revenues and costs, assuming that all provisions of the ACA are fully phased in, but in 2011 dollars. For this analysis, we assume that previously uncompensated costs for patients covered by the Medicaid expansion will be reimbursed at Medicaid rates that are below cost, as shown above. Payments for patients newly covered by private insurance are assumed to be made at private payment levels, which are substantially above costs. We estimate there will be more people newly covered by private insurance if the state does not expand Medicaid since those between 100 and 138 percent of FPL will be eligible for subsidized private coverage in the HBE. There is a greater reduction in uncompensated care if the state expands Medicaid (\$131.3 million), compared to \$85.9 million without the expansion. However, since hospitals would receive a much higher private payment rate compared to Medicaid, the revenues received by the hospital for this care under the expansion would be \$130.5 million compared to \$120.9 million without the expansion. The detailed calculations are shown in *Figure 33* and *Figure 34*.

Second, we assume that health system inpatient and outpatient utilization for newly insured people will increase to the same levels as insured people with similar demographic, income, and health status characteristics. If the state expands Medicaid, we estimate an increased utilization by the newly insured of \$92.3 million in costs, for which the hospital will receive about \$107.3 million in revenue due to the mix of Medicaid and commercial payments. Similarly, if the state does not expand Medicaid, we estimate an increase in utilization of \$69.0 million in costs, with \$100.1 million in payments.

Our analysis shows that about 20,500 individuals who enroll in the Medicaid expansion would have been covered by private insurance in the absence of the expansion (i.e., crowd out). Health systems would have received commercial payment rates for services provided to these people in the absence of the expansion, but will instead receive the lower Medicaid rates. Because of the lower Medicaid reimbursement, we estimate a loss to the health systems of \$38.6 million.

We also estimate that 3,500 previous Medicaid enrollees would take private coverage as their employers begin to offer coverage. Conversely, hospitals would have received Medicaid payment rates for these people in the absence of the ACA, but will instead receive higher commercial rates. We estimate the net effect would be an increase in net income of about \$6.2 million.

Overall, we estimate that health systems would see an increase in net income of about \$113.1 million under the Medicaid expansion assuming full implementation in 2014, which would represent a 28 percent increase in their current net income. However, due to more people being enrolled in private insurance in the absence of the expansion, we estimate that health system net income would increase by \$158.2 million. Although health systems would see more of an improvement in their bottom line, they would need to provide a greater volume of uncompensated care without the Medicaid expansion.

Figure 33. Impact on New Hampshire Health System Revenues and Costs Under the ACA With the Medicaid Expansion (2011)

| | Baseline Revenue and Costs Pre-ACA | Reduced Uncompensated Care | Increased Utilization | Crowd Out Private shifting to Medicaid | Medicaid Enrollees shifting to Private | Revenue and Cost under ACA |
|------------------------------|---|---|----------------------------------|---|---|---|
| Costs by Payer | | | | | | |
| Medicaid | \$449.7 | \$77.1 | \$35.2 | \$51.9 | -\$7.6 | \$606.3 |
| Medicare | \$1,826.1 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$1,826.1 |
| Commercial | \$2,000.1 | \$54.2 | \$57.2 | -\$49.3 | \$7.6 | \$2,069.8 |
| All Other | \$158.9 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$158.9 |
| Uncompensated Care | \$252.7 | -\$131.3 | \$0.0 | -\$2.6 | \$0.0 | \$118.8 |
| Total Operating Cost | \$4,687.5 | \$0.0 | \$92.3 | \$0.0 | \$0.0 | \$4,779.8 |
| Net Revenues by Payer | | | | | | |
| Medicaid | \$295.2 | \$50.6 | \$23.1 | \$34.1 | -\$5.0 | \$398.0 |
| Medicare | \$1,337.7 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$1,337.7 |
| Commercial | \$2,947.6 | \$79.9 | \$84.2 | -\$72.7 | \$11.3 | \$3,050.3 |
| All Other | \$207.4 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$207.4 |
| Other Operating | \$303.1 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$303.1 |
| Total Operating Revenue | \$5,091.1 | \$130.5 | \$107.3 | -\$38.6 | \$6.2 | \$5,296.5 |
| Net Operating Income | \$403.6 | \$130.5 | \$15.0 | -\$38.6 | \$6.2 | \$516.7 |

1/ Assumes that all provisions of the ACA are fully phased in, but illustration of impacts in 2011 dollars.
Source: Lewin Group analysis using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Figure 34. Impact on New Hampshire Health System Revenues and Costs Under the ACA Without the Medicaid Expansion

| | Baseline Revenue and Costs Pre-ACA | Reduced Uncompensated Care | Increased Utilization | Crowd Out Private shifting to Medicaid | Medicaid Enrollees shifting to Private | Revenue and Cost under ACA |
|------------------------------|------------------------------------|----------------------------|-----------------------|--|--|----------------------------|
| Costs by Payer | | | | | | |
| Medicaid | \$449.7 | \$6.8 | \$2.0 | \$0.0 | -\$7.6 | \$450.8 |
| Medicare | \$1,826.1 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$1,826.1 |
| Commercial | \$2,000.1 | \$79.0 | \$67.0 | \$0.0 | \$7.6 | \$2,153.8 |
| All Other | \$158.9 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$158.9 |
| Uncompensated Care | \$252.7 | -\$85.9 | \$0.0 | \$0.0 | \$0.0 | \$166.8 |
| Total Operating Cost | \$4,687.5 | \$0.0 | \$69.0 | \$0.0 | \$0.0 | \$4,756.5 |
| Net Revenues by Payer | | | | | | |
| Medicaid | \$295.2 | \$4.5 | \$1.3 | \$0.0 | -\$5.0 | \$295.9 |
| Medicare | \$1,337.7 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$1,337.7 |
| Commercial | \$2,947.6 | \$116.5 | \$98.8 | \$0.0 | \$11.3 | \$3,174.1 |
| All Other | \$207.4 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$207.4 |
| Other Operating | \$303.1 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$303.1 |
| Total Operating Revenue | \$5,091.1 | \$120.9 | \$100.1 | \$0.0 | \$6.2 | \$5,318.3 |
| Net Operating Income | \$403.6 | \$120.9 | \$31.1 | \$0.0 | \$6.2 | \$561.8 |

1/ Assumes that all provisions of the ACA are fully phased in, but illustration of impacts in 2011 dollars. Source: Lewin Group analysis using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Figure 35 presents our estimates of projected health system revenues by payer source from 2014 through 2020. The table also shows the change in revenues by payer under the ACA with and without the Medicaid expansion.

Figure 35. Impact on New Hampshire Health System Revenues Under the ACA Without the Medicaid Expansion 2014-2020 (in millions)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|---|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|
| Baseline Pre-ACA | | | | | | | | |
| Medicaid | \$327.4 | \$338.5 | \$350.4 | \$363.5 | \$375.9 | \$392.8 | \$414.6 | \$2,563.0 |
| Medicare | \$1,588.4 | \$1,682.7 | \$1,790.0 | \$1,908.6 | \$2,038.0 | \$2,171.1 | \$2,312.6 | \$13,491.3 |
| Commercial | \$3,251.6 | \$3,398.0 | \$3,567.9 | \$3,770.8 | \$3,989.8 | \$4,240.4 | \$4,492.7 | \$26,711.1 |
| All Other | \$231.0 | \$240.7 | \$251.0 | \$262.3 | \$275.9 | \$290.4 | \$305.5 | \$1,856.6 |
| Total | \$5,398.4 | \$5,659.9 | \$5,959.2 | \$6,305.1 | \$6,679.5 | \$7,094.7 | \$7,525.4 | \$44,622.1 |
| Change under the ACA with Medicaid Expansion | | | | | | | | |
| Medicaid | \$86.7 | \$103.8 | \$122.0 | \$126.6 | \$130.9 | \$136.8 | \$144.4 | \$851.1 |
| Medicare | -\$37.3 | -\$52.8 | -\$62.4 | -\$77.5 | -\$91.7 | -\$107.9 | -\$117.4 | -\$547.0 |
| Commercial | \$86.1 | \$104.1 | \$124.3 | \$131.3 | \$138.9 | \$147.7 | \$156.5 | \$888.9 |
| All Other | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 |
| Total | \$135.4 | \$155.1 | \$183.9 | \$180.4 | \$178.2 | \$176.6 | \$183.5 | \$1,193.0 |

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|--|---------|---------|---------|---------|---------|----------|----------|-----------|
| Change under the ACA without Medicaid Expansion | | | | | | | | |
| Medicaid | \$0.6 | \$0.8 | \$0.9 | \$0.9 | \$1.0 | \$1.0 | \$1.1 | \$6.2 |
| Medicare | -\$37.3 | -\$52.8 | -\$62.4 | -\$77.5 | -\$91.7 | -\$107.9 | -\$117.4 | -\$547.0 |
| Commercial | \$189.9 | \$229.8 | \$274.2 | \$289.8 | \$306.6 | \$325.9 | \$345.3 | \$1,961.4 |
| All Other | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 | \$0.0 |
| Total | \$153.2 | \$177.8 | \$212.7 | \$213.2 | \$215.9 | \$219.0 | \$228.9 | \$1,420.7 |

Figure 36 presents our estimates of projected health system uncompensated care by source from 2014 through 2020. The table also shows the change in uncompensated care costs under the ACA with and without the Medicaid expansion.

Figure 36. Projected Uncompensated Care costs for New Hampshire Health Systems and the Change Under the ACA Without the Medicaid Expansion 2014-2020 (in millions)

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|---------------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Baseline - Pre ACA | | | | | | | | |
| Bad debt & Charity | \$310.2 | \$332.2 | \$355.8 | \$381.0 | \$408.1 | \$437.0 | \$468.0 | \$2,692.4 |
| Medicaid shortfall | \$174.2 | \$182.6 | \$192.3 | \$203.4 | \$215.5 | \$228.9 | \$242.8 | \$1,439.6 |
| Medicare shortfall | \$550.6 | \$577.3 | \$607.8 | \$643.1 | \$681.3 | \$723.7 | \$767.6 | \$4,551.5 |
| Total Uncompensated Care | \$1,035.1 | \$1,092.2 | \$1,155.9 | \$1,227.6 | \$1,304.9 | \$1,389.6 | \$1,478.4 | \$8,683.6 |
| ACA with Medicaid expansion | | | | | | | | |
| Bad debt & Charity | \$185.3 | \$177.3 | \$167.2 | \$179.1 | \$191.8 | \$205.4 | \$220.0 | \$1,326.0 |
| Medicaid shortfall | \$220.3 | \$238.6 | \$259.2 | \$274.3 | \$290.6 | \$308.6 | \$327.4 | \$1,918.9 |
| Medicare shortfall | \$587.9 | \$630.1 | \$670.2 | \$720.6 | \$773.0 | \$831.6 | \$885.0 | \$5,098.5 |
| Total Uncompensated Care | \$993.5 | \$1,046.0 | \$1,096.7 | \$1,174.0 | \$1,255.4 | \$1,345.6 | \$1,432.3 | \$8,343.4 |
| ACA without Medicaid expansion | | | | | | | | |
| Bad debt & Charity | \$230.1 | \$232.8 | \$234.8 | \$251.5 | \$269.3 | \$288.4 | \$308.9 | \$1,815.9 |
| Medicaid shortfall | \$174.5 | \$183.0 | \$192.8 | \$203.9 | \$216.0 | \$229.5 | \$243.4 | \$1,443.1 |
| Medicare shortfall | \$587.9 | \$630.1 | \$670.2 | \$720.6 | \$773.0 | \$831.6 | \$885.0 | \$5,098.5 |
| Total Uncompensated Care | \$992.5 | \$1,046.0 | \$1,097.8 | \$1,176.1 | \$1,258.4 | \$1,349.5 | \$1,437.3 | \$8,357.5 |
| Change in Uncompensated Care | | | | | | | | |
| With expansion | -\$41.6 | -\$46.2 | -\$59.2 | -\$53.6 | -\$49.5 | -\$44.0 | -\$46.1 | -\$340.2 |
| Without expansion | -\$42.5 | -\$46.2 | -\$58.1 | -\$51.5 | -\$46.5 | -\$40.1 | -\$41.1 | -\$326.0 |

C. Federally Qualified Health Centers

From the U.S. Department of Health and Human Services' Uniform Data System (UDS), we compiled five years (2007-2011) of aggregate annual data for New Hampshire's Federally Qualified Health Centers (FQHCs), which provided the FQHCs' expenses, total charges, and collected dollar amounts by payor category. Due to an inconsistent number of health centers profiled over the duration of the five-year period, it was necessary to derive per-patient annual cost and charge figures within each payor category. We accomplished this by using patient

count data by payor category, also provided within UDS, in conjunction with the financial figures found within each annual report.

For each payor category, we projected the total number of patients, the charge per patient, and the percentage of charges collected for 2012-2020 based on historical trends. By assuming that the pre-ACA Medicaid program continues, these projections model a hypothetical baseline scenario. From these figures, we were then able to deduce total charges and total collections for each payor category.

Using the Lewin Group's Health Benefits Simulation Model (HBSM), we traced the transition of the FQHCs' patient revenues between payor categories, as care recipients who are below 200 percent of FPL transition from one payor category to another as a result of new eligibility provisions under the ACA. We performed this simulation under a Medicaid expansion scenario, as well as under a no Medicaid expansion scenario, each under several enrollment lag assumptions, presuming that approximately 76 percent of individuals who are newly eligible for program enrollment will act in the first year of implementation (2014), 83 percent during the second year, and 100 percent henceforth.

In *Figure 37*, we show the transition of FQHC patient revenues between payor categories in the absence of Medicaid expansion. Likewise, *Figure 38* shows this transition under a Medicaid expansion scenario. In both figures, the percentages shown in each row represent the proportion of total patient revenue borne by each payor category following the implementation of the expansion or no expansion scenario. For example, under Medicaid expansion, 80.7 percent of patient revenues that had previously been paid by private insurance prior to Medicaid expansion will continue to be covered by private insurance following expansion. However, Medicaid will now be responsible for 19.1 percent of patient revenues previously covered by private insurance, as a portion of care recipients who previously held private insurance now qualify for the expanded Medicaid program. A very small segment of the previously privately insured (0.3 percent) may lose or choose to forgo all sources of health insurance coverage if Medicaid expansion takes place. We adjust for the current Medicaid program's lack of coverage for substance abuse and dental services in calculating these proportions.

Figure 37. Transition of FQHC Patient Revenue Between Payor Categories in the Absence of Medicaid Expansion

| Transition from: | Transition to: | | | | |
|------------------|----------------|----------|----------|--------------|-----------|
| | Private | Medicaid | Medicare | Other Public | Uninsured |
| Private | 99.6% | 0.0% | 0.0% | 0.0% | 0.4% |
| Medicaid | 2.6% | 97.4% | 0.0% | 0.0% | 0.0% |
| Medicare | 0.0% | 0.0% | 100.0% | 0.0% | 0.0% |
| Other Public | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% |
| Uninsured | 50.2% | 4.4% | 0.0% | 0.0% | 45.4% |

Figure 38. Transition of FQHC Patient Revenue Between Payor Categories Under Medicaid Expansion^{1/}

| Transition from: | Transition to: | | | | |
|------------------|----------------|----------|----------|--------------|---------------------|
| | Private | Medicaid | Medicare | Other Public | Uninsured |
| Private | 80.7% | 19.1% | 0.0% | 0.0% | 0.3% |
| Medicaid | 2.6% | 97.4% | 0.0% | 0.0% | 0.0% |
| Medicare | 0.0% | 0.0% | 100.0% | 0.0% | 0.0% |
| Other Public | 0.0% | 0.0% | 0.0% | 100.0% | 0.0% |
| Uninsured | 31.9% | 47.1% | 0.0% | 0.0% | 21.0% ^{1/} |

^{1/} This figure may be slightly inflated, presuming that newly eligibles seeking services at FQHCs will be aided in Medicaid enrollment.

These payor-category transition projections were then used to compute ACA-weighted charge and collection amounts by payor category, for each of the projected years. We estimate costs for each payor category using an overall cost to charge ratio based on 2011 data. A summary of these figures is presented in *Figure 39 and 40* below.

Figure 39. Annual Total Cost, Revenue, and Shortfall for the Sum of All Payor Categories, Assuming Pre-ACA, ACA With Medicaid Expansion, and ACA Without Medicaid Expansion (in \$1,000s)

| | Pre-ACA | | | ACA with Medicaid Expansion | | | ACA without Medicaid Expansion | | |
|-----------|------------|-----------|-----------|-----------------------------|-----------|-----------|--------------------------------|-----------|-----------|
| | Total Cost | Revenue | Shortfall | Total Cost | Revenue | Shortfall | Total Cost | Revenue | Shortfall |
| 2014 | \$54,272 | \$29,997 | \$24,275 | \$61,115 | \$40,856 | \$20,259 | \$58,997 | \$36,483 | \$22,515 |
| 2015 | \$56,732 | \$31,328 | \$25,404 | \$64,526 | \$43,752 | \$20,774 | \$62,115 | \$38,824 | \$23,291 |
| 2016 | \$59,303 | \$32,721 | \$26,583 | \$69,081 | \$48,374 | \$20,706 | \$66,055 | \$42,259 | \$23,796 |
| 2017 | \$61,991 | \$34,178 | \$27,813 | \$72,212 | \$50,613 | \$21,599 | \$69,049 | \$44,291 | \$24,758 |
| 2018 | \$64,801 | \$35,702 | \$29,098 | \$75,484 | \$52,957 | \$22,528 | \$72,179 | \$46,424 | \$25,755 |
| 2019 | \$67,738 | \$37,298 | \$30,440 | \$78,906 | \$55,412 | \$23,494 | \$75,450 | \$48,662 | \$26,788 |
| 2020 | \$70,808 | \$38,967 | \$31,841 | \$82,482 | \$57,983 | \$24,499 | \$78,870 | \$51,012 | \$27,858 |
| 2014-2020 | \$435,645 | \$240,191 | \$195,454 | \$503,805 | \$349,947 | \$153,858 | \$482,715 | \$307,955 | \$174,761 |

With or without Medicaid expansion under the ACA, we assume there will be increased utilization for these services for newly insured individuals. Thus, total annual cost of treatment for all individuals will increase above expected total costs under a hypothetical pre-ACA scenario. Cumulative total costs under the ACA for the 2014 to 2020 period, without Medicaid expansion, is expected to be over \$482.7 million, while total cost with an expansion is expected to reach nearly \$504.0 million (*Figure 39*). However, due to higher revenues gained under the ACA, FQHCs' total annual shortfall will be substantially lower under the ACA, and lowest with a program expansion.

Figure 40. Annual Total Cost, Revenue, and Shortfall for the Uninsured, Assuming Pre-ACA, ACA With Medicaid Expansion, and ACA Without Medicaid Expansion (in \$1,000s)

| | Pre-ACA | | | ACA with Medicaid Expansion | | | ACA without Medicaid Expansion | | |
|-----------|------------|----------|-----------|-----------------------------|---------|-----------|--------------------------------|----------|-----------|
| | Total Cost | Revenue | Shortfall | Total Cost | Revenue | Shortfall | Total Cost | Revenue | Shortfall |
| 2014 | \$15,948 | \$3,085 | \$12,863 | \$6,341 | \$1,227 | \$5,114 | \$9,334 | \$1,806 | \$7,529 |
| 2015 | \$16,671 | \$3,167 | \$13,504 | \$5,727 | \$1,088 | \$4,639 | \$9,137 | \$1,736 | \$7,401 |
| 2016 | \$17,426 | \$3,250 | \$14,176 | \$3,699 | \$690 | \$3,009 | \$7,976 | \$1,488 | \$6,488 |
| 2017 | \$18,216 | \$3,337 | \$14,879 | \$3,866 | \$708 | \$3,158 | \$8,338 | \$1,527 | \$6,810 |
| 2018 | \$19,042 | \$3,425 | \$15,617 | \$4,042 | \$727 | \$3,315 | \$8,715 | \$1,568 | \$7,148 |
| 2019 | \$19,905 | \$3,516 | \$16,389 | \$4,225 | \$746 | \$3,479 | \$9,111 | \$1,609 | \$7,501 |
| 2020 | \$20,807 | \$3,609 | \$17,198 | \$4,416 | \$766 | \$3,650 | \$9,523 | \$1,652 | \$7,872 |
| 2014-2020 | \$128,014 | \$23,389 | \$104,626 | \$32,316 | \$5,952 | \$26,365 | \$62,134 | \$11,385 | \$50,750 |

D. Community Mental Health Centers

Six years of financial history data on New Hampshire's 10 Community Mental Health Centers (CMHCs) was procured from a 2010 report underwritten by the Endowment for Health/Health Strategies of New Hampshire, entitled *Community Mental Health Centers in New Hampshire – Financial Performance and Conditions*. The report contained aggregate income statement figures for the 10 New Hampshire CMHCs from 2004 through 2009, including a breakdown of the centers' operating revenue and operating expenses by category.

Annual operating revenue and operating expenses were projected through 2020 using a growth rate based on historical trends and budgetary adjustments that occur within the projected period. For example, we accounted for the 2010 Medicaid reimbursement reductions to the Centers for mental health services, which reduced Medicaid payment levels by nearly seven percentage points from the previous fiscal year.

Based on historical trends, we assumed that the Centers' revenues and expenses will grow at roughly the same rate throughout the projected period, with the aggregate operating margin fluctuating around break even (plus or minus 3.6 percent). We also assumed that the Centers will engage in a limited degree of financial self-adjustment in the face of budgetary constraints by modifying their variable inputs.

The New Hampshire Community Behavioral Health Association provided each CMHC's uncompensated care losses, for the four largest categories of loss, for calendar year 2009. These categories include:

- Losses from uncompensated emergency services
- Losses from spend down
- Losses from application of sliding fee schedule to self-pay
- Losses from uncompensated in-take services

From the 2009 figures, we computed loss due to uncompensated care as a percentage of total operating expenditures, and assumed similar proportions for all projected years.

Again, we applied the Lewin Group's Health Benefits Simulation Model payor group transition analysis, which is described in the previous section. We used a consolidated version to apply toward CMHCs. Under Medicaid expansion, 79 percent of uncompensated care will be reduced for patients below 200 percent of FPL. This is a combination of the proportion of previously uninsured individuals becoming newly eligible for Medicaid and the proportion of previously uninsured individuals obtaining private coverage. Similarly, in the absence of Medicaid expansion, 51 percent of the uncompensated care will be reduced for individuals below 200 percent of FPL.

Using these proportions applied to the projections of loss due to uncompensated care, we computed estimates of annual loss by category of uncompensated care, for each income demographic. Summaries of these estimates are shown in *Figures 41, 42, and 43*, for pre-ACA baseline, expansion, and no expansion scenarios.

Figure 41. Total Uncompensated Care, Baseline (\$1,000s)

| CBHA Losses (calendar year) | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
|--|---------------|---------------|---------------|---------------|---------------|---------------|---------------|-------------------|
| Uncompensated Emergency Services | 4,917 | 5,222 | 5,547 | 5,893 | 6,260 | 6,649 | 7,064 | 41,552 |
| Spend Down | 7,722 | 8,202 | 8,712 | 9,255 | 9,831 | 10,443 | 11,094 | 65,259 |
| Application of Sliding Fee Schedule to Self- Pay | 9,484 | 10,074 | 10,701 | 11,367 | 12,075 | 12,827 | 13,627 | 80,157 |
| In-Take Services | 2,266 | 2,407 | 2,556 | 2,715 | 2,884 | 3,064 | 3,255 | 19,147 |
| Total Losses | 24,388 | 25,905 | 27,517 | 29,230 | 31,050 | 32,984 | 35,039 | 206,114 |

Figure 42. Total Uncompensated Care Reduced, With Expansion (\$1,000s)

| CBHA Losses (calendar year) | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|-------------------|
| Uncompensated Emergency Services | 3,883 | 4,124 | 4,381 | 4,654 | 4,943 | 5,251 | 5,578 | 32,814 |
| Spend Down | 6,098 | 6,477 | 6,880 | 7,309 | 7,764 | 8,247 | 8,761 | 51,537 |
| Application of Sliding Fee Schedule to Self-Pay | 7,490 | 7,956 | 8,451 | 8,977 | 9,536 | 10,130 | 10,761 | 63,302 |
| In-Take Services | 1,789 | 1,900 | 2,019 | 2,144 | 2,278 | 2,420 | 2,571 | 15,121 |
| Total Losses | 19,260 | 20,458 | 21,731 | 23,084 | 24,521 | 26,048 | 27,671 | 162,774 |

Figure 43. Total Uncompensated Care Reduced, Without Expansion (\$1,000s)

| CBHA Losses | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | Cumulative |
|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|-------------------|
| Uncompensated Emergency Services | 2,545 | 2,703 | 2,871 | 3,050 | 3,240 | 3,442 | 3,656 | 1,506 |
| Spend Down | 3,997 | 4,245 | 4,509 | 4,790 | 5,088 | 5,405 | 5,742 | 33,777 |
| Application of Sliding Fee Schedule to Self-Pay | 4,909 | 5,214 | 5,539 | 5,884 | 6,250 | 6,639 | 7,053 | 41,488 |
| In-Take Services | 1,173 | 1,246 | 1,323 | 1,405 | 1,493 | 1,586 | 1,685 | 9,910 |
| Total Losses | 12,623 | 13,408 | 14,242 | 15,129 | 16,071 | 17,072 | 18,136 | 106,681 |

The CMHCs profiled included:

Center for Life Management, Community Council of Nashua, Community Partners, Genesis Behavioral Health, Mental Health Center of Greater Manchester, Monadnock Family Services, Northern Human Services, Riverbend Community Mental Health, Seacoast Mental Health Center, and West Central Behavioral Health.

E. Cost-Shifting

Figure 44. Individual Market and Employer Market Premiums (2011)

| | Individual Market | Employer Market | | | |
|--------------------|-------------------|---------------------------------|---------------------------------|---------------------------------|--------------------------------|
| | Single Coverage | Private-Sector- Single Coverage | Public-Sector - Single Coverage | Private-Sector- Family Coverage | Public Sector- Family Coverage |
| Members | 50,189 | 144,452 | 34,375 | 515,213 | 124,540 |
| Premium Per Member | \$3,197 | \$5,818 | \$5,939 | \$5,452 | \$4,763 |
| Total Premiums | \$160,454,233 | \$840,422,760 | \$204,151,774 | \$2,809,072,933 | \$593,136,700 |

Member enrollment for each type of coverage within the individual and employer markets were projected for the 2014-2020 period, assuming that enrollment growth will occur proportionally to the rate of population growth in the absence of the ACA.

From the Lewin Group's analysis of Current Population Survey data, it is estimated that in addition to the projected enrollment based off of current enrollment levels, 56,000 additionally individuals will gain coverage through the Health Benefits Exchange under Medicaid expansion, while nearly 75,000 individuals are expected to gain coverage through the HBE without a program expansion. These additional projected enrollments were phased in beginning in 2014, assuming that 76 percent of expected enrollees will enroll by 2014, 88 percent by 2015, and full enrollment of those participating in the HBE by 2016.

Enrollment figures for single coverage and family coverage under private insurance in the employer market were derived from Medical Expenditure Panel Survey (MEPS) data. In 2011, there were approximately 550,000 private-sector employees in the state. Based on this, we applied the percent of the private-sector establishments that offer health insurance in the state (87.6 percent), the percent of New Hampshire private sector employees who choose to enroll in employer-sponsored health insurance (58 percent), and finally, the proportion of these employees who elect to enroll in single and family coverage, respectively. For both single coverage and family coverage markets, we applied an average premium across private-sector firms of all sizes for the premium per member amount. From the most recent available MEPS information, 2011 data, we applied the Centers for Medicare & Medicaid Services' National Health Expenditure growth rate for 2012 through 2020 to arrive at annual premium projections in both submarkets.

Member totals for New Hampshire's public-sector employees (federal, state, and local) were collected from Current Population Survey data, and trended using Census Bureau population

growth rate projections, as in other markets. Premium estimates were made based on MEPS data for New Hampshire's average total single coverage or family coverage premium per enrolled employee at establishments that employ 1000 or more employees.

Figure 44 illustrates the distribution of member counts, per member premiums, total premiums across the individual and employer markets for 2011.

F. Economic Impact

Using outputs from the analysis of the impact on healthcare providers, Regional Economic Models, Inc. (REMI) used a structural macroeconomic model to quantify the impact of the ACA on the broader New Hampshire economy, with and without the Medicaid expansion. Using the Tax-PI software, REMI simulated the statewide net fiscal and economic effects of expansion, and assessed the net effect of the changes in healthcare spending along with the direct costs to the state from additional enrollees, while considering the federal contribution both in the short and longer term.

REMI built a 1-Region Tax-PI model of New Hampshire. The Tax-PI model is a dynamic, multi-sector regional economic simulation model used for economic forecasting and measuring the impact of public policy changes on economic activity. Tax-PI is a conjoined model that utilizes several different economic modeling approaches, including input-output analysis, econometrics, computable general equilibrium, and economic geography. The model used in this analysis includes more than 70 industry sectors and covers the state of New Hampshire. REMI's models have been used in thousands of national and regional economic studies, including studies of health care reform and health care issues around the United States.

While Tax-PI is a regional economic model capable of considering multiple geographies, this analysis was conducted using a single-region model of New Hampshire. The only inputs made to the model were changes in sales for the healthcare industries and consumer spending due to savings in household health spending. By entering inputs only for New Hampshire, this analysis assumed that the rest of the U.S. would carry on with normal trends. Essentially, the analysis was based on the assumption that New Hampshire will be the only state to enact an expansion of Medicaid from 2014 to 2020. We chose to make this assumption because the scope of the study did not allow for broad assumptions about other states' expansion of Medicaid, nor can New Hampshire control for the policies of other states. Therefore, we elected to conduct our study as if only New Hampshire would expand Medicaid.

By assuming that other states will not expand Medicaid, our analysis omitted a potentially large amount of economic activity in the rest of the U.S. The Medicaid-induced growth outside of New Hampshire, especially in neighboring Northeast states, would have significantly increased the economic growth already observed in our analysis of New Hampshire. This is because as one state increases GSP, business output, and personal income, it increases its interactions with neighboring states. These interactions occur in the exchange of goods and services between businesses, personal consumption expenditures by residents, migration between states, and many other forms of interlinked economic activity. Because our analysis did not account for interstate effects, the economic and fiscal impacts of Medicaid expansion in New Hampshire should be taken as conservative estimates that did not account for economic growth other states would have experienced with Medicaid expansion.

Medicaid spending data representing federal, state, and private Medicaid spending, as developed by The Lewin Group, was used as the primary input data into the Tax-PI model. This data was formatted to fit into categories of healthcare so that they may be inputted into the model as variables. The REMI model has more than 70 different industrial sectors, three of which pertain most closely to the healthcare industry data used in this analysis. The three healthcare sectors used in the model are outlined below with definitions from the U.S. Census Bureau's North American Industry Classification System:

- ***Ambulatory Health Care Services:*** Establishments in this sector provide health care services directly or indirectly to ambulatory patients and do not usually provide inpatient services. Health practitioners in this sector provide outpatient services, with the facilities and equipment not usually being the most significant part of the production process.
- ***Hospitals:*** This sector provides medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Establishments in the hospitals sector provide inpatient health services, many of which can only be provided using the specialized facilities and equipment that form a significant and integral part of the production process.
- ***Pharmaceutical Preparation Manufacturing:*** This industry comprises establishments primarily engaged in manufacturing in-vivo diagnostic substances and pharmaceutical preparations (except biological) intended for internal and external consumption in dose forms, such as ampoules, tablets, capsules, vials, ointments, powders, solutions, and suspensions.

The input data was then entered into the model using industry sales variables for the three aforementioned healthcare sectors as well as the retail and wholesale sectors involved in selling and distributing prescription medication. The sales variable induces increased growth of those industries, which simulates the effect of expanding government spending on healthcare.

Data on savings in household health spending was also included in the analysis. The household savings were inputted into the model through the consumption reallocation variable. The consumption reallocation variable spreads consumer spending across all categories of goods and services. This analysis operated under the assumption that these savings would be reintroduced into New Hampshire's economy as more consumer spending. Therefore, the household health savings were entered as new consumption in the model.

The outputs from the simulation reflected the economic growth created by the ACA and an expansion of Medicaid in New Hampshire. These outputs provided information on an array of economic and demographic indicators including total state employment, gross state product, personal income, and total revenues.



HEALTH CARE AND HUMAN SERVICES POLICY, RESEARCH, AND CONSULTING—WITH REAL-WORLD PERSPECTIVE.

New Hampshire Medicaid Expansion Study Phase III: An Analysis of Health Benefit Design Options for Current and Newly Eligible Medicaid Beneficiaries

Final Report

Prepared by:
The Lewin Group and DMA Health Strategies

September 2013

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Executive Summary

Under the June 2012 United States Supreme Court ruling on the Affordable Care Act (ACA), states may opt out of the Medicaid expansion provision of the ACA without putting existing federal Medicaid funding at risk. The Lewin Group is working with the New Hampshire Department of Health and Human Services to explore the potential impacts of expanding versus not expanding its Medicaid program. To this end, Lewin issued reports in three phases:

Phase 1 (November 2012): Estimates of the direct impacts of expansion versus no expansion on the Medicaid program's enrollment and costs.

Phase 2 (January 2013): Estimates of the secondary impacts of the Medicaid expansion, including impacts on other state program expenditures, the uninsured, providers, the state economy, and the commercial health insurance market.

Phase 3 (September 2013): Explores, in five parts, which health benefits Medicaid should cover in its existing program, as well as in an expanded Medicaid program:

- **Part 1:** Compares New Hampshire's current Medicaid benefit package to the "Essential Health Benefits (EHB)" package mandated under the Affordable Care Act. States can select one EHB benchmark plan from several options. Since the state has not selected an EHB benchmark plan, for modeling purposes, Lewin used the state's commercial benchmark plan as the comparison plan;
- **Part 2:** Estimates the cost and benefit of various Medicaid benefit design options that the state could consider;
- **Part 3:** Reviews New Hampshire's current Medicaid mental health benefit to determine the extent to which it satisfies the requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- **Part 4:** Develops an evidence-based Substance Use Disorder (SUD) benefit, as required under the ACA for newly eligible beneficiaries; and
- **Part 5:** Discusses potential savings and benefits to other cost centers as a result of the substance abuse benefit.

Key Assumptions

- All cost estimates and conclusions provided in this report assume a Medicaid fee-for-service (FFS) program, as these estimates are based upon our November 2012 report, which assumed the "baseline" scenario to be a FFS system, per state direction. However, the Phase I report includes an alternative scenario in which Medicaid operates within a managed care system; this alternative scenario results in additional savings. Phase II also identifies additional offsets under managed care.
- In estimating future costs, our model assumed that Medicaid would be expanded in January 2014. If that is not the case, the model can be updated to reflect a later implementation.

- Since the Phase I report was issued in November 2012, CMS proposed rules for Essential Health Benefits (EHBs), which are slightly different from the benefit design we used in Phase I. In this report, we adjust all estimates to reflect the new rules and regulations.
- This report does not quantify the impacts of a substance abuse benefit on non-health programs, such as the Department of Corrections and social programs, due to lack of available data. However, we are able to consider experiences in others states and strong evidence available in the literature to qualitatively discuss benefits and savings.

A. Key Findings

The key findings and recommendations for Parts 1 through 5 of this report are summarized as follows:

Part 1 – Comparing New Hampshire’s Current Medicaid Benefit Package to the Affordable Care Act’s Essential Health Benefits (EHB) Package

- For the Medicaid expansion population, the state will need to make changes to its traditional Medicaid benefits to meet the EHBs required under the ACA. These include:
 - Adding inpatient and outpatient substance abuse disorder benefits and offering mental health services at parity with physical health services; and
 - Excluding optional long-term care services and supports including nursing home and waiver long-term care services, non-emergency transportation, podiatry and adult dental services. While not required, the state still has the option of offering these services to the expansion population.

Part 2 – Cost Benefit of Various Medicaid Benefit Design Options

- The study examines the impact on spending for the Medicaid expansion under four options of benefit designs. Our analysis demonstrates that the state could provide a mix of these optional services to both the current and newly eligible Medicaid groups. The associated costs are shown in **Figure ES-1**.

Figure ES-1: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Under Various Benefit Design Options, in \$1000s

| Option | State Cost | Federal Cost | Total Cost |
|---|------------|--------------|-------------|
| Baseline (Phase I): Current and newly eligible receive current Medicaid benefits only ¹ | \$85,488 | \$2,510,922 | \$2,596,410 |
| Option 1: Provide Medicaid and Benchmark optional benefits to newly eligible, and Medicaid benefits only to currently eligible | \$78,974 | \$2,455,329 | \$2,534,145 |
| Option 2: Provide Medicaid and Benchmark optional benefits to both newly eligible and currently eligible | \$67,395 | \$2,443,750 | \$2,511,145 |
| Option 3: Provide Newly Eligible with Benchmark benefits only, and Currently Eligible with Medicaid Benefits only | \$75,155 | \$2,373,046 | \$2,448,201 |

¹ Baseline refers to estimates on the cost of the Medicaid Expansion to 138% FPL as presented in our Phase I report.

| Option | State Cost | Federal Cost | Total Cost |
|---|------------|--------------|-------------|
| Option 4: Provide Benchmark optional benefits to Current Eligibles and only Benchmark Benefits to Newly Eligible | \$63,576 | \$2,361,467 | \$2,425,043 |

Part 3- Extent to which Current Medicaid Benefit Satisfies Health Parity Requirements

- To comply with federal requirements, the state may need to modify service and financial limits for some current Medicaid enrollees to ensure that the mental health and substance abuse benefits offered to individuals enrolling under Medicaid expansion are "... offered at parity with medical services in the plan."² Our findings include:
 - Areas of Compliance: Inpatient services, physician services, emergency department services, and pharmacy services for behavioral health would likely be considered to be in compliance with MHPAEA; and
 - Areas Requiring further Action: Psychotherapy by other licensed practitioner services and Community Mental Health Center (CMHC rehabilitation) services are both subject to visit or financial limits, which would need to be modified to comply with MHPAEA. However, more specific guidance from CMS may be required to determine if any changes are needed, particularly since the CMHC rehabilitation option benefits are available to any enrollee diagnosed with serious mental illness or serious emotional disturbance.

Part 4 – Medicaid Benefit for Substance Abuse Option

- In considering a state substance abuse benefit, which New Hampshire has not previously offered, we recommend an option based on: 1) relevant national standards; 2) approaches taken by other states; and 3) the substance abuse treatment services established by the New Hampshire Bureau of Drug and Alcohol Services. The option includes the following set of services and supports that cover the entire continuum of substance use disorder care services:
 - Medically managed detoxification (level IV – hospital detox)
 - Medically monitored detoxification (level III – non-hospital)
 - Screening and Brief Intervention
 - Outpatient Counseling
 - Outpatient Detoxification
 - Intensive Outpatient Treatment
 - Community Stabilization Supports (30 to 60 days of support for people in early recovery in their own homes or in residential treatment)
 - Methadone maintenance
 - Peer Recovery Support

² Mental Health for America (2013). Fact Sheet: Medicaid Expansion. Retrieved from <http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform/fact-sheet-medicaid-expansion/fact-sheet-medicaid-expansion>.

Part 5 – Savings and Benefits to Other Programs

- Offering a substance abuse benefit may also result in savings in other programs. Lewin’s review of the literature finds that offering substance use disorder benefits results in savings in other programs, including medical costs.³ While we are unable to accurately forecast the impact of a substance abuse benefit on non-health programs, such as those under the Department of Corrections, the research indicates that a substance abuse benefit can help reduce costs in Medicaid and other programs in the following ways:
 - **Reductions in costs for other medical care:** studies show that a substance abuse benefit led to reduction in other medical expenditures among Medicaid enrollees. In fact, there were savings even when factoring in the cost of providing the substance abuse treatment;^{4,5}
 - **Reduced recidivism and imprisonment:** A 2003 meta-analysis reviewed 11 studies and found that the benefit-cost ratios associated with substance abuse treatment were between 1.33 and 23.33, and that the economic benefits were overwhelmingly due to reductions in criminal activity;⁶ and
 - **Other societal impacts:** A major study in California showed that substance abuse treatment demonstrates a 7:1 return on investment for medical care, mental health care, criminal activity, earnings, and government transfer program payments. These estimates cite an average substance abuse treatment regimen costing \$1,583, producing a societal benefit of \$11,487.⁷

This report was prepared by The Lewin Group for the New Hampshire Department of Health and Human Services. The evaluation of mental health and SUD benefits conducted in Parts 3, 4, and 5 of this report was primarily performed by Richard Dougherty, Ph.D., and Wendy Holt, M.P.P., of DMA Health Strategies.

³ Cartwright WS (2000). Cost-Benefit Analysis of Drug Treatment Services: Review of the Literature. *Journal of Mental Health Policy and Economics*, 3:11-26

⁴ State of Colorado (2010). Medicaid Outpatient Substance Abuse Treatment Benefit: Performance Audit. Department of Health Care Policy and Financing. Retrieved from [http://www.leg.state.co.us/OSA/coauditor1.nsf/All/80EE029745B4C589872577F30060F888/\\$FILE/2079SubstanceAbuseFinalReport12132010.pdf](http://www.leg.state.co.us/OSA/coauditor1.nsf/All/80EE029745B4C589872577F30060F888/$FILE/2079SubstanceAbuseFinalReport12132010.pdf)

⁵ Wickizer TM, Krupski A, Stark K, Mancuso D & Campbell K (2006). The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State. *The Milbank Quarterly* 84.3: 555-76

⁶ McCollister KE & French MT (2003). The Relative Contribution of Outcome Domains in the Total Economic Benefit of Addiction Interventions: A Review of the First Findings. *Addiction*, 98:1647-59. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16430607>

⁷ Ettner SL, Huang D, Evans E, Ash DR, Hardy M, Jourabchi M & Hser Y (2006). Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment ‘Pay for Itself’? *Health Services Research*, 41.1: 192-213. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16430607>

I. Introduction

Following the June 2012 United States Supreme Court ruling on the Affordable Care Act (ACA), states now have the option to opt out of the Medicaid expansion provision of the ACA without compromising their current federal Medicaid funding. As a result of this ruling, The Lewin Group has worked with the New Hampshire Department of Health and Human Services to explore the potential impacts of expanding versus not expanding its Medicaid program. In Phase I of our analysis, released in November 2012, we provide estimates on Medicaid enrollment and costs under the option of not expanding Medicaid compared to the option of expanding Medicaid under various program design options. Phase II of the study, released in January 2013, estimates the impact of Medicaid expansion in areas outside of Medicaid, including other state programs, the uninsured, providers, the state economy, and the commercial health insurance market.

This report represents Phase III of the study, which examines options for the New Hampshire Medicaid program to consider in establishing a benefits plan for its Medicaid expansion population under the ACA. The Deficit Reduction Act of 2005, section 1937 of the Social Security Act, provides states with flexibility to design Medicaid benefit packages under the State plan. There are a number of options available to the state in selecting a Benchmark Plan, including the option to offer the current Medicaid benefits package to newly eligible beneficiaries, while adding newly required services per federal regulations. In addition, the state could offer different Benchmark Plans to targeted populations to appropriately meet their needs.

There is no default Benchmark Benefits Plan for the Medicaid expansion population. The state must submit a state plan amendment (SPA) detailing its choice for the Medicaid Benchmark as part of the Medicaid expansion process. The options available to New Hampshire for determining a Benchmark plan are as follows:

- Traditional Medicaid benefit package;
- Blue Cross Blue Shield PPO under FEHBP;
- A plan offered to state employees;
- Largest commercial HMO in the state; or
- Other coverage appropriate for target population (as defined by the state and approved by HHS Secretary).

Regardless of the reference Benchmark Plan selected, the state must ensure that the ten statutory categories of essential health benefits (EHB) are covered, as well as family planning services and services provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). The Benchmark Plan must also assure that mental health parity under the Mental Health Parity and Addiction Equity Act (MHPAEA) is met. The EHB benefits include the following ten broad groups of services:

- Ambulatory patient services
- Emergency services

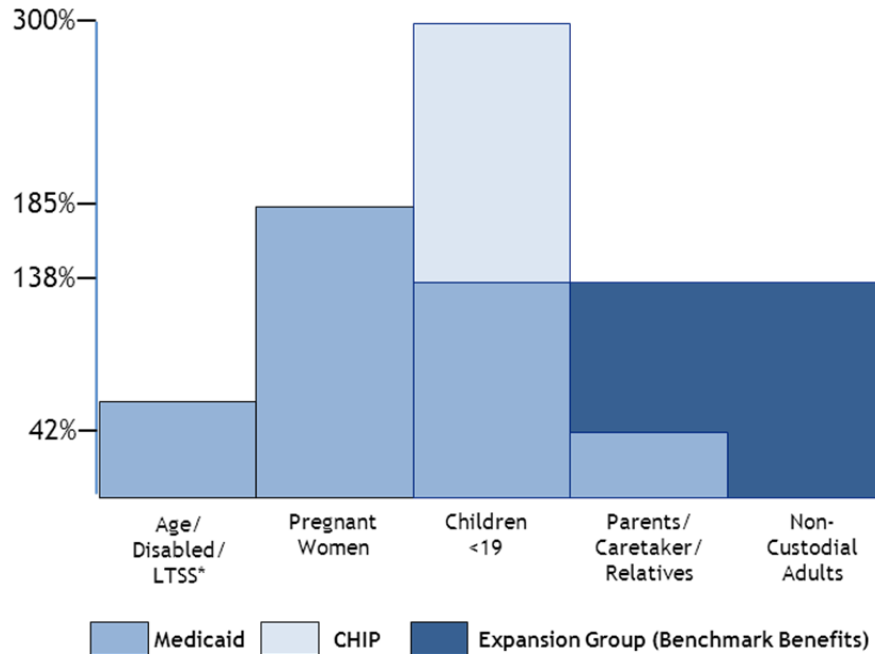
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

As of the release of this report, New Hampshire has not selected a Medicaid benchmark plan for its expansion population. However, the state has selected the Matthew Thornton Blue Health plan as its Health Insurance Marketplace benchmark benefits plan for individuals and small groups, which is a small group product HMO. However, it is also the largest commercial HMO in the state, which would qualify as a Medicaid Benchmark plan. For this report, we use the Matthew Thornton Blue plan for our comparison to the state's traditional Medicaid benefits package.

In addition to the five Benchmark plan options listed above, the state could also select a benchmark-equivalent plan, which means that the benefits include all the specified EHB services and the overall benefits are at least actuarially equivalent to one of the statutorily specified benchmark coverage packages.

The benchmark benefits plans will be provided primarily to newly eligible adults, but could be extended to other groups of adults in Medicaid in order to have a consistent set of benefits for specific population groups. *Figure 1* illustrates Medicaid and CHIP eligibility and benefit types by eligibility category in New Hampshire under health reform in 2014. Under a state plan amendment (SPA), New Hampshire could provide benchmark coverage to all Medicaid-eligible adults regardless of income.

Figure 1: New Hampshire Eligibility and Benefit Plans



* Working disabled are eligible up to 450% FPL with share of cost requirement. People requiring nursing facility care are eligible up to 220% FPL. Both also include resource limits. Medicare enrollees up to 135% FPL are eligible for certain Medicaid benefits, however full benefits are available to only those below 57% FPL.

In the report to follow, we first detail New Hampshire's current Medicaid benefit design and compare it to the state's commercial Benchmark Plan, which includes Essential Health Benefit (EHB), per guidance from the Centers for Medicare and Medicaid Services (CMS). Here, we identify outlier benefits of each benefit design to gain an understanding of what is offered in the current benefit design and not in the EHB design, and vice versa. Next, we estimate the cost and benefit of various Medicaid benefit design options. We then review New Hampshire's current Mental Health benefit to determine the extent to which it satisfies the MHPAEA. Next, we develop an option for a Medicaid substance abuse benefit for the state. Finally, we discuss potential savings and benefits to other cost centers resulting from the mental health and substance abuse benefit, including reduction in substance abuse related medical care costs, reduced recidivism, and secondary impacts in areas such as educational attainment, employment opportunities, public health, and the state economy at large.

II. Current Medicaid Benefit vs. Essential Health Benefit (EHB)

To comprehensively and effectively compare New Hampshire's current Medicaid benefit to the Benchmark Plan, which includes all Essential Health Benefits (EHBs), Lewin developed a crosswalk to compare the two sets of benefits. The objective of doing so is to confirm the outlier benefits of each benefit design; that is, to identify which benefits are included in the current Medicaid benefit package and not in the EHB Benchmark Plan design, and vice versa. We also identify areas where benefit limitations exist. Here, for illustrative purposes, we use the Matthew Thornton Blue Health plan—the state's commercial benchmark plan—as the EHB Medicaid Benchmark plan.

In comparing the benefit designs of the two plans, Lewin identified the following EHB services that are included in the Matthew Thornton benchmark plan but are not included within the current Medicaid benefit package (benchmark outlier benefits):⁸

- Substance Abuse Disorder Outpatient Services
- Substance Abuse Disorder Inpatient Services (Medicaid covers inpatient detox for adults with other medical admission)
- Habilitation Services (shares same PT, OT and SP services as rehabilitation)
- Chiropractic Care⁹

To meet CMS requirements, these services must be covered under the Medicaid Benchmark plan for the Medicaid expansion population. If New Hampshire elects to use the current Medicaid benefit design to cover the newly eligible beneficiaries, the state must include substance abuse disorder outpatient and inpatient services, chiropractic care, and habilitation services. The requirements for mental health parity and substance abuse disorder services are addressed in Section C of this report.

To meet CMS requirements for habilitation services, New Hampshire will be required to extend any rehabilitation services offered in the Medicaid Benchmark plan to cover services under the new definition of habilitation services. CMS defines habilitation services as services focused on learning new skills or functions and requires that they be offered at parity with rehabilitation services. For example, a plan that covers physical therapy, occupational therapy, and speech therapy must cover these services in similar scope, amount, and duration for services defined as rehabilitation or as habilitation. However, if New Hampshire does not wish to offer an identical benefit package for both services categories, the state may decide which habilitative services it would prefer to cover and submit to CMS for review and approval.

⁸ Mental Health Inpatient Services are covered under the benchmark plan but have different scope of providers under current Medicaid benefit (psychiatric hospitals are not covered for non-aged adults under Medicaid). However, this is not considered an outlier, as the benefit coverage is the same.

⁹ While not an explicit EHB under federal regulations, chiropractic care is a benefit in the Mathew Thornton plan and has been included in the Medicaid benchmark plans in other states and is considered a rehabilitative service.

In addition, there are services that are covered under the current Medicaid benefit package that are not essential health benefits required to be in the Medicaid Benchmark plan (Medicaid outlier benefits). These include:

- Long-term/Custodial Nursing Home Care
- Private-Duty Nursing
- Adult Day Care
- Personal Care
- HCBS Waiver Services
- Non-Emergency Transportation Services
- Podiatry (limited coverage under Medicaid)
- Certain dental services for adults

New Hampshire will have the opportunity to determine which, if any, of these services to include in the benefit offered to the Medicaid expansion group.

Finally, there are services that are required to be covered under the Medicaid Benchmark plan that are not adequately covered by the commercial benchmark plan – Matthew Thornton Blue Health. These services include services provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

For a full comparison of all reviewed services covered under traditional Medicaid and under the Matthew Thornton Plan, see *Figure 2*, below.

Figure 2: Crosswalk of New Hampshire’s current Medicaid benefit and the Matthew Thornton Blue Health Benchmark Plan to the List of Essential Health Benefits

| Essential Health Benefits | Covered Under Traditional Medicaid | Covered Under Matthew Thornton Plan |
|------------------------------------|------------------------------------|-------------------------------------|
| Ambulatory patient services | | |
| Primary Care | ✓ | ✓ |
| Specialty Care | ✓ | ✓ |
| Outpatient Surgery | ✓ | ✓ |
| Home Health Services | ✓ | ✓ |
| Hospice | ✓ | ✓ |
| Emergency services | | |
| Emergency Room | ✓ | ✓ |
| Ambulance | ✓ | ✓ |
| Urgent Care Centers or Facilities | ✓ | ✓ |
| Hospitalization | | |
| Inpatient | ✓ | ✓ |
| Bariatric Surgery | ✓ | ✓ |
| Maternity and newborn care | | |
| Prenatal and Postnatal Care | ✓ | ✓ |
| Delivery and Inpatient Maternity | ✓ | ✓ |

| Essential Health Benefits | Covered Under Traditional Medicaid | Covered Under Matthew Thornton Plan |
|---|------------------------------------|-------------------------------------|
| Mental health and substance use disorder services, including behavioral health treatment | | |
| Mental Health Outpatient | ✓ | ✓ |
| Mental Health Inpatient | Limited Provider Scope | ✓ |
| Substance Abuse Outpatient | Not Covered | ✓ |
| Substance Abuse Inpatient | Not Covered | ✓ |
| Prescription Drugs | | |
| Generic Drugs | ✓ | ✓ |
| Preferred Brand Drugs | ✓ | ✓ |
| Non-preferred Brand Drugs | ✓ | ✓ |
| Specialty Drugs | ✓ | ✓ |
| Rehabilitative and habilitative services and devices | | |
| Physical Therapy | ✓ | ✓ |
| Occupational Therapy | ✓ | ✓ |
| Speech Therapy | ✓ | ✓ |
| Chiropractic Services | Not Covered | ✓ |
| Laboratory services | | |
| Diagnostic Lab Tests | ✓ | ✓ |
| X-Rays | ✓ | ✓ |
| Diagnostic Imaging | ✓ | ✓ |
| Preventive and wellness services and chronic disease management | | |
| Preventative Care (e.g., screening, immunizations) | ✓ | ✓ |
| Routine Vision Care (adult) | ✓ | ✓ |
| Routine Dental Care (adult) | Limited Coverage | Not Covered |
| Family Planning | ✓ | ✓ |
| Podiatry | Limited Coverage | Not Covered |
| Pediatric services, including oral and vision care | | |
| Primary and Preventative Care | ✓ | ✓ |
| Routine Vision Care | ✓ | ✓ |
| Routine Dental Care | ✓ | ✓ |

✓ = Covered Service

III. Cost and Benefit of Various Medicaid Benefit Design Options

If New Hampshire elects to expand the state's Medicaid program, then the state is met with a decision as to (1) what benefits to offer the Medicaid expansion population beyond the EHBs, if any, and (2) if current Medicaid benefits should be expanded to cover services not currently covered by Medicaid that are covered under the EHB package, such as substance abuse. With each option come different costs and benefits. Here, the Affordable Care Act (ACA) also creates a potential inequity where newly eligible individuals could receive a richer benefit package than current Medicaid eligibles. To assess costs of different benefit design options, Lewin has developed a model that estimates the cost of each benefit design. Estimated costs for each of the proposed benefit design options are presented below, followed by an overview of our methodology and major assumptions used.

Phase I: Baseline estimate

Our Phase I report on the cost of the Medicaid expansion in New Hampshire to all adults below 138 percent of FPL assumes that all current Medicaid benefits would be provided to both the current Medicaid eligibles and to the expansion population; the cost of new required benefits (i.e. substance use disorder benefits) for newly eligibles was not included in our estimates. Our Phase I report was developed in November 2012, prior to CMS issuing proposed rules for EHBs. The benefit design assumption used in Phase I is no longer compliant with federal rules and regulations, per new EHB and parity requirements. However, this is used as a baseline in estimating the cost of new benefit design options.

Under our Phase I assumption, we estimated total Medicaid costs in New Hampshire, including health care and administration, would increase by \$2.6 billion from 2014 through 2020 (*Figure 3*). The federal government will pay 100 percent of the health care costs for newly eligible adults from 2014 through 2016. By 2020, the percent paid by the federal government will drop to 90 percent. However, the state will only receive the current federal matching rate for health care costs for new enrollees that are eligible under current Medicaid eligibility criteria. The additional cost of administering Medicaid eligibility and coverage for these new enrollees will be matched by the federal government at the current matching rate for program administration.

Figure 3: Impact on New Hampshire Medicaid Spending under Medicaid Expansion Under the ACA (2014-2020) - Baseline ACA Analysis ^{1/}

| | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2014-2020 |
|-------------------------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-------------|
| Change in Enrollment | 44,169 | 51,548 | 59,157 | 59,895 | 60,674 | 61,455 | 62,237 | |
| Total Costs (\$1,000s) | | | | | | | | |
| State Share | \$3,603 | \$4,322 | -\$9,138 | \$9,143 | \$13,141 | \$17,371 | \$47,046 | \$85,488 |
| Federal Share | \$264,869 | \$316,152 | \$385,000 | \$379,322 | \$388,136 | \$396,936 | \$380,507 | \$2,510,922 |
| Total | \$268,472 | \$320,474 | \$375,862 | \$388,465 | \$401,277 | \$414,308 | \$427,553 | \$2,596,410 |

1/ Assumes fee-for-service program, implementation January 1, 2014, current Medicaid eligible above 138% FPL remain in the program and all current eligibility categories are retained. Assumes current Medicaid benefits package for Newly Eligible.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model.

Below, we provide new estimates based on four benefit design options.

Option 1: Provide Medicaid and Benchmark outlier benefits to newly eligible, and Medicaid benefits only to currently eligible

| Benefits Offered | Current Eligibles | Newly Eligible |
|------------------------------------|-------------------|----------------|
| Benchmark Outlier Benefits | | |
| Substance Abuse | n/a | Covered |
| Chiropractic | n/a | Covered |
| Medicaid Outlier Benefits | | |
| Long Term Service & Supports | Covered | Covered |
| Podiatry | Covered | Covered |
| Dental | Covered | Covered |
| All Other Medicaid Benefits | Covered | Covered |

To update our Phase I cost estimate, we include the net cost of providing the additional benchmark outlier benefits to the newly eligible population, which include a substance use disorder benefit and chiropractic benefit. These benefits are in addition to all current Medicaid benefits for the newly eligible population. As mentioned above, CMS guidance on the EHB was issued after our Phase I report, so this analysis attempts to incorporate our most recent understanding of the ACA requirements for the Medicaid expansion.

Figure 4 shows the change in cost to the Medicaid program under expansion assuming the benefits structure for *Option 1*. Our review of the literature, which is described below, found that Medicaid enrollees that used substance use disorder (SUD) services reduced their utilization of physical health services in excess of the actual cost of the SUD services provided. For these cost estimates, we based our assumption for medical cost offset on a study of the Colorado Medicaid program that showed that every dollar spent on SUD services resulted in a reduction of \$1.45 on physical health spending.

Figure 4: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Option 1 Benefit Design, in \$1000s

| | CY2014 | CY2015 | CY2016 | CY2017 | CY2018 | CY2019 | CY2020 | 2014-2020 |
|---|------------------|------------------|------------------|-------------------|-------------------|-------------------|-------------------|--------------------|
| Baseline PMPM | \$696.84 | \$718.60 | \$741.85 | \$766.71 | \$792.46 | \$819.18 | \$846.94 | |
| Option 1 PMPM | \$702.62 | \$722.95 | \$743.07 | \$761.87 | \$784.06 | \$808.26 | \$835.74 | |
| % Change | 0.8% | 0.6% | 0.2% | -0.6% | -1.1% | -1.3% | -1.3% | |
| Dollar Impact (\$1,000's) | \$12,382 | \$9,855 | \$2,860 | (\$11,564) | (\$20,424) | (\$27,024) | (\$28,194) | |
| Increased Cost due to Additional Benefits | | | | | | | | |
| SUD Benefit | \$12,270 | \$14,618 | \$16,193 | \$16,894 | \$17,627 | \$18,389 | \$19,185 | \$115,175 |
| Chiropractic Benefit | \$113 | \$134 | \$149 | \$155 | \$162 | \$169 | \$176 | \$1,059 |
| Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset) | | | | | | | | |
| <i>State Share</i> | \$0 | \$0 | \$0 | (\$578) | (\$1,225) | (\$1,892) | (\$2,819) | (\$6,515) |
| <i>Federal Share</i> | \$12,382 | \$9,855 | \$2,860 | (\$10,985) | (\$19,199) | (\$25,132) | (\$25,374) | (\$55,593) |
| Total | \$12,382 | \$9,855 | \$2,860 | (\$11,564) | (\$20,424) | (\$27,024) | (\$28,194) | (\$62,108) |
| Change in Medicaid Cost Under ACA with Expansion & Benefit Changes | | | | | | | | |
| <i>State Share</i> | \$3,603 | \$4,322 | (\$9,138) | \$8,565 | \$11,916 | \$15,480 | \$44,227 | \$78,974 |
| <i>Federal Share</i> | \$277,251 | \$326,007 | \$387,860 | \$368,337 | \$368,937 | \$371,804 | \$355,133 | \$2,455,329 |
| Total | \$280,854 | \$330,329 | \$378,722 | \$376,901 | \$380,853 | \$387,284 | \$399,359 | \$2,534,303 |

Assumes a similar 1.45:1 return on investment on offering substance use disorder services.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Option 2: Provide Medicaid and Benchmark outlier benefits to both newly eligible and currently eligible

| Benefits Offered | Current Eligibles | Newly Eligible |
|------------------------------------|-------------------|----------------|
| Benchmark Outlier Benefits | | |
| Substance Abuse | Covered | Covered |
| Chiropractic | Covered | Covered |
| Medicaid Outlier Benefits | | |
| Long Term Service & Supports | Covered | Covered |
| Podiatry | Covered | Covered |
| Dental | Covered | Covered |
| All Other Medicaid Benefits | Covered | Covered |

The state may elect to offer all Medicaid beneficiaries the same benefit package, meaning services such as HCBS, nursing facility care, mental health and substance use disorder services would be available to currently eligible and newly eligible beneficiaries. *Figure 5* shows the cost to the Medicaid program under expansion assuming current Medicaid benefits plus the additional benchmark outlier benefits for both the current and newly eligible populations.

Figure 5: Impact on New Hampshire Medicaid Spending under Medicaid Expansion Under the ACA (2014-2020) Option 2 Benefit Design, in \$1000s

| | CY2014 | CY2015 | CY2016 | CY2017 | CY2018 | CY2019 | CY2020 | 2014-2020 |
|---|-----------|-----------|-----------|------------|------------|------------|------------|--------------------|
| Baseline PMPM | \$696.84 | \$718.60 | \$741.85 | \$766.71 | \$792.46 | \$819.18 | \$846.94 | |
| Option 2 PMPM | \$705.16 | \$724.64 | \$743.52 | \$760.03 | \$780.85 | \$804.05 | \$831.42 | |
| % Change | 1.2% | 0.8% | 0.2% | -0.9% | -1.5% | -1.8% | -1.8% | |
| Dollar Impact (\$1,000's) | \$17,824 | \$13,675 | \$3,897 | (\$15,943) | (\$28,225) | (\$37,425) | (\$39,069) | |
| Increased Cost due to Additional Benefits | | | | | | | | |
| SUD Benefit | \$17,543 | \$20,168 | \$22,037 | \$23,049 | \$24,112 | \$25,223 | \$26,388 | \$158,520 |
| Chiropractic Benefit | \$282 | \$312 | \$336 | \$352 | \$369 | \$387 | \$406 | \$2,444 |
| Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset) | | | | | | | | |
| State Share | \$2,721 | \$1,910 | \$519 | (\$2,768) | (\$5,126) | (\$7,093) | (\$8,257) | (\$18,094) |
| Federal Share | \$15,103 | \$11,765 | \$3,378 | (\$13,175) | (\$23,099) | (\$30,333) | (\$30,812) | (\$67,172) |
| Total | \$17,824 | \$13,675 | \$3,897 | (\$15,943) | (\$28,225) | (\$37,425) | (\$39,069) | (\$85,266) |
| Change in Medicaid Cost Under ACA with Expansion & Benefit Changes | | | | | | | | |
| State Share | \$6,324 | \$6,232 | (\$8,619) | \$6,375 | \$8,015 | \$10,279 | \$38,789 | \$67,395 |
| Federal Share | \$279,972 | \$327,917 | \$388,378 | \$366,147 | \$365,037 | \$366,603 | \$349,695 | \$2,443,750 |
| Total | \$286,296 | \$334,149 | \$379,759 | \$372,522 | \$373,052 | \$376,882 | \$388,484 | \$2,511,145 |

1/ Assumes a similar 1.45:1 return on investment on offering substance use disorder services.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model (HBSM). Includes our estimates of "woodwork" enrollees beginning in 2014 as well as our estimates for those leaving Medicaid for other coverage options under the ACA.

Option 3: Provide Newly Eligible with Benchmark benefits only, and Currently Eligible with Medicaid Benefits only

| Benefits Offered | Current Eligibles | Newly Eligible |
|------------------------------------|-------------------|----------------|
| Benchmark Outlier Benefits | | |
| Substance Abuse | n/a | Covered |
| Chiropractic | n/a | Covered |
| Medicaid Outlier Benefits | | |
| Long Term Service & Supports | Covered | n/a |
| Podiatry | Covered | n/a |
| Dental | Covered | n/a |
| All Other Medicaid Benefits | Covered | Covered |

New Hampshire could elect to have current Medicaid eligibles continue to receive their current benefits, with no addition of EHB "outlier" services such as substance abuse services, while newly eligible receive only the benefits in the selected benchmark plan. **Figure 6** shows the cost to the Medicaid program under expansion assuming only benchmark benefits are provided to the newly eligible population. The estimates assume no change in benefits for the currently eligible groups.

Figure 6: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Option 3 Benefit Design, in \$1000s

| | CY2014 | CY2015 | CY2016 | CY2017 | CY2018 | CY2019 | CY2020 | 2014-2020 |
|---|-----------|-----------|-----------|------------|------------|------------|------------|--------------------|
| Baseline PMPM | \$696.84 | \$718.60 | \$741.85 | \$766.71 | \$792.46 | \$819.18 | \$846.94 | |
| Option 3 PMPM | \$698.34 | \$718.12 | \$737.91 | \$756.58 | \$778.64 | \$802.70 | \$830.05 | |
| % Change | 0.2% | -0.1% | -0.5% | -1.3% | -1.7% | -2.0% | -2.0% | |
| Dollar Impact (\$1,000's) | \$3,210 | (\$1,073) | (\$9,246) | (\$24,193) | (\$33,601) | (\$40,771) | (\$42,536) | |
| Increased Cost due to Additional Benefits | | | | | | | | |
| SUD Benefit | \$12,270 | \$14,618 | \$16,193 | \$16,894 | \$17,627 | \$18,389 | \$19,185 | \$115,175 |
| Chiropractic Benefit | \$113 | \$134 | \$149 | \$155 | \$162 | \$169 | \$176 | \$1,059 |
| Cost of Benefits Carved Out of Expansion Population | | | | | | | | |
| LTSS | (\$3,620) | (\$4,509) | (\$4,995) | (\$5,211) | (\$5,437) | (\$5,672) | (\$5,918) | (\$35,363) |
| Private Duty Nursing | (\$122) | (\$152) | (\$168) | (\$176) | (\$183) | (\$191) | (\$199) | (\$1,192) |
| Podiatry | (\$2,821) | (\$3,513) | (\$3,892) | (\$4,060) | (\$4,237) | (\$4,420) | (\$4,611) | (\$27,554) |
| Dental | (\$3,620) | (\$4,509) | (\$4,995) | (\$5,211) | (\$5,437) | (\$5,672) | (\$5,918) | (\$35,363) |
| Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset) | | | | | | | | |
| State Share | \$0 | \$0 | \$0 | (\$1,210) | (\$2,016) | (\$2,854) | (\$4,254) | (\$10,333) |
| Federal Share | \$3,210 | (\$1,073) | (\$9,246) | (\$22,983) | (\$31,585) | (\$37,917) | (\$38,282) | (\$137,876) |
| Total | \$3,210 | (\$1,073) | (\$9,246) | (\$24,193) | (\$33,601) | (\$40,771) | (\$42,536) | (\$148,210) |
| Change in Medicaid Cost Under ACA with Expansion & Benefit Changes | | | | | | | | |
| State Share | \$3,603 | \$4,322 | (\$9,138) | \$7,933 | \$11,125 | \$14,517 | \$42,792 | \$75,155 |
| Federal Share | \$268,079 | \$315,079 | \$375,754 | \$356,339 | \$356,551 | \$359,019 | \$342,225 | \$2,373,046 |
| Total | \$271,682 | \$319,401 | \$366,616 | \$364,272 | \$367,676 | \$373,537 | \$385,017 | \$2,448,201 |

1/ Assumes a similar 1.45:1 return on investment on offering substance use disorder services.

Source: Lewin Group estimates using the New Hampshire version of the Health Benefits Simulation Model (HBSM).

Option 4: Provide Benchmark outlier benefits to Current Eligibles and only Benchmark Benefits to Newly Eligible

| Benefits Offered | Current Eligibles | Newly Eligible |
|------------------------------------|-------------------|----------------|
| Benchmark Outlier Benefits | | |
| Substance Abuse | Covered | Covered |
| Chiropractic | Covered | Covered |
| Medicaid Outlier Benefits | | |
| Long Term Service & Supports | Covered | n/a |
| Podiatry | Covered | n/a |
| Dental | Covered | n/a |
| All Other Medicaid Benefits | Covered | Covered |

New Hampshire could elect to have current Medicaid eligibles continue to receive their current benefits with the addition of EHB “outlier” services such as substance abuse services, while

newly eligible receive only the benefits in the selected benchmark plan. *Figure 7* shows the cost to the Medicaid program under expansion under this scenario. The projection assumes no reduction in benefits for the currently eligible groups and allocates additional substance abuse and chiropractic services to current populations.

Figure 7: Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020) Option 4 Benefit Design, in \$1000s

| | CY2014 | CY2015 | CY2016 | CY2017 | CY2018 | CY2019 | CY2020 | 2014-2020 |
|---|------------------|------------------|------------------|-------------------|-------------------|-------------------|-------------------|--------------------|
| Baseline PMPM | \$696.84 | \$718.60 | \$741.85 | \$766.71 | \$792.46 | \$819.18 | \$846.94 | |
| Option 1 PMPM | \$700.88 | \$719.81 | \$738.35 | \$754.74 | \$775.43 | \$798.49 | \$825.73 | |
| % Change | 0.6% | 0.2% | -0.5% | -1.6% | -2.2% | -2.5% | -2.5% | |
| Dollar Impact (\$1,000's) | \$8,652 | \$2,747 | (\$8,209) | (\$28,572) | (\$41,402) | (\$51,173) | (\$53,411) | |
| Increased Cost due to Additional Benefits | | | | | | | | |
| SUD Benefit | \$17,543 | \$20,168 | \$22,037 | \$23,049 | \$24,112 | \$25,223 | \$26,388 | \$158,520 |
| Chiropractic Benefit | \$282 | \$312 | \$336 | \$352 | \$369 | \$387 | \$406 | \$2,444 |
| Cost of Benefits Carved Out of Expansion Population | | | | | | | | |
| LTSS | (\$3,620) | (\$4,509) | (\$4,995) | (\$5,211) | (\$5,437) | (\$5,672) | (\$5,918) | (\$35,363) |
| Private Duty Nursing | (\$122) | (\$152) | (\$168) | (\$176) | (\$183) | (\$191) | (\$199) | (\$1,192) |
| Podiatry | (\$2,821) | (\$3,513) | (\$3,892) | (\$4,060) | (\$4,237) | (\$4,420) | (\$4,611) | (\$27,554) |
| Dental | (\$3,620) | (\$4,509) | (\$4,995) | (\$5,211) | (\$5,437) | (\$5,672) | (\$5,918) | (\$35,363) |
| Change in Medicaid Cost Due to Benefit Changes (Includes SUD Benefit Offset) | | | | | | | | |
| <i>State Share</i> | \$2,721 | \$1,910 | \$519 | (\$3,399) | (\$5,917) | (\$8,055) | (\$9,691) | (\$21,912) |
| <i>Federal Share</i> | \$5,931 | \$837 | (\$8,727) | (\$25,173) | (\$35,486) | (\$43,118) | (\$43,720) | (\$149,455) |
| Total | \$8,652 | \$2,747 | (\$8,209) | (\$28,572) | (\$41,402) | (\$51,173) | (\$53,411) | (\$171,368) |
| Change in Medicaid Cost Under ACA with Expansion & Benefit Changes | | | | | | | | |
| <i>State Share</i> | \$6,324 | \$6,232 | (\$8,619) | \$5,744 | \$7,224 | \$9,316 | \$37,355 | \$63,576 |
| <i>Federal Share</i> | \$270,800 | \$316,989 | \$376,273 | \$354,149 | \$352,650 | \$353,819 | \$336,787 | \$2,361,467 |
| Total | \$277,124 | \$323,221 | \$367,653 | \$359,893 | \$359,875 | \$363,135 | \$374,142 | \$2,425,043 |

Summary of Options 1 through 4

In sum, **Option 4** would serve as the least costly option for the state, where the substance abuse benefit and chiropractic benefit are extended to the current eligible population, while the newly eligible population receives the benchmark plan (including all EHBs) but does not receive current Medicaid outlier benefits such as LTSS, Dental, and Podiatry. A comparison of the state, federal, and total costs of all four options is presented in *Figure 8*, below.

Figure 8: Summary of Options - Impact on New Hampshire Medicaid Spending under Medicaid Expansion under the ACA (2014-2020), in \$1000s

| Option | State Cost | Federal Cost | Total Cost |
|--|------------|--------------|-------------|
| Baseline (Phase I): Current and newly eligible receive current Medicaid benefits only ^{1/} | \$85,488 | \$2,510,922 | \$2,596,410 |
| Option 1: Provide Medicaid and Benchmark outlier benefits to newly eligible, and Medicaid benefits only to currently eligible | \$78,974 | \$2,455,329 | \$2,534,145 |
| Option 2: Provide Medicaid and Benchmark outlier benefits to both newly eligible and currently eligible | \$67,395 | \$2,443,750 | \$2,511,145 |
| Option 3: Provide Newly Eligible with Benchmark benefits only, and Currently Eligible with Medicaid Benefits only | \$75,155 | \$2,373,046 | \$2,448,201 |
| Option 4: Provide Benchmark outlier benefits to Current Eligibles and only Benchmark Benefits to Newly Eligible | \$63,576 | \$2,361,467 | \$2,425,043 |

1/ Note: Our Phase I report was developed in November 2012, prior to CMS issuing proposed rules for EHBs. The benefit design assumption used in Phase I is no longer an option under federal rules & regulations.

Methodology highlights and assumptions

The pricing of new substance abuse and chiropractic benefits entailed the use of several sources of data. All assumptions use were conservative in nature, meaning most deviations from the model could yield even greater savings.

For the chiropractic benefit, our cost and utilization assumptions were based on the total fund savings of \$100,000 per year when the state eliminated the chiropractic benefit from Medicaid.

Substance abuse costs and utilization assumptions, by category of aid basis, relied on available data from states such as Kansas, Massachusetts, North Carolina, and Pennsylvania. For all of these states, annual costs per SUD user were approximately \$2,100, with that figure being less for children. The percentage of enrollees' utilization of these services varied per population.

The following statistics from neighboring Massachusetts were used as a benchmark for Medicaid member behavior in New Hampshire:

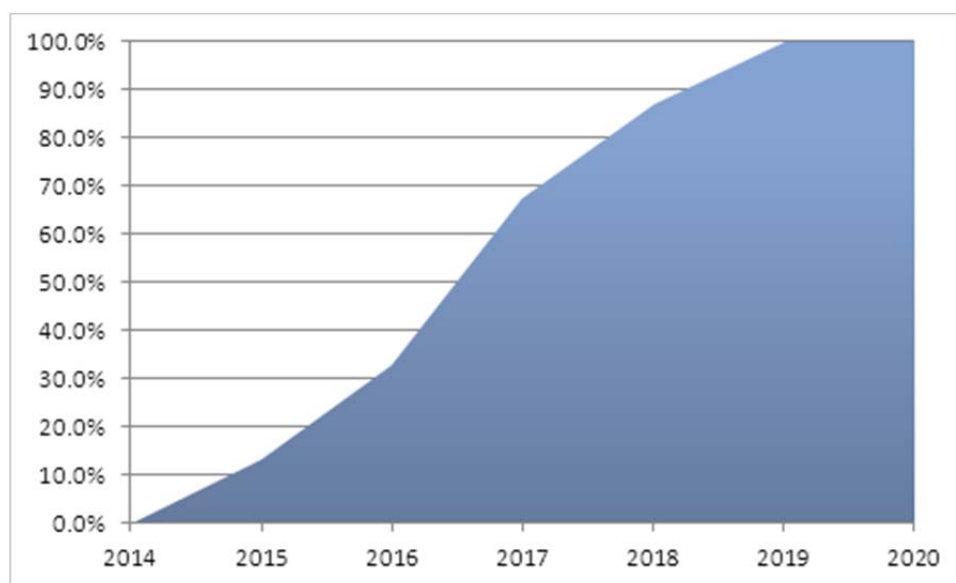
- TANF Adult: 8% of enrollees utilizing SUD benefits
- TANF Child: 1% of enrollees utilizing SUD benefits
- Disabled: 11% of enrollees utilizing SUD benefits
- Adults without children: 19% of enrollees utilizing SUD benefits
- Foster Care: 2% of enrollees utilizing SUD benefits

Cost per user, combined with the assumed percentage of population utilizing the SUB benefit, allowed us to model PMPM figures for New Hampshire Medicaid. These figures conservatively took into account economic differences between other states as well as the Medicaid fee schedules.

Our analysis of potential savings from implementing a substance abuse benefit leveraged results from several recent studies. Studies from Colorado, Washington, and California show a potential 600 percent return on investment (ROI). However, our estimates use a more conservative assumption based on national studies that find an approximate a 30 to 50 percent ROI. This means that for every \$1.00 spent on substance abuse benefits, the state would see \$1.30 to \$1.50 in cost savings. Given this positive ROI, if utilization is higher than our assumed utilization rates, though costs would be higher, this would result in an even greater volume of savings.

Additionally, cost savings from the SUD benefit were assumed to be spread over a period of time. Many studies have examined a three year period, so the majority of savings were assumed to occur in the first three years after the benefit was implemented; if the substance abuse benefit was put into place in 2014, for instance, then savings would not be assumed until 2015. The cumulative effect of the savings, as shown in *Figure 9*, would increase over the next couple years and then taper off until full savings is reached.

Figure 9: SUD Benefit - Distribution of Cost Savings Over Time



The net effect is a realistic allocation of cost savings over the projection period. Our model assumes that about 70 percent of the medical cost savings have been realized by the end of 2017. Note that utilization by currently or newly eligible members at a later time may shift this allocation or lead to greater cost savings in later years.

IV. Community Mental Health Center (CMHC) Rehabilitation Option & Satisfaction of Mental Health Parity

The purpose of this section is to review the current New Hampshire Medicaid behavioral health benefits and determine whether they meet the mental health parity requirements. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) establishes federal parity requirements that must be met by plans offered in health benefit exchanges and by plans offered to new Medicaid eligibles, under Medicaid expansion. This means that the mental health and substance abuse benefits offered to individuals enrolling under Medicaid expansion “must be offered at parity with medical services in the plan.”¹⁰ This means that mental health benefits must be at least equal to benefits provided for physical health coverage. Historically, health insurance plans have applied greater treatment limitations and higher cost-sharing to treatment of mental illness and substance use than for treatment of physical diseases. MHPAEA does not apply to Medicaid fee-for-service benefits.

Approach

To conduct the analysis, the guidance issued by CMS in the January 16, 2013 State Health Officials letter (SHO # 13-001, ACA #24) and The Interim Final Rule (IFR) published by DHS in February 2010 was reviewed. Because the rules are not final and do not address a number of issues, conclusions offered in this report should be considered preliminary and subject to further analysis once CMS provides additional guidance.

Using material submitted by the Bureau of Behavioral Health, New Hampshire’s current Medicaid mental health benefits were reviewed (*Figure 10, Columns 1 and 2*). Discussions with state staff provided further understanding of those benefits. In addition, relevant documentation of New Hampshire’s Medicaid Medical/Surgical and Pharmacy benefits was also reviewed. These include:

1. New Hampshire Medicaid Services: Recipient Information about: Recipient Responsibilities; Transportation; Service Limits: Co-Payments; Non-Covered Services; Prescription Drugs; Prior Authorization (accessed from <http://www.dhhs.nh.gov/ombp/medicaid/documents/med771.pdf> on April, 29, 2013)
2. New Hampshire Department of Health and Human Services Generic Drug List, Revision effective data August 30, 2012. (accessed from <http://www.dhhs.nh.gov/ombp/pharmacy/documents/generic.pdf> on April 29, 2013)

Medical necessity criteria were not reviewed and thus no commentary is provided on whether they differ between mental health and substance abuse services and medical/surgical services.

Overview of key parity provisions

The core requirement of MHPAEA is that the financial requirements and treatment limitations for behavioral health services are no more restrictive or do not limit access more than

¹⁰ Mental Health for America (2013). Fact Sheet: Medicaid Expansion. Retrieved from <http://www.mentalhealthamerica.net/go/action/policy-issues-a-z/healthcare-reform/fact-sheet-medicaid-expansion/fact-sheet-medicaid-expansion>

substantially all medical/surgical services. The Interim Final Rule (IFR) published by DHS in February 2010 defines “substantially all” as two-thirds. Limits or restrictions can be in the form of quantitative limits on visits, financial limits on expenditures, procedural limits based on requirements for prior approval, and limits created by medical necessity criteria. The review within this report considers these quantitative, financial and procedural limits, but does not review medical necessity criteria or non-quantitative treatment limitations. Conclusions are summarized below within each of the major service areas. A final table documents the analysis benefit by benefit (*Figure 10, column 3*).

Mental health benefits that are likely to be in compliance with MHPAEA

If New Hampshire elects to extend its current Medicaid mental health benefits to new eligibles, *inpatient services, physician services, emergency department services, and pharmacy coverage services* would likely be considered to be in compliance with MHPAEA.

Inpatient services, physician services and emergency department services are likely in compliance because they are equally available for all diagnoses, and do not distinguish between psychiatric and medical/surgical diagnoses. In addition, these services do not have a prior approval requirement. Inpatient and physician services do not have quantitative or financial limits. Use of out-of-state providers requires prior approval for any diagnosis.

- Criteria for prior approval should be reviewed to determine whether criteria for mental health or substance abuse admissions to out-of-state facilities are more restrictive than those for medical/surgical admissions.

Emergency services are included within a twelve visit annual limit on hospital outpatient services. There are provisions for waiver of this limit for medical necessity. Since mental health visits are not treated differently from medical/surgical visits they are not treated more restrictively than medical/surgical emergencies.

Medications: reviewing New Hampshire’s list of generic and brand name medications by drug class, the proportion of brand name to generic medications in the Behavioral Health classes does not appear to differ in proportion from those of other medication classes. Many of the brand name drugs have generic options. One specific behavioral health medication has a requirement for prior approval and another has a quantity limit. The remainder of behavioral health medications does not require prior authorization and are subject to a \$1.00 co-pay for generic or a \$2 co-pay for brand name drugs regardless of whether the prescription is for treating a physical or mental health symptom. Clozaril, for example, is exempt from any co-pay. In comparing these restrictions and requirements to those for drugs in other classes, it is found that prior approval and quantity limits apply to several other drugs in non-behavioral health classes. The co-pay requirements are the same for all drug classes. It is concluded that, at this level of analysis, behavioral health drugs appear to be covered on the same basis as other drug classes. However, it is possible that psychotropic medications important for treating mental health conditions are not included in the formulary or are included only in the brand name category with higher co-pays.

- Analysis by a pharmacy expert would be needed to reach a more complete determination on the adequacy of the behavioral health formulary as compared to the adequacy of the formulary for other drug classes.

Some NH mental health benefits need to be changed to comply with MHPAEA

If New Hampshire extends its current Medicaid mental health benefits to new eligibles, the following benefits may need to be modified to comply with MHPAEA: *psychotherapy by other licensed practitioner services* and *Community Mental Health Center (CMHC rehabilitation) services*. Both of these services are subject to visit or financial limits. **Exhibit 1** shows limits applicable to medical/surgical benefits. CMS defines predominant as applicable to two-thirds or more of medical/surgical benefits. If physician visits constitute two-thirds of ambulatory medical/surgical benefits, since they are unlimited, New Hampshire would have to eliminate the limits on psychotherapy. However, if physician visits do not constitute two-thirds, then New Hampshire may be able to retain benefits on psychotherapy that are no more restrictive than those on the other ambulatory medical/surgical benefits. It is not clear how CMS expects two-thirds to be measured. CMS may provide more specific guidance in its final regulations. However, our preliminary review of New Hampshire utilization data, by category of service, suggests that physician visits constitute over two-thirds of all facility visits.

Psychotherapy by other licensed practitioners is currently subject to an 18 visit annual limit for adults and a 24 visit annual limit for children.

- To provide mental health psychotherapy at parity, New Hampshire will have to eliminate these limits.

Whether or not New Hampshire maintains limits on psychotherapy:

- If New Hampshire elects to provide such services under managed care, it must ensure that any authorization procedures or medical necessity criteria health plans use to manage *ambulatory mental health benefits* are no more restrictive than those used for most medical/surgical benefits.

Exhibit 1: NH Medicaid

Financial, quantitative or procedural limitations applicable to medical/surgical services

1. Physician visits – no limit
2. Hospital outpatient visits – 12 visits per year
3. OT, PT, ST – overall 20 visit limit for any combination of these therapies
4. Podiatrist – 4 visits per year
5. Limits on dental and vision care services
6. Prior approval required for private duty nursing

CMHC services include 24-hour Emergency Services, Assessment and Evaluation, Individual and Group Therapy, Psychiatric Services, Case Management, and Community Based Rehabilitation Services.¹¹ CMHC services are unlimited for enrollees with a serious mental illness (SMI) or serious emotional disturbance (SED). An annual limit of \$4,000 is set for individuals who formerly had SMI or SED and an annual limit of \$1,800 is set for those who do not meet criteria for SMI or SED. CMHC's also deliver targeted case management for mental health, which is restricted to people with severe mental illness and a need for long term care and case management.

CMHC emergency services are a supplement to hospital emergency services. As a result, they do not have obvious counterparts on the physical health side. Thus, limits on these services should be in compliance with MHPAEA. However, it is desirable for people in psychiatric crisis to have access to emergency stabilization services whenever they are needed.

¹¹ This is a CMHC service, but may not be eligible to be reimbursed by Medicaid.

CMHC assessment and evaluation, individual and group therapies, and psychiatric assessments are comparable to services provided by physicians and licensed psychotherapists. Because physician services are not subject to limitation, CMHC psychiatric services should not be limited. Since CMHC assessment, evaluation, individual and group therapies are ambulatory mental health services comparable to psychotherapy, whatever determination is made for psychotherapy should apply to these services.

Benefits whose compliance with MHPAEA is uncertain

CMHC case management, community based rehabilitation services, and targeted case management is rehabilitation services. Health plans often cover rehabilitation services on a time limited basis, with the expectation that functionality is recovered over time. In New Hampshire Medicaid, physical, occupational and speech therapies are subject to a combined 20 visit limit. Medicaid enrollees with physical or developmental problems that require additional rehabilitation may qualify for additional case management and long term services and supports under a Home and Community Based Waiver, based on a comprehensive service plan. Our preliminary analysis suggests that CMHC community rehabilitation services can be limited in ways that are no more restrictive than the limits on other rehabilitative therapies.

- New Hampshire may wish to evaluate how the financial limitations placed on people not currently assessed to have SED or SMI compare to the 20 visit rehabilitation therapy limit. If these limits cover fewer than 20 visits, they should be expanded to include at least 20 visits. Establishing a limitation based on visits will make it easier to demonstrate parity between mental health and physical health therapies.
- New Hampshire may wish to consult final regulations for MHPAEA to see if additional guidance is provided about parity in rehabilitation services.

The medical necessity criterion of SMI or SED used to establish eligibility for unlimited rehabilitation, case management and targeted case management services appear to be similar to the criteria that apply to determination of eligibility for waiver services for people with physical and developmental disabilities. No CMS guidance was found regarding how to consider services provided under waiver. A preliminary analysis suggests that New Hampshire can make a reasonable argument that it is offering long term mental health rehabilitation services and supports on a comparable basis to those offered under waiver to people with physical and developmental problems. It is possible that final regulations will provide additional guidance on this issue.

- New Hampshire may wish to compare its SED and SMI criteria to those used to determine eligibility for its Home and Community Based Service waivers and eliminate any inconsistencies in criteria for community rehabilitation, case management or targeted case management services that are more restrictive than those for waiver services. New Hampshire may wish to revisit this issue once CMS has issued final regulations.
- New Hampshire may wish to revisit this issue once CMS has issued final regulations.

Institution for Mental Disease (IMD) Services for children and elders are currently used solely for New Hampshire State Hospital services. If this benefit is extended to new eligibles, it should

comply with parity requirements, as there are no prior approval requirements or limits placed on the service. It is not entirely clear how to think about the prohibition on coverage for adults under age 65. On one hand, similar prohibition on the medical/surgical side does not appear to exist. On the other hand, Medicaid reimbursement for adults receiving services in Institutions for Mental Disease (IMDs) has long been prohibited by federal rules for non-elderly adults, and adults do have access to inpatient psychiatric services from other hospitals. However, if the state hospital offers a distinct kind of inpatient care, not otherwise available, then parity questions might arise.

Another category of IMDs is private psychiatric facilities and skilled nursing facilities with more than 16 beds that serve 51 percent or more of people with behavioral health conditions. Medicaid regulations prohibit a skilled nursing facility considered to be an IMD from billing for either its Medicaid behavioral health patients or any Medicaid non-behavioral health patient.

As of May 13, 2013, CMS has not yet issued draft guidance on how the Medicaid restriction on IMD services for non-elderly adults will be treated in Medicaid Alternative Benefit Plans. Some parties are urging that this restriction be lifted. Regulations addressing this matter are expected shortly.

- New Hampshire should consult these regulations when they are issued to better understand the options for coverage of IMD services.

Services for children in DCYF custody

Children in DCYF custody are all currently eligible for Medicaid. The special services for children in DCYF custody will therefore not be subject to MHPAEA. It is our understanding that the state may include children in DCYF custody in managed care, but, at least initially, does not plan to include these DCYF services in the managed care benefit. Therefore, a detailed analysis of this benefit was not conducted. However, should these services be included in managed care in the future, there would be several considerations in determining eligibility. The DCYF services appear to be enhanced services, many of them addressing behavioral health needs. Provision of extra MH/SUD services should not be a consideration for parity compliance.

- If there are enhanced medical/surgical services for foster children or for other populations with similar level of need, New Hampshire should ensure that its MCO does not establish any eligibility criteria or service limits for foster care mental health services are no more restrictive than for analogous medical services.

Figure 10: Mental Health and Substance Abuse Services in Medicaid and CHIP in New Hampshire
Mandatory and Optional State Plan Services (as of April 2013) Compared to MHPAEA Parity Act
Standards

Mental Health - Medicaid

| (1) Service | (2) Service requirements and limitations | (3) Changes Needed to Comply with Parity if Benefit Extended to New Eligibles or included in Managed Care Benefits ^{1/} |
|--|--|---|
| Mandatory State Plan Services | | |
| Inpatient Hospital Services | | |
| Inpatient Care | General Hospital covered. Prior authorization required for out of state hospital. No PA required for in state hospital. | No changes needed. Same coverage is available for medical and MH inpatient care |
| Outpatient Hospital Services | | |
| Hospital Emergency Department | 4 visit limit with override possible | No changes needed. Same limit applies for medical and MH emergencies |
| Physician Services | | |
| Physician services including: <ul style="list-style-type: none"> • Psychiatric evaluation and diagnosis, • Individual, family, or group psychotherapy, • Electro-shock treatment, • Psychometric testing, and • Collateral contacts | No limit for physician services including psychiatrists | No changes needed. Psychiatrist services are treated the same as other physician services |
| Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21 | | |
| Under EPSDT, a beneficiary may receive <ul style="list-style-type: none"> • Services in amounts greater than that otherwise covered under Medicaid • Services that can be covered under Federal Medicaid law but that NH has chosen not to otherwise cover | <ul style="list-style-type: none"> • Under age 21 • Service must be needed to treat a condition identified in an EPSDT screen • All services beyond those otherwise covered by NH Medicaid require prior authorization from Medicaid agency | No changes needed. Section 509 of CHIPRA specifies that state CHIP plans are deemed to satisfy MH/SUD parity if they cover EPSDT |
| Optional State Plan Services | | |
| Inpatient Psychiatric Hospital Services (for persons under age 22 or over 64) IMD Benefit | | |
| Evaluation, diagnostic, and treatment services in psychiatric hospital ^{3/} | <ul style="list-style-type: none"> • Must be under age 21 at admission or • Over 64 at time of service | The IMD issue is unsettled, but is expected to be addressed in regulations for the Alternative Benefit Plan due to be issued shortly. |

| (1) Service | (2) Service requirements and limitations | (3) Changes Needed to Comply with Parity if Benefit Extended to New Eligibles or included in Managed Care Benefits ^{1/} |
|---|---|---|
| Psychotherapy | | |
| Practitioners licensed by the Board of Mental Health Practice <ul style="list-style-type: none"> Evaluation, diagnostic, and treatment services | <ul style="list-style-type: none"> Psychotherapy benefit 18 visits for adults 24 for kids. Services provided by the CMHC fall outside this benefit | If NH determines that physician services constitute two-thirds or more of ambulatory medical/surgical services, then limits should be eliminated because substantially all ambulatory medical benefits have no quantitative limits. Final CMS guidance should be consulted. ^{2/} |
| Rehabilitation Services | | |
| Community Mental Health Services <ul style="list-style-type: none"> 24-hour Emergency Services Assessment and Evaluation Individual and Group Therapy, Case Management, Community Based Rehabilitation Services, Psychiatric Services, and Community Disaster Mental Health Support. | <ul style="list-style-type: none"> Services up to \$1,800 in Medicaid reimbursement per state fiscal year unless the individual has functional impairments which meet the criteria for Serious Mental Illness (SMI), or Severe Emotional Disturbance (SED). SMI and SED have no set limit. Adults formerly meeting SMI criteria who are considered low utilizers have a \$4000 state fiscal year limit. Services from an out-of state provider must receive prior-authorization | <p>CMHS emergency services are supplemental and therefore, any limits are likely acceptable, though unlimited access to emergency stabilization is desirable for people in mental health crises.</p> <p>If NH determines that physician services constitute two-thirds or more of ambulatory medical/surgical services, then limits on assessment and evaluation, individual and group therapy and psychiatric services should be eliminated because substantially all ambulatory medical benefits have no financial limits. ^{2/} Final CMS guidance should be consulted.</p> <p>Limits on community based rehabilitation services for people who do not have SED or SMI should be set to ensure that they are no more restrictive than limits on physical, speech or occupational therapy. Final CMS guidance should be consulted.</p> <p>Acceptable medical necessity criteria for case management, community based rehabilitation for people with SED or SMI appear to be no more restrictive than those for eligibility for Home and Community Based Waiver services for people with physical and developmental problems. Final CMS guidance should be consulted.</p> <p>No changes required in prior approval for out-of-state providers if the same procedures and criteria apply to ambulatory medical services</p> |

| (1) Service | (2) Service requirements and limitations | (3) Changes Needed to Comply with Parity if Benefit Extended to New Eligibles or included in Managed Care Benefits ^{1/} |
|--|---|---|
| Targeted Case Management for Individuals who have a SMI or SED | | |
| <ul style="list-style-type: none"> • Crisis intervention monitoring, • Coordination of assessment and certification of eligibility for mental health services, • Development of an individual service plan and service mobilization, • Oversight of services • Periodic review of service plan, monitoring, linkage, and advocacy | <ul style="list-style-type: none"> • Beneficiary must have a severe mental illness and be in need of long-term mental health services and case management. | <p>Medical necessity criteria for targeted case management for SMI/SED appear to be no more restrictive than criteria used for other disabling conditions that are eligible for Home and Community Based Waiver services. Final CMS guidance should be consulted.</p> |

Services for children in DCYF custody^{4/}

| (1) Service | (2) Service requirements and limitations | (3) Changes Needed to Comply with Parity if included in Managed Care Benefits ^{1/} |
|---|--|---|
| Optional Services | | |
| All of these services would need to be vetted through DCYF. They are restricted to children in DCYF custody. | | Currently not planned to be included in managed care benefit. If these benefits are included in the future, MCOs cannot impose additional limits on mental health services that exceed those for medical/surgical services. However, limits included in the state plan can remain. |
| Therapeutic foster care <ul style="list-style-type: none"> Client-centered family mental health counseling, Individual counseling, Crisis intervention and stabilization, Medical care coordination | <ul style="list-style-type: none"> Prior authorization required No specific limits | MCO prior authorization and medical necessity criteria can be no more restrictive than for specialized foster care for children with significant medical conditions. |
| Intensive Day Therapy, package of services including: <ul style="list-style-type: none"> Case management, Occupational therapy, Physical therapy, Speech therapy, and Nursing services. | <ul style="list-style-type: none"> Prior authorization required, with services authorized for two-month periods with a limit of six months total Services must be provided for a minimum of four hours, five days per week | N/A not a behavioral health service. This would be considered as a potential point of comparison for MH/SUD service policies. |
| Intensive Day Programming (children): Based on clinical assessment, each child receives an individually-designed program of individual, group, and/or family system therapy and counseling | No specific service limits | No changes are likely to be needed because there are no specific limits. If this program requires prior approval, then the MCO process and criteria would need to be no more restrictive than for specialized medical services for foster children or similar high need populations. |
| Crisis Intervention <ul style="list-style-type: none"> Therapeutic and intensive counseling | <ul style="list-style-type: none"> Prior authorization required Limited to six-year period without regard to the 12 visits/year limit | We are not entirely clear what this service is or how the six year period limit works. If this program requires prior approval then the process and criteria would need to be no more restrictive than for specified medical services for Foster children or similar high need populations. |
| Home-Based Therapy services <ul style="list-style-type: none"> Psychotherapy and mental health counseling and therapy | <ul style="list-style-type: none"> Prior authorization required No specific service limits | MCO prior authorization process and criteria can be no more restrictive than those for any home based medical service for foster children or other high need populations. |

Footnotes:

1/ MHPAEA applies only to alternative benefit plans for the newly eligible, not to Medicaid fee-for-service benefits. Medicaid managed care plans for current beneficiaries can retain limits or restrictions on mental health services that are part of the state plan, but any additional criteria or restrictions that MCOs create must comply with MHPAEA.

2/ Substantially all is defined as 2/3 or more of the benefits in the applicable category. Interim regulations define the following six benefit categories:

- Inpatient in-network
- Inpatient out of network
- Outpatient in-network
- Outpatient out-of-network
- Emergency services
- Pharmacy

3/ NH Medicaid only reimburses this category for care at NH State Hospital. No private psychiatric facilities are paid.

4/ DCYF services were previously available to children at risk as well as those in DCYF custody. However, in the past year, their services have been tightly restricted to only those children in custody. They are provided by providers other than CMHCs and billed directly to Medicaid. They are considered part of NH's rehabilitation option services and parallel many CMHC services, but have been customized for the DCYF population and are governed by DCYF service standards. These services will not be included in Step 1 of managed care, though they may be added subsequently.

V. Option for Substance Abuse Benefit Design

As New Hampshire has not previously offered a Medicaid substance abuse benefit, the following section provides an evidence-based option for such a benefit based on relevant national standards, how other states have designed Medicaid substance abuse services, and the substance abuse treatment services established by the New Hampshire Bureau of Drug and Alcohol Services.

Approach

Evidence and experience suggests that a SUD benefit should include the needed continuum of substance use disorder services that would meet the range of needs for different degrees of misuse, addiction and withdrawal. To provide an option for such a continuum, the Lewin Team consulted two sets of standards for SUD treatment – (1) the framework of the American Society of Addiction Medicine (ASAM) and (2) the Substance Abuse and Mental Health Services Administration’s (SAMHSA) model for a Modern Addictions and Mental Health System. The continuum of services provided by the Bureau of Drug and Alcohol Services, whose admissions are governed by ASAM level of care criteria, are also identified. Discussions with personnel from the Bureau of Drug and Alcohol Services and the Department of Health and Human Services provided better understanding of the current scope of BDAS services and the Medicaid methadone benefit. The provisions of the MHPAEA and the benefits of New Hampshire’s selected benchmark plan were also reviewed.

Standards for continuum of substance abuse services

ASAM recognizes six dimensions that determine the nature of an individual’s need for SUD treatment. These include: Immediate Risk of Intoxication and Withdrawal; Co-occurring Biomedical Conditions; Co-occurring Emotional/Behavioral Conditions; Readiness to Change; Relapse Potential; and Support System (the individual’s social, family and environmental supports, (such as housing, job, etc.). The ASAM framework provides criteria for determining the level of SUD treatment needed to address different degrees of misuse, addiction and withdrawal. ASAM defines five levels of care that can together meet the range of needs for detoxification and treatment found among individuals with SUDs, as shown in *Figure 11*.

Figure 11: Description of ASAM Levels of Care

| ASAM Level of Care | Level of Care Description |
|--|---|
| 0.5: Early Intervention | Education, risk advice and services to people who may be at risk of developing a SUD |
| I: Outpatient Treatment | Encompasses modalities of outpatient substance abuse counseling, opioid treatment (methadone), suboxone treatment from a physician, and community support. |
| II: Intensive Outpatient/ Partial Hospitalization | II.1 Intensive outpatient treatment At least 6 hours a week of structured outpatient counseling and psychoeducation. II.5 Partial hospitalization 20 or more hours of clinically intensive programming per week, for people who require structure and support to achieve and sustain recovery. |

| ASAM Level of Care | Level of Care Description |
|--|---|
| III: Residential/ Inpatient Subacute Treatment | <p>III.1 Clinically Managed Low-Intensity Residential Services At least 5 hours a week of treatment directed toward applying recovery skills and preventing relapse. Often provided in a halfway house or group home.</p> <p>III.5 Clinically Managed Medium-Intensity Residential Services Highly structured recovery environment with medium-to-high intensity professional clinical services and a therapeutic “community”. For clients with difficult or abusive interpersonal relationships, criminal justice histories, little or no work history, and limited education.</p> <p>III.7 Medically Monitored High-Intensity Residential/Inpatient Treatment Medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians in a non-hospital twenty-four hour rehabilitation facility.</p> |
| IV: Medically-Managed Intensive Inpatient Treatment | Medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians with the full resources of a general acute care hospital or psychiatric hospital. |

Substance Abuse and Mental Health Services Administration. SAMHSA’s standards for a Modern Addiction System identify services needed by people with SUD in the following 11 categories:

- Healthcare Home/ Physical Health
- Prevention (including Promotion)
- Engagement Services
- Outpatient Services
- Medication Services
- Community Support (Rehabilitative)
- Other Supports (Habilitative)
- Intensive Support Services
- Out-of-Home Residential Services
- Acute Intensive Services
- Recovery Supports
-

Some services, such as health care homes and physical health, are not SUD treatment services but support the need for treatment of substance use problems to be integrated with physical health and primary care. Prevention and certain supportive services fall outside the range of what is traditionally considered within the scope of Medicaid and health insurance. However, the remainder of the categories encompasses the services included in the ASAM framework and some additional approaches for which evidence of efficacy is developing.

Examples of Medicaid substance abuse benefits in other states

Substance abuse services being offered by other states are examined to illustrate varying degrees of richness in substance abuse benefits. Based on an analysis performed by the National Association of State Alcohol/Drug Abuse Directors (NASADAD) in 2012, the range of coverage of Medicaid substance abuse services across ten states is presented in **Figure 12**. About half of the states shown cover screening/brief intervention services (ASAM 0.5), while nearly all of these selected states cover ASAM I through IV for certain populations or within certain service categories. A number of states, for example, cover Level III residential treatment only for youth under age 21. Lastly, methadone treatment is covered to some extent by all 10 states, though the service categories in which treatment is covered vary.

Figure 12: Medicaid Program Coverage of Substance Abuse Services Across Ten States (2012)

| State | CA | CO | IL | IA | MD | MA | MI | NY | VT | VA |
|--|-----------------|--------------------------------|----------|-----|------------|------------|------------|--------------------------|------------|-------------------------|
| Carve Out? | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Screening/Brief Intervention (ASAM 0.5) | No | No | No | Yes | Yes | Yes | Yes | ED only | No | Yes |
| Outpatient Testing and TX (ASAM I) | Rehab/clinic | Yes | Clinic | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Methadone Treatment (ASAM I) | Clinic | MD, Clinic, EPST, under Waiver | Rehab | Yes | Yes | Yes | Clinic | MD, Clinic, under Waiver | Rehab | MD, Clinic, Other Prac. |
| Intensive Outpatient/Partial Hospitalization (ASAM II) | Rehab/clinic | No | Clinic | Yes | Yes | Preg. womn | Yes | Yes | Yes | Yes |
| Short-Term Residential/Inpatient TX (ASAM III) | Gen. In-patient | < 21 yrs | < 21 yrs | Yes | < 21 yrs | No | In-patient | < 21 yrs | Yes | < 21 yrs |
| Long-term Residential/Inpatient TX (ASAM III) | Gen. In-patient | < 21 yrs | No | Yes | < 21 yrs | No | In-patient | No | Yes | < 21 yrs |
| Med. Managed Inten. Inp. Hosp. TX (ASAM IV) | Un-known | Inpat. Detox | No | Yes | Detox only | Yes | No | Detox only | Detox only | Preg. womn only |

Evidence-based guidance

Under federal regulations, New Hampshire will be required to provide a Medicaid SUD service benefit for its expansion population. This benefit will need to comply with essential health benefit requirements, include benefits at least equivalent to those in New Hampshire's selected benchmark plan, and conform to the requirements of MHPAEA. New Hampshire is not required to add such benefits to its state Medicaid plan services enrollees whether they remain in its fee for service system or enroll into a managed care program. However, the state has the option to provide a single SUD benefit that is consistent for all beneficiaries.

This section outlines an evidence-based option for a Medicaid substance abuse benefit, including justifications for the benefits option. *Figure 12* lists relevant New Hampshire Medicaid benefits, identifying what changes would be needed to carry out this option.

Figure 13 lists evidence-based SUD treatment services that provide an optimal continuum of care. This set of services includes each ASAM level thereby providing a continuum of services able to meet the full scope of need for detoxification and substance abuse treatment. This set of services, if implemented according to recommendations, is likely to meet parity requirements. Further, it provides at least the scope of services outlined in New Hampshire’s selected benchmark plan.

Figure 13: Potential SUD Treatment Medicaid Benefit

- 1) Medically managed detoxification (level IV – hospital detox)
- 2) Medically monitored detoxification (level III – non-hospital)
- 3) Screening and Brief Intervention
- 4) Outpatient Counseling
- 5) Outpatient Detoxification
- 6) Intensive Outpatient Treatment
- 7) Community Stabilization Supports (30 to 60 days of support for people in early recovery in their own homes or in residential treatment)
- 8) Methadone maintenance
- 9) Peer Recovery Support

Services required to meet applicable standards

Medically managed detoxification (inpatient detoxification), outpatient counseling and detoxification, intensive outpatient, and methadone maintenance are likely to be considered necessary to provide SUD services at parity with medical/surgical services. Medically managed detoxification is within the scope of general hospital services and the other services are already established as defined levels of care in the network of New Hampshire’s Bureau of Drug and Alcohol Services.

Medically managed detoxification (level IV – hospital detox). This level of care is needed by people in acute stages of withdrawal who need close monitoring and the ability to treat any medical problems that arise. Services include medically-directed 24-hour care by addiction physicians, nurses, and addiction credentialed clinicians with the full resources of a general acute care hospital or psychiatric hospital. An interdisciplinary team and support resources allow for the coordinated treatment of any coexisting biomedical and emotional or behavioral conditions that need to be addressed.

Outpatient Counseling. This level of care is defined as eight or less hours per week of organized, outpatient services by a licensed substance abuse professional designed to achieve permanent changes in an individual’s substance using behavior.

Outpatient Detoxification. People whose acute withdrawal symptoms do not require continuous medical monitoring can be treated at the outpatient level. Licensed Opioid Treatment Programs can dispense Methadone for detoxification and properly trained and certified physicians can prescribe buprenorphine and monitor detoxification. Outpatient detoxification has been established as an effective and efficient method for acute withdrawal that minimizes undesirable symptoms and disruption of the patient’s daily life. Physician

treatment with suboxone is particularly accessible for people who want to avoid the stigma of being treated in a known addiction program.

Both inpatient and outpatient substance abuse care are included in the Matthew Thornton benchmark plan and coverage of inpatient and outpatient care for substance abuse will need to be covered at parity with inpatient and outpatient care for other diagnoses to comply with MHPAEA. Since New Hampshire does not have prior approval or service limits for inpatient services or most outpatient services, then limits may not be applied for inpatient or outpatient substance abuse services. In addition, the state would need to ensure that any authorization procedures and medical necessity criteria for SUD treatment used by its managed care plans are no more restrictive than those used for medical/surgical services.

Methadone Treatment. In 2002, the Centers for Disease Control and Prevention (CDC) noted that “Methadone Maintenance Treatment is the most effective treatment for opiate addiction.”¹² Methadone blocks the euphoric and sedating effects of opiates and relieves craving. Daily dosing often allows individuals to maintain their employment and family responsibilities. CDC studies have shown the benefits of methadone treatment include: reduction or cessation of injection drug use; reduced risk of transmitting or becoming infected with HIV, hepatitis B or C, bacterial infections, endocarditis, soft tissue infections, thrombophlebitis, tuberculosis, and STDs; reduced risk of death; reduced criminal activity; improved family stability; and improved pregnancy outcomes. The CDC cited several studies that found it to be cost-effective. Methadone treatment is the only substance abuse service currently covered by New Hampshire Medicaid and it has no service limits.

Intensive Outpatient Services. Intensive outpatient services are offered at least three (3) hours per day at least three (3) days per week. They include structured individual and group addiction activities and services that are designed to assist people to begin recovery and learn skills for recovery maintenance. There are no more than two consecutive days between offered services. Medical and psychiatric services are made available by referral. This level of care is generally offered on a short-term basis to help people to establish sobriety after detoxification, or when greater support is needed than less frequent outpatient care can provide. This level of care is important in reducing relapse and the need for 24 hour services.

Intensive outpatient services are rehabilitation services, which are often provided on a short-term, time-limited basis. Since New Hampshire limits speech, occupational and physical therapy to 20 visits, it may not be able to establish a lower limit on intensive outpatient services. As such, the state could consider the program model used in BDAS intensive outpatient programs and set any limit to allow for treatment to be completed in conformance with the planned program design. According to the Substance Abuse and Mental Health Services Administration, intensive outpatient programs may be designed to operate as long as 12 to 16 weeks with a frequency of 3 to 5 days per week.¹³ Completion of a program of that length

¹² Methadone Maintenance Treatment (2002), Centers for Disease Control accessed from <http://www.cdc.gov/idu/facts/methadonefin.pdf> on May 10, 2013.

¹³ Center for Substance Abuse Treatment, Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

would necessitate considerably more than 20 visits. In addition, evidence suggests that New Hampshire allow for enrollees to return to this level of care if they experience a relapse or are experiencing difficulties in a less intensive outpatient program.

Additional SUD services

Our SUD benefit design option includes some additional services that can strengthen and round out the New Hampshire SUD treatment system, which are based on evidence-based guidance.

Medically Monitored Detoxification (Level III, non-hospital). Depending on the stage of withdrawal and the types of any co-occurring medical problems, patients addicted to alcohol or other drugs may need a medically monitored period of detoxification. While this level of care can be provided in a general hospital, it can also be provided in a freestanding facility with staffing that meets appropriate standards for medical monitoring, nursing and other clinical care. The majority of people requiring 24 hour oversight for detoxification can be treated in Level III.¹⁴ This level of care is significantly less expensive than hospital services. When delivered by a provider also offering outpatient and supportive community services, linkage to aftercare may be strengthened.

New Hampshire does not currently license this level of care. Adding it to covered services would require the BDAS to develop appropriate staffing, facility and operations licensing standards and a process for conducting licensure reviews. It may be challenging for New Hampshire to develop procedures that change practice to move most detoxifications into Level III facilities, since prior authorization is not routinely required for Medicaid inpatient services. Having different authorization procedures for detoxification services may be construed as being out of compliance with MHPAEA parity rules. Consultation with other states, such as Massachusetts, that manage this benefit, and building upon the widely accepted ASAM placement criteria may help address this challenge.

SUD Screening and Brief Intervention (SBIRT) is an evidence based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs. It consists of three components: screening for alcohol misuse or abuse; brief intervention from a health professional or licensed addiction professional for those whose screening shows risky use of substances; and referral for SUD treatment for those whose use warrants specialty treatment.

To include this service as a covered Medicaid benefit, the state would need to develop a method of paying for the screening and brief intervention component. Screening would utilize a validated screening tool administered in primary care, emergency departments, or in other relevant settings. The brief intervention is a short conversation, providing feedback and advice. In some models, this is a single intervention at the time of screening. In other models, up to five short (20 minute) interventions may be provided over a short time period to help individuals

¹⁴ Massachusetts Medicaid behavioral managed care plan changed authorization standards for detoxification services in the early 1990s to limit hospital detoxification only to those patients requiring medical management. This reduced hospital detoxification as a percent of all 24 hour detoxification from 89% to 1%. Shepard, DS, Daley, M, Ritter, GA, Hodgkin, D, and Beinecke, RH, Managed Care and the Quality of Substance Abuse Treatment, The Journal of Mental Health Policy and Economics, 163-174 (2002)

set and begin to implement goals for reducing risky substance use. Screening and brief intervention can appropriately be conducted by trained staff who are not SUD clinicians, such as primary care providers and nursing staff. To promote development of this capacity, the state could consider establishing flexible billing methods that can be used in multiple settings and by any appropriately qualified and trained practitioner. New Hampshire BDAS plans to apply for a SAMHSA grant that would support the development of SBIRT in a number of settings. This could help provide training and implementation support to initiate this new service.

SBIRT has a strong evidence base showing that it reduces healthcare costs, decreases severity of alcohol and drug use, and reduces risk of trauma and the percentage of at-risk patients who go without specialized substance abuse treatment. The following studies have shown evidence of cost savings:

- Multiple studies have shown that investing in SBIRT can result in healthcare cost savings that range from \$3.81 to \$5.60 for each \$1.00 spent;¹⁵
- People who received screening and brief intervention in an emergency department, hospital or primary care office experienced 20% fewer emergency department visits, 33% fewer nonfatal injuries, 37% fewer hospitalizations, 46% fewer arrests and 50% fewer motor vehicle crashes;¹⁶
- In 2002, researchers analyzed more than 360 controlled trials on alcohol use treatments and found that screening and brief intervention was the single most effective treatment method of the more than 40 treatment approaches studied, particularly among groups of people not actively seeking treatment;
- Additional studies and reports have produced similar results showing that substance use screening and intervention help people recognize and change unhealthy patterns of use;¹⁷
- Studies have found that patients identified through screening as having unhealthy patterns of drug or alcohol use are more likely to respond to brief intervention than those who drink heavily.¹⁸ The latter group is more likely to meet diagnostic criteria for a substance use disorders that needs more intensive treatment; and
- Studies on brief intervention in trauma centers and emergency departments have documented positive effects such as reductions in alcohol consumption,¹⁹ successful

¹⁵ Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B., Stauffacher, E. A., & Barry, K. L. (2000). Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. *Medical Care*, 38(1), 7-18.

¹⁶ Ibid.

¹⁷ Miller, W.R., & Wilbourne, P.L. (2002). Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders. *Addiction*, 97, 265-277.

¹⁸ Fleming M (2000).

¹⁹ Gentilello, L. M. (2007). Alcohol and injury: American College of Surgeons Committee on Trauma requirements for trauma center intervention. *Journal of Trauma*, 62, S44-S45.

referral to and participation in alcohol treatment programs,²⁰ and reduction in repeat injuries and injury hospitalizations.^{21,22}

Peer Recovery Support: Peer support through organizations such as Alcoholics Anonymous and similar organizations has long been understood as an important component of recovery from SUD for many individuals. More recently, peers who have experienced SUD and recovery have begun to serve in other roles that are also demonstrating their value. In 2011, SAMHSA developed several new roles and definitions for peer services, including: Peer Recovery Support Coaching; Relapse Prevention/Wellness Recovery Support; Peer Navigator; and Peer-Operated Recovery Community Center. Peer services include services to help individuals and families initiate, stabilize, and sustain recovery; they are non-professional and non-clinical; and they provide links to professional treatment and indigenous communities of support. They are neither professional addiction treatment services nor mutual-aid support. New Hampshire BDAS recently created a certification for peer support staff that provides a foundation for building their services into the New Hampshire continuum of SUD services. These peers can be valuable in reaching newly insured vulnerable populations who are not familiar with the medical system or the SUD treatment system. If recruited from differing cultural groups, they can bridge between linguistic/cultural subgroups and the health care community. They can offer community education and public health approaches delivered from a respected member of the community. They can take on non-clinical tasks performed by clinical staff, allowing them to practice at the top of their licenses.

Research on peer recovery support services and peer-run organizations is promising and evidence is increasing. 2011 data from SAMHSA's Recovery Community Services Program grantees demonstrated positive outcomes at 6 month follow-up on abstinence, police involvement, employment, housing and mental health symptoms.²³ We recommend that New Hampshire HHS work with BDAS to identify services and programs where services of certified peer support staff can be incorporated into existing SUD program models or fill gaps in needed recovery services for high need groups. These services might initially be provided through state and block grant funds, but closely linked to Medicaid SUD services. Over time, their track record may provide sufficient justification for Medicaid to incorporate certified peer specialists or coaches directly into the Medicaid benefit.

Community Stabilization Supports: This program would cover a package of short-term supportive services that could include the clinical component of residential services or provide community-based care coordination and clinical support for others recovering in their own homes. Payment for these services should not include the costs of room and board, which is

²⁰ Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., et al. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. *Annals of Surgery*, 230, 473–483.

²¹ Ibid.

²² Soderstrom, C. A., DiClemente, C. C., Dischinger, P. C., Hebel, J. R., McDuff, D. R., Auman, K. M., et al. (2007). A controlled trial of brief intervention versus brief advice for at-risk drinking trauma center patients. *Journal of Trauma*, 62, 1102–1112.

²³ Hill, Tom, (September 26, 2011) Peer Recovery Coaches Promote Long-term Recovery from Addiction, accessed from http://www.facesandvoicesofrecovery.org/pdf/eNews/9.19.11_Peer_Coach_Pillars_of_Support_FINAL.pdf on April 30, 2013.

prohibited in Medicaid. However, the state could design a community stabilization service that could pick up the clinical components of BDAS short-term post detoxification services (ASAM Level III, clinically managed medium intensity residential) and also include the early months of transitional living programs (ASAM Level III, clinically managed, low intensity residential).

In addition, the state could support the clinical components of BDAS long-term extended care programs for pregnant women (ASAM Level III, clinically managed high intensity) for a period of time sufficient to support a safe and substance free pregnancy. The state could work with BDAS to establish service expectations that are consistent with BDAS service models, and include staffing and documentation requirements. This could be done by using a per diem rate for these services.

Figure 14: Summary of Medicaid SUD Benefit Option

| Provider Type/Service | Service requirements and limitations | Additions to Create a Medicaid SUD Benefit |
|---|---|--|
| Mandatory State Plan Services | | |
| Inpatient Care | | |
| Level IV Detoxification | <ul style="list-style-type: none"> Only covers detoxification provided at an acute hospital as an acute care service ^{1/} Out of state inpatient requires PA | <p>Explicitly add acute SUD conditions as a covered inpatient service (Level IV Detoxification)</p> <p>Use the same process for out-of-state SUD admissions as for other out-of-state admissions</p> |
| Level III Detoxification | | Add coverage for this level of care once a licensure process is established |
| Outpatient Hospital | | |
| Hospital Emergency Department | 4 visit limit w override possible | Ensure that SUD conditions are covered emergency services subject to same limitations as for medical and MH emergencies |
| SUD Screening and Brief Intervention | | Create a billing and payment code to appropriately reimburse this service by varied personnel in all hospital settings. |
| Physician Services | | |
| Physician services | No limit for physician services including psychiatrists | Ensure that outpatient detoxification and other treatment for SUD conditions are covered physician services. |
| SUD Screening and Brief Intervention | | Create a billing and payment code to appropriately reimburse this service. |
| Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to Children Under 21 | | |
| <p>Under EPSDT, a beneficiary may receive</p> <ul style="list-style-type: none"> Services in amounts greater than that otherwise covered under Medicaid Services that can be covered under Federal Medicaid law but that NH has chosen not to otherwise cover | <ul style="list-style-type: none"> Under age 21 Service must be needed to treat a condition identified in an EPSDT screen All services beyond those otherwise covered by NH Medicaid require prior authorization from Medicaid | Ensure that the EPSDT program addresses adolescent substance abuse screening, diagnosis and treatment |

| Provider Type/Service | Service requirements and limitations | Additions to Create a Medicaid SUD Benefit |
|---|--|---|
| Optional State Plan Services | | |
| Outpatient or Community Based <i>SUD Outpatient and Intensive Outpatient Treatment</i> | <ul style="list-style-type: none"> There is no discreet substance abuse benefit The SA diagnosis does not preclude payment for any appropriate medically necessary service covered under NH Medicaid State Plan. Licensed Alcohol and Drug Counselors are not currently recognized to provide any benefit under New Hampshire Medicaid unless it is under another dually held certification | <p>Recognize Licensed Alcohol and Drug Counselors to provide SUD outpatient therapy</p> <p>Cover outpatient SUD treatment services and outpatient detoxification services without visit or financial limits</p> <p>If limits are set for intensive outpatient services, they should be no more restrictive than the limit on rehabilitation services. Any limit should be consistent with the optimal time in treatment for the program design.</p> |
| Opioid Treatment Program Methadone Maintenance | No visit or financial limits | Continue this benefit |
| Post detoxification services (clinically managed medium intensity residential) Transitional living programs (clinically managed, low intensity residential). Long-term extended care programs for pregnant women (clinically managed high intensity) Short-term Community Stabilization Supports | | Establish a benefit for short-term community stabilization that covers the clinical component of people in early recovery and pregnant women, whether they are in a residential program or recovering in a permanent housing situation. Criteria for continued community stabilization supports need to be consistent with criteria for recovery support provided for other chronic conditions. |
| Certified Peer Recovery Support Specialists | | Incorporate these positions as billable staff in other Medicaid SUD services as appropriate. Consider establishing Peer Organization services as a covered benefit. |

1/ In this instance, acute care service has been administered assuming that it must be an acute medical care service

Basis for SUD cost estimate

To estimate the cost for a SUD benefit in New Hampshire, we examine cost and utilization data from Medicaid programs in Massachusetts and Pennsylvania (*Figure 15*). These data provide information on the percent of enrollees using SUD services and the average annual claims costs per user across various eligibility groups in 2011. We also obtained 2011 average SUD costs per adult user in Medicaid programs in Kansas (\$2,268) and North Carolina (\$2,115), which we found to be similar to the other two states.

For our estimates, we use Massachusetts Medicaid utilization and cost data since the benefits offered in Massachusetts are similar to the option described above for New Hampshire, except for residential care which this option covers only room and board and not the clinical service. The Massachusetts data is also helpful because it provides usage rates for adults without children who are not currently eligible in New Hampshire but will become newly eligible under the Medicaid expansion. However, Massachusetts already covers this group to 133 percent of FPL. We would anticipate the same level of utilization for the newly eligible group in New Hampshire under the expansion. The Massachusetts utilization rates are adjusted to account for the difference in the prevalence of alcohol or illicit drug abuse or dependency between the two states.²⁴ SUD cost per user estimates for New Hampshire was adjusted to reflect the difference in Medicaid reimbursement rates between the two states.²⁵

For this analysis, we were unable to breakout the cost for each type of service specified above. The cost per person for this benefit is dependent on the entire continuum of treatment that is available, where the cost for one particular service may be dependent on other services that are also available.

Figure 15: Substance Use Disorder Utilization and Cost for Massachusetts and Pennsylvania Medicaid Programs in 2011

| Eligibility Category | Massachusetts | | Pennsylvania | | New Hampshire (Estimated) ^{1/} | |
|----------------------|-------------------|-------------------------------------|-------------------|-------------------------------------|---|-------------------------------------|
| | SUD Cost per User | Percent of Enrollees Using Services | SUD Cost per User | Percent of Enrollees Using Services | SUD Cost per User | Percent of Enrollees Using Services |
| TANF Adult | \$2,052 | 7.97% | \$2,568 | 5.26% | \$1,546 | 7.08% |
| TANF Child | \$1,592 | 0.85% | \$1,157 | 1.14% | \$1,199 | 0.84% |
| Disabled | \$2,362 | 10.90% | \$2,462 | 7.16% | \$1,779 | 9.69% |
| Adults w/o children | \$2,142 | 19.42% | n/a | n/a | \$1,613 | 17.26% |
| Foster Care | \$2,109 | 2.29% | n/a | n/a | \$1,589 | 2.27% |

1/ The utilization rates are adjusted to account for the difference in the prevalence of alcohol or illicit drug abuse or dependency between Massachusetts and New Hampshire and SUD cost per user estimates was adjusted to reflect the difference in Medicaid reimbursement rates between the two states.

Source: Colorado Behavioral Health Council, July 31, 2012

These SUD cost per user and percent of enrollees using services are used to develop the costs estimates for the Medicaid program under the various benefit design options presented above. The following section describes the potential medical cost offsets that could occur when SUD treatment is provided.

²⁴ SAMHSA, "2010-2011 NSDUH State Estimates of Substance Use and Mental Disorders"

²⁵ Stephen Zuckerman and Dana Goin, "How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees," Urban Institute and Kaiser Commission on Medicaid and the Uninsured, December 2012.

VI. Savings to Other Programs Resulting from Substance Abuse Benefit

The National Survey on Drug Use and Health (NSDUH) identifies New Hampshire as a state with one of the highest rates of drug and alcohol use and abuse.²⁶ Substance abuse is viewed as one of the state's top public health concerns, and its social and economic consequences have received much attention in recent years.

According to a 2012 inquiry by the National Association of State Alcohol/Drug Abuse Directors, Medicaid covers at least a minimum level of substance abuse services in the majority of states.²⁷ Outpatient treatment, designated by the American Society of Addiction Medicine (ASAM) as coverage level 1, is covered by Medicaid in 43 states. Intensive outpatient and partial hospitalization (ASAM level 2) is covered in 37 states. Short-term residential and inpatient treatment (ASAM level 3) in 31 states; long-term residential treatment in 21 states, and medically managed intensive inpatient treatment in a hospital setting (ASAM level 4) in 32 states.

New Hampshire currently does not have a substance abuse benefit under its state plan, but there are certain services that individuals with a substance use disorder may access. Per the ACA, substance use disorder services are classified as one of ten essential health benefits. Therefore, the Medicaid benefits offered to certain newly eligible adults in New Hampshire must cover services for substance use disorders beginning in 2014. The state may also elect to offer this substance abuse benefit to current Medicaid eligibles.

Nationwide, substance abuse treatment is largely financed with public dollars. Estimates indicate that as much as 65 percent of treatment expenses are borne by public funding, either through states' Medicaid programs, through the Divisions of behavioral health, or through separate substance abuse treatment programs funded through federal grants and state funds.

To understand the impact of substance abuse treatment coverage by a state Medicaid program, the following sections present findings from recent literature discussing outcomes across several state and health plan initiatives to integrate a substance abuse benefit into its existing benefit structure. In recent years, researchers have sought to better understand the economic impact of substance abuse treatment, or the "cost offset" of such initiatives. Here, we examine direct medical savings of a substance abuse treatment program on health care utilization and direct medical expenses. These programs offer a range of supportive and therapeutic services to clients, with the intent of reducing drug and alcohol dependence, promoting recovery, and decreasing the incidence of relapse.

Additionally, we review recent studies of the impact that substance abuse treatment programs have on crime, prison recidivism, and inmate reintegration. Lastly, we present findings from the literature that discusses the empirical evidence of the broader societal impacts that

²⁶ Office of Applied Studies (2008). States in Brief: Substance Abuse and Mental Health Issues At-A-Glance. Substance Abuse and Mental Health Services Administration. Retrieved from: http://www.samhsa.gov/statesinbrief/2009/NEW_HAMPSHIRE_508.pdf

²⁷ Bureau of Justice Assistance (BJA) Drug Court Technical Assistance/Clearinghouse Project. (2012). Medicaid Coverage for Substance Abuse and Related Services for Drug Court Clients. American University. Retrieved from: <http://www1.spa.american.edu/justice/documents/4143.pdf>

substance abuse treatment programs may contribute. This includes the impact on families and the workplace.

Medical savings from treatment of substance abuse

Economic evaluations of substance abuse treatment programs have appeared in the literature for several decades. While focused on different study populations, programs, and treatment settings, most of the evidence suggests that treatment programs provide a short-term positive cost offset.²⁸

In more recent years, the effect of substance abuse treatment on Medicaid expenses or other health care costs has been studied following the expansion of certain states' Medicaid programs to include a substance abuse benefit when one had not previously been offered. A recent robust evaluation was performed on Colorado's Medicaid Substance Abuse Benefit to offer outpatient substance abuse and addiction treatment services to all Medicaid enrollees. Another study examines the effect of treatment on Medicaid expenses among welfare clients in Washington State. Because most economic evaluations of substance abuse treatment to date have largely focused on private patients, these studies examining the potential cost offsets to providing treatment to Medicaid recipients are especially relevant.

The Colorado Outpatient Substance Abuse Benefit was implemented in July 2006. In 2010, an evaluation was performed to fulfill a legislative mandate wherein the State Auditor reviewed the state's Department of Health Care Policy and Financing's (which oversees the state's Medicaid program)

Colorado's Substance Abuse Benefit was found to cost \$2.4 million in first three years, while reducing medical costs by \$3.5 million over the same period.

analysis of the benefit's costs and also performed an independent assessment of costs using the state's Medicaid and behavioral health data. Results showed the Substance Abuse Benefit cost the Colorado Medicaid program an additional \$2.4 million in the first three years of the benefit's operation (fiscal year 2007 through 2009), while reducing medical costs by \$3.5 million for the individuals receiving the benefit in that time period.²⁹ The auditors define "savings to the Medicaid program" as "the amount invested in Substance Abuse Benefit services less the reduction in medical costs directly resulting from, or 'caused by' those Substance Abuse Benefit services." Despite these findings, however, the evaluators point to the inability to conclusively attribute these savings to the Substance Abuse Benefit alone because of other possible confounding factors, such as environmental and lifestyle choices among the beneficiary population that may have also impacted their health status and thus, medical expenditures.

Overall findings indicate that the cost of providing substance abuse services to 5,200 Medicaid clients during the 2007-2009 period cost an average of \$464 per beneficiary, amounting to \$2.3 million in claims costs, approximately \$150,000 in administrative expenses and 0.5 full time employee (FTE) to provide administrative functions for the program. The reduction in medical

²⁸ Cartwright WS (2000). Cost-Benefit Analysis of Drug Treatment Services: Review of the Literature. Journal of Mental Health Policy and Economics, 3:11-26

²⁹ Services covered under Colorado's Medicaid Substance Abuse Benefit included: substance abuse assessment, individual and family therapy, group therapy, alcohol and/or drug screening, social and ambulatory detoxification, and case management. Services are provided on a fee-for-service basis.

costs associated with the Substance Abuse Benefit included reduced claims costs for the following Medicaid services: emergency room, inpatient hospitalization, other outpatient, physician, dental, pharmacy, mental health, laboratory, and capitated claims. Various cost trending methodologies were applied, each yielding results that indicate that the Substance Abuse Benefit was financially beneficial to the state. A comparison of Medicaid costs for beneficiaries who utilized the benefit to the overall Medicaid population indicated that Medicaid costs for those who used the benefit either increased at a lower rate or declined at a higher rate than the overall Medicaid population. This is particularly notable given that average annual Medicaid expenses for Substance Abuse Benefit clients is much higher than that for a standard Medicaid enrollee.

The Colorado evaluation also provides insight regarding client costs based on the type of therapy received. Total medical costs for Substance Abuse Benefit clients who received therapy services, including individual and group therapy, decreased at a faster rate (31 percent) than costs for benefit recipients who only received detoxification, assessments and case management. Research suggests that therapy treatment can be more cost-reducing because it acts as a positive influence to the overall health of the client.³⁰

Colorado also learned that longer-term clients generally had higher average annual Medicaid cost compared to shorter-term clients. In particular, those who were enrolled in the entire 36 months of study had nearly twice the cost as those who were only enrolled for 10 months (\$8,390 and \$4,920 in Fiscal Year 2009, respectively). According to the state, the cost differential is likely due to the higher prevalence of disability and chronic or complex conditions among the longer-term clients.

In Washington State, the weighted annual average of savings for patients receiving inpatient, outpatient, and methadone substance abuse treatment was \$2,520.

A Washington study evaluates the economic impact of substance abuse treatment on medical expenditures, primarily for those enrolled in Medicaid. The study population was comprised of persons in the General Assistance program in the state –generally low-income individuals ineligible or awaiting approval for federally-funded cash assistance programs. Medicaid was responsible for 75 percent of medical expenditures in this group, while other state funding contributed the remaining 25 percent.³¹ The study found that the cost of medical care for General Assistance clients receiving inpatient treatment was, on average, \$170 less per member per month than clients in the comparison group, who needed treatment but did not receive it. For those who received outpatient treatment or methadone maintenance, costs were \$215 and \$230 lower, respectively. The weighted annual average of savings for these three treatment groups was \$2,520. The estimated cost savings associated with substance abuse treatment is 35 percent of expected cost in the first year of treatment, given that average annual medical expenses for untreated clients amount to nearly \$6,500.

³⁰ Ibid.

³¹ Wickizer TM, Krupski A, Stark K, Mancuso D & Campbell K (2006). The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State. The Milbank Quarterly 84.3: 555-76

The study also notes that the substance abuse treatment essentially “paid for itself” within the first year of treatment. While the average cost of treatment for public clients in the state is \$2,300 per episode, the estimated offset of \$2,520 within one year was more than sufficient to return the program’s investment. Furthermore, because substance use disorders left untreated can lead to expensive acute or chronic conditions over time, the long-term savings of treatment may be even more pronounced.

Another study observes a group of Medicaid-insured patients seeking treatment in Kaiser Permanente's outpatient chemical dependency treatment program for one year before the initial program visit and for three years following the start of treatment. Medical costs and utilization are compared to demographically-matched commercially insured patients entering the same program. The findings indicate that both Medicaid and non-Medicaid patients experience average declines in medical costs of 30 percent from the baseline period to the third year following treatment initiation.³² Although Medicaid-insured patients on average incur medical costs 60 percent higher than non-Medicaid patients during the 1-year pre-intake period, both groups display declines in medical costs averaging 30 percent from the baseline period to the third year of follow up. Medical expenses reflect use of hospital days, ER visits, and outpatient visits.

Kaiser Permanente's outpatient chemical dependency treatment program showed a 30 percent decline in costs for Medicaid and non-Medicaid patients by the third year of treatment.

Similarly, medical utilization and costs are examined for 18 months before and after intake of adult males entering an outpatient chemical dependency recovery program at Kaiser Permanente in Sacramento. The findings of this landmark study indicate a substantial decline in the use of medical care associated with substance abuse treatment, particularly in emergency department services and inpatient care. Inpatient, ER, and total medical costs declined by 35 percent, 39 percent, and 26 percent, respectively, in the 18-month post-treatment period.³³

Our cost estimates of providing a SUD benefit in Medicaid for newly or currently eligible assume a resulting physical health care cost reduction based on these studies. We based on cost reduction assumption on the results of the Colorado Medicaid study that showed a return on investment of 1.45 to 1.0 over a three year observed period (i.e., \$2.4 million cost for SUD services compared to \$3.4 million reduction on physical health services).

Reductions in recidivism and imprisonment

A 2003 meta-analysis reviewed 11 studies and found that the benefit-cost ratios associated with substance abuse treatment were between 1.33 and 23.33, and that the economic benefits were

³² Walter LJ, Ackerson L, & Allen S (2005). Medicaid Chemical Dependency Patients in a Commercial Health Plan: Do High Medical Costs Come Down Over Time?. J Behav Health Serv Res, 32(3): 253-63. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16010182>

³³ Parthasarathy S, Weisner C, Hu TW & Moore C. Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis. J Stud Alcohol, 62(1): 89-97. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11271969>

overwhelmingly due to reductions in criminal activity.³⁴ Substance abuse is one of a myriad of issues that lead individuals to partake in criminal activity. It is also a primary reason for the return of former inmates to correctional facilities after the initial release. Therefore, increased availability of substance abuse treatment may have the potential to deter crime and/or prevent recidivism.

Beginning in 2014, formerly incarcerated individuals with incomes below 133 percent of FPL will be eligible for Medicaid including substance use disorder services. Without this expansion in Medicaid eligibility, these individuals would not have access to substance use disorder services even if the services were to be included as a Medicaid benefit.

According to the National Center on Addiction and Substance Abuse, approximately 80 percent of inmates have a drug or alcohol abuse problem.³⁵ Studies by the New Hampshire Department of Corrections (DOC) indicate that the percent of former inmates released from prison and reincarnated within three years increased substantially between 2003 and 2005, from 40 percent to 51 percent, respectively.³⁶ Thirty-seven percent of recidivism in the state occurs due to a drug offense. According to the Justice Center at the Council of State Governments, no state dollars are appropriated to DOC for rapid drug testing or transitional substance abuse treatment in the state. The DOC does not contract with the community-based substance abuse treatment providers to facilitate rapid access to treatment following release. The Justice Center cites research indicating that effective addiction treatment is associated with an 18 percent reduction in recidivism, when used in conjunction with intensive probation or parole supervision.³⁷ The Center approximates that out of the 2,000 individuals released to parole or sentenced to felony probation in FY 2009, 700 were in need of addiction and/or mental health treatment services. The Center further estimates that an annual state investment of \$2.4 million could have provided evidence-based treatment services to all 700 medium and high risk individuals on parole or probation.³⁸

One study indicates that effective addiction treatment is associated with 18 percent reduction in recidivism.

According to Hammett et. al., some former inmates deliberately return to prison because they feel they can obtain better care in a correctional facility than in the community.³⁹ The literature cites a lack of programs to facilitate discharge planning, community linkages, and continuity of care for inmates leaving a correctional facility as a leading issue for prisoner reentry. A study on the risk of death for former inmates found that the adjusted risk of death among former inmates was 12.7 times that among other state residents, with a substantially elevated risk of

³⁴ McCollister KE & French MT (2003). The Relative Contribution of Outcome Domains in the Total Economic Benefit of Addiction Interventions: A Review of the First Findings. *Addiction*, 98:1647-59. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16430607>

³⁵ Hammett TM, Roberts C & Kennedy S (2001). Health-Related Issues in Prisoner Reentry. *Crime & Delinquency*, 47.3: 390-409. Retrieved from <http://cad.sagepub.com/content/47/3/390>

³⁶ Justice Center (2010). Justice Reinvestment in New Hampshire: Analyses & Policy Options to Reduce Spending on Corrections & Increase Public Safety. The Council of State Governments. Retrieved from https://www.nh.gov/nhdod/divisions/publicinformation/documents/012010_justice_rein_analyses.pdf

³⁷ Ibid.

³⁸ Ibid.

³⁹ Hammett TM et al. (2001)

death from drug overdose (the leading cause of death among former inmates during a two-year follow-up period).⁴⁰ Given that the DOC in New Hampshire is not appropriated funds to address many of the issues associated with community transition, the efficient transition to other public programs, such as Medicaid, after release, becomes a priority. The prolonged qualification process for the program may result in a significant gap between application and access to benefits. In some cases, this gap may span several months if the release is not eligible to apply for the program until after he or she has been released. Several corrections demonstration projects funded by the CDC have explored strategies to expedite the application process for inmates, such as allowing them to apply for Medicaid prior to release, and then holding the application so the releasee can be approved and enrolled on the day of release.

Other secondary societal impacts

The finding that substance abuse treatment “pays for itself” is consistent with other studies, especially when extended to savings in other realms, beyond health care spending. A study

One study cites an average substance abuse treatment regimen costing \$1,583 while producing a societal benefit of \$11,487.

performed on the outcomes of the California Treatment Outcome Project (CalTOP), a large-scale demonstration project that collected outcomes data for 43 substance treatment providers in 13 counties in California, suggests that substance abuse treatment demonstrates a 7:1 ratio of benefits to costs when

“costs” includes the client’s costs of medical care, mental health care, criminal activity, earnings, and government transfer program payments. These estimates cite an average substance abuse treatment regimen costing \$1,583, producing a societal benefit of \$11,487.⁴¹

Evidence of detrimental secondary effects of substance abuse on families suggests that the value of substance abuse treatment extends much farther than the budgets of public programs. Having a family member with an alcohol or drug abuse problem adversely affects family dynamics and functioning.^{42,43} Further, it has been shown that family members of individuals with substance abuse disorders experience increased prevalence of medical and psychiatric afflictions, leading to increased medical utilization and cost, compared to family members of those without such disorders.^{44,45} Researchers at the Department of Psychiatry at the University of California, San Francisco sought to determine whether the family members of persons with an alcohol or drug dependence were more likely to be diagnosed with medical conditions than

⁴⁰ Binswanger IA, Stern MF, Deyo RA, Heagerty PJ & Cheadle A (2007). Release from Prison — A High Risk of Death for Former Inmates." *New England Journal of Medicine*, 356.5: 536.

⁴¹ Ettner SL, Huang D, Evans E, Ash DR, Hardy M, Jourabchi M & Hser Y (2006). Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment ‘Pay for Itself’? *Health Services Research*, 41.1: 192-213. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16430607>

⁴² Kern RM (1992). The Other Half: Wives of Alcoholics and Their Social-Psychological Situation. *Symbolic Interaction*, 15: 247-250.

⁴³ Spear S & Mason M (1991). Impact of Chemical Dependency on Family Health Status. *Substance Use & Misuse*, 26.2: 179-87.

⁴⁴ Thomas RG, Mertens JR & Weisner C (2007). The Excess Medical Cost and Health Problems of Family Members of Persons Diagnosed With Alcohol or Drug Problems. *Medical Care*, 45.2: 116-22. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/17224773>

⁴⁵ Lennox RD, Scott-Lennox J & Holder H (1992). Substance Abuse and Family Illness: Evidence from Health Care Utilization and Cost-offset Research. *The Journal of Mental Health Administration*, 19.1: 83-95. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10171039>

family members of persons with asthma or diabetes. Health services cost and utilization were compared for the family members of both groups for one year prior and two years after the initial diagnoses of the ailing family member. The results indicate that the family members of those with alcohol or drug dependence had higher total health care costs than members of the opposing group before and after the initial diagnosis of the index person. Further, members of the former group were more likely to be diagnosed with a substance use disorder themselves, as well as depression and trauma, than the diabetes and asthma family members.⁴⁶ Thus, the conclusion suggests that substance abuse is linked to certain patterns of health conditions and higher cost in not only the afflicted individuals, but also their family members.

The benefits of substance abuse treatment also extend heavily to the workforce. Lost productivity in the workplace accounts for nearly two-thirds of the costs of substance abuse.⁴⁷ The economic benefit of chemical dependency treatment to employers is widely available. In one particularly influential study, nearly 500 individuals receiving treatment at Kaiser Permanente's Addiction Medicine programs were given assessments before and after treatment initiation that sought to investigate measures such as work productivity, absenteeism, and conflicts with coworkers or management. Assessments performed after treatment began reported a substantial reduction in the number of beneficiaries who missed work, were late for work, who were less productive at work, and/or experienced conflicts with co-workers or management. At the mean benefit utilization rate and annual salary (\$45,000), the net benefit of the substance abuse treatment was \$1,538 when assessed after two months of treatment.

⁴⁶ Thomas RG, Mertens J & Weisner C (2009). Family Members of People with Alcohol or Drug Dependence: Health Problems and Medical Cost Compared to Family Members of People with Diabetes and Asthma. *Addiction*, 104.2: 203-14. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/19149814>

⁴⁷ Substance Abuse and Mental Health Services Administration (2008). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis. U.S. Department of Health and Human Services. Retrieved from <http://store.samhsa.gov/shin/content/SMA07-4298/SMA07-4298.pdf>

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SB 413-FN-A – VERSION ADOPTED BY BOTH BODIES

03/06/14 0651s
03/06/14 0889s
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STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Fourteen

AN ACT relative to access to health insurance coverage.

Be it Enacted by the Senate and House of Representatives in General Court convened:

- 1 1 Statement of Purpose. The state of New Hampshire shall develop the New Hampshire health
2 protection program to provide a coordinated strategy to access private insurance coverage for
3 uninsured, low-income citizens with income up to 133 percent of the federal poverty level (FPL)
4 using available, cost-effective health care coverage options for Medicaid newly eligible individuals at
5 the earliest practicable date. The strategy shall promote the improvement of overall health through
6 access to private insurance coverage options and draw appropriate levels of federal funding available
7 through a Medicaid Section 1115 demonstration waiver. Increasing access to private health
8 insurance will increase provider reimbursement rates and reduce the burden of uncompensated care
9 in New Hampshire.
- 10 2 New Paragraphs; Department of Health and Human Services; Changes to State Medicaid
11 Program. Amend RSA 126-A:5 by inserting after paragraph XXII the following new paragraphs:
- 12 XXIII.(a) The commissioner shall provide access to the health insurance premium payment
13 (HIPP) program established by the department pursuant to section 1906 of the Social Security Act of
14 1935 to Medicaid newly eligible adults from 0 – 133 percent of the federal poverty level (FPL) who
15 are eligible for medical assistance under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act of
16 1935, as amended, 42 U.S.C. section 1396a(a)(10)(A)(i) (“newly eligible adults”) and their spouse and
17 dependents if applicable until December 31, 2016 to maximize the use of private insurance and
18 available federal assistance. All newly eligible adults who have access to qualified employer
19 sponsored insurance either directly as an employee or indirectly through another individual who is
20 eligible for qualified employer sponsored insurance, shall be required to participate in the HIPP
21 program in order to receive medical assistance, if eligible and determined by the department to be
22 cost effective as required by the federal Centers for Medicare and Medicaid Services (CMS).
- 23 (b) The commissioner shall seek any necessary waivers or submit a state plan
24 amendment to implement the provisions of this paragraph, including provisions to address
25 individuals determined to be medically frail after completion of a health questionnaire screening
26 process. Prior to submitting the state plan amendment or waiver to CMS the commissioner shall
27 present the state plan amendment or waiver to the fiscal committee of the general court for approval.

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03/06/14 0651s

03/06/14 0889s

03/13/14 1167EBA

2014 SESSION

14-2857

01/10

SENATE BILL ***413-FN-A***

AN ACT relative to access to health insurance coverage.

SPONSORS: Sen. Morse, Dist 22; Sen. Larsen, Dist 15; Sen. Bradley, Dist 3; Sen. Gilmour, Dist 12; Sen. Odell, Dist 8; Sen. D'Allesandro, Dist 20

COMMITTEE: Health, Education and Human Services

ANALYSIS

This bill establishes the New Hampshire health protection program. This bill also establishes the New Hampshire health protection trust fund which is to be administered by the commissioner of the department of health and human services for the purposes of paying certain costs associated with the programs established in the bill and to accept any federal moneys for such programs. The commissioner of the department of health and human services is granted rulemaking authority for the purposes of the bill.

Explanation: Matter added to current law appears in ***bold italics***.
Matter removed from current law appears ~~[in brackets and struck through]~~.
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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1 Participation in the HIPP program by newly eligible adults shall not begin until such waivers or
2 state plan amendments have been approved by CMS.

3 (c) A determination of eligibility for the HIPP program shall be a qualifying event under
4 the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individuals who
5 participate in the HIPP program shall:

6 (1) Provide all necessary information regarding financial eligibility, residency,
7 citizenship or immigration status, and insurance coverage to the department of health and human
8 services in accordance with rules or interim rules, adopted under RSA 541-A;

9 (2) Inform the department of any changes in financial eligibility, residency,
10 citizenship or immigration status, and insurance coverage within 10 days of such change; and

11 (3) At the time of enrollment acknowledge that the HIPP program is subject to
12 cancellation upon notice.

13 (d) The New Hampshire mandatory HIPP program under this paragraph shall be
14 implemented as soon as is practicable after the waiver or state plan amendment is approved. The
15 cost of the medical assistance provided under the HIPP program shall be paid solely from federal
16 funds provided under 42 U.S.C. section 1396d(y).

17 (e) The commissioner may adopt rules or interim rules, pursuant to RSA 541-A, as
18 necessary to implement any changes to the Medicaid program consistent with any waivers or state
19 plan amendments submitted under this paragraph.

20 (f) Nothing in this paragraph shall limit the existing and traditional regulatory
21 authority of the New Hampshire insurance department under Title XXXVII with respect to private
22 health insurance coverage in which persons are enrolled in the program under this paragraph. In
23 developing this program including drafting any necessary plan amendments or waiver requests, the
24 commissioner shall consult with the New Hampshire insurance department as necessary to ensure
25 that the program is designed to operate seamlessly with private insurance coverage and is consistent
26 with all applicable insurance regulatory standards.

27 XXIV.(a) There is hereby established the voluntary bridge to marketplace premium
28 assistance program in order to provide medical assistance for newly eligible adults and their spouse
29 and dependents, if applicable, who are ineligible for the HIPP program established in RSA 126-A:5,
30 XXIII. This program shall be administered by the department of health and human services and
31 subject to subparagraph XXV(c) shall terminate on March 31, 2015. In order to receive medical
32 assistance through the program, newly eligible adults shall choose health insurance coverage either
33 from qualified health plans (QHPs) offered on the federally-facilitated exchange if cost effective or an
34 alternative benefit plan (ABP) offered by one of the managed care organizations (MCO) awarded
35 contracts as vendors to implement Medicaid managed care under RSA 126-A:5, XIX(a). For the
36 purposes of this paragraph, alternative benefit plan is defined as the Medicaid benchmark or

1 benchmark equivalent coverage in section 1937 of the Social Security Act. Provider payments shall
2 be in an amount which shall be no less than before the effective date of this paragraph.

3 (b) The commissioner shall seek any necessary waivers or state plan amendments to
4 implement the provisions of this paragraph, including provisions to address individuals determined
5 to be medically frail after completion of a health questionnaire screening process. To the greatest
6 extent practicable the waiver or state plan amendments shall incorporate measures to promote
7 continuity of health insurance coverage and personal responsibility, including but not limited to: co-
8 pays, deductibles, disincentives for inappropriate emergency room use, and mandatory wellness
9 programs. Prior to submitting the waiver or state plan amendments to CMS, the commissioner shall
10 present the waiver or state plan amendments to the fiscal committee of the general court for
11 approval. The program shall not begin until such waivers or state plan amendments have been
12 approved by CMS.

13 (c) A determination of eligibility for the voluntary bridge to marketplace premium
14 assistance program or discontinuation of benefits, including at the conclusion of the voluntary bridge
15 to marketplace premium assistance program, shall be a qualifying event under the Health Insurance
16 Portability and Accountability Act of 1996 (HIPAA). Individuals who participate in the voluntary
17 bridge to marketplace premium assistance program shall:

18 (1) Provide all necessary information regarding financial eligibility, residency,
19 citizenship or immigration status, and insurance coverage to the department of health and human
20 services in accordance with rules, or interim rules, adopted under RSA 541-A;

21 (2) Inform the department of any changes in financial eligibility, residency,
22 citizenship or immigration status, and insurance coverage within 10 days of such change; and

23 (3) At the time of enrollment acknowledge that the voluntary premium assistance
24 program is subject to cancellation upon notice.

25 (d) Enrollment for the voluntary bridge to marketplace premium assistance program
26 under this paragraph shall begin May 1, 2014 or as soon thereafter as is practicable. Coverage
27 under the voluntary bridge to marketplace premium assistance program under this paragraph shall
28 be implemented commencing July 1, 2014 or as soon thereafter as is practicable. The cost of the
29 medical assistance provided under the voluntary bridge to marketplace premium assistance program
30 shall be paid solely from federal funds as provided under 42 U.S.C. section 1396d(y).

31 (e) For coverage under the voluntary bridge to marketplace premium assistance
32 program, the commissioner shall negotiate an amendment to its existing managed care contracts to
33 provide new private insurance plans which will qualify for this program. Alternative benefit plans
34 shall reimburse at rates that are sufficient to ensure improved access to and quality of care. Such
35 plans shall maximize to the extent allowable wellness programs, cost-sharing mechanisms, and
36 disincentives for inappropriate emergency room use.

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1 (f) The commissioner may adopt rules or interim rules, pursuant to RSA 541-A, as
2 necessary to implement any changes to the Medicaid program consistent with any waivers or state
3 plan amendments submitted under this paragraph.

4 (g) Nothing in this paragraph shall limit the existing and traditional regulatory
5 authority of the New Hampshire insurance department under Title XXXVII with respect to private
6 health insurance coverage in which persons are enrolled in the program under this paragraph. In
7 developing this program including drafting any necessary plan amendments or waiver requests, the
8 commissioner shall consult with the New Hampshire insurance department as necessary to ensure
9 that each program is designed to operate seamlessly with private insurance coverage and is
10 consistent with all applicable insurance regulatory standards.

11 XXV.(a) Consistent with the time frames in this paragraph, there is hereby established the
12 marketplace premium assistance program. This will be a premium assistance program for newly
13 eligible adults and their eligible spouse and dependents, if applicable, who are ineligible for the
14 HIPPA program established in RSA 126-A:5, XXIII until December 31, 2016 and shall be administered
15 by the department of health and human services. In order to receive medical assistance from the
16 program, newly eligible adults who are ineligible for the HIPPA program shall choose from any
17 qualified health plans (QHPs) offered on the federally-facilitated exchange if cost effective; provided,
18 however, that any newly eligible adult who had coverage under an alternative benefit plan (ABP)
19 offered by a managed care organization (MCO) under paragraph XIX during the voluntary bridge to
20 marketplace premium assistance program established under RSA 126-A:5, XXIV shall be
21 automatically enrolled at the beginning of open enrollment in a comparable QHP by that same MCO
22 if one is available, unless such newly eligible adult subsequently chooses a different QHP during the
23 enrollment period. If a comparable QHP is not offered by the newly eligible adult's MCO then the
24 newly eligible adult may choose from any QHPs, if cost effective. Provider payments shall be in an
25 amount which shall be no less than before the effective date of this paragraph.

26 (b) On or before December 1, 2014, the commissioner shall submit to CMS any necessary
27 waiver application to implement the provisions of this paragraph, including provisions to address
28 individuals determined to be medically frail after completion of a health questionnaire screening
29 process. To the greatest extent practicable the waiver shall incorporate measures to promote
30 continuity of health insurance coverage and personal responsibility, including but not limited to: co-
31 pays, deductibles, disincentives for inappropriate emergency room use, and mandatory wellness
32 programs. Prior to submitting the waiver to CMS the commissioner shall present the waiver to the
33 fiscal committee of the general court for approval. The program shall not begin until such waivers
34 have been approved by CMS.

35 (c) If the waiver to implement the marketplace premium assistance program is approved
36 on or before March 31, 2015 then, coverage under the voluntary bridge to marketplace premium
37 assistance program established in RSA 126-A:5, XXIV shall terminate on December 31, 2015.

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Enrollment in the marketplace premium assistance program shall begin on October 15, 2015 and coverage shall begin on January 1, 2016. Coverage shall end on December 31, 2016. The cost of the medical assistance provided under the marketplace premium assistance program shall be paid solely from federal funds as provided under 42 U.S.C. section 1396d(y).

(d) If the waiver to implement the marketplace premium assistance program is not approved on or before March 31, 2015 then the program shall not begin and coverage under the voluntary bridge to marketplace premium assistance program established in RSA 126-A:5, XXIV shall terminate on June 30, 2015.

(e) A determination of eligibility for the marketplace premium assistance program shall be a qualifying event under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individuals who participate in the marketplace premium assistance program shall:

(1) Provide all necessary information regarding financial eligibility, residency, citizenship or immigration status, and insurance coverage to the department of health and human services in accordance with rules, or interim rules, adopted under RSA 541-A;

(2) Inform the department of any changes in financial eligibility, residency, citizenship or immigration status, and insurance coverage within 10 days of such change; and

(3) At the time of enrollment acknowledge that the marketplace premium assistance program is subject to cancellation upon notice.

(f) The commissioner may adopt rules or interim rules, pursuant to RSA 541-A, as necessary to implement any changes to the Medicaid program consistent with any waivers or state plan amendments submitted under this paragraph.

(g) Nothing in this paragraph shall limit the existing and traditional regulatory authority of the New Hampshire insurance department under Title XXXVII with respect to private health insurance coverage in which persons are enrolled in this program under this paragraph. In developing the program under this paragraph including drafting any necessary plan amendments or waiver requests, the commissioner shall consult with the New Hampshire insurance department as necessary to ensure that each program is designed to operate seamlessly with private insurance coverage and is consistent with all applicable insurance regulatory standards.

XXVI. Any unemployed individual who qualifies for the voluntary bridge to marketplace premium assistance program established in paragraph XXIV or the marketplace premium assistance program established in paragraph XXV shall be referred to the department of employment security for the purpose of helping the unemployed individual find employment.

3 New Section; New Hampshire Health Protection Trust Fund. Amend RSA 126-A by inserting after section 5-a the following new section:

126-A:5-b The New Hampshire Health Protection Trust Fund.

I. There is hereby established the New Hampshire health protection trust fund which shall be accounted for distinctly and separately from all other funds and shall be non-interest bearing.

1 The trust fund shall be administered by the commissioner of the department of health and human
2 services and shall be used solely to provide payment and reimbursement for medical and other
3 medical-related services for the newly eligible Medicaid population as provided for under RSA 126-
4 A:5, XXIII – XXVI and RSA 126-A:67. All moneys in the trust fund shall be nonlapsing and shall be
5 continually appropriated to the commissioner of the department of health and human services for
6 the purposes of the trust fund. The trust fund shall be authorized to pay and/or reimburse:

7 (a) The cost of the employee share of premiums, co-insurance, co-payments, deductibles,
8 and supplemental cost-sharing, plus the cost of any wrap-around services that are determined by the
9 department to be cost effective to licensed health insurance carriers and/or private employers for
10 coverage under employer sponsored health insurance as provided in RSA 126-A:5, XXIII.

11 (b) The cost of medical services, including without limitation, premiums and wrap-
12 around benefits for those newly eligible adults who obtain health coverage through the voluntary
13 bridge to marketplace premium assistance program as provided in RSA 126-A:5, XXIV.

14 (c) The cost of premiums, co-insurance, co-payments, deductibles, and supplemental
15 cost-sharing plus the cost of any wrap-around services to licensed health insurance carriers on the
16 federally facilitated exchange under the marketplace premium assistance program as provided in
17 RSA 126-A:5, XXV.

18 (d) Any other costs that are fully reimbursable by the federal government pertaining to
19 the health insurance premium payment (HIPP) program, the voluntary bridge to marketplace
20 premium assistance program, and the marketplace premium assistance program for the newly
21 eligible as established under 126-A:5, XXIII – XXVI and RSA 126-A:67.

22 II. The commissioner of health and human services, as the administrator of the trust fund,
23 shall have the sole authority to:

24 (a) Apply for federal funds to support the programs established under RSA 126-A:5,
25 XXIII – XXV and RSA 126-A:67.

26 (b) Notwithstanding any provision of law to the contrary, accept and expend federal
27 funds as may be available for HIPP, the voluntary bridge to marketplace premium assistance
28 program, and the premium assistance program. The commissioner shall notify the bureau of
29 accounting services, by letter, with a copy to the fiscal committee of the general court and the
30 legislative budget assistant.

31 (c) Make payments and reimbursements from the trust fund as outlined in this section.

32 III. The commissioner shall submit a report to the governor and the fiscal committee of the
33 general court detailing the activities and operation of the trust fund annually within 90 days of the
34 close of each state fiscal year.

35 4 New Subparagraph; New Hampshire Health Protection Trust Fund. Amend RSA 6:12, I(b) by
36 inserting after subparagraph (316) the following new subparagraph:

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(317) Moneys deposited in the New Hampshire health protection trust fund established under RSA 126-A:5-b.

5 New Subdivision; Statewide Section 1115 Demonstration Waiver. Amend RSA 126-A by inserting after section 66 the following new subdivision:

Statewide Section 1115 Demonstration Waiver

126-A:67 Statewide Section 1115 Demonstration Waiver.

I. On or before June 1, 2014, the commissioner, after consultation with stakeholders including state, county, and local officials and health care providers, shall submit a statewide section 1115 demonstration waiver to enhance designated state health programs and transform the Medicaid care delivery system. The section 1115 demonstration waiver will promote the improvement of overall health through increased access to private insurance coverage options and will integrate and align New Hampshire's Medicaid care management program, the provision of coverage to the newly eligible under this chapter, existing Medicaid waived programs, and other department initiatives in a manner that improves public health, and improves the quality of care and access to care for all Medicaid and CHIP beneficiaries. The waiver shall be used to allow the state maximum flexibility to redesign Medicaid including establishing premium assistance programs that are customized to transform the state's reform goals. To the greatest degree possible programs funded under the demonstration waiver shall complement the mental health settlement and shall be designed to promote innovation, reform delivery systems, and reduce the number of uninsured patients who seek treatment from health care providers.

II. Prior to submitting the waiver to CMS, the commissioner shall present the waiver to the fiscal committee of the general court for approval. The waiver shall be approved by the CMS by December 1, 2014.

6 New Section; Ambulatory Services. Amend RSA 415 by inserting after section 24 the following new section:

415:25 Qualified Health Plans; Ambulatory Services.

I. Each qualified health plan (QHP) on the federally-facilitated exchange shall, as a condition of participation, (1) offer to each federally-qualified health center, as defined in section 1905(l)(2)(B) of the Social Security Act, 42 U.S.C. section 1396d(l)(2)(B), providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all ambulatory services that are covered by the plan that the center offers to provide; and (2) reimburse each such center for such services as provided in section 1302(g) of the Patient Protection and Affordable Care Act, Public Law 111-148, as added by section 10104(b)(2) of such Act.

II. In this section "ambulatory services" means health care services provided on an outpatient basis.

7 Department of Health and Human Services; Contracting; Transfer Among Accounts.

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1 I. Notwithstanding any law to the contrary, the department shall be authorized, subject to
2 the prior approval of governor and council, to enter into sole source contracts with qualified
3 consultants and vendors (a) for services in connection with obtaining waivers and state plan
4 amendments and (b) to implement the health coverage programs for newly eligible under RSA 126-
5 A:5, XXIII-XXVI and RSA 126-A:67.

6 II. Notwithstanding RSA 9:17-a or any other provision of law to the contrary, except as
7 provided in RSA 9:17-c and 2013, 143:1, organization note on accounting unit 05-95-48-481510-5942
8 nursing services – county participation, for the biennium ending June 30, 2015, the commissioner of
9 the department of health and human services is hereby authorized to transfer funds within and
10 among all accounting units within the department, as the commissioner deems necessary and
11 appropriate to address present or projected budget deficits, or to respond to changes in federal laws,
12 regulations, or programs, and otherwise as necessary for the efficient management of the
13 department, with the exception of class 60 transfers; provided, that any transfer of \$75,000 or more
14 shall require prior approval of the fiscal committee of the general court and the governor and council.

15 8 Appropriation; Health Care Reform Commission. Amend 2013, 144:130 to read as follows:

16 144:130 Appropriation. The sum of \$200,000 is hereby appropriated to the department of health
17 and human services for the fiscal year ending June 30, 2014, for the purpose of providing
18 administrative support to the commission established in RSA 126-A:66 as inserted by section 129 of
19 this act. Contracts for administrative support or consulting services shall not require governor and
20 council approval. *Any unspent balance of the appropriation made under this section shall be*
21 *extended and shall not lapse until November 1, 2014, and shall be for the use of the*
22 *department of health and human services in preparing or submitting any necessary*
23 *waivers or state plan amendments pursuant to RSA 126-A:5, XXIII – XXV and RSA 126-A:67.*
24 The governor is authorized to draw a warrant for said sum out of any money in the treasury not
25 otherwise appropriated.

26 9 Department of Health and Human Services; Medicaid Breast and Cervical Cancer Program.
27 Enrollment in the Medicaid breast and cervical cancer program, under 42 U.S.C. section 1396a(aa),
28 shall be suspended effective July 1, 2014 or upon the approval of any waivers or state plan
29 amendments necessary to implement RSA 126-A:5, XXIII and XXIV whichever is later. Any
30 individual covered under the Medicaid breast and cervical cancer program prior to the date the
31 program is suspended shall continue to be covered for the program unless his or her medical
32 treatment has concluded, or until the next redetermination of his or her eligibility by the
33 department, whichever event occurs later. After the date the program is suspended the individual's
34 eligibility for assistance shall be determined by the department pursuant to RSA 126-A:5, XXIII-
35 XXV. Commencing on the date the program is suspended, administrative rule He-W 641.09 shall be
36 limited in its application to only those individuals enrolled in the Medicaid breast and cervical
37 cancer program receiving treatment prior to the date the program is suspended. If, at any time after

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July 1, 2014 the assistance authorized in RSA 126-A:5, XXIII-XXV is no longer offered or fails to gain the necessary federal approvals, then the commissioner of the department of health and human services shall reinstate Medicaid coverage and open enrollment for those individuals eligible under this program.

10 Applicability; Eligibility.

I. If at any time the federal match rate applied to medical assistance for newly eligible adults under RSA 126-A:5, XXIII-XXV between July 1, 2014 – December 31, 2016 is less than 100 percent as set forth in 42 U.S.C. section 1396d(y)(1), then RSA 126-A:5, XXIII, XXIV, and XXV shall immediately be repealed upon notification by the commissioner of the department of health and human services to the secretary of state and the director of legislative services.

II Any state plan amendment or waiver required under 126-A:5, XXIII-XXV that is submitted to the Centers for Medicare and Medicaid Services (CMS), shall comply with 42 U.S.C. section 18001, et seq., as amended by 42 U.S.C. section 1305, et seq., 42 U.S.C. section 7, et seq. and any applicable regulations by CMS governing eligibility for newly eligible adults regarding citizenship, referral requirements for employment or seeking employment, and allowable income resource restrictions.

11 Severability. With the exception of section 10 of this act, if any provision of this act or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

12 Repeal. The following are repealed:

I. RSA 126-A:5, XXIII, relative to health insurance premium payment (HIPP) program.

II. RSA 126-A:5, XXIV, relative to the bridge to marketplace premium assistance program.

III. RSA 126-A:5, XXV, relative to the marketplace premium assistance program.

IV. RSA 126-A:5, XXVI, relative to unemployed individuals who qualify for the voluntary bridge to marketplace premium assistance program and the marketplace premium assistance program.

V. RSA 126-A:5-b, relative to New Hampshire health protection trust fund.

VI. RSA 6:12, I(b)(317), relative to the New Hampshire health protection trust fund.

VII. RSA 415:25, relative to qualified health plans on the federally-facilitated exchange.

VIII. 2013, 144:129 and 131, relative to the Medicaid expansion commission and the repeal of the commission.

IX. 2013, 144:130, as amended by section 8 of this act, relative to an appropriation.

13 Effective Date.

I. Section 12, paragraphs I-VII of this act shall take effect December 31, 2016.

II. Section 12, paragraph IX of this act shall take effect November 1, 2014.

III. The remainder of this act shall take effect upon its passage.

SB 413-FN-A FISCAL NOTE

AN ACT relative to access to health insurance coverage.

FISCAL IMPACT:

The Departments of Health and Human Services and Insurance state this bill, as amended by the Senate (Amendments #2014-0651s and #2014-0889s), will increase state expenditures and revenue by indeterminable amounts in FY 2014, FY 2015, FY 2016 and FY 2017. The Departments of Corrections and Administrative Services state this bill may decrease state expenditures by an indeterminable amount in FY 2015, FY 2016 and FY 2017. The New Hampshire Association of Counties and New Hampshire Municipal Association state this bill may decrease county and local expenditures by indeterminable amounts in FY 2015, FY 2016 and FY 2017. There will be no fiscal impact on county or local revenues.

METHODOLOGY:

The Department of Health and Human Services makes the following assumptions concerning the fiscal impact of this bill:

- The bill would become effective in March 2014 allowing coverage to begin no later than July 1, 2014.
- Cost estimates are based on coverage for an additional 50,000 individuals.
- Start up and operating costs are included for the FY 2014-2015 biennium only.
- Program assumptions include:
 - The Bridge to Marketplace program will begin no later than July 1, 2014. Commencement will align with the amendments to the Medicaid Managed Care contracts.
 - The Bridge to Marketplace program will continue until December 31, 2015 if the State receives federal approvals for Premium Assistance by March 31, 2015. If not, the Bridge to Marketplace program will end on June 30, 2015.
 - The mandatory Health Insurance Premium Program (HIPP) will begin July 1, 2014, serve approximately 15,000 individuals and, along with the Bridge to Marketplace Program, will ensure that all newly eligible individuals with access to cost effective employer sponsored insurance are covered by private insurance.
 - Premium Assistance Programs will provide all newly eligible persons, except those determined to be medically frail, with coverage funded 100% by the federal government for calendar years 2014, 2015 and 2016.

- The Department will coordinate the HIPP and Premium Assistance Medicaid waivers along with other section 1115 waiver requests to the Centers for Medicare and Medicaid Services (CMS) in order to align the expansion program with other Departmental initiatives.
- Consultant costs will support obtaining all required waivers from CMS. In order to begin coverage by July 1, 2014, the contracts for consultants, enrollment, systems and other operational requirements will be done on a sole-source basis, subject to prior approval of governor and council.
- Existing positions within the Department will be transferred, reclassified, recruited and filled as needed to support the program. The Division of Personnel will provide the necessary support to enable the personnel actions to be completed in a timely manner as needed.

The Department estimates the operational costs for FY 2014 and FY 2015 as follow:

| Total Operational Costs (Amounts In thousands) | FY 2014 Start up | FY 2014 Ongoing | FY 2015 Ongoing |
|--|-----------------------------|----------------------------|----------------------------|
| Division of Client Services. (Average 55% federal funds, systems costs are 90% federal) | | | |
| Eligibility Determination 50 Family Services Specialists (1 employee per 1,000 clients) | \$0 | \$553 | \$3,437 |
| Eligibility Determination 6 Family Service Supervisors (1 supervisor per 8 employees) | \$0 | \$77 | \$473 |
| Scanning/Mail Unit Personnel (6.5 employees) | \$0 | \$57 | \$357 |
| Training Unit Personnel (3 employees) | \$0 | \$34 | \$213 |
| Call Center Personnel (3 employees) | \$0 | \$33 | \$206 |
| Office Space - One-time retrofit costs. | \$400 | \$0 | \$0 |
| Office Space (250 square feet per employee @ \$3,000) | \$0 | \$31 | \$186 |
| Equipment & other operating costs (Current expense, phone, travel, supplies and other costs) | \$247 | \$49 | \$335 |
| New Heights System changes - 90% federal funds (Two testing staff, HIPP programming, and system upgrades) | \$1,083 | \$44 | \$263 |
| Office of Information Services - MMIS system changes (\$5 million to Xerox for implementation, \$500,000 to Cognosante for testing support, and unknown costs for Pharmacy Benefit Manager) 90% federal funds. | \$5,500 | \$0 | \$0 |
| Office of the Commissioner - Consultant costs to obtain HIPP, Premium Assistance, and other section 1115 (b) waivers from CMS. 50% federal funds. | \$2,000 | \$0 | \$0 |
| Office of Medicaid and Business Policy | | | |
| HIPP Contractor. Due to short timeline, consultant will determine cost effectiveness calculations under a sole-source contract. 50% federal funds. | \$0 | \$100 | \$300 |
| Maximus contract - Care management enrollment contract. Four months in FY 2014. Assumes 50,000 enrollees. 50% federal funds. | \$0 | \$100 | \$300 |
| Milliman actuarial contract. \$366k (Already in current budget.) | \$0 | \$0 | \$0 |

| | | | |
|--|-----------------|----------------|----------------|
| External Quality Review Organization (EQRO) contract. \$250k (Already in current budget.) | \$0 | \$0 | \$0 |
| Consulting, staffing and training. Additional healthcare analytic functions: develop a database, performance measures and report on improved health outcomes, cost effectiveness and comparison with other groups. 50% federal funds. | \$0 | \$250 | \$250 |
| Office of Business Operations. Based on experience with current program assumes one mailing per month. 50% federal funds. | \$0 | \$0 | \$120 |
| Bureau of Behavioral Health. Two additional staff and training/ education costs beginning June 1, 2014. 50% federal funds. | \$0 | \$14 | \$174 |
| Bureau of Drug & Alcohol Services. Two additional staff and training/ education costs beginning June 1, 2014. Staff will implement and oversee the Substance Abuse Disorder Benefit. 50% federal funds. | \$0 | \$14 | \$174 |
| Bureau of Elderly & Adult Services. Costs include: 5 additional Medical Consultant III positions, labor grade 24, to establish long-term care eligibility, 8 contract nurses to do medical eligibility assessments, and 5 Adult Protective Service Worker IIs, labor grade 21. 50% federal funds. | \$0 | \$215 | \$972 |
| Program Integrity Unit. | | | |
| Special Investigations Unit investigates cases of fraud and abuse seeking cost recovery for all DHHS programs. An increase of 50,000 clients will require additional staff. Health benefits are 100% federal and recoveries would be remitted to the federal government. 50% federal funds. | \$0 | \$0 | \$167 |
| Third Party Liability - Accident and Trauma Recoveries. The unit consists of two full-time employees and recovers Medicaid costs in cases where clients are involved in accidents and receive cash settlements. An increase of 50,000 clients will require additional staff. Since benefits are 100% federal, recoveries would be remitted to the federal government. 50% federal funds. | \$0 | \$0 | \$53 |
| Administrative Appeals Unit - Medicaid Legal Services Unit. The Appeals Unit issues written legal decisions on appeals from departmental actions. The Medicaid Legal Services Unit represents and defends the department at the appeals. DHHS general counsel provides guidance to Medicaid programs. Medicaid enrollment is currently 150,000. An increase of 50,000 will increase hearings proportionately. Need: 2 Hearings Officers, 1 Medical Services Consultant, and 2 Attorneys. Associated equipment and operating costs will be absorbed within the existing budget. 50% federal funds. | \$0 | \$0 | \$250 |
| Operating Costs: | \$9,230 | \$1,571 | \$8,230 |
| Federal Funds: | \$7,280 | \$845 | \$4,480 |
| General Funds: | \$1,950 | \$726 | \$3,750 |
| | | | |
| Total Funds by Fiscal Year | FY 2014 | FY 2015 | |
| Total: | \$10,801 | \$8,230 | |
| Federal Funds: | \$8,125 | \$4,480 | |
| General Funds: | \$2,676 | \$3,750 | |

In addition, the Department indicates federal funds would replace state expenditures for the Breast and Cervical Cancer Program (BCCP) and for certain medical costs paid by the Department of Corrections. The BCCP, which is currently funded 65% with federal Medicaid funds and 35% with state general funds, would be transitioned to 100% federal funds reducing general fund expenditures by \$1.07 million in FY 2015 and by similar amounts in the future years. The Department indicates there would be savings to the Department of Corrections as certain hospital inpatient costs would be eligible for federal Medicaid reimbursement. (See the Department of Correction's response for estimated savings). In addition, the Department assumes county and local costs associated with the detention and treatment of persons affected by mental health and substance use disorders will decrease over time as a result of the new mental health and substance use disorder benefits. These benefits are required to be included in the coverage programs authorized by the bill. The Department states there would be an increase in insurance premium tax revenue to the State general fund as more individuals would be covered by managed care or private health plans. (See the Insurance Department's response for the insurance premium tax revenue estimate). Finally, the Department assumes, as the number of uninsured individuals decreases, uncompensated care provided by hospitals will decrease resulting in an increase in hospital revenues and Medicaid Enhancement Tax collections in FY 2016 and the first half of FY 2017. The amount of any additional MET revenue cannot be estimated at this time.

The Department states the cost of the health benefits would be paid with 100% federal funds through December 31, 2016. Federal funds for payment of health benefits would be credited to, and disbursed from, the New Hampshire Health Protection Trust Fund established by the bill. For an estimate of the federally funded benefit amounts, the Department refers to the DHHS spreadsheet: "Summary Impacts of ACA on NH Medicaid Program: Update for Mental Health Parity and Additional Equity Act" dated 9/16/2013, which was presented to the Commission to study the Expansion of Medicaid Eligibility in New Hampshire. The spreadsheet is based on the reports issued by the Lewin Group in November 2012, January 2013, and September 2013. "Block B" of the spreadsheet provided an estimated impact of serving the additional population assuming an effective date of January 1, 2014. The summary estimated additional federal funds of \$289.6 million in FY 2015, and \$337.4 million in FY 2016 would pay for health coverage for the newly eligible population. These amounts provided a reasonable estimate based on certain assumptions and timing and also provide an awareness of the scale of the program. Due to differences in timing and assumptions, the amounts should not be considered a precise projection of the federal cost of benefits under this bill. No state general funds will be used to pay for the health benefits.

The Insurance Department assumes as of July 1, 2014, additional individuals would be eligible for health coverage and it would take 90 days to enroll all individuals who are potentially eligible. Coverage would continue through December 31, 2016 when the program terminates. The Department estimates the following impact on insurance premium tax collections:

| (In millions \$) | Calendar Year 2014 | Calendar Year 2015 | Calendar Year 2016 | Calendar Year 2017 |
|--|-----------------------|-----------------------|-----------------------|-----------------------|
| Premium Base Change | \$53.6 | \$146.6 | \$167.0 | \$0.0 |
| | | | | |
| | Fiscal Year 2015 | Fiscal Year 2016 | Fiscal Year 2017 | Fiscal Year 2018 |
| Premium Tax Change | | | | |
| Estimated Tax: | \$1.07 | \$2.93 | \$3.34 | \$0.0 |
| True Up: | \$1.07 | \$1.86 | \$0.41 | (\$3.34) |
| Increase / (Decrease) in Premium Tax Revenue: | \$2.14 | \$4.79 | \$3.75 | (\$3.34) |

The Department of Corrections assumes up to 90% of inmates would be eligible for Medicaid coverage if the State chooses to cover prisoners. The Department estimates, based on estimated inpatient medical costs of \$750,959 incurred in FY 2013, \$675,863 may be reimbursable by Medicaid. The Department states 36.5% of 2,650 inmates, (approximately 965) generated community-based health claims. The Department indicates in FY 2012, 61 Medicaid applications were processed by one Nurse Coordinator. In order to process an additional 904 applications, the Department assumes a minimum of three additional Correctional Counselor/Case Managers would be needed. These individuals would be supervised by the Nurse Coordinator. The Department estimates the annual fiscal impact, based on FY 2013 information, as follows:

| | |
|---|------------|
| FY 2013 Inpatient charges: | \$750,959 |
| Percentage eligible for Medicaid: | <u>90%</u> |
| Amount potentially Medicaid reimbursable (\$750,959 x 90%): | \$675,863 |

| | |
|---|--------------------|
| Three additional Correctional Counselor/Case Managers | |
| Salary and Benefits: (\$90,000 x 3 positions) | <u>(\$270,000)</u> |
| Potential decrease in state expenditures: | \$405,863 |

The Department of Administrative Services states the Health Insurance Premium Program (HIPP) would not have a fiscal impact on the state employee and retiree health benefit program since it offsets the employee's cost of coverage. The State, as the employer, would remain responsible for funding the cost of the underlying health benefits. The Department states, because the State is a public employer it is not clear if state coverage would be included in the definition of private employer-sponsored insurance. The Department indicates the fiscal impact of the Voluntary Bridge to Marketplace Premium Assistance Program is indeterminable. The Department assumes there could be savings in the event a state employee declined state employee coverage and opted for coverage under the Voluntary Bridge to Marketplace Premium

Assistance Program. The Department indicates, in order for an employee to be eligible, the State's coverage would have to be deemed not cost effective or not included in the definition of private employer -sponsored coverage. The Department is not able to provide an estimate of the number of state employees who may meet the criteria for this program. The Department states the fiscal impact of the Marketplace Premium Assistance Program on the state employee and retiree health benefit program would be similar to that of the Voluntary Bridge to Marketplace Premium Assistance Program and cannot be determined.

The New Hampshire Municipal Association states this bill creates a program to provide assistance to low income residents in purchasing health insurance. The Association states it is likely that by helping previously uninsured individuals to obtain insurance, the bill will reduce the need of some individuals for public assistance, and thus will reduce municipal welfare expenditures. The Association states it is not able to estimate the amount of such reductions and states there will be no impact on municipal revenue.

The New Hampshire Association of Counties states this bill may have a fiscal impact on county corrections costs. The Association states, to the extent an individual incarcerated in a county correctional facility is able to access Medicaid coverage for overnight hospitalization costs, county expenditures for medical costs may decrease. The Association is not able to determine the actual fiscal impact because it is unable to determine the number of individuals who may be incarcerated and need hospitalization services.

The Department of Information Technology states this bill will have no direct fiscal impact on its operating budget. The Department states the Departments of Health and Human Services and Insurance will work with contracted vendors to develop and implement any system requirements.

This bill amends the appropriation to the Health Care Reform Commission in Chapter 144:130, Laws of 2013, providing the unspent balance of approximately \$103,000 shall not lapse until November 1, 2014 and shall be used by the Department in preparing or submitting the necessary waivers or state plan amendments required by the bill.

This bill does not establish any new positions.

**CENTERS FOR MEDICARE AND MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00298/1

TITLE: New Hampshire Health Protection Program Premium Assistance

AWARDEE: New Hampshire Department of Health and Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Hampshire Health Protection Program Premium Assistance section 1115(a) Medicaid demonstration (hereinafter “demonstration”) to enable the State of New Hampshire (hereinafter “state”) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs further set forth in detail the nature, character, and extent of Federal involvement in the demonstration, the state’s implementation of the waivers and expenditure authorities, and the state’s obligations to CMS during demonstration period. The STCs are effective on the date of the signed approval. Enrollment activities for the new adult population will begin on November 1, 2015 at which time Medicaid eligible adults can enroll into health coverage under qualified health plans (QHPs) and receive premium assistance with coverage effective January 1, 2016. This demonstration will sunset after December 31, 2016 consistent with the current legislative approval for the New Hampshire Health Protection Program pursuant to N.H. RSA 126-A:5, XXIII-XXV, but may continue for up to two additional years, through December 31, 2018, if the New Hampshire legislature authorizes the state to continue the demonstration and the state provides notice to CMS, as described in these STCs.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description And Objectives
- III. General Program Requirements
- IV. Eligibility
- V. New Hampshire Health Protection Program Premium Assistance Enrollment
- VI. Premium Assistance Delivery System
- VII. Benefits
- VIII. Cost Sharing
- IX. Appeals
- X. General Reporting Requirements
- XI. General Financial Requirements
- XII. Monitoring Budget Neutrality
- XIII. Evaluation
- XIV. Monitoring

- XV. Health Information Technology and Premium Assistance
XVI. T-MSIS

II. PROGRAM DESCRIPTION AND OBJECTIVES

Under the NHHPP Premium Assistance demonstration, the state will use premium assistance to support the purchase of coverage by beneficiaries eligible under the new adult group provided by certain qualified health plans (QHPs) doing business in the individual market through the Marketplace. The demonstration will affect individuals in the new adult group covered under Title XIX of the Social Security Act who are adults from age 19 up to and including 64 with incomes up to and including 133 percent of the federal poverty level (FPL) who are neither enrolled in (or eligible for) Medicare or employer-sponsored insurance.

New Hampshire expects approximately 50,000 beneficiaries to be enrolled into the Marketplace through this demonstration program. NHHPP Premium Assistance beneficiaries will receive the State plan Alternative Benefit Plan (ABP) and will have cost sharing obligations consistent with the state plan, as amended by the state. The ABP is the same benchmark plan chosen by the New Hampshire Marketplace to establish Essential Health Benefits. QHP will pay primary for covered services. QHP payment rates will be considered payment in full for covered services, and individuals affected by the demonstration will be limited to the QHP provider network, except in the case of family planning providers.

The demonstration will further the objectives of Title XIX by reducing coverage disruptions for individuals moving between Medicaid and the Marketplace due to changes in income. The demonstration will also test whether the premium assistance structure and resulting coverage affords beneficiaries access to wider provider networks, provides for higher provider payments for covered services, encourages more cross-participation by plans in Medicaid and the Exchange, and achieves cost reductions due to greater competition.

The state proposes to evaluate whether the demonstration will achieve the following goals-

- Continuity of coverage- For individuals whose incomes fluctuate, the demonstration will permit continuity of health plans and provider networks. Individuals and families may receive coverage through the same health plans and may seek treatment and services through the same providers regardless of whether their underlying coverage is financed by Medicaid or through the Marketplace. The state will evaluate whether individuals remain in the same QHP when Medicaid payment is terminated.
- Plan Variety - The demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace would afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and would increase the selection of plans for both Medicaid and Marketplace enrollees. The state will evaluate whether there is an increase in plan variety because of this cross-program participation.

- **Cost Effective Coverage** -- The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs. This, in turn, may result in coverage that achieves cost reductions in comparison to direct Medicaid coverage. The state will evaluate whether QHP coverage is cost effective, looking at the entire demonstration period and trends that emerge as the demonstration proceeds.
- **Uniform provider access**- The state will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program and CHIP, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified budget neutrality agreement will be effective upon the implementation of the change.
 - b. If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** If the eligibility of a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. In all such instances the Medicaid state plan governs.
- a. Should the state amend the state plan to make any changes to eligibility for this population, upon submission of the state plan amendment, the state must notify CMS demonstration staff in writing of the pending state plan amendment, and request a corresponding technical correction to the demonstration.
6. **Changes Subject to the Amendment Process.** Changes related to demonstration features including eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to the demonstration without prior approval by CMS through an amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the state, consistent with the requirements of STC 15, prior to submission of the requested amendment;
 - b. A data analysis worksheet which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment neutrality worksheet, if necessary; and
 - d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

- e. A description of how the evaluation design will be modified to incorporate the amendment provisions.
- 8. Option to Continue Demonstration Beyond DY 1.** If the state intends to continue operating this demonstration beyond DY 1 and the legislature authorizes such continuation, the state must submit a letter of intent to CMS no later than 6 months prior to the end of each DY for which the state seeks continuation of the demonstration,. Otherwise, the state should submit a phase-out plan consistent with the requirements of STC 10.
- 9. Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than six months prior to the expiration date of the demonstration, the governor or chief executive officer of the state must submit to CMS either a demonstration extension request or a transition and phase-out plan consistent with the requirements of STC 10.
- a. Compliance with Transparency Requirements at 42 CFR §431.412.
 - b. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 16.
- 10. Demonstration Phase Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.
- a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft plan to CMS no less than six (6) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into the revised plan.
 - b. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of the phase-out activities. Implementation of activities must be no sooner than 14 days after CMS approval of the plan.
 - c. Transition and Phase-out Plan Requirements: The state must include, at a minimum, in its plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the program for the affected beneficiaries, and ensure ongoing coverage

for those beneficiaries determined eligible, as well as any community outreach activities including community resources that are available.

- d. **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR §431.206, §431.210, and §431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and §431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category. 42 CFR Section 435.916.
 - e. **Exemption from Public Notice Procedures** 42.CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements in the event it determines that the objectives of title XIX and XXI would be served or under circumstances described in 42 CFR Section 431.416(g).
 - f. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- 11. Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can either use its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments in the quarterly report as specified in STC 46 associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in STC 48.
- 12. Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling enrollees.
- 13. Expiring Demonstration Authority.** For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a transition plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:
- a. **Expiration Requirements.** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the

affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- b. **Expiration Procedures.** The state must comply with all notice requirements found in 42 CFR Sections 431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration enrollees as outlined in 42 CFR Sections 431.220 and 431.221. If a demonstration enrollee requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR Section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
 - c. **Federal Public Notice.** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR Section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
 - d. **Federal Financial Participation (FFP):** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling enrollees.
- 14. Withdrawal of Waiver Authority.** CMS reserves the right to amend and withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the amendment and withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn or amended, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling enrollees.
- 15. Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 16. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), to the extent applicable. The state must also comply, to the extent applicable, with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the implementing regulations for the Review and Approval Process for Section 1115 demonstrations at 42 CFR Section 431.408, and the tribal consultation requirements

contained in the state's approved state plan, when any program changes to the demonstration are proposed by the state.

- a. In states with federally recognized Indian tribes consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the state's approved Medicaid state plan if that process is specifically applicable to consulting with tribal governments on waivers (42 CFR Section 431.408(b)(2)).
 - b. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment and/or renewal of this demonstration (42 CFR Section 431.408(b)(3)).
 - c. The state must also comply with the Public Notice Procedures set forth in 42 CFR Section 447.205 for changes in statewide methods and standards for setting payment rates.
- 17. Federal Financial Participation (FFP).** No federal matching for administrative or service expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. Eligibility

- 18. Populations Affected by the NHHPP Premium Assistance Demonstration.** Except as described in STCs 19, 20, and 23, the NHHPP Premium Assistance Demonstration affects the coverage and delivery of benefits for adults aged 19 through 64 eligible under the state plan consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR Section 435.119 who are not medically frail or enrolled in employer sponsored insurance (ESI). Eligibility and coverage for these individuals are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except to the extent expressly waived. Implementation of such waiver authority must be consistent with these STCs. Any Medicaid state plan amendments to this eligibility group will apply to this demonstration.

| Medicaid State Plan Mandatory Groups | Federal Poverty Level | Funding Stream | Expenditure and Eligibility Group Reporting |
|--------------------------------------|--|----------------|---|
| Adults in Section VIII Group | Adults at or below 133 percent FPL, who are not medically frail or enrolled in cost effective ESI coverage through the state HIPP program. | Title XIX | MEG – 1 |

19. Medically Frail Individuals. New Hampshire will institute a process to determine whether an individual is medically frail. The process will be described in the ABP state plan provisions. Individuals who are medically frail will be excluded from the demonstration.

20. American Indian/Alaska Native Individuals. Individuals identified as American Indian or Alaskan Native (AI/AN) have the ability to opt out of the demonstration and access the ABP offered under the Alternative Benefit State Plan. An AI/AN individual who does not opt out of enrolling in a QHP through the NHHPP Premium Assistance will be able to access covered benefits through I/T/U facilities. Under the Indian Health Care Improvement Act (IHCIA), AI/AN I/T/U facilities are entitled to payment notwithstanding network restrictions. As of the approval of this demonstration, there are no I/T/U facilities in the state of New Hampshire.

21. Retroactive Coverage. Prior to making any change in policies regarding retroactive coverage for the demonstration population, the state shall submit data to CMS to establish that there is seamless coverage that does not result in gaps in coverage prior to the time that a Medicaid application is filed, for individuals in the populations affected by the demonstration. The state will submit a description of its renewal process and data related to that process, as well as any relevant data related to coverage continuity to evaluate whether individuals are losing coverage upon renewal. Upon a CMS determination that sufficient data has been provided to establish that retroactive coverage prior to the date of application is not necessary to fill gaps in coverage, the state shall not have to provide retroactive coverage prior to the date of application under the demonstration; coverage for demonstration applicants will begin at the date of application.

V. NHHPP PREMIUM ASSISTANCE ENROLLMENT

22. NHHPP Premium Assistance. For individuals who are eligible for the NHHPP Premium Assistance, enrollment in a QHP will be mandatory unless the individual is determined to be exempt as described in STC 23.

23. Exclusions and Exemptions from Enrollment. The following individuals are either not permitted or not required to enroll in the NHHPP Premium Assistance.

- a. Individuals who are eligible for the NH state plan Health Insurance Premium Payment (HIPP) Program for individuals with access to cost-effective ESI are not permitted to enroll in NHHPP Premium Assistance.
- b. Individuals who are determined to be medically frail are not permitted to enroll in NHHPP Premium Assistance.
- c. Individuals who are AI/AN are not required to enroll in NHHPP Premium Assistance.

24. Notices. NHHPP Premium Assistance beneficiaries will receive a notice from New Hampshire Medicaid advising them of the following:

- a. **QHP Plan Selection.** The notice will include information regarding how NHHPP Premium Assistance beneficiaries can select a QHP, including guidance on selecting the plan that will best address their needs and information on the state's auto-enrollment process in the event that the beneficiary does not select a plan.
- b. **Access to Services until QHP Enrollment is Effective.** The notice will include the Medicaid client identification number (CIN) and Medicaid card. The notice will include information on how beneficiaries can use the CIN number or Medicaid card to access services until their QHP enrollment is effective.
- c. **Wrapped Benefits.** The notice accompanying the Medicaid card will also include information on how enrollees can use the card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 37.
- d. **Appeals.** The notice will also include information regarding the grievance and appeals process.
- e. **Exemption from the demonstration.** The notice will include information describing how new adult enrollees who believe they may be exempt from the NHHPP Premium Assistance program can request an exemption determination. The notice will include information on the difference in benefits under the Premium Assistance ABP as compared to the other benefits available.
- f. **Additional Notices.** The eligibility determination notice will advise that the NHHPP Premium Assistance program is subject to cancellation upon notice.

25. QHP Selection. The QHPs in which NHHPP Premium Assistance beneficiaries will enroll will be reviewed by the New Hampshire Insurance Department (NHID) and certified through the Federally Facilitated Marketplace's QHP certification process. The QHPs available for selection by the beneficiary will be determined by the Medicaid agency.

26. Enrollment Process. The enrollment process will begin on November 1, 2015 through the following procedures for new applicants and transition population.

New Applicants:

- a. Individuals will submit a joint application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions—electronically, via phone, by mail, or in-person.
- b. An eligibility determination will be made through the New Hampshire Eligibility & Enrollment Framework (EEF).
- c. Individuals determined to be Medicaid eligible will receive coverage through the State Plan until January 1, 2016, after which they will receive coverage through the demonstration except as specified in d.
- d. Individuals who are determined to be medically frail based on the definition and process identified in the state's approved alternative benefit plan will be excluded from the demonstration and will receive direct coverage as described in the state plan Alternative Benefit Plan for the medically frail.
- e. Individuals who are not identified as medically frail will receive a notice informing them that they may select a QHP and providing guidance on how to select a QHP. The notice will also include information on selecting a QHP and comparisons highlighting the differences between plans with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.
- f. Individuals may select a QHP (1) through the state's online portal, NHEASY, (2) by phone, or (3) in person.
- g. Individuals who fail to select a QHP within 30 days of an eligibility determination will be auto-assigned. New Hampshire will send individuals a notice informing them of the QHP to which they have been auto-assigned and that they have the right to select a different plan.
- h. Once an individual has either selected a QHP or the time period to select a QHP has ended, New Hampshire will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.
- i. Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.
- j. On at least a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for New Hampshire's Department of Health and Human Services (NHHHS) to reconcile. Upon reconciliation NHHHS will send back an updated list for carriers.
- k. The state's MMIS will generate an 820 transaction to pay premiums and cost sharing reductions on behalf of beneficiaries directly to the QHP issuer.

1. State MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be medically frail and excluded from the NHHPP Premium Assistance.

Transition Population:

- a. Prior to and during the open enrollment period, New Hampshire Medicaid will send enrollees a notice informing them either: (1) that they have been auto-assigned to the QHP offered by their Medicaid managed care organization (MCO) in which they are currently enrolled (if the MCO elects to offer QHPs), but that they may select a different plan that is included in the NHHPP program or (2), if they have not been auto-assigned, that they may select a QHP that is included in the NHHPP Premium Assistance program. The notices will provide guidance on how to select a QHP. The notice will also include comparisons highlighting the differences between plans with respect to, among other things, networks, access to patient-centered medical homes, and use of care coordination programs.
- b. Individuals may select a QHP (1) through the state's online portal, NHEASY, (2) by phone, or (3) in person.
- c. Individuals who were not auto-assigned to a QHP offered by their MCO and who fail to select a QHP within 30 days of receiving the notice informing them to select a QHP will be auto-assigned. New Hampshire Medicaid will send the individuals a notice informing them of the QHP to which they have been auto-assigned and that they have the right to select a different plan.
- d. Once an individual has either selected a QHP or the time period to select a QHP has ended, New Hampshire will send an 834 transaction to the issuer. 834 transactions will be sent to carriers daily in batch.
- e. Upon receipt of an 834 enrollment transaction, the carrier will send an enrollment package, including the benefit card, to the enrollee.
- f. On at least a monthly basis, the carriers will send DHHS a list of all QHP Premium Assistance enrollees, identified by a unique ID number, for New Hampshire's Department of Health and Human Services (NHHHS) to reconcile. Upon reconciliation NHHHS will send back an updated list for carriers.
- g. The state's MMIS will generate an 820 transaction to pay premiums and cost sharing reductions on behalf of beneficiaries directly to the QHP issuer.
- h. State MMIS premium and cost sharing reduction payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan

during the next open enrollment period; the individual is determined to be medically frail and excluded from the NHHPP Premium Assistance.

- 27. Auto-assignment.** The following categories will be auto-assigned a QHP: (1) individuals who are enrolled in a Medicaid MCO that offers a QHP, and (2) individuals who are not enrolled in a Medicaid MCO or whose Medicaid MCO is not offering a QHP and who fail to select a QHP within 30 days of an eligibility determination or receipt of a notice to select a plan. New Hampshire Medicaid will send the individuals a notice informing them of the QHP to which they have been auto-assigned and their right to select a different plan. Individuals will be given a thirty-day period to request enrollment in another plan.
- 28. Auto-assignment Methodology.** The auto-assignment methodology in DY 1 will take into account, among other factors, family affiliation, primary care provider affiliation, and premium costs.
- 29. Changes to Auto-assignment Methodology.** The state will advise CMS 60 days prior to implementing a change to the auto-assignment methodology.
- 30. Disenrollment.** Enrollees in the NHHPP Premium Assistance may be disenrolled if (i) they are determined to be medically frail after they were previously determined eligible or (ii) if they become enrolled in the mandatory HIPP program.

VI. PREMIUM ASSISTANCE DELIVERY SYSTEM

- 31. Memorandum of Understanding.** The New Hampshire Department of Health and Human Services shall enter into a memorandum of understanding (MOU) with each QHP issuer that will enroll individuals covered under the demonstration. Areas to be addressed in the MOU include, but are not limited to:
- a. Enrollment of individuals in populations affected by the demonstration;
 - b. Payment of premiums and cost-sharing reductions;
 - c. Reporting and data requirements necessary to monitor and evaluate the NHHPP Premium Assistance including those referenced in STC 71, ensuring coordination of benefits and enrollee access to EPSDT and other covered benefits through the QHP;
 - d. Noticing requirements; and, audit rights.
- 32. Qualified Health Plans.** The state will provide premium assistance to support the purchase of coverage for NHHPP Premium Assistance beneficiaries through Marketplace QHPs.
- 33. Choice.** Each NHHPP Premium Assistance beneficiary will have the option to choose between at least two silver plans offered in the individual market through the Marketplace. The state will pay the full cost of QHP premiums and will provide cost sharing reductions.
- a. NHHPP Premium Assistance enrollees with incomes below 100 percent of the FPL will be enrolled in plans that effectively are 100 percent actuarial value (AV) high-value silver plans (after accounting for cost sharing reductions). Enrollees with incomes above 100 up

to 133 percent of the FPL will be enrolled in plans that effectively are 94 percent AV high-value silver plans (after accounting for cost sharing reductions).

- b. NHHPP Premium Assistance beneficiaries will be able to choose from at least two silver plans in each rating area of the state.
- c. The state will comply with Essential Community Provider network requirements, as part of the Qualified Health Plan certification process.

34. Coverage Prior to Enrollment in a QHP. The state will provide coverage through fee-for-service Medicaid from the date of application for coverage under the new adult group until the individual's enrollment in the QHP becomes effective.

- a. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment).
- b. For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective as of the first day of the second month following QHP selection (or auto-assignment).

VII. BENEFITS

35. Alternative Benefit Plan. Individuals affected by this demonstration will receive benefits described in an alternative benefit plan set forth in the approved state plan. Individuals enrolled in QHPs will be restricted to the QHP provider network (except for family planning providers) to receive such benefits, and the QHP will pay primary to Medicaid for covered benefits. The QHP payment rate will be payment in full for such benefits.

36. Medicaid Wrap Benefits. The state will provide through its fee-for-service Medicaid program wrap-around benefits that are included in the ABP but not covered by qualified health plans. These benefits include non-emergency medical transportation (NEMT), early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21, family planning services and supplies, and certain limited adult dental and adult vision services.

37. Access to Wrap Around Benefits. In addition to receiving an insurance card from the applicable QHP issuer, NHHPP Premium Assistance beneficiaries will be sent a notice. The notice will contain information on how enrollees can use the card to access wrapped benefits. The notice will include specific information regarding services that are covered directly through fee-for-service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services pursuant to STC 36.

38. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The state must fulfill its responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

- 39. Access to Federally Qualified Health Centers and Rural Health Centers.** NHHPP Premium Assistance enrollees will have access to at least one QHP in each service area that contracts with at least one FQHC or RHC.

VII. COST SHARING

- 40. Cost sharing.** Cost sharing for NHHPP Premium Assistance enrollees must be in compliance with federal requirements that are set forth in statute, regulation and policies, including exemptions from cost-sharing set forth in 42 CFR Section 447.56. All cost sharing on demonstration participants will be consistent with New Hampshire's approved state plan, as amended by the state.
- 41. Payment Process for Payment of Cost Sharing Reduction to QHPs.** Agreements with QHP issuers may provide for advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for NHHPP Premium Assistance beneficiaries. Such payments will be subject to reconciliation at the conclusion of the benefit year based on enrollee's actual usage of services. The state's reconciliation process will follow 45 CFR Section 156.430 to the extent possible.

IX. APPEALS

Beneficiary safeguards of appeal rights will be provided by the state, including fair hearing rights. No waiver will be granted related to appeals. The state must ensure compliance with all federal and state requirements related to beneficiary appeal rights.

X. GENERAL REPORTING REQUIREMENTS

- 42. General Financial Requirements.** The state must comply with all general financial requirements under Title XIX, including reporting requirements related to monitoring budget neutrality, set forth in Section XII of these STCs.
- 43. Reporting Requirements Related to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in Section XII of these STCs.
- 44. Monitoring Calls.** CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration; including planning for future changes in the program or intent to further implement the NHHPP Premium Assistance beyond December 31, 2016. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda for the calls.

Areas to be addressed include, but are not limited to:

1. Transition and implementation activities;
2. Stakeholder concerns;
3. QHP operations and performance;

4. Enrollment;
5. Cost sharing;
6. Quality of care;
7. Beneficiary access,
8. Benefit package and wrap around benefits;
9. Audits;
10. Lawsuits;
11. Financial reporting and budget neutrality issues;
12. Progress on evaluation activities and contracts;
13. Related legislative developments in the state; and
14. Any demonstration changes or amendments the state is considering.

45. Quarterly Progress Reports. The state will provide quarterly reports to CMS.

- a. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration, including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed.
- b. Monitoring and performance metric reporting templates are subject to review and approval by CMS. Where possible, information will be provided in a structured manner that can support federal tracking and analysis.

46. Compliance with Federal Systems Innovation. As MACBIS or other federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems.

47. Demonstration Annual Report. The annual report must, at a minimum, include the requirements outlined below. The state will submit the draft annual report no later than 90 days after the end of DY 1 and after the end of each additional demonstration year, if applicable. Within 30 days of receipt of comments from CMS, a final annual report must be submitted for the demonstration year (DY) to CMS.

- a. All items included in the quarterly report pursuant to STC 46 must be summarized to reflect the operation/activities throughout the DY;
- b. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately; and
- c. Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

48. Final Report. Within 120 days following the end of the demonstration, the state must submit a draft final report to CMS for comments. The state must take into consideration CMS' comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS' comments.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for Title XIX expenditures applicable to services rendered during the demonstration period. This section describes the general financial requirements for these expenditures.

- 49. Quarterly Expenditure Reports.** The state must provide quarterly Title XIX expenditure reports using Form CMS-64, to separately report total Title XIX expenditures for services provided through this demonstration under section 1115 authority. CMS shall provide Title XIX FFP for allowable demonstration expenditures, only as long as they do not exceed the pre-defined limits on the costs incurred, as specified in section XII of the STCs.
- 50. Reporting Expenditures under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:
- a. **Tracking Expenditures.** In order to track expenditures under this demonstration, the state will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 and Section 2115 of the SMM. All demonstration expenditures subject to the budget neutrality limit must be reported each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements must be recorded on the appropriate prior period adjustment schedules (forms CMS-64.9 Waiver) for the summary line 10B, in lieu of lines 9 or 10C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10C, as instructed in the SMM. The term, "expenditures subject to the budget neutrality limit," is defined below in STC 62.
 - b. **Cost Settlements.** For monitoring purposes, and consistent with annual CSR reconciliation, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (form CMS-64.9P Waiver) for the summary sheet line 10B, in lieu of lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the SMM.
 - c. **Premium and Cost Sharing Contributions.** To the extent New Hampshire collects premiums, Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 summary sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and federal share) should also be reported separately by DY on the form CMS-64 narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to

demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

- d. Pharmacy Rebates. Pharmacy rebates are not considered here as this program is not eligible.
- e. Use of Waiver Forms for Medicaid. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the demonstration, subject to the budget neutrality limit (Section XII of these STCs). The state must complete separate waiver forms for the following eligibility groups/waiver names:

- i. MEG 1 – “New Adult Group”

- f. The first Demonstration Year (DY1) will begin on January 1, 2016. In the event that the state requests an extension of the demonstration consistent with STC 8, subsequent DYs will be defined as follows:

| | | |
|----------------------------|-----------------|-----------|
| Demonstration Year 1 (DY1) | January 1, 2016 | 12 months |
| Demonstration Year 2 (DY2) | January 1, 2017 | 12 months |
| Demonstration Year 3 (DY3) | January 1, 2018 | 12 months |

51. Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration, using Forms CMS-64.10 Waiver and/or 64.10P Waiver, with waiver name Local Administration Costs (“ADM”).

52. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 and Form CMS-21 in order to properly account for these expenditures in determining budget neutrality.

53. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a. For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under STC 46, the actual number of eligible member months for the demonstration populations defined in STC 17. The state must submit a statement accompanying the quarterly report,

which certifies the accuracy of this information.

To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

- b. The term “eligible member months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.

54. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

55. Extent of FFP for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole as outlined below, subject to the limits described in STC 64:

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved state plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability or CMS payment adjustments.

56. Sources of Non-Federal Share. The state must certify that the matching non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.
- c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

57. State Certification of Funding Conditions. The State must certify that the following conditions for non-federal share of demonstration expenditures are met:

- a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
- b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for Title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under Title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
- d. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of Title XIX payments.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments

that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

- 58. Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal Title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in STC 63, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
- 59. Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for demonstration populations as defined in STC 63, but not at risk for the number of enrollees in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the state at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of current eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
- 60. Calculation of the Budget Neutrality Limit.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in STC63 below. In the event that there is more than one DY, the annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in STC 63 below.
- 61. Demonstration Populations Used to Calculate the Budget Neutrality Limit.** For each DY, separate annual budget limits of demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 66. The trend rates and per capita cost estimates for each Mandatory Enrollment Group (MEG) for each year of the demonstration are listed in the table below.

| MEG | TREND | DY 1 - PMPM |
|-----------------|-------|-------------|
| New Adult Group | 3.7% | \$701.53 |

- a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in paragraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to paragraph (a), along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
- b. The budget neutrality cap is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying total computable budget neutrality cap by the federal share.
- c. The state will not be allowed to obtain budget neutrality "savings" from this population.

62. Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. Should the demonstration be terminated prior to the end of the extension approval period (see STC 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

63. Future Adjustments to the Budget Neutrality Expenditure Limit. CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the demonstration.

64. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis, in the event that there is more than one Demonstration Year. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

| Year | Cumulative target definition | Percentage |
|------|------------------------------|------------|
| DY 1 | Cumulative budget | 3% |

| | | |
|------|--|------|
| | neutrality limit plus: | |
| DY 2 | Cumulative budget neutrality limit plus: | 1.5% |
| DY 3 | Cumulative budget neutrality limit plus: | 0% |

65. Exceeding Budget Neutrality. If at the end of the demonstration period the cumulative budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision will be based on the time elapsed through the termination date.

XIII. EVALUATION

66. Submission of Evaluation Design. The state shall submit a draft evaluation design to CMS no later than 90 days after the award of the Demonstration. The evaluation design, including the budget and adequacy of approach to meet the scale and rigor of the requirements of STC 3, is subject to CMS approval. CMS shall provide comment within 30 days of receipt from the state. The state shall provide the Final Evaluation Design within 45 days of receipt of CMS comments. If CMS finds that the Final Evaluation Design adequately accommodates its comments, then CMS will approve the Final Evaluation Design within 30 days and attach to these STCs as Attachment A.

67. Cost-effectiveness. While not the only purpose of the evaluation, the core purpose of the evaluation is to support a determination as to whether the preponderance of the evidence about the costs and effectiveness of the NHHPP Premium Assistance Demonstration using premium assistance when considered in its totality demonstrates cost effectiveness taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes.

- a. The evaluation will explore and explain through developed evidence the effectiveness of the demonstration for each hypothesis, including total costs in accordance with the evaluation design as approved by CMS.
- b. Included in the evaluation will be examinations using a robust set of measures of provider access and clinical quality measures under the NHHPP Premium Assistance Demonstration compared to what would have happened for a comparable population in Medicaid Care Management.
- c. The state will compare total costs under the NHHPP Premium Assistance Demonstration to costs of what would have happened under a traditional Medicaid expansion. This will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses over time.
- d. The state will compare changes in access and quality to associated changes in costs within the NHHPP Premium Assistance. To the extent possible, component contributions to changes in access and quality and their associated levels of

investment in New Hampshire will be determined and compared to improvement efforts undertaken in other delivery systems.

68. Evaluation Requirements. The state shall engage the public in the development of its evaluation design. The evaluation design shall be a summative evaluation and will discuss the following requirements as they pertain to each:

- a. The scientific rigor of the analysis;
- b. A discussion of the goals, objectives and specific hypotheses that are to be tested;
- c. Specific performance and outcomes measures used to evaluate the demonstration's impact;
- d. How the analysis will support a determination of cost effectiveness;
- e. Data strategy including sources of data, sampling methodology, and how data will be obtained;
- f. The unique contributions and interactions of other initiatives; and
- g. How the evaluation and reporting will develop and be maintained.

The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, data collection and analysis, interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

69. Evaluation Design. The Evaluation Design shall include the following core components to be approved by CMS:

1. **Research questions and hypotheses:** This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. At a minimum, the research questions shall address the goals of improving access, reducing churning, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for a robust assessment of cost effectiveness.

The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

- i. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.

- ii. Premium assistance beneficiaries will have equal or better access to preventive care services.
- iii. Premium assistance beneficiaries will have lower non-emergent use of emergency room services.
- iv. Premium assistance beneficiaries will have fewer gaps in insurance coverage.
- v. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
- vi. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have fewer gaps in plan enrollment, improved continuity of care, and resultant lower administrative costs.
- vii. Premium assistance beneficiaries will have lower rates of potentially preventable emergency department and hospital admissions.
- viii. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
- ix. Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits.
- x. Premium assistance beneficiaries will have appropriate access to non-emergency transportation.
- xi. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC 69 on determining cost effectiveness and other requirements in the evaluation design as approved by CMS.
- xii. The demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees.

a. Study Design: The design will consider through its research questions and analysis plan the appropriate application of the following dimensions of access and quality:

- 1. Comparisons of provider networks;
- 2. Consumer satisfaction and other indicators of consumer experience;
- 3. Provider experience; and
- 4. Evidence of improved access and quality across the continuum of coverage and related health outcomes.

b. The design will include a description of the quantitative and qualitative study design (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), including a rationale for the design selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design, use of propensity score matching and difference in differences design to adjust for differences in

comparison populations over time. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered

- c. **Study Population:** This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically valid sample size is available.
- d. **Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures:** This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the impact and/or effectiveness of the Demonstration. Nationally recognized measures may be used where appropriate. Measures will be clearly stated and described, with the numerator and denominator clearly defined. To the extent possible, the state may incorporate comparisons to national data and/or measure sets. A broad set of performance metrics may be selected from nationally recognized metrics, for example from sets developed by the Centers for Medicare and Medicaid Services Medicaid Adult Core measures, for meaningful use under HIT, or from the National Quality Forum. Among considerations in selecting the metrics shall be opportunities identified by the State for improving quality of care and health outcomes, and controlling cost of care.
- e. **Data Collection:** This discussion shall include:
 - 1. A description of the data sources; the frequency and timing of data collection; and the method of data collection. The following shall be considered and included as appropriate:
 - i. Medicaid encounter and claims data,
 - ii. enrollment data, and
 - iii. consumer and provider surveys
- f. **Assurances Needed to Obtain Data:** The design report will discuss the State's arrangements to assure needed data to support the evaluation design are available.
- g. **Data Analysis:** This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow to the greatest extent possible that the effects of the Demonstration are isolated from other initiatives occurring in the State. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses may be used when appropriate. Qualitative analysis methods may also be described, if applicable.
- h. **Timeline:** This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables.
- i. **Evaluator:** This includes a discussion of the State's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the

selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities.

- 70. Interim Evaluation Report.** If the state continues the demonstration beyond DY 1, then the state is required to submit a draft Interim Evaluation Report 90 days following completion of year two of the demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 72 for the Final Summative Evaluation Report.
- 71. Summative Evaluation Report.** The Summative Evaluation Report will include analysis of data from the Demonstration. The state is required to submit a preliminary summative report in 180 days of the expiration of the demonstration including documentation of outstanding assessments due to data lags to complete the summative evaluation. Within 360 days of the expiration date of the Premium Assistance Demonstration, the State shall submit a draft of the final summative evaluation report to CMS. CMS will provide comments on the draft within 60 days of draft receipt. The state should respond to comments and submit the Final Summative Evaluation Report within 30 days.
- 72. The Final Summative Evaluation Report.** The Final Summative Report shall include the following core components:
- a. **Executive Summary.** This includes a concise summary of the goals of the Demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral and cost effective, and policy implications.
 - b. **Demonstration Description.** This includes a description of the Demonstration programmatic goals and strategies, particularly how they relate to budget neutrality and cost effectiveness.
 - c. **Study Design.** This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the State and any sensitivity analyses, and limitations of the study.
 - d. **Discussion of Findings and Conclusions.** This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.
 - e. **Policy Implications.** This includes an interpretation of the conclusions; the impact of the Demonstration within the health delivery system in the State; the implications for State and Federal health policy; and the potential for successful Demonstration strategies to be replicated in other State Medicaid programs.

- f. **Interactions with Other State Initiatives.** This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the State's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid.
- 73. State Presentations for CMS.** The State will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 71. The State will present on its interim evaluation in conjunction with STC 72. The State will present on its summative evaluation in conjunction with STC 73.
- 74. Public Access.** The State shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within 30 days of approval by CMS.
- a. For a period of 24 months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.
- 75. Electronic Submission of Reports.** The State shall submit all required plans and reports using the process stipulated by CMS, if applicable.
- 76. Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration or any component of the demonstration, or an evaluation that is isolating the effects of Premium Assistance, the State shall cooperate fully with CMS and its contractors. This includes, but is not limited to, submitting any required data to CMS or the contractor in a timely manner and at no cost to CMS or the contractor.
- 77. Cooperation with Federal Learning Collaboration Efforts.** The State will cooperate with improvement and learning collaboration efforts by CMS.
- 78. Evaluation Budget.** A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.
- 79. Deferral for Failure to Provide Summative Evaluation Reports on Time.** The State agrees that when draft and final Interim and Summative Evaluation Reports are due, CMS may issue

deferrals in the amount of \$5,000,000 if they are not submitted on time to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

XIV. MONITORING

80. Quarterly Evaluation Operations Report. The State will provide quarterly reports to CMS. The reports shall provide sufficient information for CMS to understand implementation progress of the demonstration and whether there has been progress toward the goals of the demonstration, including the reports will document key operational and other challenges, to what they attribute the challenges and how the challenges are being addressed, as well as key achievements and to what conditions and efforts they attribute the successes.

82. Annual Discussion with CMS. In addition to regular monitoring calls, the State shall on an annual basis present to and participate in a discussion with CMS on implementation progress of the demonstration including progress toward the goals, and key challenges, achievements and lessons learned.

83. Rapid Cycle Assessments. The State shall specify for CMS approval a set of performance and outcome metrics and network characteristics, including their specifications, reporting cycles, level of reporting (e.g., the State, health plan and provider level, and segmentation by population) to support rapid cycle assessment in trends under premium assistance and Medicaid fee-for-service, and for monitoring and evaluation of the demonstration.

XV. HEALTH INFORMATION TECHNOLOGY AND PREMIUM ASSISTANCE

84. Health Information Technology (Health IT). The State will use HIT to link services and core providers across the continuum of care to the greatest extent possible. The State is expected to achieve minimum standards in foundational areas of HIT and to develop its own goals for the transformational areas of HIT use.

- a. Health IT: New Hampshire must have plans for health IT adoption for providers. This will include creating a pathway (and/or a plan) to adoption of certified EHR technology and the ability to exchange data through the State's health information exchanges. If providers do not currently have this technology, there must be a plan in place to encourage adoption, especially for those providers eligible for the Medicare and Medicaid EHR Incentive Program.
- b. The State must participate in all efforts to ensure that all regions (e.g., counties or other municipalities) have coverage by a health information exchange, to the greatest extent possible. Federal funding for developing HIE infrastructure may be available, per State Medicaid Director letter #11-004, to the extent that allowable costs are properly allocated among payers.

- c. All requirements must also align with New Hampshire's State Medicaid HIT Plan, as applicable, and other planning efforts such as the ONC HIE Operational Plan.

XVI. T-MSIS REQUIREMENTS

On August 23, 2013, a State Medicaid Director Letter entitled, "Transformed Medicaid Statistical Information System (T-MSIS) Data", was released. It states that all States are expected to demonstrate operational readiness to submit T-MSIS files, transition to T-MSIS, and submit timely T-MSIS data by July 1, 2014. Among other purposes, these data can support monitoring and evaluation of the Medicaid program in New Hampshire against which the premium assistance demonstration will be compared.

Should the MMIS fail to maintain and produce all federally required program management data and information, including the required T-MSIS, eligibility, provider, and managed care encounter data, in accordance with requirements in the State Medicaid Manual Part 11, FFP may be suspended or disallowed as provided for in federal regulations at 42 CFR 433 Subpart C, and 45 CFR Part 95.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAR - 4 2015

Administrator
Washington, DC 20201

Att. 10

The Honorable Nicholas A. Toumpas
Commissioner, Department of Health and Human Services
Brown Building
129 Pleasant Street
Concord, NH 03301

Dear Commissioner Toumpas:

The Centers for Medicare & Medicaid Services (CMS) is approving New Hampshire's application for a one-year Medicaid demonstration project entitled, "New Hampshire Health Protection Program (NHHPP) Premium Assistance" (Project Number 11-W-00298/1). The demonstration is approved on March 4, 2015 in accordance with section 1115(a) of the Social Security Act (the Act). The demonstration is effective on January 1, 2016 and is approved through December 31, 2018, assuming the state fulfills the requirements outlined within the Special Terms and Conditions (STCs) to continue the demonstration beyond December 31, 2016, and contingent upon the reauthorization of the program by the New Hampshire legislature. Enrollment for the demonstration will begin on November 1, 2015, with eligibility effective on January 1, 2016.

The demonstration will affect non-medically frail individuals aged 19-64 in the new adult coverage group. The approved demonstration provides authority to New Hampshire to provide premium assistance to such individuals in the new adult group to enable them to enroll in qualified health plans (QHPs) offered in the Marketplace. Beginning November 1, 2015, non-medically frail individuals enrolled in the state's current delivery system for the new adult group (the managed care program called "The Bridge Program"), as well as new non-medically frail applicants, will be able to select a QHP for enrollment effective January 1, 2016.

For such individuals, most benefits would be accessed through the QHP network, and the QHP payment rate would be payment in full for such benefits, subject to cost-sharing consistent with New Hampshire's approved state plan. Such individuals would receive the benefits described in New Hampshire's Alternative Benefit Plan under its state plan. Beneficiaries under age 21 will be eligible for early and periodic screening and diagnostic treatment services, and all beneficiaries in the demonstration shall be able to access out-of-network family planning, non-emergency transportation, adult vision, and limited adult dental benefits through the state Medicaid agency in coordination with the QHPs. Cost-sharing will be consistent with New Hampshire's state plan. The demonstration includes a conditional waiver of retroactive coverage, with implementation of the waiver conditioned upon receipt of data demonstrating that the state's coverage system provides a seamless eligibility determination experience for the beneficiary that ensures that the beneficiary will not have periods of uninsurance.

The authority to deviate from Medicaid requirements is limited to the specific waivers and expenditure authorities described in the enclosed lists, and to the purposes indicated for each of those waivers and expenditure authorities. The enclosed STCs further define the nature, character, and extent of anticipated federal involvement in the project, and the state's implementation of the waivers and expenditure authorities, and the state's responsibilities to CMS during the demonstration period. Our approval of the demonstration is conditioned upon the state's compliance with these STCs. Our approval is further subject to CMS receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

Your project officer for these demonstrations is Ms. Megan Lepore. She is available to answer any questions concerning your section 1115 demonstration Ms. Lepore's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-4113
E-mail: Megan.Lepore@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Lepore and to Mr. Richard McGreal, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
JFK Federal Building
Room 2275
Boston, MA 02203-0003
Telephone: (617) 565-1299
E-mail: Richard.McGreal@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

Thank you for all your work with us, as well as stakeholders in New Hampshire, over the past several months on developing this important demonstration. Congratulations on this approval.

Sincerely,



Andrew M. Slavitt
Acting Administrator

Enclosures

Page 3 – Mr. Nicholas A. Toumpas

cc: Richard McGreal, ARA, Region I

Revised Standard Cost Sharing Plan

High Value Silver Plan 94% Actuarial Value Plan

Overall Deductible

\$325

Service Specific Deductibles

Medical \$0
Brand Drugs \$0
Dental \$0
\$600

Member Out of Pocket Maximum (all services combined – does not include deductible)

| General Service Description | Subject to Deductible | Unit of Service | Copays | Coinsurance |
|--|-----------------------|-----------------|--------|-------------|
| Behavioral Health - IP | Yes | Admission | \$125 | 100% |
| Behavioral Health - OP | Yes | Visit | \$0 | 100% |
| Behavioral Health - Professional | No | Visit | \$0 | 100% |
| Durable Medical Equipment | Yes | Service | \$0 | 100% |
| Emergency Room Services | Yes | Visit | \$0 | 100% |
| High Cost Imaging (CT/PET Scans, MRIs) | No | Visit | \$35 | 100% |
| Hospital Inpatient | Yes | Admission | \$125 | 100% |
| Lab and Radiology | No | Visit | \$0 | 100% |
| Skilled Nursing Facility | Yes | Admission | \$0 | 100% |
| Other | Yes | Visit | \$0 | 100% |
| Other Medical Professionals | No | Visit | \$8 | 100% |
| Hospital Outpatient Facility | Yes | Visit | \$0 | 100% |
| Primary Care Physician | No | Visit | \$0 | 100% |
| Specialty Physician | No | Visit | \$8 | 100% |
| Pharmacy - Generics | No | Visit | \$4 | 100% |
| Pharmacy - Preferred Brand Drugs | No | Prescription | \$8 | 100% |
| Pharmacy - Non-Preferred Brand Drugs | No | Prescription | \$8 | 100% |
| Pharmacy - Specialty Drugs | No | Prescription | \$8 | 100% |
| Draft 2016 AV Calculator Result | | | | 95.0% |

December 18, 2014

Revised Standard Cost Sharing Plan

| High Value Silver Plan 94% Actuarial Value Plan | | | | |
|--|-----------------------|-----------------|-------------|-------------|
| Overall Deductible | | | | \$325 |
| Service Specific Deductibles | | | | |
| | | | Medical | \$0 |
| | | | Brand Drugs | \$0 |
| | | | Dental | \$0 |
| Member Out of Pocket Maximum (all services combined – does not include deductible) | | | | \$600 |
| General Service Description | Subject to Deductible | Unit of Service | Copays | Coinsurance |
| Behavioral Health - IP | Yes | Admission | \$125 | 100% |
| Behavioral Health - OP | Yes | Visit | \$0 | 100% |
| Behavioral Health - Professional | No | Visit | \$0 | 100% |
| Durable Medical Equipment | Yes | Service | \$0 | 100% |
| Emergency Room Services | Yes | Visit | \$0 | 100% |
| High Cost Imaging (CT/PET Scans, MRIs) | No | Visit | \$35 | 100% |
| Hospital Inpatient | Yes | Admission | \$125 | 100% |
| Lab and Radiology | No | Visit | \$0 | 100% |
| Skilled Nursing Facility | Yes | Admission | \$0 | 100% |
| Other | Yes | Visit | \$0 | 100% |
| Other Medical Professionals | No | Visit | \$8 | 100% |
| Hospital Outpatient Facility | Yes | Visit | \$0 | 100% |
| Primary Care Physician | No | Visit | \$0 | 100% |
| Specialty Physician | No | Visit | \$8 | 100% |
| Pharmacy - Generics | No | Prescription | \$4 | 100% |
| Pharmacy - Preferred Brand Drugs | No | Prescription | \$8 | 100% |
| Pharmacy - Non-Preferred Brand Drugs | No | Prescription | \$8 | 100% |
| Pharmacy - Specialty Drugs | No | Prescription | \$8 | 100% |
| Draft 2016 AV Calculator Result | | | | 95.0% |