COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 4371-03
Bill No.: HCS for SB 563
Subject: Health Care; Medicaid/MO HealthNet; Pharmacy; Social Services Department; Disabilities; Elderly
Type: Original
Date: May 14, 2018

Bill Summary: This proposal modifies provisions relating to the MO HealthNet program.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
General Revenue	($127,952)	$20,366,046 to $57,484,106	($2,077,192) to $7,202,323
Total Estimated Net Effect on General Revenue	**($127,952)**	**$20,366,046 to $57,484,106**	**($2,077,192) to $7,202,323**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Managed Care Provider Tax ***	$0	$0	$0
Total Estimated Net Effect on Other State Funds	**$0**	**$0**	**$0**

*** Revenues and expenditures between $52.0 million and $101 million annually and net to $0.

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 11 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Federal*	$0	$0	$0
Total Estimated Net Effect on <u>All</u> Federal Funds	**$0**	**$0**	**$0**

*Revenues and expenditures between $31 million and $56 million annually net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
General Revenue	1	1	1
Federal	1	1	1
Total Estimated Net Effect on FTE	**2**	**2**	**2**

☒ Estimated Net Effect (expenditures or reduced revenues) expected to exceed $100,000 in any of the three fiscal years after implementation of the act.

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2019	FY 2020	FY 2021
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

§§ 208.431 - 208.437, 208.471, and 208.480 - Managed Care Provider Tax:

Officials from the **Department of Social Services (DSS), Divisions of MO HealthNet (MHD)** and **Legal Services (DLS)** state the MO HealthNet Division (MHD) is not currently collecting the Medicaid Managed Care Organization Reimbursement Allowance under section 208.431, however, if the proposed legislation passes it would be applied to Managed Care Organizations (MCOs). As defined in this section, MCOs mean Health Maintenance Organizations (HMOs) defined in 354.400, including health maintenance organizations operating pursuant to a contract under 42 U.S.C. Section 1396b(m) to provide benefits to MO HealthNet managed care program eligibility groups.

Section 208.431.2 states the Managed Care Tax shall begin on July 1, 2019 which is the start of SFY 20. The DSS assumes all waivers from the Centers for Medicare and Medicaid Services (CMS) will be complete and the Department will begin collecting the Managed Care Tax on July 1, 2019.

Federal regulations require that a tax be broad-based, be uniform, and not include a hold harmless clause. The proposed assessment would allow for either a uniform tax or a non-uniform tax to be implemented on HMOs.

A **uniform tax** would require approval from the Centers for Medicare and Medicaid Services (CMS). The tax would be imposed on all Medicaid and non-Medicaid HMOs. The language allows for the tax to be applied to either revenues or member months. If applied to revenues, Medicaid revenues are estimated to be $1.5 billion and non-Medicaid commercial revenues are estimated at $338 million based on 2016 reported revenues. The structure of this tax requires that a maximum tax of 6% could be applied; for the purposes of this fiscal note, the DSS assumes a 5.5% tax. Applying a **5.5% uniform tax on revenues generates $101,090,000**, with **$82,500,000** coming from **Medicaid** and **$18,590,000** coming from **commercial**. DSS would need **$28,707,525 of the collection to use as state share** in adjusting the Medicaid capitation payments to reimburse the cost assessment. Therefore, the **remaining assessment available** would be approximately **$72,382,475**.

If the **tax is applied to member months** rather than revenues at a uniform tax of $10 per member month, then the estimated **tax for Medicaid HMOs is $85,701,840** ($10 x 8,570,184 2017 Medicaid member months) and **Non-Medicaid HMOs is $10,770,420** ($10 x 1,077,024 non-Medicaid member months) for a **total of $96,472,260.** DSS would **need $29,821,669** of the collection **to use as state share** in adjusting the Medicaid capitation payments to reimburse the cost assessment. Therefore the **remaining assessment available** would be approximately **$66,650,591**.

ASSUMPTION (continued)

A **non-uniform tax** would have different rates for Medicaid member months and commercial member months. Additionally it would exempt Medicare member months as well as member months associated with the Federal Employee Health Benefits Program which is also exempt under federal law. As this tax is not uniform, DSS would apply for a waiver from CMS. In order to meet CMS requirements under the waiver with a non-uniform tax, the effective tax for HMOs must meet a B1/B2 test as required of all provider taxes approved by CMS. To meet the B1/B2 test, an analysis was performed utilizing a non-uniform rate structure by member months for both the non-Medicaid HMOs and the Medicaid HMOs. The assessment is estimated based on member months from commercial HMOs from calendar year 2016 and Medicaid HMOs from February 2018 to be inclusive of statewide managed care. Non-Medicaid HMOs were assumed to receive a **tiered tax on member months**: Tier 1 (0 to 250,000 member months) $4.00 per member month, Tier 2 (250,000-500,000 member months) $3.00 per member month, Tier 3 (500,000 to 750,000 member months) $1.00 per member month. Medicaid HMOs were assumed to receive a tiered tax on member months: Tier 1 (0-250,000 member months) $45 per member month, Tier 2 (250,000-800,000 member months) $5.00 per member month, Tier 3 (greater than 800,000 member months) $1.00 per member month. **Overall the assessment** would be **expected to be $52,011,008** of which the **Medicaid Managed Care Organizations** tax collection would be **$48,126,543** and the **commercial tax collection** would be **$3,884,465**. DSS would **need $16,746,593** of the collection to use **as state share** in adjusting the Medicaid capitation payments to reimburse the cost assessment. Therefore the **remaining assessment** available would be approximately **$35,264,415**.

The Department assumes the remaining tax would be used to offset General Revenue.

MHD will require an additional 2 FTE (One Band I Manager ($53,928 annually) and one Management Analysis Specialist (MAS) II ($50,634 annually) to implement and maintain this new assessment. Staff would need to work closely and coordinate payment activities with the HMOs, State Actuary, and Department of Revenue.

MHD will need to conduct an actuarial study for $50,000 general revenue. The study is needed to calculate and analyze the tax payments for each Managed Care Organization and incorporate this adjustment into the capitated rate methodology.

The DSS is providing a range for FY20 and FY21 based on the options allowed under the language of the bill. FY19 reflects the costs for the 2 FTE and the actuarial study as the DSS will start collecting the Managed Care Tax at the beginning of FY20: Range up to:

ASSUMPTION (continued)

GR 2019 ($131,446)
GR 2020 $72,121,623 GR 2020 $35,003,563
GR 2021 $72,119,019 GR 2021 $35,000,959

Other* 2019 $0
Other* 2020 ($101,090,000) Other* 2020 ($52,011,008)
Other* 2021 ($101,090,000) Other* 2021 ($52,011,008)

Net State share 2019 $0
Net State share 2020 ($28,968,377) Net State share 2020 ($17,007,445)
Net State share 2021 ($28,970,981) Net State share 2021 ($17,010,049)

Federal 2019 ($80,244)
Federal 2020 ($55,977,315) Federal ($31,477,094)
Federal 2021 ($55,978,175) Federal ($31,477,954)

* Other - **Oversight** will use the Medicaid Managed Care Organization Reimbursement Allowance Fund (#0160) for fiscal note purposes.

Oversight assumes DSS would not need additional rental space for 2 new FTE for this single proposal. However, Oversight notes, depending on the number of proposals passed during the legislative session, that cumulatively, DSS may need additional rental space or capital improvements as determined by the Office of Administration, Facilities Management, Design and Construction.

Oversight notes the current provisions of 208.436 refers to the Medicaid Managed Care Organization Reimbursement Allowance Fund (#0160). Proposed changes remove "Medicaid" from the fund name. As there is no language in the proposal authorizing the Office of the State Treasurer to create the "Managed Care Organization Reimbursement Allowance Fund", Oversight assumes all taxes collected on managed care organizations will be deposited to the Medicaid Managed Care Organization Reimbursement Allowance Fund. Oversight will transfer from the Medicaid Managed Care Organization Reimbursement Allowance Fund to General Revenue the amount of the taxes exceeding the amount DSS needs to pay to the managed care organizations.

Oversight notes the provisions of sections 208.431 are effective July 1, 2019 (FY20), therefore, Oversight assumes the DSS will not collect the managed care provider tax for FY19. In addition, section 208.437 provides that sections 208.431 to 208.437 shall expire on September 30, 2020 (FY21). Therefore, only 3 months of managed care provider taxes will be shown for FY21.

ASSUMPTION (continued)

§208.454 - Federal Reimbursement Allowance Tax Levy

The proposed legislation would limit the amount of federal reimbursement allowance levied not to exceed 41% of the total yearly fiscal payments to hospitals including payments made to hospitals from state contracted managed care organizations.

§208.790 - MO Rx Program

MHD officials state this legislation allows individuals whose income is less than one hundred eighty-five percent of the federal poverty level for the applicable family size to be eligible for the MO Rx plan.

Currently the MO Rx program is available for dual (Medicare and Medicaid) participants only.

Subject to appropriation, if this legislation is enacted, the program will be available for dual and non-dual participants.

The federal budget recently passed by the United States Congress closes the coverage gap in Medicare Part D known as the Donut Hole. In FY17 once an individual with Medicare Part D reached the coverage gap they were responsible for 40% of the cost for brand drugs and 49% of the cost for generic drugs. In FY20 individuals will be responsible for 25% of all drug costs once they reach the coverage gap. When the MO Rx Plan included coverage for non-dual members the plan paid for 50% of the member cost once the member was in the coverage gap. As a result of the reduction in participant responsibility once in the coverage gap, the cost to add non-duals back into the MO Rx program would be reduced by $72,082 annually.

This amount was calculated assuming 31% (Forbes: The Medicare Drug 'Donut Hole' is a Much Smaller Problem Than You Think) or 19,715 of non-duals would be affected by the donut hole. Of the 19,715 it is assumed 6% or 1,183 would reach the coverage gap. The coverage gap is $1,250 but only a small percentage of Medicare Part D participants spend the full gap amount. For the purposes of this fiscal note the coverage gap is estimated to be $625. Assuming a member responsibility of 45% (average of 40% brand and 49% generic) the member responsibility in the gap would be $278. MO Rx would pay 50% or $139 for a total gap coverage cost of $164,494. In FY20 the Medicare Part D member responsibility drops to 25% for an estimated member coverage gap cost of $156. MO Rx would pay 50% or $78 for a total FY20 estimated coverage gap cost of $92,412. The annual savings applied to the cost of this fiscal note for donut hole closing is $72,082 ($164,494 - $92,412).

ASSUMPTION (continued)

The projected average number of non-duals in FY19 is 63,596. Using a per member per year cost of $281, the projected FY20 cost would be $17,891,452 (63,596 non-duals * $281 = $17,891,452 rounded). The estimated FY20 start up and administrative cost include contractor, mailings, and enrollment fees and would be $508,920 for a total cost of $18,328,290. Estimated FY20 rebate revenue of $3,521,288 would offset the cost and it is assumed MO Rx rebates are paid 6 months in arrears. FY20 savings related to the donut hole would be $72,082. FY20 net cost would be $14,807,002. Full year FY21 and FY22 net cost are $10,801,212.

MO Rx Plan Costs:

$17,891,452	Plan costs
+ $508,920	Contractor costs, mailings and enrollment fees
- $72,082	Donut hole savings
$18,328,290	Net cost before rebates
- $3,521,288	6 months MO Rx Rebates
$14,807,002	**Net FY20 costs**

$17,891,452	Plan costs
+ $205,468	Contractor costs, mailings and enrollment fees
- $72,082	Donut hole savings
$18,024,838	Net cost before rebates
- $7,223,626	12 months MO Rx Rebates
$10,801,212	**Net FY21 costs**

Oversight notes Section 208.790 provisions removing MO Rx Program benefits for non-dual (Medicare only) participants was enacted with the passage of CCS HCS SCS SB 139 in 2017. In the fiscal note MHD anticipated a 2018 savings of $13,075,876 ($16,068,071 - $2,992,195 lost rebate revenue).

MHD's FY18 budget for the MO Rx Plan for dual-eligibles only was $11,562,803; the FY19 budget request for the MO Rx Plan for dual eligibles is $11,562,803.

Expenditures for the MO Rx Drug Program covering both dual and non-dual eligibles were approximately $22.3 million in FY16 and $22.9 million for FY17.

FISCAL IMPACT - State Government	FY 2019 (10 Mo.)	FY 2020	FY 2021
GENERAL REVENUE FUND			
Transfer-in - from the Medicaid Managed Care Organization Reimbursement Allowance Fund (§§208.431 - 208.437)	$0	$35,264,415 to $72,382,475	$8,816,104 to $18,095,619
Income - DSS (§208.790)			
Rebate revenue		$3,521,288	$7,223,626
Savings - DSS (§208.790)			
Reduction in payments related to donut hole	$0	$72,082	$72,082
Costs - DSS (§§208.431 - 208.437)			
Personal service	($43,568)	($52,804)	($53,332)
Fringe benefits	($30,920)	($37,259)	($37,416)
Equipment and expense	($3,464)	($1,304)	($1,336)
Actuarial study	($50,000)	$0	$0
Total Costs - DSS	($127,952)	($91,367)	($92,084)
FTE Change - DSS	1 FTE	1 FTE	1 FTE
Costs - DSS (§208.790)			
Contractor, mailings, & enrollment	$0	($508,920)	($205,468)
Program expenditures	$0	($17,891,452)	($17,891,452)
Total Costs - DSS	$0	($18,400,372)	($18,096,920)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**($127,952)**	**$20,366,046 to $57,484,106**	**($2,077,192) to $7,202,323**
Estimated Net FTE Change on the General Revenue Fund	1 FTE	1 FTE	1 FTE

FISCAL IMPACT - State Government	FY 2019 (10 Mo.)	FY 2020	FY 2021
MEDICAID MANAGED CARE ORGANIZATION REIMBURSEMENT ALLOWANCE FUND			
Income - DSS (§§208.431 - 208.437)			
Assessment on Managed Care Provider organizations	$0	$52,011,008 to $101,090,000	$13,002,752 to $25,272,500
Transfer-out - to General Revenue			
Assessments on managed care organizations	$0	($35,264,415 to $72,382,475)	($8,816,104 to $18,095,619)
Costs - DSS (§§208.431 - 208.437)			
Cost assessment reimbursement to Managed Care Organizations	$0	($16,746,593 to $28,707,525)	($4,186,648 to $7,176,881)
ESTIMATED NET EFFECT ON THE MEDICAID MANAGED CARE ORGANIZATION REIMBURSEMENT ALLOWANCE FUND	**$0**	**$0**	**$0**

FISCAL IMPACT - State Government	FY 2019 (9 Mo.)	FY 2020	FY 2021 (3 Mo.)
FEDERAL FUNDS			
Income - DSS			
Assessment on Managed care organizations (§§208.431 - 208.437)	$0	$31,379,950 to $55,880,171	$7,844,988 to $13,970,043
Income - DSS			
Increase program reimbursements (§§208.431 - 208.437)	$77,952	$91,367	$92,084
Costs - DSS (§§208.431 - 208.437)			
Personal service	($43,568)	($52,804)	($53,332)
Fringe benefits	($30,920)	($37,259)	($37,416)
Equipment and expense	($3,464)	($1,304)	($1,336)
Total Costs- DSS	($77,952)	($91,367)	($92,084)
FTE Change - DSS	1 FTE	1 FTE	1 FTE
Costs - DSS			
Medicaid program costs	$0	($31,379,950 to $55,880,171)	($7,844,988 to $13,970,043)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change on Federal Funds	1 FTE	1 FTE	1 FTE

FISCAL IMPACT - Local Government	FY 2019 (10 Mo.)	FY 2020	FY 2021
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

No direct fiscal impact to small businesses would be expected as a result of this proposal.

FISCAL DESCRIPTION

Beginning July 1, 2019 managed care organizations will be required to pay a managed care organization reimbursement allowance for the privilege of engaging in business in the state of Missouri. The reimbursement allowance may be imposed on the basis of revenue or enrollment and may impose differential rates on Medicaid and commercial business. (§§208.431 - 208.437)

Under current law, only Medicaid dual eligible individuals meeting certain income limitations are eligible to participate in the Missouri RX Plan. This act removes the Medicaid dual eligible requirement, while retaining the income limitations. (§208.790)

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Social Services -
MO HealthNet Division
Division of Legal Services

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HWC:LR:OD