IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

SUPPLEMENTAL APPENDIX OF EXHIBITS IN SUPPORT OF PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Plaintiffs hereby submit this Supplemental Appendix of Exhibits in Support of Plaintiffs' Memorandum in Opposition to Defendants' Motion for Summary Judgment.

Respectfully submitted,
BILL MCCOLLUM
ATTORNEY GENERAL OF FLORIDA

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CERTIFICATE OF SERVICE

I hereby certify that, on this 23rd day of November, 2010, a copy of the foregoing Supplemental Appendix of Exhibits in Support of Plaintiffs' Memorandum in Opposition to Defendants' Motion for Summary Judgment was served on counsel of record for all Defendants through the Court's Notice of Electronic Filing system.

/s/ Blaine H. Winship
Blaine H. Winship
Special Counsel

TABLE OF EXHIBITS

Exhibit No.

Exhibit 1

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through
Bill McCollum, et al.,

Plaintiffs,

v. Case No.: 3:10-cv-91-RV/EMT

UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES,
et al.,

Defendants.

FURTHER DECLARATION OF VIVIANNE M. CHAUMONT

Pursuant to 28 U.S.C. § 1746, I, Vivianne M. Chaumont, being first duly sworn, hereby depose and state as follows:

1. My name is Vivianne M. Chaumont. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration.

2. I am the Director of the Division of Medicaid and Long-Term Care for the Nebraska Department of Health and Human Services (Nebraska DHHS). My responsibilities include the administration of the Medicaid program which is subject to requirements of state and federal regulatory and statutory authority. Neb. Rev. Stat. § 68-904 to 906; Title XIX, 42 USC 1396a, et seq.

3. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et*

al., a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

4. I earlier provided an affidavit in this matter describing the impact the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) would have on the Nebraska Medicaid program. That impact was analyzed by Milliman, Inc., an actuarial firm specifically retained by Nebraska DHHS for that purpose.

5. Since providing the aforementioned affidavit, Milliman has provided an updated written analysis of the impact of that federal law as it pertains to DHHS and the State's Medicaid program. A true and correct copy of the updated version of the report, with revised analysis, is attached and marked as Exhibit A.

6. The updated written analysis provided by Milliman was necessitated by a September 28, 2010 letter from the Centers for Medicare & Medicaid Services to state Medicaid directors, which revised previous instructions concerning the federal offset of Medicaid prescription drug rebates.

7. Based upon Milliman's updated written analysis and Nebraska DHHS records and projections prepared and maintained in the regular course of state business, I estimate that the PPACA will cost Nebraska

between $458.2 million and $691.5 million for the period of Fiscal Year 2011 through Fiscal Year 2020. See Exhibit A.

8. I have reviewed Defendants' claim that the PPACA will save the State of Nebraska $36 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

9. The State of Nebraska does not stand to save $36 million due to the savings elements described in the CEA report.

10. Defendants erroneously attribute savings by local governmental units to the State of Nebraska. CEA Report at 67-68. On the contrary, any savings realized by local governments from persons who newly enroll in Medicaid would actually increase costs for the State of Nebraska.

11. The CEA Report upon which Defendants rely also erroneously assumes the elimination of uncompensated care in Nebraska in the amount of $8.6 million ("Hidden Tax" estimate), CEA Report at 68, which is contrary to any known projections familiar to Nebraska DHHS. The CEA Report also bases this estimate on costs borne by both state *and local* governments. As a result, it is not accurate to attribute the full $8.6 million savings estimate to the State of Nebraska alone.

12. The CEA Report's "Hidden Tax" estimate is also likely overstated for another reason. Hospitals which report higher than average (disproportionate share (DSH)) uncompensated costs are eligible to receive

payments to help defray those costs, if they otherwise qualify. As a result, part of this uncompensated care for the uninsured is currently being paid through the DSH program, which includes state and federal funding. Not all of the cost is absorbed into the higher premiums referenced in the CEA Report's "Hidden Tax" section. The DSH program will be phased out over time as uncompensated costs go down. However, there is no assurance that the higher employee health insurance premiums will be going down. Likewise, the CEA Report says that there "may" be increased enrollment that will "potentially" allow cost savings to the states.

13. The CEA Report upon which Defendants rely forecasts that additional savings "may come" from the Children's Health Insurance Program. CEA Report at 68. However, under the PPACA, no changes to eligibility regarding CHIP can be made until 2019. The current eligibility level for CHIP in Nebraska is 200%, which is higher than the 133% provided by the PPACA. There is no mechanism in place for the State to manage or reduce this cost.

14. The $36 million figure relied on by the Defendants from the CEA Report also is based upon the federal government's provision of a 100% FMAP (CEA Report at 6, 70). As passed, however, the ACA does not provide for an indefinite 100% FMAP, but a federal contribution that decreases to 90% by 2019.

15. The CEA Report also states that the State of Nebraska and local governments spend at least $36 million on care for the uninsured, and estimate that the annual cost of Medicaid expansion to Nebraska's low income uninsured individuals would be $178 million, with Nebraska's share being approximately $18 million. However, the CEA Report bases its $178 million estimate on the number of low income uninsured individuals expanding equal to 55,345.

16. Based upon the updated analysis of Milliman, the number of low income uninsured individuals is likely to expand by far more than 55,345, as the CEA Report assumes. Instead, Milliman's analysis takes into account individuals who have the potential to enroll and estimates that enrollment will be at least 107,903 individuals, and possibly as high as 145,297 individuals (see Exhibit A), thus raising the cost to Nebraska.

17. Finally, the CEA Report bases its conclusions on income levels of 133% of the federal poverty line, not 133% with a 5% disregard, as included in the PPACA. As a result, the CEA Report does not reflect the current eligibility levels contemplated by the PPACA.

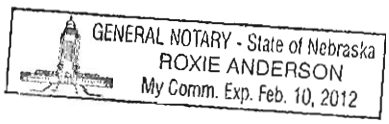
I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and

as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Vivianne M. Chaumont, Director
Division of Medicaid and Long-Term Care
Department of Health and Human Services
Date: 11/22/10

Subscribed and sworn to before me this 22nd day of November, 2010.

Notary Seal



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November 10, 2010

Ms. Vivianne Chaumont, Director
Division of Medicaid & Long-Term Care
Department of Health and Human Services
State of Nebraska
P.O. Box 95026
Lincoln, NE 68509-5026

RE: PATIENT PROTECTION AND AFFORDABLE CARE ACT WITH HOUSE RECONCILIATION – FINANCIAL ANALYSIS - UPDATE

Dear Vivianne:

Milliman, Inc. (Milliman) has been retained by the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care (DHHS) to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (Affordable Care Act) as they relate to the provisions impacting the State's Medicaid program and budget. This letter reflects an update to our analysis reflecting the instructions for the Federal offset of Medicaid prescription drug rebates, as outlined in the September 28, 2010 letter from Department of Health and Human Services October 2010 update to State Medicaid Directors.

SUMMARY OF RESULTS

Milliman has developed two estimates of the enrollment and fiscal impact associated with the Medicaid expansion and other related provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. We have developed (1) a mid-range participation scenario and (2) a full participation scenario. We have prepared our fiscal analysis to reflect the state impact for state fiscal years 2011 through 2020. We have adjusted all data to reflect the three month offset between the federal fiscal year and the state fiscal year as appropriate.

Enclosures 1 and 2 provide the fiscal impact results of the Affordable Care Act under a mid-range participation scenario (Enclosure 1) and a full participation scenario (Enclosure 2). The total fiscal impact to the Nebraska Medicaid budget during the next 10 years would be estimated to be in the range of approximately $458.2 million to $691.5 million based upon the assumptions outlined in this document. Table 1 illustrates the anticipated expenditure impacts to the Nebraska Medicaid budget for the period of SFY 2011 through SFY 2020 under each scenario.

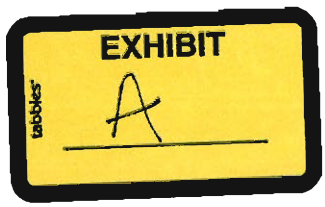

Table 1

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care
4
Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

State Budget Fiscal Impact – SFY 2011 through SFY 2020
(Values Illustrated in Millions)

Component	Estimated Fiscal Impact – State Only	
	Mid-Range Participation Scenario	Full Participation Scenario
Adults and Parents Expansion to 138% FPL	$179.3	$250.6
Children – Enrollment due to ACA	285.8	366.7
Administration	82.4	106.8
Pharmacy Rebate Loss for Nebraska	0.0	0.0
Physician Fee Schedule Increase to Medicare Rates	0.0	56.8
Foster Children Coverage to Age 26	15.1	15.1
Medically Needy Expansion to 138% FPL	5.6	5.6
DSH Reduction	(18.8)	(18.8)
CHIP Enrollment Shift and FMAP Increase	(30.9)	(30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL	(60.5)	(60.5)
Total	**$458.2**	**$691.5**

Note: Values have rounded

The results shown in Table 1 and the enclosures vary from our August 16, 2010 letter due to the impact of the pharmacy rebate loss being removed based on recent guidance from CMS. The Children population has also been shown separately from the Adult and Parent populations.

Estimated Medicaid Enrollment Impact

Table 2 illustrates the projected increase in Medicaid enrollment reflecting a 138% Federal Poverty Level (FPL) limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The values in Table 2 were derived from the 2009 Current Population Survey (2009 CPS) data from the U.S. Census Bureau collected in 2009 (representing 2008 insurance and income data) as well as Medicaid enrollment data provided by DHHS. Children were defined as ages 0 through 19. The Adult and Parent populations were defined as ages 20 through 64.

Table 2

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

State Budget Enrollment Impact – 2009 CPS Census Data

Population	FPL Range	Enrollment Full Participation Scenario	Mid-Range Participation Assumption	Enrollment Mid-Range Participation Scenario
Uninsured Adults	0% - 138%	36,779	80%	29,423
Newly Eligible Parents	50% - 138%	20,510	85%	17,433
Woodwork Parents	< 50%	4,623	70%	3,236
Woodwork Children	<138%	23,119	80%	18,496
Insured Switchers – Adults	0% - 138%	23,916	50%	11,958
Insured Switchers – Parents	0% - 138%	21,429	75%	16,071
Insured Switchers – Children	0% - 138%	14,538	75%	10,903
State Disability (1)	0% - 138%	154	DHHS 133% FPL Assumption+ 5%	154
Medically Needy (2)	43% - 138%	229	DHHS 133% FPL Assumption +5%	229
Sub-total		145,297		107,903

Notes: (1) State Disability currently covered with state funds to 100% FPL. Enrollment reflects shift to Medicaid and FPL expansion estimated as of 2014.
(2) Enrollment reflects FPL expansion estimated as of 2014.

The mid-range participation rates in Table 2 were reviewed for consistency with participation in the Medicare program which exceeds 95% and the Medicaid/CHIP programs for children which exceeds 85%. Actual participation in the Medicaid program after the expansion may exceed the participation rates noted in these other programs, since there will be an individual mandate for health insurance coverage under federal health care reform legislation.

Percentage increase in Medicaid in relation to the total number of Nebraskans

- Calendar Year 2008 Nebraska Census Estimate 1,783,000
- Increase would be approximately 6.1% to 8.2% more Nebraska residents on Medicaid
- Increase from 11.6% to range of 17.7% - 19.8% - or nearly 1 in 5 Nebraskans

The remainder of this letter discusses each of the Medicaid components of health care reform as listed in Table 1.

a. Adults/Parents/Children Expansion to 138% FPL

The fiscal impact associated with the Adults, Parents, and Children expansion to 138% FPL includes both currently insured and uninsured individuals below the 138% FPL amount and children not currently covered under Medicaid, who are also below the 138% FPL limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance. The analysis presented in this report reflects full participation (full participation scenario) as well as an alternate participation assumption (mid-range participation scenario). The participation assumptions by population are presented in Table 2. The assumed average annual cost per enrollee by population as of State fiscal year 2009 is provided in Table 3.

Table 3

Nebraska Department of Health and Human Services
Division of Medicaid and Long-Term Care

Patient Protection and Affordable Care Act
as Amended by the Health Care and Education Reconciliation Act

Average Cost per Enrollee as of SFY 2009

Population	Average Annual Cost
Uninsured Adults	$5,467
Newly Eligible Parents	$4,881
Woodwork Parents	$4,881
Woodwork Children	$2,654
Insured Switchers – Adults	$5,900
Insured Switchers – Parents	$5,268
Insured Switchers – Children	$2,950
State Disability (1)	$78,107
Medically Needy – Disabled (1)	$85,390
Medically Needy – Long-Term (1)	$109,932

Notes: (1) State Disability and Medically Needy costs provided by DHHS for FFY 2014.

The cost estimates for the State Disability and Medically Needy populations were obtained from the health care reform projection provided by DHHS. All other annual cost estimates were developed from SFY 2009 enrollment and expenditures provided in the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 with appropriate adjustments. The values in Table 3 reflect the age/gender mix of each population based upon the 2009 CPS census data. For example, the insured switcher adult population does not have the same age distribution as the uninsured adult population which impacts expected average cost. Milliman additionally used internally available data from other Medicaid expansion analyses to develop the cost relationship between adults and parents. Milliman assumed a composite annual trend of 3.0% to project the claim cost for the expansion population into future years. The 3.0% trend reflects the impact of enrollment growth as well as projected trend for utilization and intensity of services.

The Affordable Care Act reflects the following Federal Medical Assistance Percentages (FMAP) for the expansion populations.

- 100% FMAP in CY 2014, 2015, and 2016
- 95% FMAP in CY 2017
- 94% FMAP in CY 2018
- 93% FMAP in CY 2019
- 90% FMAP in CY 2020+

Milliman assumed that the projected FFY 2012 FMAP rate of 57.64% for Medicaid and 70.35% for CHIP would continue through 2020 for non-expansion populations.

b. Administration

In addition to the expenditures associated with providing medical services, Nebraska will incur additional administrative expenditures. The expenditures for the initial modifications to the current administrative systems, as well as establishment of an Exchange, are estimated to be $25 million (State and Federal) or $12.5 million (State only). On-going costs for the coverage of the additional 108,000 to 145,000 Medicaid enrollees are estimated to be $21.5 to $29.0 million per year (State and Federal) or $10.8 to $14.5 million per year (State only). The on-going costs were developed assuming approximately $200 per recipient per year or approximately 3.75% of total expected medical expenditures. Based on my experience with Medicaid programs, the state Medicaid administrative costs range from 3.5% to 6.0% of the total medical costs. The administrative expenses would be anticipated to be incurred in calendar years 2012 and 2013 for the initial administrative expenditures and in calendar year 2014 forward for the on-going expenditures.

c. Pharmacy Rebate Loss for Nebraska

The Affordable Care Act includes increased rebate percentages for covered outpatient drugs provided to Medicaid patients. The minimum rebate percentage is increased from 15.1% to 23.1% for most brand name drugs and from 11% to 13% for generic drugs effective January 1, 2010. However, the Affordable Care Act indicates that the impact will be accrued 100% to the Federal government. Based on instructions regarding the Pharmacy Rebate offset from Department of Health and Human Services to the state Medicaid Directors dated September 28, 2010, we have estimated that no impact will occur to the rebates currently accruing to the state budget.

The following provides additional details regarding the history of the anticipated pharmacy rebate losses and the resulting modification by CMS.

- In a September 28, 2010 letter, CMS modified the instructions originally outlined in an April 22, 2010 letter on how the increased pharmacy rebate will be captured from the total Medicaid rebates.
- April 22, 2010 State Medicaid Director Letter from Department of Health and Human Services RE: Medicaid Prescription Drug Rebates
  - Page 3, Changes in Non-Federal Share of Rebates: "*For brand name drugs subject to the 23.1 percent minimum rebates, we plan to offset an amount equal to the non-Federal*

share of 8 percent of AMP (the difference between 23.1 percent of AMP and 15.1 percent of AMP), regardless of whether States received a rebate amount based on the difference between AMP and best price."

- **Initial Estimated Financial Impact August 16, 2010 Letter:** Since the State of Nebraska receives a significant portion of pharmacy rebates on brand name drugs at the difference between AMP and best price, the State of Nebraska would have lost 8 percent of AMP. The overall estimated impact ranged from 20.7% to 22.6% of pharmacy rebates received.

- May 18, 2010 letter from State Medicaid Directors to Ms. Cynthia Mann, Director, Center for Medicaid, CHIP and Survey & Certification
  - Letter outlined the Medicaid Directors' concern regarding the treatment of the recapture of the non-Federal Share of Rebates
  - Page 2, *"The application of this provision to a rebate that is unaffected by the increase in the minimum rebate violates both the letter and the apparent intent thereof. By its terms, this provision applies only to 'amounts received by the State ... that are attributable ... to the increase in the minimum rebate percentage.' "*
- CMS worked with State Medicaid Directors and other organizations, including the American Academy of Actuaries Medicaid Committee, to understand their concerns.
- September 28, 2010 State Medicaid Director Letter RE: Medicaid Prescription Drugs
  - Page 1 – 2, Revised Policy on Federal Offset of Rebates: " ... *However, after further consideration of the offset provisions in section 2501 of the Affordable Care Act, we have decided to reconsider our instructions regarding the calculation of the offset provisions to reflect the lesser of the difference between the increased minimum rebate percentage and the AMP (Average Manufacturers Price) minus BP (Best Price). We plan to offset the amount equal to the increased amount of rebates resulting from the Affordable Care Act.' "*
  - **Updated Financial Impact:** Since the federal offset will only be on the increased rebate value for brand name drugs, there will not be an expected loss of pharmacy rebates to the State of Nebraska.

d. Physician Fee Schedule Increase to Medicare Rates

According to an April 2009 report by the Urban Institute's Health Policy Center, the current Nebraska Medicaid fee schedule reimburses at approximately 82% of the Medicare fee schedule for primary care services. The Affordable Care Act requires an increase in the Medicaid physician fee schedule for a limited set of primary and preventive care services to 100% of the Medicare physician fee schedule. 100% Federal funding is available for calendar years 2013 and 2014. No additional funding is available for other physician services.

Full Participation Scenario –

The full participation scenario assumes that DHHS will increase the fee schedule for the required services for both primary care and specialty care providers and will continue the increased fee schedule after calendar year 2014 to assure continued access to physician care. In addition to increasing the expected cost of corresponding existing expenditures by approximately 22%, the analysis reflects an additional $120 per year for the dual eligible population since Medicare only pays 80% of the fee schedule for Part B services.

Under the full participation scenario, the increased cost would be an estimated $27 million (State and Federal) per year for the current Medicaid program and expansion populations. During calendar years 2013 and 2014, the state would have to pay the standard state portion of the increase for specialty providers for the existing Medicaid population. Therefore, the state share in these two calendar years would be approximately $2.8 million (State only) per year. In 2015, the State only cost for the fee schedule expansion would grow to an estimated $9 million (State only).

Mid-Range Participation Scenario –

The mid-range participation scenario assumes that DHHS will only increase the fee schedule for primary care providers, not specialty care providers. The mid-range participation scenario further assumes that the fee schedule increase will only continue through calendar year 2014 and will terminate when the Federal funding level decreases. The annual cost would be approximately $18 million and reflects 100% Federal funding for the calendar year 2013 and 2014 period.

e. Foster Children Coverage to Age 26

It is Milliman's understanding that Nebraska currently provides Medicaid eligibility coverage to Foster Children to age 19. The Affordable Care Act includes mandatory coverage for Foster Children to age 26 beginning on January 1, 2014. Milliman has estimated the annual cost at $5.5 million per year (State and Federal) or approximately $2.3 million per year (State only).

f. Medically Needy Expansion to 138% FPL

The Medically Needy population is currently covered to 43% FPL. The population is limited to non-Dual eligibles under age 65. Effective January 1, 2014, the population will be covered to 138% FPL including the 5% income disregard allowance. Milliman has utilized the DHHS expenditure estimate for the Medically Needy population for fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

g. DSH Reduction

Based upon the aggregate Disproportionate Share Hospital (DSH) payment reductions indicated in the Affordable Care Act, Milliman developed average Federal fiscal year DSH reduction percentages. Milliman adjusted the Federal fiscal year percentages to a State fiscal year basis. The baseline DSH expenditures of $44.0 million provided by DHHS were ultimately reduced to two-thirds of the National reduction percentage. The reduction was reduced to two-thirds of the National percentage to reflect that Nebraska is a low DSH state.

Federal Fiscal Year	DSH Percentage Reduction	
	National Percentage	Nebraska Percentage
2014	4.4%	2.9%
2015	5.3%	3.5%
2016	5.3%	3.5%
2017	15.9%	10.6%
2018	44.1%	29.4%
2019	49.4%	32.9%
2020	35.3%	23.5%

Note: Nebraska percentage reduction was estimated at 2/3 of National percentage reduction since Nebraska is a low DSH state.

h. CHIP Enrollment Shift and FMAP Increase

Under the Affordable Care Act, the CHIP program is required to continue to 2019. However, the legislation provides an additional Federal matching rate of 23% beginning on October 1, 2015 and ending September 30, 2019. The additional 23% FMAP will increase the total FMAP for the CHIP program to approximately 93.35%. The enhanced FMAP will decrease expenditures for Nebraska and increase expenditures for the Federal share.

The projection additionally reflects that approximately 30% of current CHIP program enrollees will shift to Medicaid eligibility effective January 1, 2014. The 30% reflects CHIP enrollees <138% FPL.

i. State Disability Shift to Medicaid and Expansion to 138% FPL

Nebraska currently covers the State Disability population to 100% FPL with 100% state funds. Milliman has utilized the DHHS expenditure estimate for the State Disability population for Federal fiscal year 2014 assuming expansion to 133% FPL under the Medicaid enhanced FMAP rate. Our projection adjusts the DHHS estimate by a factor of 1.05 to reflect expansion to the 138% FPL level. We have additionally adjusted the estimate provided by DHHS from a Federal fiscal year basis to a State fiscal year basis. Although these individuals would theoretically be included in the 2009 CPS data, the cost intensity needs to be additionally reflected.

OTHER CHANGES TO CURRENT PROGRAMS

Milliman anticipates potential savings from the following populations even if the programs are not discontinued. However, savings estimates have not been included in the total impact projection for either the full participation scenario or mid-range participation scenario.

Pregnant Women above 138% FPL

The State of Nebraska currently provides eligibility for pregnant women up to 185% FPL. It would be anticipated that the majority of pregnant women between 138% FPL and 185% FPL will receive care through the insurance exchange. We have estimated that approximately 10% of the current expenditures for the pregnant women population will no longer be incurred by the Nebraska Medicaid program. We have estimated the annual savings to be approximately $3.4 million (State and Federal) per year or $1.4 million (State only) per year beginning on January 1, 2014.

Breast and Cervical Cancer Program

The State of Nebraska currently provides eligibility under the Breast and Cervical Cancer program. The total annual expenditures under the program are approximately $5.0 million (State and Federal) or $1.5 million (State only). It is not anticipated that this program will be required to be continued with the expansion requirements below 138% FPL and insurance reforms for individuals above 138% FPL. Therefore, we have estimated that this program could be terminated beginning on January 1, 2014; although, some of these individuals will become eligible under the new Medicaid eligibility requirements.

LIMITATIONS

The information contained in this correspondence, including any enclosures, has been prepared for the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by DHHS as well as enrollment and expenditure data obtained from the Medicaid Statistical Information System (MSIS) State Summary Datamart and the *Nebraska Medicaid Reform Annual Report* dated December 1, 2009 as retrieved from the DHHS website. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The data and information included in the report has been developed to assist in the analysis of the financial impact of Nebraska Medicaid Assistance expenditures. The data and information presented may not be appropriate for any other purpose. It should be emphasized that the results presented in this correspondence are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this letter.

If you have any questions or comments regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb
Enclosures

Milliman

ENCLOSURE 1

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Current Programs											
Medicaid											
Total (State and Federal)	$1,745.1	$1,792.5	$1,841.2	$1,891.3	$1,942.7	$1,995.5	$2,049.7	$2,105.4	$2,162.6	$2,221.4	$19,747.6
Federal Funds	$1,029.1	$1,036.8	$1,061.3	$1,090.1	$1,119.8	$1,150.2	$1,181.5	$1,213.6	$1,246.5	$1,280.4	$11,409.3
State Funds	$716.0	$755.7	$780.0	$801.2	$822.9	$845.3	$868.3	$891.9	$916.1	$941.0	$8,338.3
CHIP											
Total (State and Federal)	$63.2	$65.1	$67.0	$69.0	$71.1	$73.3	$75.4	$77.7	$80.0	$82.4	$724.4
Federal Funds	$45.0	$45.9	$47.2	$48.6	$50.0	$51.5	$53.1	$54.7	$56.3	$58.0	$510.3
State Funds	$18.1	$19.2	$19.9	$20.5	$21.1	$21.7	$22.4	$23.0	$23.7	$24.4	$214.1
State Disability											
Total (State and Federal)	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
All Programs											
Total (State and Federal)	$1,816.4	$1,866.0	$1,916.9	$1,969.2	$2,023.0	$2,078.2	$2,134.9	$2,193.2	$2,253.0	$2,314.4	$20,565.3
Federal Funds	$1,074.1	$1,082.7	$1,108.5	$1,138.7	$1,169.8	$1,201.7	$1,234.6	$1,268.2	$1,302.9	$1,338.4	$11,919.6
State Funds	$742.3	$783.3	$808.5	$830.5	$853.2	$876.5	$900.4	$924.9	$950.1	$976.0	$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Health Care Reform											
Adults and Parents - Expansion to 138% FPL											
Total (State and Federal) - Newly Eligible				$142.6	$293.7	$302.5	$311.6	$320.9	$330.5	$340.5	$2,042.2
Total (State and Federal) - Woodwork				$9.2	$18.9	$19.4	$20.0	$20.6	$21.2	$21.9	$131.2
Total (State and Federal) - Insured Switchers				$90.0	$185.3	$190.9	$196.6	$202.5	$208.6	$214.9	$1,288.9
Federal Funds				$237.8	$489.9	$504.6	$507.0	$506.5	$516.3	$520.7	$3,282.9
State Funds				$3.9	$8.0	$8.2	$21.2	$37.5	$44.0	$56.5	$179.3
Children - Impact due to ACA											
Total (State and Federal) - Newly Eligible				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Total (State and Federal) - Woodwork				$28.5	$58.6	$60.4	$62.2	$64.0	$66.0	$67.9	$407.6
Total (State and Federal) - Insured Switchers				$18.6	$38.4	$39.6	$40.8	$42.0	$43.2	$44.5	$267.1
Federal Funds				$27.1	$55.9	$57.6	$59.3	$61.1	$62.9	$64.8	$388.9
State Funds				$20.0	$41.1	$42.3	$43.6	$44.9	$46.3	$47.6	$285.8
Administrative Expenses											
Total (State and Federal)		$6.3	$12.5	$17.0	$21.5	$21.5	$21.5	$21.5	$21.5	$21.5	$164.8
Federal Funds		$3.1	$6.3	$8.5	$10.8	$10.8	$10.8	$10.8	$10.8	$10.8	$82.4
State Funds		$3.1	$6.3	$8.5	$10.8	$10.8	$10.8	$10.8	$10.8	$10.8	$82.4
Pharmacy Rebate Loss for Nebraska											
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Physician Fee Schedule Increase to Medicare Rates											
Total (State and Federal)			$7.2	$18.3	$9.4	$0.0	$0.0	$0.0	$0.0	$0.0	$34.9
Federal Funds			$7.2	$18.3	$9.4	$0.0	$0.0	$0.0	$0.0	$0.0	$34.9
State Funds			$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Foster Children Coverage to Age 26											
Total (State and Federal)				$2.8	$5.5	$5.5	$5.5	$5.5	$5.5	$5.5	$35.8
Federal Funds				$1.6	$3.2	$3.2	$3.2	$3.2	$3.2	$3.2	$20.6
State Funds				$1.2	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$15.1
Medically Needy Expansion to 138% FPL											
Total (State and Federal)				$10.6	$21.8	$22.5	$23.2	$23.9	$24.6	$25.3	$151.9
Federal Funds				$10.6	$21.8	$22.5	$22.6	$22.6	$23.0	$23.2	$146.2
State Funds				$0.0	$0.0	$0.0	$0.6	$1.3	$1.6	$2.2	$5.6

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Mid-Range Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
DSH Reductions											
Total (State and Federal)				($1.0)	($1.5)	($1.6)	($3.9)	($10.9)	($14.1)	($11.4)	($44.3)
Federal Funds				($0.6)	($0.9)	($0.9)	($2.2)	($6.3)	($8.1)	($6.6)	($25.5)
State Funds				($0.4)	($0.6)	($0.7)	($1.7)	($4.6)	($6.0)	($4.8)	($18.8)
CHIP Enrollment Shift and FMAP Increase											
Total (State and Federal)				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds				($1.3)	($2.7)	$6.1	$9.3	$9.5	$9.8	$0.2	$30.9
State Funds				$1.3	$2.7	($6.1)	($9.3)	($9.5)	($9.8)	($0.2)	($30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL											
Total (State and Federal)				$1.6	$3.4	$3.5	$3.6	$3.7	$3.8	$3.9	$23.6
Federal Funds				$6.1	$12.6	$12.9	$13.0	$13.0	$13.2	$13.3	$84.0
State Funds				($4.4)	($9.2)	($9.4)	($9.4)	($9.3)	($9.4)	($9.4)	($60.5)
All Programs - After Expansion											
Total (State and Federal)	$1,816.4	$1,872.2	$1,936.6	$2,307.3	$2,678.0	$2,742.4	$2,815.9	$2,886.9	$2,963.9	$3,049.0	$25,068.7
Federal Funds	$1,074.1	$1,085.8	$1,121.9	$1,446.9	$1,769.7	$1,818.4	$1,857.4	$1,888.6	$1,934.0	$1,968.0	$15,964.8
State Funds	$742.3	$786.4	$814.7	$860.5	$908.3	$923.9	$958.5	$998.3	$1,029.9	$1,081.0	$9,103.9
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$6.3	$19.7	$338.1	$655.0	$664.2	$681.0	$693.8	$710.9	$734.5	$4,503.4
Federal Funds	$0.0	$3.1	$13.5	$308.1	$599.9	$616.7	$622.9	$620.3	$631.1	$629.6	$4,045.2
State Funds	$0.0	$3.1	$6.3	$30.0	$55.1	$47.5	$58.1	$73.4	$79.8	$105.0	$458.2
Pregnant Women (133% - 185%)											
Total (State and Federal)				($1.6)	($3.3)	($3.4)	($3.5)	($3.6)	($3.7)	($3.8)	($22.8)
Federal Funds				($0.9)	($1.9)	($2.0)	($2.0)	($2.1)	($2.1)	($2.2)	($13.2)
State Funds				($0.7)	($1.4)	($1.4)	($1.5)	($1.5)	($1.6)	($1.6)	($9.7)
Breast & Cervical Cancer											
Total (State and Federal)				($2.4)	($5.0)	($5.2)	($5.3)	($5.5)	($5.6)	($5.8)	($34.8)
Federal Funds				($1.7)	($3.5)	($3.6)	($3.7)	($3.8)	($3.9)	($4.0)	($24.4)
State Funds				($0.7)	($1.5)	($1.5)	($1.6)	($1.6)	($1.7)	($1.7)	($10.3)

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ENCLOSURE 2

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Maximum Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Current Programs											
Medicaid											
Total (State and Federal)	$1,745.1	$1,792.5	$1,841.2	$1,891.3	$1,942.7	$1,995.5	$2,049.7	$2,105.4	$2,162.6	$2,221.4	$19,747.6
Federal Funds	$1,029.1	$1,036.8	$1,061.3	$1,090.1	$1,119.8	$1,150.2	$1,181.5	$1,213.6	$1,246.5	$1,280.4	$11,409.3
State Funds	$716.0	$755.7	$780.0	$801.2	$822.9	$845.3	$868.3	$891.9	$916.1	$941.0	$8,338.3
CHIP											
Total (State and Federal)	$63.2	$65.1	$67.0	$69.0	$71.1	$73.3	$75.4	$77.7	$80.0	$82.4	$724.4
Federal Funds	$45.0	$45.9	$47.2	$48.6	$50.0	$51.5	$53.1	$54.7	$56.3	$58.0	$510.3
State Funds	$18.1	$19.2	$19.9	$20.5	$21.1	$21.7	$22.4	$23.0	$23.7	$24.4	$214.1
State Disability											
Total (State and Federal)	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$8.1	$8.4	$8.6	$8.9	$9.2	$9.4	$9.7	$10.0	$10.3	$10.6	$93.3
All Programs											
Total (State and Federal)	$1,816.4	$1,866.0	$1,916.9	$1,969.2	$2,023.0	$2,078.2	$2,134.9	$2,193.2	$2,253.0	$2,314.4	$20,565.3
Federal Funds	$1,074.1	$1,082.7	$1,108.5	$1,138.7	$1,169.8	$1,201.7	$1,234.6	$1,268.2	$1,302.9	$1,338.4	$11,919.6
State Funds	$742.3	$783.3	$808.5	$830.5	$853.2	$876.5	$900.4	$924.9	$950.1	$976.0	$8,645.7

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Maximum Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
Health Care Reform											
Adults and Parents - Expansion to 138% FPL											
Total (State and Federal) - Newly Eligible				$174.6	$359.6	$370.4	$381.5	$393.0	$404.8	$416.9	$2,500.8
Total (State and Federal) - Woodwork				$13.1	$26.9	$27.8	$28.6	$29.4	$30.3	$31.2	$187.4
Total (State and Federal) - Insured Switchers				$147.2	$303.3	$312.4	$321.8	$331.4	$341.4	$351.6	$2,109.1
Federal Funds				$329.3	$678.5	$698.8	$702.2	$701.5	$715.1	$721.2	$4,546.6
State Funds				$5.5	$11.4	$11.8	$29.7	$52.3	$61.3	$78.6	$250.6
Children - Impact due to ACA											
Total (State and Federal) - Newly Eligible				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Total (State and Federal) - Woodwork				$35.6	$73.3	$75.5	$77.7	$80.1	$82.5	$84.9	$509.5
Total (State and Federal) - Insured Switchers				$24.9	$51.2	$52.8	$54.3	$56.0	$57.6	$59.4	$356.1
Federal Funds				$34.8	$71.7	$73.9	$76.1	$78.4	$80.8	$83.2	$498.9
State Funds				$25.6	$52.7	$54.3	$55.9	$57.6	$59.3	$61.1	$366.7
Administrative Expenses											
Total (State and Federal)		$6.3	$12.5	$20.8	$29.0	$29.0	$29.0	$29.0	$29.0	$29.0	$213.5
Federal Funds		$3.1	$6.3	$10.4	$14.5	$14.5	$14.5	$14.5	$14.5	$14.5	$106.8
State Funds		$3.1	$6.3	$10.4	$14.5	$14.5	$14.5	$14.5	$14.5	$14.5	$106.8
Pharmacy Rebate Loss for Nebraska											
Total (State and Federal)	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
State Funds	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Physician Fee Schedule Increase to Medicare Rates											
Total (State and Federal)			$10.1	$27.3	$28.1	$28.9	$29.7	$30.5	$31.3	$32.2	$218.0
Federal Funds			$8.9	$24.5	$22.7	$20.3	$20.6	$20.9	$21.4	$21.8	$161.3
State Funds			$1.2	$2.8	$5.4	$8.6	$9.0	$9.5	$9.9	$10.4	$56.8
Foster Children Coverage to Age 26											
Total (State and Federal)				$2.8	$5.5	$5.5	$5.5	$5.5	$5.5	$5.5	$35.8
Federal Funds				$1.6	$3.2	$3.2	$3.2	$3.2	$3.2	$3.2	$20.6
State Funds				$1.2	$2.3	$2.3	$2.3	$2.3	$2.3	$2.3	$15.1
Medically Needy Expansion to 138% FPL											
Total (State and Federal)				$10.6	$21.8	$22.5	$23.2	$23.9	$24.6	$25.3	$151.9
Federal Funds				$10.6	$21.8	$22.5	$22.6	$22.6	$23.0	$23.2	$146.2
State Funds				$0.0	$0.0	$0.0	$0.6	$1.3	$1.6	$2.2	$5.6

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Medicaid and Long-Term Care
Health Care Reform Projection - Maximum Impact Scenario
(Values in Millions)

EXPENDITURES	SFY 2011	SFY 2012	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	SFY 2011 - SFY 2020
DSH Reductions											
Total (State and Federal)				($1.0)	($1.5)	($1.6)	($3.9)	($10.9)	($14.1)	($11.4)	($44.3)
Federal Funds				($0.6)	($0.9)	($0.9)	($2.2)	($6.3)	($8.1)	($6.6)	($25.5)
State Funds				($0.4)	($0.6)	($0.7)	($1.7)	($4.6)	($6.0)	($4.8)	($18.8)
CHIP Enrollment Shift and FMAP Increase											
Total (State and Federal)				$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Federal Funds				($1.3)	($2.7)	$6.1	$9.3	$9.5	$9.8	$0.2	$30.9
State Funds				$1.3	$2.7	($6.1)	($9.3)	($9.5)	($9.8)	($0.2)	($30.9)
State Disability Shift to Medicaid and Expansion to 138% FPL											
Total (State and Federal)				$1.6	$3.4	$3.5	$3.6	$3.7	$3.8	$3.9	$23.6
Federal Funds				$6.1	$12.6	$12.9	$13.0	$13.0	$13.2	$13.3	$84.0
State Funds				($4.4)	($9.2)	($9.4)	($9.4)	($9.3)	($9.4)	($9.4)	($60.5)
All Programs - After Expansion											
Total (State and Federal)	$1,816.4	$1,872.2	$1,939.5	$2,426.7	$2,923.6	$3,004.8	$3,085.9	$3,164.7	$3,249.7	$3,343.0	$26,826.5
Federal Funds	$1,074.1	$1,085.8	$1,123.6	$1,554.2	$1,991.2	$2,053.0	$2,093.8	$2,125.6	$2,175.7	$2,212.4	$17,489.3
State Funds	$742.3	$786.4	$815.9	$872.5	$932.4	$951.8	$992.1	$1,039.1	$1,074.0	$1,130.7	$9,337.2
All Programs - Fiscal Impact											
Total (State and Federal)	$0.0	$6.3	$22.6	$457.4	$900.7	$926.6	$951.0	$971.5	$996.7	$1,028.6	$6,261.2
Federal Funds	$0.0	$3.1	$15.1	$415.5	$821.4	$851.3	$859.2	$857.3	$872.8	$874.0	$5,569.7
State Funds	$0.0	$3.1	$7.5	$42.0	$79.2	$75.3	$91.7	$114.2	$123.8	$154.6	$691.5
Pregnant Women (133% - 185%)											
Total (State and Federal)				($1.6)	($3.3)	($3.4)	($3.5)	($3.6)	($3.7)	($3.8)	($22.8)
Federal Funds				($0.9)	($1.9)	($2.0)	($2.0)	($2.1)	($2.1)	($2.2)	($13.2)
State Funds				($0.7)	($1.4)	($1.4)	($1.5)	($1.5)	($1.6)	($1.6)	($9.7)
Breast & Cervical Cancer											
Total (State and Federal)				($2.4)	($5.0)	($5.2)	($5.3)	($5.5)	($5.6)	($5.8)	($34.8)
Federal Funds				($1.7)	($3.5)	($3.6)	($3.7)	($3.8)	($3.9)	($4.0)	($24.4)
State Funds				($0.7)	($1.5)	($1.5)	($1.6)	($1.6)	($1.7)	($1.7)	($10.3)

Exhibit 2

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF ROBERT D. CHURCH, JR.

Pursuant to 28 U.S.C. § 1746, I, Robert D. Church, Jr, declare the following:

1. My name is Robert D. Church, Jr. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Alabama Medicaid Agency as the Commissioner of the Agency and as the Chief Financial Officer.

2. I have served as Chief Financial Officer since approximately November, 2009 and as Commissioner since November, 2010.

3. As Commissioner, I am the highest ranking official in the Alabama Medicaid Agency and am responsible for all activities of the Agency including the operation of the Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Alabama is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Presently, Alabama Medicaid Agency has projected that the initial administrative cost to the state will total over $76,000,000 by the conclusion of state Fiscal Year 2015 as a result of the passage of PPACA. This amount increases going forward, and by 2018 the projected administrative costs to Alabama are estimated to be in excess of $35,000,000 annually from the state's general fund. There are, currently, no projected savings as a result of PPACA.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Montgomery, Alabama.

Robert D. Church, Jr.
Commissioner
Alabama Medicaid Agency

SWORN TO and subscribed before me this 19 day of November, 2010.

Angela Williams
Notary Public

My Commission Expires: May 16, 2012

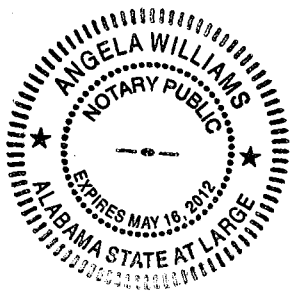

Exhibit 3

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF ROBERT M. DAMLER

Pursuant to 28 U.S.C. § 1746, I, Robert M. Damler, duly affirm under penalties for perjury that I am over 18 years of age and am competent to testify in a court of law:

1. I am making this further declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Indiana is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

2. I am a Principal and Consulting Actuary with Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries.

3. Indiana Code § 12-8-1-7 gives the secretary of the Indiana Family and Social Services Agency (FSSA) the power to employ experts and consultants to carry out the duties of the secretary and the offices. Under this power, the Secretary of FSSA hired Milliman, Inc. to provide consulting services related to the financial review of the Patient Protection and Affordable Care Act (H.R. 3590) as it relates to the provisions impacting the State's Medicaid program and budget.

4. I provided a declaration earlier in this matter certifying the authenticity of a report I provided to FSSA concerning PPACA's impact on the Medicaid program. That report is attached as Exhibit A to the declaration of Pat Casanova, the head of the Indiana Office of Medicaid Policy and Planning, which declaration was supplied as Exhibit 10 in support of the Plaintiffs' Motion for Summary Judgment. I am the principal author of that report.

5. In my report dated October 18, 2010 to FSSA, I projected that PPACA is likely to increase the Indiana expenditures on the Medicaid program to be between $2.6 billion and $3.1 billion through state fiscal year 2020. The FSSA report did not reflect savings to other areas of the Indiana budget.

6. I have reviewed Part II.C.1 of the memorandum filed on November 4, 2010, by the United States Department of Health and Human Services in support of its motion for summary judgment in this matter and Exhibit 33 thereto.

7. On pp. 39-41 of DHHS's summary judgment memorandum, DHHS claims that the PPACA will save the State of Indiana millions of dollars per year. This claim is based on Exhibit 33 to DHHS's motion for summary judgment, a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009, and titled *The Impact of Health Insurance Reform on State and Local Governments* (CEA Report).

8. There are several assumptions used in the DHHS's calculations that are not consistent with the actual experiences of the State of Indiana. Under PPACA, the State of Indiana would not be expected to save $338 million per year compared with current State indigent care programs (as described in the CEA report), but instead may incur an additional $50 million per year or more compared with current outlays for indigent care programs.

9. Page 34 of the CEA Report at Exhibit 33 presents an estimated annual increased Medicaid cost for Indiana of $62 million based on a Federal Medical Assistance Percentage (FMAP) of 90%. This calculation is based on adding to the State's Medicaid rolls 189,000 currently uninsured adults and parents at a cost of $2,974 per person per year, and 31,600 currently uninsured children at a cost of $1,898 per child per year. This equates to a total combined State and Federal outlay of $563 million for adults and parents and $60 million for children each year. My analysis shows that the CEA's estimated cost for parents and adults is too low at $2,974 per year. My estimate, based on Indiana-specific data of the actual age and gender of the uninsured population, with adjusted morbidity, would be approximately $3,600 per year, which is 21% greater than the CEA's $2,974 value. As a further comparison, the Kaiser Commission on Medicaid and the Uninsured report titled, "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL" utilized an average cost for Indiana for the period of 2014 to 2019 estimated to be $4,300 to $5,000. These values are estimates since full details were not published in the report.

10. Furthermore, the CEA's estimated annual increased Medicaid cost for Indiana in Exhibit 33 did not account for any parents or adults that are currently *insured* but who are likely to switch to the Medicaid program once that becomes available. My previously published estimate anticipates an additional 107,000 currently insured adults and parents will enroll in the Indiana Medicaid program, which is more than a 50% increase to the CEA's estimate of parents and adults likely to

join the Indiana Medicaid program. In addition to my previously published estimates, the Kaiser Commission report previously referenced 216,000 to 338,000 uninsured adults and parents will be enrolled in Medicaid by 2019. In addition to the previously uninsured enrollment, the Kaiser Commission report anticipates total adult and parent Medicaid enrollment to expand by 298,000 to 427,000 including both the uninsured and insured populations.

11. The CEA's estimates were based on earlier versions of health care reform legislation that would have expanded Medicaid eligibility to 133% of the Federal Poverty Level (FPL), which is not consistent with the final PPACA legislation. While PPACA specifies an income threshold of 133 percent of FPL for the Medicaid expansion, it also requires states to apply an "income disregard" of 5% of FPL in meeting the income test. Therefore, the effective income threshold is actually 138% of FPL. *See* Richard S. Foster, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," Centers for Medicare and Medicaid Services memorandum, April 22, 2010, at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (November 4, 2010).

12. Adjusting the CEA estimate for the higher cost per recipient noted in paragraph 9 above (a 21% increase), the likelihood that currently insured adults and parents will switch to Medicaid under the new PPACA standards noted in paragraph 10 (a 50% increase), and the expanded Medicaid population at the higher FPL noted in paragraph 11 (a 5% increase), the Adult/Parent Population would cost an estimated $1,072 million (State and Federal contribution combined) or $107 million State contribution at 90% FMAP. The $107 million State contribution would compare to the $56.3 million illustrated by the CEA.

13. The CEA calculations need further modifications. First, the illustration applied the 90% FMAP to the children population, which would not be appropriate. Rather, this population will receive the standard FMAP, which is approximately 66% for Indiana in FFY 2011. This 34% State contribution for children means that the State portion of the Medicaid increase will be $20 million, not $6 million as the CEA estimates on page 37, Table 2 of Exhibit 33. With this correction, the total estimate of the State's increased Medicaid exposure would be $127 million, as compared to the $62 million the CEA has estimated in Exhibit 33.

14. Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive provisions of major health and welfare programs authorized under the Act, thus allowing states to use federal Medicaid and CHIP funds in ways that are not otherwise allowed under federal rules. Indiana received such a waiver for the Healthy Indiana Plan. Because of the waiver, in addition to adjusting the FMAP on the children population, the State of Indiana may incur lower FMAP on a portion of the expansion population. Indiana may lose the enhanced FMAP of 90% on the first 34,000 lives, which corresponds to the number of childless adults that are allowed under Indiana's Section 1115 waiver for the Healthy Indiana

Plan. Although a final decision has not been provided by CMS, the loss in the enhanced FMAP would have a significant financial impact on the Medicaid Assistance budget. The 24% reduction in FMAP yields an additional $75 million cost for Indiana per year of Federal funds. This would be added to the $127 million value noted in paragraph 13.

15. The CEA's illustrations for Indiana in Exhibit 33 also does not include an estimate for administrative costs for enrollment, claims processing, and other administrative functions of serving an additional 300,000 lives. The administrative costs are generally matched at 50% Federal share/50% State share. We estimate that state share of these administrative costs would be $28 million per year.

16. After accounting for the modifications listed in paragraphs 12-15 above, Indiana's share of increased Medicaid costs under PPACA may be estimated at nearly $230 million per year, as compared to CEA illustrated amount of $62 million per year.

17. Another aspect that is unique to Indiana and other state Medicaid agencies relates to the disabled population eligibility requirements. The State of Indiana operates as a Section 209(b) state, which allows the State of Indiana to have different disability eligibility criteria. Since Indiana is a Section 209(b) state, it also provides eligibility under a spend-down provision requiring recipients to spend down their excess monthly income toward medical expenses before they are eligible for Medicaid. Due to this eligibility determination rule, there are approximately 22,000 individuals that are SSI disabled that do not qualify for the Medicaid disability eligibility in Indiana. Although CMS has not yet provided a final determination, Indiana may not receive the enhanced FMAP for these additional individuals under the new eligibility provisions of ACA. To the extent that the standard FMAP applies to the disabled population, the additional cost to the State of Indiana would be $90 million per year. It does not appear that the CEA estimate included an adjustment for this population. By combining the annual cost savings noted in this paragraph of $90 million with the total of $230 million in paragraph 16, the cost could be re-stated as $320 million.

18. Exhibit 33 also over-estimates cost savings that Indiana is likely to realize as a result of the Medicaid Expansion. For example, the CEA has illustrated a value of $154 million for the cost of the Healthy Indiana Plan. These funds may be diverted beginning in January 1, 2014, to assist in covering the cost of the Medicaid expansion. However, the State's actual commitment to the Healthy Indiana Plan is limited by the amount of the State's Cigarette Tax revenues that the General Assembly has allocated to HIP. The current annual revenue has been approximately $125 million per year, rather than the $154 million illustrated by the CEA.

19. Exhibit 33 also illustrates a savings of $126 million per year through the Hospital Uncompensated Care for the Indigent (HCIP) program. However, CEA

inadvertently illustrated the biennial budget amount for HCIP rather than the single year value. The actual annual savings for canceling HCIP in light of expanded Medicaid under PPACA would be $63 million per year.

20. The CEA report also *under*estimates cost savings the State may realize from cancelling its high-risk pool ICHIA program. The CEA estimates that the State currently spends about $15 million annually on that program, but annual outlays are closer to approximately $40 million per year.

21. By combining the annual savings figures noted in paragraphs 18, 19 and 20 ($125M + $63M + 40M), the savings would be re-stated at approximately $228 million per year from these three sources rather than the $296 million estimated by CEA on page 38, Table 3 of Exhibit 33.

22. The differences between our estimates for Indiana and CEA's estimates are illustrated in the following table:

	Milliman/Indiana	CEA, Exhibit 33 at Table 3
Medicaid Expansion	$(320)M	$(62)M
Healthy Indiana Plan	$125M	$155M
ICHIA	$40M	$15M
Tax Credit	$12M	$12M
HCIP	$63M	$126M
Hidden Tax	$30M	$30M
Net Impact	$(50)M	$275M

Note: Values have been rounded to millions.

23. There are further qualifications of these amounts. HCIP, for example, is not a stand-alone state program, but is instead part of Indiana's Medicaid Plan. Accordingly, Indiana will actually continue to incur the full cost of HCIP even as it assumes greater costs for expanded Medicaid coverage under PPACA. So, reducing that savings line item to zero, Indiana's Medicaid exposure will actually be near $113 million.

24. It is also important to observe that, while Medicaid expansion costs are in today's dollars which will inflate over time, the State's revenue stream currently dedicated for funding HIP and HCIP, the Indiana Cigarette Tax, will not. In fact, since Indiana's Cigarette Tax increased to 44 cents per pack and an additional federal cigarette tax has been implemented, Cigarette Tax revenue has decreased as more and more smokers quit smoking. That revenue stream is, thus, highly unlikely to keep pace with inflation, meaning that Indiana will have to find other revenue sources to pay its share of the expanded Medicaid program that is mandated by PPACA, not by its own program decisions.

25. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on this 18th day of November, 2010.

Robert M. Damler, FSA, MAAA, Principal and Consulting Actuary, Milliman, Inc.,
111 Monument Circle, Suite 601, Indianapolis, Indiana 46204

Exhibit 4

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

FURTHER DECLARATION OF ELIZABETH DUDEK

Pursuant to 28 U.S.C. § 1746, I, Elizabeth Dudek, declare the following:

1. My name is Elizabeth Dudek. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida Agency for Health Care Administration (AHCA) as the Interim Secretary.

2. I have served as Interim Secretary since September 2010.

3. As the Interim Secretary, I am the highest ranking official in AHCA and am responsible for all activities of the Agency including the operation of the Medicaid program.

4. The facts and statements in this further declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I previously provided a declaration in this matter describing the projected impacts of the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA) on the Florida Medicaid program. As I stated in that declaration, AHCA projects that PPACA will cost the Florida Medicaid program $142,460,765.00 in state general revenue in Florida's 2013-2014 fiscal year. This amount increases going forward, and by 2018-19 the projected costs to Florida are estimated to be just over a billion dollars per year, or $1,012,206,268.00, in general revenue.

6. I have since reviewed the Defendants' claim that PPACA will save the State of Florida $377 million per year, which appears to be based on a report by the

Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. The CEA report, however, does not appear to address the impact of the final version of PPACA on the state government of Florida. In fact, at the time the CEA Report was issued in September 2009, PPACA was not yet in its final form. Thus, it appears that the CEA Report only attempted to address possible impacts of PPACA, while guessing at what the national health care reform effort would look like when it was completed.

8. The Defendants appear to draw their $377 million savings figure from a column of a chart on page 26 of the Report (the exact figure in the column is $377.3 million). Two assumptions made with respect to this $377 million amount did not come to pass, however, in PPACA's final version. First, the $377 million figure assumes 100% federal financing of Medicaid expansion. CEA Report p. 26. PPACA itself only ultimately provides for 90% federal financing. The state governments, including Florida's, will supply the other 10%. The $377 million figure in the Report thus underestimates the costs to the state government of Florida from Medicaid expansion. Second, the CEA Report appears to assume that, if the national health care reform effort were to be successful, all uncompensated care would disappear. This also did not come to pass in PPACA's final form.

9. Using the CEA Report to forecast savings to the State of Florida also presents other issues. For example, the CEA Report analyzes possible savings to be realized by state *and local* governments taken together. All or virtually all of the $377 million in projected savings described in the report would accrue to local governmental entities such as Miami-Dade County, Hillsborough County, and Duval County. As AHCA Interim Secretary, I have no knowledge regarding any alleged or projected costs or savings to these local governments, and thus cannot testify as to whether the localities described will realize any net savings from PPACA.

10. The CEA Report, however, appears to project that all uncompensated care in Florida would disappear (which did not actually occur in PPACA's final form), and that local governments will save as a result. CEA Report at p. 24, 26. Uncompensated care is not likely to disappear as a result of PPACA. To the extent uncompensated care diminishes as a result of PPACA, local government savings from its disappearance generally will not result in any savings to the state government's budget. In fact, a reduction in uncompensated care may be at least partially the result of previously uninsured persons enrolling in Medicaid. In other words, any savings realized by local governments from a reduction in uncompensated care might actually increase costs for Florida Medicaid.

11. Finally, the CEA Report forecasts that additional savings ($117 million) "may come" from the Children's Health Insurance Program. CEA Report at pp. 24-25. My prior declaration included AHCA projections that incorporated the State of Florida's potential for savings related to CHIP (*see* ¶ 20), such that this figure does not discount the annual estimated cost to the State of Florida to which I previously attested (*see* ¶ 5, above).

12. As a result of the factors described above, AHCA stands by the projections contained in my previous declaration, and will not alter its projections based on the CEA Report.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 18, 2010, in Tallahassee, Florida.

Elizabeth Dudek
Interim Secretary
Agency for Health Care Administration

Exhibit 5

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.
_____/

DECLARATION OF J. ERIC PRIDGEON

Pursuant to 28 U.S.C. § 1746, I, J. Eric Pridgeon, declare the following:

1. My name is J. Eric Pridgeon. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Florida House of Representatives as the Budget Chief for Health Care Appropriations.

2. I have served as Budget Chief since 2008. I have 15 years of experience working on Medicaid budget and policy matters at the state level.

3. As the Budget Chief, I write the annual budget for the Florida Medicaid program. In addition, I serve as a principal for the Social Services Estimating Conference which projects enrollment and costs for the Medicaid program, and monitor Medicaid expenditures and analyze budget amendments throughout the fiscal year. Based on my employment, I am familiar with the Patient Protection and Affordable Care Act (PPACA) and the effects (actual and projected) of the PPACA on Florida's Medicaid program.

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Florida is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. Earlier declarations were provided in this matter by Elizabeth Dudek, Interim Secretary, State of Florida, Agency for Health Care Administration, and by Joanne Leznoff, Staff Director of the Appropriations Committee, State of Florida, House of Representatives. Those declarations attested to the impact of the

Medicaid program provided in the Patient Protection and Affordable Care Act (H.R. 3590) (PPACA).

6. I have since reviewed the Defendants' Memorandum in Support of their Motion for Summary Judgment and their claim that the PPACA will save Florida's state and local governments $377 million per year, which is based on a report by the Executive Office of the President, Council of Economic Advisors, dated September 15, 2009 (CEA Report).

7. Defendants cite several local government programs to arrive at this savings estimate.

8. To the extent that local governments seek to reduce some of the cited expenditures, they could only do so at a cost to the State of Florida.

9. Hillsborough County and Miami-Dade County both participate in funding the Medicaid program along with 20 other local governments that collectively provide over $584 million in intergovernmental transfers – funds that are used for the state Medicaid program.

10. The Hillsborough County and Miami-Dade County funding cited by the CEA Report are incorporated into the Medicaid program because these same sources (in whole or in part) are transferred to the State of Florida and used to draw federal Medicaid matching funds before being paid to hospitals within those counties in support of the local programs and providers described in the CEA Report.

11. Miami-Dade County and Hillsborough County contributed approximately $269 million of the intergovernmental transfers from local governments incorporated into the FY 2010-11 Medicaid budget.

12. Regardless of whether the specific local programs cited in the CEA Report remain intact following implementation of PPACA, the State of Florida is dependent upon the contribution of local tax dollars to underwrite core costs of the Medicaid program including funding of specific or "exempt" payment rates to select hospitals (e.g. teaching hospitals, children's hospitals, and rural hospitals) and funding for specialty services such as trauma care and pediatric services.

13. The specific payment rates are known as "exempt" rates because these rates are not bound by statutory ceilings established by the Legislature as a way to manage Medicaid hospital expenditures within appropriations.

14. Loss of the local funding, should such a loss result from implementation of PPACA, would cost the State of Florida the equivalent of any "savings" to local government because the availability of essential services funded by intergovernmental transfers would be at risk if payments were reduced to non-exempt rates and funding for specialty services was eliminated.

15. The CEA Report upon which Defendants rely also assumes the elimination of uncompensated care in Florida ($102 million "Hidden Tax" estimate (CEA Report at 24)), which is contrary to the PPACA's own estimate of providing less than universal coverage (PPACA § 1501(a)). The CEA Report also bases this estimate on costs borne by both state *and local* governments, such that it is not accurate to attribute the full $102 million savings estimate to the State of Florida alone. The CEA Report does not set forth all the assumptions used to arrive at this number.

16. Defendants cite John Holahan & Stan Dorn, Urban Institute, *What Is the Impact of the [PPACA] on the States?* (June 2010) at 2 for the proposition that state and local governments would save approximately $70-80 billion over the 2014-19 period by shifting state-funded coverage into federally-matched Medicaid. The Holahan and Dorn report does not set forth all the assumptions used to arrive at this number. The Congressional Research Service (CRS) reports that varying impacts are projected for different states, with one state anticipating some savings, but no offsets are noted. (Six states anticipate more than $38 billion in increased costs.) Memorandum, *Variations in Analyses of PPACA's Fiscal Impact on States* (September 8, 2010).

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 22, 2010, in Tallahassee, Florida.

J. Eric Pridgeon
Budget Chief, Health Care Appropriations Committee
Florida House of Representatives

Congressional Research Service

MEMORANDUM September 8, 2010

To: General Distribution Memorandum

From: Evelyne Baumrucker, Analyst in Health Care Financing, 7-8913
Bernadette Fernandez, Specialist in Health Care Financing, 7-0322

Subject: **Variation in Analyses of PPACA's Fiscal Impact on States**

This congressional distribution memorandum, prepared to enable distribution to more than one congressional client, summarizes existing analyses of the impact of the new federal health reform law, the Patient Protection and Affordable Care Act (PPACA), on state costs. The memorandum identifies select coverage provisions (specifically Medicaid and private health insurance) that relate directly to state costs, and discusses the challenges to producing state-level estimates. Such challenges include the pre-reform variation across states; uncertainty about future federal guidance and regulations relating to health reform implementation; state decisions regarding such implementation; data issues; and other factors outside of the health reform law and its implementation.

Introduction

The President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (P.L. 111-148) on March 23, 2010, which has since been amended by several laws. PPACA, as amended, makes many significant changes to the private and public markets for health insurance, and modifies aspects of the publicly financed health care delivery system. Among the major provisions, the law establishes an individual mandate for most U.S. residents to obtain health insurance, reforms the private health insurance market, establishes American Health Benefits Exchanges for individuals and small businesses to shop for private coverage; expands Medicaid eligibility; creates programs to improve quality of care; addresses healthcare workforce issues; and makes a number of other Medicaid and Medicare program and federal tax code changes. It also offers mechanisms to increase care coordination, encourage more use of preventive health, and improve the quality of care.

Enormous variation already exists across states in terms of health insurance coverage rates, generosity of coverage under state-administered public programs, generosity of state-financed programs to purchase private coverage, health insurance regulation, and other factors that affect state responsibilities and budgets. PPACA modifies many of those programs and insurance standards. Given the complexity of the health care system prior to PPACA, and the many changes generated by the new law, the impact on states will vary and will be difficult to estimate, even with the best modeling.

Another challenge in producing cost estimates of the impact of PPACA will be to disentangle such costs from the overall trend of increasing health care costs that would have occurred in its absence. In recent years, "the cost of health coverage continued its steady climb, while employer-sponsored coverage fell.

While the full impact of the recession on employer-sponsored coverage (and overall rates of uninsurance) remains to be seen, state revenues declined just when demand for services rose."[1] Given such trends, it would be useful to identify the costs that states would face in the absence of comprehensive reform in order to understand the cost differences associated with PPACA. One study attempted to do such an analysis, modeling best, intermediate, and worst case scenarios over a 10-year span. Even in the best case, the researchers estimated that without reform, about ¼ of states would see Medicaid/CHIP cost growth of more than 65 percent over the 10 year period, and that employer spending on health insurance premiums would increase in all states.[2]

In response to congressional interest resulting from PPACA, we developed this memorandum to address issues related to potential costs to states. The focus of this memorandum is on health insurance coverage provisions of PPACA, specifically major provisions that permanently change existing state programs and requirements, such as Medicaid and private health insurance regulations. For ease of analysis we address Medicaid and private health insurance separately, but implementation of PPACA necessitates interaction between private and public provisions. Likewise, any thorough estimate of costs should consider these provisions in the context of the current health insurance system and its multiple moving parts.

Given that CRS does not produce cost estimates, we have no plan to produce fiscal impact statements for any state. However, individual states, CBO, and other organizations have generated national and, in some cases, state-level cost estimates based on PPACA coverage provisions (or some portion thereof).[3] In general the cost estimates that we identified focused on the Medicaid program, presumably because it generally represents a substantial portion of state health care budgets, and is an existing program for which current and historical data exists. To the extent that these state studies discussed private health insurance provisions, the discussion focused on mainly descriptive analyses of state responsibilities under PPACA.

It is not our intent to evaluate the validity of the assumptions or the analytic rigor of the methodological approaches used to generate these estimates. Instead, we present the general findings as well as selected assumptions and limitations as reported in the studies that will help the reader put the results into context and better understand the complexity involved in generating estimates of the law's impacts.

In some cases it is unclear whether the cost analyses only consider changes to existing programs and regulations, and do not account for new funding opportunities which may help states with implementation costs.[4] In addition, analyses might not account for the interaction among provisions that could significantly affect costs. According to the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary, "the actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are uncertain. The legislation would result in numerous changes in the

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[1] "State of the States: The State We're In," Robert Wood Johnson Foundation, Jan. 2010, p. 5, available online at http://www.statecoverage.org/files/State%20of%20the%20States%202010.pdf.

[2] J. Holohan, L. Doan, and I. Headen, "The Cost of Failure to Enact Health Reform: Implications for States," Urban Institute, Oct. 1, 2009, available online at http://www.urban.org/publications/411965.html.

[3] We use the phrase "coverage provisions" to refer to the provisions in PPACA that would affect existing public programs (e.g., Medicaid) or establish new coverage options (e.g., exchanges). Generally, these provisions are in Titles I and II of PPACA.

[4] Examples of such state funding opportunities include grants for planning and implementing exchanges, and grants to establish (or expand) health insurance consumer assistance programs. See "Patient Protection and Affordable Care Act (P.L. 111-148): Potential Funding Opportunities for States," National Association of Insurance Commissioners, April 7, 2010, available online at http://www.naic.org/documents/index_health_reform_general_nga_funding_chart.pdf.

way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation."[5]

What follows is a summary of selected state-level cost analyses (available as of August 31, 2010) that were prepared by a variety of organizations to assess the impact of PPACA on the state's budget. These organizations include: (1) state agencies that administer Medicaid and/or the State Children's Health Insurance Program (CHIP); (2) state legislative support agencies, (3) independent consultants retained by the state to provide a financial review of the impacts of PPACA on the state's budget, and (4) organizations (e.g., independent Boards established by the state legislature) whose role is to provide input into policy and planning for the state. **Table 1** (see Appendix) summarizes state-specific analyses of PPACA's impact on enrollment in public programs, the uninsured, and costs.

State-specific cost estimates vary. This variation is a function of the fact that each state analysis employs different methods and assumptions, and considers different sets of variables in producing coverage and cost estimates. For example, the Texas study (April 2010) provides cost estimates associated with the Medicaid and CHIP provisions for the time period between state fiscal year (SFY) 2014 through SFY2023. In addition to the fact that cost estimate is reported in terms of the state's fiscal year (as compared to federal fiscal year), it represents a timeframe that includes 4 additional years beyond the budget horizon that CBO, for example, takes into account in its cost estimate (through FY2019).[6] In another example, the Kansas study (May 2010) reports that its cost estimates are expressed in constant dollars using 2011 as a base, but other states do not specify how their estimate is expressed. Finally, because many non-citizens are not eligible for either Medicaid or CHIP, and unlawfully present individuals are ineligible for subsidies to purchase coverage through state exchanges, imputations to account for immigration status must also be applied. In the Kaiser report (May 2010) the methodology section describes how the researchers attempted to account for legal immigrant status in their model. However, it is not clear whether or to what extent other state specific cost estimates have attempted to capture this component. Because these state-specific analyses vary considerably in terms of what they have tried to take into consideration, it is not useful or advisable to compare their results against one another. Nonetheless, the state-specific analyses do provide value in understanding the law's provisions that states are currently focusing on the impacts on their state budgets.

Table 2 (see Appendix) summarizes studies whose state cost estimates provided a break out of the Medicaid/CHIP effects of PPACA's coverage provisions (e.g., increases in enrollment due to the individual mandate, the mandatory expansions of the Medicaid program, and the requirement for Medicaid and CHIP to coordinate with exchange coverage). It is important to note that while these studies have attempted to answer the same basic question, variation in the findings exists. To further underscore this point, the Kaiser study (May 2010)[7] shows that results fluctuate considerably when different

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[5] Foster, R. S., "Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended," Centers for Medicare and Medicaid Services, Baltimore, MD, April 22, 2010, available at http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf.

[6] CBO's estimate covers the FY2010-FY2019 time frame to be consistent with the budget horizon used under S. Con. Res. 13, the Concurrent Resolution on the Budget for Fiscal Year 2010. Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010.

[7] John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010, available at http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.

participation rates are assumed. In an attempt to capture a range of potential impacts, Kaiser modeled the PPACA's impacts on Medicaid and CHIP enrollment and spending based on two levels of program participation (i.e., 57% participation rate as compared to a 75% participation rate). **Table 2** shows the variation that results when these different participation rates are applied.

Major PPACA Provisions with Potential State Cost Implications

For ease of analysis we address Medicaid and private health insurance provisions separately here, but implementation of PPACA necessitates interaction between private and public provisions. Likewise, cost estimates should account for such interactions within the context of the broader health insurance system.

Medicaid and CHIP

PPACA makes significant changes to the Medicaid[8] and CHIP[9] programs.[10] Although not an exhaustive list, some of the major changes that could potentially increase state costs include:

- State requirement to expand Medicaid to nonelderly, nonpregnant adults with income up to 133% of the federal poverty level (FPL).[11] From 2014 to 2016, the federal government will cover 100% of the Medicaid costs of "newly eligible"[12] individuals, with the percentage dropping to 90% by 2020. States cover the percentage not paid by the federal government.
- State requirement to maintain existing Medicaid and CHIP eligibility levels (MOE) for adults until exchanges are fully operational (presumably CY 2014) and for children through 2019 as a condition of receiving federal matching funds for Medicaid expenditures.
- State requirement to improve outreach, streamline enrollment, and coordinate with CHIP and the proposed exchanges that may result in increases in applications and enrollment

[8] Medicaid is a federal and state matching program that finances the delivery of health care services for certain populations with limited incomes. Each state that chooses to participate designs and administers its own version of Medicaid under broad federal rules. Individuals who meet state eligibility requirements are entitled to services covered under the state plan. To qualify, an individual must meet both categorical (i.e., must be a member of a covered group such as children, pregnant women, families with dependent children, the elderly, or the disabled), and financial eligibility requirements.

[9] CHIP, also a federal and state matching program, provides health care coverage to certain low-income, uninsured children in families with income above Medicaid income standards. States may also extend CHIP coverage to pregnant women when certain conditions are met. In designing their CHIP programs, states may choose to expand Medicaid, create a stand-alone program, or use a combined approach.

[10] For more information on PPACA's changes to Medicaid and CHIP see CRS report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP): Summary and Timeline,* Coordinated by Julie Stone, August 19, 2010.

[11] For individuals whose income will be determined using new income counting rules, the law also specifies that an income disregard in the amount of 5% FPL be deducted from an individual's income when determining Medicaid eligibility. This income counting rule effectively raises the upper income eligibility threshold for the new Medicaid eligibility group to 138% FPL.

[12] "Newly eligible" individuals are defined as nonelderly, nonpregnant individuals with family income below 133% FPL who (1) are not under the age of 19 (or such higher age as the state may have elected), and (2) are not eligible under the state plan (or a waiver) for full Medicaid state plan benefits or for Medicaid benchmark or benchmark-equivalent coverage, or are eligible but not enrolled (or are on a waiting list) in such coverage as of December 1, 2009.

among those who were previously eligible but not yet enrolled, as well as increases in administrative costs in the short run.

- Federal requirement to apply reductions in Medicaid disproportionate share hospital (DSH) allotments. While the health reform law is designed to reduce the number of low-income and patients whose care would otherwise be funded in part by DSH payments to hospitals who treat such individuals, with the law's requirement to apply aggregate reductions in DSH payments going forward it remains to be seen if the states will have to finance care that was previously paid in part through federal DSH allotments.
- Federal requirement to increase the amount of Medicaid drug rebates going to the federal government. Medicaid law requires prescription drug manufacturers who wish to sell their products to Medicaid agencies to enter into rebate agreements with the Secretary on behalf of states. Beginning January 1, 2010, with certain exceptions, PPACA increases the flat rebate percentage used to calculate Medicaid's basic rebate by an amount that varies by drug class. PPACA also requires the Secretary to recover the additional funds states received from drug manufacturers from increases in the basic Medicaid rebates (some of which were previously retained by states).

However, there are also a number of changes to Medicaid and CHIP that may offset some of the increased state costs. Some examples include:

- States that currently finance care for childless adults with state-only dollars will now have access to federal matching funds for those individuals under Medicaid.
- With the expiration of the adult coverage MOE requirement in 2014, states may opt to cut back on some of their prior law income eligibility levels for certain groups with annual income greater than 133% FPL, and move them into state exchange coverage where they would be eligible for federal subsidies to share in the cost of their care.
- CHIP allotments were extended through FY2015. This extension guarantees states access to the program's enhanced federal matching rate for two years beyond the prior expiration date of FY2013.
- The law requires states to set Medicaid payments for primary care services relative to Medicare payment rates, and fully finances the payment rate increase for a temporary period (i.e., 2013 and 2014). After this two year period, it is unclear whether states will continue to pay primary care physicians at the higher rate.
- The law also provides additional options for states to expand home and community-based services as an alternative to institutional care and provides states with increased matching rates for certain long-term care services.

Private Health Insurance

PPACA makes significant changes to private health insurance and therefore directly affects multiple stakeholders. States are impacted by the private market provisions through the various roles they play: as sponsors of health benefits to state employees, dependents, and retirees; as administrators of coverage; and financial assistance programs, and as the primary regulators of the insurance industry. Among the major private market provisions in PPACA that permanently affect these state roles are the new federal insurance standards, establishment of health insurance exchanges, and monitoring and enforcement activities related to the regulation of the health insurance industry.

- The federal market reforms that *may* impact private coverage offered to state employees include the prohibition on certain annual and lifetime dollar limits, coverage of preventive health services with no cost-sharing requirements, extension of dependent coverage, use of uniform coverage documents, prohibition of salary-based discrimination, quality of care provisions, reporting of medical loss ratios and rebates, grievance and appeals processes, standards for electronic billing and other administrative transactions, patient protections, and prohibition on excessive waiting periods.[13] Such requirements may add to the cost of coverage in the private market, which, in turn, may affect states' costs related to offering such health benefits.
- PPACA requires the states to establish exchanges (with federal fallback) to facilitate the purchase of private insurance by individuals, families, and small businesses. PPACA provides appropriations (no specified amount), prior to 2015, for state grants to establish and run exchanges. The general assumption is that states will have to provide ongoing funding for exchanges through assessments on insurers or other means, except in those states that fail to establish their own exchange, in which case the HHS Secretary is required to establish it.[14]
- While PPACA does not include specific enforcement provisions, the addition of the federal market reforms discussed above expands the scope of existing state enforcement responsibilities, which may have implications for state costs. In addition, PPACA establishes a federal standard in a regulatory area that has been solely under the jurisdiction of states: review of health insurance rates submitted by insurance carriers. While PPACA requires an insurer to justify "unreasonable" premium increases to both HHS and the relevant state, it is the state's responsibility to review the materials and provide information to the Secretary based on the rate review. PPACA appropriates $250 million in grants to states to support this effort, however total state costs are not known, in part because HHS guidance on the rate review process is still forthcoming and states vary in their existing authority and resources to conduct rate reviews.

However, despite these potential sources of increased state costs, interactions of various provisions may lead to cost offsets in other areas. Examples include:

- The Texas Health and Human Services Commission noted in its presentation to the Texas House Select Committee on Federal Legislation that a potential cost offset resulting from health reform may be increased premium revenue.[15] Estimates of the impact of PPACA on health insurance coverage generally finds substantial growth in private coverage, including through exchanges. Given that states currently generate revenue through

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[13] This list of reforms was generated based on these assumptions: state employee health benefit plans include fully and self-insured plans, and would be provided to large groups only. The list excluded reforms that largely duplicate existing requirements in the group market (e.g., non-discrimination based on health factors), are not permanent (e.g., temporary high-risk health insurance pool), or likely would not have a direct impact on state employee health benefits plans (e.g., guaranteed issue).

[14] On July 29, 2010, HHS issued a Funding Opportunity Announcement (FOA) that announced the availability for the first round of funding for these state grants. Each state and D.C. could apply for up to $1 million in grant money during this first round. The filing date for applications was September 1, 2010. For additional information, see "State Planning and Establishment Grants," at http://www.hhs.gov/ociio/initiative/index.html.

[15] "Federal Health Care Reform – Impact to Texas Health and Human Services," Texas Health and Human Services Commission, April 22, 2010.

premium taxation, growth in private coverage is assumed to lead to increased revenue to states.

- California's Legislative Analyst's Office noted that once the full implementation date of PPACA is reached, the state could likely terminate an existing state-financed health insurance program because other programs under health reform would be established by then.[16]

Analysis

While Medicaid and CHIP differ from private health insurance, both public programs and private coverage share similar challenges with respect to producing state-level cost estimates. Such challenges include pre-reform variation across states; uncertainty about future federal guidance and regulations relating to health reform implementation; state preferences regarding implementation; data issues; and factors outside of health reform. The following discussion describes these challenges in more detail and provides examples from Medicaid and CHIP, as well as private health insurance.

Pre-Reform Variation across States

State impacts will vary based on current coverage levels across states, generosity of the state's Medicaid/CHIP eligibility rules and other state-financed coverage programs, existing private insurance regulatory authority, standards, and resources, current state fiscal health, and other factors. Such variation creates difficulties in accurately estimating costs across states.

- There are substantial differences among states in terms of the percentages of the states' populations that would meet the definition of "newly eligible" under the mandatory Medicaid expansion as compared to previously eligible individuals. Federal matching rates to share in the cost of Medicaid/CHIP coverage for these individuals under health reform will vary by state, by year, and by eligibility status. Although from 2014-2016, the federal government will cover 100% of the Medicaid costs of "newly eligible" individuals.
- It could be argued that PPACA will require limited changes to the benefits of state and local government employee health plans, as current employment-based health plans are grandfathered. Grandfathered plans are exempt from all but a handful of reforms under PPACA. That said, it is difficult to assess the impact of the changes that are required, as some requirements may already be in place. For example, one new requirement under PPACA is that children up to age 26 (and until 2014, who are not offered coverage through their own employer) can remain/enroll on their parent's plan. Some plans may not necessarily see a difference because some states already impose requirements beyond age 26, and may continue to do so. For states that do not have a dependent coverage requirement already in place, insurers may see this as adding to the cost of coverage and *may* pass such costs along to consumers and employers (e.g., states as employers providing health benefits to state employees).

[16] "The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs," Legislative Analyst's Office, May 13, 2010.

Federal Guidance to Shape Implementation

State-by-state impacts of PPACA's program and regulatory changes will depend, in part, on future federal guidance and interaction with states in implementing the new law.

- Medicaid program participation rates are among the many moving parts that are relevant in assessing the impacts of PPACA. While PPACA includes provisions to encourage states to improve outreach, streamline enrollment, and coordinate with exchanges, states face mixed fiscal priorities that may inhibit their ability and/or willingness to maximize program enrollment. As a result, federal guidance laying out the minimum requirements in these areas will ultimately affect state costs.
- There is a great deal of uncertainty regarding state costs associated with establishing and running exchanges, in part because HHS has not issued guidance regarding the form and structure of exchanges. Moreover, PPACA appropriated an unspecified amount for the purpose of providing grants to the states for planning and establishment of the exchanges.[17] The grants can be renewed if states comply with specific requirements, but no grant may be awarded after January 1, 2015 when exchanges must be self-sustaining. This lack of specificity regarding the amount of federal funding is another source of uncertainty regarding potential state costs.

State Preferences Regarding Implementation

PPACA provides states with some flexibility regarding implementation of many of the law's coverage provisions. Given that states are still formulating their approach to implementation, this creates uncertainty in the scope of future state activities and associated costs.

- PPACA gives states some flexibility regarding implementation and operation of exchanges. A state may opt to have HHS establish its exchange. States also have the option to establish separate exchanges for individuals and small businesses, or establish just one exchange for both. Individual states also may decide to allow large businesses in the exchange. These decisions, individually and collectively, may impact state spending on exchanges.
- The PPACA insurance reforms do *not* uniformly apply to all employer-provided coverage. The type of plan matters with respect to which market reforms it must comply with. For example, a self-insured plan does not have to comply with the medical loss ratio provisions, but a fully-insured plan does.[18] Thus, the decision states make in

[17] See footnote 14.

[18] Organizations that self-insure (or self-fund) do not purchase health insurance from an insurance carrier. Self-insurance refers to coverage that is provided by the organization seeking coverage for its members (e.g., an employer offering health benefits to his employees). Such organizations set aside funds and pay for health benefits directly. (Enrollees may still be charged a premium.) Under self-insurance, the organization itself bears the risk for covering medical expenses. Firms that self-fund health benefits typically contract with third-party administrators to handle administrative duties such as enrollment, premium collection, customer service, and utilization review. With fully insured plans, the insurance carrier charges the plan sponsor (e.g., employer) a fee for providing coverage for the benefits specified in the insurance contract. The fee typically is in the form of a monthly premium. (In turn, the sponsor may decide that each person or family who wishes to enroll must pay part of the premium cost.) Under the fully insured scenario, the insurance carrier bears the insurance risk; that is, the carrier is responsible for covering the applicable costs associated with covered benefits.

funding employee health benefits plans has implications for what insurance reforms such plans are subject to. As mentioned previously, insurers may see these additional requirements as adding to the cost of coverage and *may* pass such costs along to consumers and employers in the form of higher premiums (or higher cost-sharing or reduced benefits).

Data Issues

Data issues range from limitations of existing data sources to a lack of data.

- Some state specific cost estimates use national surveys such as the Current Population Survey (CPS), the American Community Survey (ACS) or the National Health Interview Survey (NHIS) to simulate eligibility for Medicaid, CHIP, or exchange subsidies. However, these national surveys have their own limitations many of which have been well documented and acknowledged by the Census Bureau and other research organizations.[19] For example, the CPS and NHIS have historically undercounted Medicaid enrollees and are less reliable for small states.[20] With much larger sample sizes than that of the CPS or NHIS, the ACS does a better job of reducing error associated with small sample size. However, regardless of the survey used, discrepancies exist between survey estimates of enrollment in Medicaid and the number of enrollees reported in state and national administrative data.
- Given that so many aspects of exchanges are as of yet not known, costs cannot be attributed to the various components with a sufficient degree of confidence. In addition, the exchanges, as specified in the statute, are new entities. While a few states have created similar entities, none have the federal-state design of those established under PPACA. Therefore, there is no dataset from an existing program that could be used to accurately model the initial experience of the exchanges. This contrasts with, for example, the Medicaid program, which has existed for many years and has past administrative data that provides a baseline for state costs.

Factors Outside of Health Reform

Given that health insurance coverage in the U.S. traditionally has been linked with employment, changes in the labor market generally lead to changes in coverage rates. Typically, when the general economy is in decline and unemployment rises, individuals and families lose access to their primary source of insurance. Data on coverage trends typically find that when employment-based coverage decreases, enrollment in

[19] For links to the results of research projects conducted by the University of Minnesota's State Health Access Data Assistance Center (SHADAC), the National Center for Health Statistics (NCHS), the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare and Medicaid Services (CMS), and the U.S. Census Bureau to explain why discrepancies exist between survey estimates of enrollment in Medicaid and the number of enrollees reported in state and national administrative data, see http://www.census.gov/did/www/snacc/

[20] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2008," Current Population Reports P60-236(RV), Washington, DC, 2009, at [http://www.census.gov/prod/2009pubs/p60-236.pdf], p. 20, and p. 57.

Medicaid increases.[21] The public-private mix of enrollment will affect state spending related to both types of coverage.

CRS contacts:

Medicaid: Evelyne Baumrucker (7-8913), April Grady (7-9578)

Private Health Insurance: Bernadette Fernandez (7-0322), Mark Newsom (7-1686), Hinda Chaikind (7-7569).

[21] "Losing a job often means that people lose health insurance. Many individuals, especially children will become eligible for Medicaid...We estimate that if unemployment rises from an average of 4.6 percent in 2007 to 7 percent in 2009, the number of people with employer sponsored insurance (ESI) would decline by 5.9 million, Medicaid and SCHIP enrollment would increase by 2.4 million and there would be an additional 2.6 million uninsured." John Holahan and A. Bowen Garrett, "Rising Unemployment, Medicaid, and the Uninsured," Jan. 2009, p. i.

Appendix

Table 1. State-Specific Analyses of PPACA's Impact on State Costs

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
California	"The Patient Protection and Affordable Care Act: An Overview of Its Potential Impact on State Health Programs" Provides an estimate of the impact of PPACA on Medicaid enrollment and state spending on Medicaid. Cost estimate attributed to increase in Medicaid enrollment, accounting for eligible but not enrolled and expansion populations (eligibility up to 133 percent FPL and former foster children), and increased primary care provider payments. Prepared by the Health Section of the Legislative Analyst's Office, a state governmental office providing fiscal and policy information to the California Legislature. http://www.lao.ca.gov/reports/2010/hlth/fed_healthcare/fed_healthcare_051310.pdf	2,000 (no timeframe provided)	N/A	"low billions of dollars" (annual)
Florida	"Overview of National Health Reform Legislation" Provides an estimate of the impact of PPACA on enrollment in the state's Medicaid and CHIP programs and the increase in Medicaid primary care provider payments. Does not include impacts associated with increases in administration costs, changes to the federal pharmacy rebate or changes to state disproportional share hospital payment allowances. Takes into account potential shift of individuals with annual income <133% FPL who are currently enrolled under private health plans to shift to the Medicaid program. Assumes CHIP children with annual income <133% FPL will shift to Medicaid program. Assumes SFY 2012-2013 Medicaid expenditures program expenditures and caseloads for non- expansion populations and uses Census data increase by 1.6% through 2014 for expansion population. Prepared by The Agency For Health Care Administration, the chief health policy and planning entity for the state.	1,772 (by 2019)	N/A	$1,203 (by 2019)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
	http://ahca.myflorida.com/Medicaid/Estimated_Projections/docs/National_Health_Care_Reform_040110.pdf			
Indiana	"Patient Protection and Affordable Care Act with House Reconciliation – Financial Analysis" Provides a financial review of PPACA as it relates to the provisions impacting the state's Medicaid program and budget. The study considered the following components when generating their assessment of the impacts of health reform on the state budget: the Medicaid Expansion to 133% FPL, the impact of the reduced federal medical assistance percentage (FMAP) rate for their Healthy Indiana Plan eligibles, spend down and their SSI eligible population, the state's projected pharmacy rebate loss, the impact of the physician fee schedule increase, the mandatory expansion to foster care children, administrative costs, the enhanced match rate under the CHIP program, the state's current thoughts on the treatment of their Breast and Cervical Cancer program and pregnant women coverage for individuals with annual income greater than 133% FPL at full implementation. Prepared by Milliman, Inc., a consulting service retained by the State of Indiana, Family and Social Services Administration to provide consulting services related to the financial review of PPACA. http://www.in.gov/fssa/files/Milliman_financial_analysis_May2010.pdf	1,554 (SFYs 2011 through 2020)	N/A	$3,579 (SFYs 2011 through 2020)
Kansas	"Preliminary Estimates of the Impact of Federal Health Reform on State Spending in Kansas" Provides preliminary estimates of the impact of PPACA on state spending in Kansas. Estimates represent the most likely outcome of PPACA reforms. Assumes state takes no additional actions to expand coverage or reduce spending, and increased costs in program administration. Cost estimate is for spending on medical care only in the Medicaid program. Excludes administrative costs and changes in DSH spending. Estimates are expressed in constant dollars using 2011 as a base. Prepared by the Kansas Health Policy Authority, an independent Board comprised of members selected by the Governor and the leadership of the state legislature to provide governance and thoughtful policy direction for the state's health care-related agenda. http://www.khpa.ks.gov/ppaca/download/Impact%20of%20Federal%20Health%20Reform%20on%20Kansas%20-%20allison%20presentation.pdf	131 (by 2020)	191 (by 2020)	$621 (by 2020)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
Kansas	"Kansas: Impact of Federal Health Reform" Provides presentation of preliminary estimates of PPACA's impact on coverage and state costs based on 4 scenarios. Four scenarios modeled using two different counts of remaining uninsured (98,000 and 143,000) and two different provider reimbursement rate increases (0% increase and 5% increase). Medicaid enrollment includes both Medicaid and CHIP, according to just one of the scenarios modeled. Study did not attribute the cost estimate to any particular program or coverage initiative. It is unclear what this state costs estimate represents. Prepared by Schramm-Raleigh Health Strategy for the Kansas Health Policy Authority, the state's main health policy agency. http://media.khi.org/news/documents/2010/05/18/5-18-10_SRHealth_Presentation.pdf	120 ("post-reform")	191-237 ("post-reform")	$2-36.3 ("post-reform")
Maryland	"Interim Report" Provides estimates of PPACA's impact on the uninsured rate and costs associated with changes to both public and private coverage. Savings estimate is the net result of cost increases due to Medicaid expansion, increased spending for state employee/retiree health benefits, and administrative costs (e.g., establishing exchange), and revenue growth/savings from increased federal support of state's CHIP program, new hospital assessments, increased premium taxation revenue, and reduction in state funding for safety net programs. Prepared by the state's Health Care Reform Coordinating Council for submission to the Governor. http://www.healthreform.maryland.gov/documents/100726interimreport.pdf	N/A	Decrease of 7.3 percentage points (by 2017)	Savings of $829 (FY 2011-2020)
Michigan	"Fiscal Analysis of the Federal Health Reform Legislation" Examines the fiscal impacts of PPACA on state and local government in Michigan. Assumes a Medicaid federal matching rate of 66.7%. Discusses the cost to the state to continue the Medicaid primary care physician payment rates at the Medicare levels beyond the two years during which the federal government will fully fund this payment rate increase, but not clear if these amounts are included in the state's expenditure estimate. Provides impacts on the CHIP program beyond the	375 (by 2019)	N/A	$200 (by 2019)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)
	PPACA funding (i.e., through FY2015) appropriation, but it is unclear if these amounts are included in the state's expenditure estimates. Acknowledges impacts of Medicaid drug rebate provisions, but does not provide a state specific cost estimate of the impacts. Acknowledges the potential impacts of the various long-term care related provisions and provisions directed at increasing care coordination, encouraging more use of health prevention, and improving the quality of care. However, the state did not report a dollar figures associated with these potential costs. Acknowledges impacts of Medicaid DSH reduction provisions, but does not provide a state specific cost estimate of the impacts. Prepared by the Senate Fiscal Agency whose role is to provide technical, analytical, and preparatory support to the state's Senate Appropriation Committee and other members of the Senate. http://www.senate.michigan.gov/sfa/Publications/Issues/HealthReform/FedHealthReformLegislation.pdf			
North Dakota	Provides preliminary estimates of the overall cost of implementing health reform. The cost estimates are based on the following assumptions: current enrollees in private market will remain in grandfathered plans (based on Blue Cross/Blue Shield enrollment that represents 80+% of the market) throughout the study period (2010-2019), and all covered public-sector employees will remain in grandfathered plans through that period. The cost estimate does not include possible offsets from grants or subsidies. The analysis states that "estimates should be used with caution, as amounts will change when additional guidance and policy decisions are made at the federal level." Prepared for North Dakota's Industry, Business, and Labor Committee. http://www.legis.nd.gov/assembly/61-2009/interim-info/minutes/ib080310minutes.pdf	N/A	N/A	$1,114 (2010-2019)
Texas	"Federal Health Care Reform – Impact to Texas Health and Human Services" Discusses PPACA requirements, describes model, and provides estimates of PPACA's impact on enrollment in and state spending on Medicaid. The enrollment estimate includes the eligible but not enrolled and Medicaid expansion populations. The cost estimate includes costs associated with the eligible but not enrolled and Medicaid expansion populations, and full rate increases for primary care providers. The provider rate increase is assumed to apply to both Medicaid and CHIP. Prepared by the Texas Health and Human Services Commission for the House Select Committee on Federal Legislation.	2,345 (by 2023)	N/A	$27,000 (SFY 2014-2023)

State	Description	Estimates of Increase in Medicaid Enrollment in thousands (timeframe)	Estimates of Reduction in the Number of Uninsured in the State (time frame)	Estimates of State Costs/Savings in millions (time frame)

http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf

Source: CRS analysis of existing state-level cost analyses prepared by a variety of organizations including: (1) state the Agencies that administer Medicaid and/or the State Children's Health Insurance Program (CHIP), (2) state legislature support agencies, (3) independent consultants retained by the state to provide a financial review of the impacts of PPACA on the state's budget, and (4) organizations (e.g., independent Boards established by the state legislature) whose role is to provide input into policy and planning for the state.

Table 2. Summary of Published Estimates of the Impact of PPACA's Coverage Provisions on Medicaid and CHIP

Study (publication date)	Summary of Analysis	Estimates of Increase in Medicaid Enrollment in millions (time frame)	Expenditure Estimates in billions (time frame)		Selected Assumptions
			Overall State Spending	Federal Spending	
CBO Cost Estimate (March 2010)[a]	National estimate of effects of all of the insurance coverage provisions in health reform on Medicaid/CHIP	16 million (by CY2019)	$20 billion[b] (FY2010-2019)	$434 billion (FY2010-2019)	Detailed assumptions not provided in cost estimate.
Kaiser Commission on Medicaid and the Uninsured (May 2010)[c]	State-by-state[c] estimates of impact of coverage provisions on Medicaid/CHIP for adults relative to enrollment and spending on such adults in absence of health reform for the period between 2014 and 2019.	15.9 (CY2014-CY2019)	$21.1 (CY2014-2019)	$443.5 (CY2014-2019)	Assumes moderate (57%) participation levels among uninsured in the new eligibility group and lower participation among other coverage groups.
		22.8 (CY2014-CY2019)	$43 (CY2014-2019)	$532 (CY2014-2019)	Assumes robust (75%) participation levels among uninsured in the new eligibility group, and lower participation among other coverage groups.

Source: CRS analysis of various national estimates of the impacts of PPACA's coverage provisions on Medicaid and CHIP enrollment and spending.

Notes:

a. Congressional Budget Office, letter to Honorable Nancy Pelosi, March 20, 2010.

b. The Congressional Budget Office does not prepare state-by-state estimates.

c. John Holahan and Irene Headen, Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or below 133% FPL, Kaiser Commission on Medicaid and the Uninsured, May 2010.

d. The Kaiser report shows results for three general groupings (i.e., states with low prior law Medicaid eligibility rates for adults, states that have broader prior law coverage for parents, but no coverage for childless adults, and states that cover both parents and childless adults under prior law). See the report for trends by state groupings as well as state-by-state results.

Exhibit 6

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
Pensacola Division

STATE OF FLORIDA, by and through Bill McCollum, et al.,

Plaintiffs,

v. **Case No.: 3:10-cv-91-RV/EMT**

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al.,

Defendants.

DECLARATION OF BRUCE R. RAMGE

Pursuant to 28 U.S.C. § 1746, I, Bruce R. Ramge, declare the following:

1. My name is Bruce R. Ramge. I am over the age of eighteen, of sound mind, and otherwise fully competent to testify to the matters described in this declaration. I am employed by the Nebraska Department of Insurance (NDOI) as the Director.

2. I have served as Director of Insurance since November 15, 2010. Previously, I was Acting Director from October 30, 2010 through November 14, 2010. Prior to October 30, 2010, I served in the capacity of Deputy Director and Chief of Market Regulation.

3. As the Director of Insurance, I am the highest ranking official at the NDOI and oversee all activities of the Agency including the regulatory oversight of the Comprehensive Health Insurance Pool (CHIP).

4. I am making this declaration in connection with *State of Florida, et al. v. United States Department of Health and Human Services, et al.*, a lawsuit to which the State of Nebraska is a party. The facts and statements in this declaration are true, correct, and within my personal knowledge as of the date of this declaration.

5. I reviewed the Defendants' claim that the PPACA will save the State of Nebraska approximately $27 million per year beginning in 2014 when the CHIP program ends with the individuals insured obtaining insurance through a proposed exchange. This is based on a report by the Executive Office of the

President, Council of Economic Advisors, dated September 15, 2009 (CEA Report, page 67).

6. The State of Nebraska does not subsidize premiums for the CHIP program. Under Nebraska law, the state is required to subsidize claims exceeding the amount collected in premiums from the CHIP members. In 2008, this amount was $27,375,209. In 2009, this amount was $24,051,163.

7. The provisions of PPACA currently anticipate the transfer of CHIP participants to Medicaid or health insurance products offered through a proposed exchange beginning January 1, 2014. A number of factors prevent me from predicting, at this time, the precise impact the transfer of CHIP participants to Medicaid will have on the State of Nebraska in 2014, including: claims in process, incurred but not reported claims, and the remaining administrative and wrap up costs. However, said transfer is not anticipated to be a cost savings for the State of Nebraska due to the additional burden of enrolling such individuals in the Medicaid system.

8. With the influx of CHIP policyholders who may purchase insurance through an exchange, the health insurance premium charged to all persons obtaining coverage through the exchange will necessarily increase to cover high claim individuals. Essentially, the experience of the high claim individuals will be reflected in the price of the premium for individual insurance coverage offered in Nebraska generally resulting in higher premium costs for all participating in an exchange. This results in a cost shift to all citizens of Nebraska purchasing through the exchange via an increase in premium costs.

9. Further, individual coverage in the exchange may become so costly that the CHIP policyholders will not be able to afford it even with a subsidy for which the CHIP policyholder may be eligible. An unknown number of current CHIP policyholders may also qualify for Medicaid, resulting in an increase in costs incurred by the state.

I declare under penalty of perjury that the foregoing is true and correct. The information and projections included above are complete and accurate to the best of my knowledge as of the date of this Declaration, and are subject to revision as additional information is generated over time and as PPACA is amended or as federal agencies promulgate guidance and regulations on PPACA's application.

Executed on November 19, 2010, in Lincoln, Nebraska.

Bruce R. Ramge

Bruce R. Ramge
Director, Nebraska Department of Insurance

Exhibit 7

kaiser commission on medicaid and the uninsured

Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories

prepared by

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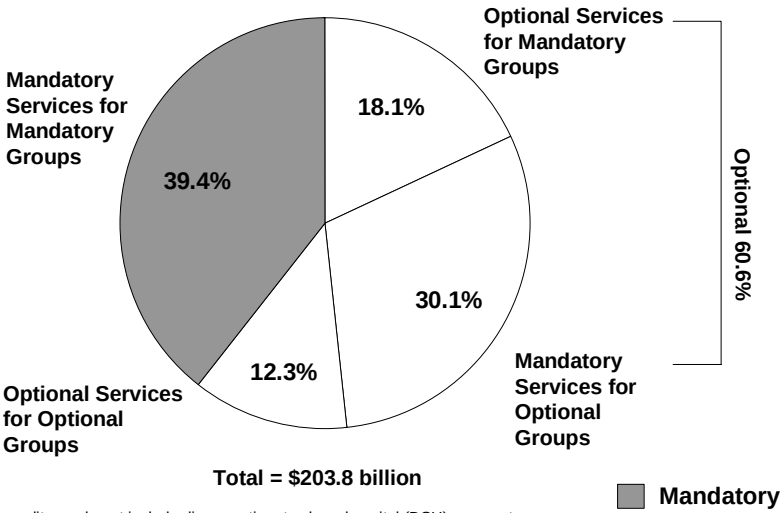
THE HENRY J. KAISER FAMILY FOUNDATION

Mandatory and Optional Medicaid Spending

In 2001, Medicaid spent $203.8 billion on acute and long-term care services for low-income families, individuals with disabilities, and the elderly (Figure 4). This includes $5.0 billion of mandatory payments to Medicare for individuals dually eligible for Medicaid and Medicare, in the form of premiums, copayments, and coinsurance. Of the $203.8 billion in Medicaid expenditures, 39.4% was mandatory, or spending on mandatory benefits for mandatory eligibility groups. The remaining 60.6% was considered optional spending: 18.1% of spending was on optional benefits for mandatory groups, 30.1% was for mandatory benefits for optional groups, and 12.3% was for optional benefits for optional groups.

Figure 4

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

A total of $80.4 billion was spent on mandatory services for mandatory groups in 2001 (Figure 5). The vast majority of mandatory spending, 78 percent or $62.6 billion, was attributable to acute care services other than prescription drugs. Over 90% of these expenditures were attributable to "major" acute care services, defined as inpatient, outpatient hospital, physician, lab/x-ray, clinic, and managed care services. Long-term care accounted for 16% of all mandatory spending, of which just over half (54%) was for nursing facility care. Payments to Medicare for premiums and coinsurance for mandatory dual eligible individuals accounted for nearly 4% of mandatory spending.

A total of $123.4 billion was spent on optional services for mandatory groups combined with all spending for optional groups in 2001 (Figure 5). Nearly sixty percent of all of this optional spending (57.3%) was attributable to long-term care. Payments to Medicare for premiums and coinsurance for optional dual eligible