Government of the District of Columbia
Office of the Chief Financial Officer

Natwar M. Gandhi
Chief Financial Officer

JUN 30 2008

MEMORANDUM

TO: **The Honorable Vincent C. Gray**
Chairman, Council of the District of Columbia

FROM: **Natwar M. Gandhi**
Chief Financial Officer

DATE: **Transmitted 6/27/08**

SUBJECT: **Fiscal Impact Statement (Revised): "Insurance Coverage for Emergency Department HIV Testing Amendment Act of 2007"**

REFERENCE: **B17-487 (as Introduced)**

Conclusion

Funds are sufficient in the proposed FY 2009 through FY 2012 budget and financial plan to implement the proposed legislation, but the legislation could exert upward pressure on costs in the future. The proposed legislation would result in increased direct costs to the Department of Health Care Finance (DHCF) of $18,800 in FY 2009 and $136,000 in the FY 2009 through FY 2012 financial period; however, the DHCF can absorb this increase in the proposed budget and financial plan. Pressure on negotiated per-member-per-month fees paid to Managed Care Organizations (MCOs) providing services to Medicaid and Alliance managed care enrollees may lead to further increased costs in the future if increased MCO costs are passed on to the D.C. government.

Background

The proposed legislation would amend D.C. Official Code § 31-2801 to require that health insurers provide health insurance benefits to cover the cost of a voluntary, annual HIV test for any insured patient between the ages of 13 and 64 years of age when the insured is receiving emergency medical services at a hospital emergency department.

The proposed legislation would also require that Emergency Department (ED) personnel advise eligible patients that unless they withhold consent,

- an HIV test will be performed;

- the cost of the test will be covered by their health insurer;
- the results are confidential; and,
- in the case of a positive test result, where to obtain health care and supportive services.

Financial Plan Impact

Funds are sufficient in the proposed FY 2009 through FY 2012 budget and financial plan to implement the proposed legislation, but the legislation could exert upward pressure on costs in the future. The proposed legislation would result in increased direct costs to the Department of Health Care Finance (DHCF) of $18,800 in FY 2009 and $136,000 in the FY 2009 through FY 2012 financial period; however, it is estimated that the DHCF can absorb this increase in the proposed budget and financial plan. Pressure on negotiated per-member-per-month fees paid to Managed Care Organizations (MCOs) providing services to Medicaid and Alliance managed care enrollees may lead to further increased costs in the future if increased MCO costs are passed on to the D.C. government.

Utilization of EDs in the District of Columbia varies significantly by insured class. Those covered by private insurance made up 32.5% of total ED visits in FY 2005, the most recent year for which data are available. In comparison, uninsured patients made up 19.0% of visits, Medicaid and Alliance patients made up 37.1% of visits, and Medicare patients 11.4% of visits.

Given the age restrictions on the testing guidelines included in the proposed legislation (i.e., those over 64 do not fall within the testing eligibility guidelines), it is assumed that the Medicare program would incur no cost increases as a result of implementation of the proposed legislation. Further, uninsured ED patient care is generally absorbed by providers and passed-on to insured patients through standard pricing structures used by providers. Therefore, the potential costs of implementation of the proposed legislation to the District of Columbia government would be limited to increases in costs to the Medicaid and Alliance insurance programs.[1]

However, the majority of Medicaid recipients and all Alliance members are enrolled in managed care programs, for which the District pays managed care organizations (MCOs) a per-member-per-month (PMPM) rate which is set during annual contract negotiations. It is not possible to reliably estimate the pass-through cost impact that this mandate would have on the negotiated PMPM rates, and therefore the District's budget and financial plan. However, a direct fiscal impact will occur for the 50,137 Medicaid recipients who are enrolled in a fee-for-service program.

It is estimated that approximately 8,700 Medicaid fee-for-service enrollees between the ages of 13 and 64 will report to an ED in a given year. The D.C. Department of Health (DOH) estimates that approximately 40% of age-appropriate ED patients meet other eligibility requirements for testing and would accept the offer of testing in an ED setting.[2, 3] Applying this ratio yields an

[1] While the District of Columbia government is a consumer of private health insurance for its employees, it is not estimated that the proposed legislation would have any impact on premium costs.
[2] Other eligibility requirements may include that the ED patient: not require urgent care; have an unknown or previously negative HIV status; speak English or Spanish; and present no evidence of an altered mental status.

estimate of approximately 3,400 ED-based HIV tests annually for Medicaid fee-for-service enrollees once the testing program is implemented fully across all District of Columbia hospitals. We assume here that similar ED utilization by Medicaid fee-for-service enrollees will continue throughout the estimation period.

It is important to note that full District-wide implementation of an ED-based HIV testing program will take several years to affect. Based on performance of pilot testing programs at GWU Hospital and other urban areas, it is assumed that full implementation of the HIV testing program across all D.C. hospital EDs would be phased in over the course of three or more years. DOH estimates that implementation rates would be 30% in 2009, 60% in 2010; and 85% in 2011 and 2012.[4]

Assuming billing costs of $45 per test, and taking into account federal government reimbursement of 70% of Medicaid costs, total increases in costs are included in the table below.

Estimated Direct Increase to Medicaid Program (in Thousands)					
	FY 2009	**FY 2010**	**FY 2011**	**FY 2012**	**4 Year Total**
Impact on Medicaid fee-for-service costs	**$62.5**	**$109.4**	**$140.6**	**$140.6**	**$453.2**
Less: 70% Federal Medicaid Reimbursement	**($43.8)**	**($76.6)**	**($98.5)**	**($98.5)**	**($317.2)**
Total Increase in Local Expenditures	**$18.8**	**$32.8**	**$42.2**	**$42.2**	**$136.0**

Source: Office of Revenue Analysis

Sources

Branson, Bernard M., Associate Director for Laboratory Diagnostics, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention.

Brown, Jeremy, et al. *Routine HIV Screening in the Emergency Department Using the New US Centers for Disease Control and Prevention Guidelines: Results from a High-Prevalence Area.* Journal of Acquired Immune Deficiency Syndrome, Volume 46, Number 4, December 1, 2007, pp. 395-400.

RAND Health. *Assessing Health and Health Care in the District of Columbia.* Working paper prepared for the Executive Office of the Mayor, District of Columbia, January 2008.

[3] This estimate is based on pilot testing programs at George Washington University Hospital, as well as other CDC pilots in urban areas.
[4] Revised estimates provided by DOH in June, 2008.