Testimony
Senate Bill 2221– Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
January 25, 2011

Chairman Lee, members of the Senate Human Services Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services. I am here to provide information about the fiscal note for Senate Bill 2221.

Senate Bill 2221 would require the Department of Human Service to negotiate with state and private entities to purchase private health insurance coverage and public employees retirement system (PERS) health insurance coverage for Medicaid-eligible adults in the Caretaker and Transitional Medicaid groups. The bill requires the Department, effective January 1, 2012, to annually provide a choice of coverage options to the identified groups.

Definitions:

To be covered under Medicaid, if an individual is between the ages of 21 and 65, they must be either pregnant, disabled, or the single caretaker of a deprived child.

A "single caretaker" of a deprived child must be related to that child within the 5th degree. It may be:

1. a natural or adoptive parent,
2. a grand-parent, (including a great, great-great or great-great-great-grandparent)

3. a sibling if age 16 or older
4. an aunt or uncle (including a great, or great-great aunt or uncle)
5. a niece or nephew (including a great or great-great niece or nephew)
6. a first cousin (uncle or aunt's child) or first cousin once removed (an aunt or uncle's grandchild)
7. a second cousin (a great aunt or great uncle's child)
8. a stepparent (if a natural or adoptive parent is not in the home)
9. a stepbrother or stepsister; or
10. a spouse of any of the above individuals even after the marriage is terminated by death or divorce.

The child must be living with the caretaker relative.
If not a parent, the caretaker must be single, or if married, cannot be residing with their spouse.
If the child is residing with both parents, the parents may be covered if one of the parents is:

- aged (over age 65)
- disabled (as determined by SSA or the state review team)
- incapacitated (as determined by the state review team)
- if the primary wage earner is un- or under-employed (net income is below the family coverage group income levels AND the primary wage earner works less than 100 hours within a 30-day period).

The transitional caretaker relative may be any of the above, except that, the household must have been eligible under the Family Coverage for at least 3 of the past 6 months, and in the most current month; but will fail

the family coverage group due to the increased earnings or increased work hours of a caretaker. If the parents have been family coverage eligible under the un- or under-employment reasons and the primary wage earner's hours are expected to exceed 100 hours per month, these will also become transitional caretakers.

Assumptions:

In preparing the fiscal note, the Department needed to make quite a few assumptions. Because this is not an expansion of coverage, but rather a proposal to consider various coverage options, one overarching assumption is that clients would have the same "benefit plan" as they do today on Medicaid, with the exception of Home and Community-Based Services, which currently, are accessed by several individuals in both of the proposed eligibility groups. Attachment A provides a list of the mandatory and optional Medicaid services.

The Department needed to estimate how many clients would select each of the options (Medicaid, private insurance, PERS coverage). After consideration of the benefits offered under PERS, the Department determined that very few adults would choose this option, primarily because PERS does not offer dental and vision coverage. In addition, through a discussion with Sparb Collins at PERS, the proposed bill does not give PERS the "negotiating" authority that it provides to the Department. Currently, the statute for the PERS coverage specifically identifies to whom they can provide coverage. Therefore, the fiscal note does not contain any costs associated with the PERS option.

Other assumptions made:

The Caretaker and Transitional Medicaid adults currently receiving Home and Community-Based Services would chose the Medicaid coverage option.

The private insurance would be a full-risk contract. A premium would be paid per member per month and the insurer would be responsible for all health care costs within the benefit plan.

There would be no private insurance retroactive eligibility. Like the Children's Health Insurance Program (CHIP), premiums would only be paid prospectively. Currently Medicaid coverage is available "three months prior" and it would need to be determined how we would provide coverage to clients who are "eligible" for retroactive coverage, but choose the private insurance option.

Future biennium costs were inflated at the same rate used to inflate the CHIP premium, as the premium would be outside of the inflationary increases provided by the Legislature.

There were no adjustments made for charging copayments higher than the currently established levels in the Medicaid State Plan. North Dakota Medicaid could impose higher cost sharing for the groups identified in this bill; however, the Department was not certain of intent, so we assumed the copayments would stay the current, nominal amounts. Also, if copayments were increased above the current Medicaid levels, we believe that fewer individuals would choose the private insurance. Attachment B is a list of the current copayments and service limits for the North Dakota Medicaid program.

Private Insurance Coverage:

The Department prepared the estimate of the cost for private insurance coverage based on the best information. We acknowledge that there could be various ways to prepare an estimate for this type of proposal.
As of December 31, 2010, there were 2,257 adults eligible under the Transitional Medicaid coverage and 7,374 eligible Caretaker adults. For State Fiscal Year 2010, the per member per month (PMPM) Medicaid cost for these groups was $331.30 and $304.92, respectively. The Department inflated the PMPMs by six percent to account for the inflationary increase granted to providers for services on after July 1, 2010. The Department then added a 20 percent increase to the PMPMs as it is expected that private insurance carriers would have fee schedules that would exceed that of Medicaid; and to compensate for the retaining the nominal Medicaid copayments. After calculating the final "new" cost to cover individuals under private insurance, we subtracted the "current" cost to provide coverage under Medicaid. Assuming **95 percent** of the Medicaid population selected the private insurance option, the estimated total (net) cost of providing coverage under private insurance is:

Description	11-13 Biennial cost	General	Federal
95% Participation in private insurance	8,113,168	3,618,473	4,494,695

If **50 percent** of the identified population selected private insurance coverage, the estimated total (net) cost of providing coverage under private insurance is:

Description	11-13 Biennial cost	General	Federal
50% Participation in private insurance	4,270,090	1,904,460	2,365,630

Administrative Costs:

The fiscal note also contains various administrative costs that would be necessary to operate a private insurance (managed care) arrangement within the Medicaid program.

The Department would need to contract with an External Quality Review Organization (EQRO), as required by CMS to ensure that services provided under the plan meet appropriate quality standards. The review is required annually and it was assumed that one review would occur in 2011-2013; therefore, the estimated cost for the EQRO contract is $140,000 of which $70,000 would be general funds.

In addition, the rates set for the private insurance product would need to be established and certified by an actuary; and would need to be approved by the Centers for Medicare and Medicaid Services (CMS). The estimated cost for the actuary services for 2011-2013 is $35,000; of which $17,500 would be general funds.

The estimate also includes $12,039 of which $6,019 would be state general funds for increased postage costs related to the annual notice the Department would need to provide clients about their choice of coverage options.

Changes would need to be made to the Department's information technology systems, including Vision (eligibility), the current Medicaid Management Information System (MMIS) and the new MMIS (to be implemented in June 2012). The estimated cost for changes to the Vision system is $197,978, of which 98,989 are general funds. The estimated

cost for changes to the current MMIS is $70,538 of which $17,634 are general funds. The technology projects are estimated to take five and four months, respectively. Based on the estimated length of the projects and the outstanding work requests for the current MMIS, the Department is not certain the necessary system changes could be made in time for a January 1, 2012 implementation. Also, additional discussions will need to be held with the vendor developing the new MMIS to determine if the necessary changes could be incorporated prior to the system roll-out in June 2012.

Finally, the Department would need to hire a temporary staff person to design and implement the private insurance coverage option. This effort would require the development of a Request for Proposal to competitively procure the insurance coverage, oversee the contract with an Actuary to develop the rates, negotiate a contract with the eventual vendor, oversee the process to ensure each client has a choice of coverage, and work with CMS to ensure the private insurance coverage meets federal requirements. Between now and the roll-out of the new MMIS, current staff will have responsibilities above and beyond their normal workloads and it will not be possible to redirect current staff toward this effort. Therefore, the fiscal note contains $114,442 of total funds of which $52,221 are general funds to hire a temporary staff person.

I have shared Senate Bill 2221 with the Centers for Medicare and Medicaid Services to seek their feedback. In addition to the input they have offered regarding copayments, actuary and quality review services, freedom of choice, and benefit plan design, they advised the Department that the development process and approval of a new delivery system can take some time and will require various approvals from their office. If Senate

Bill 2221 is adopted, the Department would begin conversations with CMS to determine a feasible implementation date.

I would be happy to respond to any questions you may have.