Testimony
Engrossed House Bill 1362 – Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman
March 13, 2013

Chairman Lee, members of the Senate Human Services Committee, I am Maggie Anderson with the Department of Human Services (Department). I am here today to support House Bill 1362, which was initially included as Section 3 of House Bill 1012, the Appropriations bill for the Department.

Who Would Be Covered?

The Affordable Care Act (ACA), or "health care reform" as enacted, included a mandate, effective January 1, 2014, to expand the Medicaid program to cover all individuals under the age of 65 (including "childless adults") with incomes below 138 percent of the federal poverty level (133 percent plus a 5 percent income disregard).

On June 28, 2012, the United States Supreme Court upheld the 2014 Medicaid expansion; however, they **struck down the mandate** indicating that the federal government could not withhold all federal Medicaid funding if a state chooses to not expand Medicaid. Therefore, the decision about whether to expand the Medicaid program is **left to each state**. Please refer to **Attachment A** for a chart that illustrates "who would benefit" from the expanded coverage proposed in House Bill 1362.

There has been considerable guidance issued to date and we expect more guidance over the next eleven months as we move toward January 2014. Attached to this testimony is an excerpt from a set of Questions and

Answers provided by the Centers for Medicare and Medicaid Services (CMS) on December 10, 2012. The answers provide important guidance about the 100 percent federal poverty level and about the ability to reverse a decision about the Medicaid expansion in the future. Please refer to **Attachment B**.

How will eligibility be determined for the "newly eligibles"?

The Affordable Care Act (ACA) requires that eligibility determinations for Medicaid and the Children's Health Insurance Program (CHIP) follow modified adjusted gross income (MAGI) methodologies beginning January 1, 2014. North Dakota currently uses net income for Medicaid and CHIP eligibility determinations. The MAGI methodologies follow the definition of MAGI in the Internal Revenue Code, with a few exceptions. The ACA requires that MAGI methodologies no longer allow for disregards or deductions from income. Instead, the MAGI methodologies require an income limit that, at a minimum, is a gross income equivalent to the net income limit. The determination of the limit is based on a conversion template being developed by CMS. The MAGI standard is intended to ensure that income eligibility is calculated consistently for Medicaid and CHIP (and the premium tax credits and cost sharing reductions available for plans in the Health Insurance Exchange). In essence, the MAGI equivalent, in the aggregate, should not increase or decrease eligibility overall.

How would the expansion impact Medicaid enrollment?

As of January 2013, there were 65,932 individuals enrolled in North Dakota Medicaid. Of those, 38,524 were children and 27,408 were adults. The Medicaid expansion would increase the adult enrollment.

To calculate our estimates, the Department used a range of potential enrollees, primarily because there are considerable "what ifs?" and unknowns. The Kaiser Family Foundation, in their November report "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State by State Analysis" estimated **as many as 32,000** individuals could enroll in North Dakota Medicaid as a result of the Medicaid expansion. The Department's staff prepared a separate estimate, based on the Current Population Survey Annual Social and Economic Supplement – US Census Bureau for the state of North Dakota. This estimate suggests the increase in enrollment **may be closer to 20,500**.

Calculating the estimates is not an exact science, and there are rules and policies that are not final. Also, the Kaiser Family Foundation includes many variables in their micro-simulation model – including rates of unemployment, wages, and expected "dropping" of employer sponsored coverage. In addition, in the end, the "take up" rates will be about individual choice and concern about the individual mandate penalty.

What Benefit Package Would the Newly Eligible Group Receive?

The health care status and needs of the "new" population are relatively unknown. There has been much speculation, but until we have one to two years of claims experience, the true health care needs of this population are difficult to predict.

The state does have options for coverage of the "new" population. As proposed, states would pick from one of the benchmark coverage options authorized in section 1937 of the Social Security Act. The four benchmark options are:

(1) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program;
(2) State employee coverage that is offered and generally available to state employees;
(3) The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state; and
(4) Secretary-approved coverage, which can include the Medicaid state plan benefit package offered in that state.

Once a benchmark option is selected, the package would need to be analyzed to ensure consistency with the Essential Health Benefits (EHBs), as the Affordable Care Act requires that Alternative Benefit Plans cover EHBs which include the following ten benefit categories: (1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventive and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care. In addition, the Mental Health Parity and Addiction Equity Act (MHPAEA) applies to Alternative Benefit Plans.

The Amendments adopted by the House indicate the coverage for the Expansion population would be provided by bidding through private carriers or through utilizing the health insurance exchange.

What is the Expected Cost of the Medicaid Expansion?

The ACA affords 100 percent federal funding for the expansion population in Calendar Years 2014, 2015, and 2016; and then the federal support tapers to 90 percent by 2020 according to the following schedule:

Calendar Year	Federal Match Percentage
2014	100 Percent
2015	100 Percent
2016	100 Percent
2017	95 percent
2018	94 percent
2019	93 percent
2020 and future years	90 percent

To provide perspective to how the increased estimated expenditures will impact the North Dakota Medicaid budget, please refer to **Attachment C**. House Bill 1012 (DHS Appropriation) requests a total of $2.8 billion for the 2013-2015 biennium. Of that, approximately $1.8 billion is for Medicaid payments to providers. Of that $1.8 billion, approximately $1.1 billion is for Medicaid payments to developmental disability and long-term care providers. The expansion is not expected to impact these areas. The increased expenditures for the Medicaid expansion would be in the acute services such as hospitals, physician services, dentists, etc.

The Executive Budget request for the Department includes $9.1 million to cover the expected costs of the "previously eligible" individuals. This is a group that is expected to apply for coverage – **regardless of whether there is a Medicaid expansion**. These are individuals who are eligible for Medicaid today, but have not applied for coverage – perhaps because they did not know they qualified, perhaps because they did not have a medical need. In 2014, when the individual mandate within the ACA is in force and considerable federal outreach occurs, it is expected that these individuals will apply for coverage. Those found eligible based on current eligibility rules will be enrolled in Medicaid, and the services they receive

will be **eligible for 50 percent federal match** (which is the Federal Medical Assistance Percentage effective October 1, 2013) rather than the 100 percent federal funding for the expansion population. This group is referred to as the "previously eligibles" or "woodwork" group.

Using the low end of the potential enrollment range (adjusted for potential increases due some insured individuals applying for Medicaid coverage), and after consultation with a private insurance carrier, the estimated cost to expand coverage as defined in Engrossed House Bill 1362 is between **$154 million and $171 million** in federal funds for the **2013-2015 biennium**.

Administrative Costs

The estimated administrative costs for the Medicaid expansion by bidding through private carriers or utilizing the health insurance exchange are detailed as follows:

	Staffing required for 2013 - 2015 Budget (and on-going), for Medicaid Expansion		
Position	**Total Funds**	**General Funds**	**Start Date**
Medical Services			
Administrative Support	78,226	43,337	November 1, 2013
Medicaid Policy	133,187	66,594	August 1, 2013
Economic Assistance Quality Assurance	129,924	63,858	October 1, 2013
Total	**$341,337**	**$173,789**	

In addition to the above ongoing staff positions, the Department is estimating the need for one-time funding of $150,000 ($75,000 general fund) for the purpose of procuring a vendor to assist the Department in either writing a Request for Proposal, Premium Assistance State Plan and/or Medicaid 1115 Waiver (if needed).

What are other states doing?

Attachment D and **Attachment E** show information from statereforum.org and advisory.com. Both of these sites have been tracking updates and activities related to state decisions regarding the Medicaid expansion.

Are there other considerations or unknowns?

On January 22, 2013, CMS issued a Notice of Proposed Rulemaking on Essential Health Benefits Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Process for Medicaid and Exchange Eligibility Appeals and other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing. The rule is 474 pages, and we are digesting the potential impacts and developing questions and comments.

In addition, according to CMS, we can expect the following items in the next two to three months:

- State Medicaid Director letter on newly eligible beneficiaries
- Final regulation on FMAPs
- Targeted Enrollment Strategies

There are many other items expected over the next eleven months, including final rules and regulations.

In addition, there are current coverage groups such as the Workers' with Disabilities Buy In and the Women's Way (Breast and Cervical Cancer Treatment). These groups are currently "**optional**" Medicaid coverage. In 2014, these populations **should have private coverage options** through the Health Insurance Exchange. We continue to explore options

for these groups, including portions of the groups falling under the "new adult/expansion" group.

Bottom line - additional guidance is still expected and the assumptions used in calculating the estimates are not "set in stone." We cannot be certain of the number of people who will seek coverage or be able to precisely predict their health care needs and service usage. The estimates provide a projection of potential enrollment and estimated costs. I would be happy to address any questions that you may have.