Department of Human Services
Health Care Reform Review Committee
Representative George Keiser, Chairman
October 1, 2014

Chairman Keiser, members of the Health Care Reform Review Committee, I am Julie Schwab, Director of Medical Services for the Department of Human Services (Department). I appear before you to provide an update on the Medicaid Expansion.

Medicaid Expansion

Enrollment

As of September 1, 2014, Medicaid Expansion enrollment was approximately 12,850 individuals. The enrollment data shows that most enrollees are childless adults (there are some adults with dependent children). Slightly over half of the expansion enrollees are female (55%); 46.6% were ages 19-35, 17.1% were ages 36-44, and 36.3% were ages 45-64. The majority (65%) are rural. These trends have remained consistent since enrollment began in January 2014. Enrollment has continued to grow each month.

As I mentioned during the last Health Care Reform Review Committee meeting, the next open enrollment period for 2015 at the Federal Marketplace is November 15, 2014–February 15, 2015. Individuals may also qualify for Special Enrollment Periods outside of open enrollment if they experience certain qualifying life events. Examples of qualifying life events are moving to a new state, certain changes in income, and changes in family size (for example, marriage, divorce, or the birth of a baby). Individuals are still able to apply for Medicaid and CHIP at the

federal website throughout the year. Information on those who apply for Medicaid and CHIP are sent to the State via a weekly, flat file.

The Department continues to have a contract with Automated Health Systems (AHS) to assist with taking applications via the telephone and entering them into the existing OASIS system. AHS is also ready to assist in processing of applications for counties that may need assistance. We will continue the AHS contract through the open enrollment period and assess further needs at the close of the open enrollment period.

Assessment State to a Determination State

As of July 1, 2014, North Dakota became a determination state. In a determination model, the State accepts the determinations made by the Federal Marketplace. The Department is working with CMS to address inconsistencies in the files being sent and will process applications that contain inconsistencies at the department level.

Medicaid – Cost Sharing Out of Pocket Costs

States can impose copayments, coinsurance, deductibles, and other similar charges on most Medicaid-covered benefits and the amounts that can be charged vary with income. For enrollees with income at or below 100% of the federal poverty level (FPL), cost sharing for most services is limited to nominal or minimal amounts. States have the options to establish alternative out-of-pocket costs which may be target certain groups of Medicaid enrollees with income above 100% of the FPL. These out-of-pocket costs may be higher than nominal charges depending on the type of service and cannot exceed 5% of the family income.

In Michigan, the state obtained approval from the Centers for Medicare and Medicaid Services (CMS) to amend its 1115 demonstration waiver, "Healthy Michigan", to implement Medicaid Expansion which included an alternative cost sharing plan for enrollees. The following table provides general comparisons between North Dakota (ND) Medicaid Expansion and Michigan (MI) Medicaid Expansion.

	North Dakota Medicaid Expansion	Michigan Medicaid Expansion
Covered Lives	As of September 2014, there were approximately 12,850 individuals enrolled.	Estimated between 300,000 to 500,000 individuals statewide eligible for coverage.
Covered Population	Adults ages 19 to 64 from 0 to 138% FPL	Childless adults ages 19 to 64 from 0 to 138% FPL
Delivery System and Benefits	Managed Care Organization (MCO) enrollment is required unless it is determined that the beneficiary meets one of the exemption criteria. Benefit Package contains the Affordable Care Act's 10 Essential Health Benefits, transportation, and EPSDT services, including dental and vision for those ages19 & 20. It is patterned after the largest HMO and same as the State Benchmark Plan. Other covered services include medically necessary services as prior authorized, as well as other services required to be covered pursuant to state or federal law, regulation, or policy	Managed Care enrollment is required, using existing Medicaid Managed Care Organizations (MCOs) and Pre-Paid Inpatient Health Plans (PIHPs). Benefit Package contains the Affordable Care Act's 10 Essential Health Benefits, transportation, and EPSDT services, including dental and vision for those ages 19 & 20 Other covered services include medically necessary services as prior authorized, as well as other services required to be covered pursuant to state or federal law, regulation, or policy
Premiums	Beneficiaries not required to pay	• Beneficiaries between 0 to 100% FPL not required to pay • Beneficiaries above 100% FPL will pay monthly premiums in the amount of 2% of income
Cost Sharing	**Copayments:** Consistent with cost sharing for ND Traditional Medicaid population as contained in the State Plan Cost sharing and premiums cannot exceed 5% of household income	**Copayments:** • Based on MI Medicaid State Plan • Beneficiaries obligations will be based on their prior 6 months of copays, billed at the end of each quarter - No cost sharing for the first six months of enrollment in a Managed Care Organization (MCO) • Can be reduced through compliance with

		healthy behaviors • Paid into health accounts Cost sharing and premiums cannot exceed 5% of household income
Health Account	Not applicable	All beneficiaries enrolled receive a MI Health Account in which money from any source (i.e.; beneficiary, his/her employer, private/public entities, or etc.) may be deposited for the beneficiary's use in paying for incurred health expenses as covered by the plan. The State will commit to making contributions to the account in the amount necessary to cover the beneficiary's health care expenditures, minus the beneficiary's individual cost-sharing contributions. Beneficiaries between 100 to 133% FPL will be required to make additional contributions to their MI Health Account. This amount is limited to 2% of their annual household income. No beneficiary, regardless of income level, may be removed from the Health MI Plan for failure to pay contributions or copays. MI will be developing consequences for beneficiaries who consistently fail to meet cost-sharing requirements. Once a beneficiary is enrolled, healthcare providers will not be responsible for collecting copays directly from the beneficiary at the point of service – instead this will be a function of Medicaid Health Plan. Note: Protocols pending CMS approval
Healthy Behavior Incentive	Not applicable	All beneficiaries may be eligible for copay reduction if certain healthy behaviors are attained or maintained. MI will work with its stakeholders to identify uniform standards for healthy behaviors that would be eligible for the reduction – this shall require information sharing among the State and healthcare providers through the use of surveys and/or submission of health risk assessment. Note: Protocols pending CMS approval

Please see attachment A attached for the current Medicaid service limits and copayments.

This concludes my testimony. I am happy to answer any questions.