2013 HOUSE HUMAN SERVICES

HB 1362

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1362
January 30, 2013
Job #17981

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:
An appropriation for expansion of Medicaid program.

Minutes: *See Testimonies #1-14*

Chairman Weisz: Called the hearing to order on HB 1362.

Rep. Al Carlson: Introduced and sponsored the bill. He testified in opposition of the bill. (See Testimony #1)

13:56 Rep. Holman: You talked about 100% of poverty level which a family of 4 would be at less than $2,000 a month, so anyone above that would have to provide for their own health insurance. Is that a problem or not?

Rep. Carlson: Is that a gross or net income figure? I can't tell you that side of it. The state should be looking at those numbers and the state should be looking at all those people uninsured not some federal over reach program.

Rep. Fehr: Do states have a choice to opt in and out of this? If we sign up for two years can we get out of it or are we locked in?

Rep. Carlson: My understanding is no, but Maggie Anderson can answer that. She says we can go in and out and she will have to answer that.

Rep. Mooney: If ND does their own program what would make us follow through with what we say we are going to do?

Rep. Carlson: I would say our word would be a lot easier to trust than that of the federal government who has broken many promises. It will cost us some money and we have existing vehicles. We have underused vehicles. We would probably have to expand, but it would be better if the state handle it rather than federally.

Rep. Mooney: What would make us do that?

Rep. Carlson: Right now they are telling us take or not take the money and we are at the stage of, is it an issue of that many ND families uninsured? Are they being turned down coverage? The answer is no. Are there bills in to address hospitals having trouble collecting? Yes there is. I believe the state solution is much better than a federal one.

19:18 Maggie Anderson: With the Department of Human Services (DHS) testified in support of the bill. (See Testimony #2)

33:41 Chairman Weisz: Do you have legislation that is going to address the CHIPS problem when you do find out?

Anderson: Yes, the department has SB 2109 which was introduced to give us the ability to create that MAGI equivalent for the children's health insurance program.

37:06 Rep. Kreidt: Do you have the percentage estimate who would qualify for Medical Assistance that is not on the role now?

Anderson: I'll answer that shortly in my testimony.

43:01 Chairman Weisz: If they decide to go through the exchange, would the federal subsidies that are part of the exchange, apply to that population? If they did, would that mean that those who had income less than 100% who don't qualify for the exchange, get no federal subsidy and those at the 100-138% would get whatever that subsidy was based on their income? Or, would the state be required to pay the full amount?

Anderson: For the new population instead of enrolling them in Medicaid when they go through the exchange for determining eligibility, they would be able to pick a private insurance? It would be covered 100% the first three years by the federal government. At that point it would have nothing to do with the subsidies or tax credit. It would be there coverage.

Chairman Weisz: Is that going to be after the subsidy?

Anderson: No.

Chairman Weisz: If the state decided to pay the premium in the exchange and in 2020 when we are required to pay 10%.

Anderson: Then we would pay 10% of the cost of the private insurance to cover them.

Chairman Weisz: Would that be after the subsidy?

Anderson: There would be no subsidy. They can't qualify for subsidies if they qualify for Medicaid or CHIP.

49:40 (Handout #3) Maggie Anderson started talking about this handout.

54:13 Rep. Nelson: Going back to your first chart. This is the blue box is it not?

Anderson: No it's the green box.

Rep. Nelson: They are eligible for Medicaid today, but not receiving it.

Anderson: This is the new group, not the previous group.

Rep. Nelson: We are not talking about the woodwork?

Anderson: No, we aren't talking about the new group. (Resumed going through the chart.)

56:22 Rep. Pollert: The new eligibles we are talking about in the blue or yellow sheet, are those are the ones in your green, right?

Anderson. Yes.

Rep. Nelson: Is there any way you can develop this type of sheet for the blue box? We need to make a decision on how do we address the blue box. Can you figure out the number of people and what the cost of coverage would be for that group?

Anderson: Yes. Do you want us using 50/50 FMAP or using state funds? We just can't cover the blue box we have to cover the whole green box if we want to get the 100% match. So we can't do that without reducing the amount of match that we receive.

Rep. Nelson: We need both.

Chairman Weisz: The only two options you have in the blue box are 50/50 match Medicaid or 100% state funded, correct?

Anderson: That is correct.

Rep. Nelson: I think that is what Majority Leader Rep. Carlson was asking for was it not?

Chairman Weisz: I agree.

Anderson: The blue box represents 13,976 of the 20,547, so we put back into the chart. Do you want it the full Medicaid plan or scaled down approach similar to what we cover through CHIP or the caring for children program?

Chairman Weisz: If it is easily done maybe you should do them all.

Anderson: We could do this plan and scale down the services.

Rep. Nelson: I would most likely cover those with a scaled down plan.

Anderson: We can do both.

Chairman Weisz: I think that would be best.

Anderson: (Resumed going through the chart.)

1:03:37 Anderson: (Back to her testimony.)

1:05:53 Rep. Pollert: If the wood working effect comes into effect is that included in your current budgets that we have in 1012 right now? You have a, total funds and a general funds; can you explain the percentage why you have like this? Is it a federal mandate or a match?

Anderson: First question answer is yes. The staff needed to support HB 1012, which includes the 9.1 for the wood work effect; those FTEs are in 1012. The total funds and general funds are showing that the administrative costs are not supported with 100% federally funded. It is just the cost for the care for the people. It is not the initial cost the state incurs. Some of these positions we can receive a 75% match and other positions a 50%. That is how we calculate the total and general funds. (Resumes testimony.)

1:09:20 Rep. Nelson: Can you tell me in your estimates for on page 7, you ramp up after the first quarter of the new biennium; so the next biennium would include 24 months and this doesn't, would that be the cost in the next biennium? How stable are the state federal matches? Do they change as we go along with the ACAA act or does that change as time goes on?

Anderson: Would this be the exact amount for '15-'17? The answer to that would be no. The reason is that the start dates of the positions are into the biennium and not calculated in this total of 24 months. The cost for '15-'17 would be larger than the number before you. Second question, do the federal match rates change, not generally, but it could.

Rep. Mooney: The chart on page 7 the 890 and 338 thousand; that is if we do our own program? And the one on page 8 is if we go with the exchange?

Anderson: That is correct.

1:18:02 Chairman Weisz: When you look at the private running them through the exchange you gave a number of roughly $3,200 a year. Do you have an estimate of cost for the purchase of that product through the exchange?

Anderson: I have some information from BC/BS. Based on the estimate of 20,457, we could expect the private insurance to cost between $107-147 a year.

Chairman Weisz: Is that based on the 20,457?

Anderson: Yes it is and their current fee schedules.

Rep. Pollert: If you were to cover the people in the blue box vs. the Medicaid it is like what you show on the blue sheet of approximately $75,000 and the state match would be 50%?

Anderson: No, and the reason for that is that 13,591 ends up to be the monthly average individuals receiving service. You have to start with the actual enrollment numbers. When we run our numbers for you at that lower number the 13, 591 will drop because those are recipients not eligible.

Rep. Pollert: Yes.

Anderson: I you round the 13,000 to 14,000, then the 20,000 is the proportionate difference between 14,000 and 20,000 is what our new estimate would be.

Rep. Porter: What happens to our recipient liability component and our Medicaid buy in component? Can some of that be adjusted to do that 5% on the 138 side to have an actual buy in program and still maintain compliance with the new federal law if we decide to do the 0-133 component?

Anderson: That is some of the questions we have right now into CMS. Specifically about the medically needy or buy in or recipient liability group. Are medically needy group are at 83% of poverty level. People above that level can actually qualify for Medicaid if they have a medical need, but they have to spend down to 83% of poverty before Medicaid pays dollar one each month on the cost of their care. Is that group between 0-133 really new eligible is our question. Can we move the medically needy level to 138 and or could they go through the exchange and get private coverage? We are trying to work out answers with CMS.

Rep. Porter: The number floating because people reaching 65; do they then become eligible for a co-insurance component of the Medicaid program? How did you factor that?

Anderson: The group that qualifies for Medicaid cost sharing assistance for Medicare duos; there are some duos where we assist with cost sharing or premium amounts. But, those levels are set in statute and some are set at 100% and some between 100-120% and they don't change. The 65 year olds would qualify for one of the Medicare savings programs, and we have their cost sharing built into the traditional side of the Medicaid budget regardless of an expansion.

Rep. Holman: If we do not do the do the Medicaid expansion, does the law require us to cover the group we are talking about bringing in?

Anderson: No. The groups would stay the same. We will have to make that a MAGI equivalent of 133 and would cover them at that level. We would not have to cover the group if we do not do the expansion.

Rep. Fehr: My question is on recipient liability. Do we know kind of recipient liabilities these individuals will have?

Anderson: I'm not sure we would have a situation where someone who qualifies for the Medicaid expansion would have a recipient liability. Because they will or won't be eligible

at 138. The recipient liability will come in is the elderly and disabled group because their eligibility determinations aren't going to change. Aren't able to tell what the recipient liability would be.

Rep. Porter: If we choose to go the exchange route, what happens to the product we are purchasing? Cane we purchase a product with normal deductibles and cost share components or are we creating a hybrid inside of the exchange specific to the state of ND coverage of the 0-133 group?

Anderson: Closer to the second option you said. We would be creating a hybrid. We would not be able to have the same deductibles and cost sharing that are associated with private insurance. There are restrictions on what we can charge for the cost sharing for the Medicaid population.

Chairman Weisz: Regarding the MAGI, if I understood you correctly you said it would be determined in the (inaudible) it is possible to leave some people off that were currently on?

Anderson: That is correct. We will have children that will go from Medicaid to CHIP because their disregards may be as such that they would now qualify for CHIP instead of Medicaid. Some kids will go from CHIP to Medicaid. And some that are on either program will no longer be eligible for either program. We have to make sure that they are covered on one of the programs. For children we have maintenance of eligibility until September of 2019.

Rep. Nelson: Have you or your staff looked at those states which do not support the expansion and which one them had higher eligibility limits and was complicated to come down to the 138?

Anderson: No we haven't looked at that.

Rep. Nelson: Most of the states who have not supported Medicaid expansion there was legislation that did include Medicaid expansion and other blank from the governor or legislative side.

Anderson: We could provide to you a website called, statehealthfacts.org by the Kaiser Foundation. They collect all of the data and sort it. We could go out there and put in where the other states sit with their Medicaid eligibility and could provide that to you.

Rep. Nelson: That might be helpful, thank you.

1:37:25 Josh Askvig: Associate State Director of Advocacy for AARP ND testified in support of the bill. (See Testimony #4)

Allen Dockter: An AARP member testified in support of the bill. (See Testimony #5).

Pat Herbel: An AARP member testified in support of the bill. (See Testimony #6)

Nancy McKenzie: Public Policy Director Mental Health America of ND testified in support of the bill. (See Testimony #7)

1:56:29 Dan Ulmer: From BC/BS testified in support of the bill. I have no prepared testimonies, just reality checks. We have spent thousands of man hours and millions of dollars in attempting to comply with the Patient Protection and Affordable Care Act. The Obamacare is the law. If you back off from this particular piece, you are going to leave a large hole that we will be cost shifted to. You will have a big whole with uninsured people in it. We have to go forward an implement. Unfortunately, in your infinite wisdom, have decided to allow this law to be run by the federal government. You are losing a substantial amount of controlling your own regulatory environment. We have to comply to the law and what is the best compliance? Rep. Carlson talked about what we should be able to do in ND. We are with you on that. We are looking for some kind of opt out in 2017 under this bill, but there isn't anything on the table right now. The difficult question is, are you going to take care of these people now or later?

Rep. Holman: Of the 22,000 and some that Maggie mentioned that are uninsured, don't a lot of them now get health care, but are not paying for it, but we are?

Ulmer: Yes to the tune of about a $100 a month in premiums.

2:01 Tom Regan: Here on behalf of ND Rural Behavioral Health (RBHN) testified in support of the bill. (Testimony #8)

2:05 Deborah Knuth: Director of Government Relations for the American Cancer Society Action Network testified in support of the bill. (See Testimony #9)

2:09 Karen Ehrens: Volunteer for ND Economic Security and Prosperity Alliance testified in support of the bill. (See Testimony #10)

2:13 Jerry Jurena: President of the ND Hospital Association gave information. (See Testimony #11)

2:17:31 Rep. Pollert: You said it will reduce the bad debt in the state. If the Medicaid expansion is allowed, it should not only reduce the bad debt, won't the number coming into the hospital so you can lower your hospital bills to the private pay?

Jurena: Theoretically yes, but the numbers we heard this morning, I'm not sure that would enough to offset? We'd have reduced bad debt, and have more income coming in, but don't know if it would be that much to see a difference in your charges that we would send out.

2:19 Katie Cashman: Handed out and read testimony for Courtney Koeble, Executive Director for ND Medical Association. (See Testimony #12)

2:23 Rep. Pollert: A lot of the argument of ACA there won't be enough physicians out there to handle the increased workload. Does the Medical Association have any position on that?

Cashman: The board didn't discussed that last night. I can ask Courtney about that.

Rep. Pollert: Yes please.

Stacey Pfliiger: Read Christopher Dobson,Executive Director of ND Catholic Conference testified in support of the bill. (See Testimony #13)

Mike Tomasko: From West Fargo handed in testimony (See Testimony #14)

Chairman Weisz closed the hearing on HB 1362

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1362
February 25, 2013
Job #19435

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion.

Minutes:

Chairman Weisz took up HB 1362. I have a suggested amendment and I know there are others also. My first amendment would be to implement this starting January 1, 2014 and have a sunset of August 1, 2017. There would be language added that would be, this expansion is not an entitlement. If federal funds disappear, this program could disappear. The sunset would require the legislature to take a look at it and see if it wants to continue the funding or change directions.

Rep. Mooney: We would then have numbers and statistics to draw live data from?

Rep. Weisz: That would be part of the purpose.

Rep. Fehr: I move the amendment.

Rep. Hofstad: Second.

VOICE VOTE: MOTION CARRIED.

Rep. Fehr: I motion the following amendment; "The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange".

Rep. Porter: Second.

Rep. Fehr: The expansion can be more than just for Medicaid. It could be a health insurance plan that Medicaid dollars pay for. What would the cost be and how does that happen? One way is that the department contracts directly an insurance company either through bidding or people could go on the exchange and the department pays the premium for that insurance on the exchange. I want those looked at because I think it will be administered better. Right now the Medicaid expansion does not include administration dollars, however if it is contracted out the company getting the bid will do the administration, so it may be less expensive in the short run.

Rep. Weisz: The feds still share the administrative costs if we do the Medicaid portion. You are correct that the administrative costs to the state would be less going through a private or the exchange. The state in those first three years saves money. We are paying the full premium cost if we run them through the exchange and not saving any money.

Rep. Porter: The way we did SCHIP is very similar fashion to this amendment. I think that has been a successful private partnership and with this expansion I think that could also work. I support the amendment.

Rep. Laning: Talking about funding, is that an item that is reimbursable through the federal program as well or is this going to be 100% state sponsored?

Rep. Weisz: The exact same cost share would be 100% federally funded through 2016. Only thing that changes is the administrative costs through 2016.

Rep. Mooney: This amendment would really allow for some flexibility on the department's behalf in the next three years. Is that correct?

Rep. Fehr: I am putting forward an amendment to take the Medicaid expansion and let's make it into the private health arena opposed to it being an additional Medicaid.

VOICE VOTE: MOTION CARRIED

Rep. Porter: This act is a dramatic change in the health care system across the state of North Dakota. We have to have a consideration of the ill effects that this act has on the providers of North Dakota. We need to add a section inside of this to study those affects in this interim. I offer the following as an amendment: "Legislative management shall consider studying the affects the Federal Affordable Care Act due to the dramatically changing health care system in North Dakota. Legislative management shall further consider studying the alternatives to the Federal Affordable Care Act and the Medicaid expansion provisions to make heath care more accessible and affordable to the citizens of North Dakota including access, cost to provide service, Medicaid payment system and the Medicare penalty to North Dakota providers."

Rep. Fehr: Second.

Rep. Mooney: We would be studying this at the same time that this is going on, so by 2017 we would be looking at data and in relation to the affects to the local providers? We'd have two ways to look at the final result.

Rep. Porter: We'd have three ways. We would have the accessibility, affordability and cost components.

Rep. Silbernagel: Would that require a fiscal note?

Rep. Weisz: Legislative council has something like $400,000 that is budgeted for studies. We don't have to have a fiscal note.

VOICE VOTE: MOTION CARRIED

Rep. Fehr: I move a Do Pass as Amended on HB 1362.

Rep. Porter: Second.

Rep. Looysen: With Rep. Fehr's amendment, are the doctors and physicians being reimbursed at the BC/BS or Medicaid rates?

Rep. Weisz: They would still be reimbursed at Medicaid rates. If we buy the premium on the exchange we just pay the premium. We'd have the flexibility to say whether we use the blues schedule or Medicaid if they were to bid it out on a contract.

Rep. Kiefert: The blue box in the handout at the hearing, where 14,000 people in that group. Now it says no subsidies for that group; are they out of coverage?

Rep. Weisz: When we had the informal meeting, I made an incorrect statement on what I call the donut hole. If we do the expansion they are covered. They are left out to dry without the expansion. They do not qualify for the exchange, but they aren't penalized and I said they would be. That statement was incorrect. Your premium cost cannot exceed 8% of your income.

Rep. Laning: Nine and a half.

Rep. Weisz: Nine and a half. That is the problem with the FACA, it leaves a gap. If we do the expansion then they are all covered.

Rep. Kiefert: With Rep. Fehr's amendment, does that leave them in or out?

Rep. Weisz: They are in.

Rep. Looysen: I see it as a lot of doctors only take a limited amount of Medicaid patients or don't like to take them at all.

Rep. Weisz: The private doctors don't have to take Medicaid patients, but the others have too.

Rep. Silbernagel: To what extent will this eliminate the bad debt expenses across the state if we pass this?

Rep. Weisz: A minimum effect. In the larger cities it will have some effect, but not much for the cities out west. Sanford gave some information that they thought it would save them $2 million a year.

Rep. Damschen: I'm torn about this, but I like the amendment and not sure how I'll vote.

Rep. Kiefert: I have a hard time with this too. This whole package comes with $500 billion in new tax hikes from the federal side. How much is this going to impact each household in ND? I have a hard time doing what the federal government did by voting for this thing and see what happens. We don't know how this is going to impact our people.

Rep. Weisz: You are correct, but those taxes are coming whether we do it or not.

ROLL CALL VOTE: 12 y 1 n 0 absent

Bill Carrier: Rep. Weisz

2013 HOUSE STANDING COMMITTEE MINUTES

House Human Services Committee
Fort Union Room, State Capitol

HB 1362
February 25, 2013
Job #19451

☐ Conference Committee

Committee Clerk Signature Vicky Crabtree

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion.

Minutes:

Chairman Weisz: We have been asked to put more amendments on HB 1362. So we need to reconsider the bill if that is your wishes.

Rep. Fehr: These amendments will not change the action we took on this bill, but to clarify?

Rep. Weisz: The amendments won't change anything to do with the study and with the implementation or sunset dates. We are only looking at the section that authorizes appropriation.

Rep. Hofstad: It will bring it back to policy.

Rep. Damschen: Was the intent of the bill's sponsors to do what we did this morning?

Rep. Weisz: The assumption was we are putting a bill in whether we are going to do it or not.

Rep. Porter: All we need to do today is reconsider or action and add another amendment on the bill that authorizes a creation of a section in the Century Code and then it matches the amendment.

Rep. Weisz: That is correct. I will hand the amendments out to the committee whenever I get them to ensure it agrees with what we passed.

Rep. Porter: I move we reconsider our action of HB 1362.

Rep. Hofstad: Second.

Rep. Fehr: You mentioned appropriation and do you know what that is?

Rep. Weisz: The fiscal note is $102 million, in federal and $273,000 in general funds.

Rep. Fehr: I thought that was going to change.

Rep. Weisz: It could possibly, but it won't affect what we send out here.

VOICE VOTE: MOTION CARRIED

Rep. Porter: I move the amendment to create a new section authorizing the expansion.

Rep. Silbernagel: Second.

VOICE VOTE: MOTION CARRIED

Rep. Hofstad: I move a Do Pass As Amended.

Rep. Fehr: Second.

ROLL CALL VOTE: 13 y 0 n 0 absent

Bill Carrier: Rep. Weisz

FISCAL NOTE
Requested by Legislative Council
01/21/2013

Bill/Resolution No.: HB 1362

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$101,781,672	$0	$152,581,672
Expenditures	$0	$0	$273,172	$101,781,672	$2,573,172	$152,581,672
Appropriations	$0	$0	$273,172	$101,781,672	$2,573,172	$152,581,672

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1362 Appropriates to the Department of Human services any amount of federal funds relating to implementing the provisions for the expansion of the medical assistance program from the Patient Protection and Affordable Care Act.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 appropriates from special funds derived from federal funds any amounts received relating to the Patient Protection and Affordable Care Act. The Department provides a range for the estimated cost of implementing the Medicaid Expansion due to several unknown factors and the fact that not all of the final rules relating to the Affordable Care Act have been adopted. The unknown factors include how many people will enroll for coverage. The Department estimates 20,547 persons would be eligible while the Kaiser Commission estimates as many as 32,000 North Dakotans would be eligible. The State Fiscal Effect shown in Section 1A. of this fiscal note is the low estimate. The Department estimates implementation of the Affordable Care Act including the addition of 5 to 7 FTE in the 13-15 biennium will range between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range form $155,154,844 and 241,090,975 of which between $2,573,172 and $3,837,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The increase in revenues in each biennium is the additional federal funding the state will receive due to the increased expenditures relating to Medicaid Expansion.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The costs associated with implementing Medicaid Expansion are estimated to be between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range form $155,154,844 and 241,090,975 of which between $2,573,172 and $3,837,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation in the 13-15 biennium of between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department will need an appropriation in the 15-17 biennium of between $158,854,844 and 237,590,975 of which between $273,172 and $337,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

Name: Debra A. McDermott

Agency: Department of Human Services

Telephone: 701 328-1980

Date Prepared: 02/07/2013

VK
2/25/13

13.0628.01002
Title.02000

Adopted by the Human Services Committee

February 25, 2013

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1362

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medicaid expansion;"

Page 1, line 2, after "program" insert "; to provide for a legislative management study; to provide an effective date; and to provide an expiration date"

Page 1, after line 3, insert:

"**SECTION 1.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medicaid expansion.

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty level, based on modified adjusted gross income.

2. The department of human services shall inform new enrollees in the medical assistance program that benefits may be reduced or eliminated if federal participation decreases or is eliminated. The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange."

Page 1, after line 10, insert:

"**SECTION 3. LEGISLATIVE MANAGEMENT STUDY - AFFORDABLE CARE ACT IMPLICATIONS.** The legislative management shall consider studying during the 2013-14 interim the effects of the federal Patient Protection and Affordable Care Act [Pub. L. 11-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], due to the dramatically changing health care system in the state. The study must address alternatives to the federal Patient Protection and Affordable Care Act and the medicaid expansion provisions to make health care more accessible and affordable to the citizens of the state, including access, the cost of providing services, the medicare penalty to the state's providers, and the medicaid payment system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fourth legislative assembly.

SECTION 4. EFFECTIVE DATE. Section 1 of this Act becomes effective on January 1, 2014.

SECTION 5. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2017, and after that date is ineffective."

Renumber accordingly

Date: 2-25-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Fehr Seconded By Rep. HOFSTAD

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

add language
START DATE 1-1-14
Sunset 7-31-17

Voice Vote Motion Carried

Date: 2-25-13
Roll Call Vote #: 2

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment (Second)

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Fehr Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:
add language
"The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange."

Voice Vote
Motion Carried

Date: 2-25-13
Roll Call Vote #: 3

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Third Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

"Legislative management shall consider studying the affects the FACA due to the dramatically changing healthcare systems in ND" and more language added

Voice Vote
Motion Carried

Date: 2-25-13
Roll Call Vote #: 4

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Fehr Seconded By Rep. Porter

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. MOONEY	✓	
VICE-CHAIRMAN HOFSTAD	✓		REP. MUSCHA	✓	
REP. ANDERSON	✓		REP. OVERSEN	✓	
REP. DAMSCHEN		✓			
REP. FEHR	✓				
REP. KIEFERT	✓				
REP. LANING	✓				
REP. LOOYSEN	✓				
REP. PORTER	✓				
REP. SILBERNAGEL	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Rep. Weisz

If the vote is on an amendment, briefly indicate intent:

Date: 2-25-13
Roll Call Vote #: 1

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☒ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Hofstad

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent: Voice Vote
Motion Carried

Date: 2-25-13
Roll Call Vote #: 2

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Porter Seconded By Rep. Silbernagel

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ			REP. MOONEY		
VICE-CHAIRMAN HOFSTAD			REP. MUSCHA		
REP. ANDERSON			REP. OVERSEN		
REP. DAMSCHEN					
REP. FEHR					
REP. KIEFERT					
REP. LANING					
REP. LOOYSEN					
REP. PORTER					
REP. SILBERNAGEL					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Create a new section authorizing the expansion

Voice Vote Motion Carried

Date: 2-25-13
Roll Call Vote #: 3

2013 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

House Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Rep. Hofstad Seconded By Rep. Fehr

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN WEISZ	✓		REP. MOONEY	✓	
VICE-CHAIRMAN HOFSTAD	✓		REP. MUSCHA	✓	
REP. ANDERSON	✓		REP. OVERSEN	✓	
REP. DAMSCHEN	✓				
REP. FEHR	✓				
REP. KIEFERT	✓				
REP. LANING	✓				
REP. LOOYSEN	✓				
REP. PORTER	✓				
REP. SILBERNAGEL	✓				

Total (Yes) 13 No 0

Absent

Floor Assignment Rep. Weisz

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1362: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1362 was placed on the Sixth order on the calendar.

Page 1, line 1, after "Act" insert "to create and enact a new section to chapter 50-24.1 of the North Dakota Century Code, relating to medicaid expansion;"

Page 1, line 2, after "program" insert "; to provide for a legislative management study; to provide an effective date; and to provide an expiration date"

Page 1, after line 3, insert:

"**SECTION 1.** A new section to chapter 50-24.1 of the North Dakota Century Code is created and enacted as follows:

Medicaid expansion.

1. The department of human services shall expand medical assistance coverage as authorized by the federal Patient Protection and Affordable Care Act [Pub. L. 111-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152] to individuals under sixty-five years of age with income below one hundred thirty-eight percent of the federal poverty level, based on modified adjusted gross income.

2. The department of human services shall inform new enrollees in the medical assistance program that benefits may be reduced or eliminated if federal participation decreases or is eliminated. The department shall implement the expansion by bidding through private carriers or utilizing the health insurance exchange."

Page 1, after line 10, insert:

"**SECTION 3. LEGISLATIVE MANAGEMENT STUDY - AFFORDABLE CARE ACT IMPLICATIONS.** The legislative management shall consider studying during the 2013-14 interim the effects of the federal Patient Protection and Affordable Care Act [Pub. L. 11-148], as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152], due to the dramatically changing health care system in the state. The study must address alternatives to the federal Patient Protection and Affordable Care Act and the medicaid expansion provisions to make health care more accessible and affordable to the citizens of the state, including access, the cost of providing services, the medicare penalty to the state's providers, and the medicaid payment system. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-fourth legislative assembly.

SECTION 4. EFFECTIVE DATE. Section 1 of this Act becomes effective on January 1, 2014.

SECTION 5. EXPIRATION DATE. Section 1 of this Act is effective through July 31, 2017, and after that date is ineffective."

Renumber accordingly

2013 SENATE HUMAN SERVICES

HB 1362

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1362
3/13/13
19855

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion; to provide an appropriation to the department of human services for the expansion of the medical assistance program; to provide for a legislative management study

Minutes: See attached testimony.

Chariwoman J. Lee opens hearing for HB 1362

Rep. Al. Carlson. Introduced HB 1362. Medicaid expansion should be open for public debate. See attached testimony #1, #2

(0:08:48) Dever: We could put together a state program and still access federal resources.

Rep. Al. Carlson: to my understanding, we modeled the amendments in the house after a bill after Florida.

(0:10:49) Rep. Weisz: This is an important public policy debate. Clarified the amendments to the HB 1362. Language in the bill will do the expansion through a private insurance, through the exchange or contract through a private carrier. We did put a sunset clause, to take a look at it in 2017. This expansion is not entitlement, benefits may be reduced or eliminated if federal participation decreases or eliminated. I can't change the affordable care act, the reasons for the bill and covering those that are uninsured.

(0:20:49) Senator Anderson: Clarification of eligibility of those that will turn over private insurance.

Rep. Weisz: The same process will be used to determine eligibility that we currently use for Medicaid.

(021:30) Chairwoman J. Lee: We do have a new edibility system in the state. For example SNAP is under Dept. AG., those are determined not under DHS. This should combine the systems that should make a difference. Not sure why they left out 0 to 100%, the people that need it the worst are the ones that don't get anything.

Rep. Weisz: They never assumed the expansion would become optional. They didn't want them in the exchange, the cost would go up.

(0:24:34) Chairwoman J. Lee: the unexpected consequence of the Supreme Court ruling that the expansion was optional, is that safety net for the Affordable Care Act to provide insurance. Business owners are trying to figure out how they are going to cover the employees.

Rep. Weisz: we did look at if we just wanted to cover the "donut hole" the 0-100% and we can do that and use federal funds. The Supreme Court ruling does allow the state option to be flexible in the future and make changes.

(0:27:12) Senator Anderson: How is the counties pay for additional FTE's. There was a bill that the state would pay admission costs for the counties, the money was taken out in the house.

Rep. Weisz: You are correct there will be additional costs to the counties, under the current state law and system. With the private insurance the administration load will be less, but not eliminated.

(0:29:21) Senator Dever: Private insurance is acceptable to the federal government and the coverage, co-pays, and deductibles have to be comparable to Medicaid.

Rep. Weisz: We do need to meet essential health benefits, bound by the Affordable Care Act.

(0:31:17) Chairwoman J. Lee; there are 4 levels of polices, bronze, silver, gold and platinum. That have various levels of coverage.

Rep. Weisz: We need to make sure that we meet the minimum level within the exchange.

Senator Dever: Some would argue the Medicaid goes beyond that now.

Rep. Weisz: It might, we are not go through the Medicaid, and we have meet the essential health benefits, the bench mark coverage.

(0:33:13) Maggie Anderson with Department of Human Services. Testified in support of HB 1362. See attached testimony #2. Senator Larsen asks about insurance agents fit in with the exchange, there is a discussion about insurance agents.

(1:23:35) Jerry E. Jurena. President of the North Dakota Hospital Association testified in favor of HB 1362. See attached testimony #3. Chairwoman J Lee, asks about cost shifting. There is a discussion about cost shifting and costs.

(**1:33:23) Dan Ulmer with BCBSND** gave information about cost shifting. Testified in favor of HB 1363. There is a discussion about those that are not covered by insurance.

(**1:38:50) Josh Askvig**, Associate State Director of Advocacy for AARP North Dakota. Testifies in support of HB 1362. See attached testimony #4

(1:46:09) Karen Ehrens From Bismarck North Dakota Economic Security and Prosperity Alliance. Testifies in favor of HB 1162 See attached Testimony #5

(1:48:10) Tom Regan member of the ND Rural Health Behavioral Health Governance Committee. Testifies in favor of HB 1362. Seed attached testimony #6

(1:50:53) Andy Peterson greater North Dakota chamber of Commerce testifies in support of HB 1362. Testifies about cost shifting and taxes, businesses are the ones picking them up. Senator Dever asks a question about Washington and debt. There is a discussion about businesses and taxes and the expansion. Senator Axness asks about having healthy workers in North Dakota, and sending a message to Washington. There is a discussion about how we figure how to cover individuals.

(1:58:54) Christine Hogan with the North Dakota Protection and Advocacy project,. Works with individuals with disabilities from abuse neglect and exploitation and advocates for their civil rights, and supports HB 1362 see attached testimony #7

(2:00:13) Bruce Murry, on behalf of Deborah Knuth of the American Cancer Society, Cancer Action Network supports HB 1362. See attached Testimony #8

(2:00:58) Nancy McKenzie: Public Policy Director for mental Health of North Dakota. Supports HB 1362 See attached testimony #9. There is a discussion about federal parody and mental health coverage.

(2:05:29) Katie Cashman: communications director for the North Dakota Medical Association. Supports HB 1136. See attached testimony #10

Chairwoman J. Lee Close hearing.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1362
3-25-13
20397

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion; to provide an appropriation to the department of human services for the expansion of the medical assistance program; to provide for a legislative management study

Minutes:

Chairwoman J. Lee opens the committee discussion on HB 1362.

Chairwoman J. Lee goes over testimony previously received, and goes over the reasons for HB 1362.

There is Discussion about testimony given by Maggie Anderson from DHS.

There is a discussion about individuals that fall within the 100% poverty level that will not be covered. **Senator Larsen** asks clarification about private insurance and the Medicaid expansion. **Senator Dever**: discusses about the Fiscal Note.

Dan Ulmer form NDBCBS was recognized. Discusses about expanding Medicare or bid it out to a private contractor. **Senator Dever**: asks about the funding on the Fiscal Note. **Senator Axness** asks for clarification for about the $100 million being federal money for the first five years. **Senator Larsen** asks for clarification about the benefit package that is required, and what is the price? There is a discussion about the benefits that are required by the federal government, and the insurance plan(s). **Senator Larsen**: asks what the costs today would be with the required benefits. There is discussion about the benefits and the costs for the individuals. **Senator Larsen**: ask about the fine for those that choose not to carry insurance and when they decide to carry insurance. **Chairwoman J. lee** talks about age band for insurance and the premiums. **Mr. Ulmer**; talks about premium rates and how those are determined. **Chairwoman J. lee** discusses about those that would currently qualify for Medicaid that have not signed up. **Senator Dever**: Asks about options if it only covers individuals at the poverty level.

Chairwoman J lee recess the discussion.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1362
3/25/13 PM
20427

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion; to provide an appropriation to the department of human services for the expansion of the medical assistance program; to provide for a legislative management study

Minutes: "attached testimony."

Chairman J lee reopens the afternoon discussion on HB 1362

Maggie Anderson DHS is recognized to the podium.
Senator Larsen asks about the policies and premiums and the costs for a family.
There is a discussion about who is covered and how they will be covered. **Senator Dever** questioned if there could be sliding scale, at for those under 100% poverty level. **Chairwoman J. lee** asked if there is data about cost share that it's a loss. **Senator Axness**: questions about the 4 options what are the fiscal impact of the all 4 or just the private insurance. **Senator Larsen** asks about the tax credit and if there percentage that each person can receive regardless were they fall percentage of poverty. **Senator Dever**; asks who we are covering exactly. **Senator Anderson**; discusses the costs of the premiums and the fiscal note for the program. **Chairwoman J Lee.** Discusses about the struggle to come up with parameters. **Senator Dever** asks about Indian Health Services. **Chairwoman J. Lee** asks about the VA. **Chairwoman J. lee** refers to chart is previous testimony. **Chairwoman J. Lee** asks about the effective date and discusses about sunset clause and that it's not entitlement. There is discussion about section 1 of HB 1362. **Chairwoman J. Lee** asks about the program in Arkansas. **Senator Dever**; discussion about Medicaid you do not need to pre-enroll asks will they need to pre-enroll with the private insurance. **Senator Dever** asks how you get people enrolled. **Chairwoman J. Lee** likes that there is a private option. **Chairwoman J. Lee** talks about financial impact and the bad debt of hospitals and health care providers would be better managed. **Senator Anderson** discusses about premiums and if it would go down.

Dan Ulman NDBCS is recognized.

There is a discussion about pulling out of the expansion after 2 years.

There is a discussion about the bill, and action on the bill.

Senator Anderson explains why he is not in favor of the Medicaid expansion, and HB 1362

Senator Axness states that he is in favor of HB 1362.

Chairwoman J lee discusses the fiscal note.

Chairwoman J lee closes the discussion.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1362
3/26/13
20490
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion; to provide an appropriation to the department of human services for the expansion of the medical assistance program; to provide for a legislative management study

Minutes: Attachments

Vice Chairman Larsen opens the committee discussion on HB 1362.

Senator Larsen discusses about information that he provided for the committee. **See attachments #11, #12, #13.**

There is a discussion about how the private insurance works with the expansion.

Dan Ulmer with NDBCBS is recognized
Senator Larsen asks for clarification on the deductible and the 5% limit. **Senator Dever**: asks about deductibles and co-pays. **Senator Larsen** discusses about Arizona Medicaid expansion.

Senator Axness disagrees with sources of information, provided by **Senator Larsen**.

There is more discussion on information provided by Senator Larsen.

Chairwoman J. Lee asks what happens if we delay two years.
Josh Askvig form AARP is recognized states that delaying will cut the federal funding of 100% reimbursement.

John Vastag HPC is recognized states that delaying it for two years that will continue to delay a problem of bad debt. **Senator Dever** asks how we know if this will make the difference. **Senator Larsen** would like to know what the tax payers of North Dakota are going to pay. **Chairwoman J Lee** discusses the eligibility at 100% and 138% poverty level.

Chairwoman J. Lee talks about the Medicaid expansion, the effect on businesses, the hospitals, and individuals.

Dan Ulmar discusses about how we are going to pay for the expansion. **Senator Dever** what was his position before the House Amendment and added private insurance.

Jerry Jurena the hospital association is recognized. Discusses about how we are going to pay Medicaid expansion. **Chairwoman J. Lee** asks about the reeducation to the DISH and reimbursement. **Senator Dever** talks about taxes and fraud, waste and abuse of Medicaid. **Senator Larson** asks if we could just insure the "blue box" the 100% poverty level.

Dan Ulamer: discusses about of Medicare Advantage.

Chairwoman J. Lee discusses Rep. Weizes testimony.

Senator Axness discusses about not doing anything for two years, and not waiting the two years.

Chairwoman J. Lee discusses attachments #14, and #15.

Chairwoman J. Lee discusses the taxes associated with Medicaid expansion.

Maggie Anderson from DHS is recognized.
Senator Larsen asks if we pull the expansion is the Federal Government let us go back business as usual or will they not give us the waiver back. **Senator Dever**, asks if this bill would not have been introduced would some other of considering this program. **Chairwoman J. Lee** asks about just covering up to 100% poverty. **Chairman J. Lee** asks about how much it would cost. There is discussion on the private policy that is comparable to the Medicaid coverage. **Senator Dever** asks about co-pays and deductibles under the expansion group.

Senator Dever shares his opposition to the affordable care act. Would like to narrow the focus of HB 1362.

There is discussion about the Medicaid expansion and the choices.

Chairwoman J. lee discusses testimony from Maggie Anderson see attached testimony #2

Dr. Dave Larson with the Denver CMS office. Is recognized and introduced the committee.

Chairwoman J. Lee closes the discussion.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1362
3-26-13
20510

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion; to provide an appropriation to the department of human services for the expansion of the medical assistance program; to provide for a legislative management study

Minutes:

Chairwoman J. Lee opens the discussion for HB 1362

There is a discussion about covering individuals at 100% of poverty and less, that are single and uninsured.

Maggie Anderson DHS is recognized
Senator Dever asks how they come up with those numbers. **Senator Dever** how do we deal with outreach. There is discussion about veterans and Medicaid.

There is a discussion about DHS providing data to the committee.

There is a discussion about the population that needs it.

Chairwoman J. lee shares her opinion on the resistance of the Medicaid expansion and HB 1362.

Senator Axness shares his opinion about passing the Medicaid expansion.

Chairwoman J. Lee discusses how the demographics of those are 100%

Senator Axness: We are all in to get the 100% match or just get the 50./50

Senator Dever, I think we need to act tomorrow, share his concerns with 17 trillion in dept.

There is a discussion about the federal debt and the federal budget and about the Medicaid expansion.

Chairwoman J. Lee closes the discussion

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1362
3/27/13
20534

☐ Conference Committee

Committee Clerk Signature 

Explanation or reason for introduction of bill/resolution:

Relating to Medicaid expansion; to provide an appropriation to the department of human services for the expansion of the medical assistance program; to provide for a legislative management study

Minutes:

Chairwoman J. Lee opens the discussion on HB 1362

Chairwoman J. lee ask about who are currently covered in Medicaid and were they would be with the expansion.
Maggie Anderson with DHS is recognized, goes over the groups for the Medicaid expansion. **Attachment #16 Chairwoman J. Lee** asks for about the private insurance for coverage and the difference in the fiscal note. **Senator Dever** asks about those that are currently covered with Medicaid and any one in the future that qualifies.

Chairwoman J. Lee discusses the information from **Senator Larsen**.

Senator Dever would like more information about the taxes associated with the affordable care act.

Dan Ulmer BCBSND is recognized and discusses the taxes associated affordable care act.

Chairwoman J. Lee discusses the taxes **attachment #15**

Jerry Jurena ND Hospital Association is recognized. Discusses about how the hospitals will be affected by the Medicaid expansion. **Chairwoman J. Lee** discusses attachment. #14

Josh Askvig with AARP is recognized

Chairwoman J. Lee closes the discussion.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1362
3/27/13
20578

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

"Click here to type reason for introduction of bill/resolution"

Minutes: You may make reference to "attached testimony."

Chairwoman J. Lee opens the discussion on HB 1362

Senator Anderson shares his opinion being opposed to HB 1362.

Senator Anderson motions for a Do Not Pass on HB 1362

There is no second

The motion fails.

Senator Larsen shares his opinion about not having a choice.

Senator Larsen motions for a Do Pass and rerefer to Appropriations.

Senator Axness seconds.

Senator Dever shares his opinion and frustration about HB 1362 likes that there is a study and a sunset clause and that it can be revisit this in the next session.

Chairwoman J. Lee agrees with Senator Dever and with his frustration.

Do Pass 4-1-0

Senator J. Lee will carry

FISCAL NOTE
Requested by Legislative Council
02/26/2013

Revised
Amendment to: HB 1362

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$154,742,548	$0	$213,781,489
Expenditures	$0	$0	$248,789	$154,742,548	$2,896,434	$213,781,489
Appropriations	$0	$0	$248,789	$154,742,548	$2,896,434	$213,781,489

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1362 Appropriates to the Department of Human services any amount of federal funds relating to implementing the provisions for the expansion of the medical assistance program from the Patient Protection and Affordable Care Act.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 directs the Department to expand the Medicaid program, as authorized by the Patient Protection and Affordable Care Act. The Department estimates that between 20,547 and 32,000 individuals in North Dakota will be eligible for the expanded coverage. Section 1 also requires the coverage to be provided by bidding through private carriers or utilizing the health insurance exchange. Through consultation with a private insurer, the Department received an estimated cost range from $103,000,000 to $114,000,000 per year. (The lower range estimate is based on the same underlying assumptions used to calculate the original fiscal note for HB 1362, which includes the assumption that only 90% of the eligible individuals will apply for coverage. The higher range estimate is based on the assumption that 100% of the eligible individuals will apply for coverage.) The expanded coverage would be available for 18 months in the 2013-2015 biennium; therefore, the biennial cost estimate ranges from $154,500,000 to $171,000,000. The Department estimates Administrative Costs for the 2013-2015 biennium to be $491,337, of which $248,789 are general funds. ($150,000 ($75,000 general fund) of the administrative costs will be one-time.) Assuming a 5% increase in premiums and the continued funding of the 3 FTE, the estimated cost for the 2015-2017 biennium are from $216,667,923 to $239,777,923, with from $2,896,434 to $3,185,184 being general fund. The estimates DO NOT include increases that may be associated with morbidity rates that are greater than the fully insured group insurance holders; and DO NOT include any increases that may occur if currently insured individuals between 0% and 138% of the federal poverty level drop private insurance to enroll in the Medicaid expansion.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The increase in revenues in each biennium is the additional federal funding the state will receive due to the increased expenditures relating to Medicaid Expansion.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The costs associated with implementing Medicaid Expansion are estimated to be between $154,991,337 to $171,491,337 of which $248,789 will be general fund and between $154,742,548 to $171,242,548 being federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range from $216,677,923 to $239,777,923, with $2,896,434 to $3,185,184 being general fund and from $213,781,489 and $236,592,739 being Federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation in the 13-15 biennium of between $154,991,337 to $171,491,337 of which $248,789 will be general fund and between $154,742,548 to $171,242,548 being federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range from $216,677,923 to $239,777,923, with from $2,896,434 to $3,185,184 being general fund and from $213,781,489 and $236,592,739 being Federal funds.

Name: Debra A. McDermott

Agency: Department of Human Services

Telephone: 701 328-1980

Date Prepared: 03/21/2013

FISCAL NOTE
Requested by Legislative Council
01/21/2013

Bill/Resolution No.: HB 1362

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$101,781,672	$0	$152,581,672
Expenditures	$0	$0	$273,172	$101,781,672	$2,573,172	$152,581,672
Appropriations	$0	$0	$273,172	$101,781,672	$2,573,172	$152,581,672

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1362 Appropriates to the Department of Human services any amount of federal funds relating to implementing the provisions for the expansion of the medical assistance program from the Patient Protection and Affordable Care Act.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 appropriates from special funds derived from federal funds any amounts received relating to the Patient Protection and Affordable Care Act. The Department provides a range for the estimated cost of implementing the Medicaid Expansion due to several unknown factors and the fact that not all of the final rules relating to the Affordable Care Act have been adopted. The unknown factors include how many people will enroll for coverage. The Department estimates 20,547 persons would be eligible while the Kaiser Commission estimates as many as 32,000 North Dakotans would be eligible. The State Fiscal Effect shown in Section 1A. of this fiscal note is the low estimate. The Department estimates implementation of the Affordable Care Act including the addition of 5 to 7 FTE in the 13-15 biennium will range between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range form $155,154,844 and 241,090,975 of which between $2,573,172 and $3,837,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The increase in revenues in each biennium is the additional federal funding the state will receive due to the increased expenditures relating to Medicaid Expansion.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The costs associated with implementing Medicaid Expansion are estimated to be between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range form $155,154,844 and 241,090,975 of which between $2,573,172 and $3,837,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation in the 13-15 biennium of between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department will need an appropriation in the 15-17 biennium of between $158,854,844 and 237,590,975 of which between $273,172 and $337,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

Name: Debra A. McDermott

Agency: Department of Human Services

Telephone: 701 328-1980

Date Prepared: 02/07/2013

Date: 3-27-13
Roll Call Vote #: 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☒ Do Not Pass ☐ Amended ☐ Adopt Amendment
☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen Anderson Seconded By N/A

Senators	Yes	No	Senator	Yes	No
Chariman Judy Lee			Senator Tyler Axness		
Vice Chairman Oley Larsen					
Senator Dick Dever					
Senator Howard Anderson, Jr.					

FAILED

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

No 2nd

Date: 3-27-
Roll Call Vote #: 2

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1362

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment
☒ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen Larsen Seconded By Sen Axness

Senators	Yes	No	Senator	Yes	No
Chariman Judy Lee	✓		Senator Tyler Axness	✓	
Vice Chairman Oley Larsen	✓				
Senator Dick Dever	✓				
Senator Howard Anderson, Jr.		✓			

Total (Yes) 4 No 1

Absent

Floor Assignment Sen J. Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1362, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (4 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1362 was rereferred to the **Appropriations Committee**.

2013 SENATE APPROPRIATIONS

HB 1362

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1362
04-03-2013
Job # 20803

☐ Conference Committee

Committee Clerk Signature Alice Delzer

An Explanation or reason for introduction of bill/resolution:

A BILL regarding Medicaid Expansion

Minutes: See attached testimony."

Chairman Holmberg called the committee to order on Wednesday, April 03, 2013 at 8:30 am in regards to HB 1362. All committee members were present.

Sheila M. Sandness- Legislative Council
Lori Laschkewitsch-OMB

Representative Carlson, District 41, Fargo: introduced the bill and provided Testimony attached # 1. I am not in favor of expanding Medicare. There is a cost of $9 million to expand. On the other hand do we understand when the compensation goes down, do we want to be in it or out? That is a decision for legislatures to make. In North Dakota we have a lot of various programs available. No one is turned down for care. I understand why the hospitals want this because they can collect something when before they were collecting nothing. You have to make some decisions. This does have long term ramifications and that is why I introduced the bill. My recommendation is to wait two years from now and review this when the full implementation of Obamacare is put into effect.

Senator Mathern: I agree with you that we could have done some other things. There have been proposals through the years. The house voted against the proposals and we have attempted other things, but they have not passed. Is there something else that you would suggest at this point instead of this bill?

Rep. Carlson: We have CHIPS and we have dollars that aren't being used. If there are children that are uncovered, we should be looking how to cover them. You have to understand the reality of our national debt. They are sequestering as we speak. Our National Guard is going to have their hours cut. The federal government is broke.

Maggie Anderson, Interim Director Department Human Services: testified in support of HB 1362 and provided written Testimony attached # 2- which explains several aspects of what the bill would do. This is the original house bill. The committee did not make any

changes. She explained the different sections of the bill to the committee. She referred to attachment A and B and explained them. (Ended at 30:00)

Vice Chairman Bowman: If the rules haven't been completely written, how can you commit the state? If we sign up, the rules can change and we may not like those. The state's cost will keep increasing so we need to be really sure about what we're getting into before we go this route. Things haven't gone well in Washington so that will cost the people of North Dakota in the long run.

Maggie Anderson: We determine eligibility based on net income. Most of our population will move to modified adjusted gross income, MAGI levels. We are trying to figure out some of those rules. A state can end their participation at any time. Since it is not a mandate, the state can start and stop. The rules are still in process, but they are falling into place.

Vice Chairman Bowman: Does that include the technology to orchestrate this? That is getting to be an expensive part of our budgeting process today.

Maggie Anderson: The claim processing system shouldn't be considerably impacted based on the house amendments because we would send the names across to that vendor and the private insurance company would be processing the claims. There shouldn't be any additional large increases.

Senator Carlisle: Relative to the rules question, you are comfortable at this point with the rules you have in hand?

Maggie Anderson: The question about the medical expansion is more related to the law. The rules will play out. I have been keeping CMS informed of HB 1362 and the amendments. So yes, I am comfortable with what we have.

Senator Mathern: if we were going to send people to the exchange who would decide what product that person could have, and could that person do all of the data entry on the exchange and not have to come to DHS or the counties to apply in addition to the exchange work?

Maggie Anderson: The first question about who will decide is a DHS will decision. If the bill passes we would visit with the insurance department. The way the bill reads today, the DHS would need to vent both of those options and then have a product in exchange. With regard to the second question, that is exactly how the process should work. Our system has to do the Medicaid eligibility determination and if we made the decision to cover them through the exchange, and it should all be able to be done from their home, the library, to the county, etc.

Representative Jim Casper, District 46, Testimony attached # 3. I just want to make the committee aware of a study done by the Heritage Foundation. It says the Medicaid expansion in ND, is being projected through 2022 to cost the state of North Dakota $159 million and their statement says it would result in a rapid increase in spending beginning in 2017 passing any amount of savings from deductions in state payments to providers for uncompensated care. There is no rush. We can decide this in two years.

Dan Ulmer, Blue Cross: If you delay this for two years, you will miss out of two years at 100% matching. Cost shifting has been going on. If Medicare pays $100, we pay $160 for that. In order to cover the unfunded treatment, $100 a month of the premium goes to pay for uninsured. We would like to hold it at that. PPACK is paid for. We are going to pay the taxes under Obamacare no matter what. The question is whether or not we are going to bet any benefit from it. Senator Conrad said when the bill was done it would $139 billion. Medicare Advantage is where CMS decided to pay premiums to private companies to manage the care they would give seniors. The $500 billion cut to Medicare is cutting profit margins to insurance companies. The bill sunsets in 2017 so you have two more bienniums to decide. There was a strong about entitlement. That language is in there as well. People understand this benefit may be removed. I am disappointed with what we did with the exchange during the special session because we lost a lot of our state regulatory environment. That will be the biggest thing we will have to claw back. If you do the math with these folks, these are the folks that create bad debt. It is a matter they can't afford.

Josh Askvig, Associate State Director of Advocacy for AARP ND: Testimony attached # 4, "We Support Medicaid Expansion" (a statement from several entities saying they are in support of HB 1362) and Testimony attached # 5 from AARP in support of the bill. (51.46)

Jerry E. Jurena, President of ND Hospital Association: testified in favor of HB 1362 and provided written Testimony attached # 6 in support of HB 1362. (58.48)

Senator Kilzer: Do you have any hard statistics on the cost shifting? What are the long term effects down the road? They must be substantial.

Jerry E. Jurena: We do not have an aggregate number. Each hospital takes a look at their Medicare and Medicaid discounts and their bad debt when they are calculating their revenues. They make adjustments at that time with cost shifting. As an association we don't have an aggregate for you.

Senator Kilzer: These hospitals do have their own statistics for their institution as they put together the negotiations with the most frequently used carrier in the state so I am surprised that you don't gather a congregate figure from the hospitals. It would be useful to know that.

Jerry E. Jurena: We have not done that.

Vice Chairman Bowman: The hospitals lose a lot of money over this but the federal government is broke over all of the promises they made for several years. $17 trillion is a huge amount of money. What guarantee is there that in two years this program will be here?

Jerry E. Jurena: There are no guarantees and you are right. The way they are going to pay for this program is they are going to take money from the left pocket of the hospital Medicare and put it in the right pocket. We won't get any more money. We are just shifting that money from Medicare to Medicaid. If we don't participate, the money that comes out of the left pocket for Medicare reductions are going to go to the other states doing this.

Chairman Holmberg closed the hearing on HB 1362.

Written testimony submitted after the hearing was closed are as follows:

Testimony # 7 from Jon Godfread, Greater ND Chamber of Commerce, stating their organization is in support of HB 1362.

Testimony #8 from Deborah Knuth, Government Relations Director; American Cancer Society Cancer Action Network stating their organization is asking for a Do Pass on HB 1362.

2013 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1362
04-03-2013
Job 20809

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:
A BILL regarding Medicaid Expansion

Minutes: Attached testimony:

Chairman Holmberg opened the hearing. All committee members were present.

Brady Larson - Legislative Council and **Joe Morrissette** - OMB

Senator Mathern moved a do pass. 2nd by Senator Warner

Senator Wanzek: Given that there is a mandate to buy insurance and you don't, do you pay the fine then?

Maggie Anderson, Interim Director, Department of Human Services: The individuals in the green box (in the chart) if you split them right down that 100% of federal poverty: the group above a hundred is subject to the individual mandate, if they choose not to do anything they have penalties. If they show up to a hospital for non-emergencies, it will be the individual hospital decision to treat them or not. If an emergency room visit, the hospital has to assess and treat them. Those below the 100 will be on Medicaid.

Senator Wanzek: those who might be worth a lot of money, but their income might not be high they might qualify for Medicaid? (Told yes)

Senator Carlisle: 9 of 10 people are covered by insurance in ND? (Told that is about right)

Senator Kilzer: I am going to vote against this, everything we are hearing is patchwork coverage. The cost shifting is going to get worse, not just from one third party payer to another, but to the state government. We are already getting that in order to keep our smaller hospitals open, and I don't hear anything at all on adequate payment by the government which is taking this over, we are just getting less control and Vice Chairman Bowman is right about this.

A Roll Call vote was taken. Yea: 7; Nay :6; Absent: 0

Chairman Holmberg: This will go back to Human Services. Judy Lee will carry the bill. Hearing closed on HB 1362.

FISCAL NOTE
Requested by Legislative Council
02/26/2013

Revised
Amendment to: HB 1362

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$154,742,548	$0	$213,781,489
Expenditures	$0	$0	$248,789	$154,742,548	$2,896,434	$213,781,489
Appropriations	$0	$0	$248,789	$154,742,548	$2,896,434	$213,781,489

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1362 Appropriates to the Department of Human services any amount of federal funds relating to implementing the provisions for the expansion of the medical assistance program from the Patient Protection and Affordable Care Act.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 directs the Department to expand the Medicaid program, as authorized by the Patient Protection and Affordable Care Act. The Department estimates that between 20,547 and 32,000 individuals in North Dakota will be eligible for the expanded coverage. Section 1 also requires the coverage to be provided by bidding through private carriers or utilizing the health insurance exchange. Through consultation with a private insurer, the Department received an estimated cost range from $103,000,000 to $114,000,000 per year. (The lower range estimate is based on the same underlying assumptions used to calculate the original fiscal note for HB 1362, which includes the assumption that only 90% of the eligible individuals will apply for coverage. The higher range estimate is based on the assumption that 100% of the eligible individuals will apply for coverage.) The expanded coverage would be available for 18 months in the 2013-2015 biennium; therefore, the biennial cost estimate ranges from $154,500,000 to $171,000,000. The Department estimates Administrative Costs for the 2013-2015 biennium to be $491,337, of which $248,789 are general funds. ($150,000 ($75,000 general fund) of the administrative costs will be one-time.) Assuming a 5% increase in premiums and the continued funding of the 3 FTE, the estimated cost for the 2015-2017 biennium are from $216,667,923 to $239,777,923, with from $2,896,434 to $3,185,184 being general fund. The estimates DO NOT include increases that may be associated with morbidity rates that are greater than the fully insured group insurance holders; and DO NOT include any increases that may occur if currently insured individuals between 0% and 138% of the federal poverty level drop private insurance to enroll in the Medicaid expansion.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   The increase in revenues in each biennium is the additional federal funding the state will receive due to the increased expenditures relating to Medicaid Expansion.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   The costs associated with implementing Medicaid Expansion are estimated to be between $154,991,337 to $171,491,337 of which $248,789 will be general fund and between $154,742,548 to $171,242,548 being federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range from $216,677,923 to $239,777,923, with $2,896,434 to $3,185,184 being general fund and from $213,781,489 and $236,592,739 being Federal funds.

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

   The Department will need an appropriation in the 13-15 biennium of between $154,991,337 to $171,491,337 of which $248,789 will be general fund and between $154,742,548 to $171,242,548 being federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range from $216,677,923 to $239,777,923, with from $2,896,434 to $3,185,184 being general fund and from $213,781,489 and $236,592,739 being Federal funds.

Name: Debra A. McDermott

Agency: Department of Human Services

Telephone: 701 328-1980

Date Prepared: 03/21/2013

FISCAL NOTE
Requested by Legislative Council
01/21/2013

Bill/Resolution No.: HB 1362

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2011-2013 Biennium		2013-2015 Biennium		2015-2017 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$101,781,672	$0	$152,581,672
Expenditures	$0	$0	$273,172	$101,781,672	$2,573,172	$152,581,672
Appropriations	$0	$0	$273,172	$101,781,672	$2,573,172	$152,581,672

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2011-2013 Biennium	2013-2015 Biennium	2015-2017 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB1362 Appropriates to the Department of Human services any amount of federal funds relating to implementing the provisions for the expansion of the medical assistance program from the Patient Protection and Affordable Care Act.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 appropriates from special funds derived from federal funds any amounts received relating to the Patient Protection and Affordable Care Act. The Department provides a range for the estimated cost of implementing the Medicaid Expansion due to several unknown factors and the fact that not all of the final rules relating to the Affordable Care Act have been adopted. The unknown factors include how many people will enroll for coverage. The Department estimates 20,547 persons would be eligible while the Kaiser Commission estimates as many as 32,000 North Dakotans would be eligible. The State Fiscal Effect shown in Section 1A. of this fiscal note is the low estimate. The Department estimates implementation of the Affordable Care Act including the addition of 5 to 7 FTE in the 13-15 biennium will range between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range form $155,154,844 and 241,090,975 of which between $2,573,172 and $3,837,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The increase in revenues in each biennium is the additional federal funding the state will receive due to the increased expenditures relating to Medicaid Expansion.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The costs associated with implementing Medicaid Expansion are estimated to be between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department estimates that the Affordable Care Act costs for the 15-17 biennium will range form $155,154,844 and 241,090,975 of which between $2,573,172 and $3,837,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department will need an appropriation in the 13-15 biennium of between $102,054,844 and $158,590,975 of which between $273,172 and $337,960 will be general fund and between $101,781,672 and 158,253,015 will be federal funds. The Department will need an appropriation in the 15-17 biennium of between $158,854,844 and 237,590,975 of which between $273,172 and $337,960 will be general fund and between $152,581,672 to $237,253,015 will be federal funds.

Name: Debra A. McDermott

Agency: Department of Human Services

Telephone: 701 328-1980

Date Prepared: 02/07/2013

Date: 4-3-13

Roll Call Vote # 1

2013 SENATE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1362

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Adopt Amendment ☑ Do Pass
☐ Do Pass as Amended ☐ Do Not Pass

Motion Made By Mathern Seconded By Warner

Senators	Yes	No	Senator	Yes	No
Chariman Ray Holmberg	✓		Senator Tim Mathern	✓	
Co-Vice Chairman Bill Bowman		✓	Senator David O'Connell	✓	
Co-Vice Chair Tony Grindberg	✓		Senator Larry Robinson	✓	
Senator Ralph Kilzer		✓	Senator John Warner	✓	
Senator Karen Krebsbach	✓				
Senator Robert Erbele		✓			
Senator Terry Wanzek		✓			
Senator Ron Carlisle		✓			
Senator Gary Lee		✓			

Total (Yes) 7 No 6

Absent 0

Floor Assignment Human Services J Lee

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1362, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (7 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1362 was placed on the Fourteenth order on the calendar.

2013 TESTIMONY

HB 1362

#1

Testimony by Rep. Al Carlson, 1.30.12,

House Human Services Committee

January 30th, 2012

In the wake of the US Supreme Court's decision on the Patient Protection and Affordable Care Act (PPACA), also known as Obamacare, states must now decide whether to expand their Medicaid programs by accepting a larger federal subsidy.

As passed, PPACA required states to expand their Medicaid eligibility to all individuals with incomes between 133 percent and 138 percent of the federal poverty level. States that failed to meet this requirement would no longer receive any federal Medicaid grants at all.

The Supreme Court, however, ruled states could not be required to expand their Medicaid programs in order to continue receiving current levels of federal support.

Therefore, states are not required to expand their Medicaid programs, but the offer of "free money" is proving tempting to many states.

In reality, the money isn't free. Accepting federal funds to expand Medicaid rolls will impose new costs upon states and, ultimately, state taxpayers.

The federal matching rate starts at 100 percent for newly eligible enrollees, but it declines over time, leaving states to find other ways to pay for the newly eligible population.

States that choose to expand, instead of reforming an already broken system, will subject even more of their lower-income residents to a program that provides inferior care.

Policy Solution

We should avoid Medicaid expansion and instead reform our fiscally unsustainable programs in ways that will offer better care and lower costs to the state. Solutions to consider may include a premium-based model like Florida's pilot program, which saved $118 million a year in the five counties in the program, or a block-grant program that gives states more flexibility over how they run Medicaid and manage its costs.

So What Could We Do:

1. Help the needy up to 100 percent of the federal poverty level to obtain access to care but do not create an entitlement program that we cannot afford,
2. The exclusion of single people from Medicaid coverage is an issue we need to seriously look at for innovative solutions

*Note, individuals that are not covered by Medicaid are adults between the ages of 21 and 65 who are not blind or disabled, pregnant, or a caretaker of deprived children.

- How can we work on state solutions instead of federally mandated controls and dictates that have steered our country towards bankruptcy?
- Our country has $16.5 trillion in debt and the federal politicians continue to add entitlements that we absolutely know we cannot afford.
- How can we expand Medicaid on a national basis when the country is broke?
- Do you think Medicare will really be cut by the politicians to pay for the Medicaid expansion under Obamacare?
- Do we as citizens of this state and country care about the debt we are passing on to our children and grandchildren?
- The feds will pull this Medicaid expansion money in a few years out of fiscal necessity and we will be left with a bureaucratic program that does not achieve its objective efficiently or effectively.
- Will we ever work on designing health coverage that is affordable for North Dakotans?
- Do we want to address medical inflation which is out of control?
- We should be experimenting with innovative policies here in ND to cover the truly needy while creating systems to incentivize individuals to manage their own health and health care better, rather than having a debt financed federal government expansion of entitlements dictated from Washington which has a clear history of making promises it does not keep and adding rules and regulations we can ill afford.

I would respectfully ask the department to:

1. Identify the cost of a proposal that provides a safety net for individuals that are not married that fall under 100% of the federal poverty guidelines. We need to know how much it would cost to provide coverage to single folks that fall under 100% of the federal poverty level?
2. We should work on a state wide level to address the issues associated with access to health care. We should remember our children first. They represent our future. We should not saddle them with more and more debt – robbing them of the opportunity to achieve the American Dream.

3. The figures I have indicate that there are less than 9,000 children that are uninsured. We have done a good job with covering children in Medicaid, healthy steps and the Caring Program run by Blue Cross Blue Shield.

4. We should consider using our medical residency programs to provide primary care to needy citizens and also work to maximize their use of the state's Federally qualified health care centers.

5. The long term solution for the uninsured problem involves creating the conditions in our state for businesses to flourish. Most businesses that are successful offer health coverage as a benefit. We need to ensure that North Dakota continues to be a great state to start and expand businesses that create decent paying jobs with benefits including health coverage.

States Which HAVE Supported Medicaid Expansion:

Arkansas	Washington
California	Vermont
Washington, DC	Rhode Island
Delaware	Illinois
Hawaii	Maryland
Massachusetts	Connecticut
Minnesota	Nevada
Missouri	

States Which HAVE NOT Supported Medicaid Expansion:

Alabama	Georgia
Florida	Iowa
Kansas	Maine
Louisiana	Wisconsin
Mississippi	Texas
Nebraska	South Dakota
Oklahoma	South Carolina

#2

Testimony
House Bill 1362 – Department of Human Services
House Human Services Committee
Representative Robin Weisz, Chairman
January 30, 2013

Chairman Weisz, members of the House Human Services Committee, I am Maggie Anderson with the Department of Human Services (Department). I am here today to support House Bill 1362, which is also 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 November 2012, there were 66,323 individuals enrolled in North Dakota Medicaid. Of those, 38,686 were children and 27,637 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 estimates prepared are based on the Medicaid state plan benefit package offered in North Dakota. We are analyzing the Essential Health Benefits requirements to determine any additions that may be needed, such as habilitation.

Other options for coverage include selecting one of the benchmark plans and supplementing the coverage to meet the requirements of the

Essential Health Benefits; or allowing the newly eligible population to select a plan through the Health Insurance Exchange.

The choice of coverage has a direct impact on the administrative costs to support the Medicaid expansion. If the coverage is a Medicaid "look-a-like" or "Medicaid-like" plan, there are more administrative expenses for the Department then there would be if the newly eligibles secured coverage through the Exchange. Details of the administrative costs are included in the following section.

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 potential enrollment range, the Department is estimating to need between $101 million and $158 million in federal funds for the Medicaid expansion for the **2013-2015 biennium**. Please refer to the yellow and blue handouts that contain the estimated costs for the "newly eligibles" as well as the other estimated costs to the Medicaid program **through Calendar Year 2020** and **through the 2019-2021** biennium. The expected administrative costs are not included in these handouts.

Administrative Costs

The increased administrative costs are expected to vary depending on the coverage option selected. If the coverage provided is the existing Medicaid benefit plan, the Department would need the following additional staff to manage the increased workload associated with the increase in Medicaid enrollees:

	Salaries required for 2013 - 2015 Budget, For Medicaid Expansion		
Position	**Total Funds**	**General Funds**	**Start Date**
Fiscal Administration Mailroom Staff	77,376	34,595	October 1, 2013
Provider Relations	87,789	21,947	October 1, 2013
Provider Relations*	87,789	21,947	October 1, 2013
Medical Services			
Nurse	148,342	42,841	September 1, 2013
Nurse*	148,342	42,841	September 1, 2013
Administrative Support	78,226	43,337	November 1, 2013
Eligibility Policy	133,187	66,594	August 1, 2013
Economic Assistance Quality Assurance	129,924	63,858	October 1, 2013
Total	**$ 890,975**	**$ 337,960**	

*Second Provider Relations and Nurse positions are only needed if the expansion enrollment achieves a level between the DHS and Kaiser Family Foundation estimates.

In addition, if coverage is provided through the existing Medicaid benefit plan, the Department would incur other increased administrative costs for services such as issuing Medicaid Identification Cards and the cost of several contracts. These other administrative cost increases are estimated to be:

Administrative Area	**Estimated Cost for 2013-2015 Biennium**
Medicaid ID Cards	32,320
Inpatient Utilization Review	114,820
Pharmacy Prior Authorization	45,000
Retro-Drug Utilization Review	37,500

TOTAL	**$229,640**
Federal Funds	$164,150
State Funds	**$65,490**

If the coverage for the newly eligibles is provided through the Exchange, the administrative costs are less than what is needed to expand the number covered under the existing Medicaid benefit plan. The additional staff needed under this scenario are:

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

The other administrative costs are not included for this scenario, as it is expected that the insurers selected through the Exchange would issue ID cards and would be responsible for the various utilization review services.

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. The rule has a 30-day comment period.

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.

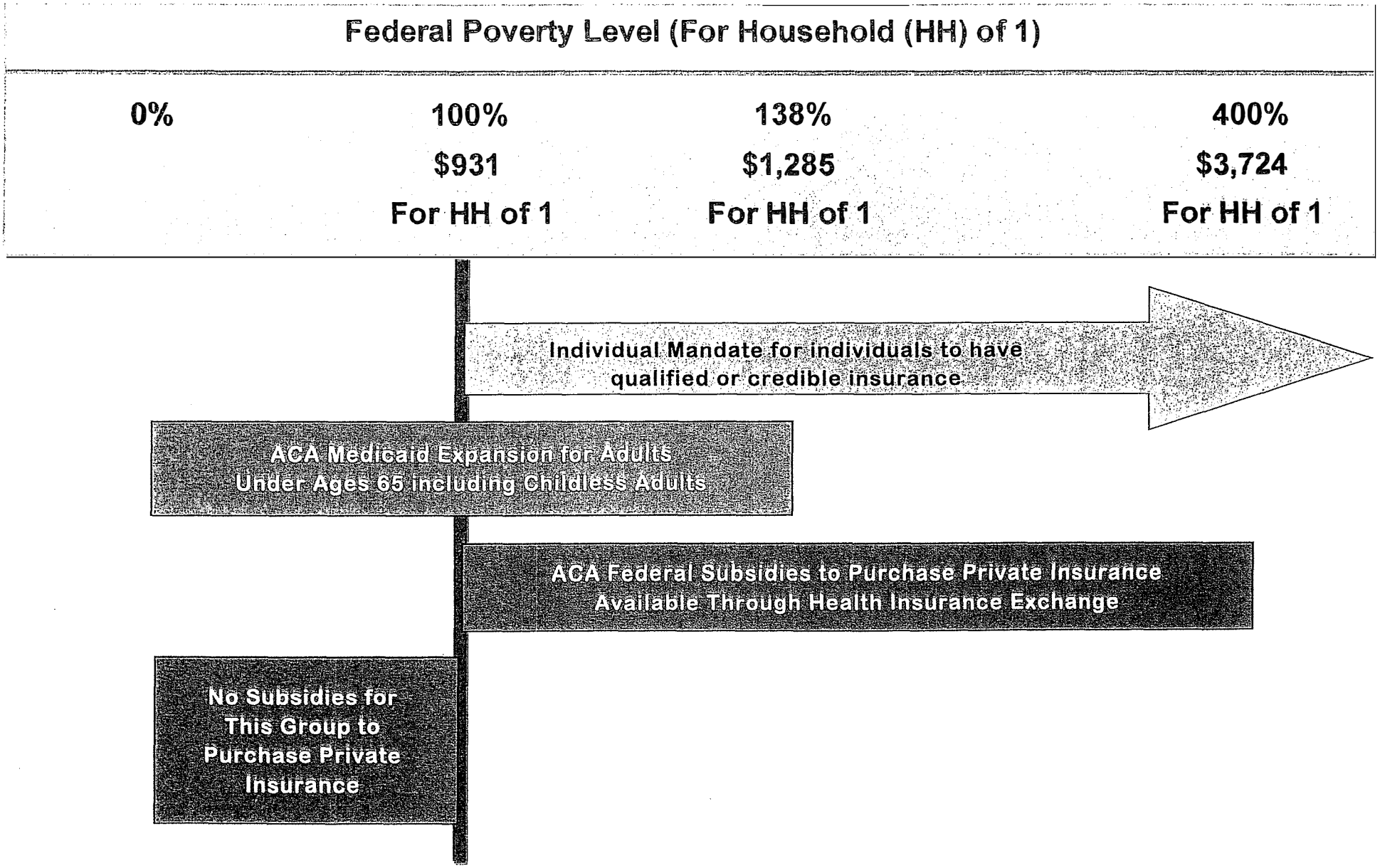
In addition, there are current coverage groups such as the Workers' with Disabilities Buy In and the Women's Way (Breast and Cervical Cancer Treatment). These groups are currently "**optional**" Medicaid coverage. In 2014, these populations **should have private coverage options** through the Health Insurance Exchange. We are seeking answers from CMS about the options for these groups, including portions of the groups falling under the "new adult/expansion" group. We are hopeful that within the next few weeks we will be in a better position to make a recommendation about the coverage for these groups.

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.

Att. .nent A

North Dakota Department of Human Services
Affordable Care Act (ACA)

Medicaid Expansion Illustration



Department of Human Services

Medical Services Division

Questions and Answers from the Centers for Medicare and Medicaid Services

Excerpt from the Attachment to December 10, 2012

Letter from Secretary Sebelius to Governors

House Bill 1362

MEDICAID

Expansion

24. Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care Act?

A. No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions.

As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process.

While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to "newly eligible individuals" are tied by law to specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.

25. If a state accepts the expansion, can a state later drop out o/the expansion program?

A. Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.

26. Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?

A. No. Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing.

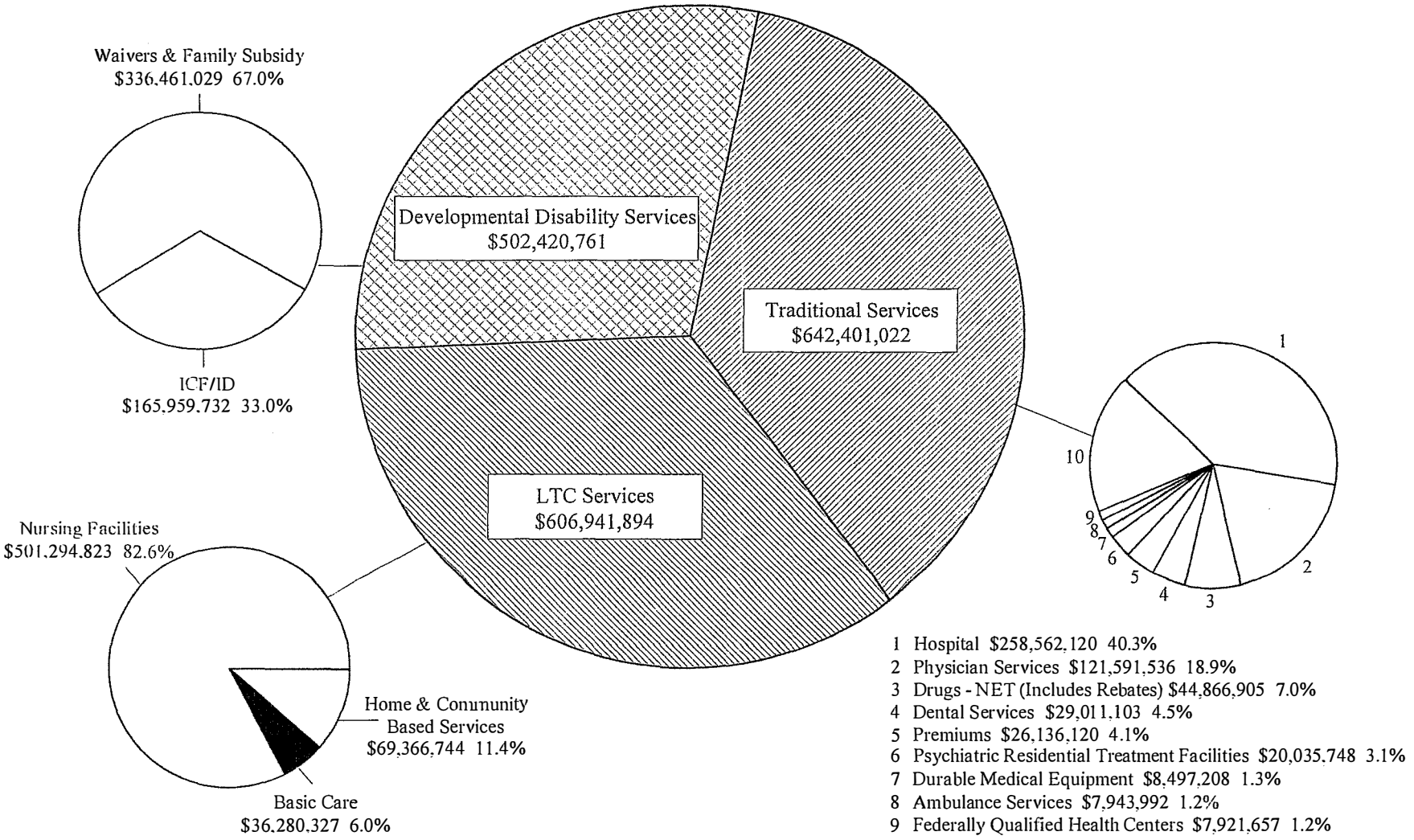
In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. This demonstration authority offers states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.

31. Will low-income residents in states that do not expand Medicaid to 133 percent of the FPL be eligible for cost sharing subsidies and tax credits to purchase coverage through an Exchange?

A. Yes, in part. Individuals with incomes above 100 percent of the federal poverty level who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage will be eligible for premium tax credits and cost sharing reductions, assuming they also meet other requirements to purchase coverage in the Exchanges.

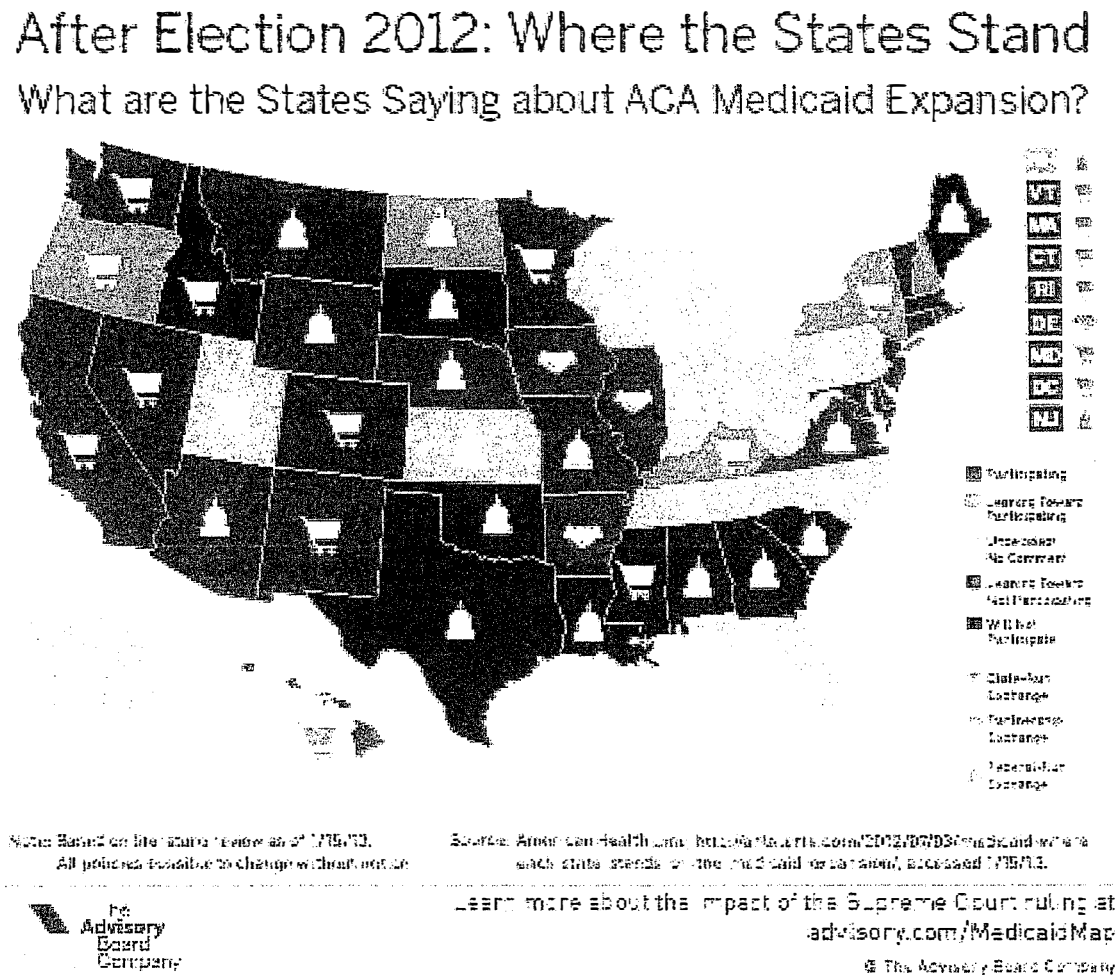
Department of Human Services
Executive Budget Request
Medical Assistance Grants

Attachment C



1 Hospital $258,562,120 40.3%
2 Physician Services $121,591,536 18.9%
3 Drugs - NET (Includes Rebates) $44,866,905 7.0%
4 Dental Services $29,011,103 4.5%
5 Premiums $26,136,120 4.1%
6 Psychiatric Residential Treatment Facilities $20,035,748 3.1%
7 Durable Medical Equipment $8,497,208 1.3%
8 Ambulance Services $7,943,992 1.2%
9 Federally Qualified Health Centers $7,921,657 1.2%
10 Other $117,834,633 18.4%

North Dakota Department of Human Services
Medical Services Division
House Bill 1362



Reference: Advisory.com,(January 15, 2013). The Advisory Board Company. Where Each State Stands on Medicaid Expansion.

North Dakota Department of Human Services
Medical Services Division
House Bill 1362

State	Governor or Executive Branch Activity	Activity in the Legislature
	Announcement regarding the state's Medicaid expansion decision from a governor in the state's budget, state of the state address, other official statement or news article.	State bills related to Medicaid expansion moving forward in the legislature. May also include city or county legislative materials.
AL		
AK		
AZ	Governor supports expansion	
AR	Governor supports expansion	
CA	Governor supports expansion	
CO	Governor supports expansion	
CT		
DE		
DC		
FL		
GA	Governor against expansion	Senate proposed resolution to expand Medicaid
HI		
ID	Governor against expansion	
IL	Governor supports expansion	House and Senate filed a bill (HB 106 and SB 26) to expand Medicaid
IN		
IA	Governor against expansion	
KS	Governor undecided on expansion	Proposed House Bill (HB2032) to support Medicaid Expansion
KY		
LA		
ME		
MD	Governor supports expansion	Two Administration bills proposed to expand Medicaid: SB 274 and HB 228
MA		
MI		
MN		
MS	Governor against expansion	
MO	Governor supports expansion	Senate bill proposed to reduce Medicaid eligibility levels
MT	Governor supports expansion	
NE	Governor against expansion	Proposed bill to expand Medicaid (LB 577)

State	Governor or Executive Branch Activity	Activity in the Legislature
NV	Governor supports expansion	
NH	Governor supports expansion	
NJ		Senate Concurrent Resolution No. 132 proposed to expand Medicaid
NM	Governor supports expansion	
NY		
NC		
ND	Governor supports expansion	Governor proposed bill to expand Medicaid
OH		
OK	Governor undecided on expansion	
OR		
PA		
RI	Governor supports expansion	
SC	Governor against expansion	
SD	Governor against expansion	
TN		
TX		Senate Joint Resolution (SJR) 8 proposing a constitutional amendment to require Texas to expand Medicaid
UT		
VT		
VA	Governor against expansion	Proposed resolution in the city of Charlottesville, VA to expand Medicaid
WA		
WV		
WI		
WY	Governor undecided on expansion	Proposed bill to change Medicaid eligibility levels for pregnant women and children to comply with the ACA but prevent further expansion of Medicaid. Proposed bill to expand Medicaid.

Chart produced by: Kaitlin Sheedy and Sonya Schwartz, National Academy for State Health Policy. Contributions by Shuchita Madan, Medicaid Health Plans of America.

Reference: StateReforum.org website, 2013. Last updated January 28, 2013.

North Dakota Department of Human Services
INCOME ELIGIBILITY LEVELS
Effective April 1, 2012

Family Size	Family Coverage (1931)	Medically Needy 83% of Poverty	SSI (Effective 01/01/13)	Children Age 6 to 19 and QMB 100% of Poverty	SLMB 120% of Poverty	Pregnant Women & Child to Age 6 133% of Poverty	QI-1 135% of Poverty	Healthy Steps 160% of Poverty	Transitional Medicaid 185% of Poverty	Caring for Children & Children with Disabilities & Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$311	$ 773	$ 710	$ 931	$ 1,117	$1,238	$1,257	$1,490	$1,723	$1,862	$2,095
2	417	1,047	1,068	1,261	1,513	1,677	1,703	2,018	2,333	2,522	2,837
3	523	1,321		1,591	1,909	2,116	2,148	2,546	2,944	3,182	3,580
4	629	1,595		1,921	2,305	2,555	2,594	3,074	3,554	3,842	4,322
5	735	1,869		2,251	2,701	2,994	3,039	3,602	4,165	4,502	5,065
6	841	2,143		2,581	3,097	3,433	3,485	4,130	4,775	5,162	5,807
7	947	2,416		2,911	3,493	3,871	3,930	4,658	5,386	5,822	6,550
8	1,053	2,690		3,241	3,889	4,311	4,376	5,186	5,996	6,482	7,292
9	1,159	2,964		3,571	4,285	4,750	4,821	5,714	6,607	7,142	8,035
10	1,265	3,238		3,901	4,681	5,189	5,267	6,242	7,217	7,802	8,777
+1*	107	274		330	396	439	446	528	611	660	743

Spousal Impoverishment Levels			
Community Spouse Minimum Asset Allowance (Effective 01/01/13)	Community Spouse Maximum Asset Allowance (Effective 01/01/13)	Community Spouse Income Level (Effective 01/01/03)	Income Level for each Additional Individual (Effective 04/01/12)
$23,184	$115,920	$2,267	$630

Average Cost of Nursing Facility Care	
Average Monthly Cost of Care (Effective 01/01/13)	Average Daily Cost of Care (Effective 01/01/13)
$6,792	$223.30

Notes: Nursing Home personal needs allowance increased from $40 to $50 effective with the benefit month of 01/01/02.
ICF/ID and Basic Care personal needs allowance increased from $50 to $85 effective 1/1/2010.

#3

Department of Human Services
Medicaid Expansion and Other ACA Fiscal Impacts
Potential Enrollment (20,547) is Based on Current Population Survey Annual Social & Economic Supplement - US Census Bureau for the State of North Dakota

Estimated ***Calendar Year*** *Totals for Medicaid*

	2014	2015	2016	2017	2018	2019	2020	Cumulative TOTAL of CY2014 thru CY2020
FMAP	100%	100%	100%	95%	94%	93%	90%	
Newly Eligible##	12,685	13,591	13,591	13,591	13,591	13,591	13,591	
Total Costs	$ 58,700,000	$ 73,800,000	$ 75,900,000	$ 78,900,000	$ 82,100,000	$ 85,300,000	$ 88,800,000	$ 543,500,000
State Costs	-			3,945,000	4,105,000	4,265,000	4,440,000	16,755,000
Rounded to nearest $100,000								$ -
FMAP	50%	50%	50%	50%	50%	50%	50%	
Previously Eligible**	1,257	1,300	1,300	1,300	1,300	1,300	1,300	
Total Costs	$ 5,400,000	$ 6,000,000	$ 6,200,000	$ 6,500,000	$ 6,700,000	$ 7,000,000	$ 7,300,000	$ 45,100,000
State Costs	2,700,000	3,000,000	3,100,000	3,250,000	3,350,000	3,500,000	3,650,000	22,550,000
Rounded to nearest $100,000								
Foster Care Coverage from age 19 Thru 25^^								
Total Costs	$ 102,000	$ 147,000	$ 196,000	$ 249,000	$ 305,000	$ 366,000	$ 431,000	$ 1,796,000
State Costs	51,000	73,500	98,000	124,500	152,500	183,000	215,500	898,000
Projected Enrollment	31	43	55	67	79	91	103	
Drug Rebates - reduction in amount retained by North Dakota~								
Reduction	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 9,800,000
Drug Rebate impact prior to January 1, 2014								
Reduction in amount retained by State January 1, 2010 thru December 31, 2013								$ 4,000,000
Combined Total Cost	$ 65,602,000	$ 81,347,000	$ 83,696,000	$ 87,049,000	$ 90,505,000	$ 94,066,000	$ 97,931,000	$ 604,196,000
Combined State Cost	4,151,000	4,473,500	4,598,000	8,719,500	9,007,500	9,348,000	9,705,500	54,003,000

Estimated ***Biennium*** *Totals for Medicaid*

	13-15 Biennium	15-17 Biennium	17-19 Biennium	19-21 Biennium	Cumulative TOTAL over 4 Bienniums
Newly Eligible##	10,307	13,591	13,591	13,591	
Total Costs	$ 101,400,000	$ 152,200,000	$ 164,700,000	$ 178,100,000	$ 596,400,000
State Costs	-	2,300,000	10,000,000	16,700,000	29,000,000
Rounded to nearest $100,000					
FMAP					
Previously Eligible**	1,067	1,300	1,300	1,300	
Total Costs	$ 9,100,000	$ 12,500,000	$ 13,500,000	$ 14,600,000	$ 49,700,000
State Costs	4,550,000	6,250,000	6,750,000	7,300,000	24,850,000
Rounded to nearest $100,000					
Foster Care Coverage from age 19 Thru 25^^					
Total Costs	$ 180,000	$ 400,000	$ 620,000	$ 870,000	$ 2,070,000
State Costs	90,000	200,000	310,000	435,000	1,035,000
Drug Rebates - reduction in amount retained by North Dakota~					
Reduction	$ 2,800,000	$ 2,800,000	$ 2,800,000	$ 2,800,000	$ 11,200,000
Drug Rebate impact prior to July 1, 2013					
Reduction in amount retained by State January 1, 2010 thru June 30, 2013					$ 3,100,000
	$ 113,480,000	$ 167,900,000	$ 181,620,000	$ 196,370,000	$ 662,470,000
	7,440,000	11,550,000	19,860,000	27,235,000	69,185,000

New Adult Group/Newly Eligibles: This is the group that would be eligible for coverage through an expansion of Medicaid. The expansion would include all adults under the age of 65. Most notably the "childless adult" population would become eligible for Medicaid.

**Previous Eligibles (Woodwork): This group is eligible for Medicaid today; however, they have not applied for coverage. It is expected that with the outreach efforts and the individual mandate in 2014 that individuals in this group will present for coverage. They are eligible for Medicaid – regardless of a Medicaid expansion- and they will be enrolled. Their services are eligible for the regular (50%) FMAP.

^^Former Foster Care Children: The Affordable Care Act establishes eligibility for children who have aged-out of the foster care system and had previously received Medicaid while in foster care, until they turn 26. Foster care children will remain eligible for the full scope of Medicaid benefits (Effective January 1, 2014).

~Medicaid Drug Rebates: The Affordable Care Act included changes in the way Medicaid prescription drug rebates are calculated and retained by the state and how much goes to the federal government. The Affordable Care Act increases the federal share of some rebates which reduces the "revenue" collected.

Note:

Children's Health Insurance Program: Requires states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. According to the Act, beginning in 2016, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%; however, this is not factored into the calculations because the funding past September 2015 is not authorized and it is unknown how the future funding will be provided.

Total Costs inflated 4 percent each year.

FMAP (Federal Medical Assistance Percentage)

Department of Human Services
Medicaid Expansion and Other ACA Fiscal Impacts
Potential Enrollment (32,000) Based on Kaiser Commission on Medicaid and the Uninsured Analysis November 2012
The Cost and Coverage Implications of the ACA Medicaid Expansion

Estimated ***Calendar Year*** *Totals for Medicaid*

	2014	2015	2016	2017	2018	2019	2020	Cumulative TOTAL of CY2014 thru CY2020
FMAP	100%	100%	100%	95%	94%	93%	90%	
Newly Eligible##	19,756	21,167	21,167	21,167	21,167	21,167	21,167	
Total Costs	$ 91,200,000	$ 114,800,000	$ 118,000,000	$ 122,700,000	$ 127,600,000	$ 132,700,000	$ 138,000,000	$ 845,000,000
State Costs	-			6,135,000	6,380,000	6,635,000	6,900,000	26,050,000
Rounded to nearest $100,000								$ -
FMAP	50%	50%	50%	50%	50%	50%	50%	
Previously Eligible**	1,257	1,300	1,300	1,300	1,300	1,300	1,300	
Total Costs	$ 5,400,000	$ 6,000,000	$ 6,200,000	$ 6,500,000	$ 6,700,000	$ 7,000,000	$ 7,300,000	$ 45,100,000
State Costs	2,700,000	3,000,000	3,100,000	3,250,000	3,350,000	3,500,000	3,650,000	22,550,000
Rounded to nearest $100,000								
Foster Care Coverage from age 19 Thru 25^^								
Total Costs	$ 102,000	$ 147,000	$ 196,000	$ 249,000	$ 305,000	$ 366,000	$ 431,000	$ 1,796,000
State Costs	51,000	73,500	98,000	124,500	152,500	183,000	215,500	898,000
Projected Enrollment	31	43	55	67	79	91	103	
Drug Rebates - reduction in amount retained by North Dakota~								
Reduction	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 1,400,000	$ 9,800,000
Drug Rebate impact prior to January 1, 2014								
Reduction in amount retained by State January 1, 2010 thru December 31, 2013								$ 4,000,000
Combined Total Cost	$ 98,102,000	$ 122,347,000	$ 125,796,000	$ 130,849,000	$ 136,005,000	$ 141,466,000	$ 147,131,000	$ 905,696,000
Combined State Cost	4,151,000	4,473,500	4,598,000	10,909,500	11,282,500	11,718,000	12,165,500	63,298,000

Estimated ***Biennium*** *Totals for Medicaid*

	13-15 Biennium	15-17 Biennium	17-19 Biennium	19-21 Biennium	Cumulative TOTAL over 4 Bienniums
Newly Eligible##	16,052	21,167	21,167	21,167	
Total Costs	$ 157,700,000	$ 236,700,000	$ 256,000,000	$ 276,900,000	$ 927,300,000
State Costs	-	3,500,000	15,600,000	26,000,000	45,100,000
Rounded to nearest $100,000					
FMAP					
Previously Eligible**	1,067	1,300	1,300	1,300	
Total Costs	$ 9,100,000	$ 12,500,000	$ 13,500,000	$ 14,600,000	$ 49,700,000
State Costs	4,550,000	6,250,000	6,750,000	7,300,000	24,850,000
Rounded to nearest $100,000					
Foster Care Coverage from age 19 Thru 25^^					
Total Costs	$ 180,000	$ 400,000	$ 620,000	$ 870,000	$ 2,070,000
State Costs	90,000	200,000	310,000	435,000	1,035,000
Drug Rebates - reduction in amount retained by North Dakota~					
Reduction	$ 2,800,000	$ 2,800,000	$ 2,800,000	$ 2,800,000	$ 11,200,000
Drug Rebate impact prior to July 1, 2013					
Reduction in amount retained by State January 1, 2010 thru June 30, 2013					$ 3,100,000
	$ 169,780,000	$ 252,400,000	$ 272,920,000	$ 295,170,000	$ 993,370,000
	7,440,000	12,750,000	25,460,000	36,535,000	85,285,000

New Adult Group/Newly Eligibles: This is the group that would be eligible for coverage through an expansion of Medicaid. The expansion would include all adults under the age of 65. Most notably the "childless adult" population would become eligible for Medicaid.

****Previous Eligibles (Woodwork):** This group is eligible for Medicaid today; however, they have not applied for coverage. It is expected that with the outreach efforts and the individual mandate in 2014 that individuals in this group will present for coverage. They are eligible for Medicaid – regardless of a Medicaid expansion- and they will be enrolled. Their services are eligible for the regular (50%) FMAP.

^^**Former Foster Care Children**: The Affordable Care Act establishes eligibility for children who have aged-out of the foster care system and had previously received Medicaid while in foster care, until they turn 26. Foster care children will remain eligible for the full scope of Medicaid benefits (Effective January 1, 2014).

~**Medicaid Drug Rebates:** The Affordable Care Act included changes in the way Medicaid prescription drug rebates are calculated and retained by the state and how much goes to the federal government. The Affordable Care Act increases the federal share of some rebates which reduces the "revenue" collected.

Note:

Children's Health Insurance Program: Requires states to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015. According to the Act, beginning in 2016, states will receive a 23 percentage point increase in the CHIP match rate up to a cap of 100%; however, this is not factored into the calculations because the funding past September 2015 is not authorized and it is unknown how the future funding will be provided.

Total Costs inflated 4 percent each year.

FMAP (Federal Medical Assistance Percentage)

#4

HB1362- SUPPORT MEDICAID EXPANSION
Wednesday, January 30, 2013
House Human Services and
House Appropriations Committee, Human Resources Division

Josh Askvig- AARP-ND
jaskvig@aarp.org or 701-989-0129

Chairman Weisz and Chairman Pollert, members of the House Human Services and House Appropriations Committee Human Resources Division, I am Josh Askvig, Associate State Director of Advocacy for AARP North Dakota.

Dr. Ethel Percy Andrus, a retired educator and AARP's founder, became an activist in the 1940's when she found a retired teacher living in a chicken coop because she could afford nothing else. Dr. Andrus couldn't ignore the need for health and financial security in America and set the wheels in motion for what would become AARP. We are a nonprofit, nonpartisan membership organization with nearly 88,000 members in North Dakota and 37 million nationwide. We understand the priorities and dreams of people 50+ and are committed to helping them live life to the fullest, including here in North Dakota.

As you know HB1362 would authorize the Governor's recommendation to expand Medicaid under the Affordable Care Act.

AARP believes everyone should have access to affordable health care. By expanding Medicaid this year, North Dakota can help hard-working people who have jobs without health insurance to get Medicaid health coverage if their incomes are less than $15,000 a year or 138 percent of the federal poverty level.

This issue is particularly important to low-income individuals who are over age 50 and not yet eligible for Medicare. These middle-aged adults are more likely to face the onset of health conditions that if left untreated could inevitably increase their need for and use of health and long term care. With the expansion, AARP estimates approximately 4,366 50-to-64-year-olds could qualify for Medicaid in North Dakota.

Expanding Medicaid will provide coverage for individuals struggling to make ends meet. In addition, it will give people without insurance access to preventive care that can save lives, and ease dangerous and expensive emergency room overcrowding that hurts all of us.

Medicaid expansion will both expand access to health care coverage for people who desperately need it and infuse the state's economy with millions of dollars. Under the law, the federal government will pay the cost of the state's Medicaid expansion for three years beginning in 2014, and then the federal government's match rate gradually drops beginning in 2017, decreasing to 90 percent in 2020 and thereafter.

This means North Dakota has an opportunity to provide health care coverage to an estimated 32,000 uninsured residents at no cost to the state for the first three years and no more than 10 percent of the cost in the future. North Dakota taxpayers will also find savings after expanding Medicaid due in large part to reducing the need for other medical service programs that are currently paid for now entirely by the state, like mental health services.

Finally, hospitals and health care providers won't end up with uninsured patients using expensive emergency room care.

I want to offer a couple of brief notes on some of the potential state savings as a result of Medicaid Expansion. The Kaiser Family Fund issued a report in November 2012 (ATTACHMENT A) that considered the impact of expanding Medicaid coverage to uninsured low income adults with chronic illness. The report found notable levels of chronic illness among the uninsured, indicating largely unmet health care needs among potentially newly eligible adults. Among the uninsured, prevalence of the four conditions ranged from 5% for diabetes to 13% for mental illness. The report posits that it is possible that the uninsured (who are less likely than those with Medicaid to see a medical provider) also have undiagnosed illness that weren't captured in the numbers but still would require treatment.

Out of pocket spending among these individuals varied from $904 for uninsured adults with respiratory disease to $1,498 for those with diabetes, with the remainder of their overall spending coming from health care providers or uncompensated care funds. These expenses are hard to meet on small budgets, meaning many are simply not getting the care they need to manage these chronic illnesses. Another issue raised by the report is that lack of consistent source of care by uninsured adults. Medicaid enrollees were much more likely to have a check-up in the past two years than their uninsured counterparts with the same illnesses. This indicates that these people are disconnected from the health system and exacerbating problems for people with chronic conditions that require ongoing medical attention.

The report concludes that Medicaid eligibility expansion in 2014 "may provide improved access to a variety of health services and prescription medications, as well as reductions in out-of-pocket costs, for many currently uninsured adults with chronic conditions. The relatively comprehensive Medicaid benefits package and improved care management could also foster more appropriate care patterns for the uninsured at a greatly reduced out-of-pocket cost, potentially improving both their health and personal economic security, as these individuals have quite limited incomes. For these reasons, Medicaid eligibility may have a substantial, positive impact on the quality of life for poor, uninsured adults with chronic conditions, especially those without children—a vulnerable population that has historically been excluded from health coverage."

Beginning in 2014, those living between 100 percent through 400 percent of poverty will be eligible for a federal tax subsidy should they choose to purchase health insurance coverage through a health insurance exchange. If North Dakota fails to exercise the Medicaid expansion option as it currently exists, thousands of residents will not have access to affordable coverage and the state will, in fact, be creating a coverage gap for the poorest individuals and families under 100% of poverty who will have no access to health care subsidies.

AARP urges the State of North Dakota to participate in Medicaid expansion because it makes sense both for the health of our residents, and for the state budget. For those who will be newly eligible in 2014, North Dakota will be able to take advantage of the 100 percent federal match rate. Expansion meets the needs of over 32,000 individuals in the state, including 4,366 50-64 year olds, while taking advantage of federal dollars that can be used to ensure that all North Dakota residents have access to affordable health care coverage.

I appreciate your time Mr. Chairman and members of the Committees. We strongly encourage you to move forward with the Medicaid Expansion included in HB1362.

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

November 2012

The Role of Medicaid for Adults with Chronic Illnesses

Introduction

Medicaid is the nation's health coverage program for the low-income population, covering over 60 million people, or one in five Americans. Medicaid beneficiaries are a diverse group that includes low-income parents, children, and pregnant women, low-income Medicare beneficiaries, and people with disabilities. Many individuals covered through Medicaid have special needs, which is a result of the program's eligibility rules that explicitly extend coverage to disabled and medically needy groups. Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid to nearly all people with income at or below 138% of the federal poverty level (FPL). This expansion would extend coverage to millions of currently uninsured adults, particularly non-elderly adults without dependent children who have typically been excluded from the program. Since this newly eligible group is largely uninsured and faces limited access to the health care system as a result, they may have substantial unmet need for health care services.

Understanding the current and future role of Medicaid for adults with chronic illnesses can aid policymakers in designing programs to efficiently and effectively meet the needs of enrollees. Specifically, decisions related to benefit design, delivery systems, and provider networks may be better informed with information on Medicaid's current role for individuals with chronic illnesses, how well the program serves these individuals, and how the health needs of the newly-eligible compare to those already enrolled. This brief summarizes a series of policy briefs that examine Medicaid's role for adults with chronic illnesses including diabetes, cardiovascular disease (CVD), respiratory disease, and mental illness.* It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to health needs, health care spending, access to care, and utilization of services. [A more detailed description of the data and methods for the analysis in this brief is included in the Appendix at the end of the report.] The information provides a profile of Medicaid's role in supporting population health and how this role could change through the expansion of eligibility in 2014.

* Separate pieces examine each of these conditions individually. See: http://www.kff.org/medicaid/8383.cfm.

0 G Street, NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274
www.kff.org/kcmu

Findings

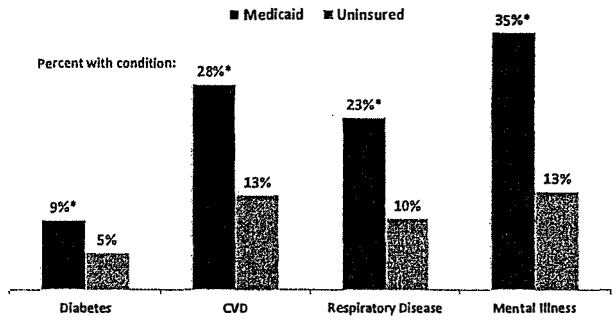
Prevalence

Among nonelderly adult Medicaid enrollees in 2009, the prevalence of chronic conditions varied by disease (Figure 1). Around one in ten adult Medicaid enrollees had diagnosed diabetes, and higher shares had diagnosed cardiovascular disease (28%) or respiratory disease (23%). Over a third (35%) had a diagnosed mental illness.

The prevalence of all four conditions was higher among Medicaid adults than among the uninsured (Figure 1). The higher rate of chronic illness among Medicaid beneficiaries is likely a result of Medicaid rules that explicitly extend program eligibility to people in poor health, such as the medically needy and people with disabilities. While lower than prevalence rates among Medicaid enrollees, there are still notable levels of chronic illness among the uninsured, indicating the considerable health care needs among potentially newly eligible adults. Among the uninsured, prevalence of the four conditions ranged from 5% for diabetes to 13% for mental illness. It is quite possible that the uninsured (who are less likely than those with Medicaid to see a medical provider) also have undiagnosed illness that do not appear in the prevalence rates above but still would require treatment.[1]

Figure 1

Prevalence of Chronic Illnesses among Medicaid and Uninsured Nonelderly Adults ≤138% FPL, 2009

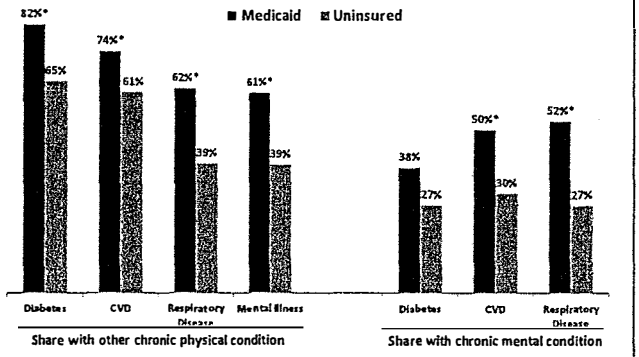


*Statistically different from Uninsured (p<0.05).
All insurance groups include only those nonelderly with full-year coverage or a full year without coverage.
Excludes dual eligibles.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Comorbidity, or an individual having more than one illness, is common among individuals with chronic conditions, and this pattern holds among low-income Medicaid and uninsured adults. In fact, a majority of Medicaid beneficiaries with each of the four conditions had an additional physical chronic condition—ranging from 61% to 82%—evidence of the complex health care needs of this population (Figure 2). Moreover, between 38% and 52% of nonelderly Medicaid enrollees with one of the three physical conditions (diabetes, CVD, and respiratory disease) also had a comorbid mental illness. Comorbidities were also common among uninsured adults with the four chronic conditions. The shares of these uninsured groups with a physical comorbidity ranged from 38% to 64%, and the shares of those with one of the three physical chronic conditions with a comorbid mental health condition were around three in ten.

Figure 2

Comorbidity among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



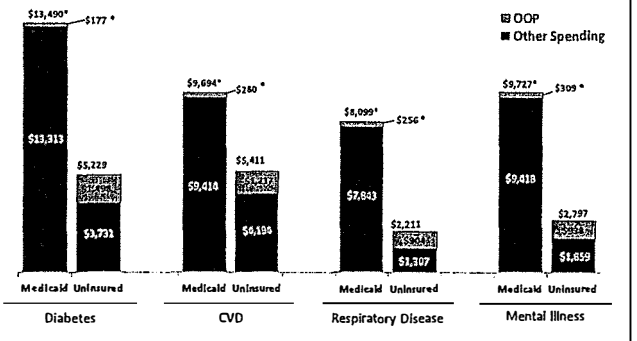
*Statistically different from Uninsured (p<0.05). All insurance groups include only those nonelderly with full-year coverage or a full year without coverage. Excludes dual eligibles.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Spending

Chronic illnesses may be costly to treat, and the presence of comorbid conditions—each with costly treatment needs—means that individuals with these illnesses may incur substantial health costs. Health spending for nonelderly adult Medicaid enrollees with chronic illness ranged from $8,099 per capita among those with respiratory disease to $13,490 per capita among those with diabetes (Figure 3). Individuals with diabetes had the highest per capita spending of the illnesses analyzed; this result is likely related to the fact that individuals with diabetes also had the highest comorbidity rates and the spending levels in Figure 3 represent spending on all services (not just spending for each disease). High spending levels among Medicaid beneficiaries with chronic illness are related to their poor health status: spending for nonelderly adult Medicaid beneficiaries without these conditions was significantly lower (around $5,000 per capita, data not shown).

Figure 3

Per Capita Spending among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



*Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Compared to Medicaid enrollees, uninsured low-income adults had per capita spending between $2,211 (respiratory disease) and $5,411 (CVD) (Figure 3). The differences in spending levels again reflect both the particularly complex health care needs of the Medicaid population with chronic illnesses and lower utilization among uninsured individuals with the same illnesses.

Conversely, out-of-pocket spending was consistently lower and more similar across the illness groups for Medicaid beneficiaries than for uninsured adults (Figure 3). For the illness groups in Medicaid, out-of-pocket spending per beneficiary fell between $177 per year for those with diabetes and $309 for those with mental health conditions. By contrast, those figures varied from $904 for uninsured adults with respiratory disease to $1,498 for those with diabetes, with the remainder of their overall spending coming from health care providers or uncompensated care funds. The substantial differences in out-of-pocket spending between Medicaid adults and the uninsured result from Medicaid rules that limit cost-sharing for beneficiaries to nominal amounts.

Utilization

The spending patterns in Figure 3 reflect differences in utilization by illness and coverage. Across the four illnesses, Medicaid beneficiaries with chronic illnesses had greater service utilization than the uninsured with the same illness (Table 1). Specifically, Medicaid adults had had roughly two to three times as many office visits in the previous year (10.2–12.3 versus 3.2–5.6) and prescriptions filled per month (3.3-5.3 versus 1.1-2.2) as the corresponding groups of the uninsured. Adults in Medicaid were also more likely than the uninsured to have had an inpatient stay or an emergency department (ED) visit in the previous year, though the differences in ED use were smaller than differences for other utilization measures. These higher relative rates of ED use among the uninsured could reflect the relative inelasticity of emergency service utilization compared to other, non-emergent services. The lower rates of other types of utilization, particularly office visits and prescription drug use, may indicate unmet need for services, especially when one considers the high rates of comorbidity among these individuals.

As with spending, utilization was higher among Medicaid enrollees with diabetes compared to other illnesses, with the exception of emergency department visits. Again, this group is most likely to have comorbid conditions and thus may have greater health needs than other groups.

Table 1

Service Utilization among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

	Medicaid	Uninsured
Number of Provider Office Visits		
Diabetes	12.3*	4.8
CVD	10.2*	5.6
Respiratory Disease	10.7*	3.2
Mental Illness	10.9*	5.0
Number of Prescriptions/Month		
Diabetes	5.3*	2.2
CVD	3.9*	1.9
Respiratory Disease	3.5*	1.1
Mental Illness	3.3*	1.3
Share who had an Inpatient Stay		
Diabetes	29%*	10%
CVD	22%*	9%
Respiratory Disease	19%*	6%
Mental Illness	22%*	7%
Share who had an Emergency Department Visit		
Diabetes	34%	34%
CVD	36%*	23%
Respiratory Disease	39%*	26%
Mental Illness	33%*	23%

*Statistically significant difference from Uninsured, $p < .05$

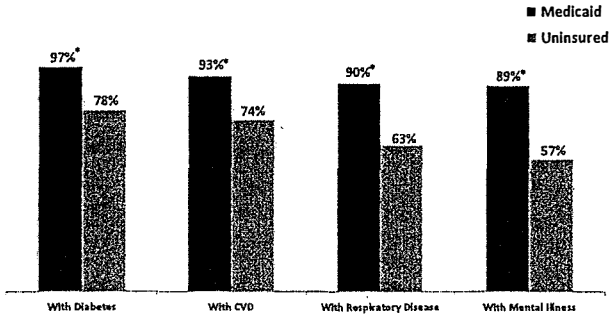
SOURCE: KCMU analysis of 2009 Medicaid Expenditure Panel Survey data.

Access

Despite higher levels of comorbidity, nonelderly adult Medicaid enrollees with chronic illness report better access to care than uninsured adults with the same illnesses. Specifically, most Medicaid beneficiaries with chronic illness reported having a usual source of care (Figure 4), ranging from 89% of those with a mental illness to 97% of those with diabetes. Consistently lower shares of the uninsured with chronic illness reported having a usual source of care, and the trend across the illness groups was similar to that of the Medicaid population, ranging from 57% of those with mental illness to 78% of those with diabetes. Not having a usual source of care indicates disconnection from the health system and may be especially problematic for people with chronic conditions that require ongoing medical attention.

Figure 4

Usual Source of Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

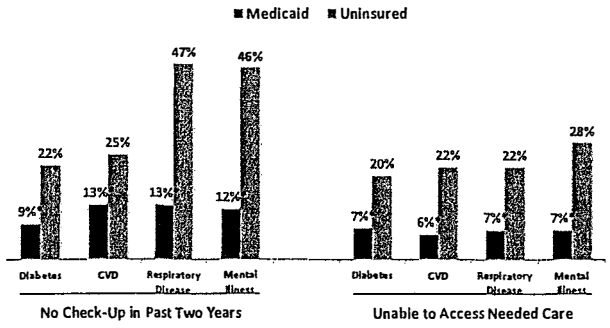


* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

On most measures of having a problem accessing care, nonelderly adult Medicaid beneficiaries with chronic disease were less likely than their uninsured counterparts to report a problem (Figure 5). Medicaid enrollees were much more likely to have a check-up in the past two years than their uninsured counterparts with the same illnesses. Notably high shares of uninsured adults with respiratory disease (47%) or mental illness (46%) reported not having a recent check-up, indicating potential barriers to regular care for their conditions. Further, all four groups of Medicaid beneficiaries were less likely than their uninsured counterparts to have been unable to access necessary medical care, with shares steady in the single digits among Medicaid adults and ranging from 20% to 28% among uninsured adults.

Figure 5

Barriers to Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Policy Implications

Medicaid plays an important role in providing access to care for people with chronic conditions. There is a high prevalence of chronic conditions among low-income, nonelderly adult Medicaid beneficiaries, and most of these individuals have complex care needs stemming from comorbid conditions. Reflecting these high needs, Medicaid enrollees with chronic conditions have relatively high spending and utilization rates. Notably, Medicaid seems to meet the health care needs of this high use population, as most report being linked to care and few report barriers to accessing services. Compared to Medicaid enrollees with the same illness, uninsured adults with chronic illness have poorer access to care, are less likely to utilize basic services, and have a greater out-of-pocket burden. Thus, while prevalence of chronic illness among uninsured low-income adults was lower than among Medicaid enrollees, many newly-eligible individuals may present with complex health needs.

The results of this analysis also suggest that the implementation of the Medicaid eligibility expansion in 2014 may provide improved access to a variety of health services and prescription medications, as well as reductions in out-of-pocket costs, for many currently uninsured adults with chronic conditions. The relatively comprehensive Medicaid benefits package and improved care management could also foster more appropriate care patterns for the uninsured at a greatly reduced out-of-pocket cost, potentially improving both their health and personal economic security, as these individuals have quite limited incomes. For these reasons, Medicaid eligibility may have a substantial, positive impact on the quality of life for poor, uninsured adults with chronic conditions, especially those without children—a vulnerable population that has historically been excluded from health coverage.

The ACA also offers opportunities to improve the care that Medicaid beneficiaries receive. The relatively high number of ED visits and hospital stays, as well as provider office visits and prescriptions filled, among Medicaid adults with chronic conditions in this analysis indicates that there are opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rates of mental health comorbidity among adults with chronic physical conditions present opportunities for improved coordination of physical and mental health services. The Medicaid health homes option in the ACA presents an opportunity for states to coordinate care across providers to prevent duplicative or inappropriate care, especially for patients with multiple conditions and complex health needs. The health homes option extends a 90% federal matching rate for state spending on health home services for eight quarters. Qualifying health home services include care coordination and management, referral to community and social supports, and transitional and follow-up care.

While the ACA provides a number of opportunities to improve access to and quality of care for many uninsured adults with chronic conditions, it will be critical for states to ensure adequate provider capacity in their Medicaid programs so that these new enrollees have adequate access to the primary, preventive, and specialized care necessary to adequately treat their conditions. If states can meet the challenges of effectively implementing the ACA Medicaid expansion, the results of this analysis suggest that enrollment in Medicaid may provide greater access to important services that would enable newly eligible adults with chronic conditions to better manage their conditions.

Appendix

This analysis draws on data from the 2009 Medical Expenditure Panel Survey (MEPS) household component. The publicly-available MEPS-HC dataset is a nationally-representative survey of healthcare access, utilization, and expenditure among the United States civilian, non-institutionalized population. We restrict our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We exclude those with coverage changes throughout the year to match the timing of insurance and access measures, which ask about all access and use over the past year. We define "low-income" as having family income at or below 138% FPL. Medicaid beneficiaries with Medicare ("dual-eligibles") are excluded.

To identify individuals with chronic conditions, we use the MEPS Medical Conditions file, which is based on self-reports of whether a person had been told by a health care provider that he or she had any "priority" condition,[2] self-reports of individuals taking a day or more of disability during the year for a condition and of a condition "bothering" a respondent, and ICD-9 codes, classified using Clinical Classification Codes, from the event files. We also use the HCUP Chronic Condition Indicator (CCI) to specify whether a condition was chronic; only chronic conditions are included in this analysis. Spending data include expenditures from all payers and on all health care services. All spending values are calculated as annual, per capita expenditures.

---

[1] Wilper AP, Woolhandler S, Lasser KE, McComick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured US adults. *Health Affairs*. 2009;28(6):w1151-9

[2] See MEPS documentation available at http://meps.ahrq.gov/mepsweb/data_stats/download_data/pufs/h128/h128doc.shtml#Appendix4 for a list of priority conditions.

This publication (#8383) is available on the Kaiser Family Foundation's website at www.kff.org.

Extending Affordable Health Coverage to Older Adults — Medicaid Expansion

AARP believes everyone should have access to affordable health care. By expanding Medicaid this year, North Dakota can help hard-working people who have jobs without health insurance to get Medicaid health coverage if their incomes are less than $15,000 a year or 138 percent of the federal poverty level. AARP estimates this will mean approximately 4,366 50 to 64 year-olds could qualify for Medicaid in North Dakota.

This issue is particularly important to individuals who are over age 50 and not yet eligible for Medicare. These middle-aged adults are more likely to face the onset of health conditions that if left untreated could inevitably increase their need for and use of health and long term care.

Expanding Medicaid will provide coverage for individuals struggling to make ends meet. In addition, it will give people without insurance access to preventive care that can save lives, and ease dangerous and expensive emergency room overcrowding that hurts all of us.

Medicaid expansion under the Affordable Care Act will both expand access to health care coverage for people who desperately need it, and infuse the state's economy with hundreds of millions of dollars. Under the law, the federal government will pay the cost of the state's Medicaid expansion for three years beginning in 2014, and then the federal government's match rate gradually drops beginning in 2017, decreasing to 90 percent in 2020 and thereafter.

This means North Dakota has an opportunity to provide health care coverage to an estimated 32,000 uninsured residents by 2022 at no cost to the state for the first three years and no more than 10 percent of the cost in the future. North Dakota taxpayers will also find savings after expanding Medicaid due in large part to reducing the need for other medical service programs that are currently paid for now entirely by the state, like mental health services. Finally, hospitals and health care providers won't end up with uninsured patients using expensive emergency room care.

Beginning in 2014, those living between 100 percent through 400 percent of poverty will be eligible for a federal tax subsidy should they choose to purchase health insurance coverage through a health insurance exchange. If North Dakota fails to exercise the Medicaid expansion option as it currently exists, thousands of residents will not have access to affordable coverage and the state will, in fact, be creating a coverage gap for the poorest individuals and families under 100% of poverty who will have no access to health care subsidies.

AARP urges the State of North Dakota to participate in Medicaid expansion because it makes sense both for the health of North Dakota residents, and for the state budget. For those who will be newly eligible in 2014, North Dakota will be able to take advantage of the 100 percent federal match rate. Expansion meets the needs of over 32,000 individuals in the state, including 4,366 50-64 year olds, while taking advantage of federal dollars that can be used to ensure that all North Dakota residents have access to affordable health care coverage.

#5

HOUSE BILL 1362 – SUPPORT MEDICAID EXPANSION
HOUSE HUMAN SERVICES AND HOUSE APPROPRIATIONS COMMITTEE,
HUMAN RESOURCES DIVISION
REPRESENTATIVE WEISZ, CHAIRMAN
JANUARY 30, 2013

Chairman Weisz and Chairman Pollert, members of the House Human Services and House Appropriations Committee, Human Resources Division, I am Allen Dockter, from Bismarck, and am an AARP member.

I am here today asking for your support House Bill 1362. Increases in health care costs challenge the continued availability and affordability of health insurance. Low-income and lack of access to affordable care challenges many of North Dakota's individuals and families.

Regular health checkups save lives through screening and monitoring. Early detection and intervention can mean the difference between health maintenance and major medical decisions. Uninsured adults are more likely to be diagnosed with a disease in an advanced stage.

For many of these uninsured people, the consequences of going without coverage are dire. The uninsured frequently face medical debt or go without necessary care, and too many of them die prematurely.

Those who have limited financial resources and options may use the emergency room as their primary source of health care. Some may choose to put off care until an emergency room is the only option. North Dakota can do better for its residents.

Expanding Medicaid through HB1362 will help the underserved people in North Dakota. I urge you to support HB1362.

Thank you for your time and consideration.

#6

HOUSE BILL 1362 – SUPPORT MEDICAID EXPANSION
HOUSE HUMAN SERVICES AND HOUSE APPROPRIATIONS COMMITTEE,
HUMAN RESOURCES DIVISION
REPRESENTATIVE WEISZ, CHAIRMAN
JANUARY 30, 2013

Chairman Weisz and Chairman Pollert, members of the House Human Services and House Appropriations Committee, Human Resources Division, I am Pat Herbel, from Bismarck, and a member of AARP.

Why am I here to support HB1362? I support this bill because I believe this identifies a disenfranchised group of North Dakota citizens who are very deserving of health services.

As a former educator who worked with Chapter I/TitleI/Basic Skills (as it was known), I noted the small group of children who just barely missed the eligibility criteria to receive services. With a little support at their critical juncture, their struggle to be successful would have been minimized. Luckily, the government realized this; as a result the school wide program came into being and most of the North Dakota schools now participate in it.

This is the very reason that I fully support this concept – an expansion that will provide assistance to a small group of deserving citizens who are not eligible to receive medical services. Many are older, long time workers and not at a juncture for increased career mobility. Therefore; they do not have access to the health services they deserve. In fact, I personally know several people in this age group without health insurance who have been using the ER for their primary health services.

At this time when our state is leading all others in economic growth, how can we say no to ensuring the health and well-being of these well deserving ~~three-to-five-~~thousand, North Dakota citizens, between the ages of 50 and 64?

I urge your support for Medicaid Expansion in HB1362.

Thank you for your time and consideration.

#7

Testimony
House Bill 1362
House Human Services Committee
Representative Weisz, Chairman
January 30, 2013

Chairman Weisz, members of the House Human Services Committee, I am Nancy McKenzie, Public Policy Director for Mental Health America of North Dakota (MHAND). I am here today to speak in support of HB1362, authorizing the Department of Human Services (DHS) to accept federal funds from the Patient Protection and Affordable Care Act (ACA) to implement the provisions for the Medicaid expansion.

The mission of Mental Health America is to promote mental health through education, advocacy, understanding and access to quality care for all individuals. We strongly support Medicaid expansion because it will cover so many individuals with mental health and substance use problems, many for the first time. Thus, it is a significant opportunity to improve treatment access for these people.

MHAND supports that Medicaid expansion in North Dakota is a positive and effective investment because:

1) Expansion is good for people -
   - Having coverage, and thereby improved access to healthcare, results in better health outcomes and resulting improved productivity;
   - For many individuals with serious mental health or substance use problems, we know that health status and average lifespan are currently less than that of the general public;

- Coverage provides protection against high medical costs, which for some individuals can result in bankruptcy and financial devastation; and,
- Medicaid expansion ensures that many people, often the "poorest of the poor" are not left out in the cold. Those with incomes <100% of the federal poverty level (FPL) would not be eligible for premium tax support for insurance products available through the exchange, so likely would remain uninsured without expansion.

2) Expansion is good for providers –

- The list of providers who would see increased percentage of revenue from Medicaid is significant, including: nursing homes, community health centers, hospitals, and behavioral health providers. This is important because we all want to see our providers, including those in smaller, rural areas, benefit economically;

- We are all aware of the challenges of "uncompensated" care that North Dakota's providers have faced. The prevalence of individuals with mental illness in uncompensated emergency room care, for example, has had a big impact on hospitals. Presumptive eligibility will cover people who now present at hospitals uninsured; resulting in less uncompensated care; and,
- Under the ACA, even if Medicaid expansion is not implemented, states will still have reduced disproportionate share hospital (DSH) funding, so while need for compensated care may remain stable, there will be fewer federal funds to subsidize some of that care than is available today. As a result, some hospitals may see severe financial hardship, having to increase costs to paying patients or providing less uncompensated care.

3) Expansion is good for the state's economy –

- For the reasons noted in #2 above, Medicaid expansion will help free up state and local spending that now goes to uncompensated care;
- Medicaid expansion will avoid costs associated with transitions and churning as people's income and eligibility for insurance coverage fluctuate. Expansion provides stability in coverage, which means lower administrative costs in addition to continuity of care; and,
- Expansion will keep North Dakota residents' federal tax dollars flowing into the State. Taxpayers who live in states that do not implement expansion will be paying out dollars to states that do expand. New federal Medicaid dollars will travel through the state's economy and turn over multiple times.

Who is hurt by rejecting Medicaid expansion? Poorer adults with serious chronic conditions, and many of our North Dakota providers in the state whose ability to serve this population is so vital.

The opportunity we have to expand Medicaid is a very positive and unusual opportunity. The ability for more individuals to have the care they need, and to seek that care sooner because they have coverage, rather than waiting for a more costly and complex crisis, will truly mean more recovery. Treatment works, recovery is real, and we want individuals to be able to access that.

Some people express concern about the ability to pay the state's share of expansion, though, as we know, there will be some increase in Medicaid spending to states whether there is expansion or not. Electing to choose expansion allows a majority of increase to be paid with federal funds.

The Coalition for Whole Health has noted that those states who to date are strongly rejecting expansion tend to be those states that historically are low spenders on mental health community-based services, with more individuals in institutions. Conversely, states that have embraced expansion, tend to currently support strong community-based services, and have fewer individuals residing in institutions.

In closing, North Dakota has a strong history of continually moving forward to develop more community-based services that are evidence-based and provide the best opportunity for individual recovery. As a legislature, you have supported that philosophy and contributed to those improvements. Providers and advocates are proud that our state has done that, while recognizing that there are needs that remain to be met.

In North Dakota, as we all know, we are so fortunate to be in a better financial position than are many parts of the country. Mental Health America in North Dakota strongly urges you to support Medicaid expansion, for the multiple benefits it will bring to so many individuals, families, and providers. It's the right thing to do, and the right time to do it.

Thank you for giving me the time to testify today; I'll be happy to answer any questions you may have.

Interesting point:

- **"Rejecting" states are historically lower spenders on mental health and community based MH services (more in institutions)**
- **Accepting states spend more in these areas now, and have better community services**

#8

Testimony
House Bill 1362
House Human Services Committee
Representative Weisz, Chairman
January 30, 2013

Chairman Weisz, members of the House Human Services Committee, I am Tom Regan, member of the ND Rural Behavioral Health (RBHN) Governance Committee. I am here today, on behalf of the ND RBHN, to speak in support of HB 1362, authorizing the Department of Human Services (DHS) to accept federal funds from the Patient Protection and Affordable Care Act (ACA) to implement the provisions for the Medicaid expansion.

The mission of the newly formed RBHN is: *To improve access to behavioral healthcare and eliminate behavioral health disparities in rural and tribal communities.* We strongly support Medicaid expansion because it will increase access to services for individuals with behavioral health (mental health and substance use) issues. The RBHN is made up of individuals and organizations that include providers, consumers, family members and advocates. Our Governance Committee consists of the original partners: ND Area Health Education Center (AHEC), ND Federation of Families for Children's Mental Health (FFCMH), Coal Country Community Health Center (CCCHC), Sakakawea Medical Center, Mental Health America of ND (MHAND), Essentia Health and the MHA Nation.

The following are the reasons we support Medicaid expansion:

- It will provide more individuals an opportunity to access behavioral health services;
- It will provide an opportunity to encourage individuals to seek behavioral health services before it becomes a need for more expensive emergency room and/or inpatient care;

- It will address the fact that, under the ACA even if Medicaid expansion is not implemented, states will still have a reduced disproportionate share of hospital (DSH) funding, so while need for compensated care may remain stable, there will be fewer federal funds to subsidize some of that care than is available today. As a result, some hospitals may see severe financial hardship, having to increase costs to paying patients or providing less uncompensated care;
- It provides an opportunity to keep North Dakota residents' federal tax dollars flowing into the state. Taxpayers who live in states that do not implement expansion will be paying out dollars to states that do expand.
- ND is experiencing a high rate of individuals with behavioral health issues becoming involved with the ND Department Corrections and community services for those who are homeless. Medicaid expansion is part of the solution since accessing behavioral health services, before it becomes a crisis, can be a successful prevention strategy;
- We understand that, due to the economic development related to oil in western ND, the current behavioral health system is stretched to capacity. Medicaid expansion will be part of the solution to address the increased need for services.

RBHN urges support of Medicaid expansion for the multiple benefits it will bring to many individuals, families, and providers. It's the right thing to do for the people we serve.

Thank you for giving me the time to testify today.

#7

Testimony

House Bill 1362

House Human Services Committee

Wednesday, January 30, 2013
9:00 AM

Deborah Knuth
Government Relations Director, American Cancer Society Cancer Action Network (ACS CAN)

Good morning, Chairman Robin Weisz and members of the House Human Services Committee. My name is Deborah Knuth, and I am the director of government relations for the American Cancer Society Cancer Action Network (ACS CAN). I am here today to testify in support of House Bill 1362, and am asking for a "do pass" recommendation from this committee.

Cancer Patients and volunteers with the American Cancer Society Cancer Action Network (ACS CAN) call on the House Human Services Committee to accept the millions of dollars of federal funding being offered to North Dakota to increase access to health coverage through Medicaid—a move that would provide an estimated 32,000 of currently uninsured people in the state with access to lifesaving preventive care and treatments for cancer and other serious diseases, at no cost to the state for the first three years and no more than 10 percent of the cost in the future.

North Dakota should take advantage of this opportunity to support the 100 percent federal match rate. We can cover more people and save thousands of dollars in taxpayer money that is currently spent to treat the uninsured in emergency rooms. Covering more people makes moral and fiscal sense.

This also gives us the opportunity to provide hardworking low-income North Dakota residents the security of quality health coverage so they can see a doctor regularly and get lifesaving cancer screenings and treatment when they need it, without facing huge medical bills. We can significantly reduce the number of uninsured with incomes at or below 138% of the federal poverty level who know they are one diagnosis away from financial ruin.

Increased coverage will help to improve public health and reduce the cancer burden in North Dakota. ACS CAN urges this Committee to accept the money to cover more people and save taxpayer dollars by fully expanding access to Medicaid coverage.

Thank you for the opportunity to speak with you today. Are there any questions?

ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a

major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit www.acscan.org.

#10

Testimony on Behalf of
The North Dakota Economic Security & Prosperity Alliance (NDESPA)
House Bill 1362 – Human Services and Appropriations Committees
January 30, 2013

Chairman Pollert, Chairman Weisz and members of the Joint Committee, I am Karen Ehrens from Bismarck and am here today as a volunteer for the North Dakota Economic Security & Prosperity Alliance. NDESPA is a coalition of citizens and organizations working to build assets for North Dakotans of low and moderate income through public policy change.

Even in these times of prosperity, people of low and moderate-income – 1 out of every 8 North Dakotans – struggle to make ends meet. More than 75 percent of these households have earned income – they are working people and families. There are more than 80,000 people living with low or moderate-income in North Dakota, nearly 25,000 of who are children. More than 9,600 of these people are senior citizens – those who helped build North Dakota into the great state we are today.

NDESPA supports Medicaid expansion for North Dakota, as do others here today. We can probably all agree that North Dakota is a great place to live and raise a family. We care about our quality of life and we strive to live healthy lives. We want North Dakota to stay that way and, when our children grow up, we want this state to be the place they raise their children. For that to happen, we have to invest in the health of people because healthy kids need healthy parents. And healthy communities need a reliable and healthy workforce. Today, we are putting the health of our children, our families and our state at risk. Too many North Dakotans don't have reliable health care because our health care system is inconsistent. Some employers pay for health care and others do not. Some North Dakotans have access to healthcare through public programs and others do not.

We can make healthcare more reliable and less risky for more North Dakotans by investing in our public health systems. People get sick whether they have health coverage or not. Expanding Medicaid coverage can help ensure that people see a medical provider when they are sick, and even before they get sick. An Oregon study found that people who gained access to Medicaid had better access to health care, were less likely to experience unpaid medical bills, and were more likely to report being in good health and less depressed compared to people without insurance. Such coverage and preventive care options will preclude more costly crisis care in the future. Timely preventive services and medical care help to keep citizens productive and improve quality of life.

We urge the committee to take advantage of this unprecedented opportunity for an investment in the people of North Dakota and pass HB 1362.

Attached to this testimony is a list of NDESPA partners who support this effort.

I would be happy to take questions from the Committee.

North Dakota
Economic Security
and Prosperity
Alliance

North Dakota Economic Security & Prosperity Alliance
(NDESPA) Partners
2013

North Dakota Women's Network
North Dakota Council on Abused Women's Services
North Dakota Disabilities Advocacy Consortium
North Dakota Head Start Association
North Dakota Community Action Partnership
AARP North Dakota
Catholic Charities of North Dakota
American Association of University Women in North Dakota
North Dakota Chapter of the National Association of Social Workers
Childcare Resource & Referral
Mental Health America of North Dakota
Children's Defense Fund in North Dakota
North Dakota Public Employees Association
Prevent Child Abuse of North Dakota

NDESPA works to build and sustain a system of economic security for all North Dakotans through poverty awareness and education, grassroots and community capacity building, research and data development, and promotion of policies and practices to eliminate disparities and obstacles for achieving economic security.

1003 E Interstate Avenue, Suite #7 Bismarck, ND 58503 NDESPA@agree.org

#11

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1362
House Human Services Committee
House Appropriations: Human Resources Division
Expansion of the Medical Assistance Program
January 30, 2013

Chairman Weisz and Members of the House Human Services Committee and House Appropriations: Human Resources Division; I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am here today to present testimony on HB 1362, the Expansion of the Medical Assistance Program.

Information that I have today on states considering Medicaid Expansion is:

No Expansion	8	
Expansion	18	Includes the District of Columbia
Undecided	25	

I gave this information to show that this issue is inundated with uncertainty across the country, and does not have a strong consensus.

Medicaid Expansion establishes a minimum eligibility Level of 133% of the Federal Poverty Level; also in the formula for most new enrollees is the Modified Adjusted Gross Income which, thereby allows new enrollees to quality with incomes up to 138% of the Federal Poverty Level. There is no asset test and no resource test. There are also new mandatory categories of eligibility: Childless Adults, Parents and Former Foster Care Children to age 26.

This is information is provided so you are aware of who is qualified.

If Medicaid Expansion up to 138% of the Federal Poverty Level is not going to be implemented in North Dakota those individuals below 100% of the

Federal Poverty Level, will not have access to subsidies to purchase private insurance.

Under the Medicaid Expansion provision there is a new Federal Medical Assistance Percentage or FMAP. For those individuals that meet the requirements of the Expansion, the Federal Match is as follows:

2014	100%	
2015	100%	
2016	100%	
2017	95%	
2018	94%	
2019	93%	
2020	90%	Remains at this level going forward

Current Medicaid FMAP is 50% as will be recipients who are now eligible and not enrolled at this time.

Question as to how this will this be paid for: current proposal is Medicare and Medicaid offsets, including hospital updates reductions, Disproportionate Share Hospital (DSH) reductions and Taxes.

AHA estimates the North Dakota population under 138% to be between 19% and 24.8%. The US Average is 27.8%. States that refuse to implement Medicaid Expansion can do so without penalty, if they implement must do so at the 138% level. States can implement in 2014 or later; however, the 100% is fixed until 2016. Again if not implemented those below 100% of the Federal Poverty Level will have no source of subsidy provisions. The Congressional Budget Office (CBO) projection is one-third of the states will come on after 2016.

In our discussions at NDHA; we have no hard numbers to back this up, there will be hospitals in the state that will benefit from the expansion of Medicaid thereby reducing their bad debt. When people are covered or have health insurance we believe they are healthier individuals; therefore, not using more expensive services at a later or at an inappropriate time, i.e. emergency rooms after hours. Hospital services provided to non-covered individuals adds to the cost of daily operations and increases a hospital's bad debt.

In regards to the pay-for; all the hospitals in North Dakota will be included in the pay-for process regardless of our participation. We, the Hospitals in North Dakota, will have reduced payments based on the fiscal impact of the Expansion process in other states whether or not North Dakota participates.

Our recommendation is to consider the impact of Medicaid Expansion based on the health benefits provided to those not covered at this time, and to consider the effects of having additional insured covering some of the uncompensated care now being provided in the state. Again we do not have numbers but we believe that expanding Medicaid will reduce some of the bad debt in the state.

Respectfully Submitted,

Jerry E. Jurena, President
North Dakota Hospital Association

#12

NDMA
NORTH DAKOTA MEDICAL ASSOCIATION

House Appropriations Committee

House Bill 1362

January 30, 2013

Chairman Pollert and Committee Members, I'm Courtney Koebele, executive director for the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students. The North Dakota Medical Association supports Medicaid expansion. Medicaid expansion is one of the most consequential state decisions in the history of Medicaid. Each state decision will directly affect health care and health status of a large share of the state's citizens, with ripple effects throughout the entire health care system, the state budget, the economy, employers and others paying for health insurance

Expanding Medicaid will provide much needed coverage to our low-income patients, improve access to care, and improve the health and well-being of the newly insured.

- Low-income adults in states that expanded Medicaid had better coverage and better access to care compared to states that did not expand.
- Low income adults in states that expanded Medicaid had a significant decrease in mortality compared to states that did not expand.

Medicaid expansion is not simply a budget issue. Lawmakers must also consider the real human effects of this decision, including the health and well-

being of those who gain coverage under expansion. Medicaid expansion supports better health care for families and children. If a state chooses not to expand, fewer patients will be eligible for coverage which may negatively impact the number of children enrolled and the health and well-being of these families.

In states that choose not to expand Medicaid – an unfortunate scenario could unfold where those with incomes below the poverty level will be left with no coverage while those with incomes above the poverty level can access coverage on the exchange. However, even those with incomes just above the poverty level who can access coverage on the exchange will do so only with greater financial burden due to cost sharing requirements, etc.

A recent Kaiser Family Foundation study found that if all states expanded Medicaid, the federal government would pay for the vast majority of the costs, while many states would realize net budget savings and some only modest costs. By expanding Medicaid, states could save money by moving programs currently paid for through state-only funds or by state and federal funds to Medicaid, allowing states to receive the enhanced federal match rate for these services.

States that do not expand Medicaid will continue to face the health, social and economic costs of caring for the uninsured, including likely over-utilization of the emergency room and lost wages for sick time off. Without expansion, these costs will continue to be borne entirely by the state.

In a study published in the New England Journal of Medicine, researchers summarized results from a randomized-controlled trial they conducted when Oregon's Medicaid program used a lottery to select low-income adults who could apply to Medicaid for coverage. Approximately 30,000 of the 90,000 individuals who applied were chosen. Of these

individuals, approximately 10,000 of those selected ended up enrolling in Medicaid. Researchers compared those who were selected and enrolled in Medicaid to those who applied for the lottery but were not selected and found that individuals with Medicaid coverage were:

- 70 percent more likely to have a regular place of care,
- 55 percent more likely to have a regular doctor,
- 40 percent less likely to borrow money or skip payments on other bills because of medical expenses,
- 25 percent less likely to have medical bills sent to a collection agency.

Thank you for the opportunity to present NDMA's views on this bill. I would be happy to answer any questions.

#13

North Dakota Catholic Conference

Representing the Diocese of Fargo and the Diocese of Bismarck

Christopher T. Dodson
Executive Director and
General Counsel

To: House Human Services Committee
Subject: House Bill 1362
Date: January 30, 2013

The North Dakota Catholic Conference supports House Bill 1362 to exercise the option to expand Medicaid coverage with federal dollars consistent with Governor Dalrymple's budget request.

Our approach to health care is shaped by a simple but fundamental principle: "Every person has a right to adequate health care. This right flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God." For this reason the Catholic bishops of the United States have since 1917 consistently and persistently called for access to quality, affordable, life-giving health care for all in a manner that respects human life and religious freedom.

By increasing access to health care and health care coverage to uninsured eligible North Dakotans who are below 138 percent of the federal poverty level, House Bill 1362 could reduce the number of uninsured adults living below that poverty level by 69 percent in North Dakota.

We applaud Governor Dalrymple for including this important piece of the social fabric in his budget request. We urge the Legislative Assembly to support this effort.

We respectfully request a **Do Pass** recommendation on House Bill 1362.

103 S. 3rd St., Suite 10 • Bismarck, ND 58501
(701) 223-2519 • 1-888-419-1237 • FAX # (701) 223-6075
http://ndcatholic.org • ndcatholic@btinet.net

#14

HOUSE BILL 1362 – SUPPORT MEDICAID EXPANSION
HOUSE HUMAN SERVICES AND HOUSE APPROPRIATIONS COMMITTEE,
HUMAN RESOURCES DIVISION
REPRESENTATIVE WEISZ, CHAIRMAN
JANUARY 30, 2013

Chairman Weisz and Chairman Pollert, members of the House Human Services and House Appropriations Committee, Human Resources Division, my name is Mike Tomasko of West Fargo. I had hoped to offer my testimony in person, and I thank you for understanding an important commitment to my grandson. I am very much aware that the important bill before you today, Medicaid expansion, has become mired in politics but that will not be the context of my testimony today.

The context of my testimony today comes from my career of 35 years as a health care administrator, CEO of Mid Dakota Clinic and an Administrator of the PrimeCare health group, both of Bismarck. In all those years not a week went by without me visiting with a handful of patients with the same refrains: *my family doesn't have insurance, I can't get insurance, my employer doesn't provide health insurance, I lost my job and can't afford to pay for company health insurance under COBRA,* or the one I heard most often *the Doctor says I need this test and I can't afford it,* this concerned our Doctors the most because preventive care delayed very often results in expensive emergency and critical care at a later date. I was thankful to be able to respond that our organization provided health care regardless of ability to pay for those truly in need, and indeed "charity care", so to speak, was a major line item in our budgets, and in the budgets of all the health care systems in our state. Most often these folks were some of your neighbors and mine going through an unfortunate time in their lives, and I add often reticent to accept help, indeed we often had to convince them to get the care now to prevent more serious health problems in the future.

On my retirement in 2007, I was pretty sure my involvement in such health care issues had come to an end. The opposite has been true and has of late intensified my involvement in health care issues relating to access, affordability, insurance and billing.

There isn't a month that goes by that I am not approached by a neighbor, friend, or someone referred to me to sort through their health care insurance and billing issues.

This past fall I had the privilege of participating in the fall health care fair in Wahpeton, which was very well organized and attended. Along with presentations on health care, there was discussion about health care affordability and access. I was struck by a couple who had just turned 62, they told me they had just applied for early social security not by choice, but because the company where they worked for 30 plus years had gone "belly-up" - to use their term – and they found their pension money had been spent by the company. They said that social security is their only retirement income. They further told me that despite both having health problems they were at this time without health insurance and not accessing their Doctor for regular check ups and they just hope and pray they make it to age 65 when they will be eligible for Medicare. Good people who worked hard all their life, a case of when bad things happen to good people through no fault of their own. Expanding Medicaid would give this couple access to the preventive care they need.

I appreciate you allowing me to present this testimony and your consideration of this important legislation that could literally be the salvation for many who need that helping hand, for them this bill is very personal.

I said at the beginning that the politics of this bill would not be the context of my testimony today, but I will end by quoting our honorable Governor who recently said that "...politics shouldn't deter implementation..." a statement with which I wholeheartedly agree.

Thank you.
###

7

Testimony by Rep. Al Carlson, 3.13.12,

Senate Human Services Committee

In the wake of the US Supreme Court's decision on the Patient Protection and Affordable Care Act (PPACA), also known as Obamacare, states must now decide whether to expand their Medicaid programs by accepting a larger federal subsidy.

As passed, PPACA required states to expand their Medicaid eligibility to all individuals with incomes between 133 percent and 138 percent of the federal poverty level. States that failed to meet this requirement would no longer receive any federal Medicaid grants at all.

The Supreme Court, however, ruled states could not be required to expand their Medicaid programs in order to continue receiving current levels of federal support.

Therefore, states are not required to expand their Medicaid programs, but the offer of "free money" is proving tempting to many states.

In reality, the money isn't free. Accepting federal funds to expand Medicaid rolls will impose new costs upon states and, ultimately, state taxpayers.

The federal matching rate starts at 100 percent for newly eligible enrollees, but it declines over time, leaving states to find other ways to pay for the newly eligible population.

States that choose to expand, instead of reforming an already broken system, will subject even more of their lower-income residents to a program that provides inferior care.

Policy Solution

We should avoid Medicaid expansion and instead reform our fiscally unsustainable programs in ways that will offer better care and lower costs to the state. Solutions to consider may include a premium-based model like Florida's pilot program, which saved $118 million a year in the five counties in the program, or a block-grant program that gives states more flexibility over how they run Medicaid and manage its costs.

So What Could We Do:

1. Help the needy up to 100 percent of the federal poverty level to obtain access to care but do not create an entitlement program that we cannot afford,
2. The exclusion of single people from Medicaid coverage is an issue we need to seriously look at for innovative solutions

*Note, individuals that are not covered by Medicaid are adults between the ages of 21 and 65 who are not blind or disabled, pregnant, or a caretaker of deprived children.

*Note, individuals that are not covered by Medicaid are adults between the ages of 21 and 65 who are not blind or disabled, pregnant, or a caretaker of deprived children.

- How can we work on state solutions instead of federally mandated controls and dictates that have steered our country towards bankruptcy?
- Our country has $16.5 trillion in debt and the federal politicians continue to add entitlements that we absolutely know we cannot afford.
- How can we expand Medicaid on a national basis when the country is broke?
- Do you think Medicare will really be cut by the politicians to pay for the Medicaid expansion under Obamacare?
- Do we as citizens of this state and country care about the debt we are passing on to our children and grandchildren?
- The feds will pull this Medicaid expansion money in a few years out of fiscal necessity and we will be left with a bureaucratic program that does not achieve its objective efficiently or effectively.
- Will we ever work on designing health coverage that is affordable for North Dakotans?
- Do we want to address medical inflation which is out of control?
- We should be experimenting with innovative policies here in ND to cover the truly needy while creating systems to incentivize individuals to manage their own health and health care better, rather than having a debt financed federal government expansion of entitlements dictated from Washington which has a clear history of making promises it does not keep and adding rules and regulations we can ill afford.

I would respectfully ask the department to:

1. Identify the cost of a proposal that provides a safety net for individuals that are not married that fall under 100% of the federal poverty guidelines. We need to know how much it would cost to provide coverage to single folks that fall under 100% of the federal poverty level?

2. We should work on a state wide level to address the issues associated with access to health care. We should remember our children first. They represent our future. We should not saddle them with more and more debt – robbing them of the opportunity to achieve the American Dream.

3. The figures I have indicate that there are less than 9,000 children that are uninsured. We have done a good job with covering children in Medicaid, healthy steps and the Caring Program run by Blue Cross Blue Shield.

4. We should consider using our medical residency programs to provide primary care to needy citizens and also work to maximize their use of the state's Federally qualified health care centers.

5. The long term solution for the uninsured problem involves creating the conditions in our state for businesses to flourish. Most businesses that are successful offer health coverage as a benefit. We need to ensure that North Dakota continues to be a great state to start and expand businesses that create decent paying jobs with benefits including health coverage.

States Which HAVE Supported Medicaid Expansion:

Arkansas	Washington
California	Vermont
Washington, DC	Rhode Island
Delaware	Illinois
Hawaii	Maryland
Massachusetts	Connecticut
Minnesota	Nevada
Missouri	

States Which HAVE NOT Supported Medicaid Expansion:

Alabama	Georgia
Florida	Iowa
Kansas	Maine
Louisiana	Wisconsin
Mississippi	Texas
Nebraska	South Dakota
Oklahoma	South Carolina

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 **$207 million and $282 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.

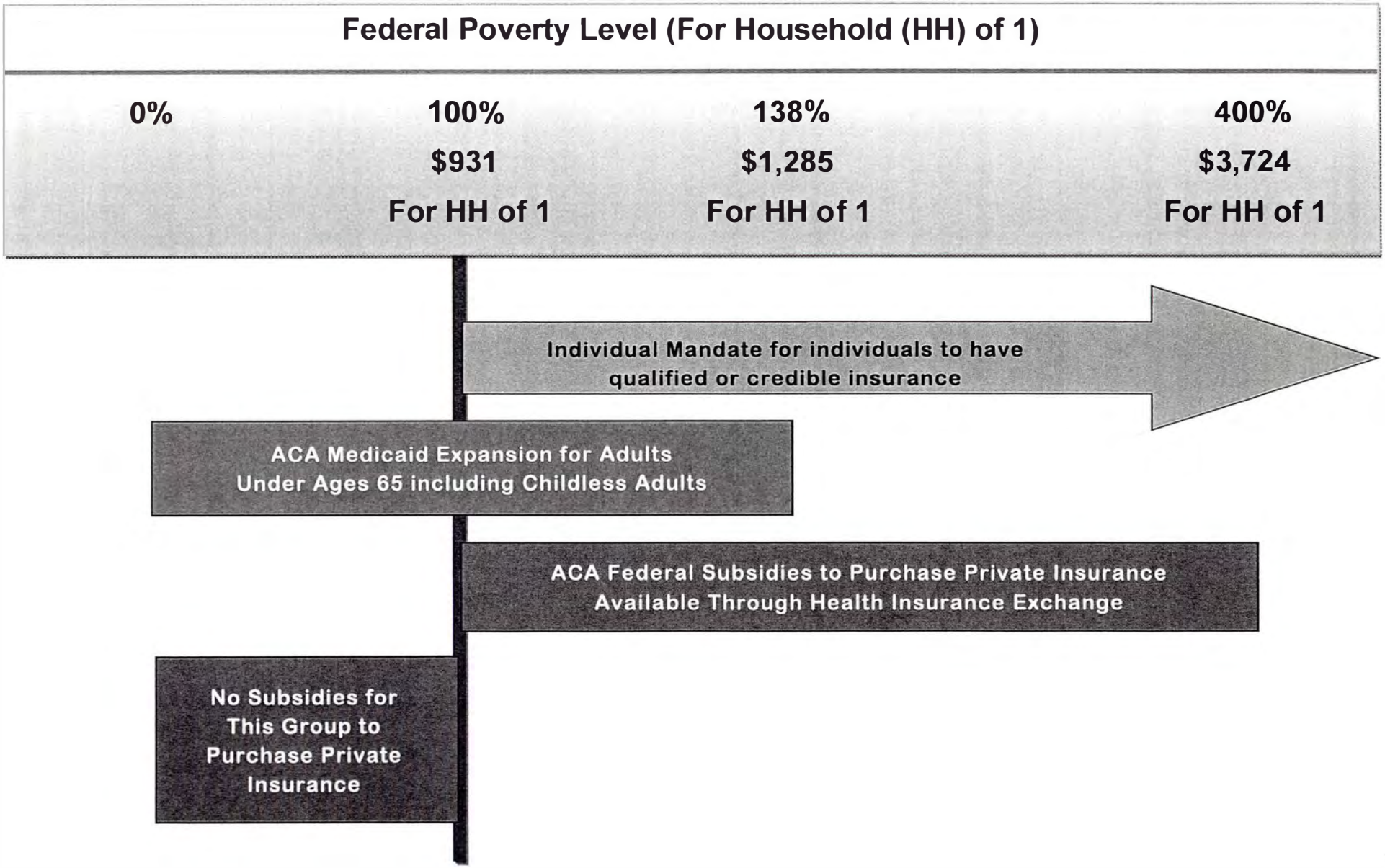
In addition, there are current coverage groups such as the Workers' with Disabilities Buy In and the Women's Way (Breast and Cervical Cancer Treatment). These groups are currently "**optional**" Medicaid coverage. In 2014, these populations **should have private coverage options** through the Health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

North Dakota Department of Human Services
Affordable Care Act (ACA)

Medicaid Expansion Illustration



Attachment B

Department of Human Services

Medical Services Division

Questions and Answers from the Centers for Medicare and Medicaid Services

Excerpt from the Attachment to December 10, 2012

Letter from Secretary Sebelius to Governors

House Bill 1362

MEDICAID

Expansion

24. Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care Act?

A. No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions.

As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process.

While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to "newly eligible individuals" are tied by law to specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.

25. If a state accepts the expansion, can a state later drop out o/the expansion program?

A. Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.

26. Can a state expand to less than **133% o**f *FPL and still receive 100% federal matching funds?*

A. No. Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing.

In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. This demonstration authority offers states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.

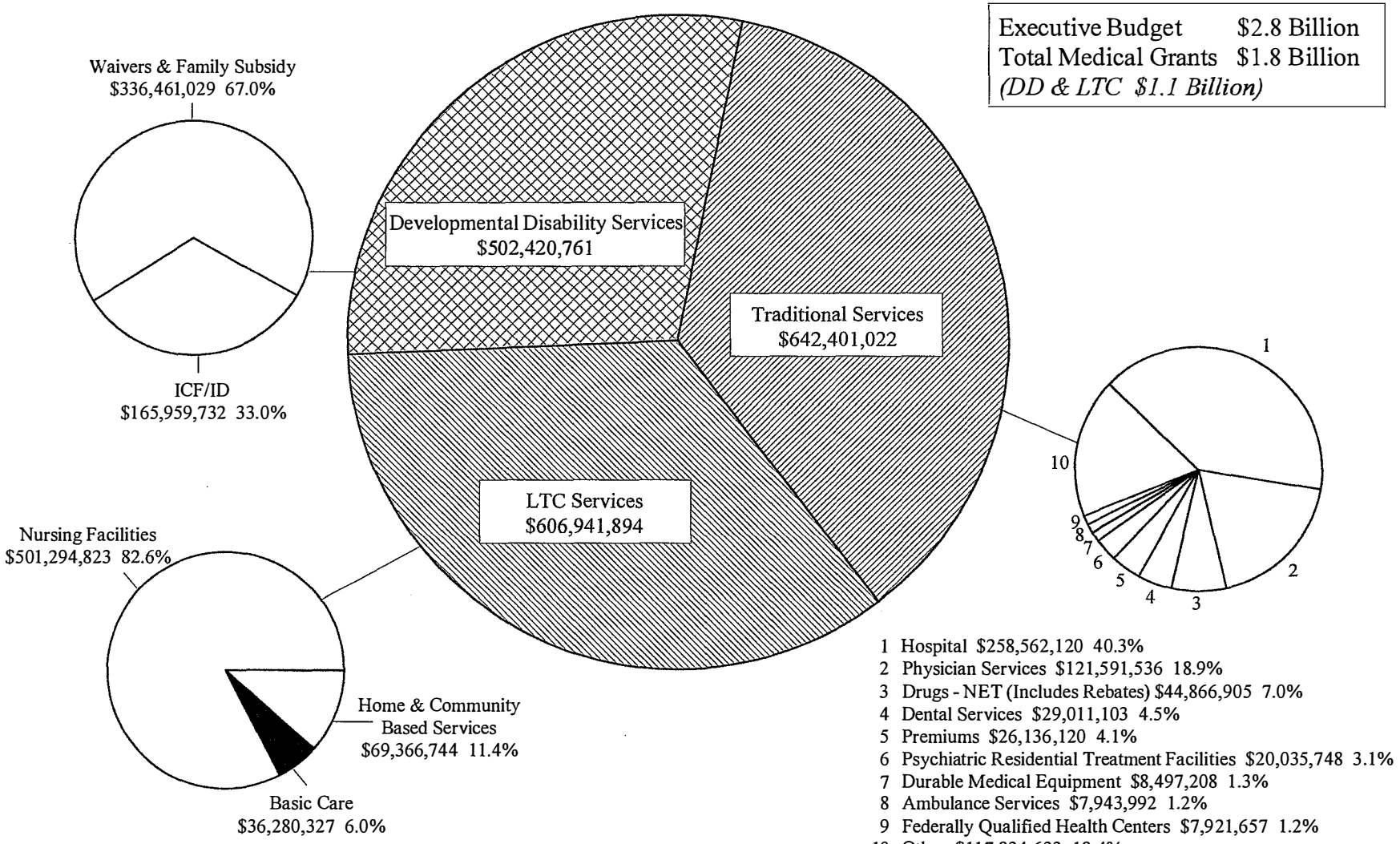
31. Will low-income residents in states that do not expand Medicaid to 133 percent of the FPL be eligible for cost sharing subsidies and tax credits to purchase coverage through an Exchange?

A. Yes, in part. Individuals with incomes above 100 percent of the federal poverty level who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage will be eligible for premium tax credits and cost sharing reductions, assuming they also meet other requirements to purchase coverage in the Exchanges.

Department of Human Services
Executive Budget Request
Medical Assistance Grants

Attachment C

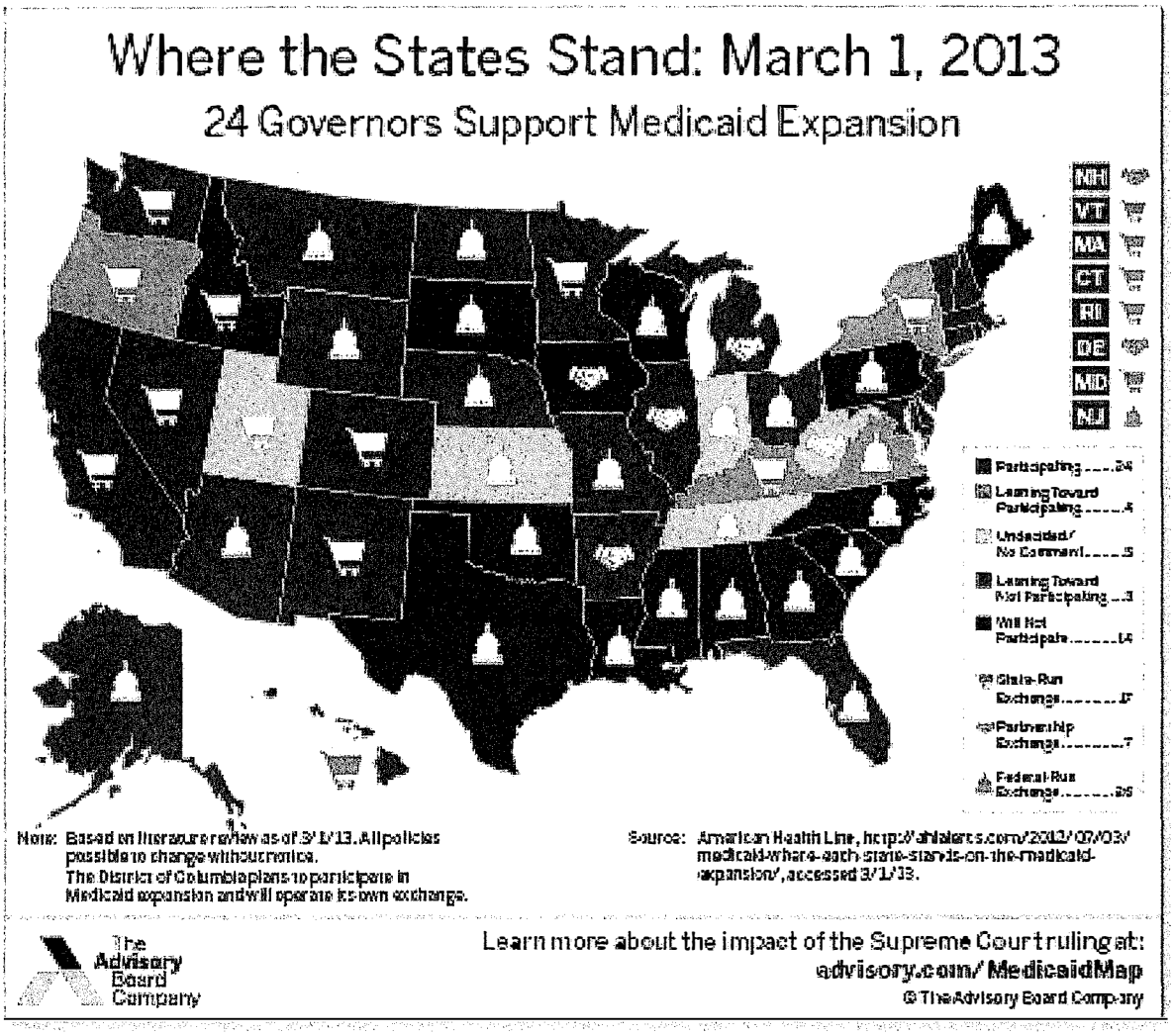
Executive Budget	$2.8 Billion
Total Medical Grants	$1.8 Billion
(DD & LTC $1.1 Billion)	



1 Hospital $258,562,120 40.3%
2 Physician Services $121,591,536 18.9%
3 Drugs - NET (Includes Rebates) $44,866,905 7.0%
4 Dental Services $29,011,103 4.5%
5 Premiums $26,136,120 4.1%
6 Psychiatric Residential Treatment Facilities $20,035,748 3.1%
7 Durable Medical Equipment $8,497,208 1.3%
8 Ambulance Services $7,943,992 1.2%
9 Federally Qualified Health Centers $7,921,657 1.2%
10 Other $117,834,633 18.4%

Attachment D

North Dakota Department of Human Services
Medical Services Division
Engrossed House Bill 1362



Reference: Advisory.com,(January 15, 2013). The Advisory Board Company. Where Each State Stands on Medicaid Expansion.

Attachment E

North Dakota Department of Human Services
Medical Services Division
Engrossed House Bill 1362

State	Governor or Executive Branch Activity	Activity in the Legislature
	Announcement regarding the state's Medicaid expansion decision from a governor in the state's budget, state of the state address, other official statement or news article.	State bills related to Medicaid expansion moving forward in the legislature. May also include city or county legislative materials.
AL	Governor against expansion	Proposed bill (SB 259) to expand Medicaid
AK	Governor against expansion	
AZ	Governor supports expansion	
AR	Governor supports expansion	
CA	Governor supports expansion	Proposed bill (AB 1X-1) to expand Medicaid eligibility
CO	Governor supports expansion	
CT	Governor supports expansion	
DE		
DC	Mayor supports expansion	
FL	Governor supports expansion	
GA	Governor against expansion	Senate proposed resolution to expand Medicaid
HI		
ID	Governor against expansion	
IL	Governor supports expansion	House and Senate filed a bill (HB 106 and SB 26) to expand Medicaid
IN	Governor against expansion	Senate approved SB551 to block grant Medicaid program
IA	Governor against expansion	Proposed Senate bill (SF71) to expand Medicaid
KS	Governor undecided on expansion	Proposed House Concurrent Resolution No. 5013 against Medicaid expansion Proposed House bill (HB 2032) to support Medicaid expansion
KY		
LA	Governor against expansion	
ME		
MD	Governor supports expansion	Two Administration bills proposed to expand Medicaid: SB 274 and HB 228
MA	Governor supports expansion	
MI	Governor supports expansion	
MN	Governor supports expansion	Governor signed a bill (HF9) to expand Medicaid
MS	Governor against expansion	
MO	Governor supports expansion	Proposed House bill (HB 627) to expand Medicaid Senate bill proposed to reduce Medicaid eligibility levels

State	Governor or Executive Branch Activity	Activity in the Legislature
MT	Governor supports expansion	Proposed House bill (HB458) to implement Medicaid expansion
NE	Governor against expansion	Proposed bill to expand Medicaid (LB 577)
NV	Governor supports expansion	
NH	Governor supports expansion	Proposed bill (HB 271) to prevent Medicaid expansion
NJ	Governor supports expansion	Senate Concurrent Resolution No. 132 proposed to expand Medicaid
NM	Governor supports expansion	
NY		
NC	Governor against expansion	Proposed Senate bill (SB4) against Medicaid expansion
ND	Governor supports expansion	Governor proposed bill to expand Medicaid House passed bill (HB 1362) to allow the Department of Human Services to accept funding for expansion
OH	Governor supports expansion	
OK	Governor against expansion	Proposed bill (SB 777) to mandate Medicaid expansion
OR		
PA	Governor against expansion	
RI	Governor supports expansion	
SC	Governor against expansion	
SD	Governor against expansion	
TN	Governor undecided on expansion	Proposed bill (HB 82) to prevent Medicaid expansion
TX	Governor against expansion	Senate Joint Resolution (SJR) 8 proposing a constitutional amendment to require Texas to expand Medicaid
UT		Proposed bill (HB 153) to expand Medicaid
VT		
VA	Governor against expansion	General Assembly passed a budget bill (HB 1500) with amendments providing for Medicaid expansion under certain conditions Proposed resolution in the city of Charlottesville, VA to expand Medicaid
WA	Governor supports expansion	
WV		
WI	Governor against expansion	Proposed bill (SB 38) to expand Medicaid
WY	Governor undecided on expansion	Proposed bill to change Medicaid eligibility levels for pregnant women and children to comply with the ACA but prevent further expansion of Medicaid Proposed bill to expand Medicaid

Chart produced by: Kaitlin Sheedy and Sonya Schwartz, National Academy for State Health Policy. Contributions by Shuchita Madan, Medicaid Health Plans of America.

Reference: StateReforum.org website, 2013. Last updated March 11, 2013.

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1362
Expansion of the Medical Assistance Program
Senate Human Services Committee
March 13, 2013

Chair Judy Lee and Members of the Senate Human Services Committee; I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am here today to present testimony on HB 1362, the Expansion of the Medical Assistance Program.

I know at this time there are several states struggling with this decision; this issue is inundated with uncertainty across the country. The dilemma many states have is; how will Medicaid Expansion be paid for and will the commitment by CMS to have Federal dollars available for the next several years realistic.

Medicaid Expansion establishes a minimum eligibility Level of 133% of the Federal Poverty Level; also in the formula for most new enrollees is the Modified Adjusted Gross Income which, thereby allows new enrollees to quality with incomes up to 138% of the Federal Poverty Level. There is no asset test and no resource test. There are also new mandatory categories of eligibility: Childless Adults, Parents and Former Foster Care Children to age 26.

This information is provided so you are aware of who is qualified.

An issue that needs to be considered is; if Medicaid Expansion up to 138% of the Federal Poverty Level is not going to be implemented in North Dakota those individuals below 100% of the Federal Poverty Level, will not have access to subsidies to purchase private insurance.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701 224-9732 Fax 701 224-9529

Under the Medicaid Expansion provision there is a new Federal Medical Assistance Percentage or FMAP. For those individuals that meet the requirements of the Expansion. The Federal Match is as follows:

2014	100%	
2015	100%	
2016	100%	
2017	95%	
2018	94%	
2019	93%	
2020	90%	Remains at this level going forward

Current Medicaid FMAP is 50% for recipients who are now eligible and not enrolled at this time, if and when they are enrolled.

I have been asked how Medicaid Expansion will be paid for: the current proposal is Medicare and Medicaid offsets, including hospital updates reductions, Disproportionate Share Hospital (DSH) reductions and Taxes.

AHA estimates the North Dakota population under 138% to be between 19% and 24.8%. The US Average is 27.8%. States that refuse to implement Medicaid Expansion can do so without penalty; however, if a State does implement Medicaid Expansion they must do so at the 138% level. States can implement in 2014 or later; however, the 100% is fixed until 2016. Again if not implemented those below 100% of the Federal Poverty Level will have no source of subsidy provisions. The Congressional Budget Office (CBO) projection is one-third of the states will come on after 2016.

In our discussions at NDHA; we have no hard numbers or data that will provide a statewide overview. There will be hospitals in the state that will benefit from the expansion of Medicaid thereby reducing their bad debt. As an example:

Sanford Health in Bismarck:

In 2012 had bad debt of $17.3 million of that number $11.56 million or 61% was attributed to self-pay, mostly the uninsured population. Information from the Kaiser Family Foundation, they estimate up to 47% of the North Dakota population may qualify for Medicaid. Using a conservative estimate of 30% that would qualify for Medicaid Expansion, we estimate $3.468

million in additional revenue maybe realized, ($11.56 million X 30% = $3.468 million) for just one tertiary hospital. There are six tertiary hospitals in North Dakota. Most of the hospitals in North Dakota do not have systems in place to provide a breakdown of where there bad debt is coming from. If we take even $3 million as a figure of new revenue the six large hospitals could see an increase of $18 million of additional revenue, again offsetting their bad debt. There are 36 Critical Access Hospitals in the state that would also benefit with additional people being covered by Medicaid.

When people are covered or have health insurance we believe they are healthier individuals; therefore, not using more expensive services at a later or at an inappropriate time, i.e. emergency rooms after hours. Hospital services provided to non-covered individuals adds to the cost of daily operations and increases a hospital's bad debt. I have been asked if Medicaid is expanded will we have enough physicians to take care of the influx of patients; we are already treating these patients through our hospitals at inappropriate times and with little follow-up.

In regards to the pay-for; all the hospitals in North Dakota will be included in the pay-for process regardless of our participation. We, the Hospitals in North Dakota, will have reduced payments based on the fiscal impact of the Expansion process in other states whether or not North Dakota participates.

Our recommendation is to consider the impact of Medicaid Expansion based on the health benefits provided to those not covered at this time, and to consider the effects of having additional insured covering some of the uncompensated care now being provided in the state. Again we do not have numbers but we believe that expanding Medicaid will reduce some of the bad debt in the state.

Respectfully Submitted,

Jerry E. Jurena, President
North Dakota Hospital Association

We Support Medicaid Expansion

We, the undersigned, support the expansion of Medicaid in North Dakota. North Dakota has the opportunity to provide health care coverage to an estimated 20,500-32,000 uninsured residents with the federal government paying 100% of the costs of health coverage for the first three years and no less than 90% of the cost in the future. Expanding Medicaid will provide coverage for low-income individuals and families. It will give people now without insurance access to preventive care that can save lives, and greatly lessen the use of uncompensated emergency room care, which will result in lowering the overall cost of health care for everyone. Medicaid expansion will also infuse the state's economy with hundreds of millions of dollars. If North Dakota fails to exercise the Medicaid expansion option as it currently exists, thousands of residents will not have access to affordable coverage and the state will, in fact, be creating a coverage gap for the poorest individuals and families under 100% of poverty who will have no access to health care subsidies.

The bottom line is that if North Dakota does not expand Medicaid coverage, our residents will be subsidizing expansion in other states without receiving the benefit of additional federal funding for our own uninsured population. We urge the State of North Dakota to participate in Medicaid expansion because it makes sense both for the health of ALL North Dakota residents and for the state budget.

AARP North Dakota

American Cancer Society-Cancer Action Network

Blue Cross Blue Shield North Dakota

Greater North Dakota Chamber

American Lung Association

American Heart Association

Community HealthCare Association of the Dakotas (CHAD)

Family Voices of North Dakota

North Dakota Economic Security and Prosperity Alliance

North Dakota Public Employees Association

North Dakota Education Association

North Dakota Center for Persons with Disabilities

North Dakota Rural Behavior Health Network

North Dakota Catholic Conference

North Dakota Hospital Association

North Dakota Medical Association

North Dakota Farmers Union

North Dakota Nurses Association

Mental Health America of North Dakota

March of Dimes, North Dakota Chapter

National Multiple Sclerosis Society, Upper Midwest Chapter

North Dakota Women's Network

North Dakota Federation of Families for Children's Mental Health

Protection & Advocacy

The North Dakota Board of Physical Therapy

The North Dakota Physical Therapy Association

WelCore Health, Grand Forks, ND

North Dakota Disability Advocacy Consortium

North Dakota Occupational Therapy Association

March 13, 2013

4

HB1362- SUPPORT MEDICAID EXPANSION
Wednesday, March 13, 2013
Senate Human Services
Josh Askvig- AARP-North Dakota
jaskvig@aarp.org or 701-989-0129

Chairman Lee, members of the Senate Human Services committee, I am Josh Askvig, Associate State Director of Advocacy for AARP North Dakota.

Dr. Ethel Percy Andrus, a retired educator and AARP's founder, became an activist in the 1940's when she found a retired teacher living in a chicken coop because she could afford nothing else. Dr. Andrus couldn't ignore the need for health and financial security in America and set the wheels in motion for what would become AARP. We are a nonprofit, nonpartisan membership organization with nearly 88,000 members in North Dakota and 37 million nationwide. We understand the priorities and dreams of people 50+ and are committed to helping them live life to the fullest, including here in North Dakota.

As you know HB1362 would authorize the Governor's recommendation to expand Medicaid under the Affordable Care Act.

AARP believes everyone should have access to affordable health care. By expanding Medicaid this year, North Dakota can help hard-working people who have jobs without health insurance to get Medicaid health coverage if their incomes are less than $15,000 a year or 138 percent of the federal poverty level.

This issue is particularly important to low-income individuals who are over age 50 and not yet eligible for Medicare. These middle-aged adults are more likely to face the onset of health conditions that if left untreated could inevitably increase their need for and use of health and long term care. With the expansion, AARP estimates approximately 4,366 50-to-64-year-olds could qualify for Medicaid in North Dakota.

Expanding Medicaid will provide coverage for individuals struggling to make ends meet. In addition, it will give people without insurance access to preventive care that can save lives, and ease dangerous and expensive emergency room overcrowding that hurts all of us.

Medicaid expansion will both expand access to health care coverage for people who desperately need it and infuse the state's economy with millions of dollars. Under the law, the federal government will pay the cost of the state's Medicaid expansion for three years beginning in 2014, and then the federal government's match rate gradually drops beginning in 2017, decreasing to 90 percent in 2020 and thereafter.

This means North Dakota has an opportunity to provide health care coverage to an estimated 32,000 uninsured residents at no cost to the state for the first three years and no more than 10 percent of the cost in the future. North Dakota taxpayers will also find savings after expanding Medicaid due in large part to reducing the need for other medical service programs that are currently paid for now entirely by the state, like mental health services. Finally, hospitals and health care providers won't end up with uninsured patients using expensive emergency room care.

I want to offer a couple of brief notes on some of the potential state savings as a result of Medicaid Expansion. The Kaiser Family Fund issued a report in November 2012 (ATTACHMENT A) that considered the impact of expanding Medicaid coverage to uninsured low income adults with chronic illness. The report found notable levels of chronic illness among the uninsured, indicating largely unmet health care needs among potentially newly eligible adults. Among the uninsured, prevalence of the four conditions ranged from 5% for diabetes to 13% for mental illness. The report posits that it is possible that the uninsured (who are less likely than those with Medicaid to see a medical provider) also have undiagnosed illness that weren't captured in the numbers but still would require treatment.

Out of pocket spending among these individuals varied from $904 for uninsured adults with respiratory disease to $1,498 for those with diabetes, with the remainder of their overall spending coming from health care providers or uncompensated care funds. These expenses are hard to meet on small budgets, meaning many are simply not getting the care they need to manage these chronic illnesses. Another issue raised by the report is that lack of consistent source of care by uninsured adults. Medicaid enrollees were much more likely to have a check-up in the past two years than their uninsured counterparts with the same illnesses. This indicates that these people are disconnected from the health system and exacerbating problems for people with chronic conditions that require ongoing medical attention.

The report concludes that Medicaid eligibility expansion in 2014 "may provide improved access to a variety of health services and prescription medications, as well as reductions in out-of-pocket costs, for many currently uninsured adults with chronic conditions. The relatively comprehensive Medicaid benefits package and improved care management could also foster more appropriate care patterns for the uninsured at a greatly reduced out-of-pocket cost, potentially improving both their health and personal economic security, as these individuals have quite limited incomes. For these reasons, Medicaid eligibility may have a substantial, positive impact on the quality of life for poor, uninsured adults with chronic conditions, especially those without children—a vulnerable population that has historically been excluded from health coverage."

Beginning in 2014, those living between 100 percent through 400 percent of poverty will be eligible for a federal tax subsidy should they choose to purchase health insurance coverage through a health insurance exchange. If North Dakota fails to exercise the Medicaid expansion option as it currently exists, thousands of residents will not have access to affordable coverage and the state will, in fact, be creating a coverage gap for the poorest individuals and families under 100% of poverty who will have no access to health care subsidies.

AARP urges the State of North Dakota to participate in Medicaid expansion because it makes sense both for the health of our residents, and for the state budget. For those who will be newly eligible in 2014, North Dakota will be able to take advantage of the 100 percent federal match rate. Expansion meets the needs of over 32,000 individuals in the state, including 4,366 50-64 year olds, while taking advantage of federal dollars that can be used to ensure that all North Dakota residents have access to affordable health care coverage.

I appreciate your time Ms. Chairman and members of the Committees. We strongly encourage you to move forward with the Medicaid Expansion included in HB1362.

kaiser commission on medicaid and the uninsured
KEY FACTS

THE HENRY J. KAISER FAMILY FOUNDATION

November 2012

The Role of Medicaid for Adults with Chronic Illnesses

Introduction

Medicaid is the nation's health coverage program for the low-income population, covering over 60 million people, or one in five Americans. Medicaid beneficiaries are a diverse group that includes low-income parents, children, and pregnant women, low-income Medicare beneficiaries, and people with disabilities. Many individuals covered through Medicaid have special needs, which is a result of the program's eligibility rules that explicitly extend coverage to disabled and medically needy groups. Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid to nearly all people with income at or below 138% of the federal poverty level (FPL). This expansion would extend coverage to millions of currently uninsured adults, particularly non-elderly adults without dependent children who have typically been excluded from the program. Since this newly eligible group is largely uninsured and faces limited access to the health care system as a result, they may have substantial unmet need for health care services.

Understanding the current and future role of Medicaid for adults with chronic illnesses can aid policymakers in designing programs to efficiently and effectively meet the needs of enrollees. Specifically, decisions related to benefit design, delivery systems, and provider networks may be better informed with information on Medicaid's current role for individuals with chronic illnesses, how well the program serves these individuals, and how the health needs of the newly-eligible compare to those already enrolled. This brief summarizes a series of policy briefs that examine Medicaid's role for adults with chronic illnesses including diabetes, cardiovascular disease (CVD), respiratory disease, and mental illness.* It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to health needs, health care spending, access to care, and utilization of services. [A more detailed description of the data and methods for the analysis in this brief is included in the Appendix at the end of the report.] The information provides a profile of Medicaid's role in supporting population health and how this role could change through the expansion of eligibility in 2014.

* Separate pieces examine each of these conditions individually. See: http://www.kff.org/medicaid/8383.cfm.

1330 G Street, NW, Washington, DC 20005
Phone: 202-347-5270, Fax: 202-347-5274
www.kff.org/kcmu

Findings

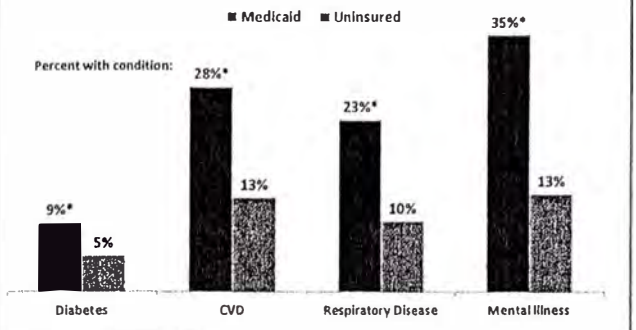
Prevalence

Among nonelderly adult Medicaid enrollees in 2009, the prevalence of chronic conditions varied by disease (Figure 1). Around one in ten adult Medicaid enrollees had diagnosed diabetes, and higher shares had diagnosed cardiovascular disease (28%) or respiratory disease (23%). Over a third (35%) had a diagnosed mental illness.

The prevalence of all four conditions was higher among Medicaid adults than among the uninsured (Figure 1). The higher rate of chronic illness among Medicaid beneficiaries is likely a result of Medicaid rules that explicitly extend program eligibility to people in poor health, such as the medically needy and people with disabilities. While lower than prevalence rates among Medicaid enrollees, there are still notable levels of chronic illness among the uninsured, indicating the considerable health care needs among potentially newly eligible adults. Among the uninsured, prevalence of the four conditions ranged from 5% for diabetes to 13% for mental illness. It is quite possible that the uninsured (who are less likely than those with Medicaid to see a medical provider) also have undiagnosed illness that do not appear in the prevalence rates above but still would require treatment.[1]

Figure 1

Prevalence of Chronic Illnesses among Medicaid and Uninsured Nonelderly Adults ≤138% FPL, 2009

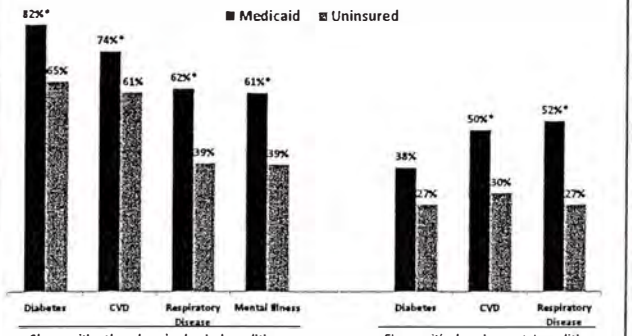


*Statistically different from Uninsured (p<0.05).
All insurance groups include only those nonelderly with full-year coverage or a full year without coverage.
Excludes dual eligibles.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Comorbidity, or an individual having more than one illness, is common among individuals with chronic conditions, and this pattern holds among low-income Medicaid and uninsured adults. In fact, a majority of Medicaid beneficiaries with each of the four conditions had an additional physical chronic condition—ranging from 61% to 82%—evidence of the complex health care needs of this population (Figure 2). Moreover, between 38% and 52% of nonelderly Medicaid enrollees with one of the three physical conditions (diabetes, CVD, and respiratory disease) also had a comorbid mental illness. Comorbidities were also common among uninsured adults with the four chronic conditions. The shares of these uninsured groups with a physical comorbidity ranged from 38% to 64%, and the shares of those with one of the three physical chronic conditions with a comorbid mental health condition were around three in ten.

Figure 2

Comorbidity among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



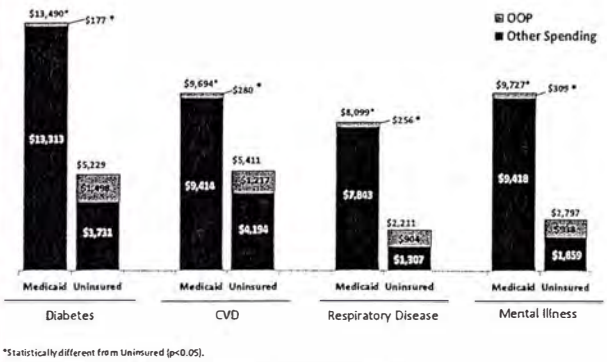
*Statistically different from Uninsured (p<0.05). All insurance groups include only those nonelderly with full-year coverage or a full year without coverage. Excludes dual eligibles.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Spending

Chronic illnesses may be costly to treat, and the presence of comorbid conditions—each with costly treatment needs—means that individuals with these illnesses may incur substantial health costs. Health spending for nonelderly adult Medicaid enrollees with chronic illness ranged from $8,099 per capita among those with respiratory disease to $13,490 per capita among those with diabetes (Figure 3). Individuals with diabetes had the highest per capita spending of the illnesses analyzed; this result is likely related to the fact that individuals with diabetes also had the highest comorbidity rates and the spending levels in Figure 3 represent spending on all services (not just spending for each disease). High spending levels among Medicaid beneficiaries with chronic illness are related to their poor health status: spending for nonelderly adult Medicaid beneficiaries without these conditions was significantly lower (around $5,000 per capita, data not shown).

Figure3

Per Capita Spending among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



*Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Compared to Medicaid enrollees, uninsured low-income adults had per capita spending between $2,211 (respiratory disease) and $5,411 (CVD) (Figure 3). The differences in spending levels again reflect both the particularly complex health care needs of the Medicaid population with chronic illnesses and lower utilization among uninsured individuals with the same illnesses.

Conversely, out-of-pocket spending was consistently lower and more similar across the illness groups for Medicaid beneficiaries than for uninsured adults (Figure 3). For the illness groups in Medicaid, out-of-pocket spending per beneficiary fell between $177 per year for those with diabetes and $309 for those with mental health conditions. By contrast, those figures varied from $904 for uninsured adults with respiratory disease to $1,498 for those with diabetes, with the remainder of their overall spending coming from health care providers or uncompensated care funds. The substantial differences in out-of-pocket spending between Medicaid adults and the uninsured result from Medicaid rules that limit cost-sharing for beneficiaries to nominal amounts.

Utilization

The spending patterns in Figure 3 reflect differences in utilization by illness and coverage. Across the four illnesses, Medicaid beneficiaries with chronic illnesses had greater service utilization than the uninsured with the same illness (Table 1). Specifically, Medicaid adults had had roughly two to three times as many office visits in the previous year (10.2–12.3 versus 3.2–5.6) and prescriptions filled per month (3.3-5.3 versus 1.1-2.2) as the corresponding groups of the uninsured. Adults in Medicaid were also more likely than the uninsured to have had an inpatient stay or an emergency department (ED) visit in the previous year, though the differences in ED use were smaller than differences for other utilization measures. These higher relative rates of ED use among the uninsured could reflect the relative inelasticity of emergency service utilization compared to other, non-emergent services. The lower rates of other types of utilization, particularly office visits and prescription drug use, may indicate unmet need for services, especially when one considers the high rates of comorbidity among these individuals.

As with spending, utilization was higher among Medicaid enrollees with diabetes compared to other illnesses, with the exception of emergency department visits. Again, this group is most likely to have comorbid conditions and thus may have greater health needs than other groups.

Table 1

Service Utilization among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

	Medicaid	Uninsured
Number of Provider Office Visits		
Diabetes	12.3*	4.8
CVD	10.2*	5.6
Respiratory Disease	10.7*	3.2
Mental Illness	10.9*	5.0
Number of Prescriptions/Month		
Diabetes	5.3*	2.2
CVD	3.9*	1.9
Respiratory Disease	3.5*	1.1
Mental Illness	3.3*	1.3
Share who had an Inpatient Stay		
Diabetes	29%*	10%
CVD	22%*	9%
Respiratory Disease	19%*	6%
Mental Illness	22%*	7%
Share who had an Emergency Department Visit		
Diabetes	34%	34%
CVD	36%*	23%
Respiratory Disease	39%*	26%
Mental Illness	33%*	23%

*Statistically significant difference from Uninsured, $p < .05$

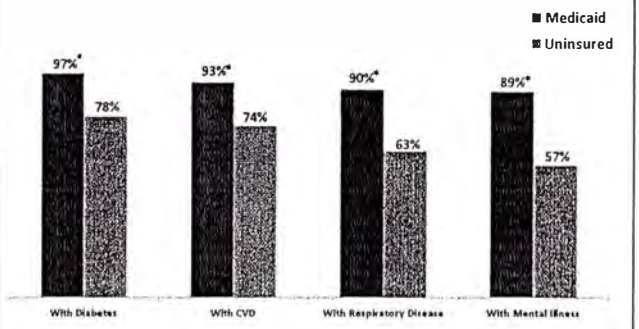
SOURCE: KCMU analysis of 2009 Medicaid Expenditure Panel Survey data.

Access

Despite higher levels of comorbidity, nonelderly adult Medicaid enrollees with chronic illness report better access to care than uninsured adults with the same illnesses. Specifically, most Medicaid beneficiaries with chronic illness reported having a usual source of care (Figure 4), ranging from 89% of those with a mental illness to 97% of those with diabetes. Consistently lower shares of the uninsured with chronic illness reported having a usual source of care, and the trend across the illness groups was similar to that of the Medicaid population, ranging from 57% of those with mental illness to 78% of those with diabetes. Not having a usual source of care indicates disconnection from the health system and may be especially problematic for people with chronic conditions that require ongoing medical attention.

Figure4

Usual Source of Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

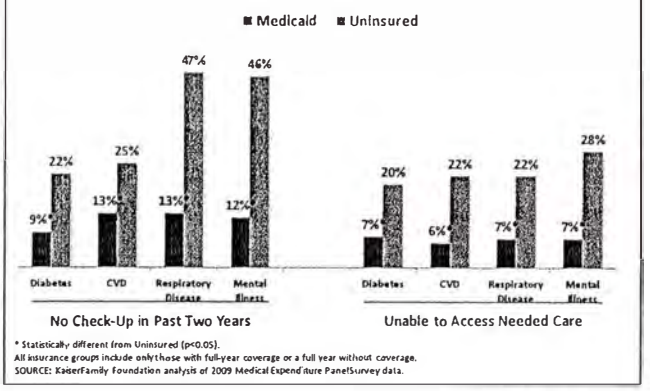


* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverageor a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

On most measures of having a problem accessing care, nonelderly adult Medicaid beneficiaries with chronic disease were less likely than their uninsured counterparts to report a problem (Figure 5). Medicaid enrollees were much more likely to have a check-up in the past two years than their uninsured counterparts with the same illnesses. Notably high shares of uninsured adults with respiratory disease (47%) or mental illness (46%) reported not having a recent check-up, indicating potential barriers to regular care for their conditions. Further, all four groups of Medicaid beneficiaries were less likely than their uninsured counterparts to have been unable to access necessary medical care, with shares steady in the single digits among Medicaid adults and ranging from 20% to 28% among uninsured adults.

Figure 5

Barriers to Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: KaiserFamily Foundation analysis of 2009 Medical Expenditure PanelSurvey data.

Policy Implications

Medicaid plays an important role in providing access to care for people with chronic conditions. There is a high prevalence of chronic conditions among low-income, nonelderly adult Medicaid beneficiaries, and most of these individuals have complex care needs stemming from comorbid conditions. Reflecting these high needs, Medicaid enrollees with chronic conditions have relatively high spending and utilization rates. Notably, Medicaid seems to meet the health care needs of this high use population, as most report being linked to care and few report barriers to accessing services. Compared to Medicaid enrollees with the same illness, uninsured adults with chronic illness have poorer access to care, are less likely to utilize basic services, and have a greater out-of-pocket burden. Thus, while prevalence of chronic illness among uninsured low-income adults was lower than among Medicaid enrollees, many newly-eligible individuals may present with complex health needs.

The results of this analysis also suggest that the implementation of the Medicaid eligibility expansion in 2014 may provide improved access to a variety of health services and prescription medications, as well as reductions in out-of-pocket costs, for many currently uninsured adults with chronic conditions. The relatively comprehensive Medicaid benefits package and improved care management could also foster more appropriate care patterns for the uninsured at a greatly reduced out-of-pocket cost, potentially improving both their health and personal economic security, as these individuals have quite limited incomes. For these reasons, Medicaid eligibility may have a substantial, positive impact on the quality of life for poor, uninsured adults with chronic conditions, especially those without children—a vulnerable population that has historically been excluded from health coverage.

The ACA also offers opportunities to improve the care that Medicaid beneficiaries receive. The relatively high number of ED visits and hospital stays, as well as provider office visits and prescriptions filled, among Medicaid adults with chronic conditions in this analysis indicates that there are opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rates of mental health comorbidity among adults with chronic physical conditions present opportunities for improved coordination of physical and mental health services. The Medicaid health homes option in the ACA presents an opportunity for states to coordinate care across providers to prevent duplicative or inappropriate care, especially for patients with multiple conditions and complex health needs. The health homes option extends a 90% federal matching rate for state spending on health home services for eight quarters. Qualifying health home services include care coordination and management, referral to community and social supports, and transitional and follow-up care.

While the ACA provides a number of opportunities to improve access to and quality of care for many uninsured adults with chronic conditions, it will be critical for states to ensure adequate provider capacity in their Medicaid programs so that these new enrollees have adequate access to the primary, preventive, and specialized care necessary to adequately treat their conditions. If states can meet the challenges of effectively implementing the ACA Medicaid expansion, the results of this analysis suggest that enrollment in Medicaid may provide greater access to important services that would enable newly eligible adults with chronic conditions to better manage their conditions.

Appendix

This analysis draws on data from the 2009 Medical Expenditure Panel Survey (MEPS) household component. The publicly-available MEPS-HC dataset is a nationally-representative survey of healthcare access, utilization, and expenditure among the United States civilian, non-institutionalized population. We restrict our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We exclude those with coverage changes throughout the year to match the timing of insurance and access measures, which ask about all access and use over the past year. We define "low-income" as having family income at or below 138% FPL. Medicaid beneficiaries with Medicare ("dual-eligibles") are excluded.

To identify individuals with chronic conditions, we use the MEPS Medical Conditions file, which is based on self-reports of whether a person had been told by a health care provider that he or she had any "priority" condition,[2] self-reports of individuals taking a day or more of disability during the year for a condition and of a condition "bothering" a respondent, and ICD-9 codes, classified using Clinical Classification Codes, from the event files. We also use the HCUP Chronic Condition Indicator (CCI) to specify whether a condition was chronic; only chronic conditions are included in this analysis. Spending data include expenditures from all payers and on all health care services. All spending values are calculated as annual, per capita expenditures.

---

[1] Wilper AP, Woolhandler S, Lasser KE, McComick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured US adults. *Health Affairs*. 2009;28(6):w1151-9

[2] See MEPS documentation available at http://meps.ahrq.gov/mepsweb/data_stats/download_data/pufs/h128/h128doc.shtml#Appendix4 for a list of priority conditions.

This publication (#8383) is available on the Kaiser Family Foundation's website at www.kff.org.

Testimony on Behalf of
The North Dakota Economic Security & Prosperity Alliance (NDESPA)
House Bill 1362 – Human Services and Appropriations Committees
March 13, 2013

Chairperson Lee and members of the Senate Human Services Committee, I am Karen Ehrens from Bismarck, and I am here today as a volunteer for the North Dakota Economic Security & Prosperity Alliance. NDESPA is a coalition of citizens and organizations working to build assets for North Dakotans of low and moderate income through public policy change.

Even in these times of prosperity, people of low and moderate-income – 1 out of every 8 North Dakotans – struggle to make ends meet. More than 75 percent of these households have earned income – they are working people and families. There are more than 80,000 people living with low or moderate-income in North Dakota, nearly 25,000 of who are children. More than 9,600 of these people are senior citizens – those who helped build North Dakota into the great state we are today.

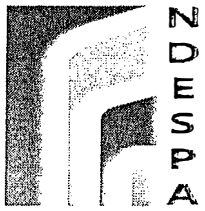
NDESPA supports Medicaid expansion for North Dakota, as do others here today. We can probably all agree that North Dakota is a great place to live and raise a family. We care about our quality of life, and we strive to live healthy lives. We want North Dakota to stay that way and, when our children grow up, we want this state to be the place they raise their children. For that to happen, we have to invest in the health of people because healthy kids need healthy parents. And healthy communities need a reliable and healthy workforce. Today, we are putting the health of our children, our families and our state at risk. Too many North Dakotans don't have reliable health care because our health care system is inconsistent. Some employers pay for health care and others do not. Some North Dakotans have access to health care through public programs and others do not.

We can make healthcare more reliable and less risky for more North Dakotans by investing in our public health systems. People get sick whether they have health coverage or not. Expanding Medicaid coverage can help ensure that people see a medical provider when they are sick, and even before they get sick. An Oregon study found that people who gained access to Medicaid had better access to health care, were less likely to experience unpaid medical bills, and were more likely to report being in good health and less depressed compared to people without insurance. Such coverage and preventive care options will preclude more costly crisis care in the future. Timely preventive services and medical care help to keep citizens productive and improve quality of life.

We urge the committee to take advantage of this unprecedented opportunity for an investment in the people of North Dakota and pass HB 1362.

Attached to this testimony is a list of NDESPA partners who support this effort.

I would be happy to take questions from the Committee.



North Dakota
Economic Security
and Prosperity
Alliance

North Dakota Economic Security & Prosperity Alliance
(NDESPA) Partners
2013

North Dakota Women's Network
North Dakota Council on Abused Women's Services
North Dakota Disabilities Advocacy Consortium
North Dakota Head Start Association
North Dakota Community Action Partnership
AARP North Dakota
Catholic Charities of North Dakota
Family Voices of North Dakota
American Association of University Women in North Dakota
North Dakota Chapter of the National Association of Social Workers
Childcare Resource & Referral
Mental Health America of North Dakota
Children's Defense Fund in North Dakota
North Dakota Public Employees Association
Prevent Child Abuse of North Dakota

NDESPA works to build and sustain a system of economic security for all North Dakotans through poverty awareness and education, grassroots and community capacity building, research and data development, and promotion of policies and practices to eliminate disparities and obstacles for achieving economic security.

1002 E Interstate Avenue, Suite #7 Bismarck, ND 58503 NDESPA.org

6

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

Chairman Lee, members of the Senate Human Services Committee, I am Tom Regan, member of the ND Rural Behavioral Health (RBHN) Governance Committee. I am here today, on behalf of the ND RBHN, to speak in support of HB 1362, authorizing the Department of Human Services (DHS) to accept federal funds from the Patient Protection and Affordable Care Act (ACA) to implement the provisions for the Medicaid expansion.

The mission of the newly formed RBHN is: *To improve access to behavioral healthcare and eliminate behavioral health disparities in rural and tribal communities.* We strongly support Medicaid expansion because it will increase access to services for individuals with behavioral health (mental health and substance use) issues. The RBHN is made up of individuals and organizations that include providers, consumers, family members and advocates. Our Governance Committee consists of the original partners: ND Area Health Education Center (AHEC), ND Federation of Families for Children's Mental Health (FFCMH), Coal Country Community Health Center (CCCHC), Sakakawea Medical Center, Mental Health America of ND (MHAND), Essentia Health and the MHA Nation.

The following are the reasons we support Medicaid expansion:

- It will provide more individuals an opportunity to access behavioral health services;
- It will provide an opportunity to encourage individuals to seek behavioral health services before it becomes a need for more expensive emergency room and/or inpatient care;

- It will address the fact that, under the ACA even if Medicaid expansion is not implemented, states will still have a reduced disproportionate share of hospital (DSH) funding, so while need for compensated care may remain stable, there will be fewer federal funds to subsidize some of that care than is available today. As a result, some hospitals may see severe financial hardship, having to increase costs to paying patients or providing less uncompensated care;
- It provides an opportunity to keep North Dakota residents' federal tax dollars flowing into the state. Taxpayers who live in states that do not implement expansion will be paying out dollars to states that do expand.
- ND is experiencing a high rate of individuals with behavioral health issues becoming involved with the ND Department Corrections and community services for those who are homeless. Medicaid expansion is part of the solution since accessing behavioral health services, before it becomes a crisis, can be a successful prevention strategy;
- We understand that, due to the economic development related to oil in western ND, the current behavioral health system is stretched to capacity. Medicaid expansion will be part of the solution to address the increased need for services.

RBHN urges support of Medicaid expansion for the multiple benefits it will bring to many individuals, families, and providers. It's the right thing to do for the people we serve.

Thank you for giving me the time to testify today.

TESTIMONY – PROTECTION AND ADVOCACY PROJECT

House Bill 1362 (2013)

Senate Human Services Committee

Honorable Judy Lee, Chair

March 13, 2013

Senator Lee, and members of the committee, I am Christine Hogan, a lawyer with the North Dakota Protection and Advocacy Project (P&A). P&A is an independent state agency that acts to protect persons with disabilities from abuse, neglect, and exploitation, and advocates for the civil rights of persons with disabilities. I am asking for your support for HB 1362, which authorizes North Dakota to accept Medicaid Expansion.

Medicaid Expansion is vitally important to people with disabilities in North Dakota. The disability rate among poor or near-poor North Dakotans is more than twice that of those with higher incomes.* People with disabilities on SSI already receive their health coverage from Medicaid. But people with disabilities who work at minimum-wage or low–wage jobs are frequently not eligible to receive SSI benefits and they are not otherwise on a waiver. They do not receive health coverage through Medicaid under the current laws and regulations even though they are working—sometimes at two jobs! These are the working poor people with disabilities for whom Medicaid Expansion is critical!

In North Dakota, there are a lot of people with disabilities who fall into this health coverage gap. They are neither on SSI nor on a waiver and they do not have any health coverage for basic health care, doctors, prescriptions, and hospitalizations. It is estimated the number of people in North Dakota under age 65 with disabilities who are at or under 138% of the federal poverty level who are not currently receiving Medicaid based on SSI or Waiver is at least 3,453 people.**

These North Dakotans live their lives in abject fear of getting sick or injured. These are the people with disabilities for whom Medicaid Expansion is critical! Thank you for your consideration of this information.

* Based on data from the 2010 American Community Survey

** same

8

Testimony

House Bill 1362

Senate Human Services Committee

Wednesday, February 13, 2013
9:00 AM

Deborah Knuth
Government Relations Director, American Cancer Society Cancer Action Network (ACS CAN)

Good morning, Chairman Judy Lee and members of the Senate Human Services Committee. My name is Deborah Knuth, and I am the director of government relations for the American Cancer Society Cancer Action Network (ACS CAN). I am here today to testify in support of House Bill 1362, and am asking for a "do pass" recommendation from this committee.

Cancer Patients and volunteers with the American Cancer Society Cancer Action Network (ACS CAN) call on the Senate Human Services Committee to accept the millions of dollars of federal funding being offered to North Dakota to increase access to health coverage through Medicaid—a move that would provide an estimated 32,000 of currently uninsured people in the state with access to lifesaving preventive care and treatments for cancer and other serious diseases, at no cost to the state for the first three years and no more than 10 percent of the cost in the future.

North Dakota should take advantage of this opportunity to support the 100 percent federal match rate. We can cover more people and save thousands of dollars in taxpayer money that is currently spent to treat the uninsured in emergency rooms. Covering more people makes moral and fiscal sense.

This also gives us the opportunity to provide hardworking low-income North Dakota residents the security of quality health coverage so they can see a doctor regularly and get lifesaving cancer screenings and treatment when they need it, without facing huge medical bills. We can significantly reduce the number of uninsured with incomes at or below 138% of the federal poverty level who know they are one diagnosis away from financial ruin.

Increased coverage will help to improve public health and reduce the cancer burden in North Dakota. ACS CAN urges this Committee to accept the money to cover more people and save taxpayer dollars by fully expanding access to Medicaid coverage.

Thank you for the opportunity to speak with you today. Are there any questions?

ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit www.acscan.org.

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

Chairman Lee, members of the Senate Human Services Committee, I am Nancy McKenzie, Public Policy Director for Mental Health America of North Dakota (MHAND). I am here today to speak in support of HB1362, authorizing the Department of Human Services (DHS) to accept federal funds from the Patient Protection and Affordable Care Act (ACA) to implement the provisions for the Medicaid expansion.

The mission of Mental Health America is to promote mental health through education, advocacy, understanding and access to quality care for all individuals. We strongly support Medicaid expansion because it will cover so many individuals with mental health and substance use problems, many for the first time. Thus, it is a significant opportunity to improve treatment access for these people.

MHAND supports that Medicaid expansion in North Dakota is a positive and effective investment because:

1) Expansion is good for people -
   - Having coverage, and thereby improved access to healthcare, results in better health outcomes and resulting improved productivity;
   - For many individuals with serious mental health or substance use problems, we know that health status and average lifespan are currently less than that of the general public;

- Coverage provides protection against high medical costs, which for some individuals can result in bankruptcy and financial devastation; and,
- Medicaid expansion ensures that many people, often the "poorest of the poor" are not left out in the cold. Those with incomes <100% of the federal poverty level (FPL) would not be eligible for premium tax support for insurance products available through the exchange, so likely would remain uninsured without expansion.

2) Expansion is good for providers –
   - The list of providers who would see increased percentage of revenue from Medicaid is significant, including: nursing homes, community health centers, hospitals, and behavioral health providers. This is important because we all want to see our providers, including those in smaller, rural areas, benefit economically;
- We are all aware of the challenges of "uncompensated" care that North Dakota's providers have faced. The prevalence of individuals with mental illness in uncompensated emergency room care, for example, has had a big impact on hospitals. Presumptive eligibility will cover people who now present at hospitals uninsured; resulting in less uncompensated care; and,
- Under the ACA, even if Medicaid expansion is not implemented, states will still have reduced disproportionate share hospital (DSH) funding, so while need for compensated care may remain stable, there will be fewer federal funds to subsidize some of that care than is available today. As a result, some hospitals may see severe financial hardship, having to increase costs to paying patients or providing less uncompensated care.

3) Expansion is good for the state's economy –

- For the reasons noted in #2 above, Medicaid expansion will help free up state and local spending that now goes to uncompensated care;
- Medicaid expansion will avoid costs associated with transitions and churning as people's income and eligibility for insurance coverage fluctuate. Expansion provides stability in coverage, which means lower administrative costs in addition to continuity of care; and,
- Expansion will keep North Dakota residents' federal tax dollars flowing into the State. Taxpayers who live in states that do not implement expansion will be paying out dollars to states that do expand. New federal Medicaid dollars will travel through the state's economy and turn over multiple times.

Who is hurt by rejecting Medicaid expansion? Poorer adults with serious chronic conditions, and many of our North Dakota providers in the state whose ability to serve this population is so vital.

The opportunity we have to expand Medicaid is a very positive and unusual opportunity. The ability for more individuals to have the care they need, and to seek that care sooner because they have coverage, rather than waiting for a more costly and complex crisis, will truly mean more recovery. Treatment works, recovery is real, and we want individuals to be able to access that.

Some people express concern about the ability to pay the state's share of expansion, though, as we know, there will be some increase in Medicaid spending to states whether there is expansion or not. Electing to choose expansion allows a majority of increase to be paid with federal funds.

The Coalition for Whole Health has noted that those states who to date are strongly rejecting expansion tend to be those states that historically are low spenders on mental health community-based services, with more individuals in institutions. Conversely, states that have embraced expansion tend to currently support strong community-based services, and have fewer individuals residing in institutions.

In closing, North Dakota has a strong history of continually moving forward to develop more community-based services that are evidence-based and provide the best opportunity for individual recovery. As a legislature, you have supported that philosophy and contributed to those improvements. Providers and advocates are proud that our state has done that, while recognizing that there are needs that remain to be met.

In North Dakota, as we all know, we are so fortunate to be in a better financial position than are many parts of the country. Mental Health America in North Dakota strongly urges you to support Medicaid expansion, for the multiple benefits it will bring to so many individuals, families, and providers. It's the right thing to do, and the right time to do it.

Thank you for giving me the time to testify today; I'll be happy to answer any questions you may have.

NDMA
Est. 1887 NORTH DAKOTA MEDICAL ASSOCIATION

Senate Human Services Committee

House Bill 1362

March 13, 2013

Chair Lee and Committee Members, I am Katie Cashman, communications director for the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents and medical students. The North Dakota Medical Association supports Medicaid expansion. Medicaid expansion is one of the most consequential state decisions in the history of Medicaid. Each state decision will directly affect health care and health status of a large share of the state's citizens, with ripple effects throughout the entire health care system, the state budget, the economy, employers and others paying for health insurance

Expanding Medicaid will provide much needed coverage to our low-income patients, improve access to care, and improve the health and well-being of the newly insured.

- Low-income adults in states that expanded Medicaid had better coverage and better access to care compared to states that did not expand.
- Low income adults in states that expanded Medicaid had a significant decrease in mortality compared to states that did not expand.

Medicaid expansion is not simply a budget issue. Lawmakers must also consider the real human effects of this decision, including the health and well-

being of those who gain coverage under expansion. Medicaid expansion supports better health care for families and children. If a state chooses not to expand, fewer patients will be eligible for coverage which may negatively impact the number of children enrolled and the health and well-being of these families.

In states that choose not to expand Medicaid – an unfortunate scenario could unfold where those with incomes below the poverty level will be left with no coverage while those with incomes above the poverty level can access coverage on the exchange. However, even those with incomes just above the poverty level who can access coverage on the exchange will do so only with greater financial burden due to cost sharing requirements, etc.

A recent Kaiser Family Foundation study found that if all states expanded Medicaid, the federal government would pay for the vast majority of the costs, while many states would realize net budget savings and some only modest costs. By expanding Medicaid, states could save money by moving programs currently paid for through state-only funds or by state and federal funds to Medicaid, allowing states to receive the enhanced federal match rate for these services.

States that do not expand Medicaid will continue to face the health, social and economic costs of caring for the uninsured, including likely over-utilization of the emergency room and lost wages for sick time off. Without expansion, these costs will continue to be borne entirely by the state.

In a study published in the New England Journal of Medicine, researchers summarized results from a randomized-controlled trial they conducted when Oregon's Medicaid program used a lottery to select low-income adults who could apply to Medicaid for coverage. Approximately 30,000 of the 90,000 individuals who applied were chosen. Of these

individuals, approximately 10,000 of those selected ended up enrolling in Medicaid. Researchers compared those who were selected and enrolled in Medicaid to those who applied for the lottery but were not selected and found that individuals with Medicaid coverage were:

- 70 percent more likely to have a regular place of care,
- 55 percent more likely to have a regular doctor,
- 40 percent less likely to borrow money or skip payments on other bills because of medical expenses,
- 25 percent less likely to have medical bills sent to a collection agency.

Thank you for the opportunity to present NDMA's views on this bill. I would be happy to answer any questions at this time.

Of course, even these savings are highly speculative. They assume that uncompensated care costs actually decrease under a Medicaid expansion. Analysis of other states shows that this is not always the case. In fact, in Maine, uncompensated care continued to grow.

Furthermore, the assumed reductions in state supplemental payments to providers for uncompensated care are conditional on state lawmakers enacting explicit payment cuts. Depending on policies adopted by state lawmakers, those reductions could be higher or lower—or even zero—if a state does not enact payment cuts.

As Heritage analyst Ed Haislmaier points out:

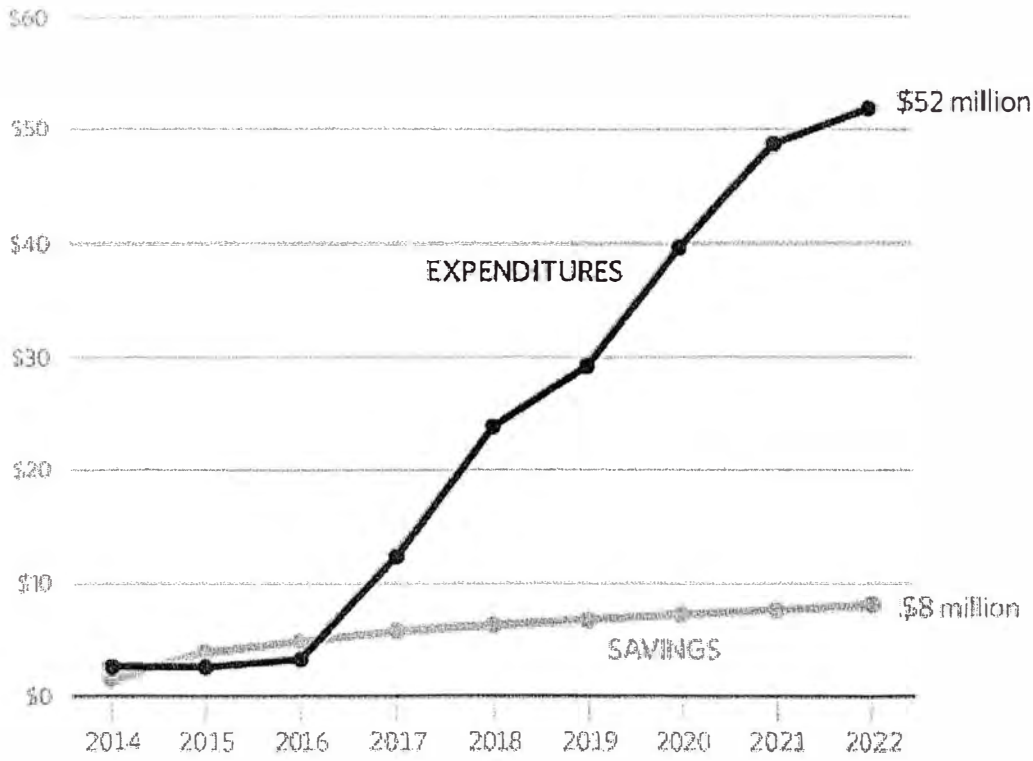
> *Under Obamacare, it is even more implausible to assume states would be able to cut uncompensated care funding. That's because any state payment cuts would have to be imposed on top of Obamacare's federal payment cuts. Obamacare cuts federal Medicaid "Disproportionate Share Hospital" (DSH) funding by $18.1 billion and Medicare DSH funding by $22.1 billion over the years 2014–2020.*

Therefore, Haislmaier predicts, "governors and state legislators should expect their state's hospitals and clinics to lobby them for more—not less—state funding to replace cuts in federal DSH payments."

Medicaid Expansion in North Dakota: $159 MILLION

*Medicaid expansion in North Dakota would result in a rapid increase in spending beginning in 2017, quickly surpassing any modest savings from reductions in state payments to providers for uncompensated care. On net, the expansion would cost North Dakota taxpayers **$159 million** through 2022.*

STATE EXPENDITURES AND SAVINGS DUE TO MEDICAID EXPANSION, IN MILLIONS



Sources: Heritage Foundation calculations based on data and methodology from John Holahan et al., the Urban Institute, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Kaiser Foundation, November 2012, http://www.kff.org/medicaid/upload/8384.pdf (accessed February 28, 2013).

heritage.org

This infographic supports

Health Care

If state lawmakers really want a clear picture of what Medicaid expansion under Obamacare will look like, they should start with Arizona, where expansion was tried more than a decade ago — with disastrous results.

In 2000, Arizona received a federal waiver to extend Medicaid to all childless adults and parents earning less than 100 percent of the federal poverty level. This is nearly the same group that would be eligible for Medicaid under the federal health care law, except that Obamacare would include those earning up to 138 percent of the federal poverty level, a slightly larger group.

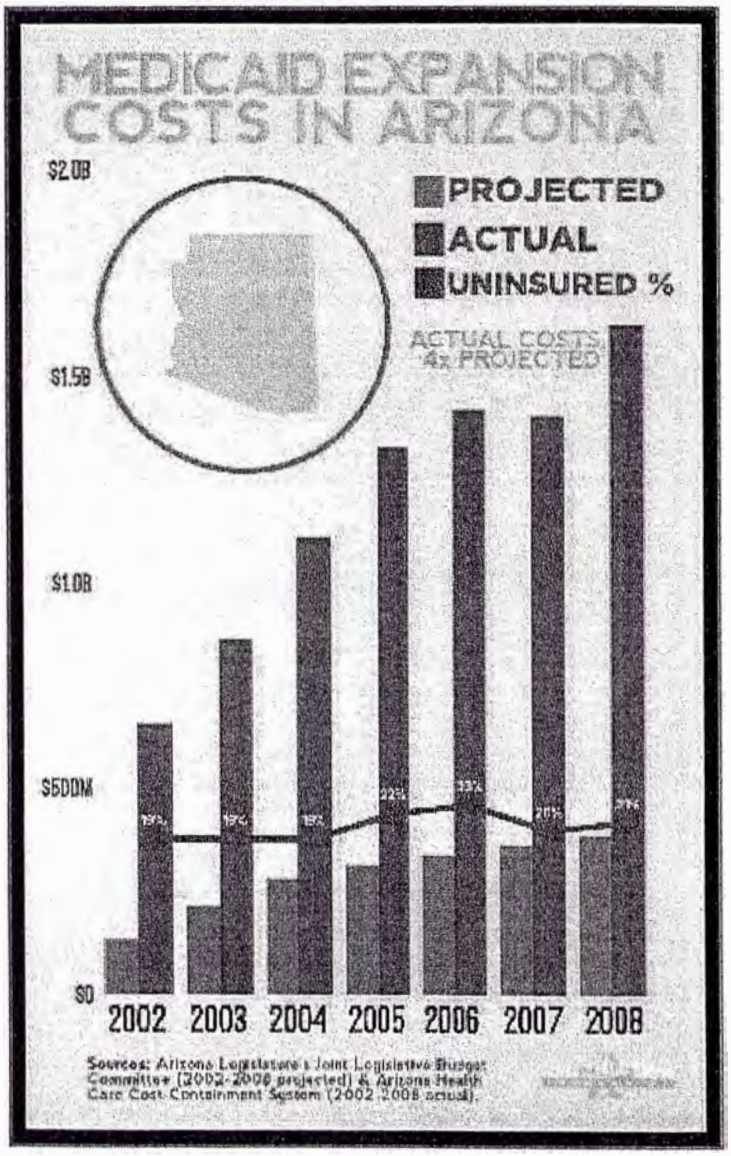
At the time, Arizona lawmakers and expansion advocates promised that expanding Medicaid would lower the uninsured rate, reduce uncompensated care costs, decrease the "hidden tax" on private insurance for uncompensated care, and save about $30 million a year in state funds.

These same promises — lower uninsured rate and reduced uncompensated care costs — are being made by those calling for Medicaid expansion in other states.

None of the promises came true. In fact, the opposite happened. Enrollment of parents was more than triple what was forecast, while enrollment of childless adults was more than double.

As a result, costs skyrocketed. Spending per enrollee was much higher than anticipated, especially among childless adults, who proved to be twice as expensive to cover as parents. By 2008, Arizona had spent $8.4 billion on Medicaid expansion — more than four times what had been forecast.

What about the promise that expansion would lower the uninsured rate? In 2002, about 18.7 percent of Arizona's non-elderly population was uninsured. By 2011, that group had actually increased to 19.4 percent. Meanwhile, the percentage of Arizonans with private insurance dropped from 61.8 percent to 55.5 percent, while Medicaid enrollment grew far beyond what had been predicted.



When the recession hit in 2008, Arizona faced a budget shortfall and scaled back Medicaid benefits for childless adults, including organ transplantation. It later froze enrollment for that group, which dropped from 227,000 to 86,000.

Arizona Gov. Jan Brewer's January announcement that she will support the Obamacare Medicaid expansion should not have come as a surprise. Arizona's waiver expires in 2013, and the state had no choice but to go along with expansion. If it did not, the feds would likely not renew the state's waiver, which would force some 86,000 people out of the Medicaid program and into the ranks of the uninsured.

The Arizona experience is not unique. In 2002, Maine implemented an almost identical Medicaid expansion — with almost identical results. Within two years, enrollment was more than double what had been forecast, with childless adults costing more than four times as much as parents. Between 2002 and 2011, the uninsured rate remained the same, while the share of those with private insurance shrank, from 66 percent to 59 percent.

Proponents of Medicaid expansion claim it will reduce the uninsured rate and therefore reduce uncompensated care costs. The hope and expectation is that federal expansion dollars will free up state funds and relieve taxpayers, much like advocates of expansion hoped for Arizona and Maine.

Tags: Arizona, John Davidson, Medicaid, Obamacare

Next Page

Continued on Page 2 >>

1
2

Featured Articles

14

Medicaid Expansion

BACKGROUND

The Patient Protection and Affordable Care Act (ACA) calls for a nationwide expansion of Medicaid eligibility in 2014. Nearly all individuals with incomes up to 133% (effectively 138% with disregards) of the federal poverty level (FPL) were supposed to qualify for Medicaid under the expansion. The U.S. Supreme Court in June 2012 upheld the Medicaid expansion so that while it was originally mandatory for states to expand Medicaid, now it is optional.

Medicaid does not cover many low-income adults today. To qualify for Medicaid prior to health reform, individuals had to meet financial eligibility criteria and belong to one of the following specific groups: children, parents, pregnant women, people with severe disability, and seniors. Non-disabled adults without dependent children were generally excluded from Medicaid unless the state obtained a waiver to cover them.

Health Insurance Coverage of the Nonelderly (ages 19-64) with Incomes up to 139% FPL

	ND #	ND %	ND % of US Total	US #	US %	US % of US Total
Employer	20,800	19%	<1%	12,782,800	17%	100%
Individual	13,100	12%	<1%	4,633,700	6%	100%
Medicaid	36,100	33%	<1%	31,775,000	41%	100%
Other Public	NSD	NSD	NSD	2,862,900	4%	100%
Uninsured	34,400	31%	<1%	24,522,300	32%	100%
Total	109,300	100%	<1%	76,576,700	100%	100%

WHO BENEFITS?

The target population for Medicaid expansion is uninsured people making less than 138 percent of the federal poverty level:

- Individual: $15,415
- Family of three: $26,344
- Family of four: $31,809

WHO PAYS?

Fiscal Year	*Increased FMAP for newly eligible individuals*
2014-2016	100%
2017	95%
2018	94%
2019	93%
2020 and beyond	90%

THE BOTTOM LINE FOR NORTH DAKOTA HOSPITALS

As part of the complicated negotiation process for the Accountable Care Act, U.S. hospitals conceded to significant cuts to reimbursements and programs like the disproportionate share (DSH*) payment program in exchange for the promise of increased insurance coverage, i.e. fewer patients accessing health care without the ability to pay. In other words, hospitals agreed to cuts in exchange for the promise of reduced bad debt that is inherent among the uninsured.

The cuts we've agreed to ...

DSH payment cuts

- National DSH cuts: $56 billion
- North Dakota hospitals DSH cuts: $xxxxx million
- Sanford DSH cuts: approx. $10.4 million (based upon 2011 Medicare cost report)

Medicare reimbursement cuts

- Example A
- Example B

N.D. Hospitals Bad Debt/Charity Care

- PPS = $194 million ($127 million bad debt/$67 million charity care)
- CAH = $30 million ($23 million bad debt/$7 million charity care)
- Total = $224 million ($150 million bad debt/$74 million charity care)

Sanford Bismarck Payor Mix/Bad Debt

Financial Class	Bad Debt	Bankruptcy	Charity Care	Self Pay Discount	Grand Total
Blue Cross	$ 1,240,150	$ 7,677	$ 267,462	$ 563	$ 1,515,852
Commercial	$ 714,334	$ 18,101	$ 283,951	$ 3,486	$ 1,019,871
Indian Health Services	$ 252,622		$ 153,844		$ 406,466
Liability	$ 372,593	$ 10,461	$ 100,490		$ 483,544
Medicaid	$ 258,638	$ 29,111	$ 473,500	$ 224	$ 761,473
Medicare	$ 550,049	$ 10,250	$ 461,182		$ 1,021,481
Military	$ 162,528	$ 7,145	$ 41,474	$ 35	$ 211,182
Sanford	$ 6,661		$ 1,013	$ 324	$ 7,998
Self Pay	$ 5,957,854	$ 181,124	$ 5,598,635	$ 21,734	$ 11,759,348
Workers Comp	$ 150,475		$ 44,993	$ 776	$ 196,244
Grand Total	**$ 9,665,905**	**$ 263,869**	**$ 7,426,544**	**$ 27,142**	**$ 17,383,459**

	Bad Debt	Bankruptcy	Charity Care	Self Pay Discount	Grand Total
Blue Cross	12.83%	2.91%	3.60%	2.07%	8.72%
Commercial	7.39%	6.86%	3.82%	12.84%	5.87%
Indian Health Services	2.61%	0.00%	2.07%	0.00%	2.34%
Liability	3.85%	3.96%	1.35%	0.00%	2.78%
Medicaid	2.68%	11.03%	6.38%	0.82%	4.38%
Medicare	5.69%	3.88%	6.21%	0.00%	5.88%
Military	1.68%	2.71%	0.56%	0.13%	1.21%
Sanford	0.07%	0.00%	0.01%	1.19%	0.05%
Self Pay	61.64%	68.64%	75.39%	80.08%	67.65%
Workers Comp	1.56%	0.00%	0.61%	2.86%	1.13%
Totals	100.00%	100.00%	100.00%	100.00%	100.00%

15

Bloomberg

Refusal to Expand Medicaid May Cost Employers $1 Billion

By Alex Wayne - Mar 13, 2013

Governors who refuse to expand their Medicaid programs for the poor may cost employers in their states as much as $1.3 billion in federal fines, a study found.

A clause in the 2010 health-care overhaul penalizes some employers when their workers aren't able to obtain affordable medical coverage through the company. Employers can avoid those fees if their workers qualify for Medicaid as part of an expansion that as many as 22 states have rejected, according to a report today by Jackson Hewitt Tax Service Inc.

Without Medicaid, a "shared responsibility" payment of as much as $3,000 may be triggered for each employee who can't get insurance through their company. In Texas, the largest state to refuse to increase Medicaid, employers may be liable for as much as $448 million in fines, the study found. In Florida, where the legislature has refused an expansion supported by Governor Rick Scott, employers may pay as much as $219 million.

"A lot of businesses have taken the position that they oppose a Medicaid expansion because it would increase their taxes," Brian Haile, senior vice president for health policy at Jackson Hewitt in Parsippany, New Jersey, said in an interview. "The irony of this, or the paradox, is that the opposite may be true, at least for some businesses in some states."

Under the Affordable Care Act, states are expected to expand Medicaid, the joint federal-state health plan for the poor, to cover every person earning wages close to the poverty level. Medicaid's expansion is one of two core provisions in the law's mission of extending health coverage to about 27 million uninsured people. The Supreme Court said in June the federal government can't force states to expand the program.

Shared Responsibility

With as many as 22 states potentially opting out, more workers will have to rely on the other core provision of the law, subsidized insurance sold through health exchanges. That would trigger the

shared responsibility payment for each employee who can't get insured through their company and in turn qualifies to use the exchanges.

Employers wouldn't have to pay the penalties if their workers enroll in Medicaid. Under the law, a family of four making about $32,500 this year would be eligible for the program.

The shared responsibility clause applies to companies that offer health insurance and have at least 50 employees.

To contact the reporter on this story: Alex Wayne in Washington at awayne3@bloomberg.net

To contact the editor responsible for this story: Reg Gale at rgale5@bloomberg.net

North Dakota Department of Human Services
INCOME ELIGIBILITY LEVELS
Effective April 1, 2012

Family Size	Family Coverage (1931)	Medically Needy 83% of Poverty	SSI (Effective 01/01/13)	Children Age 6 to 19 and QMB 100% of Poverty	SLMB 120% of Poverty	Pregnant Women & Child to Age 6 133% of Poverty	QI-1 135% of Poverty	Healthy Steps 160% of Poverty	Transitional Medicaid 185% of Poverty	Caring for Children & Children with Disabilities & Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$311	$ 773	$ 710	$ 931	$ 1,117	$1,238	$1,257	$1,490	$1,723	$1,862	$2,095
2	417	1,047	1,068	1,261	1,513	1,677	1,703	2,018	2,333	2,522	2,837
3	523	1,321		1,591	1,909	2,116	2,148	2,546	2,944	3,182	3,580
4	629	1,595		1,921	2,305	2,555	2,594	3,074	3,554	3,842	4,322
5	735	1,869		2,251	2,701	2,994	3,039	3,602	4,165	4,502	5,065
6	841	2,143		2,581	3,097	3,433	3,485	4,130	4,775	5,162	5,807
7	947	2,416		2,911	3,493	3,871	3,930	4,658	5,386	5,822	6,550
8	1,053	2,690		3,241	3,889	4,311	4,376	5,186	5,996	6,482	7,292
9	1,159	2,964		3,571	4,285	4,750	4,821	5,714	6,607	7,142	8,035
10	1,265	3,238		3,901	4,681	5,189	5,267	6,242	7,217	7,802	8,777
+1*	107	274		330	396	439	446	528	611	660	743

Spousal Impoverishment Levels			
Community Spouse Minimum Asset Allowance (Effective 01/01/13)	Community Spouse Maximum Asset Allowance (Effective 01/01/13)	Community Spouse Income Level (Effective 01/01/03)	Income Level for each Additional Individual (Effective 04/01/12)
$23,184	$115,920	$2,267	$630

Average Cost of Nursing Facility Care	
Average Monthly Cost of Care (Effective 01/01/13)	Average Daily Cost of Care (Effective 01/01/13)
$6,792	$223.30

Notes: Nursing Home personal needs allowance increased from $40 to $50 effective with the benefit month of 01/01/02.
ICF/ID and Basic Care personal needs allowance increased from $50 to $85 effective 1/1/2010.

HB1362
4-3-13
#1

Testimony by Rep. Al Carlson, 4.3.2013,

Senate Appropriations Committee

In the wake of the US Supreme Court's decision on the Patient Protection and Affordable Care Act (PPACA), also known as Obamacare, states must now decide whether to expand their Medicaid programs by accepting a larger federal subsidy.

As passed, PPACA required states to expand their Medicaid eligibility to all individuals with incomes between 133 percent and 138 percent of the federal poverty level. States that failed to meet this requirement would no longer receive any federal Medicaid grants at all.

The Supreme Court, however, ruled states could not be required to expand their Medicaid programs in order to continue receiving current levels of federal support.

Therefore, states are not required to expand their Medicaid programs, but the offer of "free money" is proving tempting to many states.

In reality, the money isn't free. Accepting federal funds to expand Medicaid rolls will impose new costs upon states and, ultimately, state taxpayers.

The federal matching rate starts at 100 percent for newly eligible enrollees, but it declines over time, leaving states to find other ways to pay for the newly eligible population.

States that choose to expand, instead of reforming an already broken system, will subject even more of their lower-income residents to a program that provides inferior care.

Policy Solution

We should avoid Medicaid expansion and instead reform our fiscally unsustainable programs in ways that will offer better care and lower costs to the state. Solutions to consider may include a premium-based model like Florida's pilot program, which saved $118 million a year in the five counties in the program, or a block-grant program that gives states more flexibility over how they run Medicaid and manage its costs.

So What Could We Do:

1. Help the needy up to 100 percent of the federal poverty level to obtain access to care but do not create an entitlement program that we cannot afford,
2. The exclusion of single people from Medicaid coverage is an issue we need to seriously look at for innovative solutions

*Note, individuals that are not covered by Medicaid are adults between the ages of 21 and 65 who are not blind or disabled, pregnant, or a caretaker of deprived children.

- How can we work on state solutions instead of federally mandated controls and dictates that have steered our country towards bankruptcy?

- Our country has $16.5 trillion in debt and the federal politicians continue to add entitlements that we absolutely know we cannot afford.

- How can we expand Medicaid on a national basis when the country is broke?

- Do you think Medicare will really be cut by the politicians to pay for the Medicaid expansion under Obamacare?

- Do we as citizens of this state and country care about the debt we are passing on to our children and grandchildren?

- The feds will pull this Medicaid expansion money in a few years out of fiscal necessity and we will be left with a bureaucratic program that does not achieve its objective efficiently or effectively.

- Will we ever work on designing health coverage that is affordable for North Dakotans?

- Do we want to address medical inflation which is out of control?

- We should be experimenting with innovative policies here in ND to cover the truly needy while creating systems to incentivize individuals to manage their own health and health care better, rather than having a debt financed federal government expansion of entitlements dictated from Washington which has a clear history of making promises it does not keep and adding rules and regulations we can ill afford.

I would respectfully ask the department to:

1. Identify the cost of a proposal that provides a safety net for individuals that are not married that fall under 100% of the federal poverty guidelines. We need to know how much it would cost to provide coverage to single folks that fall under 100% of the federal poverty level?

2. We should work on a state wide level to address the issues associated with access to health care. We should remember our children first. They represent our future. We should not saddle them with more and more debt – robbing them of the opportunity to achieve the American Dream.

3. The figures I have indicate that there are less than 9,000 children that are uninsured. We have done a good job with covering children in Medicaid, healthy steps and the Caring Program run by Blue Cross Blue Shield.

4. We should consider using our medical residency programs to provide primary care to needy citizens and also work to maximize their use of the state's Federally qualified health care centers.

5. The long term solution for the uninsured problem involves creating the conditions in our state for businesses to flourish. Most businesses that are successful offer health coverage as a benefit. We need to ensure that North Dakota continues to be a great state to start and expand businesses that create decent paying jobs with benefits including health coverage.

States Which HAVE Supported Medicaid Expansion:

Arkansas	Washington
California	Vermont
Washington, DC	Rhode Island
Delaware	Illinois
Hawaii	Maryland
Massachusetts	Connecticut
Minnesota	Nevada
Missouri	

States Which HAVE NOT Supported Medicaid Expansion:

Alabama	Georgia
Florida	Iowa
Kansas	Maine
Louisiana	Wisconsin
Mississippi	Texas
Nebraska	South Dakota
Oklahoma	South Carolina

OTHER VOICES
Excerpts from editorials around the region

gi Bear with iPad? You bet

Denver Post

t's a question that tends licit strong responses, h pro and con: Should national parks have bet- digital connectivity? We love the peaceful soli- e of the national parks as ch as anyone, but we ık there are valid reasons expanded technology in ks, and don't think the on of some ought to ne the experiences of all visit the parks.

recent proposal by the ional Park Service to t enhanced digital cov- ge in five parks at ances, lodges, visitor ters and main roads ıld not make every cor- of the parks Internet essible.

On the contrary, it would is on areas that already built-up, and that's ropriate. We could easily

TRIBUNE EDITORIAL

Expanding Medicaid questionable

N.D. shouldn't take the federal dollars

North Dakotans should be uncomfortable with the proposed expansion of Medicaid.

The federal government offers between $100 million and $150 million during the 2013-15 biennium to insure 20,000 to 30,000 additional residents, mostly adults. It would cost the state more than $300,000 to administer the program.

While North Dakota can afford its share, the federal government already has a nearly $17 trillion debt and can ill afford to add to it. Further, this is within the context of a vigorous North Dakota economy with as close to full employment as is possible, less than 3 percent unemployed.

What percentage of North Dakotans ought to be dependent on government for health insurance? Presently, 66,322 North Dakotans are enrolled in Medicaid, or about 9 percent of the state's population. Add covering 20,000 adults to that number, and the percentage enrolled in Medicaid rises to 12 percent of the population.

In testimony before the House Human Resources Committee recently, the case was not made for an urgent need for the coverage. And if that case should be made in the future, the state is in financial position to act. Rep. Al Carlson, R-Fargo, suggests block grants, and that should be explored.

Also, the consequences of accepting that money would go beyond 2015. The federal government sets up programs like this, begins to fund them and then requires the state to pick up the costs. In the future, the state could be on the line for countless millions. North Dakota may be flush now, but history suggests that might not always be the case.

The expansion of Medicaid is part of the Affordable Care Act. When the country looked at reforming health care, one of the primary motivations was to control costs. Heath care costs have been increasing much faster than the rate of inflation, taking larger and larger bites out of family budgets. But the Affordable Care Act did not contain effective measures to control costs. Rather, it shifts the burden of those costs to state and federal governments.

If North Dakota accepts the expansion of Medicaid, those funds go right to the federal obligation, in other words, pushing the federal debt even higher. People sympathetic to those 20,000 or 30,000 North Dakotans who might qualify for expanded Medicaid might find this a painful truth, for these are our friends and neighbors.

However, most North Dakotans also understand the need to deal with the federal government's growing debt. These are uncomfortable choices for all. We should not talk fiscal conservatism in North Dakota and then continue to accept increased federal payments at the expense of the federal debt.

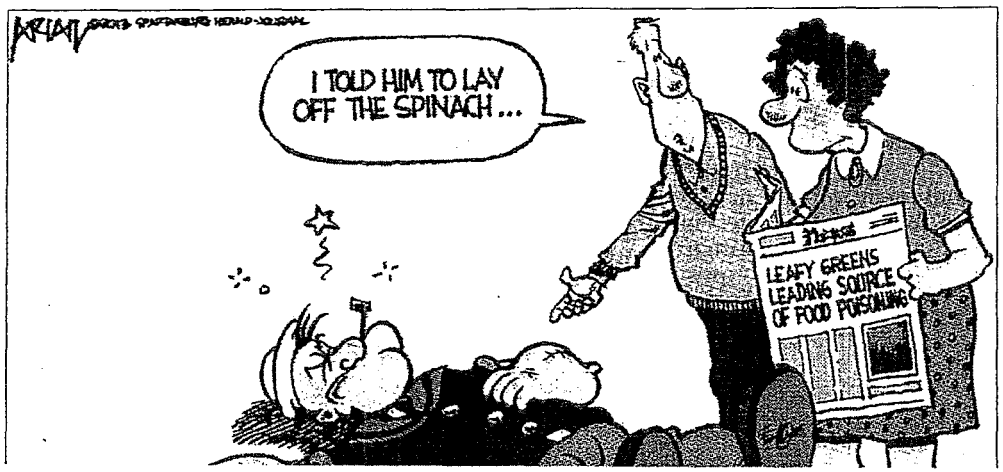
VOICES OF THE PEOPLE

People control would ensue

By GARY E. BERUBE
Mandan

It has nothing to do with gun control. It has everything to do with people control.

Take away our guns and you can force us to do anything. Hitler and other dictators have been successful using this technique. This country was founded because a king



from the abortionist's knife in Fargo and we were taken to jail in handcuffs and, the next day, taken to court in our orange suits with handcuffs and leg chains, broadcast on television.

I say 32 babies because we pro-lifers kept better records than the abortion mill kept and gave to the government.

We faced what appeared to be six years in prison, but through a half-dozen court appearances and plea bargaining, we got one year probation, which

#2

Testimony
Engrossed House Bill 1362 – Department of Human Services
Senate Appropriations Committee
Senator Ray Holmberg, Chairman
April 3, 2013

Chairman Holmberg, members of the Senate Appropriations 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.

How would the expansion impact Medicaid 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 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

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).

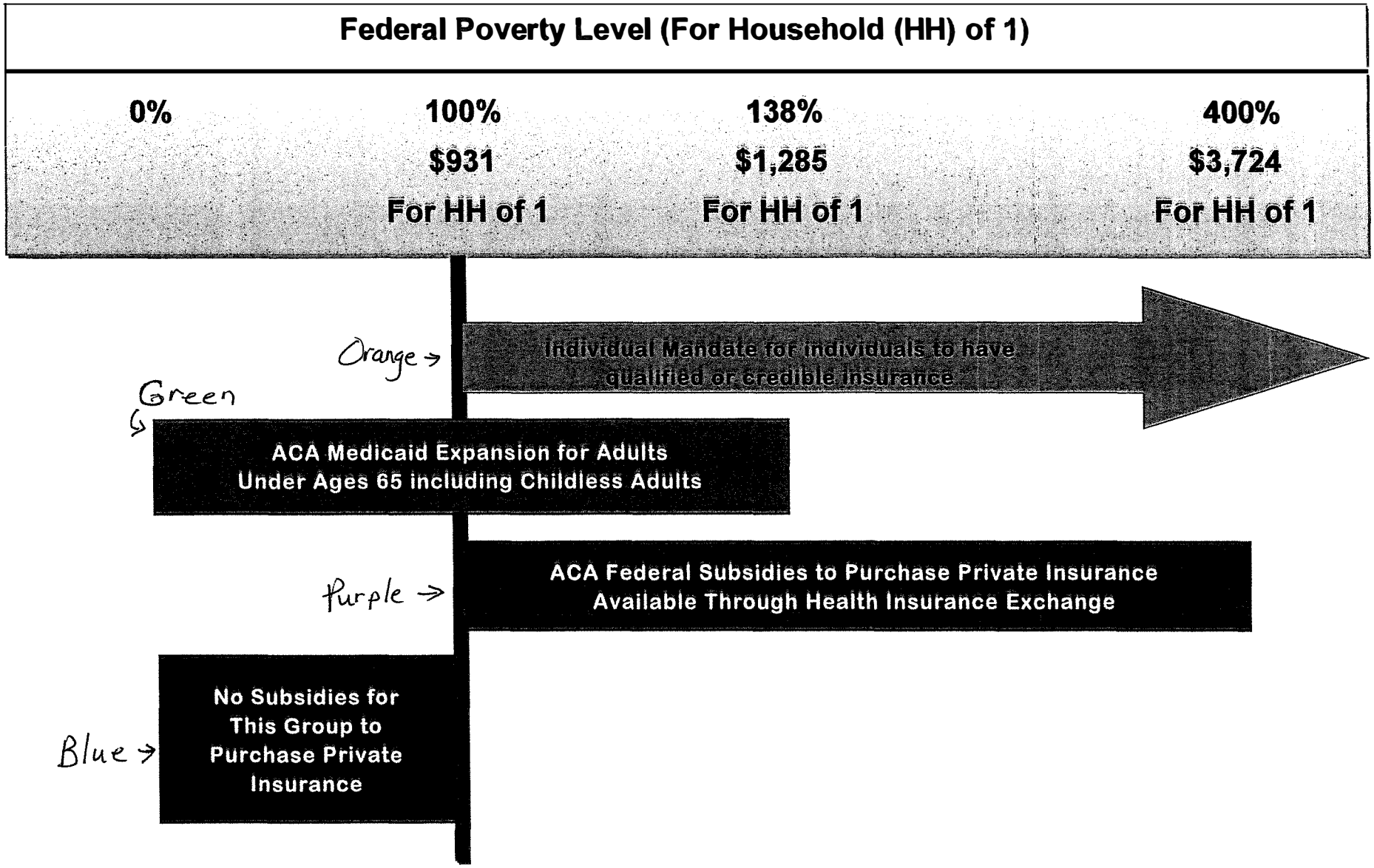
Conclusion - additional guidance is still expected and the assumptions used in calculating the estimates are not "set in stone." We cannot be certain of the number of people who will seek coverage or be able to precisely predict their health care needs and service usage. The estimates provide a projection of potential enrollment and estimated costs.

I would be happy to address any questions that you may have.

Attachment A

North Dakota Department of Human Services
Affordable Care Act (ACA)

Medicaid Expansion Illustration



Department of Human Services

Medical Services Division

Questions and Answers from the Centers for Medicare and Medicaid Services

Excerpt from the Attachment to December 10, 2012

Letter from Secretary Sebelius to Governors

House Bill 1362

MEDICAID

Expansion

24. Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care Act?

A. No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions.

As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process.

While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to "newly eligible individuals" are tied by law to specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.

North Dakota Department of Human Services
INCOME ELIGIBILITY LEVELS
Effective April 1, 2012

Family Size	Family Coverage (1931)	Medically Needy 83% of Poverty	SSI (Effective 01/01/13)	Children Age 6 to 19 and QMB 100% of Poverty	SLMB 120% of Poverty	Pregnant Women & Child to Age 6 133% of Poverty	QI-1 135% of Poverty	Medicaid Expansion 138% of Poverty	Healthy Steps 160% of Poverty	Transitional Medicaid 185% of Poverty	Caring for Children & Children with Disabilities & Women's Way 200% of Poverty	Workers with Disabilities 225% of Poverty
1	$311	$ 773	$ 710	$ 931	$ 1,117	$1,238	$1,257	**$1,285**	$1,490	$1,723	$1,862	$2,095
2	417	1,047	1,068	1,261	1,513	1,677	1,703	**1,740**	2,018	2,333	2,522	2,837
3	523	1,321		1,591	1,909	2,116	2,148	**2,196**	2,546	2,944	3,182	3,580
4	629	1,595		1,921	2,305	2,555	2,594	**2,651**	3,074	3,554	3,842	4,322
5	735	1,869		2,251	2,701	2,994	3,039	**3,107**	3,602	4,165	4,502	5,065
6	841	2,143		2,581	3,097	3,433	3,485	**3,562**	4,130	4,775	5,162	5,807
7	947	2,416		2,911	3,493	3,871	3,930	**4,017**	4,658	5,386	5,822	6,550
8	1,053	2,690		3,241	3,889	4,311	4,376	**4,473**	5,186	5,996	6,482	7,292
9	1,159	2,964		3,571	4,285	4,750	4,821	**4,928**	5,714	6,607	7,142	8,035
10	1,265	3,238		3,901	4,681	5,189	5,267	**5,384**	6,242	7,217	7,802	8,777
+1*	107	274		330	396	439	446	**456**	528	611	660	743

Spousal Impoverishment Levels

Community Spouse Minimum Asset Allowance (Effective 01/01/13)	Community Spouse Maximum Asset Allowance (Effective 01/01/13)	Community Spouse Income Level (Effective 01/01/03)	Income Level for each Additional Individual (Effective 04/01/12)
$23,184	$115,920	$2,267	$630

Average Cost of Nursing Facility Care

Average Monthly Cost of Care (Effective 01/01/13)	Average Daily Cost of Care (Effective 01/01/13)
$6,792	$223.30

Notes: Nursing Home personal needs allowance increased from $40 to $50 effective with the benefit month of 01/01/02.
ICF/ID and Basic Care personal needs allowance increased from $50 to $85 effective 1/1/2010.

Rev 3-2013

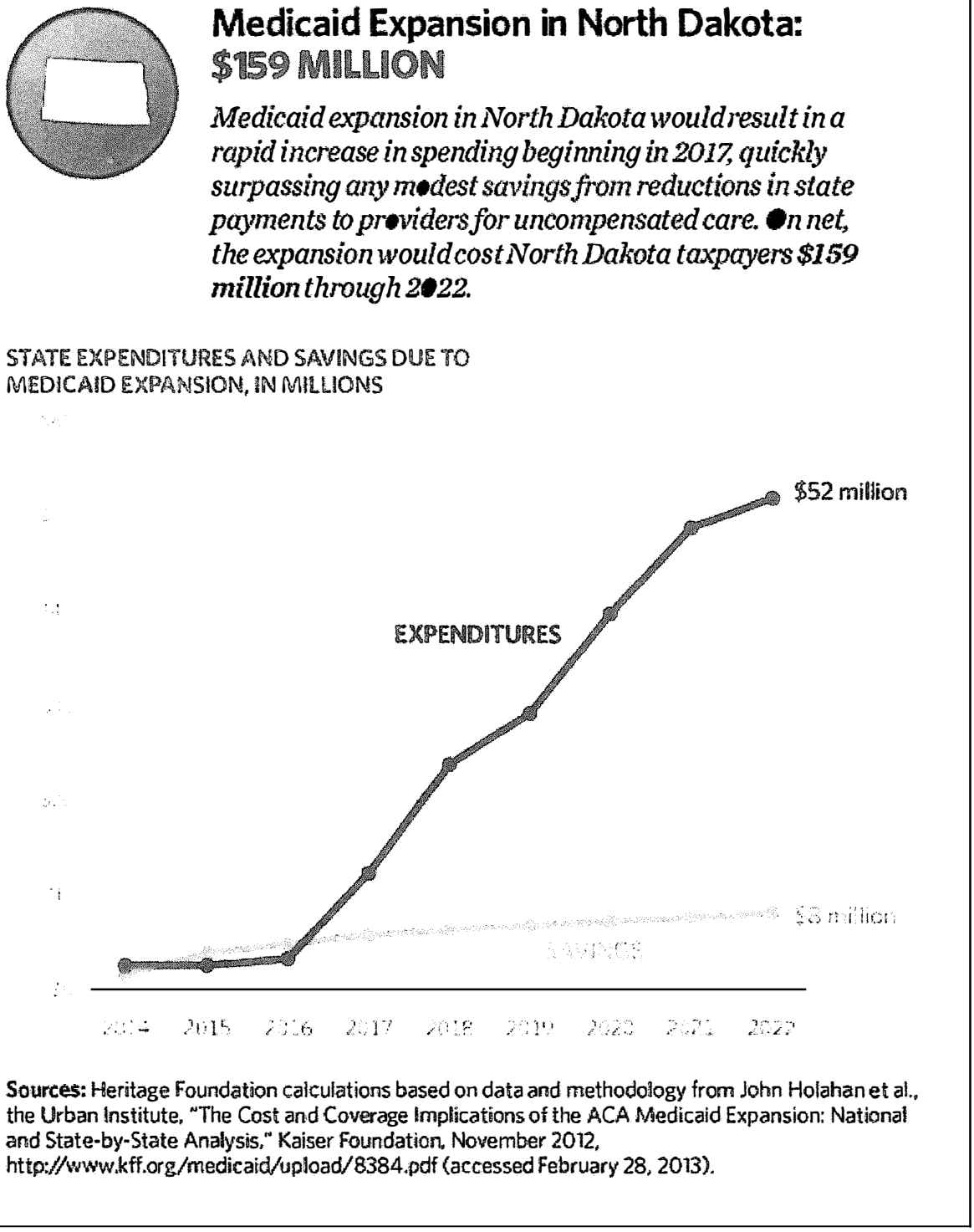
#3
HB1362
4-3-13

The Heritage Foundation
LEADERSHIP FOR AMERICA

Search Heritage for

Medicaid Expansion in North Dakota: Impact and Cost to Taxpayers

Created on March 5, 2013



This infographic supports

Health Care

THE IMPACT OF
OBAMACARE

Medicaid Expansion in the States

> Alabama
> Alaska
> Arizona
> Arkansas
> California
> Colorado
> Connecticut
> Delaware
> D.C.
> Florida
> Georgia
> Hawaii
> Idaho
> Illinois
> Indiana
> Iowa
> Kansas
> Kentucky
> Louisiana
> Maine
> Maryland
> Massachusetts
> Michigan
> Minnesota
> Mississippi
> Missouri
> Montana
> Nebraska
> Nevada
> New Hampshire
> New Jersey
> New Mexico
> New York
> North Carolina
> North Dakota
> Ohio
> Oklahoma
> Oregon
> Pennsylvania
> Rhode Island
> South Carolina
> South Dakota
> Tennessee
> Texas
> Utah
> Vermont
> Virginia
> Washington
> West Virginia
> Wisconsin
> Wyoming

Download all of the charts

HB 1362 #4
4-3-13

We Support Medicaid Expansion

We, the undersigned, support the expansion of Medicaid in North Dakota. North Dakota has the opportunity to provide health care coverage to an estimated 20,500-32,000 uninsured residents with the federal government paying 100% of the costs of health coverage for the first three years and no less than 90% of the cost in the future. Expanding Medicaid will provide coverage for low-income individuals and families. It will give people now without insurance access to preventive care that can save lives, and greatly lessen the use of uncompensated emergency room care, which will result in lowering the overall cost of health care for everyone. Medicaid expansion will also infuse the state's economy with hundreds of millions of dollars. If North Dakota fails to exercise the Medicaid expansion option as it currently exists, thousands of residents will not have access to affordable coverage and the state will, in fact, be creating a coverage gap for the poorest individuals and families under 100% of poverty who will have no access to health care subsidies.

The bottom line is that if North Dakota does not expand Medicaid coverage, our residents will be subsidizing expansion in other states without receiving the benefit of additional federal funding for our own uninsured population. We urge the State of North Dakota to participate in Medicaid expansion because it makes sense both for the health of ALL North Dakota residents and for the state budget.

AARP North Dakota

American Cancer Society-Cancer Action Network

Blue Cross Blue Shield North Dakota

Greater North Dakota Chamber

American Lung Association

American Heart Association

Community HealthCare Association of the Dakotas (CHAD)

Family Voices of North Dakota

North Dakota Economic Security and Prosperity Alliance

North Dakota Public Employees Association

North Dakota Education Association

North Dakota Center for Persons with Disabilities

North Dakota Rural Behavior Health Network

North Dakota Catholic Conference

North Dakota Hospital Association

North Dakota Medical Association

North Dakota Farmers Union

North Dakota Nurses Association

Mental Health America of North Dakota

March of Dimes, North Dakota Chapter

National Multiple Sclerosis Society, Upper Midwest Chapter

North Dakota Women's Network

North Dakota Federation of Families for Children's Mental Health

Protection & Advocacy

The North Dakota Board of Physical Therapy

The North Dakota Physical Therapy Association

WelCore Health, Grand Forks, ND

North Dakota Disability Advocacy Consortium

North Dakota Occupational Therapy Association

March 13, 2013

#5

HB1362- SUPPORT MEDICAID EXPANSION
Wednesday, April 3, 2013
Senate Appropriations
Josh Askvig- AARP-North Dakota
jaskvig@aarp.org or 701-989-0129

Chairman Chairman Holmberg, members of the Senate Appropriations committee, I am Josh Askvig, Associate State Director of Advocacy for AARP North Dakota.

Dr. Ethel Percy Andrus, a retired educator and AARP's founder, became an activist in the 1940's when she found a retired teacher living in a chicken coop because she could afford nothing else. Dr. Andrus couldn't ignore the need for health and financial security in America and set the wheels in motion for what would become AARP. We are a nonprofit, nonpartisan membership organization with nearly 88,000 members in North Dakota and 37 million nationwide. We understand the priorities and dreams of people 50+ and are committed to helping them live life to the fullest, including here in North Dakota.

As you know HB1362 would authorize the Governor's recommendation to expand Medicaid under the Affordable Care Act.

AARP believes everyone should have access to affordable health care. By expanding Medicaid this year, North Dakota can help hard-working people who have jobs without health insurance to get Medicaid health coverage if their incomes are less than $15,000 a year or 138 percent of the federal poverty level.

This issue is particularly important to low-income individuals who are over age 50 and not yet eligible for Medicare. These middle-aged adults are more likely to face the onset of health conditions that if left untreated could inevitably increase their need for and use of health and long term care. With the expansion, AARP estimates approximately 4,366 50-to-64-year-olds could qualify for Medicaid in North Dakota.

Expanding Medicaid will provide coverage for individuals struggling to make ends meet. In addition, it will give people without insurance access to preventive care that can save lives, and ease dangerous and expensive emergency room overcrowding that hurts all of us.

Medicaid expansion will both expand access to health care coverage for people who desperately need it and infuse the state's economy with millions of dollars. Under the law, the federal government will pay the cost of the state's Medicaid expansion for three years beginning in 2014, and then the federal government's match rate gradually drops beginning in 2017, decreasing to 90 percent in 2020 and thereafter.

This means North Dakota has an opportunity to provide health care coverage to an estimated 32,000 uninsured residents at no cost to the state for the first three years and no more than 10 percent of the cost in the future. North Dakota taxpayers will also find savings after expanding Medicaid due in large part to reducing the need for other medical service programs that are currently paid for now entirely by the state, like mental health services. Finally, hospitals and health care providers won't end up with uninsured patients using expensive emergency room care.

I want to offer a couple of brief notes on some of the potential state savings as a result of Medicaid Expansion. The Kaiser Family Fund issued a report in November 2012 (ATTACHMENT A) that considered the impact of expanding Medicaid coverage to uninsured low income adults with chronic illness. The report found notable levels of chronic illness among the uninsured, indicating largely unmet health care needs among potentially newly eligible adults. Among the uninsured, prevalence of the four conditions ranged from 5% for diabetes to 13% for mental illness. The report posits that it is possible that the uninsured (who are less likely than those with Medicaid to see a medical provider) also have undiagnosed illness that weren't captured in the numbers but still would require treatment.

Out of pocket spending among these individuals varied from $904 for uninsured adults with respiratory disease to $1,498 for those with diabetes, with the remainder of their overall spending coming from health care providers or uncompensated care funds. These expenses are hard to meet on small budgets, meaning many are simply not getting the care they need to manage these chronic illnesses. Another issue raised by the report is that lack of consistent source of care by uninsured adults. Medicaid enrollees were much more likely to have a check-up in the past two years than their uninsured counterparts with the same illnesses. This indicates that these people are disconnected from the health system and exacerbating problems for people with chronic conditions that require ongoing medical attention.

The report concludes that Medicaid eligibility expansion in 2014 "may provide improved access to a variety of health services and prescription medications, as well as reductions in out-of-pocket costs, for many currently uninsured adults with chronic conditions. The relatively comprehensive Medicaid benefits package and improved care management could also foster more appropriate care patterns for the uninsured at a greatly reduced out-of-pocket cost, potentially improving both their health and personal economic security, as these individuals have quite limited incomes. For these reasons, Medicaid eligibility may have a substantial, positive impact on the quality of life for poor, uninsured adults with chronic conditions, especially those without children—a vulnerable population that has historically been excluded from health coverage."

Beginning in 2014, those living between 100 percent through 400 percent of poverty will be eligible for a federal tax subsidy should they choose to purchase health insurance coverage through a health insurance exchange. If North Dakota fails to exercise the Medicaid expansion option as it currently exists, thousands of residents will not have access to affordable coverage and the state will, in fact, be creating a coverage gap for the poorest individuals and families under 100% of poverty who will have no access to health care subsidies.

AARP urges the State of North Dakota to participate in Medicaid expansion because it makes sense both for the health of our residents, and for the state budget. For those who will be newly eligible in 2014, North Dakota will be able to take advantage of the 100 percent federal match rate. Expansion meets the needs of over 32,000 individuals in the state, including 4,366 50-64 year olds, while taking advantage of federal dollars that can be used to ensure that all North Dakota residents have access to affordable health care coverage.

I appreciate your time Mr. Chairman and members of the Committees. We strongly encourage you to move forward with the Medicaid Expansion included in HB1362.

kaiser commission on medicaid and the uninsured
KEY FACTS
THE HENRY J. KAISER FAMILY FOUNDATION

November 2012

The Role of Medicaid for Adults with Chronic Illnesses

Introduction

Medicaid is the nation's health coverage program for the low-income population, covering over 60 million people, or one in five Americans. Medicaid beneficiaries are a diverse group that includes low-income parents, children, and pregnant women, low-income Medicare beneficiaries, and people with disabilities. Many individuals covered through Medicaid have special needs, which is a result of the program's eligibility rules that explicitly extend coverage to disabled and medically needy groups. Beginning in 2014, the Affordable Care Act (ACA) enables states to expand Medicaid to nearly all people with income at or below 138% of the federal poverty level (FPL). This expansion would extend coverage to millions of currently uninsured adults, particularly non-elderly adults without dependent children who have typically been excluded from the program. Since this newly eligible group is largely uninsured and faces limited access to the health care system as a result, they may have substantial unmet need for health care services.

Understanding the current and future role of Medicaid for adults with chronic illnesses can aid policymakers in designing programs to efficiently and effectively meet the needs of enrollees. Specifically, decisions related to benefit design, delivery systems, and provider networks may be better informed with information on Medicaid's current role for individuals with chronic illnesses, how well the program serves these individuals, and how the health needs of the newly-eligible compare to those already enrolled. This brief summarizes a series of policy briefs that examine Medicaid's role for adults with chronic illnesses including diabetes, cardiovascular disease (CVD), respiratory disease, and mental illness.* It compares low-income adults with Medicaid coverage to low-income adults who are uninsured with respect to health needs, health care spending, access to care, and utilization of services. [A more detailed description of the data and methods for the analysis in this brief is included in the Appendix at the end of the report.] The information provides a profile of Medicaid's role in supporting population health and how this role could change through the expansion of eligibility in 2014.

* Separate pieces examine each of these conditions individually. See: http://www.kff.org/medicaid/8383.cfm.

1330 G STREET, NW, WASHINGTON, DC 20005
PHONE: 202-347-5270, FAX: 202-347-5274
WWW.KFF.ORG/KCMU

Findings

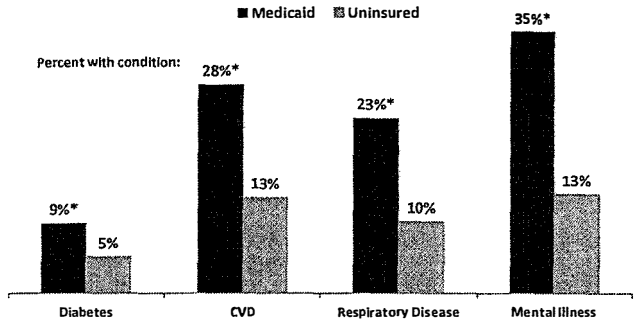
Prevalence

Among nonelderly adult Medicaid enrollees in 2009, the prevalence of chronic conditions varied by disease (Figure 1). Around one in ten adult Medicaid enrollees had diagnosed diabetes, and higher shares had diagnosed cardiovascular disease (28%) or respiratory disease (23%). Over a third (35%) had a diagnosed mental illness.

The prevalence of all four conditions was higher among Medicaid adults than among the uninsured (Figure 1). The higher rate of chronic illness among Medicaid beneficiaries is likely a result of Medicaid rules that explicitly extend program eligibility to people in poor health, such as the medically needy and people with disabilities. While lower than prevalence rates among Medicaid enrollees, there are still notable levels of chronic illness among the uninsured, indicating the considerable health care needs among potentially newly eligible adults. Among the uninsured, prevalence of the four conditions ranged from 5% for diabetes to 13% for mental illness. It is quite possible that the uninsured (who are less likely than those with Medicaid to see a medical provider) also have undiagnosed illness that do not appear in the prevalence rates above but still would require treatment.[1]

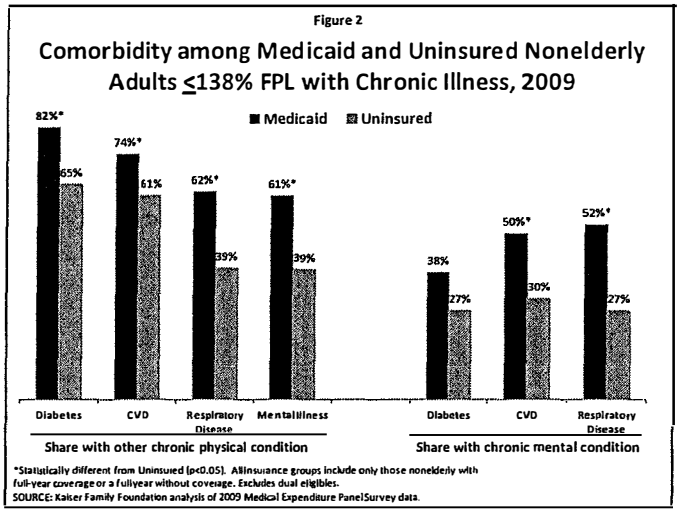
Figure 1

Prevalence of Chronic Illnesses among Medicaid and Uninsured Nonelderly Adults ≤138% FPL, 2009



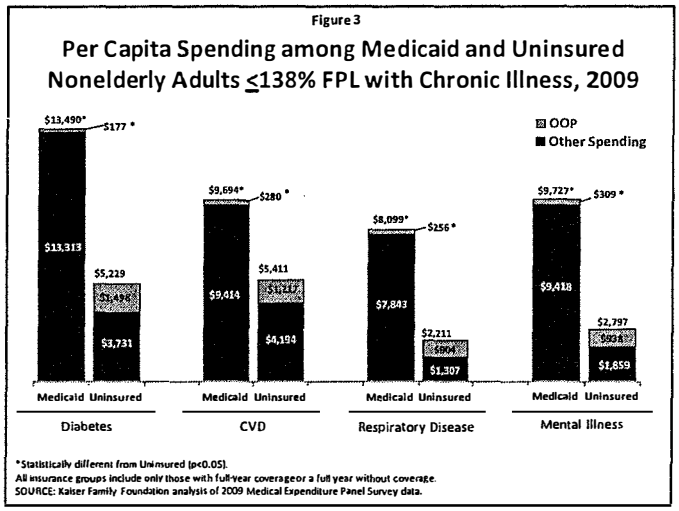
*Statistically different from Uninsured (p<0.05).
All insurance groups include only those nonelderly with full-year coverage or a full year without coverage.
Excludes dual eligibles.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Comorbidity, or an individual having more than one illness, is common among individuals with chronic conditions, and this pattern holds among low-income Medicaid and uninsured adults. In fact, a majority of Medicaid beneficiaries with each of the four conditions had an additional physical chronic condition—ranging from 61% to 82%—evidence of the complex health care needs of this population (Figure 2). Moreover, between 38% and 52% of nonelderly Medicaid enrollees with one of the three physical conditions (diabetes, CVD, and respiratory disease) also had a comorbid mental illness. Comorbidities were also common among uninsured adults with the four chronic conditions. The shares of these uninsured groups with a physical comorbidity ranged from 38% to 64%, and the shares of those with one of the three physical chronic conditions with a comorbid mental health condition were around three in ten.



Spending

Chronic illnesses may be costly to treat, and the presence of comorbid conditions—each with costly treatment needs—means that individuals with these illnesses may incur substantial health costs. Health spending for nonelderly adult Medicaid enrollees with chronic illness ranged from $8,099 per capita among those with respiratory disease to $13,490 per capita among those with diabetes (Figure 3). Individuals with diabetes had the highest per capita spending of the illnesses analyzed; this result is likely related to the fact that individuals with diabetes also had the highest comorbidity rates and the spending levels in Figure 3 represent spending on all services (not just spending for each disease). High spending levels among Medicaid beneficiaries with chronic illness are related to their poor health status: spending for nonelderly adult Medicaid beneficiaries without these conditions was significantly lower (around $5,000 per capita, data not shown).



Compared to Medicaid enrollees, uninsured low-income adults had per capita spending between $2,211 (respiratory disease) and $5,411 (CVD) (Figure 3). The differences in spending levels again reflect both the particularly complex health care needs of the Medicaid population with chronic illnesses and lower utilization among uninsured individuals with the same illnesses.

Conversely, out-of-pocket spending was consistently lower and more similar across the illness groups for Medicaid beneficiaries than for uninsured adults (Figure 3). For the illness groups in Medicaid, out-of-pocket spending per beneficiary fell between $177 per year for those with diabetes and $309 for those with mental health conditions. By contrast, those figures varied from $904 for uninsured adults with respiratory disease to $1,498 for those with diabetes, with the remainder of their overall spending coming from health care providers or uncompensated care funds. The substantial differences in out-of-pocket spending between Medicaid adults and the uninsured result from Medicaid rules that limit cost-sharing for beneficiaries to nominal amounts.

Utilization

The spending patterns in Figure 3 reflect differences in utilization by illness and coverage. Across the four illnesses, Medicaid beneficiaries with chronic illnesses had greater service utilization than the uninsured with the same illness (Table 1). Specifically, Medicaid adults had had roughly two to three times as many office visits in the previous year (10.2–12.3 versus 3.2–5.6) and prescriptions filled per month (3.3-5.3 versus 1.1-2.2) as the corresponding groups of the uninsured. Adults in Medicaid were also more likely than the uninsured to have had an inpatient stay or an emergency department (ED) visit in the previous year, though the differences in ED use were smaller than differences for other utilization measures. These higher relative rates of ED use among the uninsured could reflect the relative inelasticity of emergency service utilization compared to other, non-emergent services. The lower rates of other types of utilization, particularly office visits and prescription drug use, may indicate unmet need for services, especially when one considers the high rates of comorbidity among these individuals.

As with spending, utilization was higher among Medicaid enrollees with diabetes compared to other illnesses, with the exception of emergency department visits. Again, this group is most likely to have comorbid conditions and thus may have greater health needs than other groups.

Table 1
Service Utilization among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

	Medicaid	Uninsured
Number of Provider Office Visits		
Diabetes	12.3*	4.8
CVD	10.2*	5.6
Respiratory Disease	10.7*	3.2
Mental Illness	10.9*	5.0
Number of Prescriptions/Month		
Diabetes	5.3*	2.2
CVD	3.9*	1.9
Respiratory Disease	3.5*	1.1
Mental Illness	3.3*	1.3
Share who had an Inpatient Stay		
Diabetes	29%*	10%
CVD	22%*	9%
Respiratory Disease	19%*	6%
Mental Illness	22%*	7%
Share who had an Emergency Department Visit		
Diabetes	34%	34%
CVD	36%*	23%
Respiratory Disease	39%*	26%
Mental Illness	33%*	23%

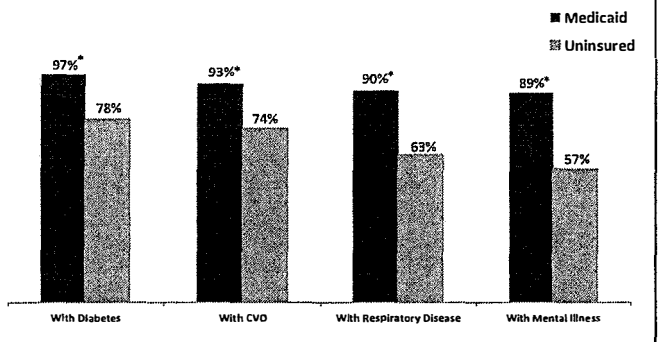
*Statistically significant difference from Uninsured, $p < .05$
SOURCE: KCMU analysis of 2009 Medicaid Expenditure Panel Survey data.

Access

Despite higher levels of comorbidity, nonelderly adult Medicaid enrollees with chronic illness report better access to care than uninsured adults with the same illnesses. Specifically, most Medicaid beneficiaries with chronic illness reported having a usual source of care (Figure 4), ranging from 89% of those with a mental illness to 97% of those with diabetes. Consistently lower shares of the uninsured with chronic illness reported having a usual source of care, and the trend across the illness groups was similar to that of the Medicaid population, ranging from 57% of those with mental illness to 78% of those with diabetes. Not having a usual source of care indicates disconnection from the health system and may be especially problematic for people with chronic conditions that require ongoing medical attention.

Figure4

Usual Source of Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009

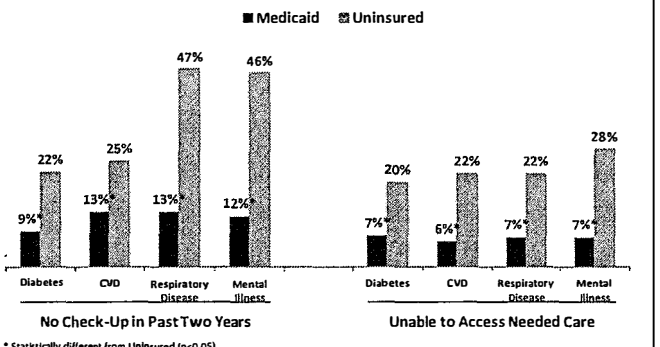


* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

On most measures of having a problem accessing care, nonelderly adult Medicaid beneficiaries with chronic disease were less likely than their uninsured counterparts to report a problem (Figure 5). Medicaid enrollees were much more likely to have a check-up in the past two years than their uninsured counterparts with the same illnesses. Notably high shares of uninsured adults with respiratory disease (47%) or mental illness (46%) reported not having a recent check-up, indicating potential barriers to regular care for their conditions. Further, all four groups of Medicaid beneficiaries were less likely than their uninsured counterparts to have been unable to access necessary medical care, with shares steady in the single digits among Medicaid adults and ranging from 20% to 28% among uninsured adults.

Figure 5

Barriers to Care among Medicaid and Uninsured Nonelderly Adults ≤138% FPL with Chronic Illness, 2009



* Statistically different from Uninsured (p<0.05).
All insurance groups include only those with full-year coverage or a full year without coverage.
SOURCE: Kaiser Family Foundation analysis of 2009 Medical Expenditure Panel Survey data.

Policy Implications

Medicaid plays an important role in providing access to care for people with chronic conditions. There is a high prevalence of chronic conditions among low-income, nonelderly adult Medicaid beneficiaries, and most of these individuals have complex care needs stemming from comorbid conditions. Reflecting these high needs, Medicaid enrollees with chronic conditions have relatively high spending and utilization rates. Notably, Medicaid seems to meet the health care needs of this high use population, as most report being linked to care and few report barriers to accessing services. Compared to Medicaid enrollees with the same illness, uninsured adults with chronic illness have poorer access to care, are less likely to utilize basic services, and have a greater out-of-pocket burden. Thus, while prevalence of chronic illness among uninsured low-income adults was lower than among Medicaid enrollees, many newly-eligible individuals may present with complex health needs.

The results of this analysis also suggest that the implementation of the Medicaid eligibility expansion in 2014 may provide improved access to a variety of health services and prescription medications, as well as reductions in out-of-pocket costs, for many currently uninsured adults with chronic conditions. The relatively comprehensive Medicaid benefits package and improved care management could also foster more appropriate care patterns for the uninsured at a greatly reduced out-of-pocket cost, potentially improving both their health and personal economic security, as these individuals have quite limited incomes. For these reasons, Medicaid eligibility may have a substantial, positive impact on the quality of life for poor, uninsured adults with chronic conditions, especially those without children—a vulnerable population that has historically been excluded from health coverage.

The ACA also offers opportunities to improve the care that Medicaid beneficiaries receive. The relatively high number of ED visits and hospital stays, as well as provider office visits and prescriptions filled, among Medicaid adults with chronic conditions in this analysis indicates that there are opportunities to better coordinate care or provide it more efficiently for beneficiaries with complex care needs. In addition, the high rates of mental health comorbidity among adults with chronic physical conditions present opportunities for improved coordination of physical and mental health services. The Medicaid health homes option in the ACA presents an opportunity for states to coordinate care across providers to prevent duplicative or inappropriate care, especially for patients with multiple conditions and complex health needs. The health homes option extends a 90% federal matching rate for state spending on health home services for eight quarters. Qualifying health home services include care coordination and management, referral to community and social supports, and transitional and follow-up care.

While the ACA provides a number of opportunities to improve access to and quality of care for many uninsured adults with chronic conditions, it will be critical for states to ensure adequate provider capacity in their Medicaid programs so that these new enrollees have adequate access to the primary, preventive, and specialized care necessary to adequately treat their conditions. If states can meet the challenges of effectively implementing the ACA Medicaid expansion, the results of this analysis suggest that enrollment in Medicaid may provide greater access to important services that would enable newly eligible adults with chronic conditions to better manage their conditions.

Appendix

This analysis draws on data from the 2009 Medical Expenditure Panel Survey (MEPS) household component. The publicly-available MEPS-HC dataset is a nationally-representative survey of healthcare access, utilization, and expenditure among the United States civilian, non-institutionalized population. We restrict our analysis to low-income nonelderly adults who are either uninsured or covered by Medicaid for twelve consecutive months. We exclude those with coverage changes throughout the year to match the timing of insurance and access measures, which ask about all access and use over the past year. We define "low-income" as having family income at or below 138% FPL. Medicaid beneficiaries with Medicare ("dual-eligibles") are excluded.

To identify individuals with chronic conditions, we use the MEPS Medical Conditions file, which is based on self-reports of whether a person had been told by a health care provider that he or she had any "priority" condition,[2] self-reports of individuals taking a day or more of disability during the year for a condition and of a condition "bothering" a respondent, and ICD-9 codes, classified using Clinical Classification Codes, from the event files. We also use the HCUP Chronic Condition Indicator (CCI) to specify whether a condition was chronic; only chronic conditions are included in this analysis. Spending data include expenditures from all payers and on all health care services. All spending values are calculated as annual, per capita expenditures.

---

[1] Wilper AP, Woolhandler S, Lasser KE, McComick D, Bor DH, Himmelstein DU. Hypertension, diabetes, and elevated cholesterol among insured and uninsured US adults. *Health Affairs*. 2009;28(6):w1151-9

[2] See MEPS documentation available at http://meps.ahrq.gov/mepsweb/data_stats/download_data/pufs/h128/h128doc.shtml#Appendix4 for a list of priority conditions.

This publication (#8383) is available on the Kaiser Family Foundation's website at www.kff.org.

Extending Affordable Health Coverage to Older Adults — Medicaid Expansion

AARP believes everyone should have access to affordable health care. By expanding Medicaid this year, North Dakota can help hard-working people who have jobs without health insurance to get Medicaid health coverage if their incomes are less than $15,000 a year or 138 percent of the federal poverty level. AARP estimates this will mean approximately 4,366 50 to 64 year-olds could qualify for Medicaid in North Dakota.

This issue is particularly important to individuals who are over age 50 and not yet eligible for Medicare. These middle-aged adults are more likely to face the onset of health conditions that if left untreated could inevitably increase their need for and use of health and long term care.

Expanding Medicaid will provide coverage for individuals struggling to make ends meet. In addition, it will give people without insurance access to preventive care that can save lives, and ease dangerous and expensive emergency room overcrowding that hurts all of us.

Medicaid expansion under the Affordable Care Act will both expand access to health care coverage for people who desperately need it, and infuse the state's economy with hundreds of millions of dollars. Under the law, the federal government will pay the cost of the state's Medicaid expansion for three years beginning in 2014, and then the federal government's match rate gradually drops beginning in 2017, decreasing to 90 percent in 2020 and thereafter.

This means North Dakota has an opportunity to provide health care coverage to an estimated 32,000 uninsured residents by 2022 at no cost to the state for the first three years and no more than 10 percent of the cost in the future. North Dakota taxpayers will also find savings after expanding Medicaid due in large part to reducing the need for other medical service programs that are currently paid for now entirely by the state, like mental health services. Finally, hospitals and health care providers won't end up with uninsured patients using expensive emergency room care.

Beginning in 2014, those living between 100 percent through 400 percent of poverty will be eligible for a federal tax subsidy should they choose to purchase health insurance coverage through a health insurance exchange. If North Dakota fails to exercise the Medicaid expansion option as it currently exists, thousands of residents will not have access to affordable coverage and the state will, in fact, be creating a coverage gap for the poorest individuals and families under 100% of poverty who will have no access to health care subsidies.

AARP urges the State of North Dakota to participate in Medicaid expansion because it makes sense both for the health of North Dakota residents, and for the state budget. For those who will be newly eligible in 2014, North Dakota will be able to take advantage of the 100 percent federal match rate. Expansion meets the needs of over 32,000 individuals in the state, including 4,366 50-64 year olds, while taking advantage of federal dollars that can be used to ensure that all North Dakota residents have access to affordable health care coverage.

HB1362 #6

North Dakota Hospital Association

Vision
The North Dakota Hospital Association will take an active leadership role in major Healthcare issues.

Mission
The North Dakota Hospital Association exists to advance the health status of persons served by the membership.

Testimony: HB 1362
Expansion of the Medical Assistance Program
Senate Appropriations Committee
April 3, 2013

Chair Ray Holmberg and Members of the Senate Appropriations Committee; I am Jerry E. Jurena, President of the North Dakota Hospital Association. I am here today to present testimony on HB 1362, the Expansion of the Medical Assistance Program.

As you have heard Medicaid Expansion establishes a minimum eligibility Level of 133% of the Federal Poverty Level and includes an adjustment of 5% for the Modified Adjusted Gross Income (MAGI) which; thereby, allows new enrollees to quality with incomes up to 138% of the Federal Poverty Level. There is no asset test and no resource test.

An issue that needs to be considered is; if Medicaid Expansion up to 138% of the Federal Poverty Level is not going to be implemented in North Dakota those individuals below 100% of the Federal Poverty Level, will not have access to subsidies to purchase private insurance.

Under the Medicaid Expansion provision there are new Federal Medical Assistance Percentages or FMAP. For those individuals that meet the requirements of the Expansion. The Federal Match is 100% for years 2014, 2015 and 2016. In 2017 the FMAP is reduced to 95% and by 2020 and thereafter the FMAP is 90%.

The Medicaid FMAP as of October 1, 2013 will be 50% for recipients who are now eligible and not enrolled at this time, if and when they are enrolled. This is the woodwork group.

At this time there are several states struggling with the decision to expand their Medicaid program; this issue is inundated with uncertainty across the

country. The dilemma many states have is; how will Medicaid Expansion be paid for and is the commitment by CMS to have Federal dollars available for the next several years realistic. I cannot tell you with any certainty that our Federal Government will have dollars available at the quoted amounts for Medicare, Medicaid or any other program where there is cost sharing, i.e. highways.

The current proposal is to pay for the expansion via Medicare and Medicaid offsets; including hospital update reductions, reduction in reimbursement for Disproportionate Share Hospital (DSH) and Taxes, including individual and corporate.

The American Hospital Association (AHA) estimates the North Dakota population under 138% to be between 19% and 24.8%. The US Average is 27.8%. States that refuse to implement Medicaid Expansion can do so without penalty; however, if a State does implement Medicaid Expansion they must do so at the 138% level. States can implement in 2014 or later; however, the 100% is fixed until 2016. Again if not implemented those below 100% of the Federal Poverty Level will have no source of subsidy provisions. The Congressional Budget Office (CBO) projection is one-third of the states will come on after 2016.

In our discussions at NDHA; although we have no hard numbers or data that will provide a statewide overview, we have compiled assumptions based on data from Department of Human Services and from AHA to estimate an offset of Bad Debt if Medicaid Expansion is approved.

N.D. Hospitals	2012 bad debt	Reduction of bad debt
PPS hospitals (6)	$194 million	$58.2 million
CAH (36)	$ 31.7 million	$ 9.51 million

One hospital that does break down their Bad Debt, Sanford Health in Bismarck, shared with us their numbers and we calculated their impact.

In 2012 their bad debt was $17.3 million of that number $11.56 million or 61% was attributed to self-pay, mostly the uninsured population. The Kaiser Family Foundation estimates up to 47% of the North Dakota population may qualify for Medicaid. We used a more conservative estimate of 30% that would qualify for Medicaid

Expansion; with that we estimate $3.468 million in additional revenue maybe realized, ($11.56 million X 30% = $3.468 million) for just one tertiary hospital. This we believe is a very conservative estimate.

When people are covered or have health insurance we believe they are healthier individuals; therefore, not using more expensive services at a later or at an inappropriate time, i.e. emergency rooms after hours. Hospital services provided to non-covered individuals adds to the cost of daily operations and increases a hospital's bad debt.

Another question I have been asked is if Medicaid is expanded will we have enough physicians to take care of the influx of patients? We are already treating these patients through our hospitals at inappropriate times, in inappropriate settings and with little to no follow-up, hospital emergency rooms.

In regards to the pay-for; all the hospitals in North Dakota will be included in the pay-for process regardless of our participation. The Hospitals in North Dakota; will have reduced payments based on the fiscal impact of the Expansion process in other states whether or not North Dakota participates.

Our recommendation is to consider the impact of Medicaid Expansion based on the health benefits provided to those not covered at this time, and to consider the effects of having additional insured off-setting some of the uncompensated care now being provided in the state.

Again we do not have numbers but we believe that expanding Medicaid will reduce some of the bad debt in the state.

Respectfully Submitted,

Jerry E. Jurena, President
North Dakota Hospital Association

GNDC
Greater North Dakota Chamber

Testimony of Jon Godfread
Greater North Dakota Chamber of Commerce
HB 1362
April 3, 2013

Mr. Chairman and members of the committee, my name is Jon Godfread and I am here today representing the Greater North Dakota Chamber of Commerce, the champions for business in North Dakota. GNDC is working on behalf of our more than 1,100 members, to build the strongest business environment in North Dakota. GNDC also represents the National Association of Manufacturers and works closely with the U.S. Chamber of Commerce. As a group we stand in support of HB 1362.

We support HB 1362 calling for the expansion of Medicaid in North Dakota. If North Dakota does not expand Medicaid coverage, our residents will be subsidizing expansion in other states without receiving the benefit of additional federal funding for our own uninsured population. Additionally, without increased insurance coverage for our residents, the uninsured will continue to seek primary care in emergency rooms resulting in increased healthcare costs for the insured.

A Direct Impact on Health Care Bad Debt

As part of the negotiation process for the ACA, U.S. hospitals conceded to significant payment cuts from Medicare and the disproportionate share (DSH) payment program in exchange for the promise of increased insurance coverage. Medicaid expansion is a critical piece of increased coverage.

Medicaid expansion would help reduce North Dakota health care's bad debt. It is estimated that more than 60% of hospitals' bad debt is from the uninsured. Of this patient population it is estimated that half would qualify for Medicaid through the expanded program. This means approximately 30% of each hospital's bad debt could be relieved by Medicaid expansion.

N.D. Hospitals	2012 Bad Debt	Medicaid Expansion Reduction of Bad Debt
PPS Hospitals *	$197 Million	$58.2 Million
Critical Access Hospitals **	$31.7 Million	$9.51 Million

***Prospective payment system (PPS) hospitals** include Altru Health System, Grand Forks; Essentia Health, Fargo; Sanford Health, Bismarck; Sanford Health, Fargo; St. Alexius Medical Center, Bismarck; and Trinity Health, Minot.
****North Dakota's 36 critical access hospitals** (CAHs) include St. Joseph's Hospital, Dickinson; McKenzie County Healthcare Systems, Watford City; Tioga Medical Center, Tioga; Jamestown Regional Medical Center; Jamestown; Mercy Hospital, Devils Lake; St. Luke's Hospital, Crosby; and Mercy Medical Center, Williston

Champions (for) Business

PO Box 2639
Bismarck, ND 58502

P: 701-222-0929
F: 701-222-1611

www.ndchamber.com

GNDC
Greater North Dakota Chamber

Who Pays for Medicaid Expansion if Implemented Now?

Fiscal Year	*Federal Government*	*North Dakota Government*
2014-16	100%	0%
2017	95%	5%
2018	94%	6%
2019	93%	7%
2020 and beyond	90%	10%

Bottom Line:

States that do not expand Medicaid leave employers exposed to higher "shared responsibility" payments under the Affordable Care Act (ACA) and our residents will be subsidizing expansion in other states without receiving the benefit of additional federal funding for our own uninsured population.

Thank you for the opportunity to appear before you today in support of HB 1278, and urge a Do Pass recommendation from this committee. I would be happy to answer any questions.

Champions (for) Business

PO Box 2639
Bismarck, ND 58502

P: 701-222-0929
F: 701-222-1611

www.ndchamber.com

#8

Testimony

House Bill 1362

Senate Appropriations Committee

Wednesday, April 3, 2013
8:30 AM

Deborah Knuth
Government Relations Director, American Cancer Society Cancer Action Network (ACS CAN)

Good morning, Chairman Ray Holmberg and members of the Senate Appropriations Committee. My name is Deborah Knuth, and I am the director of government relations for the American Cancer Society Cancer Action Network (ACS CAN). I am here today to testify in support of House Bill 1362, and am asking for a "do pass" recommendation from this committee.

Cancer Patients and volunteers with the American Cancer Society Cancer Action Network (ACS CAN) call on the Senate Appropriations Committee to accept the millions of dollars of federal funding being offered to North Dakota to increase access to health coverage through Medicaid—a move that would provide an estimated 32,000 of currently uninsured people in the state with access to lifesaving preventive care and treatments for cancer and other serious diseases, at no cost to the state for the first three years and no more than 10 percent of the cost in the future.

North Dakota should take advantage of this opportunity to support the 100 percent federal match rate. We can cover more people and save thousands of dollars in taxpayer money that is currently spent to treat the uninsured in emergency rooms. Covering more people makes moral and fiscal sense.

This also gives us the opportunity to provide hardworking low-income North Dakota residents the security of quality health coverage so they can see a doctor regularly and get lifesaving cancer screenings and treatment when they need it, without facing huge medical bills. We can significantly reduce the number of uninsured with incomes at or below 138% of the federal poverty level who know they are one diagnosis away from financial ruin.

Increased coverage will help to improve public health and reduce the cancer burden in North Dakota. ACS CAN urges this Committee to accept the money to cover more people and save taxpayer dollars by fully expanding access to Medicaid coverage.

Thank you for the opportunity to speak with you today. Are there any questions?

ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a

major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit www.acscan.org.