17.0262.02000

FISCAL NOTE

Requested by Legislative Council
12/20/2016

Bill/Resolution No.: HB 1032

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.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

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

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties			
Cities			
School Districts			
Townships			

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).*

HB1032 removes the Medicaid Expansion sunset, changes the rates used for Medicaid Expansion, and allows the Department to operate Medicaid Expansion as fee for service.

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.*

The Department's 2017-2019 budget in HB1072 for Medicaid Expansion is at the Medicaid fee schedule rates. The Department did not build the Medicaid Expansion budget at the current commercial rates. HB1032 has no fiscal impact on HB1072.

Medicaid Expansion has $6.7 million general fund included in HB1012. ($8.2 million less the $1.5 million allotment.) An additional $23.7 million is estimated to be needed in HB1012 to continue Medicaid expansion at Medicaid rates and operated as fee for service rather than currently as a managed care program.

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.*

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.*

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 or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

Name: Jennifer Scheet

Agency: Department of Human Services

Telephone: 328-4608

Date Prepared: 01/16/2017

2017 HOUSE APPROPRIATIONS

HB 1032

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1032
1/19/2017
27156

☐ Subcommittee
☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Relating to provider reimbursement rates for the Medicaid expansion program.

Minutes: Attachments 1-10

Chairman **Delzer:**

Representative **Keiser: District 47** This address the changes in the affordable care act. One of the dilemmas we have is that we can't get fiscal notes because of the large amount of numbers. 2 points in all three bills
1) All three bills do remove the sunset, if we do nothing Medicaid expansion will go away
2) If the department of human services, they could move it in house as well as current or could go to the exchange. If moving it in house would have some fiscal affect to the state of ND
HB 1032 Require that the rates move provider reimbursement rates would be the standard Medicaid rates instead of the commercial rates.

5:40 Chairman **Delzer:** Other than removing the sunset bill, simply says that the rate has to be the same as traditional Medicaid. Nothing about moving in-house
Representative **Keiser:** That's correct, and the language for moving it is page 1 line 19-21

Chairman **Delzer:** Can individuals between 100% and 38% of poverty, go into the exchange?
Representative **Keiser:** We had put that in originally but I do not believe that is a provision at this time. The federal standard would allow that but we made the decision to contract in state.

8:00 Questions of the committee

Jennifer Clark, Legal Counsel of the Legislative Council: I need to do some research for you, there may be a doughnut hole of individuals that would not be able to access the exchange. If Medicaid expansion went away but I need to do some checking and get back to you.

10:30- 38:00 Maggie Anderson: Director of Medical Services Division of the Department of Human Services. (see attachment 1 testimony)

18:45 Chairman **Delzer:** You're talking about deferring, so this would actually take place in the 4 years from now?
Ms. Anderson: No, this is deferred until we find out what the legislature is going to do. If we operated Medicaid expansion as fee for service, if that is authorized, we won't need this change request and we'd just be able to not do it at all. If the legislature does not approve us bringing the operation to run it as fee for service, the senator Medicare and Medicaid service would require us to begin work immediately. These things that are currently being done manually would have to be done automated, required by the federal government, so we would have to start on the 3.4-million-dollar work request probably by May or June.

19:50 Representative **Kempenich:** What are we paying on average per member?
Ms. Anderson: Current premium on average right now is $1,229 per person per month.

Representative **Kempenich:** How did you come up with total of utilization on the program?
Ms. Anderson: We looked at the claims that Sanford because they are currently processing those claims and we look at the membership that we have at the Medicaid rates. It's saying on average if we pay at the Medicaid rate as a fee for service the average per person per month is about $789 times about 20 thousand people to get to that 389 million number.

22:20 Chairman **Delzer:** So your 15 FTEs for two years will only cost you 209 thousand dollars?
Ms. Anderson: It's the combination of all those expenses, so the FTE cost's the state's share isn't the 209 it's the FTE cost minus the ongoing costs of not having ongoing services, not having extremal quality review and then there's savings because there's some 1-time costs. Total saving of 336 thousand dollars for the 18-month period, but for next biennium it would but 650 thousand.

26:15 Medicaid expansion and estate collections, this is one of the policy considerations that need to be considered as we advance Medicaid expansion no matter which form.

28:20 Representative **Kempenich:** Is that a blended rate on the premiums? What is the break out of utilization, the costs, of the different population segments?
Ms. Anderson: We could get you a chart with ages, gender, and urban rural cohorts

30:15 Representative **Kreidt:** In your discussions did you consider waiting to see what is going to happen with the affordable care act.
Ms. Anderson: Yes, we looked at all of that, there's also the big change that must happen to MMIS, did but it's not just about the money, it's because that change request becomes priority.

Representative **Pollert:** The going form managed are to fee for service, is the state is assuming all the risks?
Ms. Anderson: Yes, we would have all the risk is there where high cost cases. With managed care, they're resuming the risk. There's a tolerance of risk in the contract, anything outside of that would be to Sanford's determent and the federal government pays that difference.

Chairman Delzer: You have a signed contract?
Ms. Anderson: We have never had a contract on time since the start of the affordable care act. About an hour ago we received approval from the federal government for the rates that ended December 31st 2016.

35:25 Ms. Anderson: Of that 19,300 people about 25% above 100% and 75% are below 100% poverty level.

38:00-41:00 Josh Askvig, State Director of AARP North Dakota (see attachments 2 &3)

41:40-48:50 Jerry E. Jurena President of the North Dakota Hospital Association (NDHA) (see attachment 4 testimony)

43:30 Chairman **Delzer:** You blamed almost all the bad debt on people not paying their bills and it didn't have anything to do with Medicaid or the expiation, what changed?
Mr. Jurena: During that time, we had a large number of people coming into the state who didn't have coverage and weren't paying the bills

Representative J. **Nelson:** What does your membership prefer? Standard Medicare fee schedule or the commercial rate?
Mr. Jurena We'd prefer to stay with the commercial rates; we get paid more

Representative **J. Nelson:** Is there longer times of period before getting paid?
Mr. Jurena: Yes, but they are getting closer.

47:00 Representative **Pollert:** Managed care or fee for service and do you have a dog in that fight
Mr. Jurena: Commercial

49:00 – 51:40 Dave Molmen; CEO Altru Health Systems, I am testifying in favor of this bill HB 1032 with some modifications; We would like to see the removal of sub paragraph 3 which sets rates of reimbursement of services at the Medicaid rate. The reason is, we don't feel that it doesn't serves a useful purpose, if we continue to pursue a free market approach to the provision of services, the reimbursement risk and utilization of services can be transferred to the private insurance companies which the state contracts for the care of these lives. Deleting this provision allows for the free market to negotiate appropriately.

52:00-56:20 Andy Peterson, Greater North Dakota Chamber (see attachment 5 testimony)

56:30- 1:02:30 Kurt Snyder Executive Director of the Heartview and the Chair of the ND Behavior Health Planning Council. (see attachment 9 & 10)

Chairman **Delzer:** You say expanded Medicare is helping with things and shifting? I haven't seen a reduction in our human service budgets.

1:03:10-1:06:45 Carlotta McCleary; Executive Director of both ND Federation of Families for Children's Mental Health and Mental health American of ND (see attachment 6 testimony)

1:07:30-1:11:40 Christine Hogan lawyer with the North Dakota Protection and Advocacy Project (P&A) (see attachment 7 testimony)

1:12:00- 1:13:00 Deb Knuth Government Relations Director of American Cancer Society (see attachment 8)

We are in support of this bill simply because people that have coverage are more likely to screen for cancer and get treated.

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1032
2/15/2017
28411

☐ Subcommittee
☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Relating to provider reimbursement rates for the Medicaid expansion program.

Minutes:

Recording 28411 Starting @ 17:00

Chairman Delzer: Everything out of here that you wanted has been moved to HB 1012, HB 1032 and HB 1033 both are about fee for service.

Representative Pollert: Moved Do Not Pass

Representative Meier: Second that

Chairman Delzer This is one of those bill that came to us out of the interim committee, on health career form and review. All those issues have been dealt with in the budget.

Representative Delmore: Can you give me a little more on why we are doing a do not pass?

20:30 Representative Pollert: HB 1012 is only going to fee for services for age groups of 19-20. Everything else will be back to managed care, plus the study of managed care as well. That's why we don't need HB 1032 and HB 1033 aren't needed anymore.

Representative J. Nelson: The current Medicaid expansion is at a commercial rate. Sanford health has that and in HB 1012 you will see the same thing. We change the commercial rate to services rate, and that is a lowering of the standards.

Chairman Delzer: That was does during the allotment and we are continuing, what was done.

A Roll Call vote was taken. Yea: 17 Nay: 0 Absent: 4

Representative Meier will carry the bill

Date: 2/15/2017
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB1032

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☐ Do Pass ☒ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Representative Pollert Seconded By Representative Meier

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X				
Representative Kempenich	X		Representative Streyle	X	
Representative: Boehning	X		Representative Vigesaa	X	
Representative: Brabandt	X				
Representative Brandenburg	X				
Representative Kading	A		Representative Boe	X	
Representative Kreidt	A		Representative Delmore	X	
Representative Martinson	X		Representative Holman	X	
Representative Meier	X				
Representative Monson	X				
Representative Nathe	A				
Representative J. Nelson	X				
Representative Pollert	X				
Representative Sanford	X				
Representative Schatz	A				
Representative Schmidt	X				

Total (Yes) 17 No 0

Absent 4

Floor Assignment Representative Meier

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

MOTION CARRIES

REPORT OF STANDING COMMITTEE

HB 1032: Appropriations Committee (Rep. Delzer, Chairman) recommends **DO NOT PASS** (17 YEAS, 0 NAYS, 4 ABSENT AND NOT VOTING). HB 1032 was placed on the Eleventh order on the calendar.

2017 TESTIMONY

HB 1032

Att 1 1/19/17 HB 1032

Testimony
House Bills 1032, 1033 and 1034 – Department of Human Services
House Appropriations Committee
Representative Delzer, Chairman
January 19, 2017

Chairman Delzer, members of the House Appropriations Committee, I am Maggie Anderson, Director of the Medical Services Division for the Department of Human Services (Department). I am here to provide information about Medicaid Expansion and support the provisions of House Bill Numbers 1032, 1033, and 1034 that are consistent with the Executive Budget request.

Medicaid Expansion

2013 House Bill 1362 authorized the Department to expand the Medicaid Program to adults under age 65 with incomes up to 138% of the federal poverty level. Medicaid Expansion in North Dakota was implemented January 1, 2014 as managed care through a contract with Sanford Health Plan. 2013 HB 1362 included a sunset clause of July 31, 2017.

Slightly over half of the Expansion enrollees are female 54%; approximately 48% were ages 19-35, 18% were ages 36-44, and 34% were ages 45-64. The majority, 58%, are rural. These trends have remained consistent since enrollment began in January 2014. The Department estimated Medicaid Expansion would provide coverage to approximately 20,500 low-income North Dakotans. Enrollment has been fairly stable during 2016 and as of September 2016 there were 19,358 enrolled in Medicaid Expansion.

Attachment A shows the entire Medicaid Enrollment (eligibles) and the unduplicated count of recipients for the last 24 months. **Attachment B**

shows the Medicaid Expansion premiums paid from January 1, 2014, through October 2016.

The ACA provided 100% federal funding for the Expansion population in Calendar Years 2014, 2015, and 2016. Starting January 1, 2017 the federal match began to decrease and will taper to 90% by 2020 according to the following schedule:

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

The Executive Budget for Medicaid Expansion is **$389,202,022** of which **$30,449,727** is general fund. The Executive request includes several changes to Medicaid Expansion:

Included in the Executive Budget	1032	1033	1034
Removal of the Sunset Clause	✓	✓	✓
Reduction of the fee schedule from a commercial level to the traditional Medicaid fee schedule	✓		
Transition of the operation of Medicaid Expansion from a managed care arrangement to a fee-for-service operation	✓	✓	✓

The change from managed care to fee-for-service (FFS) is estimated to save about $650,000 in state general fund for the period of January 1, 2018 through June 30, 2019. As part of this transfer, 15 FTE were transferred from other parts of the Department to cover resulting staffing needs in the Medical Services and Information Technology Services Divisions. The FTE are needed for those areas that would see increases

in efforts by transferring the Medicaid Expansion enrollees (19,358 as of September 2016) to FFS. The FTE include: Claims Processing Staff; Medicaid Utilization Review (Nurses and Transportation Coordination); and Medicaid Program Integrity, including Third Party Liability (TPL). There would be decreasing and increasing operational costs. Decreases would include savings from Actuarial Services and External Quality Review contracts ($1.2 million). Increases include Medicaid ID Cards, Drug Prior Authorization, Hospital Utilization Review, Primary Care Case Management, TPL Location Services and printing/postage for various mailings. Transferring the program to FFS will also allow the Department to save an estimated $3.4 million for a change request to MMIS so the system can process premium payments, create the eligibility roster, and accept and process Medicaid Expansion managed care encounter claims. Currently, the Department has approval from CMS to defer work on the change request, pending the outcome of the legislative session.

Attachment C provides the analysis completed by the Department to calculate the savings of transitioning the Medicaid Expansion operation from managed care to fee-for-service.

In April of 2016, CMS issued final regulations that revise and significantly strengthen existing Medicaid managed care rules. According to the Kaiser Family Foundation summary: "... the regulatory framework and new requirements established by the final rule reflect increased federal expectations regarding fundamental aspects of states' Medicaid managed care programs. Major goals of CMS' in revising the regulations were to align Medicaid and CHIP managed care requirements with other major health coverage programs where appropriate; enhance the beneficiary experience of care and strengthen beneficiary protections; strengthen actuarial soundness payment provisions and program integrity; promote

quality of care; and support efforts to reform the delivery systems that serve Medicaid and CHIP beneficiaries." The breadth of the 405 page managed care final rule is significant. The increased State costs to comply with the requirements of the final rule if Medicaid Expansion remained managed care are not included in the estimated $650,000 savings as it would be difficult, at this time, to accurately predict the increased costs associated with the final rule.

Premium Cost Sharing Waiver (House Bill 1033)

Page 2, Lines 17-22 of House Bill 1033 contains a requirement for the Department to pursue a federal waiver to allow for premium cost-sharing for the Medicaid Expansion enrollees. The premiums cannot exceed five percent of household income and cannot be implemented unless the cost savings exceed the increased administrative costs.

Please refer to **Attachment D**, **Attachment E** and **Attachment F** for information related to Medicaid Cost Sharing and Medicaid 1115 Waivers.

Medicaid Expansion and Estate Collections

During the 2015 session, amendments were adopted on Senate Bill 2050 to restrict estate collection to certain expenditures made on behalf of Medicaid Expansion enrollees. The amendments adopted were specific to payments made on behalf of a recipient who received coverage through a private carrier (N.D.C.C. 50-24.1-07). With the Executive Budget request to operate Medicaid Expansion as fee-for-service, the existing law would no longer restrict the Department from estate collections for the Medicaid Expansion population.

This concludes my testimony and I would be happy to answer any questions.

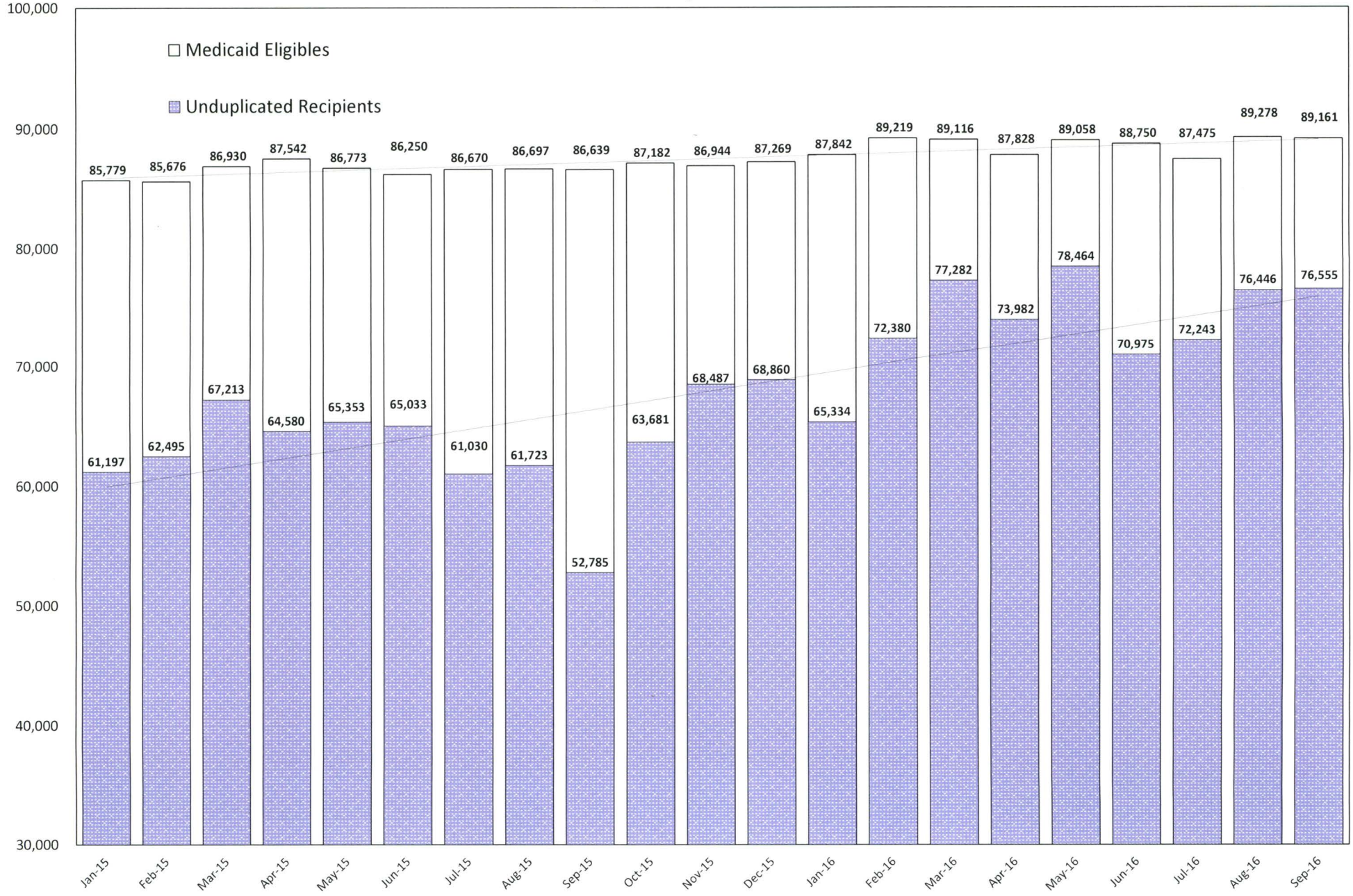
[redacted] [redacted] [redacted] ment A

North Dakota Departm[redacted]f Human Services

Comparison of Medicaid Eligibles (Including QMB's Or[redacted]LMB's Only, & QI's) and Unduplicated Recipients

This Graph Includes Medicaid Expansion

January 2015- September 2016

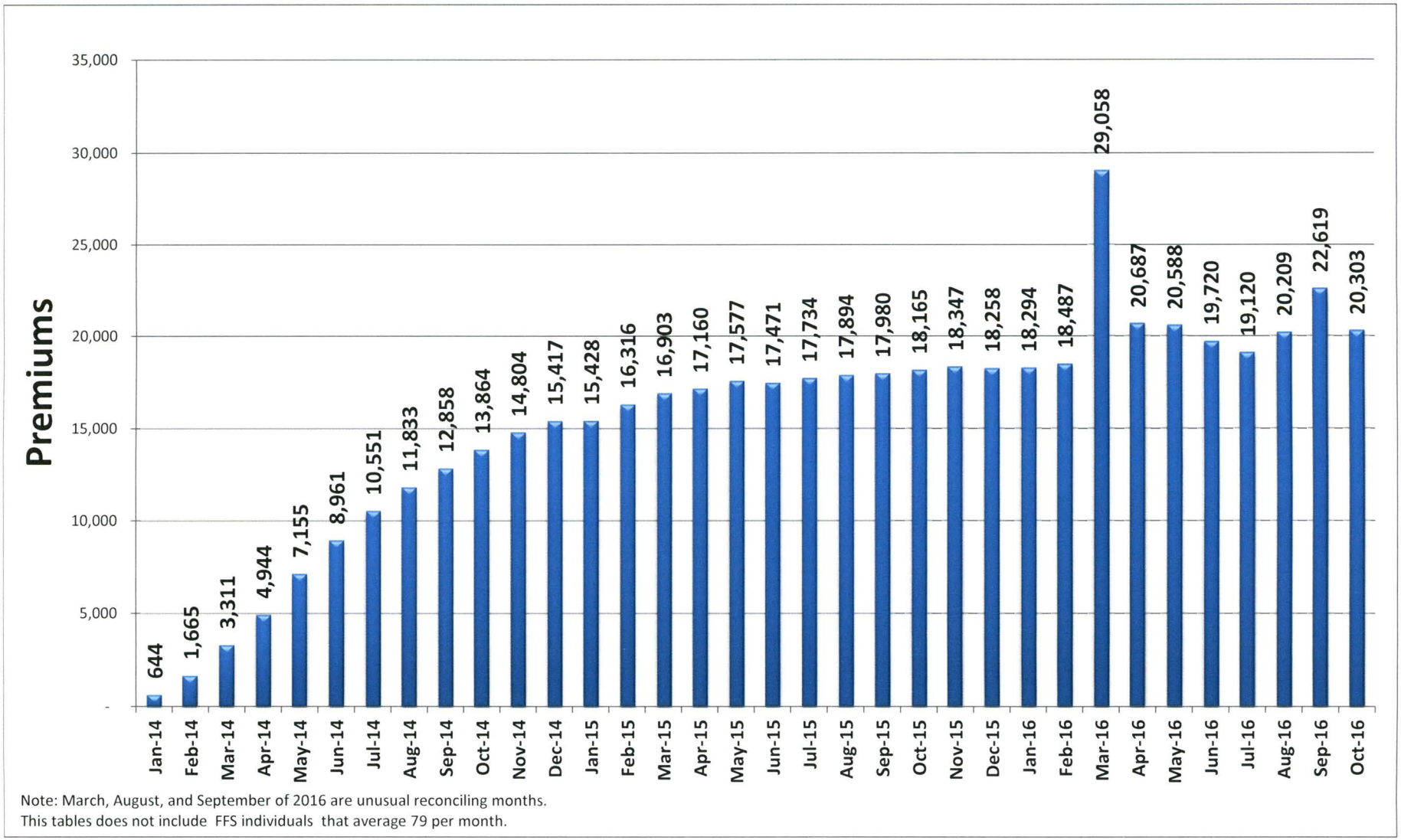


Due to implementation of the ND Health Enterprise MMIS on October 5, 2015 there were limited provider payments from August until October 2015

Attachment B

North Dakota Department of Human Services

Medicaid Expansion Premiums Paid



Note: March, August, and September of 2016 are unusual reconciling months.
This tables does not include FFS individuals that average 79 per month.

Comparison of Costs for Medicaid Expansion

ADMINISTRATIVE COSTS - Managed Care		
Amount per PMPM	$	35.27
Estimated Members		19,832
Months of Impact (CY 2018)		12
Months of Impact (CY 2019)		6
Estimated Cost (CY 2018)	$	8,393,695.68
State Share	$	550,710.37
Estimated Cost (CY 2019)	$	4,196,847.84
State Share	$	316,820.04
TOTAL State Share	$	867,530.42

SUMMARY OF STATE SHARE		
Managed Care	$	867,530.42
DHS	$	209,230.51
Savings for State Admin	$	658,299.91

Savings Without One-Time:	$	336,644.51

ADMINISTRATIVE COSTS - DHS	Total Costs	Federal Match	State Share	
Staff:				
2 Nurses (Utilization Review)	$ 393,965.00	75%	$ 98,491.25	$ 98,491.25
Third Party Liability	$ 189,040.00	50%	$ 94,520.00	$ 94,520.00
Program Integrity	$ 189,040.00	50%	$ 94,520.00	$ 94,520.00
Transportation - Admin Staff Officer (Utilization Review)	$ 129,814.00	50%	$ 64,907.00	$ 64,907.00
Claims Processing Staff	$ 1,051,626.00	75%	$ 261,844.50	$ 261,844.50
Contracts:				
Actuarial Services	$ (900,000.00)	50%	$ (450,000.00)	$ (450,000.00)
External Quality Review	$ (267,240.00)	50%	$ (133,620.00)	$ (133,620.00)
Medicaid ID Cards (One-time)	$ 36,689.20	50%	$ 18,344.60	$ -
Medicaid ID Cards (ongoing) 1/3 of Trad Med # per month	$ 19,469.40	50%	$ 9,734.70	$ 9,734.70
Hospital Utilization Review and Medical Consultants	$ 200,000.00	75%	$ 50,000.00	$ 50,000.00
Drug Prior Authorization ($5,762 to $10,372 per month)	$ 82,980.00	50%	$ 41,490.00	$ 41,490.00
TPL Contract for Location TPL	$ 67,500.00	50%	$ 33,750.00	$ 33,750.00
Other:				
EPSDT (5 per year) and PCCM (4 per year) Notices (1,087 EPSDT and 19,832 PCCM)	$ 71,200.92	50%	$ 35,600.46	$ 35,600.46
PCCM Payments ($2 Per Member Per Month)	$ 659,296.00	50%	$ 329,648.00	$ 329,648.00
MMIS Savings:				
Defer MMIS Change to support Managed Care	$ (3,400,000.00)	90%	$ (340,000.00)	$ -
TOTAL	$ (1,476,619.48)		$ 209,230.51	$ 530,885.91

Premiums/Monthly Contributions for Adults Under Section 1115 Waiver Authority

[redacted]kansas received waiver approval to require certain enrollees to make monthly income-based contributions to health savings accounts (HSAs) to be used in lieu of paying point-of-service copayments and co-insurance. Medically-frail individuals, including those with disabilities or complex health conditions, are exempt from these payments. Monthly contributions are $10 for expansion adults with incomes between 101% - 115%, and $15 for individuals with incomes between 116% - 138%. Under the waiver, Arkansas can charge monthly HSA contributions for expansion adults with incomes down to 50% FPL, but the state is not currently charging those with incomes below poverty. Adults with incomes above poverty who fail to make monthly HSA contributions are responsible for copayments and co-insurance at the point of service, and providers can deny services for failure to pay cost-sharing. Cost-sharing charges are at amounts otherwise allowed under federal law.

In **Iowa**, the waiver allows the state to impose monthly contributions of $5 per month for non-medically frail beneficiaries with incomes between 50% and 100% FPL and $10 per month for non-medically frail beneficiaries with incomes above poverty beginning as of the second year of enrollment. The state cannot disenroll individuals below poverty due to unpaid premiums. Individuals above poverty have a 90-day grace period to pay past-due premiums before they are disenrolled, and the state must waive premiums for enrollees who self-attest to financial hardship. Individuals who are disenrolled for nonpayment can reenroll at any time.

The waiver in **Indiana** imposes monthly contributions at 2% of income for most newly eligible adults and [redacted]tion 1931 parents. Those with incomes between 0% and 5% FPL must pay $1.00 per month. Individuals [redacted]th incomes below poverty cannot be disenrolled due to nonpayment but receive a more limited benefit package and are subject to copayments at the point of service. (Medically frail individuals are not placed in the more limited benefit package.) Individuals above poverty are not enrolled in coverage until they make their first monthly payment. In addition, non-medically frail individuals above poverty can be disenrolled due to nonpayment after a 60-day grace period and are subject to a 6-month lock-out period.

Michigan's waiver provides for monthly premiums of 2% of income for enrollees with incomes above poverty, as well as monthly payments into HSAs based on their prior six months of copayments for services used. The copayments are at the same level as what would have been collected without the waiver. Enrollees cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copayments or premiums.[12]

In **Montana**, non-medically frail expansion adults with incomes above 50% FPL are subject to monthly premiums of 2% of income. Enrollees receive a credit in the amount of their premiums toward copayments incurred, so that they effectively only have to pay copayments that exceed 2% of income. Those with incomes above poverty can be disenrolled for nonpayment after notice and a 90-day grace period and can reenroll upon payment of arrears or after the debt is assessed against their state income taxes, no later than the end of the calendar quarter. Reenrollment does not require a new application, and the state must establish a process to exempt beneficiaries from disenrollment for good cause. Individuals below poverty cannot be disenrolled for [redacted]payment of premiums.

Source: M. Musumeci and R. Rudowitz, "The ACA and Medicaid Expansion Waivers," The Kaiser Commission on Medicaid and the Uninsured, November 2015, available at http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers

North Dakota Department of Human Services
Feedback from Medicaid Medical Advisory Committee
Medicaid Cost Sharing

Copayments

- Copayments end up being a provider reduction in provider reimbursement.
- Copayments are cost prohibitive for providers to spend time to collect if they are unable to collect at the time of the service.
- Copayments do not have the same effect on utilization as they do within private insurance.
- Copayments do not appear to be worth the trouble to recipients, providers and the Department.
- Family Member: copayments try to limit what people get for healthcare. Some recipients should be seeking care sooner. Copayments can be a disincentive for recipients to seek healthcare contributing to delayed care which ends up being more expensive care in the long run.
- For many people/families, it is difficult to get recipient to the doctor in the first place (disability or transportation) and then they have to have copayments.

Premiums

- Premiums would be a financial burden to consumers, but a different burden than copayments. Copayments can disproportionately impact the sickest individuals.
- There may be positive intrinsic impacts for consumers contributing to their coverage.
- Premiums minimize the burden on recipients and providers but may increase burden on counties and Department.
- Premiums may be easier for recipients to manage.
- With ACA and mandate for health care coverage, people have to have coverage and may be a low utilizer of services. They would prefer to have copayments over monthly premium.
- Concerns expressed about impact on county eligibility work if more Medicaid recipients had to make premium payments.
- Would need to manage process of premium collection. How to collect? For people on limited incomes, they may need to pay with cash, or look at money orders (additional financial burden).
- Most people recognize that investment in their care is good, but when people are living hand to mouth, this is not clear to people.
- If clients fail to pay premiums, could lead to increased uninsured rate and higher churning. Having point of sale copayments (like for Pharmacy) would assist all providers in collecting copayments up front.

Summary of Montana Premiums for Medicaid Expansion

Montana premium

Montana assesses two percent of income (modified adjusted gross income (MAGI)) for individuals participating in the Medicaid Expansion program. The two percent is a premium, and is credited against the five percent aggregate cap. The individual receives the "credit" even if they do not pay the premium. The ability to assess the premium is authorized under a Section 1115 Waiver.

Example

Say for example, the 5% aggregate cap for the individual (based on their MAGI) for a quarter is $30. The 2% premium is $10. The individual receives a $10 "credit" toward their aggregate cost sharing cap (*whether they pay the $10 premium or not*). The first $10 of copayments for the individuals are "credited" and not paid by the individual. Once the individual incurs the 11th dollar of copayments, they then become responsible for any additional copayments assessed – up to the $30 quarterly aggregate cap.

Once the individual reaches the $30 aggregate cap for the quarter, the individual will not be assessed any additional copayments for that month.

Status and Resources

In the first six months of the Montana Medicaid Expansion, $1.1 million in premiums have been paid. The $1.1 million in premiums represent about 70% of the premiums that have been charged.

Once the member gets past 120 days of no payment, they are disenrolled at the start of the next month. The first month Montana had this in place, they disenrolled around 350 individuals, the second month they disenrolled around 650 individuals. Individuals can re-enroll upon payment of arrears or after the debt is assessed against their state income taxes, no later than the end of the calendar quarter.

Because the federal government is paying 100% of the coverage for the Medicaid Expansion, 100% of the premiums collected are returned to the federal government. (In January 2017, when the federal match on Medicaid Expansion goes to 95%, then 95% of the premiums collected will go back to the federal government, and Montana will keep 5% of the premiums collected.)

Montana has a Third-Party Administrator involved with their Medicaid Expansion product and the Third-Party Administrator is responsible for the collection efforts for the premiums. They are also responsible for processing most claims for the Expansion population (Pharmacy and Dental excluded). The Third-Party Administrator is paid $26.59 per member per month. (This payment is reimbursed at 50/50.)

Montana hired an outside entity (Manatt Health Solutions) to help write the required Section 1115 Waiver. Montana indicates there are considerable reporting requirements with the Section 1115 Waiver and a dedicated staff position would be needed for the work associated with the Waiver.

North Dakota does not have a Third Party Administrator for the Medicaid Expansion population, so there would also be an increased need for staffing/contract assistance to assess and collect premiums.

Attachment #2 1/19/17 HB 1032

We Support Medicaid Expansion!

We the undersigned organizations support the continuation of Medicaid Expansion. Currently almost 20,000 North Dakota lives receive health insurance through Medicaid Expansion. This coverage has led to individuals seeking more affordable preventative care rather than much more costly acute care. Additionally, it has an economic impact of over $540 million that goes toward employing individuals in local community healthcare facilities. Continuing Medicaid Expansion ensures that North Dakota receives its 95% federal funding match to assist in the expense of covering these vulnerable individuals age 18-64, with incomes under 138% of the federal poverty level. Without continued expansion some facilities could face closure, all North Dakotas will see higher insurance premiums, and individuals would certainly see more wait times and less affordable access to healthcare.

As groups representing a wide cross section of North Dakota, from business, to healthcare, to consumers, to working North Dakotans, we encourage the 2017 legislative session to reauthorize Medicaid Expansion, because it makes sense for both the health of ALL North Dakotans and for the state budget.

AARP North Dakota

Altru Health System, Grand Forks

American Cancer Society-Cancer Action Network

American Heart Association

American Lung Association

Ashley Medical Center, Ashley

BCBSND

Cavalier County Memorial Hospital, Langdon

Charles Hall Youth Services

CHI Lisbon Health, Lisbon

CHI Mercy Health, Valley City

CHI Mercy Hospital, Devils Lake

CHI Oakes Hospital, Oakes

CHI St. Alexius Health Carrington Medical Center

CHI St. Alexius Health Dickinson Medical Center

CHI St. Alexius Health Garrison Memorial Hospital

CHI St. Alexius Health Turtle Lake

CHI St. Alexius Health Williston Medical Center

CHI St. Alexius Health, Bismarck

Coal Country Community Health Center

Community Action Partnership of North Dakota

Community Health Services, Inc.

Community HealthCare Association of the Dakotas

Cooperstown Medical Center, Cooperstown

Essentia Health, Fargo

Family HealthCare Center

Family Voices of ND

Farmers Union Insurance

First Care Health Center, Park River

First Step Recovery

Greater ND Chamber

Great Plains Food Bank

Healthcare Policy Consortium

Heart of America Medical Center, Rugby

Heartview Foundation

Jacobson Memorial Hospital, Elgin

Jamestown Regional Medical Center, Jamestown

Linton Hospital, Linton

Mayor's Blue Ribbon Commission of Addiction - Fargo and West Fargo

McKenzie County Healthcare Systems, Watford City

Mental Health America of ND

Mid Dakota Clinic

Mountrail County Medical Center, Stanley

Native American Development Center

ND Addiction Counselors Association

ND Addiction Treatment Providers Coalition

ND AFL-CIO

ND Association of Counties

North Dakota Association of County Social Service Directors

ND Autism Spectrum Disorders Advocacy Coalition (NDASDAC)

ND Catholic Conference

ND Disability Advocacy Consortium

ND Economic Security & Prosperity Alliance

ND Farmers Union

ND Federation of Families for Children's Mental Health

ND Hospital Association

ND League of Cities

ND Medical Association

ND Nurse Practitioners Association

ND Nurses Association

ND Occupational Therapy Association

ND Optometric Association

ND Public Health Association

ND Rural Behavioral Health Network

ND State Association of City and County Health Officials

ND Substance Abuse and Mental Health Planning Council

ND United

ND Women's Network

Nelson County Health System, McVille

North Dakota Academy of Nutrition and Dietetics

Northland Health Centers

Northwood Deaconess Health Center, Northwood

Pembina County Memorial Hospital, Cavalier

Planned Parenthood Minnesota, North Dakota, South Dakota

Prairie St. John's, Fargo

Presentation Medical Center, Rolla

Protection & Advocacy

Quentin Burdick Memorial Healthcare Facility, Belcourt

Red River Behavioral Health System, Grand Forks

Sacred Pipe Resource Center

Sakakawea Medical Center, Hazen

Sanford Hillsboro Medical Center, Hillsboro

Sanford Mayville Medical Center, Mayville

Sanford Medical Center, Bismarck

Sanford Medical Center, Fargo

ShareHouse

Southwest Healthcare Services, Bowman

St. Aloisius Medical Center, Harvey

St. Andrew's Health Center, Bottineau

St. Luke's Medical Center, Crosby

The Village Family Service Center

ThinkND

Tioga Medical Center, Tioga

Towner County Medical Center, Cando

Trinity Kenmare Community Hospital, Kenmare

Trinity Medical Center, Minot

Unity Medical Center, Grafton

Valley Community Health Centers

Vibra Hospital Central Dakota, Mandan

Vibra Hospital, Fargo

West River Regional Medical Center, Hettinger

Wishek Community Hospital, Wishek

AH #3
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AARP Real Possibilities in

North Dakota

SUPPORT HB 1032

Josh Askvig, State Director
jaskvig@aarp.org – 701-989-0129

Chair Delzer, and members of the House Appropriations Committee, I am Josh Askvig, State Director for AARP North Dakota. We stand in support of HB 1032.

AARP is a nonprofit, nonpartisan membership organization with 87,000 members in North that leads positive social change and delivers value to all people 50+ and to society through advocacy, service and information. 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.

AARP supports health care reforms that significantly improve access to adequate coverage for those who either are without public or private insurance or are at risk of losing coverage. We want to ensure that options providing adequate coverage are both available and affordable, so as to prevent people from being unable to afford care despite their coverage. Our first priority is to groups that are currently without coverage and are not benefiting from current tax incentives; include assistance for those who earn too little income to pay taxes and who may have insufficient resources to pay premiums out-of-pocket during the tax year. Affordability, accessibility, and maintaining coverage for those in need of healthcare is very important to our members. As you know, the current Medicaid Expansion program provides coverage for approximately 20,000 North Dakota lives, 33% of whom are between the ages of 45-64. That is why we support the continuation of Medicaid Expansion.

Again, Chairman Delzer, members of the committee, AARP North Dakota supports access to quality healthcare and coverage for all in our state. That is why we urge this committee to support Medicaid Expansion.

Att #4
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NDHA
North Dakota Hospital Association
Est. 1934

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: 2017 HB 1032
House Appropriations Committee
Representative Jeff Delzer, Chairman
January 19, 2017

Good afternoon Chairman Delzer and Members of the House Appropriations Committee. I am Jerry E. Jurena, President of the North Dakota Hospital Association (NDHA). I am here to testify regarding 2017 House Bill 1032 and ask that you give this bill a **Do Pass** recommendation.

This bill would reauthorize the Medicaid expansion program in North Dakota. The Medicaid expansion program fills historical gaps in Medicaid eligibility for low-income adults and currently covers 20,000 North Dakotans. It covers individuals under the age of 65 (including "childless adults") with incomes at or below 138 percent of the federal poverty level. This is a population that was never covered before because traditional Medicaid covers only qualifying low-income children, their adult caregivers, pregnant women, and individuals with disabilities including the aged and blind.

If Medicaid expansion is not reauthorized, childless adults would again become ineligible for Medicaid. These individuals also do not earn enough to qualify for premium tax credits to purchase Marketplace coverage through the health insurance exchange. Most of these individuals are likely to become uninsured as they have limited access to employer coverage and are likely to find the cost of unsubsidized Marketplace coverage prohibitively expensive.

Medicaid expansion was designed to significantly reduce the number of uninsured and

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improve their health by providing access to routine health care. Increasing health coverage rates can help promote increased access to care, lower inappropriate emergency room use, and address the persistent disparities many people of lower income levels encounter in securing health coverage.

Medicaid expansion's economic impact in North Dakota was $542 million during this biennium and, even with cuts, is projected in the executive budget to be $389 million for the 2017-2019 biennium. The program is predominantly funded with federal dollars - with 95 percent federal funding for the expansion population in 2017, tapering to 90 percent by 2020. The state's investment of $31 million in general funds captures $373 million in federal funds, which is a 12:1 return on investment. It is hard to imagine a better pay back for improving the health of North Dakotans. This significant increase in federal funds was partly offset by cutting the special payments for hospitals for the uninsured, called disproportionate share hospital (DSH) payments. In other words, because the Affordable Care Act (ACA) reduced existing funding to hospitals in order to pay for Medicaid expansion, states are already paying for it whether they chose to implement it or not.

As shown in the attachment to my testimony, since the implementation of Medicaid expansion, there has been a significant reduction in the rate of uncompensated care provided by our hospitals. In 2010, as oil activity increased in North Dakota, we saw an increase of 69% in bad debt and charity care. Hospitals provided $173 million in uncompensated care that year. That number continued to increase until 2014 when it started to turn around. In 2016, the amount of charity care and uncollectible debt was down to $150 million even though the volume of care being provided rose. This significant decrease in uncompensated care has contributed to positive operating margins for a number of our hospitals.

This bill would also set provider reimbursement rates at the traditional medical assistance rates. We ask that you set fair and sustainable provider reimbursement rates. Choosing to ignore this population doesn't mean the cost of that care is ever going to go away. There will always be a minimum level of health care that people are going to consume, so the cost is still there. If the rates do not provide fair reimbursement, hospitals and the entire system must bear the cost. It must be paid by the remaining users of the system otherwise

hospitals have to close their doors. As some pay less, others must pay more. As a consequence, private payments go up, taking health insurance premiums along with them.

In summary, Medicaid expansion is good not only for the health of individuals but for our communities as well. Federal Medicaid dollars flow directly into local economies, supporting wages, employment, consumer spending, and state tax revenue. Again, it is projected to have a $389 million impact in the upcoming biennium on North Dakota's healthcare infrastructure alone. It keeps the cost of health insurance low for the businesses that drive our economy. It is critical to covering operating costs at our hospitals and clinics, the loss of which will result in staff cuts and closed facilities. Medicaid expansion pays additional salaries of employees who work at those hospitals and clinics, which in turn results in income and sales tax collections in the State of approximately an additional $6.6 million. The State's net investment is closer to $24 million – a return on investment of 16:1.

Medicaid expansion has significantly reduced the uninsured in our State and decreased the amount of uncompensated care that hospitals and clinics provide. It improves the health of those who are covered by it and it provides substantial economic benefits to our communities.

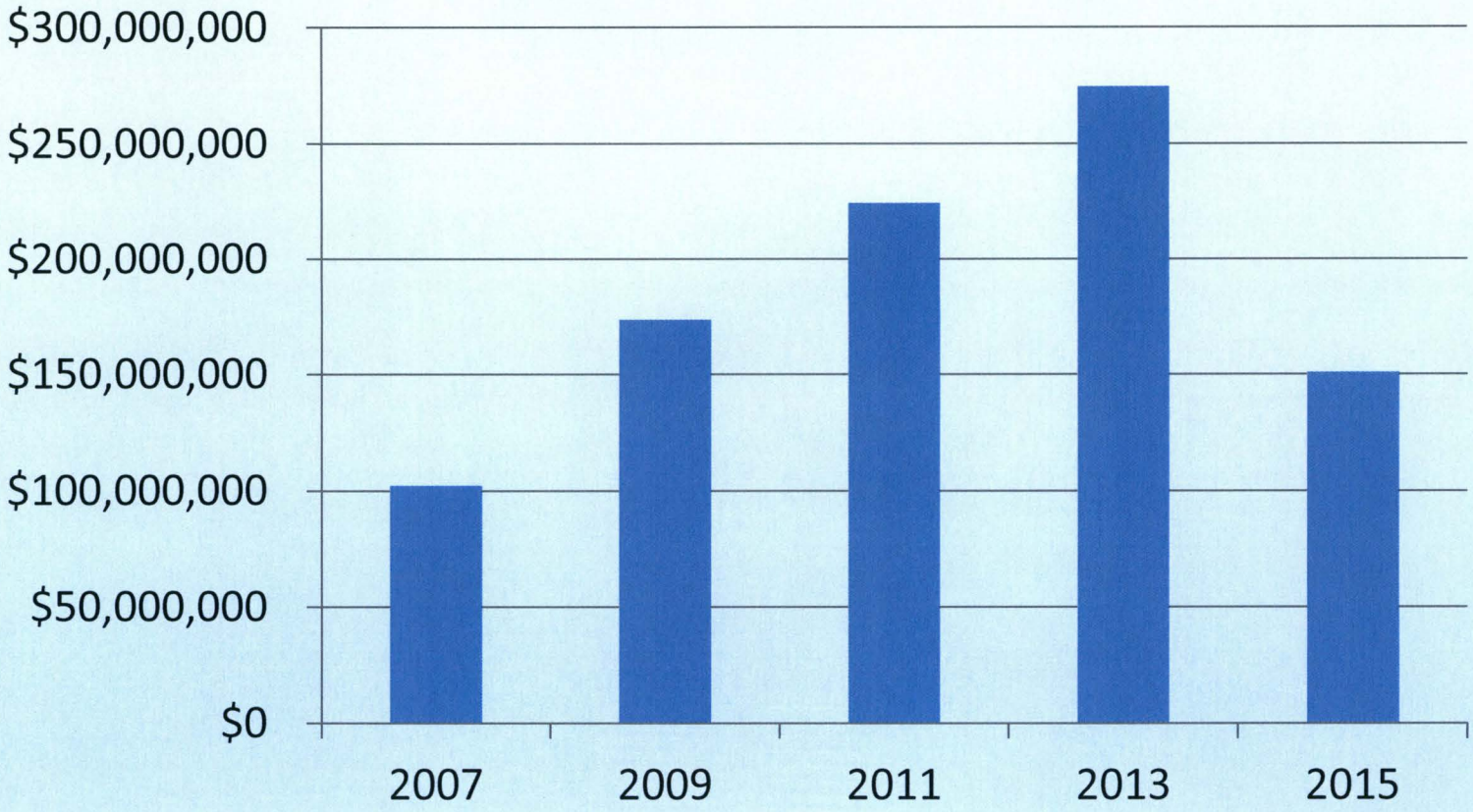
We support this bill and ask that you give it a **Do Pass** recommendation.

I would be happy to try to answer any questions you may have. Thank you.

Respectfully Submitted,

Jerry E. Jurena, President
North Dakota Hospital Association

North Dakota Hospital Uncompensated Care



NDHA
North Dakota Hospital Association
Est. 1934

Att # 5
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GNDC
Greater North Dakota Chamber

Testimony of Andy Peterson
Greater North Dakota Chamber of Commerce
HB 1032
House Appropriations Committee
Honorable Jeff Delzer - Chair
January 19, 2017

Mr. Chairman and members of the committee, my name is Andy Peterson and I am here today representing the Greater ND Chamber, local chambers of commerce, and other business associations throughout north Dakota. Some members of the media describe the GNDC as the most prominent business organization in North Dakota. We stand in support of HB 1032 and ask for a "do pass" recommendation.

The GNDC decided to support this bill after a long process. Member companies were surveyed regarding this and other priorities. Once we understood Medicaid Expansion to be something the larger membership supported the topic was debated within our Government Affairs committee, then it was forwarded for further debate to the board of directors who unanimously voted in favor of making this a priority on our legislative agenda.

Why would the Chamber support Medicaid expansion? Simply, we have hospitals and clinics as members and they are amongst the largest employers in North Dakota. They are bound, as we all know, to provide treatment to those who enter their doors, regardless of their ability to pay. Most uninsured come in through the emergency room and seek care in the most expensive manner possible. Medicaid expansion allows a greater number of these people to have some type of coverage thereby reducing the expensive emergency room care in favor of traditional preventative care offered through a primary physician, nurse practitioner, or physician assistant.

Few other businesses are bound to provide goods or services to those who cannot

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pay. Imagine if convenience store owners were required to provide gasoline to those without the means to pay. The stores would either have to raise the price of gas to others with the means to pay, or they could simply take the loss and hope to recover some profit through the sales of other items, or if they were unable to do either one of these they could simply let themselves operate until they went broke. It's laughable to think of any business operating under these conditions. Yet, we routinely – in the name of humanity – require healthcare providers to provide care to those without the means to pay. If we, as a society, continue to demand health care facilities treat those who are unable to pay it is imperative we find some manner to cover those costs.

The second reason the GNDC supports Medicaid expansion is cost shifting. Without Medicaid expansion costs are shifted to those who can afford to pay. This means higher premiums to every business in North Dakota. Costs are shifted, and employer burdens become heavier. This is not right.

Lastly, Medicaid expansion is good for the workforce. I have to assume that all people, regardless of their current situation, want to improve their lot in life. Let me be brutally honest – healthier people are hired first. Having a healthier population to draw from also provides additional people to buttress a stressed workforce. We are at the crossroads of boomer retirements, a flat or declining birthrate, and an emerging technological economy wherein those not ready or prepared will be left behind. A healthy population is one aspect of solving some of these problems. Workers – plumbers, electricians, nurses, those in the service industries to name a few – are the bedrock that has made America the economic powerhouse of the world.

Medicaid expansion is a challenge given our budget shortfalls. You have difficult choices to make, I get that. However, I do urge a do pass on HB 1032.

Thank you and I'll stand for any questions.

Champions for Business

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Att. 6
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Testimony
Human Services Committee
Representative Jeff Delzer, Chairman
January 19, 2017

Chairman Delzer and members of the committee, my name is Carlotta McCleary. I am the Executive Director for both North Dakota Federation of Families for Children's Mental Health (NDFFCMH) and Mental Health America of North Dakota (MHAND). NDFFCMH is a parent run organization focused on the needs of children and youth with emotional, behavioral, or mental disorders and their families. MHAND's mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

NDFFCMH and MHAND support the continuation Medicaid Expansion. Medicaid Expansion increases the access to behavioral health services for North Dakotans with behavioral health conditions. Access to behavioral health services in North Dakota is extremely difficult. Renee Schulte released a report in 2014 at the request of the North Dakota legislature and concluded that, "The North Dakota mental health and substance abuse system is in crisis." The Schulte Report highlighted that whether it is Medicaid or Medicaid Expansion, having a funding source to pay for services is paramount to increasing the access to behavioral health services. Among those that are eligible for Medicaid expansion, there is a higher percentage of those in need of behavioral health services. A research study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), reported that during the years 2009 to 2013, nearly 11 million uninsured adults between the ages of 18 to 64 had a behavioral health disorder. Of those nearly 11 million people, 48.3% of them had incomes that met the requirements for Medicaid Expansion.

The increase in funding because of Medicaid Expansion has also resulted in substantial budget savings in the human service centers and contracts that the human service centers have for hospitalization. The House Appropriations-Human Resources Division Committee had heard from Dr. Etherington (the Superintendent of the North Dakota State Hospital and the Chief Clinics Officer for the Department of Human Services) on January 10. Dr. Etherington credited Medicaid Expansion for significant reductions that amounted to over $5.4 million in general funds for the Human Service Centers and an additional $2.7 million for inpatient hospital contracts, totaling over $8.1 million. She further elaborated that should Medicaid Expansion be removed from the state of North Dakota, that $8.1 million in revenue would need to be replaced by general fund dollars.

We do have some concerns, however. In HB 1033 there is a plan for cost sharing by paying a portion of premiums. We are concerned that this share of premium payment may not be affordable for a lot of individuals. This could cause individuals to go on and off coverage which would result in additional hours spent by clients and eligibility workers going through the eligibility process multiple times. This would also have the potential for disrupted treatment for individuals with behavioral health concerns.

While continuing Medicaid Expansion in North Dakota does not address the existing mental health and substance abuse crisis in North Dakota, it does prevent the crisis from deepening. The continuation of Medicaid Expansion is both critical to individuals with behavioral health conditions as well as the already struggling behavioral health system in North Dakota.

Thank you for your time and I will be happy to answer any questions you may have.

J

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House Appropriations Committee

House Bills 1032, 1033, and1034
Honorable Jeff Delzer, Chair
January 19, 2017

Chair Delzer and members of the House Appropriations 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 and legal rights of persons with disabilities. I am asking for your support for removing the sunset clause for Medicaid Expansion. Although we do support each of the three Bills being considered in this committee today, we do have some concern that the premium cost-sharing proposal in HB 1033 might negatively impact access to health care services for some people.

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 served through on a waiver. Before the adoption of Medicaid Expansion, they did not receive health coverage through Medicaid 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 substantial number of people with disabilities who, without Medicaid Expansion, would likely fall back into this health coverage gap. They are neither on SSI nor on a waiver and, without Medicaid Expansion, they

would not have any health coverage for basic health care, doctors, prescriptions, and hospitalizations. It is estimated the number of people in North Dakota in this category (under age 65 with disabilities who are at or under 138% of the federal poverty level who are not currently eligible for regular Medicaid based on SSI or a waiver) is at least 3,453 people.** Thanks to Medicaid Expansion, these folks are now eligible for health insurance! Protection & Advocacy strongly urges that access to health care be allowed to continue seamlessly for people with disabilities. These are the folks for whom Medicaid Expansion is critical.

Thank you for your consideration of this information.

* Based on U.S Census data from the 2010 American Community Survey

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AH-8 1/19/17

Study Shows Low-Income Uninsured in Need of Colorectal Cancer Screening Services

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HB 1032

A study released by the American Cancer Society Cancer Action Network (ACS CAN) and the National Colorectal Cancer Roundtable (NCCRT) estimates that in 2017 over 2.7 million low-income men and women aged 50-64 will remain uninsured and continue to lack access to an affordable health care coverage option, including colorectal cancer screening services. The report, *Health Reform and the Implications for Cancer Screening*,[1] provides national and state-specific estimates of the number of uninsured men and women in 2017 based on three scenarios: Medicaid expansion decisions as of April 2015, no state Medicaid expansions, and if all states expand Medicaid.

Colorectal Cancer and the Need for Screening

Colorectal cancer (cancer of the colon and rectum) is the third most common cancer in men and women and the second leading cause of cancer death in the United States among men and women combined.[1] An estimated 134,490 men and women will be diagnosed with colorectal cancer in 2016, and 49,190 individuals are estimated to die from the disease.[2]

Colorectal cancer is preventable. It begins as a non-cancerous formation, known as a polyp. If the polyp is detected during the screening process, the entire polyp is removed before it can become cancer. Screening is also critical to detecting cancer at the earliest stages, when treatment is most effective. Five-year survival rates for colorectal cancer at a localized stage are 90 percent, with 5-year survival rates decreasing to 13 percent for more distant stages.[3] Colorectal cancer screening is recommended for those 50 and older who are at average risk for colorectal cancer. One American Cancer Society study found that if 80 percent of adults alive today were regularly screened for colorectal cancer by 2018, roughly 200,000 fewer people would die from the disease by 2030.[4]

Despite the overwhelming benefits of screening for colorectal cancer, only 39 percent of patients are diagnosed at a localized stage, partly due to the underuse of screening.[5] Individuals 50 to 64 years old – particularly men, Hispanics, American Indians, Alaska Natives, persons living in rural areas, and individuals with lower income and education are the groups least likely to be screened for colorectal cancer, contributing to higher death rates from the disease.[6]

Americans are up to three times more likely to receive preventive care for potentially deadly chronic diseases if they have health care coverage.[7] Evidence shows that uninsured adults are significantly less likely to receive recommended colorectal cancer screenings than insured adults.[8] In addition to insurance coverage, often cited barriers to colorectal cancer screening uptake are affordability, lack of a family history or symptoms, feelings of embarrassment or fear, competing health priorities, no recommendation from a health professional, and logistics (e.g. transportation issues, unable to take time off work or arrange for care of a family member, etc.). Implementing policy proposals that address these barriers could help to improve screening rates.

Key Report Findings

The report estimates that over 2.7 million or 13.4 percent of low-income (at or below 250 percent of federal poverty level (FPL), earning less than $29,700)[9] men and women aged 50-64 will remain uninsured in 2017. Notably, the uninsured rates are higher among men than women, particularly in states that have not expanded Medicaid, as childless adults are largely excluded from eligibility of traditional Medicaid programs.

[1] Study conducted by the George Washington University Milken Institute School of Public Health.

Study Shows Low-Income Uninsured in Need of Colorectal Cancer Screening Services

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The following table details the number of men and women aged 50-64, earning less than 250 percent of the FPL, who are estimated to remain uninsured in 2017, based on Medicaid expansion decisions as of April 2015:

	Medicaid Non-Expansion States (22 States)	Medicaid Expansion States (29 States)	Total
Estimated # of Uninsured Men & Women age 50-64, at or below 250 percent of the FPL	1.8 million	899,273	2.7 million
Estimated % of Uninsured Men & Women age 50-64, at or below 250 percent of the FPL	20.9%	8%	13.4%

The study also estimates that the percentage of low-income men and women aged 50-64 who are uninsured will decline from 29.4 percent in 2013 to 13.4 percent in 2017, as a result of the 28 states and the District of Columbia that expanded their Medicaid programs as of April 2015. Disparities in access to colorectal cancer screening will widen in states that do not broaden eligibility for Medicaid. If all states expanded Medicaid, the number of low-income men and women aged 50 to 64 years who are uninsured could drop to 9.2 percent in 2017.

Broadening Access to Health Care Coverage through Medicaid Could Improve Screening Rates in Low-Income Adults

The study's findings reveal that an estimated 21 percent of low-income men and women 50-64 years of age will be uninsured in 2017 and reside in a non-expansion state. States that do not expand their Medicaid programs are likely to face more challenges in increasing their state's colorectal cancer screening rates, due to a lack of access to comprehensive, affordable health care coverage. Data indicates that individuals who have access to health care coverage and insurance are screened for colorectal cancer at significantly higher rates than those who are uninsured.[10]

Providing uninsured, low-income men and women access to health care coverage by expanding state Medicaid programs could also address a known barrier to colorectal cancer screening – affordability. Colonoscopy is the most commonly used colorectal cancer screening test and is required as follow up to all other colorectal cancer screening tests that come back positive, but it has a significant price tag. Similarly, treatment costs can be very high, especially for advanced forms of colorectal cancer. Estimates suggest that over $14 billion is spent on treatment for colorectal cancer each year in the United States.[11] Some of these costs can be avoided if precancerous polyps are detected and removed during the screening procedure, thereby preventing the cancer from developing altogether.[12] Affording low-income Americans access to health care coverage could not only increase colorectal cancer screening rates, but could also reduce a significant amount of treatment costs in Medicare, Medicaid, and private plans if an individual is screened at recommended intervals and precancerous polyps are removed.

Continued Need for the Colorectal Cancer Control Program to Improve Screening Rates in Low-Income Adults

While the ACA provides many individuals access to health care coverage through marketplace ('exchange') plans or Medicaid expansion, the report highlights that at least 2.7 million men and women between the ages of 50-64 will remain uninsured in 2017. Therefore, the need to maintain funding for the Colorectal Cancer Control Program

Study Shows Low-Income Uninsured in Need of Colorectal Cancer Screening Services

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(CRCCP) continues at both the state and federal levels to ensure screening coverage and screening promotion among the uninsured and underinsured.

Congress established the CRCCP in 2009 to increase screening rates among men and women 50 to 75 years of age.[13] Administered by the Centers for Disease Control and Prevention (CDC) through a grantee program, the CRCCP helps reduce barriers to screening among men and women by providing evidence-based, system-level interventions to achieve greater colorectal cancer screening rates and providing a limited number of screening services to at-risk populations. Because of limited funding, the program currently reaches only 24 state health departments, six universities, and one American Indian tribe.[14] Six out of the 31 grantees are also granted funding to provide limited screening services for at-risk populations.[15,16]

A number of other states provide state level funding to support low-income uninsured and underinsured individuals access to colorectal cancer control services, including screening, diagnostic services and referrals to treatment services. However, many of these programs are limited in the scope of services and the level of benefits provided to eligible individuals.

While health care coverage removes a significant barrier to screening, programs like the CRCCP are important to raise awareness and educate the public - especially the newly insured - about the importance of colorectal cancer screening, while also directing them to utilize the benefits and services available through their health plans. CRCCP-based programs aim to systematically increase use of evidence based interventions that we know can increase colorectal cancer screening rates. These programs can also work with health system partners, including federally qualified health centers, to increase provider recommendations for screening and address patient- and community-level barriers to screening. This will help ensure that states have a greater opportunity to increase colorectal cancer screening rates and save lives, regardless of whether they are a Medicaid expansion state or not.

ACS CAN Position

ACS CAN urges all states to expand their Medicaid programs to cover individuals up to 138 percent FPL, as insurance coverage is one of the most important factors in determining if an individual receives preventive services. People with insurance are three times more likely to have received a colorectal cancer screening than people without coverage.[17] If all states increased eligibility to their Medicaid programs, nearly 846,000 Americans aged 50 to 64 – at or below 250 percent FPL – would gain access to lifesaving colorectal cancer screenings and services. Given the shared goal of the National Colorectal Cancer Roundtable (NCCRT) to regularly screen 80% of adults for colorectal cancer by 2018, it becomes apparent that realizing this goal will be an even greater challenge in states that continue to opt out of Medicaid expansion – nearly 21 percent of low-income residents in non-expansion state will remain uninsured versus 8 percent in expansion states.

ACS CAN also strongly encourages states to appropriate funds to support existing or create new colorectal cancer screening and control programs. Additionally, we are working tirelessly to increase both federal and state funding for colorectal cancer screening and control programs.

Federal and state policymakers can further help to achieve greater access by supporting legislative and regulatory policies that require insurers to cover colorectal cancer screenings, including follow-up colonoscopies after a positive stool test without patient cost sharing and guarantee that patients do not face cost-sharing for the facility, polyp removal, anesthesia, pre-screening consultations, bowel prep, or laboratory services related to the screening colonoscopy.

Study Shows Low-Income Uninsured in Need of Colorectal Cancer Screening Services

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January 19, 2017
House Appropriations

Chairman Delzer and Members of the Committee,

My name is Kurt Snyder and I am the Executive Director of the Heartview Foundation. The demand for behavioral health services in ND has outpaced the private and public provider's ability to meet demands. In many parts of the state, individuals with behavioral health needs are extremely underserved or services do not exist. From the 2014 Schulte report, it is clear North Dakota is in a crisis situation in terms of behavioral health services.

In 2006 Heartview employed less than 10 staff. Heartview has tried to respond to this crisis and we have grown to employ over 80 employees. We offer comprehensive services in Bismarck and in 2015 we opened a 16 bed residential center in Cando, ND. We employ a very diverse staff including a psychiatrist, MD, Family Nurse Practitioner, psychologists, nurses, addiction counselors, social workers, and mental health counselors.

The Medicaid Expansion population is a very important part of the population we serve. Medicaid Expansion currently makes up 28% of our payer source in our Bismarck location and 46% of our payer source in Cando. The Medicaid Expansion population have traditionally been uninsured and were served through public funding within the human service centers. The Medicaid Expansion coverage has shifted much of the burden off of the public human service system and has allowed private providers to help meet demand.

I also want to make the connection with the criminal justice system. It was recently reported that 2 out of every 3 judges have sentenced individuals to prison terms in order for them to access treatment services. In order for criminal justice diversion and re-entry strategies to be effective, they must be supported by a full continuum of accessible behavioral healthcare.

Medicaid Expansion is a critically important to bend the cost burden of both the Department of Human Services and the Department of Corrections & Rehabilitation. To put it simply, without Medicaid Expansion reenactment, we

would essentially grow government by excluding private providers and increase the burden of an already overwhelmed public system specifically DHS and DOCR.

Thank you,

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I am here to voice support for Medicaid Expansion reenactment through House Bill 1032. I did want to voice two concerns:

1. I have concerns that the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) would not apply if the administration of Medicaid Expansion was rolled into traditional Medicaid. Currently, traditional Medicaid is exempt from following the provisions of the parity law. This means that they do not cover residential levels of care. It is vitally important that we sustain a full continuum of care and excluding residential coverage level of care is comparable to excluding coverage for a skilled nursing facility level of care on the medical surgical side.
2. I also need to voice concerns about "Days in Receivables" for Medicaid. Days in receivables is an average of how long it takes to be reimbursed for a service provided. Medicaid Expansion was 56 days. In 2015 Medicaid had 90 days and with the web portal (MMIS) Medicaid had 180 days in receivables through 2016. Without timely payment for services provided smaller behavioral healthcare and healthcare providers cannot sustain cash flow necessary for operations.

This concludes my testimony and I would be open to answer any questions you may have.

Kurt Snyder, Executive Director

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