2011 SENATE HUMAN SERVICES

SB 2221

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2221
1-25-2011
Job Number 13352

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage for health insurance providers.

Minutes: Includes written testimony

Chairman Lee, opened the hearing on SB 2221 which includes a FN. It indicates that in this upcoming biennium, we would have approximately $3.9 million in general funds and approximately $4.8 million in other funds. Noting that in the following biennium, approximately $10 million in general funds and approximately $12 million in other funds, will be used.

Senator Mathern introduces SB 2221. (Attached Testimony #1).

Senator Uglem asks if **Senator Mathern** could expand on the two groups, the "caretaker adult group" and the "transitional Medicaid group" so I can understand more of what they are?

Senator Mathern states that some our programs are essentially focused on children. The program was developed for the children. However, the children have parents. We have a group called, "the caretaker adult group" that relates to parents that we want to keep healthy because they have children. The other group is "transitional Medicaid group" and I see that group, as literally, a group of people that we have in a "transition system" between being off and on Medicaid. The guidelines, or the situation of people's lives, are not always that clear cut. We have some programming that permits this. I would prefer, we get more clarification for your question, from the Department.

Senator Dever states he is looking at FN and I realize bill takes effect January 2012 but shows $8.6 million for the coming biennium and $22.6 million for the following biennium. Is there an explanation of that?

Senator Mathern states that the greatest part of that explanation is, "delayed implementation". The first biennium, of the bills implementation, only covers part of the biennium, for this benefit. So it would cost less this biennium because it would only be in effect for a short number of months, compared to the next biennium, when it would be enforced for 24 months. I discussed with the Department the complicated nature of placing something like this, into effect, both in terms of getting the waivers and in terms of creating

some products that would be available. In that regard, I thought it best, to have an implementation date, that would be much later, than most of our bills take effect, to give the Department the ability to do this right. The first biennium covers a much smaller number of months than the second biennium.

Senator Lee states that it covers ¾ which would suggest $12 million. I wonder if the federal healthcare bill would have some implications on eligibility etc.?

Senator Mathern states he doesn't think so but that is a great question for the Dept.

Senator Uglem asks if we went to this type of program, would the FMAP apply to the premiums paid to the private insurance?

Senator Mathern states the federal government would want to hold itself "harmless" essentially, probably, only giving what they would give under the **FMAP (Federal Medical Assistance Percentage)** formula. That would still have to be worked out. I suspect the premium was the exact amount, as what would be the average pay out, had it been traditional Medicaid. I suspect the federal government would pay the same portion of that premium that it pays for Medicaid. However, this has a further feature. It assumes, the provider, would get the rate that the insurance company is now paying on other premiums. I don't think, the federal government, would be interested in paying more than they would under traditional Medicaid.

Senator Judy Lee comments on the statement made by Senator Dever, about healthcare reform. I was thinking more about the exchanges than some of the other components. However, this is important for us to review, new ideas, on how they address things. One of the concerns, as it relates to healthcare reform, is that, we are hoping **MMIS (Medical Management Information Systems)** is up and running by 2012. So, there are a lot of changes, still within the department, about that. There will be additional changes that will have to be made, as various provisions of healthcare reform, move forward. The exchange will be something that, for some of these folks, if they are looking at private insurance, will affect part of their lives, such as coming on and off it. That will be part of the scene as well. I am wondering, if this is almost the "straw that will break the camel's back", as far as dealing with all of these different components, which are rolling at the same time? Do you have an observation about that at all?

Senator Mathern states that **Senator J. Lee** accurately expresses it, in terms of all of these kinds of options,that are rolling around. It is really one of the reasons why I introduced this bill. I think, we as a state, have a large stake in the outcome. We have a huge part of our budget that goes into healthcare for individuals and impacted. My hope would be that a number of these people, who would normally come on assistance, would have insurance in three or four years, as part of the healthcare reform act. However, it could happen, they do not, if healthcare reform does not move forward. That doesn't mean people "get well" depending on how we work on this in the political process. People still have healthcare needs, no matter how we resolve this. As such, I think that a lot of these people, won't need any of this. The fiscal note could go down, because healthcare reform is going to create an insurance product, for those folks. It could also happen, that there will

be less people on insurance. I think, we need to position ourselves, **to do more with less.** When someone comes in for assistance, this is eligible; we give them a BC/BS card or another insurance card. Then, take it directly from their need, into the private sector. I wonder if that a good option for us to have available and that's what this bill does. Essentially, it is a narrow part of the Medicaid group and it has a design that permits us, to experiment, without upsetting the entire Medicaid program.

Maggie Anderson, Director of Medical Services Division for the Dept. of Human Services, speaks about providing information about the FN for SB 2221. (Attached Testimony #2).

Senator Lee speaks on the broad range of what a "caretaker is?"

Senator Dever asks, "What a non-parent caretaker is and are they eligible?"

Mr. Volesky states "yes" if they are going to be eligible as a caretaker, then we will look at their income, to determine eligibility.

Discussion ensues "that being the case, if they have insurance, they would be covered under their non-parents insurance? Answer is, "Yes, if they have a legal relationship."

Mr. Volesky states that insurance "may cover the children" but not necessarily in all situations.

Senator Lee is asking for clarification. "How much is the likelihood, that a non relative, who is not a guardian or adoptive parent, who would be a caretaker, have insurance and would cover this child or this Medicaid eligible person? It appears, that there would have to legal relationship, even if there is not some familial relationship, in order for coverage to exist, either with a private insurer. Mr. Collins could respond for **PERS.**

Maggie Anderson continues with more testimony, page 4. (Attached Testimony #2).

Senator Lee asks, "What is **EPSDT**?"

Maggie Anderson responds it is, "**Early Periodic Screening Diagnosis and Treatment".** That is the portion of Medicaid that says, "If a child goes in for a visit or screening and some type of medical issue is identified, we are required to provide that service, if it is considered medically necessary, regardless, of whether we cover the service under the state plan."

Senator Mathern asks, "Do we have any states that would have received a waiver to permit Medicaid recipient to choose their own private product, without the limitations of that private product, including services not covered and deductible, as an alternative to Medicaid? I am thinking that there is a group of people, who would forgo certain coverage, willing to figure out how to pay certain deductibles, if I could have this plan.

Maggie Anderson states there are various options about how that could be approached. I will clarify. Since the bill provides an option, we felt we had to make them equal. I can't

list, who those states are but there are states, allowing clients to pay a portion of the premium or have a deductible.
There is also a provision that came out of the **Deficit Reduction Act,** passed in 2006, that allows for "benchmark coverage", where you can establish coverage, that is different from the traditional Medicaid state plan. So that is an option. We would have to file that "benchmark coverage" and it would have to be approved by Secretary of Health and Human Services. It looks more like a state plan amendment, than a waiver, but then, if we were going to require people to take that coverage, then that would start involving waivers. Since we are doing a choice, I confirmed with **CMS, (Center for Medicare and Medicaid)** that this meets all the "freedom of choice" requirements.

Senator Lee asks, "Why would anyone do that, why would anybody choose to go with private coverage, that is less generous and has higher co pays, especially, if they are a lower income family in the first place, wouldn't be on Medicaid?

Senator Mathern states he thinks there are people who struggle so much with the stigma, that they would make that choice or they also have a hard time getting a provider. I suspect, there are providers, that would also give encouragement to do it, even if they didn't get their co pays and deductibles. There are providers, who rather eat part of cost, than deal with Medicaid.

Senator Lee asks about prescription drug coverage. Medicaid is much more generous than **PERS** or any other private policy. My understanding is that there isn't any type of private product or **PERS** product that would give the same prescription drug coverage, as Medicaid does. Is that true?

Maggie Anderson states, based on what she knows that it true. She continues on with (Attached Testimony #2).

No opposition to SB 2221.

Rod St. Aubyn, BC/BS of ND. They are neutral on this bill. (Attached Testimony #3)

Senator Mathern asks if the benefit plan, that **PERS** has now, is pretty close to another plan that BC/BS has, for non **PERS** people? Is there a name for that?

Rod St. Aubyn states that **PERS** plan is a fully insured product. We submit to insurance department and get approved, just like the rest of our plans. The difference is, it is only offered to the PERS group, itself. We don't market that to anyone else and are not permitted to. We offer about 30 different product designs in the "individual market" and the same number in the "group market."
There are numerous variations of these. These are all subject to change, with federal healthcare reform. Starting in 2014, the plan designs, are going to be limited to 4 basic concepts. I cannot say, that we have a product that exactly, or very closely, is like the PERS plan, because there are different "cost sharing" arrangements. There are different levels. Another thing, 50% of our plan, is self funded. Under a self funded market, the employers, design their benefit plans themselves.

Senator Mathern states he was trying to describe a "benefit plan" that would be considered customary or easy for people to understand. Are the four options, in federal healthcare reform, planned? Have they been clarified, to the extent, that your company, can already start to determine cost of those things or is it still cloudy enough that you can't do that?

Rod St. Aubyn states there is a minimal amount of "clarity." They identify, what the basic benefits have to include, but don't go into specifics, of the "essential" benefits. There is a federal entity that is reviewing that and trying to identify those things. The question being, "Are they going to get so specific on those essential benefits or will they be somewhat broad?" The essential benefits include: many things, plus pediatric, dental, vision services. "What does that mean?"

Senator Mathern asks if there is a official definition yet of those four plans? Outlines or is this still part of committee discussion or industry discussion?

Rod St. Aubyn states what they have established in actual law. "They say there shall be these four plans, the platinum, the gold, the silver and the bronze." They all must have essential benefits and give broad categories of what "essential benefits" are. Other qualifications are that they have to have actuarial value of 90-80-70-60%. What does that mean? Actuarial value" means if you take all of your claims, what percent would the insurance cover and what percent would you be paying through cost share? Big issue is to define what "essential benefits" are?

Close the public hearing on SB 2221.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

SB 2221
1-31-2011
Job Number 13745

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to medical assistance coverage by health insurance providers.

Minutes: Attachments

Senator Judy Lee opened committee discussion on SB 2221.

Senator Tim Mathern addressed amendment 11.0179.04001. Attachment #4 The amendment does a number of things to simplify the bill and make it possible to give more of an accurate fiscal note in terms of the intent of the bill.
He went through and explained the changes.

Senator Tim Mathern moved to accept the amendments.

The motion died for lack of a second.

Discussion followed on the amendment proposed by Senator Tim Mathern - whether stigma is an issue and differences in providers in terms of difficulty they have with the payment schedule under Medicaid. Senator Tim Mathern said this is a way of creating another option, experimenting, looking at different ways of delivering a product. Also discussed - moving in and out of Medicaid – computer changes and removing costs.

Senator Judy Lee referred to an amendment suggested by Rod St. Aubyn and pointed out that if they were going through with an amendment, they should look at those also.

Senator Gerald Uglem moved a **Do Not Pass.**

Seconded by **Senator Spencer Berry**.

Senator Tim Mathern voiced his disappointment that the bill was not amended and stated that he would support the bill as it is.

Roll call vote 4-1-0. **Motion carried.**

Carrier is **Senator Dick Dever**.

FISCAL NOTE

Requested by Legislative Council
01/18/2011

Bill/Resolution No.: SB 2221

1A. **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.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$4,797,328		$12,502,131
Expenditures			$3,885,836	$4,797,328	$10,096,769	$12,502,131
Appropriations			$3,885,836	$4,797,328	$10,096,769	$12,502,131

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

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

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

This Bill would allow a portion of medical assistance-eligible adults the opportunity to select whether to receive medical coverage through the traditional medical assistance program or to receive coverage through a separate health insurance plan.

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 of this bill requires the department of human service to negotiate with the state and private entities to purchase health insurance policies and annually provide a portion of medical assistance-eligible adults the opportunity to select whether to receive medical service coverage through the traditional medical assistance program or to receive coverage through a separate health insurance policy. This would also require system changes to the Department's eligibility system and MMIS along with other administrative costs.

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 revenue increase in each biennium is the additional federal funds the state would receive for the higher cost incurred if these changes are approved.

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.*

Expenditures for the 11-13 biennium include administrative cost for required quality reviews, actuarial cost, and mailings which total $187,039. Required changes to IT Systems will cost 268,516 and temporary salaries for assistance initiating the new option were included at $114,442. Assuming 95% utilization, insurance premium costs were estimated at $8,113,168 for 18 months of 11-13 biennium. The total estimated cost for the 11-13 biennium is $8,683,164 of which $3,885,836 would be general funds.

Expenditures for the 13-15 biennium include administrative cost for required quality reviews, actuarial cost, and

mailings which total $327,039. Assuming 95% utilization, insurance premium costs were estimated at $22,271,862 for 24 months of 13-15 biennium. The total estimated cost for the 13-15 biennium is $22,598,900 of which $10,096,769 would be general 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 increase of $8,683,164 in the 11-13 biennium, of which $3,885,836 would be general funds and $4,797,328 would be federal funds.

The Department will need an appropriation increase of $22,598,900 in the 13-15 biennium, of which $10,096,769 would be general funds and $12,502,131 would be federal funds.

Name:	Debra A. McDermott	**Agency:**	Dept. of Human Services
Phone Number:	328-3695	**Date Prepared:**	01/24/2011

Date: 1-31-2011

Roll Call Vote # _____

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2221

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.** Uglem Seconded By **Sen.** Berry

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		**Sen. Tim Mathern**		✓
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 4 No 1

Absent 0

Floor Assignment Senator Dever

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

REPORT OF STANDING COMMITTEE

SB 2221: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO NOT PASS** (4 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). SB 2221 was placed on the Eleventh order on the calendar.

2011 TESTIMONY

SB 2221

#1

Senate Human Services Committee
January 25, 2011
Senator Tim Mathern

Madame Chairman Lee and Members of the Human Service Committee

My name is Tim Mathern. I am the Senator from District 11 in Fargo and I am here to introduce SB 2221. **Passage of this bill will permit the Department of Human Services to issue health insurance company coverage to individuals eligible for Medicaid instead of using the traditional Medicaid program for receiving and processing claims.** The bill limits the groups of people on Medicaid for which this change applies to 2 groups which makes it like a pilot project. After some experience with the program we can make an informed decision as to whether to proceed with more groups or go back to our traditional method of claims processing. **Essentially with implementation of this bill the government claims processing system becomes privatized.** The option is conditional to approval of the federal government. (Go through sections)

Making such an option available in North Dakota will have at least three attributes;

1. help people know the health insurance system which they will need to learn once employed,
2. reduce state expenses in employees processing claims as insurance companies already have these people in place,
3. and assist health care providers and consumers to consider the care of low income persons the same as anyone else as now there is some negative stigma associated with a person using Medicaid.

(NOTE Council of State Governments Jan Feb 2011 **Capitol Ideas** issue.)

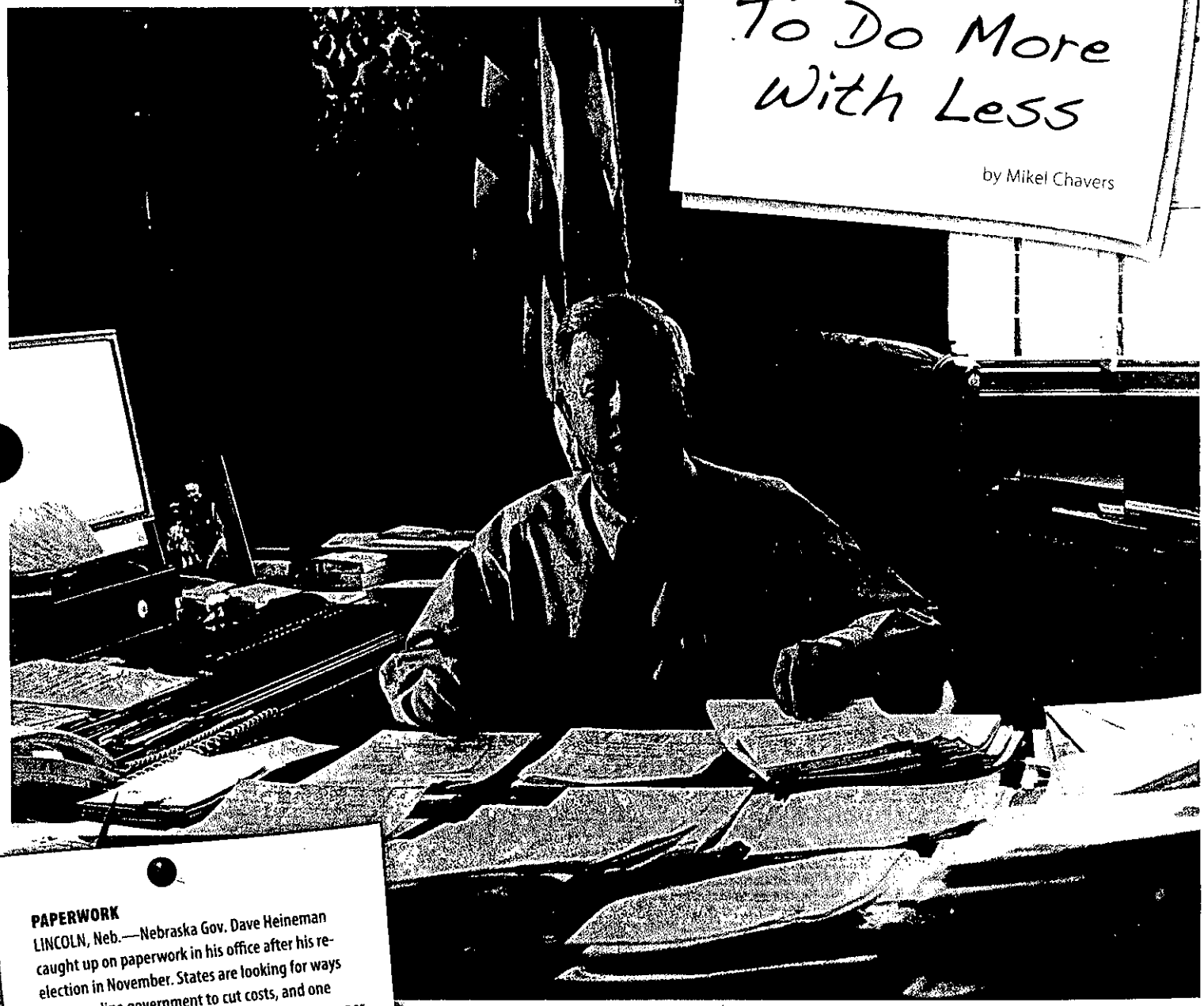
I am happy to address any questions you have. I informed the department of my intentions of this bill and they may have some comments also.

Thank you for your time and consideration. I ask you to give this bill a Do Pass recommendation.

SB2221 #1

Streamlining Government To Do More With Less

by Mikel Chavers



PAPERWORK
LINCOLN, Neb.—Nebraska Gov. Dave Heineman caught up on paperwork in his office after his re-election in November. States are looking for ways to streamline government to cut costs, and one option—in Pennsylvania—is cutting back on paper. The Pennsylvania Comptroller's office, for instance, eliminated paper invoices. AP Photo/Nati Harnik

"That's going to be additional monies com- into the state every month."

And more money is important because, "It's no secret the state of Illinois has some budget issues," Chambers said.

Tennessee Shifts Business Tax Collection

In 2009, the Tennessee legislature passed a law to shift the collection of business taxes from the county to the state department of revenue. Collecting the taxes through the revenue department meant greater efficiencies for the state.

"With this change, the Department of Revenue has used its resources and experience in tax administration to provide greater efficiency in the collection process and increased revenue for the state and for local governments," said Sara Jo Houghland, director of communications for the revenue department.

"We decided to administer this tax as we do all of the other taxes we cover with our expertise and our databases," she said. "Also, generally, people are more compliant at the federal level than the state, and it goes the same with people being more compliant on e state level than the local level."

Through the state's ability to leverage streamlined processes, the department of revenue was able to identify nonfilers by making use of existing data sources including other state tax registration information and data from other state and federal agencies.

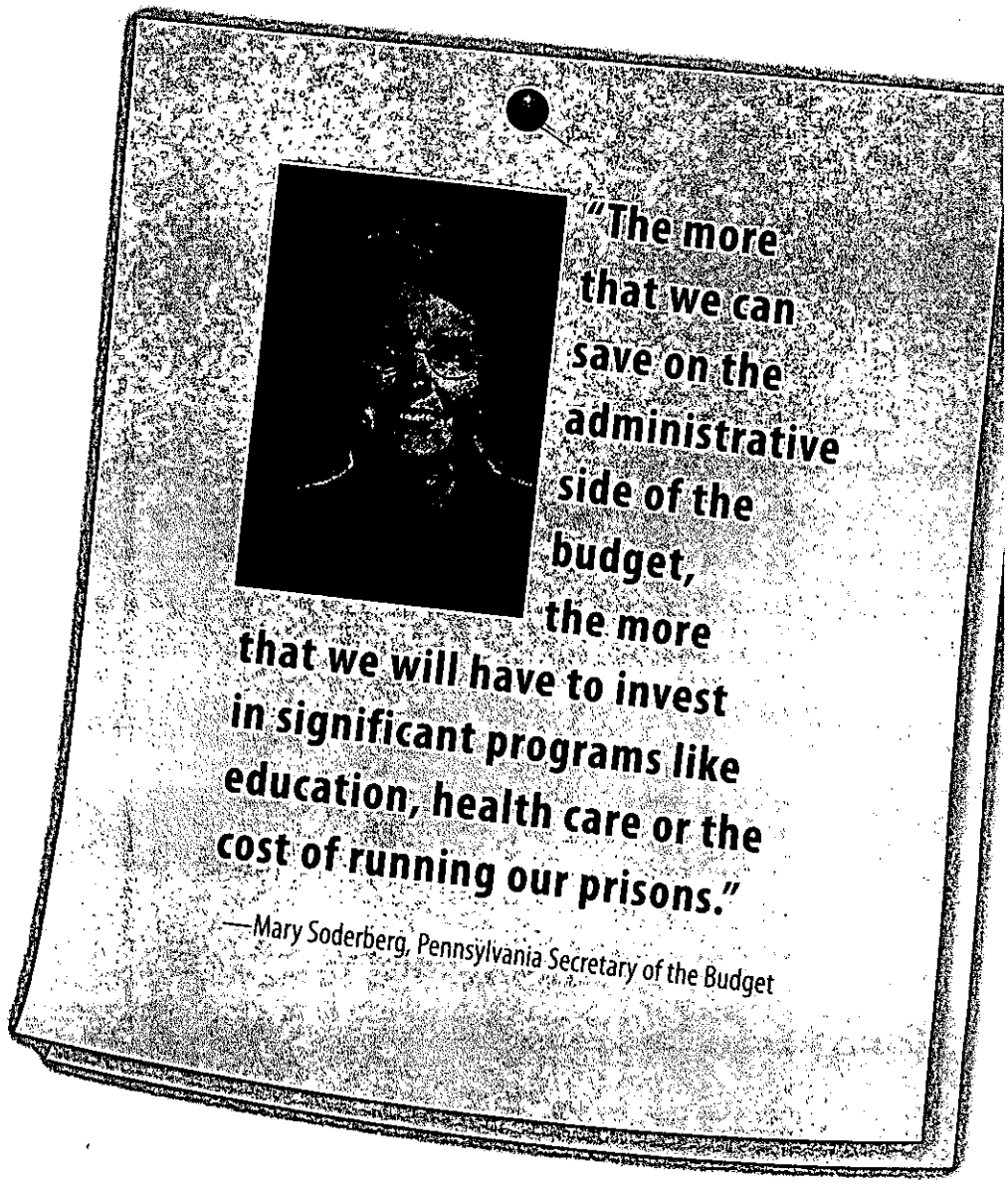
Because of more efficient efforts, the department has assessed in excess of $1.7 million in business taxes and collected more than $1.2 million of that amount, according to Houghland.

New Tax System in Maryland Nets Big Bucks

Maryland's new Modernized Integrated Tax System has snagged the state nearly $65 million in back taxes, just by upgrading to the latest technologies. Using other strategies, the agency collected more than $1.4 billion in late taxes over the last four years, according to the comptroller's office.

The centerpiece of that effort is a state-of-the-art data warehousing and tax collection system that brings the office processes to a whole new level of efficiency.

That's allowed the office to take on more ata-matching projects to determine where xes were being underreported and "these were new projects that we were able to automate," said Daniel Riley, deputy director of compliance division in Maryland.



That's important because without an automated, efficient system, big data-matching projects would have to be done by hand, involving more staff to do all the legwork. Sure, the office could run all kinds of projects to make sure folks are paying their taxes, but that's the kind of effort that takes massive manpower.

"If everyone had all the staff that they wanted, this wouldn't be an issue," Riley said. "The reality is that government agencies are being asked to work with less all the time."

#2

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

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

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

Definitions:

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

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

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

SB 2221 #2

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

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

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

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

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

Assumptions:

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

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

Other assumptions made:

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

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

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

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

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

Private Insurance Coverage:

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

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

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

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

Administrative Costs:

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

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

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

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

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

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

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

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

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

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

Attachment A

North Dakota Department of Human Services
Medical Services Division

MEDICAID MANDATORY AND OPTIONAL SERVICES

MANDATORY	OPTIONAL	OPTIONAL
Inpatient Hospital	Chiropractic Services	Mental Health Rehab / Stabilization
Outpatient Hospital	Podiatrist Services	Inpatient Hospital / Nursing Facility / ICF Services 65 and older in IMD
Laboratory X-ray	Optometrists / Eyeglasses	Intermediate Care Facility Services for MR
Nursing Facility Services for beneficiaries age 21 and older	Psychologists	Inpatient Psychiatric Services Under Age 21
EPSDT for under age 21	Nurse Anesthetist	Personal Care Services
Family Planning Services & Supplies	Private Duty Nursing	Targeted Case Management
Physician Services	Clinic Services	Primary Care Case Management
Nurse Mid-wife Services	Home Health Therapy	Hospice Care
Pregnancy Related Services and services for other conditions that might complicate pregnancy	Dental & Dentures	Non-Emergency Transportation Services
60 Days Post Partum Pregnancy-Related Services	Physical Therapy & Occupational Therapy	Nursing Facility Services Under Age 21
Home Health Services (Nursing), including Durable Medical Equipment and Supplies	Speech, Hearing, Language Therapy	Emergency Hospital Services in Non-Medicare Participating
Medical and Surgical Services of a Dentist	Prescribed Drugs	Prosthetic Devices
Emergency Medical Transportation	Diagnostic/Screening/Preventative Services	
Federal Qualified Health Center (FQHC) / Rural Health Center (RHC)		

Note: ALL Optional services are available to children under the age of 21, if medically necessary (Required through EPSDT)

North Dakota Department of Human Services
Medical Services Division

CURRENT MEDICAID SERVICE LIMITS AND COPAYMENTS

SERVICE LIMITS	COPAYMENTS
Chiropractic Manipulations 12/year	$2 Occupational Therapy
Chiropractic X-rays 2/year	$2 Optometry Service
Physical / Occupational / Speech Therapy Evaluation 1/year	$2 Psychological Service
Occupational Therapy 20 visits/year	$1 Speech Therapy
Psychological Testing 4 hours/year	$2 Physical Therapy
Psychological Therapy 40 visits/year	$3 Podiatry Service
Speech Therapy 30 visits/year	$2 Hearing Test
Physical Therapy 15 visits/year	$3 Hearing Aid
Eyeglasses for Individuals 21 & Older once every 2 years	$75 Inpatient Hospital
Eye exams for Individuals 21 & Older once every 2 years	$3 non-emergent use of Emergency Room
Ambulatory Behavioral Health – limited based on level of care	$2 Physician Visit
Inpatient Psychiatric – 21 days per admission, not to exceed 45 days per year	$3 Federally Qualified Health Center / Rural Health Center Visit
Inpatient Rehabilitation Services – 30 days per admission	$3 Brand Prescriptions
Nursing facilities – 15 days hospital leave; 24 therapeutic leave days per year	$1 Chiropractic Services
Wheelchairs – limited to once every 5 years	$2 Dental Services
Nebulizers limited to once every 5 years	
Dentures – limited to once every 5 years	
Dietitian – 4 visits per year	
Biofeedback – 6 visits per year	

#3

Testimony on SB 2221
Senate Human Services Committee
January 25, 2011

Madam Chair and Committee members, for the record I am Rod St. Aubyn representing Blue Cross Blue Shield of North Dakota.

We are neutral on this bill, but had several questions and wanted to inform the committee on other issues as well as it relates to this bill.

- On lines 10-12 it states that the Department of Human Services shall "negotiate with state and private entities to purchase private health insurance coverage and PERS coverage." Does this involve formal bidding or simply negotiating the cost and benefits? Exactly how will this occur?
- Utilization of PERS coverage may be problematic since NDPERS' eligibility is determined by statute (NDCC 54-52.1) and does not presently include the Medicaid population.
- The current rates for PERS have been bid and priced for this biennium and adding this population was not contemplated in the bids.
- The bill is not clear what the benefits/cost shares will be for this group. I believe that these standards are established by the federal government and the state. It is a certainty that these would not match up with the current benefits/cost shares reflected by PERS coverage.
- Would this population be permitted to be rated based on a separate pool from the current PERS pool?
- While we are not sure, we assume that the costs and utilization from this pool will be higher than standard insurance pools.
- Medicaid and Medicare rates are fairly comparable, whereas our rates are about 50 to 65% higher than those rates. Would Medical Providers be willing to contract with us at the standard Medicaid rates? If not, it is safe to say that the cost for this insurance would be significantly higher.
- While the concept is intriguing, the concept of considering some type of managed care plan for Medicaid may have merit. A pilot program for a Medicaid Managed Care product was previously tried. This may be something that the legislature may want to explore further. Perhaps as an alternative to this proposal, the committee may want to study this and consider the possibility of implementing some type of managed care option within Medicaid.

I want to stress that we are not experts on the federal laws and regulations as it pertains to this concept. I'm sure that the Department of Human Services would be able to answer or possibly research some of these issues.

I would be willing to try to answer any questions the committee may have. Thank you.

SB 2221 #3

#4

11.0179.04001
Title.

Prepared by the Legislative Council staff for
Senator Mathern
January 28, 2011

PROPOSED AMENDMENTS TO SENATE BILL NO. 2221

Page 1, line 9, remove "and for medical assistance-eligible adults in the"

Page 1, line 10, remove "transitional medicaid group"

Page 1, line 11, remove "state and"

Page 1, line 11, replace the second "and" with ". The scope of covered services; benefit levels; and deductibles, coinsurance factors, copayments, exclusions, and limitations under the private health insurance coverage must be comparable to that provided under the"

Page 1, line 12, after the underscored period insert "The department may allow for the terms of the private health insurance coverage to vary from the terms of the public employees retirement system coverage as appropriate to meet the needs of the caretaker adult group."

Page 1, line 15, replace "January" with "July"

Page 1, line 18, remove "and medical assistance-eligible adults in the transitional medicaid group"

Page 1, line 21, after the underscored period insert "In order to assist in informed decisionmaking, the department shall provide the eligible adults in the caretaker adult group information regarding the differences and similarities between the traditional medical assistance program coverage and private health insurance coverage, including information regarding covered services and out-of-pocket expenses."

Renumber accordingly

SB 2221 - Revised Estimate - Based upon Proposed Amendments

Per request of Senator Mathern

Description	2011 - 2013 Biennial Cost Total	General Fund	Federal Funds
Private Insurance Premiums	198,876	88,699	110,178
Administration:			
External Quality Review Contract	140,000	70,000	70,000
Actuary Services	35,000	17,500	17,500
Mailing Costs	6,460	3,230	3,230
Temporary Salaries	114,442	57,221	57,221
Eligibility System (Vision) changes	197,978	98,989	98,989
Total	692,756	335,639	357,117

Assumptions:

Start Date - July 1, 2012

No more than 5% of Cartaker adults would choose the private insurance coverage option.

The proposed amendments indicate that the private insurance would need to be comparable to the PERS plan (including covered services, benefit levels, and cost sharing.) The Department considered the benefits offered under PERS **as well as** the cost sharing under PERS as compared to the current Medicaid cost sharing and determined that very few adults would choose this option. For example, PERS does not offer dental and vision coverage and the co-payment for a physician office visit under PERS is $25, while for Medicaid, it would be $2. Also, Medicaid does not have coinsurance and deductibles; however, PERS coverage does. Even if the insurance product was "negotiated" to add dental and vision coverage, because of the cost sharing, the Department does not believe a large number of individuals would take this option. If the cost sharing was also negotiated to be similar to the Medicaid cost sharing, the Department would expect the fiscal estimate to be more similar to the fiscal note for Senate Bill 2221.