

**North Dakota Department of Human Services
Interim Health Care Reform Review Committee
Representative George Keiser, Chairman
September 7, 2016**

Chairman Keiser and members of the Health Care Reform Review Committee, I am Erik Elkins, Assistant Director, Medical Services Division for the Department of Human Services (DHS/Department). I appear before you to provide information on Medicaid Expansion cost sharing.

The information in my testimony is compiled from materials prepared by the Medicaid and Children's Health Insurance Program (CHIP) Learning Collaborative, the Centers for Medicare and Medicaid Services (CMS), from various reports and studies regarding Medicaid cost sharing, and from current North Dakota Medicaid cost-sharing policies.

Current Medicaid Copayments (For Both Traditional and Medicaid Expansion)

<u>Service</u>	<u>Copayment</u>
For office visit/consultation codes 99201-99215 and 99381-99429 that are performed by providers authorized within their scope of practice to perform these services	\$2 for each office visit
Brand name prescription drugs	\$3 for each prescription
Dental clinic appointment – oral examination	\$2 for each appointment
Optometry appointment – visual examination	\$2 for each appointment
Spinal manipulation received during a chiropractic appointment	\$1 for each appointment
Outpatient speech therapy	\$1 for each visit
Outpatient physical therapy	\$2 for each visit
Outpatient occupational therapy	\$2 for each visit
Outpatient psychological appointment	\$2 for each appointment
Outpatient hearing test	\$2 for each visit
Hearing aid dispensing service	\$3 for each
Rural Health Clinic or Federally Qualified Health Center	\$3 for each appointment
Podiatry office appointment	\$3 for each appointment
Emergency room visit that is not an emergency	\$3 for each visit
Inpatient hospital stay	\$75 for each stay

Background and Requirements

- Cost sharing may include copayments and premiums.
- Cost sharing may be imposed on individuals in the following eligibility groups: single adults, parents, and aged, blind and disabled (some exceptions).
- Copayments can assist health care payers (such as Medicaid) in controlling utilization of services, thus hoping to control (reduce) overall costs. Premiums are assessed before someone is enrolled in coverage; therefore, they do not generally control utilization of services.

Services Exempt from Cost Sharing

- Emergency Services
- Family Planning Services
- Preventative Services provided to children
- Pregnancy-related services
- Services resulting from provider preventable services

Mandatory Exempt Populations

- Children under 18 (limited exceptions – premiums for the Medicaid Buy-in for Children) (***Optional exemption for individuals 19 and 20***)
- Pregnant Women
- Individuals living in an institution who are required to contribute nearly all of their income toward the costs of their care
- Individuals receiving hospice
- American Indians/Alaskan Natives who are eligible to receive or have ever received a service from an Indian health care provider
- Women enrolled under the Breast and Cervical Cancer Treatment Program (Women's Way)

What if beneficiaries do not pay cost sharing?

If the beneficiary is in a household whose income is at 100 percent of the Federal Poverty Level (FPL) or less, a provider may not refuse to provide a service if the beneficiary cannot pay their cost sharing.

If the beneficiary is in a household whose income is above 100 percent FPL, the provider may refuse to provide a service if the beneficiary cannot pay their cost sharing.

Medicaid Cost Sharing Limits

Cost sharing for most services is limited to nominal or minimal amounts. Federal law limits the amounts states can charge Medicaid beneficiaries for premiums and cost sharing.

Maximum Medicaid cost sharing, by Federal Poverty Level (FPL)

	< 100% FPL	100% to 150% FPL	>150% FPL
Outpatient Services	\$4	10% of the fee paid by the state	20% of the fee paid by the state
Inpatient Services	\$75 per stay	10% of the amount paid by the state per stay	20% of the amount paid by the state per stay
Prescription Drugs	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: 20% of the amount paid by the state
Non-Emergent ER	\$8	\$8	No limit (but subject to 5% cap)
PREMIUMS	Not Allowed*	Not Allowed*	Permitted, subject to 5% cap
Aggregate Cost Sharing Cap	5% Household Income	5% Household Income	5% Household Income

* May be allowed with a waiver from CMS

Aggregate Limits on Premiums and Cost Sharing

Medicaid premiums and copayments are limited to 5 percent of family (household) income.

States must track beneficiary premium and copayments. This system used for tracking must:

1. Be an effective mechanism that does not rely on beneficiary documentation,
2. Include a mechanism for notifying beneficiaries and providers when the aggregate limit has been reached,
3. Track the amount of cost sharing and premiums incurred, not paid, and
4. Determine whether each beneficiary's cost sharing and premiums exceed the aggregate limit on either a monthly or quarterly basis (state option).

Tracking and Monitoring of Cost Sharing

The Medicaid agency must inform each beneficiary/household of their cumulative cost sharing maximum, and be able to track and monitor all cost sharing based on both individual and household income. This requires integration of the eligibility and claims payment systems. While both of the recently-implemented systems, the Medicaid Management Information System (MMIS) and of Phase I of the Eligibility System (SPACES), will support this integration, the current CMS requirements surrounding calculating and tracking cost sharing were not included in the original requirements for the systems. To provide a bit of perspective on the requirements, please see **Attachment A** for a subset of slides CMS prepared to provide training to State Medicaid agencies. The Department

is working with the vendors for both systems to determine a timeline for the necessary integration of the two systems.

Waiver of Cost Sharing Limits

Cost sharing waivers may be granted under a demonstration project (1115 Waiver). A waiver under this authority is limited to a two-year period (or less) and requires that all 1115 Waiver requirements be followed. Examples of premiums waivers approved by CMS can be reviewed on **Attachment B**.

Premiums

Without a waiver, the Medicaid agency may not impose premiums under the state plan for individuals with incomes below 150 percent FPL.

To provide perspective on premium efforts from one of our neighboring states, we spoke with staff from Montana about the premiums they have included in their recently-implemented Medicaid Expansion product. Please reference **Attachment C** for a summary of the Montana premium.

If premiums are considered for the Medicaid Expansion population, there will be impacts on existing county and state staff and information technology systems. There are also early results from Montana that premiums have resulted in the disenrollment of some individuals for failure to pay premiums.

Reports and Studies on Medicaid Cost Sharing

Prior to providing similar information to the Interim Human Services Committee, the Department reviewed the information in this testimony with the Medicaid Medical Advisory Committee and sought their input on current copayments, the possibility of increasing copayments, and the

possibility of adding a premium for the Medicaid Expansion population. Their input is summarized in **Attachment D**.

If there would be cost sharing (premium) changes to the Medicaid Expansion product that would require additional tracking, the Department, Sanford Health Plan, and the actuaries would need to determine if there would be an impact on the per member per month payments, including the administrative component of the payment.

I would be happy to address any questions that you may have.

**Constructing a Household and Calculating
Income for Purposes of Determining
the 5% Aggregate Household Cap**

Constructing a Household and Calculating Income



In all interviewed states, the Eligibility and Enrollment (E&E) System constructs a MAGI household for each individual and verifies household income for several purposes, including determining the 5% aggregate household cap. (*Georgia, Michigan, West Virginia*)

Household composition for purposes of determining eligibility

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Household composition for purposes of calculating 5% aggregate household cap

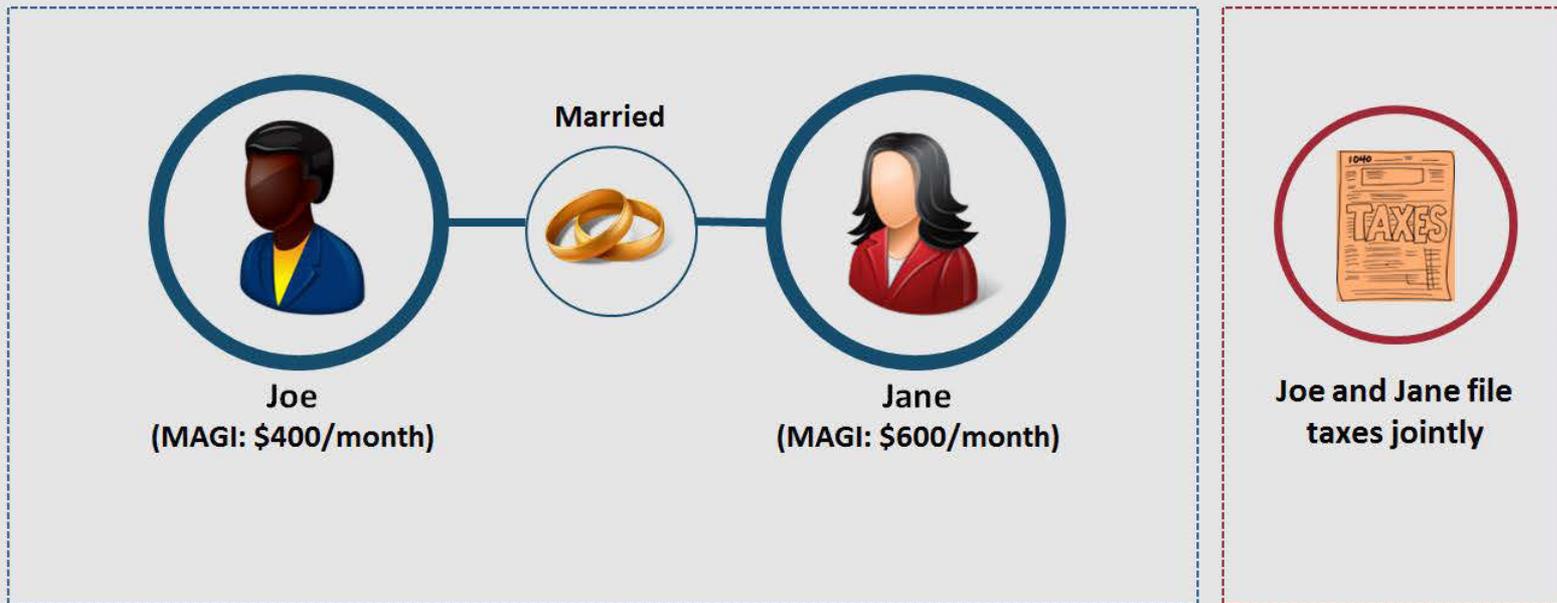
Each household member is assigned a cost-sharing cap based on his or her household size and income.

In some-households (e.g., MAGI and non-MAGI; filers and non-filers), each individual within the household may have a different household size and income.

- As a result, an individual could have a cost-sharing cap that is different from other members of the household.

Cost-Sharing Tracking Scenario #1

Meet the Smith family. Joe and Jane Smith are married, live together and file taxes jointly.



Scenario #1: MAGI Household Composition, Income and Caps

Joe and Jane are in the same household and have the same cost-sharing cap

Joe's Household (HH)



- **HH Members: 2.** Joe + Jane
- **HH Income:** \$1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** \$50/month (5% of \$1,000)

Jane's Household



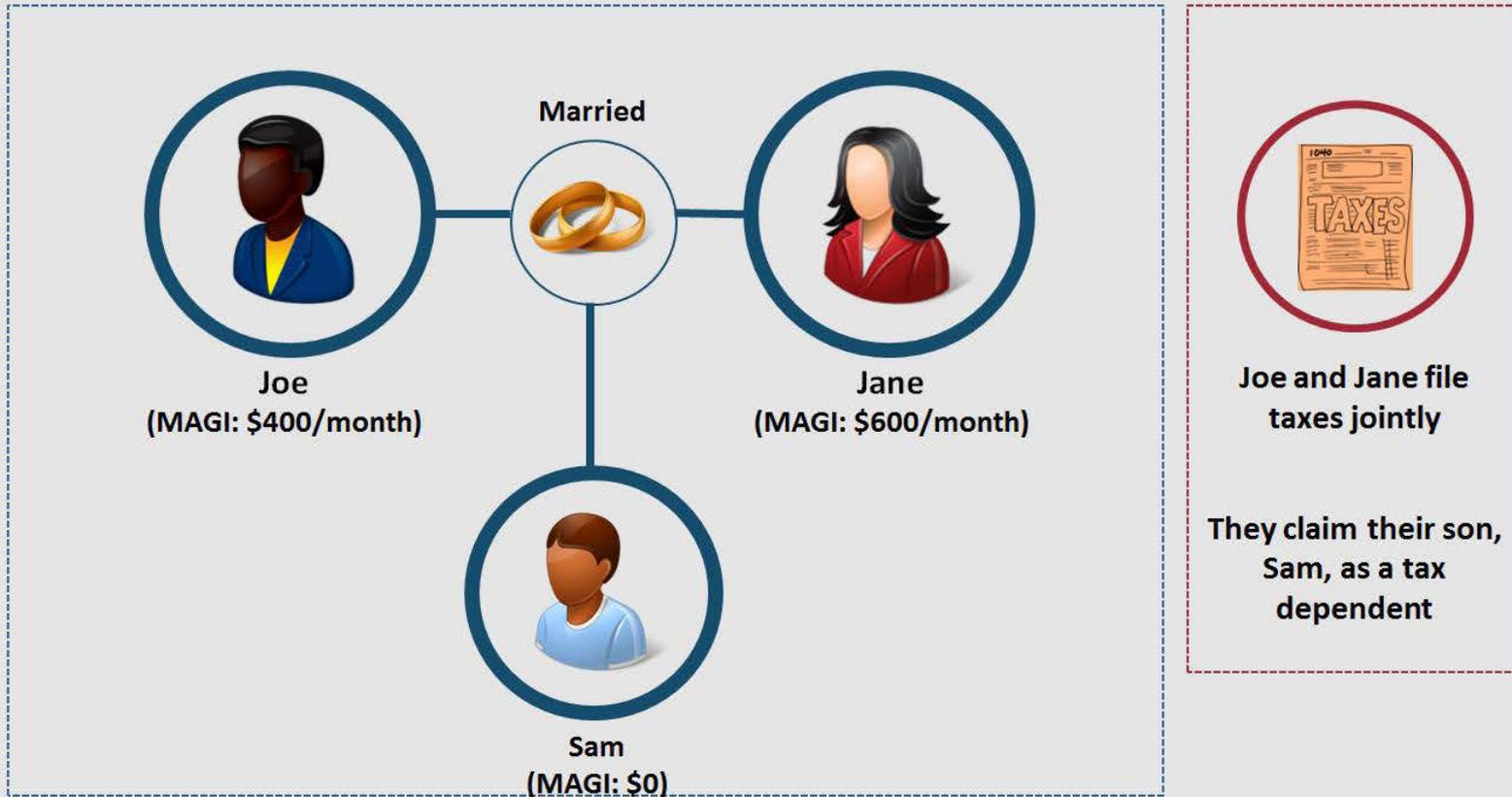
- **HH Members: 2.** Joe + Jane
- **HH Income:** \$1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** \$50/month (5% of \$1,000)

States must track incurred copayments against the 5% cap across the entire Smith household. Let's assume a state were tracking the cap on a monthly basis:

- When Jane visits the hospital, she incurs a copayment of \$15. The amount remaining under Jane's monthly aggregate copayment cap is decreased by \$15. Jane's remaining monthly copayment cap is now \$35 (\$50-\$15).
- The amount remaining under Joe's aggregate copayment cap must also be decreased by \$15 because Jane is part of Joe's household. Joe's remaining copayment cap is also \$35 (\$50-\$15).
- If Joe incurs a copayment in the same month of \$5, both Jane and Joe's remaining copayment cap is reduced to \$30 (\$35-\$5).
- In a household with the same cost sharing obligation, if one person hits the cap the entire family hits the cap.

Cost-Sharing Tracking Scenario #2

Meet the Smith family. Joe and Jane Smith are married, live together and file taxes jointly. They are the biological parents of Sam (age 10) and they claim Sam as a tax dependent.



Scenario #2: MAGI Household Composition With Child

Joe and Jane are in the same household and have the same cost-sharing cap.
Sam is a child and is not subject to co-payments.

Joe's Household (HH)



- **HH Members: 3.** Joe + Jane + Sam
- **HH Income:** \$1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** \$50/month (5% of \$1,000)

Jane's Household (HH)



- **HH Members: 3.** Joe + Jane + Sam
- **HH Income:** \$1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** \$50/month (5% of \$1,000)

Sam's Household (HH)

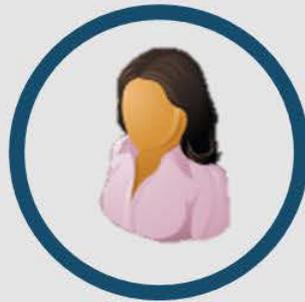


- **HH Members: 3.** Joe + Jane + Sam
- **HH Income:** \$1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** No cost sharing obligation = \$0

- When Jane visits the hospital, she incurs a copayment of \$15. The amount remaining under Jane's monthly aggregate copayment cap is decreased by \$15. Jane's remaining monthly copayment cap is now \$35 (\$50-\$15)
- The amount remaining under Joe's aggregate copayment cap must also be decreased by \$15 because Jane is part of Joe's household. Joe's remaining copayment cap is also \$35 (\$50-\$15).
- Jane's incurred co-payments do not impact Sam because Sam is a child and has no cost sharing obligations.

Cost-Sharing Tracking Scenario #3

Meet the Jones family. Maria Jones lives with her Aunt Joanne (66 y/o).



Maria
(MAGI:
\$500/month in
earned income)



Jane's Aunt, Joanne
(Non-MAGI:
\$300/month in
unearned Income)



- ✓ Maria claims her Aunt Joanne as a tax dependent
- ✓ Aunt Joanne is over age 65 and eligible under non-MAGI rules
- ✓ Aunt Joanne's income is over the tax filing threshold

Scenario #3: MAGI/Non-MAGI Household Composition, Income and Caps

Maria and Joanne have different household compositions and cost-sharing caps

Maria's Household



- **HH Members: 2.** Maria + Joanne
- **HH Income:** \$800/month (Maria + Joanne's income)
- **HH Monthly Copayment Cap:** \$40/month (5% of \$800)

Joanne's Household



- **HH Members: 1.** Joanne only
- **HH Income:** \$300/month (Joanne's income)
- **HH Monthly Copayment Cap:** \$15/month (5% of \$300)

Joanne's incurred cost-sharing counts toward Maria's cap, but Maria's incurred cost-sharing does not count toward Joanne's cap because Maria is not counted in Joanne's household.

- When Aunt Joanne visits the hospital she incurs a copayment of \$15. The amount remaining under Aunt Joanne's monthly aggregate copayment cap will be decreased by \$15. Aunt Joanne's remaining monthly copayment cap is now \$0 (\$15-\$15).
- Maria's aggregate copayment cap must also be decreased by \$15 because Aunt Joanne is part of Maria's household. The amount remaining under Maria's copayment cap is now \$25 (\$40-\$15).
- If Maria incurs a \$10 copayment, that amount is subtracted from Maria's cap but not from Joanne's cap because Maria is not in Joanne's household.

Constructing a Household: Key Takeaways

- Household composition for the purposes of determining eligibility is the same as household composition for purposes of calculating the 5% aggregate household cap.
- Each household member's incurred cost-sharing (premiums and copayments) must be counted against the cap of all the other household members in the member's household.
- In some circumstances, individuals living together may be in different MAGI households and therefore may have different household sizes, incomes and cost-sharing caps.

Calculating the 5% Aggregate Household Cap

Two interviewed states assign the actual 5% household income cap for each individual. (*Georgia and Michigan*)

Joe's Household

- **HH Members: 2.** Joe + Jane
- **HH Income:** \$1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** \$50/month (5% of \$1,000)



Jane's Household

- **HH Members: 2.** Joe + Jane
- **HH Income:** \$1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** \$50/month (5% of \$1,000)



Calculating the 5% Aggregate Household Cap

- One interviewed state identifies household income, compares income against a set of Tiers and charges a flat copayment for each Tier. (*West Virginia*)

Example: A state could calculate a copayment cap amount based on the lower end of an income range within a Tier and use a household of one.

Tier	Copayment Limit
Tier 1 (0-50% FPL)	\$0/month
Tier 2 (51-100% FPL)	\$24/month (Cap amount based on 5% of 51% of the FPL for a household of 1)
Tier 3 (101-138% FPL)	\$50/month (Cap amount based on 5% of 101% of the FPL for a household of 1)



**Jane and Joe's Household Income = \$1,000/month
= 102% FPL**



HH Monthly Copayment Cap: \$50/month (Tier 3)

Alternative Approaches to Calculating the Cap

A state could allocate the cap amount by pro-rating the 5% cap across all household members. State would no longer need to aggregate incurred copayments across household members.

Joe and Jane's Household

Joe and Jane each have a household cap of **\$50/month**

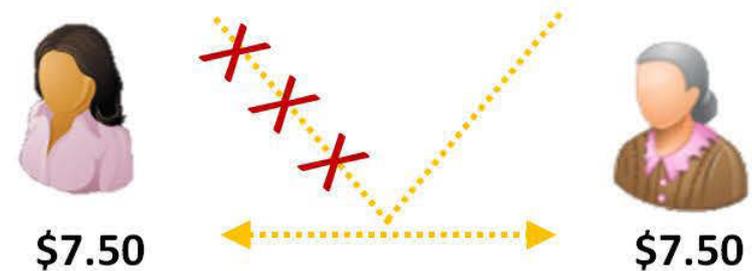


A state could divide the household cap evenly across household members so Joe and Jane have a cap amount of \$25/month each.

Example 1

Maria's and Joanne's Households

Maria has a household cap of **\$40** Joanne has a household cap of **\$15**

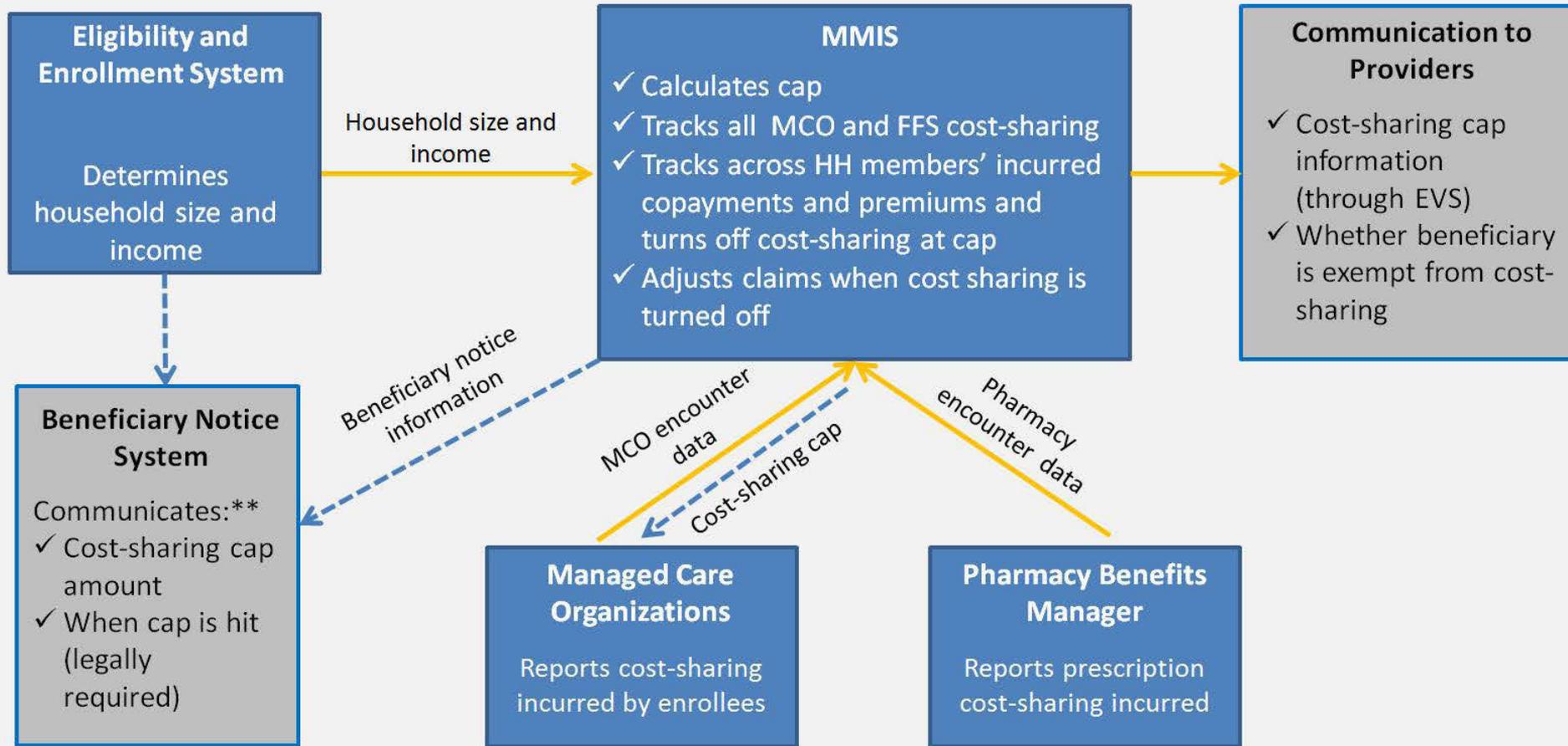


A state could divide the household cap evenly across household members based on the *lower* household cap amount. Each individual's cap is \$7.50.

Example 2

Tracking Incurred Copayments of Each Household Member: Example Process Flow*

Different IT systems interact throughout the tracking process



*Process flow is simplified and does not include all systems involved in the tracking process.

**System responsible depends on State.

Premiums/Monthly Contributions for Adults Under Section 1115 Waiver Authority

Arkansas 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 Section 1931 parents. Those with incomes between 0% and 5% FPL must pay \$1.00 per month. Individuals with 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 nonpayment 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>

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.

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.