17.0263.02000

FISCAL NOTE

Requested by Legislative Council
12/20/2016

Bill/Resolution No.: HB 1033

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				$334,057		$185,408
Expenditures			$195,000	$334,057		$185,408
Appropriations			$195,000	$334,057		$185,408

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).*

Section 1 of HB1033 has no fiscal impact as the Department of Human Services Executive Budget Recommendation (HB1072) includes removal of the Medicaid Expansion sunset. Subsection 5 requires the Department to pursue a Medicaid 1115 Waiver to implement a premium cost-sharing for Medicaid expansion.

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.*

Included in HB1012 is $6.7 million of general funds for Medicaid Expansion. This is the legislatively approved $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 current managed care.

Subsection 5 of Section 1: The savings realized from implementing cost sharing requirements and the corresponding administrative costs would not be known until the federal waiver is designed. Most states seek outside consulting assistance to design the Medicaid 1115 waiver. One of the most recent states to do so, and one of comparable size is Montana. The Department of Human Services (Department) Medical Services Division contacted the Montana Medicaid program and learned the cost of their consultant was about $780,000 (for the first twelve months of assistance). The Department is requesting one-half of that amount and will pursue a competitive procurement to seek the necessary outside assistance. The premium (cost sharing) provisions are expected to have minimal savings, and as directed in the bill, the Department would not pursue the necessary waiver unless the savings exceed the new (ongoing) administrative costs. Minimal (state) savings are estimated due to the limits the federal government has placed on how much states may assess for premiums, the high federal match for Medicaid Expansion (and the corresponding savings is "shared" with the federal government at the same match rates) and the administrative costs associated with the calculation of premiums at the time of eligibility, premium collection, notices of eligibility cancellation, reinstatement of coverage (if delinquent accounts are paid), and administration of a Medicaid 1115 waiver. The Department would also need a dedicated staff person to complete the work associated with managing a Medicaid 1115 Waiver. The FTE for managing the 1115 waiver would not be filled until the waiver is designed and the analysis demonstrates state savings; therefore, the FTE is estimated to start no sooner than January 1, 2018 at an estimated of cost $139,057, for the 17-19 biennium and 185,408 for the 19-21 biennium. The cost of the FTE as defined in the bill must be offset by the state’s share of premiums collected.

The Department of Human Services would incur $390,000 in consultant fees, of which $195,000 is general fund, to determine the feasibility of a 1115 waiver and if feasible assist in obtaining the waiver.

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 premium (cost sharing) provisions are expected to have minimal savings, and as directed in the bill, the Department would not pursue the necessary waiver unless the savings exceed the new (ongoing) administrative costs. Minimal (state) savings are estimated due to the limits the federal government has placed on how much states may assess for premiums, the high federal match for Medicaid Expansion (and the corresponding savings is "shared" with the federal government at the same match rates) and the administrative costs associated with the calculation of premiums at the time of eligibility, premium collection, notices of eligibility cancellation, reinstatement of coverage (if delinquent accounts are paid), and administration of a Medicaid 1115 waiver. In order to support an FTE the department would need to generate $69,528 from the state share of premiums collected. The department will receive $69,529 in federal funds for the remainder of the cost of the FTE. The department will also receive $195,000 of federal funds for the consultant fees.

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.*

Most states seek outside consulting assistance to design the federal Medicaid waiver. One of the most recent states to do so, and one of comparable size is Montana. The Medical Services Division contacted the Montana Medicaid program and learned the cost of their consultant was about $780,000 (for the first twelve months of assistance). The Department is requesting one-half of that amount and, if this legislation is approved, will pursue a competitive procurement to seek the necessary outside assistance.

The department would incur $390,000 of operating expenses, of which $195,000 is general fund, for the cost of the consultant fees. The cost of the FTE is estimated at $139,057 for the 17-19 biennium and $185,408 for the 19-21 biennium, and as defined in the bill must be offset by the state’s share of premiums collected.

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.*

Most states seek outside consulting assistance to design the Medicaid 1115 waiver. One of the most recent states to do so, and one of comparable size is Montana. The Medical Services Division contacted the Montana Medicaid program and learned the cost of their consultant was about $780,000 (for the first twelve months of assistance). The Department is requesting one-half of that amount and will pursue a competitive procurement to seek the necessary outside assistance. The premium (cost sharing) provisions are expected to have minimal savings, and as directed in the bill, the Department would not pursue the necessary waiver unless the savings exceed the new (ongoing) administrative costs. Minimal (state) savings are estimated due to the limits the federal government has placed on how much states may assess for premiums, the high federal match for Medicaid Expansion (and the corresponding savings is "shared" with the federal government at the same match rates) and the administrative costs associated with the calculation of premiums at the time of eligibility, premium collection, notices of eligibility cancellation, reinstatement of coverage (if delinquent accounts are paid), and administration of a Medicaid 1115 waiver. The Department would also need a dedicated staff person to complete the work associated with managing a Medicaid 1115 Waiver. The FTE for managing the 1115 waiver would not be filled until the waiver is designed and the analysis demonstrates state savings; therefore, the FTE is estimated to start no sooner than January 1, 2018.

For the 17-19 biennium the Department would need additional appropriation authority of $390,000, of which $195,000 is general fund, for the cost of the consultant fees added to their executive budget recommendation (HB1072) and the base level budget (HB1012).

For the 17-19 biennium the Department would need $139,057 of other fund appropriation for the FTE needed to manage the 1115 waiver and $185,408 of other fund appropriation would be needed in the 19-21 biennium.

Name: Debra A McDermott

Agency: Human Service

Telephone: 328-3695

Date Prepared: 01/18/2017

2017 HOUSE APPROPRIATIONS

HB 1033

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1033
1/19/2017
27157

☐ Subcommittee
☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Relating to cost-sharing under the Medicaid expansion program; and to provide a statement of legislative intent.

Minutes: Attachments 1-3

Representative **Keiser: HB 1033** Simply states; in addition to extending Medicaid expansion it also does say that the department shall pursue a waiver, which they would have to do should we implement this, in order to implement any form of cost sharing. There was a significant presents of opinion during our hearing, they wanted limitations amount that can be collected can't exceed, must be less than or equal to 5% of household income. Providers testified somewhat divided, majority stated that the co-payments where so small that it wasn't worth them going after if they are couldn't collect at the time of service. Some wrote those amounts off, other providers felt that this had some good things to offer.

6:15 Chairman **Delzer:** On HB 1033 did you talk about the time it takes to get waiver?

Representative **Keiser:** It's not a simple process, some state has never gotten a waiver. We have not gotten a waiver so we didn't find out how long that takes, I would guess 9-12 months

Chairman **Delzer:** So even if this started shortly it could not be done by July 1?

7:50 –9:00 Josh Askvig: (see attachment 1) Just one thing, page 2 line 17-23. We don't oppose the premium cost sharing; we support the bill as a whole but have a couple of suggestions. 1) Combination of premium AND co-pay must not equal more than 5% of household income, right now it just says premiums 2) There should still be some kind of an amendment for hardship assistance to be sure that those that can't pay the premium still have access to affordable health care. 3) individuals that falls 100% under the poverty level should NOT have a premium cost share.

10:00-11:40 Jerry Jurena ND Hospital Association (see attachment 2)

Andy Peterson (see attachment 3)

Chairman Delzer: Further discussion? We'll close this meeting

2017 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1033
2/15/2017
28411

☐ Subcommittee
☐ Conference Committee

Explanation or reason for introduction of bill/resolution:

Relating to cost-sharing under the Medicaid expansion program; and to provide a statement of legislative intent.

Minutes:

24:10 Of recording 28411

Representative Pollert: HB 1033 Deals with the sunset clause, it deals with the premium cost sharing on the 115 waiver, which is the fee for services.

Representative Pollert I would make a motion Do Not Pass HB 1033

Representative Meier: I will second that.

Chairman Delzer: Further discussion?

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

Motion carries

Representative Holman will carry the bill

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

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB1033

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 Holman

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

MOTION CARRIES

REPORT OF STANDING COMMITTEE

HB 1033: Appropriations Committee (Rep. Delzer, Chairman) recommends **DO NOT PASS** (17 YEAS, 0 NAYS, 4 ABSENT AND NOT VOTING). HB 1033 was placed on the Eleventh order on the calendar.

2017 TESTIMONY

HB 1033

Att. 1 1/19/17 HB 1033

AARP Real Possibilities in

North Dakota

SUPPORT HB 1033

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 1033 with some reservations.

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.

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.

Our questions on this bill relate to the new language on page 2 lines 17-23. AARP does not oppose premium cost sharing as long as:

- The combination of premiums AND co-pays must not total more than 5% of an enrollee's income.
- The bill is amended so that to allow for a hardship assistance to ensure that those who cannot pay the premium still have coverage to access affordable healthcare.
- Individuals with incomes below 100 FPL should have a premium cost share.

Again, Chairman Delzer and 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 2 1/19/17 HB 1033

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 1033
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 1033 and ask that you amend the bill and give it a **Do Pass** recommendation.

This bill would reauthorize the Medicaid expansion program in North Dakota and it would require the Department of Human Services to pursue a federal Medicaid waiver that would require enrolled individuals to pay a portion of the premium. We support the reauthorization of the program but believe that the cost sharing requirement would be counterproductive.

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.

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

We ask that you remove the cost-sharing provision of the bill. It would require a significant expenditure of time and resources to charge monthly premiums, track payments, send notices, and administer non-payment penalties, while likely providing little benefit. States must track fees to ensure that enrollees are not required to pay more than a capped percentage of their income on cost-sharing. One State found that a fee tracking system can cost millions of dollars to implement. In addition, research has shown that Medicaid cost-sharing is not very successful in generating revenue nor encouraging more personal responsibility in health care choices. Cost-

sharing has, instead, been found to act as a barrier to obtaining, maintaining and accessing health coverage and health care services, particularly for individuals with low-incomes and significant health care needs. And the State must have a process to exempt beneficiaries from disenrollment for good cause. So you can imagine how setting up such a system to assess and collect premiums, send notices of delinquency, re-enroll beneficiaries who want to get back into the program, and determine whether there was good cause to exempt an individual from dis-enrollment is likely to use more time, money and resources than it is worth.

In summary, we support the reauthorization of Medicaid expansion. It 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 net 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.

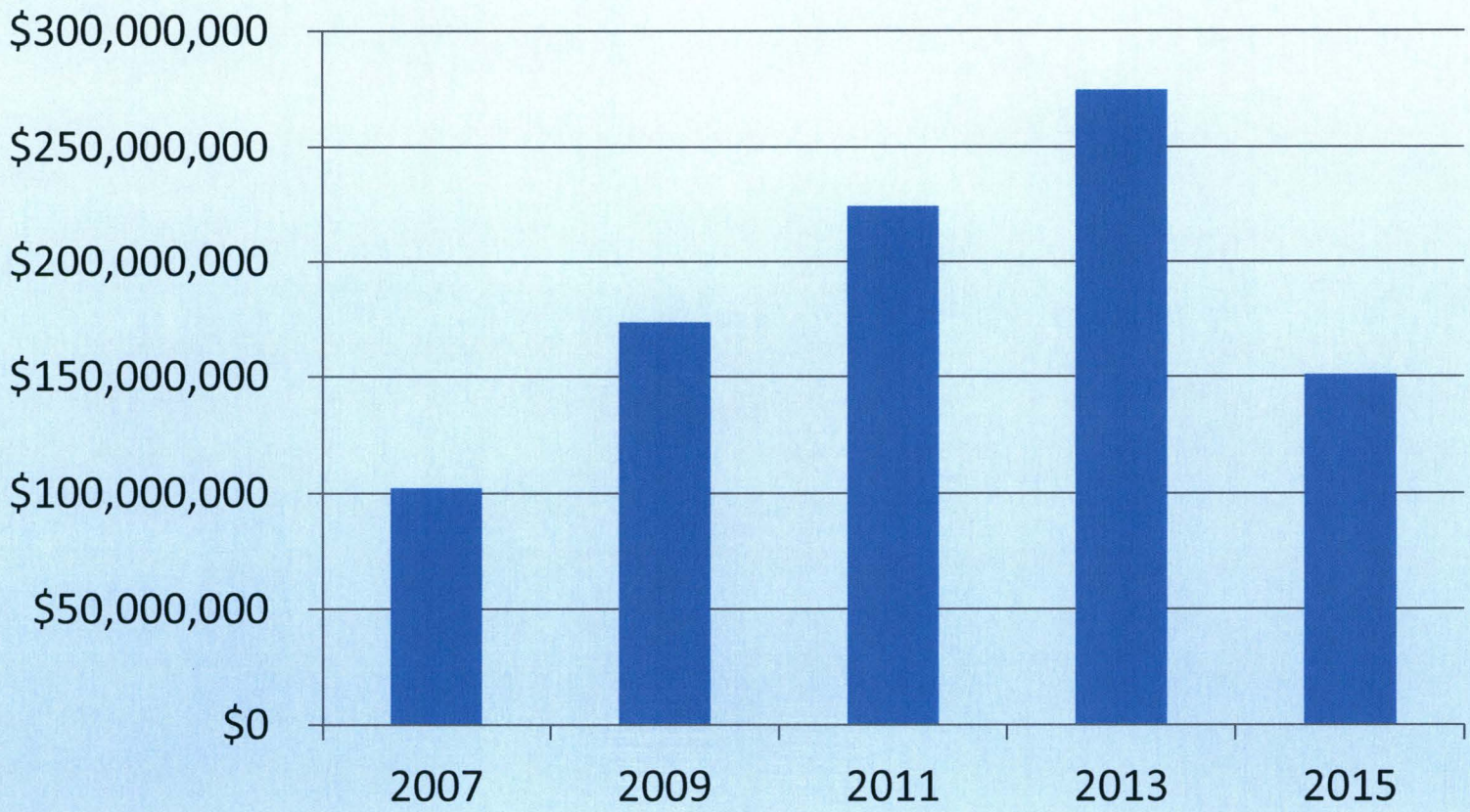
We support this bill and ask that you give it a **Do Pass as Amended** recommendation.

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

1/19/17 HB 1033 Att. 3

Greater North Dakota Chamber

Testimony of Andy Peterson
Greater North Dakota Chamber of Commerce
HB 1033
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 1033.

Thank you and I'll stand for any questions.

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