NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH CARE REFORM REVIEW COMMITTEE

Thursday, February 2, 2012
Roughrider Room, State Capitol
Bismarck, North Dakota

Representative George J. Keiser, Chairman, called the meeting to order at 9:00 a.m.

Members present: Representatives George J. Keiser, Robert Frantsvog, Eliot Glassheim, Nancy Johnson, Jim Kasper, Gary Kreidt, Lisa Meier, Ralph Metcalf, Marvin E. Nelson, Karen M. Rohr, Robin Weisz, Lonny B. Winrich; Senators Dick Dever, Jerry Klein, Tim Mathern

Members absent: Representatives Donald L. Clark, Lee Kaldor; Senators Spencer D. Berry, Judy Lee

Others present: Representative Jerry Kelsh, member of the Legislative Management, was also in attendance.

See Appendix A for additional persons present.

It was moved by Representative Meier, seconded by Senator Dever, and carried on a voice vote that the minutes of the October 20-21, 2011, meeting be approved as distributed.

CHAIRMAN'S COMMENTS

Chairman Keiser said the morning portion of the meeting will address the committee studies relating to the federal Affordable Care Act (ACA), and the afternoon portion will address the study of the feasibility and desirability of developing a state plan that provides North Dakota citizens with access to and coverage for health care which is affordable for all North Dakota citizens. During the afternoon break, he said, the Ronald McDonald Care Mobile will be parked at the west door of the Capitol to offer tours to committee members and members of the public.

Chairman Keiser distributed two articles (Appendix B) regarding the far-reaching impact of the increasing use of opioids. He said the committee will pursue this topic in more detail at future committee meetings.

AFFORDABLE CARE ACT

Insurance Department

Chairman Keiser called on Mr. Adam W. Hamm, Commissioner, Insurance Department, for an update (Appendix C) on the status of state implementation of the ACA, including updates on:

- The health benefit exchange requirements of the ACA;
- The status of state lawsuits in opposition to the implementation of the ACA;
- The essential health benefits (EHB) requirements under the ACA;
- The status of the implementation of appropriations made to the Insurance Commissioner under House Bill No. 1475 (2011 special session); and
- The status of the federal review of North Dakota's health insurance external review law amended by House Bill No. 1476 (2011 special session).

In response to a question from Representative Kasper, Mr. Hamm said since the special session the department has not received any clear information regarding how much flexibility the federal government will give a state if at some point the state chooses to transition from a federally administered health benefit exchange to a state-administered health benefit exchange. However, he said, based on past federal decisions in which the federal government has tried to be as flexible as possible and based on his belief the federal government does not want to administer the health benefit exchange exchanges long term, it is likely the federal government will be very flexible in allowing states to take over administration.

Mr. Hamm said in fairness to the states, it is imperative the federal government provide the states with information regarding what the federally administered health benefit exchange will look like.

In response to a question from Representative Winrich, Mr. Hamm said he will provide the committee with a copy of the questions he submitted to the federal Department of Health and Human Services (HHS) regarding federal administration of the state's health benefit exchange and with information regarding the Early Innovator Grant received by the University of Massachusetts Medical School providing for a multistate consortia.

In response to a question from Representative Keiser regarding the likelihood the federally administered health benefit exchange will use an active purchasing model, Mr. Hamm said he does not have a crystal ball, and he is unsure what the North Dakota health benefit exchange will look like.

In response to a question from Representative Kasper regarding what he perceives to be inconsistent data provided by the Insurance Department--now and during the special session--regarding the number of states that have elected to have a state-administered health benefit exchange, Mr. Hamm said at the time of

the special session he was aware of 13 states that had passed legislation providing for a state-administered health benefit exchange. He said since the special session, the District of Columbia has also chosen to have a state-administered health benefit exchange.

In response to a question from Representative Frantsvog, Mr. Hamm said he is not sure how much input the federal government will allow states to have in development of the federally administered health benefit exchanges.

In response to a question from Senator Mathern, Mr. Hamm said he has not submitted any documents to the federal government laying out the state's preferences for the federally administered health benefit exchange.

Representative Keiser said although Louisiana has announced it will not pursue a state-administered health benefit exchange, he does not think North Dakota should be quick to follow Louisiana's lead as Louisiana has an abysmal track record for providing health care.

In response to a question from Representative Kasper, Mr. Hamm said he will provide the committee with a summary of the 24 lawsuits challenging the ACA.

In response to a question from Representative Keiser, Mr. Hamm said within the 24 different lawsuits, the lower courts have made a broad range of findings. He said he expects the reason the United States Supreme Court selected *NFIB v. Sebelius* to be the first ACA case it hears is that the lower court found the entire ACA was invalid.

In response to a question from Representative Winrich, Mr. Hamm said he does not know how the United States Supreme Court will rule in the *NFIB* case; however, he does not believe the ruling will adversely impact the country's current system for requiring automobile liability insurance. He said unlike an automobile, which a person has a choice whether to drive, a person does not have a choice of whether to breath and therefore to be subject to the ACA.

In response to a question from Representative Weisz, Mr. Hamm said that although HHS has not yet issued any definitive guidance on the matter, from what he does know, he does not believe North Dakota will be required to pay for any of the state's 23 health care mandates. He said of primary importance in the EHB discussion is how to give the Legislative Assembly the time it needs to make a decision on selecting a benchmark plan for the state's EHB.

In response to a question from Representative Glassheim, Mr. Hamm said the states want to know if the default EHB is used as the initial EHB, whether the states can change the EHB the following year. He said thus far, HHS has provided inconsistent responses to this question.

In response to a question from Representative Kreidt, Mr. Hamm said if the Legislative Assembly were to come into special session before the end of the third quarter of 2012, then the state could select the state's EHB benchmark plan and would not be subject to the default EHB.

In response to a question from Representative Keiser, Mr. Hamm said he is not aware of the federal government taking the position that only state-administered health benefit exchanges are authorized to select the EHB. Additionally, he said, the EHB bulletin issued by HHS will likely not change very dramatically between issuance and implementation.

Mr. Hamm said the federal government has provided the state with the opportunity to choose one of eight North Dakota health plans as the state's EHB benchmark plan and has provided the state the opportunity to consider the state's best interests in making the best decision regarding what the EHB should be for this state. He said to make this decision, there should be an analysis of which of these plans best meets the needs of the state. Ultimately, he said, it seems like the Legislative Assembly should make the decision regarding the state's EHB plan selection; however, the federal government appears to be taking the position Governors can make the EHB determination.

Representative Keiser said he thinks the Health Care Reform Review Committee should evaluate the eight plans and be ready to make a recommendation to the Legislative Management. Representative Kasper and Mr. Hamm agreed the Health Care Reform Review Committee is the appropriate forum for these EHB discussions.

In response to a question from Senator Mathern, Mr. Hamm said his office has not compiled a spreadsheet with the EHB options. He said such a spreadsheet would take a considerable amount of time to create, but he will do what he can to provide this information to the committee in a timely manner. However, he said, it is likely Blue Cross Blue Shield of North Dakota already has this information for at least seven of the eight plans.

In response to a question from Representative Kasper, Mr. Hamm said the process of creating the portion of the spreadsheet which addresses which policies cover which benefits is not the time-consuming step, it is the analysis portion of the document which will be time consuming and may require the assistance of a third party.

In response to a question from Senator Dever, Mr. Hamm said regardless of whether there is a state-administered or federally administered health benefit exchange, as Insurance Commissioner he has the authority to determine which insurance companies can do business in the state.

Representative Keiser said regardless of whether an insurance company has been authorized to do business in the state, a federally administered health benefit exchange may limit the number of companies allowed to participate in the health benefit exchange.

Mr. Hamm said if the federal government provides for an active purchasing model for the health benefit exchange and limits the number of companies or policies offered through the health benefit exchange,

this would seem contrary to the position the ACA is intended to increase competition.

In response to a question from Representative Keiser, Mr. Hamm said regardless of whether there is a federal or state health insurance external review process, it is essentially the same process, and the only thing that will really differ is whether it will be the state or federal government administering the process.

Insurance Companies

Chairman Keiser called on Mr. Rod St. Aubyn, Blue Cross Blue Shield of North Dakota, Fargo, for comments regarding the EHB requirements under the ACA. Mr. St. Aubyn distributed written testimony and material (Appendix D) regarding benchmark plans.

In response to a question from Representative Kasper, Mr. St. Aubyn said although the ACA does not expressly limit health carriers from offering coverage and services, the need to be competitive likely will limit the range of policies offered. He said he does not think there will be any significant variance from the EHB. Additionally, he said, if the federally administered health benefit exchange uses an active purchaser model, there may be a limited number of policies allowed on the health benefit exchange.

In response to a question from Representative Glassheim, Mr. St. Aubyn said Blue Cross Blue Shield has asked HHS whether the state's selection of an EHB benchmark plan will allow the state to revise the coverage offered or instead whether the state will be required to be identical to the benchmark plan selected.

Representative Keiser said in considering the benchmark plans, it makes sense to not consider the nongrandfathered plans. Mr. St. Aubyn agreed with this approach.

In response to a question from Representative Keiser, Mr. St. Aubyn said once the EHB decision is made by the state, the plans then will be placed within the metallic tier classification system--platinum, gold, silver, and bronze.

Mr. St. Aubyn clarified that the metallic levels do not refer to medical loss ratio but instead are based on the percentage of full actuarial value for plan benefits that are covered by the plan's premium, with the remaining percentage being the responsibility of the covered party.

In response to a question from Representative Keiser, Mr. St. Aubyn said his interpretation of "largest plan" for the purpose of selection of a benchmark plan is the plan with the highest enrollment.

Mr. St. Aubyn said he thinks the benchmark plans, except the federal plans, are obligated to include the state's health mandates. However, he said, although it appears the federal plans do provide coverage for the state health mandates, he is not certain if the federal plans have any coverage limitations that would be impermissible under the state health mandates.

In response to a question from Representative Keiser, Mr. St. Aubyn said one concern Blue Cross Blue Shield has regarding the benchmark plans is some plans offer services that have limitations, such as dollar limitations on infertility services. He said the ACA appears to provide the EHB are not allowed to have any limitations of coverage.

In response to a question from Representative Weisz, Mr. St. Aubyn said the reason not all of the state's 23 health mandates are reflected on the benchmark document he provided is that some of the state's health mandates are provider mandates, such as requiring direct payment. He said according to the black letter of the HHS essential health benefits bulletin, the state would not be able to select a benchmark plan that covered infertility services and then remove infertility services. He said, in theory, if Blue Cross Blue Shield were to quickly revise one of its benchmark plans, for instance to remove infertility services, and if that revised plan were selected as the state's EHB plan, that would be one way to address the concern of the limitations.

In response to a question from Representative Winrich, Mr. Hamm provided the following statistics:

Plan Name	Number of Contracts	Number of Members
Comprehensive Choice	10,028	20,396
Select Choice	8,326	16,009
Classic Blue	4,893	10,213

In response to a question from Senator Mathern, Mr. St. Aubyn said there are similarities between many of the Blue Cross Blue Shield plans, but oftentimes these plans have unique provisions, such as the provisions of the Public Employees Retirement System (PERS) plan. He said he would suggest the committee not consider using the PERS Preferred Provider Organization Grandfathered plan for consideration as the state's benchmark. Additionally, he said, regardless of which plan is used as the state's benchmark, there will be benefits added to the plan, such as pediatric vision and dental.

In response to a question from Representative Rohr, Mr. St. Aubyn said the benefit subcategories used in the benchmark plan document are based on the national Blue Cross Blue Shield survey of all state plans.

Mr. Jack McDonald, America's Health Insurance Plans, provided a copy (Appendix E) of the questions America's Health Insurance Plans submitted to HHS regarding the EHB bulletin and provided a copy of a summary of the briefs submitted to the United States Supreme Court in the *NFIB* case.

Ms. Lisa Carlson, Sanford Health Plan, Sioux Falls, South Dakota, was unable to attend the committee meeting but submitted her comments (Appendix F) in writing.

Chairman Keiser called on Mr. St. Aubyn for comments (Appendix G) regarding how the state's Comprehensive Health Association of North Dakota (CHAND) may be impacted by implementation of the ACA.

Mr. St. Aubyn said although the state high-risk pools are not required to abide by the ACA, North Dakota law could be amended to provide for the CHAND product to be identical to the state's EHB benchmark plan.

In response to a question from Senator Mathern, Mr. St. Aubyn said the CHAND Board establishes the total amount of funding needed through assessment, and the Insurance Commissioner calculates the amount assessed to each carrier.

In response to a question from Representative Frantsvog, Mr. St. Aubyn said it is a policy decision whether to eliminate CHAND once the health benefit exchange is implemented. However, he said, there are classes of CHAND applicants, such as Trade Adjustment Assistance Reform Act of 2002 (TAARA) applicants and Medicare supplement applicants, who are not addressed under the ACA. Additionally, he said, in passage of the ACA, it was stated that people could keep the coverage they have and to repeal CHAND would be inconsistent with this statement.

In response to a question from Representative Keiser, Mr. St. Aubyn said effective January 2014, the federal high-risk pool will cease functioning.

Chairman Keiser said the committee will continue to receive information regarding how the ACA may impact the CHAND program.

Appropriations

Chairman Keiser called on Ms. Jenny Witham, Director, Information Technology Services Division, Department of Human Services, for comments (Appendix H) regarding the implementation of appropriations made to the Department of Human Services and the Information Technology Department under House Bill No. 1475.

In response to a question from Representative Keiser, Ms. Witham said the implementation of the department's eligibility determination system is on target to be completed in time for the ACA open enrollment period.

NORTH DAKOTA HEALTH INFORMATION NETWORK

Chairman Keiser called on Mr. Sheldon Wolf, Director, Office of Health Information Technology, Information Technology Department, for comments (Appendix I) regarding the implementation of the North Dakota Health Information Network (NDHIN).

In response to a question from Representative Kasper, Mr. Wolf said under the NDHIN there are some types of health data that government entities will be able to access. For example, he said, there will be an immunization registry that can be accessed under the NDHIN; however, this is no different from the information accessible under the current system.

Representative Kelsh said he is concerned people may overlook the benefits of the NDHIN and instead focus on privacy and Big Brother concerns. Mr. Wolf said that just as under the current system, the NDHIN will have similar risks that the wrong person could access private information; however, steps are being taken to minimize and address these risks.

In response to a question from Representatives Rohr and Winrich, Mr. Wolf said the plan is for the NDHIN to connect with existing electronic systems, such as the system used by the Department of Veterans' Affairs and to share information from state to state.

In response to a question from Representative Nelson, Mr. Wolf said the current plans for NDHIN do not allow for Workforce Safety and Insurance to have access to the network.

In response to a question from Representative Keiser, Mr. Wolf said the $5 million appropriated by the Legislative Assembly for a loan program has been distributed to critical access hospitals to assist in implementation of the NDHIN. He said there is a balance of approximately $4 million under this loan program. He said as of the third quarter of 2011, North Dakota scored a 2.5 on a scale of 7 for implementation.

HEALTH CARE DELIVERY

Emergency Room Usage in Oil Country

Chairman Keiser called on Ms. Courtney Koebele, Executive Director, North Dakota Medical Association, and Mr. Jerry Jurena, President, North Dakota Hospital Association, for comments regarding emergency room visits in counties impacted by the oil industry. Ms. Koebele distributed written testimony (Appendix J).

In response to a question from Representative Nelson, Mr. Jurena said the data reflected in Ms. Koebele's written testimony does not break down the numbers based on trauma visits and nontrauma visits.

Representative Keiser said the federal Emergency Medical Treatment and Active Labor Act requires hospitals and emergency rooms to treat anyone who comes in with a need for emergency health care treatment, regardless of ability to pay. He said the high number of emergency room visits results in hospitals facing staffing issues.

State Health Officer

Chairman Keiser called on Dr. Terry Dwelle, State Health Officer, State Department of Health, for comments (Appendix K) regarding the state's current model for health care delivery, alternative health care delivery models, and data regarding emergency room usage.

In response to a question from Representative Kasper regarding how the state should go about implementing Dr. Dwelle's recommended changes, Dr. Dwelle said if there were a simple, easy answer, it would have been done. However, he said, if the appropriate people in the state sit down together, we can figure this out. He said a focus on workplace wellness can be an early step in implementation.

Representative Kasper said in his private capacity in the insurance industry, he has worked with Mr. Dick Hedahl, President, Hedahl Inc., since 1991 to redesign the company's federal Employee Retirement Income Security Act (ERISA) health plan. He said a major element of the redesign has been implementation of a worksite wellness plan that incentivizes employees in the areas of weight, tobacco use, and alcohol use. He said federal limitations have impacted the ability of the employer to include some elements of this plan, such as incentivizing spouses as well as asking employees about alcohol use. He said this workplace wellness plan has resulted in decreased health costs for the company.

Dr. Dwelle said Mr. Hedahl serves as the chairman of the North Dakota Worksite Wellness Committee. He said incentives are only one of the many approaches that can be taken to address workplace wellness. He said community transformation is a slow process, but it is possible.

In response to a question from Representative Winrich, Dr. Dwelle said through his experience in community engagement, he thinks there are steps we can take with existing resources to better address workplace wellness.

In response to a question from Representative Rohr, Dr. Dwelle said he is not an expert in the topic of community paramedics. He said although the scope of practice of paramedics was extended in North Dakota, a paramedic is not allowed to be a stand-alone practitioner.

In response to a question from Senator Mathern regarding how to address the fact there seems to be a disconnect between the long history of wellness and health discussions but the failure of the Legislative Assembly to pass legislation addressing these matters, Dr. Dwelle said it is the State Department of Health's role to present information and it is the legislature's role to set public policy. However, he said, he thinks there are steps that can be taken within the current resources to address workplace wellness. He said the legislature determines the appropriate role of the state in participating in workforce wellness matters.

Representative Keiser said the first person who will reach age 140 has been born. He thinks health care will be facing issues similar to what the Social Security Administration is currently facing with the aging and increasing longevity of our population.

Dr. Dwelle said there are multiple spokes to this issue. He said the whole point of comprehensive wellness is to keep us as healthy as possible for as long as possible so that when end of life does occur, it is a short process not a protracted process.

Third Street Clinic

Chairman Keiser called on Mr. Corey Mock, Executive Director, Third Street Clinic, Grand Forks, for comments regarding the services offered through this organization. Mr. Mock gave a computer presentation (Appendix L) and distributed a Third Street Clinic brochure (on file in the Legislative Council office).

In response to a question from Representative Keiser, Mr. Mock said he is not sure what impact full implementation of the ACA will have on his organization. He said if the ACA results in the medical needs of the community being met, that is a great thing. However, he said, historically the Third Street Clinic has evolved to meet the needs of the community, and unmet needs may include expansion of services to address drug and alcohol issues.

Bridging the Dental Gap

Chairman Keiser called on Ms. Marcia Olson, Executive Director, Bridging the Dental Gap, for comments regarding the dental services offered through this organization. Ms. Olson provided written testimony (Appendix M) and distributed copies of a Ronald McDonald Care Mobile brochure and a Bridging the Dental Gap brochure (on file in the Legislative Council office).

In response to a question from Senator Mathern regarding the possibility that the services provided by Bridging the Dental Gap may not actually be increasing the provision of dental services but instead may be transferring who provides the services, Ms. Olson said although the number of dentists in the Bismarck-Mandan area has increased since 2005, there has also been an increase in population so it appears to be a wash. Additionally, she said, she does not think the dental services offered through Bridging the Dental Gap have been a transfer of care because the fees charged through her organization for people with medical assistance coverage are the same as charged under the medical assistance program.

During the committee's afternoon break, the committee was invited to tour the Ronald McDonald Care Mobile.

MediQHome

Chairman Keiser called on Dr. David Hanekom, Medical Director, Blue Cross Blue Shield, Fargo, for comments regarding the MediQHome program. Dr. Hanekom gave a computer presentation (Appendix N) and distributed a bound copy of the *MediQHome 2010-11 Annual Report* (on file in the Legislative Council office). He stated the MediQHome program has realized a $3 return on every $1 spent under the program.

In response to a question from Representative Nelson, Dr. Hanekom said the MediQHome approach is a different approach from the traditional approach under which copayment amounts and deductible amounts are increasing. He said the focus under the MediQHome program is to focus on getting people in to the doctor's office for preventative care and to keep those people healthy.

In response to a question from Representative Weisz, Dr. Hanekom said Blue Cross Blue Shield has

partnered with the state's diabetes management program and is just beginning to see the positive results.

Senator Mathern said he understands a program in Washington resulted in a decision to close the health system's hospitals so the system could focus on wellness. He said the program recognized the need to remove the financial desire to fill the hospital's beds.

Dr. Hanekom said although he recognizes the statistics support the idea of "increased capacity=increased usage", his experience with the MediQHome program has been that emergency room usage has decreased, but there has not been a decrease in the number of hospital beds. However, he said, North Dakota has experienced a change in who is filling the hospital beds and for what reason. For example, he said, he has seen a decrease in the number of diabetes-related hospitalizations, but he has seen an increase in the number of joint replacement surgeries. He said it seems like a win-win situation if people are healthier and are using hospitals for quality of life procedures.

In response to a question from Representative Keiser, Dr. Hanekom said the MediQHome program is not restricted to primary care doctors; however, approximately 75 percent of the primary care physicians are participating in the program.

Chairman Keiser called on Dr. David Field, Medcenter One, for comments regarding his experience in Medcenter One's participation in the MediQHome program. Dr. Field introduced himself stating he is a family doctor, and he introduced his staff in attendance at the meeting.

Dr. Field quoted Albert Einstein "Insanity: doing the same thing over and over again and expecting different results." He said the health care delivery system needs to change its focus from payment for office visits to payment for health and wellness. He said a multifaceted approach may include addressing diet, activity, education, and patient followup.

Dr. Field said from a provider's perspective, the MediQHome approach is very fulfilling and the patients benefit. He said in implementing the MediQHome approach, although patient office visits have increased approximately 30 percent, the patients have also become healthier and experience fewer emergencies.

In response to a question from Representative Kreidt, Dr. Field said the statistics indicate that with the more frequent office visits his patients' medical situations do not become as elevated, and they are healthier. He said the $3 savings for every $1 spent is a great benefit.

In response to a question from Representative Glassheim, Dr. Field said a large number of additional office visits his patients have are for appointments with his mid-level practitioners, and Blue Cross Blue Shield provided some seed money to help him hire additional mid-level practitioners. He said under the MediQHome program the billing is still based on a fee-for-service structure; however, if his treatment is successful and his patients are healthier, he receives an increase in the amount of reimbursement as an incentive.

In response to a question from Representative Kasper, Dr. Field said his staff supports the MediQHome approach, and they have a variety of ways to incentivize patients to embrace this change in health care delivery. He said he does not want to give up on his patients, and he recognizes it may take time for them to embrace this approach. Ultimately, he said, 95 percent of the patients embrace the MediQHome approach, and at the end of the day, it is okay if 5 percent of his patients do not make the transition.

In response to a question from Representative Keiser, Dr. Field said as a doctor, initially it was difficult for him to let go and let his mid-level practitioners care for his patients.

In response to a question from Representative Winrich, Dr. Field said he and his staff try to be very sensitive to the issues of the uninsured.

Ms. June Herman, Manager, American Heart Association, Jamestown, said the MediQHome program is a wonderful collaboration with positive results.

COMMITTEE DISCUSSION

Chairman Keiser said he plans to have the committee develop a legislative recommendation to address the EHB issue.

Senator Mathern said as the committee pursues the study of providing health care to North Dakotans, he would like to receive reports on the cost of putting all of the state's uninsured under coverage of the PERS health care policy. Additionally, he said, he would like to receive information regarding implementing a buyin approach to the medical assistance program. He said both of these approaches would allow the state to use programs we already have to increase access to health care.

In response to a question from Representative Winrich, Chairman Keiser said the committee will continue to receive updates from the Insurance Commissioner regarding the external review process and in order to determine whether it may be appropriate to recommend legislation to address this matter.

No further business appearing, Chairman Keiser adjourned the meeting at 3:55 p.m.

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Jennifer S. N. Clark
Committee Counsel

ATTACH:14