SELECTION OF ESSENTIAL HEALTH BENEFITS UNDER HOUSE BILL NO. 1378 - BACKGROUND MEMORANDUM

Section 1 of 2015 House Bill No. 1378 (attached as an appendix) requires the Legislative Management to charge an interim committee to study the proposed and final federal rules relating to the essential health benefits (EHB) under the federal Affordable Care Act (ACA). The Legislative Management assigned the interim study to the Health Care Reform Review Committee.

BACKGROUND

Under the ACA, a health insurance issuer that offers health insurance coverage in the individual or small group market must ensure that such coverage includes the EHB package required under the ACA. Initially, it was assumed the federal government would issue a single set of EHB requirements that all states would be required to follow. However, on December 16, 2011, the United States Department of Health and Human Services (HHS) released a bulletin that each state's EHB package will be based upon a benchmark plan selected by the state.

The HHS bulletin provided that each state may choose a benchmark plan from one of the following four benchmark plan types:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
2. Any of the three largest state employee health benefit plans by enrollment;
3. Any of the three largest national Federal Employees Health Benefits Plan options by enrollment; or
4. The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

In addition to the services covered by the state's selected benchmark plan, the state's EHB package must include the following 10 categories of services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

If a state failed to choose a benchmark plan by September 30, 2012, the default plan would be the nongrandfathered small group plan with the largest enrollment in the state. For this initial EHB package selection, the 2011-12 interim Health Care Reform Review Committee researched the state's options and ultimately North Dakota chose to use the largest insured commercial non-Medicaid HMO operating in the state as its benchmark plan for 2014 through 2016 plan years.

Once again, the federal government has directed the states to select their EHB benchmark plans for plan years 2017 and beyond. The basic process for selecting the state's EHB package is the same as before; however, the federal government selected a June 1, 2015, deadline for states to make this selection. Again, if a state fails to choose a benchmark plan by the federal deadline, the default plan will be the nongrandfathered small group plan with the largest enrollment in the state.

Unlike the first time North Dakota was faced with selecting a benchmark plan, this time the 64th Legislative Assembly passed House Bill No. 1378, which establishes a process for an interim committee to study the state's options, for the Legislative Management to make an ultimate determination, and for the Governor to notify the federal government of North Dakota's selection.

STUDY PARAMETERS

The study charge sets out specific parameters for the study, committee findings, and Legislative Management directives. In addressing the federal rules, the interim study conducted by the Health Care Reform Review Committee:

- Must include consideration of the state's ability to participate in defining the state's EHB package for plan years 2017 and beyond;
- Must include consideration of how the state may be authorized to select an EHB benchmark plan;
- Must include consideration of the federal deadlines related to these federal rules and related decisions; and
- Must include making findings and reporting the findings to the Legislative Management, which may issue a directive to the Governor to notify the federal government of the state's decisions relating to the state's benchmark plan and EHB package for 2017 plans and beyond.

If the Legislative Management issues a directive under this bill, the directive may not direct the federal government to modify the state's existing EHB package for the 2017 plan year in a way that adds benefits to the EHB package, unless the added benefits:

- Were in one or more of the state's benchmark plan options considered for plan year 2014;
- Were in the benchmark plan options for 2014 plan year; or
- Are in at least one of the 10 benchmark plan options for plan years 2017 and beyond.

Regardless of whether a Legislative Management directive under this bill complies with the listed parameters, the directive may not result in state liability due to the state reimbursement requirements under the ACA.

Additionally, if over the course of the interim, all or a portion of the ACA is repealed, the committee is directed to consider whether the repeal impacts the state's decision regarding the state's benchmark plan and EHB package for the 2017 plan year and beyond.

STUDY APPROACH

As the initial June 2015 federal deadline for selection of the state's EHB plan has already passed, time is of the essence in conducting this study. Historically, under the ACA, the federal government has been flexible in order to encourage state involvement; however, as the federal rules are finalized, this flexibility will likely lessen. Although it may be valuable to briefly review the steps the committee took during the 2011-12 interim in studying the initial EHB benchmark options; the federal process for selecting an EHB plan specifically focuses on the current 10 benchmark plans.

In order to implement the new EHB package and to assist the committee with this study, the Insurance Department has been in contact with the federal government and has conducted a survey of the carriers of the 10 benchmark plans. Presentation of the Insurance Department's ongoing consultation with the federal government and presentation of the survey results may be a good starting point for the study.

Additionally, it may be valuable to have the relevant insurance carriers provide information regarding the similarities and differences between the 10 benchmark plans, including the price for some of the benefits that differ from plan to plan.

Once the committee is ready to forward its findings to the Legislative Management, the Legislative Management will then determine whether to issue a directive to the Governor.

Finally, throughout the 2015-16 interim, the committee should follow the status of the ACA, including possible legislative or judicial repeal or modification of the ACA, to determine whether there may be changes to the ACA which impact the state's selection of the EHB benchmark plan and EHB benefit package.

ATTACH:1

Sixty-fourth Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 6, 2015

HOUSE BILL NO. 1378
(Representative Keiser)

AN ACT to provide for a legislative management study, decisions, and directive regarding the federal Affordable Care Act and the state's benchmark plan and state-based essential health benefits package for the 2017 plan year and beyond.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE MANAGEMENT STUDY, DECISIONS, AND DIRECTIVE - AFFORDABLE CARE ACT.

1. During the 2015-16 interim, the legislative management shall assign a committee to study the proposed and final federal rules issued by the federal health and human services department relating to the essential health benefits under the federal Affordable Care Act. Specifically, the study must include a review of the rules relating to the state's ability to participate in defining the state-based essential health benefits package for plan years 2017 and beyond, how the state may be authorized to select a benchmark plan for plan years 2017 and beyond, and the deadlines related to these rules and related decisions.

2. Based on the committee's findings, the legislative management may issue a directive to the governor to notify the federal government of the state's decisions relating to the state's benchmark plan and state-based essential health benefits package for the 2017 plan year and beyond.

   a. A directive issued by the legislative management under this section may not direct the federal government to modify the state's state-based essential health benefits for the 2017 plan year and beyond to include benefits that were not in one or more of the state's benchmark plan options for plan year 2014, the state's 2014 state-based essential health benefits package, or the state's benchmark plan options for plan years 2017 and beyond.

   b. A directive issued by the legislative management under this section may not result in state liability due to state reimbursement requirements under the federal Affordable Care Act.

3. If during the course of the committee's study under this section, all or a portion of the federal Affordable Care Act is repealed, the committee shall consider whether the repeal impacts the state's decisions relating to the state's benchmark plan and state-based essential health benefits package for the 2017 plan year and beyond.

4. The legislative management shall report its findings, decisions, directives, and recommendations, together with any legislation required to implement the recommendations, to the sixty-fifth legislative assembly.