NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

# HEALTH CARE REFORM REVIEW COMMITTEE

Tuesday, November 12, 2013
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, Alan Fehr, Robert Frantsvog, Eliot Glassheim, Kathy Hogan, Nancy Johnson, Jim Kasper, Alex Looysen, Karen M. Rohr; Senators Tyler Axness, Spencer Berry, Oley Larsen, Judy Lee, Tim Mathern, Dave Oehlke

**Member absent:** Representative Rick Becker

**Others present:** Representative Mark S. Owens, member of the Legislative Management, was also in attendance.
See Appendix A for additional persons present.

**It was moved by Senator Mathern, seconded by Representative Fehr, and carried on a voice vote that the minutes of the September 4, 2013, meeting be approved as distributed.**

## WELCOME

Chairman Keiser said the committee agenda provides for a full-day meeting. He said because of the full agenda, there were some items he had intended to include on the agenda which will have to be delayed and addressed at the next meeting of the committee.

## MEDIQHOME

Chairman Keiser called on Eunah Fischer, M.D., Internal Chief Medical Officer, Blue Cross Blue Shield of North Dakota, Fargo, to give a presentation (Appendix B) regarding the MediQHome program.

In response to a question from Representative Frantsvog, Dr. Fischer said when reviewing claims, insurers have a policy of applying "medical necessity criteria" to determine whether to pay the claim. However, she said, clinical, evidence-based research used to evaluate what care is effective is continually changing.

In response to a question from Representative Johnson, Dr. Fischer said in a clinical environment, it is very important to have effective sharing of data. She said fragmented decision points are problematic in providing effective care.

In response to a question from Representative Rohr regarding ethical issues that accompany consideration of how to address the fact that 5 percent of the population uses 50 percent of the medical resources, Dr. Fischer said comorbidity is part of the equation in addressing this situation of use of medical resources. For example, she said, in the case of a cancer patient who becomes depressed, data indicates the depression increases the cost of cancer treatment. As it relates to ethics, she said, in the case of geriatric patients, end-of-life issues are an appropriate topic for patients to discuss with medical providers, and this topic should be included as part of the educational process for these medical providers.

In response to a question from Representative Kasper, Dr. Fischer said under the MediQHome program, Blue Cross Blue Shield of North Dakota (BCBSND) has recognized savings by fewer hospital admissions and a decrease in emergency room usage. In response to a question from Representative Keiser, Dr. Fischer said studies performed by BCBSND indicate there has been a net savings; however, the data is not without fault.

In response to a question from Representative Frantsvog, Dr. Fischer said if a provider has a patient with a diagnosis that falls within one of the 12 MediQHome suites, that patient should receive a notification letter from the provider. She said BCBSND was not prescriptive in outlining how or whether a provider notifies patients, and BCBSND is still learning how best to roll out the program.

In response to a question from Representative Glassheim, Dr. Fischer said participation in MediQHome does not impact what services will be covered by BCBSND. She said policies provide what services will be covered or excluded.

In response to a question from Representative Owens, Dr. Fischer said MediQHome is designed to provide patients more opportunity to be engaged in the health care process. Representative Keiser said based on his experience, if a physician participates in MediQHome, the patient will likely see a change in the delivery of services, including increased patient contact and patient participation.

Senator Lee said there is no boogeyman in the MediQHome program. She said she supports practitioners practicing at the top of their scope of practice.

Senator Mathern said he is impressed with what he has learned about the MediQHome program; however, he questions why the program is not growing more quickly. He inquired about steps the Legislative Assembly might be able to take to help the program grow.

Dr. Fischer said although BCBSND is the largest commercial insurer in North Dakota, the Centers for Medicare and Medicaid Services (CMS) is the largest payer. She said BCBSND has applied for CMS grants that would assist in expansion of MediQHome. She said in being awarded grants from CMS, oftentimes North Dakota does not get priority because the state is not urban and therefore does not meet some of the grant requirements.

In response to a question from Senator Mathern, Dr. Fischer said in the Medicaid and Medicaid expansion population, there is more that can be done to utilize programs such as MediQHome.

In response to a question from Representative Fehr, Dr. Fischer said areas in the health care delivery system which could be improved to decrease waste include increasing coordination of care and increasing transparency. She said the MediQHome program seeks to change the current paradigm to address some of these areas of waste; however, change is hard. She said on a macrolevel, different areas of the country are at various levels of embracing this change.

In response to a question from Representative Hogan, Dr. Fischer said BCBSND is working on developing a suite for depression; but there are challenges, such as how best to measure improvement. Additionally, she said, BCBSND is considering whether to add a pharmacy suite, an ADHD suite, and a metabolic syndrome suite.

In response to a question from Representative Kasper, Dr. Fischer said there has been an evolution of the health care system over time, and the Affordable Care Act (ACA) is building on these changes that were made in the past. She said cost issues related to providing medical care are not the fault of any one sector--providers, insurers, or pharmaceutical companies.

Representative Kasper said because pricing for medical services is set by agreements made between providers and insurers, he does not think the parties can then claim the prices are too high.

In response to a question from Senator Oehlke, Dr. Fischer said insurers are at a time when they need to recognize the need to work better with each other. She said programs such as MediQHome and accountable care organizations (ACOs) are based on systems that provide communication in order to ensure the correct care is offered. She said with ACO contracts currently in place, BCBSND has begun sharing data with providers. She said the process of sharing data will continue to evolve.

In response to a question from Representative Glassheim, Dr. Fischer said although the impetus for the MediQHome program predates the ACA, the program fits well with the ACA. She said providing patient-centered care is at the crux of ACOs.

In response to a question from Representative Keiser, Dr. Fischer said she can look into whether BCBSND has or may be able to use the Public Employees Retirement System (PERS) uniform group insurance plan as a control group to evaluate whether the MediQHome program is accomplishing what is intended to accomplish.

In response to a question from Senator Larsen, Dr. Fischer said the policies BCBSND is offering under the ACA's Marketplace will utilize MediQHome just as current policies do.

Senator Mathern said he would like to receive additional data regarding how implementation of the MediQHome program impacts state programs, such as Medicaid, the children's health insurance program (CHIP), and the PERS uniform group health plan. Chairman Keiser agreed this data would be valuable for the committee to receive to determine whether there are any advantages for the state plans.

## INSURERS

Chairman Keiser called on Mr. Luther Stueland, Director, Health Policy Impact and Exchanges, Blue Cross Blue Shield of North Dakota, Fargo; and Ms. Sarah Delaney, Associate Actuary, Sanford Health Plan, Sioux Falls, South Dakota, for a panel discussion regarding the ACA Marketplace. Mr. Stueland provided written testimony (Appendix C). Additionally, Mr. Jay McLaren, Director of Governmental Relations, Medica, Minneapolis, Minnesota, submitted written testimony (Appendix D).

In response to a question from Senator Larsen, Mr. Stueland said under the ACA, individual and small group policy rating requirements include consideration of age, tobacco use, geography, and family size. He said he is not aware of any federal changes to allow consideration of body mass index (BMI). Ms. Delaney said as it relates to small group policies, it may be possible for employer contribution levels to be based on an employee's BMI.

In response to a question from Representative Kasper, Mr. Stueland said if the implementation of the provisions of the ACA which are scheduled to go into effect January 2014 are delayed, BCBSND will address that change to ensure the law is followed.

In response to a question from Senator Mathern, Mr. Stueland said BCBSND is reviewing the new federal rules that were just released relating to mental health and substance abuse coverage parity. He said the effective date of the rules is July 1, 2014, so this will impact individual and small group plans effective January 1, 2015.

In response to a question from Representative Keiser, Mr. Stueland said the two reasons insurers issued cancellation notices for health policies are the plans failed to meet the ACA's essential health benefits (EHB) requirements or the policies did not fall within the designated actuarial value parameters, or both. For example, he said, the gold policy actuarial values must fall between 78 to 82 percent and silver 68 to 72 percent, so if a plan has an actuarial value above 72 percent but less than 78 percent, that plan does not meet the actuarial value requirements of the ACA.

In response to a question from Representative Glassheim, Mr. Stueland said the 31,600 policies BCBSND will cancel are nongrandfathered plans, which means the plans were either not purchased before March 23, 2010--the date the ACA became law--or which were significantly modified after the ACA went into effect. He said he will try to provide the committee with additional information regarding the exact basis for these 31,600 cancellations.

In response to a question from Representative Kasper, Mr. Stueland said BCBSND did not take a position on whether a consumer should stay in a grandfathered plan. Ms. Delaney said from a small group standpoint, the determination of whether to stay in a grandfathered plan should be based on that group's specific needs. She said one thing that differs between the grandfathered and nongrandfathered plans is the change from 5-to-1 rating banding to 3-to-1 rating banding.

Ms. Delaney explained because Sanford expanded into North Dakota after the ACA went into effect, all of Sanford's 425 member contracts will be canceled. She said Sanford offers individual and group policies that meet the ACA requirements. She said one difference between the policies offered by Sanford pre-ACA and post-ACA is the previous policies offered a la carte options, whereas for these new policies, Sanford is focusing on simplifying its offerings.

Ms. Delaney said Sanford's Marketplace experience has been that three plans of eight plans come in through brokers. She said in North Dakota and South Dakota, approximately one-third of the enrollments have had subsidies attached to them. Additionally, she said, if the ACA's individual mandate were removed, it would have a negative impact on the solvency of the plans on the Marketplace because it is expected the higher-risk consumers would enroll at higher rates than lower-risk consumers.

In response to a question from Representative Keiser, Ms. Delaney said in layperson terms, the actuarial value of a plan refers to the share of benefits paid for by the plan. She said the formula is complicated, so for a 70 percent plan, there may be some services for which the insurer covers more than 70 percent and some for which less than 70 percent is covered.

Senator Berry said he would like additional information regarding the number of policies in North Dakota canceled based on the policy being purchased after the effective date of the ACA--to better understand the number of policyholders who had no reason to believe a policy would continue versus those policyholders who may not have had a reason to expect the policy would continue to be offered.

In response to a question from Senator Berry, Mr. Stueland said it is true that in the regular course of business it is common for groups to change plans; however, it is less common for insurers to discontinue plans.

Representative Glassheim said Section 1251 of the ACA is entitled "Preservation of right to maintain existing coverage" and seems to say that if you like your plan you can keep it.

## INSURANCE COMMISSIONER

Chairman Keiser called on Mr. Adam W. Hamm, Insurance Commissioner, to address the committee telephonically regarding the status of the implementation of the ACA. A copy (Appendix E) of the Insurance Commissioner's release of information regarding the Marketplace enrollment numbers was distributed.

Mr. Hamm stated of the 35,585 people with canceled policies in North Dakota, 31,600 had policies through BCBSND; 3,173 through Medica; and 812 through Sanford. He said data indicates that these three insurers have enrolled a total of 30 policies through the Marketplace.

Mr. Hamm said in gathering data from the three insurers, he asked whether the Marketplace enrollment files appear to be accurate. In general, he said, the insurers report the rates appear to be accurate; however, the "See Plans Now" feature appears to have some limitations.

In response to a question from Senator Mathern, Mr. Hamm said all of the 35,585 people who had a policy canceled were covered under nongrandfathered plans. He said the insurers did inform insureds the plans did not meet the grandfathered status. He said over time he expects there will be fewer and fewer plans with grandfathered status.

In response to a question from Representative Kasper, Mr. Hamm said if there is a change in the law to delay implementation of the 2014 provisions of the ACA, this change would apply to all states including North Dakota.

In response to a question from Representative Glassheim, Mr. Hamm said the enrollment numbers from states with state-administered health benefit exchanges are skewed because the numbers include Medicaid enrollees.

Mr. Hamm said low enrollment numbers support North Dakota's decision to not facilitate the health benefit exchange. He said North Dakota can take over the marketplace at a later date if it seems appropriate. He said it is a good thing the state is not on the hook for the financial risk of facilitating a state health benefit exchange.

## DEPARTMENT OF HUMAN SERVICES

Chairman Keiser called Ms. Maggie D. Anderson, Executive Director, Department of Human Services, for a presentation (Appendix F) regarding the status of the implementation of Medicaid expansion under the ACA and the status of the development and implementation of the department's eligibility system.

Ms. Anderson said because the enabling legislation provides the Medicaid expansion population is required to go to managed care, the department was required to apply for a federal Section 1915(b) waiver.

Ms. Anderson said the Medicaid expansion contract is different from all other contracts the department has entered. She said the contract is several hundred pages. She said the Medicaid expansion contract is expected to be awarded by the end of the week.

In response to a question from Representative Keiser, Ms. Anderson said the department eligibility system is not operational at this time; therefore, the department will be implementing a contingency plan. She said the vendor award for the contingency plan is expected to take place tomorrow.

Ms. Anderson said with Medicaid expansion, some CHIP-enrolled children will be moving to Medicaid expansion. She said originally this transition was expected to take place January 1, 2014; however, the state has been authorized to make these transitions from CHIP to Medicaid expansion as the CHIP renewal dates arise. She said due to some changes in Medicaid eligibility disregards and deductions, there will be some children on Medicaid now who will not be eligible under this new formula; however, these children will be allowed to remain on Medicaid for one year. She said in the case of adults who are found ineligible due to these new eligibility standards, the adults will receive a six-month period of continued eligibility.

In response to a question from Representative Keiser, Ms. Anderson said absent fraud, if a Medicaid applicant is initially found to be presumptively eligible but later determined to not be eligible, that enrolled will not be required to reimburse the state and the providers will be paid for that period.

Ms. Anderson said there are several differences in coverage between the traditional Medicaid coverage for adults and the coverage for adults under Medicaid expansion, including dental and vision.

In response to a question from Representative Hogan, Ms. Anderson said the determination of whether a person is "medically frail" does include consideration of behavioral health issues. She said she is not aware of any significant differences between North Dakota's Medicaid and Medicaid Expansion coverage of mental health. Additionally, she said, the Medicaid expansion coverage will be required to comply with the federal parity law.

In response to a question from Senator Mathern, Ms. Anderson said the department has not received any feedback regarding the inquiry of whether a traditional Medicaid enrollee will be allowed to opt to be covered through the Medicaid Expansion program. She said initially this will not be allowed, but perhaps this is something that could be explored for the 2015 legislative session.

In response to a question from Representative Owens, Ms. Anderson said if a child ages out of the foster care program, that child will remain eligible for Medicaid from age 18 to 26. Additionally, she said, in the case of a young person who is unemployed but does not have coverage available on a parent's plan, that person may be eligible for Medicaid or Medicaid Expansion or may be eligible for subsidies for a plan purchased through the Marketplace.

Senator Mathern said he would like the Legislative Assembly to consider opening the PERS uniform group insurance plan to all North Dakotans. He said the state has control over the plan, and this approach utilizes the private market.

## STATE DEPARTMENT OF HEALTH

Chairman Keiser called on Ms. Bridget Weidner, Hospital Program Manager, State Department of Health, to provide a brief overview (Appendix G) of the federal Emergency Medical Treatment and Labor Act (EMTALA) and challenges faced by hospitals regarding colocation of clinics and emergency rooms.

In response to a question from Representative Fehr, Ms. Weidner said the determination of whether a person has an emergency medical condition is established by conducting a medical screening examination. She said a patient's condition does not need to be life-threatening in order to be an emergency medical condition but does need to be treated and stabilized in order for that patient to have a favorable outcome.

In response to a question from Representative Keiser, Ms. Weidner said she agrees there are instances of nonemergent patients presenting at emergency rooms; however, EMTALA does not have a waiver provision that would allow a facility to provide treatment that varies from the EMTALA requirements. However, she said, it may be valuable for hospitals to review the hospital policies to ensure reasonable steps are being taken to increase use of walk-in clinics.

Chairman Keiser said he would like to have the department work with the committee and the North Dakota Congressional Delegation to address the issues related to emergency room usage and the possibility of allowing emergency room referrals to walk-in clinics. He said he recognizes the problems associated with an emergency room investing the time and resources in conducting a medical screening examination and then referring a patient to a clinic and the resulting double billing and consumption of time.

Senator Lee requested more information and possible approaches to address these problems of nonemergent cases presenting at emergency rooms.

## HEALTH CARE TECHNOLOGY

### Telemedicine

Chairman Keiser called on Ms. Tammy Hatting, Business Development Manager, eCare; Ms. Lisa Lindgren, Director, eEmergency, Avera Health, Sioux Falls, South Dakota; and Ms. Marcie Schulz, R.N., Director of Patient Care, Sakakawea Medical Center, Hazen; to give a presentation regarding the opportunity for North Dakota critical access hospitals to use out-of-state emergency and trauma services, such as eEmergency services. Ms. Hatting and Ms. Lindgren gave a computer presentation (Appendix H).

Ms. Schulz said Sakakawea Medical Center uses eEmergency for a variety of reasons, including use of the system for professional education, the nurses and physicians appreciate the additional support, use of the system allows the facility to improve patient care by decreasing the need to transfer a patient to a facility that is further from home, improved safety for staff, the speed of using the service is faster than calling the on-call provider, the assistance provided in arranging transfers of patients, and the documentation services offered through using the service. She said the facility considers the benefits associated with the system to be a factor that helps with recruitment of providers. She said now that the facility has become comfortable with using eEmergency, it is hard to imagine going back to how things were done before the service was provided.

In response to a question from Senator Mathern, Ms. Lindgren said the initial setup is the most expensive and time-consuming aspect of the eEmergency system. Ms. Schulz said her facility pays $2,800 per month for the eEmergency services.

In response to a question from Representative Fehr, Ms. Lindgren said the monthly fee for the eEmergency services is a flat monthly fee based on the hospital's size, volume, and acuity of care. Ms. Schulz said when her facility uses eEmergency to treat a patient, the billing does not change.

In response to a question from Representative Rohr, Ms. Hatting said both Medicare and Medicaid reimburse for telemedicine. She said meeting credentialing requirements is an important element of providing telemedicine. She said in addition to meeting state licensure requirements, some states also require that the remote physician have hospital admission privileges. Additionally, Ms. Lindgren said the hospital trauma certification does not recognize that the hospital has access to services through telemedicine, such as eEmergency.

Chairman Keiser requested that Avera Health submit additional information regarding any specific North Dakota legislative issues and suggestions or recommendations regarding how these issues could be addressed.

## Secure Communications

Chairman Keiser called on Ms. Kim Ducy, Partnership Manager, DocbookMD, to give a presentation (Appendix I) regarding the DocbookMD application designed for use by physicians. Ms. Ducy appeared telephonically and gave a computer presentation.

In response to a question from Representative Keiser, Ms. Ducy said the DocbookMD application allows the user to take a photograph with a phone to send to the recipient; however, the application does not provide for forwarding of original documents or images.

In response to a question from Senator Oehlke, Ms. Ducy said although there are not any studies showing the use of the application saves money, the use may be considered to be liability mitigation. Additionally, she said, in North Dakota the physicians are able to use the application for free and can add functions for a fee.

In response to a question from Representative Hogan, Ms. Ducy said DocbookMD is being used in 39 states. Ms. Katie Cashman, North Dakota Medical Association, said in the five weeks or six weeks since the application has been available in North Dakota to North Dakota Medical Association members, 36 physicians are using the application.

## Remote Units

Chairman Keiser called on Mr. Ken Guse, LifeLine Mobile, Inc., Columbus, Ohio, to give a presentation regarding opportunities for medical facilities and providers to use mobile units for health care delivery. Mr. Guse gave a computer presentation (Appendix J).

In response to a question from Representative Rohr, Mr. Guse said he is not aware of any state or local laws restricting the use of these mobile units.

In response to a question from Senator Oehlke, Mr. Guse said in North Dakota the Ronald McDonald House uses one of his mobile units for Bridging the Dental Gap.

In response to a question from Representative Glassheim, Mr. Guse said his largest customer is the federal government; but in the private sector, the units are used by hospitals and clinics. He said users at the federal government level include Indian Health Service, the Veterans Administration, and federally qualified health centers.

In response to a question from Representative Fehr, Mr. Guse said connectivity issues for the mobile units are lessening more and more over time as the technology improves.

In response to a question from Senator Lee, Mr. Guse said states typically do not purchase these mobile units; however, it is not uncommon for institutions of higher education and rural public health units to purchase a mobile unit.

In response to a question from Representative Keiser, Mr. Guse said the mobile units can be used to offer a broad range of services, including pediatric medicine, dental care, vision services and laboratories, and women's health.

## LEGISLATION UPDATE

Chairman Keiser called on Mr. John Vastag, Health Policy Consortium, Sanford Health, Fargo, for comments (Appendix K) regarding the implementation of 2013 legislation, with a focus on 2013 Senate Bill No. 2187.

Mr. Vastag said he is a member of the Medical Facility Infrastructure Loan Program Task Force, which has the statutory duty to review loan applications and make recommendations to the Bank of North Dakota. He said the task force met in September to review the initial six applications, which totaled just under $61 million. Senate Bill No. 2187 provided $50 million of initial funding with a possibility of more funding at the completion of calendar year 2014.

Mr. Vastag said Tioga requested $8 million, and the task force recommended $6 million; Stanley requested and the task force recommended $2.25 million; Watford City requested $15 million, and the task force recommended $12.5 million; Bowman requested $15 million, and the task force recommended $12.5 million; Hazen requested $7,246,000, and the task force recommended $6,746,000; and Dickinson requested $15 million, and the task force recommended $10 million. He said as of November 7, 2013, the Bank of North Dakota has approved the loan requests from Tioga and Stanley; expects to approve the Watford City request in December; and is still processing the applications from Bowman, Hazen, and Dickinson.

In response to a question from Representative Keiser, Mr. Vastag said the medical facility infrastructure loan program has a local matching fund requirement.

Chairman Keiser called on Mr. Sheldon Wolf, Director, North Dakota Health Information Technology, to provide a status update (Appendix L) on 2011 and 2013 legislation relating to health information technology funding.

In response to a question from Representative Keiser, Mr. Wolf said he does not know the exact number of platforms being used by providers in the state; however, difficulties do arise in the area of laboratory results.

Chairman Keiser called on Ms. Arvy Smith, Deputy State Health Officer, State Department of Health, to provide information (Appendix M) regarding emergency medical services (EMS) funding provided through 2011 and 2013 legislation.

In response to a question from Senator Lee, Ms. Smith said great strides have been made in funding and providing EMS in the state; however, steps could be taken to reduce emergency room visits, such as implementation of a call-a-nurse program. Mr. Tom Nehring, Director, Emergency Medical Services and Trauma, State Department of Health, said funding has helped to implement EMS training so both EMS and critical access hospitals are better trained. Mr. Nehring said across the country, North Dakota is being looked at as an example of how to provide EMS.

Chairman Keiser called on Ms. Beth Zander, Director, Workforce Development Division, Department of Commerce, to provide an update (Appendix N) on Section 8 of 2013 House Bill No. 1358, which provides funds to nursing homes, basic care facilities, and developmental disability providers in the designated oil-producing counties in the state.

## MENTAL HEALTH

Chairman Keiser called on Mr. Kurt Snyder, Executive Director, Heartview Foundation, Bismarck, for comments (Appendix O) regarding concerns about ACA coverage of mental health and substance abuse services.

Chairman Keiser called on Mr. Lance Schreiner, Bismarck, for comments regarding the impact of the ACA on providing substance abuse services. Mr. Schreiner said he is a member of the Heartview Foundation Board of Directors, an attorney, and an interested member of the public.

Mr. Schreiner said he became interested in this issue when BCBSND notified the Heartview Foundation that its insurance policies would be reducing residential treatment coverage under the BCBSND grandfathered plans. Additionally, he said, BCBSND informed him the BCBSND metallic plans would be limiting coverage as well. He said he thinks it is possible there may be some glitch in the North Dakota benchmark plan selected for EHB, as the benchmark may not be in compliance with North Dakota Century Code Sections 26.1-36-08 and 26.1-36-08.1.

Chairman Keiser thanked Mr. Snyder and Mr. Schreiner for bringing this issue to the committee. He said this appears to be a critical issue that will need more study and discussion at a future meeting.

No further business appearing, Chairman Keiser adjourned the meeting at 5:05 p.m.

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Jennifer S. N. Clark
Committee Counsel

ATTACH:15