NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH CARE REFORM REVIEW COMMITTEE

Tuesday, January 19, 2016
Roughrider Room, State Capitol
Bismarck, North Dakota

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

Members present: Representatives George Keiser, Rick C. Becker, Alan Fehr, Mary C. Johnson, Mike Lefor, Alisa Mitskog, Karen M. Rohr; Senators Tom Campbell, Gary A. Lee, Tim Mathern, Ronald Sorvaag

Members absent: Representatives Robert Frantsvog, Eliot Glassheim, Jim Kasper, Alex Looysen; Senator David O'Connell

Others present: Representative Kathy Hogan, Fargo, member of the Legislative Management
See Appendix A for additional persons present.

It was moved by Senator Lee, seconded by Representative Fehr, and carried on a voice vote that the minutes of the November 12, 2015, meeting be approved as distributed.

Chairman Keiser began the meeting by expressing his frustration in planning the agenda for this meeting. He said late in the game, the representative of America's Health Insurance Plans scheduled to make presentations, contacted the Legislative Council staff to report she was unable to make her presentation as initially planned. He reported he later learned America's Health Insurance Plans actions were in response to one of its North Dakota members making this request. He said he's never before heard of a committee's plans being disrupted like this and he is not happy.

PUBLIC EMPLOYEES HEALTH INSURANCE STUDY

Hedahls Inc.

Chairman Keiser called on Mr. Dick Hedahl, President, Hedahls Inc., to give a presentation (Appendix B) regarding his company's self-insurance health plan for employees.

Mr. Hedahl provided an overview of the history of his company providing health insurance to employees and he said as a result of a spike in health insurance premiums in the early 1990s, it was necessary for the company to look at alternatives to its historic manner of providing health insurance for employees. He said as the company moved to a self-funded health plan, it added incentives for wellness. However, he said, as a result of changes in federal law the company is no longer able to consider alcohol usage and the status of the employee's spouse.

In response to questions from Senator Campbell and Chairman Keiser, Mr. Hedahl said the current health plan provides for base funding and then incentives based on tobacco usage and weight, and the employee is able to put this money toward a health plan. He said if an employee does not use tobacco and does not exceed the weight parameters, the company provides approximately $380 per month for a family health plan.

In response to a question from Senator Mathern, Mr. Hedahl said health and health care is very personal. He said if the state were to take on a wellness-based health plan, it would be important for the employer to be committed to making wellness part of the corporate culture.

In response to a question from Senator Campbell, Mr. Hedahl said he is not interested in looking into whether his company could use penalties instead of incentives. Instead, he said, he wants to focus a positive culture on wellness.

In response to a question from Representative Fehr, Mr. Hedahl said he does not have statistics on what exact impact his company's health plan has had on employee lifestyle. He said he tries to stay out of the details of his employees' health, but instead wants to provide the opportunity to improve health and lifestyle. Additionally, he said, the health plan offers annual health benefits assessments, which provide information on how to pursue healthy lifestyles. However, he said, statistics indicate a minority of the employees actually participate in these assessments.

In response to a question from Senator Lee, Mr. Hedahl said he thinks the slow increase in the cost of the health plan is related to the wellness activities. Without these activities, he said, he thinks the cost would increase more rapidly.

In response to a question from Representative Lefor, Mr. Hedahl said he has very limited access to employee health information.

In response to a question from Senator Mathern, Mr. Hedahl said that although it is likely an employer could collect data to compare a health plan like his to a traditional group health insurance plan, he is not interested in collecting this data.

In response to a question from Chairman Keiser, Mr. Hedahl said that his company annually reviews the cost of a fully funded health insurance plan to his self-funded plan, and this review shows the self-funded plan recognizes savings of approximately 20 percent.

Public Employees Retirement System

Chairman Keiser called on Mr. Sparb Collins, Executive Director, North Dakota Public Employees Retirement System, to make a presentation regarding the status of the Public Employees Retirement System (PERS) uniform group health insurance plans and the differences and similarities between and the pros and cons relating to grandfathered, nongrandfathered, self-insured, and fully insured health plans as they relate to the PERS uniform group health insurance plans. Mr. Collins gave a computer presentation (Appendix C), and distributed a document (Appendix D) by The Henry J. Kaiser Family Foundation, Preventative Services Covered by Private Health Plans under the federal Affordable Care Act (ACA), and a table (Appendix E) comparing the services covered under the PERS grandfathered and nongrandfathered plans.

Chairman Keiser distributed a document (Appendix F) prepared by Blue Cross Blue Shield of North Dakota (BCBSND), entitled *Making the Right Health Plan Choice for North Dakota Public Employees*. Mr. Collins said although this document shows North Dakota as using a fully insured plan for public employees, it is likely the state is unique in its ability to have a hybrid plan under which there is a risk corridor through which the parties have the opportunity to share profits and losses.

In response to a question from Chairman Keiser, Mr. Collins said if PERS were to move to a self-insured health plan, it would follow North Dakota Century Code Section 54-52.1-04.2, and in compliance with this section individual stop-loss coverage would be made part of the plan. Additionally, Mr. Collins agreed that although there is a risk under a self-insured plan that costs may increase, there is the benefit of spreading risk out amongst a large pool.

Mr. Collins said it is still very early in the current health insurance contract to have much data on the status of the current contract. However, he said, it is likely that PERS will not receive any payments through the hybrid element of the contract due to the tight profit margin under the current PERS contract with Sanford Health Plan.

Chairman Keiser said he is concerned the current PERS health plan is transferring the state's cost savings to providers and employees.

In response to a question from Representative Lefor, Mr. Collins said when PERS issued the request for proposal (RFP) for the uniform group health plan BCBSND submitted a proposal with a 19 to 20 percent increase for the 2015-17 biennium and Sanford Health Plan submitted a proposal with a 15 percent increase. He said analysts had expected an increase of approximately 18 percent. He said BCBSND also submitted a self-insurance proposal with an increase of 15 percent.

Mr. Collins said when PERS issues an RFP for the uniform group health plan, it includes an RFP for a self-funded plan and a fully insured (hybrid) plan.

In response to a question from Chairman Keiser, Mr. Collins said if PERS changes to a self-funded plan, it is important to recognize that unlike most other states, North Dakota does not have an annual budget. He said with biennial budgets and legislative sessions, there is a greater risk PERS would have to appear before the Emergency Commission if costs exceeded the appropriation. He said North Dakota currently has a 2-year reserve and if that fund was exhausted, there would be financial concerns.

In response to a question from Chairman Keiser, Mr. Collins said although he does believe there are benefits to adding wellness provisions to a health plan, if PERS moved from the primary plan, which is a grandfathered plan, to the PERS nongrandfathered plan, there would be a 3 percent increase in premium. He said this 3 percent reflects

the immediate financial impact of building the wellness provisions into the plan, but does not reflect the anticipated savings in the long term--with the PERS grandfathered plan costing $1,085 and the nongrandfathered plan costing $1,300 per month.

In response to a question from Senator Mathern, Mr. Collins said even though the wellness provisions in the nongrandfathered plan may recognize long-term benefits, these savings are not built into the costs associated with the initial transition.

Insurer Panel

Chairman Keiser called on the following representatives of health insurance carriers to participate in a panel discussion regarding the carriers' activities and opportunities relating to wellness and prevention and patient-centered medical homes--Ms. Jacquelyn Walsh, Blue Cross Blue Shield of North Dakota, (Appendix G); Mr. Tony Tiefenthaler, Sanford Health Plan; Ms. Katherine Johansen, Medica; Ms. Katie Nermoe, Sanford Health Plan; and Ms. Lisa Carlson, Sanford Health Plan.

In response to a question from Representative Fehr, Ms. Walsh said that although in the past, behavioral health was isolated, more recently it has been included in the care-coordination model. Additionally, she said, caregiver conferences have been included in the care-coordination model.

In response to a question from Senator Campbell, Ms. Walsh said some employers choose to offer financial incentives for participation in wellness activities and there are multiple innovative ways to do this.

In response to a question from Senator Mathern, Ms. Walsh said although she does not have specific metrics regarding the direct impact wellness initiatives have on premium, with employers' goals of keeping premium low, wellness initiatives have continued to play a role.

Mr. Tiefenthaler provided an overview of care management and clarified it includes behavioral health components.

Ms. Johansen stated that under ACA, there is a wellness pilot project in the individual market and data from this pilot project may be of value for the committee to review as it moves forward.

Ms. Johansen said as insurers work within the parameters of ACA, the two primary ways insurers address wellness is through the structure of benefits, such as networks, and through wellness incentives. She said Medica addresses wellness incentives as an add on to all individual and small group plans.

Ms. Nermoe provided an overview of worksite wellness, including a review of the six dimensions of wellness--occupational, physical, social, intellectual, spiritual, and emotional. She said in order to be effective, we need to shift the focus from the individual to society.

Ms. Nermoe said three keys to being successful in implementing worksite wellness are to train leaders to train the culture, tie incentives to actions, and provide employees with the tools necessary to be successful.

Ms. Carlson said leaders of employer groups lead by example and have the largest impact on whether the worksite wellness program is successful.

Chairman Keiser said health maintenance organizations were outcome based, but ultimately failed. He said he thinks we see cycles of outcome-based approaches. He requested that the insurers make aggregate data available to allow the committee to evaluate the effectiveness of these approaches. Overall, he said, he thinks MediQHome, through BCBSND is effective, but the providers are becoming exhausted and are therefore not as enthusiastic as they had been. He said he thinks the improvements are smaller than the providers expected and this is disheartening.

Ms. Walsh said BCBSND will provide aggregate data to the committee. She said providers have expressed a need for more data as well. Additionally, she said, July 1, 2016, accountable care organization value-based purchasing will go live.

Mr. Tiefenthaler agreed that data is important, and payors may want to evaluate data on readmission and admission rates as well as the length of in-patient stays. He said in evaluating data it is also important to know which provider is attributable to a patient and it is necessary to have the ability to track chronic diseases and health status.

Ms. Carlson said in looking at attribution data, a payor needs to be transparent and provide the necessary data to providers. She said one size does not fit all.

Representative Hogan asked for data regarding the number of enrollees in care coordination.

Ms. Walsh said approximately 80 percent of BCBSND members interact with a care coordinator, and 35 to 40 percent interact on a regular basis. She said this regular participation rate is equal between behavioral health and physical health and care coordination is equally available in rural and urban communities.

Mr. Tiefenthaler said Sanford Health Plan insureds are automatically in coordinated care unless they opt out. He said care coordination is triggered in the case of a hospital admission that indicates high risk and may be triggered in the case of readmission.

Representative Becker said Centers for Medicare and Medicaid Services is moving away from fee-for-service, with patient control being moved to administrators and therefore market forces being less of a driver.

Chairman Keiser said there has been a move to greater use of walk-in clinics; however, this goes against the strategy of case coordination.

Senator Mathern stated public health and education are going to be important in keeping people well.

Chairman Keiser said he has an ongoing interest in having a PERS pilot project to increase care coordination and help with the data collection process.

HEALTH CARE DELIVERY SYSTEM STUDY

Department of Human Services

Chairman Keiser called on Ms. Stephanie Waloch and Ms. Brenda Peterson, Department of Human Services, and Mr. Tiefenthaler and Ms. Barb Vandonslear, Sanford Health Plan, to give presentations (Appendices H and I) regarding the status of ACA implementation, the eligibility modernization project, and Medicaid Expansion utilization.

In response to a question from Representative Hogan, Mr. Tiefenthaler said Sanford Health Plan collects Medicaid Expansion enrollment data by county and zip code.

In response to a question from Chairman Keiser, Mr. Tiefenthaler said he can provide the committee with additional information regarding mammography and colorectal screening rates, which compares the commercial population to the Medicaid Expansion population.

In response to a question from Chairman Keiser, Mr. Tiefenthaler agreed the Medicaid Expansion population is a high-utilization population. Ms. Vandonslear said Sanford Health Plan is evaluating options to address this high utilization.

In response to questions from Representative Hogan and Chairman Keiser, Ms. Vandonslear said she can provide the committee with additional data regarding Medicaid Expansion utilization data on behavioral health, emergency room usage, and emergency room usage for dental-related issues.

In response to a question from Senator Lee, Ms. Vandonslear said the Medicaid Expansion population has adequate access to primary care providers, but the failure to use these providers is more likely related to patterns of behavior and practice.

In response to a question from Senator Sorvaag, Ms. Vandonslear said Sanford Health Plan will review timeliness of care standards on at least an annual basis.

In response to a question from Chairman Keiser, Ms. Vandonslear said Sanford Health Plan is working with emergency room care plans and actions are being taken to address usage concerns. In addition, Mr. Tiefenthaler said it is important to realize the Medicaid Expansion population is rather volatile, in that individuals move in and out of eligibility and this makes it more challenging to help these individuals establish care systems.

In response to a question from Representative Hogan, Mr. Tiefenthaler said he can provide the committee with information regarding federally qualified health centers.

In response to a question from Senator Mathern, Mr. Tiefenthaler said if a Medicaid Expansion client moves off of Medicaid Expansion and into a commercial product of Sanford Health Plan's, Sanford Health Plan will continue to provide coordinated services for that individual.

In response to a question from Representative Hogan, Ms. Vandonslear said she can provide the committee with data regarding whether there is adequate availability of followup care for behavioral health issues.

In response to a question from Senator Mathern, Ms. Vandonslear said as part of the quality improvement project for Medicaid Expansion, it is not uncommon to find a behavioral health issue has lead to self-medication. She said this followup and screening helps identify these situations.

Mr. Tiefenthaler said that because Medicaid Expansion is so new, the data is just now beginning to become available. He said that until now, the focus has been on benchmarking.

In response to a question from Chairman Keiser, Mr. Tiefenthaler said if Medicaid Expansion is expanded to include vision and dental services, it will be an additional expense and there may be issues regarding availability of providers.

In response to a question from Senator Mathern, Ms. Peterson recognized that although Phase II does provide some good features, she said Phase II of the eligibility systems modernization project requires additional input and building of the state program rules and requirements. She said the contract for the project designed the roll out of Phase I to address the needs of ACA.

Mr. Neil Scharpe, North Dakota Center for Persons with Disabilities, raised concerns he has experienced as an ACA navigator in that there is a backlog in eligibility determinations. Additionally, he said, he would prefer eligibility be based on annualized income.

In response to a question from Chairman Keiser, Ms. Peterson said during the ACA open enrollment period, there has been a bit of a lag in determining eligibility due to the high volume of applicants. She said the backlog was approximately 1,300 to 1,500 applicants.

In response to a question from Representative Mitskog, Ms. Peterson said once an applicant is found eligible, eligibility is not rechecked for 12 months, unless the recipient reports a change or unless another program provides income information that indicates a change.

In response to a question from Representative Johnson, Ms. Peterson said if a recipient fails to report a change, resulting in an overpayment, repayment of any overpayment results.

Insurance Department

Chairman Keiser called on Ms. Rebecca Ternes, Deputy Commissioner, Insurance Department, to testify (Appendix J) regarding the status of implementation of ACA, open enrollment under ACA, and states' opportunities to apply for innovation waivers under ACA.

In response to a question from Representative Fehr, Ms. Ternes said it appears the Section 1332 innovation waiver has a fairly lengthy approval process by the federal government; however, the specifics of the process are not yet known. She said if the state were to pursue this waiver, the Insurance Department would not have the data necessary to do the state analysis requirement, nor would the Department of Human Services. She said pursuit of this waiver would require third-party experts.

Ms. Ternes said the federal government seems to be taking the position that its rules are in final form. She said perhaps the general nature of these rules is designed to give states room to be innovative.

Chairman Keiser said his recollection is that there is an application timeline established. He said he thinks the federal government will be flexible if the basic requirements are met. He said he thinks if the state pursues this waiver, it will likely require significant legislation and significant agency and legislative branch work. Perhaps, he said, at a future meeting a representative of a think tank might be available to address the committee regarding innovation waivers.

Health Policy Consortium

Chairman Keiser called on Mr. Dan Hannaher, Executive Director, Health Policy Consortium, to provide an update (Appendix K) of the consortium's activities in gathering data relating to the impact of ACA on hospitals in the state.

Chairman Keiser said at a future meeting he would like to receive information regarding medical bankruptcy. Mr. Hannaher said he expects Medicaid Expansion will result in a decrease in medical bankruptcies; however, with Medicaid Expansion the policyholder does have responsibility to pay copayments and other out-of-pocket expenses not covered by the program.

COMMITTEE DISCUSSION

Senator Mathern said he would like to receive testimony from public health units and universities regarding the impact of ACA. Additionally, he said, he would like to track what educational services are provided to recipients of Medicaid Expansion at the point of approval.

Chairman Keiser mentioned that although Medicaid Expansion and Medicaid should cover dental services for children, the Ronald McDonald CareMobile is still providing services to these kids.

Representative Fehr said he would like more information regarding the Section 1332 innovation waiver, to determine whether there is anything the state might gain by being granted a waiver. He said he wants to better understand whether pursuit of the waiver is worth the time and money required.

No further business appearing, Chairman Keiser adjourned the meeting at 2:35 p.m.

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Jennifer S. N. Clark
Counsel

ATTACH:11