NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH CARE REFORM REVIEW COMMITTEE

Thursday, September 14, 2017
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, Rick C. Becker, Bill Devlin, Gretchen Dobervich, Kathy Hogan, Jim Kasper, Mike Lefor, Karen M. Rohr; Senators Dick Dever, Jerry Klein, Oley Larsen, Judy Lee, Carolyn C. Nelson, Nicole Poolman

Members absent: Representative Robin Weisz; Senator Karen K. Krebsbach

Others present: See Appendix A

Chairman Keiser reviewed the information the committee received at its August 3, 2017, meeting and called on Senator Lee to review the activities of the Health Services Committee, Representative Lefor to review the activities of the Employee Benefits Programs Committee, and Representative Hogan to review the activities of the Human Services Committee. He said the study charges of the four committees are interrelated and it will be helpful to be aware of what each of the committees is doing.

Representative Hogan provided a written summary (Appendix B) of the Human Services Committee.

MANAGED CARE STUDY

Chairman Keiser called on Mr. Joe Moser, Principal, Health Management Associates, to provide an overview (Appendix C) of Medicaid managed care.

In response to a question from Representative Hogan, Mr. Moser said although managed care can be used to cover all types of special care services, it is up to the state to design the managed care model and determine what services and populations to cover through managed care.

In response to a question from Chairman Keiser, Mr. Moser said although North Dakota uses primary care case management, this model of managed care is falling out of favor, and nationwide is being phased out for other models of managed care.

In response to a question from Representative Hogan, Mr. Moser said initially it was a bit of a hardship to provide managed care in rural areas; however, the trend has changed and now more health plans are bidding to provide managed care in rural areas.

In response to a question from Chairman Keiser, Mr. Moser said nationwide, the majority of health care is provided through contracts with health plans.

In response to a question from Senator Lee, Mr. Moser said North Dakota has a unique Medicaid model for long-term care as it in effect has rate equalization for Medicaid and private pay. He said he is not prepared to address how risk-based managed care might work in this unique situation.

In response to a question from Senator Poolman, Mr. Moser said case managers for the developmental disability and early intervention populations can work for health plans; however, for these special populations, the health plan case managers typically work closely with the Medicaid waiver case managers with the goal of streamlining services and minimizing duplication of services.

In response to a question from Senator Lee, Mr. Moser said at the federal level there are ongoing discussions of repealing the institution for mental disease rules, but the fiscal impact on the federal level is a barrier to repealing these rules.

In response to a question from Representative Dobervich, Mr. Moser said once managed care is off the ground, there are few cons; however, making the change from fee-for-service to managed care is a challenge.

In response to a question from Senator Poolman, Mr. Moser said issues related to the use of pharmacy benefit managers are generally not related to a state's managed care model, but typically are related to program integrity. He said the typical managed care model provides for prescription drug coverage to be included in the managed care plan. He said inclusion of the prescription drug coverage has the benefit of allowing for data sharing between the parties. As it relates to pharmacy benefit management, he said, a state would have the choice whether to retain control of a formulary list.

In response to a question from Representative Kasper, Mr. Moser said as it relates to prescription drug coverage, states typically meet the federal requirements for credentialing; however, managed care plans typically go beyond what the states require for credentialing.

In response to a question from Chairman Keiser, Mr. Moser said the federal government has Medicaid requirements related to network adequacy.

In response to a question from Senator Nelson, Mr. Moser said access to care in a Medicaid managed care organization (MCO) ultimately is determined and defined at the state level. He said typically, Medicaid ensures people get the services they need because it would be a dereliction of duty to do something not in the best interest of those people.

In response to a question from Representative Hogan, Mr. Moser said it takes approximately 3 years for a managed care program to mature and fully recognize benefits and savings.

In response to a question from Senator Dever, Mr. Moser said there appears to be some similarities between Medicaid moving to managed care and having a health benefits plan move from a fully insured model to a self-insured model.

Chairman Keiser called on Ms. Maggie D. Anderson, Director, Medical Services Division, Department of Human Services, to provide a presentation (Appendix D) regarding North Dakota's experience and opportunities with managed care for the state's Medicaid populations, including Medicaid Expansion and the children's health insurance program (CHIP).

In response to a question from Representative Hogan, Ms. Anderson said the state's Medicaid Expansion program provides for a risk corridor. For the first 2 years, she said, the insurer received additional payments; however, for 2016 it appears the insurer will be making payments to the federal government.

In response to a question from Chairman Keiser, Ms. Anderson said the state's Medicaid Expansion program and CHIP use a full-risk MCO model with a risk corridor. She said the department's experiences in contracting for these programs may be a good staring place if managed care is expanded to other populations under the Medicaid program.

In response to a question from Representative Kasper, Ms. Anderson said under the current contract for Medicaid Expansion, providers are reimbursed at a higher level than under traditional Medicaid. She said the provider fee schedule for Medicaid Expansion more closely resembles commercial rates than Medicaid rates.

In response to a question from Chairman Keiser, Ms. Anderson said it is her understanding under the state's Medicaid Expansion program, the provider reimbursement rates vary between different providers.

In response to a question from Representative Hogan, Ms. Anderson said the state's program of all-inclusive care for the elderly (PACE) is not limited to urban communities in the state, as Dickinson and Minot are considered rural under the federal definitions.

In response to a question from Senator Lee, Ms. Anderson said challenges with PACE are related to a combination of factors, which may include workforce issues and the legislative decision to stop expansion of PACE.

In response to a question from Senator Poolman, Chairman Keiser said he thinks the Legislative Assembly manipulated the system to maximize the rates of reimbursement for Medicaid Expansion for the benefit of the providers.

Ms. Anderson said during the 2015-16 interim, the Health Care Reform Review Committee made recommendations to decrease the Medicaid Expansion reimbursement rates to be more in line with traditional Medicaid rates.

In response to a question from Representative Hogan, Ms. Anderson said she hesitates to state whether the state would save money if it placed all Medicaid populations in managed care.

In response to a question from Senator Larsen, Ms. Anderson said the state retains the option of ending participation in Medicaid Expansion.

In response to a question from Representative Hogan, Ms. Anderson said if the state expands Medicaid managed care, the department will need to review multiple existing contracts.

In response to a question from Representative Kasper, Ms. Anderson said the state already is implementing MCO models for the CHIP and Medicaid Expansion programs and is using care coordination for the general Medicaid population.

In response to a question from Representative Dobervich, Ms. Anderson said if the state is able to establish care coordination agreements with tribal health care organizations, the 2019 Legislative Assembly will need to decide how to use any money that comes back to the state. She said to incentivize tribes to participate in these agreements, it might be worth considering sending some of the money back to the tribes for health-related programs.

Chairman Keiser called on Mr. Moser to provide a presentation (Appendix E) regarding Indiana's experience in implementing Medicaid managed care.

In response to a question from Representative Lefor, Mr. Moser said states vary in how they implement transitions to managed care. He said early on, states seemed to take a phasein approach; however, the current trend is to take a single step. He said if a state pursues a phasein approach, it could be by population groups or by geographical regions of the state. He said one drawback to phasing in by geographical region is that Medicaid recipients tend to move frequently.

In response to a question from Representative Kasper, Mr. Moser said a move to managed care might not result in decreasing Department of Human Services full-time positions, but it would result in changes in job positions. He said if North Dakota pursues something like the Healthy Indiana Plan (HIP 2.0), it is possible North Dakota could do this without moving to managed care. However, he said, this move likely would require that North Dakota receive federal waivers, and it is likely the state would not recognize the same savings as Indiana.

In response to a question from Representative Rohr, Mr. Moser said under Indiana's managed care program, Medicaid recipients have appeal rights, and if these appeals are exhausted, there is a right to an administrative hearing. He said in Indiana the consumer perception has been very positive.

In response to a question from Representative Lefor, Mr. Moser said Indiana was one of the first states to implement a "skin in the game" approach. He said a condition of the federal waiver is that Indiana provide quarterly and annual evaluations.

In response to a question from Representative Dobervich, Mr. Moser said Indiana is in the process of building longitudinal data on population health. He said because this program only has been in effect for 2 years, Indiana does not have the population health data, and it may be 10 years before there is meaningful population health data.

Mr. Moser said one lesson Indiana learned in implementing managed care is it is necessary to be flexible to allow the program to evolve.

AFFORDABLE CARE ACT STUDY

Chairman Keiser called on Mr. Jon Godfread, Insurance Commissioner, to provide a report on the status of the federal Affordable Care Act (ACA). Mr. Godfread reviewed a letter (Appendix F) he sent to United States Senator Lamar Alexander, Chairman, Senate Committee on Health, Education, Labor, and Pensions.

In response to a question from Chairman Keiser, Mr. Godfread said he is not certain whether the cost-sharing deductions under ACA will be extended for the 2018 plan year.

Chairman Keiser said he expects Congress will not pursue a block-grant approach unless it limits federal costs.

Mr. Godfread said he expects these fiscal concerns may be in part why the ACA block grants are not gaining momentum in Congress.

PUBLIC EMPLOYEES HEALTH BENEFITS STUDY

Chairman Keiser called on Mr. Jeff Ubben, Deputy Insurance Commissioner, for comments (Appendix G) regarding the Insurance Department's administrative rules relating to a multiple employer welfare arrangement.

In response to a question from Senator Dever, Mr. Ubben said of the eight multiple employer welfare arrangements in the state, none are public employers.

Chairman Keiser called on Mr. Tony Piscione, Vice President of Actuarial, and Mr. Pat Bellmore, Chief Marketing Officer and Vice President of Marketing, Blue Cross Blue Shield of North Dakota, to make a presentation (Appendix H) regarding basic principles of self-insured health insurance.

Representative Kasper said if a private employer moves from a fully insured health plan to a self-insured health plan, the employer saves money by no longer having to pay premium taxes.

Mr. Bellmore said risk charges will vary from plan to plan.

In response to a question from Senator Dever, Mr. Bellmore said in 2017, the ACA premium tax was waived, but there is still uncertainty whether this tax will be waived in 2018.

In response to a question from Chairman Keiser, Mr. Bellmore said under a self-insured plan, the amount of the administrative fee depends on the size of the group--the larger the group, the less the administrative fee.

Mr. Piscione said on slide 6 of the presentation, the current Public Employees Retirement System (PERS) health benefit plan is left of the fully insured plan, due to the risk corridor.

In response to a question from Senator Dever, Mr. Bellmore said typically under a self-funded plan, the administration fee includes consultation services, such as plan design consultation. In addition to considering the administration fee, he said, it would be important to evaluate the depth of the in-state and out-of-state networks and the related discounts.

Mr. Piscione said it would be the duty of the administrator to establish and maintain these networks.

In response to a question from Chairman Keiser, Mr. Piscione said for a self-insured health benefits plan, the administrator would work with the employer to establish the appropriate funding level.

Mr. Bellmore said an employer would need to establish goals for the plan which may vary based on multiple factors, including the employer's funding capacity. Additionally, he said, generally there is greater plan flexibility with a self-funded plan than a fully insured plan.

Chairman Keiser called on the following insurer representatives to participate in a panel discussion of North Dakota insurers' experiences in self-funding in the state--Mr. Piscione and Mr. Bellmore; Mr. Andrew Marshall, Senior Director of Client Retention and Growth, Medica; and Ms. Lisa Carlson, Senior Director of Planning and Regulation, and Mr. Adam Craghead, Director of Underwriting, Sanford Health Plan.

Ms. Carlson said there is value in the committee's discussion, but it is important to recognize comparing the current PERS health benefit plan to a self-insured plan is like comparing apples to oranges. She said under a self-insured plan the employer takes all the risk, under the current plan PERS shares in profit but not the risk, and there is a big difference in cashflow demands.

Mr. Craghead said as it relates to taxes and fees, under its current plan, PERS does not pay premium taxes, so this does not factor into savings in changing to self insurance.

Mr. Marshall said very large employers, such as PERS, often offer multiple or dual offerings to their employees.

Mr. Bellmore said an employer's interest in what type of insurance model to use is related to more than administration costs. He said employers seek value and high level of care. Additionally, he said, moving to a self-insured plan would increase competition in the PERS bidding process.

In response to a question from Senator Larsen, Ms. Carlson said she is not aware of any of Sanford Health Plan's clients paying 100 percent of the premium for a family plan.

Chairman Keiser raised the hypothetical of bidding on a PERS hybrid plan versus a fully insured plan. Mr. Marshall, Mr. Craghead, and Mr. Piscione said they expect the premium would be higher for a hybrid plan under which the insurer would share profits and each of the insurers have stop-loss coverage. Ms. Carlson said the spirit of competition drives the lowest price and bids reflect commitments to a partnership with the state.

Chairman Keiser called on Mr. Sparb Collins, Executive Director, Ms. Rebecca Fricke, Wellness Coordinator, and Ms. Sharon Schiermeister, Chief Operating Officer and Finance Manager, Public Employees Retirement System, for a presentation (Appendix I) regarding the statutory requirements for the provision of health benefits for state employees, including how the state could implement a self-funded insurance plan for health benefits for state employees, the impact of ACA on the provision of health benefits for state employees, and the status of health insurance reserve funds.

In response to a question from Chairman Keiser, Mr. Collins said the contract for health benefits coverage is a 2-year contract with two additional 2-year renewal options.

In response to a question from Representative Kasper, Mr. Collins said the law allows PERS discretion in setting the amount of stop-loss insurance.

In response to a question from Chairman Keiser, Mr. Collins said when PERS compares bids for a fully insured plan and self-insured plan, PERS considers the impact of the insurance reserve requirements.

Chairman Keiser said as the committee and the Legislative Assembly move forward it will be important to recognize PERS is using insurance reserve funds to buy down the premium for the 2017-19 biennium.

In response to a question from Senator Klein, Ms. Fricke said ACA provides an employee's share of a change to a grandfathered health plan may not exceed 5 percent, or the plan will lose its grandfathered status.

In response to a question from Chairman Keiser, Ms. Fricke said if the PERS plan loses grandfathered status, the plan will have enhanced benefits for the employer, and the employer will experience a cost increase of approximately 3 percent.

No further business appearing, Chairman Keiser adjourned the meeting at 4:20 p.m.

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Jennifer S. N. Clark
Counsel

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