North Dakota Legislative Council
Prepared for the Health Care Committee
LC# 23.9023.01000
August 2021

HEALTH INSURANCE NETWORK STUDY - BACKGROUND MEMORANDUM

INTRODUCTION

Section 3 of House Bill No. 1465 (2021) directs the Legislative Management to study health insurance networks, including narrow networks. The study must include:

- Consideration of the use and regulation of broad and narrow networks in the state by individuals and employers, the sales and marketing of broad and narrow networks, opportunities for consumer choice-of-provider, and premium differentials among states with choice-of-provider laws;
- A review of legislative and court history regarding the impact of choice-of-provider laws on exclusive provider organizations and preferred provider organizations and how choice-of-provider laws apply to risk-pooled health plans regulated by the federal Employee Retirement Income Security Act of 1974 (ERISA);
- The impact of the consolidation of the health care market on consumer cash prices, insurance plan deductibles and premiums prices, and consumer options;
- A comparison of health maintenance organizations (HMOs) provider network designs and other health insurer provider network designs;
- A review of how vertical integrated networks utilize HMO plans; and
- A comparison of premiums of health benefit plans offered in the individual and small group markets in relation to the provider network design associated with those plans along with the growth of value-based purchasing.

BACKGROUND

As introduced, House Bill No. 1465 would have created an any willing provider (AWP) provision for health insurance policies, providing an insurer's policy may not deny a health care provider the right to participate as a participating provider for any policy on the same terms as conditions as are offered to any other provider of health care services under the policy. As amended in Conference Committee, the bill was hoghoused to provide for this study.

Generally, North Dakota health insurers are either organized as a preferred provider organization (PPO) or an HMO. Medica Health Plan and Sanford Health Plan are organized as HMOs, and Blue Cross Blue Shield of North Dakota, United Healthcare, and Medica are organized as PPOs. The type of entity--HMO or PPO--dictates what type of health plan the health insurance company can issue in the state. An HMO can issue both HMO and PPO plans, whereas a PPO can issue a PPO plan or exclusive provider organization (EPO) plan. In North Dakota a PPO has limitations on issuing EPO plans. A primary difference between HMO, PPO, and EPO plans is the treatment of out-of-network coverage.

	HMO	PPO	EPO
Out-of-network coverage	For medical emergencies only	Yes, at a higher cost	For medical emergencies only

Broad and Narrow Networks

Generally, health insurers may define and adjust the number, the qualifications, and the quality of providers in the insurer's network. In an effort to provide greater consumer value through lower premiums, a health insurer may sell a "narrow network" health plan that covers fewer providers, such as an HMO or EPO. Typically, providers negotiate rebated reimbursement rates with the expectation of higher volume due to the narrow network. Additionally, the narrower network may facilitate coordination of care.

In addition, network adequacy requirements, which refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network providers, may limit an insurer's ability to issue

narrow network plans. The federal Affordable Care Act (ACA) included many reforms intended to make health care more affordable and accessible, including network adequacy standards for qualified health plans sold on the exchange. For example, under North Dakota Century Code Section 26.1-47-03(1)(d), PPO organization health plans must offer health care services within a 50-mile radius of a covered person's residence. This section, in effect, has made EPO plans unfeasible in this state.

The National Association of Insurance Commissioners (NAIC) reports the insurance industry trend toward narrow network health plans caught the attention of state insurance regulators, and in 2015 the NAIC revised its model language for network adequacy. North Dakota has not enacted this NAIC model language.

Employee Retirement Income Security Act of 1974 Plans

The federal Employee Retirement Income Security Act of 1974 is a federal law that establishes minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans. There are two types of ERISA health plans--the "self-funded" or "self-insured" plan, and the "fully insured" or "unfunded" plan. If a plan is self-funded, the employer pays the benefits directly through the employer's general assets or through a trust fund established for that purpose. If a plan is fully insured, the employer does not pay the benefits, but instead, the employer purchases an insurance policy, and an insurance company recognizes any profit or pays the losses. A health plan that falls completely outside the scope of ERISA, or that is otherwise excluded from ERISA coverage, is considered a non-ERISA plan, such as a government or church plan.

Although ERISA provides for federal preemption under 29 U.S.C. 1144(a), which provides all state law is preempted to the extent the state law "relates to employee benefit plans," ERISA also provides for a savings clause under 29 U.S.C. 1144(b)(2)(A), which provides the savings clauses saves from preemption state laws that "regulate insurance." Additionally, ERISA's deemer clause, 29 U.S.C. 1144(b)(2)(B), prevents states from opting out of federal preemption of employee benefit law by deeming self-funded plans to be subject to the state law for purposes of the savings clause. The deemer clause essentially creates a distinction between self-funded and fully insured ERISA plans, providing a state cannot deem a self-funded ERISA plan an insurance company and thereby regulate the plan.

Although the ERISA preemption provision limits the ability of states to regulate ERISA health plans, multiple states have enacted AWP laws that appear to meet the ERISA preemption standard for fully-funded ERISA health plans. For example, by initiated measure in 2014, South Dakota enacted South Dakota Codified Laws Section 58-17J-2, which provides:

> **Patient choice--Health care provider participation.** No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

Consumer Prices and Options

Insurers market narrow network health plans as coordinated care at a reduced premium. Some narrow network plans do not require referrals when care is provided within the designated health care system. Some narrow network plans claim the plans can decrease long-term health care costs by encouraging the development of relationships with primary care providers. Additionally, some narrow network plans offer additional benefits, such as case management, for insureds at risk for chronic health conditions.

Health Maintenance Organization Plans

An HMO plan is a type of managed care insurance plan with a narrow network. North Dakota Century Code Chapter 26.1-18.1 is the primary law regulating HMO organizations and HMO plans in this state. The North Dakota Insurance Department states:

> [A]n HMO provides health services through a network of doctors, hospitals, laboratories, etc. The health care providers may either be HMO employees or have some other contract arrangement with the HMO. HMO plans pay providers a monthly set amount (a capitation fee) regardless of the number of services performed. When you enroll in an HMO, you choose one of the doctors as your primary care physician (PCP) to manage all of your health care. Whenever you need health care, you first consult your PCP. Your PCP may refer you to an HMO-approved specialist.

Vertical Integrated Network Utilization of Health Maintenance Organization Plans

An HMO plan network may be vertically integrated, through common ownership, or may be virtually integrated, through contractual networks. According to the Insurance Department, Sanford Health Plan, organized as an HMO, primarily uses vertical integration through common ownership for its narrow network for its HMO plans, whereas Medica Health Plan, also organized as an HMO, uses virtual integration through contractual networks for its narrow network for its HMO plans.

Premiums and Value-Based Purchasing

In a broad sense, value-based purchasing (VBP) is the linking of health care provider payments to improved performance by the health care provider. The primary purpose of VBP is to hold health care providers accountable for both the cost and the quality of care provided. Benefits recognized by patients might include reduced costs, increased patient satisfaction, a reduction in medical errors, and the promotion of healthy habits.

Under the umbrella of VBP, there are multiple reimbursement models, including pay-for-performance, under which providers typically are reimbursed for services using a fee-for-service structure, but providers also can qualify for value-based incentive payments or penalties based on quality and cost performance; shared savings arrangements, under which a provider is reimbursed under a fee-for-service model, but if a provider can reduce health care spending below an established benchmark set by the payer, the provider can retain a portion of the savings produced; and capitation payments, under which the provider takes on full financial risk for care quality and health care spending.

An HMO plan is designed based on capitated payments. A 1996 *Health Affairs* article discussed the differences between fee-for-service payments and capitated payments:

> Under retrospective fee-for-service payment, every component of the health care delivery system is both a cost center and a revenue center. Services are reimbursed a la carte, with more cost bringing in more revenue. The profit centers are those services and facilities that can price highest above cost; historically, this glory has accrued to specialist physicians and acute care hospitals. Under prospective capitation payment, however, every component of the delivery system is a cost center and none a revenue center. Revenues are received on a monthly per capita basis regardless of the level of services used. The profitability of the health care provider organization now depends on its ability to win contracts from HMOs, to attract patients, and to manage care so that expenditures are held below the capitated payment rate. All three of these objectives require that the organization have an adequate number of primary care physicians and that these physicians cooperate in managing the costs and the quality of care.

STUDY APPROACH

In conducting this study, the committee may wish to consult with:

- The Insurance Department;
- Health insurance carriers in the state;
- Health care providers; and
- Health insurance consumers.