NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH CARE REFORM REVIEW COMMITTEE

Thursday, February 1, 2018
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, Gretchen Dobervich, Kathy Hogan, Mike Lefor, Robin Weisz; Senators Dick Dever, Jerry Klein, Oley Larsen, Carolyn C. Nelson, Nicole Poolman

Members absent: Representatives Rick C. Becker, Bill Devlin, Jim Kasper, Karen M. Rohr; Senators Karen K. Krebsbach, Judy Lee

Others present: See Appendix A

It was moved by Senator Nelson, seconded by Senator Larsen, and carried on a voice vote that the minutes of the November 30, 2017, meeting be approved as distributed.

PUBLIC EMPLOYEES RETIREMENT SYSTEM

Chairman Keiser called on representatives of health insurers to participate in a panel discussion regarding potential revisions to North Dakota Century Code relating to the Public Employees Retirement System (PERS) provision of health benefits for state employees. The panel based its discussion on the presentation (Appendix B) given by the Executive Director of PERS at the committee meeting on September 14, 2017. Mr. Pat Bellmore, Chief Marketing Officer, Blue Cross Blue Shield of North Dakota; Ms. Lisa Carlson, Senior Director of Market Strategy, Sanford Health Plan; and Mr. Jim Wynstra, Senior Director of Actuarial Services, Sanford Health Plan, participated on the panel.

Mr. Bellmore said the statutory provisions regarding the request for proposal bidding process does not require any amendments.

Ms. Carlson said in the private marketplace it is common to unbundle prescription drug coverage from the health benefits coverage. Additionally, she said, it is common to require sharing of data between carriers if the coverage is unbundled. She said if a carrier provides both a bundled and an unbundled bid, the carrier tends to be more aggressive on the bundled bid.

Mr. Bellmore said bundled plans tend to be more common and it is likely the bid presentation would address the pros and cons of bundling versus unbundling.

In response to a question from Representative Hogan, Ms. Sharon Schiermeister, Interim Director, Public Employees Retirement System, said the receipt of unbundled bids is relatively new for PERS. She said the most recent bid was the first time PERS received both bundled and unbundled bids.

Mr. Bellmore said the statutory language in Section 54-52.1-05(4) regarding bid renewals which references the "board's expectations" seems ambiguous and could be clarified by using language such as actuarial adequacy and sustainability.

Ms. Carlson said for a self-insurance plan, it is common to tie performance guarantees to contract renewal, which would be included in the terms and conditions of the contract. She said in practice this performance review occurs today even though it is not codified. Additionally, she said, it would be beneficial to have contract terms longer than 2 years.

Mr. Wynstra said it is difficult to legislate something that requires judgment, and no change is necessary in the contract renewal law.

Senator Dever said last time the PERS Board renewed the health benefits contract, the board considered member satisfaction surveys as well as whether the proposed premium increase was in line with the market. He said the statute implies the board is required to renew the contract unless a specific reason in support of nonrenewal is articulated.

Ms. Carlson said typically in bid renewals, it is common to have score cards and it is common for an employer to state the reason for nonrenewal. In practice, she said, it likely is not feasible for a party to the contract to terminate 60 to 90 days in advance because it would take PERS longer than this to transition to a new carrier.

In response to a question from Representative Lefor, Ms. Schiermeister said in the contract renewal process the data the board reviews is concrete, and if expectations are not being met under the contract, PERS will have issued an action plan to address the unmet expectations.

In response to a question from Chairman Keiser, Ms. Schiermeister said she will provide the most recent 2 quarters of the executive report.

In response to a question from Representative Lefor, Ms. Carlson said although benchmarks typically do not factor into plan design, plan design should be considered when evaluating the scores.

Mr. Bellmore said the bid timeline in Section 54-52.1-04, which requires solicitations be made at least 90 days before the expiration of an existing contract, would not work in practice. For the PERS health benefit coverage, he said, the solicitation needs to be made months in advance of the expiration of the existing contract.

Ms. Carlson said in practice, PERS issues solicitations well in advance of the contract expiration. In addition, she said, the June 30 contract expiration date for the health benefits contract is unique in that the plan year actually begins on January 1.

Ms. Schiermeister said Section 54-52.1-04 applies to multiple uniform group insurance plans and not just the health benefits plan. She said for the smaller plans, such as dental and vision, less time is required than for the hospital and medical benefits plan.

Mr. Bellmore said the bid solicitation timelines for the fully insured and the self-insured plans should be consistent. In addition, he said, rate and reserve adequacy should be part of the stop-loss discussion.

Mr. Wynstra said although the law allowing for a self-insurance plan requires stop-loss insurance, it does not specify the amount. He says it is reasonable to not legislate the amount and allow PERS to address this based on the market and circumstances.

Ms. Carlson said the factors the board considers in determining whether to fully insure or to self-fund is a policy decision; however, it should be clear what factors the board would need to consider in comparing the costs of the plans.

Mr. Bellmore said it might be helpful to give the board more flexibility in determining whether to fully insure or self-insure, to allow the board to consider long-term goals and benefits.

Mr. Wynstra and Mr. Bellmore said the statutory reserve requirements of 1.5 to 3 months under Section 54-52.1-04.3 seem reasonable.

Mr. Wynstra provided written testimony (Appendix C) regarding reserve adequacy. He said from a carrier perspective it is desirable to have costs as close to actual as possible.

Mr. Bellmore said if reserves become too large and excess is used in future pricing, there could be future risks of underfunding.

Chairman Keiser called on Mr. Jeffrey Ubben, Deputy Commissioner, Insurance Department, for a presentation (Appendix D) regarding proposed statutory revisions to Century Code regarding the duties of the Insurance Commissioner to regulate health benefits for state employees.

Mr. Ubben said the bill draft clarifies the Insurance Department regulates a PERS fully insured health plan just as it would a self-insured plan. Under current law, he said, the regulatory authority of the department to regulate a PERS self-insured plan lacks clarity. Without this bill, he said, the PERS self-insurance plan would lack several health mandates included in the fully insured plan and there would be fewer consumer protections.

Chairman Keiser called on Ms. Schiermeister for a presentation (Appendix E) regarding the status of the PERS survey of how other states provide and regulate health benefits for state employees and regarding proposed legislation PERS may introduce during the 2019 legislative session.

In response to a question from Senator Larsen, Ms. Schiermeister said the survey did not ask whether the state had an employer contribution. She said she can gather additional information on this for a future meeting.

AFFORDABLE CARE ACT STUDY

Chairman Keiser called on Mr. Jon Godfread, Insurance Commissioner, for a presentation (Appendix F) regarding the status of the federal Affordable Care Act and related federal legislation.

In response to a question from Chairman Keiser, Mr. Godfread said as it relates to association health plans (AHPs), the primary issue seems to be determining which state would regulate the AHP. He said states are awaiting these details from the federal government. He said there is a risk of a "race to the bottom" by the AHP looking to domicile in a state with few regulations. This, he said, is the risk of sale of insurance across state lines. He said although the goal of AHPs is to increase access to insurance, they may negatively impact North Dakota insurance companies.

Chairman Keiser called on Mr. Erik Elkins, Assistant Director, Medical Services Division, Department of Human Services, for comments regarding the status of federal legislation relating to public benefit programs, such as the federal children's health insurance program (CHIP). Mr. Elkins said CHIP was reauthorized on January 22, 2018.

MANAGED CARE STUDY

Chairman Keiser called on Ms. Maggie D. Anderson, Director, Medical Services Division, Department of Human Services, for a presentation (Appendix G) regarding Department of Human Services contract timelines and how the timelines may intersect if the state moves to providing Medicaid through a contract for managed care services.

In response to a question from Representative Hogan, Ms. Anderson said it is not possible to purchase a fully functioning Medicaid management information system (MMIS) product from another state. She said when states replace information technology, the systems tend to be modular and not be a full replacement all at once. She said without knowing the details of a proposed change to managed care, she would not expect MMIS or staff savings. She said without knowing the managed care model, it is impossible to anticipate how managed care might affect the department; however, it is possible the costs would not be less for the department, just different.

In response to a question from Chairman Keiser, Ms. Anderson said MMIS would be the same regardless of whether the state implements managed care; however, how the system would be used would differ and maintenance of effort would differ.

Chairman Keiser called on Mr. Darrold Bertsch, Chief Executive Officer, and Dr. Aaron Garman, MD, Sakakawea Medical Center; Ms. Jody Link, Director of Policy and Communications, and Ms. Shelly Ten Napel, Chief Executive Officer, Community HealthCare Association of the Dakotas; and Ms. Mara Jiran, Chief Executive Officer, and Ms. Robin Landwehr, Licensed Professional Clinical Counselor, Valley Community Health Centers, for comments (Appendix H) regarding the rural hospital and federally qualified health center perspectives relating to managed care.

In response to a question from Representative Hogan, Mr. Bertsch said he does not have formal relationships or care coordination agreements with the tribes.

In response to a question from Chairman Keiser, Mr. Bertsch said his system is a managed care model, and it has improved quality and cost.

Chairman Keiser called on Mr. David Molmen, Chief Executive Officer, Altru Health System, representing tertiary hospitals in the state, for a presentation (Appendix I) regarding an urban model concept of providing managed care for the state's Medicaid population. Mr. Molmen said executives from Trinity Health; Essentia Health; Sanford Health, Fargo; Sanford Health, Bismarck; and CHI St. Alexius Health, Bismarck, also are present at the meeting.

In response to a question from Representative Hogan, Mr. Molmen said he sees a lot of managed care moving toward North Dakota from the east. He said managed care in Minnesota utilizes multiple models.

Chairman Keiser called on Dr. Benjamin Chaska, MD, CHI Fargo Division CMO and Physician Enterprise Executive, Catholic Health Initiatives, for comments (Appendix J) regarding his experiences with managed care.

Chairman Keiser called on Ms. Cheryl Rising, Legislative Liaison, North Dakota Nurse Practitioners Association, for comments (Appendix K) regarding managed care in the nursing profession.

Chairman Keiser called on Mr. William R. Sherwin, Executive Director, North Dakota Dental Association, for comments (Appendix L) regarding managed care in the practice of dentistry.

Chairman Keiser said within the Medicaid population, there are access issues because some dentists will not take Medicaid patients. He said the committee is looking for access solutions.

Mr. Sherwin said there are access issues dentists are working to address.

Chairman Keiser the six tertiary hospitals for working together to help the committee in its study of Managed Care and thanked Mr. Jerry Jurena, President, North Dakota Hospital Association, and Ms. Courtney Koebele, Executive Director, North Dakota Medical Association, as well as the allied health professionals in helping the committee move forward on this study.

Representative Dobervich said she is interested in community-based care. She said she would like to receive additional information at a future meeting on how North Dakota might use these providers.

No further business appearing, Chairman Keiser adjourned the meeting at 3:55 p.m.

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Jennifer S. N. Clark
Counsel

ATTACH:12