

NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH CARE REFORM REVIEW COMMITTEE

Wednesday, August 22, 2018
Coteau AB 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, Bill Devlin, Kathy Hogan, Jim Kasper, Mike Lefor, Karen M. Rohr; Senators Dick Dever, Jerry Klein, Oley Larsen, Judy Lee, Carolyn C. Nelson

Members absent: Representatives Rick C. Becker, Gretchen Dobervich, Robin Weisz; Senators Karen K. Krebsbach, Nicole Poolman

Others present: See [Appendix A](#)

PUBLIC EMPLOYEES HEALTH BENEFIT PLAN STUDY

Chairman Keiser called on the Legislative Council staff to review a bill draft [[19.0148.03000](#)] relating to the requirements and regulation of a self-insurance health plan for state employee health benefits.

In response to a question from Representative Kasper, the Legislative Council staff said Section 1 of the bill draft directs the Insurance Department to adopt rules setting reserve requirements and Section 7 addresses a Bank of North Dakota line of credit. She said it was a drafting oversight not to provide the maximum line of credit is \$50 million.

In response to a question from Representative Kasper, Chairman Keiser said determining whether to decrease health benefits is a policy decision for the Legislative Assembly. He said the bill draft provides the health benefit requirements for a self-insurance health plan would be the same as for a contract for insurance.

Senator Lee said it would be a significant change for the state to transition from a contract for insurance to a self-insurance health plan and it would be an even more significant change to decrease health benefits as well. She said if health benefits are decreased, this bill draft may not move forward.

Chairman Keiser called on Mr. Jeff Ubben, Deputy Commissioner, Insurance Department, for comments regarding the bill draft. Mr. Ubben said any rules adopted as a result of this bill draft likely would clarify whether and how much of the self-insurance health plan's line of credit could qualify as the required reserves. He said if this bill draft is enacted during the 2019 legislative session, the Insurance Commissioner would need to act quickly to have rules in place in time for the Public Employees Retirement System (PERS) to transition to a self-insurance health plan effective July 1, 2019, because the rules would not qualify for emergency rulemaking.

In response to a question from Chairman Keiser, Mr. Ubben said the bill draft provides for a fair, balanced regulatory approach of self-insurance health plans.

Chairman Keiser called on Mr. Scott Miller, Executive Director, Public Employees Retirement System, for comments regarding the bill draft. Mr. Miller said he is reasonably comfortable with the bill draft. He said PERS anticipates having approximately \$25 million in its reserve account going into the 2019 legislative session. He said suggested changes include on page 1, line 22, changing "and" to "or", and page 7, line 11, adding "and rules adopted under chapter 26.1-36.6."

In response to a question from Representative Lefor, Mr. Miller said he is comfortable with the reserve fund requirement language in the bill draft.

In response to a question from Senator Larsen, Mr. Miller said neither current law nor the bill draft authorize PERS to provide health benefits through a plan with another state. He said although generally more is better in the context of group insurance plans, PERS has not considered joining a compact with another state. He said establishing a compact with another state would take a long time to implement.

Senator Lee said if PERS entered a compact with another state, the result may be the state losing control of the health plan.

Representative Kasper said the topic of state compacts is a different topic than self-insurance.

In response to a question from Senator Dever, Chairman Keiser said although the law allows PERS to transition to a self-insurance health plan, that law is so constraining that in practice, it is unlikely the state would move to a self-insurance health plan.

Mr. Ubben said if this bill draft is not enacted, the state will have a mix of laws with grey areas and conflicts regarding regulation of self-insurance health plans. He said this bill draft clarifies the law and regulation of these plans.

The Legislative Council staff said if the committee approves and recommends the bill draft to the Legislative Management, she will notify the Employee Benefits Programs Committee because the bill draft likely impacts the PERS system.

MEDICAID MANAGED CARE AND AFFORDABLE CARE ACT STUDIES

Work Group

Chairman Keiser called on Ms. Cristal Thomas Gary, Principal, Leavitt Partners, for testimony ([Appendix B](#)) regarding the status of the activities of the North Dakotans for the Advancement of Care Medicaid Work Group.

Chairman Keiser said there appears to be a shift from hospitals establishing a managed care program to the Department of Human Services (DHS) establishing a managed care program. He said this shift seems contrary to the initial position that hospitals wanted to design a plan. He said this seems "more process than outcome."

Ms. Gary said the hospitals recognize DHS's need to have a role in designing a managed care program and the hospitals need to be active participants.

In response to a question from Representative Kasper, Ms. Gary said an accountable care organization (ACO) model has several goals, one of which is decreasing the cost of care. She said Leavitt Partners has worked with several states with ACOs and the degree of cost-savings varies from state to state.

In response to a question from Representative Hogan, Ms. Gary said the work group is at the front end of the project and nothing has been taken off the table. She said it will be important to include providers in the discussions and to evaluate different Medicaid populations.

Chairman Keiser called on Ms. Mylynn K. Tufte, State Health Officer, State Department of Health, for comments regarding the activities of the work group. Ms. Tufte said she encourages the work group and DHS to review how Oregon has utilized coordinated care organizations, as community health partnerships can be opportunities upon which to build.

Department of Human Services

Chairman Keiser called on Mr. Christopher D. Jones, Executive Director, Department of Human Services, for testimony ([Appendix C](#)) regarding the relationship of managed care to Medicaid and DHS's operations.

In response to a question from Representative Hogan regarding page 9 of [Appendix C](#), Mr. Jones said although a combination of factors account for North Dakota's low percentage of its population on Medicaid, the largest factor likely is North Dakota has some of the most stringent qualifying standards.

In response to a question from Senator Lee, Mr. Jones said rate equalization for long-term care impacts the state's spending.

Chairman Keiser said North Dakota's Medicaid Expansion rates are significantly higher than the state's traditional Medicaid rates.

Insurance Department

Chairman Keiser called on Mr. Jon Godfread, Insurance Commissioner, for testimony ([Appendix D](#)) regarding the status of the federal Affordable Care Act, alternative health plans such as association health plans and short-term, limited duration health plans, and state regulation of managed care organizations.

In response to a question from Senator Lee, Mr. Godfread said faith-based health plans generally fall outside the regulation of the Insurance Department. He said he shares some of Senator Lee's concerns regarding these plans, and the Insurance Department is monitoring as to whether the plans enter the state.

In response to a question from Chairman Keiser, Mr. Godfread said the state's multiple employer welfare arrangement (MEWA) rules are designed to ensure claims can be paid, regardless of the number of people in the plan. He said it is important to make certain the reserve requirements are not too low, resulting in claims not being paid if a plan fails. He said because association health plans (AHPs), such as MEWAs, fall outside the state's guarantee association, adequate reserve requirements are especially important.

Chairman Keiser called on Mr. Matt Fisher, Insurance Department, to testimony regarding the MEWA reserve requirements. Mr. Fisher said the state's MEWA reserve requirements are based on reasonableness, which takes into account group size as well as experience and actuarial analysis.

Mr. Godfread said the state is being cautious in the MEWA/AHP market, but at the same time recognizing this is a market in which risky health coverage may be better than no health coverage.

Chairman Keiser said based on the experience of long-term care insurance companies defaulting, it clearly is the consumer who ultimately pays.

In response to a question from Representative Kasper, Mr. Godfread said it likely would require legislation to require short-term limited duration plans cover pre-existing conditions.

Managed Care Organizations - Introductions

Chairman Keiser said the committee reached out to several insurers that provide managed care services and the following six insurers expressed an interest in providing the committee with information regarding their managed care philosophy and how these different insurers might operate as managed care organizations (MCOs) to provide managed care for the state's Medicaid population--Aetna, Blue Cross Blue Shield of North Dakota, Medica, Meridian Health Plan, Sanford Health Plan, and WellCare Health Plans. He called on each MCO to briefly introduce itself.

Aetna

Mr. Russell Harper, Aetna, said Aetna is an international company of more than 46,000 employees based in Hartford, Connecticut with an office in Bismarck. He said Aetna covers more than 22 million medical members, providing health, dental, and prescription drug plans. He said Aetna has moved to a person-centered model, with a proactive instead of reactive product, including a move to supporting healthier lifestyles by equipping members with the tools they need to be healthier.

Blue Cross Blue Shield of North Dakota

Mr. Roger Stinton, Blue Cross Blue Shield of North Dakota, provided an introduction to the company ([Appendix E](#)).

Medica

Mr. Tom Lindquist, Medica, provided an introduction to the company ([Appendix F](#)). He summarized the four primary focuses--experience, local focus, collaboration, and tailored programs to serve different needs of different populations.

Meridian Health Plan

Mr. Christopher Van Antwerp, Meridian Health Plan, provided an introduction to the company ([Appendix G](#)).

In response to a question from Representative Kasper, Mr. Van Antwerp said Meridian's pharmacy benefits manager plan is offered as a stand-alone plan available to self-insurance plans, as well as a fully integrated plan.

Senator Lee said she prefers a consumer-focused model over a provider-focused model.

Mr. Van Antwerp said Meridian Health Plan's beneficiaries choose to stay with Meridian, which reflects the strong partnerships the beneficiaries have with their providers.

Sanford Health Plan

Ms. Lisa Carlson, Sanford Health Plan, provided an introduction to the company ([Appendix H](#)).

WellCare Health Plans

Ms. Elizabeth Gianini, WellCare Health Plans, introduced the representatives present--Ms. Stephanie Davis, Ms. Lauralie Rubel, Dr. Pamme Taylor, Dr. Marketa Wills, Mr. Michael Edmondson, and Ms. Shoshana Sayers. Ms. Davis provided an introduction to the company ([Appendix I](#)).

Managed Care Organizations - Information

Chairman Keiser said, at the committee's request, DHS developed the document "Managed Care Organization Approach and Philosophy Questions" for which each of the MCOs could respond. He said each of the six MCOs submitted written responses ([Appendix J](#)) in advance of the committee meeting. The following six topics were addressed in the questionnaire:

- Overview, standard versus tailored plans;
- Enrollment;
- Benefits;
- Provider contracting;
- Access; and
- Social determinants of health.

Chairman Keiser invited each of the MCOs to participate in a panel discussion to review and supplement the written responses to the six questions. He invited Mr. Jones and Ms. Stephanie Waloch, Department of Human Services, to sit with the committee and participate during the panel discussion. The committee reviewed each of the questions in order, giving each MCO an opportunity to testify before addressing the next question.

The following MCO representatives participated in the panel discussion:

- Aetna--Mr. Harper;
- Blue Cross Blue Shield of North Dakota--Mr. Stinton and Ms. Regina Vercilla;
- Medica--Mr. Lindquist and Ms. Chris Reiten;
- Meridian Health Plan--Mr. Van Antwerp and Ms. Renee Miskimmin;
- Sanford Health Plan--Ms. Carlson, Mr. Don Schott, and Dr. Timothy Donelan; and
- WellCare Health Plans--Ms. Davis, Ms. Rubel, Dr. Wills, and Dr. Taylor.

Overview

The panelists responded to the following question:

Managed care organizations will be required to meet minimum standards set by DHS but also will be given sufficient flexibility to innovate to improve quality and efficiency of care. Managed care organizations will be responsible for establishing and maintaining an adequate network of providers to meet the health care needs of their beneficiaries by contracting with a diverse range of providers and establishing provider payment rates. Managed care organizations will be encouraged to participate in both Medicaid and the commercial marketplace. The Department of Human Services seeks to contract only with MCOs that offer a statewide offering.

Statewide plans must be licensed by the Insurance Department and will be subject to the department's solvency standards and financial oversight. Requirements include, but are not limited to, Medicaid managed care payment requirements, network adequacy requirements, program integrity requirements, grievances and appeals rules, cost-sharing limitations, accreditation requirements, and marketing restrictions.

The Department of Human Services intends to permit MCOs to develop and offer two types of products--standard plans and tailored plans.

Standard plans are proposed to serve most Medicaid and Medicaid Expansion enrollees, including adults and children. They will provide integrated physical health and behavioral health services at the launch of North Dakota's Medicaid managed care program.

Tailored plans are proposed to be specifically designed to serve special populations with unique health care needs. Examples could include a behavioral health and intellectual/developmental disability tailored plan; dually eligible for Medicare and Medicaid, etc.

The Department of Human Services is interested in suggested tailored plans given North Dakota's demographics and geography.

Most Medicaid and Medicaid Expansion will be mandatorily enrolled in MCOs, although not simultaneously. There may be limited exceptions to mandatory enrollment for certain populations who may be better served outside of Medicaid managed care. These populations may be either exempt, meaning that they may choose to enroll in either fee-for-service or Medicaid managed care, or excluded, meaning they must remain enrolled in fee-for-service. The Department of Human Services is interested in which populations should be exempt.

The transition of high-need populations to Medicaid managed care requires special care and planning to ensure that provider relationships and care regimens transition smoothly. The Department of Human Services believes that certain targeted populations with complex health care needs should be allowed more time to make the transition to Medicaid managed care. This would mean phasing in mandatory enrollment of some vulnerable populations after the Medicaid managed care program is fully established. During the transition period, to avoid care disruption, special populations will continue to have access to their existing provider networks. The Department of Human Services is interested in suggested approaches to phasing in high-need vulnerable populations.

The topics discussed by panelists and committee members included standard versus tailored plans; how to transition to managed care; whether to phase-in coverage of various population groups; whether to implement managed care statewide or phase-in based on region; how to address provider and patient disruption during a transition to managed care; how managed care might affect various special needs population groups; how managed care works with the Native American population; and how managed care addresses reimbursement and appeals.

Enrollment

The panelists responded to the following question:

A simple, streamlined eligibility and enrollment process, one that ensures a timely and accurate determination of Medicaid is critical for Medicaid and Medicaid Expansion applicants and their families. The Department of Human Services' goal is to reduce the administrative burden of enrolling into an MCO, provide beneficiaries with the tools and resources to make a well-informed choice, and particularly to ensure beneficiaries have up-to-date and accurate information about MCOs' provider networks. As managed care launches, DHS may contract with an enrollment broker to provide educational materials and support beneficiary enrollment into MCOs.

1. How can DHS and the enrollment broker help beneficiaries understand and make educated choices when selecting an MCO that will meet their needs?
2. What special considerations should DHS be aware of with respect to supporting enrollment for:
 - a. Medicaid beneficiaries with qualifying behavioral health and intellectual/developmental disabilities diagnoses who are eligible for the behavioral health intellectual/developmental disability tailored plans;
 - b. Foster care children;
 - c. Newborns;
 - d. Members of federally recognized tribes (for those who elect to enroll);
 - e. Individuals accessing state plan long-term services and supports?

The topics discussed by panelists and committee members included the use of enrollment brokers; that enrollment brokers may not be necessary if there is a single MCO; distinguishing between enrollment and eligibility; and enrollment by providers.

Ms. Waloch said until recently, federal regulations required states to have at least two MCOs; however, a recent change in the regulations allows North Dakota to have a single MCO.

Benefits

The panelists responded to the following question:

For which services, or categories of services, should MCOs be permitted to develop their own clinical policies? For which services, or categories of services, should MCOs be required to follow existing DHS

clinical policies? Describe the operational, financial, or clinical benefits and issues that allowing MCOs to create their own clinical policies would present. How will MCOs gauge beneficiary and provider satisfaction?

The topics discussed by panelists and committee members included assessing the population needs; population health strategies; case management; and population health tools.

Provider Contracting

The panelists responded to the following question:

At what level should risk be held and can risk be shared differently across providers and across the state? What are some of the contracting constructs that will be used with providers? If you have provider contracts today, do you intend to keep, or will you need to recontract? What is the approximate time frame to have providers contracted across the state?

To protect against anticompetitive behavior, DHS may prohibit exclusivity provisions in contracts between MCOs and providers and require that providers that partially own or control an MCO to negotiate with rival MCOs in "good faith."

1. Generally, how should DHS define "good faith" related to contracting negotiations between MCOs and providers?
2. How can DHS ensure that providers who partially own or control an MCO negotiate acceptable contract rates or terms in "good faith" with MCO competitors?

The topics discussed by panelists and committee members included how to bend the cost curve; how to decrease hospital admissions and unnecessary care; long-term care and rate equalization; paying for outcomes instead of fee for services; the impact managed care might have on critical access hospitals; cost shifting; and contracting with specific providers, such as prospective payment system hospitals, skilled nursing facilities, provider clinics, critical access hospitals, and developmental disability providers.

Access

The panelists responded to the following question:

The Department of Human Services is committed to building health care capacity in rural and underserved areas.

1. How can DHS build a program that ensures access to quality care in (a) rural and (b) underserved areas? Are there special considerations which DHS should weigh for beneficiary populations?
2. What specific strategies are necessary to ensure sufficient access to behavioral health, intellectual/developmental disability, obstetrician, and long-term services and supports services in rural areas?

The topics discussed by panelists and committee members included access issues unique to rural communities; telehealth and mobile clinics; network adequacy; and community health partners.

Social Determinants of Health

The panelists responded to the following question:

Research shows that while access to high-quality health care is vital, the majority of health outcomes are tied to nonmedical social determinants, such as healthy food, safe housing, reliable transportation, employment supports, and community supports. Any call for Medicaid transformation that aims to improve health and reduce cost must address these.

1. How can MCOs use flexibility with "in lieu of services" to address members' social determinants of health? What impact can the use of "in lieu of" services have on cost-savings and/or members' health outcomes?
2. In what ways can MCOs partner with alternative provider types (like community health workers) or community-based organizations to address members' social determinants of health? What impact can this have on cost-savings and/or members' health outcomes?
3. The Department of Human Services seeks information on what State Department of Health pilots DHS should consider implementing through managed care while considering the clinical impact on beneficiaries and potential return on investment or fiscal impact of a regional or statewide program?

The topics discussed by panelists and committee members included identifying social determinants of health and implementing short- and long-term plans; reimbursement for social histories; social barriers; peer support; and community outreach workers.

No further business appearing, Chairman Keiser adjourned the meeting at 3:50 p.m.

Jennifer S. N. Clark
Counsel

ATTACH:10