NORTH DAKOTA LEGISLATIVE MANAGEMENT

Minutes of the

HEALTH CARE REFORM REVIEW COMMITTEE

Thursday, June 28, 2018
Brynhild Haugland 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, Kathy Hogan, Jim Kasper, Mike Lefor, Karen M. Rohr; Senators Dick Dever, Jerry Klein, Karen K. Krebsbach, Oley Larsen, Judy Lee

Members absent: Representatives Gretchen Dobervich, Robin Weisz; Senators Carolyn C. Nelson, Nicole Poolman

Others present: See Appendix A

MANAGED CARE STUDY

Drug Benefits

Chairman Keiser called on Ms. Melodie Shrader, Senior Director, State Affairs, Mr. Peter Harty, Consultant, Pharmaceutical Care Management Association, and Ms. LuGina Mendez-Harper, Government Affairs Principal, Prime Therapeutics, for testimony (Appendices B and C) regarding an introduction to pharmacy benefits managers (PBMs), an overview of the PBM regulatory environment, an overview of the drug benefit request for proposal process and pricing mechanism, a review of PBM clinical tools, and a PBM value proposition.

In response to a question from Representative Kasper, Mr. Harty said under North Dakota law, PBMs are regulated the same as any other third-party administrator. He said although registration as an administrator is more than a piece of paper, he is not aware of the Insurance Department auditing a PBM.

Ms. Shrader said typically requirements filter though the health plan to the PBM.

In response to a question from Chairman Keiser, Ms. Shrader said the National Conference of Insurance Legislators' Pharmacy Benefits Manager Licensure and Regulation Model Act is based on Arkansas law. She said when the court analyzed Arkansas law, it determined a state can regulate insurance, but it may not regulate a health plan.

Chairman Keiser said there are interesting dynamics with common ownership between PBMs and health plans.

Mr. Harty said Pharmaceutical Care Management Association membership includes several members with vertical integration.

In response to a question from Chairman Keiser, Mr. Harty said he attended the committee's May 9, 2018, meeting at which Ms. Linda Cahn, President, Pharmacy Benefit Consultants, presented testimony to the committee. He said the data Ms. Cahn used to compare the pharmacy benefits of the traditional Medicaid plan to Medicaid Expansion was a snapshot in time making it difficult to draw any conclusions. Additionally, he said, the Medicaid Expansion demographic differs from that of traditional Medicaid, which causes a major blip in the data.

In response to a question from Representative Kasper, Mr. Harty said the age of the traditional Medicaid population is younger than the Medicaid Expansion population.

Representative Hogan said providers are dissatisfied with the prescription drug appeal process, and complain of heavy paperwork with little likelihood of success.

Ms. Mendez-Harper said Prime Therapeutics is sensitive to concerns with paperwork and is working to simplify the appeal process and to provide resources for assistance.

In response to a question from Representative Kasper, Ms. Mendez-Harper said pharmacy errors typically are technical errors. She said a benefit of a desktop audit is that the pharmacist typically is not penalized.

In response to a question from Representative Kasper regarding how with increasing rebates and that lack of correlation between drug prices and rebates, Mr. Harty said the experience with Hepatitis C drugs helps illustrate drug pricing. He said PBMs were not able to affect the drug price until other drug options became available.

Representative Kasper said the Hepatitis C drug example does not address his concern, as the price drop was related to competition.

Mr. Harty said ending rebates would not make drugs cheaper.

Ms. Shrader said as an industry, the goal of PBMs is to get the lowest price for its clients. She said the statistics support the position the setting of drug prices does not take into account rebates.

Chairman Keiser called on Mr. Jack McDonald, America's Health Insurance Plans, for comments regarding PBMs. Mr. McDonald provided a letter (Appendix D) from Ms. Sara Orrange, Regional Director, State Affairs, America's Health Insurance Plans.

The committee received written testimony (Appendix E) from Mr. Danny Weiss, Senior Executive Director of Pharmacy, Sanford Health Plan, regarding the committee's review of PBMs.

Chairman Keiser called on Mr. Brendan Joyce, Administer, Pharmacy Services, Medical Services Division, Department of Human Services, for a presentation (Appendix F) regarding fee-for-services and managed care organization pharmacy benefit coverage for Medicaid.

In response to a question from Chairman Keiser, Mr. Joyce said the presentation slide listing the "top drugs" reflects the drugs with the greatest cost pre-rebate. He said he is not able to provide a post-rebate analysis because that data could be used to disclose the rebate amount.

In response to a question from Representative Kasper, Mr. Joyce said if the Department of Human Services (DHS) ran the prescription drug component of Medicaid Expansion as it does for traditional Medicaid, both programs would have the same rebates.

In response to a question from Representative Becker, Mr. Joyce said the Medicaid rebate of 59.3 percent for 2017 includes supplemental drug rebates.

In response to a question from Representative Hogan, Mr. Joyce said DHS maintains good communication with consumers and providers. He said the claims system is very robust and has been streamlined resulting in fewer prior authorizations and very few formal appeals.

In response to a question from Senator Dever, Mr. Joyce said on the medical side, Medicaid rebates are approximately 55 percent and Medicaid Expansion rebates are approximately 20 percent.

In response to a question from Representative Kasper, Mr. Joyce said if DHS administered the drug component of Medicaid Expansion, the department likely would require an additional 1 or 2 full-time equivalent (FTE) positions.

Chairman Keiser called on Mr. Mike Schwab, Executive Vice President, North Dakota Pharmacists Association, for testimony regarding pharmacy benefit coverage. Mr. Schwab said as a result of legislation, North Dakota pharmacists are able to dispense Naloxone and are able to provide diabetes management services.

Mr. Schwab said as it relates to rebates, the data indicates no correlation between rebates and net prices, but the net price or negotiated price is not the price being used to establish copayments, coinsurance, and the amount actually being billed to employers. He said although PBMs actually do not set drug prices, they contribute to the actual cost of drugs.

Mr. Schwab reviewed the status of active litigation regarding 2017 PBM legislation. He said little has changed since his last update, but expects to have more to report in August or September.

Hospitals

Chairman Keiser called on Mr. Dave Molmen, Chief Executive Officer, Altru Health System, representing tertiary hospitals in the state, for testimony regarding the activities of the hospitals working together. He said the hospitals have retained the services of Leavitt Partners to assist in the project. He said the primary goals are to:

1. Select and define an approach to care in North Dakota to propose to the committee;

2. Seek input from state entities and partners on desired goals and outcomes; and
3. Prepare any necessary drafts of enabling legislation.

Chairman Keiser called on Ms. Cristal Thomas Gary, Principal, Leavitt Partners, to provide a presentation (Appendix G) on Medicaid models.

In response to a question from Senator Larsen, Ms. Thomas Gary said in general, the larger the Medicaid population, the greater the cost-savings.

Senator Lee said if the Legislative Assembly had funded a health information hub, the data the state needs to make policy, such as determining whether to implement managed care for Medicaid, would have been gathered.

Chairman Keiser said the committee and the Legislative Assembly will need concrete plans, not just concepts.

Ms. Thomas Gary said one reason Leavitt Partners was retained is to help establish a concrete plan. However, she said, the group is in the early stages and it is too early to report on a concrete plan.

Indian Country

Tribes

Chairman Keiser called on representatives of the Mandan, Hidatsa, and Arikara Nation, Spirit Lake Tribe, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians for testimony regarding each tribe's experiences of providing health services in Indian country through a managed care model and regarding the status of care coordination agreements for the provision of Medicaid in Indian country.

Ms. Michelle Belt, Chief Executive Officer, Spirit Lake Health Center, Spirit Lake Tribe, said the Spirit Lake Tribe has assumed responsibility for and operates the tribe's health center, which operates as a clinic, not a hospital. She said the Indian Health Service (IHS), which provides health care to the smaller tribes in the state, is not adequate, in part because of the lack of hospitals. She said the health center does not have managed care experience specifically, but has experience in care coordination. She said the health center has a care coordinator and two managed care nurses on staff.

Ms. Belt said assuming the role of providing health services has been a large undertaking and more work than the tribe anticipated, but the result has been an evolution of the health services provided, which has benefited the tribal members. She said if the state moves to managed care for Medicaid, it should be as streamlined as possible to minimize disruptions and to minimize additional administrative burdens. She said if the state recognizes savings from a move to managed care, the tribe would like to share in the savings.

Ms. Belt said the Spirit Lake Health Center has approximately 8,800 active patients, of which 47 percent are on Medicaid, and 667 are on Medicaid Expansion. She said she applauds the state for adopting Medicaid Expansion as it not only benefits tribal members but all North Dakotans. She said any changes in the Medicaid program made by the Legislative Assembly will impact the health center. She said the state must continue to work with the tribes as the state considers whether to change the Medicaid delivery model.

Ms. Belt said over the last 15 to 20 years, health care has become significantly more complicated. She said by assuming responsibility for the provision of health services, the tribe now has more input in how services are delivered.

In response to a question from Representative Lefor, Ms. Belt said if Medicaid moves to managed care and as the tribes move to care coordination agreements, the tribes need to be involved in the design and need to receive education regarding any changes. She said the paperwork involved in providing health care is overwhelming. She said it is important to minimize additional administrative steps.

In response to a question from Chairman Keiser, Ms. Belt reviewed how the Spirit Lake Tribe moved from receiving health services from IHS to having the tribe assume responsibility for the operation of the clinic. She said since 2016, the tribe has operated its health center under a self-governance compact and funding agreement under Title V of the Indian Self-Determination and Education Assistance Act. She said the Spirit Lake Tribe is the only tribe in the Great Plains area to enter such an agreement. She said a Title V agreement, under which the tribe has independence, differs from a Title I agreement, under which the tribe continues to work with IHS and has less independence. She also reviewed the current health center staff and the staffing and program goals.

Ms. Belt said although the health center does not have a hospital, which requires tribal members to go offsite for emergency room or hospital services, the health center continues to act as a hospital in that it retains responsibility for the patients. She said the tribe is gathering data on the impact of moving to a tribally run health center.

In response to a question from Representative Hogan, Ms. Belt said she has not reviewed community health centers and whether some commonalities exist.

Mr. Lynn Gourneau, Council Representative, Ms. Alice Lunday, Council Representative, and Ms. Stephanie Jay, Tribal Health Outreach Coordinator, Turtle Mountain Band of Chippewa Indians, provided testimony (Appendix H) regarding care coordination agreements.

Ms. Lunday said the Turtle Mountain Band of Chippewa Indians does not have Medicaid care coordination agreements with providers, but seeks to move forward with these agreements if the tribe can benefit from reinvestment of the state savings. She said the state and the tribes should work together to structure the sharing of state savings fairly to help address the unmet needs of the Native American population. She said the tribe seeks to have tribal communities be as healthy as outside communities by providing services to prevent chronic disease and increase life expectancy.

Ms. Lunday said reinvestment opportunities for the Turtle Mountain Band of Chippewa Indians include investing in treatment facilities, increasing the capacity for onsite behavioral health services for adults and youth, and investing in public health services.

In response to a question from Representative Hogan, Ms. Lunday said the tribe is working to establish care coordination agreements with providers. She said because IHS does not have specialty services, but has established relationships with outside facilities, care coordination agreements should be a natural evolution.

Mr. Joseph White Mountain Jr., Council Member, and Mr. Brandon Mauai, Council Member, Standing Rock Sioux Tribe, provided testimony (Appendix I) regarding care coordination agreements.

Mr. White Mountain introduced additional tribal members in attendance--Ms. Margaret M. Gates, Ms. Petra Harmon One Hawk, and Ms. Danielle Ta'Sheena Finn.

Mr. Mauai said IHS has signed care coordination agreements with Sanford Health and St. Alexius Medical Center, and the tribe requests the state provide the tribe with 100 percent of the savings from the health care trust fund. He said the tribe has moved forward with care coordination agreements in good faith, and the savings would help to address public health needs and health disparities.

Chairman Keiser said a common theme has been IHS is underfunded and therefore is under performing. He said if this is the case, it seems ill-advised to increase the burden on IHS through care coordination agreements. He said it may be better to work with the tribes to improve tribal health.

Mr. Mauai said given the system that is in place, the tribe needs to work with what the tribe has. He said the tribe requests it receive the savings from the care coordination agreements.

Representative Becker said while the tribe is in a tough position as it seeks increased funding to help improve the health of tribal members, it also is important to address the underlying system. He said the entire IHS and tribal health system is in need of an overhaul.

Mr. Mauai said the tribe continues to try to mitigate long-standing problems, such as high rates of diabetes, and recognizes the history of the problem and that the system is faulty. However, he said, the tribe cannot afford to wait for the system to be changed and the tribe needs to move forward given the current situation and current system.

In response to a question from Senator Larsen, Mr. Mauai said the tribe does not have staff to assist in federal Affordable Care Act (ACA) enrollment, but IHS has staff to assist in enrollment.

Senator Lee said the rest of the state could learn from the successes the tribes have had with community health representatives.

Mr. Mauai said the community health representatives could be impacted positively with additional funding.

Ms. Jana Gipp, Standing Rock Sioux Tribe, said she is employed by IHS. She said IHS has worked well with the tribes within IHS's limited financial resources. She said regardless of whether clinics are run by IHS or the tribes, the clinics face the same issues and seek to improve the health of patients.

Ms. Gipp said the IHS pursuit of coordination agreements was done with the goal of improving the health of patients. She said state savings should be reinvested in improving the health of patients.

Department of Human Services

Chairman Keiser called on Ms. Maggie D. Anderson, Director, Medical Services Division, Department of Human Services, for testimony (Appendix J) regarding the status of care coordination agreements for the provision of Medicaid in Indian country.

In response to a question from Representative Hogan, Ms. Anderson said DHS has not discussed strategy for the 2019 legislative session regarding the health care trust fund and shared savings yet as the savings the state will recognize under the care coordination agreements is unknown.

In response to a question from Representative Becker, Ms. Anderson explained how the state is expected to save money under Medicaid care coordination agreements. She said IHS or tribal 638 programs will incur additional expenses regarding increased work to facilitate state savings. She said under Medicaid Expansion the providers are benefiting due to reimbursement at private rates and the state benefits based on increased federal reimbursement. She said the encounter rate is set by the federal government, and Medicaid is not allowed to bill for care coordination encounters. However, she said, DHS is researching whether it is possible for these care coordination encounters to be paid under Medicaid.

In response to a question from Chairman Keiser, Ms. Anderson said it is her understanding that other states are sharing care coordination savings with the tribes.

Providers

Chairman Keiser called on Mr. Bruce Murry, Executive Director, North Dakota Association of Community Providers, for testimony (Appendix K) regarding managed care services provided by community providers.

The committee received written testimony (Appendix L) from Ms. Kirsten Dvorak, Executive Director, The Arc of North Dakota, regarding managed care for the developmental disability community.

Chairman Keiser called on Ms. Joyal Meyer, Program Administrator, and Ms. Tammie Johnson, Program Administrator, Special Health Services Section, State Department of Health, for a report (Appendix M) on the status of and proposals for the newborn screening program and metabolic foods program.

PUBLIC EMPLOYEE HEALTH BENEFITS STUDY

Chairman Keiser called on Mr. Scott Miller, Executive Director, Public Employees Retirement System, to introduce himself as the new Executive Director.

The committee reviewed the second version of a bill draft [19.0148.02000] to clarify the authority of the Insurance Commissioner to regulate a Public Employees Retirement System (PERS) self-insurance health benefit plan.

Chairman Keiser called on Ms. Sharon Schiermeister, Chief Operating Officer, Public Employees Retirement System, for comments (Appendix N) regarding the new version of the bill draft as well as comments regarding the bill draft [19.0149.01000] the committee received at its May 2018 meeting, and Mr. Jeff Ubben, Deputy Commissioner, Insurance Department, to comment (Appendix O) regarding the new version of the bill draft.

In response to a question from Representative Kasper, Ms. Schiermeister said current law provides a minimum reserve amount for a self-insurance health plan but does not set a maximum reserve amount.

In response to a question from Representative Hogan, Mr. Ubben said he has not researched how other states regulate public employee health plans.

In response to a question from Representative Kasper, Mr. Ubben said if the federal government changes the law regarding multiple employer welfare arrangements or Employee Retirement Income Security Act law, the Insurance Department has adequate rulemaking authority to address these changes.

Chairman Keiser said because the Insurance Department regulates all other forms of insurance, it makes sense to have the department regulate a PERS self-insurance health plan as well. He said the reserve requirement should be an actuarily established amount based on the circumstances. He said the state should have to infuse the startup funds, and the law needs to address how to reimburse that money over time. He said the reserve requirements also should take into account whether stop-loss coverage exists. He said it is important to build in success actuarily.

Representative Devlin said he cannot support a section that statutorily grants emergency rulemaking authority.

AFFORDABLE CARE ACT STUDY

Chairman Keiser called on Mr. Jon Godfread, Insurance Commissioner, to provide an update (Appendix P) on the ACA and a status report on the activities of the Insurance Department.

In response to a question from Chairman Keiser, Mr. Godfread said Idaho has not received a decision yet on the state-based plan it submitted to the federal government.

In response to a question from Representative Hogan, Mr. Godfread said he is aware of groups talking about whether to pursue association health plans (AHPs). He said now that the federal rules are final, he can help educate parties of the option, but it would not be appropriate for him to encourage parties to establish AHPs.

In response to a question from Chairman Keiser, Mr. Godfread said an AHP that operates under the state's multiple employer welfare arrangement rules would not be eligible for coverage under the insolvency guarantee fund.

The committee received committee updates from Representative Hogan regarding the activities of the Human Services Committee and from Representative Lefor regarding the activities of the Employee Benefits Programs Committee.

No further business appearing, Chairman Keiser adjourned the meeting at 4:10 p.m.

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Jennifer S. N. Clark
Counsel

ATTACH:16