

HEALTH CARE DELIVERY SYSTEM STUDY - BACKGROUND MEMORANDUM

INTRODUCTION

During the 2015-16 interim, the Health Care Reform Review Committee is charged with performing three health care-related studies:

- Section 1 of 2015 House Bill No. 1035 ([Appendix A](#)) directs the committee to continue its ongoing study of the needs and challenges of the North Dakota health care delivery system. The study may include monitoring the implementation of the federal Affordable Care Act (ACA), examining Medicaid Expansion and Medicaid reform, reviewing any impact on rural access to primary health care and emergency services, making recommendations to maintain and enhance rural primary health care and emergency services, and considering the feasibility of developing a state-based plan for a health care model that will comply with federal health care reform in a manner that will provide high-quality access and affordable care for North Dakota citizens. The University of North Dakota School of Medicine and Health Sciences Advisory Council shall make periodic reports to the committee on the status of the biennial report developed pursuant to North Dakota Century Code Section 15-52-04.
- Section 1 of 2015 House Bill No. 1378 directs the committee to study the proposed and final federal rules issued by the federal Department of Health and Human Services (HHS) relating to the essential health benefits under the ACA. Specifically, the study must include a review of the rules relating to the state's ability to participate in defining the state-based essential health benefits package for plan years 2017 and beyond, how the state may be authorized to select a benchmark plan for plan years 2017 and beyond, and the deadlines related to these rules and related decisions.
- 2015 House Concurrent Resolution No. 3003 directs the committee to study state contributions for state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution for state employee health insurance premiums and the effect of losing the state's grandfathered status under the ACA.

This memorandum focuses on the continuing study of the needs and challenges of the state's health care delivery system.

BACKGROUND Affordable Care Act

In March 2010 President Barack Obama signed into law two pieces of legislation that laid the foundation for a multiyear effort to implement health care reform in the United States--the Patient Protection and Affordable Care Act (H.R.3590) and the Health Care and Education Reconciliation Act of 2010 (H.R.4872)--which together are referred to as the Affordable Care Act or ACA. The ACA crafted new structural models to increase access and affordability of health care coverage, to improve operational governance of the health insurance industry, to provide consumers protection, and to provide new tools for the improvement of the health care delivery system and patient outcomes.

Of particular interest to states regarding the ACA are the multiple specific provisions of the ACA and the implementation timeline of these specific provisions. The Henry J. Kaiser Family Foundation document ([Appendix B](#)) "Summary of New Health Reform Law" last modified April 23, 2013, provides a summary of the multiple provisions of the ACA. Additionally, the Henry J. Kaiser Family Foundation website has created an interactive tool to help explain how and when the provisions of the ACA will be implemented over the next several years.

Since enactment of the ACA, North Dakota has made several decisions regarding implementation, including whether to administer the health benefit exchange, whether to select the state's essential health benefits or instead allow the essential health benefits to be selected through the default method, and whether to participate in Medicaid expansion. A future decision may include whether to submit an application for a state innovation waiver to allow the state more flexibility in meeting the requirements of the ACA.

Health Benefit Exchanges

During the November 2011 special session, the Legislative Assembly did not enact legislation providing for a state-administered health benefit exchange or to allow for state participation in a federally administered health benefit exchange; therefore, the state is allowing the federal government to administer its health benefit exchange. Guidelines issued by HHS indicate that in the future, states will be allowed to transition from one

exchange model to another. A state may alter its exchange structure and administration model by submitting an exchange blueprint and having it approved by HHS.

Essential Health Benefits

Starting January 1, 2014, the ACA required individual and small group plans to include all essential health benefits, limit consumers' out-of-pocket costs, and meet the Bronze, Silver, Gold, and Platinum coverage level standards; however, grandfathered and self-insured plans are exempt. Large group plans are required to meet the cost-sharing limits and the benefit levels, but are not required to provide the full scope of benefits in the essential benefits package.

The federal Department of Health and Human Services issued a bulletin providing that each state may choose a benchmark plan from one of the following four benchmark plan types:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
2. Any of the largest three state employee health benefit plans by enrollment;
3. Any of the largest three national Federal Employees Health Benefits Plan options by enrollment; or
4. The largest insured commercial non-Medicaid health maintenance organization (HMO) operating in the state.

In addition to the services covered by the state's selected benchmark plan, the state's essential health benefits must include the following 10 categories of services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

If a state failed to choose a benchmark plan by September 30, 2012, the default plan would be the nongrandfathered small group plan with the largest enrollment in the state, which in North Dakota was the Medica Choice Passport plan. On September 28, 2012, the Insurance Commissioner submitted a selection of an essential health benefit benchmark plan to HHS, designating the Sanford Health Plan, the largest insured commercial non-Medicaid HMO operating in the state. This benchmark plan applies in 2014 and 2015 plan years.

For plan years 2017 and beyond, the federal government again directed the states to select their essential health benefits. The basic process for selecting the state's employee health benefits package was the same as before; however, the federal government selected a June 1, 2015, deadline for states to make this selection. Again, if a state fails to choose a benchmark plan by the federal deadline, the default plan will be the nongrandfathered small group plan with the largest enrollment in the state.

Medicaid Expansion

As enacted, the ACA provided for all states to expand Medicaid coverage to eligible state residents with incomes below 138 percent of the federal poverty line. Failure to comply with this Medicaid expansion requirement would result in penalties. However, the June 28, 2012, ruling of the United States Supreme Court in *NFIB v. Sebelius*, found the ACA's Medicaid Expansion provision is unconstitutionally coercive on states and that this situation is remedied by limiting HHS's enforcement authority. The practical effect of the ruling is that states have the option of expanding Medicaid under the ACA. A state that does not expand Medicaid is not subject to penalties under the ACA.

Section 1 of 2013 House Bill No. 1362 directed the Department of Human Services to expand the state's Medicaid program coverage as authorized under the ACA. The department was directed to implement the expansion by bidding through private carriers or utilizing the health benefit exchange. Section 1 of the bill has an expiration date of August 1, 2017.

State Innovation Waivers

Section 1332 of the ACA authorizes states to submit applications for state innovation waivers. The final rules for these waivers were published March 14, 2011, providing that beginning in 2017, a state may qualify for a state innovation waiver to allow the state to pursue its own innovative strategies to ensure residents have access to high-quality affordable health insurance. In order to qualify for a waiver, the state's plan must provide affordable insurance coverage to at least as many residents as the ACA and may not increase the federal deficit. A copy of the federal Centers for Medicare and Medicaid Services fact sheet and frequently asked questions dated July 22, 2015, is attached as [Appendix C](#) and a copy of the final rules relating to state innovation waivers is attached as [Appendix D](#).

Medicaid Waivers

The federal government provides four primary types of waivers and demonstration projects to allow states to test new or existing ways to deliver and pay for health care services through Medicaid and the children's health insurance program (CHIP).

1. Section 1115 research and demonstration projects - Allows states to apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP. Typically, Section 1115 demonstrations are approved for a five-year period and may be renewed, for an additional three years. Demonstrations must be budget neutral to the federal government, so during the course of the project federal Medicaid expenditures will not be more than federal spending without the waiver.
2. Section 1915(b) managed care waivers - Allows states to apply for waivers to provide services through managed care delivery systems or otherwise limit a person's choice of providers. Within this waiver, there are four options:
 - a. Section 1915(b)(1) allows an applicant to implement a managed care delivery system that restricts the types of providers people may use to get benefits;
 - b. Section 1915(b)(2) allows a county or local government to act as a choice counselor or enrollment broker to help people pick a managed care plan;
 - c. Section 1915(b)(3) allows the use of savings the state gets from a managed care delivery system to provide additional services; and
 - d. Section 1915(b)(4) allows a state to restrict the number or type of providers that may provide specific services, such as disease management or transportation.
3. Section 1915(c) home- and community-based services waivers - Allows states to apply for waivers to provide long-term care services in home and community settings rather than in institutional settings.
4. Concurrent Sections 1915(b) and 1915(c) waivers - Allows states to apply to simultaneously implement two types of waivers to provide a continuum of services to elderly people with disabilities.

University of North Dakota School of Medicine and Health Sciences Advisory Council - Biennial Report.

Under Section 15-52-04 ([Appendix E](#)) the University of North Dakota School of Medicine and Health Sciences Advisory Council is charged with working with the School of Medicine and Health Sciences and other entities represented on the advisory council to conduct a study and make recommendations regarding the strategic plan, programs, and facilities of the School of Medicine and Health Sciences.

Legislative Interim Background

2013-15 Interim Health Care Reform Review Committee

During the 2013-14 interim, the interim Health Care Reform Review Committee was assigned three studies:

- Section 15 of 2013 House Bill No. 1012 directed the committee to study the immediate needs and challenges of the North Dakota health care delivery system, implementing the Healthy North Dakota initiative, examining Medicaid reform, and the feasibility of developing a plan for a private health care model that will comply with federal health care reform in a manner that will provide high-quality, accessible, and affordable care for North Dakota. In performing the study, the committee was allowed to consider population shifts, facility needs, personnel needs, rural access, regulatory public health functions, and

vulnerable populations; determine the scope of the weakness in the current health care system; take into account the ongoing impact that federal health care reform under the ACA is having on state delivery of health care and on state delivery of Medicaid; and consider how to forge partnerships with federal payers and regulators in order to work toward addressing medical reimbursement system reform.

- Section 1 of 2013 House Bill No. 1034 directed the committee to study health care reform options, including the implementation of the ACA if the federal law remains in effect and state alternatives for state-based health care reform if the federal law is repealed. As part of this study, the Insurance Commissioner, State Department of Health, and Department of Human Services were directed to provide status reports on the state of health insurance and health-related public assistance.
- Section 3 of 2013 House Bill No. 1362 directed the committee to consider studying the effects of the ACA, due to the dramatically changing health care system in the state, including alternatives to the ACA and the Medicaid Expansion provisions to make health care more accessible and affordable to the citizens of the state, including access, the cost of providing services, the Medicare penalty to the state's providers, and the Medicaid payment system.

The committee recommended:

- 2015 House Bill No. 1035, results in this continuing study;
- 2015 House Bill No. 1036, directs the State Department of Health during the 2015-16 interim to evaluate state programs to assist health professionals, including behavioral health professionals, with a focus on state loan repayment programs for health professionals. During the 2015-16 interim the State Department of Health is directed to make periodic reports to the Legislative Management on the outcome of the study, including presentation of recommended legislation. The interim Health Services Committee is charged with receiving these reports during the 2015-16 interim.
- 2015 House Bill No. 1037, directs the Department of Human Services during the 2015-16 interim to study options for implementing income-based cost-sharing provisions for the Medicaid and Medicaid Expansion programs. This study must include consideration of provider recovery rates for copayments, information technology capacity for implementing income-based cost-sharing provisions, consideration of how income-based cost-sharing has been implemented by other states, analysis of the costs and benefits of cost-sharing, and consideration of whether cost-sharing improves the effectiveness of Medicaid and Medicaid Expansion programs. Before July 1, 2016, the Department of Human Services is required to report to the Legislative Management the outcome of the study and the associated legislative recommendations and related draft legislation. The Interim Human Services Committee is charged with receiving this report during the 2015-16 interim.
- 2015 House Bill No. 1038, requires that the Public Employees Retirement System Board provide health benefits coverage under a policy that provides coverage for health services delivered by means of telehealth, which is the same as the policy coverage for health services delivered by in-person means. The mandate is limited to the Public Employees Retirement System Board and expires in two years.
- 2015 House Bill No. 1039, would have amended the group health policy mandate for substance abuse coverage. The bill would have applied the substance abuse coverage requirements to all health insurance policies, removed the coverage requirement formulas for different types of substance abuse services, and clarified that required coverage must include inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment. The bill failed.
- 2015 House Bill No. 1040, revises the involuntary commitment proceeding law to update the language and to expand the statutory authority of physician assistants and advanced practice registered nurses to authorize physician assistants and advanced practice registered nurses to act as independent expert examiners in involuntary commitment proceedings.
- 2015 House Bill No. 1041, provides when implementing medical assistance expansion under the ACA, the contract between the Department of Human Services and a private carrier must provide a reimbursement methodology for all medications and dispensing fees that identifies the minimum amount paid to pharmacy providers for each medication, provides full transparency of all costs and all rebates in aggregate, allows an individual to obtain medication from a pharmacy that provides mail order service, ensures pharmacy services obtained in jurisdictions other than this state and its three contiguous states are subject to prior authorization and reporting to the department for eligibility verification, and ensures the payments to pharmacy providers do not include a required payback amount to the private carrier or one of the private carrier's contractors or subcontractors which is not representative of the amounts allowed under the reimbursement methodology.

2011-12 Interim Health Care Reform Review Committee

During the 2011-12 interim, the interim Health Care Reform Review Committee was assigned three studies.

- Section 1 of 2011 House Bill No. 1252 directed the committee to monitor the impact of the ACA, rules adopted by federal agencies as a result of that legislation, and any amendments to that legislation. The study charge directed the committee to report to the Legislative Management before a special session of the Legislative Assembly if a special session was necessary to adopt legislation in response to the federal legislation.
- 2011 Senate Concurrent Resolution No. 4005 directed the committee to study the impact of the ACA on the Comprehensive Health Association of North Dakota (CHAND) and the statutes governing CHAND.
- A Legislative Management directive directed the committee to study the feasibility and desirability of developing a state plan that provides North Dakota citizens with access to and coverage for health care which is affordable for all North Dakota citizens.

In addition to the committee's three studies, the Health Care Reform Review Committee was charged with receiving the following updates:

- Regular updates from the Insurance Commissioner during the 2011-12 interim regarding administration and enforcement of the ACA, proposed legislation for consideration at a special legislative session, and proposed legislation by October 15, 2012, for the 2013 regular session (2011 House Bill No. 1125, Section 2);
- Regular updates from the Insurance Commissioner and Department of Human Services during the 2011-12 interim on planning and implementing a health benefit exchange for the state and proposed legislation for consideration at a special legislative session, or proposed legislation by October 15, 2012, for the 2013 regular session (2011 House Bill No. 1126, Section 3); and
- Regular updates from the Insurance Commissioner during the 2011-12 interim with respect to steps taken to ensure health insurer procedures are in compliance with the ACA, proposed legislation for consideration at a special legislative session if the Commissioner is required by federal law to implement any requirement before January 1, 2013, and proposed legislation by October 15, 2012, for any requirement that must be implemented between January 1, 2013, and January 1, 2014 (2011 House Bill No. 1127, Section 6).

The committee held six meetings before the November 2011 special session, with a primary focus of determining what actions the state should take to address the health benefit exchange requirement under the ACA and reviewing additional information regarding other elements of the ACA, such as Medicaid Expansion and external review requirements. The committee recommended three bills for the special session:

1. 2011 House Bill No. 1474 would have provided for a state-administered health benefit exchange. This bill failed in the House.
2. 2011 House Bill No. 1475 provided an appropriation of federal funds received by the Department of Human Services for ACA-related costs of the Department of Human Services and the Information Technology Department relating to incorporating the Medicaid and CHIP eligibility determination functionality into the health benefit exchange and for the purpose of defraying the corresponding costs related to the modification of the department's economic assistance eligibility system, including 1 full-time equivalent (FTE) position for the Department of Human Services and 10 FTE positions for the Information Technology Department; an appropriation from the general fund and federal funds to the Department of Human Services for the purpose of defraying the expenses of implementation of the ACA's Medicaid Expansion provisions, including 7 FTE positions for the Department of Human Services; and an appropriation of special funds to the Insurance Commissioner for the purpose of defraying the expenses of implementation of the ACA, including 4 FTE positions. This bill passed as introduced.
3. 2011 House Bill No. 1476 amended the law relating to the external review procedures required for health insurance policies. This bill passed as amended.

Following the special session, the committee held an additional four meetings and the committee continued receiving regular status reports from the Insurance Commissioner and representatives of the Insurance Department regarding the federal grants that were available to states to assist in implementation of the health benefit exchanges and the status of other states' implementation of health benefit exchanges, the essential health benefits requirements under the ACA, and the state's external review procedure. Additionally, the committee received reports on activities in the state relevant to the committee's study of the state's health care delivery plan and reviewed the June 28, 2012, ruling of the United States Supreme Court in *NFIB v. Sebelius*, regarding the

constitutionality of the ACA. The committee recommended 2013 House Bill No. 1034, to provide for a Legislative Management study of health care reform options, which passed and was assigned to the Health Care Reform Review Committee.

2009-10 Interim Industry, Business, and Labor Committee Study

During the 2009-10 interim the Chairman of the Legislative Management directed the interim Industry, Business, and Labor Committee to monitor federal health care reform legislation, including its effect on North Dakota citizens and state government; the related costs and state funding requirements; related tax or fee increases; and the impact on the Medicaid program and costs, other state programs, and health insurance premiums, including the Public Employees Retirement System.

The interim committee recommended House Concurrent Resolution No. 3003 to direct the Legislative Management to continue studying the impact of the ACA during the next interim. Although the resolution was adopted, the Legislative Management did not prioritize the study.

POSSIBLE STUDY APPROACH

The committee's studies focus on several different aspects of health care in North Dakota. In organizing the committee's study activities, the committee may choose to address the studies as follows:

1. Continue tracking the implementation of the ACA, including receipt of status reports on elements of the ACA which have already been implemented, reports on elements of the ACA which have not yet been implemented, consideration of state actions that may impact this implementation of the ACA provisions, and the anticipated long-term impact of the various elements of the ACA;
2. Continue considering health care delivery system alternatives to the ACA, including consideration of the feasibility and desirability of applying for a state innovation waiver;
3. Continue considering health care delivery system actions that may complement or work within the requirements of the ACA;
4. Continue collecting data and other information regarding the current health care delivery system and proposed changes to this system, with a focus on access to primary health care and emergency services; and
5. Receive periodic reports from the University of North Dakota School of Medicine and Health Sciences Advisory Council on the status of its biennial report.

In conducting all of the committee's study charges, the committee may benefit from continuing the committee's established practice of working with public and private stakeholders to coordinate committee meetings.

ATTACH:5