AFFORDABLE CARE ACT STATUS STUDY - BACKGROUND MEMORANDUM

STUDY CHARGE

A directive of the Legislative Management charges the Health Care Reform Review Committee with monitoring and reviewing proposed federal changes to the federal Affordable Care Act (ACA).

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 (House Resolution No.3590) and the Health Care and Education Reconciliation Act of 2010 (House Resolution No. 4872)--which together are referred to as ACA. The Affordable Care Act affects states in multiple areas, including insurance regulation, human services, labor laws, and employee benefits.

Since enactment of 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.

Health Benefit Exchanges

During the November 2011 special legislative 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. A state may alter its exchange structure and administration model by submitting an exchange blueprint and having it approved by the U.S. Department of Health and Human Services.

Essential Health Benefits

Starting January 1, 2014, 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 health benefits package.

The U.S. 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 Program 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 was 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 the U.S. Department of Health and Human Services, designating the Sanford Health Plan, the largest insured commercial non-Medicaid HMO operating in the state. This benchmark plan applied in 2014, 2015, and 2016 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 failed to choose a benchmark plan by the federal deadline, the default plan was the nongrandfathered small group plan with the largest enrollment in the state. The 2015-16 interim Health Care Reform Review Committee recommended to the Legislative Management the state choose the default plan. For plan years 2017 and beyond the state's essential health benefits are based on the new default benchmark plan.

Medicaid Expansion

As enacted, 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 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 the U.S. Department of Health and Human Services' enforcement authority. The practical effect of the ruling is states have the option of expanding Medicaid under ACA. A state that does not expand Medicaid is not subject to penalties under 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 ACA. The department was directed to implement the expansion by bidding through private carriers or utilizing the health benefit exchange. The 2017 Legislative Assembly extended the original expiration date of August 1, 2017, to August 1, 2019, but added a contingent repeal of the Medicaid Expansion program if the federal government ends the program.

PREVIOUS LEGISLATIVE STUDIES

Beginning with the passage of ACA in March of 2010, the Legislative Management has been studying the implementation of ACA. During the 2009-10 interim, the Industry, Business, and Labor Committee incorporated a study of ACA as part of the committee's charge to study factors impacting the cost of health insurance and health insurance company reserves. During the 2011-12, 2013-14, and 2015-16 interims, the Health Care Reform Review Committee pursued the specific charge to study the implementation of ACA and the state's health care delivery system.

STUDY PLAN

To assist the committee to put in context any federal proposals to amend or repeal ACA, the committee may benefit from receiving periodic updates from the Insurance Commissioner and representatives of the Department of Human Services on the state's implementation of ACA. Throughout the interim, the committee may consider receiving testimony from other stakeholders to understand the potential impact of any federal proposals to amend or repeal ACA.