HEALTH CARE COMMITTEE

The Health Care Committee was assigned four studies.

Section 3 of House Bill No. 1106 (2019) directed a study of ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution based to reduce costs and may include consideration of whether a strict managed care model might be effective.

Section 17 of Senate Bill No. 2010 (2019) directed a study of the feasibility and desirability of state guaranteed issue provisions for health insurance. The study must include consideration of protections for individuals with pre-existing conditions and consideration of whether to restructure the Comprehensive Health Association of North Dakota.

Section 48 of Senate Bill No. 2012 (2019) directed a study of the delivery of health care in the state. The study must review the needs and future challenges of the North Dakota health care delivery system, including rural access to primary health care, the use of emergency medical services, strategies to better serve residents, and the role of health care services in the future development of the state.

Section 3 of Senate Bill No. 2317 (2019) directed a study of the State Department of Health licensing process for health facility construction and renovation projects, including consideration of the appropriate role of the State Department of Health.

In addition to its study responsibilities, the committee was charged with receiving the following six reports:

- A report from the State Fire Marshal each interim on the State Fire Marshal's findings and any recommendation for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes (North Dakota Century Code Section 18-13-02(6)).
- A report from the Department of Human Services (DHS), State Department of Health, Indian Affairs Commission, and Public Employees Retirement System before June 1 of each even-numbered year on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes (Section 23-01-40).
- A report by the State Department of Health before June 1 of each even-numbered year, regarding progress made toward the recommendations provided in Section 23-43-04 regarding the stroke centers and stroke care and any recommendations for future legislation (Section 23-43-04).
- A report before July 1, 2020, from the State Department of Health on the status and progress of implementing a public awareness campaign to provide information, public service announcements, and educational materials regarding abandoned infants and approved locations for abandoned infants (2019 House Bill No. 1285, § 2).
- A report from the Insurance Department regarding a detailed analysis of health care in the state (2019 Senate Bill No. 2010, § 15).
- A report before July 1, 2020, from the State Department of Health regarding the implementation of innovation waivers for health facilities construction or renovation projects, waivers for basic care facilities, and review of construction, renovation, or construction and renovation projects (2019 Senate Bill No. 2317, § 4).

Committee members were Representatives George Keiser (Chairman), Dick Anderson, Gretchen Dobervich, Clayton Fegley, Jim Kasper, Mike Lefor, Lisa Meier, Marvin E. Nelson, Bob Paulson, and Robin Weisz and Senators Dick Dever, Kathy Hogan, Judy Lee, Tim Mathern, Dave Oehlke, Kristin Roers, and Shawn Vedaa.

HEALTH INSURANCE PREMIUM TREND STUDY

Legislative History

House Bill No. 1106 was introduced at the request of the Insurance Commissioner. Sections 1 and 2 of the bill directed the Insurance Commissioner to apply for a federal Affordable Care Act (ACA) Section 1332 Innovation Waiver to establish an invisible reinsurance pool for the individual health insurance market to limit the amount of risk insurance companies assume for the high-risk North Dakotans the companies insure.

The goal of the invisible reinsurance pool is to reduce health insurance premiums in the individual market, making insurance more affordable, while protecting insurers from unpredictable high-cost claims that significantly contribute to the rising cost of health insurance. This is accomplished by using a reinsurance mechanism to help fund high-cost claims. The Insurance Commissioner testified the invisible reinsurance pool should result in double digit decreases in the cost

of health insurance in the individual market, resulting in more individuals staying in the market, some individuals who left the market due to unaffordability of health insurance returning to the market, and more insurers being willing to write policies in North Dakota counties. Ultimately, the invisible reinsurance pool is intended to help stabilize the individual health insurance market in the state.

Section 3 of the bill, which provided for this study, was added to the bill by the House, as was Section 4, which provides for an expiration date of December 31, 2021. The legislative history indicates a goal of the study is to look at long-term solutions to the problem of the trend of increasing health insurance premiums. In addition, Section 15 of Senate Bill No. 2010, directs the Insurance Department to assist the committee with the study and to conduct a detailed analysis of health care in the state.

Background

Premium rates for the individual health insurance market have continued to increase under the ACA. In May 2019, the Kaiser Family Foundation published the report *Individual Insurance Market Performance in 2018*. On average, premiums per enrollee grew 26 percent from 2017 to 2018, while per-person claims grew only 7 percent.

Cost-Sharing Reduction Subsidies

On October 12, 2017, President Donald Trump signed an executive order terminating cost-sharing reduction (CSR) subsidies. The CSR subsidy is the smaller of two subsidies paid under the ACA. The CSR subsidy was paid from 2013 to 2017 to insurance companies on behalf of eligible enrollees in the ACA earning 100 to 250 percent of the federal poverty level to reduce copayments and deductibles. The report attributes this growth in 2018 premiums in part to the loss of the CSR subsidy payments, as insurers are required by law to provide cost-sharing subsidies to eligible enrollees but are no longer being reimbursed by the federal government.

One concern about rising premiums in the individual market is the increased premiums may cause healthy enrollees to drop out of the market instead of paying the high premium rates. Although most ACA exchange enrollees are subsidized, and therefore sheltered from paying premium increases, those enrolling off-exchange pay the full increase in premium. However, despite this dynamic, the average number of days individual market enrollees spent in the hospital in 2018 was slightly lower than inpatient days in the previous 3 years.

Health Care Expenditures

Health care expenditures drive health insurance premiums. The following are the top five drivers of health care cost increases reported by health insurance carriers for 2017:

1. Prescription drugs;
2. Physician services;
3. Outpatient services;
4. Mental health and chemical dependency services; and
5. Diagnostic imaging.

Managed-Care Model

Managed care is a health care delivery system organized to reduce the cost of providing health care and providing health insurance while improving the quality of that care. Managed care can take several forms, including integrated delivery systems, exclusive provider organizations, preferred provider organizations, and health maintenance organizations.

During the 2017-18 interim, the Health Care Reform Review Committee studied options to operate the state's public benefits programs as managed care. Although the committee studied this topic in depth, the committee did not make any legislative recommendations to direct public benefits be provided through a managed-care model.

Testimony

Social Determinants of Health

The committee received testimony regarding the state's role in addressing gaps in social determinants of health. The Department of Human Services enables access to social determinants of health services when community resources are insufficient.

The committee received testimony regarding a local service delivery method and related programs provided through Lutheran Social Services of North Dakota which are helping address a variety of the social determinants of health.

The committee received testimony on the impact of human behavior on health and health care. The committee received a presentation on the Mutual Accountability and Information Therapy Program, which combines human factors and systems engineering, web technology, and behavior science to improve health and lower overall medical costs by tapping into the doctor-patient relationship via aligned incentives, promoting health literacy, rewarding compliance, and dignifying all parties. The Mutual Accountability and Information Therapy Program is implemented through adoption by health insurers that in turn offer aligned financial incentives to both beneficiaries and doctors for accessing the program's digital health website during each office visit to hold one another accountable for completing the program's information therapy process. The process is described as a unique method proven to nudge an improvement in health behaviors, lowering hospitalizations, emergency room visits, and costs, which in turn produces a return on investment for the insurer.

Insurance Department

The committee received periodic updates on the status of the Insurance Department's submission of an ACA Section 1332 Innovation Waiver to implement a health insurance reinsurance program. On July 31, 2019, the Insurance Department received federal approval of the state's Section 1332 Innovation Waiver submission.

The committee received a preliminary version of the report *Private Health Insurance Market Report 2014-2018*, prepared by a consultant for the Insurance Department. The report provides findings regarding health-spending costs for health insurance plans in the state for the period 2014 through 2018. The report used information gathered from the top 99 percent of health insurers by premium in the state through a data request from the department. The report provided:

- The percentage of the North Dakota population uninsured has been between 7 and 8 percent for the past 5 years (2014-2018).
- In 2018, North Dakota did not allow carriers to refile plan rates due to the federal government's decision to defund CSRs.
- Total individual market membership has decreased every year from 2016 to 2018, likely driven by large rate increases.
- An analysis of the top drivers of higher and lower health care costs shows population change, physicians, inpatient hospital, and outpatient hospital as major drivers of lower health insurance costs. On a net basis, the drivers of lower health insurance costs outweigh the drivers of higher health insurance costs.

The report identified the following findings regarding hospital costs:

- On a per-capita basis, hospital expenses in North Dakota were highest in the nation in 2017, and the hospital expenses growth rate of about 8 percent per year since 2010 was among the fastest in the country.
- That 8 percent growth was comprised of a 1.5 percent growth in utilization and about 6.5 percent growth in unit costs between 2010 and 2019.
- The hospitals' largest expense is wages and benefits. Among the nine largest hospitals in North Dakota, aggregate wages and benefits grew by about 7 percent annually between 2010 and 2019. This growth, in turn, was comprised of employment growth of about 3 percent annually, and wage and benefit growth per employee of about 4 percent.
- North Dakota's average wage per full-time equivalent employee was about $90,000 in 2018, and wage growth also was among the fastest in the nation between 2010 and 2018.
- Several North Dakota hospitals are near the Minnesota border, which indicates these hospitals may be net importers of patients with the potential to increase measures of North Dakota "per resident" costs.

The report identified the following findings regarding insurance costs:

- Individual market premiums rose by about 10 percent in 2018, with an estimated 15 percent increase in 2019. However, premiums fell in 2020 by about 9 percent due to the establishment of North Dakota's reinsurance program. Premiums in the small group and large group markets have been slightly more stable, growing by roughly 4 to 6 percent per year on average in recent years.
- Despite higher than average hospital costs, North Dakota's premium levels compare favorably with those of other states.
- There are several possible explanations for North Dakota's lower-than-average premium costs.

    North Dakota's prescription drug claims have been moderate.

The state's insurers have had lower than average administrative costs, although those costs in North Dakota rose rapidly in the 2014-2018 period.

North Dakota's individual market demographics are more favorable than most other states. A federal study of enrollment in 2017 set North Dakota's enrollment of children under age 18, who collectively tend to have lower claims costs than older enrollees, at 60 percent higher than the national average, while enrollment of people aged 35-64, who tend to have higher claims costs, was 12 percent less than the average nationally.

North Dakota's health plans have relatively high average deductibles compared with other states. In the individual market, it is estimated deductibles average more than $4,000.

The report included a variety of policy alternatives, recognizing not all the alternatives will work in the state and some may contradict one another. Under the heading of utilization and case management the following policy alternatives were identified:

- Benchmark plan revisions - Mandate optimized medication plans;
- Private insurance (group) mandate - Optimized medication plans;
- Medicaid integrated health homes;
- Medicaid strict managed care/value-based benefit design;
- Other options:

  Limit Medicaid Expansion to 100 percent of poverty; and

  Reform Medicaid Expansion as an exclusively managed care model.

Under the heading of prices, coverage, and insurance initiatives, the following policy alternatives were identified:

- Cap out-of-network payment rates;
- Private reinsurance - ACA Section 1332 Innovation Waiver amendment; and
- Telehealth improvements.

Under the heading of transparency, the following policy alternatives were identified:

- Direct to consumer pricing - Disclosure of consumer prices; and
- Right to shop.

Under the heading of program integrity, the following policy alternatives were identified:

- Medicaid integrity audit;
- State group health integrity audit;
- State group health waiver or "opt-out"; and
- Coordination of benefits and identifying third-party liability.

Under the heading of crisis and pandemic planning, the policy alternative of hospital and insurer own risk insolvency assessment was identified.

The conclusion of the report provided the underlying medical cost drivers in North Dakota include rapid growth in hospital operating expenses as well as growth in average length of stay for patients and admissions. Insurers' administrative costs also grew rapidly in recent years, although the costs remain near national averages.

The committee received testimony in response to the report. A representative of hospitals testified hospital prices do not drive prices, as prices in North Dakota are set by Medicare, Medicaid, and the dominant commercial insurer.

In addition, the representatives of the hospitals have several concerns regarding the data used and the conclusions drawn in the report. It was asserted policy recommendations of the report do not correlate with the data.

The committee received testimony in opposition to the report's suggestions to make cuts to the Medicaid Expansion program. While cutting Medicaid Expansion payments to health care providers may save $5 to $8 million in general funds as the report points out, the recommendations do not acknowledge the loss to the North Dakota health care system of $200 million in federal funds. It was argued although Medicaid Expansion represents a major impact on North Dakota's

economy, if Medicaid rates do not provide fair reimbursement, the cost must be paid by the remaining users of the system and hospitals will close.

The committee received testimony in opposition to the report recommendations that the state set maximum hospital rates in the private insurance market and in the state employee plan by limiting the amounts payable to out-of-network health care providers to a percentage of Medicare rates. The testimony noted the recommendations fail to understand hospitals and physicians largely participate in all networks and North Dakota does not have an out-of-network, surprise billing problem, as in other states. Additionally, it was noted these recommendations fail to recognize the unique market in North Dakota in which hospitals do not have negotiating power with the dominant insurer and rate caps simply would allow the dominant insurer to further lower its rates.

The committee received testimony hospitals are in the middle of a storm due to the Coronavirus (COVID-19) pandemic. Hospitals have suffered catastrophic financial losses due to the pandemic. Hospitals are not able to sustain a loss of this magnitude and continue to provide the care. It was noted now is not the time to reduce coverage or reimbursement.

The committee received testimony regarding the report from a representative of a consortium of hospitals in the state. According to the testimony, North Dakota's health care system has the unique challenge of delivering care in one of the most rural parts of the country. North Dakota hospitals provide the same advanced medical services offered in urban areas, competing for the same medical professionals and investing in the same technology--the two biggest drivers of health care costs--all while serving a much smaller population.

Testimony in support of managed care indicated the remedy to the rising cost of health care is not government regulations or price capping. It was argued real solutions are found in rethinking the way care is delivered and the health care industry must move from fee-for-service to quality-based payments. To change provider behavior, it is necessary to change the way the health care industry is incentivized to take care of patients--pay doctors and nurses to keep people out of the hospital, not to put people in the hospital.

The committee received testimony in support of moving Medicaid Expansion and traditional Medicaid to a higher level of managed care, in support of expanding the use of telemedicine, and in support of pursuing medication adherence protocols.

Testimony regarding the report suggested improvements may include recognizing economies of scale, consideration of the financial implications of chronic diseases, and consideration of the variances in Medicare reimbursement rates from state to state.

Testimony from representatives of DHS expressed agreement with the hospital and insurer trends described in the report. The testimony noted because the hospitals' data was used in the report, there should be no more debate about if hospital rates are high. The testimony suggested progress can be made by shifting the discussion to how the state can drive more value into the Medicaid program through public policy.

Testimony from a health care insurer in support of the report indicated the report is an opportunity to improve the delivery of health care in the state.

Drivers Affecting Premium

Four health insurers in the state provided testimony regarding the drivers affecting health insurance premiums.

The committee received testimony regarding pooling of risk among similar populations and subsidization within risk pools, including major considerations and assumptions relating to the fully insured line of business rating, the renewal and underwriting calculation process for the fully insured line of business, and the self-insured group rating.

Testimony regarding increases in medical costs and utilization trends indicated increased utilization in the individual market drove higher per-member-per-month costs, and claims costs nearly doubled from 2009 through 2015, with a 38 percent increase in 2014 and nearly 30 percent growth in 2015. Conversely, the large and small group markets were relatively stable during this time frame.

According to the testimony, significant increases in the cost of specialty drugs appear to drive overall cost increases, while insurers paid an increasing share of pharmaceutical costs. In the large and small group markets, the overall cost of pharmaceuticals increased by 6 to 8 percent in both 2014 and 2015. However, in the individual market, pharmaceutical costs increased by about 25 percent in both 2014 and 2015.

In the large and small group markets, the per-member-per-month cost of specialty drugs increased 30 percent in 2014 and more than 20 percent in 2015. The percentage of pharmaceutical costs paid by insurers increased from 63 to 73 percent in 2014, increasing to 80 percent in 2015.

The projected medical trend for 2020 is expected to be consistent with that for 2019, which ranged from an increase of 5 to 8 percent. Although the growth in spending for specialty drugs is expected to remain high, spending growth for prescription drugs overall has leveled and is expected to be similar to or slightly higher than medical spending growth.

Alternative Delivery Models

The committee received testimony regarding accountable care organizations, which are networks of physicians and hospitals which share a financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending. Additionally, the committee received testimony regarding BlueAlliance, a value-based program implemented by a North Dakota insurer.

Health Insurance Plans

Testimony indicated the annual premium trend for the last several years has been an increase of 6 to 8 percent. The reasons for this increase include advancements in medical technology and treatment options that are exponentially increasing or decreasing costs in an unpredictable manner, and unknown variables the health plans need to anticipate, such as new treatment options that will be introduced to the market.

According to the testimony, prescription drug costs are on the rise. The timing of when new prescription drugs hit the market is critical, and health plans constantly are monitoring the status of brand conversions to generic and other medications in development stage which may hit the market. It was asserted future variables that may impact premium trend include new prescription drugs, new medical treatment, social determinants of health, utilization management, health care literacy, new state and federal rules and regulations, benefit mandates, and new efficiencies, such as telehealth.

According to testimony, multiple factors can be used to help decrease premium cost, including payment models, price transparency, personal responsibility, and lifestyle and wellness.

High Deductible Health Plans

The committee received testimony regarding high deductible health plans, including information regarding the prevalence among employers, enrollment among employees, premiums for family and single coverage, and deductibles for high deductible health plans and non-high deductible health plans.

For small employers, enrollment in high deductible health plans grew in the early 2000s, but enrollment began to level starting in the early 2010s. The prevalence of high deductible health plans for mid- and large-employers continued to expand for more than a decade but appears to be leveling in the past few years.

Family premiums for high deductible health plans versus non-high deductible health plans have increased by very similar percentages over more than a decade. Single premiums for high deductible health plans versus non-high deductible health plans have increased by similar percentages over more than a decade.

High deductible health plan deductibles have increased by about 44 percent over more than a decade. However, after considering employer contributions, the deductible has been even steeper, at 62 percent, meaning employer contributions have not kept pace with deductible increases in terms of percentage. Non-high deductible health plan deductibles have increased by approximately 158 percent over the same period. In dollar terms, the actual dollar changes in deductibles have moved by similar amounts.

Drug Cost

Testimony from a representative of the health insurance sector expressed a need for more transparency regarding drug pricing. It was argued drug manufacturers are permitted to operate in a "black box" with respect to pricing, free from public view and unaccountable to market forces. However, health plans are subject to multiple layers of state and federal regulations that provide a picture of how premiums are earned and spent.

Testimony was received in support of including drug wholesalers in any efforts to improve drug cost transparency and to require reporting by pharmacy service administration organizations.

The committee received testimony in support of drug pricing transparency legislation that would:

- Limit the disclosure of proprietary or trade secret data and limit publication of nonpublic data, or data unrelated to the price of the prescription drug.

- Place pharmaceutical manufacturers on similar footing with respect to financial disclosures as other sectors of the health care industry.
- Provide advance notification of excessive significant drug price increases by pharmaceutical manufacturers.

The committee received testimony other states, such as California, Minnesota, Oregon, and Texas, have enacted drug cost transparency laws. Of the $344 billion total cost of drugs in 2018, approximately one-half the cost of drugs, $166 billion, was rebated.

A representative of AARP testified in support of addressing the high cost of drugs by improving transparency of drug manufacturers, pharmacy benefit managers, and insurance companies.

Testimony was received in support of drug cost transparency legislation that provides for the Insurance Department to collect and publish data, in part, because insurance companies are more comfortable reporting to the Insurance Department than the State Board of Pharmacy.

Testimony in opposition to drug cost transparency legislation indicated such legislation:

- Would not help patients;
- Could threaten access to needed prescription drugs;
- Could chill the innovation of future treatments;
- Would mandate additional disclosure of proprietary information and would not benefit patients or decrease health care costs;
- Would improperly target rebates as increasing the cost of drugs;
- Does not recognize that drug costs are the only costs in the health care system which diminish over time due to market changes; and
- Does not adequately protect proprietary or confidential information.

The committee reviewed federal Food and Drug Administration regulations regarding interchangeable biosimilar drugs. A biologic is a drug that generally comes from a living organism, such as yeast and bacteria, which differs from a conventional drug that commonly is made from chemicals. A biosimilar is a biologic that is highly similar to the original biologic and has no clinically meaningful differences from the original biologic. An interchangeable biosimilar is a biosimilar that meets additional federal requirements established in 2019, allowing substitution by a third party for the reference biologic. To date, no biologic drugs have been deemed interchangeable.

The committee considered whether there are barriers in state law to the dispensing of biosimilar drugs and received testimony regarding the prescription of interchangeable biosimilar drugs under Section 19-02.1-14.3. The testimony indicated support of biosimilar legislation if the language is consistent with the notice requirements in other states, such as a 72-hour notice.

Considerations

Drug Cost Transparency

The committee considered a bill draft that would have directed the State Board of Pharmacy to collect and publish data regarding drug costs.

Biosimilar Drugs

The committee considered a bill draft to remove possible barriers to the substitution of an interchangeable biosimilar for a reference biologic under Section 19-02.1-14.3. The committee considered a version of the bill draft that would have abolished the 24-hour notice requirement for substitution of an interchangeable biologic.

The committee considered a version of the bill draft that would have provided a 5-business-day period within which a pharmacist shall notify the prescriber of a substitution of an interchangeable biologic and would have clarified how the notice could be provided by electronic means.

The committee received testimony from a representative of the North Dakota Medical Association in opposition to a bill draft to amend Section 19-02.1-14.3.

Recommendations

The committee recommends a bill draft directing the State Board of Pharmacy to collect and the Insurance Department to publish data regarding prescription drug costs.

The committee recommends a bill draft to require notice within 2 business days if a pharmacist substitutes an interchangeable biosimilar for the reference biologic and to clarify how notice may be provided by electronic means.

HEALTH INSURANCE GUARANTEED ISSUE STUDY

Legislative History

Senate Bill No. 2010, the Insurance Commissioner's appropriation bill, was amended by the House to create a new section to Chapter 26.1-36, which would have prohibited an accident and health insurance policy issued under this chapter from taking into account any pre-existing condition of an insured or applicant, including waiting periods, refusal of coverage, and ratesetting.

This section was replaced in the Conference Committee with language that provides for a study of the feasibility and desirability of state guaranteed issue provisions for health insurance.

Background

In the United States and other developed nations, population health care spending is highly concentrated. In any given year, the healthiest 50 percent of the population accounts for less than 3 percent of total health care expenditures, and the sickest 10 percent account for nearly 66 percent of population health spending. The risk nature of the private health insurance pool is that premiums paid by most enrollees, who have low claims costs, help pay claims for the small share of enrollees with high claims costs.

The membership of who is included in the high-cost and low-cost groups changes from year to year. Most people are healthy most of the time; however, illness and injury can and do onset unexpectedly. Some high-cost conditions, such as hemophilia or HIV, persist and require treatment for extended periods, whereas, other high-cost conditions may improve or resolve, allowing a patient to return to low annual health care spending. Annually, among the 50 percent least expensive people, 73 percent will remain in that low-cost group for a 2nd year. Of the people in the most expensive 10 percent of the population in a year, only 45 percent will be in that group the following year.

Medical Underwriting

Guaranteed issue is a term used in health insurance to describe a situation in which a policy is offered to any eligible applicant without regard to health status. Before private insurance market rules under the ACA, which became effective in 2014, health insurance sold in most states was medically underwritten. Medical underwriting is the process used by insurers to evaluate the health status, health history, and other risk factors of applicants to determine whether and under what terms to issue coverage. Medical underwriting can apply to an entire group or to an individual. Medical underwriting could result in an applicant being declined and could result in adverse underwriting practices.

Over the years, various state and federal regulations have been implemented to limit medical underwriting for major medical coverage in the individual and small group market. Under the ACA, medical underwriting for new enrollees is no longer used for major medical coverage in the individual and small group market.

Before 2014, insurers in most states could consider an individual applicant's health status to determine whether the applicant was eligible for coverage and, if eligible, whether to include pre-existing condition exclusions or increased rates based on health status. Since 2014, an insurer may not consider the applicant's health status other than consideration of tobacco usage.

Before 2014, in the small group market, insurers in 38 states, including North Dakota and the District of Columbia, could base a small group's premiums on the overall health status of the group. Although individual employees could not be charged differing premiums based on health status or denied eligibility for coverage, employees who did not have continuous creditable coverage could have pre-existing condition exclusion periods. The ACA discontinued pre-existing condition exclusion periods and the practice of basing a small group's total premiums on the health history of the group's members.

The rules for large groups are different, even with the implementation of the ACA. Most large groups and many medium-sized groups opt to self-insure rather than purchase coverage from an insurer. However, when a large group buys coverage from an insurer, premiums can be based on the group's overall claims history which means less healthy groups can be charged higher total premiums than healthier groups. Individual employees within a group are covered on a guaranteed issues basis and are not charged different rates based on the individual's medical history.

Although medical underwriting no longer exists for new enrollees in the individual market and for new small group plans, the several types of coverage that use medical underwriting are called excepted benefits under the ACA. Excepted benefits include short-term health insurance and supplemental insurance products, such as dental plans, vision plans, accident supplements, critical illness plans, and fixed indemnity plans. Most excepted benefits are designed to supplement major medical coverage, rather than replace the coverage.

Medical underwriting may result in a policy with pre-existing condition exclusions or a premium higher than the standard rate. Medical history that results in adverse medical underwriting may include acne, allergies, anxiety, asthma, basal cell skin cancer, depression, ear infections, fractures, high cholesterol, hypertension, incontinence, joint injuries, kidney stones, menstrual irregularities, migraine headaches, being overweight based on a high body mass index, restless leg syndrome, tonsillitis, urinary tract infections, varicose veins, and vertigo.

Affordable Care Act Legislation

The case of *Texas v. Azar,* 340 F.Supp.3d 579 (N.D. Tex., 2018), was filed in federal court in February 2018 by Texas and 19 other states, including North Dakota. This lawsuit, which builds on the repeal of the ACA's individual mandate, which was part of the 2017 federal tax reform law, argued because the individual mandate was an essential part of the ACA, the entire ACA should be invalidated. On December 14, 2018, a federal district court judge in Texas issued a ruling holding the ACA in its entirety is unconstitutional; however, since the court did not issue an injunction, immediate compliance is not required. On July 8, 2019, the Fifth Circuit Court of Appeals held hearings on the constitutionality of the individual mandate in *Texas v. Azar*.

This case will be heard by the United States Supreme Court on November 10, 2020, and the ACA remains in effect while this case makes its way through the court system. However, if the district court decision is upheld, the ACA's limitations on medical underwriting will cease to exist and absent new federal legislation, states will again rely on state law to regulate medical underwriting.

High-Risk Pools

The ACA contains various provisions with various effective dates. Title 1 of Subtitle B of Section 1101 of the ACA created the temporary high-risk pool program, which was named the Pre-existing Condition Insurance Plan. The goal of the Pre-existing Condition Insurance Plan was to make health insurance quickly available to uninsured people who had pre-existing conditions. This federal high-risk pool provision became effective June 21, 2010, with individual policies offered for sale in all states by September 2010. This program remained in effect until January 1, 2014, at which time it was replaced by policies sold through the health benefit exchanges, as market changes resulted in pre-existing conditions no longer preventing people from qualifying for private health insurance coverage.

Under the ACA, each state had the choice of running its own high-risk pool that complied with the ACA requirements or deferring to the federal government and allowing the federal government to run the new program. Twenty-seven states chose to run state programs, and 23 states and the District of Columbia had the federal government run the program. North Dakota chose to have the federal government run the state's ACA high-risk pool, while providing the state's high-risk pool--Comprehensive Health Association of North Dakota--continued to operate separately.

North Dakota is one of 35 states that implemented a high-risk health insurance pool before 2010. The National Conference of State Legislatures reports as of 2010, more than 200,000 people were served by these state high-risk health insurance pools.

Testimony and Committee Considerations

The committee received testimony that before the ACA, people were locked into their jobs because they needed to ensure employer group health insurance coverage. According to the testimony, every American deserves affordable, comprehensive health coverage--regardless of income, employment status, health status, or pre-existing conditions. No one should be denied or priced out of affordable health coverage because of health status. The ACA pre-existing condition protections were implemented in cooperation with provisions to incentivize broad enrollment and continuous coverage and a well-balanced risk pool. Additional safeguards are needed in tandem with pre-existing condition protection for the market to be stable and function properly. Most critically, broad-based individual participation is critical for an affordable and stable individual insurance marketplace. It was argued premium tax credits and the infrastructure for consumers to shop and purchase health insurance are crucial to ensuring North Dakotans who do not have employer-sponsored coverage, Medicaid, or Medicare can find and afford coverage. Without these elements, North Dakota's market may deteriorate because individuals and families drop coverage because it is unaffordable.

The committee received testimony in support of including a contingent effective date in any legislation the committee might recommend so the bill would not go into effect unless the ACA is repealed or found unenforceable.

The testimony received by the committee raised the concern of the consequences of lapses in coverage and people choosing to remain uninsured unless or until a health emergency arises.

The committee considered legislative language submitted by stakeholders. The committee worked with the Insurance Department in preparing bill drafts for consideration by the committee.

The committee considered two versions of a bill draft addressing health insurance guaranteed issue. One version of the bill draft would have provided for guaranteed issue and prohibited pre-existing condition provisions in individual health insurance plans.

Recommendation

The committee recommends a bill draft that provides for guaranteed issue for small employer health insurance plans and individual health insurance plans, providing limited pre-existing condition provisions in cases of lapse of coverage.

HEALTH CARE DELIVERY STUDY

Legislative History

Senate Bill No. 2012, the DHS appropriation bill, was amended by the Senate to provide for a Legislative Management study of health care delivery in the state. The Senate Appropriations Committee received testimony from multiple stakeholders, including DHS and the University of North Dakota School of Medicine and Health Sciences Center for Rural Health, regarding critical access hospitals, rural health care, and implementation of the ACA, including Medicaid Expansion.

Background

During the previous four interims, the Legislative Management has studied the state's health care delivery system. Typically, these studies have included or been accompanied by a study of implementation of the ACA. This interim, although the study did not prohibit considering how the ACA may impact the delivery of health care, the primary focus was the delivery of health care.

The broad directive to study the delivery of health care in the state required the study to include a review of the needs and future challenges of the state's health care delivery system, including:

- Rural access to primary health care;
- Use of emergency medical services;
- Strategies to better serve residents; and
- The role of health care services in the future development of the state.

Although the study was not limited to rural health care, according to the North Dakota Census Office, 39 of the state's 53 counties are classified as completely rural, 3 as mostly rural, and 11 as mostly urban. North Dakota is one of five states classified as frontier under the ACA.

Testimony and Committee Considerations

Rural Health

The committee received testimony regarding the following 10 key factors to understanding rural health in North Dakota:

1. Demographics drive health conditions, services, demand, and supply.
2. Networking, collaboration, and partnerships are fundamental.
3. Equity and interdependence are ways to think about rural communities and rural health.
4. You cannot focus on rural health without focusing on the community.
5. Rural health providers--hospitals, clinics, long-term care, emergency medical services--are vulnerable.
6. Rural health is more than just rural hospitals, primary care clinics, emergency medical services, public health, and infrastructure. Rural health also refers to the health of the population.
7. Quality of rural health care is high.
8. Health workforce may be even more problematic in rural areas than larger communities.
9. Rural health providers are up to date with technology and telehealth.
10. Healthy policy is critical to rural health.

The committee also received testimony regarding the demographics of the state. With a population of over 760,000, North Dakota is the fourth youngest state, with a median age of 35 years. Oil counties and urban counties continue to grow, but most other rural counties have experienced marginal growth or even population loss. Demographics influence rural health care through patient base, employment base, the type and availability of services, volunteer base, and the distance to services, work, day care, and home.

The testimony emphasized rural health care providers are vulnerable. A key point in rural North Dakota is the hospital is more than a hospital. If a rural hospital closes there is a loss of primary care, emergency medical services, and in many cases nursing homes and other elder care services. It was noted rural health serves a more vulnerable population:

- 63 percent of people 65 and older live in rural North Dakota, with approximately 39 percent of critical access hospital inpatient base being Medicare.
- 46 percent of North Dakota veterans are rural residents.
- More than 9 percent of rural North Dakotans have not finished high school, compared to 6.2 percent of urban North Dakotans.
- Distance, weather, and transportation are factors contributing to health disparities for rural North Dakotans.

According to the testimony, the state's health workforce is not only experiencing shortages but also maldistribution. However, there are efforts being taken through the educational system and by the rural communities to address these workforce and distribution issues.

In terms of access to technology, the state is heavily wired. Technology connects rural communities not only to tertiary hospitals, but to the world. Technology allows rural clinics to have electronic medical records or electronic health records, telemedicine, and telepharmacy.

The testimony indicated federal and state health policy drives rural health. The committee was informed federal policies on the horizon include global budgets, community outpatient hospitals and rural emergency care hospitals, and Medicare reimbursement methodologies for rural providers.

The committee received a summary of a 2017 survey of critical access hospital chief executive officers' perceptions of issues. Of the 22 issues identified in the survey, the following are the top 12 issues listed as a problem, moderate problem, or severe problem:

1. Access to mental health inpatient services (94.5 percent);
2. Access to substance use disorder inpatient treatment services (92.7 percent);
3. Access to substance use disorder outpatient treatment services (91.4 percent);
4. Access to mental health outpatient services (86.2 percent);
5. Transportation of patients with mental health or substance use disorders to treatment services (80.5 percent);
6. Hospital reimbursement - Medicaid (69.4 percent);
7. Impact of the under-insured (69.4 percent);
8. Impact of the uninsured (68.6 percent);
9. Service area economic change (66.7 percent);
10. Hospital reimbursement - Third-Party Payer (63.9 percent);
11. Service area population change (61.1 percent); and
12. Hospital reimbursement - Medicare (50 percent).

Critical Access Hospital Finances

The committee received a summary of the report on the 2018-19 critical access hospital financial analysis. The report provided:

- Patient Revenue continues to trend positively:

  Inpatient revenue continues to trend fairly flat; and

  Outpatient and clinic revenue experiences the greatest growth;
- Contractual deductions trend proportionate to patient revenue;

- Bad debt and charity care expense increased to the highest level ever, increasing by nearly $3 million to $42.7 million this past year;
- Medicaid Expansion accounted for nearly 4 percent of net patient revenue;
- $24 million in Medicaid Expansion payments to North Dakota critical access hospitals in the past year;
- Eighteen critical access hospitals had a positive operating margin in 2018, compared to 19 in 2017;

  Total operating margin for all critical access hospitals was $8.5 million or 1.4 percent; and

  Average operating margin was $234,000;
- Operating expenses have been experiencing modest increases;
- Critical access hospitals incurred $15 million in contract nursing expenses in 2018;
- 27 critical access hospitals had a positive net margin;
- 7 critical access hospitals are participating in a Medicare accountable care organization; and
- Multiple critical access hospitals are participating in Blue Cross Blue Shield of North Dakota's managed care program, BlueAlliance.

Community Paramedic Program

The Sanford Health community paramedic program in the Fargo-Moorhead community was established as a pilot project in 2015 through a State Department of Health grant. According to testimony, the program initially had one full-time equivalent position but is increasing to three positions. Although the initial focus of the program was on high utilizers of emergency medical services, such as those with chemical dependency and behavioral health issues, the current focus is on filling gaps in health care services. The goal of the program is to prevent unnecessary admissions and readmissions, to lower the cost of care by providing the right level of care at the right time to the right patient, and to improve quality of care of the patients.

Telehealth in Schools

A telehealth school nurse program provided through eCARE provides nurse extender services, primary school nurse services, and behavioral health services to schools. The committee received testimony that although state law does not hinder nurses from performing telehealth, improvements in behavioral health provider licensure requirements could help facilitate telehealth services. Additionally, it would be helpful to have a state law requiring nurse oversight in all schools in the state.

Conclusions

The committee makes no recommendations regarding its study of health care delivery.

HEALTH FACILITY CONSTRUCTION AND RENOVATION STUDY

Legislative History

Senate Bill No. 2317, as introduced, provided for State Department of Health licensure of pediatric subacute care facilities. The bill, as passed, addressed State Department of Health life safety survey determinations for construction and renovation of health facilities licensed by the State Department of Health Division of Health Facilities and department licensure standards for basic care facilities. Additionally, the bill provided for the Legislative Management study and an interim report to the Legislative Management by the State Department of Health regarding implementation of the bill.

The testimony in support of Senate Bill No. 2317 indicated with limited department resources for inspection and project plan approval, small projects are being delayed and, in some instances, losing access to grant funds due to the delays in having project plans approved. The testimony recognized there is a balance between the value of having authorization to avoid expensive and timely noncompliance issues discovered at the completion of a project and the delays in initiating small projects. Additionally, testimony raised the concern it may not be appropriate to have the State Department of Health conducting these project reviews.

Testimony in support of the innovation waiver language indicated the department would like flexibility to approve projects that may not meet the letter of the law, but do not adversely affect health or safety and do not violate federal requirements.

Health Facility Construction and Renovation Project Timelines and Innovation Waivers

Section 1 of Senate Bill No. 2317 amended Section 23-01-37, the law directing the State Department of Health to conduct a life safety survey for all health facilities licensed by the Division of Health Facilities. The law requires the department to conduct the survey during and at the conclusion of a construction, renovation, or construction and

renovation project. The 2019 legislation required determinations of projects that do not exceed $1 million to be made within 60 days of receipt of a complete application. Additionally, the department may approve a request for a waiver of a state law or rule relating to an innovative construction, renovation, or construction and renovation project if the lack of compliance does not adversely affect health or safety. The department's survey program may not violate the federal Medicare-certified life safety surveys.

Basic Care Facility Licensure Waivers

Section 2 of Senate Bill No. 2317 amended Section 23-09.3-04, the law directing the State Department of Health to establish standards for basic care facilities. Under this section the department is required to inspect all places and grant an annual license to basic care facilities that comply with the standards established and rules adopted. The 2019 legislation authorized the department to waive all or a portion of a license standard if the department determines the lack of compliance does not adversely affect the health or safety of residents.

The testimony in support of Section 2 of Senate Bill No. 2317 indicated because basic care facilities are a creation of state law and are not required to follow the federal life safety survey requirements, the state has more flexibility than it does in conducting Medicare-certified life safety surveys of facilities. Testimony further indicated the State Department of Health sought flexibility in licensing basic care.

Testimony and Committee Considerations

The committee received periodic reports from the State Department of Health on the implementation of Senate Bill No. 2317.

Health Facility Construction and Renovation Project Timelines

The State Department of Health employs four full-time positions and one part-time temporary employee to work on the health facility construction and renovation plan review program. The program is responsible for plan review and monitoring of construction and revocation projects in hospitals, nursing facilities, and basic care facilities.

According to the testimony, due to limited resources and the legislative prioritization of review of plans for smaller construction and renovation projects, the smaller projects are being reviewed before the larger projects.

The department provided an overview of its process for health care facility review. Delayed review and approval processes negatively impact health care leaders' ability to manage capital and human resource investments and can ultimately delay access to care.

The department also provided testimony regarding how neighboring states address plan review for health facility construction and renovation.

The department testified it is implementing a multipronged approach to address concerns over the timeliness of the plan review process. The department will continue to attempt to bolster the program with an additional temporary position as provided through funding included in House Bill No. 1004 (2019), and will continue to explore the innovative approach of utilizing qualified outside vendors found through a request for proposal to aid in the plan review and provide facilities an expedited route in their plan review process. If these approaches are not successful, the department will examine if there is a way to potentially add additional full-time equivalent positions to the program.

Testimony was received in support of the department's multipronged efforts to address timeliness. It was noted the key to better communication, shorter review times, and better alignment between a design team and the department is the ability to continue to have an open dialogue and communication with the department. It was suggested one way to improve open dialogue may include implementation of a process in which there are opportunities during the design phases for the team to sit together and perform a page-by-page review of the plans at multiple points. This collaborative approach would allow the department to better understand the project earlier in the process as well as to raise concerns during design so the design team can implement changes into the drawings during the design phase, thereby streamlining the review process.

Waivers

In response to Senate Bill No. 2317, the department developed internal policies and procedures that went into effect on July 15, 2019, to address the application for an innovative construction, renovation, or construction and renovation project. Additionally, the department developed internal policies and procedures that went into effect on June 14, 2019, to address the application for a waiver of all or a portion of a basic care facility license standard. According to the testimony, the reason for adopting internal policies and procedures for these waiver projects was that adoption of policies and procedures is quicker than addressing through administrative rules.

The testimony indicated the department's basic care waiver policies are more stringent than Senate Bill No. 2317 provides. Concerns were raised that the adoption of the policies was not transparent, and stakeholders did not have an opportunity for public comment. Committee members also expressed concern regarding the department's strategy of addressing the basic care waiver through agency policy and avoiding public comment. Additional concern was raised the waiver application decision is not appealable.

Representatives of the department testified the department would adopt administrative rules to address the basic care waiver. The rules were drafted, reviewed by industry, and approved by the Health Council. However, due to the response to COVID-19, the adoption of the rules was temporarily halted.

Under the proposed rules, a health care facility may apply for a waiver of state law or rule relating to innovative construction, renovation, or construction with supporting evidence. This waiver would not adversely affect the health and safety of patients, residents, employees, or the general public. The department may deny an innovative waiver request within 60 days of receiving a complete application. If the applicant chooses to proceed, the health care facility has 7 days after receiving the notice to appeal the decision to the State Health Officer, who has 7 days upon receipt of the appeal, to make a final decision. The decision by the State Health Officer, or designee, is final and conclusive. The draft rules require the health care facility to submit a complete and separate waiver application for each law, rule, or construction standard. The draft rules also provide basic care facilities may request a waiver of licensure requirements for specific periods of time, providing compliance with the requirement would result in unreasonable hardship upon the facility, and lack of compliance does not adversely affect the health or safety of the residents. A waiver of licensure requirements also can be provided if the basic care facility does not intend to come into compliance, provided the health or safety of residents is not adversely affected.

Conclusions

The committee makes no recommendations regarding its study of health facility construction and renovation.

REPORTS

Ignition Propensity Standards for Cigarettes

The committee received a report from the State Fire Marshal on the State Fire Marshal's findings and any recommendation for legislation to improve the effectiveness of the law on reduced ignition propensity standards for cigarettes.

The committee received the recommendation to correct the language of Section 18-13-02(1)(a) to include "ASTM E2187-04 or the most current standard test method under designation E2187 (Standard test method for measuring the ignition strength of cigarettes)". This change would clarify the current standard should be used and enable the State Fire Marshal's office to enforce the most current and safest standards in place.

Reduction of the Incidence of Diabetes

The committee received a report from a representative of DHS, the State Department of Health, Indian Affairs Commission, and Public Employees Retirement System on their collaboration to identify goals and benchmarks while also developing individual agency plans to reduce the incidence of diabetes in the state, improve diabetes care, and control complications associated with diabetes.

The report included action plans by each of the parties and identified actionable items through a cross-sector, community-based approach. While none of the contributing entities suggested a need for additional funding for their current workplans, the report provided implementation of the actionable items would best occur at the local level. For that reason, the report suggested creation of a community grant fund specifically for communities and organizations to apply which would support local implementation of diabetes and risk-factor prevention strategies. Additional budget considerations related to action items included:

- The costs associated with the financial burden for individuals in North Dakota is related to the daily choices individuals face which are beyond diabetes care, including access to affordable nutritious food, safe places to engage in physical activity, and out-of-pocket health care costs for prevention and intervention.
- The costs associated with insurance and Medicaid coverage of improved glucose monitoring technology.
- Many schools are ill-equipped without onsite school nurses or access to telehealth school nursing for children with type 1 diabetes requiring insulin. Ensuring all schools have access during the entire school day to nurses through telehealth to assist children with insulin dose calculation would be a cost-effective approach for delivering care.

Stroke Centers and Care

The committee received a report by the State Department of Health regarding progress made toward the recommendations provided in Section 23-43-04 relating to stroke centers and stroke care.

Abandoned Infants

The committee received a report from the State Department of Health on the status and progress of implementing a public awareness campaign to provide information, public service announcements, and educational materials regarding abandoned infants and approved locations for abandoned infants.

Section 50-25.1-15(1)(b) defines "approved location" regarding abandoned infants as a hospital or other location as designated by administrative rule adopted by DHS. The Department of Human Services adopted administrative rules relating to approved locations. The Department of Human Services facilitated meetings with stakeholders to ensure their support and consent as approved locations. As a result of these meetings, the following entities have been added as approved locations that include physical locations as well as on-duty staff members of the following:

- Local public health units;
- Human service zones;
- Regional human service centers;
- Long-term care nursing facilities;
- Children's advocacy centers;
- Emergency medical services operations; and
- Criminal justice agencies.

The committee received testimony to enhance public awareness, the State Department of Health produced 60-second and 2.5-minute public service announcements that explain North Dakota's safe haven law regarding abandoned infants.

According to the report, to develop ongoing public education and training materials to medical providers, law enforcement, and social service agencies, DHS amended an existing contract with Prevent Child Abuse North Dakota, which is working with a vendor to create these materials in consultation with the State Department of Health and DHS.

An educational flyer is in development which includes a medical history form for the infant. These materials will be provided without cost to the public and the staff of approved locations by December 2020.

Health Care Analysis

The committee received a report from the Insurance Department regarding a detailed analysis of health care in the state. This report is addressed in this report under the heading "**HEALTH INSURANCE PREMIUM TREND STUDY**".

Health Facility Construction and Renovation

The committee received a report from the State Department of Health regarding the implementation of Senate Bill No. 2317. This report is addressed in this report under the heading "**HEALTH FACILITY CONSTRUCTION AND RENOVATION STUDY**".