

TESTIMONY

Presented by: **Melissa Hauer**
 General Counsel
 North Dakota Insurance Department

Before: **Health Care Reform Review Committee**
 Representative George Keiser, Chairman

Date: **October 20, 2011**

Good morning, Chairman Keiser and members of the Health Care Reform Review Committee. My name is Melissa Hauer and I am the General Counsel for the North Dakota Insurance Department. I appear before you to provide an update on the implementation of the federal health care reform law, the Patient Protection and Affordable Care Act (PPACA).

1. Update on Federal Activities

Community Living Assistance Services and Supports (CLASS) program.

The Obama administration cancelled the CLASS program because it was determined the program could not simultaneously meet three important criteria: be self-sustaining, financially sound for 75 years, and affordable to consumers. The CLASS program would have allowed working adults to pay for coverage that would provide up to \$50 a day in cash benefits if they became disabled. The money could be used for services such as in-home assistance or nursing home care.

2. Contractor Work Update

Health Benefit Exchange Planning Grant Update

Exchange Consultant

The Department contractor, HTMS, continues its work to research issues regarding Exchange planning in North Dakota. A copy of the latest weekly status

report from HTMS is attached. We will continue to provide the committee with copies of the weekly status report as we receive them from HTMS.

3. Follow Up From Last Committee Meeting

Consumer Operated and Oriented Plan (CO-OP)

As requested at the last meeting, we requested written confirmation from the U.S. Department of Health and Human Services (HHS) regarding whether a Consumer Operated and Oriented Plan (CO-OP) will be established in each state. The response, a copy of which is attached, states that it is HHS's "...goal to establish at least one CO-OP in each state consistent with the statutory requirement to ensure funding for one CO-OP in each state. To the extent that there is not a candidate in a specific state, the statute allows [HHS] to use this funding to encourage CO-OP development in these areas where there are no prospective applicants."

Stakeholder Meetings

As requested at the last meeting, a copy of the consumer stakeholders list is attached. A survey was sent to the attached list and it was also distributed via news release.

Small Employer Definition

At the last meeting, a question arose as to whether the current definition of "small employer" in N.D.C.C. § 26.1-36.3-01 should be amended to be consistent with the definition contained in PPACA and federal regulations. The definition will need to change eventually but there is still uncertainty regarding the federal definition. The regulations are proposed and are still subject to comment and possible change. It is possible that the requirements for how employees are counted for purposes of determining the size of the employer may change. Because of this uncertainty, we do not feel a change to the state law is warranted at this time and would be better addressed during the 2013 legislative session.

Federal Planning Grant Balance

The federal planning grant balance is currently \$768,106.19. The Department anticipates using approximately \$10,000 more of the federal planning grant before December 1, 2011, and, therefore, expects to be able to transfer \$758,106.19 to OMB.

4. Bill Draft Comments

Bill Draft 11.0806.0400 – Exchange Bill

- a. Page 1, line 22, and page 26, starting at line 27, state the Exchange board would be given the authority to increase the premium tax on health insurers. This would result in uncertainty for insurers regarding their tax liability. There is no upper limit on the increase that could be levied and the amount of tax could change every year. Rather than risk this uncertainty and have to deal with the administrative burden of adjusting their tax reporting and payments, some companies may simply choose not to do business in North Dakota. In addition, it would be administratively difficult to collect a tax that is subject to such fluctuation each year. Forms and computer systems would have to be modified with each change in the tax rate. Companies, being used to paying one tax rate for a long period of time, would likely make errors in payment of tax which will require the state to devote time to following up with those companies and having to request and review corrected tax statements and impose penalties for late payment of tax. The bill provides that notice of the change would not have to be made until October of each year. This would not be enough time to make all of the changes necessary to the forms and computer systems and implement the new rate by January 1 and currently the Department does not have the staff to do this work.

- b. Page 6, line 30, page 14, line 2, and page 26, line 13 provide that the Exchange must meet an obligation by a certain date specified "...or later as otherwise specified by the commissioner...". It is unclear what authority the Insurance Commissioner would have to modify the dates specified. If this language is

deemed necessary, perhaps the authority should be given to the Exchange board or OMB or some other agency or official.

- c. Page 10, line 13 states that only voting members are exempt from the provisions of N.D.C.C. chapter 51-08.1 (the state Anti-Trust Act). It is unclear why the word “voting” was added to this sentence but it could mean that nonvoting members would not be exempt from that law. It is uncertain if that result was intended.
- d. Page 10, line 24 states that the Exchange board shall consult with the Indian Affairs Commission. As noted at the last meeting, the federal regulations require Exchanges to consult with Indian tribes.
- e. Page 20, line 14 creates a Navigation office within the Exchange division. Section 1311 of PPACA requires an Exchange to “...establish a program under which it awards grants to entities described...” to carry out navigator duties. The entities described are: “trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, [and] other licensed insurance agents and brokers...”. The language of the bill does not provide for state grants to navigators nor does it require the state’s navigators to be made up of any of the entities specified in PPACA.
- f. Pages 29-32 provide for appropriations to the Office of Management and Budget, the Department of Human Services, and the Information Technology Department. Because there will be additional filings made by insurers wishing to do business in the Exchange and additional financial examination and analysis needed of the impacts of the Exchange the resources of the Insurance Department will need to be increased to deal with them as well. Rate and form filings are already backlogged in the Department currently. If rates and forms cannot be reviewed due to lack of resources, rate increases could be deemed approved before the Department gets a chance to review them. Equally

problematic will be that insurance plans will not get to the Exchange for sale to consumers if they cannot be reviewed and approved in a timely manner. There is a need for one additional actuary, one filing analyst, one financial analyst, and one financial examiner. In order to deal with this increase in filings, the Department is requesting the following appropriation clause be added to the bill:

APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of \$642,350, or so much of the sum as may be necessary, to the insurance department for the purpose of defraying the expenses of implementation of the federal Affordable Care Act, for the period beginning December 1, 2011, and ending June 30, 2013. The insurance department is authorized four full-time equivalent positions for this implementation

Bill Drafts Regarding External Review

The committee is considering three bill drafts to modify the external review laws. It is our understanding that one of the bill drafts incorporates the provisions of 2011 House Bill No. 1127 essentially as introduced. The other two bill drafts were proposed by Blue Cross Blue Shield of North Dakota and are relatively short in that they modify only the external review law that applies to new health plans (non-grandfathered plans).

If the desire of the committee is to accept the bill draft that has the highest likelihood of securing approval from HHS as a sufficient claims, appeals, and external review process such that the state can oversee that process, the bill modeled on 2011 House Bill No. 1127 is the safest bet. For a state external review process to apply, the state process must include the 16 minimum consumer protection standards set forth in the federal regulations. The two other bills do not meet all of the 16 requirements.

Mr. Chairman, members of the committee, this concludes my testimony. I would be happy to try to answer any questions you may have. Thank you.

ND HBE Planning Status Report

Status Date:	10/14/2011
Project owner:	Nancy Wise
Prepared by:	Jonathan Leonard

Recent Accomplishments:

- Compiled the results of the Carrier survey
- Completed funding options research
- Completed analysis of implications of merging individual and small group markets
- Held two stakeholder meetings with small business groups
- Demographic models ready to review with client
- Kicked off consumer survey
- Met with State PERS Department
- Reached out to legislators for individual meetings

Current In-Process/On-Going Activities:

- Continued research on demographic and market data requests as identified in the RFP
- Continued to compile interviews
- Continued development of demographic models
- Continued schedule meetings with providers groups and legislators
- Continued research activities, specifically compiling research from other State HBE's.
- Continued developing operational model framework and modular components to costs including assumptions list
- Began coordinating model definitions and costs for the exchange with ITD
- On track for delivering Mid Stage findings October 18.

Issues and Risks

No known issues or risks at this time

Schedule	Impact	Risks	Overall

Milestones / Deliverables for this Phase:	Due	Complete
Project Initiation Project Planning Call Project Kick-Off Meeting in Bismarck	09.17.11	100%
Initial Research Findings Materials supplied in advance of the HB1126 bill deadline to introduce legislation – Oct 15	09.30.11	100%
Interim Deliverable Draft materials provided before the special legislative session scheduled to begin 11-7	10.31.11	
Project Packaging and Wrap-Up		
Final Deliverable to Client	12.02.11	

Important Dates:

- September 30 - Preliminary findings due to client for legislative planning
- November 7 – Interim Deliverable for legislative session due.
- December 2 – Final deliverable due to client



Hauer, Melissa A.

From: Bollinger, Anne M. (CMS/CCIIO) [anne.bollinger@cms.hhs.gov]
Sent: Monday, October 17, 2011 1:09 PM
To: Hauer, Melissa A.
Cc: Elrington, Meghan (CMS/CPC)
Subject: RE: CO-OP Program question

Hi Melissa,

I am sorry for the delay in getting back to you. Our goal is to establish at least one CO-OP in each state consistent with the statutory requirement to ensure funding for one CO-OP in each state. To the extent that there is not a candidate in a specific state, the statute allows us to use this funding to encourage CO-OP development in these areas where there are no prospective applicants. I hope this answers your question. Please let me know if you need anything else.

Thanks,
Annie

Anne Bollinger
Email: anne.bollinger@cms.hhs.gov
Desk: (301) 492-4395
BB: (202) 380- 8211

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the fullest extent of the law.

From: Hauer, Melissa A. [mailto:mahauer@nd.gov]
Sent: Thursday, October 06, 2011 3:24 PM
To: Bollinger, Anne M. (CMS/CCIIO)
Cc: Elrington, Meghan (CMS/CPC)
Subject: Re: CO-OP Program question

Anne

One more followup question. Given the language in section 1322 that says the Secretary shall ensure there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, wouldn't that mean one is supposed to be set up in each State?

From: Bollinger, Anne M. (CMS/CCIIO) <anne.bollinger@cms.hhs.gov>
To: Hauer, Melissa A.
Cc: Elrington, Meghan (CMS/CPC) <Meghan.Elrington@CMS.hhs.gov>
Sent: Thu Oct 06 13:23:56 2011
Subject: RE: CO-OP Program question

Hi Melissa,

Here is a link to section 1322 of the ACA: <http://www.gao.gov/about/hcac/section1322.pdf> and a link to our notice of proposed rulemaking: <http://www.gpo.gov/fdsys/pkg/FR-2011-07-20/pdf/2011-18342.pdf>.

The statute permits HHS to award loans to encourage the establishment of a CO-OP in each state in order to expand the number of health plans available in the Exchanges. However, this is not a “requirement” and we are permitted to fund more than one CO-OP in a single state.

I have also attached a slide deck presentation on CO-OPs to give you a more thorough overview of our program.

Thanks,
Annie

Anne Bollinger
Email: anne.bollinger@cms.hhs.gov
Desk: (301) 492-4395
BB: (202) 380- 8211

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the fullest extent of the law.

From: Hauer, Melissa A. [mailto:mahauer@nd.gov]
Sent: Thursday, October 06, 2011 1:36 PM
To: Bollinger, Anne M. (CMS/CCIIO)
Subject: CO-OP Program question

Ms. Bollinger,

Can you please tell me if the Patient Protection and Affordable Care Act or its implementing regulations require establishment of a Consumer Operated and Oriented Plan (CO-OP) in each State? A member of our State Legislative Assembly is requesting this information. Thank you for your assistance.

Melissa Hauer, General Counsel
North Dakota Insurance Department
600 East Boulevard Avenue
State Capitol - Fifth Floor
Bismarck, ND 58505
(701) 328-2440

Consumer stakeholder list

First name	Last name	Affiliation	Email
Cherry	Schmidt	Aging and Disability Resource Link	cschmidt@nd.gov
Christine	Hogan	ND PROTECTION & ADVOCACY	chogan@nd.gov
Dana	Mees	ND Council on Abused Womens Services	dmees@ndcaws.org
David	Zentner	CHAD	izentner@bis.midco.net
Deborah	Knuth	American Cancer Society govt relations	deb.knuth@cancer.org
Donene	Feist	FAMILY VOICES	fvnd@drtel.net
Josh	Askvig	AARP	jaskvig@aarp.org
June	Herman	American Heart Association	june.herman@heart.org
Lyle	Halvorson	AARP	lhalvorson@aarp.org
Marlow	Kro	AARP	mkro@aarp.org
		Minot Vocational Adjustment Workshop	info@mvaw.org
		ND Assoc for the Blind	klarson@dia.net
		ND Center for Persons with Disabilities (MSU)	Brent.Askvig@minotstateu.edu
		ND Protection and Advocacy Project	panda@nd.gov
		NDAD	fargo@ndad.org
Reba	Mathern-Jacobson	March of Dimes	rmathern-jacobson@marchofdimes.com
Susan	Helgeland	MHAND	srhelgeland@gmail.com
Tammy	Gallup-Millner	Children's Special Health Services	tgallupmillner@nd.gov
		The Arc	dsheppard@arcuv.com
Tony	Richards	CHAD	tony@communityhealthcare.net
NATHAN	AALGAARD	FREEDOM RESOURCE CENTER	natea@freedomrc.org
TOM	ALEXANDER	MIG PROJECT - MSU	tom.alexander@minotstateu.edu
HOWARD	ANDERSON	ND BOARD OF PHARMACY	ndboph@btinet.net
MIKE	ANDERSON	ND HOUSING & FINANCE	maanders@ndhfa.org
BRENT	ASKVIG	NDCPD	Brent.Askvig@minotstateu.edu
JUDY	BAHE	PEDIATRIC TASK FORCE GROUP	ibahe@mohs.org
JOE	CICHY	ND DENTAL ASSOC	jcichy@midconetwork.com
TIM	COX	NORTHLAND HEALTHCARE ALLIANCE	tcox@northlandhealth.com
POLLY	FASSINGER	NORTH DAKOTA KIDS COUNT	ndkidscount@yahoo.com

LISA	FAUL	ND CARING FOR CHILDREN	lisa.faul@bcbsnd.com
DONENE	FEIST	FAMILY VOICES	fvnd@drtel.net
KEVIN	FIRE	AUDIOLOGISTS/DME PROVIDER TASK FORCE GROUP	kfire@hearingaidnd.com
MARY ANN	FOSS	DEPT. OF HEALTH, WOMEN'S WAY	mfoss@nd.gov
DIXIE	GAIKOWSKI	INDIAN HEALTH SERVICE ABERDEEN	dixie.gaikowski@ihs.gov
PAM	GALLAGHER	MERITCARE HOSPITAL/ SOC. SERV. DEPT.	pam.gallagher@meritcare.com
WAYNE	GLASER	ND DEPT OF COMMERCE	wglaser@nd.gov
CHERYL	HEFTA	MEDICAL NEEDS TASK FORCE	manch@gondtc.com
DUANE	HOUDEK	ND BOARD OF MEDICAL EXAMINERS	DHOUDEK.NDBME@MIDCONETWORK.COM
ERIC	MONSON	ANNE CARLSEN CENTER FOR CHILDREN	eric.monson@annecenter.org
JERRY	JURENA	ND HOSPITAL ASSOCIATION	jjurena@hamc.com
CONNIE	KALANEK	ND BOARD OF NURSING	ckalanek@ndbon.org
NANCY	KOPP	ND OPTOMETRIC ASSOCIATION	nkopp@btinet.net
THERESA	LARSON	ND PROTECTION & ADVOCACY	tlarsen@nd.gov
JUDY	LEE	IPAT	jlee@ndipat.org
COURTNEY	KOEBELE	ND MEDICAL ASSOCIATION	courtney@ndimed.com
GREG	LORD	DME PROVIDER TASK FORCE GROUP	glord@primecare.org
LOIS	MACKAY	ND PUBLIC HEALTH ASSOCIATION	ndpha@sft.com
CARLOTTA	MCCLEARY	FEDERATION OF FAMILIES	carlottamccleary@bis.midco.net
BARBARA	MURRY	ND ASSOC OF COMMUNITY FACILITIES	barbndacf@midco.net
VICKY	NESS	LTC SOCIAL WORKERS ASSOC	sklein@mslcc.com
SHELLY	PETERSON	ND LONG TERM CARE ASSOCIATION	shelly@ndltc.org
ANN	POLLERT	COMMUNITY ACTION	ndcaa@sendcaa.org
VINCENT	ROKKE	ND CHIROPRACTIC ASSOCIATION	vrokke@ndca.net
PAUL	RONNINGEN	CHILDREN'S DEFENSE FUND	pronningen@hotmail.com
ROYCE	SCHULTZE	DAKOTA CENTER FOR INDEPENDENT LIVING	royces@dakotacil.org
MIKE	SCHWAB	ND PHARMACY ASSOCIATION	mchwab@nodakpharmacy.net
MARCIA	SJULSTAD	ND ASSOC FOR HOME CARE	Marcia.sjulstad@meritcare.com
RANDY	SORENSEN	OPTIONS RESOURCE CNTR	randy@myoptions.info
LESLIE	STASTNY	ND ASSOC FOR THE DISABLED	lstastny@nddad.org

MYRNA	HANSON	COMMUNITY OF CARE	coc@communityofcare.nd.com
TAMMY	THEURER	ND ASSOCIATION FOR HOME CARE	ttheurer@primemecare.org
MICHAEL	TILUS	MENTAL HEALTH SOCIAL SERVICES	Michael.Tilus@ihs.gov
KRIS	TODD	NDNPA	ktodd@bis.midco.net
J. PATRICK	TRAYNOR	DAKOTA MEDICAL FOUNDATION	pattraynor@dakmed.org
TODD	TWOGOOD	ND AAP CHAPTER PRESIDENT / Q & R CLINIC	ttwogood@mohs.org
JOSH	ASKVIG	AARP	jaskvig@aarp.org
MIKE	ZAINHOFSKY	BURLEIGH CO HOUSING AUTHORITY	mike@bchabis.com
HEATHER	ZIETZ	MEDICAL NEEDS TASK FORCE	heatherzietz@aol.com
ERIKA	CERMAK	NORTH DAKOTA ASSN. OF HOME CARE	erika.aptn.d.com
KURT	SNYDER	THE ND ADDICTION TREATMENT PROVIDERS COALITION	heartview@midconetwork.com
CHERYL	UNDERHILL	CHAD	cheryl@communityhealthcare.net
JOHN	VASTAG	SANFORD HEALTH	john.vastag@sanfordhealth.org
TEX	HALL	THREE AFFILIATED TRIBES	redtippedarrow@mhnanation.com
SCOTT	DAVIS	ND INDIAN AFFAIRS COMMISSION	sjdavis@nd.gov
ROGER	YANKTON SR.	SPIRIT LAKE NATION	rogeryankton@spiritlakenation.com
RON	HIS HORSE IS THUNDER	ABERDEEN AREA TRIBAL CHAIRMANS HLTH BD	ron.hishorseisthunder@gpthb.org
WALT	MORAN	TRENTON INDIAN SERVICE CENTER	tisachair@nccray.net
JODY	COURNOYER	BELCOURT IHS HOSPITAL	jody.cournoyer@ihs.gov
CAROLYN	CAVANAUGH	SPIRIT LAKE HEALTH CENTER	carolyn.cavanaugh@ihs.gov
KIMBERLY	CRAIG	FORT YATES IHS HOSPITAL	kimberly.craig@ihs.gov
DORI	JUNKER	I.H.S. RESOURCE MGMT BUSINESS OFFICE	dori.junker@ihs.gov
CHARLES	MURPHY	STANDING ROCK SIOUX TRIBE	cwmurphy@standingrock.org
CECELIA	FIRE THUNDER	GREAT PLAINS TRIBAL CHAIRMANS HEALTH BD	cecella.firethunder@gptchb.org
MERLE	ST. CLAIRE	TURTLE MOUNTAIN BAND OF CHIPPEWA	merle.stclair@yahoo.com

There are a range of funding options for HBE

Funding option	Description	Advantage	Disadvantages
Health carrier Exchange participation fee¹	<p>Applied to Qualified Health Plan(s) in HBE</p> <ul style="list-style-type: none"> • Per member fee • Percentage of premium of Exchange members 	<ul style="list-style-type: none"> • Applies to the products offered and paid by those receiving value from the Exchange 	<ul style="list-style-type: none"> • Dependent on enrollment volume • May not be enough to fund startup and early years • Charge may ultimately be passed to consumer thus raising premiums
General health carrier fee¹	<p>Assessed for privately insured members in state</p> <ul style="list-style-type: none"> • Per member fee • Percentage of premium of privately insured members 	<ul style="list-style-type: none"> • Spreads cost of Exchange operations over a wider population 	<ul style="list-style-type: none"> • May not be enough to fund startup and early years • Charge may ultimately be passed to consumer thus raising premiums
Employer fee	<p>Paid by employer accessing QHP in HBE</p>	<ul style="list-style-type: none"> • Applies to the products offered and paid by those receiving value from the Exchange 	<p>Might deter employers from the Exchange if total cost for Exchange plan premium + fee is higher cost overall</p>

¹At least 10 states mentioned in their legislation or planning documents considering the health carrier Exchange participation fee or the general health carrier fee or the combination of both as potential approaches for generating revenue for financial sustainability: CA, CT, IL, IA, MD, MT, NJ, NM, OH, and OR

There are a range of funding options for HBE (cont)

Funding option	Description	Advantage	Disadvantages
Member fee	Paid by member (either individual or small group employee) obtaining QHP in the Exchange	<ul style="list-style-type: none"> Increases with HBE enrollment Applies to the products offered and paid by those receiving value from the Exchange 	Might deter employers and employees from the Exchange if total cost for Exchange plan premium + fee is higher cost overall
Broker fees	Paid by broker selling QHP in HBE	Additional revenue stream	Increase in overall QHP cost
General revenue	State funding	May provide reliable funding for start up and early years	<ul style="list-style-type: none"> Subject to political and state priorities May fall short if HBE cannot meet initial enrollment targets
Revenue diversion	Divert revenue from programs that are phased out due to health reform	Savings opportunity for state while supporting Exchange sustainability	Funding may not be available for start up or Y1-Y2 as transition from program needs to occur first
Targeted income tax	Income tax usually imposed on high income earners	High income earners better able to bear the tax	Political headwind
Public & private sources	Grants, endowments, contributions from public and private sources	Additional sources of income	<ul style="list-style-type: none"> Grants require resources to apply and maintain Exposure to political & special interests Potential for jeopardizing Exchange credibility May not be reliable source long term

There are a range of funding options for HBE (cont)

Funding option	Description	Advantage	Disadvantages
Funding from other programs	Fees from other programs for performing eligibility determination, referral, and enrollment for other governmental programs	Reimbursement from other programs	<ul style="list-style-type: none"> • Will require policies/ procedures/ service level agreements between Exchange and associated programs that can be complex • Tracking and financial reconciliation can be complex
Excise taxes	Special taxes on specified products or services associated with unhealthy lifestyles such as soda, tobacco, candy, alcohol, etc.	Unhealthy lifestyles taxes are targeted to product users linked to health care utilization	These types of taxes have been reversed
Provider fees	Fees for clinical services and products including elective procedures, pharmaceuticals, etc.	Targeted at users of health care services	<ul style="list-style-type: none"> • May be difficult to collect • May not be politically feasible • Those with health issues pay more than the healthy
ACA penalty	Penalty income for forgoing health insurance is paid to the Exchange	Additional revenue source	<ul style="list-style-type: none"> • Declines with increasing enrollment in HBE • Individual mandate still TBD

EXTERNAL REVIEW PROCESS REQUIREMENTS

For a State external review process to apply (or continue to apply) to health insurance issuers (and certain plans) for plan years (in the individual market, policy years) beginning on or after July 1, 2011, the State process was required to include the 16 minimum consumer protection standards set forth in paragraph (c)(2) of the July 2010 federal regulations. These 16 minimum consumer protection standards were amended, in limited respects, by an amendment to the July 2010 regulations that was issued in June 2011. That amendment to the July 2010 regulations also modifies the transition period described in the first sentence of this paragraph.

These 16 minimum consumer protection standards, as amended, may be summarized as follows:

Minimum Consumer Protection Standard	BCBSND Option 1	BCBSND Option 2
1. The process must provide for external review of adverse benefit determinations and final internal adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.	No (appeal of rescissions not included)	No (appeal of rescissions not included)
2. Issuers must be required to provide effective written notice to claimants of their rights to external review.	Yes (2(b)). Lacks detail though.	Yes (2(b)). Lacks detail though.
3. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (a) the issuer waives the exhaustion requirement; (b) the issuer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.	Yes 2(c). Doesn't track the exact language of T.R. No. 2011-02	Yes 2(c). Doesn't track the exact language of T.R. No. 2011-02
4. The cost of an independent review organization (IRO) to conduct an external review must be borne by the issuer, although the process may require a nominal filing fee from the claimant requesting external review.	Yes 2(d).	Yes 2(d).
5. There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for	Yes 2(e).	Yes 2(e).

external review.		
6. The process must allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.	Yes 2(f).	Yes 2(f).
7. The IRO must be assigned by the State or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process (such as rotational assignment), and in no event assigned by the issuer, the plan, or the individual.	No. 2(g) conflicts in that it allows the insurer to assign the IRO.	Yes 2(g).
8. The process must provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the health care service that is the subject of the review.	Yes 2(g).	Yes 2(g).
9. Approved IROs must have no conflicts of interest that will influence their independence.	Yes 2(h).	Yes 2(h).
10. Claimants must be allowed to submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO; the IRO must allow the claimant at least 5 business days to submit any additional information and any additional information submitted by the claimant must be forwarded to the issuer within one business day of receipt by the IRO.	Yes 2(i).	Yes 2(i).
11. The IRO decision must be binding on the claimant, as well as the plan or issuer (except to the extent that other remedies are available under State or Federal law).	Unclear if this would be met due to the exception in 2(j).	Unclear if this would be met due to the exception in 2(j).
12. For standard external review, the IRO must provide written notice to the issuer and the claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review.	Yes 2(k). Unclear how giving the decision to the Insurance Dept. in	Yes 2(k)

	addition to the claimant and issuer might be viewed though.	
13. The process must provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).	Yes 2(k). Unclear how giving the decision to the Insurance Dept. in addition to the claimant and issuer might be viewed though.	Yes 2(k)
14. Issuers must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees, substantially similar to section 17 of the NAIC Uniform Model Act.	Unclear if this would be met due to the lack of detail in 2(l).	Unclear if this would be met due to the lack of detail in 2(l).
15. The IRO must maintain written records and make them available upon request to the State, substantially similar to section 15 of the NAIC Uniform Model Act.	Unclear if this would be met due to the lack of detail in 2(m).	Unclear if this would be met due to the lack of detail in 2(m).
16. The process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act.	No. Lacks provision for: oral requests; Commissioner authority to override company's determination that external review request isn't eligible for review; treating physician to certify why treatment is necessary; IRO to select health care professionals	No. Lacks provision for: oral requests; Commissioner authority to override company's determination that external review request isn't eligible for review; treating physician to certify why treatment is necessary; IRO to select

	<p>who are experts in the treatment of the covered person's condition; decision to be issued by IRO within 20 days; description and analysis by IRO of any medical or scientific evidence used in reaching its opinion.</p>	<p>health care professionals who are experts in the treatment of the covered person's condition; decision to be issued by IRO within 20 days; description and analysis by IRO of any medical or scientific evidence used in reaching its opinion.</p>
--	---	---