

TESTIMONY

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

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Good afternoon Chairman Keiser and members of the committee. My name is Rebecca Ternes and I am the Deputy Insurance Commissioner at the North Dakota Insurance Department.

I was asked to present an update on the Affordable Care Act (ACA) and updated enrollment numbers on the Federally Facilitated Marketplace (FFM).

2017 Section 1332 Waiver for State Innovation

The Affordable Care Act (ACA) requires the U.S. Secretary of Health and Human Services (HHS) and the Secretary of the Treasury to issue regulations regarding procedures for Waivers for State Innovation under Section 1332 of the ACA.

In February 2012, final rules were published reinforcing the general concept of the waiver as written in the ACA but omitting any specifics as to what thresholds would be set for meeting the requirements.

The rules stated an application for a waiver must provide a comprehensive description of the enacting legislation and a program to implement a plan that meets all of the requirements for a waiver; a list of all provisions of law that a state would seek to waive and the reasons for waiving; and the analyses, actuarial certifications, data, assumptions, targets and other information sufficient to provide the Secretaries with the

necessary data to determine the state's proposed waiver meets the ACA's requirements. Those requirements include:

- That the waiver plan provide health insurance coverage that is at least as comprehensive as the coverage defined in the Essential Health Benefits (EHB) section of the ACA;
- That the waiver plan provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provision of the ACA;
- That the waiver plan would provide coverage to at least a comparable number of its residents as the provisions of the ACA intended; and
- That the waiver plan would not increase the federal deficit.

These 2012 regulations created a laundry list of statistics that must be compiled by states to include in their waiver applications but did not provide any specific targets to meet, formulas to use or language that would be required. Predictably, it would be almost impossible for a legislative body to create language that would cover all of these requirements prior to applying and prior to the inevitable negotiations with the multiple federal agencies having jurisdiction within the ACA.

Beyond the comprehensive, affordable, comparable and deficit requirements, the regulations require additional information such as information on the impact of administrative burdens on individuals, insurers and employers; an explanation of how the waiver will affect the implementation of the ACA in the state; and an explanation of how the waiver will affect residents who need to obtain health care services out of state.

Quarterly, annually and cumulative reporting to the federal government would be required as is typical with all federal programs. The regulations also state that "other information consistent with guidance" and "additional supporting information" may also be required as determined by the Secretaries. This statement leaves open the possibility of any requirements these federal agencies decide in the future.

Additionally, the federal agencies have laid out a labyrinth of federal approval and compliance for any waiver that includes state public notice and comment periods, federal public notice and comment periods, state periodic reviews and annual public progress forums.

The federal government has not declared how much funding will be available, but we know it is limited by the ACA. In late 2015, more guidance was released stating the amount of federal pass-through funding equals the Secretaries' annual estimate of what the Exchange (FFM) financial assistance that would have been provided in a year but will not be claimed as a result of the waiver. That amount will be calculated annually. Any state application has to estimate this amount. States can consider cost savings to the federal government in doing so. We do know there are no additional grants available for start-up or administrative costs.

This latest guidance does little to further clarify the numerical or value-based targets or goals a waiver must achieve. It does make it clear that the impact of the waiver can be calculated globally and not individually. In other words, it is not about the impact to only one person, but to the state's population as a whole.

The guidance also restricts states in suggesting any waiver plans that would alter the way in which the FFM operates as it cannot be customized for each state. For example, North Dakota could not change the dates of enrollment periods or how financial assistance is calculated. Additionally, the guidance cautions against any waiver plans that change the calculations for premium tax credits or eliminate other tax provisions because it would create administrative costs for the U.S. Internal Revenue Service.

Candidly, the regulation and guidance provided to date provides more specifics in what a state cannot do rather than what a state will be allowed to do within the five-year waiver period. This may be an attempt to encourage innovation and creativity in states but the cost of the analysis, application process, reporting obligations and the yet

unknown additional requirements allowed by the regulation leaves states with no way to determine program design or cost prior to writing enacting legislation.

To date, only Hawaii has come forward with any type of draft proposal. It is based on a long-standing law (Prepaid Health Care Act) that requires almost every employer in the state with at least one permanent full-time employee to purchase employee health insurance coverage. It severely limits how much an employee can contribute to the costs of this insurance, sets robust plan coverage benefits and if these coverage benefit limits are not met, then requires employers cover at least half the premium cost for dependents as well.

Hawaii estimates only three to four percent of its population is individually insured and only three to five percent are uninsured. Most are covered by employer-sponsored plans, Medicaid, Medicare or military coverage.

In its draft waiver language, Hawaii points out that even though the state aggressively pursued a state-based Exchange, it was not sustainable and that its 40-year-old Prepaid program provides a better plan for the state's overall population.

2016 Health Insurance Open Enrollment

Open enrollment for private health insurance plans started on November 1, 2015, and ends January 31, 2016. People who enroll within this period will not incur a tax penalty. To get coverage as of January 1, 2016, people had to enroll by December 17, 2015. People can also purchase coverage throughout the year through special enrollments if they have a qualifying event such as the birth of a child, marriage, losing other coverage, etc.

Insured in North Dakota

There are 32 major medical health insurance plans and 23 stand-alone dental plans available in North Dakota for the plan year beginning January 1, 2016.

The attached chart indicates enrollment on the Marketplace as of January 9, 2016. The effectuated number of covered lives, as reported by the companies directly to the Department, is 16,038. The federal count, which only counts the selection of a plan, not necessarily payment for that plan, is 20,046. Prior to open enrollment beginning, the companies reported 16,251 covered lives in effectuated contracts.

We would expect the number to increase slightly before open enrollment ends on January 31, but over the past year, the Marketplace enrollment has remained fairly steady at approximately 16,000 lives.

That concludes my testimony. I would be happy to answer any questions.

2015 ND Federally Facilitated Marketplace Enrollment

(as of 1/09/16)

| BCBS ND | |
|---|---------------|
| Effectuated contracts (enrolled and first month paid) | 5,685 |
| Covered lives under effectuated contracts | 10,645 |
| Medica | |
| Effectuated contracts (enrolled and first month paid) | 2,293 |
| Covered lives under effectuated contracts | 3,309 |
| Sanford | |
| Effectuated contracts (enrolled and first month paid) | 1,251 |
| Covered lives under effectuated contracts | 2,084 |
| Total All Carriers | |
| Effectuated contracts (enrolled and first month paid) | 9,229 |
| Covered lives under effectuated contracts | 16,038 |
| <hr/> | |
| *Federal number as of 1/9/2016 | 20,046 |

*The federal number represents a preliminary total of those who have submitted an application and selected a plan.

