

TESTIMONY

Presented by: Adam Hamm
Insurance Commissioner
North Dakota Insurance Department

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

Date: February 2, 2012

Good morning, Chairman Keiser and members of the Health Care Reform Review Committee. My name is Adam Hamm and I am the North Dakota Insurance Commissioner. 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 the Health Benefit Exchange Requirements of PPACA

An update of the actions of other States is attached. Since your last meeting, Wisconsin has turned back its innovator grant to the federal government and it appears that South Carolina intends to return its planning grant. The final rules regarding exchanges have not yet been issued. Many States have written to the United States Department of Health and Human Services (HHS) with questions regarding how a federally administered exchange will be run. We are awaiting answers to these questions.

2. Status of Lawsuits In Opposition to the Implementation of PPACA

There are 24 lawsuits challenging PPACA that the Department monitors on an ongoing basis. The lawsuit initially brought by the State of Florida and joined in by North Dakota

and 25 other states as well as the National Federation of Independent Businesses will be the first PPACA lawsuit to be heard by the United States Supreme Court. The Court will hear 5½ hours of arguments spread over three days on March 26-28, 2012. The decision is expected in late June 2012.

The initial decision in this case came on January 31, 2011, when a court ruled that the law's requirement for individuals to purchase insurance is unconstitutional, and therefore, the rest of the law is unconstitutional because the provision is too central to making the law function. That decision was appealed by the Obama Administration to the 11th Circuit Court of Appeals which, by a divided three-judge panel, affirmed the lower court's decision in part. The court of appeals agreed that the mandate was unconstitutional, but held that it could be severed, allowing the rest of PPACA to remain.

The fundamental question to be addressed by the Supreme Court is whether Congress had the power under the U.S Constitution to enact the individual mandate provision. The Court could uphold the law, strike down just the individual mandate or some or all of the rest of it, or decline to issue a definitive decision entirely as premature. This is the most closely watched case in the ongoing battle over the health-care overhaul. The Department will continue to watch it closely and will update this Committee in future meetings.

3. Essential Health Benefits Requirements Under PPACA

On December 16, 2011, the United States Department of Health and Human Services (HHS) issued a bulletin outlining the approach that HHS intends to use in rulemaking to define essential health benefits as required by the Patient Protection and Affordable

Care Act (PPACA). The law requires that health plans offered in the individual and small group markets, both inside and outside of the Exchanges, provide a comprehensive package of items and services known as “essential health benefits.” Essential health benefits must include items and services within the following 10 categories:

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

The bulletin indicates that HHS intends to propose that essential health benefits are defined using a benchmark approach. Rather than HHS deciding one essential health benefits package that applies to all policies in all states, the proposed approach would leave that decision up to the States - within certain limits. States would choose a benchmark plan that reflects the scope of services offered by a “typical employer plan” from one of the following:

- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment;

- The largest HMO plan offered in the state’s commercial market by enrollment.

The Department has gathered information on the various benchmark plans. Here are the plans in each category for North Dakota:

CATEGORY	NAME OF PLANS
Three largest small group plans in ND by enrollment	CompChoice, Select Choice, and Classic Blue (all BCBSND plans)
Three largest state employee health plans by enrollment	North Dakota Public Employee Retirement System (NDPERS) plan
Three largest federal employee health plan options by enrollment;	Federal employee Standard Plan, Basic Plan, and FEP GEHA
Largest HMO plan offered in ND’s commercial market by enrollment	Sanford Elite 1 plan

Under the proposed approach, HHS will require a State to select a benchmark in the third quarter of 2012 using enrollment data from the first quarter of 2012. Plans will need some time to adjust their products and get approval of revised contracts, forms, and rates from their regulators before the Exchanges have to begin enrolling people in October 2013. If a state does not select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state.

The decision as to what is in the essential benefit package is clearly a decision on mandated health insurance coverage. These decisions in North Dakota have always been made by the Legislature. It is unclear how our legislature will be able to make this

critical decision by the third quarter of this year given that it will not be in session again until January 2013.

As with all guidance coming from HHS lately, there are a multitude of unanswered questions that states have posed as to the actual choices, implementation and future impact of the essential health benefit decision. We are still waiting for the answers from HHS to many critical questions.

It is my recommendation and intent that North Dakota request from HHS additional time for North Dakota to make its decision so that the appropriate branch of government - the Legislative branch - is able to deliberate and decide what is best for North Dakota's health insurance buyers.

In the meantime, I assure you that we are working on gathering as much information and data as possible to attempt to allow a meaningful analysis of choices.

4. Status of Implementation of HB 1475

2011 H.B. 1475 provided an appropriation for the Insurance Department of \$642,350 and 4 FTEs. The Department began advertising for an actuary on November 21, 2011. As we expected, it is very difficult to get qualified applicants for this position and because of a recent retirement announcement by the existing life and health actuary, Mike Fix, we will now have two vacant actuary positions. Because these are difficult positions to fill, the Department will likely need an actuarial consultant for some life and health rate filings. Staff are working on that procurement now.

Another position, a life and health filing analyst, will be advertised soon and will also be assuming the division director duties previously attached to the actuary position. The remaining two positions are in our Company Licensing and Financial Exams Division. We expect to advertise the financial analyst position within the next month and the financial examiner position within six months.

Additionally, the Department has recently notified HHS that it is requesting a transfer of the remainder of the Exchange Planning Grant to the North Dakota Department of Human Services (DHS). The original grant award was \$1 million. \$768,022.27 remains unspent after expenses related to the Exchange Research and Analysis project completed by HTMS, stakeholder consultation project and minor travel expenses. We are awaiting confirmation of the transfer from HHS and then DHS will submit a plan to spend the balance of the grant award.

5. External Review

On Nov. 15, 2011, the Insurance Department requested a redetermination from HHS regarding the passage of House Bill 1476 during the special session and whether it represents a PPACA-compliant external review process. As you may recall, the State's external review process laid out in House Bill 1127, passed in the regular 2011 session, was deemed ineffective by HHS earlier this year.

On Dec. 30, 2011, HHS notified the Department that North Dakota's external review process does not meet all of the standards of the NAIC-parallel process. HHS did find,

however, that North Dakota's external review process meets the temporarily allowed NAIC-similar process. Therefore, issuers of non-grandfathered health insurance plans and policies must comply with the external review process provided in State law until January 1, 2014. We have already informed the insurance carriers of the need to submit external review requests to the Department and that the Department is developing an external review process that will be distributed in the near future to all stakeholders for input.

Beginning January 1, 2014, a State external review process will need to satisfy all 16 of the minimum consumer standards of the NAIC-parallel process or the insurers will become subject to a Federally-administered external review process. HHS found that our process does not meet the requirements for a fully compliant external review process. They noted that there is no explicit provision in HB 1476 addressing deemed exhaustion of internal appeals for either the issuer's failure to meet internal appeals process timelines or their failure to comply with the internal appeals requirements. They did recognize that the law has a general provision that requires an issuer to meet the minimum federal requirements and so, read as a whole, they found our statute to require deemed exhaustion. But, HHS noted that if issuers are not permitting deemed exhaustion in practice, HHS will revisit North Dakota's compliance with this standard.

HHS found our process noncompliant because it does not require independent review organizations (IRO) to maintain written records and make them available upon request to the State nor does it contain reporting requirements substantially similar to the NAIC

Uniform Model Act. In a recent discussion with HHS, we were told that we could impose these record requirements on the IROs in our contract and if we submit those contracts to HHS with a request for redetermination our process may be found fully compliant.

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.

State-By-State Status of Exchanges and Grants – January, 2012

State	Legislation to Create State Exchange	Other – establishing committee, planning, etc.
AL	Failed	Executive Order 17 (study/planning)
AK	Failed	
AZ	Failed	
AR	Failed	
CA	AB 1602 (2010); SB 900 (2010)	
CO	SB 200 (2011)	
CT	SB 921 (2011)	
DE		In lieu of legislation, the Delaware Health Care Commission, housed within the Department of Health and Social Services, leads the process of planning a state-based exchange.
DC	Pending – B19-0002 (2011)	
FL	No legislation	They are creating a small business Exchange, unrelated but similar to HBE
GA	Failed	Executive Order 06.02.11.01 (study/planning)
HI	SB 1348 (2011)	
ID	No legislation	Have conducted stakeholder meetings
IL	SB 1555 (2011)	
IN		Executive Order 11-01 (forms Indiana Insurance Market Inc. as Exchange)
IA	Failed	
KS	No legislation	Insurance commissioner pursuing
KY	No legislation	
LA	No legislation	Louisiana has announced they will not pursue a state Exchange
ME	Pending - LD 1497 (2011); LD 1498 (2011)	LD 1582 (2011) (study/planning)
MD	SB 182 (2011); HB 166 (2011)	
MA		Existing Exchange
MI		Pending - S595 (2012) Would establish a Michigan basic health program for certain low-income residents in lieu of benefits under a health exchange
MN	Failed	
MS	HB 377 (2011)	
MO	Failed	
MT	Vetoed	Joint Resolution HJ 133 (study/planning)
NE	Failed	
NV	SB 440 (2011)	

NH	Tabled – SB 163 (20011)	
NJ	Pending – S2553 (2010); A 1930 (2010); S 1288 (2010); A 3561 (2010); S 2597 (2010); A 3733 (2010)	
NM	Vetoed	
NY	Failed	
NC	Pending – HB 115 (2011); HB 126 (2011); SB418 (2011)	
ND	Failed	
OH	No legislation	
OK	Failed	
OR	SB 99 (2011)	
PA	Pending – HB 627 (2011); SB 940 (2011)	
PR		
RI	Failed	Executive Order 11-09 (established Exchange)
SC	Failed	Executive Order 2011-09 (study/planning)
SD	No legislation	
TN	No legislation	
TX	Failed	
UT	HB 128 (2011) – changes to existing statute	Existing Exchange
VT	H 202 (2011)	
VI		
VA	HB 2434 (2011)	
WA	SB 5445 (2011)	
WV	SB 408 (2011)	
WI		Executive Order 10 (study/planning) Gov. Walker plans to sign Executive Order 57, repealing Executive Order 10
WY		HB 50 (2011) (study/planning)

Total states (and DC) and territories included = 53

Total that have established an Exchange or have expressed intention of a state-run Exchange = 18 (CA, CO, CT, DC, HI, IL, IN, MD, MA, MS, NV, OR, RI, UT, VT, VA, WA, WV)

Total that have pending legislation to establish a state-run Exchange = 5 (ME (also studying), NH, NJ, NC, PA,)

Total that have taken action to further study or plan = 6 (AL, GA, ME, MT, SC, WY)

Total that have only failed or vetoed legislation as the last action = 12 (AK, AZ, AR, IA, MN, MO, NE, NM, NY, ND, OK, TX)

Total that have taken no legislative or executive action that allows for the planning of or establishment of a state-run Exchange = 13 (DE, FL, ID, KS, KY, LA, MI, OH, PR, SD, TN, VI, WI)

Early Innovator Grants

- Maryland Dept of Health and Mental Hygiene, \$6,227,454
- University of Massachusetts Medical School (multi-state consortia), \$35,591,333
- New York Department of Health, \$27,431,432
- Oregon Health Authority, \$48,096,307
- Kansas Insurance Department, \$31,537,465 (Sent back)
- Oklahoma Health Care Authority, \$54,582,269 (Sent back)
- Wisconsin Department of Health Services, \$37,757,266 (Sent Back)

Establishment grant summary

State	Grantee	Amount	Level
Alabama	Alabama Department of Insurance	\$8,592,139	1
Arizona	Governor's Office of Economic Recovery	\$29,877,427	1
California	California Health Benefit Exchange	\$39,421,383	1
Connecticut	Connecticut Office of Policy and Management	\$6,687,933	1
Delaware	Delaware Department of Health and Social Services	\$3,400,096	1
District of Columbia	District of Columbia Department of Health Care Finance	\$8,200,716	1
Hawaii	Department of Insurance, Office of Commerce and Consumer Affairs	\$14,440,144	1
Idaho	Idaho Department of Health and Welfare	\$20,376,556	1
Iowa	Department of Public Health	\$7,753,662	1
Illinois	Illinois Department of Insurance	\$5,128,454	1
Indiana	Indiana Family and Social Services Administration	\$6,895,126	1
Kentucky	Kentucky Cabinet for Health and Family Services	\$7,670,803	1
Maine	State of Maine Dirigo Health Agency	\$5,877,676	1
Maryland	Maryland Department of Health and Mental Hygiene	\$27,186,749	1
Michigan	State of Michigan, Department of Licensing & Regulatory Affairs	\$9,849,305	1
Minnesota	Minnesota Department of Commerce	\$4,168,071	1
Mississippi	Mississippi Department of Insurance	\$20,143,618	1
Missouri	Missouri Health Insurance Pool	\$20,865,716	1
Nebraska	Nebraska Department of Insurance	\$5,481,838	1
Nevada	Nevada Department of Health and Human Services	\$4,045,076	1
New Mexico	New Mexico Human Services Department	\$34,279,483	1
New York	New York State Department of Health	\$10,774,898	1
North Carolina	North Carolina Department of Insurance	\$12,396,019	1
Oregon	Oregon Health Insurance Exchange Corp	\$8,969,600	1
Rhode Island	Rhode Island Department of Business Regulation	\$5,240,668	1
Rhode Island	Rhode Island Department of Business Regulation	\$58,515,871	2
Tennessee	Tennessee Bureau of TennCare	\$1,560,220	1
Vermont	Vermont Agency of Human Services	\$18,090,369	1
Washington	Washington State Health Care Authority	\$22,942,671	1
West Virginia	West Virginia Offices of the Insurance Commissioner	\$9,667,694	1

Source: cciio.cms.gov