TESTIMONY

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

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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. Essential Health Benefits under PPACA

I was asked to provide information to the committee regarding several issues involving the essential health benefits (EHB) package required by PPACA. Beginning in 2014, the EHB package must include specific categories of benefits, meet certain cost-sharing standards, and provide certain levels of coverage.

a. Benchmark Plans

PPACA required the Secretary of Health and Human Services (HHS) to define the essential health benefits that will have to be covered in nongrandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs. EHB must include items and services within the following 10 benefit 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.

EHB is defined by a benchmark plan that must be selected by each state by the third quarter of this year. States may choose from one of the following four benchmark plan types for 2014 and 2015:

1. The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;

2. Any of the largest three state employee health benefit plans by enrollment;

3. Any of the largest three national Federal Employees Health Benefits Plan (FEHBP) plan options by enrollment; or

4. The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

If a state fails to choose one of the benchmark plans, HHS intends to use as a default the largest plan by enrollment in the largest product in the state's small group market.

Enrollment data is necessary to determine which plans fit into the four categories. HHS plans to report the top three FEHBP benchmark plans to states based on information from the Office of Personnel Management and it plans to provide states with a list of the top three small group market products in each state based on data from HealthCare.gov from the first quarter of the 2012 calendar year. HHS is trying to reconcile discrepancies between the enrollment data it has with the data that states have for the small group market product. HHS will capture the data for the end of the first quarter (March 31, 2012), which will be collected in late April or early May. HHS stated it intends to get this enrollment data to states as soon as possible. At this point, there is no discrepancy between what HHS and the Department have identified as benchmark choices for North Dakota.

The choice of the benchmark plan is really a choice for a new set of health insurance mandates and has important financial and policy implications for our state and is one I believe should be made by the Legislative Assembly. I sent a letter to HHS on March 1, 2012, requesting an extension for our state's selection of the benchmark plan since our Legislature is not in session. I have not received a written response.

b. Limits in the EHB

I was also asked to address whether limits may be included in the EHB. Once a benchmark plan is chosen, all the benefits in that package become the "Essential Health Benefits" that must be provided in all plans. HHS has determined that EHB can have internal limits (i.e., a limit on number of visits, day limits) but no annual or lifetime dollar limits are allowed.

There remains, however, a question as to whether benefits in the benchmark plan that are outside the 10 categories can have per beneficiary limits. We do not have a definitive answer to this question yet but the National Association of Insurance Commissioners' (NAIC) reading of the guidance indicates that the dollar limit would not be allowed. In other words, if the limit is a visit limit or some other nondollar limit, it might be acceptable. Whether a dollar limit on a benefit outside the 10 categories could be retained if in the benchmark is not clear at this point.

Regardless of which benchmark plan is picked for North Dakota, certain benefits will predictably need to be added because none of the plans currently contain all of the benefits that are required. For example, not all of the plans currently cover pediatric oral and vision services which will be required as part of the EHB package.

States must select a benchmark plan by the third quarter of this year. (If a state does not exercise the option to select a benchmark health plan, HHS has indicated that it intends to use, as the default benchmark plan, the largest plan by enrollment in the largest product in the state's small group market.) If a state does select a plan, HHS will need to review the plan to ensure that it complies with the EHB requirements.

c. State-Mandated Benefits

I was asked to address whether a state could add state-mandated benefits to the EHB benchmark plan without having to defray the costs of those mandated benefits. The answer is no.

Section 1311(d)(3) of PPACA requires states to defray the cost of any benefits required by state law to be covered by qualified health plans beyond EHB. Any state-mandated benefits enacted after December 31, 2011, could not be part of EHB for 2014 or 2015, unless it already happened to be included within the benchmark plan regardless of the mandate. HHS has stated that it intends to revisit this approach for plan years starting in 2016.

2. Exchanges

As you know, PPACA required states to establish a state-based Exchange by January 1, 2014. If a state does not, the federal government is authorized to do so. While in a technical sense there are two Exchange models—state-based or federally-facilitated—Exchanges will really operate along a continuum from entirely state-operated to entirely federally-operated, with several variations of shared operations in between. I have been asked to review the core functions of an Exchange in a federally facilitated model.

The core responsibilities of an Exchange are the same regardless of who runs it. They are: certification, recertification, and decertification of qualified health plans (QHPs); eligibility determinations for public health programs (Medicaid, CHIP); plan enrollment; plan management; consumer assistance; and, financial management. States that are likely to have a federally facilitated Exchange are wrestling with the degree of responsibility they want to assume. And, HHS has not provided a definitive list of the functions it is willing to cede to the states in such a model.

Based on the guidance provided by HHS so far, it appears that the Exchange design options are to have a:

1. Federally-facilitated Exchange where HHS handles all functions;

2. State-established Exchange where the state handles all functions;

3. Federally-facilitated Exchange where the state does plan management (i.e., decides which plans may participate; rate and form review; plan oversight; data collection and analysis) and consumer assistance (complaints and inquiries; manage the navigators, conduct outreach and education) functions;

4. Federally-facilitated Exchange where HHS receives applications, but the state does final determinations for Medicaid and CHIP; or

5. State-established Exchange where HHS does subsidy and exemption determinations.

States can also decide whether to operate their reinsurance program regardless of whether it has a federal or state Exchange. Reinsurance is designed to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation through contributions by health issuers to a reinsurance entity to support reinsurance payments to individual market issuers that cover high risk individuals.

Again, it has not been made clear by HHS exactly which functions it will allow states to take on in a partnership model. With respect to the federally-facilitated Exchange, HHS, in the November 29, 2011, guidance, noted that "[t]o the greatest extent possible, HHS intends to work with states to preserve traditional responsibilities of state insurance departments when establishing a federally-facilitated Exchange."

In summary, given the information we have at this time, it appears that the key decision points for a potential partnership model Exchange would be:

- What functions does the state want to retain?

- What functions does the state not want to take on?

- If the state does not take on the plan management (for example) how will federal oversight be coordinated with state oversight (i.e., solvency, licensure, rate review, market conduct examination)?

- How will plans inside the Exchange differ from plans outside the Exchange if they are regulated differently?

- Does that state want to run its reinsurance or risk adjustment program?

The Insurance Department continues to have discussions with the federal government on the resources and authority of the Department and what is best for our consumers.

3. Status of United states Supreme Court Review of PPACA Lawsuit

Oral argument on the lawsuit 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 was heard by the United states Supreme Court on March 26-28, 2012. The decision is expected in late June 2012.

On the first day of oral argument, the Supreme Court considered the technical question of whether the Court has the right to hear the case at this juncture. A federal law, the Anti-Injunction Act, prohibits federal courts from hearing challenges to taxes before they have been enforced. If PPACA's penalty for not purchasing health insurance is considered a tax, the Supreme Court could not entertain challenges to the law before 2015.

On the second day, the Supreme Court considered whether Congress is empowered under the Constitution's Commerce Clause to require individuals to obtain health insurance or else pay a penalty. On the last day, the Supreme Court took up whether voiding the individual mandate requires the entire law to be struck down and the constitutionality of the Medicaid expansion.

There are a range of decisions the Court could make from avoiding to decide the law's constitutionality at all to upholding the law to striking it down in its entirety. Here are some of the potential decisions:

- The Supreme Court upholds the law.
- The Supreme Court strikes the entire law.
- The Supreme Court strikes the individual insurance requirement, but leaves the rest of PPACA in place.
- The Supreme Court strikes the mandate and also invalidates other provisions including potentially the preexisting condition exclusion prohibition and community rating.
- The Supreme Court decides that the constitutional challenge is premature.

4. Future of CHAND

I was asked to address the future of the Comprehensive Health Association of North Dakota (CHAND) given the current health care reform requirements. CHAND was created by the Legislature in 1981 to provide comprehensive health insurance to residents who have been denied health insurance or have been given restricted coverage because they had health problems and are considered to be in a high risk category.

It is important to note that what we refer to as CHAND is really four programs. An individual can be eligible if they qualify as a:

1. Traditional applicant;

2. Health Insurance Portability and Accountability Act of 1996 (HIPAA) applicant;

3. Federal Trade Adjustment Assistance Reform Act of 2002 (TAARA) applicant; or

4. Age 65 and over or disabled supplement applicant.

People who currently obtain health coverage through CHAND can maintain their current coverage so long as the program continues to exist. In 2014, some CHAND enrollees may transition into coverage offered through the Exchange because health plans will be prohibited from denying coverage due to preexisting conditions. People may also choose to buy a traditional health plan in order to get the premium subsidy or cost-sharing subsidies, which are only available through the Exchange. It is possible that CHAND enrollees may also receive more affordable coverage in the Exchanges than they currently have through CHAND.

It is possible, however, that CHAND premiums could be more affordable than private health plans. Because CHAND is a system of health coverages that was created by statute, it is not governed by PPACA. It is not required to cover the essential health benefits package and is not subject to lifetime or annual limits, or any of the other requirements of PPACA. Current law requires that CHAND premiums be set at 135% of the average amount charged for standard health insurance coverage in North Dakota. The premium charged for CHAND could be uncoupled from the private health insurance market so that CHAND premiums reflect a different benefit package than standard health insurance coverage. This would take a legislative change.

The future of CHAND is uncertain and will likely be uncertain for some time to come as we see how health care reform impacts the market in North Dakota. It is possible that there will remain a place for CHAND, or at least some of the parts of CHAND, even if PPACA is implemented.

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.

Essential Health Benefit Services	Largest Small Group Plans by Enrollment			State Employee Plans	Federal Employee Plans		HMO Plan
	#1 - BCBSND CompChoice	#2 - BCBSND SelectChoice	#3 - BCBSND Classic Blue	#1,#2 & #3 - NDPERS PPO, Basic & HDHP	#1 & #2 BCBS Std & Basic	#3 GEHA Std	Sanford Health Plan
Ambulatory Patient Services							
Primary Care Visit to Treat an Injury or Illness	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Specialist Visit	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outpatient Surgery Physician/Surgical Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Home Health Care Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Skilled Nursing Facility	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency Services							
Emergency Room Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency Transportation/Ambulance	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Urgent Care Centers or Facilities	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hospitalization							
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Inpatient Physician and Surgical Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maternity and Newborn Care							
Prenatal and Postnatal Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Delivery and All Inpatient Services for Maternity Care	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mental Health & Substance Use Disorder Services, Including Behavioral Health Treatment							
Mental/Behavioral Health Inpatient Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mental/Behavioral Health Outpatient Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Substance Abuse Disorder Inpatient Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Substance Abuse Disorder Outpatient Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prescription Drugs							
Generic Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Preferred Brand Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Non-Preferred Brand Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Rider Option
Specialty Drugs	Yes	Yes	Yes	Yes	Yes	Yes	Rider Option
Rehabilitative and Habilitative Services and Devices							
Outpatient Rehabilitation Services	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Habilitation Services	Yes	Yes	Yes	Yes	Yes	Yes	No
Durable Medical Equipment	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Laboratory Services							
Diagnostic Test (X-Ray and Laboratory Tests)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Imaging (CT and PET Scans, MRIs)	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Preventive & Wellness Services & Chronic Disease Mgmt							
Preventive Care/Screening/Immunization	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pediatric Services, Including Oral and Vision Care							
Dental Check-Up for Children	No	No	No	No	Yes	Yes	No
Vision Screening for Children	No	No	No	No	Yes	Yes	Rider Option
Eye Glasses for Children	No	No	No	No	No	No	No