

TESTIMONY

Presented by: Adam Hamm
Insurance Commissioner
North Dakota Insurance Department

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

Date: July 25, 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. 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, non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB. 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 EHB package but it must include, at a minimum, the 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.

In December 2011, HHS announced its decision that states are now permitted to select a single benchmark to serve as the standard for qualified health plans inside the Exchange operating in their state and plans offered in the individual and small group markets in their state. Previously, HHS had said states must make this EHB selection by September 30, 2012. We received information from HHS late last week that September 30 is now being termed a “soft date” because the final regulations have not been issued. HHS explained that it recommends but does not require submission by that date. States must choose from one of the following four benchmark plan types:

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 will use, as a default, the largest plan by enrollment in the largest product in the state’s small group market.

As we have discussed before, I sent a letter to the Secretary of HHS on March 1, 2012, requesting an extension of the deadline for the state’s selection of the benchmark plan since our Legislature is not scheduled to be in session until January 2013. I received the attached written response on July 3 which denies the request. However, as noted above, the September 30 deadline has now been extended somewhat.

b. Limits on Benefits

I was also asked to address whether benefit limits will be allowed. The benefit limits contained in a comprehensive health benefit plan today may take the form of a dollar limit, a day limit, or a visit limit and these limits generally apply on a per person per calendar year basis. 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 benefits can have internal limits (i.e., a limit on number of visits, day limits) but no annual or lifetime dollar limits are allowed.

There was a question as to whether benefits in the benchmark plan that are outside the 10 categories can have dollar limits. We asked HHS this question last week and the response was that once a plan is chosen, every coverage in that plan becomes the required benefit package. So no dollar limits may be imposed on any of the covered items in that plan, regardless of whether the covered item is in one of the 10 categories.

c. Consultants Report

The North Dakota Insurance Department engaged INS Consultants, Inc. (INS) to prepare a report regarding essential health benefits. We have just received the draft report in the last few days.

Upon initial review, there are some interesting key findings:

- Generally, plans comply with the North Dakota’s mandated benefits with the exception of the national Federal Employees Health Benefits Plans.
- If any of the three federal plans are selected, they would need to be supplemented by certain benefits required by North Dakota’s mandates. This would require North Dakota to pay for the cost of these additional benefits.

- The three federal plans might be considered as plans providing benefits on a nationwide basis and to a specific subset of the U.S. population. They may not be the best representation of the specific needs of North Dakota residents.
- Of the 10 benchmark plans, 7 are Blue Cross Blue Shield plans. Five are issued by Blue Cross Blue Shield of North Dakota or, in the case of two federal plans, are sponsored and administered by the Blue Cross and Blue Shield Association. For these seven plans there are few variations among the benefits provided by these plans (with the possible exception of the two federal plans).
- The Sanford Health Plan HMO appears to provide fewer benefits than the other nine plans.
- It appears the two small group insurance products issued by Blue Cross Blue Shield of North Dakota would involve the fewest potential benefit additions.
- By choosing a plan already covering significant numbers of North Dakota residents, there may be fewer problems associated with providing an adequate number of in-network primary care and specialty physicians.

Now that the EHB decision deadline has apparently been softened by HHS there appears to be a little more time to finalize this report and move forward. Our intent is to distribute more of the detailed data behind this report to the insurers before the consultants finalize the report.

2. Exchanges

a. Role of States in Partnership Model

I was also asked to discuss the potential role of states in partnership model. As you know, PPACA required states to establish a state-based Exchange that is operational by October 1, 2013. If a state does not, the federal government is authorized to do so.

Based on the guidance provided by HHS so far, it appears that the Exchange design options are to have a federally-facilitated Exchange where HHS handles all functions; a state-established Exchange where the state handles all functions; or a 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.

You asked me to address which activities a state may perform in a partnership model. The Exchange final rules outline states' options to operate a State Partnership with HHS to administer and operate select activities. A State Partnership Exchange may assume primary responsibility for activities including:

- **Plan Management.** In a Plan Management Partnership, a state will conduct all analyses and reviews necessary to support qualified health plans (QHP) certification, collect and transmit necessary data to HHS, and manage certified QHPs.
- **Consumer Assistance.** In a Consumer Assistance Partnership, a state will provide in-person application and other assistance to consumers. In-person assistance may include supporting consumers in filing an application, obtaining an eligibility determination or reporting a change in status, comparing coverage options, and selecting and enrolling in a QHP.
- **Both Plan Management and Consumer Assistance.** In a Plan Management and Consumer Assistance Partnership, a state will perform all of the partnership activities described above.

In addition to Plan Management and Consumer Assistance Partnership activities, partnership or non-partnership states may elect to perform the following Exchange activities:

- Reinsurance.
- Medicaid and CHIP eligibility: a state may coordinate with the Center for Medicaid and CHIP Services (CMCS) on decisions and protocols for either an assessment or determination model for eligibility in the Exchange.

Finally, financial and other issues are still being sorted out regarding the partnership model. According to information learned by the NAIC, there will be a memorandum of understanding entered into by the federal government and any state wishing to do a partnership that will detail how all funding issues will be handled (i.e., who pays for what) and how information will be shared. To date, very few states have indicated a potential interest in the partnership option.

b. Changes to Federally Run Exchange if State Later Assumes Authority

I was asked to address whether any changes may be made to an Exchange when a state lets the federal government set up and start running the Exchange and then later the state takes it over. The question is whether the state would be able to change anything in the Exchange that the federal government had set up in that state.

The regulations on Exchanges require that a state wishing to take over an Exchange that was started by HHS submit a transition plan and have it approved at least 12 months before the change. 45 C.F.R. § 155.106. These regulations also address that there may be differences between a federally-facilitated Exchange and a state-run Exchange and specifically mention that the state plan must include a transition to the new rules. 45 C.F.R. § 155.106(a)(3). The preamble to the first (interim final) rules on Exchanges shows that HHS understood that changes would be likely:

In paragraph (a)(3), we propose that such a State must work with HHS to develop a plan to transition from a Federally-facilitated Exchange to a State Exchange. We anticipate that this would include the smooth transition of operational functions from the Federally-facilitated Exchange to the State Exchange, including transitioning enrollees from QHPs

certified by the Federally-facilitated Exchange to QHPs certified by a State Exchange, **which may or may not differ**.

Federal Register, Vol. 76, No. 136, Friday, July 15, 2011, p. 41871. [emphasis added]

And the preamble to the final regulations shows that HHS continued to believe that changes would be likely in the transition from a federally-facilitated Exchange to a state-run Exchange:

Suggestions for the transition plan included: demonstration of consumer input and tribal consultation; process for educating consumers about **potential changes**; process for ensuring QHP issuers have sufficient time to comply with **new standards** (such as a one-year grace period); and, a plan to protect enrollees from lapses of coverage. A number of commenters recommended a Statebased Exchange starting after 2014 must have **similar or better levels** of insured rates, affordability, covered benefits, and administrative simplicity or quality of services.

Federal Register, Vol. 77, No. 59, Tuesday, March 27, 2012, p. 18317. [emphasis added]

While there may be some ability to make changes regardless of the implementation model—state-based, partnership, or federally-facilitated—Exchanges must still ensure that core functions are carried out in compliance with PPACA. In other words, there may not be a great deal of variation between a federally-facilitated Exchange and a state-based one because all Exchanges will have to perform the same basic functions.

Lastly, regarding this entire issue of Exchanges, my position is and has been very straight forward. Because of all the fiscal, regulatory and political uncertainty that surrounded the Exchange issue in November 2011, I agreed with the North Dakota Legislature's decision during the special session not to build and run a PPACA compliant Exchange.

Fast forward eight months and all that uncertainty still exists. Fiscal uncertainty still exists as it is unclear whether the Exchanges will be able to pay for themselves or will become a money pit for states. Regulatory uncertainty still exists as all the rules and regulations regarding how the Exchanges must be run have not been set by the federal government. Political uncertainty still exists as PPACA may not survive depending on the results of the November elections. As such, my opinion has not changed that the North Dakota Legislature made the right decision not to build and run a PPACA compliant Exchange.

Further, and based on what we know now, even if the law survives after the results of the November elections, there is so much fiscal uncertainty regarding the Exchanges that the best course of action would be to make the federal government prove that they can make the Exchanges work. Let them prove to us and to other states that Exchanges can work financially. If they can prove that, North Dakota could, if it wanted to, take over the Exchange.

3. Grants

I was also asked to address grant opportunities. The following chart indicates other grant funding opportunities from HHS still available.

Grant Opportunity	Focus	Current Due Date(s)
Exchange Establishment Grant Level II (a Level I is not required for a Level II award)	To build a SBE, FFE or Partnership FFE	Quarterly through October 15, 2014
Rate Review Grant Cycle II, Phase II	To enhance states' current processes for reviewing health insurance premium increases	August 15, 2012; August 15, 2013

SBE – State Based Exchange
 FFE – Federally Facilitated Exchange
 Partnership FFE – Plan Management or Consumer Assistance or combination with FFE
 (No Medicaid grants or other grants in other sections of PPACA are included)

4. External Review

Lastly, I was asked to address external review status. Since the last meeting of this committee, the Insurance Department has finalized its internal process for handling external review requests. The process was finalized after sending drafts to all stakeholders twice, receiving several comments and making several suggested changes.

An explanation of external review is posted on our website for consumers.

On May 2, the Insurance Department requested a second redetermination of North Dakota's external appeals process based on the fact that the only factor in determining we had not met the full obligations required for 2014 in the previous determination was the lack of record retention requirements for the Independent Review Organizations (IRO). Because we included the record retention requirement in contracts with the eight IROs, we were notified by HHS on July 10 we are now fully compliant (copy of letter from HHS is attached).

To date, we have had two requests for external review.

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.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 20, 2012

The Honorable Adam Hamm
Commissioner
North Dakota Insurance Department
600 E. Boulevard Avenue
Bismarck, ND 58505



Dear Commissioner Hamm:

Thank you for your letter regarding the timing of state benchmark plan selection for the essential health benefits.

As you know, the Essential Health Benefits Bulletin, published on December 16, 2011, outlines the comprehensive, affordable, and flexible approach the Department of Health and Human Services (HHS) intends to pursue in rulemaking to define essential health benefits. Under this approach, a state would select a benchmark plan from a list of plan types provided by HHS to define essential health benefits in that state.

I appreciate North Dakota's commitment to selecting a benchmark plan that best meets the needs of its citizens and current marketplace. I also understand your concerns regarding benchmark selection in North Dakota and the timing of the legislative session. Benchmark selection in the third quarter of 2012 is intended to provide adequate time for potential qualified health plans (QHPs) to design benefit packages that offer the essential health benefits and for those QHPs to receive certification in the spring of 2013. To provide states with additional information about the small group market products in each state, HHS released a list of the top three small group market products in each state based on data collected from HealthCare.gov in June 2011. The Department released a list of the top three nationally available Federal Employee Health Benefit Program (FEHBP) plans at the same time.

As noted in the Frequently Asked Questions related to the Essential Health Benefits Bulletin, published on February 17, 2012, each state selects its benchmark plan by whatever process and whatever state entity is appropriate under state law. Our intended regulatory approach does not require a state to pass new laws to establish its benchmark plan, and it allows states to select existing plans. If a state does not select a benchmark plan, HHS intends to choose a state-specific default benchmark, which will be the largest plan by enrollment in the largest product in the state's small group market. Although the benchmark plan selected in 2012 applies for 2014 and 2015, HHS intends to revisit the benchmark options and approach for plan years starting in 2016.

While as a practical matter a benchmark needs to be proposed before 2013, HHS will continue to solicit and consider comments on this Bulletin and plans to issue a proposed regulation in the future, which will provide an opportunity to submit further comments. Please know we will carefully consider your concerns and all other comments we receive on the Bulletin.

The Honorable Adam Hamm

June 20, 2012

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Thank you for your interest in this important issue. Please do not hesitate to contact me if you have any further thoughts or concerns.

Sincerely,

A handwritten signature in black ink that reads "Kathleen Sebelius". The signature is written in a cursive style with a large, stylized "K" and "S".

Kathleen Sebelius



July 10, 2012

The Honorable Adam Hamm
Insurance Commissioner
600 E. Boulevard Avenue, 5th Floor
Bismarck, ND 58505-0320

Re: State External Review Process Redetermination

Dear Commissioner Hamm:

This letter follows up on North Dakota's request for a redetermination of its external review laws. The Affordable Care Act ensures that health care insurance consumers have access to strong external review processes under section 2719 of the Public Health Service Act (PHS Act).¹ In implementing this provision, the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) have focused on ensuring that State external review processes can be maintained to the extent possible.² We have actively worked with States to provide guidance and assist States seeking to amend their external review processes to meet federal standards.

Through this process, the Departments have established two categories of State external review processes that will satisfy these statutory standards: 1) a State external review process that meets the 16 minimum consumer protections described in paragraph (c)(2) of the regulations as authorized under section 2719(b)(1) of the PHS Act (hereinafter referred to as "NAIC-parallel process"); or 2) a State external review process that meets the minimum standards established by the Secretary of Health and Human Services through guidance under section 2719(b)(2) (hereinafter referred to as "NAIC-similar process").³

We applaud your efforts and progress to date to provide a strong external review process. After reviewing the information North Dakota submitted, including a copy of its contract with IROs, the Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS) has determined that North Dakota's external review process meets the standards of the NAIC-parallel process. Therefore, issuers of non-grandfathered health insurance plans and policies in the State of North Dakota must comply with North Dakota's external review process. This finding is a final determination.

¹ Section 2719 does not apply to grandfathered health plans. See interim final regulations regarding status of a group health plan or health insurance coverage as a grandfathered plan under section 1251 of the Affordable Care Act issued on June 17, 2010 (75 FR 34538), amended on November 17, 2010 (75 FR 70114).

² Regulations implementing PHS Act section 2719 were published on July 23, 2010, at 75 FR 43330, and amended on June 24, 2011, at 76 FR 37208 (corrected on July 26, 2011, at 76 FR 44491).

³ HHS established these minimum standards in Technical Release 2011-02 on June 22, 2011, which can be found at: http://cciio.cms.gov/resources/files/appeals_srg_06222011.pdf. Beginning January 1, 2014, issuers of non-grandfathered health insurance plans and policies in a State with an external review process that does not satisfy the standards of the NAIC-parallel process will need to participate in a federally administered process.

Please note that in order for issuers of non-grandfathered health insurance plans and policies in the State of North Dakota to continue using the State of North Dakota's external review process, North Dakota may not reduce the consumer protections in their external review process below the levels that apply as of July 10, 2012. Failure to uphold the existing consumer protections in the State of North Dakota could result in a redetermination by CCIIO that issuers of non-grandfathered health insurance plans and policies in the State of North Dakota must use the federally-administered external review process.

As always, CCIIO welcomes questions from state regulators and remains available to provide technical assistance on proposed modifications to the external review processes. Please feel free to contact Wendi Moy Akin at Wendi.Akin@cms.hhs.gov with any questions or concerns.

Sincerely,



Vicki Gottlich

Director, Consumer Support Group

Center for Consumer Information and Insurance Oversight

cc: Rebecca Ternes