2009 SENATE JUDICIARY

SB 2306

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2306

Senate Judiciary Committee

☐ Check here for Conference Committee

Hearing Date: February 2, 2009

Recorder Job Number: 8349

Committee Clerk Signature	Cassie Kroh

Minutes:

Sen. Nething opened the hearing on SB 2306, a bill relating to the rate filing procedure for mutual insurance companies that offer accident and health insurance.

Sen. Nething, district 12, testified in favor of the bill.

Sen. Nething- I introduced this bill because it was brought to my intention that the time it takes in a rate filing by a mutual provider of insurance which has a impact on all of their members. And that particular impact carries with it a lot of consideration of dollars and so the purpose of this bill is to shorten the time frame which could ultimately go to about a year to about 7-8 months, which is still a long time but there are a lot of people that are titled a do process in this rate filing process and we do not want to short change any of those interests. You will be hearing from people not so much why it is here but what it will do and why they believe it is important.

Rod St. Aubyn, representative from Blue Cross Blue shield ND, see written testimony attachment #1.

Sen. Olafson- Has every rate filing been approved without going through the appeal?

Rod St. Aubyn- this is the first time they have ever had to appeal.

Sen. Schneider- what are other states doing?

Rod St. Aubyn- most states have a file and use process.

Opposition

Michael Fix, Director of the Life and Health Division and Actuary ND Insurance Department, see written testimony attachment #2.

Sen. Nething- on pages 2 and 3, on the bottom of page 2 you talk about the provisions of chapter 26 as applying to 40 mutual companies, what does 26.1-12-11 actually read, you don't show that in here.

Michael Fix- that is a section that applies to non-profit mutual insurance companies

Sen. Nething- we have 40 of those non-profits in ND?

Michael Fix- the 40 companies are mutual companies so that would be both non-profit mutuals and for profit mutuals so the bill the way it is written would apply to fewer to 40 companies out of 300 some.

Sen. Nething- why did you say that it is only 40 that is would apply to if that is not true.

Michael Fix- this is a change to the way that the bill is worded that it applies to mutual insurance companies offering accident and health insurance companies in ND.

Sen. Nething- on page 6 where we are talking about the independent consulting actuary, my impression was that the commissioner would appoint that actuary? Was it your understanding that the insurance company would appoint them?

Michael Fix- from the reading of the bill that was my understanding.

Sen. Nething- so if we change that to make sure that if the intent was that it be the commissioner you wouldn't have any objection to it?

Michael Fix- I think that we would still have an objection with some of the companies being able to depend.

Sen. Fiebiger- do you think that a system that takes upwards of a year is an efficient and effective way that protects consumers?

Michael Fix- this situation that Mr. St. Aubyn refers to is a unique situation.

Sen. Fiebiger- I am wondering what the time frame is of this, do you think that this length of time benefits consumers in the long run, that it is worth the delay to work this way?

Michael Fix- no its not, the goal that we have is that we would like to have all filings resolved reviewed and done within a 60 time period.

Sen. Nething- the way that this bill is written you get 3 separate inquiries and you can ask as many questions in a inquiry as you want and it has a time frame, what could be more fair to you?

Michael Fix- the part of that that we have the problem with is limiting it to 3.

Sen. Nething- so it seems to me that you could instead of asking a different question why not ask them all at the same time?

Michael Fix- typically that may happen but the reason it might not is if the responses generate additional questions or additional things come up in the review process.

Adam Hamm, ND state insurance commissioner, testified in opposition to the bill.

Adam Hamm- I am here in strong opposition to SB 2306, Mr. Fix has done an outstanding job in going point to point through our opposition to the bill but I wanted to make sure that I was here this morning to answer any specific questions that you may have. With respect to Sen. Nething's last question of Mr. Fix, to me the main problem with that issue is that if that were to go into law that would encourage gamesmanship to start happening. For example, if we were limited to three with an unlimited amount of subparts, what that could potentially encourage an insurance commissioner to do at some point is to simply ask questions with hundreds of subparts to pull that period of time to try to get as many questions in there as possible to buy

as much time as possible, right now that doesn't exist. This is a give and take of information back and forth with the end goal being a decision made by the insurance commissioner, this provision of that bill particularly the fact that it is told and that there is an unlimited amount of subparts could easily encourage gamesmanship at some point. Now if there are any other questions that members of the committee have of me I would be happy to answer them.

John Kapsner, Attorney with the Vogel Law firm and counsel to the ND Healthcare Association testified in opposition, see attached testimony, attachment #3.

Bruce Levi, ND medical association, testified in opposition to the bill see attached testimony, attachment #4.

Sen. Nething- which came first the denial or the contract change.

Bruce Levi- my understanding is that there were two rate denials, the first one I believe was based on an information exchange the second was based on the contractional inadequecys, is that not true?

Adam Hamm- No. The notification to providers that there was going to be a withhold was at the end of May 2008, the first denial was in July the second denial was in November. That was a big part of the denial for both of the rate increases last year for the group block and for the individual block.

Sen. Nething- and we are talking 2008, that there was three different events in 2008?

Adam Hamm- correct.

Rod St. Aubyn- I need to clarify a couple things first off there was not just 2 rate denials there was a denial of the individual rate, there was a denial of the group rate the non-group student rate was denied twice we administered the VSI and DSC those were both denied. I need to say that a lot of people said that this was a unique situation and that is the reason that the time frame has extended has nothing to do with the facts of this situation. The facts of the length of

the appeal process would not be true in this situation this is truly just the way the process works, it has nothing to do with this. We have to abide by the deal of the administrative hearing from there all of those rules then the judge has 30 days and then it goes back to the insurance commissioner in this case but the administrative agency, it has nothing to do with our particular case that drug that out those are just the time frames based on current law. The other thing I might mention is that a lot of people think that this is an unusual situation and I disagree if you go back to November of 2007, when the insurance commissioner took office his first act was to significantly reduce our group filing for groups and it reduced it from about 17% to about 9.9% in the hearing it became very clear in the testimony of the hearing that that decision was not made on a actual basis but was made by the commissioner but in reality if we face that situation again that is why we think that the insurer should have the right to get that to see what the rate basis was based on to see if we wish to appeal a decision or not. There are different standards that are used in the rate review process. We would have no objection if you would want to apply this to every insurance company.

Adam Hamm- I need to make one comment to correct one comment that was just made by Mr. St. Aubyn. The comment with respect to the fall of 2007, the specific rate increase that was requested was 17.3% of the group block of business what was ultimately approved was a 9.9% increase, it was based on the recommendation of the actuary of the insurance department Mr. Fix, that was the lowest possible rate increase that built in the information provided by blue cross blue shield. That was the increase justified by the facts, it was not a number that was picked out of the air, thank you.

Sen. Nething- we assumed it was justified by the facts.

Sen. Nething closed the hearing.

2009 SENATE STANDING COMMITTEE MINUTES

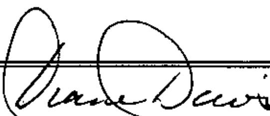
Bill/Resolution No. 2306

Senate Judiciary Committee

☐ Check here for Conference Committee

Hearing Date: 2/11/09

Recorder Job Number: 9152

Committee Clerk Signature	

Minutes: **Senator Nething, Chairman**

Committee work

Committee reviews the proposed amendments

Senator Lyson motions do pass the amendment

Senator Olafson seconds

Verbal – all yes

Discussion

Senator Schneider moves do pass as amended

Senator Lyson seconds

Vote – 6-0

Senator Nething will carry

90595.0102
Title.

Prepared by the Legislative Council staff for
Senator Lyson
February 9, 2009

PROPOSED AMENDMENTS TO SENATE BILL NO. 2306

Page 1, line 1, after "A BILL" replace the remainder of the bill with "to create and enact sections 26.1-30-22 and 26.1-30-23 of the North Dakota Century Code, relating to premium rate requirements and rate filing procedures for accident and health insurance; and to amend and reenact sections 26.1-18.1-15, 26.1-30-19, and 26.1-30-21 of the North Dakota Century Code, relating to health maintenance organization rate filings and insurance rate filing procedures.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26.1-18.1-15 of the North Dakota Century Code is amended and reenacted as follows:

26.1-18.1-15. Filing requirements for rating information.

1. ~~No~~ A premium rate may not be used until ~~either~~ a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

2. ~~Either a~~ A specific schedule of premium rates~~,~~ or a methodology for determining premium rates~~,~~ must be established in accordance with actuarial principles for various categories of enrollees, provided that the premium applicable to an enrollee may not be individually determined based on the status of the enrollee's health. ~~However, the premium rates may not be excessive, inadequate, or unfairly discriminatory.~~ A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, ~~shall~~ must accompany the filing along with adequate supporting information.

3. The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection 2 and the requirements of sections 26.1-30-22 and 26.1-30-23 are met. The procedures set forth in sections ~~26.1-30-20~~ 26.1-30-22 and ~~26.1-30-21~~ 26.1-30-23 govern the approval and disapproval of rating information required to be filed under this section.

SECTION 2. AMENDMENT. Section 26.1-30-19 of the North Dakota Century Code is amended and reenacted as follows:

26.1-30-19. Policy forms to be filed with and approved by commissioner.

1. ~~No~~ An insurance policy, contract, agreement, or rate schedule may not be issued or delivered in this state until the form of that policy, contract, agreement, or rate schedule has been filed with and approved by the commissioner.

2. ~~No~~ A life insurance policy, certificate, contract, or agreement or annuity contract may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof has been filed with and approved by the commissioner and is in compliance with chapters 26.1-33, 26.1-34, 26.1-35, and 26.1-37.

3. ~~No~~ An insurance policy, certificate, contract, or agreement or notice of proposed insurance against loss or expense from the sickness, bodily injury, or death by accident of the insured may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof and the classification of risks and the premium rates, or in the case of cooperatives or assessment companies the estimated costs pertaining thereto, have been filed with and approved by the commissioner. A form must be disapproved if the benefits ~~provided are unreasonable in relation to the premium charge or if the benefits~~ do not comply with chapters 26.1-36 and 26.1-37. Sections 26.1-30-22 and 26.1-30-23 apply to rate filings required under this subsection.

4. ~~No~~ A casualty or fire and property insurance policy, certificate, contract, or agreement may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof has been filed and approved by the commissioner to the extent rates are filed and approved pursuant to chapter 26.1-25.

SECTION 3. AMENDMENT. Section 26.1-30-21 of the North Dakota Century Code is amended and reenacted as follows:

26.1-30-21. Disapproval of form by commissioner - Notice and hearing.

1. ~~If~~ Except as otherwise provided, if the commissioner disapproves any form, the commissioner shall notify the company or organization ~~which~~ that filed the form within sixty days after filing or within the additional period provided for in section 26.1-30-20 and provide written notice of disapproval of the form, specifying the reasons for disapproval and stating that a hearing may be requested in writing within forty-five days. ~~No~~ A company or organization may not issue any insurance policy in the form ~~which~~ that has been disapproved. If a hearing is requested, the commissioner may suspend or postpone the effective date of disapproval.

2. ~~The commissioner may~~ Except as otherwise provided, at any time after a hearing of which not less than twenty days' written notice has been given to the insurer, the commissioner may withdraw approval of any form if ~~it~~ the form contains a provision ~~which~~ that is unjust, unfair, inequitable, misleading, or deceptive, or on any of the grounds stated in this title. It is unlawful for the insurer to issue the form or use ~~it~~ the form in connection with any policy after the effective date of withdrawal of approval. The notice of any hearing called under this subsection must specify the matters to be considered at the hearing and any decision affirming disapproval or directing withdrawal of approval under this section must be in writing and must specify the reasons for the decision.

SECTION 4. Section 26.1-30-22 of the North Dakota Century Code is created and enacted as follows:

26.1-30-22. Accident and health insurance - Premium rate requirements.

1. Premium rates associated with any insurance policy, certificate, contract, or agreement or notice of proposed insurance against loss or expense from the sickness, bodily injury, or death by accident of the insured may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection with such a policy, certificate, contract, agreement, or notice until the classification of risks and premium rates, or in the case of cooperatives or assessment companies

the estimated costs pertaining thereto, have been filed with and approved by the commissioner as provided under section 26.1-30-23.

2. For purposes of this section, premium rates:

   a. Must cover reasonably anticipated claims;

   b. Must cover reasonable costs of operation and overhead expenses;

   c. Must be reasonable in relation to benefits provided;

   d. For an insurer subject to section 26.1-17-33.1, notwithstanding the prohibition of use of risk-based capital information for ratemaking as defined in section 26.1-03.1-08, must maintain a risk-based capital margin between six hundred percent and seven hundred fifty percent based on the risk-based capital instructions defined in chapter 26.1-03.1;

   e. May not be excessive;

   f. May not be inadequate, unless mutually agreed by the insurer and the commissioner; and

   g. May not be unfairly discriminatory.

3. Reliance on the risk-based capital instructions under chapter 26.1-03.1 for establishing reasonable premium rates does not waive the confidentiality protection and other restrictions.

4. Except as otherwise provided, as used in this section:

   a. "Excessive rates" means rates that are projected to not meet the minimum loss ratios specified in section 26.1-36-37.2.

   b. "Inadequate rate" means a rate that is projected to return benefits to group policyholders in the aggregate of more than ninety percent of premium received and to return benefits to individual policyholders in the aggregate of more than eighty-five percent of premium received.

   c. "Unfairly discriminatory rate" means a rate established in violation of subsection 7 of section 26.1-04-03.

SECTION 5. Section 26.1-30-23 of the North Dakota Century Code is created and enacted as follows:

26.1-30-23. Accident and health insurance - Procedure for use of premium rates filed with commissioner - Appeals.

1. Except as otherwise provided or except upon receipt of written approval by the commissioner, a premium rate or a rate schedule required to be filed under this section may not be issued, nor may any application, rider, or endorsement be used in connection with such a rate or rate schedule, until the expiration of forty-five days following the filing of the rate or rate schedule with the commissioner. The commissioner may extend the forty-five-day period for an additional period, not to exceed fifteen days, if the commissioner provides written notice to the insurer within the initial forty-five-day period. The written notice must advise the insurer that the additional time is necessary for the commissioner to consider the filing. If the applicable time period for consideration of a premium rate filing by the commissioner expires without a written response as required under

subsection 2, the filing is deemed approved until the next time the same rate filing for the associated insurance policy, certificate, contract, agreement, or rate schedule, or any associated application, rider, or endorsement, is submitted to the commissioner for review.

2. The commissioner shall review the premium rate filing, including additional information requested related to the rate filing, and shall provide a written response that:

   a. Approves the premium rate schedule as filed;

   b. Disapproves the premium rate schedule as filed, and which includes the specific actuarial basis and reasons for the denial, and which is accompanied by the actuarial analysis used in making the determination by the commissioner; or

   c. Disapproves the submitted premium rate schedule as filed and approves an alternative rate schedule, and which includes the specific actuarial basis and reasons for the alternate rate schedule, and which is accompanied by the actuarial analysis used in making the determination by the commissioner.

3. If the commissioner disapproves the rate schedule or approves an alternative rate schedule, as part of the written response the commissioner shall notify the insurer that the insurer may request an administrative hearing by filing a written request within fifteen days of the written response.

4. If the insurer requests a hearing under subsection 3, the commissioner shall coordinate with the office of administrative hearings, in consultation with the insurer, to schedule an administrative hearing that must be conducted by an independent hearing officer within forty-five days of the hearing request. Upon a determination of just cause, the hearing officer may extend the forty-five-day deadline for no more than fifteen days.

5. The hearing officer shall issue a final decision within thirty days following completion of the administrative hearing and any posthearing briefs. The insurer and the commissioner have thirty days from the issuance of the final decision to file an appeal with the district court."

Renumber accordingly

Date: 1/11/09
Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2306

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

amendments

Legislative Council Amendment Number ______

Action Taken ☐ **Do Pass** ☐ **Do Not Pass** ☐ **Amended**

Motion Made By Lyson Seconded By Olafson

Senators	Yes	No	Senators	Yes	No
Sen. Dave Nething – Chairman			**Sen. Tom Fiebiger**		
Sen. Curtis Olafson – V. Chair.			**Sen. Carolyn Nelson**		
Sen. Stanley W. Lyson			**Sen. Mac Schneider**		

Total (Yes) ______ (N) ______

Absent ______

Floor Assignment ______

If the vote is on an amendment, briefly indicate intent:

Verbal yes

Date: 2/11/09
Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES 2306
BILL/RESOLUTION NO.

Senate **JUDICIARY** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☒ **Do Pass** ☐ **Do Not Pass** ☒ **Amended**

Motion Made By Sen Schneider Seconded By Sen Lyson

Senators	Yes	No	Senators	Yes	No
Sen. Dave Nething – Chairman	X		**Sen. Tom Fiebiger**	X	
Sen. Curtis Olafson – V. Chair.	X		**Sen. Carolyn Nelson**	X	
Sen. Stanley W. Lyson	X		**Sen. Mac Schneider**	X	

Total (Yes) 6 (N) 0

Absent

Floor Assignment Sen. Nething

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2306: Judiciary Committee (Sen. Nething, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2306 was placed on the Sixth order on the calendar.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "for an Act to create and enact sections 26.1-30-22 and 26.1-30-23 of the North Dakota Century Code, relating to premium rate requirements and rate filing procedures for accident and health insurance; and to amend and reenact sections 26.1-18.1-15, 26.1-30-19, and 26.1-30-21 of the North Dakota Century Code, relating to health maintenance organization rate filings and insurance rate filing procedures.

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approved by the commissioner and is in compliance with chapters 26.1-33, 26.1-34, 26.1-35, and 26.1-37.

3. ~~No~~ An insurance policy, certificate, contract, or agreement or notice of proposed insurance against loss or expense from the sickness, bodily injury, or death by accident of the insured may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof and the classification of risks and the premium rates, or in the case of cooperatives or assessment companies the estimated costs pertaining thereto, have been filed with and approved by the commissioner. A form must be disapproved if the benefits ~~provided are unreasonable in relation to the premium charge or if the benefits~~ do not comply with chapters 26.1-36 and 26.1-37. Sections 26.1-30-22 and 26.1-30-23 apply to rate filings required under this subsection.

4. ~~No~~ A casualty or fire and property insurance policy, certificate, contract, or agreement may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof has been filed and approved by the commissioner to the extent rates are filed and approved pursuant to chapter 26.1-25.

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26.1-30-22. Accident and health insurance - Premium rate requirements.

1. Premium rates associated with any insurance policy, certificate, contract, or agreement or notice of proposed insurance against loss or expense

from the sickness, bodily injury, or death by accident of the insured may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection with such a policy, certificate, contract, agreement, or notice until the classification of risks and premium rates, or in the case of cooperatives or assessment companies the estimated costs pertaining thereto, have been filed with and approved by the commissioner as provided under section 26.1-30-23.

2. For purposes of this section, premium rates:

   a. Must cover reasonably anticipated claims;

   b. Must cover reasonable costs of operation and overhead expenses;

   c. Must be reasonable in relation to benefits provided;

   d. For an insurer subject to section 26.1-17-33.1, notwithstanding the prohibition of use of risk-based capital information for ratemaking as defined in section 26.1-03.1-08, must maintain a risk-based capital margin between six hundred percent and seven hundred fifty percent based on the risk-based capital instructions defined in chapter 26.1-03.1;

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the expiration of forty-five days following the filing of the rate or rate schedule with the commissioner. The commissioner may extend the forty-five-day period for an additional period, not to exceed fifteen days, if the commissioner provides written notice to the insurer within the initial forty-five-day period. The written notice must advise the insurer that the additional time is necessary for the commissioner to consider the filing. If the applicable time period for consideration of a premium rate filing by the commissioner expires without a written response as required under subsection 2, the filing is deemed approved until the next time the same rate filing for the associated insurance policy, certificate, contract, agreement, or rate schedule, or any associated application, rider, or endorsement, is submitted to the commissioner for review.

2. The commissioner shall review the premium rate filing, including additional information requested related to the rate filing, and shall provide a written response that:

   a. Approves the premium rate schedule as filed;

   b. Disapproves the premium rate schedule as filed, and which includes the specific actuarial basis and reasons for the denial, and which is accompanied by the actuarial analysis used in making the determination by the commissioner; or

   c. Disapproves the submitted premium rate schedule as filed and approves an alternative rate schedule, and which includes the specific actuarial basis and reasons for the alternate rate schedule, and which is accompanied by the actuarial analysis used in making the determination by the commissioner.

3. If the commissioner disapproves the rate schedule or approves an alternative rate schedule, as part of the written response the commissioner shall notify the insurer that the insurer may request an administrative hearing by filing a written request within fifteen days of the written response.

4. If the insurer requests a hearing under subsection 3, the commissioner shall coordinate with the office of administrative hearings, in consultation with the insurer, to schedule an administrative hearing that must be conducted by an independent hearing officer within forty-five days of the hearing request. Upon a determination of just cause, the hearing officer may extend the forty-five-day deadline for no more than fifteen days.

5. The hearing officer shall issue a final decision within thirty days following completion of the administrative hearing and any posthearing briefs. The insurer and the commissioner have thirty days from the issuance of the final decision to file an appeal with the district court."

Renumber accordingly

2009 HOUSE INDUSTRY, BUSINESS AND LABOR

SB 2306

2009 HOUSE STANDING COMMITTEE MINUTES

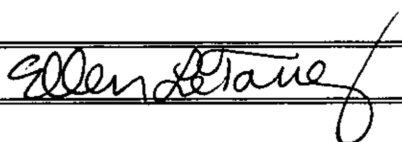
Bill/Resolution No. 2306

House Industry, Business and Labor Committee

☐ Check here for Conference Committee

Hearing Date: March 11, 2009

Recorder Job Number: 10652

Committee Clerk Signature 

Chairman Keiser: Opened the hearing on SB 2306 relating to premium rate requirements, filing procedures for accident & health insurance, health maintenance organization rate filings & insurance rate filing procedures.

Rod St Aubyn~Blue Cross Blue Shield of North Dakota. There has been a lot of press lately regarding several issues with our company. Our board has taken serious action dealing with these issues. Our board is committed to making significant changes in starting a new chapter for our company. We will continue to strive to serve our members. In that spirit of cooperation to start better communications, our board chairmen and interim CEO, initiated discussion with the Insurance Commission yesterday and we offer to start a new chapter and in fostering a better relationship with the insurance department. Insurance Commissions likewise offered his commitment in working better with BCBS of North Dakota. While we still feel that SB 2306 has some merits, in good faith, we have offered to the commissioner that we would ask your committee to give SB 2306 a Do Not Pass with the expectations of both our company and commissioner will try to work out all the differences that we may have.

Adam Hamm~North Dakota State Insurance Commissioner. I appreciate the BCBS comments. Yesterday, I did have a couple of good conversations with BCBS. We have very

open and frank discussions on a number of issues. I anticipate that we will have many more over the days to come. The focus was on going forward not backward.

Chairman Keiser: Anyone else who wants to testify for, against or in a neutral position on SB 2306. Closes the hearing, what are the wishes of the committee?

Representative Ruby: Moves a Do Not Pass.

Vice Chairman Kasper: Second.

Voting roll call was taken on SB 2306 for a Do Not Pass with 12 ayes, 0 nays, 1 absent and Representative Vigesaa is the carrier.

Date: Mar 11- 2009

Roll Call Vote # 1

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 2306

House House, Business & Labor Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Do Pass ☒ Do Not Pass ☐ As Amended

Motion Made By Seconded By

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper	✓		Representative Boe		
Representative Clark	✓		Representative Gruchalla	✓	
Representative N Johnson	✓		Representative Schneider	✓	
Representative Nottestad	✓		Representative Thorpe	✓	
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total (Yes) 12 No 0

Absent 1

Floor Assignment Vigesaa

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2306, as engrossed: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **DO NOT PASS** (12 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2306 was placed on the Fourteenth order on the calendar.

2009 TESTIMONY

SB 2306

Attachment 1
SB 2306

Testimony on SB 2306
Senate Judiciary Committee
February 2, 2009

Chairman Nething and members of Senate Judiciary Committee, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota also known as Nordian Mutual Insurance Company.

We asked for SB 2306 to be introduced to deal with an issue that we have encountered during the past 9 months. We typically submit rate filings **annually** to adjust the insurance premium rates in order that premiums are adequate to cover anticipated claims during the following year. Historically these filings have been done within an average of 20 days. We submitted several rate filings for our insurance products in 2008. Most of these filings were denied by the Insurance Commissioner. As provided by the ND Century Code, we elected to appeal these denials and are currently still going through that process. This is the first time in our history that we have had to pursue this appeal process. To better illustrate the current situation, I am providing a chart showing the current process and the effects of that same rate filing if this bill were to pass. As the chart will show, one whole year is expected to pass before we get a final decision on our appeal from the date of the original filing. So in effect, we will lose almost one year's worth of premium increase with the current process. These are dollars necessary to pay our members' claims. In the example shown, we are losing almost $1 million dollars of premium income a month from August 1, 2008 until a final decision is made. The ironic part of this appeal process is that the ultimate decision in this appeal process will be made by the same person that originally denied the rate increase. It is only after that point that the insurer can ask for a review by the District Court. One can only guess how much longer that will take before getting a court decision. In the meantime, we expect to be experiencing an underwriting loss from this filing.

SB 2306 as proposed will do the following:

- Reduce the time period for the rate filing process and the appeal process.
- Establish a clearer definition of the standards for consideration of rate filings.
- Ensure that politics will not be a component of any decision.
- Establish that the first appeal process is not ultimately decided by the same individual that made the original denial decision.
- Protect the consumer from having an even higher insurance rate as a result of the delays in an appeal process. (See Attached Chart)
- Ensure a more stable premium rate increase environment for our members, rather than no increase in one year and then a significant increase in the following year.

Before discussing the bill, I think it is necessary to explain some basic insurance definitions and processes. As a nonprofit mutual insurance company, we are owned by our members. Technically there are no profits. Any gains realized are added to the company's reserves to protect our members during times of unexpected losses. There are statutory requirements for maintaining these reserves. These requirements vary depending upon the type of insurer. For example, prior to our conversion from a

nonprofit health service corporation, we were obligated to maintain reserves in the range of 2 to 4 months worth of premium dollars. After our conversion, this reserving requirement switched to risk based capitol levels, as derived from the National Association of Insurance Commissioner's (NAIC) model act and specified in NDCC 26.1-03.1 and 26.1-03.2 (Risk-Based Capital).

Risk-based capital (RBC) is a method developed by the National Association of Insurance Commissioners to measure the minimum amount of capital that an insurance company needs to support its overall business operations. As of October 31, 2008, BCBSND's was at 517 percent RBC. That calculation has dropped even lower at the end of November, 2008 to 511. In terms of that former 2 to 4 months of reserve, we will be very close to the 2 month level before the end of the year without any increases in our premium levels.

State Regulatory Requirements

200% RBC: State company action
150% RBC: Regulatory action
100% RBC: State authorized to take control of insurance company

In addition to the state's RBC requirements, BCBSND is subject to requirements from the Blue Cross and Blue Shield Association. If BCBSND's RBC falls below 200 percent, it can no longer be a Blue Plan. North Dakotans would lose their Blue Card® status and could not receive services outside the state at Blue Card® rates.

BCBSA Requirements

375% RBC: Early warning
300% RBC: Concern level
200% RBC: No longer a Blue Plan

In addition to meeting the requirements set by the state and BCBSA, BCBSND needs capital for major capital investments such as systems conversions and to provide rate stability in the marketplace.

Several press releases and statements from the Insurance Commissioner stated that the reserves of BCBSND continue to grow despite reductions in approved insurance rate filing requests. Though that is technically true, it is also misleading. Our reserves need to continually grow at least at the same rate of increase as premiums to insure that we will continually have adequate reserves to cover catastrophic health crisis such as a flu epidemic or some pandemic such as the bird flu. Our members have the expectation and the right that we have adequate reserves to cover such events when claims drastically outpace the income from premiums. It is important to note that we pay out claims in excess of $1.3 billion dollars a year. **We are expecting to pay out over $25 million dollars a week in hospital, physician, pharmaceutical, and other medical claims a week.**

I have attached a chart showing the drastic drop in our RBC levels during the past few years. We believe that our RBC levels are the lowest or second lowest of any of the Blues plans across the country.

A second area I want to define is the two types of health insurance we offer. We offer "Individual" coverage (also called our Bank Depositors insurance) and Group insurance coverage. It is easiest to think of Individual coverage as "non group" insurance. For example, a farm family may elect to purchase this type of coverage for their family. The "Group" coverage is what is most often thought of as the type of coverage offered by an employer for their entire group of employees. Please differentiate between Individual and single coverage. It's best to remember that Individual is basically non group coverage.

Now I would like to point out specific changes that this bill will encompass. Section 1 limits these provisions to only mutual insurance companies offering health insurance. To our knowledge, we believe this will only affect our company. Subsection 3 incorporates the same review standard (reasonable in relation to benefits provided) as we currently have, but also establishes a Risk-Based Capital (RBC) corridor that our company should be operating when approving premium rates. Current statutes only provide a minimum standard as previously discussed. This will now say the maximum RBC level should be no higher than 750%. That is very close to the maximum 4 months standard that we faced when we were a nonprofit health insurance corporation and still exists in statute. During our recent administrative hearing on our appeal of the Bank Depositor's rate filing denial, Bob Dobson, an actuarial consultant from Milliman Associates testified of his past experience working with many other health insurance companies and insurance commissioners in other states. Milliman is the same company utilized by the Legislature in reviewing the anticipated cost/benefit for health insurance mandate bills. Mr. Dobson's testimony indicated that his experience shows that the optimal levels to operate are in the range of 800% to 1,200%. This bill lowers that RBC range to a 600% to 750% range.

Subsection 4 establishes another standard that is current law under the nonprofit health service corporation – rates may not be excessive, inadequate, or unfairly discriminatory (note NDCC 26.1-17-25). However the terms "excessive, inadequate, or unfairly discriminatory" are not defined. This bill defines those terms tied to loss ratios. Loss ratios are basically the percentage of the premium that is used to actually pay for direct claims. For example a 90% loss ratio means that 90 cents of every premium dollar is used for direct reimbursement of medical claims, while only 10 cents of every dollar is used in the administrative expense of the insurance company to operate. Current law in NDCC 26.1-36-37.2 states that the minimum loss ratios for health insurance companies can be no lower than 70% for group policies and 55% for individual policies (non-group).

Subsection 5 merely reinforces the confidentiality protections established under the RBC statute.

Section 2 and 3 establishes the time periods and procedures for rate filings and also the appeal process. These two sections reduces the time periods, creates language to toll the time period during any inquiries of the Insurance Commissioner, provides that the insurer can request an independent consulting actuary perform the initial rate review at the insurer's expense, specifies the options of the Insurance Commissioner, establishes a time period for the appeal hearing, and dictates that the administrative law judge's decision is a final decision subject to appeal by either side to the district court. To give you a better idea of these time frames, historically, it has taken the Insurance Department about 20 days to review our rate filings. This past year, they utilized the entire 60 days permitted by law plus the allowed 15 day extension before denying all of these filings. To better show the changes, I offer the following summary:

	Current Law	SB 2306
Initial time for review by Insurance Dept.	60 days	30 days
Ins. Dept. option for extended time	15 days	15 days
Deemed approved if no action within time period	Yes	Yes
Time for inquiries by Ins. Dept.	Counts within days	Tolled until response
Insurer time to appeal	45 days	15 days
Time until scheduled hearing	No limit	45 days
Time for hearing officer to issue ruling	30 days	30 days
Time for insurance comm.. to make final dec.	60 days	Not applicable
Hearing Office decision is final	No	Yes
Decision can be appealed to District Court	Yes	Yes

Mr. Chairman and Committee members, as I indicated this appeal process is very new to us, since this is first time we have had to resort to this option. However, after experiencing it, it is obvious that is it not a workable solution. We have had our administrative hearing on the Bank Depositor's product, the final briefs were submitted last Friday, the Judge's decision/recommendation is due in 30 days, and then the Insurance Commissioner has 60 days to make his final decision. That will put a decision very close to one year from when we originally filed the product. So in effect, we will have lost close to one years worth of necessary premium. Our next option is to take it to District Court. Our outside lawyers are optimistic that we will ultimately prevail, but at what expense to our members. We can not recover the loss revenue, we can only be granted the option to use the rates submitted after a 30 day notification and the necessary time to prepare documents before the notification. And after losing this year, we are now approaching a new rate filing time. It is our members that will experience a dramatic increase in their rate, significantly higher than originally submitted, because of continually rising health care costs and higher utilization.

So in effect, the current appeal process is not a viable option for insurers. We currently have 2 other rate filings under appeal. Those two are scheduled for administrative hearing toward the end of March and early April. Between these 3 appeal hearings, our member-owned company is losing revenues close to $4 million dollars a month since January 1 and those revenues can never be made up. It simply results in decreasing our reserves and lowering of our RBC. We urge a Do Pass on SB 2306. I would be willing to answer any questions the committee may have.

Attachment 1
2306

Submitted by Rod St. Aubyn, Blue Cross Blue Shield of ND

Mr. Chairman and Committee members, several of our staff including our CEO met last Friday with representatives of the ND Healthcare Association (hospitals) and the ND Medical Association concerning their concerns with SB 2306. We discussed the situation we currently face and they had a better picture of the problems we continually encounter (declining Risk Based Capital (RBC) which worsens the financial stability of our company) with the current system. One point that I forgot to mention is that Standard and Poor's recently lowered our rating because of the situation with our financial situation due to lack of rate increases.

After our discussions, we have agreed to offer amendments to address many of the concerns expressed during the hearing. I would like to individually address each of Mr. Kapsner's concerns in his testimony.

1. Places BCBSND under a different process than other insurance companies. In reality, that current exists. There are numerous different standards for review for different insurance companies within the Century Code. For example, the standard for Nonprofit Health Service Corporations (which we used to be before we converted to a nonprofit mutual insurance company) has a different standard than we currently have (see NDCC 26.1-17- Rate Requirements versus the standard we have in NDCC 26.1-30-19 (3)). We are under a RBC requirement while nonprofit health service corporations must maintain 2 to 4 months of reserve. I could cite many other differences if you desire, but the point is there are many differences in current law. **However, we would be more than agreeable to have SB 2306 apply to all health insurers, with the exception of the RBC corridor, because we are sure there are many other insurers already in excess of the top number in that corridor and we are willing to be in a corridor similar to the 2-4 month standard expressed in RBC numbers.**
2. Different rules for BCBSND than other companies. **As already expressed we are agreeable to have this apply to all health insurers.**
3. Timelines are too restrictive for the Commissioner and the Administrative Law Judge. We disagree because the Commissioner has 60 days plus another 15 days extension when historically they have only needed 20 days to make a decision, until this past year, when they have used the entire 75 days to make a decision to totally deny our rate requests. At the same time, during statements made under oath it was discovered through the Administrative Rate Appeal Hearing, that many of our competitors' rates were approved in the range of 14% to 20%. No other companies' rates were denied totally as ours was. The timelines for the Administrative Law Judge has not been changed other than the scheduling of the hearing (45 days after the appeal with the judge having discretion to extended that by another 15 days). After the hearing is scheduled, no other changes are made regarding the time line the judge has, other than making the Judge's ruling final, but can be appealed by either side. The judge has the freedom to decide when post hearing briefs are due and the 30 days for the judge's decision does not change from current law. **However, we would agree to increase the number of**

days for the review by the Insurance Department from 30 days plus the 15 day extension to 45 days plus the 15 day extension.

4. Objects to the number of inquiries for the Insurance Commissioner. **We would agree to delete that reference and also to delete the tolling of the time period.**
5. Objects to the use of an independent consulting actuary. **Our amendments will strike that reference as well.**

In addition, Mr. Kapsner indicated a need to clarify that the appeal of the Administrative Law Judge can be appealed by both the insurer and the Insurance Department. **We think the proposed language is clear, but we would also offer amendments to make it very clear.**

Our proposed amendments would address most of the issues addressed by Mr. Kapsner, but would still shorten the unreasonable time period for rate filing appeals that the current Century Code dictates. In summary, the proposed amendments would do the following:

- **Have the changes apply to all health insurers with the exception of the risk-based capital corridor which will apply to only to Noridian since most other insurers are probably above that RBC level.**
- **Increases the number of days for review by the Insurance Dept from 30 days as shown in the bill to 45 days, but still permits an extension of 15 days if needed.**
- **Deletes the tolling section.**
- **Deletes the option of the independent consulting actuary.**
- **Clarifies that the ruling of the ALJ can be appealed by either the insurer or the insurance dept. based on a concern you expressed in your testimony before the committee.**

We anticipate the Administrative Law Judge's decision for our Individual Rate Denial Appeal within the next 2 to 3 weeks. While our outside lawyers are optimistic that we will prevail in that process, even a victory there does not change anything. The Insurance Commissioner will then have 60 days to make a final decision. It is not until that process is over that we could take the decision to District Court, literally one year after the rate filing was originally submitted. In the meantime, we have lost these revenues for one year and are then up to the date that we normally submit our annual rate filing, only to be facing the same process. Our other rate denial hearings are scheduled for late March and early April. **Collectively, we are losing about $4 million a month from lost premium revenues effective January 1.** We urge that the committee adopt the amendments proposed and give SB 2306 a Do Pass as amended.

The sections to be modified will have to be changed by the legislative council to reflect that these changes will apply to all health insurance companies, and not just those under Chapter 26.1-12.

The proposed changes to SB 2306 are reflected in the copy below. Proposed new language to the bill are reflected in underlined text. Proposed deleted text is reflected with strike-throughs.

90595.0100
Sixty-first
Legislative Assembly **SENATE BILL NO. 2306**
of North Dakota
Introduced by
Senators Nething, Fiebiger, Olafson
Representatives DeKrey, Delmore, Klemin
A BILL for an Act to create and enact sections 26.1-12-33, 26.1-12-34, and 26.1-12-35 of the
North Dakota Century Code, relating to rate filing procedures for mutual insurance companies
that offer accident and health insurance.
BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:
SECTION 1. Section 26.1-12-33 of the North Dakota Century Code is created and enacted as follows:
26.1-12-33. Accident and health insurance - Premium rate requirements.
1. This section is limited in application to a mutual insurance company that offers accident and health insurance contracts as defined under section 26.1-12-11.
2. Premium rates associated with any insurance policy, certificate, contract, or agreement or notice of proposed insurance against loss or expense from the sickness, bodily injury, or death by accident of the insured may not be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection with such a policy, certificate, contract, agreement, or notice until the classification of risks and premium rates have been filed with and approved by the commissioner.
3. Premium rates must cover reasonably anticipated claims; cover reasonable costs of operation and overhead expenses; be reasonable in relation to benefits provided; and for an insurer subject to section 26.1-17-33.1, notwithstanding the prohibition of use of risk-based capital information for ratemaking as defined in section 26.1-03.1-08, ~~be presumed reasonable if established to~~ maintain a risk-based capital margin between six hundred percent and seven hundred fifty percent based on the risk-based capital instructions defined in chapter 26.1-03.1. Reliance on the risk based capital instructions under chapter 26.1-03.1 for establishing reasonable premium rates does not waive the confidentiality protection and other restrictions.
4. Rates may not be excessive; inadequate, unless mutually agreed by the insurer and the commissioner; or unfairly discriminatory. Except as otherwise provided, as used in this section:
a. "Excessive rates" means rates that are projected to not meet the minimum loss ratios specified in section 26.1-36-37.2.
b. "Inadequate rate" means a rate that is projected to return benefits to group policyholders in the aggregate of more than ninety percent of premium received and to

return benefits to individual policyholders in the aggregate of more than eighty-five percent of premium received.

c. "Unfairly discriminatory rate" means a rate established in violation of subsection 7 of section 26.1-04-03.

~~5. Reliance on the risk-based capital instructions under chapter 26.1-03.1 for establishing reasonable premium rates does not waive the confidentiality protection and other restrictions for a mutual insurance company under section 26.1-03.1-08.~~

SECTION 2. Section 26.1-12-34 of the North Dakota Century Code is created and enacted as follows:

26.1-12-34. Accident and health insurance - Procedure for use of premium rates filed with commissioner.

1. Notwithstanding chapter 26.1-30, this section is limited in application to a mutual insurance company that offers accident and health insurance contracts as defined under section 26.1-12-11.

2. Except as otherwise provided or except upon receipt of written approval by the commissioner, a premium rate or a rate schedule may not be issued, nor may any application, rider, or endorsement be used in connection with such a rate or rate schedule, until the expiration of ~~thirty~~ forty-five days following the filing of the rate or rate schedule with the commissioner. The commissioner may extend the ~~thirty~~ forty-five -day period for an additional period, not to exceed fifteen days, if the commissioner provides written notice to the mutual insurance company within the initial ~~thirty~~ forty-five -day period. The written notice must advise the mutual insurance company that the additional time is necessary for the commissioner to consider the filing. ~~During the initial thirty-day review period and any extension, the commissioner may request no more than three separate inquiries as specified in section 26.1-02-03. An inquiry may include more than one question. The thirty-day period and any extension must be tolled from the date an inquiry is made by the commissioner until the insurer issues a response. A request for clarification of an original inquiry is not included in the specified three separate inquiries.~~ If the applicable time period for consideration of a premium rate filing by the commissioner expires without a written response as required under subsection 4, the filing is deemed approved until the next time the same rate filing for the associated insurance policy, certificate, contract, agreement, or rate schedule, or any associated application, rider, or endorsement, is submitted to the commissioner for review.

~~3. At the time the rate filing is submitted, the mutual insurance company may demand that the actuarial review of the rate filing be completed by an independent professional consulting actuary, at the expense of the mutual insurance company.~~

~~The commissioner shall consider findings of such an independent professional consulting actuary prima facie evidence as to the reasonableness of the submitted premium rate filing.~~

4. The commissioner shall review the premium rate filing, including additional information requested related to the rate filing~~, as well as the submitted actuarial analysis,~~ and shall provide a written response that:

a. Approves the premium rate schedule as filed;

b. Disapproves the premium rate schedule as filed, and which includes the specific actuarial basis and reasons for the denial, and which is accompanied by the actuarial analysis used in making the determination by the commissioner; or

c. Disapproves the submitted premium rate schedule as filed and approves an alternative rate schedule, and which includes the specific actuarial basis and reasons for the alternate rate schedule, and which is accompanied by the actuarial analysis used in making the determination by the commissioner.

SECTION 3. Section 26.1-12-35 of the North Dakota Century Code is created and enacted as follows:

26.1-12-35. Accident and health insurance - Disapproval of premium rate – Notice and hearing.

1. This section is limited in application to a mutual insurance company that offers accident and health insurance contracts as defined under section 26.1-12-11.
2. If the commissioner disapproves the rate schedule or approves an alternative rate schedule as provided under section 26.1-12-34, as part of the written response the commissioner shall notify the mutual insurance company that the mutual insurance company may request an administrative hearing by filing a written request within fifteen days of the written response.
3. If the mutual insurance company requests a hearing under subsection 2, the commissioner shall coordinate with the office of administrative hearings, in consultation with the mutual insurance company, to schedule an administrative hearing that must be conducted by an independent hearing officer within forty-five days of the hearing request. Upon a determination of just cause, the hearing officer may extend the forty-five-day deadline for no more than fifteen days.
4. The hearing officer shall issue a final decision within thirty days following completion of the administrative hearing and any posthearing briefs. The ~~parties~~ insurer and the insurance department have thirty days from the issuance of the final decision to file an appeal with the district court.

Individual PersonalChoice $500 Deductible

Illustrative Monthly Premium - Age 35 Single

2006

2007

2008

2009

$157.60

$155.60

$155.20

$169.90

$180.60

$169.90

$202.00

$195.00

$169.90

$218.20

$169.90

Additional premium rate needed to cover rising claims expense.

Actual Premium Needed

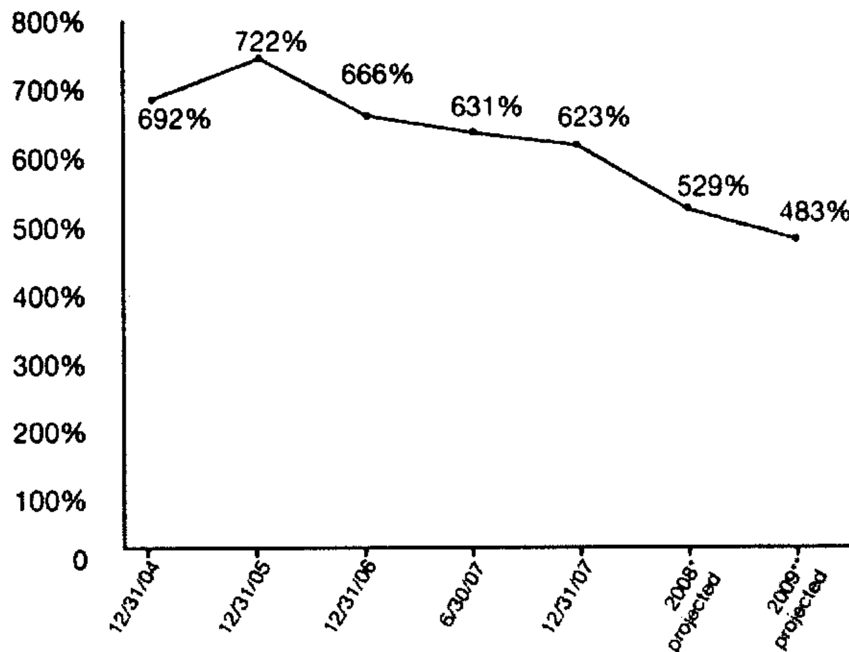
Premium Requested by BCBSND

Premium Approved by DOI

Primary Licensee Health RBC Ratios

Risk Based Capital Ratio

5 Year Trend



* Projected. Assumes a 6.8% claims trend, NDPERS loss of $1.5 million and no rate increase for individual business.

** Projected. Assumes a 8.5% claims trend, NDPERS loss of $7 million and an estimated group and individual rate increase effective 4/1/09

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
May 6, 2008 Bank Depositor Rate Increase Request
Notice of Disapproval

The May 6, 2008, filing by Blue Cross Blue Shield of North Dakota (BCBS) to increase the premium rate charged on its bank depositor individual policies is disapproved for the following reasons:

1. The assumptions underlying the rate increase are not reliable. The documentation and responses to Insurance Department questions submitted by BCBS state that one of the assumptions BCBS used to calculate the rate includes a 5.6% increase being paid to healthcare providers. In the company's last group rate increase request, it also stated that it would provide a 5.6% increase to providers. Approximately six months later, after it implemented the approved group rate increase, BCBS announced its intent to "withhold" from providers up to 2.5% of that 5.6% increase. BCBS verified to the Department that the 2.5% withhold applies to the bank depositor policies as well. Given that BCBS asked for a rate increase ostensibly to increase provider reimbursement and then in a communication to providers said it was reducing that rate, the assumption of a 5.6% increase is not reliable.

2. For lack of information necessary to support the rate increase. The filing was not accompanied by sufficient information to justify the rate increase requested and thus the North Dakota Insurance Commissioner is not able to determine whether the filing meets the requirements of N.D.C.C. title 26.1. The filing was based on an assumption of BCBS paying a 5.6% increase to providers. However, BCBS announced its intention to implement a provider withhold of up to 2.5%. When the Commissioner requested information regarding this provider withhold issue, BCBS did not provide, among other things, any assurances that this withheld payment will ever be paid to providers.

3. The rate requested would not be in compliance with N.D.C.C. section 26.1-30-19 in that the benefits provided would be unreasonable in relation to the premium charged.

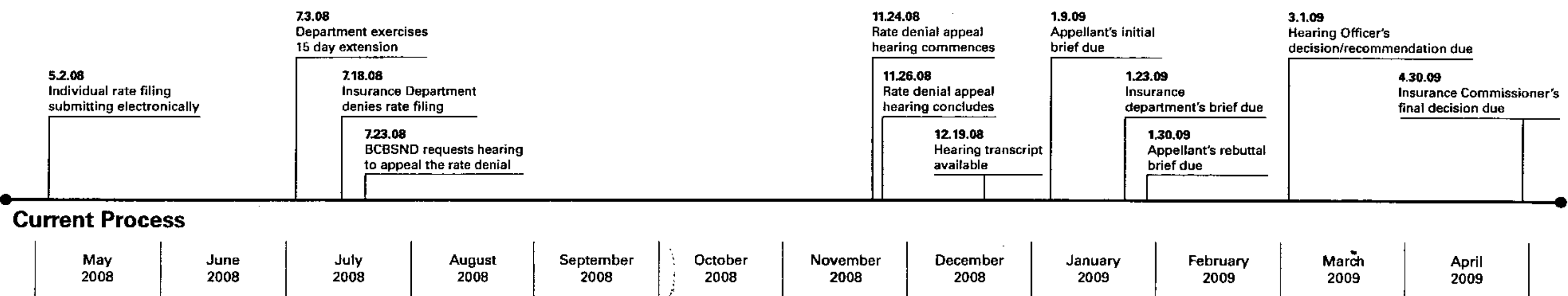
The proposed rate increase shall not be implemented.

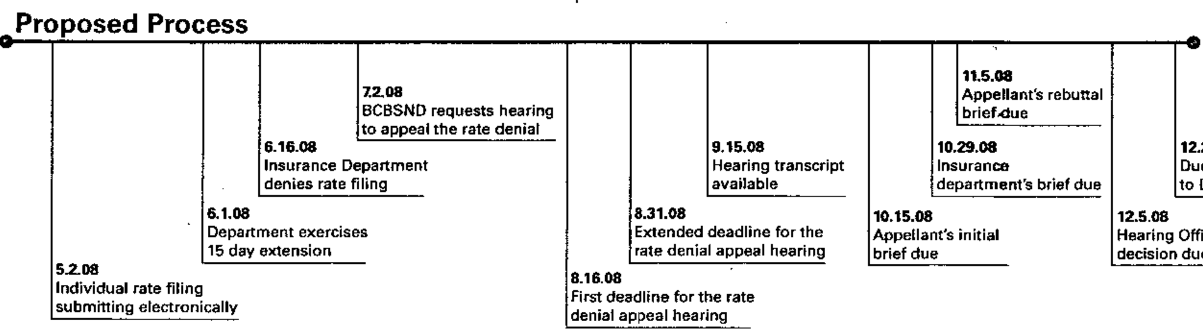
If you disagree with this decision, you may request a hearing by sending a written request within forty-five days of the date of this notice to:

North Dakota Insurance Commissioner
600 East Boulevard Avenue
State Capitol – fifth floor
Bismarck, ND 58505

Attachment 1 Continued
SB 2306

Appeals Process





Noridian Mutual Insurance Company

Attachment 2
SB-2306

SENATE BILL NO. 2306

Presented by:	**Michael L. Fix** **Director of the Life and Health Division and Actuary** **North Dakota Insurance Department**
Before:	**Senate Judiciary Committee** **Senator David Nething, Chairman**
Date:	**February 2, 2009**

TESTIMONY

Good morning, Chairman Nething and members of the Senate Judiciary Committee. My name is Michael Fix, and I am the Director of the Life and Health Division, and the Life and Health Actuary for the North Dakota Insurance Department.

As Director of the Life and Health Division, my responsibilities include, in addition to supervising and reviewing rate and form filings, the Consumer Hotline and Life & Health Complaint functions; and the State Health Insurance Counseling and Prescription Connection programs. In my capacity as Division Director, I hear the difficulties of North Dakota consumers in meeting their health care needs, and the challenges that face them, and providers, in dealing with healthcare cost and availability issues.

As the Life and Health Actuary, my responsibilities include supervision and review of form filings, and I review all rate filings. In my capacity as the Life and Health Actuary, I hear the concerns from companies who believe their rate increases should all be approved as requested, from consumers who believe there should be no rate increases, and from some who believe that rate increases higher than requested should be approved with the excess amount mandated to be paid out in certain ways.

The mission of the Insurance Department, and the role of the Commissioner and his staff, is to "protect consumers while fostering a strong, competitive marketplace that

provides consumers with choices and access to affordable insurance products and services". Current law allows us to do that.

In both my capacities as Director of the Life and Health Division, and as the Life and Health Actuary, I appear *strongly* in opposition to Senate Bill No. 2306, a bill which seeks to significantly impair the Insurance Commissioner's ability to regulate insurance companies in North Dakota, for the protection of North Dakota consumers. Protecting North Dakota consumers *is* the primary job of the North Dakota Insurance Commissioner and his staff. In addition, the changes proposed in Senate Bill No. 2306 do not apply to all companies, only to some of the companies, creating a nonlevel playing field for companies currently offering health insurance products to North Dakota consumers, and companies that may consider entering the state.

Senate Bill No. 2306 adds three new sections to N.D.C.C. chapter 26.1-12, including:

- Premium rate requirements (26.1-12-33);
- Procedure for use of premium rates filed with the Commissioner (26.1-34); and
- Disapproval of premium rate – Notice and hearing (26.1-12-35)

The testimony that I have distributed includes an executive summary, plus a line-by-line outline of the changes being proposed. I would like to cover the points included in the executive summary, but will answer questions relating to any of the material I have distributed.

There are eight significant changes to the current regulatory process that are being proposed in Senate Bill No. 2306. I will briefly describe each one.

Senate Bill No. 2306 is limited in applicability to "mutual insurance companies that offer accident and health insurance". (Page 1, Lines 8-9; Page 2, Lines 19-21; Page 3, Lines 3-4)

Senate Bill No. 2306 would apply only to mutual insurance companies offering accident and health insurance contracts. Currently, there are 317 companies licensed to sell accident and health insurance in North Dakota. Of these, only 40 are mutual companies, and it is only these 40 to whom Senate Bill No. 2306 would apply. These 40 companies include Noridian (BCBS), the dominant insurance company in the state, but not Medica, the second largest company in market share in North Dakota and growing.

Having different regulatory processes for competitors creates a nonlevel playing field, and runs counter to the Department's attempts to attract and maintain quality companies and products for the consumers of North Dakota.

The review of a rate/form filing must be completed by the Commissioner within 30 days, or it will be deemed approved. The 30-day period can be extended by the Commissioner for up to 15 additional days. (Page 2, Lines 22-30)

The current time frame for review of rate and form filings is 60 days. The Commissioner can request an additional 15 days to complete a review if necessary. A filing currently can be deemed approved after this time period, but that "deemed" approval can be withdrawn by the Commissioner through a hearing process. Senate Bill No. 2306 reduces this time period by half for the 40 mutual companies. Meeting a 30-day timeframe for those 40 companies may mean that the other 277 companies will simply have to wait. Shortening the time period will affect the quality of the review process, and may not be possible with existing staff resources. In that case, additional staff and a fiscal note would be necessary. To require a shorter review period, but only for 40 out of 317 companies, where the 40 includes the company with a dominant market share in North Dakota; and excludes the company with the second largest market share and who is growing, gives a competitive advantage to a few companies, and creates an additional barrier to some of the existing companies offering products to North Dakota consumers, and to others that may be considering an entry into the North Dakota market.

This provision is not equitable for all accident and health insurance companies in North Dakota, and is not good for North Dakota consumers because it stifles competition by giving favorable treatment to the dominant health insurer.

During the 30-day initial review period, and any extension, the Commissioner can request no more than three separate inquiries. (Each inquiry could include more than one question.) (Page 2, Lines 30-31; Page 3, Lines 1-5)

This provision limits the Commissioner's ability to do his job in protecting North Dakota consumers. Currently, the Commissioner has no limit to the number of times he can ask questions of companies. Typically, one or two rounds of questions are sufficient to address any concerns the Insurance Department has with a particular filing. There are situations, however, where additional information or clarification is necessary and prudent. To limit the number of inquiries may require the Commissioner to make decisions without adequate information, and this will be to the detriment of the consumers we are charged to protect. This may force the Commissioner to disapprove a filing for lack of necessary information. This, in turn, may result in more litigation and added burdens on the Department's budget and staff.

If the applicable time period (30 days plus any extension) expires without a written response from the Commissioner, the filing is deemed approved until the next time the same rate filing is submitted to the Commissioner for review. (Page 3, Lines 5-10)

Currently, the review period is 60 days, and can be extended by the Commissioner for an additional 15 days. If no decision is communicated to the Company within that time frame, the Company can deem the filing approved. In those cases, however, the Commissioner can withdraw approval by going through a hearing process. This prevents poor products from being released into the North Dakota market, and is a disincentive for companies to exercise this "deemer" provision of law. Very few companies currently exercise the deemer provision when it is available because if the

approval is overturned, they will be required to undo what they have implemented. Senate Bill No. 2306 removes that protection, and would be bad for North Dakota consumers because they would be paying a higher premium than necessary.

Premiums would be presumed reasonable if they were established to maintain a Risk Based Capital (RBC) ratio between 600% and 750%. (Page 1, Lines 17-23)

Risk Based Capital (RBC) defines the amount of required capital that an insurance company must maintain based on the inherent risks in their operation. It is a formula calculation unique to each company that measures asset risk, liability risk, interest rate risk, and business risk.

In order to protect financial solvency of companies, or at least warn regulators of potential danger of insolvency, states including North Dakota have incorporated into statute defined degrees of action required of the Commissioner when a company's ratio of surplus to RBC (their "RBC Ratio") drops to specified levels. The first RBC Ratio level that requires action by the Commissioner is 200% RBC, defined as the "Company Action Level". Other levels include Regulatory Action Level (150% RBC); Authorized Control Level (100% RBC); and Mandatory Control Level (70% RBC). At the Mandatory Control Level, the Insurance Commissioner is required by law to assume control of the company.

There are additional levels that trigger warning signs for other associations as well. For example, a RBC Ratio equal to 375% will trigger an Early Warning to Blue Cross Blue Shield Association from a member company; 300% RBC will trigger a Concern Level; and 200% RBC can jeopardize the use of the Blue Cross Blue Shield symbol.

Mr. Chairman, and members of the Committee, That's some background for how RBC Ratios are being used.

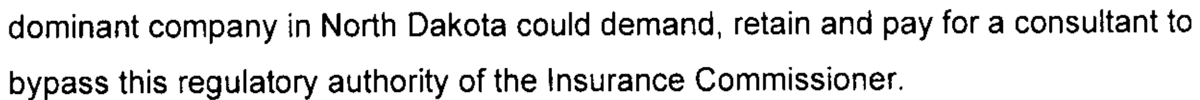
Senate Bill No. 2306 provides that if premiums are established to maintain an RBC Ratio between 600% and 750%, those premiums are to be "presumed" reasonable. This requirement has never been in place for rate reviews in North Dakota and, to put it in perspective, beginning in 2001, every rate increase requested by BCBS would have been presumed reasonable without review.

This provision would remove an important rate review capability by the Insurance Commissioner, to the detriment of North Dakota consumers. Consumers would be forced to pay the increased premiums demanded by the dominant health insurer in North Dakota, with essentially no oversight by the insurance regulator. Meanwhile, the company's surplus is well above any level that would even trigger concern for a regulator or health insurer associations.

For a rate filing, the Company under Senate Bill No. 2306 can "demand" that the actuarial review be completed by an independent consulting actuary paid for by the Company. The Commissioner would be required to consider the findings of the consultant as prima facie evidence of the reasonableness of the rate filing. (Page 3, Lines 11-16)

The language of this provision gives companies (but only 40 mutual insurance companies out of a total of 317) the authority to "regulate the regulator" by *demanding* that the actuarial review be completed by an outside consulting actuary and that the Commissioner must accept their findings unless the Commissioner can disprove them. This shifts the burden from the company to prove that it needs a premium increase to the Commissioner to prove that the actuary was wrong. Insurers have always had the burden to demonstrate their need to increase premiums. This would turn that long history of regulation upside down.

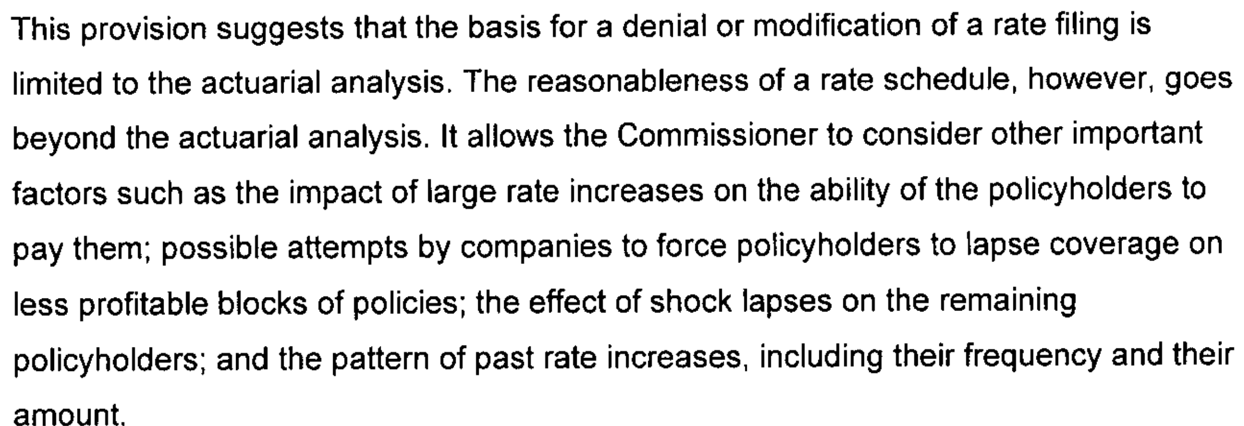
This provision removes an important rate review capability by the Insurance Commissioner, to the detriment of the North Dakota consumers, particularly when the



dominant company in North Dakota could demand, retain and pay for a consultant to bypass this regulatory authority of the Insurance Commissioner.

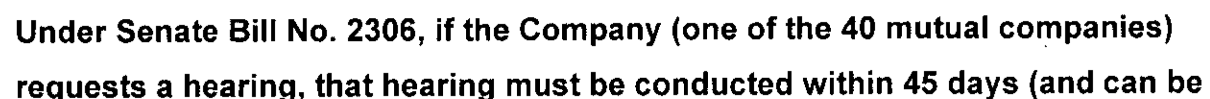
This provision is bad for the North Dakota consumer; bad for the companies that would not have the authority to make "demands" of their regulator; and it creates a nonlevel playing field for companies currently selling policies in the state, or for those considering entry into the state.

Under Senate Bill No. 2306, if a rate filing is disapproved or modified by the Commissioner, the Commissioner is required to provide the specific actuarial basis and actuarial analysis used in making the determination to deny or modify that rate request. (Page 3, Lines 17-28)



This provision suggests that the basis for a denial or modification of a rate filing is limited to the actuarial analysis. The reasonableness of a rate schedule, however, goes beyond the actuarial analysis. It allows the Commissioner to consider other important factors such as the impact of large rate increases on the ability of the policyholders to pay them; possible attempts by companies to force policyholders to lapse coverage on less profitable blocks of policies; the effect of shock lapses on the remaining policyholders; and the pattern of past rate increases, including their frequency and their amount.

Not allowing the Commissioner to include these other factors in the review of a rate filing is a significant departure from long standing Insurance Department regulation and weakens the consumer protection responsibilities of his job. It can result in premiums that are unaffordable; coverages that are dropped; and products introduced through new filings that are priced on an actuarially sound basis but inappropriate for consumers.



Under Senate Bill No. 2306, if the Company (one of the 40 mutual companies) requests a hearing, that hearing must be conducted within 45 days (and can be

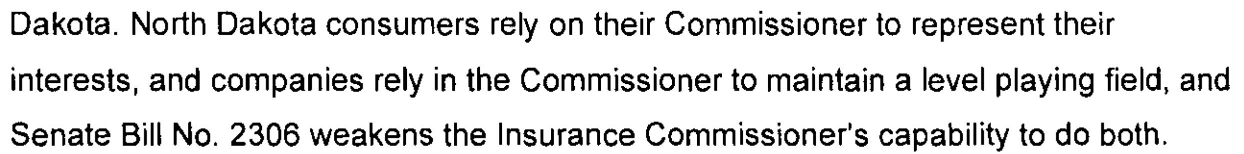
extended by no more than 15 additional days); and the hearing officer must issue a final decision within 30 days upon completion of administrative and posthearing briefs. Final decision is made by the hearing officer; and parties have 30 days from the issuance of the final decision to file an appeal with district court. (Page 4, Lines 5-19)

This provision requires an administrative hearing officer to hold a hearing within 45 days with a possible 15-day extension); and issue a final decision within 30 days after closing briefs have been filed, regardless of the schedule of that hearing officer. This would seriously hamper both parties' ability to conduct proper discovery before the hearing. It would give very limited time, for example, to take depositions of witnesses or find out about the other side's position through interrogatories. It also limits the ability of the hearing officer to have adequate time to issue an appropriate decision, one that can affect tens of thousands of North Dakota policyholders.

This provision also takes away the authority from the Insurance Commissioner to make a final decision. Currently, an administrative hearing officer makes a recommended finding to the Insurance Commissioner. This is also an unprecedented taking away of authority from an executive official. In no other administrative hearing proceeding is the Administrative Law Judge required to make a final decision.

The nonprevailing party can then appeal the Commissioner's decision to district court. Senate Bill No. 2306 gives authority to approve rate increases to the hearing officer and takes it away from the Insurance Commissioner, who has been elected to serve the consumer and regulate the insurance industry. It inhibits the Insurance Commissioner from doing the job he was elected to do.

Mr. Chairman, and members of the Senate Judiciary Committee, the mission of the North Dakota Insurance Department is to protect consumers while fostering a strong, competitive marketplace. Senate Bill No. 2306 dilutes and in some instances removes the authority of the Insurance Commissioner to regulate health insurance in North



Dakota. North Dakota consumers rely on their Commissioner to represent their interests, and companies rely in the Commissioner to maintain a level playing field, and Senate Bill No. 2306 weakens the Insurance Commissioner's capability to do both.

If this bill passes, consumers will pay higher health insurance premiums. As I already noted, every increase requested by BCBS beginning in 2001 would have been implemented under this bill. I urge the Committee to give a unanimous Do Not Pass.

Thank you for your consideration, and I would be willing to answer any questions.

SENATE BILL 2306
Section Outline

A. **SECTION 1. 26.1-12-33 Accident and health insurance – Premium rate requirements.**
   1. Limited to mutual insurance companies that offer accident and health insurance as defined by 26.1-12-11.
   2. Premiums must be filed and approved by the Commissioner before they can be used.
   3. Premiums must
      a. cover reasonably anticipated claims;
      b. cover reasonable costs of operation and overhead expenses;
      c. be reasonable in relation to benefits provided; and
      d. be presumed reasonable if established to maintain RBC between 600% and 750%.
   4. Rates must not be excessive; inadequate (unless mutually agreed by insurer and commissioner); or unfairly discriminatory.
      a. "Excessive rates" means they don't meet the minimum loss ratio requirements.
      b. "Inadequate rates" means projected loss ratios exceed 90% for group; and 85% for individual.
      c. "Unfairly discriminatory rate" means a rate established in violation of 26.1-04-03(7).
   5. Reliance on RBC in establishing reasonable rates doesn't waive confidentiality protection (and other restrictions) for mutual companies under 26.1-03.1-08.

B. **SECTION 2. 26.1-12-34 Accident and health insurance – Procedure for use of premium rates filed with commissioner.**
   1. Limited to mutual insurance companies that offer accident and life insurance as defined by 26.1-12-11.
   2. "Except as otherwise provided or except upon written approval by the Commissioner
      a. Premiums/forms can't be used until 30 days after filed with the Commissioner.
      b. Commissioner can extend the 30-day period for up to 15 additional days.
         (1) Commissioner must notify "mutual insurance company" within initial 30-day period.
         (2) Written notice must advise company that the additional time is necessary for Commissioner to consider the filing.
      c. During initial 30-day period and any extension, Commissioner can request no more than three separate inquires. (An inquiry can include more than one question.)

(1) The 30-day period and any extension must be "tolled" from date inquiry is made by Commissioner until insurer responds.
(2) Request for clarification isn't included in the specified three separate inquiries.

d. If applicable time period expires without written response, the filing is deemed approved until the next time the same rate filing is submitted to the Commissioner for review.

3. When rate filing is submitted, "mutual insurance company" may demand the actuarial review of the rate filing be completed by an independent professional consulting actuary.
   a. Independent consulting actuary to be paid for by the company.
   b. Commissioner "shall" consider findings of the consultant prima facie evidence of the reasonableness of the rate filing.
4. Commissioner shall review the filing, including additional information requested, and provide written response that
   a. Approves the premium request as filed;
   b. Disapproves the premium request as filed;
      (1) Must include specific actuarial basis and reasons for denial; and
      (2) Must be accompanied by actuarial analysis used in making the determination by the Commissioner.
   c. Disapproves the submitted premiums submitted and approves an alternate premium schedule.
      (1) Must include specific actuarial basis and reasons for the alternate rate schedule; and
      (2) Must be accompanied by the actuarial analysis used in making the determination by the Commissioner.

C. SECTION 3. 26.1-12-35 – Accident and health insurance – <u>Disapproval of premium rate – Notice and hearing.</u>

1. Limited to mutual insurance companies that offer accident and health insurance as defined by 26.1-12-11.
2. If Commissioner disapproves or approved alternate premiums, written notice of that decision must include notice that company can request administrative hearing by written request within 15 days of the written response.
3. If "mutual company" requests a hearing,
   a. Commissioner must coordinate with OAH, in consultation with company, to schedule the hearing.
   b. Hearing must be conducted by independent hearing officer within 45 days.
   c. Upon determination of just cause, hearing officer may extend the 45-day deadline for no more than 15 days.
4. Hearing officer shall issue final decision within 30 days following completion of administrative hearing and posthearing briefs. Parties have 30 days from issuance of final decision to file an appeal with district court.

Blue Cross Blue Shield of North Dakota

Rate increases and financial results

Year	Rate increases				Financial results			
	Group		Individual					
	Requested	Approved	Requested	Approved	Annual underwriting gain	Annual net income	Total surplus	RBC ratio
2001	14.8%	12.5%	0.0%	0.0%	$17.0	$23.8	$137.3	623%
2002	13.8%	11.9%	10.9%	10.2%	$17.0	$17.7	$137.2	564%
2003	11.2%	9.9%	10.5%	8.9%	$21.2	$26.6	$187.8	703%
2004	10.8%	8.5%	8.5%	4.2%	$6.5	$18.6	$200.6	692%
2005	6.0%	6.0%	13.2%	10.4%	$30.3	$38.5	$222.7	722%
2006	10.8%	7.0%	4.2%	2.9%	$-17.1*	$3.9*	$233.3	666%
2007	17.3%	9.9%	10.0%	9.4%	-$3.1	$18.0	$236.3	629%
2008	14.9%	Denied**	14.8%	Denied**				

*Reflects $26.5 million premium refund

All monetary amounts in millions.

**The requested 14.8% increase was denied on July 11, 2008.

BCBS has requested an administrative hearing.

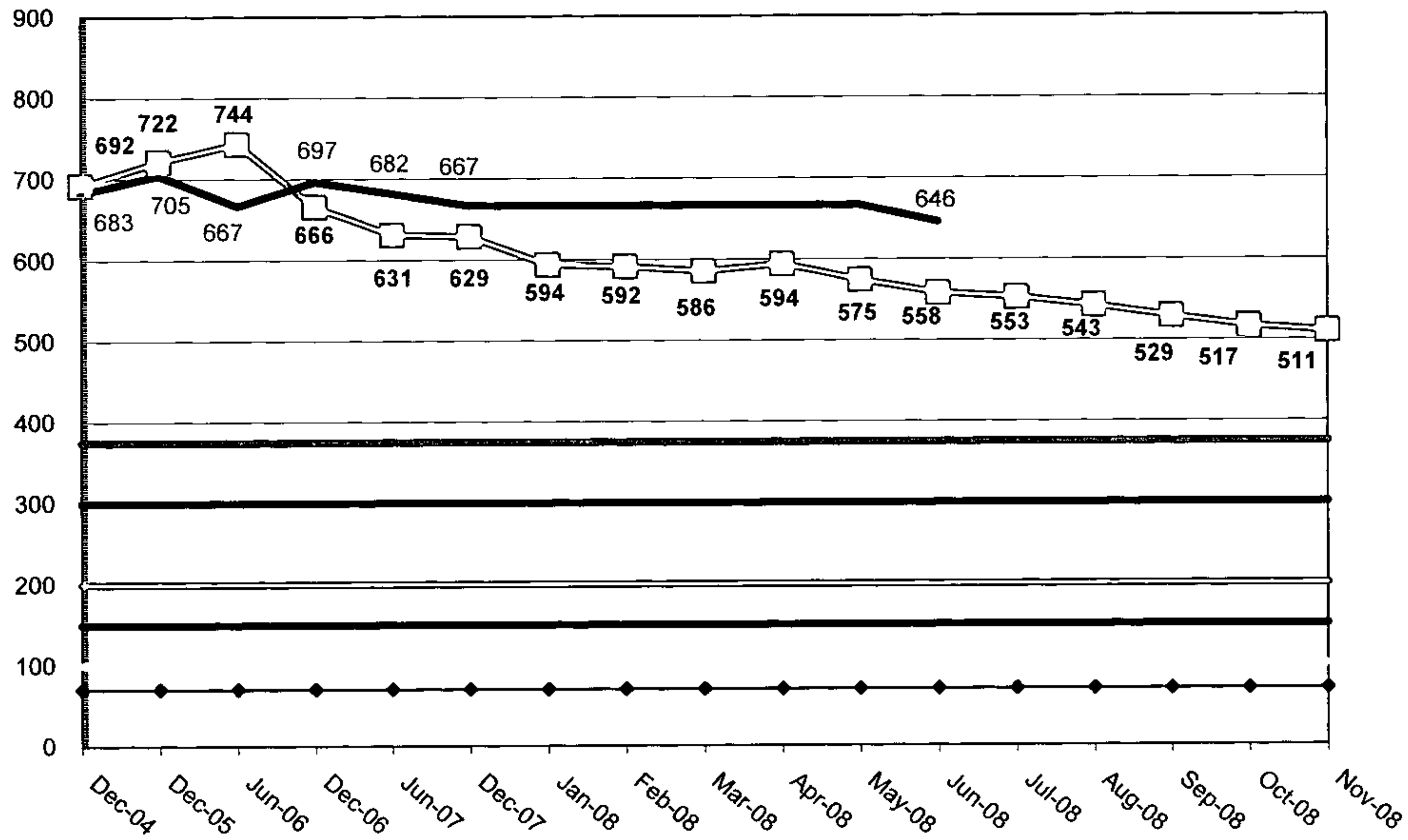
**The requested 14.9% increase was denied Oct. 10, 2008.

Market Share by Premium(000) – Major Med – 2007

	Amount	Percent
1. Blue Cross Blue Shield	$415,830	89.9%
2. Medica	17,340	3.8%
3. John Alden/Time Insurance	12,538	2.7%
4. American Family Mutual	6,315	1.4%
5. Heart of America (HMO)	2,878	0.6%
6. American Republic	1,691	0.4%
7. Continental General	1,663	0.4%
8. Madison National	933	0.2%
9. MII Life	634	0.1%
10. State Farm Mutual Auto	581	0.1%

Blue Cross Blue Shield Market Share

	Total	Individual	Small Group	Large Group
1994	**80.6%**	74.5%	83.3%	85.0%
1995	**79.9%**	75.4%	81.0%	83.6%
1996	**80.0%**	76.2%	80.8%	82.8%
1997	**78.8%**	75.3%	79.9%	80.8%
1998	**80.4%**	71.7%	85.7%	82.0%
1999	**80.1%**	70.4%	85.0%	81.9%
2000	**82.6%**	67.6%	89.1%	84.3%
2001	**87.1%**	63.3%	92.1%	96.0%
2002	**88.9%**	66.2%	94.2%	96.1%
2003	**90.3%**	70.3%	94.3%	96.7%
2004	**89.5%**	73.3%	93.0%	95.6%
2005	**90.0%**	74.6%	93.5%	95.4%
2006	**89.6%**	73.7%	92.7%	95.8%
2007	**89.9%**	75.8%	92.8%	95.7%



Noridian Risk Based Capital Reporting
Percent
900
800
700
600
500
400
300
200
100
0
692
722
744
697
682
667
646
683
705
667
666
631
629
594
592
586
594
575
558
553
543
529
517
511
Dec-04
Dec-05
Jun-06
Dec-06
Jun-07
Dec-07
Jan-08
Feb-08
Mar-08
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
NORIDIAN RBC
BCBSA System-Wide
BCBSA Early Warning
BCBSA Concern Level
State Company Action/Blues Symbols
State Regulatory Action
State Authorized Control
State Mandatory Control

Noridian (BCBS) Surplus Levels

12/31/07 Noridian Surplus (000): $236,335

12/31/07 Risk Based Capital Level: $ 37,575

12/31/07 RBC Ratio: 629%

11/30/08 Noridian Surplus (000): $200,764

11/30/08 Risk Based Capital Level: $ 39,288

11/30/08 RBC Ratio: 511%

RBC Warning Levels

- 375%: BCBSA Early Warning Level
- 300%: BCBSA Concern Level
- 200%: North Dakota Company Action Level/Blue Symbols
- 150%: North Dakota Regulatory Action Level
- 100%: North Dakota Authorized Control Level
- 70%: North Dakota Mandatory Control Level

Surplus (000) based on RBC Ratio:

	12/31/07	**11/30/08**
• Existing Surplus:	$236,335	$200,764
• 375% RBC:	$140,905	$147,330
• 300% RBC:	$112,725	$117,864
• 200% RBC:	$ 75,150	$ 78,576
• 150% RBC:	$ 56,362	$ 58,932
• 100% RBC:	$ 37,575	$ 39,288
• 70% RBC:	$ 26,302	$ 27,502

RBC – Regulatory Action Levels

RBC takes into account, on a formula basis:

1. asset risk
2. liability risk
3. interest rate risk
4. business risk

If Company surplus < 200% RBC *("Company action level event")*, insurer must submit to Commissioner risk-based capital plan that

1. identifies the conditions leading to the company action level event;
2. proposes corrective action that will result in the elimination of the company action level event;
3. provides financial projections for the current year and at least the succeeding 4 years with and without the corrective action to give effect of the proposed corrective actions;
4. identifies key assumptions that impact the projections and the sensitivity of the financial projections to the assumptions;
5. identifies the quality of, and the problems associated with the insurer's business, including
    a. assets
    b. anticipated business growth and associated surplus strain
    c. extraordinary exposure to risk
    d. mix of business
    e. use of reinsurance

If Company surplus < 150% RBC (*"Regulatory action level event"*), the Commissioner shall

1. require insurer to submit risk-based capital plan or, if applicable, a revised risk-based capital plan;
2. perform such examination or analysis of assets, liabilities, operations, and risk-based capital plan as the Commissioner deems necessary;
3. issue an order specifying corrective actions as the Commissioner determines are required

If Company surplus < 100% RBC *("Authorized control level event")*, the Comissioner shall

1. take actions as required under "regulatory action level event";
2. take action to place the insurer under regulatory control if the Commissioner deems it to be in the best interests of the policyholders, creditors of the insurer and the public

If Company surplus < 70% RBC *("Mandatory control level event")*

1. the Commissioner must take action to place the company under regulatory control

Attachment 5
SB 2306

TESTIMONY OF
NORTH DAKOTA HEALTHCARE ASSOCIATION
ON SENATE BILL 2306

My name is John Kapsner. I am an attorney with the Vogel Law Firm and counsel to the North Dakota Healthcare Association. The North Dakota Healthcare Association ("NDHA") opposes passage of Senate Bill 2306. As a general matter, the NDHA believes that the proposed bill creates excessive restrictions on both the authority and discretion of the Commissioner of Insurance. NDHA also has the following specific observations:

1. The bill places North Dakota's single dominant insurer of health care under a different premium regimen than other insurance companies competing in the same insurance market. In effect, one company is allowed to follow a different set of rules than other companies in the same line of business.

2. The Association is concerned that this difference in the applicability of rules between and among various health insurance providers will lead to less competition in the health insurance market in North Dakota.

3. The timelines contained in §26.1-12-34(2) for Commissioner action, and the timelines contained in §26.1-12-35(3) and (4) for Administrative Law Judge decisionmaking, are too restrictive.

4. In addition, §26.1-12-34(2) limits the number of inquiries for information the Commissioner can make to the insurance provider. This provision makes it easier for the insurance provider to restrict the amount of information made available to the Insurance Commissioner. Frequently, information provided to a state agency by a regulated entity will trigger additional inquiries. Here such additional inquiries are strictly limited.

5. Section 26.1-12-34(3) effectively eliminates the ability of the Commissioner to utilize his own actuary in reviewing rates. This section requires, at the request of the Company, use of an "independent professional consulting actuary" whose decision constitutes prima facie evidence of reasonableness. In effect, this provision does not allow the Commissioner to disagree with the determination of an actuary outside the control of the Commissioner or any other entity in the State of North Dakota. Further, because the ultimate decision based on the determination of such outside actuary is presumed reasonable, the rate determined by that actuary will become the decision of the Commissioner. Thus, the Commissioner is in the unusual position of approving a rate with which the Commissioner disagrees, while not being able to appeal such rate because it is the determination of the Commissioner.

In conclusion, Senate Bill 2306 limits the authority and discretion of the Commissioner of Insurance as regards one company providing health insurance in the State of North Dakota, while continuing existing authority and discretion in the regulation of all other companies providing health insurance in the State of North Dakota.

NDHA recommends a do not pass on Senate Bill 2306.

738928.1

Attachment 4 SB 2306

Physicians Dedicated to the Health of North Dakota

NORTH DAKOTA MEDICAL ASSOCIATION

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Leann Tschider
Director of Membership
Office Manager

Annette Weigel
Administrative Assistant

Testimony in Opposition to SB 2306
Senate Judiciary Committee
February 2, 2009

Chairman Nething and Committee Members, I'm Bruce Levi and I represent the North Dakota Medical Association. NDMA is the professional membership organization for North Dakota physicians, residents and medical students.

NDMA opposes SB 2306, which in our view would inappropriately reduce the authority of the Commissioner of Insurance to make timely and accurate decisions regarding premium rate filings by certain insurance carriers, including BlueCross BlueShield of North Dakota.

From our prospective, our interest in this issue arose after BCBSND unilaterally chose to implement a process for withholding payments from physicians, hospitals and other providers last spring, and according to the Insurance Commissioner, has also been less than fully responsive in providing information to the Insurance Department over this past year of rate filing requests. In our view, the concerns expressed by BCBSND are more the result of BCBSND's own self-induced difficulty, rather than any underlying weakness or inadequacy in the current rate filing process.

The bill limits information requests by the Insurance Commissioner and incorporates several legal presumptions and procedural limitations that would supersede the longstanding authority of the office of Insurance Commissioner to independently determine the appropriateness of premium rates. In our view, the bill would cause more delay, not less, and result in a considerable diminishment in the role of the Commissioner in regulating insurance carriers.

The lack of competition in the health insurance market in North Dakota has allowed BCBSND over many years to systematically underfund reimbursements for physicians and hospitals. Reimbursement levels are one of the underlying assumptions that carriers and the Insurance Department consider in the rate filing process. BCBSND pays for medical and hospital

services at levels considerably less in North Dakota than by commercial insurers in other states in our region.

At the request of NDMA, the six major health systems in North Dakota and BCBSND, the consulting firm Milliman prepared a report comparing health insurance premiums and provider reimbursement levels in North Dakota against other nearby states. Milliman was tasked with a comparison against other states in CMS' West North Central Region (Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska and South Dakota). In general, Milliman found that North Dakota has lower premiums, provider costs and provider reimbursement levels than the benchmark comparison states. The BCBSND average premium of $332 compares to the other states' average of $399, or a BCBSND premium that is only 83% of the premium in other states in our region. The BCBSND Private Payer Hospital Reimbursement per RVU (geographically adjusted) is $66 compared to the rest of the region's average of $96, or only 69% of that compared to other states in the region. The Private Payer Physician Reimbursement as a percentage of Medicare (geographically adjusted) is 152% of Medicare compared to the rest of the region's average of 164%, or 93% of that compared to the rest of the region. Hospital costs are 91% of that compared to the rest of the region; however, hospital margins are considerably less at 1.8% compared to 6.9% in the rest of the region.

The physicians of North Dakota are very concerned that this continuing trend of poor payment does not bode well for the future of health care in our state, which is compounded by poor payments from Medicaid which is reimbursed at 51% of cost, and Medicare which is reimbursed using geographic formulas that result in the lowest payment provided for physician services provided to North Dakota seniors.

In our view, we were fortunate the Insurance Commissioner used the rate filing procedure to require BCBSND to change its provider contracts to prohibit unilateral payment withholds and reductions at any time. Diminishing the regulatory authority of the Insurance Commissioner in SB 2306 is not good for medicine and not good for patients. We urge a "Do Not Pass" on SB 2306.