19.8068.04000

FISCAL NOTE

Requested by Legislative Council
03/05/2019

Amendment to: Reengrossed HB 1106

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$(31,702,006)		$(11,620,742)	
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1106 creates the Reinsurance Association of ND, sets up an invisible reinsurance pool for the state's individual health insurance market, and allows companies to take the assessment created by the bill as a premium tax credit.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of the bill creates a premium tax credit for the amounts assessed to insurers as a result of section 2. The credit would reduce premium tax revenue for the year paid, limited by the amount of premium tax due.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The actuarial study done indicated the amounts needed to fund the invisible reinsurance pool. These amounts were allocated in accordance with the bill, in proportion to projected premiums written, and limited to estimated premium tax due.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill would have no fiscal impact on expenditures.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The bill would have no fiscal impact on appropriations.

Name: Melissa Seifert
Agency: Insurance Department
Telephone: 328-2930
Date Prepared: 03/05/2019

19.8068.03000

FISCAL NOTE

Requested by Legislative Council
02/15/2019

Revised
Amendment to: Engrossed HB 1106

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$(31,702,006)		$(11,620,742)	
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1106 creates the Reinsurance Association of ND, sets up an invisible reinsurance pool for the state's individual health insurance market, and allows companies to take the assessment created by the bill as a premium tax credit. The amendment sets an expiration date for the act.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of reengrossed HB 1106 creates a premium tax credit for the amounts assessed to insurers as a result of section 2 of the bill. The credit would reduce premium tax revenue for the year paid, limited by the amount of premium tax due. The amendment provides an expiration date, reducing the fiscal impact to the 2021-2023 biennium. The remaining amount is the result of finishing out the 2021 plan year.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The actuarial study done indicated the amounts needed to fund the invisible reinsurance pool. These amounts were allocated in accordance with the bill, in proportion to projected premiums written, and limited to estimated premium tax due.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill would have no fiscal impact on expenditures.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The bill would have no fiscal impact on appropriations.

Name: Melissa Seifert

Agency: Insurance Department

Telephone: 328-2930

Date Prepared: 02/15/2019

19.8068.03000

FISCAL NOTE

Requested by Legislative Council
02/15/2019

Amendment to: Engrossed HB 1106

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$(31,702,006)			
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1106 creates the Reinsurance Association of ND, sets up an invisible reinsurance pool for the state's individual health insurance market, and allows companies to take the assessment created by the bill as a premium tax credit. The amendment sets an expiration date of July 31, 2021.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of reengrossed HB 1106 creates a premium tax credit for the amounts assessed to insurers as a result of section 2 of the bill. The credit would reduce premium tax revenue for the year paid, limited by the amount of premium tax due. The amendment provides an expiration date of July 31, 2021, removing the fiscal impact to the 2021-2023 biennium.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The actuarial study done indicated the amounts needed to fund the invisible reinsurance pool. These amounts were allocated in accordance with the bill, in proportion to projected premiums written, and limited to estimated premium tax due.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill would have no fiscal impact on expenditures.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The bill would have no fiscal impact on appropriations.

Name: Melissa Seifert

Agency: Insurance Department

Telephone: 328-2930

Date Prepared: 02/15/2019

19.8068.02000

FISCAL NOTE

Requested by Legislative Council
01/23/2019

Amendment to: HB 1106

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			$(31,702,006)		$(43,082,938)	
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1106 establishes the Reinsurance Association of ND and sets up an invisible reinsurance pool for the state's individual health insurance market. The amendment would allow companies to take the assessment created by the bill as a premium tax credit, but limited to the amount of premium tax due.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of engrossed HB 1106 creates a premium tax credit for the amounts assessed to insurers as a result of section 2 of the bill. The credit would reduce premium tax revenue for the year paid, limited by the amount of premium tax due.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The actuarial study done indicated the amounts needed to fund the invisible reinsurance pool. These amounts were allocated in accordance with the bill, in proportion to projected premiums written, and limited to estimated premium tax due.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill would have no fiscal impact on expenditures.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The bill would have no fiscal impact on appropriations.

Name: Melissa Seifert

Agency: Insurance Department

Telephone: 328-2930

Date Prepared: 01/24/2019

19.8068.01000

FISCAL NOTE

Requested by Legislative Council
12/31/2018

Bill/Resolution No.: HB 1106

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

HB 1106 establishes the Reinsurance Association of North Dakota and sets up an invisible reinsurance pool for the state's individual health insurance market.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

This bill, as written, will have no fiscal impact.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

This bill has no fiscal impact.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

This bill has no fiscal impact.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

This bill has no fiscal impact.

Name: Melissa Seifert
Agency: Insurance Department
Telephone: 328-2930
Date Prepared: 01/04/2019

2019 HOUSE INDUSTRY, BUSINESS AND LABOR COMMITTEE

HB 1106

2019 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1106
1/15/2019
Job # 30771

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Amy Crane

Explanation or reason for introduction of bill/resolution:

Joint hearing with House IBL on a bill relating to the establishment of invisible reinsurance pool for individual health insurance market.

Minutes: Att # 1-7

Chairman Keiser: Opened the conference committee on bill on HB 1106.

Jon Godfread, Commissioner, North Dakota Insurance Department: See Attachment #1 for testimony in support of the bill.

(13:43)Representative Kasper: The Texas judge recently ruled the ACA unconstitutional, he put a stay on it as you know, to see what might come of appeals. So right now it's in the state process and may get to the Supreme Court. If ACA is deemed unconstitutional, how much are we going to need a plan like this compared to the department able to develop its own rules without a plan like this?

Jon: It's our belief that if that makes it all the way to the Supreme Court and is ruled unconstitutional, congress will likely act with some kind of reform. We don't know what the reform looks like. We would hope to say that it would allow us, to come back and rework our health insurance regulation and give us control back, which would likely necessitate the need for a special session, depending where that time comes. But within this bill, we're granted the authority to pause any reinsurance program, if the ACA is ruled unconstitutional and be repealed. We're able to stop and figure out what we're doing before we continue going down this road. It is our belief that this plan makes sense with or without the ACA. Reinsurance is a fundamental principle of insurance, and it may be funded and structured a bit differently but we thing there is value in this plan, outside of the ACA because of the reinsurance principles that come with that. What you'll notice in the study is, and it's an anecdote we've used for years is that there are a small number of individuals with very high claims costs that drive the cost of health insurance for everybody else. In the study we did, if you set that attachment point at $100,000,.24% of North Dakota would fall between a $100,000 and $1 million, so it would fall under that reinsurance pool. So if we can address, again .24% those high claims costs that we see in North Dakota, we can turn around and offer a 20% reduction on that individual market. So that gives us some data that, yeah that's actually happening. There's a small number of North Dakotans who would reach that reinsurance pool, but by being able

to address those individuals and cost share those individuals, we can see significant savings in the individual market.

Representative Kasper: Your plan assumes that a good portion of your reinsurance pool funding is from the federal government, I think its 70-75%. Do you have any numbers on what the assumed federal share would be if this plan were approved?

Jon: Yeah, that would be the $25 million, its almost 50-50 its probably 55% federal governments kicking in, the savings we would see from those subsidy reductions, would get passed on to the states to the tune of about $25 million. So those would be dollars coming to the state from the federal government, and then we'd need about an additional $20-22 million would be necessary to fund the state portion of that reinsurance pool.

Representative Kasper: Per year?

Jon: Yep.

Representative Schauer: On the bottom of page 3, you say the department, for the most part, is agnostic on how this program is funded, what would your choices be? Those options first, second, and third, be?

Jon: The cleanest mechanism, would be a straight appropriation. Other states have done that, that are doing that. I certainly am aware of the budgeting situation and process in this legislature, a good compromise would be utilizing those premium tax dollars that are coming from our health insurers, and allowing them to take that assessment that would be needed to fund this reinsurance pool and credit that back on their premium taxes. So essentially, it would be a diversion of existing tax dollars. It comes down to do we want to spend current dollars or do we want to deplete or change future revenue streams. With option number 1, there are some issues there in terms of passing that along to every other health insurance plan basically that the state regulates. We're seeing an increase in healthcare across the board, so to add an additional 1-2% on our large and small group, would have an impact. But especially on our self-funded groups, they run on generally pretty small margins and that may discourage some more self-funded groups from getting into that market. And I think we've taken a stance in North Dakota with some of our MEWA rules and some of the things that we've done and regulations to help try to encourage folks to look at the self-funded option as an option. It's a risk and it's a big lift for some of our employers to do that. Under the bill as written, in option one, I can see that as a significant road block to current self-funded plans and then even looking at expanding further.

Representative Johnson: On the same page, your third option calls for a $40 million appropriation, is that a onetime appropriation or is that an ongoing, yearly appropriation?

Jon: That would be something we'd come back to the state every year and look for that continued appropriation to keep that program running. It would be an ongoing expense, and that ultimately where the policy question comes. Is this an important enough public policy decision to look at utilizing these dollars? And in our opinion it is because if we get to a point where we don't have carriers that are willing to write that business on the individual market, then my fear is that somebody is going to find a way to cover those individuals where it's

through Medicaid or Medicare and then we're all paying for it in increased taxes. And I'll tell you that's likely gonna be more than that 1-2% assessment.

Representative Ruby: In your testimony you mentioned that there would be no fiscal effect with using a portion of the credit, or the assessment with credit. I believe is the plan right? The assessment and then there's a credit on the premium tax?

Jon: That's option 2 that would be about a $37 million fiscal note on there to fund that program.

Representative Ruby: Anytime we look at doing something new like this, my first that thought is that is there no options in the private sector for this type of product?

Jon: I think we'd run into a number of issues trying to do that. Under the ACA we're pretty well tied. And to do some of these reinsurance programs like this we'd have to get a waiver from the federal government, and I have not seen an idea where they'd allow that private market option. Also I'm not sure we'd have private industry that would be willing to write this risk. Ms. Novak may be able to weigh in a little bit more. From what we've seen over the course of the last two years, when the reinsurance programs have started to gain some more interest as those premiums have increased on the individual market. This type of reinsurance program is ultimately the only one that's been approved by the federal government in that 1332 waiver and ultimately the policy portion of the bill, we've sent it over to CMS and HHS to get their review; they like it. it's the funding aspect of the bill that we are able to change, I would caution us against making any amendments to the policy portion of it because again, as we've seen with Iowa and Oklahoma and some other states that have tried to do this in the past, the feds denied their wavier and then we're back to square one. So we feel we're on a good track with that but to answer your question directly, I don't think we can do that with this 1332 waiver. Which again goes back to one of our main criticism of the ACA, is the fact that we have to ask permission from the federal government for something that already makes sense in our head, frustrates me to say the least.

Representative Kasper: How many insureds are covered in the individual market now? Have you seen a decrease in the number of individual insureds since the mandate has gone, which is really not that long ago but it's still gone?

Jon: About 8% of North Dakotans are insured on the individual market that equates to about 42,000 people. Of those, approximately 21,000 receive some sort of premium subsidy, so that advanced premium tax credit. Another 21,000 are the ones who would be really impacted by this plan. Those are the individuals who are hairdressers, farmers, ranchers, anybody who owns a small business, who doesn't have access to that large group market. Those are the ones who are taking it here. In terms of have we seen a decrease, we haven't looked at the numbers quite yet. We get numbers from the feds during the open enrollment period, but we've found that there's a big difference between signing up for coverage, and making that first payment. So we're more interested in waiting for the February numbers and folks that have actually effectuated that contract and made that first payment, and in our sense would actually have that insurance versus signing up for it and then dropping it in January or not making that first payment. We'll know more in a couple weeks. It's my argument that that mandate never had the intended effect of what it was meant to be, because even young

healthy people can do math. A $600 penalty versus a $1200 premium, I'd rather lesson my refund on my taxes than have to pay $1200 a month for coverage.

Representative Kasper: In a prior conversation we discussed the number of insured, insurance company options in North Dakota. Would you share that with the committee?

Jon: In 2018, we had three companies that were writing in our state and on the individual market, that's Blue Cross Blue Shield, Sanford health, and Medica. United Healthcare has come into the market, in the small group market. And it's our hope that a move like this may incentivize them to strongly consider entering that individual market which would increase competition in that market which is always a good thing. But to expand on it a little more, is when we talk about carriers leaving the marketplace we don't have to look too far. We can look back to 2017, when we forty-eight of our counties had one carrier offering in the individual market. That was Blue Cross Blue Shield. Sanford pulled out to the five main counties, where they're located, so Bismarck and Fargo. Medica pulled off the exchange. There's a lot of things that went into those decisions. But it's certainly not an unrealistic reality as this market continues to deteriorate. If I'm in business and I have a significant population that is getting more and more concentrated with really bad risk, at some point I've got to make the decision that it doesn't make fiscal sense to write that business.

Representative Kasper: This does not impact the small group market, this only impacts the individually written and issued insurance contracts is that correct?

Jon: Correct, the people it truly effects are those people, who don't receive a subsidy on the individual market.

Senator Burckhard: Its gonna benefit small business owners, this is a plus, it's a win?

Jon: Oftentimes we've seen with small business owners that they have chosen not to offer health insurance through their employment group because it's too expensive, thus forcing those employees onto the individual market. And what that ends up doing is, you have to decide if you can afford to pay $1200-1500 a month in premium to cover our family or does one individual need to stay in a job that offers family coverage. It's my opinion that we have a lot of creative folks in the state who are entrepreneurs that want to go out on their own and start businesses but aren't able to jump fully into it because one member needs to stay in a large employment position where they can get coverage through the state because they can't afford to do that outside. This isn't going to be the silver bullet, but what this does is provide that relief that hopefully keeps them in the market and allows us to get to the point where we can see significant healthcare reform. So if I'm a small business owner or anyone that doesn't have access to that large group market, I'd be pretty excited about this opportunity.

Senator Piepkorn: One of your options I believe called for approximately $25 million from the federal government, $25 million from the state of North Dakota to invest in this high claim pool of approximately 2.4% of the population is that correct?

Jon: It would be $25 million from the feds in the pass through, we're looking for another $20-22 million in some kind of state funds. And it would impact those .24% of North Dakotans

because they've got those high claims costs. But the full impact would go to the individual market so it would affect all of those.

Senator Piepkorn: So then what kind of dollars is that gonna transfer then? That 20%, how many dollars is that gonna save the rest of the population? Just trying to translate the dollars of savings for the citizens of North Dakota.

Jon: I'm going to save the for Ms. Novak, I think she probably has charts and everything for that. Its also in the book as well.

Representative Schauer: You said that you analyzed Idaho's state based initiative, give me some background on that. What has Idaho shown that worked and not worked? How long has it been going and how identical is our plan to Idaho's?

Jon: We analyzed the Idaho plan to see if it was something we could bring to North Dakota. Idaho went out and looked at what could we do that would allow our health insurers a little more flexibility that would essentially allow, still be a part of single risk pool, to be part of the same pool, but allow some incentive and some premium reductions or credits for healthy behavior. For if I'm managing my diabetes, if I have a certain health class, health assessment classification I'm able to credit my premium down to hopefully a more affordable level. It's akin to rewarding good behavior without punishing bad behavior. Because the ultimate cap to that premium would be whatever's on that ACA market. This too is up for some discussion, with HHS and CMS. There are threats being thrown around about if Idaho goes forward with this plan they may be sued for not enforcing the ACA. At this point the determination, we were hopeful during our study that CMS was going to come to an agreement with Idaho, so the backstory is that CMS said Idaho said if you agree to these four things we'll be closing to looking at this plan. Idaho sent back a letter the same day saying we agree, we're gonna take this letter as acceptance, and we're gonna move forward to promptly be met with well actually we've got to do more review. And so they're still on pause. What the federal government has done has been really pushing Idaho and other states to move that short-term limited duration market, as the state flexibility market. I've got some major concerns with that, in terms of trying to, you're essentially trying to fit a round peg into a square hole, when you're trying to make your short-term market into a major medical comprehensive market. In light of that and the lack of progress from Idaho and the discussion from CMS, that's not included in the bill, that's just part of the study. At this point we don't think it's a good option to move forward because it would really probably just add more uncertainty to this already uncertain market, and probably have more headaches then its worth. But it goes back to the point of, if we could get more state control, we're confident we could design plans and a market place with our carriers that would adequately cover our folks. But again we don't have that flexibility at this point.

Representative Ruby: Does this have anything to do with or have any effect on grandfather status or are these individual polices pretty much non-grandfathered anyway because they're not part of a group?

Jon: This would not have any effect on any kind of grandfathered status like that, and that individual market is a non-grandfather market and so, and even if it did its ultimately going

through the framework of the ACA that exists now so there would be no impact to that status at all.

Chairman Keiser: Looking at table one, with option at $100,000, inching up towards $1 billion in ten years, I can share with you and committee members and certainly the audience that in the A committee meeting this morning, we almost had to get nitroglycerin for Jeff Delzer when he started talking about this. But when you look at $1 billion over a ten-year period, there's no way we can do that. Literally. And the feds can't do it, for this pool. So, on the one hand we need an immediate fix to start to address this problem. But what else, how do we stop this? Shouldn't we have something in the legislation that requires us to do something that eventually says wait a minute we cannot afford this? We simply cannot afford $1 billion.

Jon: Within the legislation we're granted the flexibility to adjust that attachment point and move it up if we need to in order to address your exact point. The table is run out at the $100,000 straight attachment point throughout those ten years cause that's the data we need to provide CMS. I do think we would have that flexibility and we also will come in every two years, and I'm likely to guess this committee isn't going to allow us some kind of continuing appropriation that says we'll see you in ten years. So we would be back in front of you on a biannual basis to have this discussion and with the long-term, was hoping to get to that healthcare reform. I think we'll get there eventually, I believe we have to and if we can stave off moving to that what I believe is single-payer move by eliminating the individual market, I think that goes a long way in preserving any kind of healthcare reform we may get.

Chairman Keiser: But if you start adjusting the attachment points, then it becomes less affordable. And you're defeating the purpose. You can't, it doesn't work. There's no discussion of cost. We can't afford this plan, on the long-term. We can't afford to have the department remove or lower the attachment rate where you're at 300,000-400,000 to minimize well then the plan becomes unaffordable anyway. I just bring that up as an issue, speaking for myself, I'm not comfortable going forward unless we have some idea of a plan of how to get out of it.

Jon: I don't disagree with a lot of what you're saying but in the same vein, we've got 21,000 North Dakotans who contemplating whether or not they can afford health insurance. And this is an option we've got to at least provide some relief, until we get to that federal reform. On cost discussion, I agree, as the thing that we are insuring keeps going up at a rate like this, our insurance is going to continue to ramp up. And as you members of the committee know, we don't have any regulatory authority over our hospitals or providers, not that I want it. So as it stands right now, the system we have, our hospitals are somewhat insulated from that discussion because everybody's mad at their insurance company. Well if the cost of healthcare is continuing to ramp up, the insurance is gonna go up and everybody is pointing the finger pointing is at their insurance companies, and perhaps missing the true target. Which is why we're encouraged by the Trump administration coming out with the requirement to post costs on the website, I don't think its gonna do a whole lot but it's a good first step in that direction of transparency. Why we're supportive of HSA's, that gets the money back in the consumer's pockets to make them have those discussions that says okay what is the true cost of this. The issue with the HSA's is that you have to fund them. We're finally chipping away at that discussion, and I'm liking the direction we're heading I'd love to move there a

lot quicker but in the short term we were asked to bring ideas forward for you to consider, on how do we impact our health insurance market and at this point under the current guidelines, under our current structure with the ACA, this is probably our best idea.

Donna Novak, President of NovaRest Consulting: See Attachments #2 and #3 for testimony in support of the bill.

(51:33)Representative Lefor: You've heard the insurance commissioner's options that were given to us and you obviously have experience, what would your recommendation be? What's the easiest option?

Donna: There's no easy option here. Are you asking to fund the reinsurance or to stabilize the market? To fund the insurance, that's a very local decision, to be based on things I honestly don't know about. As far as North Dakota, as far as the provider community. I know in Maryland they manage the hospital fees and still they have costs that are going through the roof, so I don't know that I have the answer, I think that's a very local question.

Representative Kasper: One of the things we haven't talked about in the cost cycle, are PBMs, do you do any analysis or studies on the tremendous drug cost increases around the country? And the role that the PBMs may be playing in that.

Donna: Yes, we review Medicare bids, in particular part d. there's a problem with the rebates and how they're getting passes through. The federal government is trying to do something in that area, for Medicare and Medicaid primarily. I don't know if any state has looked at the drug issue. I'm in Arizona, not far from Mexico. You border Canada. You can really see a difference in the cost, a lot of people go across the border and I'm sure that has something to do with PBMs and the whole financing of the drug companies in this country.

Representative Kasper: So the point I'm trying to make is the cost component, which is really what drives the premiums. It's not only the providers' cost of care going up but it's the drug part of it, which I think is now 20-25% of the healthcare cost. Increasing in some cases out of control, in a black hole that nobody really knows what's going on behind the scenes.

Donna: In one state we did a study on if they require a closed formulary and the impact it would have on premiums, and it was about 1.3-1.4%, you went to more restrictive formulary.

Representative Bosch: Is there a chart within your presentation that looks at the cost of analysis on a family plan?

Donna: We aggregate families in order to estimate what the maximum premium that family would have to pay if they're so under 400%. it's not in the report, but we look at families under the 400% and we did look at how many families there are at different family sizes. I don't know if it's in the report though.

(56:13)Jeff Olson, Chair, Credit Union Health Benefits Trust: Testified in support in support of the bill. One of the eight MEWAs, the Multiple Employer Welfare Arrangement in the state, an association trust plan with a $5 million trust. We have 20 credit unions participating in the trust and we insure about 1100 lives. We are not in the marketplace; we

assume all of the risk. We pay about $1.2 million a year in that insurance, we're one-year-old. We're supporting this bill with the exemptions and amendments presented by the commissioner because we believe that MEWAs should be exempt from that. Because again, we're assuming our own risk and we're providing our own stop-loss coverage. So we applaud the commissioner for allowing the MEWAs to put a part of the conversation so we are in support of the amendments.

(57:30)Megan Houn, Director of Government Relations, Bluecross Blueshield of North Dakota: See attachment #4 for testimony in support of the bill.

Representative Keiser: Has there been discussion within BCBSND or the insurance community as to, alternative approaches with this group? Would there be any potential, regardless of the insurance provider, once they get this subsidy they go into a new group, and that group, rather than simply managing the claims, we have a more restrictive MCO management format for this group to control costs, similar to WSI or what the state does with Medicaid. Has there been any discussion about that?

Megan: Looking forward we have not specifically had those discussions. Internally we've had discussion about several options, certainly the Blues folks in Idaho are taking a look at what's happening there. We've followed commissioner's lead and done our own assessment in terms of what that might look like. There are still many concerns there. In North Dakota, we did keep CHAND intact, so there is that high risk pool that still exists. But if you're looking forward at this particular group of people, I can't say that we as industry or as an insurer have looked at that specifically.

(1:00:47)Eric Spenser, President/CEO, Greater North Dakota Chamber: Testified in support of the bill. We are the largest statewide business advocacy organization in North Dakota. We think that the concept put forward by the commissioner is worth a close examination. It would benefit a number of small business owners. Our support is conditional upon acceptance of either of the two amendments offered by the commissioner. The bill as written would have the impact of increasing health insurance for in the group market and or MEWAs by a percent or two. When we travel around the state, increasing health insurance costs is certainly a concern that we hear.

Senator Piepkorn: Might've missed it, what's a MEWA?

Chairman Keiser: Multiple Employer Group, like a chamber of commerce, they have members join a MEWA, they basically self-insure.

(1:02:14)Dana Bacon, Regional Government Affairs Director, The Leukemia & Lymphoma Society: See attachment #5 for testimony in support of the bill.

(1:04:21)Matt Schafer, Director of Government Relations, Medica Healthplans: Testified in support of the bill. Medica is a nonprofit health plan based in Minnetonka, Minnesota. We've been providing health insurance to North Dakotans since the early 1990s. Reinsure is a mechanism that reduces premium increases because it helps us pay for costs associated with very expensive claims. It softens the impact of health expenses for enrollees who've had unusually high claims. In a plan year, it provides great predictability for our claims costs.

Representative Kasper: Do you have any objection as the funding objective being the premium tax credit compared to what other funding mechanism we might come up with?

Matt: We agree with the statements that the commissioner stated.

(1:06:04)Matthew Larsgaard, Automobile Dealers Association of North Dakota: See attachment #6 for testimony in support of the bill.

Chairman Keiser: Either amendment?

Matthew: Either number 2 or number 3.

Representative Kasper: Just for clarification your plan is totally self-funded by your members and does not obtain any federal or state subsidies, credits or anything, you take care of your own, is that correct?

Matthew: That's correct.

Senator Klein: So what I'm hearing is that you like this bill but you want someone else to pay for it? We understand the program but it's gonna be difficult to make this work, if we don't have a little bit of help from those groups because ultimately, won't it just cost more in the future as we continue to go down this road with having to struggle? I see your point but I'm thinking that there is gonna have to be some buy in from everyone to make this work. Do you have any comments to that?

Matthew: If this committee if this legislative body believes that this is good policy and benefits North Dakota and all residents of North Dakota. Then we should look at funding that assesses or we'd grab the funding from all residents from the general fund or the premium tax credit. On the other side are we going to be paying for this later, I've heard the argument that we will pay more for those that are not insured, and I believe that is the case. The providers have to make a certain amount of margins; they have to get it from the marketplace. However, I would argue, that I don't know that that would be commensurate with a 1 or 2% assessment on our MEWAs. So to be more clear, the increase is in cost, to our groups and our insured. I don't know that that would equate to a 1-2% based on the increased costs that are derived from the uninsured.

Representative Ruby: So what I'm hearing is that you have your own reinsurance companies that you use currently, so you would not be participating in this association?

Matthew: That's correct.

Barry Haugen, President of the Independent Community Banks of North Dakota: Testified in support of the bill. Our association represents 60 community banks across North Dakota and is also a cosponsor association of the North Dakota banks benefit trust which is a self-insured, multi-employer welfare arrangement, MEWA, covering about 3500 lives, we support HB 1106 with either amendment 2 or 3. We do feel its important to stabilization of the individual market and that is important. More importantly, we don't believe self-insured

MEWAs should be assessed a tax as proposed in the original bill itself, absent amendments. For already taking the initiative and the risk, to move into the multi-employer welfare arrangement that was set up by the North Dakota banks benefits trust in 2014. Back to Chairman Klein's point, we're already just covering costs. A 1-2% I could envision a larger bank that participates in this looking at that and saying that's just enough to make us go back to a single-employer, self-insured plan which would be exempted in the original language. I don't think there should be penalties for those groups for going out and taking the risk and the initiative to do what really needs to be done in this marketplace. While we accept the regulatory authority of the commissioner, there's no benefit of the reinsurance pool to a MEWA because we already have our stop-loss coverage.

(1:12:55)Rick Clayburgh, President of North Dakota Bankers Association: Testified in support of the bill. We along with the Independent Community Banks have started North Dakota banks benefit trust. From our standpoint we're about a $17-18 million trust. We oppose the bill as written but would be in support of either amendment 2 or 3. The concern we have is that 1-2% that Barry had mentioned, we had a number of larger members that are a part of our trust that have come into our trust because we put together a good plan and they're helping along with the 1700 members, 3500 lives that we're insuring. If one or two of those banks decides that they can go out on their own and not deal with the 1-2% premium increase that we'd have to pass on; we take those out and then the next thing you know our total cost is starting to go up and then other banks will be starting looking at that and say you're not as attractive to be part of it we can find another alternative, and then we go into a death spiral. Its occurred across the country, there's a number of trade associations throughout the country that provide health plans to try to keep premiums down. For a variety of reasons, many of those plans don't exist anymore, went into that death spiral. We run on a very tight margin. This type of 1-2% tax would be very detrimental. But we do appreciate the public policy that is occurring and think it should be funded from a public perspective.

Representative Kasper: Could you dig in more to the key point about the larger employers moving out of your trust, and there's a reason for that the way the bill is drafted. Would you share that reason?

Rick: My point is that the larger employers have had their own plans, but have joined ours because we've offered them benefits to them and their employees. And also they're supporting the association, of many coming together creates a stronger one. But they're still looking at the bottom line and if we become unaffordable to them, they could step back out.

Representative Kasper: The reason is the bill exempts a single-employer self-funded plan from the tax. So your larger single-employers that are in your plan, they pay the tax if we impose it on self-funded MEWAs but if they step out of the plan because they're a single-employer, self-funded plan and the bill exempts them from this cost.

Rick: Correct.

(1:16:37)Zac Smith North Dakota Association of Rural Electric Cooperatives: We have 21 members, 16 are distribution cooperatives and 5 are generation and transmission cooperatives. As an association we also have a health benefit trust of which not all of our members, are members, but the ones who aren't generally are also self-funded or single

employer self-funded. We support the amendments to this bill, we had issues with the original draft, but with the amendments that clears up the problem. To hit on the point, not only the employers but thinking about our membership and the 21,000 folks that the commissioner referenced, the ranchers, farmers, small business owners, this disproportionately would affect them. Just as a quality of life and for those folks that we represent, I think it's a concern there a good public policy to make sure we get that fixed.

(1:18:13)Lisa Carlson, Senior Director of Market Strategy at Sanford Health Plan: see attachment #7 for testimony in support of the bill.

Chairman Klein: Are those groups going to participate in the costs because did I hear you say, those groups' costs are going to continue to grow also? The MEWAs are going to pay more down the road because everybody shares in the cost of healthcare? Ultimately premiums don't go up if everything is managed well? If there's a hurricane in Florida it affects all premiums across the country? Does it not get spread across these other businesses in the healthcare industry also?

Lisa: I agree that healthcare costs are shared, I would say more regionally. In the aspect of when you have a stable regional market, and a high percentage of individuals who are insured, that has a positive ripple effect on MEWAs, on self-employed plans, single-employer, on individual, and the small and large group market. Because then your providers are acknowledging when they're negotiating their rates and they are receiving downward pressures from health plans and insurance companies to be paid based on quality and performance indicators and not just volume. It provides for a healthier market when everyone is walking in the door carrying an insurance card.

Dave Mitta, Mitta Benefits Consulting: Testified in support of the bill. I'm an insurance agent who does business in the state of North Dakota and I have all my life. We do business in the individual market, the small group market, large group market, the self-funded individual plan market, and the multiple employer association self-funded plan market. We handle insurance for approximately 20,000 people in North Dakota, I'm in support of this bill with amendments, because the commissioner is absolutely correct. The market place for the individual market is in peril. With the repeal of the mandate it will increase the problem over the coming years. I believe that this is a problem for all of North Dakota and it should be addressed by spreading the funding over all North Dakotans. Chairman Klein, you asked Lisa a question about weren't MEWAs affected by this increase, and the answer is yes but the existence of association health plans helps counter the increase in cost, because small businesses banding together gives them the ability to offer wellness and education programs, to get people involved in being involved by having health savings accounts, consumer directed health plans, and with an association banding together, people can be brought back into the involvement in costs and that is a positive for everyone. The MEWAs serve a very useful purpose. We are in favor of this bill with amendments. It is good policy and it is just a matter of funding and it should be all North Dakotans that are involved.

Kristi Schlosser Carlson, representing Farmers Union Service Association: Testified in support of the bill. We market as Farmers Union Insurance and we market for a number of products including health insurance. We've taken it upon ourselves particularly upon the passage of the Affordable Care Act to become trusted advisors to North Dakotans in

particular those in rural North Dakota. We have seen the issues that we've talked about, we are agnostic in the funding but recognize that it's important to deal with the situation and we stand in support.

Chairman Klein: Closed the hearing on HB 1106.

2019 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1106
1/21/2019
31072

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Establishment of an invisible reinsurance pool for the individual health insurance market.

Minutes: Attachment 1, 2, 3, 4, 5, 6, 7, 8

Jon Godfread~Insurance Commissioner: Attachment 1.

Rep Kasper: Just to be sure, there are no change?

Jon Godfread: Yep, no changes.

Jon Godfread: Attachment 2.

7:50

Chairman Keiser: The first & last pages of attachment 2 doesn't seem to work quite right for me. Hospital care is going up in the 4-5 year about 50%. The other services are going up significantly less than 50%, yet on table 26 on the last page, you show prescription drug show the most significant increase. Hospital & outpatient going 17%. Is that just for one year?

Jon Godfread: Yes.

Chairman Keiser: On page one, why did hospital care increased so much more than the other segment?

Jon Godfread: I don't know at this early stage & we haven't analyzed it yet. I thought it would be helpful in the discussion.

Vice Chairman Lefor: Table 26 & 27, what time frame does this represent on prescription drugs?

Jon Godfread: I believe it's the last year 2017-2018.

Rep M Nelson: The premiums for the 21-year-old nonsmoker. Would the most expensive one be this times 3? How do the other age group tiers compare to this?

Jon Godfread: What would be three times. The younger side has increased.

Rep M Nelson: What projections would Medicare do at 55 with premiums?

Jon Godfread: No, we have not.

Rep Kasper: You are only showing information up to 2014, that old information. Do you have more current information.

Jon Godfread: With the healthcare expenditure on the front page.

Rep Kasper: Who complied this?

Jon Godfread: Our actuaries.

Rep Ruby: Do we not have any other programs for people to fall back on if they weren't eligible or able to afford these kinds of plans?

Jon Godfread: I share your frustration. I agree with you, they created this problem & they should fix it. We have not change as far as people covered. We have the same uninsured before & during the ACA. At the end of the day, the reinsurance make sense with or without the ACA. We could have had better control if it was at the state level with reinsurance.

Rep Ruby: If we left it to its owns devices & process, it would cause a higher uninsured rate as a result of the ACA.

Jon Godfread: That would be our contention.

16:15

Chairman Keiser: Attachment 3 & 4. Hands out amendments & explains the amendments.

Chairman Keiser: The first amendment will exempt PERS from participating process. It's the use of the premium tax to offset the cost. We had three options, let the market pay for it, premium tax could be used & we could do an appropriation. I'm offering the amendment to let the premium tax, if we go forward with this, pay for it. The one qualification on the back of attachment 3, it is a "shall study", there is no way we can fund this program over the next ten years with the price tag associated with it.

Rep Ruby: With using the premium tax. First question, what is that money generally being used for now? Have you projected how long with the projections of increases will eventually eat up all the premium tax.

Jon Godfread: Yes, the premium tax surplus dollars go into the general fund. What would eat all the dollars, it's based on the assessment. It will be close. There is an argument that the money would be essentially diverted from the general fund & used in this program.

21:45

Rep Kasper: We've seen a nice increase in the premium tax. What data are you using that would eat up the 2/3 reserve?

Jon Godfread: It's going to cost more in time. The growth in our state is going to be the same. I would rather on the side of error & be cautious. I believe this is a good program.

Rep Kasper: I agree with that but my point is that in 10 years, we are using 100 to 140 million a year for a premium tax subsidy. That is going to scare a lot of people about this program.

Jon Godfread: That is our market as a whole is the premium tax. Depending what changes we will see in the health market, as it stands today the health market isn't the most sable market out there. I just want to be cautious in making predictions.

Vice Chairman Lefor: What happens if we don't do this?

Jon Godfread: That is what this chart is for (Attachment 1). There is a group that will go without coverage. The loss of single market is the first step to single payer market & the elimination of the private market. We'll be heading down a road that we won't be coming back from. If the individual market goes away, it won't come back. There is no incentive to get back in the game. We are going to pay for it one way or another.

Rep Ruby: How are the funds accessed by the private insurance companies?

Jon Godfread: The reinsurance will kick from 0 dollars in claims to 100,000 dollars in claims. That's paid by the insurance carrier for their contract. Once it hits a 100,000 & a million, they would see those claims in the reinsurance pool. Total claims per person. That would be 75% by the reinsurance & 25% by the carrier. Anything above a million, it's a 60/40 split with the feds & the carrier.

Rep Ruby: You need this bill in place so you can apply for the waiver. Then that's a process to get that approved. How long before it actually gets implemented?

Jon Godfread: Our goal is for the 2020 plan year.

31:55

Rep Adams: If we get into this invisible pool, a 21-year-old pay $400 a month, what would his premium be if we got on this program? Would his premium go down significantly?

Jon Godfread: We estimate a 20% reduction, about $80.

Chairman Keiser: CMS had no edits, in addition to that, how many states have this similar concept approved?

Jon Godfread: The reinsurance program is getting approved across the country. This is the wave for the future. This is not a new concept.

Rep Ruby: If insurance companies would purchase a traditional reinsurance product to cover this, do you know what the premium will be?

Jon Godfread: I don't think that market exists.

Chairman Keiser: Would you walk through the committee with handout relative to the PERS fiscal notes.

34:50

Jon Godfread: Attachment 5, 6. Fiscal notes "with PERS" & without "PERS". If PERS is part of the assessment pool & without PERS means PERS been removed. The other amendment we offered is adopted, in what taxes has the general fund going forward.

38:55

Rep Ruby: How is the assessment assessed to the point where that much higher than the percentage of premiums tax would be?

Jon Godfread: Based on premium volume. The largest book of business that Sanford has is the PERS plan, that obviously increase their assessment pool. That PERS business doesn't pay any premium tax. There is no additional tax that Sanford would pay in & get credited back.

Chairman Keiser: If we then said, PERS, you are going to start paying the premium tax, then it gets increased for the state. We are robbing Peter to pay Paul.

41:30

Scott Miller~Executive Director of PERS: Attachment 7. We are exempted from the premium tax.

Chairman Keiser: I would like to share with you how much I look forward to taking the increased of the PERS contract to appropriations.

Chairman Keiser: Anyone here to testify in support of HB 1106, opposition, neutral. Closed the hearing. What are the wishes of the committee?

Rep Kasper: Moves to adopt amendment 19.8068.01001.

Rep Laning: Second.

Chairman Keiser: Further discussion? There are three options, one, keeps it in the insurance side, but I certainly support.

Voice vote~motion carried.

Chairman Keiser: We have a 2nd amendment, the PERS amendment.

Vice Chairman Lefor: Moves to adopt the amendment from PERS exempting PERS from the premium tax. There is no wonderful solution, so I'm going to support it.

Rep D Ruby: Second.

Voice vote~motion carried.

Rep Ruby: I have a lot of frustrations. Why we have to do this & who's responsible. We are dancing around subsidizing these policies. I don't see another way of doing it. I reluctantly support it.

Vice Chairman Lefor: I agree with Rep Ruby; I'm going to support it.

Rep Kasper: I frustrated also, but from a different perspective. Mine happen in 2010 with the federal government made a decision to get involved in health care. Another frustration is congress to fix this. If we don't do something, we are faced with some dire consequences. This is as good as it gets.

Chairman Keiser: We have a serious problem that needs to be addressed in the next biennium.

Rep Kasper: Move a Do Pass as Amended & rerefer to Appropriations.

Vice Chairman Lefor: Second.

Roll call was taken for a Do Pass as Amended & rerefer to Appropriations with 13 yes, 0 no, 1 absent & Rep D Ruby is the carrier.

Jay McLaren~MEDICA: Attachment 8.

Prepared by the Legislative Council staff for
Representative Keiser
January 16, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1106

Page 1, line 3, after the semicolon insert "to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study;"

Page 1, after line 4, insert:

"**SECTION 1. AMENDMENT.** Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1."

Page 2, line 11, remove ", single employer"

Page 2, line 11, remove "not regulated by the state"

Page 3, line 14, after the first underscored comma insert "and"

Page 3, line 14, remove ", a self-funded multiple employer welfare"

Page 3, remove lines 15 through 19

Page 3, line 20, remove "prescription claims in excess of a previously determined amount"

Page 3, line 21, replace "11." with "10."

Page 3, remove lines 23 through 28

Page 6, line 9, remove "and based on third-party administrator"

Page 6, line 10, remove "premium equivalents in this state"

Page 6, line 12, remove "and third-party administrator premium equivalents"

Page 6, line 13, after the underscored period insert "An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due."

Page 6, line 17, remove "and third-party administrator premium"

Page 6, line 18, remove "equivalent"

Page 6, line 18, remove "The"

Page 6, remove lines 19 and 20

Page 8, after line 12, insert:

"**SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PREMIUM TREND.** During the 2019-20 interim, the legislative management shall study ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution based to reduce costs and may include consideration of whether a strict managed care model might be effective. The legislative management shall report its findings and recommendations, together with any legislation necessary to implement the recommendations, to the sixty-seventh legislative assembly."

Renumber accordingly

Prepared by the North Dakota
Insurance Department
January 21, 2019

PROPOSED AMENDMENTS TO BILL NO. 1106

Page 6, line 13, after the underscored period, insert "A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment."

Renumber accordingly

DF 1/21/19
1 of 2

19.8068.01002
Title.02000

Adopted by the Industry, Business and Labor Committee

January 21, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1106

Page 1, line 3, after the semicolon insert "to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study;"

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Page 3, remove lines 23 through 28

Page 5, line 23, after the underscored period insert "A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment."

Page 6, line 9, remove "and based on third-party administrator"

Page 6, line 10, remove "premium equivalents in this state"

Page 6, line 12, remove "and third-party administrator premium equivalents"

DF 1/21/19
2 of 2

Page 6, line 13, after the underscored period insert "An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due."

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Page 6, line 18, remove "equivalent"

Page 6, line 18, remove "The"

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Page 8, after line 12, insert:

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Renumber accordingly

Date: Jan 21, 2019

Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1106

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description: 19.8068.01001

Recommendation

☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐

Motion Made by Rep Kasper **Seconded By** Rep Laning

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Rep O'Brien		
Vice Chairman Lefor			Rep Richter		
Rep Bosch			Rep D Ruby		
Rep C Johnson			Rep Schauer		
Rep Kasper			Rep Adams		
Rep Laning			Rep P Anderson		
Rep Louser			Rep M Nelson		

Total (Yes) _____ No _____

Absent _____

Floor Assignment voice vote - motion carried

Date: Jan. 21, 2019

Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1106

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description: PERS = Short one
Attachment 2

Recommendation

☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐ _____

Motion Made by Rep Lefor **Seconded By** Rep Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Rep O'Brien		
Vice Chairman Lefor			Rep Richter		
Rep Bosch			Rep Ruby		
Rep C Johnson			Rep Schauer		
Rep Kasper			Rep Adams		
Rep Laning			Rep P Anderson		
Rep Louser			Rep M Nelson		

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

exempting PERS from the premium tax.
Voice vote - motion carried

Date Jan 21, 2019

Roll Call Vote #: 3

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 1106

House Industry, Business and Labor **Committee**

☐ **Subcommittee**

Amendment LC# or Description:

Recommendation

☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions ☐ Reconsider ☐

Motion Made by Rep Kasper **Seconded By** Rep Lefor

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	X		Rep O'Brien	X	
Vice Chairman Lefor	X		Rep Richter	X	
Rep Bosch	X		Rep Ruby	X	
Rep C Johnson	X		Rep Schauer	AB	
Rep Kasper	X		Rep Adams	X	
Rep Laning	X		Rep P Anderson	X	
Rep Louser	X		Rep M Nelson	X	

Total (Yes) 13 No 0

Absent 1

Floor Assignment Rep Ruby

REPORT OF STANDING COMMITTEE

HB 1106: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (13 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1106 was placed on the Sixth order on the calendar.

Page 1, line 3, after the semicolon insert "to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study;"

Page 1, after line 4, insert:

"**SECTION 1. AMENDMENT.** Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1."

Page 2, line 11, remove ", single employer"

Page 2, line 11, remove "not regulated by the state"

Page 3, line 14, after the first underscored comma insert "and"

Page 3, line 14, remove ", a self-funded multiple employer welfare"

Page 3, remove lines 15 through 19

Page 3, line 20, remove "prescription claims in excess of a previously determined amount"

Page 3, line 21, replace "11." with "10."

Page 3, remove lines 23 through 28

Page 5, line 23, after the underscored period insert "A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment."

Page 6, line 9, remove "and based on third-party administrator"

Page 6, line 10, remove "premium equivalents in this state"

Page 6, line 12, remove "and third-party administrator premium equivalents"

Page 6, line 13, after the underscored period insert "An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due."

Page 6, line 17, remove "and third-party administrator premium"

Page 6, line 18, remove "equivalent"

Page 6, line 18, remove "The"

Page 6, remove lines 19 and 20

Page 8, after line 12, insert:

"**SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PREMIUM TREND.** During the 2019-20 interim, the legislative management shall study ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution based to reduce costs and may include consideration of whether a strict managed care model might be effective. The legislative management shall report its findings and recommendations, together with any legislation necessary to implement the recommendations, to the sixty-seventh legislative assembly."

Renumber accordingly

2019 HOUSE APPROPRIATIONS

HB 1106

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1106
2/7/2019
32367

☐ Subcommittee
☐ Conference Committee

Committee Clerk Risa Bergquist by Caitlin Fleck

Explanation or reason for introduction of bill/resolution:

Relating to premium taxes and credits for insurance companies; to provide for a legislative management study

Minutes:

Chairman Delzer: Opened hearing.

Representative Keiser: Here to present HB 1106. HB1106 is a bill that will create an insurance plan for the individual insurance market. The problem occurred with a change in the Federal insurance market. This is only for the reinsurance market. The problem is the net result of a dramatic increase in the individual policy premiums and that leads to an unsustainable rate which results in a failure of our insurance market because when they don't have coverage, the only access to health care is through private pay or using the emergency room where they can receive unpaid services. Who's effected by this? Farmers, ranchers, individuals, small business people who have individual plans. As coverage declines the minute we transfer more on unfunded coverage then the funded coverage goes up disproportional to the risk. If you take 21-year-old nonsmoker it would be $4734 per year in 2019, if we don't do this by 2024 the same premium is $8269.

Chairman Delzer: Can't most people be on their parent's plan?

Representative Keiser: The majority are on an employer's plan; this is the individual market that is being impacted. What are the solutions? The solutions that we come up with are for the short term. We now have 10 states that have a reinsurance pool, we looked at several solutions and we found one that if you are on it you won't know. To get to this we have to get a waiver from CMS and we can't get a waiver without this bill. There are 2 options. We could assess all federal plans. They are large group plans. The solution here is not viable because it is unacceptable to the employees or the state. The other solution is the direct appropriation. Ten states have gone to a direct appropriation, and our solution is that we will assess the large and small group markets a fee and the insurance company will bill that into the rate structure and whatever their cost is as a result of this underwriting will be available for them to use as a credit on their premium tax. It's the same as a direct appropriation. In 2020 that will result in the state putting in 22 million dollars. In 2021 it would be 23 million. In 2020 the

federal government will put in 26 million and in 2021 27 million will go in. We don't like this, but we have a crisis. We have built up a rate increase that should have occurred, but didn't. The way the plan works is from 0 to 100 thousand dollars the insurance company carries that the full liability and they can underwrite that. From 101 thousand to 1 million dollars the reinsurance portion of this plan will pick up 75% and the insurers with pick up 25%. Once we are over 1 million it goes back onto the insurance companies. The one concern we had is that this problem doesn't just go away after this biennium, so we added a requirement for a study. We have to find a way to control costs for health care in our state. It's not a solution that I love, but it's a solution.

Chairman Delzer: The fiscal note you mentioned for 2020 and 2021, there's 22 and 23 million that doesn't match the fiscal note. The fiscal note is 31 million and 43 million, and is there federal money on top of that?

Representative Keiser: I apologize I was looking at the consultant's report for the projections. It is part of the federal money.

Chairman Delzer: Do you see any upcoming changes being made? What is the level of the insurance premium tax that is coming to the state, and are we going to get to the point in the future that you won't be able to cover what you want to do here?

Commissioner Godfread: The 22 million doesn't include the federal dollars, so they would be on top of that. Under the present congress I don't see any changes or health insurance reform. The level of the premium tax is about 60 million dollars a year, and that includes all lines of insurance.

Representative Keiser: Congress isn't going to address this.

Chairman Delzer: What's the deal with the Bank of ND line of credit?

Commissioner Godfread: The reason that the committee put that line of credit in there is to insulate against any delays in payment from the Federal government.

Representative J. Nelson: Was CSR pool scheduled to be eliminated? What happened to make that go away?

Representative Keiser: I am not use if that was an act of the president or a non-funding act by congress, it simply went away.

Representative J. Nelson: So that has to be acted on annually to exist?

Commissioner Godfread: It was part of the affordable care act, but it was removed. The elimination of the CSI payments came from the president, so it was an executive order. I can't speak for the president's thoughts on that but I think that there was some confusion around it, and it did impact our state greatly.

Chairman Delzer: What % of insured is the private market?

Representative Keiser: The individual is 9% of the market and uninsured is 8% and that is where the shift would occur.

Chairman Delzer: What we're doing here is putting together a pool for the 9%. And it's the ones that are above the 400% and don't have group insurance.

Representative Keiser: That's right because it's the farmer and ranchers.

Chairman Delzer: That is all based on the next income.

Representative Keiser: That is correct.

Chairman Delzer: What is 400% on net income?

Representative Keiser: I don't know that off hand.

Chairman Delzer: Commissioner Godfread, can you get that for us?

Commissioner Godfread: Yes.

21:00 Representative Nathe: Is this something that we can expect ever session now?

Representative Keiser: Yes, this problem does not go away.

Chairman Delzer: What would you think if we put a sunset on it and had to hear it again after the study?

Representative Keiser: I would strongly support that. We have the study, and the sunset will help incentivize the providers.

Chairman Delzer: If we put the sunset on it, would your carrier still carry that bill?

Representative Keiser: Yes.

Chairman Delzer: Can we find out the projection of when your premium tax dollar will not cover this, so it would be general fund on top of general fund so to speak.

Meeting closed.

2019 HOUSE STANDING COMMITTEE MINUTES

Appropriations Committee
Roughrider Room, State Capitol

HB 1106
2/14/2019
32729

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Risa Bergquist

Explanation or reason for introduction of bill/resolution:

Relating to the establishment of an invisible reinsurance pool for the individual health insurance management study

Minutes:

Chairman Delzer: When we had 1106 before us last time we had a couple questions. I have a list of the coverage guidelines. A family of four at 400% of poverty is 100 thousand dollars, modified gross income. The issue with this bill is that it deals with setting up reinsurance pool, it happened because the individual market is sitting here in a position where the premiums are getting so high that people can't afford it and there is no penalty for not having insurance. Came out of IBL with a Do Pass. We will caption some federal money but it's going to cost the state 31 million this biennium 43 million next biennium. That'll be an ongoing cost. I think we should put a sunset on the bill if we want to pass it.

2:40 Representative J. Nelson: It's important that we do pass this, I don't know if this is a problem of the Executive Care Act.

Representative Kempenich: The problem is, when the government gets involved they are trying to force this. When you try to make it universal it's too expensive for everyone. This here is just an outgrowth of what has been going on for years.

Chairman Delzer: The companies take the first 100 thousand then the state picks up to a million and then they buy reinsurance.

Representative Martinson: I'll make a motion to adopt amendment .02001

Representative Nathe: Second

Chairman Delzer: Any further discussion on the motion to amend? **Voice vote all in favor motion carries**.

Representative Kempenich: I'll make a mmotion for a Do Pass as Amended

Representative Holman: Second

Chairman Delzer: Any further discussion on the motion to Do Pass? We will take a roll call vote.

A Roll Call vote was taken. Yea: 20 Nay: 0 Absent: 1

Motion Carries Representative D. Ruby will carry the bill

Chairman Delzer: With that we will close this meeting.

DD 2/14/19

19.8068.02001
Title.03000

Prepared by the Legislative Council staff for
Representative Delzer
February 11, 2019

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1106

Page 1, line 5, after the semicolon insert "to provide an expiration date;"

Page 8, after line 25, insert:

"**SECTION 4. EXPIRATION DATE.** This Act is effective through July 31, 2021, and after that date is ineffective."

Renumber accordingly

Date: 2/14/2019
Roll Call Vote #: 1

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1006

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: **19.8068.02001**

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By **Representative Martinson** Seconded By **Representative Nathe**

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer					
Representative Kempenich					
Representative Anderson			Representative Schobinger		
Representative Beadle			Representative Vigesaa		
Representative Bellew					
Representative Brandenburg					
Representative Howe			Representative Boe		
Representative Kreidt			Representative Holman		
Representative Martinson			Representative Mock		
Representative Meier					
Representative Monson					
Representative Nathe					
Representative J. Nelson					
Representative Sanford					
Representative Schatz					
Representative Schmidt					

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

Voice Vote/Motion Carries

Date: 2/14/2019
Roll Call Vote #: 2

2019 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1006

House Appropriations Committee

☐ Subcommittee

Amendment LC# or Description:

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐

Motion Made By **Representative Kempenich** Seconded By **Representative Holman**

Representatives	Yes	No	Representatives	Yes	No
Chairman Delzer	X				
Representative Kempenich	X				
Representative Anderson	X		Representative Schobinger	X	
Representative Beadle	X		Representative Vigesaa	X	
Representative Bellew	X				
Representative Brandenburg	X				
Representative Howe	X		Representative Boe	X	
Representative Kreidt	X		Representative Holman	X	
Representative Martinson	X		Representative Mock	A	
Representative Meier	X				
Representative Monson	A				
Representative Nathe	X				
Representative J. Nelson	X				
Representative Sanford	X				
Representative Schatz	X				
Representative Schmidt	X				

Total (Yes) 20 No 0

Absent 1

Floor Assignment **Representative D. Ruby**

Motion Carries

REPORT OF STANDING COMMITTEE

HB 1106, as engrossed: Appropriations Committee (Rep. Delzer, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (20 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1106 was placed on the Sixth order on the calendar.

Page 1, line 5, after the semicolon insert "to provide an expiration date;"

Page 8, after line 25, insert:

"**SECTION 4. EXPIRATION DATE.** This Act is effective through July 31, 2021, and after that date is ineffective."

Renumber accordingly

2019 SENATE INDUSTRY, BUSINESS AND LABOR

HB 1106

2019 SENATE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Roosevelt Park Room, State Capitol

HB 1106
3/4/2019
JOB # 33101

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Florence Mayer

Explanation or reason for introduction of bill/resolution:

Relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study; to provide an expiration date; and to declare an emergency.

Minutes: Attachments # 1 - 3

Chairman Klein: Opened the hearing on Engrossed HB 1106. All members were present.

Jon Godfread, Insurance Commissioner of North Dakota: Introduced the bill and provided Attachment #1. Went over the changes in the bill and provided a suggested amendment, Attachment # 2.

(7:19) Chairman Klein: Under the current plan and developing the fiscal note, we're looking at what? Help me with the dollars, how did we chose $100,000 - $1M, and 75%? If we changed those numbers would it relieve the stress on the fiscal note?

Jon Godfread: We looked at the $100,000 attachment point and a $200,000 point in our study. From $200,000 to $1M, that cuts the impact to about half. We are projecting a 20% reduction on the individual market. With 200,000 we project a 10-12% reduction. Coming out of the interim committee, it is our directive to keep it at that $100,000. We also did the numbers on the $200,000. That would cut it in about half in terms of the fiscal note.

Chairman Klein: So more people can be included at the $100,000?

Jon Godfread: We are having a greater impact. Dropping the rates by 20%, keeps more people insured and attracts some back. At the 10%, we would lessen our impact. We had the discussion of lets create a big impact. I think 20% is enough to turn some heads and get people engaged.

Chairman Klein: Who are we out there helping?

Jon Godfread: Direct impact is the individual marketplace. We have about 42,000 of North Dakotans who purchase their own insurance, not through an employer or government option. About half of those receive a subsidy because of their income level. The other 21,000 is made up of our small business owners, farmers, ranchers, folks who don't have access to the large group market. Those folks have taken year after year of 20% increases. They are considering forgoing health care. The 400% poverty level and below is who receive that tax credit. For a family of 4 that is around $100,000. Those numbers are tough for families. If all that good risk leaves the market place, there isn't a lot of incentive for our carriers to offer those plans. In 2018, when Medica pulled out, Sanford was down to 5 counties, Blue Cross wrote the entire state. We can't force carriers to take on this risk. If they don't the feds will step in to solve it for us. The minute that happens, the employers will say they won't offer the healthcare coverage. Then we are steaming towards a single payer system. That is a risky proposition. By keeping the individual market alive, we keep the private health care alive.

(13:35) Senator Burckhard: You talk about the $100,000-$200,000 attachment point, what does that mean?

Jon Godfread: We have to set an attachment point for reinsurance programs. In the bill as written, it is a $100,000 point. $101,000- $1M, the carrier is able to seed those claims over to the reinsurance pool. That covers those claims at a 75% level. Anything above a million, there is a federal reinsurance program that kicks in that is a 60% level they cover. This is trying to smooth out the peaks and valleys, take out some of those outliers. We have seen $2-3M claims for individuals in ND. We will eventually reach a point of being too risky and unaffordable.

Chairman Klein: We're going to hold a line on the premium be being the reinsurer. It's been going up steadily at double digits, where do you see that number going? Holding that premium dollar is what this is all about.

Jon Godfread: This program makes sense with or without the ACA. The issue we see with the ACA and costs, is we don't have the flexibility to offer new products. Wouldn't it be great to do a catastrophic plan with a high deductible savings; That would make insurance cheap for that 26 year old just entering the market. A lot of that would be fantastic, we can't do that under the ACA. This is keeping our individual market alive. I can't answer where I see the leveling off point being. That has a lot to do with why the study is in here is those cost drivers. As long as the thing you're insuring is expensive, your insurance will be expensive. A lot of the arrows are pointed at the insurance companies right now. We are dealing with it at a national level and looking into the cost of health care. It is tough to get down to that cost and get that data from the hospitals, The administration has issued an order to put the charge on the website. You will get a spreadsheet 800 pages long. It is a step in the right direction to get more transparency behind these costs. I am a big believer in the high deductible health savings accounts. That puts the dollars back in consumers hands. They are then responsible for having that discussion with the health care provider. Giving that consumer control back, is what we'd like to see. Until we get a true handle on our health care costs, we will be in for a ride for a while.

Chairman Klein: This discussion has gone on for 30-40 years? The state PERS insurance was $542 not that many years ago. Now we are at more than a $1,000.

(21:13) Bill Kalanek, Blue Cross Blue Shield of North Dakota: Distributed absentee support testimony for **Megan Houn, Director of Government Relations for Blue Cross Blue Shield.** Attachment #3.

Scott Rising, North Dakota Soy Bean Growers Association: We think we support this.

Chairman Klein: Insurance isn't sexy, it is difficult to understand. We talk about the relationship you have with your agent, because that is who you trust. Insurance is complicated and we aren't making it any easier. We want to help provide some incentive to hold that line. I am trusting that is the good intentions of the commissioner as well.

Scott Rising: In the last dozen years, 2 times we tried to figure out some group insurance for members.

Senator Burckhard: Trump will be doing away with the tariffs with China, and we'll be selling them more soybeans?

Scott Rising: Just about every boat that is hauling soybeans is off the South American Coast. If I owned those boasts and wanted to buy soybeans tomorrow in the USA, I would do that at the mouth of the Mississippi River, rather than the Pacific North West where our beans go. My prayer for the soybean community is somehow those bins will stay 30 below zero, the ground will warm up, and we'll put a new crop in. Otherwise we are going to have a new crop and tofu in quantity.

Arik Spencer, President & CEO Greater North Dakota Chamber: We hear concerns from employers about the rising costs of health care. From full proprietor main street businesses, to larger employers who aren't self-funded. We support this proposal.

Chairman Klein: Those who have insured groups, this will help them stabilize because we are helping keep the individual market from spiking. So we don't have those folks in their own group saying, 'what about us'.

Arik Spencer: Self-funded plans have been proactive and have already taken steps to do so. When those costs are spread among everyone, we all pick up those costs. We see this as a way to help stabilize the increases we see year after year.

Chairman Klein: Closed the hearing on HB 1106. We know there is one change before we send it to appropriations. Do we need to ponder this? The policy is there, the question might be within appropriations.

Senator Roers: Moved a Do Pass on Amendment that would replace page 8, line 26, July with December.

Senator Kreun: Seconded.

A Roll Call Vote Was Taken: 6 yeas, 0 nays, 0 absent.

Motion Carried.

Senator Roers: Moved a Do Pass on re-engrossed HB 1106 as amended and re-refer to appropriations.

Senator Burckhard: Seconded.

A Roll Call Vote Was Taken: 6 yeas, 0 nays, 0 absent.

Motion Carried.

Senator Klein will carry the bill.

Committee continued with discussion on HB 1333.

19.8068.03001
Title.04000

Adopted by the Industry, Business and Labor Committee

March 4, 2019

SJC
3-4
1951

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1106

Page 8, line 26, replace "July" with "December"

Renumber accordingly

Date: 3-4-19
Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1106 amendment

Senate Industry, Business and Labor Committee

☐ Subcommittee

Amendment LC# or Description: 19.8068.03001

Recommendation: ☒ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Roers Seconded By Kreun

Senators	Yes	No	Senators	Yes	No
Chairman Klein	✓		Senator Piepkorn	✓	
Vice Chairman Vedaa	✓				
Senator Burckhard	✓				
Senator Kreun	✓				
Senator Roers	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Klein

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

Date: 3-4-19
Roll Call Vote #: 2

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1106

Senate Industry, Business and Labor Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☒ As Amended ☒ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Roers Seconded By Burckhard

Senators	Yes	No	Senators	Yes	No
Chairman Klein	✓		Senator Piepkorn	✓	
Vice Chairman Vedaa	✓				
Senator Burckhard	✓				
Senator Kreun	✓				
Senator Roers	✓				

Total (Yes) 6 No 0

Absent 0

Floor Assignment Klein

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

REPORT OF STANDING COMMITTEE

HB 1106, as reengrossed: Industry, Business and Labor Committee (Sen. Klein, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1106 was placed on the Sixth order on the calendar.

Page 8, line 26, replace "July" with "December"

Renumber accordingly

2019 SENATE APPROPRIATIONS

HB 1106

2019 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

HB 1106
3/14/2019
Job # 33699

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Rose Laning / Carie Winings

Explanation or reason for introduction of bill/resolution:

Relating to the establishment of an invisible reinsurance pool for the individual health insurance market.

Minutes: Testimony # 1 – 3.

Legislative Council: Alex Cronquist
OMB: Larry Martin

Chairman Holmberg called the committee to order on HB 1106. Roll call was taken.

Jon Godfread, Commissioner, North Dakota Insurance Department:
Engrossed House Bill No. 1106 - Attached # 1.
Why do we need HB 1106? - Attached # 2.
House Bill No. 1106 - Attached # 3.

(11:24) Senator Oehlke: We see what the guesstimate is for the premium tax credit of $31 million for the initial biennium. What is the total taxes that we collect from you major players that you are figuring this on?

Jon Godfread: Roughly $45 million is from the health insurance side of it.

Senator Oehlke: So a little over 2/3 would go toward this event?

Jon Godfread: Yes.

Senator Oehlke: Is that affecting your budget in other ways?

Jon Godfread: No, because our budget is paid through our regulatory trust fund; which is the fees and the other pieces of the insurance market. The premium taxes go right into the general fund.

Senator Mathern: Let's assume we support this concept. Why not just take the $31million direct and pay for that insurance rather than go through the assessment of the insurers. It

seems like another step in between, but the consequence to our general fund is exactly the same.

Jon Godfread: I can't disagree. This is a lessening of future revenue versus a lessening of current revenue, because this will affect the premium tax that we collect this time. There will not be a check that will be written on day one. I think there is more comfort in that in terms of adjusting for the next biennium. As I mentioned in some of the opening comments, a vast number of states are doing that direct appropriation right into the program. I think it is a little bit of a distinction without a difference in some respects. The money is going to be paid if we want to do this. If the policy decision is go forward with this, the money will be paid and it just depends on the timing. This is a different timing mechanism.

Senator Mathern: We don't lose anything in the process by running the assessment through the major insurers?

Jon Godfread: No, we don't lose anything. Another step in this program would be to find legislative approval, signed by the governor, and then get it approved by the federal government to go forward. We have been working with CMS in the development of our draft application and I will give a lot of credit to deputy commission Uben. In the conversation we've gotten really no comments back in terms of changes that we need to make. I don't believe it would impact the program in any way in terms of us going forward. It is really depending on how we want to fund it. It is a decision that is up to this body.

Senator Grabinger: How are we guaranteed that this would reduce the rates? They are going to get the premium tax break and then are we guaranteed they are going to lower the rates or not?

Jon Godfread: We are a prior rate approval state. Every rate that is used in our state has to be approved by my office. If we put forward this kind of investment, we will be finding that kind of reduction. The buck would stop in my office. If the reduction isn't there, and we approve rates that didn't meet the reductions, the arrows would be coming to me.

Senator Oehlke: The assessment could vary from year to year, correct?

Jon Godfread: Yes.

Senator Oehlke: So there is flexibility there. If we pretend that it's not necessary to use the $31 million to solve the issue for claims over $100,000 and there is $15 million left in the pot at the end of the year, then the assessment on the companies would probably go down for the next year or two, and that is built into this correct?

Jon Godfread: Yes. There is language in the bill that requires, if there is an excess in collections of the assessment, those dollars to be used to offset the next year.

Senator Oehlke: That way makes more sense – if you just pay the premium, then you'll use your $30 million plus all the time every year. This way, you have the flexibility and you might be able to lower that assessment.

Jon Godfread: The way that it's structured; how the dollars get into the fund are separate from the operation of the fund itself. If the governor signs it, and on July 1st there is $31 million in this fund and we only use $15 million, we would not be able expend it other places. If there is a direct appropriation, that $15 million dollars is not going to be lost or spent. It will be spent based on the claims that fall in that window between $100,000 and $1 million.

(18:25) Senator Krebsbach: Is there going to be an impact on the providers in filing claims?

Jon Godfread: No. there should not be any impact on the filing of the claims. This should be solely an interaction between the insurance company and the insurance department. As they track those claims for the individual consumer, once it hits $ 100,000 mark. We are in discussions on how it will exactly work, but on terms of rolling those claims over, I'm anticipating it would be on a quarterly or half year basis. As we get to the end of the year, that is when we will start seeing the claims over that $100,000 mark. They may want to wait until the year is done, wrap up their books, and then ask for reimbursement for those consumers who are over $100,000. The devil in the details on some of the regulations in terms of how that works, but it should not have any impact on how providers interact with the insurance company. It is solely with the insurance company and the insurance department.

(19:45) Senator Bekkedahl: You mentioned 42,000 North Dakotan's could potentially be involved in this market, and 21,000 are eligible for ACA subsidy at this point. Would this target the 21,000 not eligible for the ACA subsidies?

Jon Godfread: That's the very direct impact. It will go to those 21,000. By having or stabilizing that market place and keeping it alive and having that option really stabilizes the rest of our health insurance marketplace. The impact is broader onto a large group of employer based health care. If this market goes away - in 2017 we had three carriers, and in 2018 Medica dropped off, Sanford dropped down to 5 counties, and Blue Cross wrote the entire state. There is going to reach a point, if there is nothing done to stabilize this marketplace, that our carries are going to say it is either exponentially too expensive for consumers to buy this product or the risk will be too great to continue to be on this marketplace. If that happens, and there is no one willing to sell insurance on the individual marketplace, that is where we roll into the federal type option; which will send us down the road of a single payer system. I don't believe anyone really wants that.

Senator Bekkedahl: I don't know if we can ever stop that train if they do at the federal level but appreciate your consideration of that. The fiscal note for the next biennium was over $11million and this was $32 million. Can you explain the reason for the difference?

Jon Godfread: As the bill came out of the House, there was a sunset placed on there. We had to make an amendment in Senate IBL because the sunset that came from the House said July 1, 2020, and we needed to changed that to January 1 because our healthcare plans run on an annual calendar year basis versus a fiscal year basis. The $11 million is accounting for the last half of the first biennium.

Senator Bekkedahl: But the intention would be if it is roughly $32 million for this biennium, that would be a continuing cost ongoing to support this market.

Jon Godfread: Yes, this would be an ongoing cost. This would be a program that would likely have to continue if we chose to until we see some sort of health care reform. It may be a bridge of further healthcare reform to get us there.

Senator Bekkedahl: Do you have a history of the premium tax over the years and if there has been any increases or decreases in the tax structure last decade or so?

Jon Godfread: Yes. It has been relatively stable I believe. Especially in the health insurance side which this would be impacting.

Senator Bekkedahl: If we could see that. My concern is that if we have been giving some types of decreases in tax rate, and now we are giving a premium credit, did your office ever need to increase or put the cost back on all the insurers in the state to cover this before you got to this funding strategy. I wanted to see if there was room for premium tax credit or premium tax increases to bring more revenue to the system and lessen the effect on the general fund.

Jon Godfread: I can do that. I'll speak again to what we believe is the importance of this program. It could stabilize the marketplace, and this would offer help to some of those individuals that have been facing year over year of pretty dramatic rate increases. Those are the folks that I hear from. Often times it is the farmer who have a family of four and they are staring down the barrel of a $2800 a month health insurance premium and it is truly becoming unaffordable and some are making the decision to forego health insurance, which is a risk. Some other options we looked at were catastrophic plans or base level plans that maybe were cheaper to cover the real catastrophes and maybe folks layer coverage on top of that. We looked at Idaho and what they were trying to do with something similar to that. Under the current structure of the ACA, it's not possible. The reinsurance program is our best bet under the current structure of the ACA to provide relief to the marketplace. It's by no means a silver bullet, and does not solve our healthcare issues. Which is why we will continue to advocate at the federal level to allow us some more state based control like we have in every other line of insurance. In the meantime, we have a population of North Dakotans who up to this point have seen no relieve or assistance in this area. We've expanded Medicaid in the state, and that has helped that population. The advanced premium tax credits helped the folks under the 400% poverty level until they can get into Medicaid expansion. But we've got a window of folks that don't have access to other government options for health insurance. This would help those in dire need of health insurance, and help stabilize our marketplace at all levels of health insurance.

(27:55) Megan Houn, Director of Government Relations, Blue Cross Blue Shield:
We stand in support of the bill, and we support the efforts of the legislature, the commissioner's office, and the executive branch to alleviate some of the pressure of those folks in the individual marketplace. We have collaborated closely with the department and the other carriers to work on this plan.

Jon Godfread: One more thing to bring to your attention. We are under some time constraints a little bit. Our goal is to make it active January 1, 2020. Any help you can offer us in moving this through quickly if there is support for it. We do have to turn around and file with the federal government and there are public comment periods, and they have time frames to get through. We have been working with them closely so we believe we are in a good position, but any buffer you can offer us would be greatly appreciated in order to help shore up those time frames. As it stands right now, we are requesting two rates from our carriers. One with the reinsurance program, and one without. In all likelihood the earliest we will probably get approval from the feds at this point is August/September. The bill would have to go back to the House because of the sunset change.

Vice-Chairman Wanzek: It does have the emergency clause.

Jon Godfread: Yes, but it needs approval from the House.

Vice-Chairman Wanzek: Closed the hearing on HB 1106.

2019 SENATE STANDING COMMITTEE MINUTES

Appropriations Committee
Harvest Room, State Capitol

HB 1106
4/3/2019
JOB # 34488

☐ Subcommittee
☐ Conference Committee

Committee Clerk: Alice Delzer

Explanation or reason for introduction of bill/resolution:

A BILL for an Act to create and enact chapter 26.1-36.7 of the North Dakota Century Code, relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study; to provide an expiration date; and to declare an emergency. (Do Pass)

Minutes: 1.Amendment # 19.0194.02002

Chairman Holmberg: opened the hearing on HB 1006. All committee members were present. Adam Mathiak, Legislative Council and Larry Martin, OMB were also present.

Chairman Holmberg: Explained the bill. What is the wish of the committee?

Senator Dever: I would prefer to see it the way it is.

Senator Dever: moved a do pass on HB 1106. 2nd by V. Chairman Wanzek.

Senator Bekkedahl: (the recording was started during his comments.) I plan to vote for this bill.

Senator Oehlke: Commented about the discount

Chairman Holmberg: Call the roll on do pass on HB 1106.

A Roll Call vote was taken. Yea: 14; Nay: 0; Absent: 0. This goes back to IBL. Senator Klein will carry the bill.

The hearing was closed on HB 1106

Date: 4-3-19

Roll Call Vote #: 1

2019 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 1106

Senate Appropriations Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Dever Seconded By Wanzek

Senators	Yes	No	Senators	Yes	No
Senator Holmberg	✓		Senator Mathern	✓	
Senator Krebsbach	✓		Senator Grabinger	✓	
Senator Wanzek	✓		Senator Robinson	✓	
Senator Erbele	✓				
Senator Poolman	✓				
Senator Bekkedahl	✓				
Senator G. Lee	✓				
Senator Dever	✓				
Senator Sorvaag	✓				
Senator Oehlke	✓				
Senator Hogue	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment TBL

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

Klein

REPORT OF STANDING COMMITTEE

HB 1106, as reengrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Reengrossed HB 1106, as amended, was placed on the Fourteenth order on the calendar.

2019 TESTIMONY

HB 1106

HB1106 1/15/19 Att. #1

House Bill No. 1106

Presented by: Jon Godfread
Commissioner
North Dakota Insurance Department

Before: Joint hearing of the House and Senate Industry Business and Labor Committees
Representative George Keiser, Chairman
Senator Jerry Klein, Chairman

Date: January 15, 2019

Good morning Mr. Chairman and members of the House and Senate Industry Business and Labor Committees. For the record, my name is Jon Godfread, Insurance Commissioner. I want to start by saying thank you for allowing us to have this joint hearing. By doing so, we are able to have our actuarial consultant, who helped us in with the study that led to this legislation, here in person. Donna Novak, President of NovaRest Consulting, will be appearing after me. She was the lead actuary on this report and NovaRest has significant experience with 1332 Waivers and the analysis needed to apply to the Federal Government for such waiver.

HB 1106 is the product of an in-depth study conducted by the North Dakota Insurance Department; this study was fully presented at the Interim Health Care Reform Review Committee last September. Following that presentation, the Insurance Department drafted the bill you have before you.

The Department conducted a study to find out the feasibility and desirability of a North Dakota Section 1332 Waiver. Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue strategies for providing its residents with access to high quality, affordable health insurance; while retaining the provisions included in the ACA. The study conducted looked at three main areas to pursue a 1332 Waiver:

- The modification of North Dakota's current high-risk pool, the Comprehensive Health Association of North Dakota (CHAND), to allow a greater number of high-risk North Dakotans to obtain their health insurance from CHAND, along with an analysis of the corresponding insurance company assessments necessary for CHAND to successfully operate with an increased high-risk membership.
- The modification of CHAND into an invisible high-risk pool where high-risk North Dakotans can obtain their health insurance.
- The creation of an invisible reinsurance program independent of CHAND. An invisible reinsurance program would limit the amount of risk insurance companies take on for the high-risk North Dakotans they insure.

The study also analyzed Idaho's state-based plan initiative and how a similar state-based plan allowance could operate in North Dakota. The state-based plan initiative would allow insurance carriers to offer health insurance plans outside of the existing ACA exchange that would be more

flexible in how they are underwritten and designed. These state-based plans would still be required to offer all ACA-mandated essential health benefits and be guaranteed issue, but would allow for credits for healthy behavior or other health-related factors. The state-based plans would also be a part of the single-risk pool for the general marketplace, which could incentivize young and healthy membership into the risk pool and help stabilize the rates.

Upon completion of this study and subsequent presentation to the Interim Health Care Reform Review Committee, we determined that the best option would be to pursue legislation that authorized the Insurance Commissioner to pursue a 1332 waiver that created an invisible reinsurance pool independent of CHAND.

It is our belief that our 1332 Waiver will reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims which significantly contribute to the rising cost of health insurance. This would be accomplished by using a reinsurance mechanism to help fund high cost claims. The result, should be double digit **decreases** in the cost of health insurance on the individual market, which will result in more individuals staying in the market, some individuals who left the market due to unaffordability of health insurance returning to the market, and more insurers being willing to write policies in North Dakota counties. Both of these will help stabilize the individual health insurance market in North Dakota.

Under HB 1106, North Dakota would implement a reinsurance mechanism that would be similar to traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. The reinsurance program we are proposing in this legislation is estimated to reduce premiums by approximately 20% in 2020 compared to the baseline premium (without the waiver). Due to the reduced premium, the membership in the 2020 individual market would increase, 1% compared to the baseline without the waiver.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. The approach of an "invisible" reinsurance allows enrollees to remain in the individual market with their current plan and carrier, and have all the choices of health insurance plans that everyone else has, but a portion of their claims would be reimbursed by the reinsurance pool. The enrollee is not aware that their claim is being paid via the reinsurance pool, meaning there is no effect on the enrollee as the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

For the 2020 plan year, the proposed reinsurance program would cover 75% of paid claims between the $100,000 attachment point and $1,000,000. This level of reinsurance was assumed in the future projections, but under HB 1106 we would have the flexibility to change the parameters in the future, if needed.

The reinsurance payable under the Waiver is estimated to be $48 million in 2020. It will increase over the next ten years due to medical inflation unless the reinsurance parameters are modified. The actual amount that will be paid under the reinsurance will depend on submitted claims. Based on NovaRest projections, the reinsurance paid in future years will be approximately as shown in Table 1 of the report.

These solutions do not come without a cost, and we fully expect a healthy discussion regarding how this program could and should be funded. A portion of the funding for the reinsurance would come from the federal government due to the reduction in advanced premium tax credits (APTC) being passed back to North Dakota. The reduction in premiums for the second lowest Silver plan in each region directly reduces the APTC for the individuals eligible for APTCs.

Under the current version of HB 1106, the additional funding required by the reinsurance program would come from assessments against the group health insurance market, self-insurance business, and Third-Party Administrators (TPAs) that pay claims for self-insured employers. NovaRest projects the APTC pass through from the federal government in 2020 to be $26 million and the assessment requirement to be $22 million. The 2020 assessment would be between 1% and 1.5% of group health insurance premium and TPA premium equivalent (claim paid plus administrative fees). These percentages are higher than the current estimates in order to provide a cushion in the first year of operation.

The ultimate policy question that will be before this body is should the state increase the premiums of group health insurance policies by 1% or 1.5%, or, in the alternative, expend state funds, in order to reduce the cost by approximately 20% for the individual market. In that spirit, we wanted to propose you three different funding options in order to have an in-depth discussion. My office has prepared two amendments to HB 1106 for your consideration along with a proposed cost to the state for each amendment. The three options are as follows:

1. HB 1106 as introduced, the additional funds needed on top of the federal government funding (estimated at $22M for 2020) would come from a 1 – 2% assessment to our heath carriers, TPAs and self-funded insurers. With this option, there would be no fiscal note and no state funds expended.
2. Premium Tax Credit Amendment: This option would remove the self-funded groups and TPAs from assessment. It would also allow the health insurers to credit any assessment back from their premium taxes they pay the state. This would decrease future state revenues by approximately $37 million per biennium.
3. A straight appropriation from the state to cover the costs of the additional funds needed. This would remove the assessment from our health carriers, TPAs and self-funded insurers. We would still have the option to assess our health carriers, in the event of a shortfall from the state appropriation. This amendment calls for an appropriation from the general fund to the Insurance Department of $40 million in order to fund the reinsurance program.

Each of these options has pros and cons, with the biggest pro being the creation of the reinsurance pool, stabilization of the individual market and reduction of premiums to those individuals on that market that have faced year after year of double digit increases on this market. The challenges are how does this get funded, do we increase the cost of health insurance for every other group in our state or do we expend state revenue to help make up that difference?

The Department, for the most part, is agnostic on how this program is funded; we simply believe there is significant value in stabilizing our failing individual market. It is no secret that the individual markets across the country are facing trouble; the rising premiums are akin to the

canary in the mine. We are reaching a point where individuals are no longer able to afford to purchase their own health insurance. These are individuals who are our small business owners, farmers and ranchers, individuals who make too much money to receive any kind of premium subsidy or assistance, individuals that cannot continue to afford to pay the costs that come with year after year of double-digit health insurance increases. Couple that with an individual market that is getting more and more concentrated with high claims cost individuals, and you can see that we are approaching a death spiral.

When good risk no longer enters the individual market because the costs associated with it are simply too high, companies will leave that market. If that happens, we will no longer have an option for individuals to purchase health insurance and the federal government will likely step in and provide a form of Medicare coverage to those individuals. This will be the first step in moving to a single payer system and the first step in the elimination of our private health insurance market.

We continue to wait for the federal government to offer us significant health insurance reform; we hope that reform allows states more control of our health insurance markets. In the meantime, HB 1106 allows us to start to regain some control of this market, it offers us a public-private partnership that would reduce premiums and provide lower-cost plans to individuals, and most importantly, this legislation will stabilize our individual market, which is important to keep us from moving toward a form of government run, single-payer health insurance system in the future.

Before I invite Ms. Novak up to the podium, I would like to pause to see if there are any questions.

At this point, I would like to invite Donna Novak up to talk through some more of the specifics regarding our proposed 1332 waiver and the invisible reinsurance pool.

--Donna Novak Presentation--

Thank you Ms. Novak, from here, we can walk through the bill section by section and answer any questions you have, or we could sit down and allow other individuals to testify. Do you have a preference Mr. Chairman?

Breakdown of HB 1106:

Section 1: Definitions – these definitions are modeled after definitions from other areas of our code.

Waiver proposal and application (pg.4, ln 1-8): This gives the authority to the commissioner to apply for a 1332 waiver.

Reinsurance Association of North Dakota (pg.4, ln 9-31): This established the Reinsurance Association of North Dakota (RAND) as a nonprofit legal entity. Allows RAND to begin operation of January 1st following approval of the waiver, or January 1st upon the ACA being repealed, amended, or adjudicated by a court of law with jurisdiction of North Dakota, thus making the granting of an innovation waiver unnecessary or inapplicable.

Board of Directors (pg. 5, ln 1-17): Creates a governing board of directors, consisting of the state health officer, one senator appointed by the majority leader of the senate, one representative appointed by the speaker of the house, one individual from each of the four insurers in our state. This also allows for two non-voting members from the insurance department appointed by the commissioner.

Powers and Duties of Commissioner and board (pg.5 ln18 – pg.6 ln 4): The commissioner is to administer RAND and approve assessments to fund RAND. The board is to formulate policies, scheduling audits, verify the assessment base, and approve bylaws.

Assessments against insurers (pg.6 ln 5 – pg.7 ln 20): This outlines the process for assessments and sets time lines. Outlines that any federal funds received by the association must be used to reduce assessments to insurers. The board of directors is responsible to provide a recommendation to the commissioner for the amount of assessment. An insurer may apply for a deferral from assessment if it is determined by the commissioner that the payment of the assessment would place the insurer in a financially impaired condition. Any surplus from the assessments must be used to offset future losses, reduce future assessments or pay off the line of credit authorized in this chapter.

Bank of North Dakota line of Credit (pg. 7 ln 21-27): Authorizes a line of credit at the bank of North Dakota, to provide reimbursements to member insurers, this would be used in the event that the federal government is slow in their payment of the APTC pass through dollars.

Reinsurance (pg. 7 ln 28 – pg. 8 ln 2): Establishes the reinsurance attachment point of $100,000 and the reimbursement rate of 75% for claims above $100,000.

Reimbursement of member insurer (pg. 8 ln 3 – 9): Reimbursement of claims for the individual market.

Rulemaking (pg. 8 ln 10 – 12): Grants the commissioner rule making authority for this chapter.

Section 2 Emergency Clause: We would need to seek federal government approval of our 1332 waiver and that process needs to start sooner than later in order to implement this program for the 2020 plan year.

I know there are others who are seeking to testify on this issue, so I would pause for questions, but I also want to ensure everyone else gets an opportunity to address the joint committee. Thanks you.

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Prepared by the North Dakota
Insurance Department
January 15, 2019

PROPOSED AMENDMENTS TO BILL NO. 1106

Page 1, line 3, after the semicolon, insert "to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies;"

Page 2, line 11, remove ", single employer"

Page 2, line 11, remove "not regulated by the state"

Page 3, line 14, after the first comma insert "and"

Page 3, line 14, remove ", a self-funded multiple employer welfare"

Page 3, remove lines 15 and 16

Page 3, line 17, remove "benefits which is subject to state insurance regulation"

Page 3, line 18, remove ""Medical stop-loss premiums" means amounts paid for health benefit plan insurance"

Page 3, remove lines 19-20

Page 3, remove lines 23-28

Page 6, line 9, remove "and based on third-party administrator"

Page 6, line 10, remove "premium equivalents in this state"

Page 6, line 12, remove "and third-party administrator premium equivalents"

Page 6, line 13, after the period insert "An assessment not paid within 45 days of the end of the previous quarter shall accrue interest at twelve percent per annum on and after the due date."

Page 6, line 17, remove "and third-party administrator premium"

Page 6, line 18, remove "equivalent"

Page 6, line 18, remove "The"

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Page 6, remove lines 19 and 20.

Page 8, after line 12, insert:

SECTION 2. AMENDMENT. Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under subsection 1 of section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

Page 8, line 13, replace "**2**" with "**3"**

Renumber accordingly

19.8068.01000

HB1106 1/15/19 Att#1 pg9

Sixty-sixth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1106

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

A BILL for an Act to create and enact chapter 26.1-36.7 of the North Dakota Century Code, relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1 - 36.7 - 01. Definitions .

For purposes of this chapter, unless the context otherwise requires:

1. "Association" means the reinsurance association of North Dakota.

2. "Board" means the board of directors of the reinsurance association of North Dakota.

3. "Earned group health benefit plan premiums" means premium owed to an insurer for a period of time during which the insurer has been liable to cover claims for an insured pursuant to the terms of a group health benefit plan issued by the insurer.

4. "Future losses" means reserves for claims incurred but not reported.

5. "Group health benefit plan" means a health benefit plan offered through an employer, or an association of employers, to more than one individual employee.

6. "Health benefit plan" means any hospital and medical expense-incurred policy or certificate, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care.

   a. "Health benefit plan" does not include any one or more of the following:

      (1) Coverage only for accident or disability income insurance, or any combination of the two;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workforce safety and insurance or similar workers' compensation insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics;

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits; and

(9) Self-funded, ~~single employer~~ plans ~~not regulated by the state~~.

b. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination of this care; and

(3) Other similar limited benefits specified under federal regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104 - 191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; and any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

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(1) Medicare supplement health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 13295ss(g)(1)];

(2) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(3) Similar supplemental coverage provided under a group health plan.

7. "Individual health benefit plan" means a health benefit plan offered to individuals, other than in connection with a group health benefit plan. The term does not include short-term, limited-duration health insurance as defined by section 26.1 - 36 - 49 .

8. "Insured" means an individual who is insured by a health benefit plan.

9. "Insurer" means an entity authorized to write health benefit plans or that provides health benefit plans in the state. The term includes an insurance company as defined in section 26.1 - 02 - 01, a nonprofit health service organization, a fraternal benefit society, and a health maintenance organization~~, a self-funded multiple employer welfare arrangement, a reinsurer that reinsures health insurance in this state, a third-party administrator, and any other entity providing health insurance coverage or health benefits which is subject to state insurance regulation~~.

~~10. "Medical stop-loss premiums" means amounts paid for health benefit plan insurance protection issued in this state providing reimbursement of all or a portion of medical or prescription claims in excess of a previously determined amount.~~

~~11.~~ "Member insurer" means an insurer that offers individual health benefit plans and is actively marketing individual health benefit plans in this state.

~~12. "Third-party administrator" means an entity licensed in this state which is paying or otherwise processing health benefit plan claims on behalf of an insurer.~~

~~13. "Third-party administrator premium equivalents" means health benefit plan claims paid by the third-party administrator, administrative fees charged by the third-party administrator to process health benefit plan claims paid to in-state providers for North Dakota residents, and medical stop-loss premiums.~~

26.1 - 36.7 - 02. Waiver proposal and application .

1. The commissioner may develop a proposal for an innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111 - 148 119 Stat. 124; 42 U.S.C. 1801 et seq.].

2. On behalf of the state, in accordance with the proposal developed under subsection 1, the commissioner may submit an application the to the United States department of health and human services and to the United States secretary of the treasury. The commissioner may implement any federally approved waiver.

26.1 - 36.7 - 03. Reinsurance association of North Dakota .

1. The reinsurance association of North Dakota is established as a nonprofit legal entity. As a condition of writing health insurance business in this state, an insurer that has issued or administered a group health benefit plan within the previous twelve months or is actively marketing or administering a group health benefit plan in this state shall participate in the association.

2. The association may begin operation on either:

   a. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the state's innovation waiver application has been approved by the federal government pursuant to section 1332 of the federal Patient Protection and Affordable Care Act [Pub L. 111 - 148 Stat. 124; 42 U.S.C. 1801 et seq.]; or

   b. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the Patient Protection and Affordable Care Act [Pub. L. 111 - 148] has been repealed, amended, or finally adjudicated by a court of law with jurisdiction over North Dakota as invalid or in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.

3. If the federal funding associated with an approved innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111 - 148 Stat. 124; 42 U.S.C. 1801 et seq.] is terminated or otherwise discontinued, the commissioner may cease or suspend operations of the reinsurance association of North Dakota beginning on the January first following the date the commissioner notifies the board that federal funding has been terminated or otherwise discontinued.

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26.1 - 36.7 - 04. Board of directors .

1. The association is governed by the board of directors of the reinsurance association of North Dakota.

2. The board consists of the state health officer, one senator appointed by the majority leader of the senate of the legislative assembly, one representative appointed by the speaker of the house of representatives of the legislative assembly, one individual from each of the four insurers of the association with the highest annual market share as determined by annual market share reports of health benefit plans provided by the commissioner annually, and two nonvoting, members from the insurance department appointed by the commissioner.

3. Members of the board may be reimbursed from the moneys of the association for expenses incurred by the members due to their service as board members, but may not otherwise be compensated by the association for board services.

4. The costs of conducting the meetings of the association and the board are borne by the association.

5. For cause, the commissioner may remove any board member representing one of the four insurers.

26.1 - 36.7 - 05. Powers and duties of commissioner and board .

1. The commissioner shall:

   a. Perform all functions necessary for the association to carry out the purposes of this chapter; and

   b. Approve any assessments to the insurers writing or otherwise issuing group health benefit plans.

2. The board shall:

   a. Formulate general policies to advance the purposes of this chapter;

   b. Schedule and approve independent biennial audits in order to:

      (1) Ensure claims are being processed appropriately and only include services covered by the individual health benefit plan for the contracted rates; and

      (2) Verify that the assessment base is accurate and that the appropriate percentage was used to calculate the assessment;

   c. Approve bylaws and operating rules; and

d. Provide for other matters as may be necessary and proper for the execution of the commissioner's and board's powers, duties, and obligations.

3. The commissioner and the members of the board are not liable for any obligations of the association.

26.1 - 36.7 - 06. Assessments against insurers .

1. For the purpose of providing the funds necessary to carry out the purposes of the association under this chapter, the commissioner shall assess insurers writing or otherwise issuing group health benefit plans based on the insurer's group health benefit plan premium written in this state ~~and based on third-party administrator premium equivalents in this state~~. The assessment must be paid quarterly within forty - five days of the end of the previous quarter on all earned group health benefit plan premiums ~~and third-party administrator premium equivalents~~ for the previous calendar quarter. An assessment not paid within 45 days of the end of the previous quarter shall accrue interest at twelve percent per annum on and after the due date.

2. The commissioner may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the commissioner. The commissioner may use any reasonable method of estimating an insurer's group health benefit plan premium ~~and third-party administrator premium equivalent~~ if the specific number is not reported to the commissioner. ~~The assessments are due not less than thirty days after written notice to the insurers and accrue interest at twelve percent per annum on and after the due date.~~

3. Any federal funding obtained by the association must be used to reduce the assessments of insurers writing or otherwise issuing group health benefit plans pursuant to this section.

4. Before April second of each year, the association shall determine and report to the board the association's net gains or net losses for the previous calendar year.

5. Before April sixteenth of each year, the association shall provide an estimate to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

6. Before May second of each year, the board may provide a recommendation to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

7. An insurer may apply to the commissioner for a deferral of all or part of an assessment imposed by the association under this section. The commissioner may defer all or part of the assessment if the commissioner determines the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited from reinsuring any person through the association until such time as the insurer pays the assessments.

8. The board shall use any surplus, including any interest earned on the surplus, to:

a. Offset future losses;

b. Reduce future assessments to insurers writing or otherwise issuing group health benefit plans; or

c. Pay off a line of credit issued pursuant to section 26.1 - 36.7 - 07 .

9. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the commissioner may use any power granted to the commissioner by this title to collect any unpaid assessment.

26.1 - 36.7 - 07. Bank of North Dakota line of credit .

The Bank of North Dakota shall extend to the association a line of credit not to exceed twenty - five million dollars. The association shall repay the line of credit from assessments against insurers writing or otherwise issuing group health benefit plans in this state or from other funds appropriated by the legislative assembly. The association may access the line of credit to the extent necessary to provide reimbursements to member insurers as required by this chapter.

26.1 - 36.7 - 08. Reinsurance .

For claims of an insured which total one hundred thousand dollars to one million dollars incurred per plan year, a member insurer must be reinsured by the association at seventy - five

percent of the member insurer's responsibility for claims incurred by the insured pursuant to the terms of an individual's nongrandfathered individual health benefit plan.

26.1 - 36.7 - 09. Reimbursement of member insurer .

For nongrandfathered individual health benefit plans issued or renewed after the November second preceding to the date the association begins operation, a member insurer may seek reimbursement from the association and the association shall reimburse the member insurer pursuant to the provisions of section 26.1 - 36.7 - 08 to the extent the claims incurred by the insured and submitted by the member insurer to the association are eligible for coverage and reimbursement according to the terms of insured's individual health benefit plan.

26.1 - 36.7 - 10. Rulemaking .

The commissioner may adopt rules for the implementation and administration of this chapter.

SECTION 2. AMENDMENT. Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under subsection 1 of section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

SECTION ~~2~~3. EMERGENCY. This Act is declared to be an emergency measure.

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Prepared by the North Dakota
Insurance Department
January 15, 2019

PROPOSED AMENDMENTS TO BILL NO. 1106

Page 1, line 3, after the semicolon, insert "to provide an appropriation to finance the reinsurance association of North Dakota;"

Page 2, line 11, remove ", single employer"

Page 2, line 11, remove "not regulated by the state"

Page 3, line 14, after the first comma insert "and"

Page 3, line 14, remove ", a self-funded multiple employer welfare"

Page 3, remove lines 15 and 16

Page 3, line 17, remove "benefits which is subject to state insurance regulation"

Page 3, line 18, remove ""Medical stop-loss premiums" means amounts paid for health benefit plan insurance"

Page 3, remove lines 19-20

Page 3, remove lines 23-28

Page 6, line 9, remove "and based on third-party administrator"

Page 6, line 10, remove "premium equivalents in this state"

Page 6, line 12, remove "and third-party administrator premium equivalents"

Page 6, line 13, after the period insert "An assessment not paid within 45 days of the end of the previous quarter shall accrue interest at twelve percent per annum on and after the due date. The commissioner may only assess an insurer under this section if the amount appropriated by the legislative assembly is less than the amount needed to reimburse insurers under the provisions of 26.1-36.7-09."

Page 6, line 17, remove "and third-party administrator premium"

Page 6, line 18, remove "equivalent"

Page 6, line 18, remove "The"

Page 6, remove lines 19 and 20.

Page 8, after line 12, insert:

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $40,000,000, or so much of the sum as may be necessary, to the North Dakota Insurance Department for the purpose of reimbursing member insurers of the reinsurance association of North Dakota pursuant to section 26.1-36.7-09.

Page 8, line 13, replace "**2**" with "**3"**

Renumber accordingly

19.8068.01000

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Sixty-sixth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1106

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

A BILL for an Act to create and enact chapter 26.1-36.7 of the North Dakota Century Code, relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to provide an appropriation to finance the reinsurance association of North Dakota; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1 - 36.7 - 01. Definitions .

For purposes of this chapter, unless the context otherwise requires:

1. "Association" means the reinsurance association of North Dakota.
2. "Board" means the board of directors of the reinsurance association of North Dakota.
3. "Earned group health benefit plan premiums" means premium owed to an insurer for a period of time during which the insurer has been liable to cover claims for an insured pursuant to the terms of a group health benefit plan issued by the insurer.
4. "Future losses" means reserves for claims incurred but not reported.
5. "Group health benefit plan" means a health benefit plan offered through an employer, or an association of employers, to more than one individual employee.
6. "Health benefit plan" means any hospital and medical expense-incurred policy or certificate, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care.
   a. "Health benefit plan" does not include any one or more of the following:
      (1) Coverage only for accident or disability income insurance, or any combination of the two;

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(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workforce safety and insurance or similar workers' compensation insurance;

(5) Automobile medical payment insurance;

(6) Credit-only insurance;

(7) Coverage for onsite medical clinics;

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits; and

(9) Self-funded~~, single employer~~ plans ~~not regulated by the state~~.

b. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination of this care; and

(3) Other similar limited benefits specified under federal regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104 - 191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; and any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplement health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 13295ss(g)(1)];

(2) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(3) Similar supplemental coverage provided under a group health plan.

7. "Individual health benefit plan" means a health benefit plan offered to individuals, other than in connection with a group health benefit plan. The term does not include short-term, limited-duration health insurance as defined by section 26.1 - 36 - 49 .

8. "Insured" means an individual who is insured by a health benefit plan.

9. "Insurer" means an entity authorized to write health benefit plans or that provides health benefit plans in the state. The term includes an insurance company as defined in section 26.1 - 02 - 01, a nonprofit health service organization, a fraternal benefit society, and a health maintenance organization~~, a self-funded multiple employer welfare arrangement, a reinsurer that reinsures health insurance in this state, a third-party administrator, and any other entity providing health insurance coverage or health benefits which is subject to state insurance regulation~~.

~~10. "Medical stop-loss premiums" means amounts paid for health benefit plan insurance protection issued in this state providing reimbursement of all or a portion of medical or prescription claims in excess of a previously determined amount.~~

~~11.~~ "Member insurer" means an insurer that offers individual health benefit plans and is actively marketing individual health benefit plans in this state.

~~12. "Third-party administrator" means an entity licensed in this state which is paying or otherwise processing health benefit plan claims on behalf of an insurer.~~

~~13. "Third-party administrator premium equivalents" means health benefit plan claims paid by the third-party administrator, administrative fees charged by the third-party administrator to process health benefit plan claims paid to in-state providers for North Dakota residents, and medical stop-loss premiums.~~

26.1 - 36.7 - 02. Waiver proposal and application .

1. The commissioner may develop a proposal for an innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111 - 148 119 Stat. 124; 42 U.S.C. 1801 et seq.].

2. On behalf of the state, in accordance with the proposal developed under subsection 1, the commissioner may submit an application the to the United States department of health and human services and to the United States secretary of the treasury. The commissioner may implement any federally approved waiver.

26.1 - 36.7 - 03. Reinsurance association of North Dakota .

1. The reinsurance association of North Dakota is established as a nonprofit legal entity. As a condition of writing health insurance business in this state, an insurer that has issued or administered a group health benefit plan within the previous twelve months or is actively marketing or administering a group health benefit plan in this state shall participate in the association.

2. The association may begin operation on either:

   a. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the state's innovation waiver application has been approved by the federal government pursuant to section 1332 of the federal Patient Protection and Affordable Care Act [Pub L. 111 - 148 Stat. 124; 42 U.S.C. 1801 et seq.]; or

   b. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the Patient Protection and Affordable Care Act [Pub. L. 111 - 148] has been repealed, amended, or finally adjudicated by a court of law with jurisdiction over North Dakota as invalid or in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.

3. If the federal funding associated with an approved innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111 - 148 Stat. 124; 42 U.S.C. 1801 et seq.] is terminated or otherwise discontinued, the commissioner may cease or suspend operations of the reinsurance association of North Dakota beginning on the January first following the date the commissioner notifies the board that federal funding has been terminated or otherwise discontinued.

26.1 - 36.7 - 04. Board of directors .

1. The association is governed by the board of directors of the reinsurance association of North Dakota.
2. The board consists of the state health officer, one senator appointed by the majority leader of the senate of the legislative assembly, one representative appointed by the speaker of the house of representatives of the legislative assembly, one individual from each of the four insurers of the association with the highest annual market share as determined by annual market share reports of health benefit plans provided by the commissioner annually, and two nonvoting, members from the insurance department appointed by the commissioner.
3. Members of the board may be reimbursed from the moneys of the association for expenses incurred by the members due to their service as board members, but may not otherwise be compensated by the association for board services.
4. The costs of conducting the meetings of the association and the board are borne by the association.
5. For cause, the commissioner may remove any board member representing one of the four insurers.

26.1 - 36.7 - 05. Powers and duties of commissioner and board .

1. The commissioner shall:
   a. Perform all functions necessary for the association to carry out the purposes of this chapter; and
   b. Approve any assessments to the insurers writing or otherwise issuing group health benefit plans.
2. The board shall:
   a. Formulate general policies to advance the purposes of this chapter;
   b. Schedule and approve independent biennial audits in order to:
      (1) Ensure claims are being processed appropriately and only include services covered by the individual health benefit plan for the contracted rates; and
      (2) Verify that the assessment base is accurate and that the appropriate percentage was used to calculate the assessment;
   c. Approve bylaws and operating rules; and

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d. Provide for other matters as may be necessary and proper for the execution of the commissioner's and board's powers, duties, and obligations.

3. The commissioner and the members of the board are not liable for any obligations of the association.

26.1 - 36.7 - 06. Assessments against insurers .

1. For the purpose of providing the funds necessary to carry out the purposes of the association under this chapter, the commissioner shall assess insurers writing or otherwise issuing group health benefit plans based on the insurer's group health benefit plan premium written in this state ~~and based on third-party administrator premium equivalents in this state~~. The assessment must be paid quarterly within forty - five days of the end of the previous quarter on all earned group health benefit plan premiums ~~and third-party administrator premium equivalents~~ for the previous calendar quarter. An assessment not paid within 45 days of the end of the previous quarter shall accrue interest at twelve percent per annum on and after the due date. The commissioner may only assess an insurer under this section if the amount appropriated by the legislative assembly is less than the amount needed to reimburse insurers under the provisions of 26.1-36.7-09.

2. The commissioner may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the commissioner. The commissioner may use any reasonable method of estimating an insurer's group health benefit plan premium ~~and third-party administrator premium equivalent~~ if the specific number is not reported to the commissioner. ~~The assessments are due not less than thirty days after written notice to the insurers and accrue interest at twelve percent per annum on and after the due date.~~

3. Any federal funding obtained by the association must be used to reduce the assessments of insurers writing or otherwise issuing group health benefit plans pursuant to this section.

4. Before April second of each year, the association shall determine and report to the board the association's net gains or net losses for the previous calendar year.

5. Before April sixteenth of each year, the association shall provide an estimate to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

6. Before May second of each year, the board may provide a recommendation to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

7. An insurer may apply to the commissioner for a deferral of all or part of an assessment imposed by the association under this section. The commissioner may defer all or part of the assessment if the commissioner determines the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited from reinsuring any person through the association until such time as the insurer pays the assessments.

8. The board shall use any surplus, including any interest earned on the surplus, to:

a. Offset future losses;

b. Reduce future assessments to insurers writing or otherwise issuing group health benefit plans; or

c. Pay off a line of credit issued pursuant to section 26.1 - 36.7 - 07 .

9. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the commissioner may use any power granted to the commissioner by this title to collect any unpaid assessment.

26.1 - 36.7 - 07. Bank of North Dakota line of credit .

The Bank of North Dakota shall extend to the association a line of credit not to exceed twenty - five million dollars. The association shall repay the line of credit from assessments against insurers writing or otherwise issuing group health benefit plans in this state or from other funds appropriated by the legislative assembly. The association may access the line of credit to the extent necessary to provide reimbursements to member insurers as required by this chapter.

26.1 - 36.7 - 08. Reinsurance .

For claims of an insured which total one hundred thousand dollars to one million dollars incurred per plan year, a member insurer must be reinsured by the association at seventy - five

percent of the member insurer's responsibility for claims incurred by the insured pursuant to the terms of an individual's nongrandfathered individual health benefit plan.

26.1 - 36.7 - 09. Reimbursement of member insurer .

For nongrandfathered individual health benefit plans issued or renewed after the November second preceding to the date the association begins operation, a member insurer may seek reimbursement from the association and the association shall reimburse the member insurer pursuant to the provisions of section 26.1 - 36.7 - 08 to the extent the claims incurred by the insured and submitted by the member insurer to the association are eligible for coverage and reimbursement according to the terms of insured's individual health benefit plan.

26.1 - 36.7 - 10. Rulemaking .

The commissioner may adopt rules for the implementation and administration of this chapter.

SECTION 2. APPROPRIATION. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $40,000,000, or so much of the sum as may be necessary, to the North Dakota Insurance Department for the purpose of reimbursing member insurers of the reinsurance association of North Dakota pursuant to section 26.1-36.7-09.

SECTION ~~2~~3. EMERGENCY. This Act is declared to be an emergency measure.

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NORTH DAKOTA

1332 WAIVER ANALYSIS

NovaRest
ACTUARIAL CONSULTING

- Partnering with state insurance regulators since 2002
- Employees some of the most senior actuaries in the industry
- Experience working on Section 1332 Waiver and reinsurance in other states
- Developed the micro-simulation NovaRest Market Migration Model

INTRODUCTION

- Use of the presentation:
  - We are providing this presentation solely for the use of supporting the State of North Dakota's 1332 Waiver analysis. The intended users of this presentation are the State of North Dakota Departments. Distribution of this presentation and/or report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by us and is done at their own risk.
  - There were a number of limitations in the data received and the availability of more accurate assumptions. Please see the full report for more details

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REINSURANCE

a) Impact and what it covers
b) Federal Funding
c) Assessment needed

REINSURANCE

- Impact
  - Lower Premiums
  - Protectscarriers from unpredictable large claims
- What does it cover?
  - 75% of claims between
  - $100,000
  - Up to $1 million

FEDERAL FUNDING

ADVANCE PREMIUM TAX CREDIT (APTC)

Advance Premium Tax Credit "APTC" or "PTC" – the federal government finances the difference between the second lowest Silver plan in an area and affordable premium levels for families that have a family income between 133% and 400% of the federal poverty level (FPL).

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2020 AGE 40 NON-SMOKER PREMIUM RATES FOR THE SECOND LOWEST SILVER PLAN.

Second Lowest Silver Monthly Premium AGE 40 Non-smoker		
	2020	
[illegible]	[illegible]	With $100,000 Attachment Point
1	$412.42	$329.94
2	$412.42	$329.94
3	$503.99	$403.20
4	$412.42	$329.94

FEDERAL FUNDING
EXCHANGE (MARKETPLACE) USER FEE

The Exchange User Fee is a federally mandated fee used to fund the federal and state exchanges. Because North Dakota did not establish a state-based exchange, the exchange is facilitated by the federal government. The fee is calculated as a percent of on-exchange premiums. Although the fee is calculated on on-exchange business, it is included in the premium for all non-grandfathered on-and-off exchange ACA business. The current fee rate in the individual market is 3.5%.

"HHS announces applicable user fees." https://www.bcbsm.com/health-care-reform/reform-alerts/hhs-announces-applicable-user-fees1.html

"HHS Notice of Benefit and Payment Parameters for 2019." https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2019

ASSESSMENT NEEDED

The federal funding from the APTC less the exchange user fee will not be sufficient to pay for the North Dakota reinsurance program. The short fall can be funded by an assessment against group health insurance premium and third party administrators (TPAs) premium equivalent. For self-insured large group plans, the large groups use TPAs to pay claims. The cost of claims paid plus administrative charges would be the equivalent of the premiums for large self-insured groups.

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REINSURANCE
2020 PROJECTION

The reinsurance payable under the Waiver is estimated to be between $26 million and $48 million in 2020.

Reinsurance and Funding, $100,000 Attachment Point											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Total Reinsurance	$47,755,003	$50,477,038	$53,354,230	$56,395,421	$59,609,960	$63,007,727	$66,599,168	$70,395,320	$74,407,854	$78,649,101	$83,132,100
Federal Funding	$25,766,844	$27,235,554	$28,787,981	$30,428,895	$32,163,343	$33,996,653	$35,934,462	$37,982,727	$40,147,742	$42,436,163	$44,855,025
Funding Needed	$21,988,159	$23,241,484	$24,566,249	$25,966,525	$27,446,617	$29,011,074	$30,664,706	$32,412,594	$34,260,112	$36,212,938	$38,277,075

FEDERAL FUNDING
2020 PROJECTION

	Reinsurance and Funding $100,000 Attachment Point
	2020
Total Reinsurance	$47,755,003
Federal Funding	$25,766,844
Funding Needed	$21,988,159
Percent of group and 3%	1.50%

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North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
JON GODFREAD, COMMISSIONER

North Dakota Insurance Department Proposed 1332 Waiver Analysis Report

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I. Executive Summary

About the Model Team

NovaRest Actuarial Consulting (NovaRest) partnered with the North Dakota Insurance Department (Department) to develop a plan to stabilize North Dakota's (State) individual health insurance market using a Section 1332 Waiver (1332 Waiver or Waiver). NovaRest has been helping state insurance regulators meet their regulatory responsibilities since 2002. NovaRest employs some of the most senior actuaries in the industry. The NovaRest actuaries are experts in the Affordable Care Act (ACA), modeling and project management. In addition, NovaRest has experience working on Section 1332 Waiver and reinsurance projects.

The primary tool that NovaRest used for the 1332 Waiver application analysis is the NovaRest Market Migration Model (NRMM). The NRMM is an actuarial tool for analyzing the impact of market migration, take-up and lapse rates resulting from proposed legislative changes.

Intent of This Report

The NovaRest team was hired by the North Dakota Insurance Department to provide Section 1332 Waiver analysis. The goal is to analyze alternate waiver strategies that will lower premiums for consumers, improve market stability, increase consumer choice and meet federal requirements. This report describes the analysis done and the conclusions drawn concerning the North Dakota 1332 Waiver alternatives.

This report is intended to facilitate the design of the North Dakota 1332 Waiver and aid in the decision-making process around the 1332 Waiver. It may be used in part or in its entirety for the ultimate waiver application to CMS, although it is not intended to fulfill all of the requirements of the waiver application. This report is for the use of North Dakota to aid in its Waiver development and is not appropriate for other uses.

The ultimate Waiver application will be required to cover a number of additional topics including the coordination of the reinsurance mechanism with the federal Risk Adjustment program.

North Dakota Waiver

It is North Dakota's desire that its 1332 Waiver will reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims. The proposal is to accomplish this using a reinsurance mechanism to help fund high cost claims. The result therefore, should be more individuals staying in the market and more insurers being willing to write policies in North Dakota counties. Both of these will help stabilize the individual health insurance market in North Dakota.

In addition to the proposed 1332 Waiver, the State would like to consider a North Dakota state based health insurance plan (North Dakota Plan) that would be sold by the current insurance carriers. The State plan would include all of the essential health benefits with a higher cost sharing and a reduced premium.

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Reinsurance

Under its 1332 Waiver, North Dakota would implement a reinsurance mechanism that would be similar to a traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. The reinsurance is estimated to reduce premiums between 10% and 20% in 2020 compared to the baseline premium (without the waiver) depending on the attachment point chosen. Due to the reduced premium the membership in the 2020 individual market would increase 1% compared to the baseline without the waiver.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. The approach of an "invisible" reinsurance allows enrollees to remain in the individual market with their current plan and carrier, but a portion of their claims are reimbursed by the reinsurance pool. The enrollee is not aware that their claim is being paid via the reinsurance pool meaning there is no effect on the enrollee as the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

For 2020, the proposed reinsurance program would cover 75% of paid claims between the attachment point and $1,000,000. The attachment points being considered are $100,000 and $200,000. This level of reinsurance was assumed in the future projections, but North Dakota may have the flexibility to change the parameters in the future.

The reinsurance payable under the Waiver is estimated to be between $26 million and $48 million in 2020. It will increase over the next ten years due to medical inflation unless the reinsurance parameters are modified. The actual amount that will be paid under the reinsurance will depend on submitted claims. Based on NovaRest projections the reinsurance paid in future years will be approximately as shown in Table 1.

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Table 1 Reinsurance Paid by Year											
Attachment Point:	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**	**2028**	**2029**	**2030**
$100,000	$47,755,003	$50,477,038	$53,354,230	$56,395,421	$59,609,960	$63,007,727	$66,599,168	$70,395,320	$74,407,854	$78,649,101	$83,132,100
$200,000	$26,726,151	$28,249,542	$29,859,765	$31,561,772	$33,360,793	$35,262,358	$37,272,313	$39,396,834	$41,642,454	$44,016,074	$46,524,990

It was decided that the use of CHAND was too disruptive to the individuals and families.

Once the decision was made to structure the 1332 Waiver as an invisible reinsurance mechanism, it was proposed that CHAND administer the reinsurance program. After discussions internally and externally, the Insurance Department decided that for conflict of interest reasons it was not appropriate to use CHAND. CHAND was staffed with Blue Cross Blue Shield of North Dakota employees and it was considered inappropriate for it to administer reinsurance for itself and the other carriers.

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North Dakota Plan

North Dakota intends to offer a state specific plan similar to the one proposed in Idaho. The intent of the North Dakota Plan is to have an affordable option for healthier individuals and to inject healthier risk into the single risk pool. Healthier individuals will pay a reduced premium.

The North Dakota Plan will cover all of the essential health benefits (EHBs) but will have higher cost sharing compared to the ACA metal level plans. The plans are still guaranteed issue, but in the event of a coverage lapse, carriers would be allowed to implement a waiting period before pre-existing conditions would be covered.

Meeting the 1332 Waiver Guardrails

CMS has determined four "guardrails" that must be met before a 1332 Waiver can be approved.

As this report shows, the proposed Waiver will meet the required guardrail conditions:

- The Waiver does not make alterations to the required scope of benefits offered in the insurance market in North Dakota and will result in an increase in the number of individuals with coverage that meets the ACA's Essential Health Benefits requirements.
- The Waiver will reduce premium and increase affordability.
- The Waiver will cover more individuals in North Dakota than would be covered absent the Waiver.
- The Waiver will not result in increased spending, administrative, or other expenses to the federal government.

Funding

A portion of the funding for the reinsurance would come from the federal government due to the reduction in advanced premium tax credits (APTC) being passed to North Dakota. The reduction in premiums for the second lowest Silver plan in each region directly reduces the APTC for the individuals eligible for APTCs.

The additional funding required by the reinsurance program would come from assessments against the group health insurance market and Third-Party Administrators (TPAs) that pay claims for self-insured employers. NovaRest projects the APTC pass through in 2020 to be between $14 million and $26 million and the assessment requirement to be between $12 million and $22 million. The 2020 assessment would be between 1% and 1.5% of group health insurance premium and TPA premium equivalent (claim paid plus administrative fees). These percentages are higher than the current estimates in order to provide a cushion in the first year of operation.

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In Conclusion

The North Dakota Waiver would reduce premiums and provide a low-cost alternative to healthier individuals. This would result in more ACA membership and a more stable individual market. It would also protect carriers from unpredictable high cost claims and make the claims costs more predictable. This would result in carriers being more willing to participate in the North Dakota individual insurance market.

The reinsurance would be funded by a combination of federal reduction in APTCs and assessments. The assessments would be against the group health insurance market and TPAs that pay claims for self-insured employers. Since the group insured market and self-insured employers are much larger than the individual market, the assessment needed to stabilize the individual market would be spread over a much larger base.

In addition to the Waiver, the lower premium charged to healthy individuals under the North Dakota Plan will provide an alternative when rate increases result in individuals and families dropping coverage. We expect this will lead to a larger insured population and a more stable market.

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II. Background

Section 1332 Waivers

Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.[1]

For 1332 Waivers, there are specific guardrails that the proposed plan must meet including:

Comprehensive Coverage – 1332(b)(1)(A)
The proposed Waiver cannot make alterations to the required scope of benefits offered in the insurance market in North Dakota and cannot result in a decrease in the number of individuals with coverage that meet the ACA's Essential Health Benefits requirements.

Affordability – 1332(b)(1)(B)
The proposed cannot decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The Waiver cannot result in any decrease in affordability for individuals.

Scope of Coverage – 1332(b)(1)(C).
The proposed will provide coverage to at least a comparable number of residents as would be provided coverage absent the Waiver in North Dakota.

Federal Deficit Neutrality – 1332(b)(1)(D)
The proposed waiver cannot result in increased spending, administrative, or other expenses to the federal government.

When examining the options available to stabilize the individual health insurance market in North Dakota each of these guardrails must be met.

[3] "Section 1332:State Innovation Waivers." The Center for Consumer Information & Insurance Oversight. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html

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Current Environment

Current State of the Affordable Care Act (ACA)

As federal healthcare reform efforts continue to face significant challenges, the ACA continues to strain North Dakota's individual insurance market. Nationally, the cost of health care is still a major barrier to obtaining coverage. According to Kaiser Family Foundation, nationally the unsubsidized premium for the lowest-cost bronze plan is increasing an average of 17% between 2017 and 2018, the lowest-cost silver plan is increasing an average of 32%, and the lowest-cost gold plan is increasing an average of 18%.[2] Since 2014, premiums in North Dakota individual health insurance market have steadily increased. Nationally, ACA market conditions have resulted in carriers leaving the market or reducing the counties in which they offer plans and North Dakota is making efforts to prevent that from happening.

Under the ACA if a family income falls between 100% and 400% of the FPL, they may be eligible for cost sharing and premium subsidies.[3] Cost sharing reductions (CSR) lower the amount of cost sharing that an individual pays out of pocket. The CSR's are available to those between 100% to 250% of the federal poverty line, with families with lower incomes paying less out-of-pocket. APTCs reduce the premium that a family pays based on their income level and are available up to 400% of FPL. Individuals purchasing the silver level plan in the region that has the second lowest premium only have to pay an affordable percentage of their income. The percentage is determined by their income level.

North Dakota Characteristics

North Dakota is one of the fastest growing states in the country. According to Census.gov, North Dakota's total population increased by 12.3% from April 1, 2010 to July 1, 2017, which is only behind the District of Columbia and Texas.[4] The population increase over the same period for the entire United States is 5.5%.[5] As of July 1, 2017, the North Dakota population is estimated to be 755,393.[6] The table below provides a breakdown of the population demographics.[7]

[2] "How premiums are Changing in 2018." Kaiser Family Foundation. November 29, 2017. https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/

[3] "2018 Federal Poverty Level". Obamacare.net. https://obamacare.net/2018-federal-poverty-level/

[4] "Population, percent change – April 1, 2010 (estimates base) to July 1, 2017, (V2017)". United States Census Bureau. https://www.census.gov/quickfacts/geo/chart/nd/PST120217#viewtop

[5] "Quickfacts: North Dakota". United States Census Bureau. https://www.census.gov/quickfacts/fact/table/nd,US/PST045217

[6] Ibid.

[7] Ibid.

Table 2 Population by Age	
Under 20 years	197,320
20 to 24 years	64,891
25 to 29 years	60,594
30 to 34 years	53,659
35 to 39 years	48,502
40 to 44 years	39,644
45 to 49 years	39,436
50 to 54 years	42,858
55 to 59 years	49,436
60 to 64 years	45,845
65 years and over	113,208
Total	**755,393**

North Dakota's GDP of $55.5 billion ranks 45th in the US.[8] The growth rate in 2017 was 1% in North Dakota compared with 2.1% for the US. Enterprises with less than 100 employees, represent 80% of the total number of establishments in North Dakota and also employ 40% of the total employed.[9]

The median household income in 2016 was $59,114, which is slightly higher than the median household income for the entire United States, which was $55,322. The income distribution for the North Dakota population, in 2016 inflation adjusted dollars, is shown in the table below:[10]

[8] "GDP for North Dakota." U.S. Bureau of Economic Analysis. May 4, 2018. https://apps.bea.gov/regional/bearfacts/action.cfm.
[9] "2015 SUSB Annual Data Tables by Establishment Industry." United States Census Bureau. January 2018. https://www.census.gov/data/tables/2015/econ/susb/2015-susb-annual.html
[10] "2012-2016 American Community Survey 5-Year Estimates." United States Census Bureau. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_5YR_DP03&prodType=table

Table 3 Population by Income		
	Estimate	**Percent**
Total Households	**305,163**	**100%**
Less than $10,000	18,488	6.1%
$10,000 to $14,999	13,946	4.6%
$15,000 to $24,999	26,735	8.8%
$25,000 to $34,999	29,627	9.7%
$35,000 to $49,999	41,423	13.6%
$50,000 to $74,999	56,626	18.6%
$75,000 to $99,999	42,372	13.9%
$100,000 to $149,999	45,763	15.0%
$150,000 to $199,999	15,324	5.0%
$200,000 or more	14,859	4.9%
Median household income (dollars)	**59,114**	
Mean household income (dollars)	**78,828**	

Per the most recent U.S. Census Bureau estimates, the number of persons in poverty in North Dakota is 10.7%, which is lower than the estimated 12.7% for the entire United States.[11] North Dakota is the 47th most populated state in the US[12], making the population density of North Dakota among the lowest 5 states in the US, with around 11 residents per square mile.[13] This makes providing adequate access to health care difficult. A biennial report by the University of North Dakota School of Medicine and Health Sciences Advisory Council indicated there is a shortage of providers particularly primary care physicians, especially in the rural and western parts of North Dakota.[14] They indicate the problem is driven by a lack of providers and more importantly by a higher concentration of providers in the more urbanized areas of the state.

North Dakota did not establish its own exchange, so enrollments are completed via HealthCare.gov.

North Dakota was one of only two states where insurers were not allowed to add the cost of cost-sharing reductions to premiums when they were defunded.[15] This prompted Medica to leave the exchange at the end of 2017 and left only Blue Cross Blue Shield of North Dakota (Noridian) and Sanford Health Plan on the exchange for the individual market in 2018.

[11] "Quickfacts: North Dakota." United States Census Bureau. https://www.census.gov/quickfacts/fact/table/nd,US/PST045217
[12] Ibid.
[13] "Population density in the U.S. by federal states including the District of Columbia in 2017." Statista. https://www.statista.com/statistics/183588/population-density-in-the-federal-states-of-the-us/
[14] "Fourth Biennial Report, Health Issues for the State of North Dakota." UND School of Medicine and Health Sciences. 2017. https://med.und.edu/alumni-community-relations/_files/docs/fourth-biennial-report-summary.pdf
[15] Norris, Louise. "North Dakota health insurance marketplace: history and news of the state's exchange." HealthInsurance.org. August 27, 2018. https://www.healthinsurance.org/north-dakota-state-health-insurance-exchange/#enrollment

Therefore, individuals looking for coverage on the exchange only had two options, Blue Cross and Blue Shield of North Dakota and Sanford Health Plan. In 2017, Medica provided coverage for 3,073 individuals of the 20,691 on North Dakota's exchange.[16]

The approved 2018 average rate increases for the individual market, including off-exchange are included in the Table 4 below.[17]

Table 4
North Dakota 2018 Final Average Individual Market Rate Increases by Company

Company	2018 Rate Increase
Blue Cross Blue Shield of North Dakota	23.15%
Medica Health Plans	18.33%
Sanford Health Plan	7.86%

For 2019, carriers could add the cost of the federally defunded CSRs to premiums. Medica is proposing to offer plans on the exchange in 2019. The proposed 2019 average rate increases for the individual market, including off exchange, are included in Table 5 below.[18]

Table 5
North Dakota 2019 Proposed Average Individual Market Rate Increases by Company

Company	2019 Rate Increase
Blue Cross Blue Shield of North Dakota	5.79%
Medica Health Plans	29.32%
Sanford Health Plan	23.25%

[16] "Medica to leave ND health insurance exchange in 2018." Post-Bulletin Company. September 28, 2017. http://www.postbulletin.com/news/business/medica-to-leave-nd-health-insurance-exchange-in/article_0190e224-ff87-55ac-9954-8296518786a9.html

[17] North Dakota Rate Review Submissions. https://ratereview.healthcare.gov/. Note: Rate increases are provided at the product level. Product rate increases are weighted by projected membership in the URRT to determine the average carrier increases.

[18] Ibid.

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The three North Dakota carriers provided NovaRest with data for each individual as of December 31, 2017 and May 31, 2018. Based on the data received, the individual insurance market membership, average premium and total premium are shown in the following Table 6. Since the premium is the average based on the age mix in the category, the premiums are not totally comparable, but give a sense of what individuals are paying in each market segment.

Table 6
Current North Dakota Individual Market

Membership Active on Census Date			**December 31, 2017**	**May 31, 2018**
	On Exchange			
		APTC	15,588	17,707
		Non-APTC	3,101	3,936
	Total On Exchange		18,689	21,643
	Off Exchange		20,379	17,902
	Total ACA		39,068	39,545
	Transitional		924	0
	Grandfathered		6,381	6,291
	Total Individual Market		46,373	45,836
Average Premium				
	On Exchange			
		APTC Premium Rate	$407 .06	$462.90
		Non-APTC	$371.06	$420.15
	Total On Exchange		$401.08	$455.12
	Off Exchange		$406.75	$493.90
	Total ACA		$404.04	$472.68
	Transitional		$261.57	
	Grandfathered		$451.47	$471.05
	Total Individual Market		$407.73	$472.45
Total Annual Premium				
	Total ACA		$189,421,176	$224,304,283
	Transitional		$2,900,288	$0
	Grandfathered		$34,570,284	$35,561,179
	Total Individual Market		$226,891,748	$259,865,462

The Federal Poverty Level (FPL) is utilized to determine if a citizen is eligible for subsidies to off-set the cost of their monthly premiums. The FPL is also used to determine eligibility for Medicaid, Children's Health Insurance Program (CHIP) and North Dakota Children's Special Health Services (CSHS). In 2017, 211,510 individuals (28% of the population) were under 200% FPL in North Dakota.[19]

The ACA provided federal funding to states that expanded their Medicaid programs. This expansion provided coverage to many who could not afford health insurance premiums. North Dakota opted to expand Medicaid to 138% FPL utilizing federal funding. Low-income adults without dependent children became eligible for Medicaid in North Dakota in 2014. Along with most states the cost of expanding Medicaid has been higher than expected in North Dakota. According to Louise Norris, "Sanford reported that the cost of claims among the Medicaid expansion group in 2014 averaged $1,215 per member, per month – far higher than the $352 average for their commercially-insured members."[20] The first three years of the program the federal government was responsible paying the cost for the new population. In 2017, North Dakota was responsible for paying 5 percent of the cost. Assuming no major changes in the coverage qualifications or other federal changes, the state will be required to pay 10 percent of the costs in 2020.[21]

Previously, residents of North Dakota who are unable to find adequate health insurance coverage in the private market due to medical conditions or who have lost their employer-sponsored group health insurance, were eligible for Comprehensive Health Association of North Dakota (CHAND). If an individual was denied health insurance coverage, insurance carriers were required to inform that individual about CHAND. Individual premiums fund approximately one-half to two-thirds of the program, not to exceed 135% of premiums charged in the state of North Dakota for similar coverage.[22] The balance is covered by assessments to health insurance carriers that write $100,000 in annual premiums on behalf of residents of North Dakota. Additional dollars may also come through federal grants. Once the ACA was implemented with its guaranteed issue requirement, CHAND was unable to gain new membership, but prior members were allowed to remain in CHAND.

[19] "Medicaid In North Dakota", Kaiser Family Foundation, June 2017, http://files.kff.org/attachment/fact-sheet-medicaid-state-ND

[20] Norris, Louise. "North Dakota and the ACA's Medicaid expansion." August 27, 2018. https://www.healthinsurance.org/north-dakota-medicaid/

[21] Ibid.

[22] The Comprehensive Health Association of North Dakota (CHAND). http://www.chand.org/

[23] Ibid.

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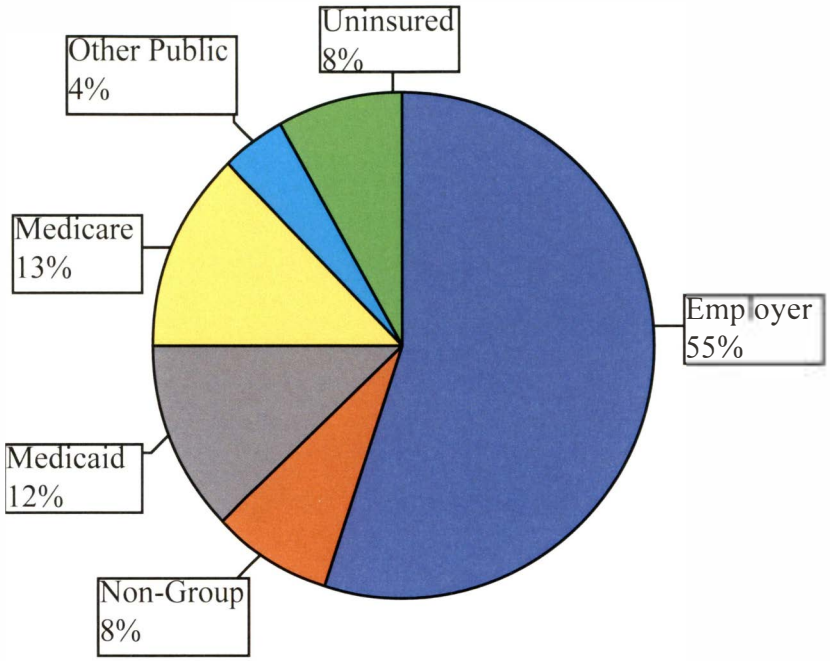
A breakdown of the health insurance coverage in North Dakota is shown below[24]:

2016 North Dakota Health Coverage



As evident from the above, North Dakota has seen a lot of change in recent years. It expanded Medicaid, had a carrier leave the Exchange, and saw significant change in population first as the oil and gas industry grew and then as it lessened. Also, a significant number of individuals have moved from the Grandfathered and Transitional policies to the ACA market. All of these changes have resulted in unusual patterns of enrollment in North Dakota's recent history.

[24] "Health Insurance Coverage of the Total Population." Henry J Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22north-dakota%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D . "Other Public" includes those covered under the military of Veterans Administration.

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III. NovaRest Analysis

Goals of NovaRest's Analysis

NovaRest's analysis is intended to be used to understand and predict the impact of implementing various strategies to stabilize the individual health insurance market in North Dakota. The plan is to implement a 1332 Waiver for the 2020 plan year. The goal of the Waiver is to increase affordability, competition, and consumer choice. This analysis will allow the State to understand the impact and funding requirements of the options under consideration, thus allowing the State to determine which option to implement.

The options under consideration were:

1. The modification of North Dakota's current high-risk pool, N.D.C.C. ch. 26.1-08 & N.D. Admin. Code ch. 45-06-02.1, (known as the Comprehensive Health Association of North Dakota or "CHAND"; hereinafter "CHAND") to allow a greater number of high-risk North Dakotans to obtain their health insurance from CHAND.
2. Modify CHAND into an invisible high-risk pool where high-risk North Dakotans can obtain their health insurance.
3. Create a reinsurance waiver that would create an invisible high-risk pool independent of CHAND.
4. Implementing a health insurance strategy similar to that implemented by the state of Idaho.

Decisions Made Concerning North Dakota's 1332 Waiver

Reinsurance

It was decided that the North Dakota reinsurance mechanism would be a traditional reinsurance program with an attachment point, coinsurance amount, and a maximum paid claims level rather than a disease-based reinsurance. The pros and cons of each are discussed in Appendix A. This program will be similar to the temporary federal reinsurance program with different attachment points and coinsurance.

There was much discussion as to whether the reinsurance program would be implemented on a prospective or retrospective basis. The final decision was to use a retrospective approach. The pros and cons of each are discussed in Appendix B.

Use of CHAND

Using CHAND for the reinsurance had been considered. CHAND already had the ability to cover high-cost individuals. There was an administrative system in place and staff that understood the process.

Also, if CHAND were used, individuals would be moved from their current plan that they were familiar with, to the CHAND plans. This may result in some family members being in CHAND and some in the exchange plans.

It was decided that the use of CHAND was too disruptive to the individuals and families.

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Once the decision was made to structure the 1332 Waiver as an invisible reinsurance mechanism, it was proposed that CHAND administer the reinsurance program. After discussions internally and externally, the Insurance Department decided that for conflict of interest reasons it was not appropriate to use CHAND. CHAND was staffed with Blue Cross Blue Shield of North Dakota employees and it was considered inappropriate for it to administer reinsurance for itself and the other carriers.

IV. North Dakota 1332 Waiver Reinsurance

Reinsurance Design

Under its 1332 Waiver North Dakota proposes to implement a reinsurance mechanism that would reduce premiums between 10% and 20% in 2020, compared to the baseline premium without the waiver. The amount of premium reduction is dependent on the attachment point selected. The reinsurance mechanism would be "invisible reinsurance", like traditional reinsurance or the temporary federal ACA reinsurance that was effective from 2014 to 2016.

Each calendar year the reinsurance would cover, for high claim insureds, a percentage (coinsurance) over a specified level of paid claims (attachment point) until a specified level of paid claims was reached (maximum amount). The current proposal is that the attachment point be either $100,000 or $200,000, the coinsurance would be 75% and the maximum amount would be $1,000,000 in paid claims.

In addition to reducing premiums, the reinsurance would allow carriers to better predict their health care claims costs and protect against unpredictable high-cost claimants.

The reinsurance would be funded by the reduction in federal Advanced Premium Tax Credits (APTC) and assessments against the group carriers and Third Party Administers (TPAs). TPAs process claims for self-insured plans.

The reduction in premiums in North Dakota results in the reduction in APTCs. The APTCs funded by the federal government are the difference between the second lowest Silver premium in a region and the maximum amount that a family pays in premium based on its income and family size. As the Silver premiums are reduced, the APTC is reduced due to the reduction in premiums. The reduction in APTC is slightly offset by exchange user fees, which the federal government will not be able to collect. The fourth guardrail - Federal Deficit Neutrality, requires that any savings from APTC be offset by any loss of income.

Since the individual market is only 13% of the total health insurance commercial market, the assessments from the group market and TPAs would be allocated to a much larger base. NovaRest estimates that the assessments would be between 1% and 1.5% of group health insurance premiums and TPA premium equivalents (claim paid plus administrative fees). These percentages are higher than the current estimates in order to provide a cushion in the first year of operation.

The reinsurance program would reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims. The result therefore, should be more individuals staying in the market and more insurers being willing to write policies in North Dakota counties. Both of which will help stabilize the individual health insurance market in North Dakota.

NovaRest Reinsurance Analysis Process and Assumptions

Data

Carrier Data Call

NovaRest requested three data files from the carriers in North Dakota, including Blue Cross Blue Shield of North Dakota, Sanford, and Medica.

NovaRest performed a data call for the individual market carriers and identified the number of members in each of the following FPL ranges. Those from 0% of the FPL to 138% of the FPL are covered by Medicaid. Members are eligible for APTC up to 400% FPL. Members at the 100% CSR level who are eligible for APTC (of which there were 560 according to the data call) were evenly distributed between the 138% to 400% FPL ranges. For members eligible for ATPC but not CSR, 45% were allocated to the 250%-300% FPL level and 55% were allocated to the 300%-400% CSR level based on 2018 Consumer Information and Insurance Oversight (CCIIO) data.[25]

Individual Files

The data provided is for fully compliant ACA policies. The individual file was used to simulate a decision-making process to predict market migration based on rate increases. Since health insurance buying decisions are family based, NovaRest requested the information for individuals to be grouped into families.

The individual files contained a record for each covered individual as of December 31 for 2017, and May 31 for 2018. Data included premium and claim information and the 2018 file included the data on individuals such as date of birth and any cost sharing reductions (CSR) or APTC that they are eligible for and the plan that they are in without the claim information.

Historic Claim Distributions

This data requested included ACA-compliant, Grandfathered, Transitional, and CHAND Policies. This historic claim distribution file was used to determine health care cost trends by claim level. That is, in North Dakota is there a significant difference in the increases in health care costs for those with total claim of $100,000 to $200,000 compared to those with total claims between $500,000 and $750,000 NovaRest received data from years 2014 to 2017. Following is a list of all claim ranges:

- Under $50,000
- $50,000 to $99,999
- $100,000 to $199,999
- $200,000 to $499,999
- $500,000 to $749,999
- $750,000 to $999,999
- $1,000,000 to $1,249,999
- $1,250,000 to $1,499,999
- over $1,500,000

[25] "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

CCIIO Public Reports

NovaRest used public reports on the CCIIO web site to estimate the membership changes in the North Dakota CSR and APTC populations over time.[26]

MEPS Data

The Medical Expenditure Panel Survey (MEPS) data was used to estimate the total premium equivalent for the self-insured. A more accurate premium equivalent level will be determined by a TPA survey before implementation of the North Dakota Waiver.[27]

The carrier data from the historic claims distributions was brought into the NovaRest model. Data was received for 2014 through 2017. The claim distribution categories were bound by; $50,000, $100,000, $200,000, $500,000, $750,000, $1,000,000, $1,250,000, $1,500,000, and above $1,500,000. The appropriate member months were used to calculate trends by claim level for each carrier and for the market in total. Trends were calculated for each year over year and for the total period.

Rate Filing Information

NovaRest used 2017 and 2018 rate filing information from Medica, Stanford, and Blue Cross and Blue Shield of North Dakota. The Unified Rate Review Templates (URRTs) include the plan metal levels and indicate if the plans were offered on-exchange or off-exchange only. The Rate Templates were used to access the 2017 and 2018 premium rates.

[26] "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

[37] "Medical Expenditure Panel Survey." U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Https://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_results.jsp?component=2&subcomponent=2&-year=2017&tableSeries=2&tableSubSeries=B&searchText=&searchMethod=1&Action=Search

2019 Market Projection

The data for individuals covered on December 31, 2017 and on May 31, 2018 included a record for each individual and information that allowed individuals to be grouped into families.

Family information is needed because the maximum amount that individuals pay when eligible for APTC is based on family size and family income. Also, decisions to shop for other coverage based on rate increases is a family decision rather than an individual decision for those with families.

Individuals that were eligible for 94% CSR, 87% CSR, 73% CSR and APTC were determined to be the ones most likely to retain coverage. Although many circumstances can arise that result in turnover in this market segment, such as becoming employed by an employer that offers health insurance or moving out of state, in general North Dakota has seen an increase in the 94% CSR, 87% CSR, 73% CSR membership. NovaRest found that Individuals eligible for APTC, but not CSR, were in Gold, Silver and Bronze metal levels. NovaRest again assumed that these individuals were likely to retain their coverage, unless obtaining employer coverage or moving. Since NovaRest cannot predict employment or moving out-of-state NovaRest treated these members as a stable block.

For non-APTC individuals, total family claims cost was also calculated to determine the probability of a family retaining coverage even when faced with large rate increases.

For all other individuals NovaRest determined elasticity for each metal level. The elasticity estimates the percentage of membership that will shop for other coverage based on the percent of rate increase. Based on the rate increase for Gold level individuals, a percentage will decide to shop for alternative coverage. Those that decide to shop may decide to purchase Silver coverage, based on the difference in the current Gold level premium and the Silver coverage. Others may find the Silver coverage too expensive and may look at Silver off-exchange coverage, Bronze coverage, or may decide to drop coverage and become uninsured.

It was assumed that all non-subsidized individuals that currently have Gold or Silver plans would not select on-exchange Silver plans, but rather would shop for off-exchange Silver plans. This is due to the decision to allow loading of CSR costs into the on-exchange Silver plans starting in 2019, which raised Silver on-exchange premiums significantly.

Individuals in Catastrophic coverage may age out or based on the rate increase decide to drop coverage and become uninsured. For the loss of membership due to aging, NovaRest used a steady state and decided that the individuals aging out would be replaced by new entrants. For the portion of the individuals deciding to drop coverage NovaRest used a Catastrophic specific elasticity.

NovaRest used its proprietary migration model (NRMM) to project the movement between the metal levels and individuals becoming uninsured under the three scenarios of 1) without the reinsurance (base scenario), 2) with the Waiver with a $100,000 attachment point, and 3) with the Waiver with a $200,000 attachment point. This allowed NovaRest to project the number of individuals that would be covered by health insurance under the three scenarios. The NRMM aggregates individuals into families and performs an analysis, using elasticity assumptions, of the likelihood of the individual and families staying with their current plan, shopping for a less expensive option or becoming uninsured. The NRMM projects the 2019 membership and increases in the uninsured with and without the reinsurance under the 1332 Waiver.

The migration model provides the 2019 APTC membership, non-APTC membership on and off the exchange and the increase in the uninsured. Using the projected 2019 membership and the rates filed by the three carriers for 2019, NovaRest calculated the average premium for APTC and Non-APTC without the Waiver's reinsurance. The 2019 Membership and average premiums are shown below for the base period and the two Waiver scenarios.

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Table 7 2019 Projection			
Membership			**2019 Without Waiver**
	On Exchange		
		94% CSR (138% to 150% FPL)	1,957
		87% CSR (150% to 200% FPL)	4,845
		73% CSR (200% to 250% FPL)	2,515
		APTC (250% to 300% FPL)	5,492
		APTC (300% to 400% FPL)	6,713
	Total APTC		21,253
	Total Non- APTC (> 400%)		2,412
	Total On Exchange		23,935
	Off Exchange		15,168
	Total ACA		39,103
Average Premium			
	On Exchange		
		APTC Aggregate Premium Rate	$496.56
		APTC Maximum Premium Paid	$135.87
		APTC	$360.68
		Non-APTC	$431.88
	Total On Exchange		$490.04
	Off Exchange		$526.99
	Total ACA		$504.37
Total Annual Premium			
	Total APTC Aggregate Premium		$128,248,764
	Total APTC Maximum Premium Paid		$35,092,776
	Total APTC		$93,155,988
	Total Non-APTC		$12,501,246
	Total On Exchange Premium		$140,750,010
	Off Exchange		$95,921,084
	Total ACA		$236,671,094

NovaRest estimates that if the North Dakota 1332 Waiver is not implemented that there will be over 400 additional uninsured in 2020. With the Waiver, the amount of new uninsured is reduced to less than 150.

Projection of 2020 Base Line Market

The following table shows the 2020 1332 Waiver Base Line, compared to the 1332 Waiver alternatives. The base line was projected by taking the 2019 NRMM model output and trending membership and premiums. NovaRest did not include the 100% FPL to 138% FPL, since they are covered by Medicaid in North Dakota.[28] NovaRest did not project changes in the subsidized population, but rather assumed a steady state for the subsidized population.

[28] "Medicaid Expansion." North Dakota Department of Human Services. http://www.nd.gov/dhs/medicaidexpansion/

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Table 8 2020 Base Line					
Membership			2020		
			Without Waiver	Waiver with $100,000 Attachment Point	Waiver with $200,000 Attachment Point
	On Exchange				
		94% CSR (138% to 150% FPL)	1,957	1,957	1,957
		87% CSR (150% to 200% FPL)	4,845	4,845	4,845
		73% CSR (200% to 250% FPL)	2,515	2,515	2,515
		APTC (250% to 300% FPL)	5,492	5,492	5,492
		APTC (300% to 400% FPL)	6,713	6,713	6,713
	Total APTC		21,523	21,523	21,523
	Total Non- APTC (> 400%)		2,412	2,478	2,498
	Total On Exchange		23,935	24,001	24,021
	Off Exchange		15,168	15,428	15,407
	Total ACA		39,103	39,429	39,428
Average Premium					
	On Exchange				
		APTC Aggregate Premium Rate	$516.92	$419.89	$460.08
		APTC Maximum Premium Paid	$139.95	$139.95	$139.95
		APTC	$376.97	$279.94	$320.13
		Non-APTC	$449.59	$356.50	$396.81
	Total On Exchange		$510.13	$407.64	$453.90
	Off Exchange		$548.60	$440.82	$488.24
	Total ACA		$525.05	$420.63	$467.49
Total Annual Premium					
	Total APTC Aggregate Premium		$133,506,963	$108,447,155	$118,827,763
	Total APTC Maximum Premium Paid		$36,145,560	$36,145,560	$36,145,560
	Total APTC		$97,361,404	$72,301,595	$82,682,204
	Total Non-APTC		$13,013,797	$10,600,187	$11,894,390
	Total On Exchange		$146,520,760	$119,047,342	$130,722,153
	Off Exchange		$99,853,848	$81,611,267	$90,268,865
	Total ACA		$246,374,609	$200,658,610	$220,991,017

The following table shows the 2020 age 40 non-smoker premium rates for the second lowest Silver plan.

Table 9
Second Lowest Silver Monthly Premium
AGE 40 Non-smoker

	2020		
Area	**Without Waiver**	**With $100,000 Attachment Point**	**With $200,000 Attachment Point**
1	$412.42	$329.94	$367.06
2	$412.42	$329.94	$367.06
3	$503.99	$403.20	$448.56
4	$412.42	$329.94	$367.06

Reinsurance and Funding Needs Projection

The reinsurance was calculated for several combinations of attachment point, coinsurance, and maximum claim level. Based on the results, the Insurance Department decided that either a $100,000 or $200,000 attachment point was appropriate. Also, it was decided that a 75% coinsurance be used up to a $1,000,000 maximum paid claims level.

NovaRest modeled 10 scenarios of trend assumptions and chose what it considered the 3 most likely sets of scenarios. The three selected trends resulted in reductions to paid claims that ranged from 10% to 11% of paid claims for the $100,000 attachment point and from 18% to 20% of paid claims for the $200,000 attachment point.

The trend assumptions selected were:

1. The historic three-year trend annualized by claim level from the carrier data;
2. The trend for 2020 and beyond from the National Health Expenditure Projections; and
3. The trend from the National Health Expenditure Projections distributed by the trends for each claim level.

[32] "National Health Care Expenditure Projections 2017-2026." Centers for Medicare & Medicaid Services. August 1, 2018. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

The first trend was selected because it was based on the historic trends in North Dakota and distinguished between trends for high-cost claimants and low-cost claimants. The trend from National Health Expenditure Projections was selected because it was considered a reasonable trend of 4.1% for 2019 to 2020 and 5.7% thereafter and had the endorsement of CMS. The trend from the National Health Expenditure Projections distributed for each claim level was used because it added the precision of distinguishing between high-cost and low-cost claimants.

After researching the issue, NovaRest decided to equate paid claim cost reduction to premium reduction. Typically, premiums increase at a higher rate than claims due to deductible leveraging and changes in morbidity, as well as, influences such as changing geographic factors and network changes. When NovaRest reviewed North Dakota's allowed and paid claim trends they did not follow typical patterns. Also, paid claim trends and premium trends did not follow typical patterns so there was no apparent basis for converting claim reduction to premium reduction based on North Dakota experience. Therefore, it was decided to use the simplifying assumption to equate reduction in claim costs to reduction in premium rates.

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Table 10 Reinsurance and Funding, $100,000 Attachment Point											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Total Reinsurance	$47,755,003	$50,477,038	$53,354,230	$56,395,421	$59,609,960	$63,007,727	$66,599,168	$70,395,320	$74,407,854	$78,649,101	$83,132,100
Federal Funding	$25,766,844	$27,235,554	$28,787,981	$30,428,895	$32,163,343	$33,996,653	$35,934,462	$37,982,727	$40,147,742	$42,436,163	$44,855,025
Funding Needed	$21,988,159	$23,241,484	$24,566,249	$25,966,525	$27,446,617	$29,011,074	$30,664,706	$32,412,594	$34,260,112	$36,212,938	$38,277,075
Percent of group and TPA	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%	1.06%

Table 11 Reinsurance and Funding, $200,000 Attachment Point											
	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
Total Reinsurance	$26,726,151	$28,249,542	$29,859,765	$31,561,772	$33,360,793	$35,262,358	$37,272,313	$39,396,834	$41,642,454	$44,016,074	$46,524,990
Federal Funding	$14,165,428	$14,972,857	$15,826,310	$16,728,410	$17,681,929	$18,689,799	$19,755,118	$20,881,160	$22,071,386	$23,329,455	$24,659,234
Funding Needed	$12,560,723	$13,276,684	$14,033,455	$14,833,362	$15,678,864	$16,572,559	$17,517,195	$18,515,675	$19,571,068	$20,686,619	$21,865,757
Percent of group and TPA	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%	0.61%

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Administrative Requirements for North Dakota Reinsurance Program

A number of functions will be needed in order to administer this program. Claims will have to be filed by the carriers and reinsurance reimbursements will have to be paid. Also, amounts will have to be collected from the federal government for APTC reductions and from the assessments against those identified in the legislation once it is finalized.

Claims Processing

Carriers will provide claim information to the administrator once the initial attachment point is reached. The administrator will accumulate the claims and determine the reinsurance payment owed to the carrier.

Once the payment amount is determined, the administrator will verify that adequate funds are available and either pay the claim or notify the carrier that payment will be delayed.

The administrator will also monitor the total claims and notify the carrier once the maximum claim level is reached.

If funding becomes an issue, the administrator will have to monitor funding levels and pay claims as adequate funding is available.

Funding Collections

It is NovaRest's understanding that federal APTC funds are made available in the first half of the year for the estimated annual funding amount. The administrator will have to coordinate with the appropriate federal office to ensure that funding is made available on a timely basis.

Assessments will be received on a periodic basis from those providing the additional funding needed for the program. The administrator will follow-up on assessments that are not received on a timely basis. NovaRest assumes that assessments will be based on premium or claim levels and therefore the assessed entities will calculate the assessment amount and not the administrator.

Periodic Audits

The administrator should periodically audit both the carrier claim submission and the assessments. An audit can be done by the administrator or an outside vendor. An outside vendor would cost approximately $9,000 according to CHAND administrators.

The audit would verify that the carrier claims were processed appropriately and only included covered services for the contracted rates.

Assessment audits would verify that the assessment base (premium, claims, etc.) was accurate and that the appropriate percentage was used to calculate the assessment.

Miscellaneous Tasks
There will be various additional tasks such as opening banking accounts and balancing account statements.

Tasks would also include reporting requirements back to the State authority that is responsible for the reinsurance program, and to the federal authority, as required.

Relationship management will require an executive director level person that would interact with the federal government, State legislators, carriers, TPAs, and the public.

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V. Meeting the Section 1332 Waiver Guardrails

Guardrails

This report will demonstrate that the four 1332 Waiver guardrails will be met by North Dakota's proposed 1332 Waiver structure.

Comprehensive Coverage – 1332(b)(1)(A)

The proposed Waiver does not make alterations to the required scope of benefits offered in the insurance market in North Dakota. It will result in an increase in the number of individuals with coverage that meets the ACA's EHB requirements.

Affordability – 1332(b)(1)(B)

The Waiver will reduce premium and increase affordability.

Scope of Coverage – 1332(b)(1)(C)

The proposed Waiver is projected to cover more individuals in North Dakota than would be covered absent the Waiver. Lower premiums will result in individuals retaining coverage rather than dropping coverage due to unaffordable premium rates.

Federal Deficit Neutrality – 1332(b)(1)(D)

The proposed Waiver will not result in increased spending, administrative, or other expenses to the federal government. There will be no increase in federal administrative expense. The federal funding will be calculated based on actual APTC subsidized enrollment and will be reduced by any reductions in exchange user fees. The Waiver will lower premiums by 10% to 20%, which will reduce the APTC that would be paid by the federal government. Since the exchange user fees are a percentage of premium, the reduced premium will reduce the exchange user fees collected by the federal government. The intention is for the lower APTCs less the reduced exchange user fees be passed to North Dakota and used to fund the reinsurance program under the Waiver.

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Table 12 2020 Difference from Base Line				
Membership			**2020**	
			Waiver with $100,000 Attachment Point	**Waiver with $200,000 Attachment Point**
	On Exchange			
		94% CSR (138% to 150% FPL)	0%	0%
		87% CSR (150% to 200% FPL)	0%	0%
		73% CSR (200% to 250% FPL)	0%	0%
		APTC (250% to 300% FPL)	0%	0%
		APTC (300% to 400% FPL)	0%	0%
	Total APTC		0%	0%
	Total Non- APTC (> 400%)		3%	4%
	Total On Exchange		0%	0%
	Off Exchange		2%	2%
	Total ACA		1%	1%
Average Premium				
	On Exchange			
		APTC Aggregate Premium Rate	-19%	-11%
		APTC Maximum Premium Paid	0%	0%
		APTC	-26%	-15%
		Non-APTC	-21%	-12%
	Total On Exchange		-20%	-11%
	Off Exchange		-20%	-11%
	Total ACA		-20%	-11%
APTC Savings			$25,059,808	$14,679,200
Exchange Fee Reduction			$877,093	$513,772
Net Federal Savings			$24,182,715	$14,165,428

VI. Federal Deficit Neutrality

Federal Budget

The reduced APTC saves the federal government money. To offset this savings are some potential losses to income for the federal government.

The shared responsibility or individual mandate penalty would be reduced if individuals remain insured rather than becoming uninsured and subject to the penalty. In December 2017, Republican lawmakers passed H.R.1, the Tax Cuts and Jobs Act, which repealed the individual mandate penalty.[30] The repeal is effective for 2019 plan year. Therefore, there is no impact on the federal deficit for individuals remaining insured.

The Patient-Centered Outcomes Research Institute (PCORI) fee payable to the federal government based on enrollment. This fee is only applicable for plan years ending between October 1, 2012 and October 1, 2019.[31] Since the fee is not applicable in 2020, it will not impact the federal deficit for the period of the North Dakota Waiver.

The Health Insurance Providers Fee (HIF) is an annual amount of $14,300,000,000 for 2018.[32] There is a moratorium for the HIF in 2019. For 2020 and beyond, the applicable amount in the preceding fee year increased by the rate of premium growth of covered entities (within the meaning of section 36B(b)(3)(A)(ii).

A covered entity is generally any entity with net premiums written for health insurance for United States health risks during the fee year that is (1) a health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company that is subject to tax under subchapter L, Part I or II, or that would be subject to tax under subchapter L, Part I or II, but for the entity being exempt from tax under section 501(a); (4) an insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA).[33]

[30] Norris, Louise. "With the GOP tax bill and the president's 2017 executive order, will the IRS still enforce the individual mandate penalty?" HealthInsurance.org. January 22, 2018. https://www.healthinsurance.org/faqs/does-the-presidents-executive-order-mean-the-irs-wont-enforce-the-individual-mandate-penalty/

[31] "Patient-Centered Outcomes Research Institute Fee." Internal Revenue Service. June 6, 2018. https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee

[32] "Affordable Care Act Provision 9010 - Health Insurance Providers Fee." Internal Revenue Service. September 4, 2018. https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

[33] Ibid.

The fee is assessed as a percentage of net premium. For entities with less than $25,000,000 no fee will be assessed.[34] For entities with between $25,000,000 and $49,999,999, 50% of the net premiums will be taken into account and for entities with over $50,000,000 in net premium, the total net premium will be taken into account.[35] If the Waiver reduces premiums sufficient enough to impact the national premium growth, the HIF collected by the federal government would be reduced. Otherwise since the HIF is a national budgeted amount, the Waiver will not impact the HIF.

The Exchange User Fee is a federally mandated fee used to fund the federal and state exchanges. Because North Dakota did not establish a state-based exchange, the exchange is facilitated by the federal government. The fee is calculated as a percent of on-exchange premiums.[36] Although the fee is calculated on on-exchange business, it is included in the premium for all non-grandfathered on-and-off exchange ACA business. The current fee rate in the individual market is 3.5%.[37]

Aggregate Premium

The NRMM also calculates the aggregate premium rate for the individuals and families that are eligible for APTCs and the maximum that a family will actually pay.

The aggregate premium rate is the premium that the individuals would pay, if they did not receive the APTC. This is the second lowest Silver rate in each region. The table below shows this premium for a person age 40. The tobacco rate charged to smokers was not considered since it is not used in the APTC determination.

Table 13
Second Lowest Silver 2019
AGE 40 Non-smoker

Area	Monthly Premium
1	$396.18
2	$396.18
3	$484.14
4	$396.18

[34] Ibid.
[35] Ibid.
[36] "HHS announces applicable user fees." Blue Cross Blue Shield Blue Care Network of Michigan. May 6, 2013. https://www.bcbsm.com/health-care-reform/reform-alerts/hhs-announces-applicable-user-fees1.html
[37] "HHS Notice of Benefit and Payment Parameters for 2019." The Centers for Medicare & Medicaid Services. April 9, 2018. https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2019

Calculation of an Individual's Maximum Payable Premium for the Advanced Premium Tax Credit

The family Federal Poverty Level (FPL) in 2018 is $12,140 for the first person plus $4,320 for each additional person.[38] A family of 4 is $12,140 plus 3 times $4,320 or $25,100. The single person FPL rate has been increasing by 1% to 3% a year and the additional person has been increasing by 0% to 4% a year.[39]

Maximum premium paid by low income as a percent of income.[40]

- For 133% to 150% of FPL the percentage is between 3.11% and 4.15%.
- For 150% to 200% it is between 4.15% and 6.54%.
- For 200% to 250% it is between 6.54% and 8.36%.
- For 250% to 300% it is between 8.36% and 9.86%.
- For 300% to 400% it is 9.86%.

Table 14
2018 Maximum Premium Paid by APTC Eligible Families

			Annual Premium		Monthly Premium	
FPL Range	FPL Mid-point	Percent of Income	Single at $12,140	Additional at $4,320	Single at $12,140	Additional at $4,320
138% to 150%	144%	3.69%	$645.79	$229.80	$53.82	$19.15
150% to 200%	175%	5.35%	$1,135.55	$404.08	$94.63	$33.67
200% to 250%	225%	7.45%	$2,034.97	$724.14	$169.58	$60.35
250% to 400%	325%	9.52%	$3,757.10	$1,336.96	$313.09	$111.41

If there is one person in a family, the Single premium is used. If there is more than one family member, the family premium is increased by the additional amount for each additional family member. For example, a family of 4 at the 200% to 250% of FPL the annual family premium would be $2,034.97 plus 3 times $724.14 or $4,207.39, which would be a monthly premium of $350.63.

[38] "Prior Poverty Guidelines and Federal Register References". Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references

[39] Ibid.

[40] "Rev. Proc. 2018-34, IRS update of the Applicable Percentage." Internal Revenue Service. https://www.irs.gov/pub/irs-drop/rp-18-34.pdf

The CSR levels are the key to the FPLs used in the calculation.

138-150% FPL = 94% Actuarial Value (CSR 94)
150-200% FPL = 87% Actuarial Value (CSR 87)
200-250% FPL = 73% Actuarial Value (CSR 73)

0%-138% would be covered under Medicaid. The APTC not CSR individuals are between the 250% and 400%. According to CCIIO's 2018 report approximately forty-five percent are in the lower category (250% to 300%) and the other fifty-five percent are in the second (300% to 400%).

Calculation of the APTC

An individual's APTC is the difference between the second lowest cost Silver plan in the region for the individual's age and the maximum premium for an individual. For a family it is the sum of all of the second lowest cost Silver plans in the region for the individual's age for each individual and the maximum family premium.

For the waiver scenario, the APTC is reduced because the second lowest Silver premium for each region is reduced due to the reinsurance. The reinsurance lowers the premiums for all plans, but the second lowest Silver plan is the one that impacts the APTC. NovaRest assumed that the premium reduction was the same percentage for all plans due to the single risk pool requirement.[41] The difference in the premiums for the second lowest Silver plans with and without the reinsurance is the difference in the APTC between the two scenarios. This is the amount that CMS will save in APTC and that can be applied to the reinsurance funding.

The amount that the federal government can contribute and remain budget neutral is the savings from the reduced APTCs less the loss of the exchange user fees. Exchange user fees for the individual market are 3.5% of premium paid on exchange plans in 2019.[42] When the premium is reduced, this income to the federal government is also reduced. The amount of federal budget savings in the reduction in APTC less the exchange user fees. For example, if APTC have a 15% reduction in premiums the net amount of savings to the federal government is 15% less the 3.5% or 11.5%.

[41] Rate increases are rarely the same for all plans due to changes such as changes in morbidity that vary between plans and geographic factor changes. It is not possible to predict these types of factors with an appropriate amount of accuracy.
[42] "HHS Notice of Benefit and Payment Parameters for 2019." The Centers for Medicare & Medicaid Services.

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Table 15
Budget Neutrality Projection, 2020-2030

Base	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
APTC Agg Prem	$133,506,963	$141,116,860	$149,160,521	$157,662,671	$166,649,443	$176,148,461	$186,188,924	$196,801,692	$208,019,389	$219,876,494	$232,409,454
APTC Max Prem Paid	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$97,361,404	$103,886,934	$110,813,697	$118,165,442	$125,967,297	$134,245,851	$143,029,235	$152,347,213	$162,231,275	$172,714,737	$183,832,844
$100,000 Waiver											
APTC Agg Prem	$106,805,571	$112,893,488	$119,328,417	$126,130,137	$133,319,554	$140,918,769	$148,951,139	$157,441,354	$166,415,511	$175,901,195	$185,927,563
APTC Max Prem Paid	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$70,660,011	$75,663,562	$80,981,593	$86,632,908	$92,637,409	$99,016,159	$105,791,450	$112,986,875	$120,627,398	$128,739,438	$137,350,954
APTC Savings	$26,701,393	$28,223,372	$29,832,104	$31,532,534	$33,329,889	$35,229,692	$37,237,785	$39,360,338	$41,603,878	$43,975,299	$46,481,891
Exchange fee	$934,549	$987,818	$1,044,124	$1,103,639	$1,166,546	$1,233,039	$1,303,322	$1,377,612	$1,456,136	$1,539,135	$1,626,866
Net Federal Savings	$25,766,844	$27,235,554	$28,787,981	$30,428,895	$32,163,343	$33,996,653	$35,934,462	$37,982,727	$40,147,742	$42,436,163	$44,855,025
$200,000 Waiver											
APTC Agg Prem	$118,827,763	$125,600,946	$132,760,200	$140,327,531	$148,326,200	$156,780,794	$165,717,299	$175,163,185	$185,147,486	$195,700,893	$206,855,844
APTC Max Prem Paid	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$82,682,204	$88,371,019	$94,413,375	$100,830,302	$107,644,054	$114,878,184	$122,557,610	$130,708,706	$139,359,373	$148,539,136	$158,279,235
APTC Savings	$14,679,200	$15,515,914	$16,400,322	$17,335,140	$18,323,243	$19,367,668	$20,471,625	$21,638,507	$22,871,902	$24,175,601	$25,553,610
Exchange fee	$513,772	$543,057	$574,011	$606,730	$641,313	$677,868	$716,507	$757,348	$800,517	$846,146	$894,376
Net Federal Savings	$14,165,428	$14,972,857	$15,826,310	$16,728,410	$17,681,929	$18,689,799	$19,755,118	$20,881,160	$22,071,386	$23,329,455	$24,659,234

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VII. Ten Year Projections

Assumptions
NovaRest used a uniform or steady state for membership projections from 2020 to 2030.

To project the 2020 premiums that resulted from the NRMM modeling, NovaRest used historic changes in FPL and National Health Expenditure Projections.[43] For the FPL increase, we used 3%, because it was conservative (produced a lower APTC) considering historic changes in the FPLs.

The National Health Expenditure Projections show a 4.1% health care cost increase from 2019 to 2020 and 5.7% thereafter. The NRMM model output premium was trended from 2019 to 2020 by 4.1% and then to 2030 by 5.7% for both the base projections and the Waiver projections. Two Waiver scenarios were modeled. One scenario used a $100,000 attachment point for the reinsurance and the other used a $200,000 attachment point.

Process
Projections were done for membership and premium Per Member Per Month (PMPM) for the following categories:[44]

- 94% CSR (138% to 150% FPL)
- 87% CSR (150% to 200% FPL)
- 73% CSR (200% to 250% FPL)
- APTC (250% to 300% FPL)
- APTC (300% to 400% FPL)
- Total Non- APTC (> 400% FPL)
- Off-Exchange
- Uninsured

The 2019 NRMM model output is used to project the 2020 base line and the following ten years. NovaRest reviewed the CCIIO public use files[45] to determine a membership trend for the CSR and APTC not CSR levels. The CCIIO data did not show a consistent pattern of subsidized enrollment. NovaRest also reviewed historic trends in North Dakota for on-exchange non-subsidized membership and off-exchange membership.The increase in the on-exchange membership was primarily driven by individuals leaving Grandfathered and Transitional policies and did not appear to be a good predictor of the future. The large decrease in off-exchange membership was projected to reverse itself in 2020 due to the increase in Silver premiums when adding the adjustment for non-funding of the CSRs. Again, the historic pattern could not be used. It was decided to use a steady state in membership for the 10-year projections.

[43] "National Health Expenditure Projections 2017-2026." The Centers for Medicare & Medicaid Services. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf
[44] Since North Dakota expanded Medicaid to 138% FPL, a project of the population under 138% FPL was not necessary.
[45] be "2018 Marketplace Open Enrollment Period Public Use Files." Centers for Medicare and Medicaid Services

NovaRest used the National Health Expenditure Projections[46] for health care spending increases. These projections showed increases of 4.1% from 2019-2020 and 5.7% for 2021-2026.

Table 16
2020-2030 Trend Assumptions

Premium		
	On Exchange	5.7%
	APTC Maximum Premium	3.0%
	Off Exchange	5.7%

Projections

The ten-year projections for the base line and for the two potential reinsurance attachment points are in the three tables below.

[46] "Projected." Centers for Medicare & Medicaid Services. August 1, 2018. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

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Table 17
2020 Base Line Without Waiver

Membership	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
On Exchange											
94% CSR	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957
87% CSR	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845
73% CSR	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515
APTC	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492
APTC	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713
Total APTC	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523
Total Non-APTC	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412	2,412
Total On Exchange	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**	**23,935**
Off Exchange	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168	15,168
Total ACA	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**	**39,103**
Average Premium PMPM											
On Exchange											
APTC Agg Prem	$517	$546	$578	$610	$645	$682	$721	$762	$805	$851	$900
APTC Max Prem	$140	$144	$148	$153	$158	$162	$167	$172	$177	$183	$188
APTC	$377	$402	$429	$458	$488	$520	$554	$590	$628	$669	$712
Non-APTC	$450	$475	$502	$531	$561	$593	$627	$663	$701	$740	$783
Total On Exchange	**$510**	**$539**	**$570**	**$602**	**$637**	**$673**	**$711**	**$752**	**$795**	**$840**	**$888**
Off Exchange	$549	$580	$613	$648	$685	$724	$765	$809	$855	$904	$955
Total ACA	**$525**	**$555**	**$587**	**$620**	**$655**	**$693**	**$732**	**$774**	**$818**	**$865**	**$914**
Total Annual Premium											
Total APTC Agg Prem	$133,506,963	$141,116,860	$149,160,521	$157,662,671	$166,649,443	$176,148,461	$186,188,924	$196,801,692	$208,019,389	$219,876,494	$232,409,454
Total APTC Max Prem	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$97,361,404	$103,886,934	$110,813,697	$118,165,442	$125,967,297	$134,245,851	$143,029,235	$152,347,213	$162,231,275	$172,714,737	$183,832,844
Total Non-APTC	$13,013,797	$13,755,584	$14,539,652	$15,368,412	$16,244,412	$17,170,343	$18,149,053	$19,183,549	$20,277,011	$21,432,800	$22,654,470
Total On Exchange	**$146,520,760**	**$154,872,444**	**$163,700,173**	**$173,031,083**	**$182,893,855**	**$193,318,804**	**$204,337,976**	**$215,985,241**	**$228,296,400**	**$241,309,294**	**$255,063,924**
Off Exchange	$99,853,848	$105,545,518	$111,561,612	$117,920,624	$124,642,100	$131,746,699	$139,256,261	$147,193,868	$155,583,919	$164,452,202	$173,825,978
Total ACA	**$246,374,609**	**$260,417,962**	**$275,261,785**	**$290,951,707**	**$307,535,954**	**$325,065,504**	**$343,594,238**	**$363,179,109**	**$383,880,318**	**$405,761,496**	**$428,889,902**

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Table 18
2020 With Waiver and $100,000 Attachment Point

Membership	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
On Exchange											
94% CSR	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957
87% CSR	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845
73% CSR	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515
APTC	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492
APTC	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713
Total APTC	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523
Total Non-APTC	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478	2,478
Total On Exchange	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**	**24,001**
Off Exchange	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428	15,428
Total ACA	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**	**39,429**
Average Premium PMPM											
On Exchange											
APTC Agg Prem	$414	$437	$462	$488	$516	$546	$577	$610	$644	$681	$720
APTC Max Prem	$140	$144	$148	$153	$158	$162	$167	$172	$177	$183	$188
APTC	$274	$293	$314	$335	$359	$383	$410	$437	$467	$498	$532
Non-APTC	$356	$377	$398	$421	$445	$470	$497	$526	$555	$587	$621
Total On Exchange	**$408**	**$431**	**$455**	**$481**	**$509**	**$538**	**$569**	**$601**	**$635**	**$671**	**$710**
Off Exchange	$441	$466	$493	$521	$550	$582	$615	$650	$687	$726	$767
Total ACA	**$421**	**$445**	**$470**	**$497**	**$525**	**$555**	**$587**	**$620**	**$655**	**$693**	**$732**
Total Annual Premium											
Total APTC Agg Prem	$106,805,571	$112,893,488	$119,328,417	$126,130,137	$133,319,554	$140,918,769	$148,951,139	$157,441,354	$166,415,511	$175,901,195	$185,927,563
Total APTC Max Prem	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$70,660,011	$75,663,562	$80,981,593	$86,632,908	$92,637,409	$99,016,159	$105,791,450	$112,986,875	$120,627,398	$128,739,438	$137,350,954
Total Non-APTC	$10,600,187	$11,204,398	$11,843,049	$12,518,103	$13,231,634	$13,985,838	$14,783,030	$15,625,663	$16,516,326	$17,457,756	$18,452,849
Total On Exchange	**$117,405,758**	**$124,097,886**	**$131,171,466**	**$138,648,239**	**$146,551,189**	**$154,904,607**	**$163,734,169**	**$173,067,017**	**$182,931,837**	**$193,358,952**	**$204,380,412**
Off Exchange	$81,611,267	$86,263,110	$91,180,107	$96,377,373	$101,870,883	$107,677,523	$113,815,142	$120,302,605	$127,159,854	$134,407,966	$142,069,220
Total ACA	**$199,017,025**	**$210,360,996**	**$222,351,573**	**$235,025,612**	**$248,422,072**	**$262,582,130**	**$277,549,312**	**$293,369,622**	**$310,091,691**	**$327,766,917**	**$346,449,631**

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Table 19
2020 With Waiver and $200,000 Attachment Point

Membership	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030
On Exchange											
94% CSR	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957	1,957
87% CSR	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845	4,845
73% CSR	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515	2,515
APTC	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492	5,492
APTC	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713	6,713
Total APTC	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523	21,523
Total Non-APTC	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498	2,498
Total On Exchange	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**	**24,021**
Off Exchange	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407	15,407
Total ACA	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**	**39,428**
Average Premium PMPM											
On Exchange											
APTC Agg Prem	$460	$486	$514	$543	$574	$607	$642	$678	$717	$758	$801
APTC Max Prem	$140	$144	$148	$153	$158	$162	$167	$172	$177	$183	$188
APTC	$320	$342	$366	$390	$417	$445	$475	$506	$540	$575	$613
Non-APTC	$397	$419	$443	$469	$495	$524	$553	$585	$618	$654	$691
Total On Exchange	**$454**	**$479**	**$507**	**$536**	**$566**	**$598**	**$632**	**$669**	**$707**	**$747**	**$789**
Off Exchange	$488	$516	$545	$577	$609	$644	$681	$720	$761	$804	$850
Total ACA	**$467**	**$494**	**$522**	**$552**	**$583**	**$616**	**$651**	**$689**	**$728**	**$769**	**$813**
Total Annual Premium											
Total APTC Agg Prem	$118,827,763	$125,600,946	$132,760,200	$140,327,531	$148,326,200	$156,780,794	$165,717,299	$175,163,185	$185,147,486	$195,700,893	$206,855,844
Total APTC Max Prem	$36,145,560	$37,229,926	$38,346,824	$39,497,229	$40,682,146	$41,902,610	$43,159,688	$44,454,479	$45,788,113	$47,161,757	$48,576,610
Total APTC	$82,682,204	$88,371,019	$94,413,375	$100,830,302	$107,644,054	$114,878,184	$122,557,610	$130,708,706	$139,359,373	$148,539,136	$158,279,235
Total Non-APTC	$11,894,390	$12,572,370	$13,288,995	$14,046,468	$14,847,116	$15,693,402	$16,587,926	$17,533,438	$18,532,844	$19,589,216	$20,705,801
Total On Exchange	**$130,722,153**	**$138,173,316**	**$146,049,195**	**$154,373,999**	**$163,173,317**	**$172,474,196**	**$182,305,225**	**$192,696,623**	**$203,680,330**	**$215,290,109**	**$227,561,645**
Off Exchange	$90,268,865	$95,414,190	$100,852,799	$106,601,408	$112,677,688	$119,100,317	$125,889,035	$133,064,710	$140,649,398	$148,666,414	$157,140,399
Total ACA	**$220,991,017**	**$233,587,505**	**$246,901,993**	**$260,975,407**	**$275,851,005**	**$291,574,512**	**$308,194,260**	**$325,761,332**	**$344,329,728**	**$363,956,523**	**$384,702,045**

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VIII. North Dakota State Plan

North Dakota intends to offer a state specific plan similar to the one proposed in Idaho's state-based plan.[47]

As of the date of this report the Idaho plan includes the following characteristic:

1. Age band is 1 to 4 (the age bands may have to stay at 1 to 3 in order to obtain CMS approval).
2. The plans would prohibit refusal to deny coverage based on a pre-existing condition but would allow carriers a waiting period that is the same as the provisions of the ACA, essentially meaning they would not cover anything that occurred in the previous 6 months, until Jan. 1 of the following year.
3. The plans include a "low risk credit approach" which would provide credits to reduce rates for healthy individuals. It would not allow increases or assessments if the health risk assessment came back at anything less than healthy.
4. The plans would allow different or higher out of pocket maximums than the ACA allows.
5. The plans would all be considered part of the ACA's single risk pool, but there would be no risk adjustment payments made for these plans.
6. No lifetime caps.
7. Plans must cover all 10 Essential Health Benefits (EHB).
8. An insurer must sell at least one plan on the ACA exchange to be permitted to sell a state-based plan.

It is North Dakota's desire that the State plan would be affordable for those that cannot afford the exchange plans and would serve as an alternative to becoming uninsured as premium rates in the individual market become more unaffordable. Having a larger insured population should help stabilize the insurance market in North Dakota.

NovaRest reviewed the impact of the inclusion of the North Dakota Plan off-exchange. The North Dakota Plan would be an option for individuals aging out of eligibility for the Catastrophic plan that is only available to individuals up to age 30. Also, individuals that cannot afford the rate increases for their current non-catastrophic could purchase the less expensive North Dakota plan. When carriers were surveyed, they replied that the North Dakota Plan could be at least 16% less expensive than the current Bronze plans. If the North Dakota Plan allowed rates for ages to differ by 1 to 4 rather than 1 to 3 as currently required by the ACA the impact would vary by age. Currently the premium rate for someone age 64 can only be 3 times the rate of a 21-year-old. If the premium rate for a person age 64 could be 4 times the rate for a 21-year old, the rates for the younger individuals would go down and the rates for older individuals would increase. This would make the North Dakota Plan very attractive to younger individuals and would be unattractive to older individuals. Since the North Dakota Plan would be part of the single risk pool, the ACA market could benefit in total from the retention of younger, healthier individuals.

If the North Dakota Plan were implemented in conjunction with the Waiver's reinsurance mechanism, it would reduce the additional uninsured to almost none. It would also likely attract some individuals that became uninsured in the last few years, but actually would purchase insurance if it were affordable.

[47] "Fair Access to Health Coverage Waiver Application." Idaho Department of Insurance. https://doi.idaho.gov/DisplayPDF?id=Draft1332Application&cat=publicinformation

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Since the North Dakota plan would be part of the single risk pool, the addition of healthy individuals would result in a reduction to all premiums. The more uninsured that decide to purchase the North Dakota plan or individuals decide to purchase the North Dakota plan rather than drop insurance the larger impact on the market premiums.

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IX. Limitations

There were a number of limitations in the data received and the availability of more accurate assumptions. Even with these limitations, NovaRest believes that the projections included in this report are appropriate for decision making purposes. NovaRest performed sensitivity testing to verify that varying the assumptions used would not significantly change the results. Actual federal funding through reduced APTC will be based on actual enrollment and filed premiums rather than on NovaRest's or other projections.

1. The data that NovaRest used were snap shots as of December 31, 2017 and May 31, 2018. With the turnover in the individual market this may overstate 2018 due to later 2018 migration from the market and understate 2017 due to earlier 2017 migration from the market.
2. NovaRest had little information on individuals eligible for 100% CSR. From the data provided NovaRest knows that they are all eligible for APTCs, but not the actual poverty level. NovaRest allocated the 100% CSR to the CSR levels for the non-100% CSR individuals.
3. For Grandfathered and Transitional, NovaRest only had member months for 2017 and 2018. NovaRest converted the member months to members using 11 months, which may understate the actual number of members in these markets.
4. Medica was not in the individual exchange market in 2018 and therefore did not provide on-exchange data for that year. NovaRest assumed that the majority of Medica's 2017 exchange membership moved to Blue Cross Blue Shield of North Dakota and Sanford.

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X. Actuarial Certification

Reliance

In the analysis described in this report, we relied on information provided by the State of North Dakota, information published by the Federal government, and information provided by insurers offering coverage in the Individual market in North Dakota.

We relied upon this information without independent investigation or audit. If information is inaccurate or incomplete, our findings and conclusions may need to be revised. We have reviewed the data for consistency and reasonableness. Where data was inconsistent or unreasonable, we requested clarification.

Actuarial Certification

I, Donna Novak, am President of NovaRest Actuarial Consulting.

We are providing this report solely for the use of supporting the State of North Dakota's 1332 Waiver application. The intended users of this report are the State of North Dakota Departments. Distribution of this report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by us and is done at their own risk.

We believe the current North Dakota Waiver proposal complies with the following requirements:

- The coverage provided under this 1332 Waiver is at least as comprehensive as the coverage available absent the 1332 Waiver.
- The coverage provided under this 1332 Waiver is at least as affordable as the coverage available absent the 1332 Waiver.
- The 1332 Waiver will provide coverage to at least a comparable number of residents as would be available absent the 1332 Waiver.
- The 1332 Waiver will not increase the federal deficit.

The actuarial methodologies utilized in order to arrive at our opinion were those which were considered generally accepted within the industry and are consistent with all applicable ASOPs.

I am a Member of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion.

If you have any questions, do not hesitate to call me at (520) 908-7246.

Sincerely,

Donna C. Novak

Donna C. Novak, FCA, ASA, MAAA, MBA

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XI. Definitions and Abbreviations

Allowed Claims – The maximum amount a plan will pay for a covered health care service.

Advance Premium Tax Credit "APTC" or "PTC" – A tax credit taken by enrollee to lower monthly health insurance payment. The enrollee will estimate yearly income when they apply for coverage in the Health Insurance marketplace. The APTC will be based on the estimate of the income entered.

Centers for Medicare & Medicaid Services "CMS" – The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).

Children's Health Insurance Program "CHIP" – The Children's Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states according to federal requirements. The program is funded jointly by states and the federal government.

Congressional Budget Office "CBO" – An agency that produces independent analyses of budgetary and economic issues to support the Congressional budget process.

Cost Sharing – The share of costs covered by an insurance plan that an enrollee will pay out of their pocket. In general, cost sharing includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

Cost Sharing Reduction "CSR" – A discount that lowers the amount an enrollee will have to pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace, cost-sharing reductions are often called "extra savings."

Essential Health Benefits "EHB" – A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

Federal Poverty Level "FPL" – A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Health Insurance Marketplace "Marketplace" or "exchange" http://www.healthcare.gov – A shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010. In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families.

High-Risk Pool Plan – States offer plans that provide coverage if an individual has been denied health insurance because of a pre-existing condition. High-risk pool plans offer health insurance coverage that is subsidized by a state government.

Metal Level, Metal Plans or Metal Categories – Plans in the Health Insurance Marketplace are presented in 4 "metal" categories: Bronze, Silver, Gold, and Platinum.

Patient Protection and Affordable Care Act "ACA" or "Affordable Care Act" – United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.

Per Member Per Month "PMPM" – Per Member Per Month, or the average cost of services per individual per month.

Premium – A health insurance premium is a monthly fee paid to an insurance company or health plan to provide health coverage.

Risk Adjustment – A statistical process that takes into account the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or health care costs.

Third Party Administrator "TPA" – A third-party administrator is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity.

XII. Appendix A - Summary of Types of Reinsurance Pooling

Summary of Types of Reinsurance Pooling

High-Risk Pool Reimbursement—Based on Health Spending

Carriers have used reinsurance or internal large claim pooling as a mechanism to improve predictability of claim cost and protect against catastrophic claims. Carriers often purchase reinsurance from an independent carrier for individuals that reach a specific level of claim cost or for a whole block of business in aggregate. Large carriers or families of carriers will pool large claims over an attachment point and charge back the business units or "sister" carriers for a share of the large claims. The result for reinsurance or claim pooling is smoother rate increases for specific blocks of business and lower risk margins due to the improved predictability of claim costs.

Similarly, an approach being used to increase market stability and remove variability in expected claims costs, is the use of high-risk pool funds to reimburse health plans a portion of the costs of their high-cost enrollees via a market-wide traditional reinsurance arrangement for all carriers. Individuals with pre-existing conditions would remain in the private individual market. Carriers pay claims, manage care and submit claims for high claim individual enrollees for reimbursement. A portion of each individual's total annual claims above a specific threshold is reimbursed by the high-risk pool each year using a retrospective view of actual claims experience. Examples of this approach include Medicare Part D's reinsurance program, the ACA's transitional reinsurance program, and recent changes to the ACA risk adjustment program to include high-cost risk pooling. The latter two of these affect the ACA market and are described in the following paragraph.

Under the ACA, a transitional reinsurance program was in effect from 2014 to 2016. It used contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market using attachment points, reinsurance maximum caps, and reinsurance coinsurance percentages. During the program's first year, the $10 billion reinsurance fund was estimated to have reduced premiums by about 10-14 percent.[48] In 2018, the ACA's risk adjustment program, which transfers money among insurers based on the relative risk of their enrollees, was altered to include a high-cost risk pooling component. A high-risk outlier payment that covers 60 percent of an enrollee's costs above $1 million will be included, funded by a percentage of insurer premiums.[49] In other words, the program will continue to transfer funds among insurers, with no additional funding source.

[48] "Drivers of 2015 Health Insurance Premium Changes." American Academy of Actuaries Issue Brief. June 2014. http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf

[49] "Using High-Risk Pools to Cover High-Risk Enrollees." American Academy of Actuaries Issue Brief. February 2017. http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf

High-Risk Pool Reimbursement—Based on Health Conditions

Rather than using high-risk pool funds to reimburse plans based on spending exceeding a threshold, reimbursements could be based on an enrollee having one or more specified high-risk conditions. Similar to when insurer eligibility for reimbursements is based on spending exceeding a threshold, this type of approach is a virtual risk pool that is invisible to the enrollee. Conditions-based programs can be tailored to target specific conditions and be used to support public health programs. This can create synergy with existing public policy goals and could potentially dovetail with population health management goals.

An example of this approach is the Maine Guaranteed Access Reinsurance Association (MGARA). MGARA predated the ACA and was suspended in 2014 when the ACA transitional reinsurance program launched. Maine's 1332 waiver application would restart the program.[50] Those with specified conditions are automatically reinsured and carriers can choose to reinsure additional members based on underwriting. The carrier pays a reinsurance premium equal to 90% of the insurance premium. For 2019, the benefit would be 90% of claims paid between $47,000 and $77,000 and 100% of claims paid in excess of $77,000, net of amounts recoverable from the federal high cost risk pool. Funding is provided by an assessment on all health insurers in addition to money recovered from the federal government through the waiver.

Another example of this approach is the Alaska Reinsurance Program (ARP), which provides payments to insurers for individual enrollees who have one or more of 33 identified high-risk conditions.[51] The program is administered by the state's risk pool board. Insurers must request that the ARP funded pool reimburse all claims for the individuals identified with these conditions. Premium revenue, pharmacy rebates, and other revenues the insurers collect for these individuals, is passed to the ARP high-risk fund. In effect, individuals with high-risk conditions are placed in a virtual risk pool separate from the other pool. For 2017, the ARP is funded through state general revenues. Premera, Alaska's only marketplace insurer, reduced its 2017 premium increase request from over 40 percent to just under 10 percent as a result of the ARP. For 2018, the state received approval for a 1332 waiver that would redirect any savings in federal premium subsidies (due to lower premiums) to the high-risk fund. Oliver Wyman projects that Alaska individual market premiums will be 20 percent lower in 2018 with the ARP than they would be without the ARP.

[50] "Executive Summary and Application for Waiver Under Section 1332 of the Patient Protection and Affordable Care Act." State of Maine. https://www.maine.gov/pfr/insurance/mgara/section_1332_innovation_waiver_application.pdf

[51] "Alaska: State Innovation Waiver under section 1332 of the PPACA." The Centers for Medicaid & Medicare Services. July 11, 2017. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf

Pros and Cons of the Approaches

Advantages the Programs Have in Common

If individuals are not moved out of the market into a separate high-risk pool, the programs are both invisible to the insured enrollee. Therefore, there is no stigma attached to eligible enrollees or disruption with provider availability in the high-risk pool network.

The premium rates for insured enrollees are the same as other individuals with the same plan, age and geographic location.

The same plan choices exist for high-risk enrollees and all others in the same geographic location.

The administration is primarily a financial function, so it is typically less expensive than administering a traditional high-risk pool where members are moved to a separate plan (like CHAND).

The program can be tailored to encourage carriers to manage care even on high risk enrollees. To encourage insurers to manage care after the reimbursement threshold is reached, insurers should have to retain the risk for a portion of claims over the threshold. High-risk reinsurance programs that reimburse insurers for 100% of the payment of large claims leave the insurer with less incentive to appropriately manage care and seek cost-saving alternatives.

Pros and Cons

Pros – Health Spending Levels

Health Spending level reinsurance results in claims cost being more predictable and therefore can reduce risk charges or margins for unpredictability.

Health Spending-based programs are straightforward. Retrospective analysis shows whether insurers qualify for reimbursement above the threshold. Large claims are always at least partially reimbursed.

Both Conditions-based and Health Spending-based programs require ongoing work to determine if reinsurance parameters need updates, but that work is limited. Parameters include attachment point(s), coinsurance percentage(s), and the reinsurance cap. Each year staff would evaluate attachment point(s), the reinsurance cap and coinsurance percentage(s) using inputs from carrier data calls, rate filings and consideration of funding constraints.

Pros – Conditions-Based

Conditions that are high year after year, but do not reach the attachment point, are reimbursed.

Cons – Health Spending Levels

Conditions that are high year after year, but do not reach the attachment point, may not be reimbursed. Using a dollar threshold approach to reimburse plans for high-cost enrollees can cause some inequities among insurers. Insurers that are able to attain lower provider payment rates and provide more care management and cost-effective care, may benefit less than plans with higher spending. Similarly, insurers in low-cost areas may benefit less from this approach than insurers in high-cost areas. Considerations could be given to whether adjustments to reflect provider payment rates and regional unit cost differentials would be appropriate and feasible.

Cons – Conditions-Based

Conditions-based programs often require the carrier to request reimbursement based upon underwriting. This prospective approach that reinsures claims based on preexisting health conditions and/or medical underwriting results in some members being reinsured who will not have large claims and some large claims not being reinsured due to large claims from conditions not specified and carrier failure to enroll members. Also, if medical underwriting is involved it adds administrative expense and requires applicants to provide medical information.

Conditions-based programs that limit reimbursements to a defined list of conditions may not sufficiently account for the financial impact of rare, costly diseases that occur only occasionally or due to new conditions or expensive treatments.

Conditions-based programs require ongoing work to evaluate new high cost conditions, and to reconsider the current condition list. Among considerations, are whether treatment protocols have changed and whether costs have changed materially. This revision would need to be done in a timely manner each year, so insurers can update their administrative systems and properly set premiums.

Care should be used when establishing a Conditions-based program and its requirements. The list of conditions would need to be determined, and the process for identifying enrollees with specified conditions would need to be defined. To avoid gaming, the conditions included should be those that are not susceptible to discretionary diagnostic coding. If carriers can decide whether to submit claims to the high-risk pool for eligible enrollees, adverse selection against the risk pool could result. For example, adverse selection would result if carriers under this system wait until the end of the year to request reinsurance for those individuals with the identified conditions whose claims are higher than their revenue, rather than requesting reinsurance for all individuals with the conditions. Requiring all insurers to submit claims on all enrollees with the specified conditions eliminates the selection opportunity.

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XIII. Appendix B - Reinsurance Based on Health Spending: Prospective vs. Retrospective

On our June 25 call, the ND Department of Insurance expressed a strong preference for a reinsurance program based on health spending above an attachment rather than on specified conditions. We then discussed prospective versus retrospective approaches. The purpose of this memorandum is to flesh out that discussion and list some pros and cons of each approach.

High-Risk Pool Reimbursement Based on Health Spending - Prospective
Under a prospective approach, carriers would need to determine at issue and/or at renewal which of their members to reinsure. The carrier would then be required to pay a reinsurance premium for that member. The carrier would receive reimbursement only if the member is reinsured and the member's claims exceed the attachment point.

An example of this approach is the Maine Guaranteed Access Reinsurance Association (MGARA). Although this program provided for automatic reinsurance based on specified conditions, it also allowed carriers to select other members to reinsure based on medical underwriting. MGARA predated the ACA and was suspended in 2014 when the ACA transitional reinsurance program launched. Maine's 1332 waiver application would restart the program.[52] The carrier pays a reinsurance premium equal to 90% of the insurance premium. For 2019, the benefit would be 90% of claims paid between $47,000 and $77,000 and 100% of claims paid in excess of $77,000, net of amounts recoverable from the federal high cost risk pool. Funding is provided by an assessment on all health insurers in addition to money recovered from the federal government through the waiver.

High-Risk Pool Reimbursement Based on Health Spending - Retrospective
Under a retrospective approach, all members in the individual ACA market would be reinsured. The carrier would receive reimbursement for all members whose claims exceed the attachment point. There would be no need for carriers to pay reinsurance premiums, but they could still be at risk through a coinsurance requirement. That is, the reinsurance benefit would be less than 100% of the portion of the claim that exceeds the attachment point.

An example of this approach is the ACA's transitional reinsurance program. This program was in effect from 2014 to 2016. No reinsurance premiums were required. The program used contributions collected from all insurers and self-funded plans to offset a portion of claims for high-cost individuals in the individual market using attachment points, reinsurance maximum caps, and reinsurance coinsurance percentages. During the program's first year, the $10 billion reinsurance fund was estimated to have reduced premiums by about 10-14%.[53] For that year (2014), the reinsurance benefit was 80% of covered claims costs between the attachment point of $45,000 and the reinsurance cap of $250,000.[54]

[52] "Executive Summary and Application for Waiver Under Section 1332 of the Patient Protection and Affordable Care Act." State of Maine.
[53] "Drivers of 2015 Health Insurance Premium Changes." American Academy of Actuaries Issue Brief. June
[54] In 2015, CMS retroactively increased the 2014 benefit to 100% of covered claims costs between the attachment point of $45,000 and the reinsurance cap of $250,000 because reinsurance contributions exceeded the requests for reinsurance payment.

Pros and Cons of the Approaches

Advantages the Programs Have in Common

Individuals are not moved out of the market into a separate high-risk pool. The programs are both invisible to the insured enrollee. Therefore, there is no stigma attached to eligible enrollees or disruption with provider availability in the high-risk pool network.

The premium rates for insured enrollees are the same as other individuals with the same plan, age and geographic location.

The same plan choices exist for high-risk enrollees and all others in the same geographic location.

Reinsurance results in claims cost being more predictable and therefore can reduce risk charges or margins for unpredictability. This increased predictability also reduces the need for carriers to purchase separately available commercial reinsurance and therefore can reduce costs which would have been included in premiums.

The program can be tailored to encourage carriers to manage care even on high risk enrollees. To encourage insurers to manage care after the reimbursement threshold is reached, insurers should have to retain the risk for a portion of claims over the threshold. High-risk reinsurance programs that reimburse insurers for 100% of the payment of large claims, leave the insurer with less incentive to appropriately manage care and seek cost-saving alternatives.

Both methods would require additional funding from assessments from the carrier's total block of business including small group and large group and from federal funds from reduced advanced premium tax credits. Both of these could be received early in the year. Minnesota received their total federal amount in April in 2018.

Pros and Cons

We understood from our call that you were considering having the carriers pay a reinsurance premium under the prospective approach and have commented on that under the prospective approach.

Pros – Prospective Approach

The requirement for a reinsurance premium paid by the carriers provides an additional source of funds early on, allowing a more generous reinsurance benefit level. However, the premiums collected are just dollar-trading among the carriers in the individual market, so it does not result in additional premium savings to members.

Carriers take on some risk of individuals not being identified at issue or renewal.

Pros – Retrospective Approach

Retrospective reinsurance programs are straightforward. Retrospective analysis shows whether insurers qualify for reimbursement above the threshold. Large claims above the threshold are always at least partially reimbursed.

Carriers are at risk for their share above the attachment point. For example, the reinsurance could only pay a percentage of claims above the attachment point and the carrier would then have a continuing incentive to manage the care being funded.

Cons – Prospective Approach
Carriers would need to medically underwrite applicants. This would add to administrative expenses. Carriers that were in the pre-ACA individual market may no longer have the expertise and personnel to do this effectively. Carriers that were not in the pre-ACA market would have even more difficulty.

Carriers could also obtain medical history from providers and pharmacies / pharmacy benefit managers or their own claim histories in order to predict which enrollees are more likely to have chronic conditions therefore result in claims over the threshold. Creating a need to negotiate third parties for this data adds an additional level of expense in the market.

Applicants would have to answer health questions so that they can be medically underwritten.
If the carriers paid a reinsurance premium, the need to collect reinsurance premiums would add administrative expense for the administrator of the reinsurance program.

The fact that it would not be known in advance how many members the carriers will choose to reinsure, would make it more difficult to predict the funding needs each year or to set an attachment point appropriate to a given amount of available funding.

Cons – Retrospective Approach
We are not aware of any drawbacks to this approach.

Joint Industry, Business and Labor Committee Hearing

HB 1106

Megan Houn, BCBSND

January 15, 2019

Good morning Chairmen Klein and Keiser and members of the joint House and Senate IBL committees, my name is Megan Houn. I am the Director of Government Relations for Blue Cross Blue Shield North Dakota (BCBSND). I appreciate the opportunity to share comments on behalf of BCBSND.

We would like to commend Commissioner Godfread for initiating the interim study to identify potential state options to reform the individual health insurance market in ND. BCBSND agrees that keeping and attracting as many people as possible in one pool is the right approach for North Dakota and we are here in support of HB 1106. We have long said that in order to have a health insurance system in which anyone can obtain coverage regardless of their health status, there must be a way to pay for the cost of caring for those with significant medical needs to ensure a balanced risk pool. Otherwise, premiums increase and coverage becomes much less affordable and accessible.

BCBSND has been committed to participating in the Marketplace to ensure optimal choice for our members across the State of North Dakota. In 2018, we were the only remaining carrier in 48 of the state's 53 counties.

We favor reinsurance programs and agree with the concept of an invisible high-risk pool. The Individual health insurance market may not be large enough in some states to support the volume of high cost cases that have entered the pool. Having some sort of reinsurance

mechanism is vitally important to help stabilize rates. It is BCBSND's preference to have a broad-based funding model which includes a premium tax credit.

We are pleased that the Commissioner and your committees are looking at solutions for those North Dakotans who can no longer afford health insurance. Thank you for your time and consideration of these comments.

I'll be happy to take any questions that you may have.

HB 1106 1/15/19 Att #5

Dear Chair and committee members:

My name is Dana Bacon. I serve as the regional government affairs director for The Leukemia & Lymphoma Society, and I'd like to thank you for the opportunity to voice our support for House Bill 1106.

At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. Our organization exists to find cures and ensure access to treatments for blood cancer patients. We believe firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care.

For cancer patients, access to meaningful health insurance coverage is crucial to getting the care and treatment they need. LLS has adopted a set of Coverage Principles that help us define what counts as "meaningful" health insurance coverage. We know that meaningful coverage for cancer patients must be both affordable and stable, and we believe that a reinsurance program will help North Dakota meet these standards for blood cancer patients and others on the individual market.

Reinsurance programs in other states have shown promising results in controlling premium growth, and in some cases significantly reducing premiums. Eight states, including Alaska and Oregon, all currently operate reinsurance programs on models similar to that proposed here, and all have received significant federal pass-through funding returned as a result of reductions in premium growth and, consequently, advanced premium tax credit payments in their states. Several states, including Colorado and Wyoming, are reviewing bills this year to launch reinsurance programs.

At the federal level, reinsurance programs have been used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the ACA and reduced premiums by an estimated 10 to 14 percent in its first year.

LLS believes North Dakota's reinsurance proposal in HB 1106 will bring greater stability to the individual market and will help relieve premium burdens for patients and consumers. We are pleased to support this legislation, and are grateful for the Department of Insurance's leadership and research efforts on this issue. Thank you for your time.

HB1106 1/15/19 Att. # 6

House Bill 1106
Testimony before House/Senate Industry, Business, & Labor Committee
Matthew C. Larsgaard, MBA
Automobile Dealers Association of North Dakota
North Dakota Implement Dealers Association
8:00 a.m., January 15, 2019

1/14/19

Mr. Chairman and members of the committee, my name is Matthew Larsgaard and I am appearing on behalf of the Automobile Dealers Association of North Dakota (ADAND) which consists of our state's franchised new car dealers and the North Dakota Implement Dealers Association (NDIDA) which represents our state's farm equipment dealers. Collectively, these dealerships generate approximately $8 Billion in annual revenue and employ roughly 6,600 employees.

We support the proposed amendment that removes the words "a self-funded multiple employer welfare arrangement" from the definition of "Insurer" on page 3, lines 14-15.

Our two Associations (ADAND & NDIDA) have a Self-funded Multiple Employer Welfare Arrangement (MEWA) through which we offer health insurance to automobile dealers, farm equipment dealers, and associate members in North Dakota. To my knowledge, our MEWA is one of the largest in the state.

It is our understanding that HB 1106 is intended to subsidize the individual market by assessing up to a 2% fee on the health insurance premiums of self-funded MEWAs. If this fee is imposed, we would be required to pass it on to our groups and employees. Many of our groups and employees have expressed concern about the increasing cost of health insurance. Some of our groups are struggling to pay their current premiums. In fact, over the last year we have had some groups in default simply because they didn't have the money to pay their premium billing. With this in mind, **we respectfully request the state not place the burden of individual health insurance affordability on those that, in some cases, are already struggling to afford their own health insurance.**

Mr. Chairman we are not questioning the merits of the legislation, simply the funding of it. Employers and employees are very sensitive to health insurance rates. Without the amendment, this bill presents a significant challenge to our Trust and the affordability of the health insurance we offer our members. We respectfully urge this committee to adopt the amendment that removes the assessment on MEWAs.

Thank you for the opportunity to testify.

Matthew C. Larsgaard, MBA
President, Automobile Dealers Association of North Dakota
President, North Dakota Implement Dealers Association

SANFORD HEALTH PLAN

Joint IBL Committee
Representative George J. Keiser, Chairperson
Senator Jerry Klein, Chairperson
January 15, 2019

Chairman Keiser and Chairman Klein, members of the Industry, Business and Labor Committees, I am Lisa Carlson, Senior Director of Market Strategy at Sanford Health Plan. Sanford Health Plan is pleased to have participated in the North Dakota Insurance Department's report on the individual health insurance market and the NovaRest report regarding the opportunity for a 1332 State Waiver. Sanford Health Plan offers testimony today in support of House Bill 1106.

Foster Stable and Affordable Premiums
The invisible reinsurance program will establish a foundation for more stable and predictable insurance premiums in North Dakota. With just three carriers participating in the individual market, a reinsurance program helps alleviate shock claims when one carrier experiences high dollar, catastrophic costs more so than other carriers do. This is best accomplished through broad-based funding, which I will discuss further.

The reinsurance program also reinforces the insurance industry's obligation to maintain affordable premiums and accountability towards bending the cost curve. Because the reinsurance program is funded through assessments on insurers, insurers are incentivized to hold down medical expenses. It will protect residents by ensuring that North Dakotans will not have to pay the high cost of medical bills through higher premium increases.

A Broad Solution Benefits both the Group and Individual Markets
Spiraling health care costs affect everyone; therefore, everyone must be part of the solution. High-dollar and catastrophic medical bills contribute to an unstable market. Employer groups of all sizes benefit when there is high percentage of insureds and a stable individual market (both on- and off-exchange).

It is important to note that not all working individuals get insurance through a group employer. Some individuals are self-employed. Some individuals are not eligible for coverage. For example, some employers impose waiting periods before individuals are eligible for insurance, or people are in between jobs, or have part-time positions and are not eligible for insurance. The individual market is used to cover some individuals episodically and some long-term.

Additionally, a subset of North Dakotans are above 400% of the FPL, thus not eligible for subsidies on the exchange. Such individuals buy insurance outside of the Marketplace. Health Plans are constantly trying to strike a balance to keep premiums affordable both on and off the exchange. All North Dakotans and employer groups benefit when the maximum number people have, and can afford, insurance. When health insurance becomes unaffordable, people start going without insurance. When the uninsured rate increases, cost shifting to the employer group market threatens the affordability of group insurance premiums as providers face increased bad debt.

SANFORD HEALTH PLAN

A Local Solution with Local Control
A new reinsurance program will also counterbalance the uncertainty in Washington, D.C. Because the reinsurance program will have oversight by local carriers and state regulators, design and administration of the reinsurance program will have local, state control and authority. A Board consisting of health plan experts, state policy experts, and legislators will ensure the reinsurance program reflects North Dakota principles with local control.

Allowing a Carrier Tax Credit
Sanford Health Plan supports allowing a carrier premium tax credit for the assessments. As a new program, it makes sense to allow carriers a tax credit on assessments.

In conclusion, we applaud the state for initiating a 1332 Waiver that has the potential of offer market stability and affordable premiums. Sanford Health Plan will continue to be an active participant in the dialogue and planning for the waiver.

Thank you.

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Monthly Projected Premium for 21 year old non smoker

Annual Projected Premium for 21yr Old Non-Smoker

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Health Care Expenditures

Health care expenditures drive health insurance premiums. As the cost of health care services increases due to the cost of the individual services or the use of the services, that increased cost is passed on to policyholders in the form of premium increases. Periodically, the Centers for Medicare and Medicaid Services (CMS) releases a provider expenditure report, which gives information on the annual health care expenditures for certain categories by state and by region. The latest report includes data from 1980 through 2014. The table below shows the total expenditures in millions for North Dakota, by category, for the most recent available 5 years included in the report.[1]

Table #22

North Dakota Expenditure Category (in millions)	2010	2011	2012	2013	2014
Hospital Care	2,642	2,974	3,142	3,528	3,827
Physician & Clinical Services	1,087	1,110	1,201	1,219	1,264
Other Professional Services	144	156	166	181	197
Dental Services	274	285	290	302	323
Home Health Care	42	50	52	54	54
Prescription Drugs	684	662	634	677	745
Other Non-durable Medical Products	110	113	121	123	124
Durable Medical Products	96	108	124	125	128
Nursing Home Care	483	505	514	549	578
Other Health, Residential, and Personal Care	459	494	521	552	602
Total Personal Health Care	6,021	6,454	6,765	7,310	7,841

The CMS report showed a consistent increase in total personal health care expenditure over the last available five years. The following graph shows the trend in total personal health care expenditure in North Dakota from 2010 to 2014.

[1] CMS.gov. "State (Provider) Health Expenditures by State of Provider, 1980-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html. Accessed December 25, 2018.

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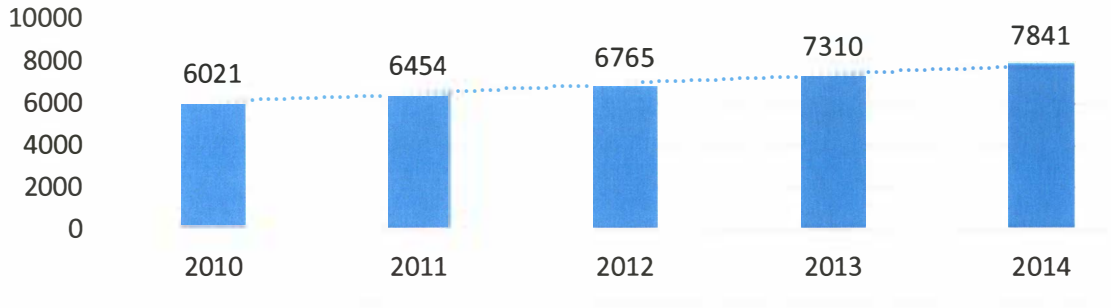
CHART #72: TOTAL PERSONAL HEALTH CARE EXPENDITURE IN NORTH DAKOTA, 2010-2014 (IN MILLIONS)



CMS also provided a report detailing the health expenditures for personal health care by state as of 2014. The following chart compares the aggregate and per capita estimates of North Dakota (in red) to the other states.[2] According to the table, North Dakota's per capita health expenditures rank 7th highest of 51[3] states (including the District of Columbia).

[2] CMS.gov. "Health Expenditures by State of Residence, 1991-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html. Accessed December 25, 2018.

[3] For readability only certain states have been included.

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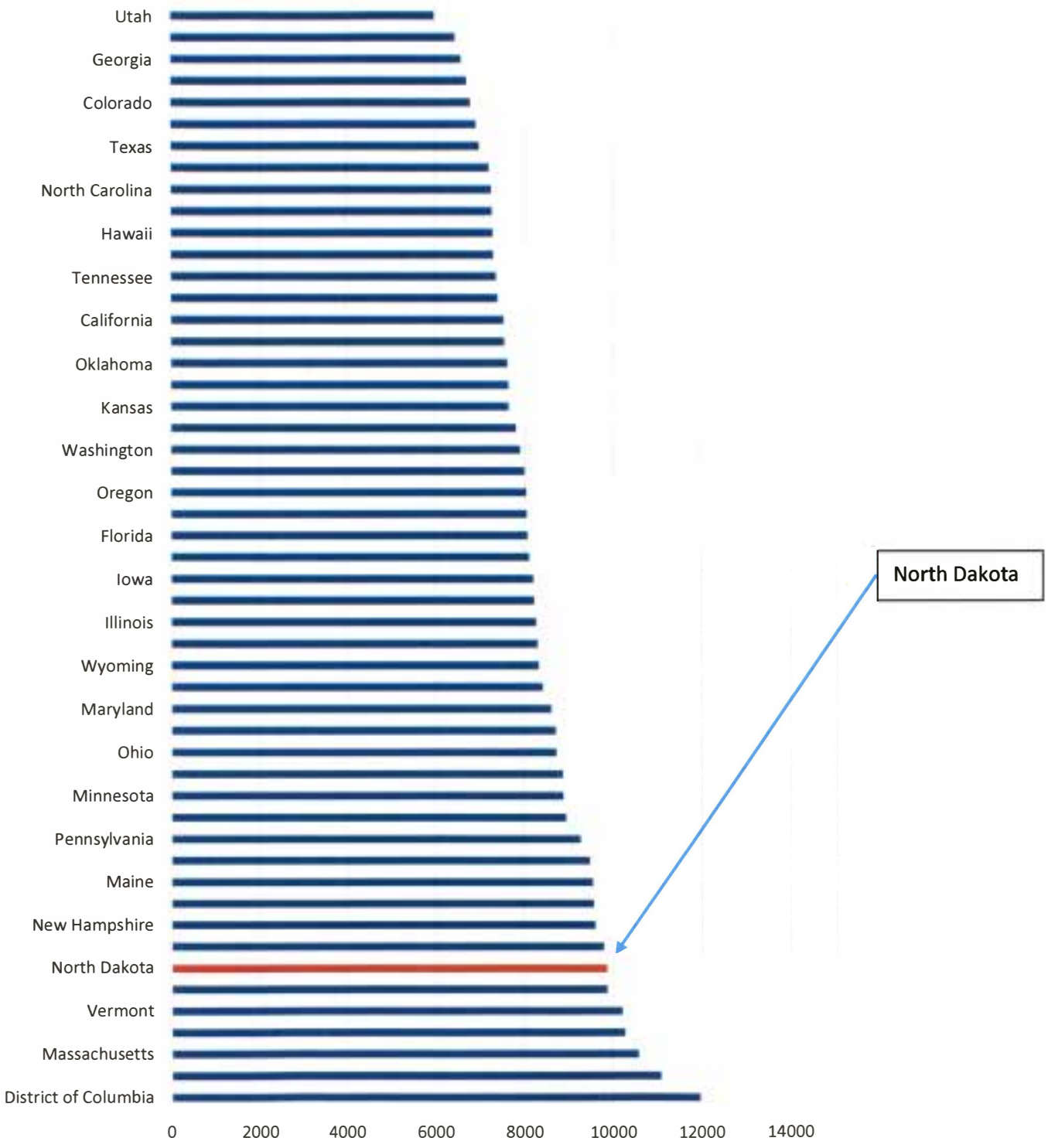
CHART #73: PERSONAL HEALTH EXPENDITURE BY STATE, 2014



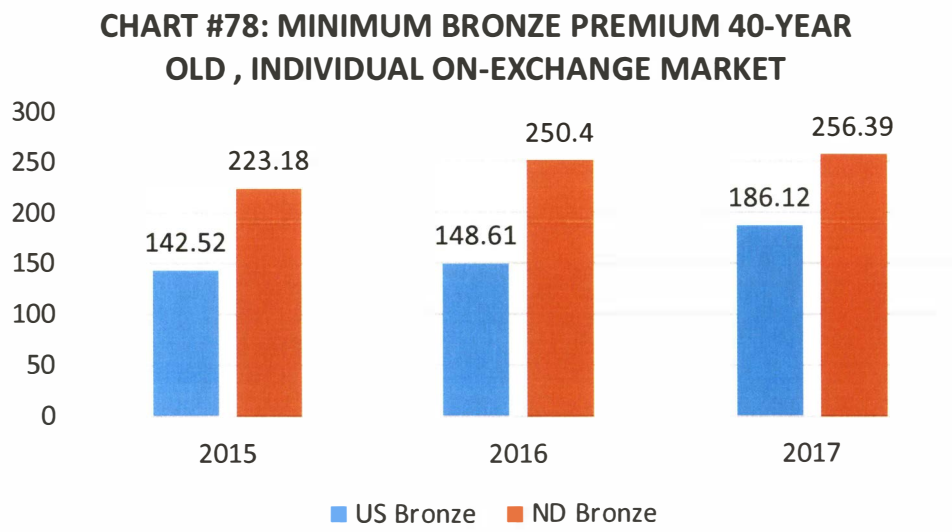
We recognize this data, while relatively recent, is outdated due to implementation of the ACA in 2014. Although, even after the implementation, the market has continued to evolve and adapt to continually changing regulations and guidance.

Premium Rates

Since premiums are typically calculated based on estimated health care claims, as health care expenditures increase, premium rates increase. There are many reasons premiums typically increase faster than health care expenses. One reason for higher premium increases is that deductible amounts do not increase, therefore, all increases from health care dollars are used to increase premiums. This results in higher premium increases. For example, if a policy has a $2,000 deductible and a $5,000 estimated claims cost ($7,000 total health care costs), and health care costs are expected to increase $700, or 10%, that is added to the estimated claims cost of $5,000 for a 14% increase in claims cost.

The charts below compare the average lowest cost on exchange premiums for a 40-year old by metal tier for North Dakota compared to the United States overall from 2015 to 2017 for the individual and small group markets.[4,5,6] Large group premiums are not available.

Individual Market



[4] Healthcare.gov. www.data.healthcare.gov. Accessed December 26, 2018.
[5] Healthcare.gov does not provide data earlier than 2015.
[6] North Dakota did not offer any on exchange platinum plans in the individual market.

CHART #79: MINIMUM SILVER PREMIUM 40-YEAR OLD , INDIVIDUAL ON-EXCHANGE MARKET

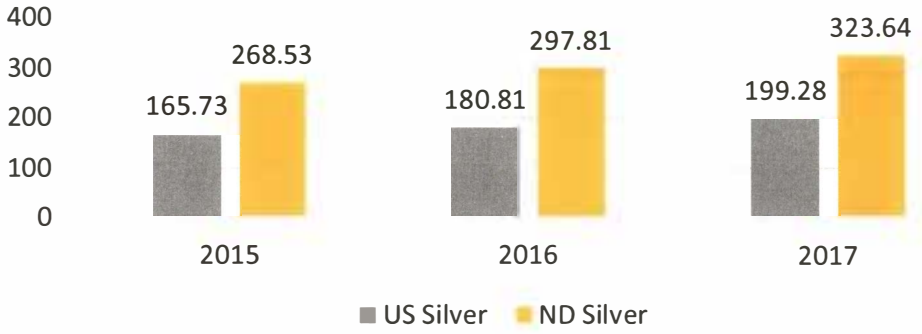
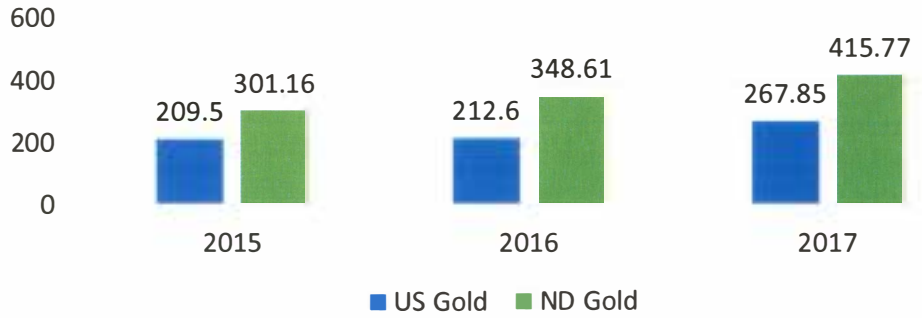


CHART #80: MINIMUM GOLD PREMIUM 40-YEAR OLD , INDIVIDUAL ON-EXCHANGE MARKET



Small Group

CHART #81: MINIMUM BRONZE PREMIUM 40-YEAR OLD , SMALL GROUP ON-EXCHANGE MARKET

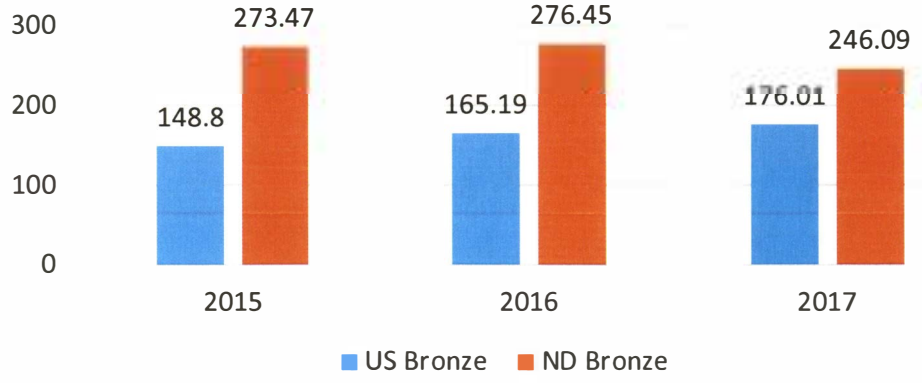


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CHART #82: MINIMUM SILVER PREMIUM 40-YEAR OLD , SMALL GROUP ON-EXCHANGE MARKET

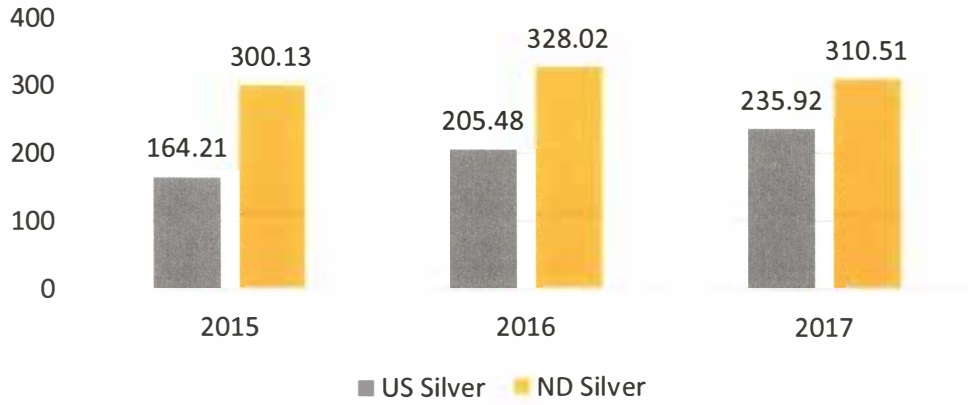


CHART #83: MINIMUM GOLD PREMIUM 40-YEAR OLD , SMALL GROUP ON-EXCHANGE MARKET

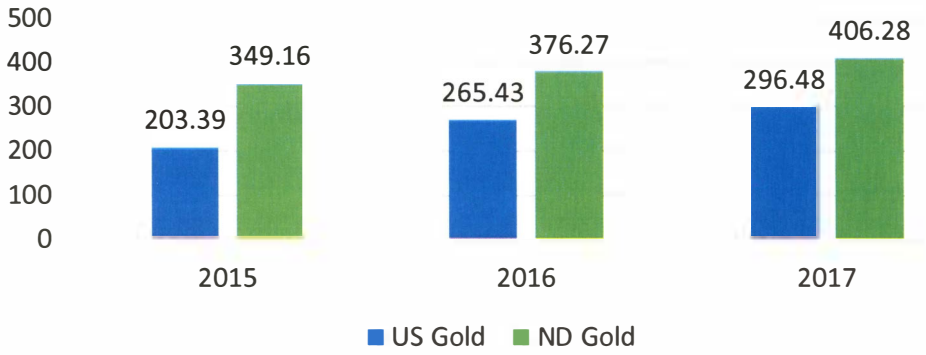
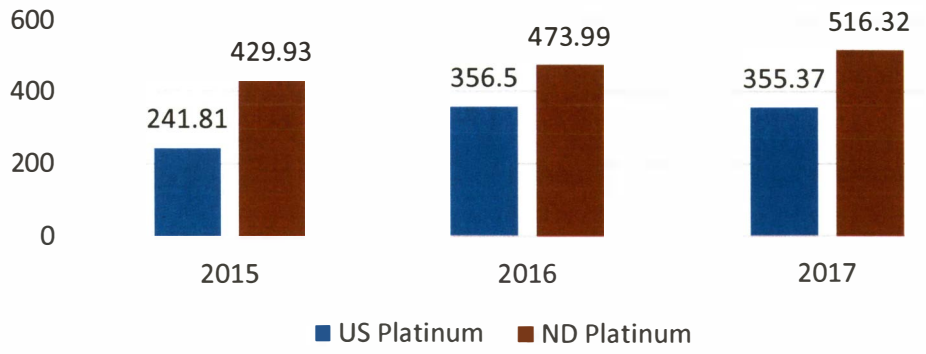


CHART #84: MINIMUM PLATINUM PREMIUM 40-YEAR OLD , SMALL GROUP ON-EXCHANGE MARKET



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Drivers of Higher Costs and Cost Reductions

We requested carriers provide a list of their top 10 drivers of higher and lower health insurance costs. For comparability, we requested carriers associate these drivers into uniform higher-level drivers that we provided. All of the data provided can be found in ***Appendix H***.

Overall, carriers reported a $36.2 million rise in health care costs from the top five increase drivers and $68 million reduction in the top five decrease drivers. The top five increase drivers accounted for 84% of the increases. The top five decrease drivers accounted for 99% of the decreases. We interpret this to imply that more of the "lessor" drivers are playing a role in the increases in health care costs rather than just the top five, while decreases are largely driven by major factors.

The top five drivers of health care cost increases reported for 2017 are prescription drug, physician, outpatient hospital, mental health/chemical dependency, and diagnostic imaging. The top five services that have decreased costs are population change, inpatient hospital, physician, benefit buy-down, and other. Services can be on both lists because some aspects of a cost or service are increasing, and some are decreasing. (Note: a driver can be included as both an increase driver and a decrease driver because of the level of reporting.) For instance, the physician category includes services that are increasing and decreasing the cost of healthcare, which causes carriers to report physician as an increasing and decreasing cost driver, although the increase outweighs the decrease. Additionally, some carriers may consider Physician an increase factor while other may consider it a decrease factor, which would also cause it to be on both lists.

The following is a ranking of the health care services that are driving increases and decreases in health insurance premiums, as reported by carriers in North Dakota after consolidation and redefinition.

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Increases:

Table #26		
Company Reported Service (Standardized Category)	**Increases**	**% of Total Listed Increases**
Prescription Drug	$11,295,000	26%
Physician	$8,274,000	19%
Outpatient Hospital	$7,357,000	17%
MH/CD	$5,128,000	12%
Diagnostic Imaging	$4,124,000	10%
Inpatient Hospital	$2,972,550	7%
Outpatient	$1,468,186	3%
Deductible Leveraging	$855,974	2%
Emergency Room	$730,000	2%
Professional	$351,245	1%
Preventive	$263,000	1%
Drug Card	$97,333	0%

Decreases:

Table #27		
Company Reported Service (Standardized Category)	**Decreases**	**% of Total Listed Decreases**
Population Change	(40,177,691)	59%
Inpatient Hospital	(21,758,000)	32%
Physician	(4,658,000)	7%
Benefit Buy Down	(830,800)	1%
Other	(564,000)	1%
Prescription Drug	(349,000)	1%
MH/CD	(140,000)	0%
Laboratory	(87,000)	0%
Ambulance	(43,000)	0%

Attachment 3
Jan 21, 2019

19.8068.01001
Title.

Prepared by the Legislative Council staff for
Representative Keiser
January 16, 2019

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1106

Page 1, line 3, after the semicolon insert "to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study;"

Page 1, after line 4, insert:

"**SECTION 1. AMENDMENT.** Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1."

Page 2, line 11, remove ", single employer"

Page 2, line 11, remove "not regulated by the state"

Page 3, line 14, after the first underscored comma insert "and"

Page 3, line 14, remove ", a self-funded multiple employer welfare"

Page 3, remove lines 15 through 19

Page 3, line 20, remove "prescription claims in excess of a previously determined amount"

Page 3, line 21, replace "11." with "10."

Page 3, remove lines 23 through 28

Page 6, line 9, remove "and based on third-party administrator"

Page 6, line 10, remove "premium equivalents in this state"

Page 6, line 12, remove "and third-party administrator premium equivalents"

Page 6, line 13, after the underscored period insert "An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due."

Page 6, line 17, remove "and third-party administrator premium"

Page 6, line 18, remove "equivalent"

Page 6, line 18, remove "The"

Page 6, remove lines 19 and 20

Page 8, after line 12, insert:

"**SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PREMIUM TREND.** During the 2019-20 interim, the legislative management shall study ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution based to reduce costs and may include consideration of whether a strict managed care model might be effective. The legislative management shall report its findings and recommendations, together with any legislation necessary to implement the recommendations, to the sixty-seventh legislative assembly."

Renumber accordingly

Attachment 4
Jan 21, 2019

Prepared by the North Dakota
Insurance Department
January 21, 2019

PROPOSED AMENDMENTS TO BILL NO. 1106

Page 6, line 13, after the underscored period, insert "A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment."

Renumber accordingly

HB 1106

Attachment 5
Jan 21, 2019

With PERS

1A. ***State fiscal effect*** *: Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

Page 1

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenue			(23,509,667)		(32,950,615)	
Expenditures						
Appropriations						

1B.

County, city, school distric and township fiscal effect *: Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2A. ***Bill and fiscal impact summary:*** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The amendment to HB 1106 would allow companies to take the assessment created by the bill as a premium tax credit, but limited to the amount of premium tax due.

2B. ***Fiscal impact sections:*** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The amounts assessed to insurers as a result of HB 1106 would reduce premium tax revenue in the year paid, limited by the amount of premium tax due.

3. ***State fiscal effect detail:*** *For information shown under state fiscal effect in 1A, please:*

A. ***Revenues:*** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The actuarial study done indicated the amounts needed to fund the invisible reinsurance pool. These amounts were allocated in accordance with the bill, in proportion to projected premiums written, and limited to estimated premium tax due.

B. ***Expenditures:*** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill would have no fiscal impact on expenditures.

C. ***Appropriations:*** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The bill would have no fiscal impact on appropriations.

Without PERS

HB 1106

Attachment 6
Jan 21, 2019

1A. ***State fiscal effect*** *: Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

Page 1

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenue			(31,702,006)		(43,082,938)	
Expenditures						
Appropriations						

1B.

County, city, school distric and township fiscal effect *: Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties			
Cities			
School Districts			
Townships			

2A. ***Bill and fiscal impact summary:*** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The amendment to HB 1106 would allow companies to take the assessment created by the bill as a premium tax credit, but limited to the amount of premium tax due.

2B. ***Fiscal impact sections:*** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

The amounts assessed to insurers as a result of HB 1106 would reduce premium tax revenue in the year paid, limited by the amount of premium tax due.

3. ***State fiscal effect detail:*** *For information shown under state fiscal effect in 1A, please:*

A. ***Revenues:*** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The actuarial study done indicated the amounts needed to fund the invisible reinsurance pool. These amounts were allocated in accordance with the bill, in proportion to projected premiums written, and limited to estimated premium tax due.

B. ***Expenditures:*** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill would have no fiscal impact on expenditures.

C. ***Appropriations:*** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

The bill would have no fiscal impact on appropriations.

Attachment 7
Jan 21, 2019

TESTIMONY OF SCOTT MILLER

House Bill 1106 – Insurance Department Invisible Reinsurance Pool

Good Morning, my name is Scott Miller. I am the Executive Director of the North Dakota Public Employees Retirement System, or NDPERS. I appear before you today in a neutral position regarding House Bill 1106. We have not had the opportunity to discuss this bill with the NDPERS Board, but will review it with them on Thursday.

At its core, HB 1106 is a policy decision for the Legislative Assembly to make involving methods to maintain the stability of the State's individual health insurance market. From a policy perspective, NDPERS has no position on that topic.

How the reinsurance pool is funded, however, would have an impact on NDPERS, the state, and its political subdivisions. As written, HB 1106 requires the commissioner to assess health insurers that are writing group health benefit plans in the state. That would include any insurer providing health insurance to the state through the uniform group insurance program that NDPERS administers. Insurers providing health insurance to the state through the uniform group insurance program would potentially pass that assessment on to us through premium increases. We have verified with Sanford Health Plan that if this bill is passed, it will result in an increase in the projected health plan premiums for the 2019-21 biennium. A reinsurance assessment of 1.5% of premium results in an additional premium of $21.40 per contract per month for the state, which is an $8.1 million increase for the 2019-21 biennium. This estimate is the basis for the fiscal note. Since this is not provided for in the proposed premium being considered by the legislature, I have attached a proposed amendment to this bill to add the additional appropriation authority to each agency's budget to pay the cost of this assessment. If this bill were to pass and the additional appropriation authority was not granted, it will be necessary for the NDPERS Board to increase member's deductibles and/or co-insurance to offset the cost of the assessment, or use our reserves to cover the additional cost.

I understand that there is a proposed amendment that would essentially remove that potential burden by allowing carriers to apply the reinsurance assessment as a credit towards the premium tax. It is our understanding that this credit would not be available for the NDPERS health plan, as we are exempt from the state premium tax pursuant to NDCC 54-52.1-10. The committee may want to consider extending this exemption to include the reinsurance assessment.

Mr. Chairman, that concludes my testimony.

Attachment 7
Jan 21, 2019
Page 2,

FISCAL NOTE HB1106

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$3,593,624	$4,528,483	$3,593,624	$4,528,483
Appropriations	$0	$0	$3,593,624	$4,528,483	$3,593,624	$4,528,483

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties	$0	$1,170,494	$1,170,494
Cities	$0	$597,830	$597,830
School Districts	$0	$564,960	$564,960
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*
This bill would establish a reinsurance pool for the individual health insurance market.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*
The cost estimate to fund the reinsurance pool is 1 ½% of group health plan premiums. This would be $21.40 per state contract per month for the 15,814 state FTE and legislators base on the existing plan design required premium.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*
N/A

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*
A 1 ½% premium assessment based on the $1426.74 NDPERS Health Plan premium for the state employee grandfathered plan would be $21.40 per contract per month.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*
A 1 ½% premium assessment based on the $1426.74 NDPERS Health Plan premium for the state employee grandfathered plan would be $21.40 per contract per month.

HB 1106

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Page 3
Jan 21, 2019

Name: Bryan Reinhardt
Agency: NDPERS
Telephone: 701-328-3919
Date Prepared: 01/18/2019

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Page 4

Department	Executive Budget 2019-2021 FTE	Monthly Change	19-21 Funding Adjustments General	Other	Total
101 Office of the Governor	18.00	$21.40	$9,244.80	$0.00	$9,244.80
108 Office of the Secretary of State	32.00	$21.40	$15,459.48	$975.72	$16,435.20
110 Office of Management and Budget	108.00	$21.40	$45,786.04	$9,682.76	$55,468.80
112 Information Technology Department	459.50	$21.40	$25,468.06	$210,531.14	$235,999.20
117 Office of the State Auditor	56.00	$21.40	$21,265.73	$7,495.87	$28,761.60
120 Office of the State Treasurer	7.00	$21.40	$3,595.20	$0.00	$3,595.20
125 Office of the Attorney General	237.00	$21.40	$91,265.90	$30,457.30	$121,723.20
127 Office of the Sate Tax Commissioner	123.00	$21.40	$63,172.80	$0.00	$63,172.80
140 Office of Administrative Hearings	5.00	$21.40	$0.00	$2,568.00	$2,568.00
150 Legislative Assembly	141.00	$21.40	$72,417.60	$0.00	$72,417.60
160 Legislative Council	36.00	$21.40	$18,489.60	$0.00	$18,489.60
180 Judicial Branch	363.00	$21.40	$182,155.69	$4,281.11	$186,436.80
188 Legal Counsel of Indigents	40.00	$21.40	$19,979.30	$564.70	$20,544.00
190 Retirement and Investment Office	20.00	$21.40	$0.00	$10,272.00	$10,272.00
192 Public Employees Retirement System	33.50	$21.40	$0.00	$17,205.60	$17,205.60
201 Department of Public Instruction	88.75	$21.40	$15,404.82	$30,177.18	$45,582.00
226 Department of Trust Lands	28.00	$21.40	$0.00	$14,380.80	$14,380.80
250 State Library	27.75	$21.40	$12,686.95	$1,565.45	$14,252.40
252 School for the Deaf	43.61	$21.40	$21,167.64	$1,230.45	$22,398.10
253 N.D. Vision Services	27.90	$21.40	$13,814.97	$514.47	$14,329.44
270 Dept of Career and Technical Ed	53.80	$21.40	$27,631.64	$0.04	$27,631.68
215 ND University System	148.90	$21.40	$51,559.50	$24,915.54	$76,475.04
227 Bismarck State College	323.93	$21.40	$71,465.74	$94,904.71	$166,370.45
228 Lake Region State College	118.10	$21.40	$28,224.79	$32,431.37	$60,656.16
229 Willliston State College	100.48	$21.40	$21,582.04	$30,024.49	$51,606.53
230 University of North Dakota	2132.17	$21.40	$286,116.34	$808,966.17	$1,095,082.51
232 UND Medical Center	485.32	$21.40	$97,135.50	$152,124.85	$249,260.35
235 North Dakota State University	1870.16	$21.40	$266,781.35	$693,732.83	$960,514.18
238 ND State College of Science	310.73	$21.40	$80,782.38	$78,808.55	$159,590.93
239 Dickinson State University	213.26	$21.40	$53,426.83	$56,103.51	$109,530.34
240 Mayville State University	209.27	$21.40	$42,722.44	$64,758.63	$107,481.07
241 Minot State University	407.58	$21.40	$94,435.62	$114,897.47	$209,333.09
242 Valley City State University	180.68	$21.40	$54,116.26	$38,680.99	$92,797.25
243 Dakota College Bottineau	82.29	$21.40	$23,139.73	$19,124.41	$42,264.14
244 ND Forest Service	27.00	$21.40	$13,867.20	$0.00	$13,867.20
301 North Dakota Department of Health	199.50	$21.40	$49,624.78	$52,838.42	$102,463.20
303 Department of Environmental Quality	160.50	$21.40	$28,064.17	$54,368.63	$82,432.80
313 Veterans Home	120.72	$21.40	$59,238.21	$2,763.58	$62,001.79
316 Indian Affairs Commission	4.00	$21.40	$2,054.40	$0.00	$2,054.40
321 Department of Veterans Affairs	7.00	$21.40	$2,976.68	$618.52	$3,595.20
325 Department of Human Services	2070.73	$21.40	$591,900.61	$471,626.32	$1,063,526.93
360 Protection and Advocacy Project	28.50	$21.40	$14,637.60	$0.00	$14,637.60
380 Job Service North Dakota	156.61	$21.40	$146.76	$80,288.14	$80,434.90
401 Office of the Insurance Commissioner	44.00	$21.40	$0.00	$22,598.40	$22,598.40
405 Industrial Commission	110.25	$21.40	$53,257.11	$3,367.29	$56,624.40
406 Office of the Labor Commissioner	14.00	$21.40	$7,190.40	$0.00	$7,190.40
408 Public Service Commission	44.00	$21.40	$13,600.28	$8,998.12	$22,598.40
412 Aeronautics Commission	7.00	$21.40	$0.00	$3,595.20	$3,595.20
413 Department of Financial Institutions	31.00	$21.40	$0.00	$15,921.60	$15,921.60
414 Office of the Securities Commissioner	10.00	$21.40	$5,136.00	$0.00	$5,136.00
471 Bank of North Dakota	181.50	$21.40	$0.00	$93,218.40	$93,218.40
473 North Dakota Housing Finance Agency	44.00	$21.40	$0.00	$22,598.40	$22,598.40
475 North Dakota Mill & Elevator Association	157.00	$21.40	$0.00	$80,635.20	$80,635.20
485 Workforce Safety & Insurance	248.14	$21.40	$0.00	$127,444.70	$127,444.70
504 Highway Patrol	197.00	$21.40	$75,782.25	$25,396.95	$101,179.20
530 Department of Corrections and Rehabilitation	938.59	$21.40	$459,367.74	$22,692.08	$482,059.82
540 Adjutant General	224.00	$21.40	$45,499.47	$69,546.93	$115,046.40
601 Department of Commerce	60.80	$21.40	$24,515.79	$6,711.09	$31,226.88
602 Department of Agriculture	71.00	$21.40	$19,708.68	$16,756.92	$36,465.60
627 Upper Great Plains Transportation Institute	43.88	$21.40	$8,163.22	$14,373.54	$22,536.77
628 Branch Research Centers	109.81	$21.40	$40,962.93	$15,435.49	$56,398.42
630 NDSU Extension Service	242.51	$21.40	$66,347.75	$58,205.39	$124,553.14
638 Northern Crops Institute	12.80	$21.40	$4,626.03	$1,948.05	$6,574.08
640 NDSU Main Research Center	340.05	$21.40	$107,487.48	$67,162.20	$174,649.68
649 Agronomy Seed Farm	3.00	$21.40	$0.00	$1,540.80	$1,540.80
670 Racing Commission	2.00	$21.40	$947.68	$79.52	$1,027 20
701 State Historical Society	75.00	$21.40	$35,574.90	$2,945.10	$38,520.00
709 Council on the Arts	5.00	$21.40	$2,567.96	$0.04	$2,568.00
720 Game & Fish Department	160.00	$21.40	$0.00	$82,176.00	$82,176.00
750 Department of Parks & Recreation	61.50	$21.40	$29,883.03	$1,703.37	$31,586.40
770 State Water Commission	90.00	$21.40	$0.00	$46,224.00	$46,224.00
801 Department Of Transportation	980.00	$21.40	$0.00	$503,328.00	$503,328.00
State Total	**15814.07**	$21.40	**$3,593,624**	**$4,528,483**	**$8,122,106**

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FISCAL NOTE HB1106

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2017-2019 Biennium		2019-2021 Biennium		2021-2023 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$3,593,624	$4,528,483	$3,593,624	$4,528,483
Appropriations	$0	$0	$3,593,624	$4,528,483	$3,593,624	$4,528,483

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2017-2019 Biennium	2019-2021 Biennium	2021-2023 Biennium
Counties	$0	$1,170,494	$1,170,494
Cities	$0	$597,830	$597,830
School Districts	$0	$564,960	$564,960
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*
This bill would establish a reinsurance pool for the individual health insurance market.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*
The cost estimate to fund the reinsurance pool is 1 ½% of group health plan premiums. This would be $21.40 per state contract per month for the 15,814 state FTE and legislators base on the existing plan design required premium.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*
N/A

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*
A 1 ½% premium assessment based on the $1426.74 NDPERS Health Plan premium for the state employee grandfathered plan would be $21.40 per contract per month.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*
A 1 ½% premium assessment based on the $1426.74 NDPERS Health Plan premium for the state employee grandfathered plan would be $21.40 per contract per month.

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Name: Bryan Reinhardt

Agency: NDPERS

Telephone: 701-328-3919

Date Prepared: 01/18/2019

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Page 7

	Department	Executive Budget 2019-2021 FTE	Monthly Change	19-21 Funding Adjustments General	Other	Total
101	Office of the Governor	18.00	$21.40	$9,244.80	$0.00	$9,244.80
108	Office of the Secretary of State	32.00	$21.40	$15,459.48	$975.72	$16,435.20
110	Office of Management and Budget	108.00	$21.40	$45,786.04	$9,682.76	$55,468.80
112	Information Technology Department	459.50	$21.40	$25,468.06	$210,531.14	$235,999.20
117	Office of the State Auditor	56.00	$21.40	$21,265.73	$7,495.87	$28,761.60
120	Office of the State Treasurer	7.00	$21.40	$3,595.20	$0.00	$3,595.20
125	Office of the Attorney General	237.00	$21.40	$91,265.90	$30,457.30	$121,723.20
127	Office of the Sate Tax Commissioner	123.00	$21.40	$63,172.80	$0.00	$63,172.80
140	Office of Administrative Hearings	5.00	$21.40	$0.00	$2,568.00	$2,568.00
150	Legislative Assembly	141.00	$21.40	$72,417.60	$0.00	$72,417.60
160	Legislative Council	36.00	$21.40	$18,489.60	$0.00	$18,489.60
180	Judicial Branch	363.00	$21.40	$182,155.69	$4,281.11	$186,436.80
188	Legal Counsel of Indigents	40.00	$21.40	$19,979.30	$564.70	$20,544.00
190	Retirement and Investment Office	20.00	$21.40	$0.00	$10,272.00	$10,272.00
192	Public Employees Retirement System	33.50	$21.40	$0.00	$17,205.60	$17,205.60
201	Department of Public Instruction	88.75	$21.40	$15,404.82	$30,177.18	$45,582.00
226	Department of Trust Lands	28.00	$21.40	$0.00	$14,380.80	$14,380.80
250	State Library	27.75	$21.40	$12,686.95	$1,565.45	$14,252.40
252	School for the Deaf	43.61	$21.40	$21,167.64	$1,230.45	$22,398.10
253	N.D. Vision Services	27.90	$21.40	$13,814.97	$514.47	$14,329.44
270	Dept of Career and Technical Ed	53.80	$21.40	$27,631.64	$0.04	$27,631.68
215	ND University System	148.90	$21.40	$51,559.50	$24,915.54	$76,475.04
227	Bismarck State College	323.93	$21.40	$71,465.74	$94,904.71	$166,370.45
228	Lake Region State College	118.10	$21.40	$28,224.79	$32,431.37	$60,656.16
229	Willliston State College	100.48	$21.40	$21,582.04	$30,024.49	$51,606.53
230	University of North Dakota	2132.17	$21.40	$286,116.34	$808,966.17	$1,095,082.51
232	UND Medical Center	485.32	$21.40	$97,135.50	$152,124.85	$249,260.35
235	North Dakota State University	1870.16	$21.40	$266,781.35	$693,732.83	$960,514.18
238	ND State College of Science	310.73	$21.40	$80,782.38	$78,808.55	$159,590.93
239	Dickinson State University	213.26	$21.40	$53,426.83	$56,103.51	$109,530.34
240	Mayville State University	209.27	$21.40	$42,722.44	$64,758.63	$107,481.07
241	Minot State University	407.58	$21.40	$94,435.62	$114,897.47	$209,333.09
242	Valley City State University	180.68	$21.40	$54,116.26	$38,680.99	$92,797.25
243	Dakota College Bottineau	82.29	$21.40	$23,139.73	$19,124.41	$42,264.14
244	ND Forest Service	27.00	$21.40	$13,867.20	$0.00	$13,867.20
301	North Dakota Department of Health	199.50	$21.40	$49,624.78	$52,838.42	$102,463.20
303	Department of Environmental Quality	160.50	$21.40	$28,064.17	$54,368.63	$82,432.80
313	Veterans Home	120.72	$21.40	$59,238.21	$2,763.58	$62,001.79
316	Indian Affairs Commission	4.00	$21.40	$2,054.40	$0.00	$2,054.40
321	Department of Veterans Affairs	7.00	$21.40	$2,976.68	$618.52	$3,595.20
325	Department of Human Services	2070.73	$21.40	$591,900.61	$471,626.32	$1,063,526.93
360	Protection and Advocacy Project	28.50	$21.40	$14,637.60	$0.00	$14,637.60
380	Job Service North Dakota	156.61	$21.40	$146.76	$80,288.14	$80,434.90
401	Office of the Insurance Commissioner	44.00	$21.40	$0.00	$22,598.40	$22,598.40
405	Industrial Commission	110.25	$21.40	$53,257.11	$3,367.29	$56,624.40
406	Office of the Labor Commissioner	14.00	$21.40	$7,190.40	$0.00	$7,190.40
408	Public Service Commission	44.00	$21.40	$13,600.28	$8,998.12	$22,598.40
412	Aeronautics Commission	7.00	$21.40	$0.00	$3,595.20	$3,595.20
413	Department of Financial Institutions	31.00	$21.40	$0.00	$15,921.60	$15,921.60
414	Office of the Securities Commissioner	10.00	$21.40	$5,136.00	$0.00	$5,136.00
471	Bank of North Dakota	181.50	$21.40	$0.00	$93,218.40	$93,218.40
473	North Dakota Housing Finance Agency	44.00	$21.40	$0.00	$22,598.40	$22,598.40
475	North Dakota Mill & Elevator Association	157.00	$21.40	$0.00	$80,635.20	$80,635.20
485	Workforce Safety & Insurance	248.14	$21.40	$0.00	$127,444.70	$127,444.70
504	Highway Patrol	197.00	$21.40	$75,782.25	$25,396.95	$101,179.20
530	Department of Corrections and Rehabilitation	938.59	$21.40	$459,367.74	$22,692.08	$482,059.82
540	Adjutant General	224.00	$21.40	$45,499.47	$69,546.93	$115,046.40
601	Department of Commerce	60.80	$21.40	$24,515.79	$6,711.09	$31,226.88
602	Department of Agriculture	71.00	$21.40	$19,708.68	$16,756.92	$36,465.60
627	Upper Great Plains Transportation Institute	43.88	$21.40	$8,163.22	$14,373.54	$22,536.77
628	Branch Research Centers	109.81	$21.40	$40,962.93	$15,435.49	$56,398.42
630	NDSU Extension Service	242.51	$21.40	$66,347.75	$58,205.39	$124,553.14
638	Northern Crops Institute	12.80	$21.40	$4,626.03	$1,948.05	$6,574.08
640	NDSU Main Research Center	340.05	$21.40	$107,487.48	$67,162.20	$174,649.68
649	Agronomy Seed Farm	3.00	$21.40	$0.00	$1,540.80	$1,540.80
670	Racing Commission	2.00	$21.40	$947.68	$79.52	$1,027.20
701	State Historical Society	75.00	$21.40	$35,574.90	$2,945.10	$38,520.00
709	Council on the Arts	5.00	$21.40	$2,567.96	$0.04	$2,568.00
720	Game & Fish Department	160.00	$21.40	$0.00	$82,176.00	$82,176.00
750	Department of Parks & Recreation	61.50	$21.40	$29,883 03	$1,703.37	$31,586.40
770	State Water Commission	90.00	$21.40	$0.00	$46,224.00	$46,224.00
801	Department Of Transportation	980.00	$21.40	$0.00	$503,328.00	$503,328 00
	State Total	**15814.07**	$21.40	**$3,593,624**	**$4,528,483**	**$8,122,106**

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PROPOSED AMENDMENT TO HOUSE BILL 1106

Page 1, Line 3, after the semicolon, insert "to provide an appropriation;"

Page 8, after line 12, insert the following:

SECTION 2: APPROPRIATION. The funds provided in this section, or so much of the funds that may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from other funds derived from federal funds and other income, to the following departments for the purpose of defraying the cost of the additional health insurance premiums necessary to pay the cost of the provisions of this bill, for the biennium beginning July 1, 2019 and ending June 30, 2021 as follows:

		19-21 Funding Adjustments	
	Department	General	Other
101	Office of the Governor	$9,244.80	$0.00
108	Office of the Secretary of State	$15,459.48	$975.72
110	Office of Management and Budget	$45,786.04	$9,682.76
112	Information Technology Department	$25,468.06	$210,531.14
117	Office of the State Auditor	$21,265.73	$7,495.87
120	Office of the State Treasurer	$3,595.20	$0.00
125	Office of the Attorney General	$91,265.90	$30,457.30
127	Office of the Sate Tax Commissioner	$63,172.80	$0.00
140	Office of Administrative Hearings	$0.00	$2,568.00
150	Legislative Assembly	$72,417.60	$0.00
160	Legislative Council	$18,489.60	$0.00
180	Judicial Branch	$182,155.69	$4,281.11
188	Legal Counsel of Indigents	$19,979.30	$564.70
190	Retirement and Investment Office	$0.00	$10,272.00
192	Public Employees Retirement System	$0.00	$17,205.60
201	Department of Public Instruction	$15,404.82	$30,177.18
226	Department of Trust Lands	$0.00	$14,380.80
250	State Library	$12,686.95	$1,565.45
252	School for the Deaf	$21,167.64	$1,230.45
253	N.D. Vision Services	$13,814.97	$514.47
270	Dept of Career and Technical Ed	$27,631.64	$0.04
215	ND University System	$51,559.50	$24,915.54
227	Bismarck State College	$71,465.74	$94,904.71
228	Lake Region State College	$28,224.79	$32,431.37
229	Willliston State College	$21,582.04	$30,024.49
230	University of North Dakota	$286,116.34	$808,966.17
232	UND Medical Center	$97,135.50	$152,124.85
235	North Dakota State University	$266,781.35	$693,732.83
238	ND State College of Science	$80,782.38	$78,808.55
239	Dickinson State University	$53,426.83	$56,103.51

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240	Mayville State University	$42,722.44	$64,758.63
241	Minot State University	$94,435.62	$114,897.47
242	Valley City State University	$54,116.26	$38,680.99
243	Dakota College Bottineau	$23,139.73	$19,124.41
244	ND Forest Service	$13,867.20	$0.00
301	North Dakota Department of Health	$49,624.78	$52,838.42
303	Department of Environmental Quality	$28,064.17	$54,368.63
313	Veterans Home	$59,238.21	$2,763.58
316	Indian Affairs Commission	$2,054.40	$0.00
321	Department of Veterans Affairs	$2,976.68	$618.52
325	Department of Human Services	$591,900.61	$471,626.32
360	Protection and Advocacy Project	$14,637.60	$0.00
380	Job Service North Dakota	$146.76	$80,288.14
401	Office of the Insurance Commissioner	$0.00	$22,598.40
405	Industrial Commission	$53,257.11	$3,367.29
406	Office of the Labor Commissioner	$7,190.40	$0.00
408	Public Service Commission	$13,600.28	$8,998.12
412	Aeronautics Commission	$0.00	$3,595.20
413	Department of Financial Institutions	$0.00	$15,921.60
414	Office of the Securities Commissioner	$5,136.00	$0.00
471	Bank of North Dakota	$0.00	$93,218.40
473	North Dakota Housing Finance Agency	$0.00	$22,598.40
475	North Dakota Mill & Elevator Association	$0.00	$80,635.20
485	Workforce Safety & Insurance	$0.00	$127,444.70
504	Highway Patrol	$75,782.25	$25,396.95
530	Department of Corrections and Rehabilitation	$459,367.74	$22,692.08
540	Adjutant General	$45,499.47	$69,546.93
601	Department of Commerce	$24,515.79	$6,711.09
602	Department of Agriculture	$19,708.68	$16,756.92
627	Upper Great Plains Transportation Institute	$8,163.22	$14,373.54
628	Branch Research Centers	$40,962.93	$15,435.49
630	NDSU Extension Service	$66,347.75	$58,205.39
638	Northern Crops Institute	$4,626.03	$1,948.05
640	NDSU Main Research Center	$107,487.48	$67,162.20
649	Agronomy Seed Farm	$0.00	$1,540.80
670	Racing Commission	$947.68	$79.52
701	State Historical Society	$35,574.90	$2,945.10
709	Council on the Arts	$2,567.96	$0.04
720	Game & Fish Department	$0.00	$82,176.00
750	Department of Parks & Recreation	$29,883.03	$1,703.37
770	State Water Commission	$0.00	$46,224.00
801	Department Of Transportation	$0.00	$503,328.00
	State Total	**$3,593,624**	**$4,528,483**

Page 8, line 13, replace “2” with “3”

Renumber accordingly

PO Box 9310
Minneapolis, MN 55440-9310
952-992-2900

Attachment 8
Jan 21, 2019
Page 1

MEDICA®

January 22, 2019

Representative George Keiser
Chairman, House Industry, Business and Labor Committee
State Capitol
Bismarck, ND 58505

RE: HB 1106 State-Based Reinsurance Program

Dear Chairman Keiser and Committee Members:

I am writing to express Medica's support for HB 1106, creating a state-based reinsurance program in order to assist North Dakotans who buy health insurance on their own. We appreciate the opportunity to provide written feedback, and thank the North Dakota Department of Insurance for bringing forward legislation and Chairman Keiser for considering the bill.

Medica is an independent and nonprofit health care organization with approximately 1.6 million members across nine states, and has offered coverage to North Dakotans since the early 1990s. Medica's mission is to be the trusted health plan of choice for our customers, members, partners, and our employees.

Medica supports HB 1106 and believe it is a practical and proven way to provide relief to North Dakota farmers, ranchers, entrepreneurs, small business owners, and others who buy health insurance on their own. Reinsurance is similar to a program the state used in the past to stabilize the individual market and enhance access to coverage: the Comprehensive Health Association of North Dakota (CHAND). CHAND and reinsurance spread the cost of high medical expenses across a broader pool of people, provide greater access to health insurance coverage, and lower premiums for North Dakotans in the individual market. These concepts work and they help make insurance premiums more stable and predictable for consumers.

Thank you for your consideration of HB 1106. We appreciate the leadership the Insurance Department, Chairman Keiser and committee members have provided on this issue and we look forward to continuing to discuss this bill with you this session.

Respectfully,

Jay McLaren

Jay McLaren
Vice President of Public Policy and Government Relations

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3-4-19
#1 pg. 1

Engrossed House Bill No. 1106

Presented by: Jon Godfread
Commissioner
North Dakota Insurance Department

Before: Senate Industry Business and Labor Committee
Senator Jerry Klein, Chairman

Date: March 4, 2019

Chairman Klein, members of the Senate Industry Business and Labor Committee, thank you for the opportunity to address you again regarding HB 1106 – our reinsurance proposal to address our health insurance market. Rather than walking through everything we discussed during the joint hearing we had in January, in the interest of time I will walk through the bill and discuss what changes were made by the House Industry Business and Labor Committee and House Appropriations Committee. I do feel its important to note that this version of the bill comes to you from the house after receiving unanimous approval.

I have also provided you a copy of the marked-up bill that show the changes, a copy of the testimony I gave at the joint hearing and a one sheet overview we have provided to the House and other interested parties.

Breakdown of HB 1106:

Section 1: Amendment – Allows for a tax credit for the amount of the assessment paid a health insurance company.

Amendment adopted by the House

Section 1: Definitions – these definitions are modeled after definitions from other areas of our code.

Self-Funded plan & Third-Party Administrators exemption: Self-funded plans and MEWAs will not be assessed to fund this reinsurance program.

Amendment adopted by the House

Waiver proposal and application: This gives the authority to the commissioner to apply for a 1332 waiver.

Reinsurance Association of North Dakota: This established the Reinsurance Association of North Dakota (RAND) as a nonprofit legal entity. Allows RAND to begin operation of January 1st following approval of the waiver, or January 1st upon the ACA being repealed, amended, or adjudicated by a court of law with jurisdiction of North Dakota, thus making the granting of an innovation waiver unnecessary or inapplicable.

Board of Directors: Creates a governing board of directors, consisting of the state health officer, one senator appointed by the majority leader of the senate, one representative appointed by the speaker of the house, one individual from each of the four insurers in our state. This also allows for two non-voting members from the insurance department appointed by the commissioner.

Powers and Duties of Commissioner and board: The commissioner is to administer RAND and approve assessments to fund RAND. The board is to formulate policies, scheduling audits, verify the assessment base, and approve bylaws.

Subsection b Exempts PERs from being assessed
Amendment Adopted by the House

Assessments against insurers: This outlines the process for assessments and sets time lines. Outlines that any federal funds received by the association must be used to reduce assessments to insurers. The board of directors is responsible to provide a recommendation to the commissioner for the amount of assessment. An insurer may apply for a deferral from assessment if it is determined by the commissioner that the payment of the assessment would place the insurer in a financially impaired condition. Any surplus from the assessments must be used to offset future losses, reduce future assessments or pay off the line of credit authorized in this chapter.

Bank of North Dakota line of Credit: Authorizes a line of credit at the bank of North Dakota, to provide reimbursements to member insurers, this would be used in the event that the federal government is slow in their payment of the APTC pass through dollars.

Reinsurance: Establishes the reinsurance attachment point of $100,000 and the reimbursement rate of 75% for claims above $100,000.

Reimbursement of member insurer: Reimbursement of claims for the individual market.

Rulemaking: Grants the commissioner rule making authority for this chapter.

Section 3: Legislative Management Study: Shall Study the cost drivers of health care and managed care study.
Adopted by the House

Section 4: Expiration: Sunset clause – Need to change to December 31, 2021 – intent was always to run plan for 2 years and come back discuss results. The fiscal note before you reflects a December 31, 2021 expiration. This change we believe was lost in translation during the appropriations process.
Adopted by House Appropriations

Section 5 Emergency Clause: We would need to seek federal government approval of our 1332 waiver and that process needs to start sooner than later in order to implement this program for the 2020 plan year.

HB 1106 is the product of an in-depth study conducted by the North Dakota Insurance Department; this study was fully presented at the Interim Health Care Reform Review Committee last September. Under HB 1106, North Dakota would implement a reinsurance mechanism that would be similar to traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. The reinsurance program we are proposing in this legislation is estimated to **reduce premiums on the individual health insurance market by approximately 20% in 2020** compared to the baseline premium (without HB 1106). Due to the reduced premium, the membership in the 2020 individual market would increase, 1% compared to the baseline without the HB 1106.

We are reaching a point where individuals are no longer able to afford to purchase their own health insurance. These are individuals who are our small business owners, farmers and ranchers, individuals who do not qualify to receive any kind of premium subsidy or assistance, individuals that cannot continue to afford to pay the costs that come with year after year of double-digit health insurance increases. When these individuals can no longer afford health insurance, they will use the ER as their primary care physician, leading to more bad debt, charity care and increased costs to the rest of the insurance market. Couple that with an individual market that is getting more and more concentrated with high claims cost individuals, and you can see that we are approaching a death spiral.

When good risk no longer enters the individual market because the costs associated with it are simply too high, companies will leave that market. If that happens, we will no longer have an option for individuals to purchase health insurance and the federal government will likely step in and provide a form of Medicare coverage to those individuals. This will be the first step in moving to a single payer system and the first step in the elimination of our private health insurance market.

We continue to wait for the federal government to offer us significant health insurance reform; we hope that reform allows states more control of our health insurance markets. In the meantime, **HB 1106 allows us to start to regain some control of this market, it offers us a public-private partnership that would reduce premiums and provide lower-cost plans to individuals, and most importantly, this legislation will stabilize our individual market, which is important to keep us from moving toward a form of government run, single-payer health insurance system in the future.**

For your consideration, I have attached a one sheet overview of the program and I have also attached the testimony I gave to the joint hearing in front of the House & Senate IBL Committee. I understand there is a cost associated with this reinsurance program, but that cost would be minor compared to the elimination of our individual market and the elimination of our private health insurance system. HB 1106 represents a true collaborative effort between, our insurance companies, our consumers, and state government. We examined many different options in our study of how to provide some relief to our health market. **Under the current constraints of the ACA, the reinsurance program offered in HB 1106 is our only viable option to provide the needed relief for our consumers.**

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As HB 1106 comes before you, it assesses our large and small group markets (with the exception of PERS and Self-Funded groups) and allows for those who get the assessment to credit that cost back on their premium taxes they pay in this state. The bill also includes a sunset provision, we support this requirement and will be happy to come back to this body in two years and analyze our progress.

Thank you, Chairman Klein, I would be happy to answer any questions.

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19.8068.01002

Sixty-sixth
Legislative Assembly
of North Dakota

HOUSE BILL NO. 1106

Introduced by

Industry, Business and Labor Committee

(At the request of the Insurance Commissioner)

A BILL for an Act to create and enact chapter 26.1-36.7 of the North Dakota Century Code, relating to the establishment of an invisible reinsurance pool for the individual health insurance market; to amend and reenact subsection 2 of section 26.1-03-17 of the North Dakota Century Code, relating to premium taxes and credits for insurance companies; to provide for a legislative management study; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 2 of section 26.1-03-17 of the North Dakota Century Code is amended and reenacted as follows:

2. An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid as a member of a comprehensive health association under subsection 3 of section 26.1-08-09 for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for the amount of any assessment paid as a member of the reinsurance association of North Dakota under section 26.1-36.7-06 for which the member may be liable for the year in which the assessment is paid, a credit as provided under section 26.1-38.1-10, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, 26.1-03-19.6, 26.1-03-22, 26.1-17-32, and 26.1-18.1-18, and a credit against the tax due for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection must be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

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SECTION 2. Chapter 26.1-36.7 of the North Dakota Century Code is created and enacted as follows:

26.1-36.7-01. Definitions.

For purposes of this chapter, unless the context otherwise requires:

1. "Association" means the reinsurance association of North Dakota.
2. "Board" means the board of directors of the reinsurance association of North Dakota.
3. "Earned group health benefit plan premiums" means premium owed to an insurer for a period of time during which the insurer has been liable to cover claims for an insured pursuant to the terms of a group health benefit plan issued by the insurer.
4. "Future losses" means reserves for claims incurred but not reported.
5. "Group health benefit plan" means a health benefit plan offered through an employer, or an association of employers, to more than one individual employee.
6. "Health benefit plan" means any hospital and medical expense-incurred policy or certificate, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes benefits that pay the costs of or provide medical, surgical, or hospital care.
   a. "Health benefit plan" does not include any one or more of the following:
      (1) Coverage only for accident or disability income insurance, or any combination of the two;
      (2) Coverage issued as a supplement to liability insurance;
      (3) Liability insurance, including general liability insurance and automobile liability insurance;
      (4) Workforce safety and insurance or similar workers' compensation insurance;
      (5) Automobile medical payment insurance;
      (6) Credit-only insurance;
      (7) Coverage for onsite medical clinics;
      (8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits; and
      (9) Self-funded~~, single employer~~ plans ~~not regulated by the state~~.

b. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(1) Limited scope dental or vision benefits;

(2) Benefits for long-term care, nursing home care, home health care, or community-based care, or any combination of this care; and

(3) Other similar limited benefits specified under federal regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. 104-191; 110 Stat. 1936; 29 U.S.C. 1181 et seq.].

c. "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits; and any exclusion of benefits under any group health insurance coverage maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same sponsor:

(1) Coverage only for specified disease or illness; and

(2) Hospital indemnity or other fixed indemnity insurance.

d. "Health benefit plan" does not include the following if offered as a separate policy, certificate, or contract of insurance:

(1) Medicare supplement health insurance as defined under section 1882(g)(1) of the federal Social Security Act [42 U.S.C. 13295ss(g)(1)];

(2) Coverage supplemental to the coverage provided under chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care; and

(3) Similar supplemental coverage provided under a group health plan.

7. "Individual health benefit plan" means a health benefit plan offered to individuals, other than in connection with a group health benefit plan. The term does not include short-term, limited-duration health insurance as defined by section 26.1-36-49.

8. "Insured" means an individual who is insured by a health benefit plan.

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9. "Insurer" means an entity authorized to write health benefit plans or that provides health benefit plans in the state. The term includes an insurance company as defined in section 26.1-02-01, a nonprofit health service organization, a fraternal benefit society, and a health maintenance organization~~, a self-funded multiple employer welfare arrangement, a reinsurer that reinsures health insurance in this state, a third-party administrator, and any other entity providing health insurance coverage or health benefits which is subject to state insurance regulation~~.

~~10. "Medical stop-loss premiums" means amounts paid for health benefit plan insurance protection issued in this state providing reimbursement of all or a portion of medical or prescription claims in excess of a previously determined amount.~~

~~11.~~10. "Member insurer" means an insurer that offers individual health benefit plans and is actively marketing individual health benefit plans in this state.

~~12. "Third-party administrator" means an entity licensed in this state which is paying or otherwise processing health benefit plan claims on behalf of an insurer.~~

~~13. "Third-party administrator premium equivalents" means health benefit plan claims paid by the third-party administrator, administrative fees charged by the third-party administrator to process health benefit plan claims paid to in-state providers for North Dakota residents, and medical stop-loss premiums.~~

26.1-36.7-02. Waiver proposal and application.

1. The commissioner may develop a proposal for an innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148 119 Stat. 124; 42 U.S.C. 1801 et seq.].

2. On behalf of the state, in accordance with the proposal developed under subsection 1, the commissioner may submit an application the to the United States department of health and human services and to the United States secretary of the treasury. The commissioner may implement any federally approved waiver.

26.1-36.7-03. Reinsurance association of North Dakota.

1. The reinsurance association of North Dakota is established as a nonprofit legal entity. As a condition of writing health insurance business in this state, an insurer that has issued or administered a group health benefit plan within the previous twelve months

or is actively marketing or administering a group health benefit plan in this state shall participate in the association.

2. The association may begin operation on either:

a. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the state's innovation waiver application has been approved by the federal government pursuant to section 1332 of the federal Patient Protection and Affordable Care Act [Pub L. 111-148 Stat. 124; 42 U.S.C. 1801 et seq.]; or

b. The January first following the date the commissioner certifies to the secretary of state and the legislative council that the Patient Protection and Affordable Care Act [Pub. L. 111-148] has been repealed, amended, or finally adjudicated by a court of law with jurisdiction over North Dakota as invalid or in a manner that makes the granting of an innovation waiver unnecessary or inapplicable.

3. If the federal funding associated with an approved innovation waiver under section 1332 of the federal Patient Protection and Affordable Care Act [Pub. L. 111-148 Stat. 124; 42 U.S.C. 1801 et seq.] is terminated or otherwise discontinued, the commissioner may cease or suspend operations of the reinsurance association of North Dakota beginning on the January first following the date the commissioner notifies the board that federal funding has been terminated or otherwise discontinued.

26.1-36.7-04. Board of directors.

1. The association is governed by the board of directors of the reinsurance association of North Dakota.

2. The board consists of the state health officer, one senator appointed by the majority leader of the senate of the legislative assembly, one representative appointed by the speaker of the house of representatives of the legislative assembly, one individual from each of the four insurers of the association with the highest annual market share as determined by annual market share reports of health benefit plans provided by the commissioner annually, and two nonvoting, members from the insurance department appointed by the commissioner.

3. Members of the board may be reimbursed from the moneys of the association for expenses incurred by the members due to their service as board members, but may not otherwise be compensated by the association for board services.

4. The costs of conducting the meetings of the association and the board are borne by the association.

5. For cause, the commissioner may remove any board member representing one of the four insurers.

26.1-36.7-05. Powers and duties of commissioner and board.

1. The commissioner shall:

   a. Perform all functions necessary for the association to carry out the purposes of this chapter; and

   b. Approve any assessments to the insurers writing or otherwise issuing group health benefit plans. A group health benefit plan issued pursuant to chapter 54-52.1 is exempt from the assessment.

2. The board shall:

   a. Formulate general policies to advance the purposes of this chapter;

   b. Schedule and approve independent biennial audits in order to:

      (1) Ensure claims are being processed appropriately and only include services covered by the individual health benefit plan for the contracted rates; and

      (2) Verify that the assessment base is accurate and that the appropriate percentage was used to calculate the assessment;

   c. Approve bylaws and operating rules; and

   d. Provide for other matters as may be necessary and proper for the execution of the commissioner's and board's powers, duties, and obligations.

3. The commissioner and the members of the board are not liable for any obligations of the association.

26.1-36.7-06. Assessments against insurers.

1. For the purpose of providing the funds necessary to carry out the purposes of the association under this chapter, the commissioner shall assess insurers writing or otherwise issuing group health benefit plans based on the insurer's group health benefit plan premium written in this state ~~and based on third-party administrator~~

~~premium equivalents in this state~~. The assessment must be paid quarterly within forty-five days of the end of the previous quarter on all earned group health benefit plan premiums ~~and third-party administrator premium equivalents~~ for the previous calendar quarter. An assessment not paid within forty-five days of the end of the previous quarter accrues interest at twelve percent per annum beginning on the date due.

2. The commissioner may verify the amount of each insurer's assessment based on annual statements and other reports determined to be necessary by the commissioner. The commissioner may use any reasonable method of estimating an insurer's group health benefit plan premium ~~and third-party administrator premium equivalent~~ if the specific number is not reported to the commissioner. ~~The assessments are due not less than thirty days after written notice to the insurers and accrue interest at twelve percent per annum on and after the due date.~~

3. Any federal funding obtained by the association must be used to reduce the assessments of insurers writing or otherwise issuing group health benefit plans pursuant to this section.

4. Before April second of each year, the association shall determine and report to the board the association's net gains or net losses for the previous calendar year.

5. Before April sixteenth of each year, the association shall provide an estimate to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

6. Before May second of each year, the board may provide a recommendation to the commissioner and the board of the amount of assessments needed for the association to carry out the powers and duties of the association under this chapter.

7. An insurer may apply to the commissioner for a deferral of all or part of an assessment imposed by the association under this section. The commissioner may defer all or part of the assessment if the commissioner determines the payment of the assessment would place the insurer in a financially impaired condition. If all or part of the assessment is deferred, the amount deferred must be assessed against other insurers in a proportionate manner consistent with this section. The insurer that receives a deferral remains liable to the association for the amount deferred and is prohibited

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from reinsuring any person through the association until such time as the insurer pays the assessments.

8. The board shall use any surplus, including any interest earned on the surplus, to:

a. Offset future losses;

b. Reduce future assessments to insurers writing or otherwise issuing group health benefit plans; or

c. Pay off a line of credit issued pursuant to section 26.1-36.7-07.

9. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment. As an alternative, the commissioner may levy a penalty on any member insurer that fails to pay an assessment when due. In addition, the commissioner may use any power granted to the commissioner by this title to collect any unpaid assessment.

26.1-36.7-07. Bank of North Dakota line of credit.

The Bank of North Dakota shall extend to the association a line of credit not to exceed twenty-five million dollars. The association shall repay the line of credit from assessments against insurers writing or otherwise issuing group health benefit plans in this state or from other funds appropriated by the legislative assembly. The association may access the line of credit to the extent necessary to provide reimbursements to member insurers as required by this chapter.

26.1-36.7-08. Reinsurance.

For claims of an insured which total one hundred thousand dollars to one million dollars incurred per plan year, a member insurer must be reinsured by the association at seventy-five percent of the member insurer's responsibility for claims incurred by the insured pursuant to the terms of an individual's nongrandfathered individual health benefit plan.

26.1-36.7-09. Reimbursement of member insurer.

For nongrandfathered individual health benefit plans issued or renewed after the November second preceding to the date the association begins operation, a member insurer may seek reimbursement from the association and the association shall reimburse the member insurer pursuant to the provisions of section 26.1-36.7-08 to the extent the claims incurred by the

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insured and submitted by the member insurer to the association are eligible for coverage and reimbursement according to the terms of insured's individual health benefit plan.

26.1-36.7-10. Rulemaking.

The commissioner may adopt rules for the implementation and administration of this chapter.

SECTION 3. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PREMIUM TREND. During the 2019-20 interim, the legislative management shall study ways the state may be able to positively affect the current trend of health insurance premium rates increasing, with a focus on the high-risk and subsidized markets. The study must be solution based to reduce costs and may include consideration of whether a strict managed care model might be effective. The legislative management shall report its findings and recommendations, together with any legislation necessary to implement the recommendations, to the sixty-seventh legislative assembly.

SECTION 4. EMERGENCY. This Act is declared to be an emergency measure.

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House Bill No. 1106

Presented by: Jon Godfread
Commissioner
North Dakota Insurance Department

Before: Joint hearing of the House and Senate Industry Business and Labor Committees
Representative George Keiser, Chairman
Senator Jerry Klein, Chairman

Date: January 15, 2019

Good morning Mr. Chairman and members of the House and Senate Industry Business and Labor Committees. For the record, my name is Jon Godfread, Insurance Commissioner. I want to start by saying thank you for allowing us to have this joint hearing. By doing so, we are able to have our actuarial consultant, who helped us in with the study that led to this legislation, here in person. Donna Novak, President of NovaRest Consulting, will be appearing after me. She was the lead actuary on this report and NovaRest has significant experience with 1332 Waivers and the analysis needed to apply to the Federal Government for such waiver.

HB 1106 is the product of an in-depth study conducted by the North Dakota Insurance Department; this study was fully presented at the Interim Health Care Reform Review Committee last September. Following that presentation, the Insurance Department drafted the bill you have before you.

The Department conducted a study to find out the feasibility and desirability of a North Dakota Section 1332 Waiver. Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue strategies for providing its residents with access to high quality, affordable health insurance; while retaining the provisions included in the ACA. The study conducted looked at three main areas to pursue a 1332 Waiver:

- The modification of North Dakota's current high-risk pool, the Comprehensive Health Association of North Dakota (CHAND), to allow a greater number of high-risk North Dakotans to obtain their health insurance from CHAND, along with an analysis of the corresponding insurance company assessments necessary for CHAND to successfully operate with an increased high-risk membership.
- The modification of CHAND into an invisible high-risk pool where high-risk North Dakotans can obtain their health insurance.
- The creation of an invisible reinsurance program independent of CHAND. An invisible reinsurance program would limit the amount of risk insurance companies take on for the high-risk North Dakotans they insure.

The study also analyzed Idaho's state-based plan initiative and how a similar state-based plan allowance could operate in North Dakota. The state-based plan initiative would allow insurance carriers to offer health insurance plans outside of the existing ACA exchange that would be more

flexible in how they are underwritten and designed. These state-based plans would still be required to offer all ACA-mandated essential health benefits and be guaranteed issue, but would allow for credits for healthy behavior or other health-related factors. The state-based plans would also be a part of the single-risk pool for the general marketplace, which could incentivize young and healthy membership into the risk pool and help stabilize the rates.

Upon completion of this study and subsequent presentation to the Interim Health Care Reform Review Committee, we determined that the best option would be to pursue legislation that authorized the Insurance Commissioner to pursue a 1332 waiver that created an invisible reinsurance pool independent of CHAND.

It is our belief that our 1332 Waiver will reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims which significantly contribute to the rising cost of health insurance. This would be accomplished by using a reinsurance mechanism to help fund high cost claims. The result, should be double digit **decreases** in the cost of health insurance on the individual market, which will result in more individuals staying in the market, some individuals who left the market due to unaffordability of health insurance returning to the market, and more insurers being willing to write policies in North Dakota counties. Both of these will help stabilize the individual health insurance market in North Dakota.

Under HB 1106, North Dakota would implement a reinsurance mechanism that would be similar to traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. The reinsurance program we are proposing in this legislation is estimated to reduce premiums by approximately 20% in 2020 compared to the baseline premium (without the waiver). Due to the reduced premium, the membership in the 2020 individual market would increase, 1% compared to the baseline without the waiver.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. The approach of an "invisible" reinsurance allows enrollees to remain in the individual market with their current plan and carrier, and have all the choices of health insurance plans that everyone else has, but a portion of their claims would be reimbursed by the reinsurance pool. The enrollee is not aware that their claim is being paid via the reinsurance pool, meaning there is no effect on the enrollee as the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

For the 2020 plan year, the proposed reinsurance program would cover 75% of paid claims between the $100,000 attachment point and $1,000,000. This level of reinsurance was assumed in the future projections, but under HB 1106 we would have the flexibility to change the parameters in the future, if needed.

The reinsurance payable under the Waiver is estimated to be $48 million in 2020. It will increase over the next ten years due to medical inflation unless the reinsurance parameters are modified. The actual amount that will be paid under the reinsurance will depend on submitted claims. Based on NovaRest projections, the reinsurance paid in future years will be approximately as shown in Table 1 of the report.

These solutions do not come without a cost, and we fully expect a healthy discussion regarding how this program could and should be funded. A portion of the funding for the reinsurance would come from the federal government due to the reduction in advanced premium tax credits (APTC) being passed back to North Dakota. The reduction in premiums for the second lowest Silver plan in each region directly reduces the APTC for the individuals eligible for APTCs.

Under the current version of HB 1106, the additional funding required by the reinsurance program would come from assessments against the group health insurance market, self-insurance business, and Third-Party Administrators (TPAs) that pay claims for self-insured employers. NovaRest projects the APTC pass through from the federal government in 2020 to be $26 million and the assessment requirement to be $22 million. The 2020 assessment would be between 1% and 1.5% of group health insurance premium and TPA premium equivalent (claim paid plus administrative fees). These percentages are higher than the current estimates in order to provide a cushion in the first year of operation.

The ultimate policy question that will be before this body is should the state increase the premiums of group health insurance policies by 1% or 1.5%, or, in the alternative, expend state funds, in order to reduce the cost by approximately 20% for the individual market. In that spirit, we wanted to propose you three different funding options in order to have an in-depth discussion. My office has prepared two amendments to HB 1106 for your consideration along with a proposed cost to the state for each amendment. The three options are as follows:

1. HB 1106 as introduced, the additional funds needed on top of the federal government funding (estimated at $22M for 2020) would come from a 1 – 2% assessment to our heath carriers, TPAs and self-funded insurers. With this option, there would be no fiscal note and no state funds expended.
2. Premium Tax Credit Amendment: This option would remove the self-funded groups and TPAs from assessment. It would also allow the health insurers to credit any assessment back from their premium taxes they pay the state. This would decrease future state revenues by approximately $37 million per biennium.
3. A straight appropriation from the state to cover the costs of the additional funds needed. This would remove the assessment from our health carriers, TPAs and self-funded insurers. We would still have the option to assess our health carriers, in the event of a shortfall from the state appropriation. This amendment calls for an appropriation from the general fund to the Insurance Department of $40 million in order to fund the reinsurance program.

Each of these options has pros and cons, with the biggest pro being the creation of the reinsurance pool, stabilization of the individual market and reduction of premiums to those individuals on that market that have faced year after year of double digit increases on this market. The challenges are how does this get funded, do we increase the cost of health insurance for every other group in our state or do we expend state revenue to help make up that difference?

The Department, for the most part, is agnostic on how this program is funded; we simply believe there is significant value in stabilizing our failing individual market. It is no secret that the individual markets across the country are facing trouble; the rising premiums are akin to the

canary in the mine. We are reaching a point where individuals are no longer able to afford to purchase their own health insurance. These are individuals who are our small business owners, farmers and ranchers, individuals who make too much money to receive any kind of premium subsidy or assistance, individuals that cannot continue to afford to pay the costs that come with year after year of double-digit health insurance increases. Couple that with an individual market that is getting more and more concentrated with high claims cost individuals, and you can see that we are approaching a death spiral.

When good risk no longer enters the individual market because the costs associated with it are simply too high, companies will leave that market. If that happens, we will no longer have an option for individuals to purchase health insurance and the federal government will likely step in and provide a form of Medicare coverage to those individuals. This will be the first step in moving to a single payer system and the first step in the elimination of our private health insurance market.

We continue to wait for the federal government to offer us significant health insurance reform; we hope that reform allows states more control of our health insurance markets. In the meantime, HB 1106 allows us to start to regain some control of this market, it offers us a public-private partnership that would reduce premiums and provide lower-cost plans to individuals, and most importantly, this legislation will stabilize our individual market, which is important to keep us from moving toward a form of government run, single-payer health insurance system in the future.

Before I invite Ms. Novak up to the podium, I would like to pause to see if there are any questions.

At this point, I would like to invite Donna Novak up to talk through some more of the specifics regarding our proposed 1332 waiver and the invisible reinsurance pool.

--Donna Novak Presentation--

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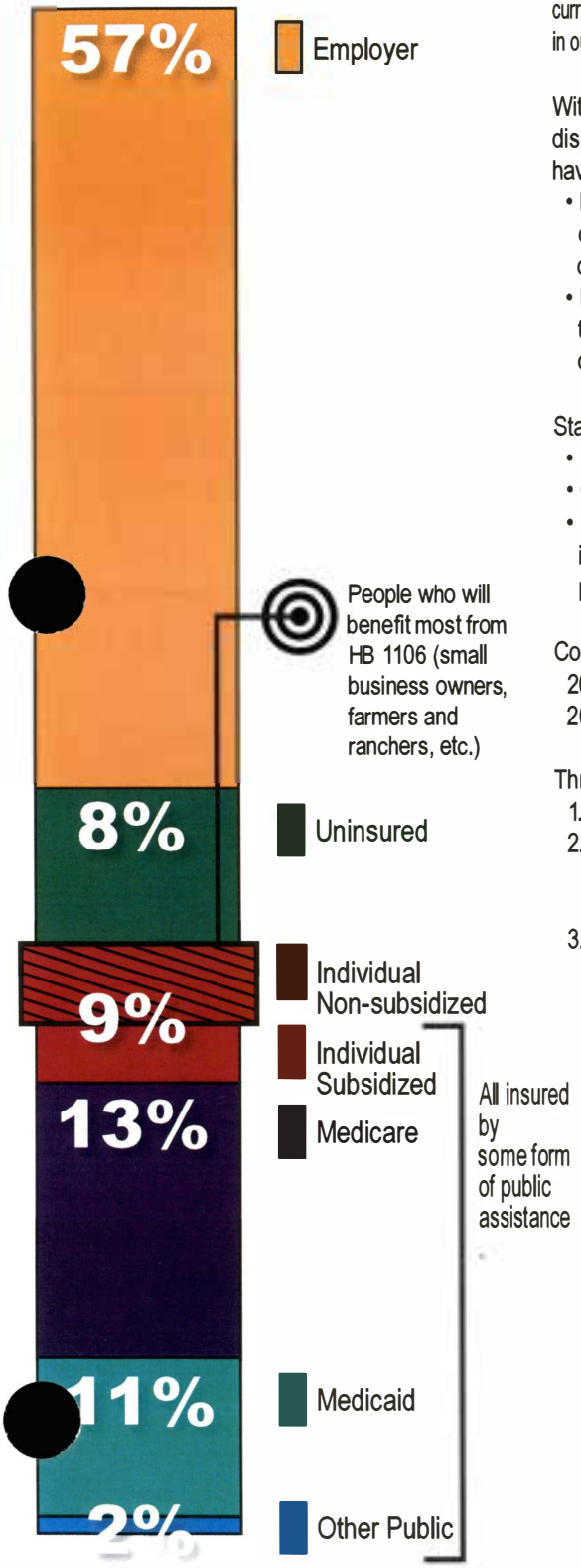
Why do we need HB 1106?

Reinsurance Association of North Dakota

Current North Dakota Insured Population by Coverage Type



Reinsurance Association of North Dakota

HB 1106 establishes the Reinsurance Association of North Dakota (RAND) – an invisible reinsurance program for the individual health market estimated to **reduce health insurance premiums on the individual market by 20%.** Under the current constraints of the Affordable Care Act (ACA), a reinsurance program is North Dakota's only real option to provide relief in our market.

Without the program, individual market premiums will continue to climb at an unsustainable rate, disproportionately impacting farmers, ranchers, small business owners and anyone who does not have access to the large group market or other government health care.

- If premiums continue to rise and the individual market continues to spiral, it will fail. A failure of our individual market is the first step to a single payer system and the first step to the elimination of our private health insurance market.
- If individuals are unable to purchase their own health insurance, a Medicare type program will be the next step. Leading to higher taxes for everyone as we move towards government run health care.

Stabilizes the individual market:

- Reduces rates
- Gives North Dakota insurance companies stability with high claims consumers
- Keeps North Dakotans insured – especially those on the brink of not being able to afford health insurance. One percent of our uninsured population who have been priced out of the market may purchase health insurance because of the decrease in rates.

Cost of the program for:

2020 $48M total cost = $26M in Federal dollars + $22M in state or assessed funds
2021 $50M total cost = $27M in Federal dollars + $23M in State or assessed funds

Three funding options:

1. Assess all group health plans in North Dakota – likely increasing those premiums by 1-2%
2. Assess the large and small group markets, except for PERS and self-funded groups – but allow for a premium tax credit for our carriers for the amount of the assessments, thereby negating any need for premium increases on those markets
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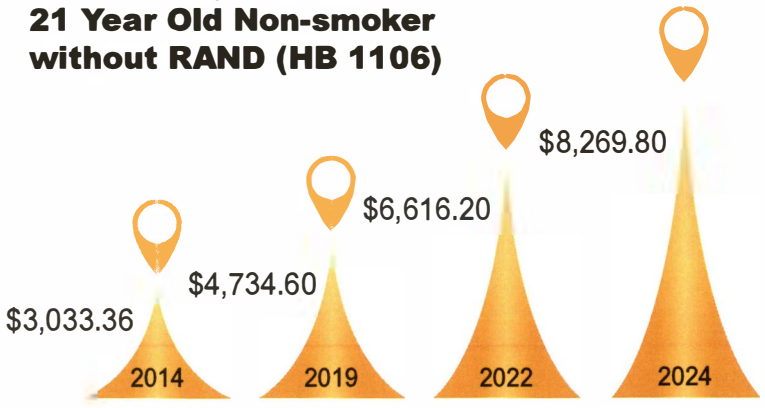
Annual Projected Premium for a 21 Year Old Non-smoker without RAND (HB 1106)



North Dakota Insurance Department
Protecting the Public Good
Jon Godfread, Commissioner

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#2 pg. 1/1

Prepared by the North Dakota
Insurance Department
March 4, 2019

PROPOSED AMENDMENTS TO REENGROSSED HOUSE BILL NO. 1106

Page 8, line 26, remove "July" and replace with "December"

Renumber accordingly

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#3 pg. 1

Joint Industry, Business and Labor Committee Hearing

HB 1106

Megan Houn, BCBSND

March 4, 2019

Good morning Chairmen Klein and members of the Senate IBL committee, my name is Megan Houn. I am the Director of Government Relations for Blue Cross Blue Shield North Dakota (BCBSND). I appreciate the opportunity to share comments on behalf of BCBSND.

We would like to commend Commissioner Godfread for initiating the interim study to identify potential state options to reform the individual health insurance market in ND. BCBSND agrees that keeping and attracting as many people as possible in one pool is the right approach for North Dakota and we are here in support of HB 1106. We have long said that in order to have a health insurance system in which anyone can obtain coverage regardless of their health status, there must be a way to pay for the cost of caring for those with significant medical needs to ensure a balanced risk pool. Otherwise, premiums increase and coverage becomes much less affordable and accessible.

BCBSND has been committed to participating in the Marketplace to ensure optimal choice for our members across the State of North Dakota. In 2018, we were the only remaining carrier in 48 of the state's 53 counties.

We favor reinsurance programs and agree with the concept of an invisible high-risk pool. The Individual health insurance market may not be large enough in some states to support the volume of high cost cases that have entered the pool. Having some sort of reinsurance

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mechanism is vitally important to help stabilize rates. It is BCBSND's preference to have a broad-based funding model which includes a premium tax credit.

We are pleased that the Commissioner and your committees are looking at solutions for those North Dakotans who can no longer afford health insurance. Thank you for your time and consideration of these comments.

I'll be happy to take any questions that you may have.

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Pg1

Engrossed House Bill No. 1106

Presented by: Jon Godfread
Commissioner
North Dakota Insurance Department

Before: Senate Appropriations Committee
Senator Ray Holmberg, Chairman

Date: March 14, 2019

Chairman Holmberg, members of the Senate Appropriations Committee, thank you for the opportunity to address you regarding HB 1106 – our reinsurance proposal to address our health insurance market.

Breakdown of HB 1106:

Section 1: Amendment – Allows for a tax credit for the amount of the assessment paid a health insurance company.

Amendment adopted by the House

Section 1: Definitions – these definitions are modeled after definitions from other areas of our code.

Self-Funded plan & Third-Party Administrators exemption: Self-funded plans and MEWAs will not be assessed to fund this reinsurance program.

Amendment adopted by the House

Waiver proposal and application: This gives the authority to the commissioner to apply for a 1332 waiver.

Reinsurance Association of North Dakota: This established the Reinsurance Association of North Dakota (RAND) as a nonprofit legal entity. Allows RAND to begin operation of January 1st following approval of the waiver, or January 1st upon the ACA being repealed, amended, or

adjudicated by a court of law with jurisdiction of North Dakota, thus making the granting of an innovation waiver unnecessary or inapplicable.

Board of Directors: Creates a governing board of directors, consisting of the state health officer, one senator appointed by the majority leader of the senate, one representative appointed by the speaker of the house, one individual from each of the four insurers in our state. This also allows for two non-voting members from the insurance department appointed by the commissioner.

Powers and Duties of Commissioner and board: The commissioner is to administer RAND and approve assessments to fund RAND. The board is to formulate policies, scheduling audits, verify the assessment base, and approve bylaws.

Subsection b Exempts PERs from being assessed

Amendment Adopted by the House

Assessments against insurers: This outlines the process for assessments and sets time lines. Outlines that any federal funds received by the association must be used to reduce assessments to insurers. The board of directors is responsible to provide a recommendation to the commissioner for the amount of assessment. An insurer may apply for a deferral from assessment if it is determined by the commissioner that the payment of the assessment would place the insurer in a financially impaired condition. Any surplus from the assessments must be used to offset future losses, reduce future assessments or pay off the line of credit authorized in this chapter.

Bank of North Dakota line of Credit: Authorizes a line of credit at the bank of North Dakota, to provide reimbursements to member insurers, this would be used in the event that the federal government is slow in their payment of the APTC pass through dollars.

Reinsurance: Establishes the reinsurance attachment point of $100,000 and the reimbursement rate of 75% for claims above $100,000.

Reimbursement of member insurer: Reimbursement of claims for the individual market.

Rulemaking: Grants the commissioner rule making authority for this chapter.

Section 3: Legislative Management Study: Shall Study the cost drivers of health care and managed care study.

Adopted by the House

Section 4: Expiration: Sunset clause – Need to change to December 31, 2021 – intent was always to run plan for 2 years and come back discuss results. The fiscal note before you reflects a December 31, 2021 expiration. This change we believe was lost in translation during the appropriations process.

Adopted by House Appropriations

Section 5 Emergency Clause: We would need to seek federal government approval of our 1332 waiver and that process needs to start sooner than later in order to implement this program for the 2020 plan year.

HB 1106 is the product of an in-depth study conducted by the North Dakota Insurance Department; this study was fully presented at the Interim Health Care Reform Review Committee last September. Under HB 1106, North Dakota would implement a reinsurance mechanism that would be similar to traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. The reinsurance program we are proposing in this legislation is estimated to **reduce premiums on the individual health insurance market by approximately 20% in 2020** compared to the baseline premium (without HB 1106). Due to the reduced premium, the membership in the 2020 individual market would increase, 1% compared to the baseline without the HB 1106.

We are reaching a point where individuals are no longer able to afford to purchase their own health insurance. These are individuals who are our small business owners, farmers and ranchers, individuals who do not qualify to receive any kind of premium subsidy or assistance, individuals that cannot continue to afford to pay the costs that come with year

after year of double-digit health insurance increases. When these individuals can no longer afford health insurance, they will use the ER as their primary care physician, leading to more bad debt, charity care and increased costs to the rest of the insurance market. Couple that with an individual market that is getting more and more concentrated with high claims cost individuals, and you can see that we are approaching a death spiral.

When good risk no longer enters the individual market because the costs associated with it are simply too high, companies will leave that market. If that happens, we will no longer have an option for individuals to purchase health insurance and the federal government will likely step in and provide a form of Medicare coverage to those individuals. This will be the first step in moving to a single payer system and the first step in the elimination of our private health insurance market.

We continue to wait for the federal government to offer us significant health insurance reform; we hope that reform allows states more control of our health insurance markets. In the meantime, **HB 1106 allows us to start to regain some control of this market, it offers us a public-private partnership that would reduce premiums and provide lower-cost plans to individuals, and most importantly, this legislation will stabilize our individual market, which is important to keep us from moving toward a form of government run, single-payer health insurance system in the future.**

For your consideration, I have attached a one sheet overview of the program and I have also attached the testimony I gave to the joint hearing in front of the House & Senate IBL Committee. I understand there is a cost associated with this reinsurance program, but that cost would be minor compared to the elimination of our individual market and the elimination of our private health insurance system. HB 1106 represents a true collaborative effort between, our insurance companies, our consumers, and state government. We examined many different options in our study of how to provide some relief to our health market. **Under the current**

constraints of the ACA, the reinsurance program offered in HB 1106 is our only viable option to provide the needed relief for our consumers.

As HB 1106 comes before you, it assesses our large and small group markets (with the exception of PERS and Self-Funded groups) and allows for those who get the assessment to credit that cost back on their premium taxes they pay in this state. The bill also includes a sunset provision, we support this requirement and will be happy to come back to this body in two years and analyze our progress.

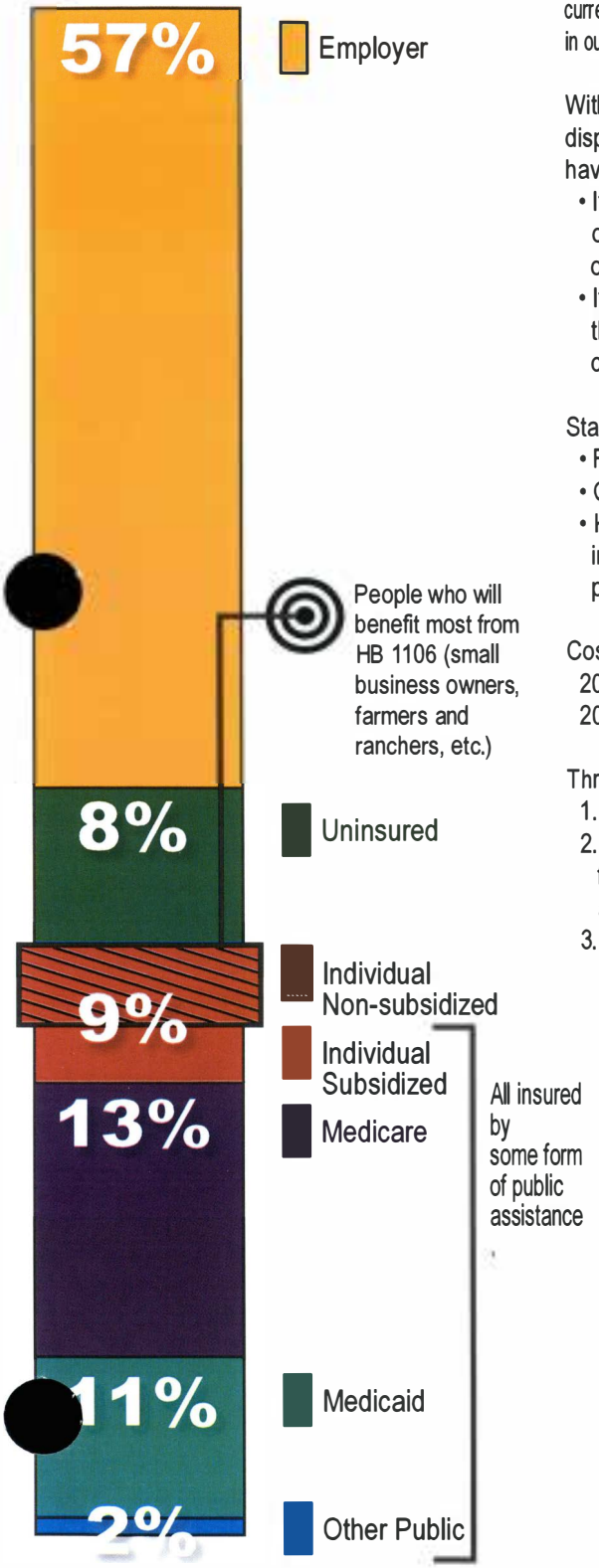
Thank you, I would be happy to answer any questions.

Why do we need HB 1106?

#2
HB1106
3-14-19
pg 1

Reinsurance Association of North Dakota

Current North Dakota Insured Population by Coverage Type



Reinsurance Association of North Dakota

HB 1106 establishes the Reinsurance Association of North Dakota (RAND) – an invisible reinsurance program for the individual health market estimated to **reduce health insurance premiums on the individual market by 20%.** Under the current constraints of the Affordable Care Act (ACA), a reinsurance program is North Dakota's only real option to provide relief in our market.

Without the program, individual market premiums will continue to climb at an unsustainable rate, disproportionately impacting farmers, ranchers, small business owners and anyone who does not have access to the large group market or other government health care.

- If premiums continue to rise and the individual market continues to spiral, it will fail. A failure of our individual market is the first step to a single payer system and the first step to the elimination of our private health insurance market.
- If individuals are unable to purchase their own health insurance, a Medicare type program will be the next step. Leading to higher taxes for everyone as we move towards government run health care.

Stabilizes the individual market:

- Reduces rates
- Gives North Dakota insurance companies stability with high claims consumers
- Keeps North Dakotans insured – especially those on the brink of not being able to afford health insurance. One percent of our uninsured population who have been priced out of the market may purchase health insurance because of the decrease in rates.

Cost of the program for:

2020 $48M total cost = $26M in Federal dollars + $22M in state or assessed funds
2021 $50M total cost = $27M in Federal dollars + $23M in State or assessed funds

Three funding options:

1. Assess all group health plans in North Dakota – likely increasing those premiums by 1-2%
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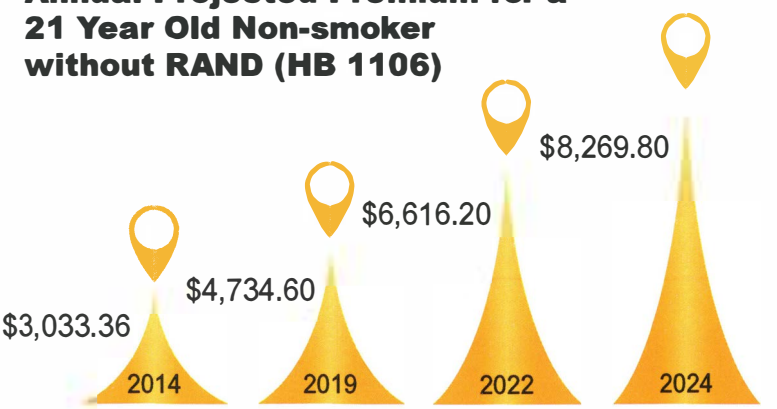

North Dakota Insurance Department
Protecting the public good
Jon Godfread, Commissioner

#3 HB 1106
3-14-19
pg 1

House Bill No. 1106

Presented by: Jon Godfread
Commissioner
North Dakota Insurance Department

Before: Joint hearing of the House and Senate Industry Business and Labor Committees
Representative George Keiser, Chairman
Senator Jerry Klein, Chairman

Date: January 15, 2019

Good morning Mr. Chairman and members of the House and Senate Industry Business and Labor Committees. For the record, my name is Jon Godfread, Insurance Commissioner. I want to start by saying thank you for allowing us to have this joint hearing. By doing so, we are able to have our actuarial consultant, who helped us in with the study that led to this legislation, here in person. Donna Novak, President of NovaRest Consulting, will be appearing after me. She was the lead actuary on this report and NovaRest has significant experience with 1332 Waivers and the analysis needed to apply to the Federal Government for such waiver.

HB 1106 is the product of an in-depth study conducted by the North Dakota Insurance Department; this study was fully presented at the Interim Health Care Reform Review Committee last September. Following that presentation, the Insurance Department drafted the bill you have before you.

The Department conducted a study to find out the feasibility and desirability of a North Dakota Section 1332 Waiver. Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue strategies for providing its residents with access to high quality, affordable health insurance; while retaining the provisions included in the ACA. The study conducted looked at three main areas to pursue a 1332 Waiver:

- The modification of North Dakota's current high-risk pool, the Comprehensive Health Association of North Dakota (CHAND), to allow a greater number of high-risk North Dakotans to obtain their health insurance from CHAND, along with an analysis of the corresponding insurance company assessments necessary for CHAND to successfully operate with an increased high-risk membership.
- The modification of CHAND into an invisible high-risk pool where high-risk North Dakotans can obtain their health insurance.
- The creation of an invisible reinsurance program independent of CHAND. An invisible reinsurance program would limit the amount of risk insurance companies take on for the high-risk North Dakotans they insure.

The study also analyzed Idaho's state-based plan initiative and how a similar state-based plan allowance could operate in North Dakota. The state-based plan initiative would allow insurance carriers to offer health insurance plans outside of the existing ACA exchange that would be more

flexible in how they are underwritten and designed. These state-based plans would still be required to offer all ACA-mandated essential health benefits and be guaranteed issue, but would allow for credits for healthy behavior or other health-related factors. The state-based plans would also be a part of the single-risk pool for the general marketplace, which could incentivize young and healthy membership into the risk pool and help stabilize the rates.

Upon completion of this study and subsequent presentation to the Interim Health Care Reform Review Committee, we determined that the best option would be to pursue legislation that authorized the Insurance Commissioner to pursue a 1332 waiver that created an invisible reinsurance pool independent of CHAND.

It is our belief that our 1332 Waiver will reduce premiums, making insurance more affordable, while protecting insurers from unpredictable high cost claims which significantly contribute to the rising cost of health insurance. This would be accomplished by using a reinsurance mechanism to help fund high cost claims. The result, should be double digit **decreases** in the cost of health insurance on the individual market, which will result in more individuals staying in the market, some individuals who left the market due to unaffordability of health insurance returning to the market, and more insurers being willing to write policies in North Dakota counties. Both of these will help stabilize the individual health insurance market in North Dakota.

Under HB 1106, North Dakota would implement a reinsurance mechanism that would be similar to traditional reinsurance and the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. The reinsurance program we are proposing in this legislation is estimated to reduce premiums by approximately 20% in 2020 compared to the baseline premium (without the waiver). Due to the reduced premium, the membership in the 2020 individual market would increase, 1% compared to the baseline without the waiver.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. The approach of an "invisible" reinsurance allows enrollees to remain in the individual market with their current plan and carrier, and have all the choices of health insurance plans that everyone else has, but a portion of their claims would be reimbursed by the reinsurance pool. The enrollee is not aware that their claim is being paid via the reinsurance pool, meaning there is no effect on the enrollee as the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.

For the 2020 plan year, the proposed reinsurance program would cover 75% of paid claims between the $100,000 attachment point and $1,000,000. This level of reinsurance was assumed in the future projections, but under HB 1106 we would have the flexibility to change the parameters in the future, if needed.

The reinsurance payable under the Waiver is estimated to be $48 million in 2020. It will increase over the next ten years due to medical inflation unless the reinsurance parameters are modified. The actual amount that will be paid under the reinsurance will depend on submitted claims. Based on NovaRest projections, the reinsurance paid in future years will be approximately as shown in Table 1 of the report.

These solutions do not come without a cost, and we fully expect a healthy discussion regarding how this program could and should be funded. A portion of the funding for the reinsurance would come from the federal government due to the reduction in advanced premium tax credits (APTC) being passed back to North Dakota. The reduction in premiums for the second lowest Silver plan in each region directly reduces the APTC for the individuals eligible for APTCs.

Under the current version of HB 1106, the additional funding required by the reinsurance program would come from assessments against the group health insurance market, self-insurance business, and Third-Party Administrators (TPAs) that pay claims for self-insured employers. NovaRest projects the APTC pass through from the federal government in 2020 to be $26 million and the assessment requirement to be $22 million. The 2020 assessment would be between 1% and 1.5% of group health insurance premium and TPA premium equivalent (claim paid plus administrative fees). These percentages are higher than the current estimates in order to provide a cushion in the first year of operation.

The ultimate policy question that will be before this body is should the state increase the premiums of group health insurance policies by 1% or 1.5%, or, in the alternative, expend state funds, in order to reduce the cost by approximately 20% for the individual market. In that spirit, we wanted to propose you three different funding options in order to have an in-depth discussion. My office has prepared two amendments to HB 1106 for your consideration along with a proposed cost to the state for each amendment. The three options are as follows:

1. HB 1106 as introduced, the additional funds needed on top of the federal government funding (estimated at $22M for 2020) would come from a 1 – 2% assessment to our heath carriers, TPAs and self-funded insurers. With this option, there would be no fiscal note and no state funds expended.
2. Premium Tax Credit Amendment: This option would remove the self-funded groups and TPAs from assessment. It would also allow the health insurers to credit any assessment back from their premium taxes they pay the state. This would decrease future state revenues by approximately $37 million per biennium.
3. A straight appropriation from the state to cover the costs of the additional funds needed. This would remove the assessment from our health carriers, TPAs and self-funded insurers. We would still have the option to assess our health carriers, in the event of a shortfall from the state appropriation. This amendment calls for an appropriation from the general fund to the Insurance Department of $40 million in order to fund the reinsurance program.

Each of these options has pros and cons, with the biggest pro being the creation of the reinsurance pool, stabilization of the individual market and reduction of premiums to those individuals on that market that have faced year after year of double digit increases on this market. The challenges are how does this get funded, do we increase the cost of health insurance for every other group in our state or do we expend state revenue to help make up that difference?

The Department, for the most part, is agnostic on how this program is funded; we simply believe there is significant value in stabilizing our failing individual market. It is no secret that the individual markets across the country are facing trouble; the rising premiums are akin to the

canary in the mine. We are reaching a point where individuals are no longer able to afford to purchase their own health insurance. These are individuals who are our small business owners, farmers and ranchers, individuals who make too much money to receive any kind of premium subsidy or assistance, individuals that cannot continue to afford to pay the costs that come with year after year of double-digit health insurance increases. Couple that with an individual market that is getting more and more concentrated with high claims cost individuals, and you can see that we are approaching a death spiral.

When good risk no longer enters the individual market because the costs associated with it are simply too high, companies will leave that market. If that happens, we will no longer have an option for individuals to purchase health insurance and the federal government will likely step in and provide a form of Medicare coverage to those individuals. This will be the first step in moving to a single payer system and the first step in the elimination of our private health insurance market.

We continue to wait for the federal government to offer us significant health insurance reform; we hope that reform allows states more control of our health insurance markets. In the meantime, HB 1106 allows us to start to regain some control of this market, it offers us a public-private partnership that would reduce premiums and provide lower-cost plans to individuals, and most importantly, this legislation will stabilize our individual market, which is important to keep us from moving toward a form of government run, single-payer health insurance system in the future.

Before I invite Ms. Novak up to the podium, I would like to pause to see if there are any questions.

At this point, I would like to invite Donna Novak up to talk through some more of the specifics regarding our proposed 1332 waiver and the invisible reinsurance pool.

--Donna Novak Presentation--

Thank you Ms. Novak, from here, we can walk through the bill section by section and answer any questions you have, or we could sit down and allow other individuals to testify. Do you have a preference Mr. Chairman?

Breakdown of HB 1106:

Section 1: Definitions – these definitions are modeled after definitions from other areas of our code.

Waiver proposal and application (pg.4, ln 1-8): This gives the authority to the commissioner to apply for a 1332 waiver.

Reinsurance Association of North Dakota (pg.4, ln 9-31): This established the Reinsurance Association of North Dakota (RAND) as a nonprofit legal entity. Allows RAND to begin operation of January 1st following approval of the waiver, or January 1st upon the ACA being repealed, amended, or adjudicated by a court of law with jurisdiction of North Dakota, thus making the granting of an innovation waiver unnecessary or inapplicable.

Board of Directors (pg. 5, ln 1-17): Creates a governing board of directors, consisting of the state health officer, one senator appointed by the majority leader of the senate, one representative appointed by the speaker of the house, one individual from each of the four insurers in our state. This also allows for two non-voting members from the insurance department appointed by the commissioner.

Powers and Duties of Commissioner and board (pg.5 ln18 – pg.6 ln 4): The commissioner is to administer RAND and approve assessments to fund RAND. The board is to formulate policies, scheduling audits, verify the assessment base, and approve bylaws.

Assessments against insurers (pg.6 ln 5 – pg.7 ln 20): This outlines the process for assessments and sets time lines. Outlines that any federal funds received by the association must be used to reduce assessments to insurers. The board of directors is responsible to provide a recommendation to the commissioner for the amount of assessment. An insurer may apply for a deferral from assessment if it is determined by the commissioner that the payment of the assessment would place the insurer in a financially impaired condition. Any surplus from the assessments must be used to offset future losses, reduce future assessments or pay off the line of credit authorized in this chapter.

Bank of North Dakota line of Credit (pg. 7 ln 21-27): Authorizes a line of credit at the bank of North Dakota, to provide reimbursements to member insurers, this would be used in the event that the federal government is slow in their payment of the APTC pass through dollars.

Reinsurance (pg. 7 ln 28 – pg. 8 ln 2): Establishes the reinsurance attachment point of $100,000 and the reimbursement rate of 75% for claims above $100,000.

Reimbursement of member insurer (pg. 8 ln 3 – 9): Reimbursement of claims for the individual market.

Rulemaking (pg. 8 ln 10 – 12): Grants the commissioner rule making authority for this chapter.

Section 2 Emergency Clause: We would need to seek federal government approval of our 1332 waiver and that process needs to start sooner than later in order to implement this program for the 2020 plan year.

I know there are others who are seeking to testify on this issue, so I would pause for questions, but I also want to ensure everyone else gets an opportunity to address the joint committee. Thanks you.