2009 SENATE HUMAN SERVICES

SB 2214

2009 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. SB 2214

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 02/10/2009

Recorder Job Number: 9079

Committee Clerk Signature Mary K Monson

Minutes:

Senator Lee Opened the hearing on SB 2214.

Rod St. Aubyn Representing Blue Cross Blue Shield ND. Spoke in support of 2214. See attachment #1.

Senator Lee The amendments are a result of a circumstance that Representative Monson ran into in his region.

St. Aubyn I would like to point you to page two of the bill. A traditional CHAND applicant can apply if they have written testimony as evidence of rejection of similar insurance, written evidence of a restrictive rider or preexisting condition, or written evidence of an offer to issue comparable insurance but at a substantially higher rate. We want to add a 4th category for someone who has reached their lifetime max on their coverage so they would be automatically eligible for CHAND. They can also make the coverage retroactive as long as it is done within the past 90 days. That is the gist of the amendment.

Senator Lee Did we talk about the fact that someone who is approaching their lifetime max could get the application in place to begin CHAND as another way to do that?

St. Aubyn We did discuss that a little bit but I do think that 90 day thing should take care of that. Our particular company does notify people ahead of time so that they know if they are getting close to their lifetime max.

Vance Magnusson ND Insurance Department. Spoke in support of 2214. The commissioner is chair of the CHAND board and is certainly supportive of the changes proposed in the bill. As to the amendments, I am not sure if he has seen them but I'm sure we would be in support of them.

Senator Lee Do you think we should delay action with the amendments?

Magnusson I don't see any reason to delay action.

St. Aubyn We did share our rough drafts with the commissioner but the board has not officially adopted them but I can't imagine there would be any opposition.

There was no neutral or opposition testimony given.

Senator Erbele I move to adopt the amendment.

Senator Dever Second.

The Clerk called the role on the motion to adopt the amendment. **Yes: 5, No: 0, Absent: 1 (Senator Marcellais)**

Senator Erbele I move **Do Pass as Amended.**

Senator Heckaman Second

The Clerk called the role on the motion to **Do Pass as Amended. Yes: 5, No: 0, Absent: 1.**

Senator Lee will carry the bill.

90670.0101
Title.0200

Prepared by the Legislative Council staff for
Senator J. Lee
February 6, 2009

2-10-09

PROPOSED AMENDMENTS TO SENATE BILL NO. 2214

Page 2, line 14, after "d." insert "For an eligible individual applying under subparagraph d of paragraph 1 of subdivision a of subsection 5, on the date the lifetime maximum occurred if the application:

(1) Is submitted within ninety days after the date that lifetime maximum occurred; and

(2) Is accompanied with premium for coverage retroactive to the date that lifetime maximum occurred.

e."

Page 2, line 18, overstrike "e." and insert immediately thereafter "f."

Page 3, after line 6, insert:

"(d) Written evidence that the applicant has reached the lifetime maximum coverage amount on the most recent health insurance coverage."

Page 5, line 21, overstrike "or"

Page 5, line 22, after "coverage" insert ", or the lifetime maximum amount being reached"

Page 7, line 2, after "under" insert "subparagraph d of paragraph 1 of subdivision a of subsection 5 or"

Page 7, after line 15, insert:

"e. To an individual who has obtained coverage as an eligible individual under subparagraph d of paragraph 1 of subdivision a of subsection 5."

Page 7, line 21, after "under" insert "subparagraph d of paragraph 1 of subdivision a of subsection 5 or"

Renumber accordingly

Date: 2-10-09

Roll Call Vote #: 1

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2214

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Rerefer to Appropriations

☒ Adopt Amendment ☐ Reconsider

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais		
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 0

Absent 1

Floor Assignment

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

Date: 2-10-09

Roll Call Vote #: 2

2009 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2214

Senate Human Services Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 90670.0101 Title .0200

Action Taken ☒ Do Pass ☐ Do Not Pass ☒ Amended

Motion Made By Sen. Erbele Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V.Chair	✓		Senator Richard Marcellais		
Senator Dick Dever	✓		Senator Jim Pomeroy	✓	

Total (Yes) 5 No 0

Absent 1

Floor Assignment Senator J. Lee

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

REPORT OF STANDING COMMITTEE

SB 2214: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2214 was placed on the Sixth order on the calendar.

Page 2, line 14, after "d." insert "For an eligible individual applying under subparagraph d of paragraph 1 of subdivision a of subsection 5, on the date the lifetime maximum occurred if the application:

(1) Is submitted within ninety days after the date that lifetime maximum occurred; and

(2) Is accompanied with premium for coverage retroactive to the date that lifetime maximum occurred.

e."

Page 2, line 18, overstrike "e." and insert immediately thereafter "f."

Page 3, after line 6, insert:

"(d) Written evidence that the applicant has reached the lifetime maximum coverage amount on the most recent health insurance coverage."

Page 5, line 21, overstrike "or"

Page 5, line 22, after "coverage" insert ", or the lifetime maximum amount being reached"

Page 7, line 2, after "under" insert "subparagraph d of paragraph 1 of subdivision a of subsection 5 or"

Page 7, after line 15, insert:

"e. To an individual who has obtained coverage as an eligible individual under subparagraph d of paragraph 1 of subdivision a of subsection 5."

Page 7, line 21, after "under" insert "subparagraph d of paragraph 1 of subdivision a of subsection 5 or"

Renumber accordingly

2009 HOUSE HUMAN SERVICES

SB 2214

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2214

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 17, 2009

Recorder Job Number: 11084

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz opened the hearing on SB 2214

Sen. Judy Lee, District 13, sponsored and introduced bill: Testified in support.

Rod St. Aubyn representing Blue Cross Blue Shield of ND: See Testimony #1.

Rep. Holman: There are five of us new on this committee and we need an acronym education. What does CHAND and TARA stand for?

Rod St. Aubyn: Comprehensive Health Association of North Dakota and Trade Adjustment Recovery Act. It is a federal program. Was geared for people who lost jobs because the jobs were shipped overseas. The federal government would pay for part of the premium for the individual.

Rep. Frantsvog: On the last page of your testimony where you make the statement, "the applicant normally knows when they are close to reaching their limit. How would they know?

Rod St. Aubyn: Most insurers will be notified by the applicant that they are getting close. We do.

Rep. Frantsvog: In my employment my whole career we were covered by BC//BS. I'm retired and picked up a policy. Do I only have one lifetime maximum or does it change each time the policy changes?

Rod St. Aubyn: It varies, but generally it does not transfer. The clock starts over in most cases.

NO OPPOSITION.

Chairman Weisz closed the hearing.

2009 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 2214

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 17, 2009

Recorder Job Number: 11088

Committee Clerk Signature Vicky Crabtree

Minutes:

Chairman Weisz: Take up 2214. There are some concerns and questions on it. This has been worked on quite awhile and there have been some changes.

Rep. Hofstad: Motion a DO PASS.

Rep. Holman: Second.

Roll Call Vote: 13 yes, 0 no, 0 absent.

BILL CARRIER: Rep. Holman.

Date: 3-17-09

Roll Call Vote #:

2009 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 2214

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken ☒ Do Pass ☐ Do Not Pass ☐ Amended

Motion Made By Rep. Hofstad Seconded By Rep. Holman

Representatives	Yes	No	Representatives	Yes	No
CHAIRMAN ROBIN WEISZ	√		REP. TOM CONKLIN	√	
VICE-CHAIR VONNIE PIETSCH	√		REP. KARI L CONRAD	√	
REP. CHUCK DAMSCHEN	√		REP. RICHARD HOLMAN	√	
REP. ROBERT FRANTSVOG	√		REP. ROBERT KILICHOWSKI	√	
REP. CURT HOFSTAD	√		REP. LOUISE POTTER	√	
REP. MICHAEL R. NATHE	√				
REP. TODD PORTER	√				
REP. GERRY UGLEM	√				

Total (Yes) 13 No 0

Absent 0

Bill Carrier Rep. Holman

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

REPORT OF STANDING COMMITTEE

SB 2214, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **DO PASS** (13 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed SB 2214 was placed on the Fourteenth order on the calendar.

2009 TESTIMONY

SB 2214

#1

Testimony on SB 2214
Senate Human Services Committee
February 10, 2009

Madam Chair and members of the Senate Human Services Committee, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota (BCBSND). SB 2214 is for the most part technical corrections to amend the Century Code for CHAND, the state's high risk pool. This bill is being introduced at the request of the CHAND Board. BCBSND administers the CHAND policy for the CHAND Board. Two legislators serve on that CHAND Board, Sen. Judy Lee and Rep. Nancy Johnson. The Insurance Commissioner serves as Chair of the CHAND Board. The following is a step by step instruction of the rationale for each change within this bill. After I have explained these suggested changes, an amendment will be offered at the request of Sen. Judy Lee and Rep. David Monson to have the legislature consider if an individual has reached their maximum lifetime maximum, if they can automatically be qualified under CHAND without first applying for other coverage and then be denied. This amendment has not been formally reviewed by the CHAND Board, but is being offered because of recent situations that have occurred.

I will now go through the proposed changes to the existing CHAND statute.

26.1-08-12. Eligibility.
1. The association must be open for enrollment by eligible individuals. Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must:
~~a. Provide the name, address, and age of the applicant.~~
~~b. Provide the length of applicant's residence in this state.~~
~~c. Provide the name, address, and age of spouse and children, if any.~~
~~d. Provide a designation of coverage desired.~~
~~e. Be~~ be completed fully and accompanied by premium and evidence to prove eligibility.

Explanation – CMS instructed CHAND that we could not require the length of residence for HIPAA applicants and we were making a clarification to comply. After reviewing the change, we noted that listing application components is not only unnecessary, but also limiting if other application changes are needed in the future, which would require legislative approval.

26.1-08-12. Eligibility.
5. An individual may qualify to enroll in the association for benefit plan coverage as:
a. A traditional applicant:
(1) An individual who has been a resident of this state and continues to be a resident of the state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:
(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.
(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.
(2) Is not enrolled in health benefits with the state's medical assistance program.
b. A Health Insurance Portability and Accountability Act of 1996 applicant:
(1) An individual who meets the federally defined eligibility guidelines as follows:
(a) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01~~, the most recent of which is covered under a group health plan, governmental plan, Medicaid, or church plan~~;
(b) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;
(c) Is not eligible for coverage under medicare or a group health benefit plan as the term is defined in section 26.1-36.3-01;
(d) Does not have any other health insurance coverage;
(e) Has not had the most recent qualifying previous coverage described in subparagraph a terminated for nonpayment of premiums or fraud; and
(f) If offered under the option, has elected continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage has exhausted.
(2) Is and continues to be a resident of the state.
(3) Is not enrolled in health benefits with the state's medical assistance program.
c. An applicant age sixty-five and over or disabled:
(1) An individual who is eligible for medicare by reason of age or disability and has been a resident of this state and continues to be a resident of this state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:
(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.
(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.
(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.
(2) Is not enrolled in health benefits with the state's medical assistance program.
d. A Trade Adjustment Assistance Reform Act of 2002 applicant:
(1) A trade adjustment assistance, pension benefit guarantee corporation individual applicant who:
(a) Has three or more months of qualifying previous health insurance coverage at the time of application;
(b) Has applied for coverage within sixty-three days of the termination of the individual's previous health insurance coverage;
(c) Is and continues to be a resident of the state;
(d) Is not enrolled in the state's medical assistance program;
(e) Is not imprisoned under federal, state, or local authority; and

(f) Does not have health insurance coverage through:
[1] The applicant's or spouse's employer if the coverage provides for employer contribution of fifty percent or more of the cost of coverage of the spouse, the eligible

individual, and the dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan.
[2] A state's children's health insurance program, as defined under section 50-29-01.
[3] A government plan.
[4] Chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care.
[5] Part A or part B of title XVIII of the federal Social Security Act [42 U.S.C. 1395 et seq.] relating to health insurance for the aged and disabled.
(2) Coverage under this subdivision may be provided to an individual who is eligible for health insurance coverage through the federal Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272; 100 Stat. 82]; a spouse's employer plan in which the employer contribution is less than fifty percent; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain coverage under this subdivision.

Explanation – CHAND has recently encountered situations where other state high risk pool members who relocate to ND would not be eligible for CHAND HIPAA should they move to North Dakota. In this situation, the applicant would have to wait to meet the residency requirement (183 days) before applying for CHAND and would then be ineligible for the CHAND HIPAA application. This would result in an individual with high risks to be uninsured for over 6 months and once again have a waiting period before receiving benefits. Many other high risk pools allow applicants from other high risk pools to be included in their HIPAA applications with no waiting period. The same situation could also occur if an individual has individual coverage for over 18 months from another state and then moves to ND. They could not apply as a CHAND HIPAA applicant because the most recent coverage is not group coverage. The first amendment removes the limitation of only group type coverages being allowed for the "most recent" types of coverage. The second change adds language under the TAARA section to clarify that the "previous health insurance coverage" must be "qualified" as defined in the federal statutes regarding TAARA.

26.1-08-12. Eligibility.
7. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to an applicant under subdivisions a and c of subsection 4 5 is not sufficient evidence to qualify.

Explanation – The proposed change is to correct an incorrect reference.

26.1-08-12. Eligibility.
10. ~~Each resident dependent of an individual who is eligible for association coverage~~ IF an individual is enrolled in association coverage, that individual's resident dependent is also eligible for association coverage.

11. ~~Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition~~ If an individual is enrolled in association coverage, that individual's resident spouse is also eligible for association coverage.

Explanation – The proposed changes are offered to reflect language from the Model High Risk Pool Act. The original language in #11 is more limiting than the model act.

26.1-08-12. Eligibility.
12. A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first thirty-one days following birth. Continued coverage through the association for the child will be provided if the association receives an application and the appropriate premium within thirty-one days following the birth. This coverage is not available to an applicant under subdivision c of subsection 5.

Explanation – The proposed change is offered to clarify that this coverage does not apply to the CHAND Med Supp-like plan.

26.1-08-12. Eligibility.
14. Waiting periods do not apply ~~to an individual who~~:
a. ~~Is receiving~~ To nonelective treatment or procedures for a congenital or genetic disease.
b. ~~Has~~ To an individual who has obtained coverage as a federally eligible individual as defined in subdivision b of subsection 5.
c. ~~Has~~ To an individual who has obtained coverage as an eligible person under subdivision a or c of subsection 5, allowing for a reduction in waiting period days by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06 and provided the association application is made within sixty-three days of termination of the qualifying previous coverage.
d. ~~Has~~ To an individual who has obtained coverage as an eligible individual under subdivision d of subsection 5.

Explanation - Subdivision a of subsection 14, which deals with a waiver of the waiting periods for preexisting conditions, is very confusing and can be interpreted at least three different ways. To better illustrate this situation, we will use an example. An individual has a congenital or genetic disease involving kidneys. This condition results in the periodic need for dialysis. Just prior to getting CHAND coverage, the individual had a knee replaced and will require several physical therapy sessions. The knee replacement is **totally unrelated** to the congenital or genetic disease. The individual goes onto CHAND immediately following the knee replacement, but before physical therapy has started. The way the current statute is worded it can be interpreted to mean that:

1. The waiting period does not apply for any claims to any individual with a congenital or genetic disease, including claims for unrelated treatments or procedures. In this case, CHAND would be required to pay the periodic dialysis and for all therapy sessions for the unrelated knee replacement surgery, or

2. The waiting period does not apply to nonelective treatments or procedures for the congenital or genetic disease for the individual with the congenital or genetic disease, but waiting periods do apply for other unrelated treatments or procedures. In this case, CHAND would be responsible for the dialysis, but not responsible for the physical therapy on the unrelated knee replacement, or

3. The waiting period does not apply to any claims for an individual who is **currently** receiving nonelective treatments or procedures for a congenital or genetic disease, but **would apply** to an individual who has a congenital or genetic disease, **but is not currently** receiving nonelective treatments or procedures for a congenital or genetic disease. In this case, one individual, (John) who has a genetic condition and is currently receiving treatments for that condition, would not have a waiting period for the dialysis or for the therapies for the knee replacement, but another individual (Jane), who has the same condition but is not currently receiving nonelective treatment for the disease, would have a waiting period for future dialysis and also for therapies for the knee surgery.

We have checked the legislative history to determine the legislative intent. The legislative history is extremely vague and impossible to determine. Amending the language to reflect interpretations 1 or 3 would be considered discriminatory as per Insurance Department staff. As a result, we offer the amended language to reflect what we feel is the appropriate language for the waiver of the waiting period (interpretation 2).

#1

Testimony on Engrossed SB 2214
House Human Services Committee
March 17, 2009

Chairman Weisz and members of the House Human Services Committee, for the record I am Rod St. Aubyn, representing Blue Cross Blue Shield of North Dakota (BCBSND). Engrossed SB 2214 is for the most part technical corrections to amend the Century Code for CHAND, the state's high risk pool. This bill is being introduced at the request of the CHAND Board. BCBSND administers the CHAND program for the CHAND Board. Two legislators serve on that CHAND Board, Sen. Judy Lee and Rep. Nancy Johnson. The Insurance Commissioner serves as Chair of the CHAND Board. The following is a step by step instruction of the rationale for each change within this bill. After I have explained these suggested changes, I will also explain an amendment offered and adopted by the Senate at the request of Sen. Judy Lee and Rep. David Monson to have the legislature consider if an individual has reached their maximum lifetime maximum to be automatically qualified under CHAND without first applying for other coverage and then be denied. This amendment was not formally reviewed by the CHAND Board, but was offered because of recent situations that have occurred.

I will first go through the CHAND program for those of you who are not familiar with the program. CHAND is the State's high risk pool. Group insurance is guaranteed issued, that is, the insurer must accept every employee in a group plan without regard to health status of the employees. Individual coverage through plans like our Bank Depositor's plan is medically underwritten, which means that coverage can be denied if the plan determines that the health risk would be too great and would significantly affect the rates of others within the plan. The individuals who are rejected coverage are automatically eligible for coverage under CHAND. Not every state has a high risk pool, but most of the states do provide some type of high risk option. Because of the higher risks and the higher utilization and costs associated with this high risk group, the claims experience is significantly higher than other insurance. As a result, state law dictates that premiums for CHAND be 135% of the average cost for individual coverage. Even with the higher premiums, CHAND loses several million dollars each year. These losses are assessed proportionately to the insurers doing business in this state. The last few years, part of these losses were reduced by federal grants awarded to the states' high risk pools.

By statute, there are 4 basic CHAND applications:

- Coverage for those who are rejected for other coverage, those who have a restrictive rider placed on their coverage, or those whose premiums are higher than the CHAND premiums.
- CHAND HIPAA coverage which will provide coverage without a significant lapse in coverage from previous qualifying coverage.
- CHAND Medicare Supplement-like coverage for those over age 65 or disabled.
- And CHAND TAARA coverage for those workers who have lost their jobs due to these jobs being transferred out of the US.

We have approximately 1,500 to 1,600 applicants on CHAND. This number has actually decreased within the past year or so.

I will now go through the proposed changes to the existing CHAND statute.

26.1-08-12. Eligibility.

1. The association must be open for enrollment by eligible individuals. Eligible individuals shall apply for enrollment in the association by submitting an application to the lead carrier. The application must:

~~a. Provide the name, address, and age of the applicant.~~

~~b. Provide the length of applicant's residence in this state.~~

~~c. Provide the name, address, and age of spouse and children, if any.~~

~~d. Provide a designation of coverage desired.~~

~~e. Be~~ be completed fully and accompanied by premium and evidence to prove eligibility.

Explanation – CMS instructed CHAND that we could not require the length of residence for HIPAA applicants and we were making a clarification to comply. After reviewing the change, we noted that listing application components is not only unnecessary, but also limiting if other application changes are needed in the future, which would require legislative approval.

26.1-08-12. Eligibility.

5. An individual may qualify to enroll in the association for benefit plan coverage as:

a. A traditional applicant:

(1) An individual who has been a resident of this state and continues to be a resident of the state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:

(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.

(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.

(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.

(2) Is not enrolled in health benefits with the state's medical assistance program.

b. A Health Insurance Portability and Accountability Act of 1996 applicant:

(1) An individual who meets the federally defined eligibility guidelines as follows:

(a) Has had eighteen months of qualifying previous coverage as defined in section 26.1-36.3-01~~, the most recent of which is covered under a group health plan, governmental plan, Medicaid, or church plan~~;

(b) Has applied for coverage under this chapter within sixty-three days of the termination of the qualifying previous coverage;

(c) Is not eligible for coverage under medicare or a group health benefit plan as the term is defined in section 26.1-36.3-01;

(d) Does not have any other health insurance coverage;

(e) Has not had the most recent qualifying previous coverage described in subparagraph a terminated for nonpayment of premiums or fraud; and

(f) If offered under the option, has elected continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act [Pub. L. 99-272; 100 Stat. 82], or under a similar state program, and that coverage has exhausted.

(2) Is and continues to be a resident of the state.

(3) Is not enrolled in health benefits with the state's medical assistance program.

c. An applicant age sixty-five and over or disabled:
(1) An individual who is eligible for medicare by reason of age or disability and has been a resident of this state and continues to be a resident of this state who has received from at least one insurance carrier within one hundred eighty days of the date of application, one of the following:
(a) Written evidence of rejection or refusal to issue substantially similar insurance for health reasons by one insurer.
(b) Written evidence that a restrictive rider or a preexisting condition limitation, the effect of which is to reduce substantially, coverage from that received by an individual considered a standard risk, has been placed on the individual's policy.
(c) Written evidence that an insurer has offered to issue comparable insurance at a rate exceeding the association benefit rate.
(2) Is not enrolled in health benefits with the state's medical assistance program.
d. A Trade Adjustment Assistance Reform Act of 2002 applicant:
(1) A trade adjustment assistance, pension benefit guarantee corporation individual applicant who:
(a) Has three or more months of qualifying previous health insurance coverage at the time of application;
(b) Has applied for coverage within sixty-three days of the termination of the individual's previous health insurance coverage;
(c) Is and continues to be a resident of the state;
(d) Is not enrolled in the state's medical assistance program;
(e) Is not imprisoned under federal, state, or local authority; and
Page No. 10
(f) Does not have health insurance coverage through:
[1] The applicant's or spouse's employer if the coverage provides for employer contribution of fifty percent or more of the cost of coverage of the spouse, the eligible individual, and the dependents or the coverage is in lieu of an employer's cash or other benefit under a cafeteria plan.
[2] A state's children's health insurance program, as defined under section 50-29-01.
[3] A government plan.
[4] Chapter 55 of United States Code title 10 [10 U.S.C. 1071 et seq.] relating to armed forces medical and dental care.
[5] Part A or part B of title XVIII of the federal Social Security Act [42 U.S.C. 1395 et seq.] relating to health insurance for the aged and disabled.
(2) Coverage under this subdivision may be provided to an individual who is eligible for health insurance coverage through the federal Consolidated Omnibus Budget Reconciliation Act of 1985 [Pub. L. 99-272; 100 Stat. 82]; a spouse's employer plan in which the employer contribution is less than fifty percent; or the individual marketplace, including continuation or guaranteed issue, but who elects to obtain coverage under this subdivision.

Explanation – CHAND has recently encountered situations where other state high risk pool members who relocate to ND would not be eligible for CHAND HIPAA should they move to North Dakota. In this situation, the applicant would have to wait to meet the residency requirement (183 days) before applying for CHAND and would then be ineligible for the CHAND HIPAA application. This would result in an individual with high risks to be uninsured for over 6 months and once again have a waiting period before receiving benefits. Many other high risk pools allow applicants from other high risk pools to be included in their HIPAA applications with no waiting period. The same situation could also occur if an individual has individual coverage for over 18 months from another

state and then moves to ND. They could not apply as a CHAND HIPAA applicant because the most recent coverage is not group coverage. The first amendment removes the limitation of only group type coverages being allowed for the "most recent" types of coverage. The second change adds language under the TAARA section to clarify that the "previous health insurance coverage" must be "qualified" as defined in the federal statutes regarding TAARA.

26.1-08-12. Eligibility.

7. A rejection or refusal by an insurer offering only stop-loss, excess of loss, or reinsurance coverage with respect to an applicant under subdivisions a and c of subsection 4 5 is not sufficient evidence to qualify.

Explanation – The proposed change is to correct an incorrect reference.

26.1-08-12. Eligibility.

10. ~~Each resident dependent of an individual who is eligible for association coverage~~ IF an individual is enrolled in association coverage, that individual's resident dependent is also eligible for association coverage.

11. ~~Each spouse of an individual who is eligible for association coverage with a preexisting maternity condition~~ If an individual is enrolled in association coverage, that individual's resident spouse is also eligible for association coverage.

Explanation – The proposed changes are offered to reflect language from the Model High Risk Pool Act. The original language in #11 is more limiting than the model act.

26.1-08-12. Eligibility.

12. A newly born child without health insurance coverage is covered through the mother's association benefit plan for the first thirty-one days following birth. Continued coverage through the association for the child will be provided if the association receives an application and the appropriate premium within thirty-one days following the birth. This coverage is not available to an applicant under subdivision c of subsection 5.

Explanation – The proposed change is offered to clarify that this coverage does not apply to the CHAND Med Supp-like plan.

26.1-08-12. Eligibility.

14. Waiting periods do not apply ~~to an individual who~~:

a. ~~Is receiving~~ To nonelective treatment or procedures for a congenital or genetic disease.

b. ~~Has~~ To an individual who has obtained coverage as a federally eligible individual as defined in subdivision b of subsection 5.

c. ~~Has~~ To an individual who has obtained coverage as an eligible person under subdivision a or c of subsection 5, allowing for a reduction in waiting period days by the aggregate period of qualifying previous coverage in the same manner as provided in subsection 3 of section 26.1-36.3-06 and provided the association application is made within sixty-three days of termination of the qualifying previous coverage.

d. ~~Has~~ To an individual who has obtained coverage as an eligible individual under subdivision d of subsection 5.

Explanation - Subdivision a of subsection 14, which deals with a waiver of the waiting periods for preexisting conditions, is very confusing and can be interpreted at least three different ways. To better illustrate this situation, we will use an example. An individual has a congenital or genetic disease involving kidneys. This condition results in the periodic need for dialysis. Just prior to getting CHAND coverage, the individual had a knee replaced and will require several physical therapy sessions. The knee replacement is **totally unrelated** to the congenital or genetic disease. The individual goes onto CHAND immediately following the knee replacement, but before physical therapy has started. The way the current statute is worded it can be interpreted to mean that:

1. The waiting period does not apply for any claims to any individual with a congenital or genetic disease, including claims for unrelated treatments or procedures. In this case, CHAND would be required to pay the periodic dialysis and for all therapy sessions for the unrelated knee replacement surgery, or

2. The waiting period does not apply to nonelective treatments or procedures for the congenital or genetic disease for the individual with the congenital or genetic disease, but waiting periods do apply for other unrelated treatments or procedures. In this case, CHAND would be responsible for the dialysis, but not responsible for the physical therapy on the unrelated knee replacement, or

3. The waiting period does not apply to any claims for an individual who is **currently** receiving nonelective treatments or procedures for a congenital or genetic disease, but **would apply** to an individual who has a congenital or genetic disease, **but is not currently** receiving nonelective treatments or procedures for a congenital or genetic disease. In this case, one individual, (John) who has a genetic condition and is currently receiving treatments for that condition, would not have a waiting period for the dialysis or for the therapies for the knee replacement, but another individual (Jane), who has the same condition but is not currently receiving nonelective treatment for the disease, would have a waiting period for future dialysis and also for therapies for the knee surgery.

We have checked the legislative history to determine the legislative intent. The legislative history is extremely vague and impossible to determine. Amending the language to reflect interpretations 1 or 3 would be considered discriminatory as per Insurance Department staff. As a result, we offer the amended language to reflect what we feel is the appropriate language for the waiver of the waiting period (interpretation 2).

I will now explain the amendment adopted by the Senate. This amendment was to take care of an issue that we have experienced recently. Typically, insurance policies have a lifetime maximum benefit. If an individual reaches that maximum, they most likely would be eligible for CHAND coverage because it is doubtful that they could secure coverage through a private insurer. However, the current law would require that they would have to apply for other coverage and be rejected before they could apply for CHAND coverage. The amendment offered by Sen. Judy Lee and Rep. Dave Monson and adopted by the
Senate Human Services Committee simply allows an individual who reaches their lifetime maximum to be automatically eligible for CHAND coverage as long as the applicant applies within 90 days of reaching their lifetime maximum and also pay premiums back to the date that they reached their lifetime maximum. By doing so, the applicant will have no lapse of coverage. The reason for the 90 days is because of the delay in submitting and processing medical claims. The applicant normally knows when they are close to reaching the limit, but they never know exactly when that event will actually occur. These amendments are primarily reflected on Page 2, lines 15 through 21, and on Page 3, lines 15 through 17 of the engrossed bill.

Mr. Chairman and committee members, those are the explanations of the changes in the CHAND statute reflected in SB 2214. On behalf of the CHAND Board, we urge a Do Pass on Engrossed SB 2214. I would be willing to try to answer any questions that the Committee may have. Thank you.