Industry Business and Labor Committee
May 27, 2010

Chairman Keiser and members of the Industry Business and Labor Committee, for the record I am Rod St. Aubyn, Director of Government Relations for Blue Cross Blue Shield of North Dakota (BCBSND). I appear before you today to testify about the impact of the proposed federal health care reform bills on BCBSND members. For my presentation today, I have been asked to address the following issues:

- Follow up on questions from your last meeting.
- Update on the near term issues that go into effect within 6 months upon enactment.
- Status and concern about "Grandfathered Health Plans".
- The anticipated financial impact on health insurance premiums by year.

Follow up on questions - I would like to first address some of the questions that were asked of our CEO, Paul von Ebers during your last meeting. Those questions centered around two main issues involving the individual and employer mandates that go into effect in 2014. Those questions included:

- How are seasonal workers treated in the employer mandate?
- If part time workers are counted in the calculation of FTE's for the employer mandate, is the employer mandated to provide insurance for part time employees?
- For individuals who have two jobs, which employer is required to insure them?

Unfortunately we could not find any definite answers to these questions at this time. The new legislation is a basic framework. The details are normally found in the regulations that will be proposed by the Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service. Because these issues do not become effective until 2014, the federal agencies are concentrating their efforts on those issues that become effective during the next year. I will share the information that I have confirmed before the proposed regulations are proposed.

The Treatment of Part-Time Employees is found in Section 1003 of the Patient Protection and Affordable Care Act (PPACA). It states that part-time employees are considered solely for the purpose of determining if an employer has an average of 50 or more full-time employees and is therefore subject to the employer responsibility and penalty provisions. Employers are required to add the number of hours worked by part-time employees in the month and divide that total by 120. This number is added to the number of full-time employees to determine the number of FTE's. However, any penalties would be assessed only on behalf of full-time employees who work, on average of 30 or more hours per week with respect to the month.

The Treatment of Seasonal Workers under the employer mandate is found in Sections 1513 and 10106 of PPACA and Section 1003 of the Health Care and Education Affordability

Reconciliation Act (HCERA) and Section 4980H of the Internal Revenue Code (IRC). In general, the employer is not considered to exceed 50 full-time employees if the workforce exceeds 50 full-time employees due to seasonal employees working for 120 days or fewer during the calendar year. "Seasonal worker" means a worker who performs labor or service on a seasonal basis as defined by the Department of Labor. This includes retail workers employed exclusively during the holiday seasons.

The Treatment of Individuals Having Two Jobs does not seem to be addressed directly in PPACA or the HCERA. It is anticipated that this issue will be addressed in future regulations that will be proposed for the requirements that become effective in 2014. As I indicated before, these regulations are a very low priority for the agencies at this time, since they are working feverishly trying to get the regulations submitted for the issues that go into effect for plan years following 6 months after the March 23 enactment.

Update on Near Term Issues – There are several issues that go into effect with the plan years following 6 months after the March 23 enactment of PPACA. Insurers are working overtime trying to be in compliance with these new requirements. Those near term issues include:

- Prohibition of Annual and Lifetime Limits
- Restrictions on Contract Rescissions
- Elimination of cost-sharing on Preventive Services
- Expansion of coverage for dependents up to the age of 26
- New patient protections regarding choice of providers, appeals, etc.
- Federal review of unreasonable rates
- No waiting periods for pre-existing conditions for children under age 19.

What is problematic for insurers is that for these new requirements to be implemented new regulations must first be proposed and approved for us to determine how to be compliant with the new laws and regulations. In addition, certain state laws may interfere with compliance, such as a requirement for a 60-day notice of benefit changes before implementation can be done. We have been in contact with our Insurance Department and their staff members have been very cooperative in trying to find solutions to these issues. They also face some of the same problems for enforcement, since they also are dependent upon the federal regulations to be developed, so they know what the new rules will be. To date, we have seen only one set of regulations dealing with these near term issues – that regulation being the one that defined "dependent". For us to make any necessary changes to our benefit plans we need clarification and definitions for:

- Grandfathered plans – which I will address next.
- Does the prohibition of Annual and Lifetime Limits apply only to dollar limits or also to visit limits?
- Which preventive services will be required?
- What is included in the term "Essential Benefits"?

- Under Essential Benefits, what ages are included in "Pediatric services"?
- And exactly what is included in "Pediatric services, including oral and vision care"? Does that include only exams or is it broader such as orthodontia services, glasses, contacts, and how often?

The list goes on and on. We simply don't have the answers, but yet we are expected to be compliant with many of these provisions for plan years following 6 months after the March 23 enactment. It is not simply changing the benefit books; there are massive changes required to our computer system to properly process claims and documentation/explanation for our member services department. These cannot be done in such a short time frame when we don't even know what the regulations will be. Our staff members are committed to make this as smooth of a transition as possible for our members, our providers, and new customers, but to say this is a challenge is somewhat of an understatement. We want to be a resource to our employer groups, individual members, and our medical providers, but it is difficult to answer their questions when the answers are not yet defined. We are hopeful that these answers through proposed regulations will soon be forthcoming.

Grandfathered Health Plans – Another significant issue we are facing is with "grandfathered health plans". President Obama and PPACA promised that "if you like the plan you have, you can keep it." That is partially true. Plans that were in existence at the time of enactment (March 23, 2010) are considered "grandfathered" and that status appears to be indefinite. However, there are some changes that are required to even "grandfathered plans". New family members and employees can be added to grandfathered coverage. Generally no changes can be made to grandfathered plans. However, they have clarified that plans can be changed to include the new definition of "dependents" without forfeiting the grandfathered status. It is anticipated that if a group wants to make minor cost sharing changes to their plan, this may be acceptable. However, if a group were to change plans or insurers, they will most likely lose their "grandfathered" status and will need to purchase one of the 4 options beginning in 2014. However, this analysis is only speculation by legal authorities. No regulations have been proposed to date to address this issue. In the meantime, we have many employer groups who wish to make minor cost sharing changes to their plans. We have to caution them that this could result in losing their "grandfathered" status if the regulations do not permit this. It has been a major issue for employer groups that we have been dealing with. Our inability to give concrete answers to our groups is frustrating for these employers. They are faced with having to make choices without definitive answers. Once again, we await the regulations to clarify this significant issue.

Anticipated Financial Impact - Chairman Keiser asked if we could project what our anticipated premium increases will be based on PPACA's new requirements. As you may recall, we previously stated that we anticipate premiums could increase up to 15% for group business and up to 75 to 100% for the individual market once the law is fully implemented. We also stressed that while premiums will indeed increase, many ND residents will receive the benefit

of premium credits and cost-sharing subsidies. In addition, some small employers may be eligible for tax credits through 2015.

In addition, it is difficult to be entirely accurate with our projections without knowing what all of the regulations will be. Our actuaries have compiled a series of charts projecting their best estimate what increases are expected for the period from 2010 through 2016. These increases are based on the following factors:

- Mandated benefit changes
- Transfer of higher cost pools (CHAND, Conversion, COBRA etc.) into the general pool
- Anti-Selection (Individual mandate with weak penalty – purchase insurance only when sick.)
- Health insurance taxes and fees
- Pharmaceutical cost increases due to higher taxes/fees

Because we will now have both grandfathered and non-grandfathered plans for Individual, Small Group, Large Group fully insured, and Large Group self funded, I have supplied projections for each of these 8 categories. The charts are based on certain assumptions that are identified and only take into account the anticipated cost increases due to the new legislation. **They do not reflect normal inflationary utilization trends, which will need to be added to these costs.** The charts will also show anticipated cost of premiums for 3 different age groups over the same time period. As per the request of Chairman Keiser, I have compiled the total increased costs based on today's dollars and enrollment counts for the different groups based on the assumptions stated. Because we do not know how many people and plans will be grandfathered, we compiled one total assuming all are grandfathered and a second total assuming that none would be grandfathered. In reality, the totals will be a mixture of both, but would be impossible to accurately project. Those total increases by year are projected to be the following:

Year	Grandfathered Total Increase	Non-Grandfathered Total Increase
2010	$20,200,000	$51,500,000
2011	$10,100,000	$10,400,000
2012	$0	$0
2013	$0	$0
2014	$55,200,000	$118,200,000
2015	$39,400,000	$43,400,000
2016	$40,500,000	$44,500,000

As I indicated, these are only actuarial estimates based on the defined assumptions. However, there is no question that we anticipate significant premium increases based on factors previously discussed.

Mr. Chairman and Committee Members, thank you again for the opportunity to testify and I hope I was able to satisfactorily respond to your questions and requests. I would be willing to try to answer any further questions the committee may have.

Effects of PPACA on Premium Rates On Individual Business
(Grandfathered Plans (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	2.5%	0.0%	0.0%	0.0%	0.0%	2.5%
Chand/Conversion/Cobra included	0.0%	0.0%	15.0%	0.0%	0.0%	15.0%
Anti-Selection	0.0%	0.0%	10.0%	10.0%	10.0%	33.1%
Health Insurance fees	0.0%	0.0%	1.5%	0.5%	0.0%	2.0%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	2.5%	1.0%	28.4%	10.6%	10.0%	61.6%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total Premium
	Premium (4)	2010	2011	2014	2015	2016	Total	with HCR
Personal Choice 350 (25 year old)	$161	$4	$2	$47	$23	$24	$99	$260
Personal Choice 350 (45 year old)	$284	$7	$3	$83	$40	$42	$175	$459
Personal Choice 350 (60 year old)	$476	$12	$5	$140	$67	$70	$293	$770
Total Premium (in millions)	$76.1	$1.9	$0.8	$22.4	$10.7	$11.2	$46.9	$123.0

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

(4) Premium is currently approved premium, but Individual premium is currently underated. All changes due to health care reform are related to the currently approved 2010 rates and don't include any increases due to trend or getting rates more adequate.

Effects of PPACA on Premium Rates on Small Group Business (< 51 employees) (for Grandfatherd Plans (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	2.0%	0.0%	0.0%	0.0%	0.0%	2.0%
Anti-selection	0.0%	0.0%	10.0%	10.0%	10.0%	33.1%
Health Insurance fees	0.0%	0.0%	1.5%	0.5%	0.0%	2.0%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	2.0%	1.0%	11.7%	10.6%	10.0%	39.9%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total Premium
	Premium	2010	2011	2014	2015	2016	Total	with HCR
SelectChoice 250 (Single)	$381	$8	$4	$46	$46	$48	$152	$533
SelectChoice 250 (SPD)	$670	$13	$7	$80	$81	$85	$267	$937
SelectChoice 250 (Family)	$990	$20	$10	$119	$120	$126	$395	$1,385
Total Premium (in millions)	$230	$4.6	$2.3	$27.6	$27.9	$29.3	$91.7	$322

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

Effects of PPACA on Premium Rates on Large Group (fully insured) (for Grandfathered Plans (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	2.0%	0.0%	0.0%	0.0%	0.0%	2.0%
Anti-selection	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Health Insurance fees	0.0%	0.0%	1.5%	0.5%	0.0%	2.0%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	2.0%	1.0%	1.5%	0.5%	0.0%	5.1%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total Premium
	Premium	2010	2011	2014	2015	2016	Total	with HCR
SelectChoice 250 (Single)	$381	$8	$4	$6	$2	$0	$19	$400
SelectChoice 250 (SPD)	$670	$13	$7	$10	$4	$0	$34	$704
SelectChoice 250 (Family)	$990	$20	$10	$15	$5	$0	$50	$1,040
Total Premium (in millions)	$161	$3.2	$1.6	$2.5	$0.8	$0.0	$8.2	$169

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

Effects of PPACA on Premium Rates for Large Group (self-funded) (for Grandfathered Plans (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	2.0%	0.0%	0.0%	0.0%	0.0%	2.0%
Anti-selection	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Health Insurance fees	0.0%	0.0%	0.5%	0.0%	0.0%	0.5%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	2.0%	1.0%	0.5%	0.0%	0.0%	3.5%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total Premium
	Cost (4)	2010	2011	2014	2015	2016	Total	with HCR
SelectChoice 250 (Single)	$381	$8	$4	$2	$0	$0	$13	$394
SelectChoice 250 (SPD)	$670	$13	$7	$3	$0	$0	$24	$694
SelectChoice 250 (Family)	$990	$20	$10	$5	$0	$0	$35	$1,025
Total Cost (4) (in millions)	$526	$10.5	$5.4	$2.7	$0.0	$0.0	$18.6	$544

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

(4) Cost represents both stop-loss premium and self-funded claim payments and are estimated based on fully insured premium

Effects of PPACA on Premium Rates On Individual Business (for New Products (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	7.5%	0.0%	10.0%	0.0%	0.0%	18.3%
Chand/Conversion/Cobra included	0.0%	0.0%	15.0%	0.0%	0.0%	15.0%
Anti-Selection	0.0%	0.0%	10.0%	10.0%	10.0%	33.1%
Health Insurance fees	0.0%	0.0%	1.5%	0.5%	0.0%	2.0%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	7.5%	1.0%	41.2%	10.6%	10.0%	86.5%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total Premium
	Premium (4)	2010	2011	2014	2015	2016	Total	with HCR
Personal Choice 350 (25 year old)	$161	$12	$2	$72	$26	$27	$139	$300
Personal Choice 350 (45 year old)	$284	$21	$3	$127	$46	$48	$246	$530
Personal Choice 350 (60 year old)	$476	$36	$5	$213	$77	$81	$412	$888
Total Premium (in millions)	$76.1	$5.7	$0.8	$34.1	$12.3	$12.9	$65.8	$141.9

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation. New Plans will have more PPACA provisions than grandfathered plans.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

(4) Premium is currently approved premium, but Individual premium is currently underated. All changes due to health care reform are related to the currently approved 2010 rates and don't include any increases due to trend or getting rates more adequate.

Effects of PPACA on Premium Rates on Small Group Business (< 51 employees) (for New Products (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	5.0%	0.0%	5.0%	0.0%	0.0%	10.3%
Anti-selection	0.0%	0.0%	10.0%	10.0%	10.0%	33.1%
Health Insurance fees	0.0%	0.0%	1.5%	0.5%	0.0%	2.0%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	5.0%	1.0%	17.2%	10.6%	10.0%	51.2%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total Premium
	Premium	2010	2011	2014	2015	2016	Total	with HCR
SelectChoice 250 (Single)	$381	$19	$4	$70	$50	$52	$195	$576
SelectChoice 250 (SPD)	$670	$34	$7	$122	$88	$92	$343	$1,013
SelectChoice 250 (Family)	$990	$50	$10	$181	$130	$136	$507	$1,497
Total Premium (in millions)	$230	$11.5	$2.4	$42.1	$30.2	$31.6	$117.8	$348

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation. New Plans will have more PPACA provisions than grandfathered plans.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

Effects of PPACA on Premium Rates on Large Group (fully insured)
(for New Products (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	5.0%	0.0%	5.0%	0.0%	0.0%	10.3%
Anti-selection	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Health Insurance fees	0.0%	0.0%	1.5%	0.5%	0.0%	2.0%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	5.0%	1.0%	6.6%	0.5%	0.0%	13.6%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total
	Premium	2010	2011	2014	2015	2016	Total	Premium with HCR
SelectChoice 250 (Single)	$381	$19	$4	$27	$2	$0	$52	$433
SelectChoice 250 (SPD)	$670	$34	$7	$47	$4	$0	$91	$761
SelectChoice 250 (Family)	$990	$50	$10	$69	$6	$0	$135	$1,125
Total Premium (in millions)	$161	$8.0	$1.7	$11.2	$0.9	$0.0	$21.9	$183

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation. New Plans will have more PPACA provisions than grandfathered plans.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

Effects of PPACA on Premium Rates for Large Group (self-funded) (for New Products (1))

Percentage Increases by Year

	2010	2011	2014	2015	2016	Total
Benefit Changes	5.0%	0.0%	5.0%	0.0%	0.0%	10.3%
Anti-selection	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Health Insurance fees	0.0%	0.0%	0.5%	0.0%	0.0%	0.5%
Drug Price Increases (2)	0.0%	1.0%	0.0%	0.0%	0.0%	1.0%
Total	5.0%	1.0%	5.5%	0.0%	0.0%	11.9%

Impact to Premium (All premium increases are indexed to 2010 (3))

		Increase due to health care reform (HCR)						Total Premium
	Cost (4)	2010	2011	2014	2015	2016	Total	with HCR
SelectChoice 250 (Single)	$381	$19	$4	$22	$0	$0	$45	$426
SelectChoice 250 (SPD)	$670	$34	$7	$39	$0	$0	$80	$750
SelectChoice 250 (Family)	$990	$50	$10	$58	$0	$0	$118	$1,108
Total Cost (4) (in millions)	$526	$26.3	$5.5	$30.8	$0.0	$0.0	$62.6	$588

(1) PPACA allows for existing coverage to be grandfathered which doesn't require all of PPACA provisions to be implemented. Eventually plans will need to modify coverage to appropriately modify cost-sharing to account for medical inflation. New Plans will have more PPACA provisions than grandfathered plans.

(2) Drug Price Increases - Drugs will increase for two reasons. Drug companies will have to pay a new federal fee starting in 2011. Also, Drug companies are being asked to fund the Medicare Part D donut hole which will result in cost shifting to others.

(3) Premium does not include future trend. In other words, the increases we are showing for the future years are showing how much premium would increase if those future PPACA provisions and policies were in place in 2010.

(4) Cost represents both stop-loss premium and self-funded claim payments and are estimated based on fully insured premium