FEDERAL HEALTH CARE REFORM UPDATE

Presented by: **Adam Hamm, Commissioner**
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Before: **Industry, Business and Labor Committee**
Representative George Keiser, Chairman

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Good morning, Chairman Keiser and members of the Committee. For the record I am North Dakota Insurance Commissioner Adam Hamm.

I am here to provide an update to you about several items related to healthcare reform. They are the current status of the health insurance exchanges, an update on the medical loss ratio provisions in the federal legislation, an update on the federal definition of essential benefits, and an accounting of the premium taxes paid to the State of North Dakota by health insurance carriers.

I will also update you on the federal offer of grant dollars for premium rate review and the federal high risk pool.

Health Insurance Exchanges

While there has been no new guidance on health insurance exchanges from the federal government, it is important to review the multiple decisions that will have to be made by states prior to the certification of the exchanges which must be completed by January 1, 2013. If states do not have certification by that date, the US Department of Health and Human Services ("HHS") will run the exchange.

States must decide where to locate the exchange. It may be within an existing or newly created state agency or a nonprofit entity. States must decide whether to run one combined exchange for individual and small business policies, or have two separate exchanges. It is up to the states to decide whether or not to join together for a multi-state or regional exchange.

As I have mentioned before, the exchanges must be very active participants in the insurance market to certify plans, rate plans, deal with consumer issues, inform employers when employees leave the exchange, verify exempt individuals, report data to the federal government and enroll consumers in other subsidized insurance programs such as Medicaid, CHIP and other state or local public programs.

Loss Ratios

The medical loss ratio requirement in the new law states that companies must meet a minimum of 80 percent claims to premiums for individual and small group plans and 85 percent for large group plans. If insurance companies do not meet these requirements for the 2010 plan years, they must pay rebates back to policyholders.

Currently, the National Association of Insurance Commissioners is working on the definitions for claims and premiums in order to make formal recommendations to HHS. Ultimately, HHS will make a final decision whether or not to certify those recommendations. The basic equation is this:

$$\frac{\text{Claims + "Quality Improvement Expenses"}}{\text{Premiums – Taxes (federal and state)}} = \text{Minimum Medical Loss Ratio}$$

The definition of quality improvement expense is a critical component that will have to be decided by the federal government. They are expenses other than those billed or allocated by a provider for care delivery for health services that are designed to improve health care quality and increase the likelihood of desired health outcomes. They must be objectively measured and produce verifiable results. These expenses may include costs associated with chronic disease management programs, medication compliance initiatives, health information technology expenses and wellness coaching sessions.

Please keep in mind that this new federal requirement to meet a minimum medical loss ratio is different than the North Dakota statutory requirements for minimum loss ratios for health insurers. The formula used to determine whether or not a major medical insurer is meeting the standards of a 70 percent for group policies and 55 percent for individual policies is:

$$\frac{\text{Incurred Claims}}{\text{Premiums}} = \text{Minimum Loss Ratio}$$

The next Legislative Assembly will want to consider whether the state statute should continue in existence or be amended given the federal requirements.

Essential Health Benefits

For plan years beginning on or after January 1, 2014, health insurers offering coverage in the individual and small group markets must ensure that the coverage they offer includes the "essential health benefits" package. The complete definition of "essential health benefits" has not been provided yet by regulation but we do know that, at a minimum, coverage must be offered for the following items: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services

and devices, lab services, preventive and wellness services, and pediatric services. We know that all non-grandfathered plans will have to include the essential benefits package and must comply with limitations on annual cost-sharing.

Rate Review Grant

The North Dakota Insurance Department applied for a $1 million grant to enhance our rate review capabilities in early July. We expect the award notice in early August. The grant funds will be used to enhance the capability, resources and access to additional tools which will allow the Department to review rates in even more detail; to study previous industry assumptions and the related outcomes in relation to premiums; and to build a new team concept consisting of existing and new employees to further expand the scope of rate review.

Health Insurance Premium Tax Totals

Following is a chart that provides information, by health insurance companies, of the amount of premium taxes paid in 2009. Note that the final amount of tax paid to the state is minus all credits. Credits are earned by companies when they pay a Comprehensive Health Association of North Dakota (CHAND) assessment, examination fees and property taxes on their North Dakota headquarters.

TOTAL PREMIUM TAX – 2009

	Premiums Collected		Tax Rate		
Accident and Health	$917,497,754	X	.0175	=	$16,056,211
Life	$275,010,713	X	.02	=	5,500,214
Property and Casualty	$994,492,187	X	.0175	=	17,403,613
					$38,960,038
Adjustments and Credits					(4,363,115)
Total Premium Tax					$34,596,923

Pre-Existing Condition Insurance Plan

As we have reported to you in the past, HHS is operating a temporary high risk pool in our state. On July 1 eligible residents—citizens or nationals of the US that have been uninsured for at least six months and have had problems getting insurance due to a pre-existing condition—were able to apply for coverage.

The premiums vary by age starting at $246 per month for individuals age 0 to 34 and topping out at $524 per month for individuals over the age of 55. The plan has a $2,500

deductible, a $25 co-pay for office visits, a $4 to $30 prescription drug copayment and an 80/20 cost sharing with a maximum out of pocket of $5,950. These expenses apply only for in-network services.

The pool is designed to provide health insurance coverage for eligible individuals until the federal health care reforms are fully implemented beginning January 1, 2014.

CHAND

At the last Committee meeting, I was asked to present information with respect to whether the CHAND Board of Directors was approached to operate the federal high-risk pool within North Dakota . The Board was not approached, nor was Blue Cross Blue Shield of North Dakota, the Administrator of CHAND. However, it is my understanding that the National Blue Cross Blue Shield Association was approached and declined.

Chairman Keiser and members of the Committee, I believe that covers all of the topics I was asked to discuss. I would be happy to try to answer any other questions you may have.