State of North Dakota
Interim IBL committee
Rep. George Keiser, Chairman

North Dakota Insurance Department

HB 1577

Commissioner's overview of the health insurance market

Presented by Adam Hamm, Insurance Commissioner
Aug. 6, 2009

North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
ADAM HAMM, COMMISSIONER

Sixty-first Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 6, 2009

HOUSE BILL NO. 1577
(Representatives Keiser, Carlson, Boucher, Kasper, Monson, Onstad)
(Approved by the Delayed Bills Committee)

AN ACT to provide for a legislative council study of factors impacting the cost of health insurance and health insurance company reserves.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. LEGISLATIVE COUNCIL STUDY - HEALTH INSURANCE COST.

1. During the 2009-10 interim, the legislative council shall consider studying:

   a. The factors impacting the cost of health insurance. The factors considered in the study must include:

      (1) Minimum loss ratio;

      (2) Three tier rating bands;

      (3) The effect of the federal Employee Retirement Income Security Act, Medicare, Medicaid, and the state children's health insurance program on individual and small group pricing;

      (4) Options for self-funding, fully insured funding, and combinations of these two methods of funding;

      (5) Prepaid coverage versus risk coverage;

      (6) Corporate structure of health insurance companies;

      (7) Health insurance company subsidiaries;

      (8) Rate, form, and reserve approval requirements;

      (9) Statutory barriers to competition and lower costs;

      (10) The role of health promotion versus risk coverage;

      (11) Transparency requirements based on tax incentive benefits;

      (12) Plan design or coverage options;

      (13) Health service mandates;

      (14) Uninsured and underinsured North Dakotans;

      (15) Proposed federal changes in health care coverage;

      (16) The business organization and tax status of health insurance companies and the impact this has on premium rates and reserves; and

      (17) Other health insurance cost and competition factors.

b. The impact of health insurance company board member compensation and employee salaries, benefits, and severance packages on health insurance rates and health insurance company reserves.

2. The legislative council shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-second legislative assembly.

Speaker of the House

President of the Senate

Chief Clerk of the House

Secretary of the Senate

This certifies that the within bill originated in the House of Representatives of the Sixty-first Legislative Assembly of North Dakota and is known on the records of that body as House Bill No. 1577.

House Vote:	Yeas	92	Nays	0	Absent	2
Senate Vote:	Yeas	41	Nays	5	Absent	1

Chief Clerk of the House

Received by the Governor at _____ M. on _____, 2009.

Approved at _____ M. on _____, 2009.

Governor

Filed in this office this _____ day of _____, 2009,

at _____ o'clock _____ M.

Secretary of State

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Table of contents

I. Regulatory authority

A. Commissioner **has regulatory authority** over insurance companies operating in the state, and insurance products marketed in the state (with some exceptions), including the following health products:

1. Hospital, surgical, medical and major medical
2. Long-term care, Medicare supplement
3. Dental, vision, disability income, accident
4. Specified disease (i.e., cancer), stop loss, credit life and disability

B. Commissioner **does not have regulatory authority** over self-funded products, products regulated by the federal government or products regulated by the SEC, including:

1. Self-funded
2. Medicare Part D
3. Medicare Advantage
4. Variable products regulated by the SEC. (variable life, variable annuities)

Notes —

II. Insurance Department responsibilities/roles

A. Consumer protection

1. Prior approval state

a. Some states are file and use, which means that companies file forms and rates with the Insurance Department, but do not wait for approval before implementing. North Dakota is a prior approval state, which means that forms and rates cannot be implemented until first approved by the Department.

b. In 2008, we received 2,677 life and health rate and form filings:
- 506 were informational filings;
- 2,038 were approved;
- 96 were disapproved;
- 11 were rejected; and
- 26 were withdrawn.

c. Some filings (rate or form) are more complicated and take more time to review; others are less complicated and can be reviewed more quickly.

d. Our life and health filing goal is to turn around all filings within 60 days.

2. Fraud protection

a. In North Dakota, insurance fraud is a Class C felony if the value of any property or services retained exceeds $5,000, and a Class A misdemeanor in all other cases.

b. Fraud may be reported by anyone through an online form on our website.

c. The Department's legal division handles all fraud issues, whether consumer fraud or agent/company fraud by performing investigations, enforcing administrative actions and working with law enforcement.

Notes _

Responsibilities: Consumer protection

3. Agent licensing/enforcement

a. The Agent Licensing Division

1. Approximately 46,000 agents are licensed to do business in the state; 6,500 are resident agents. Ten years ago we had 17,680 total agents. Of the 46,000 agents licensed to do business in the state, about 21,350 are licensed in accident/health, of which 3,566 are resident agents.
2. This division is assigned all duties necessary to carry out the issuing, renewal and ongoing processing of agent licensing, including license applications, renewals, agent appointments, continuing-education filing reports and course approval for continuing education courses.

b. Investigations and enforcement

1. The legal division is in charge of investigation and enforcement actions. Investigations may be conducted due to an agent or company issue.
2. Closing an investigation may lead to:
    - Reprimand
    - Cease and desist
    - Administrative action including suspension or revocation
    - Fine
    - Criminal charges

4. Market analysis and market conduct

a. The legal division performs regular market analysis on companies. Market analyses are broad reviews of company complaint patterns and issues, utilizing national databases.

b. Additionally, market conduct exams are performed as needed. Market conduct exams typically begin because there is a pattern of complaints or issues on a particular company. Examples of problematic issues include:

- Delays in claim payments
- Incorrect claims payments
- Denials
- Questionable cancellations
- Inappropriate advertising or marketing

Notes —

Responsibilities: Consumer protection

5. Hotline/complaints

a. All incoming calls are logged into a queue.

b. Calls are returned in the order in which they are received, usually within one business day.

c. Incoming calls generate return calls to the caller, calls to companies or agents and written correspondence.

d. People visit the Department in person as well, and staff is available to assist them. Walk-ins are a priority.

e. People can be assisted in filing a formal complaint against a company or agent by Department staff.

f. Hotline and complaint resources:

1. In 2008, there were 8,902 calls received/made; 132 walk-ins received; and 754 pieces of correspondence written
2. Through 7/30/09, there were 4,742 calls received/made; 56 walk-ins received; and 535 pieces of correspondence written.

Notes —

Responsibilities

B. Solvency

1. **Initial company requirements for ND domiciled companies**
   a. Minimum capital and surplus = $1 million
   b. Minimum 200% RBC after first year of business
   c. Must designate principal place of business (home office) in ND or place a deposit with Bank of North Dakota in an amount established by the Commissioner if some physical presence (regional office, claim center, etc.) is located in ND
   d. Membership in the ND Life & Health Insurance Guaranty Association
2. **Financial exams**
   a. The Financial Examinations and Analysis Division continually monitors the financial strength of insurance companies to help assure they have enough money to pay policyholder claims. It performs periodic financial audits of North Dakota based companies to assure they are financially sound, and complying with state laws dealing with insurance company financial matters.
   b. In 2008, the division performed eight scheduled exams. In 2009, nine exams will be performed. This division also conducts targeted financial exams as necessary. Currently, there is one targeted financial exam underway.
   c. This division oversees the licensing of approximately 1,400 insurance companies doing business in the state.

Notes —

Responsibilities: Solvency

3. Risk-based capital (RBC)

a. RBC is the amount of required capital that an insurance company calculates based on the inherent risks in the company's operation.

b. Types of risk

a. Asset risk—risk of assets' default of principal and interest or fluctuation in fair value

b. Insurance/underwriting risk—risk of underestimating liabilities from business already written, or inadequately pricing business to be written in the following year

c. Interest rate risk—risk of losses due to changes in interest rate levels (life only)

d. Credit risk—risk of recovering receivable amounts

e. Market risk—risk of losses due to changes in market levels associated with variable products (life only)

f. Business risk—risk of general business

4. Early warning signs

a. **If company surplus < 200% RBC** (company action level event), insurer must submit to the Commissioner a risk-based capital plan that:

1. Identifies conditions leading to the company action level event;
2. Proposes corrective action;
3. Provides financial projections for current and succeeding four years with and without the proposed corrective action;
4. Identifies key assumption affecting the projections and the sensitivity of the projections to the assumptions used; and
5. Identifies the quality of, and the problems associated with the company's business.

b. **If company surplus < 150% RBC** (regulatory action level event),the Commissioner shall:

1. Require the company to submit a risk-based capital plan (or a revised plan);
2. Perform an examination of the company's assets, liabilities, operations and risk-based capital plan as the Commissioner deems necessary; and
3. Issue an order specifying the corrective actions that the Commissioner determines are required.

Notes —

Responsibilities: Solvency

c. **If company surplus <100% RBC** (authorized control level event), the Commissioner shall:
   1. Take actions as required under regulatory action level event; and
   2. Take action to place the Company under regulatory control if the Commissioner deems it to be in the best interests of the policyholders, creditors of the company and the public.

d. **If company surplus <70% RBC** (mandatory control level event), Commissioner must take action to place the company under regulatory control.

5. North Dakota Life and Health Insurance Guaranty Association (NDLHGA)

a. Any company licensed to sell life insurance, annuities, or accident and health insurance must be a member of the NDLHGA.

b. NDLHGA protects a policyholder, within statutory limits, if a member insurer is found to be insolvent and is ordered to be liquidated by a court.

c. If this happens, NDLHGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep the insurance coverage in force.

d. There are limits, defined in statute, to the amount of protection NDLHGA will provide.
   1. NDLHGA will not pay more than what the insurance company would owe under a policy or contract.
   2. For any one insured life, NDLHGA will pay a maximum of $300,000, no matter how many policies or contracts are in force, even if policies provide different types of coverages.
   3. Within the overall $300,000 limit, NDLHGA will not pay (no matter how many policies or different types of coverages with the same company) more than:
      - $100,000 in cash surrender benefits;
      - $100,000 in health insurance benefits;
      - $100,000 in present value of annuities; or
      - $300,000 in life insurance death benefits.

e. Typically, an individual will be protected by NDLHGA if:
   1. The individual lives in North Dakota and holds a life or health insurance contract or annuity contract.
   2. The insured is insured under a group insurance contract issued by a member insurer.
   3. The individual is a beneficiary, payee or assignee of an insured person, even if a nonresident of North Dakota.

Notes —

Responsibilities: Solvency

f. An individual holding a policy is not covered by NDLHGA if:
   1. The individual is eligible for protection under another state
   2. The insurer was not authorized to do business in North Dakota
   3. The policy was issued by an organization that is not a member of NDLHGA; for example:
      - Health maintenance organizations (HMOs)
      - Fraternal benefit societies
      - CHAND

g. NDLHGA does not provide coverage for:
   1. A policy or portion of a policy that is not guaranteed by the insurer or for which the individual has assumed the risk (i.e., a variable contract sold by a prospectus)
   2. A policy of reinsurance (unless an assumption certificate was issued)
   3. An interest rate yield that exceeds an average rate
   4. A dividend
   5. A credit given in connection with the administration of a policy by a group contract holder
   6. An employer's plan to the extent that it is self-funded (even if an insurance company administers the plan)

h. The law prohibits agents and companies from using NDLHGA in any advertising.
   1. NDLHGA should not substitute for prudent selection of an insurance company that is well managed and financially stable.
   2. Agents are prohibited by statute from using NDLHGA as an inducement to purchase insurance.

i. The insurance company or agent is required by statute, however, to provide the policyholder a notice concerning coverage, limitations and exclusions under NDLHGA.

Notes —

Responsibilities

C. Education and outreach

1. Insurance Department website

a. North Dakota Insurance Department website is www.nd.gov/ndins.

b. Main sections include: consumers, companies, producers/agents

c. The site includes information on:

1. How to file a complaint
2. Approved long-term care insurance and Medicare Supplement plans of insurance
3. Agent/agency search
4. Bulletins, orders and other legal documents
5. Department news
6. Frequently-asked questions

d. Redesigning this fall; will include a new section called "Ask Adam" that allows consumers to submit questions to the Commissioner

2. Agent forums

a. Annual agent meetings are held in Bismarck-Mandan, Jamestown, Fargo, Grand Forks, Minot, Williston and Dickinson, with presentations by the Commissioner, and representatives from the Life and Health, Property and Casualty, Agent Licensing and Compliance and Legal Divisions.

b. These meetings are educational and interactive.

c. Approximately 1,000 agents attend each year throughout the state.

Notes —

Responsibilities: Education and outreach

3. SHIC/PC

a. State Health Insurance Counseling (SHIC) program

1. Formally initiated January 1993; funded by a grant from the Centers for Medicare and Medicaid Services (CMS), the agency that administers Medicare.
2. SHIC is a public-private-volunteer partnership between the Insurance Department, sponsoring organizations and volunteers.
3. SHIC offers free and confidential help to Medicare-eligible people regarding Medicare and other health insurance.
4. SHIC counselors are trained in all aspects of senior issues, such as Medicare, Medicare Part D, Medicare Advantage and long-term care insurance.
5. Since the beginning of the year, the SHIC program has assisted 6,362 clients; enrolled 1,956 individuals in an appropriate Part D plan; and have addressed complaints from Medicare beneficiaries regarding their Part D and Medicare Advantage plans.
6. SHIC also sponsors enrollment events across the state to assist Medicare-eligible beneficiaries in their Medicare Part D choices. In 2008 (Nov. 17 through Dec. 17), those enrollment events were held in Bismarck, Devils Lake, Dickinson, Fargo, Grand Forks, Jamestown, Minot, Valley City, Wahpeton and Williston.

b. Prescription Connection (PC) program

1. PC began Dec. 1, 2003, connecting people needing help with prescription costs with existing programs who offer that help.
2. Since PC began (through 7/31/09), we have received calls from 6,013 individuals requesting assistance for 26,215 prescriptions. Of those 6,013 individuals, we were able to find prescription matches for 5,984. This means that we have been able to connect 99.5% of the individuals who have called with at least one assistance program.

4. Outreach events (health fairs, turning 65 seminars, enrollment events, senior center presentations)

1. 2008: 103 events; approximately 30,000 people reached
2. 2009 (through 7/30/09): 55 events; approximately 19,500 people reached

Notes —

Responsibilities: Education and outreach

5. CHAT

a. CHAT (Choosing Health Plans All Together) is a unique study of what North Dakotans want and need in a basic health insurance plan.

b. Participants in the CHAT exercise are given a wide range of available health insurance services in North Dakota, and a number of markers. Each marker represents a unit of cost; and each service is assigned a number of markers as its cost.

c. Each participant chooses how they want to spend their markers to purchase the coverage that is important to them. The total number of markers given to each participant is less than what it would cost to purchase the highest level of every service that is available, so choices need to be made.

d. This individual activity is repeated as small groups of 3-4 individuals; and again with the total group.

e. The CHAT experience demonstrates that:

- There are not enough dollars to purchase all the health coverage we might desire, so choices are necessary; and
- Preferences/choices of individuals will differ from those of communities, which will differ from those of the state.

f. The CHAT experience can be done online, and also will be available in person in 10 cities: Bismarck, Bottineau, Devils Lake, Dickinson, Fargo, Grand Forks, Harvey, Jamestown, Minot and Wahpeton.

g. In early 2010, we will invite all participants, community leaders and other interested parties to attend a community discussion on the results.

Notes —

Responsibilities

D. Seek to attract quality companies/products—maintain level playing field

1. Perform appropriate due diligence before a company is licensed in the state.

2. Be fair and consistent in the treatment of companies.

3. Respond quickly, fairly and consistently to products filed for approval, to bring products to market in the state on a timely basis.
   a. Be sure the products comply with North Dakota laws.
   b. Be sure the products are good for consumers.

E. Fairness and equity for consumers, companies, producers and providers

1. "Beyond the numbers" (rate increase requests) considers:
   a. Level and frequency of past increases
   b. Ability to pay
   c. Impact on remaining policyholders
      - Shock lapse
      - Death spiral

2. Objectivity
   a. Avoid recommending one company over another
   b. Treat issues/questions consistently among companies
   c. We don't make laws; we administer and enforce them.

3. Consideration of all customer/stakeholder groups
   a. Consumers
   b. Policyholders
   c. Companies
   d. Agents
   e. Healthcare providers
   f. Legislators
   g. Other state and federal agencies

Notes —

III. Challenges

A. Cost of health care

1. **Factors affecting trend** (the forecast change in health plans' per capita claims cost)
   a. Inflation—The unit price of medical services, treatment and supplies changes each year.
   b. Utilization—The frequency and type of services utilized will change.
   c. Cost shifting—This occurs when one party absorbs the expenses included by another. For example, the cost of services incurred by people who are unable to pay is added to the cost of services incurred by the people who can pay.
   d. Leveraging—If the cost of care increases, and the deductibles and co-pays do not, insurance pays a greater portion of the cost.
   e. Technology—Different treatments and drug therapies are more widely available and may be more expensive.
   f. Mandates—Legislation requires coverage for specified services, adding to the cost of a policy. In North Dakota, there are 23 benefit mandates.

2. **North Dakota factors**
   a. North Dakota's population is aging.
   b. Several of the most expensive conditions (heart disease, mental disorders, lung disorders, cancer and trauma) are prevalent in North Dakota.
   c. The price of medical malpractice insurance
   d. Consumers demanding 24/7 health care

3. **Business owners' responses**

Business owners that cannot afford the increased cost of health insurance premiums may attempt to reduce their healthcare costs by:

   a. Requiring higher employee-paid contributions and/or higher co-payments
   b. Eliminating some benefits or restricting the number of plans offered
   c. Shopping for different products and prices within the health insurance market more frequently (if alternatives are available)

Notes —

Challenges: Cost

4. Economic impact (increased number of uninsured/underinsured)

a. The cost of uninsured care is spread to those that do have insurance.
b. Underinsured people are less likely to practice prevention, ultimately increasing costs (because an office visit is cheaper than an emergency room visit).
c. The cost of underinsured care is also spread among those with insurance through overhead costs and assistance programs.
d. Cost shifting will affect hospital profits.
e. As costs increase, smaller hospitals won't be able to absorb the overhead cost of caring for under/uninsured people, which could impact the economy and quality of life in rural communities.

5. Future implications

Future implications of continued health care cost increases that outpace inflation may include:

a. Acceleration of consumer driven approaches to health care
b. Consumers will either pay the increased cost or reduce or drop their coverage
c. Employers may:
    1. No longer offer health insurance;
    2. Offer one flat payment per month to be used for medical care; or
    3. Provide health insurance with higher deductibles and co-pays, or fewer benefits.

B. Increasing premiums

1. Increasing costs predictably means premiums will also rise
    a. Similar to other types of goods and services, as the cost of providing the goods or services increase, the price to purchase them increases as well.
    b. As the cost of health care increases, increasing health insurance premiums becomes a reality. The question is not whether there should be increases, but rather the level of increases that are justified; and that is unique to each company and each product.

Notes —

Challenges

C. Competition

1. Ways to compete

a. Price—Competition is an incentive for efficiency.
b. Benefits—Competition is an incentive for providing benefits and plan designs the customer desires (or a competitor might).
c. Service—Good service is critical to maintain market share (or lose it to a competitor).
d. Sustainability—If there is competition, the status quo will not be sufficient.

2. Number of companies selling business in North Dakota (as of 7/31/09)

a. Individual market (5 companies)
- Assurant (includes Time and John Alden)
- Blue Cross Blue Shield
- Companion Life (Association Group)
- Heart of America Health Plan (HMO)
- World insurance

b. Small group (7 companies)
- Assurant (includes Time and John Alden)
- Blue Cross Blue Shield
- Heart of America Health Plan (HMO)
- Madison National Life Insurance Company
- Medica
- UnitedHealthCare Insurance Company
- Trustmark (Association Group): available, but no business in force

Notes _____

Challenges: Competition

c. Large group (9 companies)

- Aetna Life Insurance Company: available, but no business in force.
- Blue Cross Blue Shield
- Connecticut General Life Ins Co. (CIGNA): available, but no business in force.
- Heart of America Health Plan (HMO)
- John Alden Life Insurance Co. (Assurant)
- Medica
- Trustmark: Available, but no business in force.
- Unicare Life & Health Insurance Company: available, but no business in force.
- United HealthCare Insurance Company: available, but no business in force.

3. Major Med Market Share by Company based on Premium, 2008

Company	Premium (millions)	Market share
BCBS	$447.0	89.4%
Medica	22.9	4.6%
John Alden/Time	13.1	2.6%
American Family Mutual	6.3	1.3%
Heart of America	3.2	.6%
American Republic	1.8	.4%
Continental General	1.7	.3%
Madison National	1.0	.2%
MII Life	.6	.1%
State Farm Mutual Auto	.5	.1%

Notes —

Challenges: Competition

4. BCBS Major Med Market Share by Premium

BCBS Total, Major Med

Year	Premium (millions)	Market share
2008	$447.0	89.4%
2007	415.8	89.9%
2006	393.9	89.6%
2005	379.0	90.0%
2004	356.0	89.5%
2003	348.1	90.3%
2002	335.5	88.9%
2001	303.9	87.1%
2000	279.8	82.6%
1999	233.4	80.1%

BCBS Individual, Major Med

Year	Premium (millions)	Market share
2008	$78.2	76.1%
2007	76.2	75.8%
2006	70.8	73.7%
2005	68.6	74.6%
2004	65.1	73.3%
2003	55.3	70.3%
2002	53.2	66.2%
2001	49.2	63.3%
2000	50.6	67.6%
1999	51.3	70.4%

Notes —

Challenges: Competition

BCBS Small Group, Major Med

Year	Premium (millions)	Market share
2008	$220.6	91.9%
2007	204.9	92.8%
2006	178.7	92.7%
2005	173.1	93.5%
2004	159.8	93.0%
2003	148.8	94.3%
2002	154.1	94.2%
2001	130.9	92.1%
2000	122.3	89.1%
1999	85.6	85.0%

BCBS Large Group, Major Med

Year	Premium (millions)	Market share
2008	$148.2	94.3%
2007	134.7	95.7%
2006	144.5	95.8%
2005	137.3	95.4%
2004	131.1	95.6%
2003	144.1	96.7%
2002	128.2	96.1%
2001	123.9	96.0%
2000	106.9	84.3%
1999	96.5	81.9%

Notes _

IV. Premium increase requests—process

1. Justification of a rate increase is based, in part, on minimum loss ratio requirements.
   a. The loss ratio is the ratio of claim payments to premiums, and it varies by product type and policy duration.
   b. Loss ratios for a single year typically start low (because recently underwritten), and increase as the policies get older.
   c. When comparing loss ratios with the minimum requirements, both historical experience as well as projected future experience are considered.
2. North Dakota experience, which may not be credible, is considered; as well as national experience.
3. A key assumption in projecting future claim experience is trend.
4. Premium increases typically are not considered any more often than once in a 12-month period.
5. Past premium increases, both amount and frequency, as well as affordability, are considered in determining a premium increase the Department is willing to approve.
6. If there are questions about the material submitted, or additional information is needed, the company is asked to provide it.
7. After material is reviewed, premium increase is approved, rejected, or modified.
8. If the company disagrees with the premium increase approved, they can request an administrative hearing.
9. Principle: benefits must be reasonable in relation to premiums charged.

Notes —

V. Alternatives to increasing premiums

A. Higher deductibles and/or co-pays

1. This increases the out-of-pocket costs to the insured.
2. This will reduce the overall cost of the health insurance policy, resulting in lower premiums.

B. High deductible health plans

1. These plans have high deductibles and lower premiums
2. People who buy these plans should have the ability to pay for their health care costs up to that higher deductible.

C. Limited benefit health plans

1. Expenses covered under these plans are more limited, so the premiums are lower, but does provide some insurance coverage
2. Coverage is inadequate for large claims

D. Health discount plans

1. These plan have very low premiums, but do not provide insurance coverage.
2. These plans are often misunderstood because:
   a. The larger discounts may apply only to procedures that are performed on a very limited basis.
   b. It is a provider's choice whether or not to accept a discount plan. The cost of the health care is entirely the responsibility of the consumer.
   c. Since these plans are not insurance, the consumer still assumes all the risk of incurring high cost procedures.

Notes —

VI. Effects of multiple premium increases (uninsured/underinsured)

A. Categories of uninsured

1. By ability to pay

a. High-risk, and unable to afford individual policy premiums
- Premiums higher because of existing health conditions (or the person is uninsurable)
- Other expenses that need to be paid

b. Limited ability to pay
- Other expenses that need to be paid
- Will buy it when I can afford it

c. Can afford, but chose not to purchase
- Healthy, don't need it
- Will buy it when I'm older

d. Eligible for public programs, but are not enrolled
- Unaware that these programs exist
- Unwilling to "accept welfare"

2. By employment status

a. Employed, offered coverage but declined it
- Healthy, don't need it; can buy it later
- Don't appreciate the value of insurance and establishing insurability when you can
- Other current expenses have priority

b. Employed, but not offered coverage
- Can't afford an individual policy
- Will wait for employer to provide it (or find another job where health insurance is provided by the employer)
- Will consider purchasing insurance later when I can afford it

c. Not employed
- Can't afford an individual policy
- Will wait for a job and have insurance through the employer

Notes _

Effects of multiple premium increases: Un/under insured

B. Causes and impacts of underinsured

1. As the cost of health care continues to increase, individuals and employers who value the insurance protection will accept lower benefits and/or higher cost sharing (deductibles, co-pays) in order to keep their coverage affordable.
2. As a result, the coverage is less than what it needs to be (underinsured).
3. While some coverage is preferable to no coverage, the costs of providing care to the underinsured increases the cost to the insured through higher overhead costs to the providers, potentially increasing the number of underinsured even more.
4. Continued increasing costs will eventually make health insurance unaffordable for the underinsured, and they will increase the number of uninsured.

Notes —

VII. Other programs

A. State Children's Health Insurance Program (SCHIP)

1. Provides premium-free coverage to uninsured children in qualifying families.
2. Intended to help meet the health care needs of children from working families that earn too much to qualify for full Medicaid coverage, but not enough to afford private insurance.
3. SCHIP covers children who:
   a. Do not have health insurance coverage
   b. Are 18 years of age or younger (covers children through the month they turn 19)
   c. Do not qualify for Medicaid
   d. Live in families with qualifying incomes
      - Income guidelines are established by the North Dakota Legislature.
      - To qualify, a family's net income (after subtracting childcare costs and payroll taxes such as Social Security tax, Medicare tax and income tax) must be greater than the Medicare level but cannot exceed 160 percent of the federal poverty level. (Established May 2009, HB 1012)
4. SCHIP provides comprehensive coverage including:
   a. Inpatient hospital stay, medical and surgical services;
   b. Outpatient hospital and clinic services;
   c. Mental health and substance abuse services;
   d. Prescription medications;
   e. Routine preventive services (such as well-baby check-ups and immunizations);
   f. Dental and vision services; and
   g. Prenatal services.
5. SCHIP costs to families is minimal
   a. No monthly premiums
   b. Most families are required to pay modest copayments when a child receives certain services.
      - Emergency room—$5 per visit
      - Hospitalization—$50 per hospitalization
      - Prescription—$2 per prescription
      - Copayments are waived for Native American children

Notes _____

6. SCHIP does not require families to choose a primary doctor or provider for their children.
7. A child covered by SCHIP does not need referral to a specialist (but parents may want to contact the insurance company, Noridian, for details on any coverage question, especially if the specialist is out of state).

B. CHAND

1. Comprehensive Health Association of North Dakota (CHAND) was created by the ND Legislature in 1981 to provide comprehensive health insurance to residents who:
   a. Had been denied health insurance; or
   b, Had been given restricted coverage because they had health problems and were considered to be in a high risk category.
2. An individual is eligible if they qualify as a:
   a. Traditional applicant
   b. Health Insurance Portability and Accountability Act of 1996 (HIPAA) applicant
   c. Federal Trade Adjustment Assistance Reform Act of 2002 (TAARA) applicant
   d. Age 65 and over or disabled supplement applicant
3. An individual is <u>not</u> eligible for CHAND if:
   a. They are eligible for the state's medical assistance program (for example, Medicaid);
   b. CHAND has paid $1 million in benefits on behalf of the individual;
   c. They have previously terminated CHAND coverage within the last twelve months (doesn't apply to HIPAA individuals);
   d. They are an inmate or resident of a public institution (doesn't apply to HIPAA individuals); or
   e. Their premiums are paid for or reimbursed under any government-sponsored program, government agency, health care provider, nonprofit charitable organization or the individual's employer (doesn't apply to TAARA individuals).

Notes —

Other programs

4. Plans offered through CHAND include:
   a. Major medical coverage options
      - $500 deductible without chiropractic: $500 annual deductible with 80% benefit allowance up to the $3,000 annual out-of-pocket maximum, then 100% of allowed benefits. Prescription drug coverage is included.
      - $1,000 deductible without chiropractic: $1,000 annual deductible with 80% benefit allowance up to the $3,000 annual out-of-pocket maximum, then 100% of allowed benefits. Prescription drug coverage is included.
      - $500 deductible with chiropractic: $500 annual deductible with 80% benefit allowance up to the $3,000 annual out-of-pocket maximum, then 100% of allowed benefits. Prescription drug and chiropractic coverage are included.
      - $1,000 deductible with chiropractic: $1,000 annual deductible with 80% benefit allowance up to the $3,000 annual out-of-pocket maximum, then 100% of allowed benefit. Prescription drug and chiropractic coverage are included.

   b. Supplement plans—offered to individuals age 65 and over or disabled, as supplements to Medicare A and B. (These individuals, who are eligible for Medicare A and B, may also enroll as a traditional subscriber on one of the major medical plans and the major med plan would "carve out" coverage provided by Medicare A and B.)
      - Basic supplement: Medicare Part A coinsurance plus coverage for additional 365 days after Medicare benefits end; Medicare Part B coinsurance (20% of Medicare approved expenses); three pints of blood each year; no prescription drug coverage.
      - Standard supplement: Medicare Part A coinsurance and deductibles plus coverage for 365 days after Medicare benefits end; Medicare Part B coinsurance (20% of Medicare approved expenses) plus Part B excess charges at 100%; three pints of blood each year; also includes skilled nursing coinsurance and foreign travel emergency coverage; no prescription drug coverage.
5. The CHAND program has a 180-day waiting period for pre-existing conditions that can be waived under certain specified situations.
6. CHAND is composed of accident and health insurance companies selling a minimum of $100,000 of health insurance annually in North Dakota.

Notes —

Other programs

7. CHAND premiums are equal to 135% of the average amount charged for standard health insurance coverage in North Dakota (BCBS premiums are being used because of their market share and the impact they have on the "average").
8. Losses in excess of the premiums are paid by the participating companies in the form of assessments that are based on their accident and health premium volume. (assessments in 2009 = $5 million)
9. Companies are allowed a credit against their premium tax equal to the assessment they've paid to CHAND.
10. CHAND is governed by an eight-member Board of Directors that includes the Insurance Commissioner, State Health Officer, Director of OMB, one senator, one representative and one representative from each of the three insurers with the highest premium volume.
11. BCBS is currently under contract with the State of North Dakota to administer the day-to-day business of CHAND. Premiums are collected and claims are paid through the BCBS Fargo office.
12. As of June 30, 2009, there are 1,443 individuals insured through the CHAND program.

Notes _

VIII. What the consumer can do

A. Become an educated health insurance consumer

1. Do research and ask questions.
2. Compare fees and costs for medical, pharmacy and surgical procedures (requires cost transparency).
3. The better educated you are about health care, the more informed your decisions will be.
4. Do not be afraid to ask your doctor questions.
5. Be actively involved in your health care decisions.
    a. Reduce amount of needless tests performed
    b. Keep informed about risks and benefits of procedures
    c. Gives you more control over amount of money you are spending on your health care

B. Try to use generic drugs rather than brand name ones where possible

C. Use emergency room for emergencies only

D. Reduce your chances of getting sick

1. Take advantage of free health screenings.
2. Know early warning signs and consult physician ASAP.
3. Live healthier lifestyle—balance diet, exercise, stop smoking.

Notes —

Definitions

Accident insurance—Accident insurance provides coverage for bodily injury and/or death resulting from accidental means (other than natural causes). Accident insurance can provide income and/or a death benefit if death ensues. An accident is an unexpected, unforeseen event not under the control of the insured and resulting in a loss; the insured cannot purposefully cause the loss to happen.

Credit health insurance—Credit health insurance provides coverage issued to a creditor on the life of a debtor so that if the debtor becomes disabled, the insurance policy pays the balance of the debt to the creditor.

Credit life insurance—Credit life insurance is insurance issued to a creditor (lender) to cover the life of a debtor (borrower) for an outstanding loan. If the debtor dies prior to repayment of the debt, the policy will pay off the balance of the amount outstanding. Credit life insurance is sold on a group or individual basis, and usually is purchased to cover small loans of short duration. When issued under a group policy, a certificate is issued to the debtor, the master policy being issued by the creditor. The face value of a credit life insurance policy decreases in proportion to the reduction in the loan amount until both equal zero.

Death spiral—This is a term used to describe the effect on a group of health policies when there are large and/or frequent rate increases. When there is a rate increase, a portion of the policyholders may decide that they can obtain cheaper health insurance elsewhere. It is likely that the more healthy lives within the group of policyholders will be the ones who seek coverage elsewhere. The remaining group of policyholders will be, as a group, less healthy. The resulting less-healthy group of lives will experience higher claims, resulting in requests for additional rate increases. Each time this happens, more "healthy" lives will terminate their policies, leaving the remaining lives even "less healthy" as a group. This scenario is mitigated, or even eliminated if there is a continued stream of healthier, new lives joining the group of policyholders. This scenario is accelerated, and worsened if there are no new policies being sold, i.e., the group of policies becomes a "closed block," and a "death spiral" for that block of policies can result.

Dental insurance—Dental insurance provides coverage for dental services under a group or individual policy. Dental insurance usually follows the format of comprehensive health insurance plans in that there is a coinsurance requirement of usually 75 to 80%, and a limit on benefits for any one person per calendar year. In many instances, there is no deductible for annual preventive oral examinations. Orthodontia benefits are usually provided separately.

Disability income insurance—Disability income insurance is health insurance that provides income payments to the insured wage earner when income is interrupted or terminated because of illness, sickness or accident.

Hospital insurance—Hospital insurance is health insurance that provides coverage for hospital room and board, typically a specified amount per day of hospital stay.

Long-term care insurance – Long term care insurance provides coverage for the day-to-day care that a person receives in a nursing facility or in his or her residence following an illness or injury, or in old age, such that the person can no longer perform at least two of the five basic activities of daily living (ADLs): walking, eating, dressing, using the bathroom and mobility from one place to another. Benefits paid under a long-term care insurance policy will typically be subject to a waiting period (for example, 90 days); a benefit period (for example, 5 years); and a daily amount (for example, $100 per day). The combination of these benefit provisions help to determine the premium to be paid for such a policy.

Medical insurance—Medical insurance provides coverage for miscellaneous medical expenses.

Major medical insurance—Major medical insurance provides coverage in excess of that provided by a basic hospital medical plan. After the limits of coverage have been exhausted under a basic plan, major medical then covers medical expenses relating to room and board; physician fees; miscellaneous expenses such as bandages, operating room expenses, drugs, X-ray and fluoroscopy. There may be a lifetime limit.

Medicare Advantage Plans—Medicare Advantage plans are health plan options approved by Medicare and offered by private companies. These plans are part of Medicare and are sometimes called "Part C" or "MA" plans. Companies offering Medicare Advantage plans must follow rules set by Medicare. Medicare Advantage plans must cover at least all the services that Original Medicare covers, which includes Part A (hospital insurance) and Part B (medical insurance). However,

- Each Medicare Advantage plan can charge different out-of-pocket costs through different deductibles and/or coinsurance amounts; and
- Medicare Advantage plans may offer extra coverage, such as vision, hearing, dental and/or health and wellness programs. Most include Medicare prescription drug coverage.
- Some Medicare Advantage plans have provider networks, meaning you can only see doctors who belong to the plan or go to certain hospitals to get covered services (unless an emergency).
- For some Medicare Advantage plans, if you see a doctor or other provider who doesn't contract or participate with the plan, the services may not be covered at all, or the costs will be higher.

Medicare Part D—Medicare offers prescription drug coverage (Medicare Part D) for everyone with Medicare. Medicare prescription drug coverage is obtained by joining a Part D plan (sometimes called "PDPs") offered by an insurance company or other private company approved by Medicare. Each plan can vary in cost and drugs covered. In addition to obtaining Medicare prescription drug coverage by enrolling in a Part D plan, coverage can also be obtained by purchasing a Medicare Advantage plan which includes prescription drugs as part of their benefit package (sometimes called "MA-PDs").

Medicare Supplement—Medicare Supplement insurance (Medigap insurance) is designed to act as a supplement to Medicare, providing additional benefits to that paid for by Medicare. The additional benefits are in the form of payment for medical expenses incurred but excluded

- By Medicare's deductibles;
- By Medicare's limitations on approval of medical charges;
- By Medicare's limitations on length and type of care in nursing facilities; and
- By Medicare's limitations imposed by various cost-sharing requirements.

Self-funded (self-insurance)—Self-funded health insurance describes a self insurance arrangement whereby an employer provides health or disability benefits to employees by assuming the direct risk for payment of their claims for benefits. The terms of eligibility and coverage are set forth in a plan document that includes provisions similar to those found in a typical group health insurance policy. While some large employers self-administer their self funded group health plan, most find it necessary to contract with a third party for assistance in claims adjudication and payment. Third party administrators provide these and other services, such as access to preferred provider networks, prescription drug card programs, utilization review and the stop loss insurance market. Insurance companies offer similar services under what is frequently described as "administration only" contracts. In these arrangements the insurance company provides the typical third party administration services but assume no risk for claims payment.

Shock lapse—Shock lapse refers to a significant increase (often one-time) in a lapse rate due to an event affecting policyholders. For example, if a large rate increase is implemented, a much higher than assumed number of policyholders may make the decision that they are no longer able to afford their policies and will allow them to lapse. The resulting actual lapse rate will be considerably higher than what was assumed in calculating the initial premiums.

Solvency—Solvency is the minimum standard of financial health for an insurance company, where assets exceed liabilities. State laws require insurance regulators to step in when solvency of an insurer is threatened and proceed with rehabilitation or liquidation.

Specified disease insurance/dread disease insurance—Dread disease insurance provides health insurance coverage only for a specified catastrophic disease such as cancer. It is important to ascertain the waiting period required, maximum benefits and maximum length of time they are payable, and the exact definition of the disease covered. Individual and group health insurance usually cover all diseases, including dread diseases.

Stop loss—Stop loss insurance coverage is purchased by employers in order to limit their exposure under self-insurance medical plans. This coverage is available in two types:

- Specific stop loss—Coverage is initiated when a claim reached a threshold selected by the employer. After the threshold is reached, the stop-loss policy would pay claims up to the lifetime limit per employee for the self-insurance medical plan.
- Aggregate stop loss—Coverage is initiated when the employer's self-insurance total group health claims reach a stipulated threshold selected by the employer. This threshold could be, for example, 125% of the self-insurer's annual estimated group health claims cost.

Surgical insurance—Surgical insurance provides coverage for surgeon and physician fees.

Trend—The forecasted change in health plans' per capita cost.

Variable annuities—Variable annuities are annuities where premium dollars are used to purchase accumulation units, their number depending on the value of each unit. The value of a unit is determined by the value of the portfolio of stocks in which the insurance company invests the premiums. At the time of payment of benefits to the annuitant, the accumulation units are converted to a monthly fixed number of units. The dollar value of an (for example, monthly) annuity payment is determined by the value of a unit at the time the payment is made.

Variable life insurance—Variable life insurance is an investment-oriented whole life insurance product that provides a return linked to an underlying portfolio of securities. The portfolio is typically a group of mutual funds established by the insurer as a separate account, with the policyholder given some discretion in choosing the mix of assets among, for example, a common stock fund, a bond fund, and a money market fund. Variable life insurance offers fixed premiums and a minimum death benefit. The better the total return on the investment portfolio, the higher the death benefit or surrender value of the variable life policy.

Vision insurance—Vision insurance is health insurance that provides coverage for eye examinations and eyeglass or contact lens prescriptions.

North Dakota requirements for new companies

Primary UCAA

The primary Uniform Certificate of Authority Application is found on the NAIC's website at www.naic.org/industry_ucaa.htm. A complete application must be submitted. The review process generally takes 60 to 90 days.

Minimum capital and surplus

Stock company—$500,000 capital stock and $500,000 surplus (N.D.C.C. 26.1-05-04)
Mutual company—$1,000,000 surplus (N.D.C.C. 26.1-12-08)
Risk-based capital (RBC)—a minimum 200% RBC ratio required after first year of business (N.D.C.C. ch. 26.1-03.1 and N.D.C.C. ch. § 26.1-03.2)

Physical presence in North Dakota

Must designate its principal place of business (home office) in North Dakota or place a deposit with the Bank of North Dakota in an amount established by the Commissioner, i.e., $1 million if some physical presence (regional office, claims center, etc) is located in the state (N.D.C.C. § 26.1-05-07.1).

Statutory deposit

Domestic P&C insurers—none
Domestic life insurers—securities equal to net value of all in force policies must be physically deposited or retained separate and distinct by the insurer who files a detailed verified statement listing the securities (N.D.C.C. § 26.1-05-23).

Premium taxes

The tax is levied on gross premiums (including assessments, membership, subscriber and policy fees, finance and service charges, less return premiums, refunds and abatements) at the following rates:
Life—2%
All others—1 ¾ %
Annuity premiums are not taxed in North Dakata.
All premium taxes are on a retaliatory state basis (N.D.C.C. § 26.1-03-17).

Statutory membership

Life and Health Insurance Guaranty Association (N.D.C.C. ch. 26.1-38.1)
Insurance Guaranty Association (N.D.C.C. ch. 26.1-42.1)
Other P&C: ND Automobile Assigned Claims Plan

Filing fee

Larger of $500 or retaliatory amount (N.D.C.C. § 26.1-01-07)
Additional fees of $180 when company is redomesticating
Additional fees of $145 when company is newly formed

Authority: North Dakota Century Code sections N.D.C.C. § § 26.1-05-07.1 and 26.1-05-07.2

North Dakota
INSURANCE
DEPARTMENT
PROTECTING THE PUBLIC GOOD
ADAM HAMM, COMMISSIONER

Primary UCAA requirements

Application form and attachments

- Application Checklist and Listing of Incorporators, Officers, Directors and Shareholders—Form 1P
- Primary Application executed and signed—Form 2P
- Identify all lines of insurance the applicant is requesting authority to transact (for a redomestication filing, company needs to complete the section listing the lines of business the applicant is currently licensed to transact and is transacting in all jurisdictions)—Form 3

Filing fee

- Payment of required filing fee—larger of $500 or retaliatory amount (retaliatory amount only applies to redomesticating companies)
- Copy of check

Minimum capital and surplus requirements

Explanation of compliance with minimum capital and surplus requirements

Statutory deposit requirements

Documentation explaining how the applicant meets or is meeting the statutory deposit requirements

Name approval

A company may not adopt a name that is so similar to a name already in use by an existing company organized or licensed in North Dakota as to be confusing or misleading. Upon receipt of the application, the Department will automatically check the name for conformity and notify the applicant company of the Department's determination. N.D.C.C. §§ 26.1-11-01 and 26.1-12-27

Plan of operation

- Narrative—to include significant information not captured as a part of the questionnaire below
- Pro-forma financial statements/projections—company-wide three-year pro-forma balance sheet and income statement by line; projections must support all aspects of the proposed plan of operation, including reinsurance arrangements and any delegated function agreements. Include the assumptions used to arrive at these projections.
- Completed questionnaire—Form 8: addresses various items such as encumbrances, pledged stock, change of management and control, organizational structure, sales and marketing, underwriting, claims, affiliated arrangements, reinsurance, investments, etc.
- Attachments to questionnaire—including but not limited to: copies of agreements with agents, brokers, general agencies and managing general agents, affiliated agreements, reinsurance agreements, investment advisory and management agreements, etc.

Primary UCAA requirements

Holding company Form B registration statement

If the applicant is a member of a holding company system, include either the most recent Annual Form B Registration Statement or a statement substantially similar to the NAIC model. Include all attachments, exhibits and appendices referenced in the Form B and include copies of all advisory, management and service agreements.

Statutory memberships

Documentation supporting membership application(s) in North Dakota Life and Health Insurance Guaranty Association (N.D.C.C. ch. 26.1-38.1) or Insurance Guaranty Association (N.D.C.C. ch. 26.1-42.1).

SEC filings or consolidated GAAP financial statement

• If the applicant, its parent or its ultimate holding company has made a filing or registration with the Securities and Exchange Commission (SEC) in connection with a public offering within the last three years, or filed an 8K, 10K or 10Q within the last 12 months, the application must note that the filing, including any supplements or amendments, is available electronically from the SEC.

• If the applicant, its parent or its ultimate holding company is not publicly traded, the application must include a copy of the applicant's most recent Consolidated GAAP financial statement.

Debt-to equity ratio statement

Applicants who are members of a holding company system must submit a comprehensive debt-to-equity ratio statement that includes the following information:

1. Provide the consolidated outside debt to consolidated equity ratio on a GAAP basis for the holding company.
2. Provide the most recent consolidated, holding company financial statement.
3. State if the holding company, on a consolidated basis, has a tangible net worth:
    a) for the past three years;
    b) at present and
    c) provide projections with assumptions for a three year period.
4. Applicants must clearly substantiate the sources of repayment of any debt, including, but not limited to whether the source of repayment is independent from the future income of the insurers.
5. Calculate the debt service (as reported in D above), required of each insurer as a percentage of the insurer's capital and surplus.
6. List the assets of the holding company, if any, that are pledged to fund the debt service or debt repayment of an affiliate or parent (include the assets or stock of any insurer subsidiaries).
7. List any guarantees (personal or otherwise) from the shareholders for repayment of the debt.

North Dakota requirements for new companies

Primary UCAA requirements

Custody agreements

• A statement setting forth whether or not any of the applicant's stocks, bonds or other physical or book entry securities are in the physical possession of another entity.

• Copy of any custody agreements—If any of the applicant's stocks, bonds or other securities are not in the applicant's actual physical possession or in a safe deposit box under the exclusive control of the applicant, the application must include a written agreement with each entity holding and/or administering these securities. The written agreement should include appropriate safeguards for the handling of the securities, in accordance with those specified in the NAIC Financial Examiners' Handbook.

Public records package

• Copy of Articles of Incorporation
• Copy of Bylaws
• Uniform Consent to Service of Process

NAIC biographical affidavits

NAIC Biographical Affidavit and Independent Third Party Verification on behalf of all officers, directors and key managerial personnel of the applicant and individuals with a 10 percent (10%), or more, beneficial ownership in the applicant and the applicant's ultimate controlling parent.

State-specific information

In addition to the UCAA requirements, the application for admission as a Prepaid Limited Health Service Organization must include all information required under N.D.C.C. § 26.1-17.1-03.

In addition to the UCAA requirements, the application for admission as a Health Maintenance Organization must include all information required under N.D.C.C. § 26.1-18.1-02(3).

The North Dakota Insurance Department has no state-specific forms.

Policy forms and rates that require approval prior to use are not to be submitted with the company application.