Health Care Reform Review Committee Testimony
July 25, 2012

Chairman Keiser and committee members, for the record I am Rod St. Aubyn representing Blue Cross Blue Shield of North Dakota. I was asked to speak to you today regarding the impact on our company and other insurers with the US Supreme Court's decision on the constitutionality of the ACA.

I think it is safe to say that no one predicted the outcome based on the rationale provided by Chief Justice Roberts. In particular, most legal scholars were split on their predictions of the outcome for the individual mandate. Prior to the ruling, because the ACA is current law, insurers were busy trying to comply with the many current and future provisions of the ACA. That emphasis has not changed.

Even though the Supreme Court has made its decision, the uncertainty remains with many states and policymakers deciding "to wait and see what happens in the November elections" to get a clearer picture of the future for the ACA. While there is some logic in this, the difficult part for insurers is that the ACA is still the law and we must be in compliance based on the current requirements.

I can summarize the main concerns that we have with implementation of the ACA with the following points:

- **Timely regulations**
- **Insurer taxes**
- **Cost Containment – Premium Increases**
- **Exchange – Federal vs State**

Timely Regulations - In less than one year after Election Day, insurers will be expected to design new products, develop actuarially appropriate rates, submit the products and rates to the state insurance department for approval, and submit the products for approval to whatever exchange will be operating for ND. **And at this stage of the process there are many, many regulations that have yet to be announced or adopted.** Please keep in mind that the exchange and insurance products will need to be ready by October 1, 2013, the beginning of open enrollment for the January 1, 2014 implementation date. I cannot stress enough the importance of having all the federal regulations adopted very soon. We are forced to make system design changes and product development based on our own educated assumptions until final regulations are adopted. Should our assumptions be wrong, needless time and costs would be wasted and potentially delay our ability to have products brought to the market.

I would like to give your committee one example illustrating this. Every qualified health plan will need to have the "essential health benefits (EHB)" included in the plan. Your committee was informed in a previous meeting that HHS has given temporary authority for 2014 and 2015 to the individual states in determining the EHB's. In effect, for 2 years there could potentially be 50 different EHB standards across the United States. For plans offered in 2014, states are given several options in selecting a

"benchmark plan". If the state does not select a "benchmark plan" by the end of the 3rd quarter of 2012, the federal default will be the small group plan with the largest enrollment as of the end of the 1st quarter of 2012. Beginning in 2016, HHS will make a final determination for EHB's for **ALL** states. One week ago today, HHS finalized their regulations regarding data submission for the top plans to be considered for a "benchmark plan". While the final regulations were much better than the initial proposed regulations, the top three small group plans must submit an enormous amount of data about their plans by September 4. Even with the final regulations being issued, there are still many unanswered questions. Can a plan substitute a benefit from one listed in the "Benchmark Plan"? As an example, if the "Benchmark Plan" provides for infertility benefits with a lifetime or annual limit, the ACA states that essential benefits can have not annual or lifetime dollar limits. Does this mean that all insurers must provide "unlimited" infertility benefits? Could an insurer place some other type of limit, such as "visit" limits on these procedures? What if the benchmark plan changes their benefits between "the end of the 3rd quarter of 2012" and January 1, 2014? Does this obligate all other insurers to change their benefit plans as well for 2014? Many more questions are sure to surface after the final regulations are implemented. This is why timely regulation adoption is critical. There is a legitimate fear that there simply will not be enough time to be ready by the deadline dates.

Insurer Taxes – The ACA imposes an aggregate annual tax apportioned among health insurers based on relative market share. The annual tax burden shared by health insurers are as follows:

- 2014 - $8 billion
- 2015 - $11.3 billion
- 2016 - $11.3 billion
- 2017 - $13.9 billion
- 2018 - $14.3 billion
- After 2018 – Applicable tax is indexed to the rate of premium growth of the prior year's premium.

Our staff has estimated that this tax will cost our members an additional $65 per year for an individual plan and about $200 for a family plan if this goes forward for the first year. This is in addition to other increases that are expected when the ACA is fully implemented in 2014. This tax will simply result in even higher premiums for our members. We are asking that Congress repeal this tax as it will simply be passed on to the consumer in the form of higher premiums.

Cost Containment – Premium Increases – Aside from the Insurer Tax that I just discussed, many other factors will impact premiums in the future. There is little in the ACA that actually contains or reduces health care costs. Besides the Insurer Tax, one of the big unknowns is the operational costs for the Exchange. Those costs will most likely be assessed to health insurers who will have to pass those costs on to the insured. In addition, enhanced benefits, guaranteed issue with weak penalties, and tighter community ratings (5:1 to 3:1) will all have an impact of the cost of health insurance. Premium subsidies are expected to offset some of these costs, but those individuals who will not get a subsidy or a minimal one will undoubtedly see a significant insurance premium increase. Blue Cross Blue Shield of North Dakota (BCBSND) feels everyone (the insurer, the medical provider, and the consumer) has an important

role in containing the costs for health care. Individuals can help by living a healthier lifestyle and participate in Wellness Programs. BCBSND has already started multiple initiatives that address the cost of health care through collaboration with doctors, hospitals, and clinics across the state. Through participation in programs like the MediQhome program (which you received previous testimony) and BCBSND's Total Cost of Care contracts (which compensate doctors, hospitals, and clinics for quality health outcomes for members, rather than just paying a fee for a service), medical providers are working with us to help contain the ever increasing cost of health care and improve the quality of care.

Exchange – Federal vs State – We have worked with this committee in developing a State Exchange bill that would be in the best interest of ND consumers. Unless Congress is to repeal the ACA, the Supreme Court ruling assures that the state is faced with a Health Insurance Exchange. The law makes it clear that if the state does not build its own exchange, then the default will be a Federal Exchange. As you are aware, BCBSND worked with this committee in developing a bill for a State Exchange for the Special Legislative Session last November. Unfortunately that bill was defeated. We feel that a state exchange is far better than a federal exchange. ND is now faced with a Federal Exchange. This exchange will determine how many and which insurance products will be made available to ND citizens. We strongly supported a state exchange that would allow for all qualified insurance products to be made available to ND citizens. One of our biggest fears is that the Federal Exchange could become what is called an "Active Purchaser" model. Under this model the Federal Exchange could severely limit the number of insurance products to our citizens. We understand that some of the opponents of a state exchange are hopeful that if enough states decline a state exchange the "entire ACA may fall apart". However, what if that assumption is wrong? ND would have then abdicated insurance regulatory authority to the Federal government, something that has long been the right of states to maintain. As I have alluded to before, the costs for operating an exchange (Federal or State) will ultimately be passed on to the consumer (either through a user fee, insurer fee, or some other tax or fee). We feel that the state will have far more control in the operational costs for a state exchange compared to one operated by the Federal government. While we understand the desire to see what happens with the November election, if ND is ultimately faced with a Federal exchange we would strongly urge that the state reconsider establishing its own exchange if it is given that option in the future.

Mr. Chairman and Committee members, thank you for the opportunity to address your committee. As I have illustrated, we are faced with many challenges with the ACA as a result of the recent Supreme Court ruling and the Act as it is currently written. However, BCBSND wants to assure you that we will continue to partner with your committee and the state to ensure that ND citizens are provided the best options under the ACA. I would be willing to answer any questions that the committee may have.