# TESTIMONY

**Presented by:** **Melissa Hauer**
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**Before:** **Health Care Reform Review Committee**
**Representative George Keiser, Chairman**

**Date:** **September 20, 2011**

Good afternoon, Chairman Keiser and members of the Health Care Reform Review Committee. My name is Melissa Hauer and I am the General Counsel for the North Dakota Insurance Department. I appear before you to provide an update on the implementation of the federal health care reform law, the Patient Protection and Affordable Care Act (PPACA).

## 1. Recently Released Federal Regulations

The federal government recently released the following health care reform regulations:

- **Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers**. The U.S. Department of Health and Human Services ("HHS") issued these proposed rules on August 17, 2011. These rules implement certain functions of Exchanges. The specific Exchange functions proposed in these rules include: eligibility determinations for Exchange participation and insurance affordability programs and standards for employer participation in the Small Business Health Options Program (SHOP).

- **Preventive services** (26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Part 147). The Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; and the Centers for

Medicare & Medicaid Services, Department of Health and Human Services issued interim final rules effective August 1, 2011, dealing with preventive health services. The regulations contain amendments to the interim final regulations that the Departments previously issued on July 19, 2010.

The interim final regulations provided that a group health plan or health insurance issuer must cover certain items and services, such as immunizations and health screenings, without cost sharing. The Health Resources and Services Administration ("HRSA") was charged with developing comprehensive guidelines for preventive care and screenings with respect to women (*i.e.*, the Women's Preventive Services: Required Health Plan Coverage Guidelines or "HRSA Guidelines") and those items were added to the regulations.

- **Establishment of Consumer Operated and Oriented Plan (CO-OP) Program** (45 CFR Part 156). The U.S. Department of Health and Human Services issued these proposed rules on July 20, 2011, to implement the Consumer Operated and Oriented Plan (CO-OP) program, which provides loans to foster the creation of consumer-governed, private, nonprofit health insurance issuers to offer qualified health plans in Exchanges. The purpose of the program is to create a new CO-OP in every state in order to expand the number of health plans available in the Exchanges with a focus on integrated care and greater plan accountability.

## 2. Contractor Work Update

### Health Benefit Exchange Planning Grant Update

#### Exchange Consultant

On July 18, 2011, the Department issued a Request for Proposals (RFP) from firms to conduct background research, analyze data, identify options and recommend a viable plan for developing and sustaining an Exchange in North

Dakota. The Department received five proposals and awarded the contract to HTMS, an Emdeon Company, on August 25, 2011.

To date, we have had three conference calls with HTMS to develop a research plan. HTMS representatives were also in Bismarck the week of September 12-16 and met with members of the Insurance Department, Department of Human Services, Information Technology Division, Governor, Office of Management and Budget, Department of Health, and Indian Affairs Commission.

Stakeholder Meeting Facilitator

As required by PPACA, the Department began holding meetings around the state with stakeholders. A facilitator was hired to conduct 11 stakeholder meetings in Bismarck, Fargo, Grand Forks, and Minot. The focus of the meetings was to ask interested stakeholder representatives of insurance producers, health care providers, insurers, consumers, and employers for input on the design and operation of an Exchange in the state. The last of the meetings was held on September 8. The information collected during the meetings was recorded and will be summarized in a final report due from the facilitator on September 23.

## 3. Claims, Appeals, and External Review Update

During the last legislative session, 2011 House Bill No. 1127 was prepared by the Insurance Commissioner to satisfy the requirement of PPACA related to internal appeals and external review of health insurance claims. This is the appeal process that must be made available when someone with health insurance received a health care service or treatment and the health insurer declines to pay, either in whole or in part.

States were given the chance to implement an appeals process that satisfies the requirements of PPACA and federal regulations. If that process had been deemed to be an "effective" external review process, the state would be the entity that assisted

consumers with their external review requests. The bill, however, was significantly amended from its introduced form and contained less detail regarding the required appeals and external review processes than did the original bill.

After review of 2011 House Bill No. 1127 and other state law related to external review, HHS determined that the state's external review process does not meet the minimum standards required. Therefore, consumers must send their requests for external review to either HHS or the U.S. Department of Labor (DOL) instead of the North Dakota Insurance Department. North Dakota can revise its external review statutes and ask HHS for reconsideration at a later date.

## 4. Update on States' Implementation of PPACA

Establishment grants have now been awarded to 16 states. This funding is available until a state clearly chooses the federal only exchange model.

If a state chooses to have its Exchange federally run or if it chooses the partnership model, HHS has indicated its intention to collaborate with that state on key policy implementation questions.

Since the committee's last meeting, Montana has determined that it will be allowing the federal government to run its Exchange.

## 5. Bill Draft Comments

Bill drafts 11.0805.01000 ("consensus redline" draft) and 11.0806.01000 ("committee" draft)

a. The definition of "defined benefit plan" and "defined contribution plan" used in both bill drafts seem to duplicate each other in that they both describe a defined contribution situation (see pages 13 and 11).

b. The definition of "small employer" used in both bill drafts is in conflict with the definition required by PPACA and in the federal regulations (45 C.F.R. § 155.20) which define it to mean an employer who employed an average of at least one employee. But there is also a state law governing small group health insurance that defines it to mean an employer who employed at least two employees (see N.D.C.C. § 26.1-36.3-01(32)). The committee may want to consider whether this existing state law should be revised in order to be consistent with how an Exchange must define the term.

   Both bill drafts also state that employees shall be counted "in accordance with state and federal law". As noted, one state law already defines a small employer in a way that is in conflict with the definition in PPACA and regulations so it is unclear how both state and federal law could be applied.

c. In Section 3 of the consensus draft, the board is required to be made up of three health carrier representatives and four consumer representatives. Requiring three health carriers to serve would prohibit any insurance agents or brokers from serving on the board because federal regulations state that the overall governing board membership may not be made up of a majority with a conflict of interest. Those with conflicts of interest include health insurers, agents, and brokers. Appointing even one agent or broker

would mean a majority of voting board members would have a conflict of interest.

d. In this same section, it states that the Governor must ensure that the board has expertise in several areas including "health care actuarial". It is unclear what that term means. This term is also used in the committee draft on page 6, line 3.

e. There is a prohibition in both bill drafts that states a director may not participate in deliberations or vote on any matter before the board if that director has a conflict of interest (see pages 7 and 6). Given the way conflict of interest is defined, it is unclear how health insurers, agents, or brokers could vote on most matters that are likely to come before the board.

f. The provision in both bill drafts regarding open meetings is also unclear in that premium rate information submitted by health carriers are to be considered by the board at closed meetings "before such rates are approved by the commissioner" but it does not specify who is obligated to give the rate requests to the Exchange nor how that would be done given that rate requests are generally held confidential while they are pending approval (see pages 7 and 7).

g. Both bill drafts provide that an Exchange may contract with an "eligible entity" for any of its functions (see pages 10 and 8). An eligible entity cannot be a health carrier. The language in the NAIC model act also excluded affiliates of health carriers but that language is struck in this bill draft. Allowing an affiliate of a health carrier to perform Exchange functions would violate the federal regulations that define an eligible entity to exclude not only health insurers but also a member of the same group of corporations as a health insurer (see 45 C.F.R. § 115.110(a)).

h. Both bill drafts provide that the Exchange must establish procedures and safeguards to protect the integrity and confidentiality of any data it maintains (see pages 10 and 8). It is unclear if this is designed to make Exchange information confidential and not subject to disclosure under the open records law and, if so, what information is meant to be confidential.

i. Both bill drafts would change the law regarding how the Insurance Commissioner approves rate requests (see pages 11 and 9). A new standard would be added to state law by which rate increase requests are to be judged: rates must be "neither excessive, inadequate, nor unfairly discriminatory." It is unclear who would apply this standard—the Commissioner or the Exchange. It also is in conflict with the standard set out in existing law which provides that a rate must be disapproved if the benefits provided are "unreasonable in relation to the premium charge." This portion of both bill drafts would also require a "qualified actuary" to certify that the rate has been calculated according to generally accepted actuarial practices (see pages 11 and 9). There is no definition of what constitutes a "qualified actuary" and such a certification is not currently required in state law.

All of this subsection should be deleted from both drafts. As was discussed during the interim committee's hearing on August 5, 2011, in Fargo, the regulatory authority of the North Dakota Insurance Department should not be altered in any manner if North Dakota decides to build its own Exchange. If the committee does not agree to immediately delete this subsection, then there should be, at a minimum, a complete exploration of what this potential change in regulatory authority would mean to the North Dakota Insurance Department's rate review process and to the policyholders of North Dakota (both the intended and unintended consequences of such a change).

j. Both bill drafts provide "...any amendment to state legislation made by title I of the Federal Act must be applied uniformly to all health benefit plans in each insurance market to which the standard and requirements apply." (see pages 12 and 10). It is unclear how federal law can "amend" state law. We suggest that this be clarified.

k. The committee bill draft provides that Exchange navigators must be a licensed insurance producer (see page 13, line 14). The federal regulations will not allow someone to act as a navigator if that person or entity also accepts commissions from a health insurer.

l. Both bill drafts state that any person acting on behalf of the Exchange shall act as a fiduciary and fiduciary duties are imposed requiring those persons to operate the exchange solely in the interests of the individuals and employers who purchase coverage through the Exchange (see pages 16 and 15). It is unclear to whom this duty would apply. For example, would every employee of the Exchange be a fiduciary?

m. The consensus redline draft requires a hearing to be conducted by an administrative law judge (ALJ) if a health carrier wants to appeal the denial of certification of one of its health plans (see page 21). It is unclear if this would require the Exchange to pay the Office of Administrative Hearings to provide the ALJ. It also requires the ALJ to make a final decision. Most decisions of ALJs are recommended rather than final.

Mr. Chairman, members of the committee, this concludes my testimony. I would be happy to try to answer any questions you may have. Thank you.

**Estimated Operational Cost to Run Exchange***
September 20, 2011
Prepared by the North Dakota Insurance Department

**Illinois**

- 2014 estimated cost: $32.1 million to $46.7 million ($10.47 to $16.83 on a per-member-per-month (PMPM) basis).
- In 2015, expenses are estimated to be between $57.3 million and $88.6 million ($8.92 to $13.47 PMPM).
- Medicaid and CHIP enrollment will increase by 267,000 newly eligible and 130,000 currently eligible by 2014. At such levels, increased costs to the State would be $224.5 million dollars in 2014.

**Indiana**

- Estimates $30 million a year to run.

**Kansas**

- Estimates $3.2 million per month to run.

**Massachusetts**

- 2014 estimated cost: $30 million

**North Carolina**

- 2014 estimated cost: $25 million
- Estimates 108 FTEs.

**Oregon**

- 2014 estimated cost: $36 million

**Utah**

- 2014 estimated cost: $600,000

***Caveats**:

- These are projections for the first year or two of operation. As use of an Exchange increases over time, operating costs would be expected to stabilize.
- These Exchanges reflect a range of different models, with different services included. As such, these figures do not represent an "apples to apples" comparison.
- Estimates for Utah and Massachusetts are based on current operating costs. These are expected to change as these Exchanges are revamped to meet PPACA requirements.

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