TESTIMONY

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North Dakota Insurance Department

Before: **Tribal and State Relations Committee**
Senator David O'Connell, Chairman

Date: **September 26, 2011**

Good morning, Chairman O'Connell and members of the committee. My name is Rebecca Ternes and I am the Deputy Insurance Commissioner. I appear before you today to provide a brief update on the Patient Protection and Affordable Care Act also known as "federal health care reform" or "PPACA" and the status of a Health Benefit Exchange, or Exchange for short. I will also try to point you to several items within PPACA specific to Native Americans.

Attached to this testimony are two documents for your reference related to PPACA. The first one is a timeline of key dates related to the market reforms and the Exchange in the law. The second item is a graphic that walks through how the Exchange functions.

As you know, on March 23, 2010, PPACA was signed into law and almost immediately, states were faced with making decisions. Several market reforms were in place 90 - 180 days after the bill was signed including a new high risk pool, under age 19 preexisting condition exclusion, extension of adult dependent coverage up to age 26 and changes to annual and lifetime limits allowed in coverage. The Insurance Department and the insurance carriers continue to work on ensuring these changes and those to come are implemented in the marketplace.

Within PPACA, you will also find a reauthorization of the Indian Health Care Improvement Act (IHCIA). The law extends the authorization of appropriations for IHCIA indefinitely. It expands mental health services and requires IHS to establish new programs related to youth suicide prevention among other things.

During the 2011 session, three bills specific to PPACA were brought before the legislature – H.B. 1125 dealing with the Insurance Commissioner's Authority, H.B. 1127 dealing with internal and external appeals of health insurance claims and H.B. 1126 dealing with the Exchange and a $1 million planning grant appropriation.

By January 1, 2014, PPACA requires each state to establish a state-based American Health Benefit Exchange and a Small Business Health Options Program (SHOP) Exchange. These exchanges will be online marketplaces where individuals and small businesses can shop for health plans in a way that permits comparison of available plan options based on price, benefits and services, and quality.

An Exchange must also assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs such as Medicaid and the Children's Health Insurance Program (CHIP).

There are several specific sections of the proposed rules out on Exchanges right now that are specific to Native Americans or in the terms of the Act, Indians. There are special cost-sharing rules that apply to Indians regardless of income; there are special enrollment periods for Indians in Exchanges; Exchanges that cover more than one tribal area must engage in consultation; tribes are pointed out as having the potential to be Navigators; the Exchange could allow tribes and tribal organizations to pay premiums for qualified health plans (QHPs) on behalf of qualified individuals; and there are also sections devoted to the mechanics of payment between insurance carriers and Indian health care providers.

One of the issues being addressed during the upcoming special session is whether North Dakota will run its own Exchange. If the state does not build an Exchange and have it certified by January 1, 2013, the United States Department of Health and Human Services (HHS) will create an Exchange for the state. Currently, several state agencies are meeting weekly to discuss this issue and your colleagues are meeting at the Interim Health Care Review Committee and are now drafting legislation.

The Insurance Department used part of the planning grant to facilitate stakeholder meetings held two weeks ago to gather input from several different groups. Legislators and tribal leaders were invited to attend. The final report of those meetings will be shared.

The Insurance Department is also using some of the Exchange planning grant appropriated to hire a consultant to research various issues related to the Exchange, with the goal being to summarize key decision points for state agencies and legislators prior to the special session.

Thank you for the invitation to testify. I would be happy to take any questions.

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

Health care reform timeline
2010–2018

Presented by Adam Hamm
May 27, 2010

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

2010

Issue	What law will do	Effective date
Health insurance consumer assistance offices and ombudsmen	States may establish and operate offices of health insurance consumer assistance or health insurance ombudsman programs to: • Assist with the filing of complaints and appeals • Collect, track and quantify problems and inquiries • Educate consumers on their rights and responsibilities • Assist consumers with enrollment in plans • Resolve problems with obtaining subsidies States may be required to collect and report data of all the types of problems and inquiries encountered by consumers.[1]	Effective as of date of enactment (3/23/2010)
Preservation of right to maintain existing coverage	The following provisions will apply to grandfathered plans: • Excessive waiting periods • Lifetime limits only • Rescissions • Extension of dependent coverage • Uniform summary of benefits and coverage and standardized definitions • Medical loss ratios[1]	Effective as of date of enactment (3/23/2010)
$250 Medicare Part D rebate	A $250 rebate will be available to seniors reaching the Medicare Part D donut hole.[1]	June 2010
Temporary high-risk pool program	The Secretary of Health and Human Services (HHS) is required to establish a temporary high-risk health insurance pool program to provide coverage to individuals with preexisting conditions who have been without coverage for at least six months. Pools must: • Have no preexisting condition exclusions • Cover at least 65% of total allowed costs • Have an out-of-pocket limit no greater than the limit for high deductible health plans ($5,950 for individuals and $11,900 for families) • Utilize adjusted community rating with maximum variation for age of 4:1 • Have premiums established at a standard rate for a standard population The state's current high risk pool, the Comprehensive Health Association of North Dakota (CHAND), does not meet the requirements.[1]	Effective 90 days after enactment (June 23, 2010)

Issue	What law will do	Effective date
Temporary reinsurance program for early retirees	The Secretary of HHS shall establish a temporary reinsurance program to reimburse employment-based plans for 80% of costs incurred by early retirees age 55 and over but not eligible for Medicare between $15,000 and $90,000 annually.[1]	Effective 90 days after enactment (June 23, 2010)
Web portal to identify affordable coverage options	The Secretary of HHS shall establish a mechanism, including a website through which individuals and small businesses may identify affordable health insurance coverage.[1]	07/01/ 2010
Annual and lifetime limits	Plans may not establish lifetime limits on the dollar value of essential benefits. Plans may only establish restricted limits prior to Jan. 1, 2014 on essential benefits.[1]	09/23/2010
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions- effective six months after enactment for under age 19.[1]	Effective Sept. 23, 2010 for individuals 19 and under. Effective Jan. 1, 2014 for all others.
Rescissions	Insurers cannot rescind coverage after a sickness. Coverage may be rescinded only for fraud or intentional misrepresentation of material fact.[1]	09/23/2010
Coverage of preventative health services	Plans must provide coverage without cost-sharing for: • Services recommended by the U.S. Preventive Services Task Force • Immunizations recommended by the Advisory Committee on enactment Immunization Practices of the Centers for Disease Control • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration • Preventive care and screenings for women supported by the Health Resources and Services Administration Current recommendations from the US Preventive Services Task force for breast cancer screenings will not be considered.[1]	09/23/2010
Extension of adult dependent coverage	Plans that provide dependent coverage must extend coverage to adult children up to age 26.[1]	09/23/2010
Provision of additional information	All plans must submit to the Secretary of Health and Human Services (HHS)and state insurance commissioners and make available to the public the following information in plain language: • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage[1]	09/23/2010

Issue	What law will do	Effective date
Appeals process	Internal claims appeal process: • Group plans must incorporate the Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. • Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. External review: • All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) with minimum standards established by the Secretary of HHS that is similar to the NAIC model.[1]	09/23/2010
Patient protections	A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider.[1]	09/23/2010
Ensuring that consumers get value for their dollars	The Secretary of HHS, in conjunction with the states, shall develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the State and the Secretary a justification for an unreasonable premium increase and post it online. The Secretary shall award $250 million in grants to states over a 5-year period to assist rate review activities, including reviewing rates, providing information and recommendations to the Secretary, and establishing Medical Reimbursement Data Centers to develop database tools that fairly and accurately reflect market rates for medical services. Amounts of grants to states are to be determined by the Secretary.	Effective 2010 plan year
Small business tax credit	Available to small businesses offering coverage to employees[1]	Tax credits of up to 35 percent of the cost of premiums will be available in 2010 and will reach 50 percent in 2014.

2010 (continued)

2011

Issue	What law will do	Effective date
Loss ratio	Medical loss ratios of 80 and 85 percent, respectively, are required for individual/small group and large group plans. Loss ratio is the fraction of revenue from a plan's premiums that goes to pay for medical services.[2]	01/01/2011
Bringing down the cost of health care	Carriers must report to the Secretary of HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums. Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets. All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups.[1]	01/01/2011
Long-term care	A voluntary long-term care program will begin, financed through payroll deductions.[2]	01/01/2011
Study of large group market	The Secretary of HHS shall conduct a study of self-insured and fully-insured plans to compare the characteristics of employers, plan benefits, plan reserves and solvency and determine the extent to which the bill's market reforms will cause adverse selection in the large group market and prompt small and mid-size employers to self insure.[1]	Due no later than one year after enactment (3/23/2011)
GAO study regarding the rate of denial of coverage and enrollment by health insurance and group health plans	The GAO shall conduct a study of the incidence of denials of coverage for medical services and denials of application to enroll in health insurance plans by group health plans and health insurance issuers.[1]	One year after enactment (3/23/2011)

2012

Issue	What law will do	Effective date
Ensuring quality of care	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan: • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management • Implement activities to prevent hospital readmission • Implement activities to improve patient safety and reduce medical errors Implement wellness and health promotion activities[1]	2 years after enactment (3/23/2012)
Uniform explanation of coverage documents and standardized definitions	The Secretary must develop standards for a summary of benefits and coverage explanation to be provided to all potential policyholders and enrollees.[1]	Standards must be developed by March 2011; implementation by March 2012

2013

Issue	What law will do	Effective date
Health benefit exchange	The Secretary of HHS must determine by Jan. 1, 2013 whether states intend to operate qualified exchanges.	01/01/ 2013
Administrative simplification requirements	The Secretary of HHS will develop operating rules for the electronic exchange of health information, transaction standards for electronic funds transfers and requirements for financial and administrative transactions.[1]	Rules adopted by July 1, 2011 to become effective by January 1, 2013
Employer requirement to inform employees of coverage option	Employers must provide employees with written notice at the time of hiring informing them of the existence of the Exchange and the availability of subsidies through the Exchange if the plan covers less than 60% of the cost of covered benefits.[1]	03/01/2013

2014

Issue	What law will do	Effective date
Health benefit exchange	The Secretary of HHS must determine by Jan. 1, 2013 whether states intend to operate qualified exchanges. If a state does not create a qualified exchange, the Secretary must create one. There must be two exchanges: a non-group market exchange and an exchange for small businesses. States may choose to operate only one exchange serving both groups. Some functions to be performed by an exchange include: • Certify qualified plans to be sold in the exchange • Maintain a website • Provide for initial, annual and special open enrollment periods • Maintain a toll-free number • Create a rating system for plans and perform satisfaction survey • Provide a calculator to determine enrollee premiums and subsidies • Identify those individuals exempt from the individual mandate and notify treasury • Require participating plans to provide justification for rate increases[1]	State exchanges must be operational by Jan. 1, 2014.
Free choice vouchers	Employers must provide a voucher in the amount of the employer's contribution towards the group health plan to each employee whose household income is below 400% FPL if the employees' cost of coverage under the group health plan is between 8% and 9.8% of household income and the employee does not enroll in the employer's group health plan. Employees may use these vouchers to purchase coverage through the Exchange.[1]	01/01/2014
Preexisting condition exclusions	A plan may not impose any preexisting condition exclusions on anyone.[1]	01/01/2014
Requirement to maintain minimum essential coverage	U.S. citizens and legal residents are required to have qualifying health coverage. Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income. The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.	01/01/2014

	Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold (in 2009 the threshold for taxpayers under age 65 was $9,350 for singles and $18,700 for couples).[3]	
Issue	**What law will do**	**Effective date**
Guaranteed issue and renewability in all markets	The law requires guaranteed issue and renewability and allows rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the exchanges.[3]	Plan years beginning 01/01/2014
Employers must offer coverage	Imposes a mandate on employers with 50+ workers: offer coverage by 2014 or pay $2,000/full time worker (excluding the first 30); if offer unaffordable coverage, pay $3,000/employee receiving taxpayer assistance to buy it or a total of $2,000/employee, whichever is more. Employers of 50 or fewer workers are exempt.[2]	01/01/2014
Guaranteed availability of coverage	Insurers must accept every employer and every individual that applies for coverage except that: an insurer may restrict enrollment based upon open or special enrollment periods.[1]	Plan years beginning 01/01/2014
Prohibiting discrimination against individual participants and beneficiaries based on health status	A plan may not establish rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, generic information, evidence of insurability (including conditions arising out of domestic violence), disability, any other health-status related factor deemed appropriate by the Secretary.[1]	Plan years beginning 01/01/2014
Non-discrimination in health care	Plans may not discriminate against any provider operating within their scope of practice. Does not require that a plan contract with any willing provider or prevent tiered networks.[1]	Plan years beginning 01/01/2014
Comprehensive health insurance coverage	All plans must include the essential benefits package required of plans sold in the Exchanges and must comply with limitations on annual cost-sharing for plans sold in the Exchanges.[1]	Plan years beginning 01/01/2014
Prohibition on excessive waiting periods	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.[1]	Plan years beginning 01/01/2014
Coverage for individuals participating in approved clinical trials	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.[1]	Plan years beginning 01/01/2014
Rating reforms must apply uniformly to all health insurance issuers and group health plans	Any standard or requirement adopted by a State must be applied uniformly to all health plans in each market to which the standards or requirements apply.[1]	Plan years beginning 01/01/2014

2016

Issue	What law will do	Effective date
Provisions relating to offering of plans in more than one state	Two or more states may enter into a "health care choice compact" under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where it was written or issued. Plans must be licensed in each state in which they sell coverage or must submit to the jurisdiction of the states with regard to the above laws.[1]	01/01/2016

2017

Issue	What law will do	Effective date
Waiver for State Innovation	A state may apply for waivers of the following requirements: • Requirements for Qualified Health Benefits Plans • Requirements for Health Insurance Exchanges • Requirements for reduced cost-sharing in qualified health benefits plans • Requirements for premium subsidies • Requirements for the employer mandate • Requirements for the individuals mandate The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver.[1]	Plan years beginning 01/01/ 2017

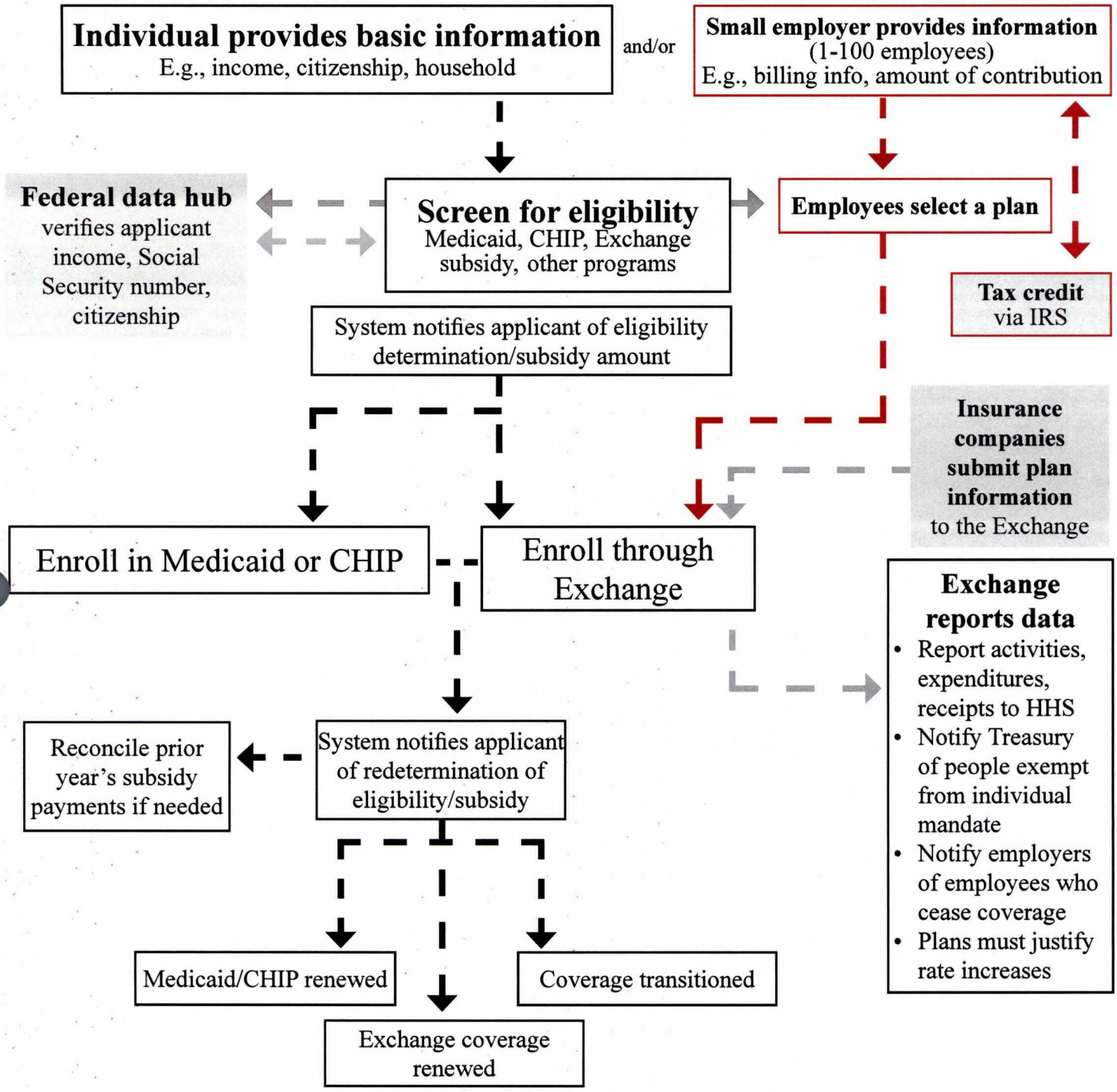
2018

Issue	What law will do	Effective date
Tax on "Cadillac" plans	Imposes new taxes on so-called "Cadillac" health insurance policies;[2] 40% tax on health insurance plans worth more than $27,500 for a family plan, $10,200 for an individual plan (family coverage now averages $13,375) [3]	01/01/2018

Sources:
1 National Association of Insurance Commissioners
2 National Conference of Insurance Legislators
3 Kaiser Health News

Health Insurance Exchange

A high-level view of what the Exchange needs to do



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