Health Care Reform Review Committee Testimony
October 6, 2011

Chairman Keiser and committee members, for the record I am Rod St. Aubyn from Blue Cross Blue Shield of North Dakota, speaking today on behalf of the health insurance companies doing business in North Dakota that worked on the original collaborative exchange bill draft. Those companies include Blue Cross Blue Shield of North Dakota, Medica, and Sanford Health Plan.

We wanted to take the opportunity to speak to you today and address some of the comments presented to your committee at your last meeting on September 20, 2011.

First of all, we would like to respond to suggestions/comments offered by the Insurance Department.

a. **The definition of "defined benefit plan" and "defined contribution plan"... seem to duplicate each other.**

We would disagree with this analysis. Your committee also had discussion about this and questioned if another term should be used because it may be confused with "retirement program" terms. These terms are common terms in the health insurance industry and in fact appear in regulations developed for the ACA. The term "defined benefit plan" refers to a plan that is offered by an employer to the employees of that company with a specific plan with defined benefits. Employers will often elect to pay for a certain percentage of a single plan for their employees. The term "defined contribution plan" refers to a scenario where an employer elects to contribute a "defined amount of money" toward one or more plans that are offered to the employees. We feel that the definitions offered in the original "Committee Bill" (11.0806.01000) adequately define these terms and are not duplicative. We urge the committee to retain those definitions as they are also used on page 11, lines 5 – 8 in the original Committee Bill.

b. **The definition of "small employer used in both bills is in conflict with the definition required by PPACA...**

The rules released by the federal Department of Health and Human Services for exchange eligibility do not require all groups of one to be eligible for group coverage. The rules specifically exclude sole proprietorships, certain S corporations, and family members of either. The rules also reference existing federal law on the type of groups of one that may be eligible, and it appears to be rather limiting. We are still trying to find out how limited this is and how it may compare to the current 2-50 definition in North Dakota law. Our recommendation is that we stick with the current definition of 2-50, and revisit this issue in the 2013 legislative session. If there is a change in the small group definition, it would be effective for all coverage inside and outside the exchange on 1/1/2014; this issue is not exclusive to the exchange. This would also allow the state to analyze the difference between their current definition and a FINAL (not preliminary) rule from HHS.

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.... Appointing even one agent or broker would mean a majority of voting board members would have a conflict of interest.**

We agree that the language dealing with conflict of interest in both the Consensus Bill and the Committee Bill is problematic and we brought that to the attention of Legislative Council staff earlier. It would be our recommendation that language be crafted to mirror the process used by the Legislature for its own members in voting on bills that may affect members' own industries. It is our understanding that a conflict will exist if legislation would affect solely and personally an individual member. We would urge some other language be considered for this purpose. In regards to the Exchange Board membership, we strongly urge that you reconsider our original Board membership, which was comprised of 3 ex officio non-voting members (Lt. Governor, Director of Human Services, and the Insurance Commissioner or their designees) and 7 voting members (3 representing insurers and four consumers). We understand that many other stakeholders have a desire to be represented on the Exchange Board. However, these stakeholders are more appropriate on the Consumer Advisory Group or other technical advisory group. We want to emphasize at this time that the insurers strongly support the language in the bill draft 11.085.01000 regarding the Consumer Advisory Group and the Technical Advisory Group (page 8, lines 1-30 and page 9, lines 1-13). The Committee Bill totally eliminated the Technical Advisory Group. One of the key focuses of this group will be the development of a reinsurance program, risk adjustment, and risk corridors. These mandated tasks will require the expertise of very specialized individuals. The Legislature must keep in mind the role and purpose of the Exchange Board. As identified in the duties of the exchange, the main duties deal with certifying and decertifying plans to be offered within the exchange and ensuring that all other requirements of the exchange are in compliance with state and federal requirements. When considering risk adjustments, a reinsurance program, and risk corridors, these are very technical in nature and having the expertise of insurers is not only important, but critical in ensuring competition within the exchange. The federal regulations recognized this importance of having that expertise on the board and the rules state that insurers just cannot be a majority of the voting members. The exchange will have no responsibilities with the role that medical providers will play within each health plan. The Exchange Board will also have to ensure that coordination of subsidies and enrollment into government plans are properly administered. The role of navigators will be defined and coordinated by the Exchange Board.

d. **In the 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.**

We think that knowledge of the actuarial field within the health care area is rather self explanatory. However, if the committee feels that this needs further clarification, we would suggest that we simply add the word "science" to make it read "health care actuarial science". All that this section does is to suggest the areas of expertise that the Governor should "consider" when appointing Board members.

e. **There is a prohibition in both bill drafts that states a director may not participate in deliberations or vote on any matter .... If that director has a conflict of interest.**

This was previously addressed in my comments. We also agree that the conflict of interest provision should identify what a conflict of interest really is and should be limited to action that would solely and personally benefit an individual Board member.

f. **The provision in both bill drafts regarding open meetings is also unclear ...**

We feel that there are several components here that would more appropriately be addressed in the administrative rules that the Exchange will have to adopt.

g. **Both bill drafts provide that an Exchange may contract with an "eligible entity for any of its functions. An eligible entity cannot be a health carrier. The language of the NAIC model act also excluded affiliates of health carriers...**

We have no problem adding "an eligible entity may not be a health carrier or an affiliate of a health carrier and must...."

h. **Both bill drafts provide that the Exchange must establish procedures and safeguards to protect the integrity and confidentiality of any data... It is unclear if this is designed to make Exchange information confidential....**

We feel that the concern noted here is unfounded. It is important to note exactly what the NAIC Model Act stated. It states: "The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the **confidentiality** of the information to be shared and comply with all State and federal laws and regulations." The proposed language simply added the following clarifying language: "The Exchange must establish procedures and safeguards to protect the integrity and confidentiality of any data it maintains." The Exchange Board will have to establish procedures and administrative rules to clarify what records must be kept confidential. The rules will have to go through the normal public notice and hearing process and will need to finally be approved by the Legislative Administrative Rules committee.

i. **A new standard would be added to state law by which rate increases 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.**

The Century Code makes it clear that the Insurance Commissioner approves rates. Nothing in the Exchange Bill changes that authority. In fact, both Sections 12 and Section 13 of the original Committee Bill make it clear that nothing supersedes the authority of the Commissioner to regulate the business of insurance. This is not a new standard in the insurance regulation world. In fact NDCC 26.1-17-25 which

applies to Nonprofit Health Service Corporations, states that "Rates must cover reasonably anticipated claims, cover reasonable costs of operation and overhead expenses, and maintain contingency reserves at a proper level of not less than the sum of incurred claims and operating and overhead expenses for at least two months, but not more than four months. **Rates may not be excessive, inadequate, or unfairly discriminatory**."

There is no definition of what constitutes a "qualified actuary" and such a certification is not currently required in state law.

Current ND Administrative Code does in fact define what a "qualified actuary" is. While this code applies to life insurance companies and fraternal benefit societies doing business in this state and authorized to reinsure life insurance, annuities, or accident and health insurance business in this state, we would like to offer amendments to clarify this term.

The purpose of this language offered by Chairman Keiser was intended to ensure that rates approved for products offered within the exchange are actuarially sound. As insurers, we all agree that the rate approval process must ensure that products offered both within and outside the exchange should ensure that rate approvals are based on sound actuarial principles and avoid the "politics" that has occurred in other states in the past. We are offering amendments to clarify the issues raised and would apply to insurance products both inside and outside the exchange.

j. **It is unclear how federal law can "amend" state law.**

We would agree with this concern and would suggest the following amendment to the original Committee Bill:

Page 10, line 21 remove ",". Page 10, line 22, delete "or any amendment to state legislation made by title 1 of the federal act,"

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

We offer no specific recommendations on this issue at this time.

l. **Would every employee of the Exchange be a fiduciary?**

We think that this may be a legitimate concern and would be better defined by the Board when adopting administrative rules. We would propose that you adopt the following amendment:

Page 15, delete lines 2-12.

m. It is unclear if this (ALJ hearing) 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 the ALJ's are recommended rather than final.

We would suggest that the "nonprevailing party" would be responsible for the cost of the ALJ services. We will offer amendments to address this concern. While the Insurance Department stated that most decisions (usually agencies) are recommended rather than final, there are in fact Board appeals through the ALJ that are final. Decisions can be appealed by law to the district court. We stand by the language regarding the decisions being final, rather than a recommendation by the ALJ, subject to appeal to the district court as is currently permitted by state law.

We also wanted to address some other comments and statements made during your last meeting.

It was mentioned that all states must have a Consumer Operated and Oriented Plan (CO-OP) program. We can find no requirement for this CO-OP program. This program can be found in Section 1322 of PPACA. There was originally $6 billion appropriated for grants and loans to establish these programs. However, that appropriation has since been reduced to $3.2 billion. The House is now proposing stripping the remaining $3.2 billion. The Senate does not support that reduction. Even though Health and Human Services has a goal of a CO-OP in every state, there is no requirement for such a program in all the research we have done.

In Senator Mathern's bill draft, 11.0802.02000, he proposes to repeal the CHAND law. This is something that this committee is responsible for studying. We would strongly discourage you from repealing the CHAND law until after you have thoroughly studied it. There are provisions within the CHAND law that the legislature may want to consider retaining, such as coverage for Trade Adjustment Assistance Reform Act (TAARA) applicants and the Age 65 and over or disabled applicants.

In that bill draft, Page 8, lines 26 – 29, Sen. Mathern calls for consultation with the Indian Affairs Commission from the Board. Current CMS regulations require that states with federally recognized tribes are required to consult with tribal leaders on exchange issues that affect American Indians. That language or something similar appears to be required by our state. It appears that this could be accomplished by including this representative on the Consumer Advisory Group.

We support our previously discussed Board composition rather than that offered by Sen. Mathern.

Regarding Rep. Glassheim's proposed amendments; we oppose his amendments, but do support the intent of his amendment on Page 9, line 29. However, we feel that should and could be addressed by the Exchange Board during the development of administrative rules after carefully considering all consequences related to this language.

We take no position on the amendments offered by OMB or the one offered by legislative council concerning agencies contracting with the Federal government without legislative authority.

We support the amendments offered by the Legislative Council correcting some drafting errors to bill number 11.0805.01000 and the same ones that were carried over to 11.0806.01000.

Mr. Chairman and Committee members, thank you for the opportunity to address your committee. We have included suggested amendments to address the concerns that I have referenced today. I would be willing to answer any questions that the committee may have.

Proposed Amendments to Exchange Bill 11.0806.01000
As Offered by the Insurance Workgroup

Adoption of the Drafting Correction Amendments offered to bill draft 11.0806.01000.

Page 6, lines 25 – 31 and Page 7, lines 1-2, this language dealing with conflict of interest must be revised to be similar to language used by the CHAND Board and utilized by the legislature for legislative members.

Pages 5, 6, and 7 (Section 3), restore the language from 11.0805.01000 concerning Board membership.

Page 6, line 3, after "actuarial" add "science"

Page 7, Replace the entire Section 4 with Sections 4 and 5 from bill draft 11.0805.01000 and add another representative to the Consumer advisory group which would be the "Executive director of the Indian affairs commission".

Page 8, line 20, after "carrier" add "or an affiliate of a health carrier"

To ensure that the process is the same both inside and outside the exchange, in addition to the language (also as amended by the legislative council's correction amendments) on page 9, lines 8 – 23, Subsection 5 of 26.1-30-19 is amended as follows:

3. No insurance policy, certificate, contract, or agreement or notice of proposed insurance against loss or expense from the sickness, bodily injury, or death by accident of the insured may be issued for delivery or delivered to any person in this state nor may any application, rider, or endorsement be used in connection therewith until the form thereof and the classification of risks and the premium rates, or in the case of cooperatives or assessment companies the estimated costs pertaining thereto, have been filed with and approved by the commissioner. <u>For purposes of this chapter, a "qualified actuary" is an individual who:</u>

a. Is a member in good standing of the American academy of actuaries;
b. Is qualified to sign statements of actuarial opinion for life and health insurance company annual statements in accordance with the American academy of actuaries qualification standards for actuaries signing the statements;
c. Is familiar with the valuation requirements applicable to life and health insurance companies;
d. Has not been found by the commissioner, or if so found, has subsequently been reinstated as a qualified actuary, following appropriate notice and hearing to have:
(1) Violated any provision of, or any obligation imposed by, the insurance law or other law in the course of the actuary's dealings as a qualified actuary;
(2) Been found guilty of fraudulent or dishonest practices;
(3) Demonstrated incompetency, lack of cooperation, or untrustworthiness to act as a qualified actuary;
(4) Submitted to the commissioner during the past five years, pursuant to this chapter, an actuarial opinion or memorandum that the commissioner rejected because it did not meet the provisions of this chapter, including standards set by the actuarial standards board; or
(5) Resigned or been removed as an actuary within the past five years as a result of acts or omissions indicated in any adverse report on examination or as a result of failure to adhere to generally acceptable actuarial standards; and
e. Has not failed to notify the commissioner of any action taken by any commissioner of any other state similar to that under subdivision d.

The health carrier's qualified actuary must provide the following certification with the rate filing. "In my opinion, the premium rates to which this certification applies have been calculated according to generally accepted actuarial practices and are neither excessive, inadequate, nor unfairly discriminatory. A form must be disapproved if the benefits provided are unreasonable in relation to the premium charge or if the benefits do not comply with chapters 26.1-36 and 26.1-37. If the premium rates are modified through the rate approval process, the certification previously referenced must be provided to the insurer by the commissioner's qualified actuary and also a statement identifying calculations or assumptions or both underlying the carrier's filed rates which were unreasonable and which necessitated modification of the premium rates. For premium rates disapproved, a statement by the commissioner's qualified actuary must be provided to the insurer identifying calculations or assumptions or both underlying the carrier's filed rates which were unreasonable and which necessitated disapproval.

Page 10, line 21 remove ","

Page 10, line 22 delete "or any amendment to state legislation made by title 1 of the federal act,"

Page 15, delete lines 2- 12

Restore from bill draft 11.0805.01000, page 21, lines 9 – 16. Add the following language to the end of line 16, "Costs associated with the state administrative hearing are the responsibility of the nonprevailing party."