HEALTH CARE REFORM REVIEW COMMITTEE

The Health Care Reform Review Committee was assigned three studies.

Section 1 of House Bill No. 1252 (2011) directed the committee to monitor the impact of the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010; rules adopted by federal agencies as a result of that legislation; and any amendments to that legislation. The study charge directed the committee to report to the Legislative Management before a special session of the Legislative Assembly if a special session is necessary to adopt legislation in response to the federal legislation.

Senate Concurrent Resolution No. 4005 (2011) directed the committee to study the impact of the PPACA and the Affordable Care Act (ACA) on the Comprehensive Health Association of North Dakota (CHAND) and the statutes governing CHAND.

Legislative Management directive directed the committee to study the feasibility and desirability of developing a state plan that provides North Dakota citizens with access to and coverage for health care which is affordable for all North Dakota citizens.

In addition to the committee's three studies, the Health Care Reform Review Committee was charged with receiving the following updates:

- Regular updates from the Insurance Commissioner during the 2011-12 interim regarding administration and enforcement of the PPACA, proposed legislation for consideration at a special legislative session, and proposed legislation by October 15, 2012, for the 2013 regular session (2011 House Bill No. 1125, Section 2);
- Regular updates from the Insurance Commissioner and Department of Human Services during the 2011-12 interim on planning and implementing an American health benefit exchange for the state and proposed legislation for consideration at a special legislative session, or proposed legislation by October 15, 2012, for the 2013 regular session (2011 House Bill No. 1126, Section 3); and
- Regular updates from the Insurance Commissioner during the 2011-12 interim with respect to steps taken to ensure health insurer procedures are in compliance with the PPACA, proposed legislation for consideration at a special legislative session if the commissioner is required by federal law to implement any requirement before January 1, 2013, and proposed legislation by October 15, 2012, for any requirement that must be implemented between January 1, 2013, and January 1, 2014 (2011 House Bill No. 1127, Section 6).

Committee members were Representatives George J. Keiser (Chairman), Donald L. Clark, Robert Frantsvog, Eliot Glassheim, Nancy Johnson, Lee Kaldor, Jim Kasper, Gary Kreidt, Lisa Meier, Ralph Metcalf, Marvin E. Nelson, Karen M. Rohr, Robin Weisz, and Lonny B. Winrich and Senators Spencer D. Berry, Dick Dever, Jerry Klein, Judy Lee, and Tim Mathern.

The committee submitted this report to the Legislative Management on November 3, 2011. The Legislative Management accepted the report for submission to the Legislative Assembly.

BACKGROUND

Affordable Care Act

In March 2010 President Barack Obama signed into law two pieces of legislation that laid the foundation for a multiyear effort to implement health care reform in the United States--PPACA (H.R.3590) and the Health Care and Education Reconciliation Act of 2010 (H.R.4872)--which together are referred to as ACA. The ACA crafted new structural models to increase access to and affordability of health care coverage, with as many as 32 million additional Americans being covered; to improve operational governance of the health insurance industry; to provide consumers protection; and to provide new tools for the improvement of the health care delivery system and patient outcomes.

Of particular interest to states regarding the ACA are the multiple specific provisions of the ACA and the implementation timeline of these specific provisions. The National Conference of State Legislatures (NCSL) identified and summarized the following ACA provisions and dates as being of interest to state legislatures:

2010

- High-risk pools established by states or federal government.
- Small business tax credits offered for employees' health coverage.
- Insurance companies required to cover young people to age 26 on their parents' plans.
- Prescription coverage gap for seniors reduced.
- Federal grants awarded to states for insurance premium reviews, health insurance exchanges, and other programs.
- Insurance companies restricted from dropping coverage for people who get sick or excluding coverage for kids with preexisting conditions.
- States offered option to expand Medicaid earlier than 2014 to cover adults with incomes up to 133 percent of poverty, at the state's regular Medicaid matching rate.

2011-13

- Medicare reforms required, such as ensuring access to physicians, improving payment accuracy, and prescription drug coverage.

2014

- Medicaid must cover an estimated 16 million additional people by 2017.
- Health exchanges start, with federal subsidies to help middle-income Americans purchase coverage.
- Individuals must purchase health insurance, with some exceptions.

- Insurance companies must cover people with preexisting conditions and policies must be renewed even if people get sick.
- Employers with 50 or more full-time employees must offer coverage or pay a fee.

2016

- States have option to join multistate compacts.

2018

- High-cost or so-called "Cadillac" health plans will be taxed.

In addition to the items addressed in the NCSL timeline, the ACA provides two deadlines by which a state must meet external review processes. The ACA provides that by January 1, 2012, group health plans and health insurance issuers in the group and individual market must comply with a state external review process that:

1. At a minimum includes the consumer protections set forth in the Uniform Health Carrier External Review Model Act issued by the National Association of Insurance Commissioners (NAIC), referred to as being an "NAIC-parallel process"; or
2. Meets the federal Department of Health and Human Services (HHS) 16-point standards, referred to as being an "NAIC-similar process."

Compliance with the NAIC-similar processes is a temporary status such that by January 1, 2014, all health plans and health insurance issuers in the group and individual market must comply with an NAIC-parallel process. If by January 1, 2012, the state process is neither an NAIC-parallel process nor an NAIC-similar process, and if by January 1, 2014, the state process is not an NAIC-parallel process, the state's health insurance issuers in the state will be subject to a federally-administered external review process. (United States Department of Labor Technical Release 2011-02, dated June 22, 2011.)

2009-10 Interim Industry, Business, and Labor Committee Study

During the 2009-10 interim, the chairman of the Legislative Management directed the interim Industry, Business, and Labor Committee to monitor federal health care reform legislation, including its effect on North Dakota citizens and state government; the related costs and state funding requirements; related tax or fee increases; and the impact on the Medicaid program and costs, other state programs, and health insurance premiums, including the Public Employees Retirement System (PERS).

The interim Industry, Business, and Labor Committee received testimony from a wide range of interested parties, including representatives of the:

1. Insurance Commissioner;
2. Department of Human Services;
3. PERS;
4. State Department of Health;
5. Tax Commissioner;
6. Bank of North Dakota;
7. Cato Institute;
8. George Mason University Center for Health Policy Research and Ethics;
9. Pharmaceutical Research and Manufacturers of America;
10. Cameron Institute;
11. Health Services Management Programme at McMaster University located in Hamilton, Ontario;
12. North Dakota Medical Association;
13. North Dakota Hospital Association;
14. North Dakota Pharmacists Association;
15. Blue Cross Blue Shield of North Dakota; and
16. Business owners and farm groups.

The interim committee recommended House Concurrent Resolution No. 3003 to direct the Legislative Management to continue studying the impact of the ACA during the next interim. Although the resolution was adopted, the Legislative Management did not prioritize the study.

The chairman of the committee developed and the committee approved a summary identifying the anticipated costs to the state of implementation of the ACA.

2011 Legislation

House Bill No. 1004

As introduced, the State Department of Health appropriation bill would have authorized the State Department of Health to apply for and spend ACA-related grants for public health infrastructure in the amount of $200,000, abstinence programs in the amount of $182,100, and intensive home visiting in the amount of $1,413,012. These appropriation clauses were not included in the enrolled version of the bill.

House Bill No. 1125

This bill directed the Insurance Commissioner to administer and enforce the provisions of the ACA.

House Bill No. 1126

This bill directed the Insurance Commissioner and the Department of Human Services to plan for the implementation of a state American health benefit exchange that facilitates the purchase of qualified health benefit plans, provides for the establishment of a small business health options program, implements eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program (CHIP), provides simplification, provides coordination among the state's health programs, and meets the requirements of the ACA; provides deadlines for implementing the exchange; directs the Insurance Commissioner and the Department of Human Services to collaborate with the Information Technology Department; and authorizes the Insurance Commissioner and the Department of Human Services to receive from and provide to federal and state agencies information gathered in the administration of the exchange as necessary. Additionally, this bill authorized the Insurance Commissioner to apply for and spend up to $1 million in federal grants for establishing the state's health benefit exchange.

House Bill No. 1127

This bill amended North Dakota law impacting health plans in order to implement the necessary provisions of the ACA, including limitations on risks, independent external review, external appeal procedures, and internal claims and appeals procedures.

House Bill No. 1165

This bill provided that subject to certain exclusions, regardless of whether a resident of this state has or is eligible for health insurance coverage under a health insurance policy, health service contract, or evidence of coverage by or through an employer or under a plan sponsored by the state or federal government, the resident is not required to obtain or maintain a policy of individual health coverage except as may be required by a court or by the Department of Human Services through a court or administrative proceeding.

Senate Bill No. 2010

As introduced, the Insurance Commissioner appropriation bill would have appropriated other funds in the amount of $2,504,005 and authorized five full-time equivalent (FTE) positions for the purpose of funding enhanced insurance premium rate review activities related to the ACA. As enacted, the bill appropriated other funds in the amount of $1,418,637 and did not authorize any additional FTE positions for this purpose.

Senate Bill No. 2012

As introduced, the Department of Human Services appropriation bill would have appropriated general funds in the amount of $225,507 and other funds in the amount of $305,588 and authorized seven FTE positions to fund the expansion of the Medicaid program. As enrolled, this bill did not include the appropriation or the FTE request.

Senate Bill No. 2037

This bill changed the membership of the Health Information Technology Advisory Committee by adding the chairman of the House Human Services Committee and the chairman of the Senate Human Services Committee or, if either or both of them are unwilling or unable to serve, a replacement selected by the chairman of the Legislative Management. The bill authorized the Health Information Technology Advisory Committee to accept private contributions, gifts, and grants. The bill required the director of the Health Information Technology Office to implement and administer a health information exchange that utilizes information infrastructure and systems in a secure and cost-effective manner to facilitate the collection, storage, and transmission of health records; adopt rules for the use of health information, use of the health information exchange, and participation in the health information exchange; and adopt rules for accessing the health information exchange to ensure appropriate and required privacy and security protections and relating to the authority of the director to suspend, eliminate, or terminate the right to participate in the health information exchange. The bill also required the director to determine fees and charges for access and participation in the health information exchange and to consult and coordinate with the State Department of Health and the Department of Human Services to facilitate the collection of health information from health care providers and state agencies for public health purposes. The bill required each executive branch state agency and each institution of higher education that implements, acquires, or upgrades health information technology systems, by January 1, 2015, to use health information technology systems and products that meet minimum standards adopted by the Health Information Technology Office for accessing the health information exchange. The bill provided that any individually identifiable health information submitted to, stored in, or transmitted by the health information exchange is confidential and any other information relating to patients, individuals, or individually identifiable demographic information contained in a master client index submitted to, stored in, or transmitted by the health information exchange is an exempt record. The bill provided immunity from criminal or civil liability for any health care provider that relies in good faith upon any information provided through the health information exchange in the treatment of a patient for any damages caused by that good-faith reliance. The bill provided that effective January 1, 2015, an executive branch state agency, an institution of higher education, and any health care provider or other person participating in the health information exchange may use only an electronic health record system for use in the exchange which is certified under rules adopted by the Office of the National Coordinator for Health Information Technology.

Senate Bill No. 2309

This bill provided that the ACA likely is not authorized by the United States Constitution and may violate its true meaning and intent as given by the Founders and ratifiers. The bill required the Legislative Assembly to consider enacting any measure necessary to prevent the enforcement of the ACA within this state and provided that no provision of the ACA may interfere with an individual's choice of a medical or insurance provider except as otherwise provided by the laws of this state.

TESTIMONY

The committee held six committee meetings before the 2011 special session. The primary focus of these meetings was determining what actions the state should take to address the health benefit exchange requirement under the ACA and reviewing additional information regarding other elements of the ACA, such as Medicaid expansion and external review requirements.

Health Benefit Exchange

In order to prepare for the 2011 special session, the committee received updates from state agencies regarding the status of other states' implementation of the health benefit exchange requirement under the ACA as well as the status of federal laws and rules relating to the health benefit exchange; received a presentation by

Mr. Michael O. Leavitt of Leavitt Partners, Salt Lake City, Utah, regarding the steps taken in Utah to create a health benefit exchange and how North Dakota may learn from this experience; held panel discussions at which the committee heard health benefit exchange perspectives of insurers, licensed insurance producers, medical professionals, hospitals, consumers, and businesses; informally surveyed state agencies and nonprofit entities for opinions relating to governance of health benefit exchanges and expectations of health benefit exchanges; and reviewed several bill drafts relating to creation of a state administered health benefit exchange.

State Administered Health Benefit Exchange

At the committee's first meeting the committee voted to pursue legislation to provide for a state-administered health benefit exchange while keeping opportunities open for cooperation with other states; however, throughout the committee's meetings the committee continued to discuss the option of federal administration and the option of a federal-state partnership for a federally administered health benefit exchange and continued to discuss the pros and cons of starting under one administration model and transitioning to another.

Montana is the only state that requested information from North Dakota regarding a multistate health benefit exchange, and this inquiry was due to a legislative directive. The committee received information that from an information technology standpoint, integration of the health benefit exchange system would work better if kept in-state. A representative of the Information Technology Department expressed concern regarding difficulties of having states share a health benefit exchange system when the state health benefit requirements vary from state to state. Additionally, a representative of the Information Technology Department testified that as an example of challenges the state may face if working with one or more other states in designing a health benefit exchange, the state is working with a neighboring state on the health information exchange system. Issues arise because that other state is not working as fast as North Dakota. The committee received testimony from a representative of the health insurance industry that although multistate exchanges may allow states to join in vendor contracts with other states, typically an insurer's products vary significantly from state to state.

The committee received testimony from insurers in support of a state-administered health benefit exchange.

The committee received status updates from representatives of the Insurance Department regarding which states have opted to have the federal government administer the state's health benefit exchange and which states have opted to administer their own health benefit exchange. The Insurance Commissioner requested the committee keep an open mind to allowing federal administration of the health benefit exchange because there are several unknowns that may impact the desirability of having a state-administered health benefit exchange, such as essential benefits, the final HHS rules, and the United States Supreme Court's ruling on the constitutionality of the ACA.

The committee received information that by January 1, 2013, HHS will approve, conditionally approve, or reject each state's health benefit exchange plan. The proposed HHS rules clarify that if a state begins with a federally administered health benefit exchange, the state retains the option to take over administration at a later date.

Committee members expressed frustration in being in the position to design health benefit exchange legislation without firm financial figures regarding the costs associated with designing and running an exchange.

The committee received testimony regarding options for administration of a state health benefit exchange, including state administration, federal administration, or a state-federal partnership for administration. Testimony indicated a partnership model technically would be a federally administered health benefit exchange.

Status Reports and Updates

The Insurance Commissioner and representatives of the Insurance Department made regular status reports to the committee regarding:

- The federal grants that are available to states to assist in implementation of the health benefit exchanges--planning grants, innovator grants, and establishment grants--and the status of these grants;
- The NAIC's and Insurance Commissioner's duties under the ACA as well as the timeline for implementation of the ACA;
- The status of states' implementation of the ACA's health benefit exchange requirement; and
- The HHS proposed rules regarding the ACA.

The committee reviewed HHS proposed rules regarding the ACA. The committee received testimony that it is expected the HHS comment period for the proposed rules will close October 31, 2011, and the final rules regarding the definition of essential benefits are not expected until May 2012 at the earliest. The committee referenced the HHS proposed rules in developing the language for the health benefit exchange bill drafts.

On July 22, 2011, North Dakota became the first state for which HHS denied an adjustment request for implementing the ACA medical loss ratio provision. The Insurance Commissioner had requested a three-year phase-in approach to the 80 percent medical loss ratio requirements under the ACA. The HHS decision was based on HHS's finding the state's adjustment request did not prove health insurance issuers would leave the market if the adjustment was not granted. The Insurance Commissioner did not appeal this decision.

The committee received a final report on the Insurance Commissioner's stakeholder meetings held across the state on behalf of the Insurance Commissioner, Department of Human Services, and Information Technology Department. The final report indicated a majority of participants thought the state should administer the health benefit exchange; reoccurring themes included cost concerns, whether health plans will be affordable; confusion, the desire that the health benefit exchange is easy to use and consumers are able to easily compare health plans; the

need for assistance in using the health benefit exchange and the importance of there being a person to answer questions and help those who do not want to or are unable to apply online; and the desire of choice as consumers want competition among carriers but they are also concerned about being overwhelmed by too much choice.

The committee reviewed the Insurance Commissioner's request for proposal (RFP) seeking a qualified and experienced firm to conduct background research, analyze data, identify options, and recommend a viable plan for developing and sustaining a health benefit exchange in the state. The RFP proposed the following contract schedule:

- Contract start date--August 26, 2011;
- Kick-off meeting with Insurance Department and other state agencies--September 6, 2011;
- Contractor begins providing biweekly progress reports--September 9, 2011;
- Contractor submits interim project report--September 28, 2011;
- Insurance Commissioner provides contractor with comments for revision of interim report as needed--October 5, 2011;
- Contractor submits revised interim report--October 10, 2011;
- Contractor submits final report--December 2, 2011; and
- Informal debriefing--December 9, 2011.

The committee received testimony from a representative of HTMS, Indianapolis, Indiana--the firm that was selected under the RFP--regarding the services HTMS is performing for the Insurance Commissioner under the contract. The actual schedule of deliverables varied slightly from the RFP's proposed schedule, but the schedule did provide for an interim report to be delivered by October 31, 2011, in order for the material to be available for the special session scheduled to begin November 7, 2011.

Michael O. Leavitt

The committee received a presentation from Mr. Leavitt regarding the ACA and the steps taken by Utah to create a health benefit exchange. Mr. Leavitt testified:

- North Dakota needs to consider how best to meet the needs of North Dakota.
- HHS will likely acknowledge the state's good faith attempts and recognize the needs of the state.
- A state should not utilize a federally administered exchange.
- The two basic questions are what is the role of government and should the health benefit exchange be inside state government or outside state government? He testified in support of government involvement in health care reform but stressed the importance of focusing on the nature of government involvement. He stated he supports the government role of helping construct an efficient environment for health care.
- The primary problem with the country's current health care system is that it focuses on volume over value, with the system based on fee for services and incentivizing high numbers of procedures instead of quality outcomes.

The Insurance Commissioner reviewed the Utah and Massachusetts health benefit exchanges, and reminded the committee that the Utah exchange does not meet the ACA requirements.

Panel Discussions

The committee held five panel discussions and received information from individuals representing health care insurers, licensed insurance producers, consumers, employers, medical professionals, and hospitals regarding:

1. The impact of the health benefit exchange on the health insurance industry;
2. The impact of the health benefit exchange on health care providers, hospitals, consumers, insurance agents, and employers;
3. Whether the state's health benefit exchange should be designed to include two separate risk pools--one for individuals and one for small businesses, called a small business health insurance program (SHOP) exchange--or whether the exchange should be designed to combine both the individual and the small business policies into a single risk pool;
4. Whether the state should restrict whether health insurers may choose to offer policies outside the state's health benefit exchange; and
5. Whether the state's health benefit exchange under the ACA should limit the qualified health plans offered through the exchange to the four benefit levels--platinum, gold, silver, and bronze--or should allow multiple types of plans within each of the benefit levels.

The committee considered the information provided at these panel discussions as the committee developed the health benefit exchange bill drafts.

Surveys

The committee performed an informal survey of state agencies and nonprofit entities to determine whether any of the state agencies or nonprofit entities in the state were interested in administering the state's health benefit exchange. None of the responding state agencies or state's nonprofit entities expressed a desire to fulfill the primary role of administering the state's health benefit exchange but several did express a willingness to participate in a board designed to govern such a health benefit exchange.

BILL DRAFTS

The committee began the health benefit exchange bill drafting process by reviewing three separate bill drafts, each of which was based on the NAIC American Health Benefit Exchange Model Act:

1. The first bill draft was revised based on the recommendations of a group of stakeholders--AARP, Blue Cross Blue Shield of North Dakota,

Medica, and Sanford Health--which worked together to create a consensus draft;

2. The second bill draft was based on the first bill draft with the primary revisions requiring navigators be licensed insurance producers and to comply with specified continuing education requirements, providing the health benefit exchange would be governed and administered by the Office of Management and Budget (OMB) and an appointed board, providing funding through a premium tax, and clarifying the health benefit exchange would not create dual regulation of health insurance;
3. The third bill draft also was based on the first bill draft with the following revisions:
   a. The governance model differed, including specific language providing for tribal involvement;
   b. Repeal of CHAND;
   c. Provision of a financing mechanism for the health benefit exchange, providing for the funding for CHAND to be transitioned to fund the exchange;
   d. The conflict of interest restrictions for the health benefit exchange board were more specific; and
   e. The health benefit exchange board was provided flexibility in several matters, including whether to establish a single risk pool for individual and small group policies and in developing navigator requirements.

The committee used the second bill draft as the vehicle for the design of the state's proposed health benefit exchange. Through the bill draft review process, the bill draft underwent several revisions. In revising the committee health benefit exchange bill draft the topics addressed by the committee included administration, board membership, risk pools, the market inside and outside the exchange, navigators, small employer definition, administrative hearings, funding, and technology.

Administration

The Insurance Commissioner testified in opposition to being charged with building or administering the state's health benefit exchange due to inherent conflicts of interest. However, the commissioner did support the concept of the Insurance Commissioner serving in an advisory capacity or serving as a member of the board of a board-administered exchange.

The committee received testimony from insurers in support of creating a state-administered health benefit exchange that meets the minimum requirements of the ACA, allowing for a design approach that will allow the state to add additional functions to the exchange once the state has a better understanding of what the state's needs are and as the individual and group markets adapt to the ACA.

Although representatives of the health insurance industry testified in support of a state-administered health benefit exchange, the committee also received testimony from insurers in support of a state-administered health benefit exchange that is governed by a nonprofit board, to ensure decisions are made free from political pressure or influence.

The committee received testimony from a representative of the Governor's office that the Governor would support a state-administered health benefit exchange that would provide for OMB to provide administrative services to a board of stakeholders that would actually govern the exchange, that would provide for the Information Technology Department to provide technology support, and that would provide the Department of Human Services would address eligibility for the Medicaid and CHIP programs.

The committee received testimony that the state's health benefit exchange should ensure that the health insurance plans offered through the exchange should have a high level of transparency and accountability in order for patients to make informed health care purchasing decisions. Additionally, steps should be taken to guard against cost-containment mechanisms that are termed quality measures.

The committee received testimony from a representative of the North Dakota Medical Association that insurance coverage options offered in a health benefit exchange should be self-supporting, have uniform solvency requirements, not receive special advantages from government subsidies, include payment rates established through meaningful negotiations and contracts, not require provider participation, and not restrict enrollees' access to out-of-network physicians.

Board Members

The committee considered several alternatives addressing the makeup of the membership of the health benefit exchange policymaking board. Related to the board composition and board policies, the committee addressed the issue of conflicts of interest for board members. Representatives of consumer organizations testified in opposition to allowing governing board members who have conflicts of interest due to affiliations with health care industries.

In establishing the makeup of the board, the committee considered the appropriate size and makeup of the board, including whether legislators should serve on the board and if so whether they should be voting members; how to define or designate who might qualify as a representative of consumers; whether to include representatives of physicians and other medical professions and whether to include representatives of health care facilities; and whether licensed insurance producers should be represented on the board. Additionally, the committee considered whether the members of the board should receive per diem and reimbursement for board-related expenses such as travel, food, and lodging.

Risk Pools

Although the committee did receive some testimony in support of a single risk pool for the individual market and the small group market, the Insurance Commissioner and representatives of the health

insurance industry testified in support of keeping these two risk pools separate. The committee received testimony there is concern that if the two risk pools are joined, the premiums for small groups would increase as a result.

Market Inside and Outside Exchange

The committee considered whether the health benefit exchange should take steps to minimize adverse selection as it relates to consumers purchasing health coverage from inside the exchange versus outside the exchange or whether steps should be taken to otherwise increase the success and viability of the health benefit exchange, including considering whether the health benefit exchange might provide that in order to sell outside the exchange an insurer is required to also sell inside the exchange. In addition, the committee considered whether the health benefit exchange should have the authority to limit the number of policies offered inside the exchange.

Generally, the committee received testimony from health insurers in support of consumer choice and consumer flexibility. However, at least one insurer testified in support of requiring a company interested in selling a product outside the exchange also be required to offer products inside the exchange in order to address the concern of adverse selection or cherry picking. Additionally, the committee received testimony that in order to keep health benefit exchange administration costs low and to minimize consumer confusion, it may be reasonable to restrict each insurer to two product options within each metallic level in the individual market and the same two product limitations within the small group market and to require that anyone wishing to sell health insurance in North Dakota must be part of the health benefit exchange.

The committee received testimony from a representative of a consumer organization in support of requiring insurers to offer similar products inside and outside the exchange to mitigate adverse selection. The committee also received testimony from a representative of a consumer organization in support of designing a health benefit exchange that acts as an active purchaser.

Navigators

The committee considered how the HHS proposed rules impact the ability of licensed insurance producers to enroll consumers in health policies through the health benefit exchange, receive compensation from an insurer, and receive navigator grants under the health benefit exchange.

The Insurance Commissioner testified the overwhelming opinion is that licensed insurance producers need to continue to be involved in the health benefit exchanges. Additionally, the committee received testimony from licensed insurance producers regarding the value of the services provided by licensed insurance producers, the level of expertise and training required of a licensed insurance producer in order to assist consumers in selecting health policies, and the need to allow licensed insurance producers to continue to perform their jobs under the new health benefit exchange.

The committee received testimony from representatives of consumer organizations reminding the committee a broad range of consumers will require a broad range of services to utilize the health benefit exchange, stressing there should be a broad range of entities working as navigators, and stating that the navigator program will play a critical role in education of and outreach to consumers.

The committee received testimony from a representative of the Department of Human Services reminding the committee that since the health benefit exchange will be used to enroll consumers in Medicaid and CHIP, for some consumers there will be a need for navigators to have expertise that goes beyond the services typically offered by licensed insurance producers.

Small Employers

The committee received information that the ACA allows states some flexibility in defining the term "small employer." Until 2016, states can limit the maximum size of a small employer to 50 employees, after which time the states will need to increase the maximum size to 100 employees. The committee received testimony from insurers in support of limiting the state's definition of small group employers to no more than 50 employees because this approach will mitigate concerns regarding the self-funded market entering and exiting the small group market.

Administrative Hearings

The committee considered what administrative hearing process should apply to appeals of insurance certification determinations, whether the law should address the award of attorney's fees for appeals, and whether a hearing officer's order should be final and appealable or should be a recommendation to the agency.

Funding

The committee received information from a representative of the Insurance Department that although HHS has unlimited funding for grants to states to implement the health benefit exchange portion of the ACA, by January 1, 2015, the health benefit exchanges must be self-sustaining.

The committee considered whether the revenues that could be raised by an increase in the insurance premium tax imposed on health insurers would be adequate to fund all or a portion of the anticipated cost of sustaining the health benefit exchange; whether an increase in insurance premium tax is a desirable funding mechanism; and whether there might be other funding sources that would preferable to increasing premium taxes, such as repealing CHAND and diverting the CHAND assessments to the health benefit exchange.

The committee received information from OMB, Department of Human Services, and Information Technology Department regarding the anticipated costs and FTE positions required to establish and implement

the health benefit exchange for the remainder of the biennium.

Technology

The committee received testimony from a representative of the Information Technology Department that the ACA requires the health benefit exchange to provide a coordinated, simple, technology-supported process through which individuals may obtain coverage through Medicaid, CHIP, and health insurance. Although the health benefit exchange is designed to be simple for enrollees on the frontend, it is not a simple process on the backend in the world of technology.

Additional Elements of the ACA

In addition to the ACA requirement for a state health benefit exchange, the ACA also expands Medicaid and requires that insurance companies comply with the ACA external review provisions.

Medicaid Expansion

The committee received the following testimony from representatives of the Department of Human Services regarding Medicaid expansion under the ACA:

- Medicaid expansion effective January 1, 2014, will include a coverage requirement for individuals under age 65 with incomes up to 133 percent of the federal poverty level based on modified adjusted gross income. North Dakota's Medicaid program is expecting up to a 50 percent increase in enrollment because of this expansion. In April 2011 North Dakota's Medicaid enrollment was 64,299. Before January 1, 2014, North Dakota will need to decide if this Medicaid expansion population will receive the current Medicaid services or if the benefit package will be more consistent with the essential health benefits package.
- Extension of Medicaid coverage for foster care children effective January 1, 2014, will provide that all individuals who were in foster care and receiving Medicaid as of the date they turned 18 will continue to be eligible for Medicaid through age 25.
- A required element of the health benefit exchange is that it apply the Medicaid and CHIP eligibility determination and provide for enrollment. In order to achieve this level of interoperability with the health benefit exchange, the Medicaid and CHIP eligibility systems will require significant modifications.

External Review

In July 2011 HHS made a determination that the state's external review law did not meet the minimum federal standards under the ACA. The Insurance Commissioner did not appeal the decision. A representative of the Insurance Department testified 2011 House Bill No. 1127 was prepared by the Insurance Commissioner to satisfy the ACA internal review and external review requirements for health insurance claims. However, that bill was amended and HHS determined this amended version does not comply with the ACA.

The committee received testimony that if the state's external review process had been determined to be effective, the state would be the entity that assisted consumers with their external review process; however, because the process was found not to be effective, consumers must send their external review requests to the federal government.

The committee considered three alternative bill drafts to provide for a state external review process that is intended to meet the ACA standards. The first bill draft essentially would have reintroduced 2011 House Bill No. 1127, as introduced, which appears to have been intended to be an NAIC-parallel process approach. The second and third bill drafts were drafted to be NAIC-similar approaches, with one bill draft directing the Insurance Commissioner to implement the selection of the independent review organization (IRO) and the other bill draft directing the health insurer to implement the selection of the IRO.

The committee received testimony the NAIC-similar process approach bill draft that directs the Insurance Commissioner to implement the selection of the IRO is the ACA-compliant approach to selecting an IRO. Additionally, the committee discussed the legislative history of House Bill No. 1127 and why it was amended during the 2011 regular session.

A representative of the Insurance Department presented information regarding the 16 points that should be met by an external review process in order to be determined to be an NAIC-similar process and how each of the three bill draft rates on each of these points.

The committee received testimony from a representative of the health insurance industry that meeting the federal external review standards is not a hardship. Regardless of what the state law provides, effective January 1, 2014, all policies certified to be sold through the health benefit exchange will have to comply with the federal requirements, i.e., an NAIC-parallel process.

The committee received testimony from a representative of the health insurance industry in opposition to the bill draft based on House Bill No. 1127, as introduced, stating the proposed language goes beyond what is required by the ACA.

RECOMMENDATIONS

The committee recommends House Bill No. 1474 to provide for a state-administered health benefit exchange. The bill draft would:

- Create the North Dakota Health Benefit Exchange Board, which would include four ex officio nonvoting members as well as nine voting members appointed by the Governor. This board would establish the policy for the administration of the health benefit exchange.
- Create the OMB Health Benefit Exchange Division, charged with implementing the policy established by the board and administering the health benefit exchange.

- Require that by January 1, 2013, the exchange be determined by HHS to be ready to begin operations by October 1, 2013, and be fully operational by January 1, 2014. The bill draft provides if the federal implementation deadlines are delayed, the director of OMB may set a later date consistent with the federal deadlines.
- Clarify the health benefit exchange may not duplicate or replace the duties of the Insurance Commissioner or the duties of the executive director of the Department of Human Services relating to the Medicaid and CHIP programs.
- Direct the Department of Human Services to take steps necessary to create and coordinate with the Health Benefit Exchange Division on those portions of the health benefit exchange relating to eligibility determination in the state's Medicaid and CHIP programs.
- Direct state agencies to cooperate with the board, the Health Benefit Exchange Division, and the Department of Human Services to ensure the success of the health benefit exchange.
- Direct the division to adopt rules consistent with the board's conflict of interest policy.
- Direct the board to regularly consult on an ongoing basis with each of the federally recognized tribes located within the state, consult with the Indian Affairs Commission, and invite the executive director of the Indian Affairs Commission to board meetings.
- Direct the board to establish a Health Benefit Exchange Advisory Group and Technical Advisory Group and allow the board to establish any other temporary advisory groups as may be appropriate.
- Direct the board to establish the criteria and procedures for certifying qualified health plans in conformity with and not exceeding the requirements of the ACA.
- Authorize the division to contract with one or more eligible entities to carry out one or more of the functions of the health benefit exchange.
- Provide the health benefit exchange must allow for a health carrier to offer a plan that provides limited scope dental benefits.
- Provide the health benefit exchange shall foster a competitive marketplace for insurance and may not solicit bids, engage in the active purchasing of insurance, or exclude a health benefit plan from the exchange based on a premium price control.
- Prevent the health benefit exchange from precluding the sale of health benefit plans through mechanisms outside the exchange.
- Prevent the health benefit exchange from precluding a qualified individual from enrolling in or a qualified employer from selecting a health plan offered outside the exchange.
- Create a Navigation Office within the Health Benefit Exchange Division which would provide navigator services, provide navigator grants to the Indian Affairs Commission, and regulate who may charge a fee to or otherwise receive consideration to assist consumers in making health coverage decisions through the use of the health benefit exchange.
- Require a separate risk pool for health plans in the individual market and a separate risk pool for health plans in the small group market.
- Provide the health benefit exchange must be self-sustaining by January 1, 2015, and that until such date the division, the Information Technology Department, and Department of Human Services shall use grant funds to finance the establishment of the exchange.
- Direct that before August 1 of each year the division shall submit a proposal to the board outlining how to raise the funds necessary to fund the board, division, and health benefit exchange.
- Direct that before October 1 of each year the board shall establish a plan for funding the board, division, and health benefit exchange.
- Authorize the board to charge assessments or user fees or otherwise generate funding necessary to support the health benefit exchange operations.
- Create the health benefit exchange fund for the deposit of funds to support the board, division, and exchange operations.
- Repeal North Dakota Century Code Chapter 26.1-54, directing the Insurance Commissioner and Department of Human Services to establish a health benefit exchange.
- Direct the Insurance Commissioner, Department of Human Services, and the Information Technology Department to provide regular updates to the Legislative Management regarding the implementation of the Act.
- Provide it is the legislative intent that OMB apply for federal Level 1 and Level 2 exchange establishment grants to fund the health benefit exchange planning activities.
- Provide it is the legislative intent that the division, Information Technology Department, and the Department of Human Services explore grant opportunities that may become available for the health benefit exchange.
- Provide it is the legislative intent that except as expressly authorized, state entities may not use state funds to fund the planning activities related to the development of and operation of the health benefit exchange.
- Provide a continuing appropriation of federal funds received from federal health insurance exchange grants to the division, Information Technology Department, and Department of Human Services, for the purposes of establishing a state health insurance exchange.
- Provide an appropriation from federal funds to OMB for the purpose of defraying the expenses of establishing and operating the health benefit exchange and authorize nine FTE positions. The federal funding is not subject to the cancellation of

unexpended funds provisions of Section 54-44.1-11.

- Provide an appropriation from federal funds to the Information Technology Department for the purposes of defraying the expenses of establishing and implementing the health benefit exchange and authorize 19 FTE positions. The federal funding is not subject to the cancellation of unexpended funds provisions of Section 54-44.1-11.
- Provide an appropriation from money in the health benefit exchange fund to the Health Benefit Exchange Division for the purpose of funding the operation and activities of the Navigation Office.
- Provide the amount remaining from the Insurance Commissioner's $1 million federal grant received for planning for the implementation of a health benefit exchange is transferred to the health benefit exchange fund for use by the Health Benefit Exchange Division, Department of Human Services, or Information Technology Department for the planning, establishing, and administering of the health benefit exchange.
- Provide it is the legislative intent that absent legislative authorization, an executive branch state agency may not enter any agreement with the federal government for the state or federal government to establish, manage, operate, or form a relationship to provide a health benefit exchange under the ACA and provide legislative intent that executive branch agencies may not work with the federal government to evade or otherwise circumvent legislative authority to establish, manage, operate, or form a federally administered or state-administered health benefit exchange.
- Provide the bill draft would become effective November 14, 2011.
- Provide the health benefit exchange law under this Act expires if the ACA is repealed by Congress or otherwise rendered invalid, in whole or in part, by judicial decree or if the state is granted a federal waiver for the health benefit exchange.

The committee also recommends House Bill No. 1475 to provide:

- An appropriation of federal funds received by the Department of Human Services for ACA-related costs of the Department of Human Services and the Information Technology Department relating to incorporating the Medicaid and CHIP eligibility determination functionality into the health benefit exchange and for the purpose of defraying the corresponding costs related to the modification of the department's economic assistance eligibility system, including 1 FTE for the Department of Human Services and 10 FTE positons for the Information Technology Department;
- An appropriation from the general fund and federal funds to the Department of Human Services for the purpose of defraying the expenses of implementation of the ACA's Medicaid expansion provisions, including seven FTE positions for the Department of Human Services; and
- An appropriation of special funds to the Insurance Commissioner for the purpose of defraying the expenses of implementation of the ACA, including four FTE positions.

This bill draft would become effective November 14, 2011.

The committee also recommends House Bill No. 1476 to amend the law relating to the external review procedures required for health insurance policies. The portions addressed by the amendments include clarification of the circumstances under which an external review must be available, expedited external review requirements, notice requirements, allowable filing fees for requesting an external review, and the method by which the Insurance Commissioner shall assign an IRO. This bill draft would become effective December 1, 2011.