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Representative George Keiser
Chair, Interim Health Care Reform Review Committee

MEDICA[®]

Dear Mr. Chairman and Committee Members:

Thank you for the invitation to discuss the changes North Dakotans are witnessing in the individual health insurance market and how they are able to access this coverage. Our organization greatly appreciates the opportunity to share our insight with the committee and, while I am unable to appear in front of the committee today, I appreciate the opportunity to offer comments on this topic.

Medica Products in the Federally-Facilitated Marketplace (FFM)

Medica offers a broad array of health insurance products for the North Dakotans who choose to use the FFM through the federal website healthcare.gov. I understand the committee has a number of questions regarding the coverage we offer on the FFM and how this coverage varies from existing coverage we offer in North Dakota's individual health insurance market.

Medica's individual and family products and the benefits they cover in the North Dakota market in 2014 are different from the products available in 2013 for a variety of significant reasons. First, the minimum level of benefits, services and items covered by our products must be expanded to meet new federal requirements. Many of the benefits that were optional will become mandatory, such as coverage for chiropractic services, chemical dependency, brand name prescription drugs, and habilitative services. Last year, the Interim Health Care Reform Review Committee recommended that North Dakota select a narrow standard for the benefits that must be included in these products in order to mitigate the impact of this new requirement on the premiums North Dakotans would pay for their health insurance in 2014. We continue to appreciate this recommendation by the committee and the final decision by the Department of Insurance to offer this flexibility to the marketplace.

Most of Medica's individual and family products are required to have lower cost-sharing requirements than in the past and must fit into specific metal levels of coverage to abide by the PPACA requirements. For your background, I've attached a handout that provides the committee a comparison of one of our most popular products in 2013 to the Bronze and Silver level co-pay plans available inside and outside the North Dakota FFM for 2014. We have several other products that will not be altered as dramatically as our Solo product; however, it offers a distinct comparison one of our most popular products against our new plans in 2014. For example, in 2013, we offered a relatively low-premium health plan with deductibles and maximum out-of-pocket limits above \$9,000 for single coverage. Due to implementation of PPACA, the maximum deductible and out-of-pocket limit for a single person buying coverage is \$6,350 in 2014, and products with higher limits are no longer allowed to be sold in the health insurance market.

As the Interim Health Care Reform Review Committee is well aware, the Patient Protection and Affordable Care Act (PPACA) applies many other new regulations and requirements to the health plans we offer in the individual market in 2014. These additional factors include, but are not limited to: 1) Guaranteed issue of health insurance coverage during the open enrollment and special enrollment periods; 2) New taxes applied to health insurance coverage in 2014 and beyond; and 3) New community

rating standards that fundamentally change the premium paid by people of different ages, health status, regions of the state, and other factors.

As the above information illustrates, the North Dakota health insurance market is moving from the existing health insurance market, with existing rules and norms, into new health insurance market with new and diametrically different rules and norms. As health plans, Medica and our competitors are required to enter this new market with a brand new portfolio of health insurance products. When all of these factors are combined, comparisons of the old individual health insurance world to the new world are similar to comparing apples to steaks, not only due to dramatic changes in the health insurance products offered in the marketplace, but also due to who has access to these products, and the protections and benefits required for consumers. Comparing the old world to the new world in a thoughtful manner does not result in one single output or metric, such as an average premium increase, due to the many factors involved and the individualized nature in which PPACA impacts North Dakota individuals and families.

Data Transfers from the FFM to Medica

In order for North Dakotans to enroll in private health insurance coverage through the FFM, there are a number of transactions that must take place. The primary consumer responsibility is to log onto healthcare.gov and complete the steps outlined on the website. In order to accomplish this, consumers must create a user account, enter information to determine if they are eligible for subsidized coverage, select a health insurance plan, arrange to pay their initial month's premium, and arrange payment for future monthly premiums.

At this point, the consumer has cleared all steps they must complete in order to receive health insurance coverage and several of the remaining steps are data transfers conducted behind the scenes between the FFM and the insurance company. The largest and most complicated transaction is the transmission of enrollment information to the health plan in a HIPAA-compliant transaction called an 834. To date, Medica has received electronic enrollment files from the North Dakota FFM and is working with the federal Centers for Medicare and Medicaid Services (CMS) to validate the accuracy of these files and improve the data incorporated in these files. We are also working with CMS to ensure timely and reliable receipt of payment from consumers and the FFM to ensure timely enrollment in health insurance coverage by January 1, 2014.

Thank you for focusing on this important and timely topic in today's committee hearing. Please do not hesitate to contact me if you have any questions.

Sincerely,



Jay McLaren

Director of Government Relations

ND Benefit comparison (2013 vs. 2014): Medica Solo to Medica Applause Copay

In-network	Current benefits (you pay)	Effective January 1, 2014 (you pay)
Annual Deductible	Individual: \$3,150, \$6,300, \$9,450, \$12,600	Individual: \$2,200 (Silver), \$6,350 (Bronze) Family: \$6,600 (Silver), \$12,700 (Bronze)
Annual Out-of-Pocket Max	80% plans (100% plans same as deductible): Individual: \$4,150, \$7300, \$10,450, \$13,600	Individual: \$6,250 (Silver), \$6,350 (Bronze) Family: \$12,700 (Silver), \$12,700 (Bronze)
Coinsurance after deductible	20% or Nothing	40% (Silver) coinsurance or Nothing (Bronze)
Office visits	With \$3,150 deductible: \$30 copay With \$6,300 deductible: \$40 copay With \$9,450 deductible: \$50 copay With \$12,600 deductible: \$60 copay Copay applies for first 3 visits per year. After 3rd visit, 20% coinsurance or nothing after deductible.	Unlimited copays: \$30 (Silver) or \$60 (Bronze) The deductible does not apply.
Convenience Care visits	\$20 copay for first 3 visits per year. After third visit 20% coinsurance or nothing after deductible.	Unlimited copays: \$20 copay per visit. The deductible does not apply.
Emergency Room visits	\$200 copayment for first visit per year. After the first visit 20% coinsurance or nothing after deductible.	40% (Silver) coinsurance or Nothing (Bronze) after deductible
Urgent Care visits	\$100 copayment for first visit per year. After first visit 20% coinsurance or nothing after deductible.	40% (Silver) coinsurance or Nothing (Bronze) after deductible
Eyewear	Medica pays up to \$50 per calendar year for in-network and out-of-network benefits combined.	Members age 18 and younger: 40% (Silver) coinsurance or Nothing (Bronze) after deductible. Coverage is limited to one pair of frames every 2 calendar years and one pair of lenses per calendar year or contacts per calendar year.
Refractive Eye Exam	Coverage limited to one visit per calendar year for in-network and out-of-network combined.	Coverage is limited to one visit per member per calendar year for in-network and out-of-network benefits combined for members 18 years and younger.
Home Health Care	Home care services (not including Home Infusion therapy) maximum 180 visits per calendar year.	Home care services (including Home Infusion Therapy) maximum 40 visits per calendar year.
Maternity care (Includes prenatal, labor and delivery services)	No coverage	40% (Silver) coinsurance or Nothing (Bronze) after deductible.
Outpatient Rehabilitation	Physical, Occupational and Speech Therapies no limits in-network. Out-of-network coverage limited to a combined maximum of 15 visits per calendar year.	Rehabilitative- Physical, Occupational and Speech therapies limited to 30 visits per therapy per calendar year for in-network and out-of-network combined. Habilitative- Physical, Occupational and Speech therapies limited to 30 visits per therapy per calendar year for in-network and out-of-network combined.
Prescription Drugs	Tier 1: \$10 copayment Tier 2: \$50 (if coverage was elected) Tier 3: \$100 (if coverage was elected) The deductible does not apply.	Tier 1: \$10 (Silver) or \$20 (Bronze) copayment. The deductible does not apply. Tier 2: 40% (Silver) coinsurance or Nothing (Bronze) after deductible Tier 3: 60% (Silver) coinsurance or Nothing (Bronze) after deductible.

Specialty Prescription Drugs	Tier 1: 20% coinsurance up to a \$200 max Tier 2: 40% coinsurance up to a \$400 max (if coverage was elected). The deductible does not apply.	Tier 1: 30% coinsurance after deductible (Silver) or Nothing (Bronze) Tier 2: 50% coinsurance after deductible (Silver) or Nothing (Bronze)
Out-of-network		
Annual Deductible	Individual: \$6,300, \$12,600, \$18,900, 25,200	Individual: \$10,000 (Silver), \$10,000 (Bronze) Family: \$20,000 (Silver), \$20,000 (Bronze)
Coinsurance after deductible	40% coinsurance	50% coinsurance
Prescription Drugs	Tier 1: 40% coinsurance Tier 2: 40% coinsurance Tier 3: 40% coinsurance	No coverage
Other:		
<ul style="list-style-type: none"> • If you elect coverage for your family, you may now add them to this policy. • Waiting periods for genetic counseling and genetic testing have been removed. • If you did not previously elect coverage for mental health and substance abuse it is now covered. • If you did not previously elect coverage for Tier 2 and 3 prescription drug coverage and Tier 2 specialty drugs, they are now covered. 		