TESTIMONY

Presented by: **Rebecca Ternes**
Deputy Commissioner
North Dakota Insurance Department

Before: **Health Care Reform Review Committee**
Representative George Keiser, Chairman

Date: **September 29, 2015**

Good morning Chairman Keiser and members of the committee. My name is Rebecca Ternes and I am the Deputy Insurance Commissioner at the North Dakota Insurance Department.

I was asked to present an update on the Affordable Care Act (ACA), some key dates coming up and changes expected in the ACA's programs.

Essential Health Benefit (EHB) Choice

In the previous meeting of this interim committee you reviewed the requirements of 2015 House Bill No. 1378 and heard public comment on the choice for the 2017 EHB benchmark plan. After discussion, this committee voted to choose the Blue Cross Blue Shield (BCBS) small group plan as the benchmark selection and forward this selection to Legislative Management. Legislative Management would then have the choice of forwarding this choice to the Governor for formal notification to the U.S. Department of Health and Human Services Secretary.

You were informed the initial decision was due to the federal government by June 1, 2015, but that states would be given additional time after the proposed selections were announced if they made a subsequent selection. States not making a selection would default to the state's largest small group plan (meeting ACA requirements) by enrollment which in North Dakota's case was what the committee had chosen, the BCBS small group plan.

On August 28, HHS, through the Centers for Medicaid and Medicare Services (CMS), announced the proposed EHB 2017 benchmark for each state. As expected, the North Dakota plan was the default plan. Even though Legislative Management has taken no further action, this committee's selection is currently set to become North Dakota's EHB benchmark plan because the state has defaulted. Should North Dakota take no further action by September 30 (the end of the public comment period on the proposed selections), the default will remain.

The HHS Secretary will likely announce final EHB benchmark plans yet this fall.

2016 Health Insurance Open Enrollment

Open enrollment for private health insurance plans beginning on January 1, 2016, starts on November 1, 2015, and runs through January 31, 2016. People can also purchase coverage throughout the year through special enrollments if they have a qualifying event such as the birth of a child, marriage, losing other coverage, etc.

Individuals and businesses that have grandfathered plans, which is most of North Dakota's policyholders, may remain on those plans if they are still offered. Any individual or business that wants to shop for or purchase health insurance may work with an insurance agent to do so at no additional cost.

Most individuals now must show evidence of minimum essential health insurance coverage on their annual taxes. If individuals do not have this coverage for 2016, they will pay the higher of 2.5 percent of their yearly household income or $695 per person ($347.50 per child under 18) up to a maximum set at the average bronze level plan premium, when known.

For 2015, the penalties were the higher of 2 percent of yearly household income or $325 per person ($162.50 per child under 18). The maximum family penalty is $975. In the future, these rates will be adjusted for inflation.

Insured in North Dakota

The Insurance Department requested covered lives data from the three active health insurers in North Dakota—Blue Cross Blue Shield of North Dakota, Medica and Sanford Health. The following chart details the number of covered lives in fully insured and self-insured plans and separates them into grandfathered (plans in place prior to March 23, 2010) and nongrandfathered plans.

The chart does not include those covered by Medicare, Medicaid (traditional or expansion), CHIP or veteran coverage. It also does not include covered lives insured by other companies that issued policies out of state.

		Covered Lives
Small Group	Non-Grandfathered	29,637
	Grandfathered	41,291
Large Group	Non-Grandfathered	38,497
	Grandfathered	19,772
Individual	Non-Grandfathered	40,004
	Grandfathered	10,871
	NDPERS	58,003
	Total Fully Insured	238,075
	Total Self-Insured	187,082
	Total Insured	425,157

As of September 12, 2015, and within the nongrandfathered numbers above, 16,651 individuals are enrolled in Federally Facilitated Marketplace (FFM, i.e., Exchange) plans.

2016 Health Insurance Plans

All plans were to be filed with the Department by May 15. The Department had to approve the filings by July 28. There were 32 major medical ACA plan filings approved

and 23 dental plan filings approved. The rates will become public when the federal government makes them public which will be no later than the first day of open enrollment.

January 1, 2016, Definition of Large Employer Change

Congress is looking at legislation to reverse the ACA's requirement to change the definition of small and large employers. As the law stands today, on January 1, 2016, the definition of small employer will rise from 1 to 50 employees to 1 to 100 employees. This means employers who once were considered large employers (those with 51 to 100 employees) will now fall under the requirement to offer health insurance containing the essential health benefits. Also, pricing of the plans purchased by these employers must change to meet the new market reforms. The two bills in Congress (H.R. 1624 / S. 1099) would allow states to decide whether or not to make the change in the numbers.

Businesses falling in this category are concerned the pricing for their groups will increase, benefit design will be limited and out-of-pocket spending could increase for their employees. Also of great concern for the states is the fact that most states have always defined their small group markets as 1 to 50 or in North Dakota's case, 2 to 50. States feel strongly that states, not the federal government, should make this choice according to their own markets. The National Association of Insurance Commissioners sent a letter to Congressional leadership expressing this concern.

The federal government has offered a nonenforcement period for businesses that renew their current plans on or before October 1, 2015, but that only delays the change; it does not fix it. Time is critical for this action. If insurers and businesses do not know the final outcome soon, it will be difficult to make decisions on new plan choices and to allow enough time for open enrollment periods which typically end well before the January 1 plan start date.

As of the writing of this testimony, H.R. 1624 was to be on the floor of the House, Monday, September 28, and is expected to pass. Passage in the Senate may not be as easy, but there is a good chance it gets done yet this year.

The ACA's Three R's

When healthcare reform was being considered, there was often great concern expressed by insurers of the heightened risk such a dramatic change to the market would cause. One of the most widely discussed risks was related to the elimination of underwriting standards and specifically, the standard that people could not be turned down or charged more if they had been or were sick.

To spread these risks among insurers, the law contained the Three R's: Risk Adjustment, Reinsurance and Risk Corridors.

The Risk Adjustment program calculates the average actuarial risk based on enrollees in nongrandfathered plans. Plans with lower than average risk must make payments and plans with higher than average risk receive payments. HHS determines which companies pay in and which companies receive payments.

The Reinsurance program is in place for years 2014 through 2016 and its purpose is to stabilize the individual insurance market. All insurers that offer fully insured and self-insured group and individual plans and third-party administrators must contribute based upon total market share.

HHS collects reinsurance fees from insurers and then makes payments out to insurers with nongrandfathered individual plans bearing the higher claims. $12 billion was collected in 2014 ($63 per enrollee per year), $8 billion ($44 per enrollee per year) is intended to be collected in 2015, and $5 billion ($27 per enrollee per year) in 2016.

Temporary Risk Corridors are in place for the years 2014, 2015 and 2016. The program applies only to ACA qualified health plans in the individual and small group markets. It requires insurers to calculate their risk corridor ratio comparing costs to premiums.

Depending on where the insurer's calculation lands, i.e., did it make money or lose money, it has to share its profits with HHS or potentially receive a payment from HHS to cover a portion of its losses.

Notably, two of the Three R's are ending in 2016 (Reinsurance and Risk Corridor). I will leave it to the companies on the insurer panel to suggest the impact for them and the market in general.

That concludes my testimony. I would be happy to answer any questions.

NAIC National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

September 8, 2015

The Honorable John Boehner
Speaker of the U.S. House of Representatives
H-232, The Capitol
Washington, D.C. 20515

The Honorable Nancy Pelosi
Democratic Leader
H-204, The Capitol
Washington, D.C. 20515

The Honorable Kevin McCarthy
Republican Leader
H-107, The Capitol
Washington, D.C. 20515

The Honorable Steny Hoyer
Democratic Whip
H-148, The Capitol
Washington, D.C. 20515

Dear Speaker Boehner, Leader Pelosi, Leader McCarthy and Whip Hoyer:

On behalf of the membership of the National Association of Insurance Commissioners[1] (NAIC), we write today in strong support of the Protecting Affordable Coverage for Employees Act (H.R. 1624/S. 1099), which would allow the states to continue defining the small group health insurance market as employers with 1-50 employees.

As you know, section 1304(b) of the Patient Protection and Affordable Care Act (ACA) changes the federal definition of the small group market to include employers with 1-100 employees. The states, however, have been allowed to continue defining the small group market as employers with 1-50 employees until January 1, 2016. Beginning on or after this date plans sold or renewed for employers with 51-100 employees will be subject to the various small group health plan regulations established by the ACA, such as essential health benefits, rating pools, actuarial value requirements, adjusted community rating rules, medical loss ratio requirements, and others.

The flexibility afforded to states with immediate passage of H.R. 1624 will help ensure stable small group health insurance markets that reflect the unique characteristics and dynamics at play in each of the states. Without it, a series of market disruptions could occur. Employers with 51-100 employees would face more restrictive rating rules, which could increase health insurance premiums. These employers would also face additional benefit and cost-sharing requirements, which would reduce benefit flexibility and could increase out-of-pocket spending. Furthermore, these regulations could lead some employers with 51-100 employees to self-insure to avoid higher premiums, which could result in adverse selection in the small group pool and higher premiums for employers with 1-50 employees.

The impact will vary by state, which is why defining the small group market should be left to the states, especially since the legislation does not prevent them from changing the definition to include all employers with 1-100 employees if they see fit.

[1] Founded in 1871, the NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and the five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

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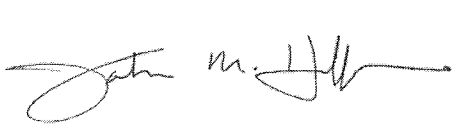
The U.S. Department of Health and Human Services has offered a transition option by publishing guidance that they will not enforce certain small group market regulations for existing health plans provided by employers with 51-100 employees if the plan is renewed on or before October 1, 2016, effectively staving off the new regulations until October 1, 2017. The NAIC surveyed the 50 states and the District of Columbia, and most responded that they will be utilizing this transition option. Nevertheless, we believe a more comprehensive fix provided by this legislation is necessary to preserve coverage options for existing and new purchasers and ensure stability for the future.

And, we encourage Congress to act quickly. Most mid-size employers shop for coverage annually to ensure the best price for themselves and their employees, but they need final rates and product information by late September in order to make these decisions and carry on with the preparing of employee communications and open enrollment materials and the actual conducting of open enrollment in advance of the effective date. Those employers who may be new entrants into the market in 2016 also need to know what options will be available to them. Quick action would avoid unnecessary confusion and disruption as we move into 2016.

For these reasons, the NAIC strongly supports immediate passage of H.R. 1624.

Sincerely,

Monica J. Lindeen
NAIC President
Commissioner
Montana Office of the Commissioner of Securities and Insurance, State Auditor



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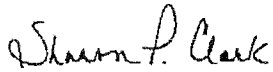

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