2011 HOUSE INDUSTRY, BUSINESS AND LABOR

HB 1126

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
January 17, 2011
12955

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution: Creation of a health insurance exchange.

Minutes:

Chairman Keiser: Opened the hearing on HB 1126.

Adam Hamm~North Dakota Insurance Commissioner: (see attached testimony). Discusses the fiscal note.

Representative N Johnson: You mentioned something about regional, is there a way for a group of states could pool resources to develop one kind of plan that work for all of them, is that possibility or any discussions along that line.

Adam Hamm: Under the law that is one possibility. Where the rubber meets the road, when you thing about the issues in building the exchange so it gets certified by the federal government, now you have taken all that complexity and you just multiplied it times other states to agree and their legislatures to bless that. I don't know any states that are thinking of moving down the road of doing that.

Representative Ruby: How different would a state exchange be from a federal exchange be when it's dictated from the federal government anyway.

Adam Hamm: In theory should be the same, the law would be the same. Where the rubber meets the road in 2014, will the state of North Dakota be better at running its own exchange.

Representative Ruby: Are all the insurance plans going to have to go through the exchange and how soon will be known?

Adam Hamm: I don't have that answer right now. Will there be allowed an outside market independent of the health insurance exchange for individuals and small businesses? The key issues there is adverse selection, we want to prevent folks from jumping back and forth between the exchange and outside the exchange if they can get some sort of advantage. Also, for small states like ours that don't have a huge population; this even becomes a bigger issue because for the federal government to be successful to attract a large numbers of companies to offer their products to a large numbers of consumers to come to the exchange and buy the products, it's built on the law of numbers. Larger state will have the advantage. For a state with a small population like ours, what will be the impact for the exchange if you also have an outside market? Can either one of them succeed? This is one of the number of issues we will have to wrestle with to decide which way is best for North Dakota. This will be an area where expert consultants will help.

Representative Ruby: If somebody is eligible for a plan but are eligible based on their income for Medicaid or SCHIP, are they forced into the Medicaid or SCHIP other than just being covered by their insurance plan?

Adam Hamm: The way it works, once the IT network is seamless and integrated and running in 2014, he goes to the exchange and starts answering all the background questions for him and his family. If the exchange determines that he doesn't need to be at the exchange insurance shopping for health insurance plan, he really needs to be in Medicaid, he now fits the new expanded role of Medicaid in the states. Remember it starts at 133% of federal poverty level. He's now eligible for Medicaid, it's just doesn't tell him that, it enrolls him, real-time enrollment.

Chairman Keiser: So the statement you can keep what you now have may not be true in the exchange?

Adam Hamm: I would concur with that statement.

Representative Amerman: On page 6, what does the commission do if the state runs the exchange? One of the bullets says, to consider whether to seek federal grant funds, in you deliberation to consider taking grant funds, why would you not take grant money.

Adam Hamm: We have already analyzed a number of grant opportunities and declined one. We applied for grants relative to the rate review issues and planning exchange, both of those were million dollar grants. We did not apply for what was dubbed a consumer assistance grant, when we analyzed it; it became apparent that it wasn't worth it. We will analyze every grant opportunity.

Representative Vigesaa: Explain how long does it take to set up the exchange and how that relates to the time lines that the federal government has given to us?

Adam Hamm: That's the 64,000 dollar question. It's going to take every day possible and this is a massive undertaking to make sure that it's done right, complies with the federal law and is ready to be operational by January 2014. There is belief that we should wait to see what happens with this law in congress over the course of the next year. If that what the legislative assemble decides to do, that will pose a challenge to the insurance department. What it would mean if we waited a year and didn't pass this bill with an emergency clause to let the department to start working, what you would be moving of these issues down the road about 8-9 months, you would be shortening that time frame to get things done. We have already started putting the list of everything that needs to be done in 2011, 2012 & 2013. What it would mean is that everything would be pushed. It would pose a very difficult challenge to get this done. My believe is that the federal government does not want to run the exchanges.My preference would be asap, there is a ton of work to be done.

Representative Vigesaa: You mentioned the shop program, the small business, is that the 50 employee cut off? What size business will use that program?

Adam Hamm: Yes, it's 50 over time and that definition can be expand in 2017 to 100 employees will be in the small group market and individuals.

Representative Vigesaa: How about larger groups, what will those people do to purchase their insurance?

Adam Hamm: The same currently, unless the exchange changes the definition.

Representative Vigesaa: To the individual, when they go to the web site and determine what they are going to pay, do they buy directly from the insurance company or run payment through the insurance department you handle?

Adam Hamm: Some of that is sorted out and some of it has not been completely hammered out, for now that subsidy has to be paid through the exchange to the insurance company.

Representative Vigesaa: The exchange becoming self funding, do you foresee being able to assess enough user fees to pay for the program or come to the legislative body each biennium asking for some assistance?

Adam Hamm: That depends how successful the exchange is. If the exchange is not successful, then there is the likely hood they will be coming to the legislative for funds to operate the exchange.

Chairman Keiser: Massachusetts is an extreme exchange and it currently has an operating budget from the state of 27 million a year.

Representative N Johnson: You testimony on the function for what the exchange would have to do, you talked about sending information to the treasurer and somebody ceases employment, can you explain more in dept what that means?

Adam Hamm: I would be happy to if there was further information, the testimony of the bottom of page 4, talks about transferring to the Secretary of the Treasure a whole host of answers, it going to put a substantial burden on the exchange to make sure these things are being done and certify to the federal government that they are happening. It's going to include having to get information that state agencies typically don't have to take, like Social Security numbers, and providing that information back and forth between the federal government, keeping track of employees. This is one of the areas where HHSS promulgating more rules and regulations as be build up to 2014.

Representative N Johnson: I heard at some point that if an employer is covering somebody and they chose to drop their insurance, then there is a penalty on the employer?

Adam Hamm: Explains how the employer mandate works. Yes there is a penalty. I will get you copies of that.

Representative N Johnson: You talked about the 3 running the exchange, the federal government, the state through some department and then the nonprofit. Has there been any talk from any nonprofit about picking this up?

Adam Hamm: We have heard from only one nonprofit that indicated some level of interest in the exchange and that was Dakota Medical Foundation.

Representative Nathe: You mentioned that there were discussions about delaying implantation of the exchange waiting to see how things play out in DC, you stated how fluid everything is here, if we decide to wait until special session, is there anything your department could do in the meantime?

Adam Hamm: Yes we can. We can use that million dollar grant that we are to receive from the federal government to bring consultants on board to start getting answers to some of these questions of what is the best way we can build this exchange. There are other grants that become available to help us plan for the exchange and the Legislature to avail ourselves of those funds.

Vice Chairman Kasper: Will the exchange be setting premiums for the products in the exchange or will you be approving premiums that the exchange companies suggest they need?

Adam Hamm: The insurance department would retain its authority over premiums.

Vice Chairman Kasper: Would you envision that each company's premiums would be the same?

Adam Hamm: No way to know, you would think some variance.

Vice Chairman Kasper: Provider side of this equation, will you be involved setting reimbursement rates between the providers and the exchange or is that something that they will continue to negotiate on their own and currently are doing?

Adam Hamm: We will not be part of that, just like we are not a part of that now.

Vice Chairman Kasper: No mandated reimbursement levels to the providers, it's going to be a negotiated situation as it currently is with the federal government if we have our state run exchange?

Adam Hamm: That's my understanding but everything that I say has the caveat of this could change.

Vice Chairman Kasper: You don't envision that the exchange will negotiate an on behalf of the insurance companies a reimbursement level that would be equal for all companies?

Adam Hamm: That's not my understanding of how it will work, no.

Representative Boe: The 3 entities that could run exchange, no one is going to be able to do this without a subsidy level? If the federal government takes this, would they expect us to send a bill for the subsidy level or will they do it at zero cost?

Adam Hamm: No, they will do it for nothing; it will not be a burden to the state of North Dakota.

Representative Boe: The deadline passes and they set up the exchange, the door is closed, would we have the opportunity to take it back?

Adam Hamm: Nobody knows the answer to that, that's not defined in the law.

Representative Frantsvog: Didn't turn on mic for recording.

Adam Hamm: I share the concerns you have whether or not the IT component can be done within this time frame. If will be a difficult issue to be resolved by 2014 because it's something that hasn't been done in North Dakota or anywhere in the country, the real time IT integrated network across all insurance plans and government assistance programs. That number we came up with, the 30 million number, there is no magic to that, is our best guess. If we have been given the authority by the emergency commission to start spending that planning grant, this was one of the first issues we were going to dig into. The other states also have to figure out how much this is going to cost. There is the possibility that states can share resources over the course of the next couple years to build this thing in a cheaper fashion. For the purpose of the Fiscal Note, we had to come up with a number.

Representative Amerman: Penalties for over 50 employees, where does the money go?

Adam Hamm: Federal Government.

Representative Nathe: Is there already a template out there already in the private sector?

Adam Hamm: If that exist, I'm not aware of any. My understanding there are no states who have this.

Representative Nathe: What the status other states getting close to meeting the deadline?

Adam Hamm: There are a few states that already have an exchange already, there are states that already worked this issue through their legislature and most states are working on it. To my knowledge, no state has said no that they are not going to do it.

Vice Chairman Kasper: Back to how the exchange, would operate in a small group market, 15 below with the current law, knowing that it might change. If an insurance company does not provide or enter into the exchange to offer an insurance product for an individual or group policy under 50, will they still be able sell that product outside the exchange or does every product must go through the exchange to be able to market in North Dakota.

Adam Hamm: That is one of the issues the department or whatever authority that is building the exchange, will wrestle with. That is the issue, will there be an outside market or will the exchange be the only one for the small and individual market. They decide which works best for North Dakota.

Vice Chairman Kasper: Under current law, you have the authority to choose whether there is an outside or it all goes through the exchange?

Adam Hamm: No, PPACA has not told us.

Vice Chairman Kasper: Will you be petitioning HHS to ask if you feel an outside market is in our best interest, how will that work?

Adam Hamm: My understanding that it's left silent, it's up to the states if you are going to build your own exchange as to whether or not you are going to have an outside market or not. You will not have to petition for it.

Representative Vigesaa: The IT spending, I assuming that it's just your department? I'm sure the Human Services is going to have to have an upgrade in their IT system.

Chairman Keiser: That is what the amendment is that Human Services is, we will wait until they come up. The question is does your 30 million dollars contained dollars to do what they need done or do they need the 15 million that they are requesting?

Adam Hamm: It's virtually impossible for me to answer that. I would like to hear what the Human Services is going to say to that question. I would hope that it's not tens of millions of dollars for each issue. I hope with one number, we can get this sorted so that it will be a seamless, integrated network. I hope the federal government makes good on what it said that the state will be given dollars to get the exchanges up and running, including this IT component. If that's the case its pretty much revenue neutral if the federal government goes dollar for dollar.

Representative Vigesaa: On page 7, you talked about the mile stone for next month, do you know what the miles stone and would the passage of this legislation be one those mile stones?

Adam Hamm: We have put together our own planning and implementation time line.

Representative Vigesaa: Those would be miles stones that would be looked at by the federal government as being in compliance with the plan and being able to apply for grants?

Adam Hamm: Yes, we already have gotten some guidance, that's very preliminary of the miles stones for each year, that will be flushed out by HHS as we move our way through, but from what we know now, that how we put the list together.

Chairman Keiser: In establishing the exchange, one of big questions is how much is available in the form of grants, do we have any idea?

Adam Hamm: No, that number you would not find.

Chairman Keiser: When we are scored, there are a set of assumptions that are sent with the bill, the assumptions are scored, so elements like, for the cost of the exchange were not included. They are identified in the bill and that they are necessary but they don't need to score them. Also, the number of new employees the IRS needs to hire to implement this bill, are not included in the scoring by CBO, only the assumptions attached to the bill.

Carol Olson~Executive Director of the Department of Human Services: (see attached testimony).

Representative Boe: Depending on who picked up the duties of implementing the exchange, how would that affect your department?

Carol Olson: No it would not. We need the eligibility to go along with the exchange where ever it's housed.

Chairman Keiser: Anyone here to testify in support of HB 1126, in opposition, neutral? Closes the hearing.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
February 1, 2011
13763

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Creation of a health insurance exchange.

Minutes:

Chairman Keiser: I did meet with the commissioner this morning and was not surprised with the amendments. He said I understands and is go along with it. The exchange at the hearing this morning, there is an additional amendments distributed, one by the insurance department and the appropriations committee handed out the formal copy for the amendment. We have a bunch of amendments to deal with. We have the amendment that I distributed this morning. Then we have the 2 appropriation amendments. If we adopt the amendment, which I distributed, the appropriations will come off the bill and no further actions will be required until the special session. However, we do need to discuss whether or not we the department should apply for and release the million dollar planning grant for designing the exchange plan and working on it. If we adopt my amendment we will have to further amendment to reinstate the 1 million dollar planning grant if that is the wishes of the committee.

Chairman Keiser: Committee, what are your wishes of HB 1126?

Representative Vigesaa: This morning they talked about the emergency commission and the budget section had put some funds on hold. Is that the money we are talking about?

Chairman Keiser: The 1 million dollar planning grant is what they were talking about.

Representative Vigesaa: Ok, so that has been already applied for and is waiting to be appropriated?

Chairman Keiser: I don't believe that is correct. They wanted to apply for it, they went to the emergency commission and said, should we apply for it and can we have the money. They put it on hold and said, wait for the legislative session.

Representative Amerman: It says that the commissioner shall submit proposed legislation to legislative management for consideration at a special legislative session; does

that mean the commissioner would go before legislative management and not the entire assembly or committee?

Chairman Keiser: No, I know the language sounds goofy, but it is the way it has to be. Once we adjourn legislation we are out of business until literally we come back into session. In order to be prepared for the special session because the special session will only last 5-7 days, to get it to that point, the strategy is that you submit it to the legislative management committee which represents the legislature when we are not in session and they would make the determination to submit it to the legislature. It's a technical thing but is a requirement.

Representative Clark: On the proposed amendment dated January 27, (inaudible) 2012?

Chairman Keiser: No, what this amendment does is it has two parts. You need to go back to the time table, everything that must to be address in 2012, must be brought forward to the special session in November, 2011. Everything that occurs in 2013 and 2014 has to come in the 2013 session. What this is doing is you bring it forward to legislative management by October 15, which is the deadline for submitting to the interim committee reports and things like that. Legislation would be developed and brought forward to the appropriate process. Then it would become committee bills to legislature on behalf of the insurance program.

Representative Ruby: Moves the amendment 11.8110.01002.

Representative Nathe: Second.

Voice vote, motion carries.

Chairman Keiser: Motion carries; the amendment is on the bill. Do you want another amendment to give the insurance department the authority to apply for and receive the 1 million dollar planning grant?

Representative N Johnson: Moves the amendment.

Representative Frantsvog: Second.

Chairman Keiser: Further questions?

Representative Vigesaa: I know there was some concern that if we applied for that grant, is it going to marry us to the federal government, but I think we are already shortening the commission's time line by almost a year. We need to allow them to have funds to work towards this goal, this is appropriate to give him some time.

Chairman Keiser: Further discussion?

Chairman Keiser: Members, if you don't give him the million from the federal grant, then we have to go to the general fund.

Representative Boe: Is the million dollars all that he needs or will he need additional funds?

Chairman Keiser: I don't know that nor does the insurance commissioner know.

Representative Amerman: Will you state again how your amendment takes away the appropriation, will it take away the same for Health and Human Services.

Chairman Keiser: Yes but we haven't adopted the Health and Human Service amendment.

Voice vote, motion carries.

Chairman Keiser: Further discussion?

Representative N Johnson: I'm looking for the Department of Human Service's amendment and in section 5, to collaborate with the Department of Human Services, without the money part, should that probably be in the bill?

Chairman Keiser: They should collaborate. Further discussion? We have amendment on HB 1126, what are the wishes of the committee?

Representative Vigesaa: When the money is put on there, should it be re-referred to appropriations?

Chairman Keiser: I think so.

Representative Vigesaa: Moves a Do Pass as Amended and re-refer HB 1126 to appropriations.

Representative Sukut: Second.

Chairman Keiser: Further discussion?

Representative N Johnson: I know we are going to end up with the 2 agencies being concerned because there is no fiscal note. If they are concerned they are going to have to address it on the Senate side. I'm sure we see this back in conference committee.

Roll call was taken for a Do Pass as Amended with a re-refer to appropriations on HB 1126 with 12 yeas, 0 nays, 2 absent.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
Feb 2, 2011
13895

☐ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Creation of a health insurance exchange.

Work Committee Session Minutes:

Chairman Keiser: Opens the work session on HB 1126.

Chairman Keiser: We could bring it back and to have the committee reconsider its actions by which we amended and passed the bill so we can deliberate further on that bill.

Representative Ruby: Motions to reconsider our action.

Representative Nathe: Second.

Chairman Keiser: This is my mistake. I started thinking on this bill and wondering whether or not by putting in the amendments yesterday, we accomplished with HB 1126 what the committee's intent. We put in there the amendment that said that the commissioner must come back to the 2 sessions but we left in the appropriation. It was confusing, it said that we were appropriating all the dollars and limited it to just the million dollars. We also, if you look at page 1, line 10 and the bill read, plan and implement. I knew there was something wrong with that. We don't want them to implement, we want them to plan. John, could you walk us through the amendment?

John Bjornson~WSI for Legislative Council: Goes over the amendment 11.8110.01002, (see attached amendment).

Chairman Keiser: We have this amendment before us, what are the wishes of the committee?

Vice Chairman Kasper: Move to adopt amendment 11.8110.01002.

Representative Ruby: Second.

Chairman Keiser: Further discussion?

Voice vote, motion carried.

Representative Ruby: Moves a Do Pass as Amended.

Representative Frantsvog: Second.

Roll call was taken for a Do Pass as Amended on HB 1126 with 14 yeas, 0 nays, 0 absent and Representative Vigesaa is the carrier.

FISCAL NOTE

Requested by Legislative Council
03/24/2011

Amendment to: Engrossed HB 1126

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$1,000,000		
Expenditures				$1,000,000		
Appropriations				$1,000,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The amended bill is to plan for the implementation of a health insurance exchange that meets the requirements of the federal health care law and any future regulations.

Amendment 11.8110.02001 adds the Department of Human Services to the planning process and creates an advisory committee.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of the amended bill authorizes planning for the implementation of the health insurance exchange.

Section 2 of the amended bill provides an appropriation of $1,000,000 out of federal funds to the Insurance Department for the purpose of planning for implementation of an American health benefit exchange for the state.

Amendment 11.8110.02001 has no additional fiscal impact to the Insurance Department.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The amended bill will allow the Insurance Department to access $1 million of federal funding that has been made available to plan for the implementation the health insurance exchange.

Amendment 11.8110.02001 has no additional fiscal impact on revenues to the Insurance Department.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The amended bill increases expenditures by authorizing the Insurance Department. Insurance Department expenditures will primarily be for contracting with experts and consultants to plan for the implementation of the health

insurance exchange.

Amendment 11.8110.02001 has no additional fiscal impact on expenditures to the Insurance Department.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The amended bill increases appropriations for the Insurance Department by $1 million dollars in federal funding.

Amendment 11.8110.02001 has no additional fiscal impact on appropriations to the Insurance Department.

Name:	Larry Martin	**Agency:**	Insurance Department
Phone Number:	701-328-2930	**Date Prepared:**	03/28/2011

FISCAL NOTE

Requested by Legislative Council
02/10/2011

Amendment to: HB 1126

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues				$1,000,000		
Expenditures				$1,000,000		
Appropriations				$1,000,000		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

The amended bill is to plan for the implementation of a health insurance exchange that meets the requirements of the federal health care law and any future regulations.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of the amended bill authorizes planning for the implementation of the health insurance exchange.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

The amended bill will allow the Department to access $1 million of federal funding that has been made available to plan for the implementation the health insurance exchange.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The amended bill increases expenditures by authorizing the Department to begin the planning process. Expenditures will primarily be for contracting with experts and consultants to plan for the implementation of the health insurance exchange.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The amended bill increases appropriations by $1 million dollars in federal funding.

Name:	Larry Martin	**Agency:**	Insurance Department
Phone Number:	701-328-2930	**Date Prepared:**	02/11/2011

FISCAL NOTE

Requested by Legislative Council
12/27/2010

Bill/Resolution No.: HB 1126

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2009-2011 Biennium		2011-2013 Biennium		2013-2015 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues		$1,000,000		$32,000,000		
Expenditures		$1,000,000		$32,764,517		
Appropriations		$1,000,000		$32,764,517		

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2009-2011 Biennium			2011-2013 Biennium			2013-2015 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill is to plan and implement a health insurance exchange that meets the requirements of the federal health care law and any future regulations.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Section 1 of the bill authorizes the planning and implementation of the health insurance exchange and authorizes the Department, with Emergency Commission and Budget Section approval, to seek federal funding for this purpose.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

This bill will allow the Department to seek Emergency Commission and Budget Section approval to receive additional federal funding that has been made available to plan and implement the health insurance exchange.

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

The bill increases expenditures for the 2009-2011 biennium by authorizing the Department to begin the planning process by contracting with experts in the health insurance industry to plan the structure of the exchange. In the 2011-2013 biennium 4 new FTEs will be hired to develop the health insurance exchange. The fiscal impact in the 2011-2013 biennium includes salaries and fringe ($602,697), operating ($2,161,820) and IT development ($30,000,000) costs.

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

The Department is requesting an appropriation of $1 million in the 2009-2011 biennium to access a federal planning grant to begin planning the health insurance exchange. The appropriation request of $32,764,517 for the 2011-2013 biennium is to allow the Department to begin hiring FTEs and to develop the IT infrastructure needed to implement the health insurance exchange by the deadline established by the 2010 federal legislation.

Funding for costs not paid for by federal funds will come from the Insurance Regulatory Trust Fund as fund levels permit.

Name:	Larry Martin	**Agency:**	Insurance Department
Phone Number:	328-2930	**Date Prepared:**	01/14/2011

Date: Feb 1 - 2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep Ruby Seconded By Rep Nathe

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

voice vote - motion carried

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: Feb 1, 2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep N Johnson Seconded By Rep Frantsvog

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby		X			
Representative Sukut					
Representative Vigesaa					

voice vote - motion

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

use of the 1 millon dollar grant

Date: Feb 1

Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Rep Vigesaa Seconded By Rep Sukut

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper	✓		Representative Boe	✓	
Representative Clark	✓		Representative Gruchalla	✓	
Representative Frantsvog	✓		Representative M Nelson	~~✓~~	AB
Representative N Johnson	✓				
Representative Kreun	✓				
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 12 No 0

Absent 2

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Rereffered - to app

Date: Feb 2, 2011

Roll Call Vote # 1

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

Motion Made By Rep Ruby Seconded By Rep Nathe

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

withdraw the Do Pass as Amended motion.

11.8110.01002
Title.

Prepared by the Legislative Council staff for
Representative Keiser
February 1, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126

Page 1, line 2, after the second semicolon insert "to provide for application;"

Page 1, line 10, replace "and implement" with "for the implementation of"

Page 1, line 17, replace "establish" with "consider establishing"

Page 1, line 19, replace "Take" with "Subject to section 3 of this Act, take"

Page 1, line 22, replace "Consider" with "Subject to section 3 of this Act, consider"

Page 2, line 1, replace "Contract" with "Subject to section 3 of this Act, contract"

Page 2, line 15, remove "**- ADDITIONAL FUNDING**"

Page 2, line 16, remove "**APPROVAL**"

Page 2, line 16, remove "The commissioner may seek emergency commission and budget section approval"

Page 2, line 17, replace "for authority to spend any general funds, special funds, or" with "There is appropriated the sum of $1,000,000, or so much of the sum as may be necessary, out of"

Page 2, line 19, after "[Pub. L. 111-152]" insert "to the insurance commissioner for the purpose of planning for implementation of an American health benefit exchange for the state"

Page 2, after line 20, insert:

"**SECTION 3. APPLICATION.** In carrying out the requirements of this Act, the insurance commissioner shall provide regular updates to the legislative management during the 2011-12 interim. In determining, planning, and implementing an American health benefit exchange for the state, the commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the commissioner is required by federal law to take any action by January 1, 2013. For any plan, program, or requirement that must be implemented between January 1, 2013, and January 1, 2014, the commissioner shall submit proposed legislation to the legislative management before October 15, 2012."

Renumber accordingly

Date: Feb 2, 2011

Roll Call Vote # 2

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8110.01002

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

Motion Made By Rep Kasper Seconded By Rep Ruby

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser			Representative Amerman		
Vice Chairman Kasper			Representative Boe		
Representative Clark			Representative Gruchalla		
Representative Frantsvog			Representative M Nelson		
Representative N Johnson					
Representative Kreun					
Representative Nathe					
Representative Ruby					
Representative Sukut					
Representative Vigesaa					

voice vote, motion carries

Total Yes _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: Feb 2, 2011

Roll Call Vote # 3

2011 HOUSE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

House **House Industry, Business and Labor** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken: ☒ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

Motion Made By Rep Ruby Seconded By Rep Frantsvog

Representatives	Yes	No	Representatives	Yes	No
Chairman Keiser	✓		Representative Amerman	✓	
Vice Chairman Kasper	✓		Representative Boe	✓	
Representative Clark	✓		Representative Gruchalla	✓	
Representative Frantsvog	✓		Representative M Nelson	✓	
Representative N Johnson	✓				
Representative Kreun	✓				
Representative Nathe	✓				
Representative Ruby	✓				
Representative Sukut	✓				
Representative Vigesaa	✓				

Total Yes 14 No 0

Absent 0

Floor Assignment Rep Vigesaa

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1126: Industry, Business and Labor Committee (Rep. Keiser, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1126 was placed on the Sixth order on the calendar.

Page 1, line 2, after the second semicolon insert "to provide for application;"

Page 1, line 10, replace "and implement" with "for the implementation of"

Page 1, line 17, replace "establish" with "consider establishing"

Page 1, line 19, replace "Take" with "Subject to section 3 of this Act, take"

Page 1, line 22, replace "Consider" with "Subject to section 3 of this Act, consider"

Page 2, line 1, replace "Contract" with "Subject to section 3 of this Act, contract"

Page 2, line 15, remove "**- ADDITIONAL FUNDING**"

Page 2, line 16, remove "**APPROVAL**"

Page 2, line 16, remove "The commissioner may seek emergency commission and budget section approval"

Page 2, line 17, replace "for authority to spend any general funds, special funds, or" with "There is appropriated the sum of $1,000,000, or so much of the sum as may be necessary, out of"

Page 2, line 19, after "[Pub. L. 111-152]" insert "to the insurance commissioner for the purpose of planning for implementation of an American health benefit exchange for the state,"

Page 2, after line 20, insert:

"**SECTION 3. APPLICATION.** In carrying out the requirements of this Act, the insurance commissioner shall provide regular updates to the legislative management during the 2011-12 interim. In determining, planning, and implementing an American health benefit exchange for the state, the commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the commissioner is required by federal law to take any action by January 1, 2013. For any plan, program, or requirement that must be implemented between January 1, 2013, and January 1, 2014, the commissioner shall submit proposed legislation to the legislative management before October 15, 2012."

Renumber accordingly

2011 SENATE HUMAN SERVICES

HB 1126

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1126
3-15-2011
Job Number 15547

☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Relating to the creation of a health insurance exchange

Minutes: Attachments

Senator Judy Lee opened the hearing on Engrossed HB 1126.

Rep. George Keiser (District 47) introduced the bill. This is the bill that addresses the insurance exchange which the federal legislation requires the states to develop. The critical date for approval of the health exchange program for each state is January 1, 2013. That is in the legislation. ND has the obligation of addressing or positioning the state of ND for implementation of the Federal Health Care Reform Act.
This short bill contains the information the House developed for the exchange. It also has an appropriation for application and declares an emergency.
There is available to all states a $1million grant for the planning/preparation for implementation of the exchange program in the states. Some in the House felt that by accepting this grant it might obligate the state in some form. He stressed that there are no strings attached if we accept this grant in terms of future implications for the state of ND relative to the implementation of a plan within our state. It does provide money for the Insurance Dept. to support the planning and development of an exchange program.
The major portion of this bill is on line 25-30 on page 2 and on to the next page.
It is the consensus of the House that we not overreach in terms of implementation of the state's response to the federal health care legislation.
There are a lot of rules being promulgated and a lot of reactions to the rules. Already three states have requested an exclusion from the minimum loss ration standards that were developed in the federal legislation. The state of ND will have to make a decision if it is going to go for exclusion. We are in a state of flux/transition relative to the promulgation of rules. He read the application of the bill - Section 3 on page 2 – and said that with that language they have brought the legislature back in to the policy position on the implementation of the Federal Health Care Reform Act relative to the state of North Dakota.

Senator Dick Dever asked if there was a need for FTE's for this planning part of the process.

Rep. Keiser thought the FTE's were in the insurance budget for the implementation of the health care act.

Senator Tim Mathern wondered what Rep. Keiser's thought would be to broaden the updates of the insurance commissioner to include all legislators in Section 3 page 2 line 26.

Rep. Keiser said it was his personal opinion that you have to use the process we have which is the interim hearing process. It works. A new precedent was set last interim. It was the first time in the history of North Dakota that interim committee hearings were live on the internet.

Senator Judy Lee said she was a part of those meetings and supports doing it.
There are examples already in other states and wondered what kind of discussions his committee had about learning from those experiences and if they felt there was anything to gain from looking at those models.

Rep. Keiser addressed the two existing models – Utah and Massachusetts. They are very far apart. The Massachusetts model is the ultimate Cadillac is showing signs of wear and tear if not failure. The Utah model at the other end of the extreme basically has a webpage. The one feature of the Utah plan that is phenomenal is that premiums can be taken from more than one source and he gave an example.

Senator Tim Mathern said one of his concerns was the number of lives covered and the need to make the plan work and the overhead costs per person that we can afford. He wondered if this bill would permit the commissioner to be in discussions with neighboring states and come back recommendations.

Rep. Keiser answered yes.

Senator Judy Lee was seeing that there are updates to Legislative Management in the application section. Aside from the fact that it ends up going to a special session she was not seeing that the receiving committee is given the authority to really make any changes. She was concerned about the authority all being rested in one person or department.
There doesn't seem to be a kind of checks and balances deal in the application section.

Rep. Keiser replied that they tried to structure that section so they have the authority through legislation to make the final determination.

Adam Hamm (ND Insurance Commissioner) testified in support of Engrossed HB 1126.
Attachment #1
He also explained that there were a couple of fiscal notes that flowed from this bill. The first had a fiscal note of over $32 million and after the bill became engrossed the second fiscal note was down to $1 million. The House decided that basically the final decision as to whether ND is going to build an exchange and who will build it will be left to the special session. Under engrossed HB 1126 the department will continue to analyze the issue, gather as much information as they can, advise the interim legislature leading up to the special session, and bring forth additional legislation for the special session to make the final call.

If the department is going to build this exchange, their analysis concluded that to build it, get the stamp of approval from HHS, it would take four FTE's. To run it on a day to day basis beginning in 2014 would take an additional four FTE's.
There are also FTE's that are needed separate and apart from the exchange. Those are related to HB 1125 and SB 2010.

Senator Tim Mathern referred to page 2 of the testimony. It seemed to him that the three questions posed should be answered by the bill. He wondered if they should be more specific in the bill to give more direction.

Commissioner Hamm replied that he would prefer that the legislature left this session saying "here is exactly what the answers are to those questions". But he understands why the House was reluctant to do that.

Senator Tim Mathern voiced his concern that the more they delay the more the answer becomes that the federal government is going to run it.

Commissioner Hamm said his understanding was that the special session would be later this year. If the special session is at the end of 2012 that means the federal government is running the exchange in North Dakota. The theory behind the law is not for the federal government to run these exchanges.

Senator Dick Dever referred to the deadline of Jan. 1, 2015 for the exchange to be self funded and wondered how that happens. Another question he had was whether the federal exchange was somewhere in its development so we have some idea of what that looks like.

Commissioner Hamm responded that to his knowledge the federal government has not started to build an exchange in the event states don't do it. The most likely way for an exchange to pay for itself is assessments on insurance companies.

Senator Judy Lee asked if he sees a lot of the authority of the insurance departments diluted by the fact that companies will be going across state lines.

Commissioner Hamm said no. They have looked at that issue in depth. Insurance companies will still have to be licensed state to state. If the federal government ran the exchange in ND they would be making those decisions on certifying, recertifying, decertifying plans. But the rates those companies would be able to charge would still have to go through the Insurance Department.

Senator Judy Lee asked if he had any regional conversations with adjoining states.

Commissioner Hamm said they have had preliminary discussions – kind of brainstorming.

Senator Spencer Berry asked what his thought was about the chance of an expedited decision coming from the Supreme Court.

Commissioner Hamm replied that if there is a special session this fall, it would be before the US Supreme Court makes a final decision. The only expedited review going on right now was just granted in the Florida lawsuit.

Senator Spencer Berry asked what he thought about a chance of extending the deadline of January 1, 2013 for the decision and January 1, 2014 for implementation.

Commissioner Hamm replied that would require a change in the law. He hadn't heard of it being discussed at this point.

Senator Spencer Berry assumed that if the federal government implements and handles the health care exchange in the state they would then bill the state. He wondered if there would be a penalty.

Commissioner Hamm said it was his understanding that if the federal government runs the exchange in the state North Dakota would not have the cost for it. The federal government would build it and then they would have to make it self-sustaining.
The theory is that in 2014 there will be substantially more insurance companies competing for all of our business.

Carol Olson (Dept. of Human Services) provided neutral testimony. Attachment #2
She pointed out that if there is an insurance exchange there has to be an eligibility system also. There can't be one without the other. The eligibility systems would require modification.

Senator Dick Dever asked how much time to do this because the bill involves planning and this is part of implementation.

Ms. Olson replied that it takes 44 months. She informed the committee that she has been in communication with both the Senate subcommittee on appropriations and the House subcommittee on appropriations as to the situation. She felt that if this goes to conference committee they would get a little planning money.

Senator Tim Mathern asked if any of the planning monies or systems were funded in the Governor's budget.

Ms. Olson said it was not in the Governor's budget. It was not in the Human Services budget and she explained timeframes and deadlines and challenges they faced.

Lisa Feldner (Information Technology Department) provided neutral testimony. Attachment #3

Senator Tim Mathern suggested the possibility of working together on common areas with counterparts in adjoining states recognizing that there are individual issues. Could it save time and money?

Ms. Feldner thought that was a good idea. In the national association of CIO's that is one of the things she has been working with. They are doing as much research as they can.

Senator Judy Lee asked Carol Olson if there is going to be any kind of latitude for Medicaid and CHIP or is it all going to be the same in every state.

Ms. Olson responded that there are standardizations of the interfaces that they can use but after that they are state specific.

Senator Dick Dever stated that insurance companies are going to have to make investments in IT, too, to access. They are going to do business in multiple states. Will there be universality in the ability to do that?

Ms. Feldner said that the federal government let out innovation grants and there were six states awarded those grants. That's for states to bring up these exchanges in cooperation with, in certain states, insurance companies. One of the other things they are supposed to be doing is coming up with technology standards so these systems can exchange information.

Senator Judy Lee asked if there is any way this can be started without any funding in the beginning.

Ms. Olson responded that what they are working on with the two appropriation sub committees right now is some start up planning money which is minimal.

There was no further testimony.

The hearing on HB 1126 was closed.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1126
3-21-2011
Job Number 15768

☐ Conference Committee

Committee Clerk Signature PMorson

Explanation or reason for introduction of bill/resolution:

Minutes:

Senator Judy Lee opened committee discussion on HB 1126.

There was review and discussion on the testimony from Carol Olson, Dept. of Human Services, and Lisa Feldner, ITD.

Senator Tim Mathern stated that he was concerned that the Dept. of Human Services is basically being set up to fail.
Even if health care reform went by the wayside the state would still want to create a method of applying for assistance online and some eligibility process. The state would be doing it right now if it wasn't for MMIS being delayed. It's not part of this bill. It's assuming everything is done in the Dept. of Insurance and it isn't.
The most part of funding for the Dept. of Human Services is health care – 62%.

Senator Judy Lee suggested having Carol Olson and Lisa Feldner return to the committee to discuss this further. She remembered them both saying that the Dept. of Human Services part of this needs to come first. She thought the Insurance Dept. is only looking at what the insurance part is and not talking to those in the Human Services part of the whole thing.

Senator Tim Mathern stated that the original bill is the Insurance Commissioners request. The bill before the committee is the House's request. He thought the bill, as introduced, was clear on what the Insurance Commissioner wanted.

Senator Gerald Uglem pointed out the fiscal note numbers.

There was discussion on the fiscal numbers and the need to recognize that the exchange won't work if the eligibility part isn't in there.

The committee adjourned until such time as Ms. Olson and Ms. Feldner could answer questions for the committee.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Human Services Committee
Red River Room, State Capitol

HB 1126
3-22-2011
Job Number 15849

☐ Conference Committee

Committee Clerk Signature Pennelson

Explanation or reason for introduction of bill/resolution:

Minutes: Attachments

Senator Judy Lee reopened committee discussion on HB 1126. It was her understanding that the eligibility portion needs to be done before going into the exchange.

Carol Olson (Dept. of Human Services) explained that in order to have a working insurance exchange there has to be an eligibility system as well. It all has to operate in real time. The current eligibility system in the ND Dept. of Human Services is on mainframe and the system for the future has to be web based so it can be real time.
She addressed the funding for the implementation of a new system - 90% federal 10% state. Maintenance would be 75/25.

Senator Judy Lee asked what needs to be done to move this forward. She pointed out that they need to acknowledge the fact that there's going to be that kind of money required.

Ms. Olson replied that she had been told by Rep. Keiser that this part of the health care reform will be brought up and decided upon in the special session. It is her understanding that there doesn't have to be any language in bill 1126 that indicates there would be an additional appropriation needed in a special session to cover that.
The department is still concerned with no preplanning for the system. She has spoken to members of Senate Appropriations about the possibility of getting some language into SB 2012 (the Dept's. appropriation bill) so it would allow the Dept. of Human Services to start a minimum of some planning.
They would work with ITD who would be the entity that would be developing the new eligibility system for the state.

Senator Spencer Berry wanted clarification on the 90/10 funding for the implementation of the new system.

Ms. Olson explained that some programs are not a true 90/10. She also pointed out that the county that does eligibility is working off five systems. Portions of the eligibility system

are about 40 years old and there have been many discussions with the legislature about the replacement of the current system.

Senator Tim Mathern asked (1) if the $1million (flat amount going to every state) should include money for the Dept. of Human Services versus just the Insurance Commissioner and (2) if they were talking of the possibility of almost eliminating most county eligibility work if the system gets up and running.

Ms. Olson wasn't sure how to answer the first question. She deferred to Jenny Withum from the IT department in Human Services.

Jenny Withum responded that the Commissioner would be looking at the architecture of the exchange. A component of that would be how they would interface with the Medicaid system but what the Dept. of Human Services is asking for would be to specifically look at how they would have to change their internal system to interact with the exchange.
She did not believe the Commissioner's funding would cover that portion of it.

More discussion followed on the 90/10 breakdown. About 60% of the rules or coding that would be needed for the eligibility system is Medicaid and CHIP. All that the exchange needs is Medicaid and CHIP to interact with it.

Ms. Withum talked about the Medicaid eligibility determination and that right now it actually exists in two separate applications - Vision and TECS.

Ms. Olson, in answer to Sen. Mathern's second question earlier, said yes they do still need the counties to interface with the clients.

Senator Tim Mathern asked if the dept. can really accomplish what they would be expected to accomplish if they aren't authorized to proceed until the special session

Discussion followed – there is so much speculation especially in Congress as to the direction the nation is going to take as a whole on health care reform. There is a need to proceed with this eligibility system regardless of health care reform. The current system is a big inconvenience and very time consuming.

Senator Dick Dever wanted to know where other states were in this process and whether it is likely the deadline will be shifted.

Ms. Withum reported on some other states and how far they are in this process.

Senator Judy Lee asked for clarification that the Dakota Medical Foundation gave money so Medicaid and CHIP eligibility could be moved together in Vision.

Ms. Withum confirmed that.

Senator Judy Lee recognized that they had the advisory committee to discuss as an amendment and asked if there was anything else that needed to be changed in 1126.

Ms. Olson said just the advisory committee.

Lisa Feldner (IT) felt the bill was ok with some kind of an advisory committee.

Senator Judy Lee asked if there was anything else she wanted to bring to the attention of the committee.

Ms. Feldner answered that the exchange portion of this is a big deal. If the feds are willing to stand it up and turn it over to us she thought that would be ITD's position – that would be the best alternative assuming they turned the technology over once they finished building it.

Senator Tim Mathern announced that he had amendments coming for 1126 and outlined them. They would do the advisory committee and also give the Dept. of Human Services the same ability to plan as what is given to the Insurance Commissioner.
He asked if it would make things work better if they were given that authority to plan for what needs to be done.

Ms. Feldner answered that the fact they are able to plan would be very beneficial.

Senator Tim Mathern said the amendments are intended to address this question and asked that they be considered when they are ready.

Senator Dick Dever asked how much time is required to put out RFP's and secure the federal dollars once the decision is made to go ahead.

Ms. Feldner responded by saying that (1) with the eligibility system and if ITD is building it an RFP is not needed (2) on the insurance exchange it depends on who is building it, who is the entity in charge, etc. They don't have answers to those things until they get more guidance from the federal government.
As far as the deadline, she didn't see how any state is going to make the deadlines other than Massachusetts.

Senator Judy Lee recessed discussion until later in the day.

Senator Judy Lee brought the committee back to order and asked the committee to look at the amendment that discusses having the advisory committee. Attachment #4.

Senator Tim Mathern thought it was a good idea. He also asked legislative council to draft it in their style in the amendment he was bringing.

Updating the system was discussed. Would they put together a system that expensive if they didn't have to meet federal guidelines? Could they do it for less and get it updated?
Another aspect is the web application. When it comes to health care staff will still be needed but to what extent.
The challenge is that there are different levels of eligibility for everything. Part of that will be resolved if PPACA moves forward.

Amendments .02001 were presented for discussion by **Senator Tim Mathern.** He walked through and explained them for the committee. Attachment #5
They recognize that both the Insurance Dept. and the Dept. of Human Services need the ability to plan and come up with recommendations to the special session of the legislature.
This describes what of the federal law must be addressed in this exchange.
The advisory committee was a new section.

Rod St. Aubyn (BC/BS) had no concerns with the amendments as drafted. He understood that the original intent was that the Commissioner was going to develop this exchange and would be working with the interim committee. There is more than just the IT part of this – how the exchange is going to work. There will be a lot of things intertwined with this.
There is a need for legislative involvement and the advisory committee to ensure conversation from all parties.

Senator Tim Mathern clarified that when he had legislative council draft this amendment he said he didn't want to diminish or change any reporting to the legislature or involvement of the legislature. There was no change in Section 3. The goal was to make sure that whatever is brought to the special session of the legislature reflects the broader concerns and not just the Commissioner's concerns.

Senator Judy Lee referred to page 2 lines 6-11 the rule section. She wanted to know if that was just the Insurance Commissioner's chapter when they are talking about rule that the Insurance Commissioner can adopt. She also wanted to know if there was a need to state in a different way that state agencies shall cooperate with the commissioner because the Dept. of Human Services is an equal player in this.

Senator Tim Mathern responded that this gives the Dept. of Human Services the same kind of latitude within their dept. as it gives the Commissioner.

Senator Judy Lee asked those in the room from the Dept. of Human Services if they were ok with the amendments. They indicated they were.

Some discussion followed on comparisons between HB 1126 and HB 1252.

Committee work was reconvened after a recess.

Senator Judy Lee reported that she had visited with the Insurance Commissioner and he was comfortable with the amendments.

Senator Tim Mathern moved to **adopt the amendments .02001.**

Seconded by **Senator Gerald Uglem**. Roll call vote 5-0-0. **Amendments adopted**.

Senator Tim Mathern moved a **Do Pass as Amended and rerefer to Appropriations**.

Seconded by **Senator Gerald Uglem**. Roll call vote 5-0-0. **Motion carried.**

Carrier is **Senator Tim Mathern.**

11.8110.02001
Title.03000

Prepared by the Legislative Council staff for
Senator Mathern
March 22, 2011

3-23-11
1 of 2

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

Page 1, line 2, after the first semicolon insert "to provide reports to the legislative management;"

Page 1, line 9, after "commissioner" insert "and department of human services, in consultation with the advisory committee established under section 26.1-54-05,"

Page 1, line 19, after "2." insert "Plan for the implementation of an American health benefit exchange for the state which at a minimum provides for eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program; simplification; and medical assistance and children's health insurance program coordination with the state health insurance exchange in a manner that meets the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

3."

Page 2, line 1, replace "3." with "4."

Page 2, line 4, replace "4." with "5."

Page 2, line 7, after "commissioner" insert "and department of human services"

Page 2, line 10, after "commissioner" insert "and department of human services"

Page 2, line 13, after "the" insert "department of human services and"

Page 2, line 16, after the second "the" insert "department of human services,"

Page 2, line 16, after "commissioner" insert an underscored comma

Page 2, after line 17, insert:

"**26.1-54-05. Advisory committee.**

An advisory committee is established to assist the commissioner and the department of human services in addressing the complexity and interdependence of the technology systems required by the health benefit exchange. The advisory committee membership is made up of the commissioner or the commissioner's designee, the executive director of the department of human services or the director's designee, the chief information officer or the chief information officer's designee, the governor or the governor's designee, and two members of the legislative assembly appointed by the chairman of the legislative management."

Page 2, line 26, after "commissioner" insert ", department of human services, and advisory committee"

Page 2, line 28, after "commissioner" insert "and department of human services"

Page 2, line 29, after "commissioner" insert "or department of human services"

Page 3, line 1, after "commissioner" insert "or department of human services"

Renumber accordingly

2 of 2

Date: 3-22-2011

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 02001

Action Taken: ☐ Do Pass ☐ Do Not Pass ☐ Amended ☒ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen. Mathern Seconded By Sen. Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 3-22-2011

Roll Call Vote # 2

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 11.8110.02001 Title 03000

Action Taken: ☑ Do Pass ☐ Do Not Pass ☒ Amended ☐ Adopt Amendment

☒ Rerefer to Appropriations ☐ Reconsider

Motion Made By Sen. Mathern Seconded By Sen. Uglem

Senators	Yes	No	Senators	Yes	No
Sen. Judy Lee, Chairman	✓		Sen. Tim Mathern	✓	
Sen. Dick Dever	✓				
Sen. Gerald Uglem, V. Chair	✓				
Sen. Spencer Berry	✓				

Total (Yes) 5 No 0

Absent 0

Floor Assignment Sen. Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1126, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1126 was placed on the Sixth order on the calendar.

Page 1, line 2, after the first semicolon insert "to provide reports to the legislative management;"

Page 1, line 9, after "commissioner" insert "and department of human services, in consultation with the advisory committee established under section 26.1-54-05,"

Page 1, line 19, after "2." insert "Plan for the implementation of an American health benefit exchange for the state which at a minimum provides for eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program; simplification; and medical assistance and children's health insurance program coordination with the state health insurance exchange in a manner that meets the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

3."

Page 2, line 1, replace "3." with "4."

Page 2, line 4, replace "4." with "5."

Page 2, line 7, after "commissioner" insert "and department of human services"

Page 2, line 10, after "commissioner" insert "and department of human services"

Page 2, line 13, after "the" insert "department of human services and"

Page 2, line 16, after the second "the" insert "department of human services,"

Page 2, line 16, after "commissioner" insert an underscored comma

Page 2, after line 17, insert:

"**26.1-54-05. Advisory committee.**

An advisory committee is established to assist the commissioner and the department of human services in addressing the complexity and interdependence of the technology systems required by the health benefit exchange. The advisory committee membership is made up of the commissioner or the commissioner's designee, the executive director of the department of human services or the director's designee, the chief information officer or the chief information officer's designee, the governor or the governor's designee, and two members of the legislative assembly appointed by the chairman of the legislative management."

Page 2, line 26, after "commissioner" insert ", department of human services, and advisory committee"

Page 2, line 28, after "commissioner" insert "and department of human services"

Page 2, line 29, after "commissioner" insert "or department of human services"

Page 3, line 1, after "commissioner" insert "or department of human services"

Renumber accordingly

TESTIMONY BEFORE JOINT HEARING OF
HOUSE APPROPRIATIONS & INDUSTRY, BUSINESS, & LABOR
HOUSE BILL 1126
FEBRUARY 1, 2011

Good morning, my name is Lisa Feldner and I serve as the Chief Information Officer for the Information Technology Department. On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) became law requiring, among other things, that states establish a system of health benefit Exchanges. PPACA includes provisions to make it easy for individuals to enroll in coverage by requiring states to create a coordinated, simple, and technology-supported process through which individuals may obtain coverage through Medicaid, CHIP, and the new Exchanges.

In my testimony today, I want to illustrate that providing what may be simple for enrollees on the front-end is all but simple on the back-end in the world of technology. In Figure 1, Step 1: The Application, you see the areas of information the individual needs to provide by entering it online into a web-based application. Step 2: Verification is where things start to get very involved. Based on the information provided by the individual, the system must then go out to multiple systems to verify the applicant's status. The Exchange must interface with the IRS, the Social Security Administration, and the systems for Medicaid, SNAP, TANF, and others. If verification cannot be made, the system must ask the applicant for more information and the process repeats. In Step 3: Eligibility, the verified information is routed to the Eligibility system to determine if the applicant is eligible for Medicaid or CHIP and if not, then eligible for subsidized coverage in the Exchange and at what level. The system will then notify the applicant of their eligibility determination or subsidy amount. In Step 4: Enrollment, the system must enroll qualifying individuals in either Medicaid or subsidized coverage and notify the employer of the enrollment. Step 5: Renewal and Reconciliation is a complex step as well. The system must retrieve updated information on the individual's status in order to renew or transition their coverage. The information is retrieved electronically from 3rd party sources such as employers, the IRS, Medicaid, vital records, etc. One important item on Figure 1 is the Key – bottom left. Notice the rectangular boxes throughout the diagram indicate technology system functions. The ovals indicate enrollee functions. There are 13 rectangles and only 2 ovals, which is a good indicator of all the back-end processing required.

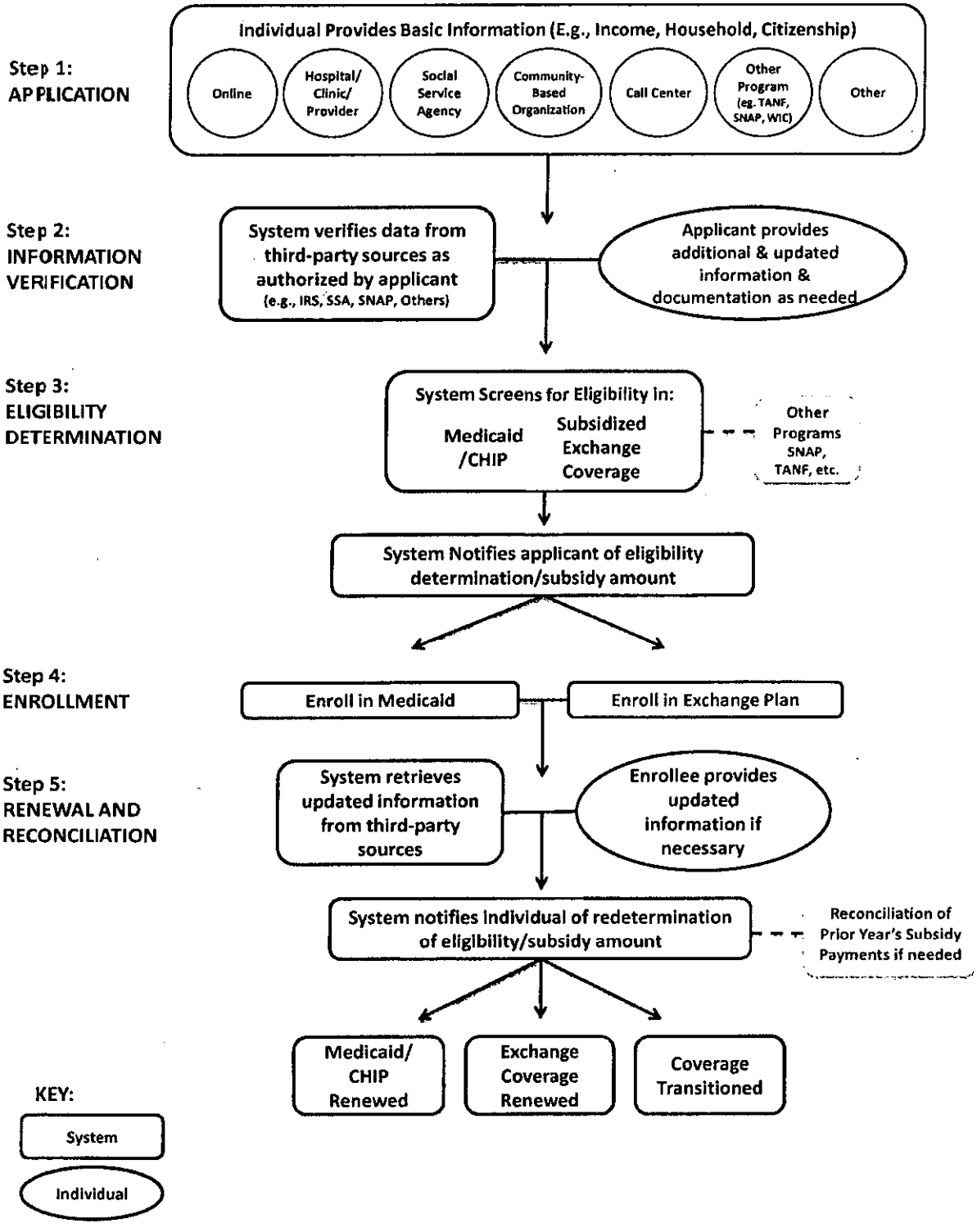
Cost: There are only two states with functioning insurance exchanges: Massachusetts and Utah. Utah does not have all the functionality required by PPACA. It doesn't provide for all eligibility enrollments nor does it verify all source data electronically. It is operating in a pilot phase now. Massachusetts has a more robust exchange with a reported operating cost of $26.6 million in FY

2009. We were able to gather estimates from only two states, Wisconsin and Oregon, on the cost to build an exchange. Wisconsin already has components in place that can be leveraged to build the exchange and is estimating the cost to be $49.6 million. Oregon estimates it will need $96 million to build an exchange, and that is above and beyond the cost of upgrading their eligibility system.

North Dakota must first update its existing Eligibility system in order to then implement a functional health benefits exchange. After analyzing Oregon's estimates, ITD analysts are estimating the cost for North Dakota's exchange would be in the $50 million range.

Options: It is possible that the Federal government could initially build an exchange for the state and then turn it over to us to run. It is might also be possible to partner with another state. It is too early to have solutions.

Figure 1:
Example of Key Steps and Processes in an Integrated Enrollment System for Medicaid and Subsidized Exchange Coverage



TECHNOLOGY-ENABLED

Summary	Section	Specifics
Maximizes role of the Internet for purposes of application and enrollment	§ 1413 § 2201	Individuals will have access to an Internet website through which they can apply for and renew coverage online using the single, streamlined application for all health subsidy programs. Through the website, applicants who are eligible for Medicaid, CHIP, and premium tax credits or other subsidies through the Exchange will be able to compare their options.
Provides for secure electronic exchange of data	§ 1413(c) § 2201	Requires states to securely exchange data to determine eligibility. "Each state shall develop for all applicable health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms...) that allows a determination of eligibility for all such programs based on a single application."
Creates information technology standards and protocols to facilitate electronic enrollment	§ 1561	The Secretary shall establish standards and protocols for electronic enrollment that allow for the following: (1) "Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation." (2) "Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility." (3) "Reuse of stored eligibility information... to assist with retention..." (4) "Capability for individuals to apply, recertify and manage their eligibility information online..." (5) "Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate." (6) "Other functionalities" necessary to streamline the process for applicants. Provides for grants to states and localities to develop or adapt existing systems to meet the new standards and protocols. More broadly, the Secretary "shall notify" states about these standards and procedures and "may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments."

This brief was prepared by Beth Morrow of The Children's Partnership and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

For further information about ACA, beyond its enrollment provisions, please go to the Kaiser Family Foundation's Health Reform site, at: http://healthreform.kff.org/.

This publication (#8090) is available on the Kaiser Family Foundation's website at www.kff.org.

Testimony
House Bill 1126 – Department of Human Services
Before the Joint Meeting of
House Industry, Business & Labor
Representative Keiser, Chairman
House Appropriations – Human Resources Division
Representative Pollert, Chairman
February 1, 2011

Chairmen Keiser and Pollert, members of the Industry, Business & Labor Committee and House Appropriations – Human Resources Division, I am Carol Olson, Executive Director of the Department of Human Services. I am here today to provide information to you regarding the relationship between an American Health Benefit Exchange and the programs within Department of Human Services.

If it is the interest of this committee to pursue the establishment of an American Health Benefit Exchange for the state that will meet the requirements as currently outlined in the Patient Protection and Affordable Care Act of 2010, it will be important for this committee to consider the implications of:

- Title I, Section 1311(d)(4)(F) requiring, at a minimum, for the Exchange to provide for eligibility determination and the enrollment of individuals in Medicaid and CHIP programs; and
- Title II Role of Public Programs, Section 2201 which outlines more specifically the requirements of enrollment simplification and Medicaid and CHIP coordination with the State Health Insurance Exchange.

The intent of these sections is to ensure that the American Health Benefit Exchange provide seamless eligibility and enrollment linkages between the exchange coverage options and public assistance programs. In order to achieve this level of interoperability with the Exchange, the Medicaid and CHIP eligibility systems will require significant modification.

I would be happy to answer any questions you may have.

HOUSE BILL NO. 1126

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

Before: **Senate Appropriations Committee**
Senator Ray Holmberg, Chairman

Date: **March 28, 2011**

TESTIMONY

Good morning, Chairman Holmberg and members of the committee. My name is Rebecca Ternes, North Dakota Deputy Insurance Commissioner. I appear before you today in support of House Bill No. 1126.

The purpose of the bill is to allow you to decide whether it is best for North Dakota, rather than the federal government, to run the health benefit exchange required by the Patient Protection and Affordable Care Act also known as "federal health care reform", or "PPACA". I will refer to this law as "PPACA".

What is an Exchange?

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

Exchanges will allow people to compare health plans and determine which one is best for them. Health plans will be placed in tiers based on out-of-pocket costs, which allows consumers to compare plans on an apples-to-apples basis. All plans sold in the exchange are offered by private insurance companies. There is no government-run plan or public insurance option.

An exchange must also assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs such as Medicaid and the Children's Health Insurance Program (CHIP). Individuals whose household income does not exceed 400 percent of the poverty line will receive subsidies through the exchange according to a sliding scale. By providing one-stop shopping, exchanges are theoretically supposed to increase competition in the marketplace and make purchasing health insurance easier and more understandable for consumers.

If North Dakota does not run its own exchange, the United States Department of Health and Human Services ("HHS") will. By January 1, 2013, HHS must determine whether the state will have an exchange in operation by January 1, 2014. If it determines that the state will not have an operational exchange by then, HHS is required to establish and operate the exchange within that state. The federal government will work with the Governor of the state as the Chief Executive Officer unless authority to operate the exchange has been delegated to a specific authority through state law.

What Does This Bill Do?

At its most basic level, this bill puts the following questions before you:

1. Do you want the federal government or the state to run the North Dakota exchange?

2. If you want the state to run its own exchange, who do you want to run it?

3. If the state will run its exchange, what resources do you want the responsible agency to have in order to build and operate the exchange?

To be clear, this bill is not an endorsement of PPACA or the wisdom or effectiveness of exchanges. It is the means by which these issues are being brought before you so that the Legislative Assembly may decide whether it is in North Dakota's best interest to run its own exchange or to let the federal government do so.

Who Can Run An Exchange?

States have the option to establish the exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state agency or a newly created, independent state agency. Alternatively, the exchange could be operated by a nonprofit entity. If none of these entities run the state's exchange, the federal government will take over that responsibility.

What Functions Must an Exchange Perform?

Exchanges must perform a lengthy list of functions. These functions should be taken into consideration when deciding which entity is best to run the exchange and the resources needed by that entity. At a minimum, an exchange must:

- Implement procedures for the certification, recertification, and decertification of health plans as qualified health plans;

- Provide for the operation of a toll-free telephone hotline to respond to assistance requests;

- Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans;

- Assign a rating to each qualified health plan offered through the exchange;

- Use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage;

- Inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program, and, if through screening of the individual's application by the exchange, it determines that such individuals are eligible for any such program, enroll such individuals in such program;

- Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction available under PPACA;

- Grant certification attesting that, for purposes of the individual responsibility penalty, an individual is exempt from the individual requirement or from the penalty imposed because he or she meets one of the exceptions provided in PPACA;

- Transfer to the Secretary of the Treasury a list of individuals who are issued certification of penalty exemption, the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit because the employer did not provide minimum essential coverage or the employer provided the minimum essential coverage but it was either unaffordable or did not provide the required minimum actuarial value, and the name and taxpayer identification number of each individual who notifies the exchange that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year;

- Provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year and the effective date of such cessation; and

- Establish a Navigator program.

There are some areas where the state has choices. Federal rules will clarify that the following policy areas, among others, are state decisions, although HHS may offer recommendations and technical assistance to states as they make these decisions:

- Whether to form the exchange as a governmental agency or a nonprofit entity.

- Whether to form regional exchanges or establish interstate coordination for certain functions.

- Whether to require additional benefits in the exchange beyond the essential health benefits (mandates).

- Whether to establish a competitive bidding process for plans.

- Whether to extend some or all exchange-specific regulations to the outside insurance market beyond what is required in PPACA.

- What additional types of services the exchange might provide to individuals and business to ensure simple and fast service.

If you believe that it would be better for the state to run its own exchange, certain things have to be accomplished by deadlines set out in PPACA. As I already noted, states must be on track for achieving certification of their exchange by January 1, 2013, or the federal government will run the exchange. And the exchange must be operating no later than January 1, 2014. Establishment of an exchange requires a planning process

to create an exchange that will meet all the requirements of PPACA. Anyone who is even somewhat familiar with a complex information technology (IT) project can recognize how short this timeframe is, especially given that most of the functionality required does not exist in North Dakota's state government or in any other entity currently operating in our state.

This bill, as amended, would require the Commissioner and the Department of Human Services to plan and implement the exchange for the state in consultation with an advisory committee made up of the Insurance Commissioner, the executive director of the Department of Human Services, ITD, the Governor and legislators. The bill would ensure that the exchange facilitates the purchase of qualified health benefit plans, provides for the establishment of a small business health options program, and meets the exchange requirements of PPACA generally.

What Must Be Accomplished if the State Runs the Exchange?

In order to plan and implement a North Dakota exchange, the bill requires the following be accomplished:

- To take actions necessary to ensure that the exchange is determined, not later than January 1, 2013, by the federal government to be ready to operate not later than January 1, 2014.

- To consider whether to seek federal grant funds for the planning and implementation of the exchange.

- To determine whether to establish one exchange that will provide services to both qualified individuals and qualified small employers or to have two separate exchanges.

- To contract with outside entities, if necessary, to provide services to implement the exchange.

- To adopt rules, if necessary or desirable, to carry out the provisions of the bill.

Exchanges will require complex and particular IT systems and other business operations to perform the functions required. Since the exchange will have to work with other state and federal agencies, for example, to fulfill its duty to determine tax credits and enroll eligible individuals in Medicaid and CHIP, the bill requires state agencies to cooperate to ensure the success of the exchange. At this time, the IT systems of the agencies likely to be involved in the exchange do not have the ability to communicate and exchange data with each other.

Because exchanges are also required to report certain information to other entities such as the United States Secretary of the Treasury, the bill allows the Commissioner and the Department of Human Services to receive from, and provide to, federal and state agencies confidential information gathered in the administration of the exchange.

What Resources Are Needed For an Exchange?

The federal government has provided three grant opportunities to states for the planning and establishment of exchanges.

Forty-eight states, including North Dakota, and the District of Columbia were awarded the exchange planning grants in September 2010. Those grants were for planning purposes. The second round of grants were for state innovations surrounding the information technology challenges in exchanges. These grants were given to seven states and the third round of grants is now available for the purpose of establishing an exchange. States will have to meet certain milestones in order to be awarded grants in 2011, and the size of state awards may be related to the number of milestones met. Necessary exchange planning and establishment costs will be funded by HHS until

2015. After January 1, 2015, exchanges must be self-funded. North Dakota was approved to receive $1,000,000 in the first round of exchange grants; however, the Emergency Commission tabled the request to utilize these funds. The $1 million reflected in the fiscal note on this bill will allow the Insurance Department to spend the grant funds to analyze options, define requirements, and estimate the probable cost to implement an electronic system to operate the state's exchange. Future grant funds will be available to pay for the cost of building the system that will operate the exchange.

In addition to the staffing and information technology infrastructure needs, the state will need resources to help it identify and address many issues and to make informed decisions along the way, including:

1. **Unified exchange.** A state has to provide an exchange that facilitates individuals' purchase of health insurance and an exchange that serves small businesses. The state may choose to operate them separately or both in one exchange as long as it serves both functions.

2. **Regional exchange**. States may form a regional exchange with other states or allow more than one exchange to operate in the state as long as each exchange serves a distinct geographic region.

3. **Stakeholders.** PPACA requires states to consult with stakeholders in implementation of the exchange. Stakeholders must include health care consumers who enroll in qualified health plans, individuals and entities experienced in facilitating enrollment in qualified health plans, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for enrolling hard to reach populations. In planning for this legislative session, the Insurance Department has already begun stakeholder conversations. I can assure you that the exchange is a focus for many of these individuals and groups.

4. **Funding.** How will the state ensure that the exchange is self-sustaining as of January 1, 2015? Exchanges are allowed to charge assessments or user fees to participating insurance issuers or to otherwise generate funding in order to support its operations.

5. **Outside market**. Will insurers be allowed to sell health plans outside the exchange? And if an external market remains, will insurers be required to offer plans both in and out of the exchange?

6. **Large employers.** Beginning in 2017, an exchange may allow businesses with more than 100 employees to purchase coverage in the exchange also.

7. **Mandates.** Does the state want to require that plans offer benefits in addition to the essential health benefits package? If so, the state must assume the cost by making payments to individuals enrolled in a qualified health plan in the state or making payments directly to the qualified health plan on behalf of the individual. HHS has not yet determined how the essential health benefits package will be defined.

8. **Data reporting.** Determination of the data that will be required to be reported, what persons will be allowed to access data, and how to ensure appropriate protection of data.

9. **Certification of plans.** The exchange must implement procedures for the certification, recertification and decertification of health plans as qualified health plans. It is expected that this will require someone to analyze the health plans offered for sale through the exchange to ensure that they meet one of the required benefit categories: bronze plans which must cover 60% of benefit costs; silver plans which must cover 70% of benefit costs; gold plans which must cover 80% of benefit costs; platinum plans

which must cover 90% of benefit costs; and catastrophic plans, which are available only to those up to age 30, which must provide catastrophic coverage only. Someone must also ensure that the plans offered in the exchange meet certain benefit requirements, marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, and use a uniform enrollment form and standard format to present plan information.

10. **Hotline.** The exchange must provide for the operation of a toll-free hotline to respond to assistance requests.

11. **Website.** The exchange must maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans.

12. **Ratings.** The exchange must assign a rating to each qualified health benefit plan offered through the exchange.

13. **Standardized format.** The exchange must use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage.

14. **Other coverage.** The exchange must inform individuals of Medicaid, CHIP, and other state or local public programs eligibility requirements and enroll eligible individuals in these programs.

15. **Calculator.** The exchange must provide an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction.

16. **Individual responsibility certification.** The exchange must grant a certification attesting that for purpose of the individual responsibility penalty (individual mandate) that an individual is exempt from the penalty because there is no affordable qualified health plan available through the exchange or the individual's employer, or the individual meets the requirement for any other exemption.

17. **Certification of penalty exemption**. The exchange must transfer to the Secretary of the Treasury a list of individuals who are issued a certification of penalty exemption.

18. **Employer notice.** The exchange must provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year.

19. **Navigator program.** The exchange must establish a Navigator program under which it awards grants to entities to carry out certain duties such as public education, facilitating enrollment in qualified health plans, and providing referrals to health insurance ombudsman or other appropriate agency for any enrollee with a grievance, complaint, or question regarding his health plan, coverage, or a determination under such plan or coverage.

20. **Producers.** The exchange must determine the role insurance producers (agents) will play in the sale of health benefit plans in the exchange.

The bill also contains an emergency clause so that it would become effective immediately upon its filing with the Secretary of State to allow work to start to address the many decisions that will have to be made and the work to begin to build an IT system that will be capable of performing all the required functions.

In closing, there are many decisions to be made about how the exchange will be run in North Dakota. There will be more decisions to be made as things are further defined or changed at the federal level. Several federal agencies are tasked with issuing regulations to implement the law and many of them have yet to be issued so various components remain undefined at this point. In addition, there is the prospect of Congress making changes to the law as well as the numerous legal challenges to the law that are making their way through the court system. For now, the law requires that there be an exchange implemented in North Dakota. The first decision is who will run it: the federal government or the state. Our stakeholders are telling us they prefer North Dakota run its own exchange and cite the numerous problems with other federal insurance programs as examples of how North Dakotans serve our own better. In fact, it is my Department that assists Medicare Part D prescription drug beneficiaries in comparing, choosing, and enrolling in Part D plans, as well as dealing with issues and complaints. This piece of legislation places similar responsibilities related to the exchange in this same agency.

This concludes my testimony. I would be happy to try to answer any questions the committee members may have. Thank you.

2011 SENATE APPROPRIATIONS

HB 1126

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1126
03-28-2011
Job # 16035

☐ Conference Committee

Committee Clerk Signature Alice Delzer

Explanation or reason for introduction of bill/resolution:

A BILL relating to a health insurance exchange; to provide an appropriation; to provide for application; and to declare an emergency.

Minutes: See attached testimony."

Chairman Holmberg called the committee to order on Monday, March 8, 2011 at 9:00 am in reference to HB 1126. Roll call was taken. All committee members were present. Joe Morrissette, OMB and Sara Chamberlin, Legislative Council was also present.

Chairman Holmberg: Start with 1126.

Representative Keiser: District 47 Bismarck; introduced HB 1126. One of the three major bills relative to address the Federal Health Care Reform commonly referred to the House side as PPACA. It is the Exchange bill, a bill designed to implement the exchange as each state must have their exchange program certified by January 1, 2013. That is immediately prior to the next time we go into our legislative session. On the House side, what we did was to delay our deliberations on the exchange literally delay it until the special session. I attended part of the NAIC meeting and the commissioners all gathered and the exchange of course is a major part of their program that they just had presented to them. One thing we can say about the exchange is, it's very dynamic at this point. There are currently two exchanges that are operational in the United States, in Utah and Massachusetts. The Utah exchange is what we would say; at one end of the continuum is the minimalist program. It provides really a Web page that the folks can go on, insurance can apply to the Utah Exchange, and if approved get listed on the exchange and it is an interactive exchange up to a point. You can go in and put up the information you want, identify the policies that are available, the options in the policy, and then select a policy. It is the beginning of giving the consumer the opportunity to participate in the decision as to the benefits they want to receive and the amount they want to pay and it achieves some of the goals of the exchange. The Massachusetts Exchange as you know is at the other end of the continuum. It is an exchange where the providers came in and requested significant increases in premium rate, the insurance denied them, the three companies took them to court, and the settlement was made out of court. It was sort of half way in between what they were requesting and the question of course is, well, are they not being under- funded and we'll have significant increase in the future. That is yet to be determined. So we have two exchanges that are operational. The head of HHS and developing

the exchange program was at this meeting. Her boss, a previous insurance commissioner did make a presentation and what I can tell you is that they still don't know what the elements of the exchange need to be. So, in the House side we felt, illogical at best to try and move forward in establishing and implementing an exchange, but on the other hand, we recognize that the Federal law, unless the courts over turn it, the federal law is currently the law of the land and easily could go forward and we have to be prepared for January 1, 2013. So in all three of our health care bills, we put a clause in the bill that says 'any decision which must be made between now and our special session, we are giving the authority to the Insurance Commissioner and the department through Administrative Rule to make that change'. As far as I know, there are no changes in that time period that are required by the Federal Health Care law. But, any change the date for which it occurs after we adjourn but prior to January 1, 2013, then the Insurance Commissioner and the department are to come to the special session with a proposal regarding how they would like to see that program, whatever it might be, and in this case it is the Exchange Bill. How the exchange bill would be implemented for North Dakota at least in concept. We on the House side, there is a $1 Million dollar planning grant that was available to every state to work on developing the concept of their exchange, not the implementation, just the development of the concept as far as I am aware. We did on the House side put the authority to apply for the $1 Million dollar planning grant for the exchange. There are two states I believe which have rejected the planning grant, the other states are all applying for it. One of our concerns on the House side was does accepting any of these dollars in any way, commit us in any way, to the federal health care reform act. We have had several opinions on that subject from HHS in Washington, D.C., our insurance read it; the Attorney General read, although its' not an official Attorney General's opinion but, by accepting this grant we would not make any commitment to the final implementation of the Federal Health Care Reform Act. The department has already applied for and received a previous grant relative to rate review and sort of thing. Again there were many deadlines that have come up as a result of the federal health care reform act which did require decisions. It is in federal law, decisions had to be made. I believe it was last April prior to our going into session, that the insurance department was required to make a decision as to whether a change our high risk pool, the CHAN program to meet the federal standards to create a second high risk pool within the state maintain CHAN but create a second high risk pool or allow the Federal government to introduce a second high risk pool in the state of North Dakota. The Insurance Commissioner and the department had to make the call, it was required by the date in the law and they did make the call and they implemented, allowed the Federal Government to come into North Dakota and create a second high risk pool rather than adjust ours. That is the sum and substance of this bill. I would be willing to answer any questions relative to what the House did, again I am not certain. I thought the Senate left it pretty much intact. but I did not have a chance to review it prior to coming down here.

Chairman Holmberg: Course the role of this committee here today will be to look at the question, should we authorize the Insurance commissioner to apply for and receive this million dollar grant. Most of the rest of the bill is obviously policy. Does this require us then to proceed or is this a stand- alone grant that if at the end of the day we decide we're not going to do something we're not locked in? I believe that is one of the questions the committee was inquiring about. Otherwise it has to do with are we going to allow them to accept a $1 Million grant from the feds. What we want to know is this money something we should take and spend and then the special session this fall, will address some of the other questions that arise between now and then.

Representative Keiser: According to the Federal health Care Law, if a state chooses and they can chose not to implement an exchange program, then the Federal government will implement a federal government exchange program in your state. That is the hammer they've got, and the question is do you want North Dakota to do it or do you want the Feds to do it?

Senator Wanzek: Invariably when you turn on the news, you hear about one group or another asking for a waiver from the Federal health care plan. Under what guise are they able to do that and are they getting a waiver and is it possible for the state even to ask for a waiver?

Representative Keiser: To my knowledge, the waivers that have been requested to date are relative to the minimum loss ratio formula the Feds came out in the law with an 80-85% minimum loss ratio. There are several states that feel they cannot meet that and remain competitive. There are three states to my knowledge that have applied for the waiver. I believe the waiver has been granted in a couple of states. But relative to the exchange and to my knowledge there is no waiver and I would suggest there will not be a waiver on this. There are several cornerstones for the Federal Health Care Act. One is that is it universal coverage in some form, that everybody has to play. Without that the system, doesn't work. That requires people to buy insurance. Another cornerstone is the exchange. In their model, they need the exchange to make it work. I cannot believe there will be a waiver, however, what we don't know and that's why were delaying this Mr. Chairman, from the House side is what are the actual requirements for the exchange? We do not want Massachusetts model. We would go to Utah's model in a heartbeat. There cost annually is around $700,000 versus $35 Million. That's not rocket science.

Senator Kilzer: You mentioned the cost to maintain it annually. And it looks like there was a $30million dollar IT initial cost in the first fiscal note. I would assume it would cost $30 Million dollars for the IT part of it. Are there additional costs in the start-up or even in the maintenance that North Dakota could or should anticipate?

Representative Keiser: The $30 M is not the tip of the iceberg; it is a big part of the iceberg. There is more to that ice berg. What you did not see because we did not adopt was Human Services came in not at the end, but, as we were moving down this path with approximate $16 Million dollar IT appropriation to attach to that. How much it's actually going to cost I cannot say. Seven states I believe now have applied for additional funding to develop IT programs. Kansas has received a $40 million dollar planning grant. A second grant they are moving ahead, they show at the meeting this weekend, they showed the flow chart for this thing. If they can pull it off, it will be a miracle, but the bottom line is that all of the states that are receiving these very large planning grants are required to share their information with other states. That is one reason I do think we do need to delay this. There is little reason for North Dakota to go out and reinvent a wheel if there has to be a wheel, there are states who have been given a great deal of money to start working on what it will look like, so, but it will have to be whatever is developed. In Kansas or any other state will have to be adjusted for our state and it is going to cost significantly on the IT program. Not only the establishment of the interface, but the maintenance.

Rebecca Ternes: Deputy Commissioner, North Dakota Insurance Department. Testified in favor of HB 1126. Written testimony attached #1. The purpose of the bill is to allow you to decide whether it is best for North Dakota, rather than the federal government, to run the

Health benefit exchange required by the Patient Protection and Affordable Care Act also known as the 'federal health care reform ' or PPACA. Her testimony shares information about what the Exchange is what this bill does, who can run the Exchange, the function of the Exchange.

Chairman Holmberg: As a member of the Emergency Commission, the discussion there was the Legislature is meeting in only a few months and we would rather have your fingerprints on it than just the fingerprints of four legislators deciding whether or not we would accept the grant. It wasn't that the Emergency Commission was against the acceptance of the grant, it was just so close to the session we were not going to commit that money to be spent until the legislature determined it.

Rebecca Ternes: She continued her testimony. On pages 8-11 these are all decisions and specific things that have to be done within the Exchange. I do want to point out the bill does contain an emergency clause so that it would become effective immediately upon filing with the Secretary of State. It's crucial that we do something here, because January 1, 2013 is frighteningly close for us. The lawsuit as you know continued to go on and they have gone both ways. They originally focused on just the individual mandate, one judge in Florida did issue a decision based on the entire lobbying unconstitutional. Then the government responded, and they are now working this out. It's probably going to make its way to the Supreme Court. We don't expect that to occur until well into next year. The court of course has to agree to hear it, schedule it, hear it and then to also make a decision. Commissioner Hamm likes to guess what the vote will be, he always says it's a 4-4 split, with Justice Kennedy being the deciding factor. There is also kind of a new wrinkle with Justice Thomas possibly having a conflict of interest so if he accuses himself then what happens? So we continue to watch it, but honestly, we don't feel we can wait for that decision given the dates that are before us and the task that is in front of us. So we're going to continue to keep an eye on it. On the fiscal notes there was an original fiscal note of over $32 Million dollars. We did that one in December 27, 2010. It also had 4 FTE's on it to start planning for the Exchange. An IT person, a grant, writer, reporter, and things like that and so it included some operating, and salaries and then $30 Million for the start of the IT development. The new fiscal note has just the $1million dollar grant that has been awarded to the state. It doesn't include any additional grants that we might be able to apply for going forward and no FTE's put on that fiscal note. As far as waivers, there are several waiver or what people are calling waivers out there right now. The first ones that people are hearing about thousands of waivers granted, were actually to mostly employers who had certain kinds of health- care plans called Mini-Med plans. They didn't meet the annual limit requirements of the new law, so you could ask for a transitional waiver to decide whether you wanted to continue to offer health insurance or not. There are also the medical loss ratio waivers that are available to states. I believe there is about 5 or 6 states that have asked for them. We actually just recently did request a medical loss ratio waiver for the individual 80% medical loss ratio that is required by the law. So that process just starts for us, we expect to go back and forth with HHS several times to answer questions with them. And then there's the waiver for health care reform. That was probably a couple of weeks ago that President Obama talked about moving up the time line that the states could request a waiver and what states would have to do to be successful in getting that waiver. Mostly the states would still have to meet the requirements of PPACA, and there would be a little bit of funding differences. Some of the funding that maybe the state would've gotten for subsidies through the Exchange, the state would get in funding to work on whatever innovative strategy that they came up with to

have the same success that was expected out of PPACA. So that might be the one that you're asking about. There is still discussion on that and that would take a congressional act to move that date up to allow states to apply for that waiver earlier.

Senator Kilzer: On the very last page of your testimony, in the middle of that large paragraph you say ' Our stakeholders are telling us they prefer North Dakota run its own Exchange', could you identify the stakeholders please'? **Rebecca Ternes**: We have several sets of stakeholders. We have certainly the insurance companies and consumers; there are many associations and groups that represent either different consumer groups or health care providers, doctors. We also have agents and brokers that are very interested to see what happens with the Exchange because you can imagine there is some issues with commissions and costs and things like that are going on. So that is probably at a global level. The main groups of stakeholders, we've had meetings with already prior to the session to talk about what is going on. **Senator Kilzer**: Are there any of your stakeholders that want the Feds to do it? **Rebecca Ternes**: We have not heard that yet.

Senator Christmann: On that line, are all the stakeholders that want the state to handle this, people who benefit far more than what it costs them in state taxes to run it, as opposed to everybody else is being left with the choice of jumping off the cliff or being pushed off the cliff, saying well, why would I pay extra to be able to jump off? **Rebecca Ternes**: In the words of the commissioner, this is a really close call. You know more about state funding probably than most people do in the general public or maybe even in some of our stakeholder groups. Some of the work that we need to do as a state is to analyze who is going to buy from the Exchange. What is it going to cost, short term, long term. How many uninsured, we think we know about approximately how many uninsured we have, but how many of them are going to end up on Medicaid with the changes. How many are actually going to buy insurance even if they get a subsidy. Are they going to spend money still or are they just going to pay the penalty and we all know that we don't think the penalty is strong enough to really make people buy insurance. So, the cost of this Exchange could be enormous to the state and the question I don't think they understand that necessarily. I think what they understand is when they have a problem they want to call the Insurance Department and get a real person who they will probably will see at the grocery store later on in the day. Or they will want to call the Department of Human Services directly and get real people to talk to. I think they understand when the Federal government has run insurance programs in the past they don't always get the service they get from the state of North Dakota. I think companies would say that as well. They want to deal with their insurance department not the feds. It comes down I think to humanity more so than dollars for them.

Senator Wanzek: If we approve this and we do use the $1Million dollars to research and develop an Exchange, do we still have the option that as we're doing that maybe we, and as we learn more, we might find out; we'll wait a minute; maybe the other way is better. We will still have that opportunity to make that decision won't we? **Rebecca Ternes**: That is a really good point. There is no commitment here, that we will do the Exchange if we find out later on this isn't worth it for us, or, we might also decide maybe it shouldn't be in the Insurance Department, maybe it should be a separate agency or something else. We can still make those decisions down the road, we can change it.

V. Chairman Grindberg: Any opposition, neutral to HB 1126. Hearing Closed on HB1126.

2011 SENATE STANDING COMMITTEE MINUTES

Senate Appropriations Committee
Harvest Room, State Capitol

HB 1126
April 5, 2011
Job # 16363

☐ Conference Committee

Committee Clerk Signature Rose Laning

Explanation or reason for introduction of bill/resolution:

A committee vote on HB 1126 relating to a health insurance exchange.

Minutes: You may make reference to "attached testimony."

Chairman Holmberg: Rep. Keiser was in to explain the bill. **Rebecca Ternes** was in. This was utilizing $1M dollars of federal money for preparing for exchanges. The money is there for ND as I understand it. The money does not guarantee that we have to continue down the road. It's just that they want to get started.

Senator Wanzek moved Do Pass.
Senator Robinson seconded.

A Roll Call vote was taken. Yea: 12 Nay: 1 Absent: 0

The bill goes back to the Human Services Committee and Senator Mathern will carry the bill.

Date: 4-5-11

Roll Call Vote # 1

2011 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. 1126

Senate APPROPRIATIONS Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken: ☒ Do Pass ☐ Do Not Pass ☐ Amended ☐ Adopt Amendment

☐ Rerefer to Appropriations ☐ Reconsider

Motion Made By Wanzek Seconded By Robinson

Senators	Yes	No	Senators	Yes	No
Chairman Holmberg	✓		Senator Warner	✓	
Senator Bowman	✓		Senator O'Connell	✓	
Senator Grindberg	✓		Senator Robinson	✓	
Senator Christmann		✓			
Senator Wardner	✓				
Senator Kilzer	✓				
Senator Fischer	✓				
Senator Krebsbach	✓				
Senator Erbele	✓				
Senator Wanzek	✓				

Total (Yes) 12 No 1

Absent 0

Floor Assignment Mathern

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1126, as engrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (12 YEAS, 1 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1126, as amended, was placed on the Fourteenth order on the calendar.

2011 HOUSE INDUSTRY, BUSINESS AND LABOR

CONFERENCE COMMITTEE

HB 1126

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
April 15, 2011
16635

☒ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Creation of a health insurance exchange

Conference Minutes:

Chairman Keiser: Opens the Conference Committee hearing on HB 1126.

Chairman Keiser: Would the Senate like to share with us their thoughts on this one?

Senator Dever: In our folder, if you look at .02001, we will walk through that. First is says in the title "to provide reports to the legislative management", that was in there previous; I'm not sure why that's included in there. In section 1, includes the Department of Human Services in consultation with the advisory committee. Subsection 2 of section 1, plan for the implementation, which we recognize would be required by PPACA to include determination eligibility for Medicaid & SCHIP. We consider that very important that they be involved in that. Down on lines 26 and following on the next page, it provides for an advisory committee that would include the Insurance Commissioner, the Department of Human Services, ITD and the development of that. The appropriation section 2 has not changed. Section 3, we just include the Department of Human Services in the application that provide reports for legislative management will be important to consider if special session becomes necessary.

Chairman Keiser: Any questions from committee members? How do you perceive the roll of the advisory committee versus the interim legislative committee? How will the two interface, be different or be similar?

Senator Dever: I would see the advisory committee would be more technical in nature in how that exchange will come about and the interim would be serving as a policy committee that would be determining what policy would be necessary. One is mechanics and other on is policy.

Senator Lee: I agree with what Senator Dever has said and would add that I see roll of the advisory group in HB 1126 much more limited. It would strictly be involved with the details of the implementation, since we know since SCHIP and medical assistance have to be at the basis of this exchange. Whereas the other one we are looking at would include all various aspects health care reform act. This as a much smaller in scope.

Senator Mathern: I saw the advisory committee as the legislature asking the executive branch to make sure they have a process wherein all departments of government in the executive branch, may have some roll in this exchange, have a formal method communicating. It's more a manner a directive to executive branch that all the agencies work together on this. It's not really a directive wherein they would report to the legislature, whatever that is still within the purview of how the legislature wants to do that. As we heard the testimony, it became very clear that these three components were interdependent and these components were actually executive branch agencies that need to be at their table as an executive branch so that we get a robust report.

Chairman Keiser: Other questions form House members or comments. Just describe what the committee will do.

Senator Lee: I don't have a job description, but my strong interest here and the interest of the Senate committee, is to make sure there is input from both IT and Human Services in the way this exchange is implemented. There was no assurance that that was going on and I don't think that there is anything threatening to anyone in just stating that these various executive agencies work together to develop this. That eligibility system for Medicaid and SCHIP, is an important component, even if we didn't have PPACA coming along. There are counties that have five computers in order to do eligibility for the six programs. MA and CHIP are the two that are important as far as health care reform is concerned but they make up the vast majority of the eligibility determinations. We would be foolish not to look at the broader picture because of we can make the whole thing better, that would be a real advantage to that. That would not be the insurance department's area of expertise, the eligibility would be the area of Human Services expertise and the way to make all of that tie together would be information technology expertise. We just want to make sure that we haven't, if we are going to spend a lot of money, that it's done in a fashion that is inclusive of the low income energy assistance program, food stamps and all of those things. Rather than having all those separate systems, we why we thought that it's really important that they all work together. We don't see this as being any kind of reflection on anybody but rather establishing a partnership, for they would be partners in figuring out on how they will do this. So in the end, not only do we have something that meets the requirements for the health insurance exchange but is would also will meet the needs for the state of North Dakota for eligibility determinations for all of those programs. That is where we are coming from.

Chairman Keiser: I agree with the general concept that you are offering. I think we can accomplish that but I cannot support forming another committee because putting it in statute and getting them going, they meet, plan, develop and act. I don't want them going down the road to far away from what the policy may or may not want to develop. What I do think you have done on page 3, section 3, on the application you have added, I would support the changing of the wording in carrying out requirement of this act "the Insurance Commissioner, Department of Human Services and IT shall coordinate their activities in developing with the interim committee". A plan for the state of North Dakota without creating some committee that may or may not go down the road that gets ahead of the policy.

Senator Mathern: When the bill came to us, we had the impression that it wasn't clear for IT and Human Services whether they were integral partners or not in that planning effort, so we included them. The goal was that they would not get ahead of policy issue, that they would be working, they would not have to be waiting for our committee and to make sure that there was the connection on the ground as this was going forward. I believe the executive branches that are included here, have demanding work in front of them. In fact, appropriations committee has put some money into making sure that the Department of Human Services can move forward. That demanding work involves daily interaction and this advisory committee structure assures us that. I would see this as eventually going away and this is only in place as a matter of session law as this process unfolds. When the project is over, up and running or there is no project, they are done.

Vice Chairman Kasper: Who makes the final decision under the Senate's version? Who is the boss?

Senator Mathern: The advisory committee is to assist the commissioner. I think the House version essentially had it structured so that the commissioner of insurance is in charge of the project and we really didn't change that. We said, OK, commissioner while you are moving down the road, make sure you have a few other folks on your team that have big parts of this project that are part of this effort. If you note the wording actually says "an advisory committee is established to assist the commissioner and the Department of Human Services in addressing the complexity".

Senator Dever: Can I ask, under section 2, the appropriation of the million dollars is for the purpose of planning for implementation. First, whether you support the expenditure of that and it's federal funding, if so, how you would otherwise go about planning for the implementation?

Chairman Keiser: Yes to the first question, that is a federal grant that is sitting out there and the Insurance Department has not been allowed to accept it to go forward. How it's implemented, again, somebody needs to be in charge and it seems to me that the Insurance Department is the appropriate entity. I would agree and disagree with the Senate. We did hear from Human Services and IT on our side and we recognize the importance of both of those to the development of an exchange. However, I think our bill covered it. I could support in the application in section 3, wording to the effect that those groups are to be there. I will not support and I can assure you, it will not pass, to form a new committee in addition to an interim committee that is going to be working with the Insurance commissioner in an advisory capacity. Moving down of the track, when from the House's perspective, that is the roll of interim committee to work with the commissioner, IT, Human Services and anyone else that is appropriate in developing that policy.

Senator Lee: Two things, threats are not productive and my opinion frankly the Human Services ought to be the one to make the decisions about the eligibility because there is nobody who knows any more. That portion needs to be in the hands of the Department of Human Services, along with IT. I see that it has to have Human Services to be the lead dog on that eligibility portion for what they manage because that's what they know best. That will plug in with what the Insurance Department know best about private policies and

all the other things that is going on, it has to be a partnership. I think we are all headed in the same direction, we want it to work.

Chairman Keiser: I can't agree more and we don't need another subcommittee to do that, that what the interim committee will assure happens.

Senator Dever: We will be back to discuss that interim committee and it seems to me thus far, has been the House objection to the Senate, trying to narrow the focus of that to apply only to the federal health care bill. If this would be subject only for the interim committee, it would narrow it further to only to include the health benefit exchange.

Chairman Keiser: I couldn't agree more.

Vice Chairman Kasper: Don"t we have various levels of decisions here? The first, this bill goes further than I would like it but we did support in the House that says that we are going to establish an exchange. I guess under the current law, we have to. One of the major decisions is what type of an exchange is it going to be? Will it be one that we have our own in the state, multi state or at this time the federal option is out? The exchange decision is one decision. Is it the Senate's position that it's a decision that the HHS needs to be involved in or that's more a decision where the department or both entities making the decision?

Senate Mathern: The way I see it, this advisory committee is doing the nuts and bolts discussion about how this exchange would work. What are the costs involved, how it would work, what are the problems that need to be solved and it would be the legislature interim committee's prerogative to set the public policy as to whether or not this goes forward this way or that way. This advisory committee is to make sure that everybody, who has a consequence to bare, about what whether this exchange works or does not work. It has an opportunity to work on the nuts and bolts of it but the legislature will set the policy. I see it also as trying to bring everybody up to the same ability to access risk. When we went into the management information system of how do we pay providers for Medicaid, we developed computer software program, wherein the process it's going up to 16 million dollars. Some people were shocked in seeing that. This exchange is also going to end up in a very large project if it goes forward and we want to make sure the governor, executive agencies and the couple from legislature have their fingers in there to hear the nuts and bolts so that the legislature to make a very informed decision about the major policy direction. This advisory committee would not set that direction.

Senator Lee: It never occurred to me that the Insurance Commissioner would be the only person involved in deciding whether we have a multi-state or an individual system. That is a policy deal and we ought to be hanging with or against, but that's our responsibility to do. I think everybody pretty much agrees that will be the case; we wouldn't be looking at that kind of issue being a part of this at all.

Lee Dever: We were told that it will take 44 months to develop this extremely important program; the deadline is January 1, 2014. I think this is extremely important program to move forward and I think that justifies the committee.

Representative Gruchalla: I don't have an answer to why these two couldn't work together.

Chairman Keiser: I share that concern, but first let's recognize that there is a deadline looming out there, January 1, 2013, that's not to implement the plan, it's just to have the plan certified. At this point, it that doesn't necessarily must know every part of your plan or have ready to go on line. There is no state, even Kansas, who received the largest grant to date to design the IT portion of their program by 2014. All we need to do is certify the plan and it doesn't need to have the programs written at all.

Senator Dever: My understand was that Congress had granted a federal agency the authority to determine whether or not we are going to be in position by January 1, 2013 and have it in place January 1, 2014, if not, for them to assume control of that.

Chairman Keiser: They can do whatever they want and we will have to do what we can to do. We don't disagree, we are all on the same page. We can accede to your amendments, take it to the floor, I think it doesn't pass. If you want at alternatives, we can. I couldn't agree more, this is a partnership, these departments work for the state, they want to be successful, they are not as territorial as everyone is making them out to be. If we are going to design an exchange, they are all going to have to participate and somebody has to be in charge. I cannot believe the Insurance Commissioner; the department wants to do anything about designing the Medicaid, Medicare and SCHIP's portion because it's not their area of expertise. I do think, I do support the concept that we identify in this language that they are to be involved, input to be gained and I don't think we need a committee that will get ahead of the interim legislative committee, suddenly we have decisions made ahead of time that we have to reverse or change from a policy standpoint.

Senator Lee: I certainly don't disagree with many of the things that we have discussed here today. I think it's important to have more than one committee meeting because we have an opportunity to hear what the folks on the other side of the hallway have in mind and we can think about it over the weekend.

Chairman Keiser: Closes the Conference Committee hearing on HB 1126.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
April 18, 2011
16708

☒ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Creation of a health insurance exchange

Conference Minutes:

Chairman Keiser: On page 1, line 10, start with the elimination of the advisory committee, I did talk about this at our last meeting, it would strike subsection 2. I concur with the concerns expressed in the Senate. Under section 3, the application, buy carrying out the requirements of this act, the Insurance Commissioner, Department of Human Services and ITD shall coordinate their activities and provide updates to the Legislative Management Committee. It's important to give clear instructions that we have the expectations that they work together. Based on my observations, we have the best staff in the state, in the country as executive branch with their ideas and the policy would be set by the Legislature.

Senator Lee: I have a draft that is somewhat similar. It's with the same thoughts in mind, that would add the Human Services Department and the ITD but eliminate the council. **(passes out attached amendment).** It would require the Insurance Department and the Department of Human Services to collaborate with ITD. They do not add ITD to the new section of rule making or sharing of records because it didn't seem that that would be particularly applicable to ITD. It removes the advisory committee. We will see how it looks and you may have other suggestions to that. This gives us something to start with because our amendments are not here.

Senator Mathern: It's appears to me that these amendments that are brought forward by Senator Lee are essentially the same in terms of the preference that these agencies work together on this proposal. The difference is removing the wordage about the advisory committee, whether there is a word in there or not, I don't think it's that significant. The significance was that these executive agencies all have an opportunity to have input. It also removes the Governor and the two Legislators from the team working together on the interests of preparing something for the next special or regular session. I suppose in some ways the Governor and the Legislature have other opportunities, but that's specifically removed with these amendments. I think the Senate's concern was that everyone would be involved working together and whether the Governor and the Legislators are on that team is not as important as the other areas brought forth by Senator Lee.

Chairman Keiser: Any questions. I think we are on track. We will have a chance to look over these amendments and meet this afternoon. Closes the Conference meeting on HB 1126.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
April 18, 2011 pm
Job #16735

☒ Conference Committee

Committee Clerk Signature Re Mae Kaeser

Explanation or reason for introduction of bill/resolution:

Creation of a health insurance exchange.

Conference Minutes:

Chairman Keiser: Asked for amendments.

Senator Lee: This amendment is getting rid of that advisory council that was creating issues. It does include the Dept. of Human Services in the discussion of the amendment. We have the paragraph we discussed earlier, page 1 line 19, that calls for the implementation of the exchange at a minimum providing for eligibility about MA and CHIP for example. Also collaborating with the IT Department as necessary and then including the Dept. of Human Services. Each of the commissioners, the head of Human Services Dept. and the IT Dept., would deal with those issues that are specifically geared up to their area of responsibility. So if there are rules being implemented on CHIP or Medicaid, it would be the responsibility of the Dept. of Human Services. It would have to be done with the Insurance Commissioner and the IT Department's collaboration to make sure all of this smoothly fits together.

Chairman Keiser: There may be an amendment that is different from this amendment.

Senator Mathern: I think the name we used in the Senate as advisory committee was really a method to make sure there was a collaborative process. I think these amendments do that also without having a formal advisory committee. At this point our state wants to be in the middle of the issue of running an exchange and we want to make sure it works. These amendments have the major parties working together. I think they address the concerns without having that advisory committee.

Chairman Keiser: I wished we could find the language to recognize that we are talking about one exchange and not two exchanges. This language creates the potential for two exchanges. I know that is not what anyone wants.

Senator Lee: I agree. If we need to provide information clarifying that, I would not oppose that. It is intended that we recognize that the exchange has to deal on the base of the pyramid with qualifying of individuals for Medicaid or Children's Health Insurance and then

moving into the private insurance policies. If we can use this as a basis of understanding and move forward with clarifying information, I would encourage that.

Senator Mathern: Where would you see these amendments on the bill moving us toward two exchanges?

Chairman Keiser: On the colored version--.2002, page 1, subsection 1, line 11, and then number 2. It is conceivable that you can meet the requirements of the law and create two exchanges. One which dealt with the purchase of qualified health benefit plans and you could generate an exchange for the state which provides for eligibility determination. The language in effect is saying you can do both of those things.

Senator Mathern: I don't read it that way. However, if there needs to be a clarification point that there is only one exchange, I think that would be just fine.

Chairman Keiser: If you look at the application, at some point, we need to decide if every partner is going to be co-equal or is there somebody that will be in charge. The language in Section 3, line 7, "American health benefit exchange for the state, the commissioner and department of human services shall submit proposed legislation." Is that together in a single plan or will they be submitting separate legislation for the exchange?

Senator Mathern: Your comments earlier about "They work together so well" as indicating they would.

Chairman Keiser: But what we are saying in language is they don't need to. I think prior language would have guaranteed that they work together. I will take time and look at it and determine what to do. Other comments on Senator Lee's proposed amendments?

Vice Chairman Kasper: What is bothering me about this bill, when reading the bill, when you go to the colored bill of Senator Lee's amendments, page 1, line 9, "To ensure that an American health benefit exchange is created in the state." My concern is we don't know if it will be created. Under current law it will be created; but we have the court challenges and we don't know if and when the Supreme Court will rule on the constitutionality of PPACA.

I would like to read through some proposed changes. I would like the committee to consider on page 1, on lines 1 & 2, adding "consideration of" after "relating to the" on line 2. Going down to line 9, I would strike the words "To ensure that" and I would substitute "plan for the possible implementation of an American health benefit exchange." Then strike "is created." On line 11, strike the word "plan" and substitute "consider options." On line 20, strike the word "plan" and substitute "consider options." On page 2, line 4, insert a comma after "ensure" and add "if required by law." Then go down to line 12, strike the word "implement" and substitute "to consider the implementation of." On line 20, after the word "exchange", insert a comma and the words "should it be established." On line 23, after "designee", insert a comma and the words "should the exchange be established" and insert a comma. On page 3, line 6, strike "determining, planning, and implementing" and replace with "considering options for." At the end of line 12, I would suggest adding a new

Section 4 which would state "if the Patient Protection and Affordability Act is deemed to be unconstitutional by the United States Supreme Court, this Act is null and void." The Emergency Clause would become Section 5.

These amendments don't change a thing a far as moving forward but it is taking away the fact that in reading the bill, it seems to me, we are going to do this. I know we have the November special session coming up.

Senator Mathern: I am wondering what your thoughts are in terms of the consequence to the federal government decision making as to whether or not the state of North Dakota is proceeding with wanting to adopting the exchange versus letting the federal government do the exchange. There are some considerations in the drafting that reflect a message to the federal government that we as a state want to be in charge of some of this versus the federal government moving ahead. With your qualifying language I am wondering if you believe that would still permit the state to do it if the act was found constitutional.

Vice Chairman Kasper: That is a good observation. My intent is not to open that door. We could add a section that would state it is the intent of the state of North Dakota to implement a state exchange if it's determined that a health exchange is required under PPACA. We are going to do it if it's going to be done.

Senator Lee: Part of this language was in the original bill that was considered by the House IBL committee in the first place. Was it considered at that time and if not, why not?

Vice Chairman Kasper: Revelations come at various times in your life. There was something gnawing at me in this bill but I couldn't put my finger on it. It came to me this morning and I started putting the language on. From my perspective, I would be more comfortable. I don't recall it being discussed in our committee.

Senator Lee: The ambivalence of the added language is not something that either committee has discussed. I am not confident that the Supreme Court will rule on this in the next several weeks. I do have a concern that language presented by Representative Keiser at the request of the Insurance Commissioner to provide enabling legislation for this to move forward is now back to "only if we have a gun to our head" language instead of "we are doing what we recognize as being necessary based on what the federal law is right now." I don't disagree with the philosophy. I just think it is about three months late.

Vice Chairman Kasper: As we live day by day, our thoughts and revelations change. If I had this thought then, it would have been brought forward then. That is what we encounter in conference committees; new thoughts and ideas come forward. I brought this language forward for consideration by the committee.

Chairman Keiser: I looked at the language and it clarifies what part of the intent of the House was. However, the House went down two different avenues in anticipation that the law was constitutional. You have 1125, 1126, 1127. We also had other resolutions and bills which went down that second track which was that we believe may be unconstitutional. I asked Representative Kasper to bring it to the committee and have discussion. It really isn't germane to the amendments on the bill. If the committee thought the language

improved the intent of the bill as it was developed then it would be relevant. Assuming there is a special session it does present an additional opportunity to look at this issue.

Senator Mathern: One of the things that is important is that we be nimble enough to take what is positive and move what is positive no matter what the federal court decides. One of the unique features about this bill is this opportunity of developing a system where the citizens themselves can put in their data, get feedback about the various options and come to a conclusion about what they are eligible for. I suspect whether there be PPACA or not, we as a state should be looking at such a vehicle so that our citizens can make decisions using this new technology. I see embedded in here a potential for our state, regardless of federal health care reform, that would be good for our citizens. I know that the appropriations committee of the Senate has looked at a number of computer programs that we have and our eligibility criteria that are out dated. My hope is that regardless how the federal and the court decide, we would want to do some of this for the good of our citizens.

Vice Chairman Kasper: I would take the opposite viewpoint. About 90% of the people in North Dakota are covered by health insurance or Medicare/Medicaid under the free enterprise competitive system we have. So to consider without federal requirement the implementation of an exchange where we have a bureaucratic organization that attempts to help people make personal decisions would be a real stretch for me to support. I support this bill because we are up against it. I wouldn't want the record to show that I support an exchange if we don't need to put one in.

Senator Mathern: If I could clarify, these programs, medical assistance or children's health insurance, there are computer programs behind these programs that don't interface with many other county and state programs. Even that portion we could get better at and become more efficient. At some point, we could have somebody from the counties tell us how many computer programs are duplicating efforts that they would like to combine. A program like this could help us combine.

Chairman Keiser: I'm going to support in the special session that we again visit this issue. We need a full committee hearing with public input.

Vice Chairman Kasper: I appreciate you listening to my thoughts and at least now they are on the record and it's something we could look at in special session.

Chairman Keiser: Closes the hearing.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
April 19, 2011
16778

☒ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Creation of the health insurance exchange

Conference Minutes:

Chairman Keiser: Opened the Conference committee hearing on HB 1126.

Chairman Keiser: (Passes out amendment .02005). You are going to find that it is very similar to the one you were given this morning but there are also changes. Walks through the changes, see attached copy.

Senator Lee: All three of us agree that partnership was important so change "with" to "and".

Chairman Keiser: What I was trying to get was, if we are going to have a team, the Insurance Department with the Department of Human Services shall submit purposed legislation. That's the intent of the language.

Senator Dever: I don't disagree, but I think the word "and" will be more consistent also with lines 13 & 14 on page 2.

Chairman Keiser: The reason I left that in there is that, rule adopting is done by departments. When we bring forward legislation for the exchange, it is my sincere hope that it's a single package not packages from different departments.

Senator Dever: As it pertains to the exchange, that might be true, but there may be legislation involving other parts of federal health care reform that might suggest legislation from the departments separately.

Chairman Keiser: Maybe under application, what we want to do is clarify "relative to exchange".

Senator Dever: That is in 2 places, in section 3 in line 5 and line 9.

Chairman Keiser: Right, because in both cases there are submitting legislation.

Senator Lee: I appreciate the fact that you see this as a team too but I think we are into grammar here. From the grammar point of view, the commissioner is the subject of this sentence and a modifying phrase is what the Department of Human Services and so forth. If you pull out the modifying phrase, the commissioner shall submit purposed legislation, so from the grammatical point of view, I think it puts the commissioner in a different position. I would agree that we need one proposal moving forward on the exchange and how can we word smith this properly? I don't want separate proposals but Senator Dever has a good point in that there may be things having to do with the eligibility. They don't have anything to do with exchange, the departments is going to have some things separate. We don't want to tie anyone's hands but this thing, I see them working together on it.

Senator Mathern: This is really the geneses of the advisory committee that was originally put in so all the people put together could bring this forward. I believe this still can be accomplished without the advisory committee by essentially eliminating "with" on line 5 & 9 and replacing with "and". This would still have all of these entities needing to look at health care reform in terms of their special purview and working with the other ones. Another thing in terms of the concern of more than one proposal coming forward, sort of checked in terms of policy options by these departments bringing this to the interim committee. The fact that we have set up an interim committee, it's in the interest of the interim committee, to make sure all of the options these folks might come up between not and then, with might be heard. Even if there was some sort of conflict, it would be better that it would be heard than it not be heard. I think with that word change, this bill is ready to go.

Vice Chairman Kasper: On page 3, line 5, what if the language said the following "the commissioner with the department of human service and information technology department shall submit a single joint proposal to the interim committee to consider presenting to the legislative management committee for consideration at the special session". We are distinctly saying, we are asking them to give us one joint proposal. That means to have to cooperate and come forward with a proposal. It can encompass their needs and desires but it would be delineated as a single joint proposal.

Senator Lee: I appreciate where you are going but I'm trying to think past the one proposal. Would we be limiting them one humongous bill? It just wanted to make sure that there is something that doesn't blend well between what the proposals might be from one to the other. That they are coming forward with a unified proposal, but I wonder if there might be some things that might be coming to the committee or do we limited them to an awkward situation if we just say one unified?

Vice Chairman Kasper: The intent of the verbiage is to allow each department to bring forward their piece of the proposal. I would envision it, if this were the committee hearing their proposal, the Insurance Department, Human Services and ITD have their piece but they would have agreed in advanced that these work together. This is the big proposal but each going to make a presentation of their segment of the proposal and they work together. That would be the intent that I'm trying to get here.

Senator Mathern: I guess one of the scenarios I could see, as the states in our region all move forward with this, I could see this proposal that Representative Kasper discusses, but

I could also see something like Senator Lee outlines in terms of there might be something outside the box that I wouldn't want to be closed to. What if Minnesota and South Dakota came together with one of our departments and said, if we could run this piece together, we could save 40 million dollars. There might be a proposal but there might be some new ones, that I would hope that we wouldn't preclude a department bringing to our attention and that's an unknown but it would be an example.

Vice Chairman Kasper: I agree that could occur and that might occur but at least the intent would be that we are asking them to bring a single joint proposal that they could outline.

Chairman Keiser: It's dangerous to draft on the fly. I do understand what you saying and I will share with you; we got into a discussion about the grant monies that both department were going to receive relative to implementing the exchange and what is the intent with those grant dollars? The grants would be used to hire consultants to put together the exchange. There was a discussion and I started getting nervous, are we going to have two different consultants going down different paths and coming up with something that doesn't interface. We all have had personal experience about how wrong sometimes the IT and the consultants can go if they aren't integrated in their effort. We have to make sure; I do see the interim committee as meeting a lot during the early phases with having great oversight and discussions with all departments relative to the exchange and health legislation. What would you say to something like "health benefit exchange for the state, the commissioner, the Department of Human Services and ITD shall work together in submitting proposed legislation"? What we want them to do is work together. I see the interim health committee playing a significant role in direction the focus of this effort.

Senator Lee: I appreciate where you are going, I wonder because we are doing it on the fly. It might be worthwhile just to go visit with somebody from Legislative Council and tell them where we are headed, how can we best say it. Another thing that just occurred to me that the fact that somebody may not agree with somebody else. I don't want to preclude somebody. I think it's going to be important that they be honest, direct and full disclosure with the committee if there is an area that is difficult to resolve. I'm confident that they will be able to work together well, but I don't want anyone not have the opportunity to speak about something. We don't know what might turn up and I want to make sure our language doesn't eliminate any of those options for the Legislative committee. Maybe Legislative Council can figure out a way to say what we all want to do.

Chairman Keiser: We can certainly do that.

Senator Mathern: I suggest as you consider your wording, that you replicate it in nine.

Chairman Keiser: I would assume that to be the case.

Senator Dever: How does this complicate things when the implementation of this requires different appropriations to different agencies?

Chairman Keiser: That's up to Appropriations. We can certainly make recommendations.

Senator Mathern: I believe section 2, which is the appropriations, clearly goes to the commissioner. I believe there is another appropriation, probably very meager, in 2012.

Chairman Keiser: The appropriations are spread out. This appropriation is specific to the Insurance Department grant. This is a federal grant to insurance departments, not to the exchanges per say, it's to insurance department to set up exchanges. The federal government sees the insurance department as being the lead on establishing the exchange, but that doesn't mean we can't have language that directs them to work together to create the best exchange for North Dakota as possible.

Vice Chairman Kasper: How do you address the two different consulting firms going down two different tracks?

Chairman Keiser: We can't move fast enough but Legislative Council will meet, committees assigned and then the health committee needs to meet immediately to begin to work with the departments. They are sitting here right now; I just can't imagine the departments going down that path. Where have they don't that before and I've never seen a problem. They are going to put together the exchange and they are going to do one heck of a job if we just stay out of their way.

Senator Lee: I was thinking about the two consultants, it is feasible that two different areas would needs to have a consultant helping but they would not be duplicating. I don't necessarily want to preclude them from getting the proper help and not just get one consultant who is good at both of those things. We are on the same direction; we just have to find a way to say it.

Chairman Keiser: I couldn't agree more. Is there any other part you want to address before the next time we meet? We will adjourn.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
April 20, 2011
16801

☒ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Creation of the health insurance care exchange

Conference Minutes:

Chairman Keiser: (Hands out and goes over amendment .02005.) What I've done is replace "commissioner" to "Insurance Department", "with" to "and" and removed ITD in some areas.

Chairman Keiser: You may want to review it and come back.

Senator Mathern: I believe the change from commissioner to the Insurance Department works. I think the rational for naming the commissioner is different from the Department of Human Services. The commissioner is an independently elected official where the Director of Human Services is not. I think this change works.

Chairman Keiser: I think that was the original intent. I want to stress that it is a program brought forth and don't think the commissioner will have heartburn over that.

Senator Lee: I do appreciate the thought you put into this, I think it looks certainly worthwhile; I would be most comfortable getting the legislative council can give us a colored copy.

Chairman Keiser: We will take this to Legislative Council and adjourns the hearing on HB 1126.

2011 HOUSE STANDING COMMITTEE MINUTES

House Industry, Business and Labor Committee
Peace Garden Room, State Capitol

HB 1126
April 21, 2011
16801

☒ Conference Committee

Committee Clerk Signature Ellen LeTang

Explanation or reason for introduction of bill/resolution:

Creation of the health insurance care exchange

Conference Minutes:

Senator Dever: It appears to me that everything is as we discussed, with the exception, now we are referring to the commissioner instead of the Insurance Department.

Chairman Keiser: After Senator Mathern's comment, I don't know about that. I had a discussion with a group of attorneys and they said we think it should remain the commissioner because that's the way it is set up in the century code throughout the insurance section. I said, will you go and check on that, if that's the case, we will make the adjustment because there should be no reason to create any doubt. This .02006 is the latest version.

Senator Dever: Moves for the Senate recede from its amendments and adopt amendment .02006.

Vice Chairman Kasper: Second.

Chairman Keiser: Further discussion. The only think I want to say, I really appreciate the Senate members. We have here a very solid positive approach to creating the exchange. I certainly support it.

Representative Gruchalla: I was going to comment on paranoia, with Chairman Keiser running or in charge of setting this up is a good thing. The citizens of North Dakota will be well served.

Senator Mathern: I think the amendments do in fact reflect the intent of the Senate and the way you expresses them is just fine. I thank you and the rest of the members for working this out in this regard.

Chairman Keiser: I want to take this opportunity to say, I think, based on my involved in NCOIL and other National Organizations; we have the best insurance, IT and Human Services department.

Roll call was take for the Senate to recede from the Senate amendments on HB 1126 with 6 yeas, 0 nays, 0 absent. Motion passes.

Chairman Keiser: Closes the conference committee hearing on HB 1126.

2011 HOUSE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: House Industry, Business and Labor

Bill/Resolution No. 1126 as (re) engrossed

Date: April

Roll Call Vote #: _____

Action Taken

- ☐ HOUSE accede to Senate amendments
- ☐ HOUSE accede to Senate amendments and further amend
- ☐ SENATE recede from Senate amendments
- ☐ SENATE recede from Senate amendments and amend as follows

House/Senate Amendments on HJ/SJ page(s) _____

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: _____ Seconded by: _____

Representatives	15	18	19	Yes	No		Senators	15	15	A	Yes	No
Chairman Keiser	✓	✓	✓				Senator Dever	✓	✓	✓		
Vice Chairman Kasper	✓	✓	✓				Senator Lee	✓	✓	✓		
Representative Gruchalla	✓	✓	✓				Senator Mathern	✓	✓	✓		

Vote Count Yes: _____ No: _____ Absent: _____

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Prepared by the Legislative Council staff for
Representative Keiser
April 20, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

That the Senate recede from its amendments as printed on pages 1516 and 1517 of the House Journal and pages 835 and 836 of the Senate Journal and that Engrossed House Bill No. 1126 be amended as follows:

Page 1, line 2, replace "a" with "an American"

Page 1, line 2, replace "insurance" with "benefit"

Page 1, line 2, after the first semicolon insert "to provide reports to the legislative management;"

Page 1, line 9, after "commissioner" insert "and the department of human services"

Page 1, line 11, replace the underscored comma with an underscored semicolon

Page 1, line 14, replace the underscored comma with "; implements eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program; provides simplification; provides coordination between medical assistance, the children's health insurance program, and the state health insurance exchange;"

Page 1, line 17, replace "commissioner" with "legislative assembly"

Page 2, line 3, remove "and"

Page 2, line 5, replace the underscored period with "; and

5. Collaborate with the information technology department as necessary and appropriate in completing the responsibilities set forth in this section."

Page 2, line 7, after "commissioner" insert "and the department of human services"

Page 2, line 10, after "commissioner" insert "and the department of human services"

Page 2, line 14, after "designee" insert "and the department of human services"

Page 2, line 16, after "commissioner" insert ", the department of human services,"

Page 2, line 16, after "or" insert "the"

Page 2, line 26, after "commissioner" insert "and the department of human services"

Page 2, line 28, after the comma insert "collectively"

Page 2, line 28, after "commissioner" insert "and the department of human services"

Page 2, line 29, replace "commissioner" with "state"

Page 3, line 1, after the fourth comma insert "collectively"

Page 3, line 1, after "commissioner" insert "and the department of human services"

Renumber accordingly

2011 HOUSE CONFERENCE COMMITTEE ROLL CALL VOTES

Committee: House Industry, Business and Labor

Bill/Resolution No. 1126 as (re) engrossed

Date: April 21, 2011

Roll Call Vote #: _____

Action Taken

- ☐ HOUSE accede to Senate amendments
- ☐ HOUSE accede to Senate amendments and further amend
- ☐ SENATE recede from Senate amendments
- ☒ SENATE recede from Senate amendments and amend as follows

House/Senate Amendments on HJ/SJ page(s) --

- ☐ Unable to agree, recommends that the committee be discharged and a new committee be appointed

((Re) Engrossed) _____ was placed on the Seventh order of business on the calendar

Motion Made by: Dever Seconded by: Kasper

Representatives	20	21		Yes	No		Senators	20	21		Yes	No
Chairman Keiser	✓	✓		✓			Senator Dever	✓	✓		✓	
Vice Chairman Kasper	✓	✓		✓			Senator Lee	✓	✓		✓	
Representative Gruchalla	✓	✓		✓			Senator Mathern	✓	✓		✓	

Vote Count Yes: 6 No: 0 Absent: 0

House Carrier _____ Senate Carrier _____

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

REPORT OF CONFERENCE COMMITTEE

HB 1126, as engrossed: Your conference committee (Sens. Dever, J. Lee, Mathern and Reps. Keiser, Kasper, Gruchalla) recommends that the **SENATE RECEDE** from the Senate amendments as printed on HJ pages 1516-1517, adopt amendments as follows, and place HB 1126 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1516 and 1517 of the House Journal and pages 835 and 836 of the Senate Journal and that Engrossed House Bill No. 1126 be amended as follows:

Page 1, line 2, replace "a" with "an American"

Page 1, line 2, replace "insurance" with "benefit"

Page 1, line 2, after the first semicolon insert "to provide reports to the legislative management;"

Page 1, line 9, after "commissioner" insert "and the department of human services"

Page 1, line 11, replace the underscored comma with an underscored semicolon

Page 1, line 14, replace the underscored comma with "; implements eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program; provides simplification; provides coordination among medical assistance, the children's health insurance program, and the state health insurance exchange;"

Page 1, line 17, replace "commissioner" with "legislative assembly"

Page 2, line 3, remove "and"

Page 2, line 5, replace the underscored period with "; and

5. Collaborate with the information technology department as necessary and appropriate in completing the responsibilities set forth in this section."

Page 2, line 7, after "commissioner" insert "and the department of human services"

Page 2, line 10, after "commissioner" insert "and the department of human services"

Page 2, line 14, after "designee" insert "and the department of human services"

Page 2, line 16, after "commissioner" insert ", the department of human services,"

Page 2, line 16, after "or" insert "the"

Page 2, line 26, after "commissioner" insert "and the department of human services"

Page 2, line 28, after the comma insert "collectively"

Page 2, line 28, after "commissioner" insert "and the department of human services"

Page 2, line 29, replace "commissioner" with "state"

Page 3, line 1, after the fourth comma insert "collectively"

Page 3, line 1, after "commissioner" insert "and the department of human services"

Renumber accordingly

Engrossed HB 1126 was placed on the Seventh order of business on the calendar.

2011 TESTIMONY

HB 1126

HOUSE BILL NO. 1126

Presented by: **Adam Hamm**
Commissioner
North Dakota Insurance Department

Before: **House Industry, Business and Labor Committee**
Representative George Keiser, Chairman

Date: **January 17, 2011**

TESTIMONY

Good morning, Chairman Keiser and members of the committee. My name is Adam Hamm, North Dakota Insurance Commissioner. I appear before you today in support of House Bill No. 1126.

The purpose of the bill is to allow you to decide whether it is best for North Dakota, rather than the federal government, to run the health benefit exchange required by the Patient Protection and Affordable Care Act also known as "federal health care reform", or "PPACA". I will refer to this law as "PPACA".

What is an Exchange?

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

Exchanges will allow people to compare health plans and determine which one is best for them. Health plans will be placed in tiers based on out-of-pocket costs, which allows consumers to compare plans on an apples-to-apples basis. All plans sold in the exchange are offered by private insurance companies. There is no government-run plan or public insurance option.

An exchange must also assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs such as Medicaid and the Children's Health Insurance Program (CHIP). Individuals whose household income does not exceed 400 percent of the poverty line will receive subsidies through the exchange according to a sliding scale. By providing one-stop shopping, exchanges are theoretically supposed to increase competition in the marketplace and make purchasing health insurance easier and more understandable for consumers.

If North Dakota does not run its own exchange, the United States Department of Health and Human Services ("HHS") will. By January 1, 2013, HHS must determine whether the state will have an exchange in operation by January 1, 2014. If it determines that the state will not have an operational exchange by then, HHS is required to establish and operate the exchange within that state. The federal government will work with the Governor of the state as the Chief Executive Officer unless authority to operate the exchange has been delegated to a specific authority through state law.

What Does This Bill Do?

At its most basic level, this bill puts the following questions before you:

1. Do you want the federal government or the state to run the North Dakota exchange?

2. If you want the state to run its own exchange, who do you want to run it?

3. If the state will run its exchange, what resources do you want the responsible agency to have in order to build and operate the exchange?

To be clear, this bill is not an endorsement of PPACA or the wisdom or effectiveness of exchanges. It is the means by which these issues are being brought before you so that the Legislative Assembly may decide whether it is in North Dakota's best interest to run its own exchange or to let the federal government do so.

Who Can Run An Exchange?

States have the option to establish the exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state agency or a newly created, independent state agency. Alternatively, the exchange could be operated by a nonprofit entity. If none of these entities run the state's exchange, the federal government will take over that responsibility.

What Functions Must an Exchange Perform?

Exchanges must perform a lengthy list of functions. These functions should be taken into consideration when deciding which entity is best to run the exchange and the resources needed by that entity. At a minimum, an exchange must:

- Implement procedures for the certification, recertification, and decertification of health plans as qualified health plans;

- Provide for the operation of a toll-free telephone hotline to respond to assistance requests;

- Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans;

- Assign a rating to each qualified health plan offered through the exchange;

- Use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage;

- Inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program, and, if through screening of the individual's application by the exchange, it determines that such individuals are eligible for any such program, enroll such individuals in such program;

- Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction available under PPACA;

- Grant certification attesting that, for purposes of the individual responsibility penalty, an individual is exempt from the individual requirement or from the penalty imposed because he or she meets one of the exceptions provided in PPACA;

- Transfer to the Secretary of the Treasury a list of individuals who are issued certification of penalty exemption, the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit because the employer did not provide minimum essential coverage or the employer provided the minimum essential coverage but it was either unaffordable or did not provide the required minimum actuarial value, and the name and taxpayer identification number of each individual who notifies the exchange that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year;

- Provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year and the effective date of such cessation; and

- Establish a Navigator program.

There are some areas where the state has choices. Federal rules will clarify that the following policy areas, among others, are state decisions, although HHS may offer recommendations and technical assistance to states as they make these decisions:

- Whether to form the exchange as a governmental agency or a nonprofit entity.

- Whether to form regional exchanges or establish interstate coordination for certain functions.

- Whether to require additional benefits in the exchange beyond the essential health benefits (mandates).

- Whether to establish a competitive bidding process for plans.

- Whether to extend some or all exchange-specific regulations to the outside insurance market beyond what is required in PPACA.

- What additional types of services the exchange might provide to individuals and business to ensure simple and fast service.

If you believe that it would be better for the state to run its own exchange, certain things have to be accomplished by deadlines set out in PPACA. As I already noted, states must be on track for achieving certification of their exchange by January 1, 2013, or the federal government will run the exchange. And the exchange must be operating no later than January 1, 2014. Establishment of an exchange requires a planning process

to create an exchange that will meet all the requirements of PPACA. Anyone who is even somewhat familiar with a complex information technology (IT) project can recognize how short this timeframe is, especially given that most of the functionality required does not exist in North Dakota's state government or in any other entity currently operating in our state.

This bill would require the Commissioner to plan and implement the exchange for the state. The bill would ensure that the exchange facilitates the purchase of qualified health benefit plans, provides for the establishment of a small business health options program, and meets the exchange requirements of PPACA generally.

What Does the Commissioner Do if the State Runs the Exchange?

In order to plan and implement a North Dakota exchange, the bill assigns the following duties to the Commissioner:

- To take actions necessary to ensure that the exchange is determined, not later than January 1, 2013, by the federal government to be ready to operate not later than January 1, 2014.

- To consider whether to seek federal grant funds for the planning and implementation of the exchange.

- To determine whether to establish one exchange that will provide services to both qualified individuals and qualified small employers or to have two separate exchanges.

- To contract with outside entities, if necessary, to provide services to implement the exchange.

- To adopt rules, if necessary or desirable, to carry out the provisions of the bill.

Exchanges will require complex and particular IT systems and other business operations to perform the functions required. Since the exchange will have to work with other state and federal agencies, for example, to fulfill its duty to determine tax credits and enroll eligible individuals in Medicaid and CHIP, the bill requires state agencies to cooperate with the Commissioner to ensure the success of the exchange. At this time, the IT systems of the agencies likely to be involved in the exchange do not have the ability to communicate and exchange data with each other.

Because exchanges are also required to report certain information to other entities such as the United States Secretary of the Treasury, the bill allows the Commissioner to receive from, and provide to, federal and state agencies confidential information gathered in the administration of the exchange including Social Security numbers if the disclosure is necessary for the Commissioner or receiving entity to perform its duties and responsibilities.

What Resources Are Needed For an Exchange?

The bill also provides that the Commissioner may seek Emergency Commission and Budget Section approval for authority to spend any general funds, special funds or federal funds available under PPACA. The federal government will provide grants for exchange planning and development.

Forty-eight states and the District of Columbia were awarded their first exchange planning grants in September 2010. Those grants were for planning purposes and the next round of grants will be for the purpose of establishing an exchange. The opportunity to apply for grants will be announced in February 2011 and will become available on a rolling basis throughout the next three years. States will have to meet certain milestones in order to be awarded grants in 2011, and the size of state awards may be related to the number of milestones met. Necessary exchange planning and establishment costs will be funded by HHS until 2015. After January 1, 2015,

exchanges must be self-funded. North Dakota was approved to receive $1,000,000 in the first round of exchange grants; however, the Emergency Commission tabled the request to utilize these funds. These funds could be important right now given the challenging infrastructure requirements needed to develop an exchange. They can be used to analyze options, define requirements, and estimate the probable cost to implement an electronic system to operate the state's exchange. Future grant funds will be available to pay for the cost of building the system that will operate the exchange. In addition to the staffing and information technology infrastructure needs, the state will need resources to help it identify and address many issues and to make informed decisions along the way, including:

1. **Unified exchange.** A state has to provide an exchange that facilitates individuals' purchase of health insurance and an exchange that serves small businesses. The state may choose to operate them separately or both in one exchange as long as it serves both functions.

2. **Regional exchange**. States may form a regional exchange with other states or allow more than one exchange to operate in the state as long as each exchange serves a distinct geographic region.

3. **Stakeholders.** PPACA requires states to consult with stakeholders in implementation of the exchange. Stakeholders must include health care consumers who enroll in qualified health plans, individuals and entities experienced in facilitating enrollment in qualified health plans, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for enrolling hard to reach populations. In planning for this legislative session, the Insurance Department has already begun stakeholder conversations. I can assure you that the exchange is a focus for many of these individuals and groups.

4. **Funding.** How will the state ensure that the exchange is self-sustaining as of January 1, 2015? Exchanges are allowed to charge assessments or user fees to participating insurance issuers or to otherwise generate funding in order to support its operations.

5. **Outside market**. Will insurers be allowed to sell health plans outside the exchange? And if an external market remains, will insurers be required to offer plans both in and out of the exchange?

6. **Large employers.** Beginning in 2017, an exchange may allow businesses with more than 100 employees to purchase coverage in the exchange also.

7. **Mandates.** Does the state want to require that plans offer benefits in addition to the essential health benefits package? If so, the state must assume the cost by making payments to individuals enrolled in a qualified health plan in the state or making payments directly to the qualified health plan on behalf of the individual. HHS has not yet determined how the essential health benefits package will be defined.

8. **Data reporting.** Determination of the data that will be required to be reported, what persons will be allowed to access data, and how to ensure appropriate protection of data.

9. **Certification of plans.** The exchange must implement procedures for the certification, recertification and decertification of health plans as qualified health plans. It is expected that this will require someone to analyze the health plans offered for sale through the exchange to ensure that they meet one of the required benefit categories: bronze plans which must cover 60% of benefit costs; silver plans which must cover 70% of benefit costs; gold plans which must cover 80% of benefit costs; platinum plans

which must cover 90% of benefit costs; and catastrophic plans, which are available only to those up to age 30, which must provide catastrophic coverage only. Someone must also ensure that the plans offered in the exchange meet certain benefit requirements, marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, and use a uniform enrollment form and standard format to present plan information.

10. **Hotline.** The exchange must provide for the operation of a toll-free hotline to respond to assistance requests.

11. **Website.** The exchange must maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans.

12. **Ratings.** The exchange must assign a rating to each qualified health benefit plan offered through the exchange.

13. **Standardized format.** The exchange must use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage.

14. **Other coverage.** The exchange must inform individuals of Medicaid, CHIP, and other state or local public programs eligibility requirements and enroll eligible individuals in these programs.

15. **Calculator.** The exchange must provide an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction.

16. **Individual responsibility certification.** The exchange must grant a certification attesting that for purpose of the individual responsibility penalty (individual mandate) that an individual is exempt from the penalty because there is no affordable qualified health plan available through the exchange or the individual's employer, or the individual meets the requirement for any other exemption.

17. **Certification of penalty exemption**. The exchange must transfer to the Secretary of the Treasury a list of individuals who are issued a certification of penalty exemption.

18. **Employer notice.** The exchange must provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year.

19. **Navigator program.** The exchange must establish a Navigator program under which it awards grants to entities to carry out certain duties such as public education, facilitating enrollment in qualified health plans, and providing referrals to health insurance ombudsman or other appropriate agency for any enrollee with a grievance, complaint, or question regarding his health plan, coverage, or a determination under such plan or coverage.

20. **Producers.** The exchange must determine the role insurance producers (agents) will play in the sale of health benefit plans in the exchange.

The bill also contains an emergency clause so that it would become effective immediately upon its filing with the Secretary of State to allow work to start to address the many decisions that will have to be made and the work to begin to build an IT system that will be capable of performing all the required functions.

In closing, there are many decisions to be made about how the exchange will be run in North Dakota. There will be more decisions to be made as things are further defined or changed at the federal level. Several federal agencies are tasked with issuing regulations to implement the law and many of them have yet to be issued so various components remain undefined at this point. In addition, there is the prospect of Congress making changes to the law as well as the numerous legal challenges to the law that are making their way through the court system. For now, the law requires that there be an exchange implemented in North Dakota. The first decision is who will run it: the federal government or the state. Our stakeholders are telling us they prefer North Dakota run its own exchange and cite the numerous problems with other federal insurance programs as examples of how North Dakotans serve our own better. In fact, it is my Department that assists Medicare Part D prescription drug beneficiaries in comparing, choosing, and enrolling in Part D plans, as well as dealing with issues and complaints. This piece of legislation places similar responsibilities related to the exchange in this same agency.

This concludes my testimony. I would be happy to try to answer any questions the committee members may have. Thank you.

Testimony
House Bill 1126 – Department of Human Services
House Industry, Business & Labor
Representative Keiser, Chairman
January 17, 2011

Chairman Keiser, members of the Industry, Business & Labor Committee, I am Carol Olson, Executive Director of the Department of Human Services. I am here today to provide information to you regarding the relationship between an American Health Benefit Exchange and the programs within Department of Human Services.

If it is the interest of this committee to pursue the establishment of an American Health Benefit Exchange for the state that will meet the requirements as currently outlined in the Patient Protection and Affordable Care Act of 2010, it will be important for this committee to consider the implications of:

- Title I, Section 1311(d)(4)(F) requiring, at a minimum, for the Exchange to provide for eligibility determination and the enrollment of individuals in Medicaid and CHIP programs; and
- Title II Role of Public Programs, Section 2201 which outlines more specifically the requirements of enrollment simplification and Medicaid and CHIP coordination with the State Health Insurance Exchange.

The intent of these sections is to ensure that the American Health Benefit Exchange provide seamless eligibility and enrollment linkages between the exchange coverage options and public assistance programs. In order to achieve this level of interoperability with the Exchange, the Medicaid and CHIP eligibility systems will require significant modification.

I would be happy to answer any questions you may have.

Testimony
House Bill 1126 – Department of Human Services
Before the Joint Meeting of
House Industry, Business & Labor
Representative Keiser, Chairman
House Appropriations, Government Operations Division
Representative Thoreson, Chairman
February 1, 2011

Chairmen Keiser and Thoreson, members of the Industry, Business & Labor Committee and House Appropriations, Government Operations Division, I am Carol Olson, Executive Director of the Department of Human Services. I am here today to provide information to you regarding the relationship between an American Health Benefit Exchange and the programs within Department of Human Services.

If it is the interest of this committee to pursue the establishment of an American Health Benefit Exchange for the state that will meet the requirements as currently outlined in the Patient Protection and Affordable Care Act of 2010, it will be important for this committee to consider the implications of:

- Title I, Section 1311(d)(4)(F) requiring, at a minimum, for the Exchange to provide for eligibility determination and the enrollment of individuals in Medicaid and CHIP programs; and
- Title II Role of Public Programs, Section 2201 which outlines more specifically the requirements of enrollment simplification and Medicaid and CHIP coordination with the State Health Insurance Exchange.

The intent of these sections is to ensure that the American Health Benefit Exchange provide seamless eligibility and enrollment linkages between the exchange coverage options and public assistance programs. In order to achieve this level of interoperability with the Exchange, the Medicaid and CHIP eligibility systems will require significant modification.

I would be happy to answer any questions you may have.

Attachment ONE

HOUSE BILL NO. 1126

Presented by: **Adam Hamm**
Commissioner
North Dakota Insurance Department

Before: **Joint Committee Hearing before**
House Industry, Business and Labor Committee and
House Appropriations – Government Operations and Human Resources Divisions

Date: **February 1, 2011**

TESTIMONY

Good morning committee members. My name is Adam Hamm, North Dakota Insurance Commissioner. I appear before you today in support of House Bill No. 1126.

The purpose of the bill is to allow you to decide whether it is best for North Dakota, rather than the federal government, to run the health benefit exchange required by the Patient Protection and Affordable Care Act also known as "federal health care reform", or "PPACA". I will refer to this law as "PPACA".

What is an Exchange?

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

Exchanges will allow people to compare health plans and determine which one is best for them. Health plans will be placed in tiers based on out-of-pocket costs, which allows consumers to compare plans on an apples-to-apples basis. All plans sold in the exchange are offered by private insurance companies. There is no government-run plan or public insurance option.

An exchange must also assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs such as Medicaid and the Children's Health Insurance Program (CHIP). Individuals whose household income does not exceed 400 percent of the poverty line will receive subsidies through the exchange according to a sliding scale. By providing one-stop shopping, exchanges are theoretically supposed to increase competition in the marketplace and make purchasing health insurance easier and more understandable for consumers.

If North Dakota does not run its own exchange, the United States Department of Health and Human Services ("HHS") will. By January 1, 2013, HHS must determine whether the state will have an exchange in operation by January 1, 2014. If it determines that the state will not have an operational exchange by then, HHS is required to establish and operate the exchange within that state. The federal government will work with the Governor of the state as the Chief Executive Officer unless authority to operate the exchange has been delegated to a specific authority through state law.

What Does This Bill Do?

At its most basic level, this bill puts the following questions before you:

1. Do you want the federal government or the state to run the North Dakota exchange?

2. If you want the state to run its own exchange, who do you want to run it?

3. If the state will run its exchange, what resources do you want the responsible agency to have in order to build and operate the exchange?

To be clear, this bill is not an endorsement of PPACA or the wisdom or effectiveness of exchanges. It is the means by which these issues are being brought before you so that the Legislative Assembly may decide whether it is in North Dakota's best interest to run its own exchange or to let the federal government do so.

Who Can Run An Exchange?

States have the option to establish the exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state agency or a newly created, independent state agency. Alternatively, the exchange could be operated by a nonprofit entity. If none of these entities run the state's exchange, the federal government will take over that responsibility.

What Functions Must an Exchange Perform?

Exchanges must perform a lengthy list of functions. These functions should be taken into consideration when deciding which entity is best to run the exchange and the resources needed by that entity. At a minimum, an exchange must:

- Implement procedures for the certification, recertification, and decertification of health plans as qualified health plans;

- Provide for the operation of a toll-free telephone hotline to respond to assistance requests;

- Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans;

- Assign a rating to each qualified health plan offered through the exchange;

- Use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage;

- Inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program, and, if through screening of the individual's application by the exchange, it determines that such individuals are eligible for any such program, enroll such individuals in such program;

- Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction available under PPACA;

- Grant certification attesting that, for purposes of the individual responsibility penalty, an individual is exempt from the individual requirement or from the penalty imposed because he or she meets one of the exceptions provided in PPACA;

- Transfer to the Secretary of the Treasury a list of individuals who are issued certification of penalty exemption, the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit because the employer did not provide minimum essential coverage or the employer provided the minimum essential coverage but it was either unaffordable or did not provide the required minimum actuarial value, and the name and taxpayer identification number of each individual who notifies the exchange that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year;

- Provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year and the effective date of such cessation; and

- Establish a Navigator program.

There are some areas where the state has choices. Federal rules will clarify that the following policy areas, among others, are state decisions, although HHS may offer recommendations and technical assistance to states as they make these decisions:

- Whether to form the exchange as a governmental agency or a nonprofit entity.

- Whether to form regional exchanges or establish interstate coordination for certain functions.

- Whether to require additional benefits in the exchange beyond the essential health benefits (mandates).

- Whether to establish a competitive bidding process for plans.

- Whether to extend some or all exchange-specific regulations to the outside insurance market beyond what is required in PPACA.

- What additional types of services the exchange might provide to individuals and business to ensure simple and fast service.

If you believe that it would be better for the state to run its own exchange, certain things have to be accomplished by deadlines set out in PPACA. As I already noted, states must be on track for achieving certification of their exchange by January 1, 2013, or the federal government will run the exchange. And the exchange must be operating no later than January 1, 2014. Establishment of an exchange requires a planning process

to create an exchange that will meet all the requirements of PPACA. Anyone who is even somewhat familiar with a complex information technology (IT) project can recognize how short this timeframe is, especially given that most of the functionality required does not exist in North Dakota's state government or in any other entity currently operating in our state.

This bill would require the Commissioner to plan and implement the exchange for the state. The bill would ensure that the exchange facilitates the purchase of qualified health benefit plans, provides for the establishment of a small business health options program, and meets the exchange requirements of PPACA generally.

What Does the Commissioner Do if the State Runs the Exchange?

In order to plan and implement a North Dakota exchange, the bill assigns the following duties to the Commissioner:

- To take actions necessary to ensure that the exchange is determined, not later than January 1, 2013, by the federal government to be ready to operate not later than January 1, 2014.

- To consider whether to seek federal grant funds for the planning and implementation of the exchange.

- To determine whether to establish one exchange that will provide services to both qualified individuals and qualified small employers or to have two separate exchanges.

- To contract with outside entities, if necessary, to provide services to implement the exchange.

- To adopt rules, if necessary or desirable, to carry out the provisions of the bill.

Exchanges will require complex and particular IT systems and other business operations to perform the functions required. Since the exchange will have to work with other state and federal agencies, for example, to fulfill its duty to determine tax credits and enroll eligible individuals in Medicaid and CHIP, the bill requires state agencies to cooperate with the Commissioner to ensure the success of the exchange. At this time, the IT systems of the agencies likely to be involved in the exchange do not have the ability to communicate and exchange data with each other.

Because exchanges are also required to report certain information to other entities such as the United States Secretary of the Treasury, the bill allows the Commissioner to receive from, and provide to, federal and state agencies confidential information gathered in the administration of the exchange including Social Security numbers if the disclosure is necessary for the Commissioner or receiving entity to perform its duties and responsibilities.

What Resources Are Needed For an Exchange?

The bill also provides that the Commissioner may seek Emergency Commission and Budget Section approval for authority to spend any general funds, special funds or federal funds available under PPACA. The federal government will provide grants for exchange planning and development.

Forty-eight states and the District of Columbia were awarded their first exchange planning grants in September 2010. Those grants were for planning purposes and the next round of grants will be for the purpose of establishing an exchange. The opportunity to apply for grants will be announced in February 2011 and will become available on a rolling basis throughout the next three years. States will have to meet certain milestones in order to be awarded grants in 2011, and the size of state awards may be related to the number of milestones met. Necessary exchange planning and establishment costs will be funded by HHS until 2015. After January 1, 2015,

exchanges must be self-funded. North Dakota was approved to receive $1,000,000 in the first round of exchange grants; however, the Emergency Commission tabled the request to utilize these funds. These funds could be important right now given the challenging infrastructure requirements needed to develop an exchange. They can be used to analyze options, define requirements, and estimate the probable cost to implement an electronic system to operate the state's exchange. Future grant funds will be available to pay for the cost of building the system that will operate the exchange. In addition to the staffing and information technology infrastructure needs, the state will need resources to help it identify and address many issues and to make informed decisions along the way, including:

1. **Unified exchange.** A state has to provide an exchange that facilitates individuals' purchase of health insurance and an exchange that serves small businesses. The state may choose to operate them separately or both in one exchange as long as it serves both functions.

2. **Regional exchange**. States may form a regional exchange with other states or allow more than one exchange to operate in the state as long as each exchange serves a distinct geographic region.

3. **Stakeholders.** PPACA requires states to consult with stakeholders in implementation of the exchange. Stakeholders must include health care consumers who enroll in qualified health plans, individuals and entities experienced in facilitating enrollment in qualified health plans, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for enrolling hard to reach populations. In planning for this legislative session, the Insurance Department has already begun stakeholder conversations. I can assure you that the exchange is a focus for many of these individuals and groups.

4. **Funding.** How will the state ensure that the exchange is self-sustaining as of January 1, 2015? Exchanges are allowed to charge assessments or user fees to participating insurance issuers or to otherwise generate funding in order to support its operations.

5. **Outside market**. Will insurers be allowed to sell health plans outside the exchange? And if an external market remains, will insurers be required to offer plans both in and out of the exchange?

6. **Large employers.** Beginning in 2017, an exchange may allow businesses with more than 100 employees to purchase coverage in the exchange also.

7. **Mandates.** Does the state want to require that plans offer benefits in addition to the essential health benefits package? If so, the state must assume the cost by making payments to individuals enrolled in a qualified health plan in the state or making payments directly to the qualified health plan on behalf of the individual. HHS has not yet determined how the essential health benefits package will be defined.

8. **Data reporting.** Determination of the data that will be required to be reported, what persons will be allowed to access data, and how to ensure appropriate protection of data.

9. **Certification of plans.** The exchange must implement procedures for the certification, recertification and decertification of health plans as qualified health plans. It is expected that this will require someone to analyze the health plans offered for sale through the exchange to ensure that they meet one of the required benefit categories: bronze plans which must cover 60% of benefit costs; silver plans which must cover 70% of benefit costs; gold plans which must cover 80% of benefit costs; platinum plans

which must cover 90% of benefit costs; and catastrophic plans, which are available only to those up to age 30, which must provide catastrophic coverage only. Someone must also ensure that the plans offered in the exchange meet certain benefit requirements, marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, and use a uniform enrollment form and standard format to present plan information.

10. **Hotline.** The exchange must provide for the operation of a toll-free hotline to respond to assistance requests.

11. **Website.** The exchange must maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans.

12. **Ratings.** The exchange must assign a rating to each qualified health benefit plan offered through the exchange.

13. **Standardized format.** The exchange must use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage.

14. **Other coverage.** The exchange must inform individuals of Medicaid, CHIP, and other state or local public programs eligibility requirements and enroll eligible individuals in these programs.

15. **Calculator.** The exchange must provide an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction.

16. **Individual responsibility certification.** The exchange must grant a certification attesting that for purpose of the individual responsibility penalty (individual mandate) that an individual is exempt from the penalty because there is no affordable qualified health plan available through the exchange or the individual's employer, or the individual meets the requirement for any other exemption.

17. **Certification of penalty exemption**. The exchange must transfer to the Secretary of the Treasury a list of individuals who are issued a certification of penalty exemption.

18. **Employer notice.** The exchange must provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year.

19. **Navigator program.** The exchange must establish a Navigator program under which it awards grants to entities to carry out certain duties such as public education, facilitating enrollment in qualified health plans, and providing referrals to health insurance ombudsman or other appropriate agency for any enrollee with a grievance, complaint, or question regarding his health plan, coverage, or a determination under such plan or coverage.

20. **Producers.** The exchange must determine the role insurance producers (agents) will play in the sale of health benefit plans in the exchange.

The bill also contains an emergency clause so that it would become effective immediately upon its filing with the Secretary of State to allow work to start to address the many decisions that will have to be made and the work to begin to build an IT system that will be capable of performing all the required functions.

In closing, there are many decisions to be made about how the exchange will be run in North Dakota. There will be more decisions to be made as things are further defined or changed at the federal level. Several federal agencies are tasked with issuing regulations to implement the law and many of them have yet to be issued so various components remain undefined at this point. In addition, there is the prospect of Congress making changes to the law as well as the numerous legal challenges to the law that are making their way through the court system. For now, the law requires that there be an exchange implemented in North Dakota. The first decision is who will run it: the federal government or the state. Our stakeholders are telling us they prefer North Dakota run its own exchange and cite the numerous problems with other federal insurance programs as examples of how North Dakotans serve our own better. In fact, it is my Department that assists Medicare Part D prescription drug beneficiaries in comparing, choosing, and enrolling in Part D plans, as well as dealing with issues and complaints. This piece of legislation places similar responsibilities related to the exchange in this same agency.

This concludes my testimony. I would be happy to try to answer any questions the committee members may have. Thank you.

- February 1, 2011
- Attachment TWO

11.8110.01001
Title.

Prepared by the Legislative Council staff for
Representative Keiser
January 27, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126

Page 1, line 2, after the second semicolon insert "to provide for application;"

Page 2, after line 20, insert:

"**SECTION 3. APPLICATION.** In carrying out the requirements of this Act, the insurance commissioner shall provide regular updates to the legislative management during the 2011-12 interim. In determining, planning, and implementing an American health benefit exchange for the state, the commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the commissioner is required by federal law to take any action by January 1, 2013. For any plan, program, or requirement that must be implemented between January 1, 2013, and January 1, 2014, the commissioner shall submit proposed legislation to the legislative management before October 15, 2012."

Renumber accordingly

- Attachment THREE
- Adam Hamm, Insurance Commissioner

February 1, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126

Page 2, line 16, replace "The commissioner may seek emergency commission and budget section approval" with "There is hereby appropriated the sum of $33,764,517, or so much of the sum as may be necessary, from federal and other funds, to the insurance commissioner for the purposes provided in section 1 of this Act, for the period beginning with the effective date of this Act and ending June 30, 2013. The insurance commissioner is authorized 4.0 additional full-time equivalent positions for the purposes provided in section 1 of this Act."

Page 2, remove lines 17 through 20

Renumber accordingly

- Attachment FOUR
- Carol Olson

Testimony
House Bill 1126 – Department of Human Services
Before the Joint Meeting of
House Industry, Business & Labor
Representative Keiser, Chairman
House Appropriations – Human Resources Division
Representative Pollert, Chairman
February 1, 2011

Chairmen Keiser and Pollert, members of the Industry, Business & Labor Committee and House Appropriations – Human Resources Division, I am Carol Olson, Executive Director of the Department of Human Services. I am here today to provide information to you regarding the relationship between an American Health Benefit Exchange and the programs within Department of Human Services.

If it is the interest of this committee to pursue the establishment of an American Health Benefit Exchange for the state that will meet the requirements as currently outlined in the Patient Protection and Affordable Care Act of 2010, it will be important for this committee to consider the implications of:

- Title I, Section 1311(d)(4)(F) requiring, at a minimum, for the Exchange to provide for eligibility determination and the enrollment of individuals in Medicaid and CHIP programs; and
- Title II Role of Public Programs, Section 2201 which outlines more specifically the requirements of enrollment simplification and Medicaid and CHIP coordination with the State Health Insurance Exchange.

The intent of these sections is to ensure that the American Health Benefit Exchange provide seamless eligibility and enrollment linkages between the exchange coverage options and public assistance programs. In order to achieve this level of interoperability with the Exchange, the Medicaid and CHIP eligibility systems will require significant modification.

I would be happy to answer any questions you may have.

- Attachment FIVE
- Carol Olson

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126 - Feb 1, 2011

Page 2, after line 2, insert:

"5. Collaborate with the department of human services to ensure the American health benefit exchange incorporates a seamless eligibility and enrollment process for individuals eligible for medicaid and the children's health insurance program."

Page 2, after line 20, insert:

"**SECTION 3. APPROPRIATION – DEPARTMENT OF HUMAN SERVICES.** There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $15,555,543, and from special funds derived from federal funds and other income, the sum of $27,062,382, to the department of human services for the purpose of defraying the expenses of incorporating the medicaid and children's health insurance program eligibility determination functionality into the American health benefit exchange created under this Act, and for the purpose of defraying the corresponding costs related to the modification of the department's economic assistance eligibility system for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

Proposed amendment to 11.8110.01000

#1

HOUSE BILL NO. 1126

Presented by: **Adam Hamm**
Commissioner
North Dakota Insurance Department

Before: **Senate Human Services Committee**
Senator Judy Lee, Chairman

Date: **March 16, 2011**

TESTIMONY

Good morning, Chairman Lee and members of the committee. My name is Adam Hamm, North Dakota Insurance Commissioner. I appear before you today in support of House Bill No. 1126.

The purpose of the bill is to allow you to decide whether it is best for North Dakota, rather than the federal government, to run the health benefit exchange required by the Patient Protection and Affordable Care Act also known as "federal health care reform", or "PPACA". I will refer to this law as "PPACA".

What is an Exchange?

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

Exchanges will allow people to compare health plans and determine which one is best for them. Health plans will be placed in tiers based on out-of-pocket costs, which allows consumers to compare plans on an apples-to-apples basis. All plans sold in the exchange are offered by private insurance companies. There is no government-run plan or public insurance option.

An exchange must also assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs such as Medicaid and the Children's Health Insurance Program (CHIP). Individuals whose household income does not exceed 400 percent of the poverty line will receive subsidies through the exchange according to a sliding scale. By providing one-stop shopping, exchanges are theoretically supposed to increase competition in the marketplace and make purchasing health insurance easier and more understandable for consumers.

If North Dakota does not run its own exchange, the United States Department of Health and Human Services ("HHS") will. By January 1, 2013, HHS must determine whether the state will have an exchange in operation by January 1, 2014. If it determines that the state will not have an operational exchange by then, HHS is required to establish and operate the exchange within that state. The federal government will work with the Governor of the state as the Chief Executive Officer unless authority to operate the exchange has been delegated to a specific authority through state law.

What Does This Bill Do?

At its most basic level, this bill puts the following questions before you:

1. Do you want the federal government or the state to run the North Dakota exchange?

2. If you want the state to run its own exchange, who do you want to run it?

3. If the state will run its exchange, what resources do you want the responsible agency to have in order to build and operate the exchange?

To be clear, this bill is not an endorsement of PPACA or the wisdom or effectiveness of exchanges. It is the means by which these issues are being brought before you so that the Legislative Assembly may decide whether it is in North Dakota's best interest to run its own exchange or to let the federal government do so.

Who Can Run An Exchange?

States have the option to establish the exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state agency or a newly created, independent state agency. Alternatively, the exchange could be operated by a nonprofit entity. If none of these entities run the state's exchange, the federal government will take over that responsibility.

What Functions Must an Exchange Perform?

Exchanges must perform a lengthy list of functions. These functions should be taken into consideration when deciding which entity is best to run the exchange and the resources needed by that entity. At a minimum, an exchange must:

- Implement procedures for the certification, recertification, and decertification of health plans as qualified health plans;

- Provide for the operation of a toll-free telephone hotline to respond to assistance requests;

- Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans;

- Assign a rating to each qualified health plan offered through the exchange;

- Use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage;

- Inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program, and, if through screening of the individual's application by the exchange, it determines that such individuals are eligible for any such program, enroll such individuals in such program;

- Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction available under PPACA;

- Grant certification attesting that, for purposes of the individual responsibility penalty, an individual is exempt from the individual requirement or from the penalty imposed because he or she meets one of the exceptions provided in PPACA;

- Transfer to the Secretary of the Treasury a list of individuals who are issued certification of penalty exemption, the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit because the employer did not provide minimum essential coverage or the employer provided the minimum essential coverage but it was either unaffordable or did not provide the required minimum actuarial value, and the name and taxpayer identification number of each individual who notifies the exchange that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year;

- Provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year and the effective date of such cessation; and

- Establish a Navigator program.

There are some areas where the state has choices. Federal rules will clarify that the following policy areas, among others, are state decisions, although HHS may offer recommendations and technical assistance to states as they make these decisions:

- Whether to form the exchange as a governmental agency or a nonprofit entity.

- Whether to form regional exchanges or establish interstate coordination for certain functions.

- Whether to require additional benefits in the exchange beyond the essential health benefits (mandates).

- Whether to establish a competitive bidding process for plans.

- Whether to extend some or all exchange-specific regulations to the outside insurance market beyond what is required in PPACA.

- What additional types of services the exchange might provide to individuals and business to ensure simple and fast service.

If you believe that it would be better for the state to run its own exchange, certain things have to be accomplished by deadlines set out in PPACA. As I already noted, states must be on track for achieving certification of their exchange by January 1, 2013, or the federal government will run the exchange. And the exchange must be operating no later than January 1, 2014. Establishment of an exchange requires a planning process

to create an exchange that will meet all the requirements of PPACA. Anyone who is even somewhat familiar with a complex information technology (IT) project can recognize how short this timeframe is, especially given that most of the functionality required does not exist in North Dakota's state government or in any other entity currently operating in our state.

This bill would require the Commissioner to plan and implement the exchange for the state. The bill would ensure that the exchange facilitates the purchase of qualified health benefit plans, provides for the establishment of a small business health options program, and meets the exchange requirements of PPACA generally.

What Does the Commissioner Do if the State Runs the Exchange?

In order to plan and implement a North Dakota exchange, the bill assigns the following duties to the Commissioner:

- To take actions necessary to ensure that the exchange is determined, not later than January 1, 2013, by the federal government to be ready to operate not later than January 1, 2014.

- To consider whether to seek federal grant funds for the planning and implementation of the exchange.

- To determine whether to establish one exchange that will provide services to both qualified individuals and qualified small employers or to have two separate exchanges.

- To contract with outside entities, if necessary, to provide services to implement the exchange.

- To adopt rules, if necessary or desirable, to carry out the provisions of the bill.

Exchanges will require complex and particular IT systems and other business operations to perform the functions required. Since the exchange will have to work with other state and federal agencies, for example, to fulfill its duty to determine tax credits and enroll eligible individuals in Medicaid and CHIP, the bill requires state agencies to cooperate with the Commissioner to ensure the success of the exchange. At this time, the IT systems of the agencies likely to be involved in the exchange do not have the ability to communicate and exchange data with each other.

Because exchanges are also required to report certain information to other entities such as the United States Secretary of the Treasury, the bill allows the Commissioner to receive from, and provide to, federal and state agencies confidential information gathered in the administration of the exchange including Social Security numbers if the disclosure is necessary for the Commissioner or receiving entity to perform its duties and responsibilities.

What Resources Are Needed For an Exchange?

The bill also provides that the Commissioner may seek Emergency Commission and Budget Section approval for authority to spend any general funds, special funds or federal funds available under PPACA. The federal government will provide grants for exchange planning and development.

Forty-eight states and the District of Columbia were awarded their first exchange planning grants in September 2010. Those grants were for planning purposes and the next round of grants will be for the purpose of establishing an exchange. The opportunity to apply for grants will be announced in February 2011 and will become available on a rolling basis throughout the next three years. States will have to meet certain milestones in order to be awarded grants in 2011, and the size of state awards may be related to the number of milestones met. Necessary exchange planning and establishment costs will be funded by HHS until 2015. After January 1, 2015,

exchanges must be self-funded. North Dakota was approved to receive $1,000,000 in the first round of exchange grants; however, the Emergency Commission tabled the request to utilize these funds. These funds could be important right now given the challenging infrastructure requirements needed to develop an exchange. They can be used to analyze options, define requirements, and estimate the probable cost to implement an electronic system to operate the state's exchange. Future grant funds will be available to pay for the cost of building the system that will operate the exchange. In addition to the staffing and information technology infrastructure needs, the state will need resources to help it identify and address many issues and to make informed decisions along the way, including:

1. **Unified exchange.** A state has to provide an exchange that facilitates individuals' purchase of health insurance and an exchange that serves small businesses. The state may choose to operate them separately or both in one exchange as long as it serves both functions.

2. **Regional exchange**. States may form a regional exchange with other states or allow more than one exchange to operate in the state as long as each exchange serves a distinct geographic region.

3. **Stakeholders.** PPACA requires states to consult with stakeholders in implementation of the exchange. Stakeholders must include health care consumers who enroll in qualified health plans, individuals and entities experienced in facilitating enrollment in qualified health plans, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for enrolling hard to reach populations. In planning for this legislative session, the Insurance Department has already begun stakeholder conversations. I can assure you that the exchange is a focus for many of these individuals and groups.

4. **Funding.** How will the state ensure that the exchange is self-sustaining as of January 1, 2015? Exchanges are allowed to charge assessments or user fees to participating insurance issuers or to otherwise generate funding in order to support its operations.

5. **Outside market**. Will insurers be allowed to sell health plans outside the exchange? And if an external market remains, will insurers be required to offer plans both in and out of the exchange?

6. **Large employers.** Beginning in 2017, an exchange may allow businesses with more than 100 employees to purchase coverage in the exchange also.

7. **Mandates.** Does the state want to require that plans offer benefits in addition to the essential health benefits package? If so, the state must assume the cost by making payments to individuals enrolled in a qualified health plan in the state or making payments directly to the qualified health plan on behalf of the individual. HHS has not yet determined how the essential health benefits package will be defined.

8. **Data reporting.** Determination of the data that will be required to be reported, what persons will be allowed to access data, and how to ensure appropriate protection of data.

9. **Certification of plans.** The exchange must implement procedures for the certification, recertification and decertification of health plans as qualified health plans. It is expected that this will require someone to analyze the health plans offered for sale through the exchange to ensure that they meet one of the required benefit categories: bronze plans which must cover 60% of benefit costs; silver plans which must cover 70% of benefit costs; gold plans which must cover 80% of benefit costs; platinum plans

which must cover 90% of benefit costs; and catastrophic plans, which are available only to those up to age 30, which must provide catastrophic coverage only. Someone must also ensure that the plans offered in the exchange meet certain benefit requirements, marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, and use a uniform enrollment form and standard format to present plan information.

10. **Hotline.** The exchange must provide for the operation of a toll-free hotline to respond to assistance requests.

11. **Website.** The exchange must maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans.

12. **Ratings.** The exchange must assign a rating to each qualified health benefit plan offered through the exchange.

13. **Standardized format.** The exchange must use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage.

14. **Other coverage.** The exchange must inform individuals of Medicaid, CHIP, and other state or local public programs eligibility requirements and enroll eligible individuals in these programs.

15. **Calculator.** The exchange must provide an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction.

16. **Individual responsibility certification.** The exchange must grant a certification attesting that for purpose of the individual responsibility penalty (individual mandate) that an individual is exempt from the penalty because there is no affordable qualified health plan available through the exchange or the individual's employer, or the individual meets the requirement for any other exemption.

17. **Certification of penalty exemption**. The exchange must transfer to the Secretary of the Treasury a list of individuals who are issued a certification of penalty exemption.

18. **Employer notice.** The exchange must provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year.

19. **Navigator program.** The exchange must establish a Navigator program under which it awards grants to entities to carry out certain duties such as public education, facilitating enrollment in qualified health plans, and providing referrals to health insurance ombudsman or other appropriate agency for any enrollee with a grievance, complaint, or question regarding his health plan, coverage, or a determination under such plan or coverage.

20. **Producers.** The exchange must determine the role insurance producers (agents) will play in the sale of health benefit plans in the exchange.

The bill also contains an emergency clause so that it would become effective immediately upon its filing with the Secretary of State to allow work to start to address the many decisions that will have to be made and the work to begin to build an IT system that will be capable of performing all the required functions.

In closing, there are many decisions to be made about how the exchange will be run in North Dakota. There will be more decisions to be made as things are further defined or changed at the federal level. Several federal agencies are tasked with issuing regulations to implement the law and many of them have yet to be issued so various components remain undefined at this point. In addition, there is the prospect of Congress making changes to the law as well as the numerous legal challenges to the law that are making their way through the court system. For now, the law requires that there be an exchange implemented in North Dakota. The first decision is who will run it: the federal government or the state. Our stakeholders are telling us they prefer North Dakota run its own exchange and cite the numerous problems with other federal insurance programs as examples of how North Dakotans serve our own better. In fact, it is my Department that assists Medicare Part D prescription drug beneficiaries in comparing, choosing, and enrolling in Part D plans, as well as dealing with issues and complaints. This piece of legislation places similar responsibilities related to the exchange in this same agency.

This concludes my testimony. I would be happy to try to answer any questions the committee members may have. Thank you.

Testimony
House Bill 1126 – Department of Human Services
Senate Human Services Committee
Senator Lee, Chairman
March 16, 2011

Chairman Lee, members of the Human Services Committee, I am Carol Olson, Executive Director of the Department of Human Services. I am here today to provide information to you regarding the relationship between an American Health Benefit Exchange and the programs within Department of Human Services.

If it is the interest of this committee to pursue the establishment of an American Health Benefit Exchange for the state that will meet the requirements as currently outlined in the Patient Protection and Affordable Care Act of 2010, it will be important for this committee to consider the implications of:

- Title I, Section 1311(d)(4)(F) requiring, at a minimum, for the Exchange to provide for eligibility determination and the enrollment of individuals in Medicaid and CHIP programs; and
- Title II Role of Public Programs, Section 2201 which outlines more specifically the requirements of enrollment simplification and Medicaid and CHIP coordination with the State Health Insurance Exchange.

The intent of these sections is to ensure that the American Health Benefit Exchange provides seamless eligibility and enrollment linkages between the exchange coverage options and public assistance programs. In order to achieve this level of interoperability with the Exchange, the Medicaid and CHIP eligibility systems will require significant modification.

Initially Representative Keiser had introduced an amendment to HB 1126, which would have included an appropriation to fund these necessary

system changes. The amount included $15,555,543 from the general fund and $27,062,382 from federal funding sources. This incorporates a 90/10 funding ratio for the Medicaid portion of the system changes. The total cost is $42,617,925.

I would be happy to answer any questions you may have.

#3

TESTIMONY BEFORE SENATE HUMAN SERVICE COMMITTEE
HB 1126
MARCH 16, 2011

Good morning, my name is Lisa Feldner and I serve as the Chief Information Officer for the Information Technology Department. On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) became law requiring, among other things, that states establish a system of health benefit Exchanges. PPACA includes provisions to make it easy for individuals to enroll in coverage by requiring states to create a coordinated, simple, and technology-supported process through which individuals may obtain coverage through Medicaid, CHIP, and the new Exchanges.

In my testimony today, I want to illustrate that providing what may be simple for enrollees on the front-end is all but simple on the back-end in the world of technology. In Figure 1, Step 1: The Application, you see the areas of information the individual needs to provide by entering it online into a web-based application. Step 2: Verification is where things start to get very involved. Based on the information provided by the individual, the system must then go out to multiple systems to verify the applicant's status. The Exchange must interface with the IRS, the Social Security Administration, and the systems for Medicaid, SNAP, TANF, and others. If verification cannot be made, the system must ask the applicant for more information and the process repeats. In Step 3: Eligibility, the verified information is routed to the Eligibility system to determine if the applicant is eligible for Medicaid or CHIP and if not, then eligible for subsidized coverage in the Exchange and at what level. The system will then notify the applicant of their eligibility determination or subsidy amount. In Step 4: Enrollment, the system must enroll qualifying individuals in either Medicaid or subsidized coverage and notify the employer of the enrollment. Step 5: Renewal and Reconciliation is a complex step as well. The system must retrieve updated information on the individual's status in order to renew or transition their coverage. The information is retrieved electronically from 3rd party sources such as employers, the IRS, Medicaid, vital records, etc. One important item on Figure 1 is the Key – bottom left. Notice the rectangular boxes throughout the diagram indicate technology system functions. The ovals indicate enrollee functions. There are 13 rectangles and only 2 ovals, which is a good indicator of all the back-end processing required.

Cost: There are only two states with functioning insurance exchanges: Massachusetts and Utah. Utah does not have all the functionality required by PPACA. It doesn't provide for all eligibility enrollments nor does it verify all source data electronically. It is operating in a pilot phase now. Massachusetts has a more robust exchange with a reported operating cost of $26.6 million in FY 2009. We were able to gather estimates from only two states, Wisconsin and Oregon, on the cost

to build an exchange. Wisconsin already has components in place that can be leveraged to build the exchange and is estimating the cost to be $49.6 million. Oregon estimates it will need $96 million to build an exchange, and that is above and beyond the cost of upgrading their eligibility system.

North Dakota must first update its existing Eligibility system in order to then implement a functional health benefits exchange. After analyzing Oregon's estimates, ITD analysts are estimating the cost for North Dakota's exchange would be in the $50 million range.

Options: It is possible that the Federal government could initially build an exchange for the state and then turn it over to us to run. It is might also be possible to partner with another state. It is too early to have solutions.

#4

PROPOSED AMENDMENT TO ENGROSSED HOUSE BILL NO. 1126

Page 2, replace lines 10-11 with "Due to the complexity and interdependence of technology systems required by the health benefit exchange, an advisory committee will be established consisting of the insurance commissioner or designee, the executive director of the department of human services or designee, the chief information officer or designee, the governor or designee, and two members of the legislature to ensure the coordination of the exchange."

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

That the Senate recede from its amendments as printed on pages 1516-1517 of the House Journal and pages 835-836 of the Senate Journal and that Engrossed House Bill No. 1126 be amended as follows:

Page 1, line 2, after the first semicolon insert "to provide reports to the legislative management;"

Page 1, line 9, after "commissioner" insert "and department of human services"

Page 1, line 19, after "2." insert "Plan for the implementation of an American health benefit exchange for the state which at a minimum provides for eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program; simplification; and medical assistance and children's health insurance program coordination with the state health insurance exchange in a manner that meets the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

3."

Page 2, line 1, replace "3." with "4."

Page 2, line 4, replace "4." with "5."

Page 2, after line 5, insert:

6. Collaborate with the information technology department as necessary and appropriate in completing the responsibilities set forth in this section.

Page 2, line 7, after "commissioner" insert "and department of human services"

Page 2, line 10, after "commissioner" insert ", the department of human services, and the information technology department"

Page 2, line 13, after "the" insert "department of human services and"

Page 2, line 16, after the second "the" insert "department of human services,"

Page 2, line 16, after "commissioner" insert an underscored comma

Page 2, line 26, after "commissioner" insert ", department of human services, and information technology department"

Proposed amendments to 11.8110.02000

Page 2, line 28, after "commissioner" insert "and department of human services"

Page 2, line 29, after "commissioner" insert "or department of human services"

Page 3, line 1, after "commissioner" insert "or department of human services"

Renumber accordingly

Prepared at the request of Senator J. Lee

Proposed amendments to 11.8110.02000

11.8110.02002
Title.

Prepared by the Legislative Council staff for
Senator J. Lee
April 18, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

Page 1, line 2, after the semicolon insert "to provide reports to the legislative management;"

Page 1, line 9, after "commissioner" insert "and department of human services"

Page 1, line 19, after "2." insert "Plan for the implementation of an American health benefit exchange for the state which at a minimum provides for eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program; simplification; and medical assistance and children's health insurance program coordination with the state health insurance exchange in a manner that meets the requirements of the Patient Protection and Affordable Care Act [Pub. L. 111-148] as amended by the Health Care and Education Reconciliation Act of 2010 [Pub. L. 111-152].

3."

Page 2, line 1, replace "3." with "4."

Page 2, line 4, replace "4." with "5."

Page 2, after line 5, insert:

"6. Collaborate with the information technology department as necessary and appropriate in completing the responsibilities set forth in this section."

Page 2, line 7, after "commissioner" insert "and department of human services"

Page 2, line 10, after "commissioner" insert ", the department of human services, and the information technology department"

Page 2, line 13, after "the" insert "department of human services and"

Page 2, line 16, after the second "the" insert "department of human services,"

Page 2, line 16, after "commissioner" insert an underscored comma

Page 2, line 26, after "commissioner" insert ", department of human services, and information technology department"

Page 2, line 28, after "commissioner" insert "and department of human services"

Page 2, line 29, after "commissioner" insert "or department of human services"

Page 3, line 1, after "commissioner" insert "or department of human services"

Renumber accordingly

Prepared by the Legislative Council staff for
Representative Keiser
April 19, 2011

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1126

That the Senate recede from its amendments as printed on pages 1516 and 1517 of the House Journal and pages 835 and 836 of the Senate Journal and that Engrossed House Bill No. 1126 be amended as follows:

Page 1, line 2, replace "a health" with "an American"

Page 1, line 2, after the first semicolon insert "to provide reports to the legislative management;"

Page 1, line 9, after "commissioner" insert "and the department of human services"

Page 1, line 11, replace the underscored comma with an underscored semicolon

Page 1, line 14, replace the underscored comma with "; implements eligibility determination and enrollment of individuals in the state's medical assistance program and the state's children's health insurance program; provides simplification; provides coordination between medical assistance, the children's health insurance program, and the state health insurance exchange;"

Page 1, line 17, replace "commissioner" with "legislative assembly"

Page 2, line 3, remove "and"

Page 2, line 5, replace the underscored period with "; and

5. Collaborate with the information technology department as necessary and appropriate in completing the responsibilities set forth in this section."

Page 2, line 7, after "commissioner" insert "and the department of human services"

Page 2, line 10, after "commissioner" insert ", the department of human services, and the information technology department"

Page 2, line 14, after "designee" insert "and the department of human services"

Page 2, line 16, after "commissioner" insert ", the department of human services,"

Page 2, line 26, after "commissioner" insert ", the department of human services, and the information technology department"

Page 2, line 28, after "commissioner" insert ", with the department of human services and the information technology department,"

Page 2, line 29, replace "commissioner" with "state"

Page 3, line 1, after "commissioner" insert ", with the department of human services and the information technology department,"

Renumber accordingly

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

Health care reform timeline
2010–2018

Presented by Adam Hamm
May 27, 2010

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

2010

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

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

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

2011

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

2012

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

2013

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

2014

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

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

2016

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

2017

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

2018

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

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

PPACA analysis overview

Provision	Applies to				PPACA section	Effective
	Grandfathered		Non-grandfathered			
	Group	Indvl	Group	Indvl		
Annual limits					1001	9/23/10
Lifetime limits					1001	9/23/10
Rescissions					1001	9/23/10
Coverage of preventive health services					1001	9/23/10
Extension of adult dependent coverage					1001 HR 4872	9/23/10
Preexisting condition exclusions under 19					1201, 10103(3)	9/23/10
Uniform explanation of coverage					1001	3/23/12
Provision of additional information					1001	9/23/10
Prohibition on salary discrimination*					1001	9/23/10
Ensuring quality of care					1001	3/23/12
Bringing down the cost of health care*					1001	1/1/11
Appeals process					1001	9/23/10
tient protections					1001	9/23/10
Consumer assistance offices/ombudsmen					1002	3/23/10
Ensure consumers get value for dollars*					1003	2010
Preexisting condition exclusion for all					1201	1/1/14
Fair health insurance premiums*					PHSA 2701	1/1/14
Guaranteed availability of coverage*					PHSA 2702	1/1/14
Guaranteed renewability of coverage*					PHSA 2703	1/1/14
Prohibit discrimination/health status					PHSA 2705	1/1/14
Non-discrimination in health care					PHSA 2706	1/1/14
Comprehensive health ins coverage					PHSA 2707	1/1/14
Prohibit excessive waiting periods					PHSA 2708	1/1/14
Coverage/individuals in clinical trials					PHSA 2709	1/1/14
Preserve right to maintain existing cvrg					1251	3/23/10
Essential health benefits requirements			Exchange	Exchange	1302	1/1/14
Fed program to establish nonprofit issuers	Co-op plans				1322	7/1/13
evel playing field					1324	1/1/14
State flexibility to establish programs for LI people not eligible for Medicaid					1331	

*Applies to only fully insured plans

Provision	Applies to				PPACA statutory section	Effective
	Grandfathered		Non-grandfathered			
	Group	Indvl	Group	Indvl		
Waiver for state innovation					1332	1/1/17
Offering plans in more than 1 state					1333	1/1/16
Multi-state plans					1334	1/1/14
Transitional reinsurance program/indvl	All plans must pay assessments				1341	'14-'16
Establish risk corridors/indvl and small	Qualified health plans				1342	'14-'16
Risk adjustment			small*		1343	1/1/14
Refundable tax credit/premium assistance	Individuals 100-400% FPL					
Reduced cost-sharing	Individuals 100-400% FPL					
Procedures/determine eligible Exchange					1411	
Advance determination/tax credits					1412	
Streamline procedures/enrollment					1413	
Credit for employee ins/small businesses	Businesses with 25 or fewer employees					
Required to maintain minimum coverage						
Auto enroll/employees of large employer	Employers with 200+ full time emp					
Employer required to inform/coverage	Subject to Fair Labor Standards Act					
Shared responsibility for employers	Employers with more than 50 workers					
GAO study						
Free choice vouchers						

Exchange

This chart is composed of information provided from the NAIC's Patient Protection and Affordable Care Act of 2009 Section-by-Section Analysis chart, Updated: 8/09/2010, posted at: http://naic.org/documents/index_health_reform_general_ppaca_section_by_section_chart.pdf

*Applies to only fully insured plans

VI. What references are on display?

The following reference has been placed on display in the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852, and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

1. Petition from Spiracur, Inc., November 3, 2008.

List of Subjects in 21 CFR Part 878

Medical devices.

■ Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 878 is amended as follows:

PART 878—GENERAL AND PLASTIC SURGERY DEVICES

■ 1. The authority citation for 21 CFR part 878 continues to read as follows:

Authority: 21 U.S.C. 351, 360, 360c, 360e, 360j, 360l, 371.

■ 2. Section 878.4683 is added to subpart E to read as follows:

§ 878.4683 Non-Powered suction apparatus device intended for negative pressure wound therapy.

(a) *Identification.* A non-powered suction apparatus device intended for negative pressure wound therapy is a device that is indicated for wound management via application of negative pressure to the wound for removal of fluids, including wound exudate, irrigation fluids, and infectious materials. It is further indicated for management of wounds, burns, flaps, and grafts.

(b) *Classification.* Class II (special controls). The special control for this device is FDA's "Class II Special Controls Guidance Document: Non-powered Suction Apparatus Device Intended for Negative Pressure Wound Therapy (NPWT)." See § 878.1(e) for the availability of this guidance document.

Dated: November 10, 2010.

Nancy K. Stade,

Deputy Director for Policy, Center for Devices and Radiological Health.

[FR Doc. 2010–28873 Filed 11–16–10; 8:45 am]

BILLING CODE 4160–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[TD 9506]

RIN 1545–BJ91

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AB42

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Consumer Information and Insurance Oversight

45 CFR Part 147

RIN 0950–AA17

[OCIIO–9991–IFC2]

Amendment to the Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Office of Consumer Information and Insurance Oversight, Department of Health and Human Services.

ACTION: Amendment to interim final rules with request for comments.

SUMMARY: This document contains an amendment to interim final regulations implementing the rules for group health plans and health insurance coverage in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding status as a grandfathered health plan; the amendment permits certain changes in policies, certificates, or contracts of insurance without loss of grandfathered status.

DATES: *Effective Date.* This amendment to the interim final regulations is effective on November 15, 2010.

Comment Date. Comments are due on or before December 17, 2010.

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. Warning: Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments may be posted on the Internet and can be retrieved by most Internet search engines. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN 1210–AB42, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *E-mail: E-OHPSCA1251amend.EBSA@dol.gov.*
- *Mail or Hand Delivery:* Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, *Attention:* RIN 1210–AB42.

Comments received by the Department of Labor will be posted without change to *http://www.regulations.gov* and *http://www.dol.gov/ebsa*, and available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code OCIIO–9991–IFC2. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

- *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the "More Search Options" tab.
- *By regular mail.* You may mail written comments to the following address ONLY: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO–9991–IFC2, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

- *By express or overnight mail.* You may send written comments to the following address only: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO–

9991–IFC2, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

• *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to the following address: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO–9991–IFC2, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the OCIIO drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the address indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

Internal Revenue Service. Comments to the IRS, identified by REG–118412–10, by one of the following methods:

• *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.

• *Mail:* CC:PA:LPD:PR (REG–118412–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

• *Hand or courier delivery:* Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–118412–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington, DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Lisa Campbell, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (301) 492–4100.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor's Web site (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (*http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp*) and the Office of Consumer Information & Insurance Oversight (OCIIO) Web site (*http://www.hhs.gov/OCIIO*).

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111–148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111–152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions in part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes. Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the date of enactment (that is, grandfathered health plans) are subject to only certain provisions.

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) previously issued interim final regulations implementing section 1251 of the Affordable Care Act; these interim final regulations were published in the **Federal Register** on June 17, 2010 (75 FR 34538). Additionally, on September 20, 2010,[2] October 8, 2010,[3] October 12, 2010,[4] and October 28, 2010,[5] the Departments issued subregulatory guidance on a number of issues pertaining to the implementation of the Affordable Care Act, including several clarifications relating to the interim final regulations on grandfathered health plans.

Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, provides that certain plans or coverage existing as of March 23, 2010 (the date of enactment of the Affordable Care Act) are subject to only certain provisions of the Affordable Care Act. The statute and the interim final regulations refer to these plans or health insurance coverage as grandfathered health plans. The statute and the interim final regulations provide that a group health plan or group or individual health insurance coverage is a grandfathered health plan with respect to individuals enrolled on March 23, 2010 regardless of whether an individual later renews the coverage. The interim final regulations specify certain changes to a plan or coverage that would cause it to no longer be a grandfathered health plan.

In addition, the statute and the interim final regulations provide that a group health plan that provided coverage on March 23, 2010 generally is also a grandfathered health plan with

[1] The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan," as used in other provisions of title I of the Affordable Care Act. The term "health plan," as used in those provisions, does not include self-insured group health plans.

[2] The subregulatory guidance took the form of "frequently asked questions" (FAQs). The September 20, 2010 FAQs are available at *http://www.dol.gov/ebsa/faqs/faq-aca.html* and *http://www.hhs.gov/ociio/regulations/questions.html*.

[3] The October 8, 2010 FAQs are available at *http://www.dol.gov/ebsa/faqs/faq-aca2.html* and *http://www.hhs.gov/ociio/regulations/implementation_faq.html*.

[4] The October 12, 2010 FAQs are available at *http://www.dol.gov/ebsa/faqs/faq-aca3.html* and *http://www.hhs.gov/ociio/regulations/implementation_faq.html*.

[5] The October 28, 2010 FAQs are available at *http://www.dol.gov/ebsa/faqs/faq-aca4.html* and *http://www.hhs.gov/ociio/regulations/implementation_faq.html*.

respect to new employees (whether newly hired or newly enrolled) and their families that enroll in the grandfathered health plan after March 23, 2010. The interim final regulations clarify that, in such cases, any health insurance coverage provided under the group health plan in which an individual was enrolled on March 23, 2010 is also a grandfathered health plan.

Paragraph (g)(1) of the interim final regulations includes rules for determining when changes to the terms of a plan or health insurance coverage cause the plan or coverage to cease to be a grandfathered health plan. In addition to the changes described in paragraph (g)(1) of the interim final regulations that cause a plan to cease to be a grandfathered health plan, paragraph (a)(1)(ii) of the interim final regulations provides that if an employer or employee organization enters into a new policy, certificate, or contract of insurance after March 23, 2010, the policy, certificate, or contract of insurance is not a grandfathered health plan with respect to individuals in the group health plan. For example, under the interim final regulations, if a group health plan changes issuers after March 23, 2010, the group health plan ceases to be a grandfathered health plan, even if the plan otherwise would be a grandfathered health plan under the standards set forth in paragraph (g)(1).[6] In contrast, under the interim final regulations, a change in third-party administrator (TPA) by a self-insured group health plan does not cause the plan to relinquish grandfather status, provided that the change of TPA does not result in any other change that would cause loss of grandfather status under paragraph (g)(1).

II. Overview of Amendment to the Interim Final Regulations

The Departments have received comments on paragraph (a)(1)(ii) of the interim final regulations, which provides that a group health plan will relinquish grandfather status if it changes issuers or policies. The comments expressed four principal concerns about this provision of the regulations. First, commenters raised the concern that this provision treats insured group health plans, which cannot change issuers or policies without ceasing to be a grandfathered health plan, differently from self-insured group health plans, which can change TPAs without relinquishing grandfather status, as long as any other plan change (such as cost sharing or employer contributions) does not exceed the standards of paragraph (g)(1) of the interim final regulations. Second, commenters raised questions about circumstances in which a group health plan changes its issuer involuntarily (for example, the issuer withdraws from the market) yet the plan sponsor wants to maintain its grandfather status with a new issuer. Third, commenters noted that the provision would unnecessarily restrict the ability of issuers to reissue policies to current plan sponsors for administrative reasons unrelated to any change in the underlying terms of the health insurance coverage (for example, to transition the policy to a subsidiary of the original issuer or to consolidate a policy with its various riders or amendments) without loss of grandfather status. Finally, commenters expressed concern that the provision terminating grandfather status upon any change in issuer gives issuers undue and unfair leverage in negotiating the price of coverage renewals with the sponsors of grandfathered health plans, and that this interferes with the health care cost containment that tends to result from price competition.

The interim final regulations issued on June 17, 2010 were based on an interpretation of the language in section 1251 of the Affordable Care Act providing that grandfather status is based on "coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of the enactment of the Act." In adopting the interim final regulations, the Departments did not consider a new insurance policy issued after March 23, 2010 to be a grandfathered health plan (except for the special rule for a group health plan maintained pursuant to a collective bargaining agreement) because "coverage" under the new policy was not in place on that date.

Following review of the comments submitted on this issue and further review and consideration of the provisions of section 1251 of the Affordable Care Act, the Departments have determined it is appropriate to amend the interim final regulations to allow a group health plan to change health insurance coverage (that is, to allow a group health plan to enter into a new policy, certificate, or contract of insurance) without ceasing to be a grandfathered health plan, provided that the plan continues to comply fully with the standards set forth in paragraph (g)(1) of the interim final regulations. For purposes of section 1251 of the Affordable Care Act, the Departments now conclude that it is reasonable to construe the statutory term "group health plan" to apply the grandfather provisions uniformly to both self-insured and insured group health plans (and, consequently, to health insurance coverage offered in connection with a group health plan). Where insured coverage is provided not through a group health plan but instead in the individual market, a change in issuer would still be a change in the health insurance coverage in which the individual was enrolled on March 23, 2010, and thus the new individual policy, certificate, or contract of insurance would not be a grandfathered health plan.

This amendment modifies paragraph (a)(1) of the interim final regulations, which previously caused a group health plan to cease to be a grandfathered health plan if the plan entered into a new policy, certificate, or contract of insurance. The modification provides that a group health plan does not cease to be grandfathered health plan coverage merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010[7] (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). The amendment applies to such changes to group health insurance coverage that are effective on or after November 15, 2010, the date the amendment to the interim final regulations was made available for public inspection; the amendment does not apply retroactively to such changes to group health insurance coverage that were effective before this date.[8] For this purpose, the date the new coverage becomes effective is the operative date, not the date a contract for a new policy, certificate or contract of insurance is entered into. Therefore, for example, if a plan enters into an agreement with an issuer on September 28, 2010 for a new policy to be effective on January 1, 2011, then January 1, 2011 is the date the new policy is effective and, therefore, the relevant date for purposes of determining the application of the

[6] In accordance with statutory provisions relating to collectively bargained group health plans, the interim final regulations include an exception for a group health plan governed by a collective bargaining agreement that was in effect on March 23, 2010. In such a case, the grandfathered group health plan is permitted to change issuers, or change from a self-insured plan to an insured plan, or make a change described under paragraph (g)(1) of the interim final regulations (which would otherwise end grandfather status) and remain a grandfathered health plan for the remainder of the duration of the collective bargaining agreement.

[7] Of course, with respect to changes to group health insurance coverage on or after March 23, 2010 but before June 14, 2010, the Departments' enforcement safe harbor remains in effect for good faith efforts to comply with a reasonable interpretation of the statute.

[8] As noted below, the Departments are inviting comments on this amendment to the interim final regulations.

amendment to the interim final regulations. If, however, the plan entered into an agreement with an issuer on July 1, 2010 for a new policy to be effective on September 1, 2010, then the amendment would not apply and the plan would cease to be a grandfathered health plan.

Notwithstanding the ability to change health insurance coverage pursuant to the modification made by the amendment, if the new policy, certificate, or contract of insurance includes changes described in paragraph (g)(1) of the interim final regulations, the plan ceases to be a grandfathered health plan. In applying this amendment, as with other provisions of the interim final regulations, the rules apply separately to each benefit package made available under a group health plan.

The amendment also provides that, to maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether any change described in paragraph (g)(1) is being made. This documentation may include a copy of the policy or summary plan description. The amendment also makes minor conforming changes to other provisions of the interim final regulations.

Thus, a plan can retain its grandfather status if it changes its carrier, so long as it has not made any other changes that would revoke its status. This amendment is being issued on an interim final basis to notify plans as soon as possible of the change and is effective prospectively to minimize disruption to participants and beneficiaries. The Departments are continuing to review and evaluate the comments received in response to the June 17, 2010 interim final regulations. In addition, the Departments invite comments on this amendment to the interim final regulations, including the prospective effective date of the rule and how that affects plans with different plan years. Final regulations on grandfathered health plans will be published in the near future.

III. Interim Final Rules and Waiver of Delay of Effective Date

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815. The rule set forth in this amendment governs the applicability of the requirements in these sections and is therefore appropriate to carry them out. Therefore, the foregoing interim final rule authority applies to this amendment.

In addition, under Section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. Although the provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act, even if the APA were applicable, the Secretaries have determined that it would be impracticable and contrary to the public interest to delay putting the provisions of this amendment to the June 17, 2010 interim final regulations in place until an additional public notice and comment process was completed.

As noted in the preamble to the June 17, 2010 interim final regulations, numerous provisions of the Affordable Care Act are applicable for plan years (in the individual market, policy years) beginning on or after September 23, 2010, six months after date of enactment. Because grandfathered health plans are exempt from many of these provisions while group health plans and group and individual health insurance coverage that are not grandfathered health plans must comply with them, it was critical for plans and issuers to receive clear guidance as to whether they were so exempt as soon as possible; accordingly, the June 17, 2010 interim final regulations were published without prior notice and comment. While the Affordable Care Act provisions have become effective with respect to certain plans and coverage, the majority of plans and coverage have not yet become subject to the Act. It is critical to provide those plans with the guidance in these interim final rules immediately. In addition, the provisions of this amendment essentially are the product of prior notice and comment, as they are a logical outgrowth of the Jun 17, 2010 interim final regulations whic provided an opportunity for public comment, and are being issued in response to public comments received.

For the foregoing reasons, the Departments have determined that it is impracticable and contrary to the public interest to engage in full notice and comment rulemaking before putting these regulations into effect, and that it is in the public interest to promulgate interim final regulations.

In addition, under Section 553(d) of the APA, regulations are to be published at least 30 days before they take effect. Again, under section 553(d)(3), this requirement may be waived "for good cause found and published with the rule." For the reasons set forth above, the Departments have determined that there is good cause for waiver of the 30 day delay of effective date requirement in section 553(d).

IV. Economic Impact and Paperwork Burden

A. Overview and Need for Regulatory Action—Department of Labor and Department of Health and Human Services

As stated earlier in this preamble, th Departments of Health and Human Services, Labor, and the Treasury (the Departments) previously issued interim final regulations implementing section 1251 of the Affordable Care Act that were published in the **Federal Register** on June 17, 2010 (75 FR 34538). Paragraph (a)(1)(ii) of the interim final regulations provides that if a group health plan changes the issuer providing the insured health coverage after March 23, 2010, the group health plan ceases to be a grandfathered health plan. Paragraph (g)(1) of the interim final regulations includes rules for determining when changes to the terms of a plan or health insurance coverage cause a plan or coverage to cease to be a grandfathered health plan.

As described earlier in this preamble, comments expressed a number of concerns regarding the change in issuer rule. Among other concerns, comments stated that the change in issuer rule provides issuers with undue leverage in negotiating the price of coverage renewals with grandfathered health plans, because a change in carrier would result in plans relinquishing their grandfathered status. Therefore, in effect, the provision could impede employers' efforts to obtain group health insurance coverage for their employees at the lowest cost. Commenters also expressed concern that the rule creates an unlevel playing field for self-insured

)nd fully-insured group health plans, Because the former could change plan administrators without relinquishing their grandfathered health plan status, while the latter could not change issuers without relinquishing such status.

After reviewing the comments concerning this issue and further analyzing the statutory provision, the Departments have determined that it is appropriate to amend the interim final regulations to allow group health plans to change a health insurance policy or issuer providing health insurance coverage without ceasing to be a grandfathered health plan, provided that the standards set forth under paragraph (g)(1) of the interim final regulations are met. The Departments expect that this amendment will result in a small increase in the number of plans retaining their grandfathered status relative to the estimates made in the interim final regulations. The Departments did not produce a range of estimates for the number of affected entities given considerable uncertainty about the behavioral response to this amendment. For a further discussion, see Section II. Overview of Amendment to the Interim Final Regulations, above.

3. Executive Order 12866—Department of Labor and Department of Health and Human Services

Under Executive Order 12866 (58 FR 51735), "significant" regulatory actions are subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determined that this amendment to the interim final regulations is significant within the meaning of section 3(f)(4) of the Executive Order. Accordingly, OMB has reviewed the amendment pursuant to the Executive Order.

C. Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the APA (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The interim final regulations were exempt from the APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA did not apply and the Departments were not required to either certify that the regulations or this amendment would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the amendment on small entities and believe that the amendment will have a positive impact on small plans, because such plans are more likely to be fully-insured. The Departments estimated in the regulatory impact analysis for the interim final regulations that small plans were more likely to relinquish grandfathered health plan status due to changes in issuers or policies than large plans. Therefore, this amendment to the interim final regulations will benefit small plans that want to retain their grandfathered health plan status while still changing health insurance issuers. This change should give employers greater flexibility to keep premiums affordable for the same plan.

D. Special Analyses—Department of the Treasury

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to these regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the **Federal Register**. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

E. Paperwork Reduction Act

As part of their continuing efforts to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, and collection requirements on respondents can be properly assessed.

As discussed earlier in this preamble, the amendment to the interim final regulation adds a new disclosure requirement that requires the group health plan that is changing health insurance coverage to provide to the succeeding health insurance issuer (and the succeeding health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health insurance coverage sufficient to make a determination whether the standards of paragraph (g)(1) are exceeded. The Departments expect that this amendment will result in a small increase in the number of plans retaining their grandfathered status relative to the estimates made in the interim final regulations. Although the Departments did not produce a range of estimates for the number of affected entities due to the considerable uncertainty regarding the behavioral response to this amendment, the Departments estimate that the new disclosure requirement associated with the amendment will result in a total hour burden of 3,845 hours and a total cost burden of $260,000.[9] The Departments welcome comments on this estimate.

The Office of Management and Budget has approved revisions to the ICRs contained under OMB Control Numbers

[9] The Departments applied the same methodology that was used in estimating the hour and cost burden associated with the information collection requests (ICRs) contained in the interim final regulations to make this estimate.

1210–0140 (Department of Labor), 1545–2178 (Department of the Treasury; Internal Revenue Service), and 0938–1093 (Department of Health and Human Services) reflecting this estimate. A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Room N–5718, Washington, DC 20210. Telephone: (202) 693–8410; Fax: (202) 219–2745. These are not toll-free numbers. E-mail: *ebsa.opr@dol.gov*. ICRs submitted to OMB also are available at reginfo.gov (*http://www.reginfo.gov/public/do/PRAMain*).

F. Congressional Review Act

This amendment to the interim final regulations is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and has been transmitted to Congress and the Comptroller General for review. The interim final rule is not a "major rule" as that term is defined in 5 U.S.C. 804, because it does not result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or Federal, State, or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic and export markets.

G. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. This amendment to the interim final regulations is not subject to the Unfunded Mandates Reform Act, because they are being issued as an interim final regulation. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, this amendment to the interim final regulations has been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

H. Federalism Statement—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, this amendment to the regulation has federalism implications, because it has direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the federalism implications of the regulation is substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standard.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Cod Cong. & Admin. News 2018.) States ma continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to "prevent the application of" the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements. Throughout the process of developing this amendment, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these regulations, the Departments certify that the Employee Benefits Security Administration and the Office of Consumer Information and Insurance Oversight have complied with the requirements of Executive Order 13132 for the attached amendment to the interim final regulations in a meaningful and timely manner.

V. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor interim fin regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec.

101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Public Law 111–152, 124 Stat. 1029; Secretary of Labor's Order 6–2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Approved: November 8, 2010.

Steven T. Miller,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Michael F. Mundaca,

Assistant Secretary of the Treasury (Tax Policy).

Signed this 5th day of November 2010.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Approved: November 9, 2010.

Jay Angoff,

Director, Office of Consumer Information and Insurance Oversight.

Approved: November 9, 2010.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

Department of the Treasury

Internal Revenue Service

26 CFR Chapter I

■ Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

■ **Par. 2.** Section 54.9815–1251T is amended by:

■ 1. Revising paragraph (a)(1).

■ 2. Redesignating paragraphs (a)(3) introductory text, (a)(3)(i), and (a)(3)(ii) as paragraphs (a)(3)(i), (a)(3)(i)(A) and (a)(3)(i)(B), respectively.

■ 3. Adding new paragraph (a)(3)(ii).

■ 4. Removing paragraphs (a)(5) and (f)(2).

■ 5. Redesignating paragraph (f)(1) as paragraph (f).

■ 6. Revising the last sentence in newly-designated paragraph (f).

■ 7. Revising paragraph (g)(4) *Example 9.*

The revisions and addition reads as follows:

§ 54.9815–1251T Preservation of right to maintain existing coverage (temporary).

(a) *Definition of grandfathered health plan coverage*—(1) *In general*—(i) *Grandfathered health plan coverage. Grandfathered health plan coverage* means coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage.

(ii) *Changes in group health insurance coverage.* Subject to paragraphs (f) and (g)(2) of this section, if a group health plan (including a group health plan that was self-insured on March 23, 2010) or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, then the plan ceases to be a grandfathered health plan.

* * * * *

(3)(i) * * *

(ii) *Change in group health insurance coverage.* To maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether a change causing a cessation of grandfathered health plan status under paragraph (g)(1) of this section has occurred.

* * * * *

(f) * * * After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010).

(g) * * *

(4) * * *

Example 9. (i) *Facts.* A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option F is a self-insured option. Options G and H are insured options. Beginning July 1, 2013, the plan increases coinsurance under Option H from 10% to 15%.

(ii) *Conclusion.* In this *Example 9*, the coverage under Option H is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options F and G is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

Department of Labor

Employee Benefits Security Administration

29 CFR Chapter XXV

■ 29 CFR part 2590 is amended as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor's Order 6–2009, 74 FR 21524 (May 7, 2009).

■ 2. Section 2590.715–1251 is amended by:
■ 1. Revising paragraph (a)(1).
■ 2. Redesignating paragraphs (a)(3), (a)(3)(i) and (a)(3)(ii) as paragraphs (a)(3)(i), (a)(3)(i)(A) and (a)(3)(i)(B), respectively.
■ 3. Adding new paragraph (a)(3)(ii).
■ 4. Removing paragraphs (a)(5) and (f)(2).
■ 5. Redesignating paragraph (f)(1) as paragraph (f).
■ 6. Revising the last sentence in newly-designated paragraph (f).
■ 7. Revising paragraph (g)(4) *Example 9.*

The revisions and addition reads as follows:

§ 2590.715–1251 Preservation of right to maintain existing coverage.

(a) *Definition of grandfathered health plan coverage*—(1) *In general*—(i) *Grandfathered health plan coverage. Grandfathered health plan coverage* means coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance coverage offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage.

(ii) *Changes in group health insurance coverage.* Subject to paragraphs (f) and (g)(2) of this section, if a group health plan (including a group health plan that was self-insured on March 23, 2010) or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, then the plan ceases to be a grandfathered health plan.

* * * * *

(3)(i) * * *

(ii) *Change in group health insurance coverage.* To maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether a change causing a cessation of grandfathered health plan status under paragraph (g)(1) of this section has occurred.

* * * * *

(f) * * * After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010).

(g) * * *

(4) * * *

Example 9. (i) *Facts.* A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option *F* is a self-insured option. Options *G* and *H* are insured options. Beginning July 1, 2013, the plan increases coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 9,* the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

Department of Health and Human Services

45 CFR Chapter I

■ Accordingly, 45 CFR part 147 is amended as follows:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 1. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 2. Section 147.140 is amended by:
■ 1. Revising paragraph (a)(1).
■ 2. Redesignating paragraphs (a)(3), (a)(3)(i) and (a)(3)(ii) as paragraphs (a)(3)(i), (a)(3)(i)(A) and (a)(3)(i)(B), respectively.
■ 3. Adding new paragraph (a)(3)(ii).
■ 4. Removing paragraphs (a)(5) and (f)(2).
■ 5. Redesignating paragraph (f)(1) as paragraph (f).
■ 6. Revising the last sentence in newly designated paragraph (f).
■ 7. Revising paragraph (g)(4) *Example 9.*

The revisions and addition reads as follows:

§ 147.140 Preservation of right to maintain existing coverage.

(a) *Definition of grandfathered health plan coverage*—(1) *In general*—(i) *Grandfathered health plan coverage. Grandfathered health plan coverage* means coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under the rules of this section). A group health plan or group health insurance coverage does not cease to be grandfathered health plan coverage merely because one or more (or even all) individuals enrolled on March 23, 2010 cease to be covered, provided that the plan has continuously covered someone since March 23, 2010 (not necessarily the same person, but at all times at least one person). In addition, subject to the limitation set forth in paragraph (a)(1)(ii) of this section, a group health plan (and any health insurance covera offered in connection with the group health plan) does not cease to be a grandfathered health plan merely because the plan (or its sponsor) enters into a new policy, certificate, or contract of insurance after March 23, 2010 (for

example, a plan enters into a contract with a new issuer or a new policy is issued with an existing issuer). For purposes of this section, a plan or health insurance coverage that provides grandfathered health plan coverage is referred to as a grandfathered health plan. The rules of this section apply separately to each benefit package made available under a group health plan or health insurance coverage.

(ii) *Changes in group health insurance coverage.* Subject to paragraphs (f) and (g)(2) of this section, if a group health plan (including a group health plan that was self-insured on March 23, 2010) or its sponsor enters into a new policy, certificate, or contract of insurance after March 23, 2010 that is effective before November 15, 2010, then the plan ceases to be a grandfathered health plan.

* * * * *

(3)(i) * * *

(ii) *Change in group health insurance coverage.* To maintain status as a grandfathered health plan, a group health plan that enters into a new policy, certificate, or contract of insurance must provide to the new health insurance issuer (and the new health insurance issuer must require) documentation of plan terms (including benefits, cost sharing, employer contributions, and annual limits) under the prior health coverage sufficient to determine whether a change causing a cessation of grandfathered health plan status under paragraph (g)(1) of this section has occurred.

* * * * *

(f) * * * After the date on which the last of the collective bargaining agreements relating to the coverage that was in effect on March 23, 2010 terminates, the determination of whether health insurance coverage maintained pursuant to a collective bargaining agreement is grandfathered health plan coverage is made under the rules of this section other than this paragraph (f) (comparing the terms of the health insurance coverage after the date the last collective bargaining agreement terminates with the terms of the health insurance coverage that were in effect on March 23, 2010).

(g) * * *

(4) * * *

Example 9. (i) *Facts.* A group health plan not maintained pursuant to a collective bargaining agreement offers three benefit packages on March 23, 2010. Option *F* is a self-insured option. Options *G* and *H* are insured options. Beginning July 1, 2013, the plan increases coinsurance under Option *H* from 10% to 15%.

(ii) *Conclusion.* In this *Example 9*, the coverage under Option *H* is not grandfathered health plan coverage as of July 1, 2013, consistent with the rule in paragraph (g)(1)(ii) of this section. Whether the coverage under Options *F* and *G* is grandfathered health plan coverage is determined separately under the rules of this paragraph (g).

[FR Doc. 2010–28861 Filed 11–15–10; 4:15 pm]

BILLING CODE 4830–01–4510–29–4120–01–P

DEPARTMENT OF JUSTICE

Office of the Attorney General

28 CFR Part 0

[AG Order No. 3229–2010]

Office of Tribal Justice

AGENCY: Department of Justice.

ACTION: Final rule.

SUMMARY: This rule will amend part 0 of title 28 of the Code of Federal Regulations to reflect the establishment of the Office of Tribal Justice as a distinct component of the Department of Justice. The Office of Tribal Justice was created by the Attorney General to provide a channel for Tribes to communicate their concerns to the Department, to help coordinate policy on Indian affairs both within the Department and with other Federal agencies, and to ensure that the Department and its components work with Tribes on a government-to-government basis. This rule, which sets forth the Office's organization, mission and functions, amends the Code of Federal Regulations in order to reflect accurately the Department's internal management structure.

DATES: *Effective Date:* November 17, 2010.

FOR FURTHER INFORMATION CONTACT: Tracy Toulou, Director, Office of Tribal Justice, U.S. Department of Justice, RFK Main Justice Building, Room 2318, 950 Pennsylvania Avenue, NW., Washington, DC 20530. Telephone: (202) 514–8812.

SUPPLEMENTARY INFORMATION:

Background

In 1995 the Attorney General established the Office of Tribal Justice (OTJ) to provide a principal point of contact within the Department of Justice to listen to the concerns of Indian tribes and other parties interested in Indian affairs and to communicate the Department's policies to the Tribes and the public; to promote internal uniformity of Department of Justice policies and litigation positions relating to Indian country; and to coordinate with other Federal agencies and with State and local governments on their initiatives in Indian country. On November 5, 2009, the President directed all Federal agencies to develop a consultation and coordination policy that ensures effective communication with Tribes. The Director of OTJ, in consultation with Tribes and with other Department components, developed the Department's comprehensive plan in response to the President's directive, and is designated as the Department official responsible for following through on the plan and reporting requirements associated with the President's directive. The Director of OTJ also is the Department official responsible for certifying to the Office of Management and Budget that the requirements of Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, have been met with regard to any regulation or legislation proposed by the Department.

On July 29, 2010, President Obama signed into law the Tribal Law and Order Act of 2010, Public Law 111–211. Section 214 of the Tribal Law and Order Act amends title I of the Indian Tribal Justice Technical and Legal Assistance Act of 2000, to provide that "[n]ot later than 90 days after the date of enactment of the Tribal Law and Order Act of 2010, the Attorney General shall establish the Office of Tribal Justice as a component of the Department." This rule implements fully that statutory directive.

Administrative Procedure Act 5 U.S.C. 553

This rule is a rule of agency organization and procedure, and relates to the internal management of the Department of Justice. It is therefore exempt from the requirements of notice and comment and a delayed effective date. 5 U.S.C. 553(b), (d).

Regulatory Flexibility Act

The Attorney General, in accordance with the Regulatory Flexibility Act (5 U.S.C. 605(b)), has reviewed this rule and by approving it certifies that this rule will not have a significant economic impact on a substantial number of small entities because it pertains to personnel and administrative matters affecting the Department. Further, a Regulatory Flexibility Analysis was not required to be prepared for this final rule since the Department was not required to publish a general notice of proposed rulemaking for this matter.

Executive Order 12866

This action has been drafted and reviewed in accordance with Executive

OCTOBER 2010

COORDINATING COVERAGE AND CARE IN MEDICAID AND HEALTH INSURANCE EXCHANGES

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) increases access to affordable coverage by creating a new continuum of coverage and providing assistance to individuals with incomes up to 400% of the federal poverty level (FPL). Medicaid eligibility is extended to a national floor of 133% FPL and subsidies are provided to individuals between 133%–400% FPL to purchase coverage through new Health Insurance Exchanges. The ACA also requires states to create a coordinated, simple, and technology-supported process through which individuals may obtain Medicaid, CHIP, and Exchange coverage. Further, coordinating delivery of care across these coverage types will be important. To explore key issues related to achieving coordinated and seamless enrollment and care in Medicaid and Exchange coverage the Kaiser Commission on Medicaid and the Uninsured (KCMU) convened the second in a series of roundtables with national and state experts focused on health reform implementation on August 31, 2010. Key issues identified by participants during the roundtable include the following:

It is critical that states begin taking steps now to create an integrated and seamless eligibility and enrollment system for Medicaid and Exchange coverage that is supported by technology. While the Medicaid expansion and Exchange coverage will not go fully into effect until 2014, states face a long-lead time for system upgrades since they must go through formal procurement processes and many will need to make large-scale upgrades. One key decision states must address is to what extent they will build on existing Medicaid systems versus creating a new eligibility and enrollment system. Further, some states may want to consider restructuring where Medicaid eligibility is determined to facilitate integration with Exchange coverage, particularly those that currently determine eligibility through county-level social service agencies. Participants agreed that states need substantial and timely federal guidance and support to make the necessary upgrades by 2014. The Secretary of Health and Human Services (HHS) recently adopted a set of standards for interoperable electronic enrollment systems, and the ACA provides grants to states to assist in developing and implementing such systems. However, further federal guidance and support will be vital. States are specifically interested in having federal prototypes of systems and more federal financial support to enhance their capacity to upgrade systems.

The requirement to integrate Medicaid and Exchange enrollment systems, combined with simplified Medicaid eligibility criteria under reform, provide a valuable opportunity for states to vastly simplify Medicaid enrollment processes. Participants suggested that eliminating state procedural and documentation requirements in Medicaid that are not required by federal law would make it easier to coordinate Medicaid and Exchange coverage. However, it was noted that some states have concerns that doing so would increase their error rates during federal audits. It was noted that states that have already implemented significant Medicaid simplifications have some of the lowest error rates in the country and suggested that the focus of federal audits could be revisited so they are better aligned with the ACA goals of expanded coverage. Participants also commented that the ACA calls for uniformity of enrollment processes across Medicaid and subsidized coverage in the Exchange which may supersede state flexibility to impose certain enrollment requirements in Medicaid, such as face-to-face interviews.

It will be important to minimize burdens on individuals by utilizing technology and existing data sources to obtain information. There was consensus among participants that utilizing existing databases to support eligibility determination and automate enrollment would go a long way in simplifying the enrollment process. With regard to income, it was noted that although eligibility for Medicaid and subsidized Exchange coverage will be based on Modified Adjusted Gross Income (MAGI)—which is captured when individuals file taxes and available through the Internal Revenue Service—there will need to be processes to collect more current income to assure individuals are enrolled in the correct program and receive the correct amount of financial assistance. Tax data may be lagged by as long as two years and, over that period, individuals may have a change in income or circumstances that affects their Medicaid eligibility and/or the level of assistance they qualify for under Exchange coverage. Moreover, the law requires that Medicaid eligibility be based on current income and that HHS establish guidelines for Exchange coverage to gather more recent income information for people who have experienced a change in circumstances. Further, not all individuals will have filed taxes and, within Medicaid, there will remain some groups (including elderly and disabled individuals) whose eligibility will continue to be based on current Medicaid methodologies. Several participants also suggested that it will be important for individuals to be able purchase coverage through the Exchange without answering any income-related questions since some will not be eligible for or interested in receiving any assistance.

Seamless and automatic renewals of and transitions between coverage will be vital components of integrated enrollment systems. Assuring there are simple and effective processes to collect updated income and other eligibility information will be key for preventing disruptions in coverage and making sure that individuals receive the appropriate coverage and amount of financial assistance at the right time. It was recognized that, within Medicaid, utilizing electronic data exchanges to obtain updated information and automatically renew coverage has been an extremely effective and efficient way to help individuals maintain coverage. Further, experience with Medicaid and CHIP suggests that transitions between programs occur most seamlessly when a single agency handles eligibility determinations for both programs; however, using electronic data exchange can help smooth transitions between separate agencies. Participants also noted that allowing states to provide 12-month continuous eligibility to adults in Medicaid would help would help minimize the frequency of transitions in coverage and thereby reduce the risk of coverage gaps and/or disruptions in care.

Developing processes and systems that facilitate continuous care across coverage types will also be important. The legislative requirements to coordinate benefits and health plans between Medicaid and the Exchange are limited. The primary requirement is that an essential health benefits package be created for Exchange coverage and that benchmark coverage for "new eligibles" in Medicaid must, at a minimum, provide the essential health benefits. A few participants suggested that having similar benefit packages for plans in Medicaid and the Exchange would facilitate coordinated care. Further, the question of whether benchmark coverage for "new eligibles" in Medicaid should resemble commercial coverage was raised, although concerns were expressed as to how this would impact enrollees with significant health needs who require more services than typically included in a commercial plan. Another topic raised was to what extent states should work to ensure that some plans participate in both the Medicaid and Exchange markets, for example, by providing incentives or utilizing selective contracting processes. While not required by legislation, having some plans that are available through both markets could help facilitate continuity of care for people who transition between programs.

In conclusion, the ACA establishes requirements to create a continuum of coverage with a coordinated enrollment process supported by technology. It also will be important to assure that care is coordinated across coverage types. A number of challenges must be addressed to achieve these goals, but the requirements also provide an opportunity for states to greatly simplify their Medicaid enrollment processes and make large-scale upgrades to their eligibility systems. The discussion emphasized that it will be vital for states to begin taking steps now to have systems in place by 2014. Further, participants stressed the importance of immediate federal guidance and support to advance state efforts.

INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010 with a number of broad goals, including increasing access to affordable health coverage and reducing the number of uninsured. To make coverage more affordable, the law creates a new continuum of coverage pathways and provides assistance to individuals with family incomes up to 400% of the federal poverty level (FPL). Medicaid eligibility is extended to a national floor of 133% FPL[1] and subsidies are provided to individuals between 133%–400% FPL to purchase coverage through new Health Insurance Exchanges. The Medicaid expansion and Exchange coverage will go fully into effect beginning in 2014.

Along with increasing affordability of coverage, the ACA includes provisions to make it easy for individuals to enroll in coverage by requiring states to create a coordinated, simple, and technology-supported process through which individuals may obtain coverage through Medicaid, CHIP, and the new Exchanges. Beyond coordinating eligibility and enrollment, it also will be important to coordinate delivery of care across these coverage types, particularly since low-income individuals often have fluctuating incomes and family circumstances that may cause their eligibility to shift over time.

To explore key issues related to achieving coordinated and seamless enrollment and care between Medicaid and the new Exchanges, the Kaiser Commission on Medicaid and the Uninsured (KCMU) convened a roundtable with national and state experts on August 31, 2010. This report is based on the discussion during this roundtable, which is the second in a series of health reform roundtables focused on implementation issues related to Medicaid.[2]

BACKGROUND: ACA REQUIREMENTS FOR COORDINATING ENROLLMENT AND CARE

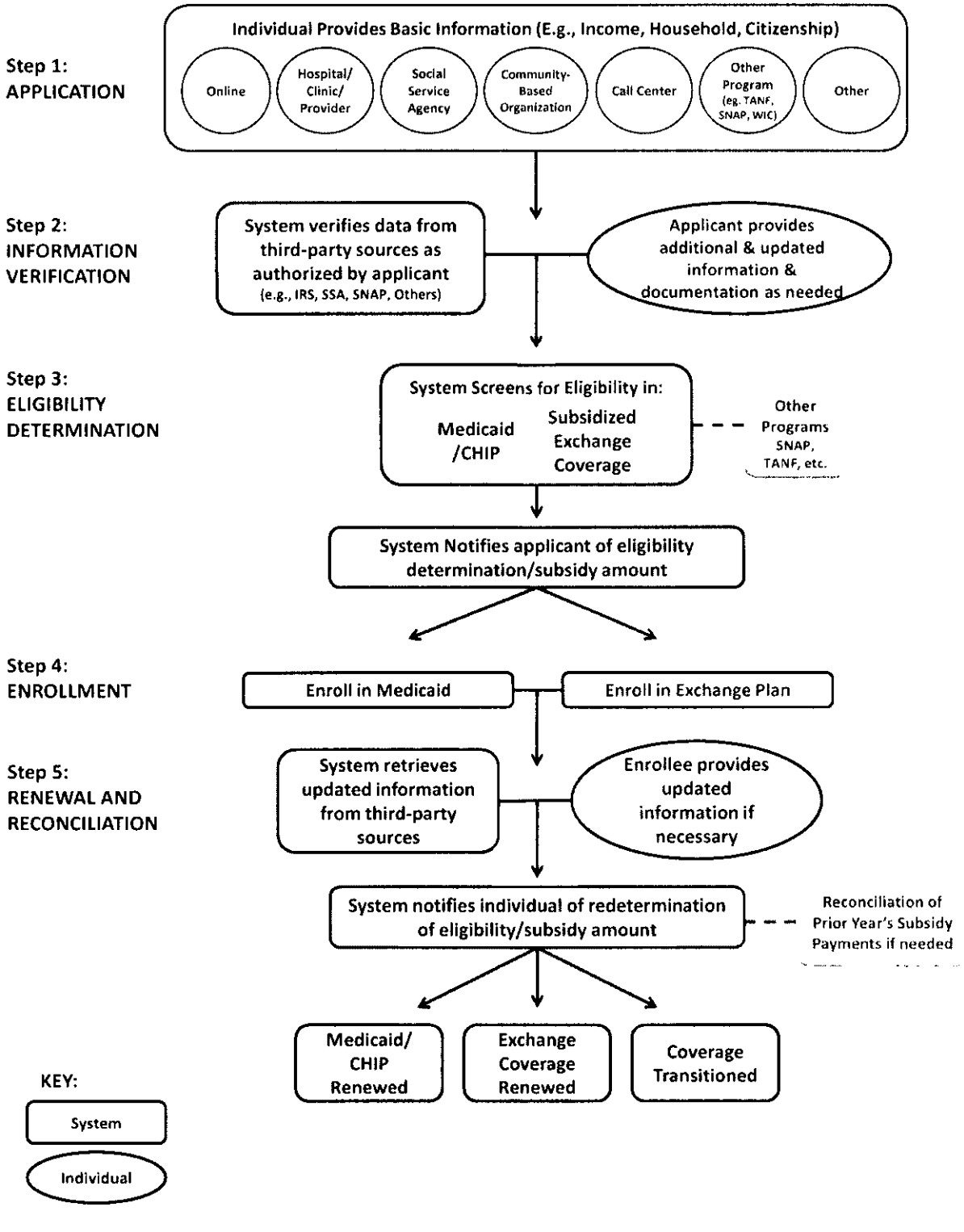
As noted, the ACA includes requirements focused on making sure enrollment and eligibility systems for Medicaid, CHIP, and Exchange coverage are streamlined and integrated and utilize technology to reduce burdens on individuals. More specifically, the law requires:

- **Web portals** through which individuals may obtain and compare information about coverage options and apply for coverage;
- **A single application form** that is available online and may be filed online as well as in-person, by mail, or by telephone and application support including "navigators" to provide education and facilitate enrollment;
- **"No wrong door"** for coverage, so that individuals are screened for all coverage options regardless of where they apply and enrolled without additional application forms or multiple eligibility determinations;
- **Standardized income rules using Modified Gross Income (MAGI)** to determine eligibility;
- **Secure electronic data exchange** that is utilized to the "maximum extent practicable" to establish, verify, and renew and update eligibility.[3]

Further, the ACA provides grants to states to support the development and implementation of these enrollment systems and the Secretary of HHS recently adopted a set of standards and protocols related to the development of these systems.[4]

The following flow chart (Figure 1) illustrates an example of key steps and processes that could be incorporated into an integrated and automated eligibility and enrollment system.

Figure 1:
Example of Key Steps and Processes in an Integrated Enrollment System for Medicaid and Subsidized Exchange Coverage



The requirements in the ACA for coordinating health plans and delivery systems across coverage types are more limited than those related to integrated eligibility and enrollment. Health plans in Exchanges must contract with essential community providers, who may serve as access points for the low-income population. There are also some requirements related to coordination of benefits. Namely, Exchange coverage must offer a specified "essential health benefits package" and benchmark coverage for new eligibles in Medicaid must, at a minimum, include the benefits in the "essential health benefits package."

KEY ISSUES IN ACHIEVING COORDINATED ENROLLMENT AND CARE

As discussed by roundtable participants and presented below, there are a number of key issues states will face in designing and implementing a system that coordinates eligibility and enrollment and delivery of care across Medicaid and Exchanges.

1. It is critical that states begin taking steps now to create an integrated and seamless eligibility and enrollment system for Medicaid and Exchange coverage that is supported by technology to be ready for 2014.

Importance of Federal Guidance and Support

States will play a key role in designing and implementing eligibility and enrollment systems that meet the ACA requirements. While the Medicaid expansion and subsidies for new Exchange coverage will not go fully into effect until 2014, states face a long lead-time associated with system upgrades, particularly since they must go through formal procurement processes. As such, participants commented that it is important for states to begin taking steps now to determine how they will integrate their Medicaid eligibility and enrollment systems with the new subsidized Exchange coverage and create a single, online application form that utilizes electronic data matching and verification.

A few states have already developed integrated, web-based enrollment systems—for example, Wisconsin has an online self-service tool that is fully integrated with its eligibility system and allows individuals to find out whether they may be eligible for Medicaid (and other assistance programs), apply for benefits, check the status of their benefits, renew their benefits, and report changes to keep their eligibility current.[5] The state also greatly streamlined its Medicaid eligibility rules, which helped support the simplicity and utility of the system.[6] While the state is a leader in developing an integrated, online system, it still faces some important limitations that prevent enrollment from being fully automated and slow application processing time. For example, because of a federal requirement that a public employee must verify eligibility, county or state workers must check each application.[7] Further, applicants must continue to submit any required documentation (e.g., paystubs) by scan, fax, mail, or in-person.[8]

Moreover, most states remain much farther behind in terms of their technology and have a long road to travel in terms of developing systems that will meet the requirements of the ACA. For example, while most states have their Medicaid and/or CHIP application available on-line, only a little more than half have the capability for it to be electronically submitted and, in most of these states, applicants still must provide paper documentation. Further, some states still rely on archaic, paper-based systems with very limited electronic capabilities.

Participants largely agreed that states will need substantial additional federal guidance and support to be able to make the necessary upgrades by 2014. It was noted that states are particularly interested in having access to federal templates or prototypes of systems that they could adopt. Under the ACA, the Federal government is required to build and provide a federal Exchange. The federal Exchange could help serve as a framework or reference model for states and could be built so that it could be adopted in whole or in part by states. This would promote increased consistency across states and reduce redundancies in terms of development efforts and costs.

Further, it was pointed out that although some grant funding is available to help support system development, current limitations and strains among state staffs make it challenging to apply for these grants. The federal government is considering whether a 90% federal match (as opposed to the traditional 50% administrative match) will be available to support eligibility system upgrades. This additional federal funding would enhance states' capacity to make eligibility system upgrades.

Determining Governance and Structure of Systems

In designing integrated systems, states will need to make decisions regarding where eligibility determinations for Medicaid and subsidies for Exchange coverage will be housed and which agencies, workers, and entities will be able to make eligibility determinations. While states already have eligibility and enrollment systems and processes in place for Medicaid, new systems and processes will need to be established to determine eligibility for premium and cost sharing subsidies for Exchange coverage. One key decision states will need to make is to what extent they will build on existing Medicaid eligibility systems to include Exchange coverage versus creating entirely new systems for Exchange coverage and Medicaid.

A number of participants commented that some states may want to consider restructuring where their Medicaid eligibility is determined to facilitate coordination and integration with new Exchange coverage. There is significant variation across states today in terms of where and how eligibility is determined for Medicaid and CHIP. For example, in some states, Medicaid eligibility is determined through a county-based system by county workers at a social services agency that also does eligibility determinations for other assistance programs, such as food stamps or Temporary Assistance for Needy Families. In other states, eligibility is determined at a centralized state office. Further, some states have state workers that conduct eligibility determinations in county offices. Still other states rely on private contractors to conduct key elements of enrollment activities, particularly for CHIP. And, some states have eligibility determined through a combination of these options.

Some states have already begun thinking about changing where their Medicaid eligibility is determined in preparation for reform. For example, Washington is planning to move its Medicaid Administration out of the Department of Social and Health Services and merge it with its Health Care Authority, which administers its existing Basic Health coverage program for low-income adults.[9] Similarly, Michigan is considering moving eligibility determinations out of the Department of Human Services and into the Department of Community Health, which administers the Medicaid program, with a goal of simplifying the eligibility determination process and consolidating program administration.[10]

Moving health coverage eligibility determinations away from county-level social services agencies may be particularly important to consider, since using a centralized state eligibility system (vs. separate eligibility systems in each county) will facilitate integration with Exchange coverage and potentially reduce application processing time. For example, New York recently passed legislation to move administration of Medicaid eligibility determinations from the county to state level over a five-year implementation period, beginning on April 1, 2011.[11] However, it also was noted that, in some states, considering moving determinations away from the county-level may be met with tension and resistance among county workers.

Tracking "New vs. Current Eligibles" and Maintaining Current Medicaid Methodologies

A complicating factor in developing eligibility systems is that, under reform, states must track who is newly eligible for Medicaid (versus who was previously eligible) since the federal government will pay the majority of costs for newly eligible individuals. Further, whether an individual is considered "newly eligible" has implications for what benefits they will receive, as states can elect to provide newly eligible adults benchmark benefits that may differ from the traditional Medicaid benefit package.[12] Moreover, while most Medicaid eligibility groups will

have eligibility determined based on MAGI under reform, there are some groups, including elderly and disabled individuals, who will continue to rely on current Medicaid eligibility methodologies. Participants noted that there are a number of unanswered questions about how states will need to continue to track these distinctions and whether they will need to maintain dual eligibility systems to do so.

2. The requirement to integrate Medicaid and Exchange enrollment systems, combined with simplified Medicaid eligibility criteria under reform, provide a valuable opportunity for states to vastly simplify Medicaid enrollment processes.

Some states have already made significant strides forward in simplifying Medicaid enrollment, for example, by moving to data-matching and other electronic or automated means to verify information (rather than requiring paper documentation) and eliminating interview requirements that are not required by federal law. However, other states still maintain these types of requirements, particularly for parents. Participants suggested that it would be beneficial for states to consider greatly simplifying their Medicaid enrollment processes as they design new integrated systems since Medicaid simplifications would make it easier to coordinate with Exchange coverage and meet other ACA enrollment-related requirements.

Participants also commented that the ACA calls for uniformity of enrollment processes across Medicaid and subsidized coverage in the Exchange and specifically requires that individuals be screened for all coverage options regardless of where they apply and enrolled without additional application forms or multiple eligibility determinations. These requirements may supersede state flexibility to impose certain requirements in Medicaid, such as face-to-face interviews. However, it was also recognized that certain eligibility categories in Medicaid will continue to require different eligibility determination and enrollment procedures (such as individuals with disabilities or those requiring long-term care services).

It was noted that some states have concerns that simplifying the Medicaid eligibility and enrollment process would increase their error rates during federal audits. In response, it was pointed out that states such as Louisiana, which have implemented significant simplifications, have some of the lowest error rates in the country. It was also suggested that rethinking the focus of federal audits and performance measures so they are better aligned with the goals of the ACA could facilitate and encourage increased Medicaid streamlining efforts among states.

3. It will be important for systems to minimize burdens on individuals by utilizing technology and existing data sources to obtain information.

Consistent with the "no wrong door" requirement, it was noted that regardless of which avenue an individual comes through to seek coverage, the individual should be evaluated for Medicaid, CHIP, and subsidies for Exchange coverage. However, participants emphasized the need to strike a balance of asking enough information to determine eligibility without making the process complex, burdensome, or intrusive, particularly given the broad income range of people that will be seeking coverage through the Exchange. The Exchange will be utilized as an entry point to coverage for people at all income levels—some will be eligible for tax credits to offset premium and cost sharing amounts of Exchange coverage, some will be eligible for Medicaid or CHIP, and some won't be eligible for assistance but will still purchase coverage through the Exchange.

Overall, it was largely agreed that eligibility and enrollment systems should be designed to obtain enough information to determine eligibility for the "majority" of individuals applying for coverage, but that additional processes and enrollment supports will need to be in place for individuals with special circumstances. In fact, the legislation requires that individuals have access to meaningful application support and alternatives to the on-line application are available. Further, it was recognized that it will be important to make sure individuals are fully informed about and understand the determination process and final enrollment decisions to assure due

process requirements are met. Participants also highlighted the importance of enrolling individuals in the correct coverage category since a set of rights and their premium costs, benefits, and cost sharing will flow from their eligibility determination.

Determining Income

Under health reform, assistance will be available to individuals with income up to 400% FPL and eligibility for both Medicaid and subsidies in the Exchange will be based on MAGI, which is defined by the Internal Revenue Code and captured through the Internal Revenue Service when individuals file income taxes. Moving to MAGI standardizes and simplifies income eligibility across states and between Medicaid and subsidized Exchange coverage. However, tax data may be lagged by as long as two years and, over that period, individuals may have a change in income or circumstances that affects their Medicaid eligibility and/or the level of financial assistance they qualify for under Exchange coverage. Further, not all individuals will have filed taxes and, within Medicaid, there will remain some non-MAGI groups (including elderly and disabled individuals) whose eligibility will continue to be based on current Medicaid methodologies.

Given these issues and that the law requires Medicaid eligibility to be based on current income and HHS to establish guidelines for Exchange coverage to gather more recent income information for people who have experienced a change in circumstances, participants noted that processes will need to be established to collect more current information from applicants. Doing so will be vital for assuring that individuals can be screened for Medicaid eligibility and that they receive the appropriate level of subsidies and/or cost-sharing reductions for Exchange coverage. Participants cautioned that it will be important for this process to remain simple and for any documentation requirements to be clearly specified to the applicant in an easily understood manner.

Moving to MAGI also changes how households are defined and family size is calculated. For example, today, Medicaid often excludes step-parent and grandparent income that would be counted in the MAGI household definition of income. Further, participants pointed out that individuals generally perceive their household as all individuals with whom they live, which is very different from the tax definition of household used for MAGI. As such, it was noted that it will be important to clearly communicate to individuals who can be counted as part of their household and collect the necessary information to determine their household size and income.

Several participants commented that not every person coming to the Exchange to purchase coverage would be eligible for or interested in receiving assistance, and some of these individuals might find any income-related questions to be intrusive or off-putting. A suggestion was made to create an initial screening question or process that would enable individuals to purchase coverage through the Exchange without having to answer any income-related questions if they were not interested in applying for a subsidy. It was further noted that if any of these individuals are eligible for premium subsidies, they would receive credits after filing their tax return.

Automating Data Collection and Express Lane Eligibility

There was consensus among participants that utilizing existing federal and state databases to obtain and verify as much eligibility information as possible and automate enrollment would go a long way in simplifying the process and making it easier for individuals. It also reduces burdens on eligibility workers and can speed up the processing time of applications.

It was recognized that states can already move forward with developing these processes for children, since, under the Children's Health Insurance Program Reauthorization Act, they can implement "Express Lane Eligibility" initiatives that draw on other data sources to identify and automatically enroll eligible but uninsured children in Medicaid and CHIP. However, this authority does not currently extend to adults. It was noted that it would likely

be advantageous to expand Express Lane Eligibility authority to include adults since adults will comprise the bulk of those newly eligible for Medicaid and many states will be faced with processing a large volume of new adult enrollees following implementation of the expansion. Further, many of the adults who will become newly eligible for Medicaid are likely enrolled in the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps). As such, providing Express Lane Eligibility authority that would allow states to borrow data from SNAP to conduct Medicaid eligibility determinations for adults could offer a highly effective and efficient strategy for states to reach and enroll newly eligible adults.

4. Seamless and automatic renewals of and transitions between coverage will be vital components of integrated eligibility and enrollment systems.

Beyond issues associated with establishing income and eligibility when individuals initially apply for coverage, participants also noted that there are questions that need to be addressed with regard to capturing and managing changes in income and eligibility over time, including when and how changes in income will be collected. Assuring there are simple and effective processes to collect updated income and other eligibility information will be key for preventing disruptions in coverage and making sure that individuals receive the appropriate coverage and amount of financial assistance at the right time.

Using Data Exchange to Automate Renewals and Coverage Transitions

It was recognized that, within Medicaid, utilizing electronic data exchanges to obtain updated information and automatically renew coverage has been an extremely effective and efficient way to help individuals maintain coverage. For example, in Louisiana, children are automatically renewed for coverage based on information available through other programs and data sources (e.g., SNAP, child support, tax information) or if their case meets specified criteria.[13] As a result of this initiative, the state has almost completely eliminated losses in coverage at renewal due to procedural reasons.[14]

It also was stressed that it will be important to develop a process that facilitates seamless, automatic transitions between coverage, particularly since a number of low-income individuals have changing circumstances and income that may cause their eligibility to shift over time. Past experience with Medicaid and CHIP suggests that transitions in coverage work best when a single, unified agency conducts eligibility determinations for both coverage programs. When transitions occur across different agencies, there is a risk that people will lose coverage during the transition.

Although transitions work best when eligibility for both programs is housed within a single agency, participants noted that there are some best practices that can be drawn on from Medicaid and CHIP for transitioning coverage between agencies. For example, in Alabama, the Department of Public Health, which administers its separate CHIP program "ALL Kids," and the Alabama Medicaid Agency have created a collaborative working relationship and taken steps to align eligibility rules, although some important differences remain.[15] The state facilitates coordination and transfers of coverage between Medicaid and ALL Kids through an electronic data exchange system that passes applications back and forth between the two programs on a nightly basis.[16] (However, a signed paper for must also be transferred before eligibility can be determined, which adds to the processing time for referred applications.)[17] Further, each agency has staff devoted to processing cases transferred from the other program.[18]

Similarly, Pennsylvania has an online application system, COMPASS, that provides a bridge between Medicaid, CHIP, and its state-funded adultBasic program for low-income adults by transferring data between the Department of Public Welfare, which administers Medicaid, and the state Insurance Department, which administers CHIP and adultBasic. This "Healthcare Handshake" automatically transfers data not only at the point

of application but also when an enrollee loses eligibility in one program but may qualify for another.[19] As part of the Handshake, the "losing agency" provides a fully populated application with all the information needed to make an eligibility determination to the "gaining agency," without requiring any action by the individual or family.[20] The transaction takes seconds and the individual is enrolled in the new program at the earliest date possible.[21]

As part of a process of transitioning individuals between coverage programs, it will be important for states to track the success of their transitions or referrals between programs. It also will be imperative to incorporate processes to educate individuals about their coverage changes, for example, by informing them about why and how their coverage changed and how their premium and cost sharing amounts, covered benefits, and health plan and provider networks are affected.

Another issue that was raised was that Medicaid provides retroactive coverage (i.e., covering health costs for the three months prior to the date of enrollment), while Exchange coverage is provided on a prospective basis (i.e., beginning on the first of the month following enrollment). It will be important to address this timing issue so that it does not create gaps in coverage as a person moves from Medicaid to Exchange coverage. Extending Medicaid through the end of the month after disenrollment was one suggestion made to prevent such gaps.

Stabilizing Coverage for Adults in Medicaid by Allowing Continuous Eligibility

Similar to employer-sponsored coverage today, enrollment in Exchange coverage will be based on an annual open enrollment period, although eligibility for premium and cost sharing subsidies may vary throughout the year based on any changes in income or family circumstances. However, currently, there is significant variation across states and population groups in terms of enrollment periods for Medicaid. Many states have a 12-month enrollment period for their Medicaid program, meaning that applicants only need to renew coverage annually. However, if enrollees experience a change in income or circumstances within that period they would be expected to report that change and would be disenrolled if the change made them ineligible. Further, some states require more frequent (e.g., 6-month) Medicaid redeterminations, particularly for parents.

States have the option to provide 12-month continuous eligibility to children in Medicaid and CHIP, meaning that children remain eligible for an entire year regardless of changes in income. However, states do not have an option to provide this continuous eligibility to adults after 2014. Participants generally concurred that providing continuous eligibility would help would minimize the frequency and burden of reporting income data and frequent transitions in coverage that increase risks of coverage gaps or disruptions in access to care. Minimizing transitions in coverage through continuous eligibility would also enhance the ability of health plans to manage and coordinate care for enrollees.

5. Developing processes and systems that facilitate continuous care across coverage types will also be important.

As noted, the legislative requirements around coordinating benefits and health plans between Medicaid and the Exchange are limited. The primary requirement is that an essential health benefits package be created for Exchange coverage and that benchmark coverage for "new eligibles" in Medicaid must, at a minimum, provide the essential health benefits.

A few participants suggested that having similar benefit packages for plans in Medicaid and the Exchange would help facilitate coordinated care. Further, the question of whether benchmark coverage for "new eligibles" in Medicaid should look more like commercial coverage was raised, although concerns were expressed as to how this would impact individuals with significant health needs who may not qualify as disabled but still require more services than those typically included in a commercial plan. Also, it was noted that the more significant the

differences are for benefits for "new eligibles" versus "current eligibles," the more important it will be for a state to continue to make the distinction as to which individuals are "newly eligible." Another topic raised was to what extent states should work to ensure that some plans participate in both the Medicaid and Exchange markets, for example, by providing incentives or utilizing selective contracting processes. However, it was noted that many Medicaid managed care plans may find it difficult to operate in the Exchange since they are smaller and/or are not set up to operate in a commercial market.

The discussion also included broader questions about whether it would be advisable to group the Small Business Heath Options Program (SHOP) and individual Exchange markets together along with the Medicaid population. While some cautioned that this would be difficult and cause complexities, others commented that it will be important to think about creating and utilizing purchasing power by combining groups under a single governance.

CONCLUSION

In conclusion, beyond expanding coverage to millions of currently uninsured, the ACA envisions and establishes requirements to create a continuum of coverage with a coordinated and seamless enrollment process supported by technology. It also will be important to assure that care is coordinated and continuous across coverage types. To achieve the goal of coordinated coverage and care, a number of challenges must be addressed, but the requirement to create modernized and integrated systems provides an important opportunity for states to greatly simplify their Medicaid eligibility and enrollment processes and make large-scale system upgrades that make better use of technology and reduce burdens for both individuals and eligibility workers. The roundtable discussion emphasized that it will be important for states to begin taking steps now to have systems in place by 2014. Further, participants stressed the importance of immediate federal guidance and increased federal financial support to advance state efforts.

ENDNOTES

[1] A standard 5% of income disregard will be used to determine Medicaid eligibility, raising the effective income limit to 138% FPL.

[2] Artiga, S., Rudowitz, R., and B. Lyons, "Expanding Coverage to Adults through Medicaid Under Health Reform," Health Reform Roundtables: Charting a Course Forward," The Kaiser Commission on Medicaid and the Uninsured, September 2010.

[3] Morrow, M. and J. Paradise, "Explaining Health Reform: Building Enrollment Systems that Meet the Expectations of the Affordable Care Act," The Henry J. Kaiser Family Foundation, October 2010.

[4] These standards focus on creating an eligibility and enrollment system that features a transparent, understandable and easy to use online process that enables consumers to make informed decisions about applying for and managing benefits; accommodates a range of user capabilities, languages, and access considerations; offers seamless integration between private and public insurance options; also connects individuals with other services and need-based programs (e.g., SNAP, TANF); and provides strong privacy and security protections. "Patient Protection and Affordable Care Act, Section 1561 Recommendations," The Office of the National Coordinator for Health Information Technology, September 17, 2010, http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

[5] "Wisconsin's ACCESS Internet Portal," Optimizing Medicaid Enrollment: Spotlight on Technology, The Kaiser Commission on Medicaid and the Uninsured, forthcoming.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Kellar, E., et al, "Staying on Top of Health Reform: An Early Look at Workforce Challenges in Five States," The Henry J. Kaiser Family Foundation, September 2010.

[10] Ibid.

[11] "Lieutenant Governor's Report on Controlling Increases in the Cost of New York Medicaid," September 20, 2010; "Right Dose of Oversight Needed to Control N.Y.'s Medicaid Costs," Observations, The Nelson A. Rockefeller Institute of Government, October 2010, http://www.rockinst.org/observations/burkec/2010-10-right_dose_oversight.aspx

[12] Essential health benefits are the benefits that must be provided to people signing up for Exchange plans or coverage in the individual or small group insurance market, beginning in 2014. The Secretary of Health and Human Services is charged with defining essential health benefits.

[13] Brooks, T., "The Louisiana Experience: Successful Steps to Improve Retention in Medicaid and SCHIP," The Georgetown University Health Policy Institute Center for Children and Families, February 2009.

[14] Ibid.

[15] Kellenberg, R., Duchan, L., and E. Ellis, "Maximizing Enrollment in Alabama: Results from a Diagnostic Assessment of the State's Enrollment and Retention Systems for Kids," A Maximizing Enrollment for Kids Diagnostic Assessment Series, National Academy for State Health Policy and the Robert Wood Johnson Foundation, February 2010.

[16] Ibid.

[17] Ibid.

[18] Ibid.

[19] Morrow, B., "Emerging Health Information Technology for Children in Medicaid and SCHIP Programs," E-health Snapshot, The Kaiser Commission on Medicaid and the Uninsured and The Children's Partnership, November 2008.

[20] Ibid.

[21] Ibid.

This brief was prepared by Samantha Artiga, Robin Rudowitz, and Barbara Lyons of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The Commission extends its deep appreciation to the officials and experts who generously shared their valuable expertise, experience, and insights and its thanks to Deborah Bachrach of Bachrach Health Strategies, LLC for her help in organizing the roundtable.

This publication (#8118) is available on the Kaiser Family Foundation's website at www.kff.org.

FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

AUGUST 2010

EXPLAINING HEALTH REFORM:
Eligibility and Enrollment Processes For Medicaid, CHIP, and Subsidies in the Exchanges

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) became law, requiring most U.S. citizens and legal residents to have health insurance and establishing a state-based system of health benefit Exchanges through which individuals can purchase coverage, with financial support for those between 133-400% of the federal poverty level, and expanding Medicaid eligibility to those with income below that level. A number of provisions in the ACA require states to design and operate coordinated, technology-supported enrollment processes to assist Americans who lack access to affordable employer-based coverage in obtaining health coverage through Medicaid, the Children's Health Insurance Program (CHIP), or the Exchange. The law requires states to develop consumer-friendly application processes for these health subsidy programs, coordinate across them to enable seamless transitions, and reduce the burdens of application and renewal by minimizing the up-front information and documentation required to establish eligibility and instead developing procedures that tap available data from other sources.

The accompanying chart summarizes and provides highlights of the legislative language from ACA regarding the main enrollment provisions, particularly those of relevance to low- and moderate-income families. These provisions require enrollment systems that are:

Consumer-friendly: ACA requires states to create enrollment systems that ensure that applicants are screened for all available health subsidy programs and enrolled in the appropriate program, with minimal collection of information and documentation from applicants.

Coordinated: ACA requires states to coordinate efforts across available health subsidy programs to enable seamless transitions between those programs.

Simplified: ACA requires states to operate a streamlined enrollment process and foster administrative simplification, using uniform income rules and forms as well as paperless verification procedures.

Technology-enabled: ACA requires states to operate enrollment Web portals and securely exchange and utilize data to support the eligibility determination. In addition, ACA directs the Secretary of Health and Human Services to establish standards and protocols for electronic enrollment and eligibility systems, to allow for significantly improved streamlining and cross-agency capabilities.

With the passage of health reform, the United States has begun to build a culture of coverage, laying the foundation for this culture shift through new health coverage options, protections, and subsidies, as well as through provisions that promote individual responsibility. The first stone in this foundation has been laid with the July 1, 2010 launch of a federal informational Internet portal (http://www.healthcare.gov) that will ultimately have significant operational capabilities. Further, ACA tasks states with constructing an enrollment system that assists people in understanding their choices and helps them obtain and keep appropriate health coverage. In order to achieve the optimal enrollment process, with the technology that can support it, states need to begin planning and developing their policies, procedures, and systems right away, to ensure deployment by 2014.

CONSUMER-FRIENDLY

Summary	Section	Specifics
Helps consumers understand their options	§ 1103	The Secretary of Health and Human Services (Secretary) will create, operate, and update an Internet portal to help consumers identify and compare available affordable coverage options, including Medicaid and CHIP. The portal was launched July 1, 2010: http://www.healthcare.gov/. It will be fully functional as of October 1, 2010.
	§ 1311(c)(5)	The Secretary will also design, for use by the Exchanges, a model template for an Internet portal that will assist individuals in "determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction," among other functions.
Helps families apply online	§ 2201 [New §1943(b)(1) of the Social Security Act (SSA)]	States are required to operate an Internet website that links the Exchange, Medicaid, and CHIP (as relevant). These websites shall allow individuals to compare available health subsidy programs and apply for or renew such coverage. State websites shall be in operation by January 1, 2014.
Provides for a single, streamlined application form	§ 1413	The Secretary is required to develop a single, streamlined form that States can use for all those applying on the basis of income to applicable State health subsidy programs and that can be filed by an applicant online, in person, by mail or phone. Applicable state health subsidy programs include: premium tax credits and cost-sharing reductions in the Exchange, Medicaid, CHIP, and § 1331 state qualified basic health plans. States can develop their own single, streamlined form as an alternative to the Secretary's form as long as it meets the same standards. For applicants not applying on the basis of income, such as foster children and SSI beneficiaries, states may use a supplemental or alternative form.
Reduces administrative burdens on applicants	§ 1413(b)(2)	Individuals filing the single form "shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless... information provided on the form is inconsistent with data used for the electronic verification... or is otherwise insufficient to determine eligibility."
	§ 2002(a)	No asset test will be applied in Medicaid for individuals whose income is calculated using modified adjusted gross income (MAGI), including parents and other non-elderly adults as well as children.
Expands presumptive eligibility for Medicaid applicants	§ 2202	At state option, all hospitals participating in a state Medicaid program can grant presumptive eligibility to all Medicaid eligible populations (not only pregnant women and children). This option is effective January 1, 2014.
Provides assistance to help consumers obtain coverage	§ 1311(i)	Exchanges will set up a Navigator grant program to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the Exchange, facilitate enrollment in qualified health plans, and provide referrals for complaints.
	§ 2201 [New SSA §1943(b)(1)(F)]	In addition, states will establish procedures for conducting outreach and providing enrollment assistance to vulnerable and underserved populations eligible for Medicaid and CHIP.

COORDINATED

Summary	Section	Specifics
Requires coordination between Exchanges, Medicaid, and CHIP so that there is no wrong door into coverage	§ 2201 [New SSA § 1943 (a) and (b)]	Requires, as a condition of Federal financial assistance (i.e., federal Medicaid matching funds) beginning January 1, 2014, that states establish streamlined application and renewal procedures that: • Enable individuals to apply for, be enrolled in, or renew Medicaid coverage through an Internet website that is linked to the Exchange website; • "Enroll... without any further determination by the State and through such website, individuals who are identified by an Exchange... as being eligible for" Medicaid or CHIP; • Ensure that individuals found ineligible for Medicaid or CHIP are screened for the Exchange and any applicable premium assistance and, if eligible, "enrolled in such a plan without having to submit an additional or separate application" and receive information regarding reduced cost-sharing and any other assistance or subsidies that are available through the Exchange.
	§ 1311(a) and (d)(4)(F)	The Secretary will award states Exchange "planning and establishment" grants by March 23, 2011, which may be renewed until January 1, 2015. Planning and establishment must ensure that the Exchange has the ability, among other specified functions, to inform individuals about Medicaid, CHIP, "or any applicable State or local public program," screen their application, and enroll such individuals in any of those programs as appropriate.
Medicaid and CHIP agencies may determine eligibility for premium tax credits	§ 2201 [New SSA § 1943(b)(2)]	A Medicaid or CHIP agency can enter an agreement with an Exchange to determine eligibility for premium assistance if the agreement "meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage."

SIMPLIFIED

Summary	Section	Specifics
Increases uniformity in income rules for all health subsidy programs	§ 2002 § 2101(d)	Modified adjusted gross income (MAGI) will be used to determine eligibility for all subsidized health programs. MAGI is defined in § 1401 (newly added § 36B(d)(2) of the Internal Revenue Code of 1986). • A standard 5% income disregard will be used to determine Medicaid eligibility. • Provides exceptions to the use of MAGI, including when eligibility is determined for elderly individuals, dual eligibles, medically needy individuals, and those for whom eligibility is based on receipt of other aid (such as SSI and foster care assistance) and when an income finding has been made by an Express Lane agency.
Standardizes information required to establish eligibility for individual coverage, financial assistance, or exemption from individual mandate	§ 1411(b)	All applicants to the Exchange in the individual market will provide: • Name, address, date of birth (DOB). • Citizenship (attestation and social security number (SSN)) or immigration status (attestation, SSN, identifying information as determined by Secretary and Homeland Security). Individuals applying for a premium tax credit and/or cost-sharing reduction, or for exemption from the individual mandate, must also supply the following information: • Information about income and family size. This can be supplied by the tax return, pursuant to § 1414. • As applicable, information related to changes in circumstances. • As applicable, information about available employer coverage.
Requires paperless verification and determination processes for the Exchange	§ 1411(c)	The Secretary shall provide that verifications and determinations of eligibility for participation in the Exchange, premium tax credits, and cost-sharing reductions, and eligibility for exemptions from the individual mandate are done electronically or by checking information submitted against federal records. The Secretary can modify the required verification methods if doing so will "reduce the administrative costs and burdens on the applicant." One possible modification specifically mentioned in ACA is the possibility of allowing an applicant to request the Secretary of the Treasury to provide information directly to the Exchange or Secretary.
Maximizes role of data-matching to support eligibility determination processes	§ 1413(c)	"Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation..." Using the data matching arrangement, each health subsidy program shall, to the maximum extent practicable: "(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement...; and (ii) determine such eligibility on the basis of reliable, third party data... obtained through such arrangement." An exception applies if the Secretary determines that "the administrative and other costs of use in the data matching arrangement... outweigh its expected gains in accuracy, efficiency, and program participation." The data matching program will apply only to individuals who receive assistance from a health subsidy program or who apply for such assistance by filing the single, streamlined application form or by requesting an eligibility determination and authorizing disclosure of information required for that purpose.

TECHNOLOGY-ENABLED

Summary	Section	Specifics
Maximizes role of the Internet for purposes of application and enrollment	§ 1413 § 2201	Individuals will have access to an Internet website through which they can apply for and renew coverage online using the single, streamlined application for all health subsidy programs. Through the website, applicants who are eligible for Medicaid, CHIP, and premium tax credits or other subsidies through the Exchange will be able to compare their options.
Provides for secure electronic exchange of data	§ 1413(c) § 2201	Requires states to securely exchange data to determine eligibility. "Each state shall develop for all applicable health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms...) that allows a determination of eligibility for all such programs based on a single application."
Creates information technology standards and protocols to facilitate electronic enrollment	§ 1561	The Secretary shall establish standards and protocols for electronic enrollment that allow for the following: (1) "Electronic matching against existing Federal and State data, including vital records, employment history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation." (2) "Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility." (3) "Reuse of stored eligibility information... to assist with retention..." (4) "Capability for individuals to apply, recertify and manage their eligibility information online..." (5) "Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate." (6) "Other functionalities" necessary to streamline the process for applicants. Provides for grants to states and localities to develop or adapt existing systems to meet the new standards and protocols. More broadly, the Secretary "shall notify" states about these standards and procedures and "may require, as a condition of receiving Federal funds for the health information technology investments, that States or other entities incorporate such standards and protocols into such investments."

This brief was prepared by Beth Morrow of The Children's Partnership and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

For further information about ACA, beyond its enrollment provisions, please go to the Kaiser Family Foundation's Health Reform site, at: http://healthreform.kff.org/.

This publication (#8090) is available on the Kaiser Family Foundation's website at www.kff.org.

11.8110.01001
Title.

Prepared by the Legislative Council staff for
Representative Keiser
January 27, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126

Page 1, line 2, after the second semicolon insert "to provide for application;"

Page 2, after line 20, insert:

"**SECTION 3. APPLICATION.** In carrying out the requirements of this Act, the insurance commissioner shall provide regular updates to the legislative management during the 2011-12 interim. In determining, planning, and implementing an American health benefit exchange for the state, the commissioner shall submit proposed legislation to the legislative management for consideration at a special legislative session if the commissioner is required by federal law to take any action by January 1, 2013. For any plan, program, or requirement that must be implemented between January 1, 2013, and January 1, 2014, the commissioner shall submit proposed legislation to the legislative management before October 15, 2012."

Renumber accordingly

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126

Page 2, after line 2, insert:

"5. Collaborate with the department of human services to ensure the American health benefit exchange incorporates a seamless eligibility and enrollment process for individuals eligible for medicaid and the children's health insurance program."

Page 2, after line 20, insert:

"SECTION 3. APPROPRIATION – DEPARTMENT OF HUMAN SERVICES. There is appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, the sum of $15,555,543, and from special funds derived from federal funds and other income, the sum of $27,062,382, to the department of human services for the purpose of defraying the expenses of incorporating the medicaid and children's health insurance program eligibility determination functionality into the American health benefit exchange created under this Act, and for the purpose of defraying the corresponding costs related to the modification of the department's economic assistance eligibility system for the biennium beginning July 1, 2011, and ending June 30, 2013."

Renumber accordingly

February 1, 2011

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1126

Page 2, line 16, replace "The commissioner may seek emergency commission and budget section approval" with "There is hereby appropriated the sum of $33,764,517, or so much of the sum as may be necessary, from federal and other funds, to the insurance commissioner for the purposes provided in section 1 of this Act, for the period beginning with the effective date of this Act and ending June 30, 2013. The insurance commissioner is authorized 4.0 additional full-time equivalent positions for the purposes provided in section 1 of this Act."

Page 2, remove lines 17 through 20

Renumber accordingly

HOUSE BILL NO. 1126

Presented by: **Adam Hamm**
Commissioner
North Dakota Insurance Department

Before: **Joint Committee Hearing before**
House Industry, Business and Labor Committee and
House Appropriations – Government Operations and Human Resources Divisions

Date: **February 1, 2011**

TESTIMONY

Good morning committee members. My name is Adam Hamm, North Dakota Insurance Commissioner. I appear before you today in support of House Bill No. 1126.

The purpose of the bill is to allow you to decide whether it is best for North Dakota, rather than the federal government, to run the health benefit exchange required by the Patient Protection and Affordable Care Act also known as "federal health care reform", or "PPACA". I will refer to this law as "PPACA".

What is an Exchange?

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

Exchanges will allow people to compare health plans and determine which one is best for them. Health plans will be placed in tiers based on out-of-pocket costs, which allows consumers to compare plans on an apples-to-apples basis. All plans sold in the exchange are offered by private insurance companies. There is no government-run plan or public insurance option.

An exchange must also assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs such as Medicaid and the Children's Health Insurance Program (CHIP). Individuals whose household income does not exceed 400 percent of the poverty line will receive subsidies through the exchange according to a sliding scale. By providing one-stop shopping, exchanges are theoretically supposed to increase competition in the marketplace and make purchasing health insurance easier and more understandable for consumers.

If North Dakota does not run its own exchange, the United States Department of Health and Human Services ("HHS") will. By January 1, 2013, HHS must determine whether the state will have an exchange in operation by January 1, 2014. If it determines that the state will not have an operational exchange by then, HHS is required to establish and operate the exchange within that state. The federal government will work with the Governor of the state as the Chief Executive Officer unless authority to operate the exchange has been delegated to a specific authority through state law.

What Does This Bill Do?

At its most basic level, this bill puts the following questions before you:

1. Do you want the federal government or the state to run the North Dakota exchange?

2. If you want the state to run its own exchange, who do you want to run it?

3. If the state will run its exchange, what resources do you want the responsible agency to have in order to build and operate the exchange?

To be clear, this bill is not an endorsement of PPACA or the wisdom or effectiveness of exchanges. It is the means by which these issues are being brought before you so that the Legislative Assembly may decide whether it is in North Dakota's best interest to run its own exchange or to let the federal government do so.

Who Can Run An Exchange?

States have the option to establish the exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the exchange could be housed within an existing state agency or a newly created, independent state agency. Alternatively, the exchange could be operated by a nonprofit entity. If none of these entities run the state's exchange, the federal government will take over that responsibility.

What Functions Must an Exchange Perform?

Exchanges must perform a lengthy list of functions. These functions should be taken into consideration when deciding which entity is best to run the exchange and the resources needed by that entity. At a minimum, an exchange must:

- Implement procedures for the certification, recertification, and decertification of health plans as qualified health plans;

- Provide for the operation of a toll-free telephone hotline to respond to assistance requests;

- Maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans;

- Assign a rating to each qualified health plan offered through the exchange;

- Use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage;

- Inform individuals of eligibility requirements for Medicaid, CHIP, or any applicable state or local public program, and, if through screening of the individual's application by the exchange, it determines that such individuals are eligible for any such program, enroll such individuals in such program;

- Establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction available under PPACA;

- Grant certification attesting that, for purposes of the individual responsibility penalty, an individual is exempt from the individual requirement or from the penalty imposed because he or she meets one of the exceptions provided in PPACA;

- Transfer to the Secretary of the Treasury a list of individuals who are issued certification of penalty exemption, the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit because the employer did not provide minimum essential coverage or the employer provided the minimum essential coverage but it was either unaffordable or did not provide the required minimum actuarial value, and the name and taxpayer identification number of each individual who notifies the exchange that they have changed employers and of each individual who ceases coverage under a qualified health plan during a plan year;

- Provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year and the effective date of such cessation; and

- Establish a Navigator program. ?

There are some areas where the state has choices. Federal rules will clarify that the following policy areas, among others, are state decisions, although HHS may offer recommendations and technical assistance to states as they make these decisions:

- Whether to form the exchange as a governmental agency or a nonprofit entity.

- Whether to form regional exchanges or establish interstate coordination for certain functions.

- Whether to require additional benefits in the exchange beyond the essential health benefits (mandates).

- Whether to establish a competitive bidding process for plans.

- Whether to extend some or all exchange-specific regulations to the outside insurance market beyond what is required in PPACA.

- What additional types of services the exchange might provide to individuals and business to ensure simple and fast service.

If you believe that it would be better for the state to run its own exchange, certain things have to be accomplished by deadlines set out in PPACA. As I already noted, states must be on track for achieving certification of their exchange by January 1, 2013, or the federal government will run the exchange. And the exchange must be operating no later than January 1, 2014. Establishment of an exchange requires a planning process

to create an exchange that will meet all the requirements of PPACA. Anyone who is even somewhat familiar with a complex information technology (IT) project can recognize how short this timeframe is, especially given that most of the functionality required does not exist in North Dakota's state government or in any other entity currently operating in our state.

This bill would require the Commissioner to plan and implement the exchange for the state. The bill would ensure that the exchange facilitates the purchase of qualified health benefit plans, provides for the establishment of a small business health options program, and meets the exchange requirements of PPACA generally.

What Does the Commissioner Do if the State Runs the Exchange?

In order to plan and implement a North Dakota exchange, the bill assigns the following duties to the Commissioner:

- To take actions necessary to ensure that the exchange is determined, not later than January 1, 2013, by the federal government to be ready to operate not later than January 1, 2014.

- To consider whether to seek federal grant funds for the planning and implementation of the exchange.

- To determine whether to establish one exchange that will provide services to both qualified individuals and qualified small employers or to have two separate exchanges.

- To contract with outside entities, if necessary, to provide services to implement the exchange. ?

- To adopt rules, if necessary or desirable, to carry out the provisions of the bill.

Exchanges will require complex and particular IT systems and other business operations to perform the functions required. Since the exchange will have to work with other state and federal agencies, for example, to fulfill its duty to determine tax credits and enroll eligible individuals in Medicaid and CHIP, the bill requires state agencies to cooperate with the Commissioner to ensure the success of the exchange. At this time, the IT systems of the agencies likely to be involved in the exchange do not have the ability to communicate and exchange data with each other.

Because exchanges are also required to report certain information to other entities such as the United States Secretary of the Treasury, the bill allows the Commissioner to receive from, and provide to, federal and state agencies confidential information gathered in the administration of the exchange including Social Security numbers if the disclosure is necessary for the Commissioner or receiving entity to perform its duties and responsibilities.

What Resources Are Needed For an Exchange?

The bill also provides that the Commissioner may seek Emergency Commission and Budget Section approval for authority to spend any general funds, special funds or federal funds available under PPACA. The federal government will provide grants for exchange planning and development. ← CAN THIS BE USED AS AN ACTION IN FED. COURTS TO CONTINUE PPACA? IF NO, DO WE REPAY?

Forty-eight states and the District of Columbia were awarded their first exchange planning grants in September 2010. Those grants were for planning purposes and the next round of grants will be for the purpose of establishing an exchange. The opportunity to apply for grants will be announced in February 2011 and will become available on a rolling basis throughout the next three years. States will have to meet certain milestones in order to be awarded grants in 2011, and the size of state awards may be related to the number of milestones met. Necessary exchange planning and establishment costs will be funded by HHS until 2015. After January 1, 2015,

exchanges must be self-funded. North Dakota was approved to receive $1,000,000 in the first round of exchange grants; however, the Emergency Commission tabled the request to utilize these funds. These funds could be important right now given the challenging infrastructure requirements needed to develop an exchange. They can be used to analyze options, define requirements, and estimate the probable cost to implement an electronic system to operate the state's exchange. Future grant funds will be available to pay for the cost of building the system that will operate the exchange. In addition to the staffing and information technology infrastructure needs, the state will need resources to help it identify and address many issues and to make informed decisions along the way, including:

1. **Unified exchange.** A state has to provide an exchange that facilitates individuals' purchase of health insurance and an exchange that serves small businesses. The state may choose to operate them separately or both in one exchange as long as it serves both functions.

2. **Regional exchange**. States may form a regional exchange with other states or allow more than one exchange to operate in the state as long as each exchange serves a distinct geographic region.

3. **Stakeholders.** PPACA requires states to consult with stakeholders in implementation of the exchange. Stakeholders must include health care consumers who enroll in qualified health plans, individuals and entities experienced in facilitating enrollment in qualified health plans, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for enrolling hard to reach populations. In planning for this legislative session, the Insurance Department has already begun stakeholder conversations. I can assure you that the exchange is a focus for many of these individuals and groups.

4. **Funding.** How will the state ensure that the exchange is self-sustaining as of January 1, 2015? Exchanges are allowed to charge assessments or user fees to participating insurance issuers or to otherwise generate funding in order to support its operations.

5. **Outside market**. Will insurers be allowed to sell health plans outside the exchange? And if an external market remains, will insurers be required to offer plans both in and out of the exchange?

6. **Large employers.** Beginning in 2017, an exchange may allow businesses with more than 100 employees to purchase coverage in the exchange also.

7. **Mandates.** Does the state want to require that plans offer benefits in addition to the essential health benefits package? If so, the state must assume the cost by making payments to individuals enrolled in a qualified health plan in the state or making payments directly to the qualified health plan on behalf of the individual. HHS has not yet determined how the essential health benefits package will be defined.

8. **Data reporting.** Determination of the data that will be required to be reported, what persons will be allowed to access data, and how to ensure appropriate protection of data.

9. **Certification of plans.** The exchange must implement procedures for the certification, recertification and decertification of health plans as qualified health plans. It is expected that this will require someone to analyze the health plans offered for sale through the exchange to ensure that they meet one of the required benefit categories: bronze plans which must cover 60% of benefit costs; silver plans which must cover 70% of benefit costs; gold plans which must cover 80% of benefit costs; platinum plans

which must cover 90% of benefit costs; and catastrophic plans, which are available only to those up to age 30, which must provide catastrophic coverage only. Someone must also ensure that the plans offered in the exchange meet certain benefit requirements, marketing requirements, have adequate provider networks, contract with essential community providers, contract with navigators to conduct outreach and enrollment assistance, be accredited with respect to performance on quality measures, and use a uniform enrollment form and standard format to present plan information.

10. **Hotline.** The exchange must provide for the operation of a toll-free hotline to respond to assistance requests.

11. **Website.** The exchange must maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on health plans.

12. **Ratings.** The exchange must assign a rating to each qualified health benefit plan offered through the exchange.

13. **Standardized format.** The exchange must use a standardized format for presenting health benefits plan options in the exchange, including the use of the uniform outline of coverage.

14. **Other coverage.** The exchange must inform individuals of Medicaid, CHIP, and other state or local public programs eligibility requirements and enroll eligible individuals in these programs.

15. **Calculator.** The exchange must provide an electronic calculator to determine the actual cost of coverage after the application of any premium tax credit and any cost-sharing reduction.

16. **Individual responsibility certification.** The exchange must grant a certification attesting that for purpose of the individual responsibility penalty (individual mandate) that an individual is exempt from the penalty because there is no affordable qualified health plan available through the exchange or the individual's employer, or the individual meets the requirement for any other exemption.

17. **Certification of penalty exemption**. The exchange must transfer to the Secretary of the Treasury a list of individuals who are issued a certification of penalty exemption.

18. **Employer notice.** The exchange must provide each employer with the name of each of its employees who ceases coverage under a qualified health plan during a plan year.

19. **Navigator program.** The exchange must establish a Navigator program under which it awards grants to entities to carry out certain duties such as public education, facilitating enrollment in qualified health plans, and providing referrals to health insurance ombudsman or other appropriate agency for any enrollee with a grievance, complaint, or question regarding his health plan, coverage, or a determination under such plan or coverage.

TV ADS? →

20. **Producers.** The exchange must determine the role insurance producers (agents) will play in the sale of health benefit plans in the exchange.

The bill also contains an emergency clause so that it would become effective immediately upon its filing with the Secretary of State to allow work to start to address the many decisions that will have to be made and the work to begin to build an IT system that will be capable of performing all the required functions.

In closing, there are many decisions to be made about how the exchange will be run in North Dakota. There will be more decisions to be made as things are further defined or changed at the federal level. Several federal agencies are tasked with issuing regulations to implement the law and many of them have yet to be issued so various components remain undefined at this point. In addition, there is the prospect of Congress making changes to the law as well as the numerous legal challenges to the law that are making their way through the court system. For now, the law requires that there be an exchange implemented in North Dakota. The first decision is who will run it: the federal government or the state. Our stakeholders are telling us they prefer North Dakota run its own exchange and cite the numerous problems with other federal insurance programs as examples of how North Dakotans serve our own better. In fact, it is my Department that assists Medicare Part D prescription drug beneficiaries in comparing, choosing, and enrolling in Part D plans, as well as dealing with issues and complaints. This piece of legislation places similar responsibilities related to the exchange in this same agency.

This concludes my testimony. I would be happy to try to answer any questions the committee members may have. Thank you.

Testimony
House Bill 1126 – Department of Human Services
Before the Joint Meeting of
House Industry, Business & Labor
Representative Keiser, Chairman
House Appropriations, Government Operations Division
Representative Thoreson, Chairman
February 1, 2011

Chairmen Keiser and Thoreson, members of the Industry, Business & Labor Committee and House Appropriations, Government Operations Division, I am Carol Olson, Executive Director of the Department of Human Services. I am here today to provide information to you regarding the relationship between an American Health Benefit Exchange and the programs within Department of Human Services.

If it is the interest of this committee to pursue the establishment of an American Health Benefit Exchange for the state that will meet the requirements as currently outlined in the Patient Protection and Affordable Care Act of 2010, it will be important for this committee to consider the implications of:

- Title I, Section 1311(d)(4)(F) requiring, at a minimum, for the Exchange to provide for eligibility determination and the enrollment of individuals in Medicaid and CHIP programs; and
- Title II Role of Public Programs, Section 2201 which outlines more specifically the requirements of enrollment simplification and Medicaid and CHIP coordination with the State Health Insurance Exchange.

The intent of these sections is to ensure that the American Health Benefit Exchange provide seamless eligibility and enrollment linkages between the exchange coverage options and public assistance programs. In order to achieve this level of interoperability with the Exchange, the Medicaid and CHIP eligibility systems will require significant modification.

I would be happy to answer any questions you may have.