Draft Pending Adoption

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Health Insurance and Managed Care (B) Committee
Washington, District of Columbia
November 17, 2014

The Health Insurance and Managed Care (B) Committee met in Washington, DC, Nov. 17, 2014. The following Committee members participated: Sandy Praeger, Chair (KS); Ted Nickel, Vice Chair (WI); Germaine L. Marks (AZ); Dave Jones (CA); Mike Chaney (MS); Scott J. Kipper (NV); Benjamin M. Lawsky (NY); Laura N. Cali (OR); Angela Weyn (PR); Julie Mix McPeak represented by Chlora Lindley-Myers (TN); Todd E. Kiser represented by Tanji Northrup (UT); and Mike Kreidler (WA). Also participating were: Lori K. Wing-Heier (AK); Steve Ostlund (AL); Karl Knable (IN); Therese M. Goldsmith (MD); Troy Oechsner (NY); Susan Dobbins (OK); John D. McDonald (VI); J.P. Wieske and Dan Schwartz (WI); and Tom C. Hirsig (WY).

1. Heard an Update from the CHIR of the Georgetown Health Policy Institute

Sally McCarty and Sabrina Corlette (Georgetown Health Policy Institute, Center on Health Insurance Reforms—CHIR) updated the Committee on the CHIR’s work related to the federal Affordable Care Act (ACA) through the State Health Reform Assistance Network, including information the updated network adequacy planning tool and two issue briefs to be released within the next few months: “Short-term Limited-duration Insurance and Excepted Benefits” and “Reference Pricing—An Overview and Suggested Policy Considerations.” Ms. McCarty said the CHIR is currently working on an addendum to its Consumer Services Manual. Ms. Corlette updated the Committee on the CHIR’s Navigator Resource Guide, which is a Web-based, searchable resource guide developed for navigators and consumer assistors who are helping consumers to enroll in the health insurance exchanges. She said the guide includes easy-to-read background information on key health insurance and exchange topics. Ms. Corlette noted that the guide also includes close to 300 searchable frequently asked questions (FAQs).

2. Heard a Briefing on the NAIC Consumer Representatives’ Report on its Network Adequacy State Insurance Survey Findings and Recommendations

Stephanie Mohl (American Heart Association) briefed the Committee on the NAIC consumer representatives’ network adequacy state insurance survey findings and recommendations. She said 36 state insurance departments and two U.S. territories responded to the survey. However, not all respondents answered each question. Ms. Mohl said she would focus on the survey findings and the NAIC consumer representatives’ recommendations to state insurance regulators to address some of the issues related to the findings. She said most states have not adopted, in full or in part, the Managed Care Plan Network Adequacy Model Act (#74). Ms. Mohl said most states have network adequacy complaint codes to monitor network adequacy, but the specific codes vary from state to state. She noted that one of the biggest challenges for state insurance regulators is ensuring consumers understand the risks and/or costs of out-of-network care. However, less than one-half of the states have transparency requirements related to out-of-network facility-based physicians and providers. Ms. Mohl said survey findings indicate that state insurance regulators rely heavily on consumer complaint data as far as monitoring ongoing network adequacy. She said state insurance regulators need to consider the greater use of strategies to identify problems on the front end rather than the back end through complaint data.

Ms. Mohl discussed the different state approaches to regulating out-of-network charges. She said that if a state regulates out-of-network charges, such regulation most likely protects consumers with respect to out-of-network emergency services charges. The survey findings indicated that, in most states, consumers are not held harmless from balance billing for out-of-network charges, even for charges related to emergency services. Ms. Mohl said the survey findings indicated that most states seem to require health carriers to update their provider directories. However, the requirements concerning the frequency of updating varied from state to state. She noted that only nine states responded that they require consumers to be held harmless if the consumer had relied on inaccurate directory information.

Ms. Mohl said the NAIC consumer representatives have a number of recommendations that state insurance regulators should consider to address some of the issues that emerged from the survey findings. She said the following recommendations could be carried out through revisions to Model #74 or individual state regulatory actions: 1) standardize use of complaint codes; 2) quantify reasonable access standards in order to measure and ensure network adequacy on the front end; 3) require prior approval of access plans; 4) institute data collection for out-of-network claims; and 5) improve the accuracy and transparency of provider directories.
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Commissioner Kreidler asked Ms. Mohl about the scope of the problem with the quality of network adequacy complaint data. Ms. Mohl said it is troubling, particularly because, currently, consumer complaints can be sent to many different entities besides state insurance departments, such as the federal health insurance exchanges, state health insurance exchanges and federal agencies, which is why the NAIC consumer representatives believe that state insurance department reliance on complaint data as evidence of ongoing network adequacy is problematic.

Commissioner Chaney acknowledged that there are issues with balance billing, particularly as related to out-of-network hospital-based physicians and other types of providers, but asked if this was an issue that state insurance regulators could resolve because it involves health care providers and state insurance regulators have no authority to regulate them. Ms. Mohl agreed that it could be difficult for state insurance regulators to resolve this issue, but she said that is why the NAIC consumer representatives have suggested that state insurance regulators partner with other state agencies that regulate health care providers to help resolve the issue.

3. Heard a Briefing from the NYSDFS on New York’s Out-of-Network, Surprise Bills Legislation

Mr. Oechsner briefed the Committee on New York’s out-of-network, surprise bills legislation: Part H of Chapter 60 of the Laws of 2014 (S.6914/A.9205). He outlined the major provisions of the legislation. Mr. Oechsner said the most difficult provision to get passed was the provision establishing an independent dispute resolution for out-of-network emergency and surprise bills. He said the key to getting the legislation passed was creating a base of support for reform. The New York State Department of Financial Services (NYSDFS) was able to accomplish this by first developing a report documenting the problems and working with key consumer groups to assist it in highlighting the problems.

Commissioner Chaney asked if the NYSDFS encountered any issues with any willing provider laws. Mr. Oechsner said there was some interest, but a decision was made not to consider it. He said the NYSDFS believed it was important to support the concept of network health benefit plan design, which an any willing provider law would undermine. Superintendent Lawsky said the NYSDFS is available to assist other state insurance departments that may be interested in trying to enact similar legislation in their state. Commissioner Kipper said the idea of establishing an arbitration process to resolve out-of-network and surprise bill disputes is an interesting concept. He asked if there was any impact on premium rates. Mr. Oechsner said that, to date, the NYSDFS has found only a negligible impact. Mr. Schwartz remarked that some aspects of the legislation would seem to encourage some hospital-based providers to refuse to participate in a network plan. Mr. Oechsner acknowledged the concern, but said the NYSDFS believed that crafting the legislation in the manner it did was a fairer way to resolve the out-of-network problems.

4. Heard Update from the CCIIO on its ACA Implementation Activities

Kevin Counihan (Center Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO’s activities related to ACA implementation. He said the CCIIO has seen positive enrollment in the health insurance exchanges to date. Mr. Counihan said enrollment in the exchanges has decreased the number of uninsured. He noted that, for this year’s open enrollment, more health carriers are participating, which provides more choice for consumers. Mr. Counihan said the CCIIO values its role with the NAIC and has a strong commitment to appropriately resolving any issues and concerns that state insurance regulators may have. He said that, for this second open enrollment in the health insurance exchanges, the CCIIO is focused on treating enrollees as customers. One result is reducing the number of online enrollment screens from 76 to 16. Mr. Counihan said the CCIIO also is focusing on agents and brokers as partners in the enrollment process. He said the CCIIO has learned from the first open enrollment and now acknowledges the need to have deadlines. The CCIIO also has learned that cost is an issue and testimonials work as to the value of enrolling in a health insurance exchange. Mr. Counihan said the CCIIO realizes that it will take time for consumers to get used to the health insurance exchanges and the enrollment process.

Commissioner Kreidler said Washington has more health carriers participating in its exchange. He said that, due to this increase, some consumers are complaining that there are too many choices. He asked Mr. Counihan if the CCIIO had anything it was working on to help resolve this concern. Mr. Counihan said that, at this point, the CCIIO has no answer to this concern. He noted that, perhaps, having better decision support tools could help ease the problem. Commissioner Praeger asked if the CCIIO had discussed options if the U.S. Supreme Court finds in King v. Burwell that federal premium tax credits may not be provided to individuals enrolling in federally facilitated exchanges. Mr. Counihan said the CCIIO is focused on ACA implementation, but he is sure others at the U.S. Department of Health and Human Services (HHS) have been discussing options. He said he believes that there are a number of good options for any states wishing to establish a state health insurance exchange in the future.
5. **Adopted its Oct. 21 Minutes**

Commissioner Nickel made a motion, seconded by Superintendent Lawsky, to adopt the Committee’s Oct. 21 minutes (Attachment One). The motion passed unanimously.

6. **Adopted its Subgroup, Working Group and Task Force Reports**

   a. **Model Law Review Initiative (B) Subgroup**

Ms. Northrup said the Model Law Review Initiative (B) Subgroup met via conference call Sept. 2. During this meeting, the Subgroup discussed its charge for reviewing the NAIC models assigned to the Committee for compliance with the NAIC’s Procedures for Model Law Development and deciding whether the models should be retained, retained and revised, converted to a guideline or archived. The Subgroup also voted to expose its preliminary recommendations for a 30-day public comment period ending Oct. 2 for five NAIC models: the Discount Medical Plan Organization Model Act (#98), the Health Policy Rate and Form Filing Model [Act] [Regulation] (#165), the Prevention of Illegal Multiple Employer Welfare Arrangements (MEWAs) and Other Illegal Health Insurers Model Regulation (#220), the Long-Term Care Insurance Model Act (#640), and the Long-Term Care Insurance Model Regulation (#641).

Ms. Northrup made a motion, seconded by Commissioner Nickel, to adopt the report of the Model Law Review Initiative (B) Subgroup (Attachment Two). The motion passed unanimously.

   b. **Health Care Reform Regulatory Alternatives (B) Working Group**

Commissioner Nickel said the Health Care Reform Regulatory Alternatives (B) Working Group met Nov. 17. During this meeting, the Working Group adopted the report of the Territories (B) Subgroup. He said the Working Group heard a presentation from the American Enterprise Institute on the policy implications of the King v. Burwell litigation, including the possibility that if the challenge is successful, the individual and employer mandates would be weakened. Commissioner Nickel said the Working Group also heard a presentation from the Hawaii Insurance Division on its state innovation waiver efforts. He said Commissioner Gordon I. Ito (HI) provided an overview of the background for the waiver, Hawaii’s policy development process and the stakeholder groups it has assembled and its timeline. The Working Group also heard a presentation from the U.S. Chamber of Commerce on the increase in the definition of “small employer” in 2016 from 50 to 100 employees. Commissioner Nickel said the business community supports a delay in the implementation of this provision to allow the states time to obtain state innovation waivers from having to comply with the size increase.

Commissioner Nickel made a motion, seconded by Commissioner Weyne, to adopt the report of the Health Care Reform Regulatory Alternatives (B) Working Group (Attachment Three). The motion passed unanimously.

   c. **Health Actuarial (B) Task Force**

Mr. Ostlund said the Health Actuarial (B) Task Force met Nov. 15. During this meeting, the Task Force adopted its interim minutes and the interim minutes of its working groups and subgroups. Mr. Ostlund said the Task Force adopted reports from its working groups. He said the Task Force also heard updates and reports from the American Academy of Actuaries (Academy)/Society of Actuaries (SOA) Cancer Claim Cost Table Work Group and the Academy’s Individual Disability Table Work Group.

Mr. Ostlund said the Long-Term Care Actuarial (B) Working Group met Aug. 14. During this meeting, the Working Group heard a report of the Long-Term Care Pricing (B) Subgroup, which is working on revisions to the Guidance Manual for the Rating Aspects of the Long-Term Care Insurance Model Regulation to reflect provisions in the recently revised Model #641. Mr. Ostlund said he anticipates being able to report more about the Subgroup’s progress at the 2015 Spring National Meeting.

Commissioner Weyne made a motion, seconded by Ms. Lindley-Myers, to adopt the report of the Health Actuarial (B) Task Force. The motion passed unanimously.
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d. Regulatory Framework (B) Task Force

Mr. Wieske said the Regulatory Framework (B) Task Force met Nov. 16. During this meeting, the Task Force adopted its Sept. 30 minutes.

Mr. Wieske said the Task Force also discussed and adopted revised drafts of the Individual Market Health Insurance Coverage Model Regulation, which is to be a companion to the Individual Market Health Insurance Coverage Model Act (#36), and the Small Group Market Health Insurance Coverage Model Regulation, which is to be a companion to the Small Group Market Health Insurance Coverage Model Act (#106). He noted that, prior to adoption, the Task Force adopted an additional revision to the draft model regulations to address the issue of applying out-of-network cost-sharing to the annual cost-sharing limitation.

Mr. Wieske said the Task Force also discussed the comments received on the Accident and Sickness Insurance Minimum Standards Model Act (#170) and the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). He said the Task Force directed NAIC staff to prepare a discussion draft for the Task Force to review during a conference call in early 2015 that will include proposed revisions that have stakeholder consensus. The Task Force also heard a status update on the proposed revisions to the Group Health Insurance Standards Model Act (#100). NAIC staff plan to prepare a discussion draft for the Task Force’s review during a conference call in early 2015.

Mr. Wieske said the Task Force adopted the report of the Network Adequacy Model Review (B) Subgroup. He said the Subgroup discussed an initial draft of revisions to Model #74 and exposed it for a public comment period ending Jan. 12, 2015. Mr. Wieske said the Task Force also adopted the report of the ERISA (B) Working Group. He said the Working Group exposed a revised draft of the Stop Loss Insurance, Self-Funding and the ACA white paper for a public comment period ending Dec. 17. The Working Group anticipates meeting via conference call in January 2015 to discuss any comments received.

Commissioner Nickel made a motion, seconded by Commissioner Jones, to adopt the report of the Regulatory Framework (B) Task Force, including adoption of the Individual Market Health Insurance Coverage Model Regulation and the Small Group Market Health Insurance Coverage Model Regulation. The motion passed unanimously.

e. Senior Issues (B) Task Force

Commissioner Kipper said the Senior Issues (B) Task Force met Nov. 16. During this meeting, the Task Force heard a presentation from the administrator for the Administration on Community Living (ACL) and assistant secretary of aging on the transfer of the State Health Insurance Assistance Program (SHIP) from the U.S. Center for Medicare & Medicaid Services (CMS) to ACL.

Commissioner Kipper said the Task Force appointed a new subgroup—the Long-Term Care Partnership Reporting (B) Subgroup—to be chaired by Rhode Island. He said the Subgroup will explore whether the NAIC can, or should, take over the job of data collection for Long-Term Care Partnership Program policies. Commissioner Kipper explained that the HHS ceased collecting this data last year and the information is no longer available to the states.

Commissioner Kipper said the Task Force discussed an initiative at CMS’ Center for Medicare and Medicaid Innovation (CMMI) to test “health plan innovations” in Medicare supplement insurance (Medigap), Medicare Part D, Medicare Advantage, Medicaid managed care and retiree supplemental health plans. For Medigap plans, he said the Task Force understands that this demonstration project, which will be released in 2015, will test “case management” services to “manage the care of complex, high-cost beneficiaries.”

Commissioner Kipper said the Task Force also distributed information received from America’s Health Insurance Plans (AHIP) that tracks state provisions to expand Medigap access for Medicare-eligible disabled individuals under the age of 65. He said this information may be of interest to the states as they make decisions about their high-risk pools.

Commissioner Kipper said the Task Force also adopted its Sept. 15 minutes. He said the Task Force also adopted the reports of its subgroups and heard a federal legislative update on issues and legislation of interest to the Task Force.

Commissioner Kipper made a motion, seconded by Commissioner Kreidler, to adopt the report of the Senior Issues (B) Task Force. The motion passed unanimously.
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7. **Heard Federal Legislative Update**

Brian Webb (NAIC) told the Committee that he anticipates the U.S. Congress will continue to consider changes to fix the Medicare sustainable growth rate (SGR) in order to increase Medicare physician payments. He said Congress has been making short-term incremental fixes to the SGR for a number of years because a permanent fix is expensive and requires difficult offsets. Mr. Webb said, however, despite this difficulty, the Congress most likely will continue its efforts to find a permanent fix that could include discussions to modify Medigap first-dollar coverage. He also said that, particularly with both houses of Congress having a Republican party majority, he anticipates additional votes to repeal the ACA. There also likely will be votes to change certain aspects of the ACA.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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