Date: 3/17/15

2015 Spring National Meeting
Phoenix, Arizona

HEALTH CARE REFORM REGULATORY ALTERNATIVES (B) WORKING GROUP
Sunday, March 29, 2015
8:00 – 9:00 a.m.
Sheraton Phoenix Downtown—Valley of the Sun D/E—2nd Level

ROLL CALL

Ted Nickel, Chair Wisconsin
TBD, Vice Chair TBD
Lori K. Wing-Heier Alaska
Linda Nemes Delaware
Kevin M. McCarty Florida
Tom Donovan Idaho
Yvonne Clearwater Illinois
Greta Hockwalt Indiana
Ken Selzer Kansas
Eric A. Cioppa Maine
John M. Huff Missouri
Monica J. Lindeen Montana
Bruce R. Ramge Nebraska
Scott J. Kipper Nevada
Roger A. Sevigny New Hampshire
Adam Hamm North Dakota
Mark O. Rabauliman Northern Mariana Islands
James Mills Oklahoma
Teresa D. Miller Pennsylvania
Andrew Dvorine South Carolina
Melissa Klemann South Dakota
Julie Mix McPeak Tennessee
Cassie Brown Texas
Tanji Northrup Utah
Osbert Potter Virgin Islands
Molly Nollette Washington
Tom Glause Wyoming

AGENDA

1. Hear Opening Remarks—Commissioner Ted Nickel (WI)

2. Consider Adoption of its 2014 Fall National Meeting Minutes—Commissioner Ted Nickel (WI)

3. Hear a Presentation on The Commonwealth Fund Report: King v. Burwell: What a Subsidy Shutdown Could Mean for Insurers—Joel Ario (Manatt Health Solutions)

4. Hear a Presentation on “Reminder on Establishing an Exchange Established by the State After King v. Burwell”—William Schiffbauer (Schiffbauer Law Office)

5. Discuss the Status of the Territories (B) Subgroup—Commissioner Ted Nickel (WI)
6. Discuss Any Other Matters Brought Before the Working Group—Commissioner Ted Nickel (WI)

7. Adjournment

W:\National Meetings\2015\Spring\Agenda\HCCRAWG.docx
Agenda Item #2

Consider Adoption of 2014 Fall National Meeting Minutes
The Territories (B) Subgroup of the Health Care Reform Regulatory Alternatives (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Washington, DC, Nov. 17, 2014. The following Subgroup members participated: John McDonald, Chair (VI); Artemio B. Ilagan (GU); and Angela Wayne (PR).

1. **Adopted its Aug. 17 Minutes**

Commissioner Weyne made a motion, seconded by Commissioner Ilagan, to adopt the Subgroup’s Aug. 17 minutes (Attachment Three-B1). The motion passed.

The Subgroup also met in regulator-to-regulator session April 28 pursuant to paragraph 8 (consideration of strategic planning issues relating to federal legislative and regulatory matters or international regulatory matters) of the NAIC Policy Statement on Open Meetings.

2. **Discussed the Impact of the HHS’ July 16 Policy Change in the Territories**

Mr. McDonald reported that, although the U.S. Virgin Islands had incorporated all the requirements of the federal Affordable Car Act (ACA) into its regulations by reference, issuers have determined that they no longer are subject to them, due to the July 16 letter of the U.S. Department of Health and Human Services (HHS). Mr. McDonald indicated that the U.S. Virgin Islands Division of Banking and Insurance disagrees with the HHS’ interpretation and believes that U.S. citizens living in the U.S. Virgin Islands should have all the same rights as other U.S. citizens. He also said that local elections may lead to some changes in the territory’s approach to ACA implementation. He said he would like to see the states join the Subgroup in order to help obtain changes to federal law needed to achieve equal treatment of the territories. He said the territories should discuss the changes they would like so that they can begin making their case.

Commissioner Weyne added that Puerto Rico has incorporated all aspects of the ACA into its requirements, so it continues to apply in the territory despite the federal action. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them. She said there are a number of questions to be resolved, particularly with respect to the continued application of U.S. Department of Labor regulations to group health plans in the territories. She noted that regulatory changes referenced in the HHS’ July 16 letter have not yet been released. Commissioner Weyne added that the Section 9010 assessment on health insurance providers continues to apply in Puerto Rico, at a cost of $130 million to $140 million, to pay for a law that does not provide subsidies or a mandate to assist them.

Commissioner Ilagan said Guam was surprised by the July 16 letter. He said Guam is enforcing some parts of the ACA, but not the market reforms, as the territory cannot afford them. He has asked HHS to look at the territories individually and how the ACA affects them. He noted that Guam has determined that establishing a health insurance exchange would obligate the territory to spend $74 million of its $710 million territorial budget to pay for advance premium tax credits. He said that he would like full inclusion under the ACA and agreed with Commissioner Wayne that the application of the Section 9010 assessment taxes the territories without providing any benefits in return. Commissioner Ilagan said that President Barack Obama recognized this problem when several commissioners met with him at the White House in April.

Having no further business, the Territories (B) Subgroup adjourned.
Health Care Reform Regulatory Alternatives (B) Working Group
Washington, District of Columbia
November 17, 2014

The Health Care Reform Regulatory Alternatives (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Washington, DC, Nov. 17, 2014. The following Working Group members participated: Ted Nickel, Chair (WI); Michael F. Consedine, Vice Chair, represented by Franca D’Agostino (PA); Kevin M. McCarty represented by Jack McDermott (FL); Yvonne Clearwater (IL); Eric A. Cioppa represented by Tom Record (ME); John M. Huff represented by Mary Mealer (MO); Monica J. Lindeen represented by Christina Goe (MT); Bruce R. Ramge represented by Martin Swanson (NE); Scott J. Kipper represented by Glenn Shippey (NV); James Mills (OK); Melissa Klemann (SD); Julie Mix McPeak represented by Chlora Lindley-Myers (TN); Jan Graeber (TX); Jaakob Sundberg (UT); John McDonald (VI); Molly Nollette (WA); and Tom C. Hirsig (WY). Also participating was: Dan Schwartzer (WI).

1. Adopted its April 22 Minutes

Ms. Lindley-Myers made a motion, seconded by Mr. McDonald, to adopt the Working Group’s April 22 minutes (Attachment Three-A). The motion passed.

2. Heard a Presentation on ACA Litigation

Tom Miller (American Enterprise Institute) made a presentation regarding the policy implications of King v. Burwell, litigation challenging the ability of federally facilitated exchanges to distribute advance premium tax credits to eligible individuals purchasing qualified health plans. The U.S. Supreme Court recently agreed to hear arguments in the case, with a hearing likely to occur in March 2015 and a decision following in June 2015. Mr. Miller said that if the Supreme Court were to side with the plaintiffs in the case, the decision would also effectively eliminate the law’s employer mandate and would substantially weaken the individual mandate. As a result, coverage would become more expensive, which would, in turn affect the composition of the risk pool. Additionally, federally facilitated exchanges would become less attractive to insurers, who could, under the terms of their contracts with the U.S. Department of Health and Human Services (HHS), cease offering coverage on the exchange, and would lead to increased claims under the ACA’s risk corridor program. He told the Working Group that this would also provide the states with additional leverage to press HHS and the U.S. Congress to make changes designed to make operating a state-based exchange more attractive to the states. He said that statutory requirements for state-based exchanges would likely limit the ability to simply contract with HHS to operate a state-based exchange. The governor, and possibly the state legislature, would need to make an affirmative decision to establish the exchange and establish a governance structure. He said that a decision prohibiting subsidies in federally facilitated exchanges would likely force Congress to make changes to the ACA, scaling back regulatory requirements on plans and providing a more state-friendly structure.

Commissioner Nickel asked if there would be an opportunity for the states to establish a state-based exchange using the federal infrastructure. Mr. Miller replied that old guidance could be revisited, but said he does not believe that even partnership exchanges could be quickly and easily transformed into state exchanges without significant work by the states. Governors or legislatures would need to take action to establish an exchange and establish a funding mechanism. Both of these requirements will provide an opportunity for political opposition. He said that congressional action in the wake of a decision eliminating federal exchange subsidies would be critical and that it is difficult to predict what Congress might do in this area.

Mr. Schwartzer asked what in the statute would prevent a state from contracting with HHS to operate a state-based exchange. Mr. Miller said he believes that several states would attempt to make such an arrangement and that the Obama administration would be receptive to it. He said a state-based exchange must have a governing board and that most contracted functions would have to be ultimately vetted and approved by some apparatus within the state, making it hard to do a “total shell operation.”
Mr. McDermott asked what would happen to subsidies already paid out and when subsidies would cease being paid if the Supreme Court rules against the administration. Mr. Miller said that, while some would take the view that subsidies should cease as soon as the court rules, the practical effect of the ruling would be to vacate an Internal Revenue Service (IRS) rule and that a new rule would have to be crafted and put into place, which could take some time. He said that there is also some enforcement discretion and that no one has a political motivation to “claw back” funds from individuals who have received them.

Timothy S. Jost (Washington and Lee University School of Law) said that there is “plain language” throughout the ACA that could support both sides of the case in King v. Burwell. He also said that federal law clearly states that a Supreme Court ruling invalidating subsidies in federal exchanges would have no retroactive effect. In addition, Mr. Jost cited projections from the RAND Corporation that unsubsidized premiums would rise by 33% and 11 million individuals would become uninsured if the plaintiffs in the case were to prevail. As a result, Mr. Jost predicted that the risk corridors program would shut down, potentially impacting the RBC scores of health insurers. He added that 18 states have signed onto an amicus brief stating that they understood the statute to provide subsidies in federally facilitated exchanges when they elected not to establish state-based exchanges.

Joel Ario (Manatt Health Solutions) cautioned against being too optimistic regarding the prospect of Congress acting in the wake of a victory for the plaintiffs and described some of the problems that could occur in that event that the states would have to deal with. He also suggested that there is significant room under the current statute for the states to assert themselves and have power under the ACA, noting that state insurance regulators would be better served by having discussions under that framework than relying on Congress to address the loss of subsidies in federally facilitated exchanges.

3. Heard a Presentation on State Innovation Waivers

Commissioner Gordon I. Ito (HI) made a presentation about Hawaii’s work to develop an application for a state innovation waiver under Section 1332 of the ACA. He said that Hawaii is in a unique situation due to the enactment of an employer mandate in 1974 that has resulted in low rates of uninsurance, low premiums and relatively rich benefit packages. He said that, under that law, employers may only offer plans that roughly equate to gold and platinum plans. Also, because of the large number of employers already providing coverage to employees, enrollment in Hawaii’s exchange was limited. Only 10,000 individuals and 1,200 to 1,300 employees have purchased coverage to date. Commissioner Ito said the Hawaii Legislature enacted legislation in its last session creating a task force with 17 members charged with developing a waiver application. The task force, among other things, is considering asking HHS to waive health insurance exchanges and essential health benefits (EHBs). He said that, under Hawaii’s law, the most prevalent plan in the state functions essentially as an EHB benchmark plan that all other plans must meet or exceed.

The task force must submit a report to address the opportunities for state agencies to collaborate, the allocation of existing monies for health care reform and innovation in any proposed legislation. Commissioner Ito said the task force created a number of “permitted interaction groups” that met throughout October and November, and the task force has started writing the draft report. The first draft report is due Jan. 1, 2015, and the task force is slated to dissolve June 30, 2017.

Commissioner Nickel asked whether Hawaii has been in consultation with HHS regarding its waiver development plans or if that part of the process would begin after the report has been completed. Commissioner Ito replied that there has been no formal discussions with HHS on the waiver, but that many issues arising during the waiver development process are being discussed on weekly calls regarding the state’s health insurance exchange. As a result, he added, the state has a pretty good idea of what the parameters of the waiver could be.

Commissioner Hirsig asked whether insurers are represented on the task force and what composition he would recommend to other states that might be considering establishing such a task force. Commissioner Ito answered that the task force includes a wide range of stakeholders, including insurers, small businesses, large businesses and community representatives.
4. **Heard a Presentation on the ACA Changes to Small Employer Definition**

Katie Mahoney (U.S. Chamber of Commerce) made a presentation regarding the upcoming change in the definition of a small group market under the ACA. She said that the upcoming change would move employers with 51 to 100 employees from the large group market, which would cause their premiums to increase and would reduce employers’ ability to provide health benefits to their employees. She noted that, despite the opportunity to do so, no state had opted to include these employers in the small group market in 2014. Ms. Mahoney said that adding these employers to the small group market would create a disparity between employers with 51 to 100 employees, whose coverage would be required to meet additional regulatory requirements that could result in higher premiums and larger employers who could purchase coverage that does not meet those requirements. She added that, because the employer mandate had been delayed, businesses with 51 to 100 employees that are purchasing coverage for the first time would be required to do so in the small group market. She said that the original intent of the statute was to allow businesses to obtain large group coverage for two years before they were moved to the small group market and for the Small Business Health Options Program (SHOP) to have two years of experience before redefining the small group market. Ms. Mahoney added that the states may remove employers with 51 to 100 employees from the small group market through a state innovation waiver in 2017, just one year after they had been added, which would cause confusion and disruption. She urged HHS to delay the expanded definition of the small group market for at least one year, until 2017, and requested that the NAIC make a similar request of the federal government.

Candy Gallaher (America’s Health Insurance Plans—AHIP) said that health plans are also concerned about the change in the definition of a small employer and support a delay in its implementation. She said the scheduled change would have a huge impact on what is now a stable and effective market, noting that the change could be disruptive.

5. **Adopted the Report of the Territories (B) Subgroup**

Mr. McDonald provided a report from the Nov. 17 and Aug. 17 meetings of the Territories (B) Subgroup. He said that, at its Aug. 17 meeting, the Subgroup discussed the implications of HHS’ policy change regarding the territories and the confusion among consumers regarding whether reforms apply to insurance sold in the territories. At that meeting, the territories reported that they were planning conversations among insurers, health care providers and consumers on how to move forward. They also discussed adding additional members to the Subgroup from the states. At its Nov. 17 meeting, Mr. McDonald reported that the Subgroup continued those discussions and received updates from the territories regarding the work they had done in the wake of the July 16 policy change as communicated in a letter from the U.S. Department of Health and Human Services. Mr. McDermott made a motion, seconded by Mr. Record, to adopt the report of the Territories (B) Subgroup (Attachment Three-B). The motion was unanimously adopted.

Having no further business, the Health Care Reform Regulatory Alternatives (B) Working Group adjourned.

W:\National Meetings\2014\Fall\Cmte\B\HCRWG\11-HCRWGmin.docx
Agenda Item #3

Agenda Item #4

Hear a Presentation on “Reminder on Establishing an Exchange Established by the State After King v. Burwell” - William Schiffbauer (Schiffbauer Law Office) -- Pending