HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Aug. 4, 2019, Minutes
  Health Insurance and Managed Care (B) Committee June 11, 2019, Minutes (Attachment One)
  Consumer Information (B) Subgroup Consumer Alert (Attachment One-A)
Consumer Information (B) Subgroup July 23, 2019, Minutes (Attachment Two)
Consumer Information (B) Subgroup July 9, 2019, Minutes (Attachment Three)
Consumer Information (B) Subgroup June 25, 2019, Minutes (Attachment Four)
Consumer Information (B) Subgroup May 31, 2019, Minutes (Attachment Five)
Consumer Information (B) Subgroup May 8, 2019, E-Vote Minutes (Attachment Six)
Consumer Information (B) Subgroup May 1, 2019, Minutes (Attachment Seven)
Health Innovations (B) Working Group Aug. 3, 2019, Minutes (Attachment Eight)
  Health Innovations (B) Working Group July 11, 2019, Minutes (Attachment Eight-A)
The Health Insurance and Managed Care (B) Committee met in New York, NY, Aug. 4, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Dean L. Cameron (ID); Vicki Schmidt (KS); Steve Kelley represented by Grace Arnold (MN); Jon Godfread (ND); Linda A. Lacey represented by Troy Oechsner (NV); Andrew Stolfi (OR); Carter Lawrence (TN); Scott A. White represented by Julie Blauevert (VA); and Mike Kreidler represented by Molly Nollette (WA). Also participating were: Steve Ostlund (AL); Ryan James (AR); Perry Kupferman (CA); Fleur McKendell (DE); Doug Ommen (IA); Alex Peck (IN); Rich Piazza (LA); Kevin Dyke (MI); Paige Duhamel (NM); Glen Mulready (OK); Todd E. Kiser (UT); Nathan Houdek (WI); and Joylynn Fix (WV).

1. **Adopted its June 11 and Spring National Meeting Minutes**

The Committee met June 11 and April 7. During its June 11 meeting, the Committee took the following action: 1) adopted the Regulatory Framework (B) Task Force’s 2019 charges, which added a charge for the HMO Issues (B) Subgroup to revise provisions in the *Health Maintenance Organization Model Act* (#430) to address conflicts and inconsistencies with the *Life and Health Insurance Guaranty Association Model Act* (#520); 2) adopted the Regulatory Framework (B) Task Force’s Request for NAIC Model Law Development for the HMO Issues (B) Subgroup to revise Model #430 consistent with its 2019 charge; and 3) adopted the Consumer Information (B) Subgroup’s consumer alert “What to Ask for When Shopping for Health Insurance.”

Ms. Nollette made a motion, seconded by Director Cameron, to adopt the Committee’s June 11 (Attachment One) and April 7 (see NAIC Proceedings – Spring 2019, Health Insurance and Managed Care (B) Committee) minutes. The motion passed unanimously.

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

Commissioner Godfread made a motion, seconded by Commissioner Atkins, to adopt the following reports: the Consumer Information (B) Subgroup, including its July 23 (Attachment Two), July 9 (Attachment Three), June 25 (Attachment Four), May 31 (Attachment Five), May 8 (Attachment Six) and May 1 (Attachment Seven) minutes; the Health Innovations (B) Working Group (Attachment Eight); the Health Actuarial (B) Task Force; the Long-Term Care Insurance (E/B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force. The motion passed unanimously.

3. **Heard an Update from the CCIIO**

Randy Pate (federal Center for Consumer Information and Insurance Oversight—CCIIO) updated the Committee on the CCIIO’s regulatory activities related to the federal Affordable Care Act (ACA) and other activities of interest to the Committee. He described the status of the current individual market and what actions the Trump Administration is taking to increase access and affordability. He discussed the average health risk, enrollment duration and costs across private insurance markets: the ACA individual market, the ACA small group market, and the large group market. He noted that enrollees in the ACA individual and small group markets tend to have shorter enrollment durations than enrollees in the large group market. In addition, individual market enrollees have 32% higher risk scores on average compared to large group enrollees.

Mr. Pate discussed enrollment patterns over the years for enrollment through state-based exchanges and HealthCare.gov. He noted that the federal Centers for Medicare & Medicaid Service’s (CMS) commitment to providing a seamless experience for consumers using HealthCare.gov. He said as reflected in consumer satisfaction rate surveys, CMS is achieving this goal.

Mr. Pate highlighted the decrease in premium for the second-lowest cost silver plan or benchmark plan from plan year 2018 to plan year 2019. He explained that this varies across the states, with some states experiencing increases in premium while others experience decreases in premium. He also discussed improvement in the states with respect to the number of insurers offering coverage. He discussed how state innovation using ACA Section 1332 waivers has played a big part in reducing premium. However, he said work still needs to be done to make the individual marketplace more attractive, particularly for those not receiving financial assistance. He discussed what actions the Trump Administration is taking to improve the individual market by encouraging more competition, state flexibility, new options and innovations.
Mr. Pate discussed how the recently finalized Health Reimbursement Account (HRA) rule will make it easier for small businesses to compete with larger businesses by creating another option for financing worker health insurance coverage. He said using an individual coverage HRA, employers will be able to provide their workers and their workers’ families with tax-preferred funds to pay all or a portion of the cost of health insurance for coverage that workers purchase through the individual market. As such, the HRA rule will significantly increase the number of Americans with private insurance coverage and thereby reduce the number of uninsured. He said the Trump Administration believes that by striking the right balance between employer flexibility and guardrails meant to protect the individual market against adverse selection, the HRA rule should significantly increase the size of the individual market, making it a more attractive option for insurers to enter and offer coverage.


The Committee heard a panel presentation on current parity implementation issues and outstanding parity issues state insurance regulators should be aware of regarding the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Varum Choudhary (Magellan Health—Magellan) provided an overview of state and federal policymaking with respect to parity in the provision of mental health and substance use disorder services. He outlined Magellan’s long-standing support of mental health parity and its policies aimed at achieving parity through its “Achieving the Triple Aim” initiative. He said the MHPAEA has improved the landscape of mental health and substance use disorder coverage, but challenges and opportunities remain. He discussed a few of those opportunities for policymakers, including state insurance regulators, to further improve parity, such as: 1) clarifying and standardizing compliance with non-quantitative treatment limits (NQTLs); 2) ensuring investment and accountability in the behavioral health system; 3) integrating behavioral and primary care; and 4) providing consumers with user-friendly information on how behavioral health benefits are developed on par with their medical/surgical benefits.

Andrew Sperling (National Alliance on Mental Illness—NAMI) explained that the MHPAEA does not mandate coverage of mental health or substance use disorder services. If a plan offers such coverage benefits, then the MHPAEA requires that the benefits must be “no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan…” and “there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits.” He said he believes the MHPAEA has been successful. However, he believes issues remain, particularly with respect to NQTLs; but even with respect to NQTLs, progress is being made. He discussed opportunities that he believes are available to state insurance regulators to improve access, including: 1) assuring compliance across both the plan managing medical-surgical benefits and the separate “carve out” plan managing behavioral health; and 2) ensuring parity for network adequacy. He also suggested a need for an independent accreditation process that insurers can use for compliance, particularly with respect to NQTLs.

Tim Clement (American Psychiatric Association—APA) expressed confidence that within the next few years, there will be full compliance with the MHPAEA given the work that is being done by state insurance regulators with insurers to improve compliance. He said, as Mr. Sperling noted, the MHPAEA has improved access and coverage, particularly with respect to quantitative treatment limits (QTLs), but more work needs to be done with respect to NQTLs. He noted that many insurers rely on checklists to achieve compliance, but some are not performing the necessary due diligence to ensure compliance “in operation.” He cited a few examples of such situations, such as prior authorization requirements or retrospective review requirements. He suggested that requiring enhanced attestation of compliance, not just attestation could address some of these issues. He said state insurance regulators, insurers, and consumers need to work as partners to resolve these issues and challenges.

Commissioner Altman asked Dr. Choudhary how Magellan works to ensure that there is “in operation” compliance with the MHPAEA’s requirements. He explained Magellan’s procedures. He said issues arise when the mental health or substance use disorder service does not translate to a comparable medical service. He said in such cases, Magellan works collaboratively to resolve the issue.

Director Wing-Heier asked about the use of telemedicine to address challenges for rural states, like Alaska, in having a sufficient number of network providers for the provision of mental health and substance use disorder services. Mr. Sperling said telemedicine is an option, but it is still challenging. Mr. Choudhary said he believes this problem with workforce and access can possibly be addressed by creating appropriate incentives.
Commissioner Kiser asked about addressing these issues through integrated care. Dr. Choudhary discussed how Magellan uses a fully integrated health model to equip primary care providers (PCPs) with what they need to treat mental health issues. Mr. Clement discussed the APA’s collaborative care model.

5. **Heard a Briefing from the CIPR on the Research Study “Rising Health Care Costs: Drivers, Challenges and Solutions”**

Dimitris Karapiperis (Center for Insurance Policy and Research—CIPR) discussed the provisions in the first installment of the research study “Rising Health Care Costs: Drivers, Challenges and Solutions,” which was released in December 2018. He said recently released installments of this study include the articles “Addressing High Care Cost Drivers—A Critical Role for Regulators” and “Prescription Drug Cost Drivers.” Jeff Czajkowski (CIPR) discussed the CIPR’s next steps regarding the study. He said the CIPR anticipates releasing three chapters prior to the Fall National Meeting, which would include articles on: 1) value-based reimbursement; 2) wasteful health spending; and 3) the use of big data to reduce health care costs. He also discussed the CIPR’s new initiatives such as its, “Regulator Insights” publication, highlighting two recent publications on long-term care insurance (LTCI) and air ambulances. He also discussed possible CIPR future projects of interest to the Committee, such as reference-pricing.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
The Health Insurance and Managed Care (B) Committee met via conference call June 11, 2019. The following Committee members participated: Jessica Altman, Chair (PA); Lori K. Wing-Heier, Vice Chair (AK); Michael Conway (CO); Dean L. Cameron (ID); Vicki Schmidt (KS); Steve Kelley represented by Grace Arnold and Candace Gergen (MN); Mike Chaney represented by Bob Williams (MS); John Elias represented by Jennifer Patterson (NH); Andrew Stolfi represented by Jesse O’Brien (OR); Julie Mix McPeak represented by Lorrie Brouse and Michael Humphreys (TN); Scott A. White represented by Don Beatty and Yolanda Tennyson (VA); and Mike Kreidler (WA). Also participating was: Angela Nelson (MO).

1. **Adopted the Regulatory Framework (B) Task Force’s 2019 Amended Charges**

Commissioner Conway said that earlier this year, the Committee adopted the Regulatory Framework (B) Task Force’s recommendation to open the *Health Maintenance Organization Model Act* (#430) for revision to address conflicts and redundancies with the *Life and Health Insurance Guaranty Association Model Act* (#520). He said the Task Force decided to reestablish the HMO Issues (B) Subgroup to carry out this work. The Task Force met via conference call May 15 to adopt 2019 amended charges to add a 2019 charge for the HMO Issues (B) Subgroup to revise provisions in Model #430 to address conflicts and redundancies with the provisions in Model #520.

Commissioner Conway made a motion, seconded by Commissioner Schmidt, to adopt the Regulatory Framework (B) Task Force’s 2019 amended charges (see *NAIC Proceedings – Summer, Regulatory Framework (B) Task Force, Attachment One-A*). The motion passed unanimously.

2. **Adopted the Regulatory Framework (B) Task Force’s Request for NAIC Model Law Development**

Commissioner Conway said that during the Regulatory Framework (B) Task Force’s May 15 conference call, the Task Force also adopted the HMO Issues (B) Subgroup’s Request for NAIC Model Law Development to revise Model #430 to be consistent with its 2019 charge to address conflicts and redundancies with the provisions in Model #520.

Commissioner Conway made a motion, seconded by Commissioner Kreidler, to adopt the Request for NAIC Model Law Development to revise Model #430 to address conflict and redundancies in Model #520 (see *NAIC Proceedings – Summer 2019, Regulatory Framework (B) Task Force, Attachment One-B*). The motion passed unanimously.

3. **Adopted the Consumer Information (B) Subgroup Consumer Alert**

Commissioner Altman said the Consumer Information (B) Subgroup recently adopted a consumer alert stemming from its charge to develop information or resources that would be helpful to state insurance regulators and others in assisting consumers to better understand health insurance. She asked Ms. Nelson to update the Committee on the Subgroup’s work and the consumer alert.

Ms. Nelson said that during its initial meetings this year, the Subgroup discussed its charge and decided to first create a consumer alert to guide consumers when shopping for health insurance. She said the Subgroup met via conference call to develop the consumer alert “What to Ask for When Shopping for Health Insurance,” which it adopted on May 8. She explained that the consumer alert is drafted generically for the NAIC to issue it, but state departments of insurance (DOIs) also can customize it for their use and issuance. She said the Missouri DOI issued the consumer alert a few weeks ago in its entirety, but also has taken parts of the alert and put the information in graphic form for sharing on social media. She said the Subgroup’s next project is to create a tool to assist consumers in using their health coverage. She said the tool would possibly touch on topics such as understanding cost-sharing and verifying that providers are in-network. Ms. Patterson made a motion, seconded by Mr. Williams, to adopt the revisions to the consumer alert “What to Ask for When Shopping for Health Insurance” (Attachment One-A). The motion passed unanimously.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.
What to Ask when Shopping for Health Insurance

Getting the right information can help you choose the right health insurance for you and your family. Here are some questions to ask yourself before you start to look for insurance and some questions to ask anyone who offers you coverage.

We all know health insurance can be complicated. There are differences in what is covered and what you will have to pay out of pocket. With so many options and information out there, it makes it even more difficult to sort through when you get solicited for health insurance online or by phone. Scammers like the anonymity of telemarketing and take advantage of that confusion. Check out Phone and Online Solicitations section below. This section offers some simple questions you can ask so that you are not taken advantage of by a scammer.

If you need help to understand health insurance, you can visit with a licensed insurance agent or a navigator. Your state Department of Insurance also may have helpful information on its website. You can find definitions of health insurance terms on healthcare.gov. If you’re a senior, you also can contact your state’s SHIP program or call 1-800-MEDICARE to talk to someone about health insurance for seniors.

<table>
<thead>
<tr>
<th>Questions to ask yourself</th>
<th>Why it’s important</th>
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<tbody>
<tr>
<td>Why do you need health insurance?</td>
<td>Life is full of surprises. Insurance helps you prepare for the unexpected, like an accident or an illness. A single trip to an emergency room can lead to a bill of thousands of dollars.</td>
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<tr>
<td>Is the plan with the lowest premium really the most affordable?</td>
<td>Plans with lower premiums often have more limited benefits. You should consider not only the cost of premiums, but also how much you’ll pay out-of-pocket when you need health care.</td>
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<td>Who are you buying health insurance for?</td>
<td>You might need coverage just for yourself, just for a family member, or for the whole family.</td>
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<tr>
<td>How long do you need health insurance – a full year or for a few months?</td>
<td>Some plans might be limited to a few months. Others will cover you for an entire year and then that coverage can be renewed.</td>
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<tr>
<td>Do you have a known health condition (a pre-existing condition)?</td>
<td>Even if you look and feel healthy, you may not be getting the routine care necessary to identify the unexpected. Thinking about your family health history, your current health conditions, prescription drugs you may need, and the health services you need will help you understand the coverage you want. But remember, accidents and unexpected illnesses happen, so you might need services you don’t expect.</td>
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<tr>
<td>What prescription drugs do you need?</td>
<td>Many plans cover services to treat pre-existing conditions, but some don’t.</td>
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<td>Do you have any chronic health conditions, like high blood pressure, diabetes or an autoimmune disorder? Even if you haven’t been to a doctor, are you in pain or having problems you believe will result in any health care services or treatment?</td>
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<td>Question</td>
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<td>Do you have a family doctor or hospital?</td>
<td>You’ll pay less to see providers that accept your health insurance – which may not include your family doctor or hospital. The terms to know are “in-network’, “tiered network”, “non-participating” and “out of network.” Many plans pay more of the costs for services you get from doctors or facilities in the plan’s network.</td>
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<tr>
<td>Are you ready to pay the full cost for services until a deductible is reached?</td>
<td>The deductible is the amount you pay before your insurance company starts paying their share of the cost of care. Even with insurance, you pay the full cost of services until you meet your plan’s deductible.</td>
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<tr>
<td>Are you able to pay the full cost for services if the plan limits how much it will pay?</td>
<td>Some plans only pay up to a certain dollar amount; you may have to pay the cost beyond that amount.</td>
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**Phone and Online Solicitations**

Whether you’re shopping to find health insurance coverage online, a telemarketer calls, or you get an email selling health insurance, there are several important tips you should follow.

- No matter what - don’t make a decision or buy a health policy after a single phone call or website visit. There’s no such thing as a limited time offer or a “special” in health insurance.
- Research the insurance company BEFORE you buy anything.
  - Check your state Department of Insurance website to make sure the insurance company (and agent if you’re talking to someone) is licensed.
  - Ask your state Department of Insurance if there are any complaints against the insurance company or the agent. You also can check the National Association of Insurance Commissioners’ (NAIC) Consumer Information Search for information about complaints against the insurance company.
- Never give any personal information such as your social security, bank account or credit card numbers until you decide what health plan to buy. You don’t need to give this information to get a quote.
- Avoid clicking on any advertisement links that pop up on websites.
- Avoid any websites that require you to create an account before you can see any information about health insurance plans.

**Other questions to ask if you receive a phone call about health insurance**

<table>
<thead>
<tr>
<th>Question</th>
<th>Why it’s important</th>
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<tbody>
<tr>
<td>How did you get my information?</td>
<td>Consumers sometimes get phone calls trying to sell health insurance. Rarely do these phone calls come directly from insurance companies. Most of the time, these calls come from agents or telemarketing centers. Sometimes the callers don’t give consumers complete information, or the purpose of the call is to gather personal information to use for other purposes. It’s best to get as much information as possible so you can verify important information with the Department of Insurance before you buy. Make sure you are always talking to a licensed insurance agent.</td>
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<tr>
<td>May I have your full name and contact information, please?</td>
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<tr>
<td>What is the exact name of your company and where are you located?</td>
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<tr>
<td>Is your company licensed? Are you a licensed insurance agent? If so, what’s your license number for (state)?</td>
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<tr>
<td>What’s the exact name of the insurance company on the policy and the name/type of policy I would be buying?</td>
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<tr>
<td>What’s your company’s phone number?</td>
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</table>
Will I need to pay a fee to join a group? You should be told about all fees upfront. Sometimes, agents sell for associations that charge a separate membership fee plus the premium. Asking about fees from the beginning means you’ll know your total costs.

Please send a copy of the information to me through the mail. With a paper copy you can take your time to make sure the policy is as described. You also have information to share with your Department of Insurance to make sure the policy is a legal product.

Can I call you back after I’ve read your plan information? Real insurance companies shouldn’t rush you to make the decision. There are no “limited time offers” or “specials” on health insurance.

Questions to ask about a plan you’re considering

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<thead>
<tr>
<th>Question</th>
<th>Why it’s important</th>
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<tr>
<td>Is this a marketplace plan?</td>
<td>Plans sold through your state’s marketplace or Healthcare.gov cover a standard set of benefits and include certain consumer protections. Federal premium tax credits can only be used to help pay for marketplace plans.</td>
</tr>
<tr>
<td>Does this plan cover the same benefits as a marketplace plan?</td>
<td>If a plan isn’t sold on the marketplace, it may not have the same benefits. It’s important to ask questions such as “Can I get insurance even if I have a pre-existing condition?” Is there coverage for Essential Health Benefits? Are prescription drug benefits included? Are preventive services covered at no cost to me?</td>
</tr>
<tr>
<td>Does the plan cover pre-existing conditions?</td>
<td>Remember that many plans cover services to treat pre-existing conditions, but some don’t.</td>
</tr>
<tr>
<td>What benefits doesn’t this plan cover?</td>
<td>Some plans may limit or not cover services that may be important to you.</td>
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<tr>
<td>What benefits have limits?</td>
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<tr>
<td>Where can I find out whether this plan covers my prescription drugs?</td>
<td>If you need a specific prescription, you can review the plan’s formulary (a listing of what drugs are covered) to learn if the drug is covered.</td>
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<tr>
<td>Where can I find the list of health care providers in this plan’s network?</td>
<td>Each insurance company with a network of providers has a provider directory. You should have access to it before you buy a policy.</td>
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<tr>
<td>What is the monthly premium I would pay for this plan?</td>
<td>The premium is the amount you’ll pay each month to have coverage. You need to pay your premium each month by the due date or you’ll lose your coverage.</td>
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<tr>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>What out-of-pocket costs will I have to pay when I need services?</td>
<td>Depending on your insurance plan, your insurance company may pay most of the cost of your care. But you’re responsible for premiums and out-of-pocket costs such as copays, deductibles and coinsurance.</td>
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<tr>
<td>What is the deductible?</td>
<td>The deductible is the amount you pay before your insurance company starts paying its share of the costs. Most plans with lower premiums have higher deductibles.</td>
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<tr>
<td>Is there a maximum I would have to pay out-of-pocket?</td>
<td>A maximum out-of-pocket amount protects you by limiting the total you’ll have to pay out-of-pocket each year. Once you reach this amount, the plan will pay the rest of the cost of covered services. In some plans there’s no limit on how much your out of pocket costs could be.</td>
</tr>
<tr>
<td>Is there a limit on what the plan pays, per day, per year, or over my lifetime?</td>
<td>A limit on what the plan pays means you may have to pay the cost of services over this limit.</td>
</tr>
<tr>
<td>How long does this plan last?</td>
<td>Some plans cover you throughout the year and can be renewed. Others may have a shorter term and might consider your health conditions at renewal – and could even refuse to renew the policy.</td>
</tr>
<tr>
<td>Am I guaranteed the right to renew this plan?</td>
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**Other Resources**

Not everyone shops for health insurance on their own. Many people are eligible for coverage through an employer or a government program like Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP). The resources below can help you find answers about several common types of coverage, but they don’t include every type of health insurance.

- Medicare: Medicare.gov
- Medicaid or CHIP: Find your state Medicaid agency at https://www.insurekidsnow.gov/coverage/index.html
- Plans from private employers: https://www.dol.gov/general/topic/health-plans/consumerinfhealth
- Plans from federal government employment: https://www.opm.gov/healthcare-insurance/healthcare/
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call July 23, 2019. The following Subgroup members participated: Angela Nelson, Chair, Jessica Schrimpf and Mary Mealer (MO); Anthony L. Williams (AL); Elaine Mellon (ID); Michelle Baldock (IL); Jenifer Groth and Karl Knable (IN); Mary Kwei (MD); Kristi Bohn and Melinda Domzalski-Hansen (MN); Martin Swanson (NE); Ron Kreiter (OK); Candy Holbrook, Gretchen Brodkorb and Jill Kruger (SD); Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall, Sue Ezalorab and Julie Walsh (W1). Also participating were: Jacob Lauten (AK); Julia Yee (CA); Dayle Axman (CO); Cynthia Banks Radke (IA); Heather Quinn (KY); Frank Opelka (LA); Bob Williams (MS); Pam Koenig (MT); Jana Jarrett (OH); Jennifer Ramcharan and Vickie Trice (TN); Yolanda Tennyson (VA); Dena Wildman and Greg Elam (WV); and Ruth Case (WY).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson thanked the Subgroup for its work on the guide so far. She said not everything can be included because it should be digestible for consumers. She reminded the Subgroup that its next product would focus on the claims process. She said some information could be included in that document, or the current guide could refer readers elsewhere.

Ms. Nelson asked for comments on the current draft. Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program) suggested that it include some direction for consumers who want information in a language other than English. Ms. Nelson said she would consider how best to include this information.

Ms. Kwei asked whether the states require insurance cards for fully insured plans to include a reference to the state department of insurance (DOI) as a place to go for help. Ms. Nelson said Missouri requires only a statement disclosing that the plan is fully insured, and she does not think many states have similar requirements. Mr. Swanson asked whether there is an NAIC model law or regulation on this topic, and Ms. Nelson said she does not believe there is. Ms. Axman said Illinois requires a statement of whether a plan is within the jurisdiction of the DOI.

The Subgroup discussed the design of the page on the Summary of Benefits and Coverage (SBC) and agreed that a call-out to make part of the text of the SBC larger was a good design. The Subgroup discussed the page on My Health Coverage. Mr. Swanson suggested that space be added for co-pays for urgent care. The Subgroup discussed the page demonstrating how costs are shared between a plan and an enrollee. Mr. Ting said both co-pays and co-insurance should be referenced, not just co-insurance.

The Subgroup discussed the use of the term “medical home,” and it concluded that the term should be revised since it has a specific meaning that may not be applicable in the context of the guide. The Subgroup discussed whether the guide should refer readers to an insurer’s handbook for information on whether a provider is in-network. Several Subgroup members said that handbooks can be out-of-date. The Subgroup decided to edit the document to clarify that an insurer’s website has the most up-to-date network information. The Subgroup discussed the section on balance billing. The Subgroup members approved of the text and asked whether an infographic should be added. Ms. Nelson said a decision could be made later.

The Subgroup discussed how to phrase advice on the process for requesting exceptions to a plan’s formulary. Some Subgroup members wished to remove the reference to what a provider “must” do; others said it was important to indicate that provider action is necessary for an exception. Ms. Baldock recommended a more basic statement that indicates that exceptions are available and urges consumers to talk to their providers. Ms. Nelson said she would add more transition and explanation of the process for prescription drug exceptions.

The Subgroup discussed its next meeting date after the Summer National Meeting.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call July 9, 2019. The following Subgroup members participated: Angela Nelson, Chair, and Amy Hoyt (MO); Elaine Mellon and Kathy McGill (ID); Michelle Baldock (IL); Alex Peck (IN); LeAnn Crow (KS); Mary Kwei (MD); Judith Watters (ME); Sherri Mortensen-Brown (MN); Kathy Shortt (NC); Laura Arp and Martin Swanson (NE); Mike Rhoads and Rebecca Ross (OK); Elizabeth Hart and Katie Dzurec (PA); Candy Holbrook and Gretchen Brodkorb (SD); Heidi Clausen and Jaakob Sundberg (UT); and Jennifer Stegall, Sue Ezalarab and Julie Walsh (WI). Also participating were: Jacob Lauten (AK); Bruce Donaldson (AR); Julia Yee (CA); Gerard O’Sullivan (CT); Mary Beth Senkewicz (DC); Matt Guy (FL); Andria Seip, Cynthia Banks Radke and Sonya Sellmeyer (IA); Shawn Boggs (KY); Emily DeLaGarza (MI); Bob Williams (MS); Jeannie Keller and Pam Koenig (MT); Chanell McDevitt (NJ); Robert Seese (OH); Jennifer Ramcharan and Vickie Trice (TN); Scott Helmcamp (TX); Jackie Myers and Yolanda Tennyson (VA); and Dena Wildman and Joylynn Fix (WV).

1. Discussed the Consumer Guide on Using Health Insurance

Ms. Nelson reminded the Subgroup that its current product is a consumer guide on using health insurance. She mentioned that the Subgroup wanted to work on issues that came up as it was developing the Summary of Benefits and Coverage (SBC). The Subgroup previously developed a tool to help consumers shop for health insurance. The current effort is to help improve consumers’ understanding and insurance literacy. Ms. Nelson said that the Subgroup’s guide will borrow from a document already in use in Maine.

Brenda J. Cude (University of Georgia) said the Subgroup should decide whether the guide will be customized by state or a single document that is applicable in any state. Ms. Nelson said she would like it to serve both purposes.

Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program) said the guide should mention the 1-800-Medicare contact number under Health Insurance Resources, and it should also include directions for those who want information in a language other than English.

Several participants discussed who receives insurance cards from a carrier and how to advise readers about cards for their families. Candy Gallaher (America’s Health Insurance Plans—AHIP) suggested that the guide direct consumers to contact their plan if they have not received a card. Ms. Cude said that is a good idea.

Ms. Nelson asked about showing sample pages from an SBC in the guide. Ms. Cude and others said it may not be readable; or, if expanded, it may take up too much space. Ms. Shortt said a portion of the SBC does provide valuable information. Participants discussed whether to show a sample or tell readers what kind of information is available and refer them to another source for the SBC. Some participants suggested that the SBC and other documents be provided as an appendix to the guide. Ms. Cude asked that the guide clarify that any SBC shown is just a sample, not the SBC that applies for any individual. She suggested a heading that covers how to know what your policy covers and what your costs will be. Participants discussed using documents that reflect the example plan with specific amounts assigned to the plan and to the consumer. Mr. Ting said for each row of the SBC, the guide should provide a brief sentence or two of explanation and directions on where to find further information.

The Subgroup discussed explanations for plan benefits. Ms. Cude said there could be only one or two examples of the benefit categories covered by health plans. Ms. Gallaher said that it is important to have a broader list of the kinds of benefits, so readers know that their plans include them.

Ms. Nelson said she would work on a draft document, taking into account the suggestions discussed during the conference call.

Having no further business, the Consumer Information (B) Subgroup adjourned.
Consumer Information (B) Subgroup
Conference Call
June 25, 2019

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call June 25, 2019. The following Subgroup members participated: Angela Nelson, Chair, Amy Hoyt, Jessica Schrimpf and Mary Mealer (MO); Anthony L. Williams and William Rodgers (AL); Alex Peck, Claire Szpara and Jenifer Groth (IN); LeAnn Crow (KS); Terri Smith (MD); Judith Watters (ME); Melinda Domzalski-Hansen (MN); Kathy Shortt (NC); Martin Swanson (NE); Rebecca Ross (OK); Elizabeth Hart (PA); Candy Holbrook, Gretchen Brodkorb and Jill Kruger (SD); Heidi Clausen (UT); Melanie Anderson (WA); and Darcy Paskey, Eric Cormany, Jody Ullman, Sue Ezalarab and Julie Walsh (WI). Also participating were: Steven Fromholtz (AZ); Julia Yee (CA); Dayle Axman (CO); Matthew Guy (FL); Cynthia Banks Radke and Sonya Sellmeyer (IA); Shawn Boggs (KY); Emily DeLaGarza (MI); Chanell McDevitt (NJ); Jana Jarrett (OH); Jennifer Ramcharan and Vickie Trice (TN); Markus Wilcox and Valerie Brown (TX); Yolanda Tennyson (VA); Dena Wildman (WV); and Denise Burke (WY).

1. Discussed a Consumer Guide on Using Health Insurance

Ms. Nelson informed the group that the Health Insurance and Managed Care (B) Committee adopted the Subgroup’s consumer alert “What to Ask When Shopping for Health Insurance.” She noted that the document is posted on the Subgroup’s web page.

Ms. Nelson reminded the Subgroup of its previous discussion of Maine’s consumer guide on using health insurance. She said that she had used the Maine guide as a template in developing a draft consumer guide for the Subgroup to consider.

Ms. Nelson asked whether the Subgroup had comments on the draft. Subgroup members said it looked comprehensive. Ms. Ezalarab said that in Wisconsin, a similar guide was broken down into multiple, smaller pieces. Brenda J. Cude (University of Georgia) approved the information included and said that the most value comes from sections other than the one that reproduces the Summary of Benefits and Coverage (SBC). She also suggested that the insurance card page include both the front and back of the card. Ms. Domzalski-Hansen said the SBC is more useful for choosing a plan, while other documents, such as the policy contract, are more for using coverage an enrollee already has. Ms. Watters suggested that some sections could be moved to appendices.

Ms. Shortt suggested including a section on how to read an explanation of benefits (EOB). Ms. Nelson said that will be part of the next module.

The Subgroup discussed the value of explaining how to file a claim. Harry Ting (Chester County Department of Aging Services, Apprise Program) suggested that the guide explain that if providers do not file a claim, enrollees must do so themselves. Several others said that virtually all claims are filed electronically by providers, even when the provider is not in a plan’s network. Ms. Watters suggested a statement advising enrollees not to panic if they receive a bill, but to wait for an EOB. Others suggested directing enrollees to look for the words “This is not a bill” on statements they receive from providers. Ms. Nelson suggested explaining briefly what a claim is, even if the guide does not describe how to file one.

Mr. Ting said that a brief glossary would be useful and that the coordination of benefits section is too long.

Candy Gallaher (American’s Health Insurance Plans—AHIP) suggested moving some pages, particularly placing the discussion of plan network types after comments on choosing a provider.

Ms. Cude said that few readers will read the document front to back. Instead, she said they will search for the information they are looking for, so clear headings are important. The Subgroup discussed adding a table of contents with headings as hyperlinks.

Ms. Cude said that suggestions to the reader should be as specific as possible. She suggested writing the rest of the guide first and then choosing the most important point as a headline.

Ms. Baldock said that Illinois receives a lot of calls from enrollees who needed a referral before their service but did not get one. Ms. Domzalski-Hansen suggested including space for enrollees to write important contact information for their plan, including a nurse line, after hours contacts and other telephone numbers.
The Subgroup discussed the usefulness of directing enrollees to consult the medical necessity criteria for their plan. Some suggested that because the policy does not always have all the details, the guide should point to where else to look. Others said that there is no simple way to get the needed information across. Ms. Nelson said that the guide should direct enrollees to their plan’s website because it would have the most updated information.

Ms. Shortt asked whether the guide should reference self-funded plans or provide contact information for the Employee Benefits Security Administration (EBSA). Ms. Nelson responded that there could be an introductory statement and a suggestion for enrollees to contact their employer’s human resources department. Ms. Shortt suggested a statement on the first page that explains that different laws apply to different plans. Ms. Baldock said she would send a fact sheet on self-insured plans that Illinois has developed.

Ms. Cude suggested referencing information on the back of an insurance card and letting enrollees know to expect to be asked for their card, both in person and over the phone. Mr. Swanson said there should be a direction to check whether the card reflect the coverage the enrollee intended to buy.

Ms. Nelson said that on the schedule of benefits page, not all of the content needed to be used. Ms. Gallaher suggested using the term “cost sharing” instead of the term “fees.” Ms. Cude suggested explaining how the term “benefit” is used in this context, perhaps starting with a question such as: “How do I know what my coverage will pay for?”

Ms. Nelson asked the Subgroup to send in further suggestions. She said that discussion would continue on the remainder of the document during the Subgroup’s next conference call.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call May 31, 2019. The following Subgroup members participated: Angela Nelson, Chair, Carrie Couch, Mary Mealer (MO); William Rodgers (AL); Donna Daniel (ID); Claire Szpara, Jennifer Groth and Karl Knable (IN); LeAnn Crow and Tate Flott (KS); Mary Kwei (MD); Rosemary Gillespie (NC); Martin Swanson and Laura Arp (NE); Cuc Nguyen and Rebecca Ross (OK); Elizabeth Hart and Katie Dzurec (PA); Candy Holbrook, Gretchen Brodkorb and Jill Kruger (SD); Heidi Clausen, Jaakob Sundberg, Nancy Askerlund, and Tanji Northrup (UT); and Sue Ezalarab, and Julie Walsh (WI). Also participating were: Steven Fromholtz (AZ); Christopher Citko and Julia Yee (CA); Michelle Baldock (IL); Shawn Boggs (KY); Renee Campbell (MI); Bob Williams (MS); Jeannie Keller (MT); Chanell McDevitt (NJ); Rolanda Pana and Viara Ianakieva (NM); Jana Jarrett (OH); Jennifer Ramcharan and Vickie Trice (TN); Chris Orr, Scott Helmcamp, Trey Beeman, and Valerie Brown (TX); Yolanda Tennyson (VA); and Dena Wildman and Joylynn Fix (WV).

1. Discussed the Drafting of a Consumer Guide on Using Health Insurance

Ms. Nelson described the current work project as a guide or tool focused on using health insurance. She said the Subgroup will probably work to complete a separate document on how to get claims paid. For both, she suggested starting with a static document that could later be converted for more interactive or online use. She mentioned that additional products or guides could be developed if the Subgroup ends up writing content that is not used in the projects currently in the work plan.

Candy M. Gallaher (America’s Health Insurance Plans—AHIP) reviewed comments she had submitted on the list of topics to cover in the guide. She supported making sure that the guide includes language on who it is for and why it is being provided. She suggested that it could mention different ways individuals might get coverage, such as through an employer, small group or association.

Ms. Nelson said references to different types of coverage should be for context, and she suggested that there should not be much space devoted to how to obtain coverage. Ms. Gallaher agreed and added that the guide should be useful whether a reader has group coverage or individually purchased coverage.

Ms. Gallaher said the guide should include a description of open enrollment periods, and it should also cover dental and vision benefits, as well as how to understand the elements of health savings accounts. Ms. Nelson clarified that the guide’s assumption will be that the reader has already enrolled in a plan. Instead of including information on enrollment, she suggested pointing to other documents that could help readers who need coverage.

Ms. Gallaher also suggested covering life changes and highlighting family and eligibility changes. She advocated for including referrals to other resources, such as where to go with questions on Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) eligibility, as well as questions on job changes.

Ms. Nelson asked the Subgroup whether these suggestions should be incorporated into the draft. Mr. Swanson said that would be a good way to handle it, and others agreed.

Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program) suggested including a Resources section with language borrowed from the California Department of Insurance website. The website references exclusive provider organizations (EPOs), and he asked if this term is still used. Ms. Gallaher said EPOs are also called open health maintenance organizations (HMOs). Ms. Nelson and several others noted that EPOs are currently available in their state, and sometimes they are the only plans available through the exchange.

Mr. Ting suggested including information on using provider networks, including tiering. He said some state guides encourage looking at insurer provider directories, but since directories are not necessarily up-to-date, he would instead recommend checking directly with the insurer and provider.

Mr. Ting said there is good language on prescription drugs from the Patient Advocate Foundation (PAF), cost-sharing from Maine’s guide, and site of care from Pennsylvania’s health literacy website.
Ms. Nelson asked whether the Subgroup wished to incorporate the change and suggestions from Mr. Ting, and there was agreement.

Ms. Baldock asked whether the guide would address preventative care or adding newborns to plans. Ms. Nelson responded that adding newborns would be part of the life changes section.

Ms. Nelson said the Maine guide is fantastic, and she does not want to recreate the wheel. It covers many of the topics that the Subgroup has outlined. Ms. Nelson asked for thoughts on using Maine’s guide as a template. Mr. Ting said it is clear and well-organized, and he added that some of the topics may have to be shortened. Ms. Nelson said she likes the Maine guide’s use of the table contents as a checklist, the references to the summary of benefits and coverage, its sample insurance card, and graphics employed to explain complex issues. Debra Judy (Colorado Consumer Health Initiative—CCHI) also expressed support for a table of contents/checklist.

Mr. Ting asked whether this guide would be in question-and-answer format, like the consumer alert the Subgroup previously developed, or something more like the Maine guide. Ms. Nelson said the Maine guide seems more appropriate for this document, and she asked whether the Subgroup should use it as a model. Ms. Arp and Ms. Kruger agreed, but Ms. Kruger noted that the length of the Maine guide may be too long. Ms. Nelson agreed that more is not always better, and graphics can be used in place of lengthy text. Brenda J. Cude (University of Georgia) observed that readers do not often read from beginning to end, but they search for the information they are looking for, so the overall length may not be very important.

Ms. Nelson said she would take what the Subgroup has discussed and work it into the format of the Maine guide. She said she would need help from others when the drafting turns to a number of the topics on the list.

Having no further business, the Consumer Information (B) Subgroup adjourned.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded May 8, 2019. The following Subgroup members participated: Angela Nelson, Chair (MO); Anthony L. Williams (AL); Elaine Mellon (ID); Alex Peck (IN); Mary Kwei (MD); Melinda Domzalski-Hansen (MN); Kathy Shortt (NC); Martin Swanson (NE); Cuc Nguyen (OK); Melanie Anderson (WA); and Jennifer Stegall (WI).

1. **-Adopted a Consumer Alert on Shopping for Health Insurance**

The Subgroup conducted an e-vote to consider adoption of a consumer alert titled, “What to Ask When Shopping for Health Insurance” (*see NAIC Proceedings – Summer 2019, Health Insurance and Managed Care (B) Committee, Attachment One-A*). A majority of the members voted in favor of adopting the alert. The motion passed.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call May 1, 2019. The following Subgroup members participated: Angela Nelson, Chair, Carrie Couch and Mary Mealer (MO); Anthony L. Williams (AL); Elaine Mellon (ID); Greta Hockwalt and Karl Knable (IN); Mary Kwei (MD); Judith Watters (ME); Maybeth Moses, Melinda Domzalski-Hansen and Sherri Mortensen-Brown (MN); Rosemary Gillespie and Ted Hamby (NC); Martin Swanson (NE); Cuc Nguyen (OK); Katie Dzurec and Elizabeth Hart (PA); Candy Holbrook and Gretchen Brodkorb (SD); Heidi Clausen and Jaakob Sundberg (UT); Melanie Anderson (WA); and Sue Ezalarab, Olivia Hwang, Julie Walsh, Jody Ullman and Jennifer Stegall (WI). Also participating were: Dayle Axman and Susan Stieg (CO); Howard Liebers (DC); Matt Guy (FL); Debra Peirce (GA); Arlene Ige and Howard Matsuura (HI); Sonya Sellmeyer and Cynthia Banks Radke (IA); Michelle Baldock (IL); Emily DeLaGarza (MI); Bob Williams (MS); Pam Koenig (MT); Chanell McDevitt (NJ); Rachel Jade-Rice (TN); Angela Herron, Rachel Bowden, Stephanie Goodman and Scott Helmcamp (TX); Jackie Myers and Yolanda Tennyson (VA); Dena Wildman and Joylynn Fix (WV); and Denise Burke (WY).

1. Reviewed a Draft of Consumer Questions

Ms. Nelson said she believes the Subgroup is close to completing work on the consumer alert with a list of questions to ask about health insurance. She asked Subgroup members whether they had any comments or concerns on the latest draft.

Ms. Anderson said the draft looks good. Ms. Mellon asked if the content on Page 2 regarding telephone solicitations could be moved closer to the beginning of the document, because some consumers might not take the time to find that content. Ms. Nelson suggested adding an internal link or a prompt in the first paragraphs directing readers to the telephone section.

Ms. Stegall suggested that the introduction refer not only to www.healthcare.gov, but also other sources where consumers can find information about health insurance, including agents and navigators. She said it is important to reference help from live people, not just the internet.

Ms. Ezalarab noted that not all the content under “Questions” is in the form of a question; one line needs to be modified to make it a question.

Ms. Mellon asked whether telemarketers would respond honestly to the question, “Is this a telemarketing call?” The Subgroup discussed the effectiveness of this question and decided to change it to, “How did you get my information?”

Harry Ting (Consumer Advocate Volunteer, Chester County Department of Aging Services – Apprise Program) said navigators can help consumers catch the subtleties of health insurance that they might not get on their own, and older consumers should be directed to their State Health Insurance Assistance Program (SHIP).

Ms. Mellon suggested directing consumers to ask for a plan’s summary of benefits and coverage (SBC), but others responded that existing questions would elicit the same information as the SBC.

Mr. Ting briefly explained the written comments he submitted. He said he sees a need for an overarching guide to point consumers to the right place, regardless of the type of insurance they are looking for. However, he said the NAIC’s efforts to revamp its website would be a more appropriate means to serve this need, so the Subgroup did not need to focus on a written guide.

Ms. Nelson said the Subgroup could share information with the NAIC Communications Division or other committees. Ms. Dzurec said if another group wants to update the website, the Subgroup could offer its assistance; however, the Subgroup should not take the lead.

Mr. Ting observed that there are several consumer guides on the NAIC website, but there is no guide for health insurance except a link to a federal Centers for Medicare & Medicaid Services (CMS) brochure on Medicare supplement (Medigap) plans.
Ms. Nelson asked whether the Subgroup should work on a consumer guide that addresses a broader swath of health insurance. Mr. Ting agreed, noting that it would be helpful for the states. He observed that many state insurance department websites describe federal Affordable Care Act (ACA) coverage, but they do not describe other types of health insurance. The Subgroup agreed to take on such a guide, but only after it has completed the more focused consumer guides already part of its 2019 work plan.

Mr. Ting provided a brief overview of a recent report commissioned by consumer representatives of consumer understanding of short-term limited duration (STLD) insurance plan features. He said plan materials are difficult for consumers to understand, and they may not understand what they are buying.

Ms. Nelson recalled that consumer testing of the SBC was enlightening, but it was also humbling. She observed that there are opportunities for the Subgroup and state insurance regulators, generally, to do outreach and education on STLD insurance plans.

2. Discussed Other Matters

Ms. Nelson reminded the Subgroup of its plan to develop three consumer guides. She asked whether the Subgroup should return to the consumer shopping tool it worked on in 2018 and convert it to a consumer guide or move on to the guide intended to help consumers in using coverage. This guide would cover topics like cost-sharing, provider networks and formulary; and it could also address site of care or balance billing.

Mr. Swanson expressed support for moving on to the using insurance guide. Other Subgroup members agreed. Ms. Nelson asked Subgroup members and interested parties to send topics that should be included in the guide to Joe Touschner (NAIC), as well as examples of similar content from other organizations.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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Health Innovations (B) Working Group  
New York, New York  
August 3, 2019 

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in New York, NY, Aug. 3, 2019. The following Working Group members participated: Marie Ganim, Chair (RI); Martin Swanson, Vice Chair, (NE); Jacob Lauten (AK); Steve Ostlund (AL); Howard Liebers (DC); Andria Seip (IA); Alex Peck and Karl Knable (IN); Vicki Schmidt and Julie Holmes (KS); Angela Nelson (MO); Jon Godfread and Chrystal Bartuska (ND); Philip Gennace and Justin Zimmerman (NJ); Paige Duhamel (NM); David Cassetty (NV); TK Keen (OR); Katie Dzurec (PA); Rachel Bowden (TX); Jaakob Sundberg (UT); Molly Nollette (WA); Nathan Houdek and Jennifer Stegall (WI); and Joylynn Fix (WV). Also participating were: Michael Conway (CO); Fleur McKendell (DE); and Kevin Beagan (MA). 

1. **Adopted its July 11 and Spring National Meeting Minutes**

Mr. Ostlund made a motion, seconded by Mr. Lauten, to adopt the Working Group’s July 11 (Attachment Eight-A) and April 6 (see NAIC Proceedings – Spring 2019, Health Insurance and Managed Care (B) Committee, Attachment Six) minutes. The motion passed unanimously.

2. **Heard a Presentation on Prices Paid to Hospitals by Private Health Plans**

Chapin White (RAND Corporation) presented the results of his research on the relative prices paid by private health plans and Medicare to hospitals for the same services. He showed that, on average, private plans pay roughly two and a half times Medicare’s rates. He shared the ratios for the states where there was sufficient data. He discussed market failures that lead to higher prices, and he described a range of policy options for limiting prices.

Working Group members asked how the states were selected for the study, whether other states could be included in the future, and what else would be done differently in updates to the research. Mr. White responded that his team gathered data from those willing to provide it—large employers and some state all-payer claims databases. He said he continues to be in discussion with other employers and states about potentially contributing their data. He said in future studies, he would like to add professional service payments to the existing facility payment data and apply repricing to both. He would also like to obtain data that shows which payments are in versus out of network.

Mr. Knable asked how changes in Medicare payments affect the ratio with payments from private plans. Mr. White responded that Medicare payments have been growing slowly, and increases are driven by out-patient costs.

Working Group members discussed whether data like that analyzed by Mr. White can be used to understand the level of payments that cause a hospital to break even in balancing revenue and costs.

Mr. Keen asked whether there are ways to encourage employers to shop for better hospital prices. Mr. White said employers do better when they collaborate. Even a large employer will represent only a small share of a hospital’s revenue, so they need to band together. He said they need to share data, educate themselves, get expert advice, and build clout to make a difference in their costs.

3. **Heard a Presentation on State Cost-Containment Initiatives**

Joel Ario (Manatt Health) said the pendulum in health care debates is moving away from access and toward affordability. He said state insurance regulators cannot address cost issues themselves; instead, they have to work across state agencies. Even then, he said cost containment is difficult.

Kathy Hempstead (Robert Wood Johnson Foundation—RWJF) said cost is a barrier to expanding coverage, taking up coverage by the uninsured, and accessing care for those with coverage. She said access to claims data is critical for policymakers to understand health care costs.
Mr. Ario said there are many uses that the data from an all-payer claims database can be put to. He referenced material he shared last year with NAIC working groups on this topic.

Mr. Ario briefly described four states’ efforts to contain health care costs. He mentioned Washington’s recently enacted public option legislation, New Mexico’s efforts to create a Medicaid buy-in, Rhode Island’s health care cost benchmarking, and Maryland’s initiative to set limits on prescription drug pricing.

Commissioner Conway asked whether cost containment would limit the resources pharmaceutical companies invest in research and development. Mr. Ario responded that mystery drives margins—companies have opportunities for larger profits when customers and policymakers do not know their true prices. He said more transparency is needed in drug pricing to know the true impact on research and the development of price limits.

4. **Discussed State Approaches to Health Care Cost Targets**

Health Insurance Commissioner Ganim provided information on Rhode Island’s cost growth target. She described the stakeholder steering committee and partnerships with a foundation and Brown University. She outlined the workstreams of setting a cost growth target, measuring cost drivers and growth trends, and using the data to improve health system performance.

Mr. Keen presented on Oregon’s health care cost growth benchmark. He said Oregon considered Maryland’s all-payer rate setting model, but it decided instead to use Massachusetts’ cost growth benchmark model. He said many details are yet to be determined, but the benchmark is scheduled to go into effect in 2021, with reporting and enforcement beginning in 2022. The benchmark applies to all providers, payers, and health care entities in Oregon; and it will be measurable on a per capita, statewide, and health care entity basis.

Mr. Beagan spoke about Massachusetts’ health care cost growth target. He said state law created a Health Policy Commission, and the Division of Insurance does not serve on the Commission. The Commission sets an annual cost growth target, and it may require health care entities that exceed the target to file and implement performance improvement plans. He shared data on private health insurance premiums in the state before and after the Commission was established.

Ms. McKendell described Delaware’s health care cost growth target. She said it was created through an executive order by the governor in late 2018. It is implemented by the Delaware Department of Health and Social Services. Delaware has set a cost growth target for each year through 2023, and it will also measure progress against quality benchmarks, starting with eight in 2020.

5. **Discussed Innovative Initiatives from Working Group Member States**

Ms. Nollette provided information on Washington’s Cascade Care program. She said the state decided it did not want to pursue a Section 1332 waiver. Under Cascade Care, Medicaid will procure a fully insured product that fits into a standard plan design. It will be offered as a qualified health plan (QHP) through the state’s exchange. The program will cap payments to providers relative to Medicare amounts, excluding prescription drugs. The role of the insurance commissioner is only to ensure that the plan meets applicable requirements.

Having no further business, the Health Innovations (B) Working Group adjourned.
The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call July 11, 2019. The following Subgroup members participated: Marie Ganim, Chair (RI), Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew Stolfi, Vice Chair (OR); Jacob Lauten and Sarah Bailey (AK); William Rodgers (AL); Andria Seip (IA); Alex Peck and Claire Szpara (IN); Julie Holmes (KS); Robert Wake (ME); Amy Hoyt, Danielle McAfee-Thoenen and Jessica Schrmpf (MO); Jeff Ubben (ND); Jennifer Patterson (NH); Chanell McDevitt (NJ); Paige Duhamel (NM); Annette James, Mark Garratt and Zhuang Zhang (NV); Alison Beam, Jessica Altman, Katie Dzurec and Sandra L. Ykema (PA); Rachel Bowden (TX); Heidi Clausen, Jaakob Sundberg and Tanji Northrup (UT); Molly Nollette (WA); Diane Dambach and Jennifer Stegall (WI); and Joylynn Fix (WV). Also participating were: Vincent Gosz (AZ); Chris Struk (FL); Arlene Ige (HI); Donna Daniel and Kathy McGill (ID); Tyler Hoblitzzell (MD); Kristi Bohn, Melinda Domzalski-Hansen and Sheri Mortensen-Brown (MN); Bob Williams (MS); Janell Williams and Pam Koenig (MT); Robert Croom (NC); Kendall Buchanan (SC); Candy Holbrook and Gretchen Brodkorb (SD); and Rachel Jade-Rice (TN).

1. Discussed State Activity on Section 1332 Waivers

Health Insurance Commissioner Ganim said that the Working Group is looking to hear updates and challenges from states with regard to waivers under Section 1332 of the federal Affordable Care Act (ACA).

She described Rhode Island’s experience of having large rate increases combined with the loss of the individual mandate and other destabilizing forces. She said that a workgroup including businesses and advocates met and developed a plan based on New Jersey’s 1332 waiver. It includes an individual mandate. Rhode Island expects a 5% to 7% reduction in rates under its waiver.

Ms. Duhamel asked whether any states were considering waivers not for reinsurance, but to wrap federal premium tax credits with additional subsidies. Ms. Dzurec said she would also like to hear from states that have considered subsidy wraps, even if they have ultimately been rejected.

Ms. Williams described Montana’s waiver application. She said that like Rhode Island, the state saw significant premium increases and convened a working group. Montana’s state funds for reinsurance would come from a fee on all insured members. The reinsurance program would total $34 million and was estimated to reduce premiums 6% to 8%. Actual premium submissions are coming in around 9% lower. She encouraged other states to reach out early to the staff at the federal Centers for Medicare and Medicaid Services (CMS) and said that the main contacts are Lina Rashid, Michelle Koltov and Adam Shaw.

Mr. Ubben described North Dakota’s waiver application. He said the state portion will be $43 million over 10 years. While the funds would immediately come from an assessment on large and small group plans, they would ultimately come out of state revenues because plans would be able to reduce their state tax payments by the amount of the assessment. The plans also agreed not to pass the assessment on to consumers. He said North Dakota expects $50 million over two years from the federal government and a rate reduction of 15% to 20%.

Health Insurance Commissioner Ganim said that states with approved waivers have already shared valuable information with other states and asked for any additional updates. Ms. Bailey said that Alaska recently held its annual public forum, but there was little participation because it is an invisible program. She said the state realigned time frames for reporting to ease the burden on issuers. Mr. Wake said that Maine’s program is functioning smoothly. Ms. Bohn reported that Minnesota’s legislature chose to reinstate the reinsurance program after its initial two-year authorization and that a board of directors was added to provide more governance for the outside agency that implements the program. Commissioner Stolfi said that Oregon approved a six-year extension of its program and raised the assessment that funds it, though some funds also go to Medicaid. He said that challenges include a lack of transparency on federal funding amounts, the difficulty in setting up a new state program, and the time lag of 2.5 years between issuers’ rate setting and when they are actually paid the reinsurance amounts. He said the state is already questioning what to do when the program ends because without it, rates will go back up.
Commissioner Altman said that Pennsylvania is just getting started because in the previous week, Pennsylvania’s governor signed a bill to create a state-based exchange (SBE) and a reinsurance waiver. She said the state will retain the existing user fee and use part to fund the SBE and the remainder to fund the waiver.

Ms. Arp asked about the CMS guidance from October 2018 and whether states believe there is truly flexibility in the requirement to have state legislation authorizing a waiver, particularly if the waiver does not require state funding. Ms. Seip said that Iowa proposed a waiver that used existing state authority, not a new law. She said that Iowa’s proposal failed for other reasons; the existing authority was sufficient for CMS.

The Working Group discussed whether reinsurance waivers led to increased enrollment, and several members commented that they are more likely to have slowed declines in enrollment than to generate true increases.

2. **Discussed its Meeting at the Summer National Meeting**

Health Insurance Commissioner Ganim reviewed the planned agenda for the Working Group’s meeting at the Summer National Meeting. She said there would be a presentation from Chapin White (RAND) on payments to hospitals and one from Joel Ario (Manatt Health) on a toolkit of cost control ideas. She said that she wants to hear from Working Group members on what they are working on or questions they have. Ms. Nollette said that she is working on Cascade Care, as known as Washington’s public option, to drive down rates. Ms. Seip asked if other states are seeing growth in direct primary care and whether insurance companies work with these services to provide coverage for non-primary care services. Health Insurance Commissioner Ganim said that it would be good to discuss how to regulate insurance plans in such an environment.

Having no further business, the Health Innovations (B) Working Group adjourned.