HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Dec. 7, 2009, Minutes
- Health Insurance and Managed Care (B) Committee Nov. 9, 2009 Conference Call Minutes (Attachment One)
- AMA Advocacy Resource Center Testimony Dec. 7, 2009 (Attachment Two)

Drafted: 12/15/09

Health Insurance and Managed Care (B) Committee
San Francisco, CA
December 7, 2009

The Health Insurance and Managed Care (B) Committee met in San Francisco, CA, Dec. 7, 2009. The following Committee members participated: Sandy Praeger, Chair (KS); Joel Ario, Vice Chair (PA); Marcy Morrison (CO); Kevin M. McCarty and Mary Beth Senkewicz (FL); Michael T. McRaith and Bill McAndrew (IL); Carol Cutter represented by Doug Webber (IN); Ralph S. Tyler, III (MD); Monica J. Lindeen (MT); Morris J. Chavez represented by Brent Moore (NM); Kim Holland (OK); Kent Michie (UT); Paulette Thabault (VT); and Jane L. Cline (WV). Also participating were: Steve Ostlund (AL); Bruce Hinze and David Link (CA); Gennet Purcell (DC); Susan E. Voss (IA); William W. Deal (ID); Bob Wake (ME); Manny Munson-Regala (MN); John M. Huff (MO); Louis Belo (NC); Roger Sevigny (NH); Scott J. Kipper (NV); Anne Jewel (OH); Teresa Miller (OR); and Sean Dilweg (WI).

1. Dec. 4 Health Care Reform Public Hearing

Commissioner Praeger explained that the purpose of the public hearing was to hear testimony on any implementation issues state insurance regulators should consider if federal health care reform legislation is enacted. She said that, depending on which version of health care reform legislation is enacted, the states will have to make numerous changes to their laws to meet federal minimum standards most likely in these areas: 1) rating rules; 2) guaranteed issue and renewability; 3) marketing; 4) rescissions; 5) health insurance exchanges; and 6) interstate compacts for sales across state lines. States will be faced with a tight timeline to prepare for the possible 2013 or 2014 implementation dates for the major market reforms. Commissioner Praeger said that, because this timeline is so daunting, the Committee is holding this public hearing to get started. She said that, although the NAIC cannot begin updating its existing models or draft new ones until the legislation is enacted, this hearing is an opportunity to focus on the issues that state insurance regulators will need to keep in mind in drafting these models and assisting state insurance departments to meet the probable implementation deadlines, including policy goals that should be pursued and unintended consequences that should be avoided.

- Schiffbauer Law Office

William G. Schiffbauer (Schiffbauer Law Office) provided an overview of the pending federal health care reform legislation. He noted that the legislation continues to exclusively rely on state insurance laws for licensure and to ensure financial stability and solvency of insurers. The legislation, however, imposes new federal standards related to marketing, unfair practices and the accessibility, affordability and content of health insurance products. Mr. Schiffbauer said the legislation pending in the U.S. Senate integrates insurance reforms into the current structure established by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The pending legislation also establishes a free-standing structure for the insurance exchange provisions instead of amending the existing structure established by HIPAA. The legislation pending in the U.S. House of Representatives has a similar structure. The House legislation, however, establishes a new, federal Health Choices Commissioner; and generally, establishes a federal regulatory structure for the implementation and enforcement of the legislation's provisions if enacted. Mr. Schiffbauer highlighted aspects in the pending legislation that were ambiguous and urged that they be resolved prior to enactment to avoid implementation problems, including: 1) too tight effective dates; 2) unclear delegation of implementation and enforcement responsibilities; 3) state preemption ambiguities, and 4) ambiguities in the scope of duties.

Commissioner Michie asked Mr. Schiffbauer if he had shared his working paper highlighting these problems with Congressional staff working on the health care reform legislation. Mr. Schiffbauer said not at this point in time. He added that he would welcome comments on his paper from state insurance regulators. Commissioner Ario said he found Mr. Schiffbauer's paper to be useful, but asked that he provide additional information on the specific tasks the states would have to complete and the timeframe within which they would have to complete them.

- National Hemophilia Foundation

Sally B. McCarty (National Hemophilia Foundation) described the daily challenges for those with hemophilia, including managing the disease and obtaining treatment. She also noted current problems they face with their health care coverage, such as lifetime caps and benefit limits. Ms. McCarty said these families need more options. They are hungry for information on how to get access to affordable coverage and are hopeful that health care reform legislation will be enacted that will provide this access. Ms. McCarty said these problems are not unique for those with hemophilia. She said state insurance departments will be the primary source of information for consumers if federal health care reform legislation is enacted. As

such, state insurance departments should be prepared and open channels of communication to consumers in their state. She suggested that state insurance departments assign staff to create a database of consumer representatives and media groups in their state to facilitate this communication. Commissioner Praeger said there have been discussions at the NAIC to bring consumer representatives from various groups together to train them on the key aspects of any enacted legislation. These consumer representatives would then give this information to consumers. Commissioner Praeger characterized this possible training initiative as a "train the trainer" program.

- Consumers Union

Sondra Roberto (Consumers Union) applauded the NAIC for initiating discussions about how the proposed federal health care reforms will impact the states even before legislation is passed. She urged the Committee, in thinking about what states will need to do to implement reform, to adopt a simple criterion: "What is best for consumers?" Ms. Roberto focused on three key concepts that Consumers Union views as critical if health care reform is to fulfill its promise of providing health insurance: available, affordable and high quality.

First, the NAIC and the states will need to maintain and improve transparency, both during and after implementation. Under the bills now before Congress, state legislatures and agencies might be required to enact laws and regulations to carry out many important elements of reform and conform their health care systems to federal standards and requirements. The bills call on the NAIC and state insurance regulators to consult with federal regulators to create standards and, in some instances, develop model laws or rules to effectuate reform. The NAIC, state legislatures and state agencies must carry out these functions in an open manner that seeks input from the public, including consumer groups and individuals, as well as other stakeholders. Consumers must be kept informed about the process and how proposed measures might affect them in the new health insurance marketplace. Ms. Roberto said any proposed new models or revisions to existing models should be well-publicized and presented with ample notice and opportunity for individuals and consumer advocacy groups to comment and lend expertise. She said that NAIC working groups or committees should have consumer representation and meetings should be open. The analysis and positions of the NAIC and state officials should be disclosed, and proposed or enacted model laws and rules must be free and obtainable by any interested party. In developing guidelines, standards or models, Ms. Roberto urged the NAIC to follow a process similar to the one used for defining Medigap standard benefit packages in the 1990s.

Ms. Roberto said the second important task for the states in implementing reform will be to help consumers efficiently purchase insurance and connect to the programs and services they need. Under the bills now before Congress, Americans might be required to purchase health insurance for the first time. This mandate will make it imperative for the states to help consumers access the market and make sound decisions. She said that, if the NAIC and state officials are called upon to help develop standards and uniform definitions for health plan materials, they should work to make purchasing health insurance easy—not just easier. This means making information understandable, relevant, and evaluable – in other words, consumers must be able to easily rank their choices from best to worst. Health plan materials should emphasize the information most important to consumers, such as out-of-pocket costs and access to doctors and specialists. Finally, consumer-education programs should be put in place as soon as possible in order to avoid the spread of misinformation. The states should work with consumer groups to make fact sheets and educational forums available so that individuals and employers are prepared for the changes that health care reform will bring. These resources must be highly publicized if they are to accomplish their intended goal.

Finally, Ms. Roberto said the states will need to increase regulation and enforcement of existing and new consumer protections in anticipation of insurer efforts to segment the market and capture market share using product diversity, rather than by competing on price and quality. State insurance regulators will need to monitor the market closely to ensure that essential benefit requirements are being adhered to, and insurers and broker/agents are not finding new ways to steer higher risk consumers away from their plans. Ms. Roberto said the states must more vigorously regulate premium increases. She said that, as part of reform, rate review processes should be more uniform, transparent and robust.

- AARP

Cheryl Matheis (AARP) expressed disappointment that the NAIC does not support 2:1 age rating. Using age as a proxy for either income or health status is wrong and would have the effect of pricing many older consumers out of the market. Ms. Matheis also expressed disappointment that the NAIC does not support efforts to include the Community Living Assistance Services and Supports (CLASS) plan in the pending federal legislation. She noted that all of the pending health care legislation assigns to the NAIC certain tasks — to consult, make recommendations or develop standards and criteria. She said some of these provisions appeared to verge on delegating to the NAIC de facto regulatory authority, effectively specifying that NAIC recommendations will be incorporated into federal regulations. Ms. Matheis acknowledged the NAIC's expertise, but said the prospect of effectively delegating regulatory authority to a nongovernmental entity is unsettling. Given this, she

urged the NAIC to utilize an open, transparent process in the development and vetting of NAIC products related to health care reform implementation. Ms. Matheis said this should go beyond holding open public hearings. The NAIC should ensure that working group meetings and hearings are open and held in locations where key consumer groups can effectively participate. The NAIC also should provide financial assistance when necessary for full participation of consumers. In addition, she said the NAIC should maintain a public record of proceedings, including the rationale for decisions that are made concerning whether to incorporate comments on draft proposals. The support and confidence of consumers will be critical to the successful implementation of this legislation, and a key ingredient will be making decisions in an open and transparent process that is responsive to consumer concerns. Ms. Matheis said that if health care reform is enacted, it would mean for nearly all Americans the first time they will be required to purchase health insurance. Consumers will legitimately expect to experience few hurdles in the process of purchasing and using this newly mandated insurance. She said state insurance regulators are in a good position to take a leadership role in their states to ensure this is the case. Ms. Matheis said that, perhaps the most important implementation task where the NAIC's expertise will be critical, is identifying strategies to mitigate against adverse selection in the new health insurance market. Ms. Matheis expressed her organization's desire to work with the NAIC and all stakeholders to ensure implementation of the health insurance market provisions of any federal health care reform legislation provides consumers meaningful, affordable coverage options. Commissioner Praeger said that, in order to encourage as much public participation as possible in the NAIC process, one possibility would be for the NAIC to hold public hearings related to its implementation activities in each of the NAIC zones. Commissioner Ario assured Ms. Matheis that the NAIC's process will be transparent. Commissioner Holland said that, in her state, the greatest challenge has been getting consumers focused on the issue. As such, she is hoping that as the NAIC and individual state insurance regulators in their implementation activities can partner with consumer organizations to get consumers more engaged.

- American Medical Association

Cecil Wilson (American Medical Association—AMA) noted the problems in the current health care delivery system. Patients are denied coverage for pre-existing conditions or are being told that their cancer or other serious medical condition cannot be treated because their coverage is capped. He said regulatory and administrative burdens for physicians have increased year after year. With these concerns in mind, Dr. Wilson said the AMA is using seven main health care reform principles to guide its efforts at both the federal and state levels. In reviewing the NAIC's health care reform principles, he said the AMA has a great deal in common with the NAIC. Dr. Wilson highlighted several issues that he hoped the NAIC would pay close attention to as the health care debate moves forward, which included: 1) health insurance exchanges and sales of health insurance across state lines; 2) adequate physician supply; 3) insurer market concentration; and 4) medical liability reform.

- Morris, Manning & Martin, on behalf of Delta Dental

Chris Peterson (Morris, Manning & Martin) noted that, although no legislation has been enacted, there could be implementation issues with the type of dental benefit to be included in the essential benefits package as outlined in the pending federal health care reform legislation. Mr. Peterson highlighted several NAIC models that would be impacted by the pending federal health care reform legislation's provisions related to this provision, including the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171), the *Coordination of Benefits Model Regulation* (#120), and the *Small Employer Health Insurance Availability Model Act* (#118). Mr. Peterson reiterated Mr. Schiffbauer's comments concerning the tight implementation timeframes provided in the pending federal health care reform legislation.

- America's Health Insurance Plans

Randi Reichel (America's Health Insurance Plans—AHIP) suggested that, given the number of tasks assigned to the NAIC in the pending federal health care reform legislation, the NAIC should not wait until its 2010 Spring National Meeting to begin work on implementation. It should have a process in place to enable it to move as quickly as possible if legislation is enacted. To facilitate this, Ms. Reichel suggested that the Committee should continue into 2010 instead of terminating in accordance with the NAIC Bylaws. She agreed with other speakers that the NAIC the process used to develop the Medigap model should be duplicated to develop or revise any NAIC models that may be necessary as a result of the federal health care reform legislation. Ms. Reichel said AHIP found the provision establishing a federal rate review process in the pending federal health care reform legislation troubling. She said this provision would duplicate processes at the state level and could result in regulatory confusion. Ms. Reichel also pointed out the proposed provision in the pending federal health care reform legislation requiring the NAIC to develop medical loss ratios. She urged the NAIC to work with industry to accomplish this task, noting that there is no need to "reinvent the wheel."

- Blue Cross and Blue Shield Association

Joan Gardner (Blue Cross and Blue Shield Association—BCBSA) noted her organization's long-standing support for the passage of bipartisan health care reform legislation. She said BCBSA is pleased that the pending health care reform legislation recognizes the need to bring everyone into the system, with subsidies to help make coverage affordable. However, many provisions included in the legislation have unintended consequences that could undermine the goals of reform and could make health care coverage unaffordable for millions of people. Ms. Gardner urged the NAIC to take the opportunity, as the legislation is still pending, to speak out on the consequences of problematic provisions and recommend improvements that would ensure greater access to more affordable coverage. She highlighted those provisions in the pending legislation, such as the individual mandate, age rating and benefit design requirements, and provided recommendations for addressing them. Ms. Gardner noted the implementation issues for the states and the NAIC regarding those provisions. She also expressed support for Ms. Reichel's and Mr. Peterson's comments. Commissioner Dilweg said that state insurance departments will need the support of industry to enforce the individual mandate. Commissioner Michie said Utah has been discussing with Colorado the possibility of entering into an interstate compact for the interstate sale of health insurance. He asked whether insurers would sell policies across state lines if such compacts are established. Ms. Reichel said insurers would sell across state lines if there is a market with understandable rules.

- Commonwealth Health Insurance Connector Authority

Jon Kingsdale (Commonwealth Health Insurance Connector Authority—Connector) advised that, in creating an insurance exchange, the first thing a state must do is decide which market—small group or non-group—the exchange needs to address first. He highlighted three concepts that states should keep in mind also when creating an insurance exchange: 1) deciding whether to hire or buy needed expertise; 2) keeping in mind that it is campaign; and 3) realizing that mistakes will be made. Mr. Kingsdale noted that, when the Connector started its operations, it engaged in a tremendous amount of public outreach. He said disseminating information to the public about the reforms was important to the Connector's success. Mr. Kingsdale recommended an article he wrote in May on the subject of implementing health reform in stages for *Health Affairs*—"Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned."

Commissioner Ario asked Mr. Kingsdale why the Connector appears to be working when similar initiatives have failed. Mr. Kingsdale noted two possibilities: 1) having a guaranteed base of membership that is attractive to insurers; and 2) prioritizing the need for coverage and focusing on that market. Mr. Link asked why the individual mandate worked in Massachusetts. Mr. Kingsdale said that, prior to its reforms, Massachusetts had a 2% uninsured rate; and the individual mandate requirements were phased-in. In addition, the Connector conducted a civic campaign for individuals to get health insurance coverage. Commissioner Holland asked about the cost to establish the Connector. Mr. Kingsdale said the Connector received $25-million from the state; it also receives an administrative fee of about 3.75% of premium. The Connector broke even in the second year of its operations.

- National Association of Health Underwriters

Janet Trautwein (National Association of Health Underwriters—NAHU) focused her testimony on insurance exchanges. She noted that the NAIC and each state insurance department will play many important roles during the implementation of any federal health care reform legislation. Ms. Trautwein also noted that, while federal health care reform legislation could make significant changes in the way health insurance is rated, pooled, subsidized and sold, many of these ideas are ones that have already been tried. Specifically, the idea of creating a "connector" or insurance exchange was not a new concept. They were introduced in the early 1990s as purchasing pools and Health Insurance Purchasing Cooperatives (HIPCs). Ms. Trautwein said the NAIC should keep in mind the lessons learned from these past successes and challenges when debating and implementing these similar reform concepts. She said there are associated issues the NAIC needs to consider—such as risk-adjustment and reinsurance—to ensure long-term viability. Ms. Trautwein said policymakers should be aware of two forms of adverse selection: 1) consumers who wait until they are sick to purchase health coverage; and 2) consumers who purchase coverage inside and outside the exchange.

Ms. Trautwein said both the House and Senate health care reform bills contain reinsurance provisions. The Senate's legislation calls for the establishment of a federal government-funded $5 billion interim reinsurance mechanism to assist the uninsured with pre-existing conditions, which might utilize the existing state high-risk pool structures. In 2014, high-risk individuals benefiting from this assistance will be transitioned to the insurance exchanges; and no additional funding will be provided. In lieu of this funding, the insurance exchanges are to assess participating insurers and their policyholders $25 billion over two years to stabilize exchange premiums. Ms. Trautwein expressed concern that this combination of events would increase most health insurance premiums. She suggested that federal reinsurance subsidies should continue after 2014

after the insurance exchanges begin operation. Ms. Trautwein also offered suggestions for making a reinsurance program work effectively.

Ms. Trautwein stated that she hoped that any federal health care reform legislation would empower the states to develop innovative models and not impose a "one-size-fits-all" approach that does not take into account the unique needs of each state. There should be flexibility in how insurance exchanges are structured and how subsidies flow through them. She also stated that she hoped Congress does not repeat mistakes that have been made in previous health care reform efforts.

- National Association of State Comprehensive Health Insurance Plans

Amie Goldman (National Association of State Comprehensive Health Insurance Plans—NASCHIP) said that early this year, when it became clear that national health care reform was a priority for Congress and the Obama Administration, NASCHIP began to formulate a series of proposals on how state high-risk pools could play a short-term and possible long-term role in health care reform. She said state high-risk pools are uniquely situated to provide expanded access to critical health care coverage for individuals with pre-existing conditions under a short timeframe with a relatively modest investment of federal funds during the years between passage of health care reform and implementation. Ms. Goldman highlighted two distinct advantages for state high-risk pools being the best option for expanding coverage beginning in 2010, when health care reform legislation is likely to be enacted: 1) state high-risk pools can be a single statewide point of entry for the uninsurable in the 35 states with pools; and 2) state high-risk pools are a proven approach for expanding coverage for high-risk individuals in those states without a high-risk pool. Ms. Goldman expressed concern about the current funding level in both the Senate and House bills for high-risk pools. NASCHIP believes that the $5 billion included might be insufficient. Ms. Goldman said that in order to ensure that the limited federal funding makes coverage accessible and affordable for those who need it during the transition period, NASCHIP recommends that the final conference language reflects the following: 1) individuals who lose coverage through no fault of their own would not be required to go without coverage for six months before becoming eligible for coverage through a state high-risk pool; 2) state high-risk pools should be required to implement administrative policies and procedures to ensure that applicants are both uninsured and uninsurable; and 3) the Secretary of the U.S. Department of Health and Human Services (HHS) should be authorized to use the available funding to reduce premiums under existing state high-risk pools or create or expand low income subsidy programs.

- American Academy of Actuaries

Shari Westerfield (American Academy of Actuaries—AAA) focused her testimony on the following implementation issues that would likely result from the enactment of federal health care reform legislation: 1) the development and filing of new policy forms and rates; 2) the implementation and/or oversight of multiple risk-sharing mechanisms; 3) changes in market dynamics and risks impacting solvency standards; and 4) changes in financial reporting needs. She said both the Senate and House bills define minimum benefit standards for all plans available post-reform, impose tighter rating and underwriting rules and specify pooling requirements. Ms. Westerfield said these provisions will require the re-filing of all policy forms and rates prior to the effective date of the new standards, which would be either 2013 (House) or 2014 (Senate). She noted that the NAIC individual health rate filing guidelines would likely need major revisions that would need to be completed in a timely manner to allow sufficient time for insurers to submit and state insurance departments to review all of the filings.

Ms. Westerfield said both the House and Senate bills contain provisions for risk-sharing mechanisms, based on risk adjustors, to mitigate adverse selection in the guaranteed issue individual and small group markets. She noted that the NAIC would likely assist federal regulators in developing and implementing the methodology and criteria for assigning risk scores and for collecting and distributing funds to and from insurers. Ms. Westerfield said the Senate bill also includes a provision for a transitional reinsurance program that identifies high-risk individuals whose claims are to be partially reimbursed by funds to be assessed on all health insurers. She said it is likely that the NAIC would be tasked to coordinate with the Secretary of HHS to develop and implement the program at the state level. Ms. Westerfield said that, given the complexities of the pending health care reform legislation, state insurance regulators could witness changes in market dynamics. She noted that changes within the marketplace, coupled with new health insurance reforms and rating and underwriting restrictions on insurers, most likely would affect the risks of the business of health insurance. As such, NAIC solvency standards would need to be updated to reflect these changing risks; specifically, underwriting risk factors and other market risk factors would need to be reviewed. Ms. Westerfield highlighted the provisions in the House and Senate bills that could necessitate changes in the current annual statement reporting requirements. In conclusion, she noted that the issues she has raised are only a few of the challenges facing the NAIC if federal health care reform legislation is enacted.

Commissioner Praeger acknowledged how valuable all of the testimony provided will be for NAIC and the individual state insurance departments in identifying the implementation challenges that may be faced if federal health care reform legislation is enacted.

2. Adoption of Nov. 9 Conference Call Minutes

Commissioner Ario motioned, and Commissioner Lindeen seconded, to adopt the Nov. 9 conference call minutes (Attachment One). The motion passed unanimously.

3. AMA Presentation

Catherine Hanson (AMA) testified about the AMA's state legislative campaign called the "AMA Campaign to Secure Meaningful and Transparent Health Care Benefits" (Attachment Two). She outlined the seven major components of this campaign, which include the enactment of the following legislative proposals: 1) Health Insurance Premium Transparency Act; 2) Truth in Out of Network Health Care Benefits Act; 3) Network Standards Act; 4) Accurate Provider Directories Act; 5) Honoring Patients' Assignment of Benefits Act; 6) An Act Concerning the Treatment of Physicians by Third Party Payers; and 7) National Conference of Insurance Legislators (NCOIL) Rental Network Contract Arrangements Model Act. Ms. Hanson said that if these legislative proposals are enacted, the AMA believes they will address the unfairness and lack of transparency that pervades the health insurance marketplace. Commissioner Ario noted that the legislative proposals included not only disclosure of insurer charges, but also provider charges. He noted the difficulties experienced by consumers related to out-of-network charges for services provided in in-network hospitals. Ms. Hanson said the vast majority of in-hospital providers want to contract with insurers due to the administrative complexities of billing patients directly for services provided. However, she suggested that, in some large markets where there are no contracts with in-hospital providers, it could be result of unfair contracts being offered. Ms. Hanson suggested that, alternatively, this situation could be addressed by: 1) making sure there are adequate provider networks; and 2) making sure provider directories indicate which providers are in-network. The key is more transparency. Commissioner Morrison noted that one component of the AMA's campaign would be to establish a complaint process for physicians to use for inappropriate third party payer activities. It suggests that the states can establish such a complaint process utilizing the existing patient complaint processes. Commissioner Morrison asked how to establish such a compliant process, given the additional costs likely to be incurred. Ms. Hanson said the AMA has not looked at the costs but, anecdotally, it appears the costs would be minimal. She also stressed the importance of including physicians in the patient compliant process. Commissioner Michie said Utah has this information and would provide that information to NAIC staff. Commissioner Ario noted that the problem with permitting providers to complain to state insurance departments occurs when the provider has a payment issue with the insurer.

4. Health Care Reform Discussion

Josh Goldberg (NAIC) referenced the presentation he gave on pending federal health care reform legislation at the Government Relations (EX) Leadership Council meeting. He said the U.S. Senate hopes to finish debate and pass its bill by Dec. 23. Congress' long-term goal is to have a bill ready for President Obama to sign before the State of the Union address. Commissioner Lindeen asked whether the Committee or some other NAIC group would be the key group at the NAIC charged with implementing any enacted federal health care reform legislation. Commissioner Praeger said she anticipated that most of the work would involve this Committee and its task forces. She said she has already spoken with NAIC officers in anticipation of increased budget needs related to the additional tasks that the Committee would have to complete to assist state insurance departments with implementation if federal health care reform legislation is enacted. Commissioner Praeger said she has already begun thinking about the process and anticipates that the Committee's first task will be to prioritize the work that would need to be done.

Commissioner Michie noted that this would be his last NAIC meeting. He expressed frustration on the ability to accomplish much of anything in the health care area. Commissioner Michie noted that this is most likely because health care delivery is different in each state. He directed the Committee's attention to a paper he prepared for the Utah Advisory Commission to Optimize State Government that outlines his solution for achieving comprehensive health care reform. His solution centers on creating the Utah Health Cooperative, a separate legal entity that utilizes a self-insured concept. Commissioner Praeger acknowledged Commissioner Michie's efforts. She agreed that expanding access to health insurance coverage without addressing the underlying problem of health care cost may be problematic in the long-term.

5. Consider Adoption of Task Force Reports

a. Regulatory Framework (B) Task Force

Commissioner Kipper said the Regulatory Framework (B) Task Force met Dec. 7. During this meeting, the Task Force adopted its Oct. 13 conference call minutes. It also received an update from a representative of the U.S. Centers for Medicare and Medicaid Services (CMS) on the status of regulations and other implementation activities related to the federal Paul

Wellstone and Pete Domenici Mental Health Parity and Addition Equity Act of 2008 (MHPAEA) and the Genetic Information Nondiscrimination Act of 2008 (GINA).
Commissioner Kipper said the Task Force reviewed a draft Rescission Data Call Report. The draft report is based on data received from 52 companies in the individual market that made up the top 80% of covered lives and 75% of premium volume in the marketplace. Commissioner Kipper said the data call revealed that there were about 27,246 rescissions out of a sampling size of about 6.7 million issued policies. He said this translates into a rescission rate of 3.7 rescissions for every 1,000 policies/certificates that were written between 2005 and 2008. Commissioner Kipper noted that the data call also revealed that the rate of rescissions peaked in 2005 and was at its lowest in 2008. He said the Task Force intends to hold a conference call sometime prior to the end of the year to discuss next steps regarding the draft report.

Commissioner Kipper said that during the Task Force's Oct. 13 conference call, the Task Force adopted the revisions to the *Uniform Health Carrier External Review Model Act* (#76). The revisions add four new appendices: 1) a model notice of appeal rights; 2) a model external review request form; 3) a model independent review organization external review annual report form; and 4) a model health carrier external review annual report form. Commissioner Kipper said these model notices and forms were developed to provide additional guidance to the states regarding what information should be included in such notices and forms. Therefore, the revisions are to be adopted as guidelines and only require a majority vote of the Committee members for adoption. Mr. McAndrew motioned, and Commissioner McCarty seconded, to adopt the Regulatory Framework (B) Task Force report, which included adoption of its Oct. 13 conference call minutes and the adoption of the revisions to the *Uniform Health Carrier External Review Model Act* (#76). The motion passed unanimously.

b. Senior Issues (B) Task Force

Ms. Senkewicz said the Senior Issues (B) Task Force met Dec. 6. During this meeting, the Task Force received an update on the Long-Term Care Partnership program. There are now partnership policies available for sale in 31 states. State plan amendments have been approved in five additional states. The Task Force discussed state implementation of revisions to the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651), as required by GINA and the Medicare Improvements for Patients and Providers Act (MIPPA). Forty-eight jurisdictions (including Puerto Rico and the District of Columbia) have adopted the revisions. Three states are waived from the federal requirement. One remaining state is moving quickly toward final adoption, pending approval from the state legislature. The Task Force received a report from the NAIC-CMS policy group, which includes CMS senior official representatives and Task Force members (Florida, Illinois and Wisconsin). The policy group held a conference call Nov. 18, during which the group discussed issues of mutual interest. It is anticipated that this group will continue to hold regular conference calls and may meet in person again in 2010. The Task Force received a report from a CMS representative on Medicare supplement issues, including a verbal overview of a pending response letter from the CMS Administrator regarding Medicare supplement hospital network arrangements. This letter reportedly states that CMS believes there is no federal authority to block such arrangements, but states continue to have the authority to disapprove them. Ms. Senkewicz said task Force members expressed concern about CMS' response and will consider developing additional guidance for state regulators. The Task Force received a report from a CMS representative on Medicare private plan issues. This month, nonrenewal notices will be sent to 412,000 beneficiaries for Medicare Advantage and Medicare prescription drug plans that are not renewing their contracts for 2010. Ms. Senkewicz said NAIC staff provided a federal update on pending federal action regarding Medicare supplement insurance, Medicare private plans and long-term care that are being considered as part of health care reform legislation. Ms. Senkewicz said the Task Force received a report from the Accident and Health Working Group of the Life and Health Actuarial Task Force on their work on Medicare supplement and long-term care insurance issues. Commissioner McCarty motioned, and Commissioner Ario seconded, to adopt the Senior Issues (B) Task Force report. The motion passed unanimously.

6. Adoption of the Accident and Health Working Group of the Life and Health Actuarial Task Force Report

Mr. Ostlund said the Accident and Health Working Group of the Life and Health Actuarial Task Force met Dec. 4. The Working Group adopted modifications to the Actuarial Opinion section of the Health Annual Statement Instructions for 2010. The Working Group discussed VM-25, the section of the valuation manual for health insurance. The Working Group decided to continue the discussion of VM-25 on a future conference call. Mr. Ostlund said the Working Group decided to modify the Medicare Supplement Compliance Manual to state that Medicare supplement plans of the same letter should be pooled for rating purposes. The Working Group appointed a subgroup to review several proposed changes to the Accident and Health Policy Experience Exhibit. Mr. Ostlund noted that the Life and Health Actuarial Task Force volunteered the actuarial services of the Working Group to work with the newly created Long-Term Care (EX) Task Force, which met for the first time Dec. 6. Commissioner McCarty motioned, and Mr. McAndrew seconded, to adopt the report of the Accident and Health Working Group. The motion passed unanimously.

7. Any Other Matters

Mara Osman (URAC) informed the Committee that URAC had completed the development of a new Uniform External Review (UER) Accreditation Program. The program is designed to help utilization management organizations, third-party administrators and other health benefit plans demonstrate compliance with the *Uniform Health Carrier External Review Model Act* (#76). Ms. Osman said she would forward detailed information and a copy of the UER standards to NAIC staff for distribution to the Committee.

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

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Drafted: 11/19/09

Health Insurance and Managed Care (B) Committee
Conference Call
November 9, 2009

The Health Insurance and Managed Care (B) Committee met via conference call Nov. 9, 2009. The following Committee members participated: Sandy Praeger, Chair (KS); Joel Ario, Vice Chair, represented by Shelley Bain (PA); Marcy Morrison represented by Peg Brown (CO); Kevin M. McCarty represented by Mary Beth Senkewicz and Eric Lingswiler (FL); Michael T. McRaith represented by Bill McAndrew and Josef Weimholt (IL); Carol Cutter (IN); Ralph S. Tyler, III, represented by Brenda Wilson (MD); Monica Lindeen (MT); Kim Holland (OK); Paulette Thabault (VT); and Jane L. Cline represented by Tim Murphy (WV). Also participating were: Joe Musgrove and Dan Honey (AR); Maria Chavira (AZ); Mary Ellen Breault (CT); Joan Krosch (ID); Glenn Griswold (ME); Ted Hamby (NC); John Rink and Martin Swanson (NE); Scott J. Kipper (NV); Austin Rinella and John Chaskey (NY); Teresa Miller (OR); Randy Moses (SD); Shawn Hawk (TN); and Guenther Ruch (WI).

1. Adoption of Appendix E Revisions to *Long-Term Care Insurance Model Regulation* (#641)

Ms. Senkewicz said the Appendix E revisions to the *Long-Term Care Insurance Model Regulation* (#641) were a result of a data call conducted in 2008 jointly by the Senior Issues (B) Task Force and the Market Regulation and Consumer Affairs (D) Committee. The results of the data call revealed that companies were using different definitions for terms in reporting data on the Appendix E – Claims Denial Reporting Form. Ms. Senkewicz said the Appendix E Subgroup determined that an equal proportion of companies were using one of two different methodologies to report claims denial information: per claimant and per transaction. The companies that count per claimant count each individual who makes one or a series of claim requests, whereas companies that count per transaction count each claim payment request. The industry reported that it would be difficult for companies to change methodologies and that there was no one dominant method being used. Given this, Ms. Senkewicz said, the revisions to the form permit companies to use either methodology, but require that they specify which method was used. The revisions also include two other Subgroup-recommended changes to make Appendix E more useful to regulators, including the reporting of the total number of in-force policies, as well as the deletion of a drafting note after Section 15F of the model regulation that limits the definition of "claim denied used" in this form to reporting purposes as provided in the federal Health Insurance Portability and Accountability Act (HIPAA). Ms. Senkewicz motioned, and Mr. McAndrew seconded, to adopt the revisions to the *Long-Term Care Insurance Model Regulation* (#641). The motion passed unanimously.

2. Adoption of Regulatory Framework (B) Task Force Report

Commissioner Kipper said the Regulatory Framework (B) Task Force met via conference call Oct. 13. The Task Force adopted its proposed 2010 charges. Commissioner Kipper said the Task Force adopted the revisions after discussion of the comments received on the draft external review model forms to be added to the recently adopted *Uniform Health Carrier External Review Model Act* (#76). The Task Force will present the revisions to the Health Insurance and Managed Care (B) Committee for its adoption at the Winter National Meeting. Commissioner Kipper said the Task Force received an update on the survey sent to companies concerning the issue of rescissions in the individual market. He said the Task Force held an organizing conference call Aug. 28 with the impacted states. During the call, it was agreed that the states would send the data call to their domiciliary companies during the first week of September, giving companies 30 days from the date of their letter to submit the requested data. After a state received the data, it was to forward the data to the NAIC. Commissioner Kipper said the Task Force anticipates receiving a preliminary report on the data call at the Winter National Meeting. The Task Force received an update on the drafts of revisions to three NAIC models impacted by the federal Genetic Information and Nondiscrimination Act of 2008 (GINA) and the special enrollment provisions in the State Children's Health Insurance Program (SCHIP). Commissioner Kipper said that, given the possibility that potential federal health care reform legislation could impact these models, the Task Force decided to delay taking action on these models until final action is taken by the U.S. Congress. The Task Force received the report of the ERISA (B) Subgroup. The Subgroup met in regulator-to-regulator session to discuss ongoing federal and state investigations into unauthorized MEWAs. Ms. Senkewicz motioned, and Commissioner Holland seconded, to adopt the Regulatory Framework (B) Task Force report. The motion passed unanimously.

3. Update on Federal Health Care Reform Legislation and Discussion of Health Care Reform Public Hearing

Brian Webb (NAIC) said that on Nov. 7, the U.S. House of Representatives passed their health care reform bill, HR 3962 – Affordable Health Care for America Act. The bill will now go to the U.S. Senate for its consideration. Mr. Webb said the U.S. Senate is continuing to work on its own legislation. He said that Senate Majority Leader Harry Reid (D-NV) is hoping to receive the Congressional Budget Office (CBO) report scoring the combined U.S. Senate legislation this week in order to begin debate on the legislation. Mr. Webb said the question is whether the U.S. Senate will be able to pass a bill with sufficient time to conference with the U.S. House of Representatives in order to enact federal health care reform legislation by the end of the year.

Mr. Webb said that, as discussed during the Committee's last conference call, the Committee will be holding a public hearing on health care reform Dec. 4 at the Winter National Meeting. He said the purpose of the public hearing is to hear testimony on any implementation issues that state regulators should consider if federal health care reform legislation is enacted. Mr. Webb said that, to date, he has received requests to testify from America's Health Insurance Plans (AHIP), BlueCross and BlueShield Association (BCBSA), NAIC funded consumer representatives, AARP, American Medical Association (AMA), National Association of Health Underwriters (NAHU), American Academy of Actuaries (AAA) and National Association of State Comprehensive Health Insurance Plans (NASCHIP). Commissioner Praeger said that it was important for key stakeholders to be represented at the hearing. She suggested that a representative from the Utah and the Massachusetts exchanges be invited to testify. Mr. Webb said AAA wanted to discuss implementation issues related to transitioning from the old to the new rating rules. He suggested that if NASCHIP testifies, its testimony should be limited to implementation issues, because NASCHIP already gave a briefing on its Health Reform Transition Proposal to the Committee at the Fall National Meeting.

Mr. Ruch suggested that the public hearing include a discussion of purchasing health insurance across state lines. Mr. Webb asked whether Mr. Ruch was referring to a provision in the current federal health care reform legislation or the interstate compact for health insurance proposal suggested by Minnesota Gov. Tim Pawlenty. Mr. Ruch said that he was referring to the provision in the proposed federal legislation. Chris Petersen (Morris, Manning & Martin, LLP) said the Georgetown University's O'Neill Institute for National and Global Health Law recently held a conference on health care reform issues and released papers on health insurance exchanges and the purchase of health insurance across state lines. Commissioner Holland suggested the testimony include information on cooperatives and the interstate compact for health insurance, because these concepts were included in all of the proposed federal health care reform legislation. Commissioner Praeger noted that the purpose of the hearing was to prepare the NAIC and state regulators for what they might be required to do if such legislation is enacted. She suggested that there be some discussion of health care cost control or cost containment. Commissioner Holland expressed support for such a discussion, but suggested that this issue could be the subject of another public hearing, possibly at the 2010 Spring National Meeting. Commissioner Thabault said Vermont has done some work in that area related to its medical home concept. Commissioner Praeger suggested that a presentation on this concept could be added to the Committee's agenda for the Winter National Meeting.

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

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STATEMENT
OF THE
AMERICAN MEDICAL ASSOCIATION

National Association of Insurance Commissioners
Health Insurance & Managed Care (B) Committee
December 7, 2009

Catherine I. Hanson, JD
Vice President
Private Sector Advocacy and Advocacy Resource Center
American Medical Association

I. INTRODUCTION

Good afternoon. My name is Catherine Hanson. I am the Vice President of Private Sector Advocacy and the State Advocacy Resource Center at the American Medical Association (AMA.) I have been working on health care issues for nearly 30 years and have been particularly involved with helping physicians on managed care related issues. On behalf of the AMA, I'd like to thank this Committee for allowing me the opportunity to testify and for your interest in establishing a more transparent, fair and administratively efficient health care system.

I am here today to elaborate on the AMA's concrete solutions to the problems that currently plague the health insurance industry. We recognize that innovative solutions must be offered to policymakers to fix these problems. Over the past year the AMA has developed a multifaceted state legislative campaign that we've titled the "AMA Campaign to Secure Meaningful and Transparent Health Care Benefits." There are seven major legislative components to this campaign, which I will outline for you today. If enacted, we believe these legislative proposals will address the unfairness and lack of transparency that pervade the health insurance marketplace. We have and will continue to promote this approach through our state medical associations, many of which have expressed considerable interest in pursuing this agenda in the upcoming state legislative sessions. We are committed to promoting the consumerism, fairness and transparency of health care information which will be required by all the health care reform proposals on the table, and welcome your suggestions to help us improve this campaign.

II. AMA APPROACH

A. Principles of the AMA State Advocacy Campaign to Promote Meaningful and Transparent Health Care Benefits

The AMA supports solutions that attack the root source of the health insurance related problems facing patients. The AMA approach would address these root causes by requiring major changes to address the following issues:

- **Patients must understand what they are buying:**
  - Health insurers must clearly disclose the scope and limitations of the benefits they provide, including any out-of-network benefit, in language that is meaningful to the average consumer. Consumers must have a clear understanding of how their premium dollars are spent.

- **Health insurance benefits must not be illusory:**
  - Health insurance premiums must reasonably reflect the actuarial value of the out-of-network benefits provided, and out-of-network benefits must be paid at the level the health insurer has promised;

  - Provider networks must have enough physicians and other health care providers, including emergency and other hospital-based physicians, to ensure that patients are able to obtain timely access to necessary medical and emergency care near where they work or live. Patients should go out-of-network only if they choose to do so, not because there are not enough contracted physicians to meet their needs; and
  - Provider directories must be accurate and comprehensive, so that consumers have all of the information that they need relevant to the medical needs of themselves and their families. Provider directories must include information on hospital-based physicians, hospital affiliation, which physicians are accepting new patients, and which physicians are in a disfavored tier or out of network.

- **Patients must know what health care services cost:**
  - Physicians and other health care providers must provide transparent and understandable pricing information to patients.

- **Patients should control their benefits:**
  - Patients' decisions to assign their health insurance benefits must be honored by health insurers.

- **Insurance Commissioners should have more access to complaints:**
  - Physicians and patients must have a right to bring concerns directly to insurance regulators.

B. AMA- Supported Solutions: Model Legislation

The AMA is committed to working with our state medical associations to advance a comprehensive state legislative

campaign to achieve these objectives. The AMA believes that enactment of the following model legislation would bring welcome transparency, understandability and fairness to an industry that has been marked by secrecy, confusion and broken promises. Moreover, by building on work already done by health insurance actuaries and modern internet technologies, these bills do not impose undue costs on either health insurers or state Insurance Departments.

- **Health Insurance Premium Transparency Act:**
  - Health insurance is too expensive and too important to be confusing. Full transparency of how health insurance premiums are spent is necessary to empower consumers to make informed purchasing decisions and to reward health insurance companies that minimize administrative waste. To permit comparison shopping, health insurer expenditures on profit and on administrative, non-medical costs (salaries and bonuses, advertising, utilization review, etc.) which are already evaluated by health insurer actuaries, must be made transparent to the public, based on a single standard definition and reporting mechanism.

  - A minimum medical expense threshold is necessary to maximize the value of health insurance premiums. This is an important step toward controlling spiraling health care costs, which are due, in part, to the dramatic rise in administrative costs and insurer profits.

  - By addressing these issues, this model legislation will enable consumers to shop intelligently for health insurance and ensure that they are getting value for their premium dollars.

- **Truth in Out of Network Health Care Benefits Act:**
  - Although 70 percent of privately insured Americans choose more expensive health insurance coverage that offers access to both in-network and out-of-network physicians,[1] the market for out-of-network benefits has been plagued by incomprehensible terminology, a lack of pricing information and wide-spread claims' settlement abuses.

  - To ensure that consumers receive the benefit of the higher premiums they pay for and the full coverage of services provided by non-contracted physicians and other health care providers, health insurers must clearly disclose the scope and limitations of any out-of-network benefit they purport to provide, in language that is meaningful to the average consumer.

  - Physicians and other health care providers that have not contracted with a patient's health insurer to provide discounted services must disclose their retail charges.

  - Consumers must be able to determine what their personal financial liability is likely to be when they choose to obtain out-of network services, and be reasonably assured that their claims will be settled fairly.

  - This model bill will address these problems by enabling consumers to compare health insurance policies offering coverage for out-of-network services, obtain meaningful estimates of their personal financial liability for out-of-network services, and ensure that they are getting value for their premium dollars.

- **Meaningful Access to Physicians and Other Healthcare Providers: Network Standards and Accurate Provider Directories Acts:**
  - A critical attribute of health insurance coverage is the actual network of contracted physicians and other health care providers, the "provider network." Inadequate provider networks deprive consumers of the benefit of the money they have paid for health care coverage, and undermine the public health and welfare by forcing consumers to reduce utilization of appropriate preventive services and forgo necessary medical care.

- **Network Standards Act:**
  - To meet consumers' reasonable expectations and maximize their welfare, health insurance benefits, including all medically necessary and emergency care, must be available at the preferred, in-network rate, on a timely and geographically accessible basis, to all enrollees. Consumers and insurance regulators need meaningful measures of network adequacy covering all aspects of the network. This includes emergency and other hospital-based physicians, and consideration of any tiering or other network restrictions.

[1] 2008 Kaiser/HRET Employer Health Benefits Survey

- In addition to subjective satisfaction data, there is a need for objective data on critical access metrics, such as the number of visits to out-of-network providers per thousand enrollees, the percent of services received from in-network providers as a percentage of total services received by enrollees, and the percentage of total costs for in-network and out-of-network services received by enrollees which were paid for by the health insurer. As health insurers' actuaries must evaluate the provider network to make premium determinations, these actuaries are positioned to provide reliable network reports to insurance regulators relatively efficiently.

- The AMA model legislation includes provisions designed to ensure that insurance regulators and consumers have access to the information necessary to determine whether the provider network includes a sufficient number of primary care and specialty physicians and other health care providers. Enrollees must be able to receive all covered services in a timely and geographically accessible basis at the preferred, in-network rate.

- **Accurate Provider Directories Act:**
  - To be able to assess the value of a health plan, consumers must have all of the provider network information relevant to the medical needs of themselves and their families, including whether their physicians and preferred hospitals are in or out-of-network and whether these physicians and hospitals are still accepting patients insured by the health plan.

  - To navigate increasingly complex health insurance products, consumers need access to a robust, up-to-date directory that covers all contracted health facilities and professionals, including hospital-based physicians. The directory must provide all information that may impact a consumer's financial responsibility when seeking medical care, including hospital affiliations, tiering arrangements, rental network relationships and out-of-network status. Moreover, this information needs to be easily accessible in an online, interactive map that allows consumers to search the provider network using their home or work address.

  - The model legislation includes provisions designed to ensure that consumers can easily access accurate and comprehensive information concerning the provider network in a format which is meaningful to their decisions.

- **Honoring Patients' Assignment of Benefits Act:**
  - One of the ways that patients can better control their health insurance benefits is to assign their benefits to their physician or other health care provider. An assignment of benefits occurs when an insured patient authorizes a third-party payment to be made directly to his or her physician for medical services rendered, irrespective of whether the physician is a participating or non-participating provider in the network.

  - Many patients choose to assign their benefits so that they need only pay the difference between the health care providers' charge and the amount of the insurance benefit rather than the full charge at the time of service, or having to worry about collecting from the insurer and then paying the medical bill.

  - The AMA's model bill requires insurers to honor patients' decisions to assign their health insurance benefits to their health care providers, rather than to disregard those decisions and instead pay the patient. Such refusals undermine patients' reasonable expectations, increase the administrative burden on patients and physicians and create unnecessary strife in the patient-physician relationship when the physician sends a bill that the patient thought was resolved by the assignment.

- **An Act Concerning the Treatment of Physicians by Third Party Payers:**
  - State Insurance Commissioners are becoming more involved in regulation of third party payers and nationwide insurance industry settlements. However, despite increased intervention, many violations remain unredressed.

  - The establishment of a meaningful complaint process for physicians to use for inappropriate third party payer activities, augmenting the complaint processes already in place for patient complaints, would significantly improve the ability of insurance regulators to learn of health insurance abuses. Because patients often do not recognize the substantial patient advocacy efforts that physicians make every day to obtain authorization for patients' medical care, let alone the challenges physicians face in getting paid, a complaint process exclusive to patients will likely understate the scope of the problems. However, most states do not have a formal process for physician complaints, and some state insurance departments will not accept physician complaints. This model legislation and complaint form will address this void.

In addition to these model bills, the AMA also encourages passage of the **NCOIL Rental Network Contract Arrangements**

Model Act.

III. CONCLUSION

In conclusion, I extend to you the AMA's commitment to work with the NAIC and this Committee in developing concrete solutions to improve the transparency and fairness of the health insurance marketplace. We are very pleased that the NAIC is interested in these issues. I appreciate the opportunity to provide our perspective and would be happy to answer any questions. Thank you.

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