

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
NASHVILLE, TENNESSEE
NOVEMBER 24, 2013
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Nashville Hilton Downtown in Nashville, Tennessee, on Sunday, November 24, 2013, at 8:00 a.m.

Rep. George Keiser of North Dakota, acting chair of the Committee, presided.

Other members of the Committee present were:

Rep. Ron Crimm, KY	Sen. David O'Connell, ND
Rep. Greg Cromer, LA	Rep. Bob Hackett, OH
Sen. Dan Morrish, LA	Rep. Brian Kennedy, RI
Rep. Pete Lund, MI	Sen. Mike Hall, WV
Sen. Jerry Klein, ND	

Other legislators present were:

Rep. Greg Wren, AL	Rep. Michael Stinziano, OH
Sen. Travis Holdman, IN	Sen. Robert Hayes, SC
Rep. Ken Goike, MI	Sen. Larry Taylor, TX
Sen. Carroll Leavell, NM	Rep. Kathleen Keenan, VT
Assem. Paul Aizley, NV	

Also in attendance were:

Susan Nolan, Nolan Associates, NCOIL Executive Director
Candace Thorson, Nolan Associates, NCOIL Deputy Executive Director
Jennifer Webb, Nolan Associates, NCOIL Director of Legislative Affairs–DC
Eric Ewing, Nolan Associates, NCOIL Director of Legislative Affairs

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 13, 2013, meeting in Philadelphia.

NEW MODELS OF CARE UNDER THE ACA

Susan Pantely of the American Academy of Actuaries (AAA) reported to the Committee on emerging models of healthcare delivery and payment under the Affordable Care Act (ACA). She said that new delivery systems seek to address the cost of healthcare by decreasing utilization through improvements in quality and efficiency. She said that the less desirable alternative is to reduce payments to providers.

Ms. Pantely said that the Open Systems model is the most familiar to patients today. She said that Open Systems allow patients to choose their provider, though they may need a referral from a primary care physician to see a specialist. She said that most Open Systems now have preferred provider networks and typically reimburse on a fee-for-service (FFS) basis. She said that the downside of the Open Systems model is that absence of coordination between providers can lead to duplicate services and other issues.

Ms. Pantely stated that the Patient-Centered Medical Home (PCMH) is one model developed in response to deficiencies in Open Systems. She said that PCMH is intended to be a wholly

patient-focused design where multiple providers and even the patient's family are involved in care. She said that PCMH makes use of technology, such as electronic medical records, to foster reporting, analysis, and communication between caregivers. She said that PCMH is particularly well-suited to people with chronic conditions because it promotes 24/7 communication with providers. She said that PCMH typically features per-member, per-month payments to a group of providers.

Ms. Pantely said that Accountable Care Organizations (ACOs) are similar to a PCMHs, but are comprised of providers that work together directly, either physician groups or physicians and hospitals. She said that interest in the ACO model has grown over the past several years, partly because it is written into the ACA, and there are now 200 ACOs in the Medicare Shared Savings Program as well as another 32 ACOs in the Pioneer Program. She stated that ACOs often set financial targets based on efficiency and quality of care. She said that although ACOs are made up of providers, they are also open-network, which places them at substantial risk if the patient sees a provider that is not part of the ACO. She said that some ACOs work on a FFS model, with bonuses or penalties for changes in cost or quality of care. She said that some ACOs are even moving toward a capitation model where they operate on a budget and bear full risk. The ACO keeps whatever money is left over at the end of the year, but they must make up for any shortfalls.

Ms. Pantely said that the Staff Model is most unlike today's healthcare system. She described it as a closed network where providers are paid on a salary basis. She pointed to Kaiser Permanente as an example. She said that Staff Model goal is similar to PCMHs in that it aims to coordinate care and remove the incentive to bill unnecessary services by moving away from FFS.

Ms. Pantely said that all of the new models raise challenges for actuaries, particularly in measuring quality and utilization in budget models as health needs change and consumers move in and out of the system. She said that new models, particularly ACOs, raise solvency concerns because they take on risk generally associated with insurance companies. She mentioned that a number of items not specific to any model of care, such as telemonitoring, are being integrated into new systems to further enhance cost savings and quality. She said that there is also a push to have more care handled by mid-level providers like nurse practitioners.

Discussing the evolution of various new models over the past several years, Ms. Pantely said that the real difference between today's models and the development of HMOs and PPOs in the past is that there are now better tools to monitor patients and measure data, whereas a number of HMOs lost money early on because they had little information and did not have the right analytic tools.

ACA-RELATED CONSUMER FRAUD

Tracey Thomas of the Federal Trade Commission (FTC) reported that although the FTC does not have jurisdiction over the business of insurance it is responsible for monitoring fraudulent activity related to the ACA. She said that the FTC maintains a database called the Consumer Sentinel Network that provides law enforcement with access to consumer complaints, as well as complaints shared by data contributors like consumer protection groups and other law enforcement agencies.

Ms. Thomas said that bad actors often use new government programs as a cover for scams, especially when consumers do not have complete information. She noted, for example, that scams seek to prey on seniors' fear of losing Medicare, so fraudsters may call a senior and

tell them that they need to get a new Medicare policy as part of the ACA, then “sell” the senior a fake policy. She said that fraudsters may also claim to be updating Medicare info and collect personal information, or they may try to sell fake policies to seniors who are not yet eligible for Medicare.

Ms. Thomas said that another recent issue is people impersonating health exchange navigators, using the guise of consumer assisters to obtain personal information such as Social Security Numbers and bank accounts. She said they may try to collect a “fee,” or steer consumers toward a fake or poor healthcare policy. She said that fraudsters have also created duplicates of state marketplace websites as a means of gathering personal information. She noted that sometimes such websites are operated by legitimate brokers, but they are designed to resemble legitimate exchange sites in order to draw more consumers to that broker. She said that plans offered by those brokers may not even be available on the exchanges. She said that some states have already sent cease and desist letters but the problem seems to be growing.

Ms. Thomas said that Medical Discount Plans are another type of scam that involves consumers being contacted by companies appearing to offer legitimate, full-time health insurance for a low price. She said that these companies make many attractive claims, but are actually offering a discount club membership that is not health insurance and offers no real discounts or coverage. She said that this is a particularly dangerous scam because consumers are often unaware they have been victimized until they need to use their health insurance.

Ms. Thomas reported that fear tactics are common in scams targeting immigrants, such as threats to report the target to immigration authorities. She said that the complexity of programs like the ACA make non-English speakers especially vulnerable. She said that fraudsters may even take advantage of shared language or shared ethnicity to convince the target that they are offering real assistance. She stated that immigrants are offered products like disability insurance and are then told that they have comprehensive coverage.

Discussing navigator oversight laws in the states, Ms. Thomas said that because it is still early in the rollout of the ACA it is difficult to have a good enough sense of navigator scams to effectively combat them. She noted that oversight of actual navigators is handled by the Centers for Medicare and Medicaid Services (CMS).

In response to a question from Rep. Keiser, Ms. Thomas said that so far the number of complaints received by the FTC has been low (in the 700 range), but is expected to grow as consumers become more aware of scams. She said that there are several problems in quantifying fraud, for example the number of complaints filed with the FTC is not an indicator of how much fraud is actually taking place and ACA-related fraud directed at seniors is frequently categorized as Medicare fraud. She noted that there are no public cases yet and could not discuss any investigations that may be underway.

MENTAL HEALTH PARITY MODEL ACT BYLAWS REVIEW

Upon a motion made and seconded, the Committee unanimously agreed to discontinue support of the NCOIL *Mental Health Parity Model Act*.

COMMITTEE CHARGES

Upon a motion made and seconded, the Committee unanimously approved the following Committee charges for 2014:

- Further explore impacts of federal reform and take positions as appropriate
- Continue to provide guidance to states implementing federal healthcare reform
- Examine state oversight of compounding pharmacies
- Explore issues regarding Medicare and Medicaid
- Investigate long-term care insurance issues and approaches
- Continue effort to educate states pursuing opioid-related insurance reforms, i.e. NCOIL best practices (*in conjunction with the Workers' Compensation Insurance Committee*)

ADJOURNMENT

There being no further business, the Committee adjourned at 9:00 a.m.