

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
INDIANAPOLIS, INDIANA
JULY 16, 2015
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Hilton Indianapolis Hotel and Suites in Indianapolis, Indiana, on Thursday, July 16, 2015, at 2:30 p.m.

Assem. Kevin Cahill of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Kurt Olson, AK	Rep. George Kesier, ND
Rep. Deborah Ferguson, AR	Sen. Jerry Klein, ND
Sen. Jason Rapert, AR	Sen. David O'Connell, ND
Rep. Ron Crimm, KY	Rep. Heather Bishoff, OH
Rep. Joe Fischer, KY	Rep. Bob Hackett, OH
Rep. Tommy Thompson, KY	Rep. Brian Kennedy, RI
Rep. Marcus Hunter, LA	Rep. Bill Botzow, VT
Sen. Dan "Blade" Morrish, LA	

Other legislators present were:

Rep. Martin Carbaugh, IN	Rep. Gary Chism, MS
Sen. Travis Holdman, IN	Sen. Kevin Bacon, OH
Sen. Tom Buford, KY	Rep. Mike Henne, OH
Rep. Lana Theis, MI	Rep. Michael Stinziano, OH
Rep. Michael Webber, MI	Sen. Larry Taylor, TX
Rep. Don Gosen, MO	Rep. Kathie Keenan, VT

Also in attendance were:

Susan Nolan, Nolan Associates, NCOIL Executive Director
Candace Thorson, Nolan Associates, NCOIL Deputy Executive Director
Molly Dillman, Nolan Associates, NCOIL Director of Legislative Affairs
Andrew Williamson, Nolan Associates, NCOIL Director of Legislative Affairs

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its February 27, 2015, meeting in Charleston, South Carolina.

ESSENTIAL HEALTH BENEFITS AND COST IMPACTS TO STATES

Chris Sears, Partner at Ice Miller LLP, stated that the Affordable Care Act (ACA) requires non-grandfathered plans in the individual and small-group markets, both inside and outside of the exchanges, to cover ten categories of essential health benefits (EHBs) beginning in 2014. He noted that this does not apply to large-group markets nor does it apply to employer self-funded plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Mr. Sears said that the ten categories included ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

Mr. Sears said the U.S. Department of Health and Human Services (HHS) in 2012 rejected a national approach to determining what benefits states require within the ten categories and instead gave states the flexibility to choose from among four “benchmark” plans. He said that if a “benchmark” plan does not cover all ten categories, than a state must supplement the plan in order to do so. Mr. Sears said that three specific services often have to be supplemented, including pediatric oral services, pediatric vision services, and habilitative services. He said that benefits provided under a plan must be “substantially equal” to the benchmark plan.

Mr. Sears stated that benefits the ACA does not require are routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing-home care benefits, and non-medical necessary orthodontia and abortion services.

Mr. Sears said states may continue to enact benefit mandates that go beyond the required EHBs. He said this is an important balance, as increased costs related to new mandates can also increase the likelihood of an employer being responsible for the excise tax on high-cost plans, the so-called “Cadillac Tax.” He said the exchange is responsible for identifying which state-required benefits are in excess of EHBs. He said states may continue to mandate benefits in large-group market plans without incurring liability to pay for those mandated benefits.

U.S. SUPREME COURT DECISION IN *KING v. BURWELL*

Mike Paton, Partner at Barnes & Thornburg LLP, provided a brief overview of *King v. Burwell*. He said the issue before the U.S. Supreme Court was how to interpret a provision in the Affordable Care Act (ACA) providing tax credits at certain income levels for individuals who purchase coverage through an exchange “established by a state.” He said that the ACA intended states to establish exchanges but that the federal government would establish an exchange if the state did not. He reported that 34 states chose not to establish exchanges and, as a result, the question arose whether individuals in those 34 states would be entitled to the premium-tax subsidy.

Mr. Paton reported that the implications had been significant for affected individuals and that the ruling also would have affected the ability of the federal government to impose tax penalties for not complying with the ACA individual mandate. He stated further that a decision for the plaintiffs would have impeded the employer mandate in those 34 states. He said employers only would have been penalized under the employee mandate if they had an employee who was eligible for the premium-tax credit and had received that credit.

Mr. Paton said that the IRS had issued regulations saying that individuals who live in states without state exchanges are still eligible for the tax subsidy. He also said that when deciding in favor of upholding the tax subsidy in all states, Justice Roberts said that the statute was ambiguous but that the issue was too important to defer to a federal agency for clarification, and so it was up to the Court to resolve.

Mr. Paton stated that Justice Roberts believed a decision for the plaintiffs would have put insurance markets into turmoil, which would have defeated the purpose of the ACA. He said that Justice Roberts' point was that despite the exact language in the ACA, Congress could not have intended to apply tax subsidies only to state exchanges.

Mr. Paton said that by virtue of how Justice Roberts decided *King v. Burwell*, the law cannot be changed by administrative ruling and that the ACA is now the "law of the land." The only way to change the law, he said, would be by legislation.

Mr. Paton said the ACA is now left to stand or fall on its own merits without judicial interference. He said the Court has signaled very strongly that any future challenges to the ACA are not likely to succeed. He commented that while there still are cases working their way through the court system, they are likely to fail. He noted that one case in particular claims that the ACA violates the origination clause because the clause requires all tax legislation to originate in the House of Representatives and the Supreme Court had decided in *National Federation of Independent Business v. Sebelius* that the individual mandate was a tax. Mr. Paton said the argument is that while the ACA was introduced and passed in the House, everything but the first sentence was changed in the Senate.

RESOLUTION REGARDING COVERAGE FOR OBESITY TREATMENTS

Rep. Hunter, sponsor of the *Proposed [Resolution](#) in Support of Efforts to Reduce the Incidence of Obesity and Chronic Disease*, stated that the resolution addressed morbid obesity. He said that when you Google the word "obesity," the first three results identify it as a disease, a disability, and a social problem. He said he felt the proposed resolution was a good way to examine the issue and, after reporting on the chronic diseases that stem from obesity, said he was asking NCOIL to adopt the resolution without including a state mandate.

Sen. Morrish said he supported the resolution, noting that it did not endorse mandating that states require obesity coverage. Assem. Cahill agreed and said the resolution urged states to pick an essential benefits plan that includes coverage for obesity and encouraged states to seek other sources of funding. The resolution did suggest, he said, that plans that are selected should be given favorable treatment if they include obesity coverage.

Rep. Keiser said he opposed the resolution and that while the issue is honorable and worthwhile, each state needs to make its own determination.

Following a motion made and seconded, legislators adopted the proposed resolution in a 13 to 3 vote.

Those in favor of adoption were:

Rep. Kurt Olson, AK	Sen. Dan "Blade" Morrish, LA
Rep. Deborah Ferguson, AR	Sen. Neil Breslin, NY
Sen. Jason Rapert, AR	Rep. Heather Bishoff, OH
Rep. Ron Crimm, KY	Rep. Bob Hackett, OH
Rep. Joe Fischer, KY	Rep. Brian Kennedy, RI
Rep. Tommy Thompson, KY	Rep. Bill Botzow, VT
Rep. Marcus Hunter, LA	

Those opposed to adopting the resolution were Rep. Keiser, ND; Sen. Klein, ND; and Sen. O'Connell, ND.

PROVIDER DIRECTORIES

Rep. Ferguson, sponsor of the proposed *Meaningful Access to Accurate Provider Directories model act* stated that her focus was on patients having access to accurate and up-to-date provider directories in order for them to make informed healthcare decisions. She reported that the Robert Wood Johnson Foundation, Georgetown University, and Avalere Health LLC recently completed a study that found 40 percent of provider directories nationwide were inaccurate. She said without access to accurate provider directories, patients can find themselves facing financial difficulty, such as balance billing due to out-of-network care. She said that as a practicing dentist, she fills out provider contracts on a daily basis and that the questions she answers are basic, such as whether she accepts new patients, what her co-pays are, whether she accepts out-of-network patients, and if so at what additional costs. She stated that providing accurate information is not time consuming.

In response to a question from Rep. Hackett, Rep. Ferguson said that she has seen a narrowing of provider networks in recent years.

ECONOMIC/STATE BUDGET IMPACTS OF PRIVATE DISABILITY INCOME INSURANCE

Chuck Piacentini, Vice President and General Counsel with Unum, reported on private disability income insurance and stated that working families often struggle to make ends meet and have limited resources to meet their needs should a wage earner be unable to work due to injury or sickness. He said that as a result many of these families are forced into state and federal welfare programs.

Mr. Piacentini said that in conjunction with the leadership of America's Health Insurance Plans (AHIP) the industry has worked to help quantify the impact of private disability income protection on states. He reported that in addition to Social Security Disability Insurance (SSDI) and other federal programs, the states contribute assistance to those who are unable to work due to accident or sickness. He said that fewer than 30 percent of working Americans have access to private disability coverage through their employers.

Mr. Piacentini defined private disability coverage as comprehensive coverage that protects individuals who are unable to earn a wage due to accident or sickness. He indicated that unlike workers' compensation, the income that private disability income insurance provides is protected regardless of whether or not the accident happened at work. He reported that 95 percent of all disabilities are due to non-work related injuries. He noted that the vast majority of disabilities are caused by sickness and not injury.

Mr. Piacentini reported that in addition to the comprehensive nature of private disability coverage, there is also a back-to-work component that helps individuals who are able to return to work have a successful transition.

Winthrop Cashdollar, Executive Director for Product Policy with AHIP, stated that private disability income (PDI) protection policies provide short-term and long-term income replacement. He said that benefits typically begin within weeks of loss, often coordinated with employer paid leave, and usually provide between 60 to 66 percent of pre-disability income. He

reported that federal Social Security Disability Insurance (SSDI) often takes more than a year to be awarded. He reported that the average monthly SSDI benefit is \$1,165.

Mr. Cashdollar said that PDI insurers work with employers and employees to get eligible employees back-to-work and that this reduces employer costs and reduces federal and state program spending. He said the case for employee coverage is that PDI protection provides financial security and assistance to workers. He reported that more than one in four of today's 20-year-olds will become disabled before the age of 67. He reported that 70 percent of American households could not pay their normal living expenses if a wage earner were disabled for six months. He said that income protection is affordable, with coverage priced as low as \$25 per month.

Mr. Cashdollar said the case for coverage from an employer's standpoint is that private disability income insurance may be part of a comprehensive benefits package, which could help recruit and retain employees. He reported that nine out of ten workers think employers should offer income protection coverage. He said that 58 percent of employees said that better benefits were one of the best ways to boost retention and that most private disability income coverage includes return-to-work services. Mr. Cashdollar then overviewed case studies of savings in various states.

ADVERSE SELECTION/DRUG COVERAGE

Clara Soh of Avalere Health LLC stated that drug coverage in exchanges must meet minimum federal standards for EHBs. She said EHBs require plans to cover the same number of prescription drugs in each EHB category and require insurers to offer at least one drug in every EHB category and drug class that the benchmark plan doesn't cover.

Ms. Soh said plans strive to keep premiums low but have limited flexibility on benefit design. She reported that four parameters of plans are EHBs, actuarial value, out-of-pocket limits, and guarantee issue and rating rules. She noted that these parameters constrain plan flexibility. She said that tier placement and utilization management help plans manage drug use while still meeting EHB drug coverage requirements. She indicated that cost-sharing for specialty products is expected to be high and said that plans will structure cost-sharing to encourage use of lower-cost products.

Ms. Soh reported on an analysis that Avalere Health had conducted regarding 2014 and 2015 offerings. She said it found that among the plans that placed drugs into specialty tiers, a significant portion of the plans mandated 30 percent or more coinsurance. She said that among the silver plans, which are the plans with the highest enrollment, 27 percent of plans in 2014 had coinsurance of 30 percent or more in a specialty tier. She reported that in 2015 that figure had risen to as high as 41 percent.

Ms. Soh said also that drugs used to treat life-threatening chronic diseases are often placed in a specialty tier, with high cost-sharing. She indicated that coinsurance is often hard for consumers to translate into a fixed-dollar amount, making out-of-pocket costs difficult to predict. She indicated that patients with high healthcare needs should be sure to balance benefit design with monthly premiums when choosing a plan on the exchange.

BALANCE BILLING

David Korsh of Blue Cross and Blue Shield Association said that the federal government defines balance billing as a situation in which a provider bills for the difference between the provider charge and the reimbursed amount. He said, for example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill the consumer for the remaining \$30. He noted that a preferred provider may not balance bill for covered services.

Mr. Korsh reported that a recent balance billing study conducted by Georgetown University and the Robert Wood Johnson Foundation described balance billing as an unexpected bill sent by a hospital, doctor, or clinic for an amount beyond that paid by the patient's insurance.

Mr. Korsh stated that the most likely situation of balance billing occurs when someone goes to an out-of-network provider. He said this can occur when a consumer has an emergency condition and goes to a hospital or other type of clinic for emergency treatment. He reported that an additional emergency situation arises when a consumer has scheduled a treatment at a hospital and the hospital and some doctors are in-network, but the doctor performing the treatment is out-of-network. He noted that this situation has received much press and is an issue being addressed by several state legislatures.

Mr. Korsh reported that another situation arises when a consumer needs a consultation or service from a specialist or subspecialist whose availability is outside the health plan's network. He noted that this can happen for several reasons, including a gap in health plan networks or inaccurate provider directories.

Mr. Korsh said states have taken a variety of approaches to address balance billing. He said one approach to protect consumers has been a push for greater transparency and disclosure. He said that some states have sought to prohibit balance billing while others have created adequate payment systems. He noted that New York State has made the most recent effort to address balance billing by incorporating all of the approaches mentioned above. He suggested that NCOIL more closely examine the New York and Texas approaches to balance billing.

In response to a question from Rep. Keiser, Mr. Korsh said the contract would determine whether or not an insurance company would have to pay for a procedure at an in-network hospital with in-network physicians but out-of-network anesthesiologists.

1332 WAIVERS

Jan Ruff of Maximis explained that Section 1332 waivers allowed a state to waive certain provisions of the Affordable Care Act (ACA). She noted that these waivers would become available to states on January 1, 2017, and would allow states to better suit their needs with new coverage models.

Ms. Ruff reported that because certain provisions of the ACA must be preserved, coverage still must include what is currently required under the Essential Health Benefit (EHB) categories, must be at least as affordable as it is now, must cover as many people as are covered under the ACA, and cannot add to the federal deficit.

Ms. Ruff said that a number of ideas were being presented in states looking to use a 1332 waiver. She stated that these ideas range from narrow fixes of current systems to

comprehensive fixes. She said that no one yet knows how much flexibility the federal government is going to give states applying for these waivers.

ADJOURNMENT

There being no further business, the Committee adjourned at 4:00 p.m.

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