

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE & RETIREMENT ISSUES COMMITTEE
NEW ORLEANS, LOUISIANA
MARCH 3, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long Term Care & Retirement Issues Committee met at the New Orleans Downtown Marriott on Friday, March 3, 2017 at 11:00 a.m.

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

Other members of the Committee present were:

Rep. Sam Kito, AK	Asm. Will Barclay, NY
Sen. Jason Rapert, AR	Sen. James Seward, NY
Rep. Justin Hill, MO	Sen. Bob Hackett, OH
Rep. John Wiemann, MO	Rep. Marguerite Quinn, PA
Rep. George Keiser, ND	

Other legislators present were:

Rep. Lois Landgraf, CO	Asm. Andrew Garbarino, NY
Rep. Lois Delmore, ND	Rep. Lewis Moore, OK
Sen. Nellie Pou, NJ	

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and second, the Committee unanimously approved the minutes of its November 19, 2016 meeting in Las Vegas, Nevada, and the minutes of its January 27, 2017 interim conference call meeting.

NETWORK ADEQUACY/PROVIDER DIRECTORIES/BALANCE BILLING DISCUSSION

Dianne Bricker of America's Health Insurance Plans (AHIP) stated that the chart prepared by AHIP summarizes the provisions set forth in: a.) Sen. James Seward's (NY) Proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers, b.) the NAIC's Health Benefit Plan Network Access and Adequacy Model Act, and c.) the NCOIL Healthcare Balance Billing Disclosure Model Act.

Sen. Seward thanked Ms. Bricker and AHIP for preparing the chart and said at this juncture the Committee's options are: a.) continue working on his proposed Model, b.) adopt the NAIC Model and/or suggest amendments to improve it, or c.) draft a Model that combines the best provisions of each Model. Sen. Seward recommended the third approach. Sen. Seward also noted that NCOIL staff may want to look to the American

Medical Association (AMA) draft Models and offered his staff's assistance when NCOIL staff begins the research/drafting process. Rep. George Keiser (ND) stated that there are very good parts in each of the Models mentioned and agreed with Sen. Seward – we should take the time to do this right with the end result being a comprehensive NCOIL Model.

Rep. Lewis Moore (OK) asked what the marketplace is doing in response to the surprise balance billing issue. Asm. Cahill stated that there are different approaches in different places and one of the things that the AHIP chart points out is that it is treated different on the regulatory and legislative levels – hopefully a comprehensive NCOIL Model can create uniformity. Rep. Moore stated that since the overall healthcare industry is in freefall right now, NCOIL has a great opportunity to provide leadership in the discussions. Rep. Justin Hill (MO) stated that he thinks networks are going to be a large part of repeal and replace and it is important to be careful of that during any drafting efforts. Rep. John Wiemann (MO) agreed and also stated that we should not be trying to micromanage the network adequacy of providers. Sen. Seward stated that after the Committee reviews the AHIP chart, please send any comments to either his staff or NCOIL staff.

DISCUSSION ON VALUE BASED INSURANCE DESIGN

Connecticut State Comptroller Kevin Lembo stated that the Health Enhancement Program in CT is a value based insurance design. What that means is that CT is driving its state employed population toward behavior that is better for them and better for the plan. CT took some of the academic information that was out there as well as some corporate experience in an effort to engage state employees in their own healthcare. Some ways of doing that were by reducing premiums, deductibles and copays for participants who opted-in to the plan. Focus was also given to five chronic diseases because they were known to be the main cost-drivers in the system – asthma, chronic obstructive pulmonary disease, diabetes, hypertension, and hyperlipidemia. There was 95% enrollment in the plan in the first year and in the second year there was a 90% compliance rate. Some criticized the plan design as a give-away and it is important for States who think about implementing this design to be prepared for those criticisms. For background purposes, TPA's operate the plan – Anthem, Blue Cross & Blue Shield, United on the health side, United and Cigna on the dental side, and CVS Health on the pharmacy side.

Compt. Lembo stated that as part of the CT design, the chronically ill population is required to engage meaningfully in their care – that means take your meds, see your doctor, and engage in some level of education about your disease and how you can improve your condition. That requirement can be satisfied in a number of ways: visiting nurse educators that are engaged with the plan, on-line education, and direct education from providers. A third party manager was hired to put nurses on the phone, engage with people when they show up in the emergency department, and handle things of that nature. Rep. George Keiser (ND) asked who the population is. Compt. Lembo clarified that it is CT state employee retirees and it is important to recognize the differences between those employees and others. State-employees tend to stay with the State, municipality, etc. so there is a great opportunity to review long-term data. Compt. Lembo stated that at the end of the year, if employees met all the requirements they received \$100 which proved to be very motivating for employees.

CT engaged with Healthcore for help to analyze how the program was doing. Healthcore performed a study with 2012 data (the current data won't be available until the fall) which showed that it was working well. There were increases in: colorectal cancer screenings, cervical cancer screenings, breast cancer screenings, cholesterol screenings; and decreases in emergency room use and overall medical costs. For non-chronically ill employees, all they really need to do to be in the plan is to get the age-appropriate screenings. CT saved about \$60 million in year one of the plan, \$30 million in year two, and \$30 million in year three. A reduction of absenteeism in the work place has also occurred. Compt. Lembo noted that State legislators have a critical opportunity to, at the very least, force a discussion on designs like this in their respective States.

Asm. Cahill asked what was the specific resistance from labor groups? Compt. Lembo stated that it was mostly complaints from the healthy employees (non-chronically ill) who didn't like the requirements to get screenings and things of that nature. Compt. Lembo stated that there are numerous stories of those same employees who complained and then called the office directly to thank them after they or their spouse had something discovered and taken care of during a screening. Asm. Cahill asked if CT had done an analysis of the relative pharmaceutical cost increases vs. other costs of delivering healthcare. Compt. Lembo stated a study had not been done but it is something that CT is looking at along with several other States. Asm. Cahill asked what is an appropriate window of study when looking at designs like this? Compt. Lembo stated that he thinks five years is sufficient.

Sen. Bob Hackett (OH) asked if there was any thought about dis-incentivizing people who don't meet the design requirements? Compt. Lembo stated that due to other laws and regulations, it had to be structured by way of setting the prices and then setting the incentives – it couldn't just be penalties for not meeting requirements. But it is important to know that once someone has reached full-compliance, if they don't continue to meet all the requirements, they are out of the plan and are accordingly subject to the higher prices in the market. It is also important to note that an important design feature is that those "kicked out" can get back in and they don't have to wait a year – they can get back in for the portion of the next coverage year after meeting requirements.

Rep. Keiser stated that in ND a medical home program which is very similar to CT's program was enacted. The providers had to opt-in and it was for a larger population. After seven years, the data shows positive effects but the program is being eliminated because of provider fatigue. Rep. Keiser asked if CT was seeing any of the same fatigue. Compt. Lembo said no, but noted that not as much pressure is put on providers in the CT program as in ND. Rep. Wiemann asked what was the annual increase in CT healthcare costs prior to implementation of the program. Compt. Lembo said it was double digits and afterwards, on average, it's been about half of that.

Rep. Moore asked what kind of leverage does CT use when working with vendors to lower costs and increase utilization. Compt. Lembo stated CT pushes everyone hard that is involved but the hardest "push" was setting up the arrangements with third parties to get all the accurate data. Rep. Moore asked if CT uses pharma code genetic DNA testing or anything like that. Compt. Lembo said no. Rep. Moore asked if CT uses some sort of constant-contact system for overall wellness or those with chronic diseases. Compt. Lembo stated that there is direct contact on a regular basis for things such as a deadline reminders to checking on compliance.

Asm. Cahill asked how CT handled the data ownership issue because NY is considering how to do so. Compt. Lembo stated that in CT the data ownership issue was limited to this specific self-insured plan and ultimately it was a condition in contracts. Asm. Cahill asked if there was any discussion about doing it by statute. Compt. Lembo said that he was not aware of any such discussions.

DISCUSSION ON ACA REPEAL/REFORM EFFORTS

Claire McAndrew, Director of Campaign Strategy at Families USA, stated that consumers who benefitted from the ACA are looking towards their elected officials to ensure that any efforts surrounding the ACA moving forward at the State or Federal level will provide at least the same quality of coverage, including the same level of benefits, at least as much cost protections, to at least as many people as the ACA did. And for people who had coverage they liked even before the ACA, they also want to make sure that any changes to the ACA do not make them any worse-off. Families USA is concerned about many of the provisions set forth in the draft bill that was released last week.

The bill provides for a flat tax credit that varies based on age, not income. Also, if you're under 250% below the poverty line, under the ACA you would get help with deductibles and cost-sharing – the draft bill wholly eliminates that. For those in favor of this type of tax-credit system, Ms. McAndrew recommended that you inquire with federal counterparts as to how it will be paid for because the draft bill removes all of the financing mechanisms that are currently in place for tax-credits – the employer mandate penalties, the individual mandate penalties, the health insurer tax, the medical device tax, the tanning bed tax, etc. The one financing mechanism the bill includes is a tax mechanism on employer health plans that fall in the 90th percentile of premiums starting in 2019. After 2019, the tax is adjusted on general inflation, not healthcare inflation which raises a concern that tax could expand. Other provisions that would be eliminated under the bill are the essential health benefits (EHB's) and the Medicaid expansion program which is very concerning. Something that is not in the bill but is rumored to be included in the future is a provision to allow for selling across State lines. Ms. McAndrew also voiced concerns over provisions regarding high-risk pools and health savings accounts (HSA's). Ms. McAndrew stressed to the Committee that consumers do not care whether what's in their health plans comes from the State or Federal government – they want healthcare that works for them. The debate on Medicaid has shown that State legislators and Governors speaking up on behalf of those they represent is making a difference.

Chris Condeluci of CC Law & Policy began by reviewing the ways which the ACA can be repealed. One is through the normal legislative process, which the Republicans currently don't have enough votes to do, and the other is through the budget reconciliation process which essentially affords passage of legislation by a simple majority in the Senate. But in order to be afforded that "luxury," the reconciliation bill can only impact taxes or spending. Therefore, through the reconciliation process, the ACA Medicaid expansion can be repealed along with premium subsidies and taxes, but the insurance market reforms like guaranteed issue, the pre-existing conditions rule, the rule for covering adult children up to age 26, cannot be repealed. Regarding the draft repeal bill, Mr. Condeluci noted the three-year transition periods involved with repealing Medicaid expansion and premium subsidies which indicate the practical and moral desire to avoiding immediately harming people who relied on ACA coverage. Mr.

Condeluci also noted that the individual mandate penalty will be repealed by way of reducing the penalty to \$0, and clarified that the news that was circulated about the Trump Administration not enforcing the individual mandate is not true. Also, regarding the Cadillac Tax, Mr. Condeluci stated that it is essentially the same thing as the 90th percentile tax that Ms. McAndrew mentioned.

Mr. Condeluci then discussed some ideas about what the replacements for those portions of the ACA repealed will look like. Regarding the premium subsidy structure: increasing subsidy payments for younger consumers and decreasing payments for older consumers; making subsidies available for off-Exchange plans “non-advanceable”; making subsidies available for ACA-defined “catastrophic plans.” Regarding Medicaid, it is a moving target and is the biggest issue/stumbling block in negotiations. It could be replaced with a per-capita cap that States would have to adhere to, but there is also some discussion about allowing States that have already expanded to continue such expansion at pre-ACA FMAP levels.

Regarding opportunities for the State legislators in this process, “State innovation grants” will be included in repeal/replace legislation and States have the flexibility on how to spend those funds. States could set up high-risk pools, a reinsurance program, or other programs designed to reduce premiums and promote health. Additionally, States may have flexibility to limit the “categories” of coverage under a specified EHB in an effort to balance cost with coverage mandates. Defining what a “state-approved” plan is and the use of 1115 and 1332 waivers are also opportunities for States.

Mike Chaney, Mississippi Insurance Commissioner cautioned State legislators about altering EHB’s and stated that he does not foresee a lot of changes to EHB’s. Cmsr. Chaney also noted that the news of transitional relief afforded to grandfathered health policies is extremely beneficial. Cmsr. Chaney further stated that he thinks that the States that did not expand Medicaid will probably receive substantial benefits to set up high-risk pools but is skeptical of such pools functioning properly under what the Administration has proposed thus far. James Donelon, Louisiana Insurance Commissioner, stated that there are several concerns with the proposals set forth thus far by the Trump Administration, particularly with those involving “writing” across State lines. Cmsr. Donelon recommended that everyone read the NAIC publication on that issue.

RE-ADOPTION OF MODEL LAWS

Upon a motion made and seconded, the Committee unanimously adopted the Model Act Banning Fee Schedules for Uncovered Dental Services, the Patient Safety Model Act, and the Rental Network Contract Arrangements Model Act. Sen. Seward recommended that due to the Model Law drafting efforts mentioned earlier in the Committee, the re-adoption of the Healthcare Balance Billing Disclosure Model Act should be deferred to the Summer Meeting in Chicago. The Committee agreed.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:30 p.m.