NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
CHICAGO, ILLINOIS
JULY 14, 2017
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long Term Care & Health Retirement Issues Committee met at the Chicago Intercontinental Magnificent Mile Hotel on Friday, July 14 2017, at 9:00 A.M.

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

Other members of the Committees present were:

Rep. Sam Kito, AK
Rep. Deborah Ferguson, AR
Sen. Jason Rapert, AR
Asm. Ken Cooley, CA
Rep. Martin Carbaugh, IN
Rep. Joseph Fischer, KY
Rep. Jim Gooch, KY
Rep. Jeff Greer, KY
Rep. Bart Rowland, KY
Rep. Greg Cromer, LA
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Rep. Don Flanders, NH
Asw. Maggie Carlton, NV
Asm. Will Barclay, NY
Sen. James Seward, NY
Sen. Bob Hackett, OH
Rep. Glen Mulready, OK
Rep. Marguerite Quinn, PA
Sen. Mike Hall, WV

Other legislators present were:

Rep. Austin McCollum, AR
Rep. David Santiago, FL
Rep. Dick Hamm, IN
Sen. Travis Holdman, IN
Rep. Peggy Mayfield, IN
Sen. Dave Robertson, MI
Sen. Jonathan Casper, ND
Sen. Neil Breslin, NY
Asw. Pamela Hunter, NY
Sen. Jay Hottinger, OH
Del. Steve Westfall, WV

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 seconded, the Committee unanimously approved the minutes of its March 3, 2017 meeting in New Orleans, Louisiana, and the June 8, 2017 Air Ambulance Task Force minutes,

NETWORK ADEQUACY/PROVIDER DIRECTORIES/BALANCE BILLING DISCUSSION

Sen. James Seward (NY) stated that he looks forward to continue working on the draft of the Out-of-Network Balance Billing Transparency Model Act, and that the goal is to have it considered by the Committee at the November Annual Meeting in Phoenix. The intent

of the Model is to provide patients with full transparency and to prevent them from being surprised with bills after receiving treatment.

Dianne Bricker of America's Health Insurance Plans (AHIP), who helped draft the proposed Model, stated that the draft Model consists mainly of language from: a.) NCOIL's existing Healthcare Balance Billing Disclosure Model Act; b.) Sen. Seward's proposed Model Act Regarding Network Adequacy and Use of Out-of-Network Providers – which is based on New York law; and c.) the NAIC's Health Benefit Plan Network Access and Adequacy Model Act. Ms. Bricker noted that some edits were made to some of the language, and some definitions were added in an effort to provide clarity. Ms. Bricker also noted that none of AHIP's policies were placed in the Model, and then proceeded to briefly summarize each section of the draft Model.

Asm. Cahill requested that Ms. Bricker's summary of the Model be forwarded to the Committee in memo format, and also requested that any comments on the draft Model be sent to NCOIL Support Services Legislative Director, Will Melofchik, within 30 days.

Upon a Motion made and seconded, the Committee unanimously agreed to further table the re-adoption of the NCOIL Healthcare Balance Billing Disclosure Model Act pending completion of Sen. Seward's Out-of-Network Balance Billing Transparency Model Act.

Assemblywoman Maggie Carlton (NV) stated that the issues that Sen. Seward's Model deals with are very important and that a balance billing piece of legislation was recently vetoed by Nevada Governor Brian Sandoval. In conjunction with that bill, the Nevada Assembly also passed a Joint Resolution (AJR 14) stating that if the issues of balance billing could not be resolved through legislation, the issues will go to the ballot – the Joint Resolution cannot be vetoed by Governor Sandoval. Asw. Carlton stated that the bill she worked on was strictly for emergency rooms, for patients who, through no fault of their own, went through the wrong door and/or ended up with a doctor who was out-of-network. The balancing act that they had to walk a fine line on was to not deter contracting. The bill (AB 382) was whittled down to just arbitration – taking the patient out of the middle and allowing the two sophisticated parties to arbitrate and then share the arbitration. Asw. Carlton stated that she looks forward to working with NCOIL on these issues.

UPDATE ON AIR AMBULANCE TASK FORCE ACTIVITIES

Asm. Cahill stated that the Task Force held an interim meeting via conference call on June 8 and it was decided that more work was needed on any work product. A problem was also identified: the Federal preemption that exists hinders the Task Force's ability to create the legislation needed to help solve the issues pervasively. Asm. Cahill noted that the Task Force declined to adopt his Resolution Urging the United States Congress to Take Legislative Action and Exempt Matters Properly Governed by the McCarran-Ferguson Act from the Scope of the Airline Deregulation Act of 1978 to Authorize States to Regulate Air Ambulance Billing, but is offering it for consideration to the Committee today.

Upon a Motion made and seconded, the Committee unanimously adopted Asm. Cahill's Resolution. Asm. Cahill stated that he looks forward to the Task Force continuing its work and that hopefully by the November Annual Meeting in Phoenix, it will have a Model Act to introduce.

UPDATE ON BETTER CARE RECONCILIATION ACT

David Smith, Chief Development Officer at Leavitt Partners stated that the updated version of the Better Care Reconciliation Act (BCRA) was released yesterday and a few key changes were: a.) additional stability funding added; b.) elimination of some taxes; c.) opioid funding; d.) the Cruz-Lee amendment which allows insurers to sell plans that do not meet certain ACA regulatory standards if they also sell a plan that does meet said standards.

Mr. Smith stated that some key issues to watch over the next few days that could impact the legislation are: a.) a CBO score; b.) trade organizations voicing their support/opposition; c.) constituents voicing their support/opposition; d.) State Governors and legislators voicing their support/opposition. Ms. Smith further stated that there most certainly will be further changes to the current version of the BCRA. If it appears that a successful vote is not likely, a "repeal and delay" scenario could be back on the table, although unlikely. Mr. Smith stated that a bi-partisan effort towards a solution to these issues also appears very unlikely, and that another issue to keep in mind is that Congress has a litany of issues to consider. By mid-August, we will most likely have a firm grasp on what exactly will happen. Mr. Smith noted that healthcare reform is a critical issue for Republicans to demonstrate that they have a governing coalition and that they can govern going into the midterm elections.

Washington Insurance Commissioner Mike Kreidler stated that the big stumbling block will be the issues regarding Medicaid. The Cruz amendment is also very problematic – the NAIC does not have a position on it yet but Cmsr. Kreidler stated that bifurcating a risk pool is a bad idea. The issue regarding stability funding is whether or not the amount included in the legislation is enough. Cmsr. Kreidler stated the CBO score will play a big role, but the Cruz amendment might be included in the score. A couple of issues that the NAIC has spoken out on are the necessity of the Cost Sharing Reduction (CSR) payments, and the negative implications of Association Health Plans (AHPs).

Asm. Cahill asked when States can expect to see action that will impact State budgets. Mr. Smith stated that the answer depends on, a.) what ends up in the legislation, b.) how quickly CMS can regulate it, and c.) how quickly can the market respond. Asm. Cahill stated that there are 9 Republican Senate seats up for re-election next year and asked how they are weighing in on healthcare reform. Mr. Smith stated that it depends on the constituency base under which they serve – of those 9 that are serving more of a more Moderate constituency, there is incredible sensitivity to making drastic changes to the ACA. Asm. Cahill asked what type of influence is President Trump exerting over Congress on these issues. Mr. Smith stated that there are broader overtures to that question and that he thinks the President has run into some roadblocks: a.) the Senate is tough to influence – they are very sure of how they want to proceed; and b.) the broader political climate surrounding the President has created some limitation in how he can work with certain Senators.

Rep. George Keiser (ND) stated that he can't imagine the CBO scoring the BCRA without the Cruz amendment. Mr. Smith stated that it would be very problematic, but stated that he believes the CBO will weigh-in on it at some point so the financial implications of it will be known.

Asw. Carlton stated that Nevada received notice from their major carriers are not going to cover the rural areas in the State so 14 of 17 Nevada counties are not going to have coverage on the Exchange. Accordingly, there are already impacts from the unknown of Federal healthcare reform. Mr. Smith stated that there is indeed an eroding confidence in the market. Cmsr. Kreidler stated that rural areas have always been a problem even prior to the ACA and that Washington State is working hard to help solve the problems through a 1332 waiver.

ANATOMY OF A HEALTH INSURANCE PREMIUM: ARE RX PRICES RESPONSIBLE FOR A DISPROPORTIONATE SHARE OF HEALTH INSURANCE PREMIUMS?

Barbara Klever, Vice Chair of the American Academy of Actuaries Individual and Small Group Markets Committee, stated that premiums are developed in the Spring of the year preceding the benefit year and are filed with the State regulator and HHS typically in the late Spring or early Summer. Rates are filed and regulated at the state level and the ACA requires a single risk pool for all individual ACA compliant business within a state both on and off the Exchange. Premiums are built up from projected medical and drug claims, the administrative costs of the insurance company, risk charges, profit, and contribution to surplus. Ms. Klever stated that the biggest part of the premium rate is the projected medical and drug claims – actuaries must make assumptions in order to project the medical costs to the future benefit period and also must consider the composition of the risk pool. A company will start with their historical claims and enrollment experience from the block they are pricing and determine a trend factor to project the experience to the benefit period. For 2018 pricing, insurance companies were looking at their 2016 claims experience and enrollment.

Ms. Klever stated that the trend is defined as being the change in unit cost of medical services as well as changes in utilization of medical services. In order to analyze that, insurers typically look at past trends and then look to projected influences that will impact future unit costs or utilization. Smaller issuers may not have credible experience – they will typically be able to blend their experience with a manual rate. Insurers must also consider changes in the anticipated risk pool. For example, if a state chose to end transitional policies at the end of the year you might expect healthier people from that pool to move into the ACA compliant pool which would tend to bring rates down. On the other hand, the impact of removing or not enforcing the mandate, you would expect healthier people to leave the risk pool which would tend to raise rates.

Ms. Klever stated that the company experience is projected on the single risk pool basis and then adjustments are made for market wide programs - the biggest one is risk adjustment. If a plan expects to be a risk adjustment payor, they need to add that payment to their claims to project their market wide experience. They then break that experience out into their plan-level indexed rates, varying from the cost-sharing design and not the health status. The final step is to develop the consumer level premiums based on the age scale, geography factors, and tobacco.

Ms. Klever stated that underlying growth in health care costs and changes in the risk pool composition and issuer assumptions are major drivers in premium changes every year. For 2018, there is also legislative/regulatory uncertainty, possible risk-sharing programs for high-cost enrollees and the health issuer fee. Regarding the underlying growth in healthcare costs, it is projected to be consistent with the 2017 trend at an increase of 5-8 percent. Ms. Klever stated that the growth in spending for prescription

drugs has leveled off as new high cost drugs are built into the base such as those for hepatitis C. Regarding changes in the risk pool composition, the changes in premium from 2017 to 2018 reflects the expected changes in the risk profile of enrollees as well as any changes in insurer assumptions based on whether the experience to date in 2017 differs from that assumed in the 2017 premiums. The 2017 premiums increased by an average of 22% across the nation – that reflects that experience was worse than projected in prior premiums. If the assumptions underlying the 2017 premiums accurately reflect 2017 experience, the rate increase would be more of a one-time correction. If, however, a deterioration or improvement of the risk pool is expected, it puts upward or downward pressure on the rates. Ms. Klever further stated that there is a concern of declining enrollment. HHS reported a slight decline in sign-ups on the marketplace during the 2017 open enrollment. If insurers expect continuing declines it puts upward pressure on rates because healthy people typically leave the market first.

Ms. Klever stated that there are several legislative and regulatory uncertainties specific to 2018 that could affect premiums: a.) the continuation of cost sharing reduction subsidies; b.) a market stabilization rule that tightened up special enrollment periods and shortened the open enrollment period ; c.) the enforcement of the individual mandate; and d.) potential changes to the ACA. Ms. Klever stated that risk-sharing programs can lower premiums if external funding is incorporated. Several states are pursuing reinsurance and invisible high risk pool options. The health insurer provider fee was waived for 2017 which resulted in a premium reduction for 1 to 3 percent for 2017. If the moratorium is not extended, premiums will increase by 1 to 3 percent for 2018. Ms. Klever stated that other premium drivers for 2018 are: changes in provider networks; benefit package changes; market competition; changes in provider competition and reimbursement structures; changes in administrative costs; and changes in geographic factors.

Rep. David Santiago (FL) stated that his preliminary research into the relationship between pharmacy benefit managers (PBMs) and healthcare providers indicates a gray area regarding rebates, and asked if Ms. Klever has seen rebates going back to healthcare providers and if they are utilizing that as a profit line or is accounted for in the rate filing. Ms. Klever stated that her experience is that the insurer will include the rebates as an offset to their paid claims and rate filings so it is built into the premiums in that way.

Cmsr. Kreidler stated that from the standpoint of looking at the rate filings as they come in for review/approval, the real driver has been and will be prescription drugs. Regulators and legislators need to look at what could be done now to provide more flexibility for the standards that apply to prescription drugs in terms of gauging their effectiveness. For the 2018 filings in Washington State, there were 2 rural counties with no health carriers – legislators and regulators again need to work together on how to make it easier for carriers to go into those tough markets. Despite the great work that PhRMA has done, we have to re-examine things in the pharmaceutical market regarding competition and international purchases. The U.S. also cannot be the pharmaceutical researcher and development for the entire world.

Bob Ridgeway of America's Health Insurance Plans (AHIP) stated that for every dollar you pay into a health insurance premium, approximately 22.1 cents goes towards prescription drugs, 22 cents towards physician services, 19.8 cents towards outpatient services, 15.8 cents towards impatient services, 17.8 cents towards operating costs, and

2.7 cents towards net margin. Mr. Ridgeway stated that it is important to understand Medical Loss Ration (MLR) under the ACA - the percent of premium an insurer spends on claims and expenses that improve health care quality. Under the ACA, insurers must pay rebates to policyholders if they don't meet an MLR standard of at least 80 percent (for individuals and small groups) or 85 percent (for large groups). Conversely, if at the end of the year, insurers find that they underestimated medical costs – they must eat the money.

Mr. Ridgeway then cited some of the main drivers of premiums: uncertainty regarding CSR payments and the future of the ACA; medical trend involving prices and utilization – which AHIP projects to be increased by 6.8% in 2018; pharmacy trend – which AHIP projects to be 13.4% of all medical spending in 2018; the weakness of the individual mandate; the high cost of essential health benefits; risk corridor and reinsurance funding changes; and taxes and fees such as the health insurer fee. Mr. Ridgeway stated that some of the tools that health insurers can use to apply downward pressure on premiums are were eliminated under the ACA, but some left are: high value networks; medical management innovations such as bundled/global funding for a medical episode rather than fee for service; and 1332 waivers.

Saumil Pandya from Pharmaceutical Research Manufacturers of America (PhRMA) stated that the report that Mr. Ridgeway referenced does not back out manufacturer rebates – it represents the negotiated amount the insurer has paid to the pharmacy. It does not mention that later, the manufacturer sends a rebate back to the insurer. In the U.S., for better or worse, a manufacturer sets a list price of a drug and then engages in contract negotiations with insurers to provide rebates and discounts to come down to a net price. The list price is similar to a sticker price on a car – a starting point for negotiations. The net price is what the insurer actually pays and is what should impact the premium. Whenever there is data regarding prescription drug spending, the most important question is whether the data reflects manufacturer rebates.

Mr. Pandya noted that accordingly to multiple sources including Express Scripts, CVS Health, and CMS, medicine cost growth is declining. And, after discounts and rebates, brand medicine prices grew just 3.5% in 2016. Spending on retail and physician-administered medicines continues to represent just 14% of all medical spending in 2015. 31% consists of hospital care. The 14% consists of brand manufacturers, generic manufacturers, and supply chain entities. Mr. Pandya stated that the question becomes what do we want to spend our money on: middle-men/administrative costs or medicines that have reduced the cancer death rate substantially.

Too often, negotiated savings do not make their way to patients. More than half of commercially insured patients' out-of-pocket spending for brand medicines is based on the full list price. Mr. Pandya closed with offering market-based reforms that can make medicines more affordable and accessible: modernize the drug discovery and development process (modernize the FDA to keep pace with scientific discovery and increase efficiency of generic approvals; promote and incentivize competition); promote value-driven healthcare (remove barriers restricting information companies can share with insurers; reform regulations discouraging companies from offering discounts tied to outcomes; modify Medicaid best price requirements); empower consumers and lower out-of-pocket costs (provide patients with access to negotiated rebates; address affordability challenges in the deductible; make more information on health care out-of-pocket costs and quality available to patients); address market distortions (address

burdensome regulations that distort programs like the 340B Drug Pricing program); and improve trade agreements (enforce existing trade agreements; ensure new trade agreements recognize value of innovative medicines).

Emily Carroll of the American Medical Association (AMA) stated that physicians provide a primary component of the healthcare system so it is therefore reasonable that a large portion of healthcare spending reflects that. Ms. Carroll stated that the AMA is concerned about the decrease in value in care that consumers are receiving from the money they pay for their health insurance. Maintaining the adequacy of provider networks is critical for consumers. Several states are enacting legislation to ensure that patients are receiving care in a reasonable and timely manner – Maryland, Connecticut and Illinoi, among others. Regarding opioids, ensuring access to mental health services is paramount and the AMA believes it is a good opportunity for States to truly promote value in premium payments for consumers.

Ms. Carroll stated that there are administrative burdens that threaten the value of the insurance premiums consumers have – plans and PBMs implement systems that double-check what physicians deem to be medically necessary for patients. Few things induce more emotion and frustration among physicians than those systems – they divert resources away from direct-patient care. It is estimated that $83,000 per physician per year is spent on administrative interactions between physicians and insurers; and physician practices are spending on average 16 hours per week on prior-authorization. In January, the AMA released a set of 21 principles that aim to make such programs less burdensome, and the AMA supports the legislation passed in Delaware, Ohio, Arkansas, and Washington on these issues. 20 States this year also introduced step-therapy reform legislation which the AMA supports. Ms. Carroll also noted that transparency is critical for consumers so that they can make informed decisions about healthcare.

Dena Mendelsohn from Consumers Union stated that it is important to note that health insurance premiums were steadily increasing before implementation of the ACA and they have slowed since, although still too expensive for consumers. Health insurance is expensive because healthcare is expensive - prescription drugs costs are a big part of the equation but we need to look at the cost of healthcare. Ms. Mendelsohn noted that the unknown regarding CSR funding significantly increases the rates for ACA customers – Blue Cross Blue Shield of North Carolina recently proposed a rate increase 22% but if they knew the outcome of CSR payments, the increase would only be about 8.8%.

States have the power to strengthen rate review protections. Rate review regulations must require plans to answer questions with verifiable data – incomplete responses must not be accepted. States must post-unredacted copies of filings as early in the rate review process as possible. Regulators must have prior approval authority so they can block unreasonable or unjustified rate filings. And regulators must be required, or at least be given the authority, to hold public hearings. Ms. Mendelsohn then provided an example of how the same actuarial memorandum was posted on one State's website with redactions, and on the other without any. There is no data to show that the States that allow redactions have stronger markets, but there is data to show that the States that do not allow redactions have strong markets. States have the power to ensure transparency. Consumers Union supports evidence-based decisions – regulators should have hard-data before them before they determine whether a rate is reasonable and justified. Active purchaser exchanges, like Covered California, can benefit consumers and more States should consider them. Ms. Mendelsohn closed by stating

that consumers want to pay a fair price for their health insurance and to understand what they are getting for their money. Strong rate review regulations and regulators committed to consumer protection are critical and needed to ensure those consumer expectations are met.

Rep. Santiago asked Mr. Pandya if Americans are subsidizing prescription drugs for the rest of the world. Mr. Pandya stated that different countries have difference healthcare systems so you cannot import prices from one country to another for prescription drugs without important other aspects of their systems. Americans do pay more for prescription drugs – that is a fact – but people continue to come to our country because we have the best healthcare system in the world. Trade agreements should allow for more competition to alleviate that burden on us.

Sen. Bob Hackett (OH) asked if we have experienced a 40% increase in prescription costs over the past couple of years. Mr. Pandya stated no, and referenced his prior testimony that accordingly to multiple sources including Express Scripts, CVS Health, and CMS, medicine cost growth is declining. And, after discounts and rebates, brand medicine prices grew just 3.5% in 2016. Spending on retail and physician-administered medicines continues to represent just 14% of all medical spending in 2015. 31% consists of hospital care. The 14% consists of brand manufacturers, generic manufacturers, and supply chain entities.

Rep. George Keiser (ND) stated that the two areas that never get brought up when these issues are discussed are: a.) consolidation of provider networks, particularly in rural areas, and b.) the reduction of trained physicians in the U.S. Ms. Mendelsohn stated provider consolidation is a major concern for Consumers Union, and Ms. Klever stated that is one of the issues discussed in the American Academy of Actuaries' issue brief on these topics.

Rep. Greg Cromer (LA) asked what is the actual pharmaceutical impact when figuring rates. Ms. Klever stated it depends on the population covered – she has seen about 15 to 20 percent. Rep. Cromer asked if insurers would be willing to disclose their actual costs per drug on their formularies, and if PhRMA would be willing to disclose Average Wholesale Price (AWPs). Mr. Pandya stated that AWP is not set by the manufacturer and is above what the list price is, which is public.

Rep. Deborah Ferguson (AR) asked whether pharmaceutical advertising have exceeded research and development costs. Mr. Pandya stated that is outside of his expertise but PhRMA spends more than any other industry on research and development.

Sen. James Seward (NY) asked if there has been a study on what the real impact is on health insurance premiums comparing prior approval states to file and use states. Mr. Ridgeway stated that he is not aware of any study, and that one thing that MLR does is put rate setting/rate review on auto-pilot to the Insurance Commissioner because she/he has only two options when looking at a rate: rebate excess money back to consumers or have the insurer eat the underestimated costs.

Rep. Bill Botzow (VT) asked what portion of prescription drugs costs could be attributed to mental health treatment and what are the trends in that area. Mr. Pandya stated that he could get that information to Rep. Botzow after the Committee.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:00 A.M.