

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
SANTA FE, NEW MEXICO
NOVEMBER 18, 2011
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Eldorado Hotel & Spa in Santa Fe, New Mexico, on Friday, November 18, at 9:30 a.m.

Rep. Charles Curtiss of Tennessee, acting chair of the Committee, presided.

Other members of the Committee present were:

Rep. Kurt Olson, AK	Sen. Carroll Leavell, NM
Rep. Greg Wren, AL	Sen. Neil Breslin, NY
Sen. Vi Simpson, IN	Assem. Nancy Calhoun, NY
Sen. Ruth Teichman, KS	Sen. James Seward, NY
Rep. Ron Crimm, KY	Sen. David Thomas, SC
Rep. Tommy Thompson, KY	Del. Harvey Morgan, VA
Rep. Susan Westrom, KY	Rep. William Botzow, VT
Rep. George Keiser, ND	Sen. Ann Cummings, VT
Rep. Don Flanders, NH	Sen. Mike Hall, WV

Other legislators present were:

Rep. Barry Hyde, AR	Rep. Joe Hoppe, MN
Rep. Reginald Murdock, AR	Sen. John Horhn, MS
Sen. Jason Rapert, AR	Sen. Ralph Hise, NC
Sen. Nancy Barto, AZ	Sen. David O'Connell, ND
Rep. Nancy McLain, AZ	Rep. Tom Taylor, NM
Rep. Ken Ito, HI	Sen. Cliff Aldridge, OK
Sen. William Haine, IL	Rep. Glen Mulready, OK
Sen. Travis Holdman, IN	Sen. Gerald Malloy, SC
Rep. Jeff Greer, KY	Sen. Jean Hunhoff, SD
Sen. Dan Morrish, LA	Del. Terry Kilgore, VA
Rep. Sharon Treat, ME	Rep. Herb Russell, VT
Rep. Peter Lund, MI	Rep. Warren Kitzmiller, VT

Also in attendance were:

Susan Nolan, Nolan Associates, NCOIL Executive Director
Candace Thorson, Nolan Associates, NCOIL Deputy Executive Director
Michael Humphreys, Nolan Associates, NCOIL Director of State-Federal Relations
Jordan Estey, Nolan Associates, NCOIL Director of Legislative Affairs & Education

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 16, 2011, meeting in Newport, Rhode Island.

FEDERAL LONG-TERM CARE CLASS ACT

Mr. Estey reported that Committee Chair Rep. Barb Byrum (MI) and Vice Chair Sen. Jake Corman (PA) had sent an August 4, 2011, letter to U.S. Department of Health & Human Services (HHS) Secretary Kathleen Sebelius regarding a new voluntary federal long-term care insurance program created under the *Affordable Care Act* (ACA). He said that the letter was sent as per a July

Committee request to relay legislator concerns with the program. He said that concerns with the Community Living Assistance Services and Supports (CLASS) Act were as follows:

- It doesn't apply risk management principles essential to a stable insurance program.
- It would pay more in benefits than it collects in premiums.
- Rates would be too low, premiums would need to rise, and adverse selection would occur.

Mr. Estey reported that federal regulators were no longer implementing CLASS. He said that HHS in September had reduced staff and that Secretary Sebelius in an October 19 letter to Congressional leaders wrote that she didn't see a financially viable path forward for CLASS implementation, despite best efforts of federal regulators.

Mr. Estey said that some Congressional Members hoped to eliminate CLASS and that repeal bills had been introduced in both the U.S. House and Senate. He said that President Barack Obama was opposed to CLASS repeal.

Geralyn Trujillo of AARP said that, regardless of a future for CLASS, long-term care costs remain a tremendous burden on state Medicaid budgets and families, and she urged states to continue efforts to find public policy solutions.

ESSENTIAL HEALTH BENEFITS RECOMMENDATIONS

Mr. Estey reported that ACA Section 1302(b) requires the HHS Secretary to define an "essential benefits" package that all qualified health plans must offer beginning in 2014. He said the law requires plans to provide coverage for ten categories of essential services, including ambulatory, emergency, hospitalization, maternity, mental health and substance abuse, prescription drugs, rehabilitative, lab, preventative, and pediatric services.

Mr. Estey said that, per an HHS request, the Institute of Medicine (IOM)—an affiliate of the U.S. National Academy of Sciences—on October 7 issued a long-awaited report on what a final package of essential benefits should look like. He said the report didn't recommend a detailed list of benefits, but instead urged federal regulators to balance benefit costs with plan affordability and said that costs shouldn't exceed those of an average small employer insurance plan. Mr. Estey said the IOM urged HHS to finalize its recommendations by May 2012.

MEDICAL LOSS RATIO DEVELOPMENTS

Wes Bissett of the Independent Insurance Agents and Brokers of America (IIABA) updated legislators on efforts to exclude agent/broker commissions from new ACA medical loss ratio (MLR) calculations, which require health insurers to spend 80 and 85 percent of premiums on medical—rather than administrative—costs in the individual/small group and large group markets respectively. He said that insurers were cutting commissions paid to agents and brokers as a result, which was harmful to consumer access and vital agent services.

Mr. Bissett said that federal bill H.R. 1206—which would exclude agent/broker compensation from the MLR requirements—had 139 bipartisan co-sponsors but was stalled in Congress and unlikely to pass. He said that the National Association of Insurance Commissioners (NAIC) would soon consider a resolution to urge Congressional action. He said the resolution would also push for HHS to explore any options available to assist agents/brokers, including to treat commissions as "improving healthcare quality."

In response to a question from Sen. Hall about new navigator programs required of state-based health insurance exchanges, Mr. Bissett urged state flexibility. He said that, because navigators are tasked to enroll consumers in health insurance plans, all licensing and other related rules governing agents and brokers should apply. He said that legislatures should impose restrictions on state monies paid to navigators as a way to ensure that only qualified individuals consult with consumers.

PREMIUM RATE REVIEWS

Mr. Estey reported on new ACA health insurance rate review requirements that took effect in September. He said that insurers must now submit a justification for any proposed rate increase of ten percent or more to regulators, including a written summary and detailed description of why the increase is necessary. He said that regulators would review information, determine if the request is reasonable, and post information online for consumers to see. He said that insurers could modify and resubmit increase requests deemed unreasonable or could go forward with such increases. He said that if a company decides to implement a large rate increase that regulators deem unreasonable, it must provide a written justification for doing so that is also posted online for consumer review.

Mr. Estey said that the federal government, in line with the new ACA rate review rules, looked at the adequacy of state laws and regulations early in 2011. He said that federal regulators determined that ten states lacked authority to carry out the new requirements and that HHS would conduct the reviews there instead. He said that starting in September 2012, state-specific percentages based on local market circumstances would be used to trigger rate reviews. He said that HHS hoped to issue these trigger levels in summer 2012.

DISCONTINUED HEALTH INSURANCE POLICIES

Athelia Battle of the Virginia Bureau of Insurance, who was speaking on behalf of the NAIC, said that when insurers offer new products, they often stop marketing and selling in-force health insurance plans. She said that enrollees in these plans, called “closed blocks” of business, face steadily increasing premiums over time because young and healthy people can’t join and those who remain in them tend to be older and sicker.

Ms. Battle said that the NAIC and the American Academy of Actuaries (AAA) spent seven years reviewing possible solutions but were unable to agree upon an answer. Instead, she said that the NAIC in 2007 completed a white paper that lists the pros and cons of six possible public policy solutions, which are to:

- require insurers to pool the experience of all individual market policies with durations beyond a set number of years, which is known as “durational pooling”
- develop a state-established Individual Medical Pool (IMP) for enrollees of closed blocks to find coverage, similar to a high-risk pool
- limit the premiums companies can charge to a specified high-low range through rate compression, based on demographics, geographic locations, and benefits
- require reserves to be set aside when policies are first issued to fund higher claims at later policy durations through a process known as “pre-funding”
- limit premium increases for closed long-duration policies to a state-estimated trend plus an additional percentage increase
- place an insurer’s closed blocks into one risk pool and then issue a single premium increase spread across all plans in the pool

Ms. Battle said that ACA reforms should resolve closed block of business concerns. Because the ACA prohibits medical underwriting and preexisting condition exclusions beginning in 2014, she said that sick enrollees, who currently may be unable to get coverage elsewhere if they leave a closed block of business, would be able to get new coverage after all. She said that ACA reforms will affect major medical policies and that closed-block issues could still occur in Medicare supplement, specified disease, and long-term care insurance plans.

Dianne Bricker of America’s Health Insurance Plans (AHIP) said that companies stop offering plans for a number of reasons, including to answer market demand and to comply with new state benefit mandates. She echoed Ms. Battle’s comments and said that over time, the number of people in the closed blocks grows smaller, and those that remain in the shrinking group grow older and sicker.

She said that—without young and healthy enrollees to share the risk—the rates for those still in a plan increase.

Ms. Bricker said that the ACA health exchange requirements, guaranteed issue mandate, and subsidies to help individuals afford coverage would make it easier for consumers to change plans at older ages. She encouraged NCOIL to revisit the issue in a few years after the ACA changes take place.

Rep. Curtiss said that—because of the uncertainty of pending ACA requirements—the Committee should continue to gather information on closed blocks of business. He said that insurers weren't purposefully trying to harm consumers but were instead trying to stay competitive by offering new products and complying with new state benefit mandates.

In response to a question from Sen. Hise about the scope of the problem and the number of people currently in closed blocks of business, Rep. Curtiss said that he found a relatively small number of enrollees in Tennessee who were affected. He said that it was a costly issue for those consumers, though, and should not be overlooked.

Rep. Mulready asked if companies provide these enrollees with a guaranteed right of conversion to a new product line if a block of business closes. Ms. Battle replied that in Virginia, companies are required to offer a conversion policy to consumers but that these policies are generally very expensive as well. Randi Reichel of Mitchell & Williams, speaking on behalf of AHIP, added that only certain policies provide a guaranteed right of conversion.

In response to Rep. Mulready's question, Rep. Curtiss said that consumers should know when a company closes a health insurance plan they're enrolled in and that costs will likely increase as a result. He said that, where applicable, enrollees should also know of any conversion rights. He said that transparency and disclosure may be an ideal way to address the issue going forward.

Upon a motion made and seconded, the Committee unanimously voted—per Rep. Curtiss' request—to 1) seek information from regulators at the NAIC on the number of people in closed blocks and 2) ask interested parties what disclosures should be made about closed blocks and conversion rights, among other things.

PHARMACEUTICAL BENEFITS MANAGER (PBM) MERGER

Susan Pilch of the National Community Pharmacists Association (NCPA) reported on a pending merger between Express Scripts and Medco, which she said were the two largest PBMs in the U.S. She said that only one other PBM could currently meet the demands of large employers and state/federal agencies and that the merger would result in unparalleled market concentration, thus reducing choices further. She said that the merger would also have a devastating effect on community pharmacists, who already had limited leverage in contract negotiations with PBMs.

Ms. Pilch said the pending merger had alarmed a number of decision makers, including the Federal Trade Commission (FTC), which had recently issued a second request for more information from Medco and Express Scripts. She said that 25 Members of Congress had sent letters to the FTC expressing their concern and 30 state attorneys general were holding working group meetings to discuss issues posed by the pending merger. She said that a U.S. House Judiciary Committee had held a September hearing to probe concerns and a Senate Judiciary Subcommittee would hold a similar hearing in December.

Michael Harrold of Express Scripts said that the FTC typically reviews acquisitions of large companies. He said that PBMs provide a valuable and cost-saving service to their clients, which often include larger employers such as the U.S. Department of Defense.

2012 COMMITTEE CHARGES

Mr. Estey said the proposed 2012 Committee charges were as follows:

- follow impacts of federal reform and take positions as appropriate
- provide guidance to states implementing federal healthcare reform
- monitor and input on a federal Community Living Assistance Services and Supports (CLASS) long-term care insurance program
- investigate closed blocks of business pricing and other issues
- examine state activity concerning mandated oral chemotherapy treatments
- review mental health parity model act, as per bylaws

Upon a motion made and seconded, the Committee unanimously approved the proposed charges.

ADJOURNMENT

There being no other business, the Committee adjourned at 11:00 a.m.