HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Health Insurance and Managed Care (B) Committee Sept. 23, 2009, Minutes
Committee 2010 Adopted Charges (Attachment One)

Drafted: 9/29/09

Health Insurance and Managed Care (B) Committee
Washington, DC
September 23, 2009

The Health Insurance and Managed Care (B) Committee met in Washington, DC, Sept. 23, 2009. The following Committee members participated: Sandy Praeger, Chair (KS); Joel Ario, Vice Chair (PA); Marcy Morrison represented by Peg Brown (CO); Kevin McCarty represented by Mary Beth Senkewicz (FL); Michael T. McRaith represented by Bill McAndrew (IL); Carol Cutter (IN); Ralph S. Tyler, III (MD); Monica Lindeen (MT); Morris J. Chavez represented by Melinda Silver (NM); Kim Holland (OK); Kent Michie (UT); Paulette Thabault (VT); and Jane L. Cline (WV). Also participating were: Steve Ostlund (AL); Linda Nemes (DE); John Huff (MO); Scott J. Kipper (NV); Teresa Miller (OR); Chris Koller (RI); and Sean Dilweg (WI).

1. NASCHIP Presentation

Vernita Bridges-McMurtrey, chair of the National Association of State Health Insurance Plans (NASCHIP) and executive director of the Missouri Health Insurance Pool and Richard Popper, executive director of the Maryland Health Insurance Plan gave a presentation to the Committee on NASCHIP's Health Reform Transition Proposal. Ms. Bridges-McMurtrey provided an overview of state high-risk pools. She said 35 states have high-risk pools, which offer comprehensive coverage to those denied individual coverage, or who have guaranteed issue under the federal Health Insurance Portability and Accountability Act (HIPAA) or the Health Coverage Tax Credit (HCTC). She said most premiums are set at 110% to 150% of standard underwritten market rates. Ms. Bridges-McMurtrey noted that high-risk pools function like special-needs coverage for individuals who cannot obtain coverage in the private market. She also noted that benefits provided by high-risk pools are much more extensive than what is available in the individual market.

Mr. Popper discussed NASCHIP's Health Reform Transition Proposal. He said NASCHIP is proposing that there be at least $6 billion in new annual federal funding provided to state high-risk pools in the form of grants to provide health insurance coverage during the anticipated transition period between the enactment and implementation of health care reforms. These new grants would operate similarly to the subsidies being proposed in the U.S. Senate and House of Representatives' health care reform bills. Mr. Popper noted, however, that the grants would provide subsidies to make premiums more affordable and to cover the high losses incurred by state high risk pools. Mr. Popper said that with the $6 billion in annual new federal funding, high-risk pools could quadruple enrollment and even with only $2 billion in annual new federal funding, state high-risk pools could double enrollment. He said the grant money could also be used by state high-risk pools to re-open closed risk-pools or expand enrollment for those with a waiting list, such as California, Florida and Illinois. Such grants also could be used to reduce premiums and expand coverage. Mr. Popper described NASCHIP's suggested methodology for allocating the grant funds by using a formula that takes into account: 1) the number of uninsured in each state; 2) the percentage of uninsured in the state; 3) state high-risk pool enrollment; and 4) state high-risk pool losses. For those states without high risk pools, Mr. Popper said the funding formula could take into account the number of HIPAA-eligible individuals in lieu of state high risk pool enrollment and losses. He also said that, as a condition for receipt of grant funds, a "maintenance-of-effort" requirement could be imposed on plan assessment formulas, based on annual assessment levels in place for the pool's 2009 fiscal year. Mr. Popper said NASCHIP's proposal appears to have some support from White House officials. It also appears to have some support from the U.S. Senate Finance Committee.

Director Huff asked whether, if NASCHIP's proposal is included in any health care reform legislation, the states would have any matching fund requirements. Mr. Popper said, to date, nothing has been included in any legislation on the subject; however, he said NASCHIP has been asked to detail its maintenance-of-effort requirement included in the proposal. Commissioner Praeger asked, given the varying nature of assessments and premiums, which year would be used to determine maintenance-of-effort. Mr. Popper and Ms. Bridges-McMurtrey said they did not know. Commissioner Ario asked how this proposal would prevent the flooding of the state high-risk pools with new enrollees. Mr. Popper said this could be managed by setting premiums and rates appropriately. Commissioner Holland asked if Mr. Popper or Ms. Bridges-McMurtrey had any information on how states, if at all, are imposing assessments on self-insured plans. Mr. Popper said that some states impose assessments on stop-loss insurers or through hospital assessments to get around any preemption issues with imposing assessments on self-insured plans. Commissioner Dilweg said Wisconsin imposes assessments on stop-loss carriers. He also noted that Wisconsin's high-risk pool premiums have dropped to about 90% of standard market rates. Commissioner Michie asked whether Mr. Popper or Ms. Bridges-McMurtrey had any recommendations on what reserving methodology state high-risk pools should use. Ms. Bridges-McMurtrey said reserving is not standardized among the states, because each state is unique. Mr. Popper said that most states have at least three months, but Maryland, for example, is different in that it has a higher level of reserves, because it offers some plans in its high-risk pool without any preexisting condition exclusions. He noted that California holds a lower reserve because it has a six-month waiting list.

Commissioner Praeger noted that Kansas was one of the 35 states with a high-risk pool. She said Kansas has been thinking about how to continue its high-risk pool if heath care reform is enacted. As such, she said, NASCHIP's presentation describing its proposal for doing that was informative and timely.

2. Adoption of 2010 Charges

Jolie Matthews (NAIC) explained that the proposed 2010 charges did not differ significantly from the 2009 charges. She said that charge #12 would have to be revised to reflect the dissolution of the National Association of Managed Care Regulators (NAMCR). Ms. Senkewicz motioned, and Commissioner Cline seconded, to adopt the 2010 charges as amended (Attachment One). The motion passed unanimously. Florida, Kansas, Pennsylvania and Utah agreed to sponsor the 2010 charges.

3. Federal Legislative and Health Care Reform Update and Discussion

Brain Webb (NAIC) provided a federal legislative update on health care reform bills being considered in the U.S. Congress. Mr. Webb noted that the U.S. House Energy and Commerce Committee is meeting to consider additional amendments to the bill that had been adopted by the Committee before the August Congressional recess. He said the House Rules Committee might introduce a single bill that combines the bills passed by the Energy and Commerce, Ways and Means, and Education and Labor Committees as early as the week of Sept. 27. He noted that the U.S. Senate Health, Education, Labor and Pensions (HELP) Committee, which also adopted a bill in July, is preparing for potential floor action in October.

Mr. Webb said the U.S. Senate Finance Committee is considering more than 500 amendments, during what is expected to be a multiple-day markup. The Committee is working from a revised mark provided Sept. 20. He noted that four key differences exist between the Finance Committee mark and the bills passed by the House committees. The Finance Committee mark: 1) includes funding for non-profit cooperatives, rather than a public plan option; 2) does not include an employer mandate; 3) funds the programs by a federal excise tax on "excessive" health insurance plans; and 4) provides much more state flexibility.

Commissioner Michie expressed his desire to see the U.S. Senate Finance Committee provide flexibility for the states to create cooperatives to provide coverage, as is being considered in Utah. Mr. Webb said the Finance Committee mark explicitly prohibits government entities from receiving the cooperative start-up funds, but that the NAIC continues to support greater state flexibility. Commissioner Holland asked whether the federal bills would allow greater state oversight over ERISA plans. Mr. Webb said that this was not part of any of the bills, although the NAIC continues to support a provision that would clarify that the states may require companies to "pay or play" if the federal bill does not include an employer mandate. Commissioner Michie noted that his U.S. senator continues to promote the sale of individual insurance across state lines as a solution to health insurance availability and costs, and asked whether this concept is widely supported. Mr. Webb said the Finance Committee mark includes a provision that would allow the states to enter into compacts to allow for the interstate sales of insurance products. This compromise was worked out by moderates who wanted to expand options, but did not want to preempt state oversight. He noted that there are still many in the U.S. House of Representatives, and a few in the U.S. Senate, who support the sale of insurance across state lines, but the majority does not.

Commissioner Lindeen asked about the ombudsman provision in the Finance Committee mark and whether the U.S. Senate Finance Committee realized that this is a role already performed by state insurance departments. Mr. Webb said that U.S. Senate Finance Committee members want something in the bill that references consumer education and that these funds could go to the state insurance departments to provide assistance, like the State Health Insurance Assistance Program (SHIP) funds currently do in some states.

Commissioner Koller asked whether the Health Insurance and Managed Care Committee is looking at the vast role given to the NAIC in the Finance Committee mark and what processes would be followed to fulfill that role. Mr. Webb said that NAIC staff is working on a list of responsibilities that would be given to the NAIC in all the bills, and that the process would be similar to that used to develop the Medigap models in the past.

4. Briefing on Wisconsin Autism Law

Commissioner Dilweg said Wisconsin recently enacted an autism law, which has a Nov. 1 effective date. He said the law requires every health insurance policy and every self-insured health plan of the state or a county, city, town, village, or school district to provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder. The coverage shall provide at least $50,000 for intensive-level services, per insured, per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of four years, and at least $25,000 for non-intensive-level services, per insured, per year, to be adjusted for inflation. Commissioner Dilweg described how the legislation was developed. Ms. Senkewicz asked whether Wisconsin had encountered any preemption issues with the federal Mental Health Parity and Addiction Equity Act

(MHPAEA). Commissioner Dilweg said the law was designed to avoid such problems. Commissioner Cutter described Indiana's autism coverage law, noting that it does not include caps on coverage. She also noted that the law does not define autism as a type of mental health coverage; as such, it avoids any preemption issues with the federal law. Commissioner Holland asked about costs, if Indiana's law does not include any coverage caps. Commissioner Cutter said that has been difficult to measure, because most plans are self-insured. She noted that parents with autistic children have tended to choose HMOs for coverage and her department has seen costs rise in this area. Commissioner Dilweg said Wisconsin has projected that its autism treatment coverage mandate will cost about $2 per insured per month. He said he would provide NAIC staff with a copy of Wisconsin's study of costs associated with this coverage.

5. Consider Adoption of Task Force Reports

a. Regulatory Framework Task Force

Commissioner Kipper said the Regulatory Framework Task Force did not meet Sept. 22. The Task Force meeting was cancelled, due to the scheduled appearance of Vice President Joe Biden. Commissioner Kipper said the Task Force would meet by conference call in a few weeks to complete the work it was scheduled to perform during the meeting.

b. Senior Issues Task Force

Ms. Senkewicz said the Senior Issues Task Force met Sept. 22. During its meeting, the Task Force adopted its 2010 charges. Ms. Senkewicz said the Task Force also adopted and exposed draft revisions to the Long-Term Care Insurance Model Regulation (#641) for a 30-day public comment period. The revisions clarify claims denial reporting in order to make this reporting clearer and more useful to state insurance regulators. This includes changes to the Claims Denial Reporting Form (Appendix E of the model regulation) and the deletion of a drafting note. Ms. Senkewicz said the Task Force anticipates that this Committee will hold a conference call prior to the Winter National Meeting to adopt the revisions, in order for the revised model regulation to be considered for adoption by the full NAIC membership at the Winter National Meeting.

Ms. Senkewicz said the Task Force discussed the implementation of charges created by recent revisions to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651) and the *NAIC Medicare Supplement Insurance Model Regulation Compliance Manual*. Those charges require the Task Force to monitor and maintain a record of state approvals of new or innovative benefits. Ms. Senkewicz said the Task Force is requesting that the states inform the Task Force, through NAIC staff, about state approvals. The states also are encouraged to report filings for such new or innovative benefits, in accordance with state public records policies.

The Task Force received an update from the U.S. Department of Health and Human Services (HHS) on the implementation of the Long-Term Care Partnership Program. Thirty-one states now sell Partnership policies. Three states have approved state plan amendments and one state has a pending state plan amendment. Twenty-six states are part of the reciprocity agreement. As data collection has begun, HHS and Partnership states have started to identify issues that might need to be addressed, including the need for adequate beneficiary notification of asset protection provisions in Partnership policies, as well as the identification of Partnership policies being sold in states with inflation-protection features that appear to not be compliant with the federal Deficit Reduction Act of 2005 (DRA). Commissioner Thabault asked if any Partnership states were reporting any savings to Medicaid. Commissioner Praeger noted that, most likely, it was too early for most states to have any data on this, except for grandfathered states. Commissioner Cutter said Indiana is a grandfathered state and has seen savings.

Ms. Senkewicz said the Task Force continued its discussion of implementation issues related to the states' adoption of revisions to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), as required by the federal Genetic Information Nondiscrimination Act (GINA) and the Medicare Improvements for Patients and Providers Act (MIPPA). She said this included an update on changes made to SERFF to accommodate electronic filing of 2010 Medicare supplement plans, as well as the issue of potential beneficiary confusion during the transition period when both the 1990 and 2010 Medicare supplement plans are being sold. Ms. Senkewicz explained that MIPPA requires the states to adopt the NAIC model revisions by Sept. 24, 2009, and most states have either completed adoption or are working rapidly toward final adoption. She said the NAIC and the U.S. Centers for Medicare & Medicaid Services (CMS) will continue to monitor the states' adoption and implementation of these major revisions.

Ms. Senkewicz said the Task Force appointed a subgroup to review and provide suggested revisions to the 2010 *Choosing a Medigap Policy Guide*, which is published jointly by CMS and the NAIC. Those states participating on the subgroup (Alabama, Florida, Illinois, Nebraska, Nevada, Pennsylvania, Texas and Wisconsin) will review the guide and provide suggested changes. Ms. Senkewicz said the Task Force established an ad hoc group made up of senior officials from CMS

and Task Force members (Florida, Illinois and Wisconsin) to act as a quick response team to respond to CMS policy questions and other high level issues.

Ms. Senkewicz said NAIC staff provided a federal update on issues of importance to the Task Force, including provisions of interest in the U.S. Senate and House of Representatives' health care reform packages, pending long-term care legislation and amendments, and other items. The Task Force received a report from CMS staff on Medicare supplement and Medicare private plan issues. This included an update on a joint letter, being signed by state insurance regulators and CMS regional offices, to directors of facilities with residents dually eligible for Medicare and Medicaid and at high risk for agent marketing abuses. Ms. Senkewicz said the Task Force received a report from the Accident and Health Working Group on their work on Medicare supplement and long-term care insurance issues.

Ms. Senkewicz motioned, and Commissioner Ario seconded, to adopt the Senior Issues Task Force report, which included the adoption of its 2010 charges. The motion passed unanimously.

6. Adoption of the Accident and Health Working Group of the Life and Health Actuarial Task Force Report

Mr. Ostlund said the Accident and Health Working Group of the Life and Health Actuarial Task Force met by conference call Sept. 14. The Working Group discussed modifications to the Actuarial Opinion section of the Health Annual Statement Instructions for 2010. Mr. Ostlund said the Working Group continued its discussions of the project to update the refund calculation in Appendix A of the Model Regulation to Implement the NAIC Medicare Supplement Minimum Standards Model Act (#651). Mr. Ostlund said a subgroup will draft a proposal for the refund calculation for the Working Group's consideration. The Working Group discussed the project to review and update the Guidelines for Filing of Rates for Individual Health Insurance Forms (#134). Mr. Ostlund said the Working Group decided to continue its 2009 charges for 2010, with the exception of the charge to update the *NAIC Medicare Supplement Insurance Model Regulation Compliance Manual*. That charge has been completed. The Working Group added two new charges for 2010. One charge relates to developing a replacement for the 1987 Commissioners Group Disability Table, and the other charge requires the Working Group to review and update the Guidelines for Filing of Rates for Individual Health Insurance Forms (#134). Commissioner Lindeen motioned, and Ms. Senkewicz seconded, to adopt the report of the Accident and Health Working Group. The motion passed unanimously.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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As of: 9/23/09

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

The mission of the Health Insurance and Managed Care (B) Committee is to consider issues relating to all aspects of health insurance.

Ongoing Maintenance of NAIC Programs, Products and Services

1. Respond to inquiries from Congress, the White House and federal agencies; analyze policy implications and effect on states of proposed legislation; communicate NAIC's position through letters and testimony when requested. *Essential*

2. Develop appropriate regulatory standards and revisions to the NAIC models, consumer guides and training material, as necessary, Medicare supplement insurance, senior counseling programs and other insurance issues which affect older Americans. Report annually (Delegated to SITF). *Essential*

3. Develop appropriate regulatory standards and revisions to the NAIC models, consumer guides and training material, as necessary, on long term care insurance. Work with federal agencies as appropriate. Report annually (Delegated to SITF). *Essential*

4. Review and monitor state and federal relations with respect to senior health care initiatives, and other impacts on the states. Work with federal agencies as appropriate. Report annually (Delegated to SITF). *Essential*

5. Coordinate and develop the provision of technical assistance to the states regarding state level implementation issues raised by federal health legislation. Report quarterly (Delegated to RFTF). *Essential*

6. Monitor, report, and analyze developments related to ERISA, and make recommendations regarding NAIC strategy and policy with respect to those developments. Report quarterly (Delegated to RFTF). *Essential*

7. Review model laws adopted in 2004 and recommend whether they be retained, revised or deleted. Report by ~~2009~~2010 Winter National Meeting. *Essential*

8. Review the NAIC's ERISA *Handbook* and modify as necessary to reflect developments related to ERISA. Report annually (Delegated to RFTF). *Essential*

9. Oversee changes and provide technical assistance as appropriate to the production of the Accident and Health Statistical Compilation and Market Share Report. Periodically evaluate the demand, utility and income derived from these reports versus their cost. *Essential*

10. Review issues surrounding the uninsured/underinsured and strategies for achieving universal coverage, determine what contributions state insurance regulators, from their unique perspective, can make to the debate, and develop appropriate vehicles to convey any positions or principles the committee develops to a multiplicity of audiences. Report by ~~2009~~2010 Winter National Meeting. *Essential*

11. Review managed health care reforms, their delivery systems occurring in the marketplace, and other forms of health care delivery; recommend appropriate revisions to regulatory jurisdiction, authority and structures. Report annually (Delegated to RFTF). *Important*

12. Serve as the official liaison between NAIC and ~~National Association of Managed Care Regulatory (NAMCR),~~ the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee on Quality Assurance (NCQA), and URAC. ~~Provide for coordination between this committee and NAMCR to facilitate input from NAMCR on improvements to the state regulation of health maintenance organizations (HMOs) and other managed care entities. Report annually.~~ *Important*

13. Review issues surrounding internal appeals and external review with respect to regulatory modernization and determine whether national standards are appropriate. If so, recommend an appropriate vehicle to achieve goals. Report by ~~2009~~2010 Winter National Meeting (Delegated to RFTF). *Important*

14. Review issues surrounding evidence-based medicine and determine whether rigorous and consistent reporting should be required. If so, develop a model law on the topic or recommend another appropriate vehicle to achieve goals. Report by ~~2009~~2010 Winter National Meeting. *Important*

15. Continue to study and evaluate evolving long-term care insurance product design, rating, suitability and other related factors, and review the existing Long-Term Care Model Act and Regulation to determine their flexibility to remain compatible with the evolving delivery of long-term care services and remain compatible with the evolving long-term care insurance marketplace. Report quarterly (Delegated to SITF). *Essential*

16. Monitor and provide assistance to the States on the implementation of the 2000 rating practices amendments to the Long-Term Care Insurance Model Regulation. Report annually (Delegated to SITF). *Important*

17. Examine issues and, as necessary, state laws and/or regulations regarding appropriate underwriting questions on applications for health insurance coverage particularly with respect to ensuring that underwriting practices and HIV testing procedures are nondiscriminatory; and, if appropriate, develop a model law or model bulletin to reflect state law and/or regulations on the subject. *Important*

Sponsors for 2010 Charges
(Except as noted, I support all charges)

Kevin McCarty	**Sandy Praeger**	**Joel Ario**	**Kent Michie**
Florida	**Kansas**	**Pennsylvania**	**Utah**

Staff Support: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

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