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The NAIC's Center for Insurance Policy and Research (CIPR) recently hosted a symposium titled, "Health Care Reform – Tools for Oversight and Assistance in the New Marketplace." Held April 30 and May 1, 2013, in Reston, VA, the symposium brought together a cadre of informed subject experts from insurance regulation, federal and state regulatory agencies, and the insurance industry.

The two-day symposium was moderated by Brian Webb, health policy team manager at the NAIC, and Linda Shepard, special counsel/health care policy and analysis director at the Kansas Insurance Department. The symposium attracted more than 75 attendees, which included health system administrators, health policy researchers and analysts, rate and form analysts, public interest organizations and consumer groups, consultants and academics.

The CIPR hosts four annual events, including a symposium, which offers a forum for opinion and discussion on major insurance regulatory issues. This year's symposium provided a great forum for the presentation of valuable insights and perspectives from a diverse group of experts who discussed impacts to regulators, insurers and consumers resulting from the federal Patient Protection and Affordable Care Act (ACA). Although health care reform was established at the federal level, the states are responsible for implementing numerous facets of the ACA. The states will continue to regulate health insurance; the federal law does not change the role of state insurance regulators.

While many of the ACA provisions have already taken effect, the most sweeping changes will take effect Jan. 1, 2014, with the implementation of market reforms, subsidies and the individual mandate. Web-based shopping portals, known as health insurance marketplaces (or exchanges), along with agents and brokers, will be the central mechanism to help individuals and small businesses purchase health insurance coverage and receive subsidies. An exchange will serve as a marketplace where consumers can go online to learn about the new law and how it affects them, shop for and compare the qualified health plans (QHPs) offered in their state, and enroll in the plan of their choice. On Oct. 1, 2013, an exchange in every state, which will be operated by the federal government or the state, will begin enrolling consumers into QHPs with the coverage taking effect in 2014.

A primary objective of the symposium was to review and discuss many of the tools and resources available to assist with the Web-based insurance marketplaces. The event also served as a platform for state insurance regulators to gain clarification on federal-state coordination and timing of the exchange rollout.

The event was divided into nine sessions featuring discussions on various issues, including: SERFF submission, validation processes and review tools; plan management; accreditation; consumer outreach and education; enforcement and market conduct; agent/brokers and navigators; and long-term cost containment. Presenters included experts from state insurance departments, NAIC staff, insurance companies and representatives from the various agencies involved in the implementation and oversight of the exchanges, including the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) and the U.S. Office of Personnel Management (OPM). This article provides an overview of the most pertinent topics of the symposium.

### ◆ SERFF SUBMISSION AND VALIDATION TOOLS

Julie Fritz, chief business strategy and development officer at the NAIC, began the symposium with a presentation about the recently released SERFF Plan Management tools. The NAIC System for Electronic Rate and Form Filing (SERFF), operated for the states by the NAIC, has been a key component in establishing uniformity and speed to market in the insurance industry. It is used by 51 NAIC-member jurisdictions to receive and review filings, communicate with filers and ultimately approve industry rate and policy form filings.

As modified to address ACA needs, the SERFF system serves as a filing submission and review vehicle and will provide a mechanism for sending data from SERFF to the state or federal exchanges. SERFF has been modified to collect carrier rate data to support rate review requirements and to support the plan management component of an exchange. The SERFF system enables the submission, review, approval and certification of QHPs, including issuer, plan, benefit, rate, accreditation and network adequacy. Fritz also shared information about how the NAIC is working with the CCIIO on quality-assurance tools, including testing to ensure that SERFF meets the needs of the states. In addition, Fritz discussed many of the training opportunities available to the states, including online help tutorials.

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◆ **PLAN MANAGEMENT**

Representatives from the CCIIO and the OPM opened the discussion on exchange plan management. The CCIIO, which is responsible for most federal aspects of ACA implementation, is coordinating with the states on the oversight of health plans. The presentation covered the CCIIO's QHP submission and certification process and review tools. In a partnership exchange, oversight responsibility and plan management are jointly shared between state and federal authorities. The CCIIO relies on a state's assessment if health plans meet QHP standards to make its final determination on QHP certification. State insurance departments review all health insurance products, rates and policy forms, regulate market practices and conduct ongoing oversight pursuant to the respective states' existing laws and regulations. The CCIIO works with the states on performing plan management functions to avoid duplication of effort.

The OPM is handling applications for multi-state plans and contracts with insurers to offer at least two plans in each state. The Multi-State Plan Program was created by the ACA and is intended to increase competition among plans offered in health exchanges.

The Arkansas Insurance Department presented iRate (Insurance Rate Analysis and Tracking Engine), a new Web-based tool designed to help automate and streamline the rate filing review process, making it easier and faster to provide an effective rate review. This application uses data from SERFF to build a robust and user-friendly reporting system to simplify the rate review process. The information in iRate includes SERFF tracking number, type of insurance (TOI) and sub-TOI, product name, the requested overall rate impact, the number of policyholders, covered lives and the prior and projected loss ratios.

With iRate, a reviewer can easily compare filings and compile all the data into easy-to-view reports that summarize the review recommendation or decision and file the information for future purposes. Also, iRate is customizable to make sure the process complies with the state's rules and regulations. Since iRate was developed through a rate review grant from the U.S. Department of Health and Human Services (HHS), it is available without cost to all grantee states. Future updates to iRate would bring new features, including plan management.

◆ **ACCREDITATION AND QUALITY**

During the "Accreditation and Quality" session, representatives from the National Committee for Quality Assurance

(NCQA) and URAC discussed the accreditation process. In order to participate in an exchange, QHPs are required to meet accreditation standards. All QHP issuers must be accredited by an accrediting entity that meets HHS standards. The NCQA and URAC are currently the only two HHS-recognized accreditation entities. There are two phases for recognition of accreditors. In Phase 1, HHS proposes to recognize NCQA and URAC on an interim basis and others upon review. Phase 2 is the process for application for entities seeking to become a recognized accrediting entity.

Accreditation quality measures for the exchanges were also discussed. The ACA requires a "quality rating system" for exchange plans. The U.S. Centers for Medicare & Medicaid Services (CMS) is working to develop a quality rating system to be used in 2016 that will reflect health plans' experience with taking care of people buying coverage in the exchanges.

◆ **OUTREACH AND EDUCATION/CONSUMER ASSISTANCE**

Representatives from CCIIO, the Maryland Insurance Administration and Consumers Union were on hand to discuss consumer outreach, assistance and education programs to help consumers better understand the health reforms and their health coverage options. The ACA provides that exchanges establish grant programs for outreach to the public for education, enrollment information, to facilitate enrollment and referrals for grievances, complaints or questions.

Consumer outreach is critical to the health of the marketplace. Consumer questions and complaints will be received by the exchanges and the state insurance departments. The need for exchanges and state insurance departments to work together and coordinate to ensure complaints go to appropriate entities was one of the concerns discussed during the session. Megan Mason, Special Assistant to the Commissioner for Health Care Reform, shared some of the consumer outreach methodologies the Maryland Insurance Administration employs, including year-round consumer information events on health insurance and coordinated hand-offs of complaints and questions with other state agencies.

In addition, a representative from Consumers Union discussed how many consumers struggle to understand their health coverage options. Although the new exchanges will provide greater access to health care, those that have never had health insurance may have trouble understanding their various coverage options. Consumers Union also discussed

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the importance of cultivating a population of informed consumers and offered a number of recommendations to improve consumer education and outreach, including:

1. Ensure that exchanges set aside enough establishment and operational money to fund extensive consumer outreach campaigns.
2. State insurance departments should develop new pathways of directly engaging consumers (e-alerts, social media).
3. The NAIC should establish a permanent and ongoing role of monitoring and disseminating best practices with respect to consumer outreach and education.

#### ◆ ENFORCEMENT/MARKET CONDUCT/CONSUMER COMPLAINTS

Representatives from the CCIIO and the NAIC led a panel discussion on enforcement, market conduct and consumer complaints. The CCIIO focused its discussion on how its recently released guidance on ACA market reforms will be enforced. The new guidance offers more opportunity for the federal government and the states to collaborate on enforcement issues. Under the guidance, state insurance departments remain the primary regulator of health insurance and can require insurance companies in their state to meet federal standards. If, however, a state fails to substantially enforce all or parts of the ACA or is not enforcing the law, then CMS will step in to enforce. The new guidance allows the states that lack enforcement authority to enter into a collaborative agreement with CMS that would give them the power to enforce the ACA while remaining compliant with state law. It should be noted that the vast majority of the states are enforcing the ACA reforms.

Tim Mullen, director of market regulation at the NAIC, discussed the multiple regulatory responses, as outlined in the Market Regulation Handbook, available to regulators when identifying compliance issues associated with network adequacy. The Market Conduct Examination Standards (D) Working Group is formally working on this project, with the initial focus on the development of examination standards for the immediate mandates of the ACA.

The examination standards are being formatted as an “examination checklist” that outlines the ACA provision, the effective date, HHS guidance and suggested audit procedures. In addition to working on examination standards, the Working Group is reviewing the complaint coding of the NAIC’s Complaints Database System to determine which complaint codes need to be added to properly track com-

plaints related to the ACA provisions. Finally, the Working Group will be discussing the additional data collection needed for more proactive monitoring of the health insurance marketplace.

#### ◆ AGENTS/BROKERS AND NAVIGATORS AND OTHER ASSISTERS

The vital role of agents/brokers, navigators and other assisters in helping consumers prepare and enroll in exchanges was also discussed during the symposium. The ACA requires the state exchanges to establish a “navigator” program that will help people who are eligible to purchase coverage through the exchange learn about their new coverage options and enroll. Navigators are to conduct public education, distribute fair and impartial information, and facilitate enrollment, but they may not advise, enroll or receive direct compensation from insurers for a participant’s enrollment in a QHP.

Each exchange must fund at least one navigator entity that is a community- and consumer-focused nonprofit group. Navigators can choose to target certain geographical locations or particular populations. Licensed agents and brokers may also be navigators if they do not receive any compensation from carriers. HHS is developing standards to ensure that navigators are qualified and trained. The exchanges must make grants to train and support volunteer navigators.

Moreover, the states will need to determine who will be responsible for monitoring navigator behavior and performance. In some of the states, navigators may report directly to the exchange, to the insurance department or to another organization altogether. To ensure consumer protections, the following recommendations were made:

1. The states should establish a system of navigator approval and rejection that allows for the removal of a navigator’s certification when they do not engage appropriately.
2. Training standards and examinations should be established.
3. The states should clarify that unfair trade requirements, market conduct and advertising laws apply to navigators.
4. The states should ensure that navigators do not perform functions that would require a producer’s license.
5. Clear enforcement authority and guidelines should be established.

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### ◆ LONG-TERM COST CONTAINMENT

Representatives from the Kansas Insurance Department, America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA) discussed the need for long-term health care cost containment solutions. The Council of Economic Advisers (CEA) estimates that the U.S. spends 18% of its gross domestic product on health care, of which 5% is estimated to be spent on ineffective care. It was noted during this session that massive price increases in the hospital sector are one of the largest contributors to overall rising health care costs. The past decade has seen a plethora of hospitals systems acquiring other hospital systems and physician practices. Consolidation allows hospitals to gain clout in pricing negotiations and to integrate services and recordkeeping, but frequently results in higher overall health care costs.

This consolidation trend is the outcome of a system that is built around guaranteed fee-based revenue streams. Studies show that fee-based systems lead to higher costs, because providers' compensation is based on the quantity of procedures performed rather than the quality of care provided. Kim Holland (BCBSA) noted that there is a growing movement away from the fee-for-service system, toward pilot programs aimed at patient-centered care and community involvement. She emphasized that this movement is in its early stages, but initial studies indicate promising cost reductions.

### ◆ SUMMARY

The success of this well-attended symposium, as part of the coordinated efforts of the state regulatory community to assure an effective and smooth implementation of the health care reforms, further attests to the commitment of insurance regulators towards meeting the needs of their local markets and consumers. Bringing together consumers, state regulators and federal agencies to discuss issues ranging from the technical aspects of the SERFF QHP submission process, the plan management systems, to quality considerations with health plan accreditation standards, to training and funding navigators and brokers, and concerns about market conduct and cost containment, is essential as the new health care system becomes reality.

For those that unfortunately missed this very informative event, they can still benefit from the information presented and the discussions by registering for the recorded sessions through the NAIC Education & Training Department.<sup>1</sup> Registration information as well as an archive of past CIPR events (including program handouts, presentations, and audio) can be found on the CIPR Events page: [www.naic.org/cipr\\_events.htm](http://www.naic.org/cipr_events.htm).

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<sup>1</sup> [www.naic.org/education\\_home.htm](http://www.naic.org/education_home.htm)



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