2017 Spring National Meeting
Denver, Colorado

HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE
Sunday, April 9, 2017
3:30 – 5:00 p.m.
Colorado Convention Center—Rooms 201/203/205—Lobby Level

ROLL CALL

Al Redmer Jr., Chair Maryland Roger A. Sevigny New Hampshire
Lori K. Wing-Heiser, Vice Chair Alaska Maria T. Vullo New York
Leslie R. Hess Arizona Teresa D. Miller Pennsylvania
Marguerite Salazar Colorado Larry Deiter South Dakota
Katharine L. Wade Connecticut Todd E. Kiser Utah
Dean L. Cameron Idaho Osbert E. Potter Virgin Islands
Jennifer Hammer Illinois Mike Kreidler Washington
Brian Maynard Kentucky

AGENDA

1. Hear Update on Work Related to “Transparency for Consumers and Regulators”
   — Joel Ario (Manatt Health Solutions) and Katherine Hempstead (Robert Wood Johnson Foundation)

2. Hear Federal Legislative and Regulatory Update—Sean Dugan (NAIC)

3. Hear Updates on the Center on Health Insurance Reforms’ (CHIR) Work Related to the Federal Affordable Care Act (ACA)—JoAnn Volk (CHIR, Georgetown Health Policy Institute)

4. Hear a Stakeholder Panel Discussion on Issues and Concerns with ACA Repeal and Replacement Proposals—
   • Industry: Candy Gallaher (America’s Health Insurance Plans—AHIP); and Paul Brown (Blue Cross and Blue Shield Association—BCBSA)
   • Actuaries: Shari Westerfield (American Academy of Actuaries—Academy)
   • Consumers: Timothy Stoltzfus Jost (Virginia Organizing); Katie Keith (Out2Enroll); Sarah Lueck (Center on Budget and Policy Priorities—CBPP); and Claire McAndrew (Families USA)

5. Consider Adoption of its March 16 and Feb. 15, 2017 and 2016 Fall National Meeting Minutes
   — Commissioner Al Redmer Jr. (MD)

6. Consider Request for Extension of Model Law Development for the Health Insurance Reserves Model Regulation (#10)—Commissioner Al Redmer Jr. (MD)

7. Hear Senior Issues (B) Task Force Recommendations for Federal Policy Options and Approaches to the Financing of Long-Term Care Needs—Commissioner Teresa D. Miller (PA)

8. Consider Adoption of its Subgroup, Working Group and Task Force Reports
   — Commissioner Al Redmer Jr. (MD)
   • Consumer Information (B) Subgroup—Angela Nelson (MO)
   • Health Care Reform Regulatory Alternatives (B) Working Group
     — Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
   • Health Actuarial (B) Task Force—Director Patrick M. McPharlin (MI) and Kevin Dyke (MI)
- Regulatory Framework (B) Task Force—Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
- Senior Issues (B) Task Force—Commissioner Teresa D. Miller (PA)

9. Discuss Any Other Matters Brought Before the Committee—Commissioner Al Redmer Jr. (MD)

10. Adjournment

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Agenda Item #1

Hear Update on Work Related to “Transparency for Consumers and Regulators”
—Joel Ario (Manatt Health Solutions) and Katherine Hempstead (Robert Wood Johnson Foundation)
Enhancing the Value of Coverage Through Data Transparency

Presentation to the NAIC Health Insurance and Managed Care Committee

Joel Ario, Manatt Health
Katherine Hempstead, Robert Wood Johnson Foundation
April 9, 2017
Agenda

- SERFF’s Role in Data Transparency
- RWJF-Manatt Data Transparency Project
- Next Steps to Enhance Data Transparency
SERFF’s Role in Data Transparency
System for Electronic Rate & Form Filing (SERFF)

A consortium of states and companies developed the first iteration of SERFF in 1997 as a pilot project to provide a cost-effective method for insurers to submit plan data to regulators.

Evolution of SERFF

- SERFF has since expanded to support other areas beyond data submission:
  - Standardizing rate/form filling processes to optimize “speed to market” for review
  - Supporting rate reviews starting in 2011
  - Increasing efficiency by using plan binders for Qualified Health Plan filings starting in 2013

- SERFF is overseen by an 11-member Advisory Board with regulator, consumer and industry representation

Source: http://www.serff.com/about.htm
SERFF Access and Plan Binders Enhance Transparency

SERFF Access was established to enhance online access to SERFF filings and the introduction of plan binders for Qualified Health Plans (QHPs) has enhanced the value of that access.

- **41 states make individual and group health filings available through SERFF Access**
  - Filings are available by plan and many insurers file multiple plan variations of their leading products.
  - SERFF Access user interface for SERFF access can be confusing and time-consuming to use.

- **13 states make plan binders available through SERFF Access and some make the binders directly available on State Insurance Department websites**
  - Insurers are required to file their QHP data in plan binders that standardize and aggregate all their QHPs in a single binder for their Marketplace offerings.
  - Some states also require insurers to use plan binders for all individual and small group plans, including plans offered outside the Marketplaces.

- **Many states could enhance transparency by requiring standardized plan binders for all health products and making them readily available to the public**
  - States may have more authority to modify plan binders as the ACA changes.
CMS has created public use files (PUFs) from a subset of Marketplace plan binder data available through SERFF and the Health Insurance Oversight System (HIOS)

**Public Use File Data Sets**
- **QHP Data Sets:** CMS compiles QHP information to assist researchers and web developers
- **Federally-Facilitated Marketplace (FFM) States:** CMS first created aggregated data files for all FFM states in 2014
- **State-Based Marketplace (SBM) States:** CMS added non-aggregated data files for SBM states in 2016
- **Public Availability:** All data sets are available on CMS’s website

**Public Use File Data Elements**
- **Benefits** (e.g., essential health benefits)
- **Cost Sharing** (e.g., deductibles, premiums, and copays)
- **Rates** (i.e., individual rates based on subscriber’s age, tobacco use, and geographic location)
- **Other Key Data Points** (e.g., coverage area, provider network URLs)
- **Business Rules** (i.e., plan-level data on the application of rates, such as allowed relationships and tobacco use)

**Recent Activity:** CMS released 2017 PUFs for FFM states in Feb 2018 and is currently working with NAIC on 2017 PUFs for SBM states
Supported by RWJF, HIX Compare is the only open access, easy to use database for individual and small group plans, on and off-Marketplace, for all 50 states

HIX Compare Benefits

- Leverages data from the CMS PUF files, SBM portals, SERFF, and carriers
- Provides machine readable data files including:
  - Premium information for four household types
  - Deductibles and out-of-pocket maximums
  - Covered benefits
- Provides a single source for researchers, web developers, and regulators to view QHP, non-QHP, and small group data
- Improving data quality will enhance value of HIX Compare

Snapshot of HIX Compare data set
What SERFF Can Add to Data Transparency

SERFF is uniquely positioned as a data source controlled by state insurance regulators with the technical expertise of the NAIC and a stakeholder-based national advisory board.

- **SERFF contains the most dependable, stable and comprehensive data elements for all individual and small group health plans**
  - Federal PUFs and HIX Compare depend on SERFF data and neither is guaranteed to continue.
  - SERFF is the most stable data source, particularly for plans not regulated by the federal government (which may be a growing category as the ACA undergoes changes in the Trump Administration).

- **SERFF allows each state to retain control over its data while working with NAIC and insurers to improve data accuracy, standardization, and transparency**
  - Better SERFF data will make it easier and faster to create machine-readable files.
  - Better SERFF data will make it easier for regulators, web developers and other audiences to access and use data for consumer and research purposes.

- **High quality SERFF data could be the basis of a machine-readable, 50-state data set**
Many still purchase individual/family coverage outside the Marketplaces:

- ACA-compliant plans outside of the Marketplace
- “Grandfathered” plans (plans purchased before ACA enactment)
- “Grandmothered” plans (plans purchased after ACA enactment but not ACA-compliant)

SERFF data is the best window into the individual market outside the Marketplaces. SERFF will become even more important if subsidies become available outside the Marketplace.

Plan Choice of Non-Group Enrollees, 2016

- 36% Purchased plan through marketplace
- 64% Purchased plan outside of marketplace

Source: Survey of Non-Group Health Insurance Enrollees, Wave 3

The Small Group Market is Even More of an Enigma

Nationally, only about 85,000 individuals from 11,000 small businesses have insurance through the SHOP.

The small group market is in flux with some companies dropping coverage, others moving to self insurance, and many still in transitional policies that don’t comply with ACA standards.

Plan Choice of Small Group Market Enrollees, 2015

RWJF-Manatt Data Transparency Project
Supported by RWJF, Manatt conducted nine stakeholder interviews in Fall 2016 and reviewed resources to assess the current state of data transparency and identify opportunities for improvement.

Stakeholder Interviewees

- Federal officials/stakeholders (CMS, MITRE) to understand the development of Public Use Files (PUFs)
- State insurance regulators (ME, NE, NY, OR, PA) to understand regulator and consumer uses for data
- SERFF staff to understand SERFF’s technical capacity to improve data quality, standardization, and transparency
- Web developers (extended through Spring 2017) (Consumers’ Checkbook, Stride Health, Clear Health Analytics) to understand how data can be used to create navigational tools that enhance consumer decision-making

Resource Review

- CMS public use files to understand structure of data sets and plan elements incorporated
- State insurance websites to view plan comparison tools, cost-sharing calculators and other publicly-available plan information
- SERFF Filing Access portals to identify how states have made plan information publicly available through SERFF
- SERFF website to understand SERFF governance and operating model
Interviewees expressed a variety of perspectives on how SERFF is used today and opportunities to leverage the platform to further strengthen data transparency.

- **Process for creating PUFs** was technically challenging but may become easier in the future as the data quality and standardization of plan binders (or their successor) improves.

- **States that have required plan binders** for both on and off-Marketplace plans have been pleased with results and see valuable uses for regulators, consumers, and third parties:
  - State regulators envision a growing role for plan binders in their regulatory oversight work and ability to enhance consumer education through department websites and other venues.
  - States that have not made plan binders publicly available generally see that as a reasonable next step, given the administrative ease of doing so through SERFF Access.

- **CMS, RWJ, and web developers** all view access to SERFF data as critical and all have views about how to improve data quality and standardization:
  - SERFF staff see their role as a support system for states that want to enhance transparency and have the capacity to improve data quality and standardization (subject to resources and competing priorities).
Spring 2017 Preliminary Interview Findings: Web Developers

Web developers use SERFF as a primary data source along with data obtained from PUFs, carriers, Marketplaces, and independent vendors

- Web developers emphasized SERFF’s role as an arbiter of data consistency and a standard-setter for the type and form of data to be collected from carriers
  - SERFF could set uniform standards on issues like provider network identifiers to improve tracking

- Plan design data is typically accurate and complete, but other data could be improved
  - Formulary template does not capture all the tier, cost sharing, and utilization management data consistently
  - Provider network data presents bigger challenges because it changes frequently and requires provider cooperation

- SERFF could play a larger role in developing metrics for data standardization, such as actuarial value, that allow consumers to compare plans across multiple variables

- Web developers prefer working with aggregated data such as the PUFs and would like to see SERFF continue to improve data collection and standardization in how carriers report data
  - Ideal is publically available data sets each year well in advance of open enrollment
  - Government role is key to ensure consistent carrier submissions
Audiences for Data Transparency

State insurance regulators and interested parties strongly support enhanced transparency and view SERFF data as valuable for regulators, consumers, web developers and other third parties.
Leveraging Plan Binders: Benefits to Regulators

Regulators are using plan binders to enhance their compliance reviews and for broader oversight roles.

- Plan binders make it easier to ensure filings are complete and consistent.
- Excel can be used to monitor market trends and develop new oversight tools.
- Plan binders make cross-state comparisons easier.

- **New York** uses plan binders to improve formulary review and enhance market conduct oversight.
- **Maine** extracts plan binder data from SERFF to create a rate calculator tool on its website.
States use plan binders to create and enhance platforms that allow consumers to more easily shop for health coverage

- Plan binders provide more detailed information on key plan attributes (e.g., benefits, cost-sharing) that further empower consumers to make informed decisions

- Some states are using plan binders to strengthen the information that’s available in Marketplace portals

- **Nebraska, Oregon, and Pennsylvania** used plan binders to build cost comparison tools that allow consumers to compare plans

- Regulators in **New York** use plan binders to populate their Marketplace portals

- **Maine** provides additional rate filing information to the public through their websites
Leveraging SERFF Data: Benefits to Web Developers

States can make SERFF data available to 3rd party web developers that create sophisticated health plan shopping tools

- Several 3rd party web developers are leveraging publicly available plan data to create easy-to-use tools that enable consumers to:
  - Review and compare plans based on benefits, cost, provider networks, quality and other key factors
  - Compare plan benefits with their health needs to identify the most appropriate product
  - Estimate premiums and cost-sharing for various plan options

Collaboration with States

Developers are using state data to create tools that incorporate information for off-Marketplace plans. Consumers’ Checkbook worked with Pennsylvania to gain access to off-Marketplace data.
# Tool Using SERFF Data: Comparing On- and Off-Exchange Plans

### Available Health Plans: 13 plans found.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Aetna Leap Everyday PinnacleHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>64844PA0120054-00</td>
<td>(Off-Exchange)</td>
</tr>
<tr>
<td>Aetna - HMO</td>
<td>Silver</td>
</tr>
<tr>
<td>Monthly Premium: $375.25</td>
<td>Deductible: $6,075</td>
</tr>
<tr>
<td><strong>Total Yearly Cost Estimate</strong></td>
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</tr>
<tr>
<td><strong>Cost in a Bad Year</strong></td>
<td>$10,583</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td><strong>Doctors</strong></td>
</tr>
<tr>
<td>(Estimated total cost for people like you in a high health care year – 2% chance)</td>
<td>(Your preferred doctors in plan)</td>
</tr>
<tr>
<td>☆ ☆</td>
<td>NONE FOUND</td>
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<tr>
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<tr>
<td>Aetna Leap Everyday PinnacleHealth</td>
<td>(On-Exchange)</td>
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<tr>
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<tr>
<td>Geisinger Health - HMO</td>
<td>Silver</td>
</tr>
<tr>
<td>Monthly Premium: $482.20</td>
<td>Deductible: Medical $500 / Drug $250 per</td>
</tr>
<tr>
<td><strong>Cost in a Bad Year</strong></td>
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<tr>
<td><strong>Quality</strong></td>
<td><strong>Doctors</strong></td>
</tr>
<tr>
<td>☆ ☆</td>
<td>NONE FOUND</td>
</tr>
</tbody>
</table>

Next Steps to Enhance Data Transparency
How States Use SERFF Today

States choose whether to require plan binders for all filings or only for Marketplace filings, and also whether to make plan binders publicly available through SERFF Access.

State requires carriers to use plan binders for rate and form filings:
- Required for Marketplace plans by all states (40+ states use SERFF, remaining states use HIOS)
- Growing trend to require plan binders for off-Marketplace filings

SERFF stores plan binder information for states:
- Some states also post information on their websites
- Plan binder information, such as cost sharing and benefits is consistently captured and reported

State decides whether to make plan binders publicly available through SERFF Access:
- Some states only make individual filings available through SERFF Access
- SERFF has the capacity to make data available at a state’s request

Web developers and other third parties use whatever data is publicly available for research, development of consumer tools, and other purposes.

SERFF makes data available in Excel but could also make it available in machine-readable formats for the benefit of web developers (e.g., XML).
Next Steps for States to Increase Data Transparency

States have a range of incremental steps they could take to enhance transparency and facilitate the development of consumer decision-making tools

- **States that only require plan binders for Marketplace filings could require carriers to use plan binders for all individual and small group filings**
  - Some states do not apply all the Marketplace requirements to off-Marketplace plans

- **States that limit access to plan binders could make all plan binders publicly available**
  - Easiest form of access would be through SERFF Access
  - States could also make plan binder data available on department web sites in consumer-friendly ways
  - States could partner with web developers to offer access to consumer tools to facilitate plan choice

- **States could work through NAIC and SERFF Advisory Board to improve data quality and standardization**
  - As an intermediate step, states could request data be available in machine-readable (e.g., XML), as well as Excel format
How the NAIC and SERFF Can Improve Data Transparency

The NAIC and SERFF Advisory Board can offer technical assistance (e.g., staff, IT resources) and help streamline state efforts to enhance transparency

- States could work with the NAIC and the SERFF Advisory Board to make SERFF Access a more standardized and consumer-friendly feature on state insurance department websites
  - States that choose public access presumably want access to be as simple and streamlined as possible
  - There may be opportunities to improve access in the SERFF modernization plan

- The states could work through the NAIC to develop a priority list for naming conventions and other data standardization that would improve data quality and consistency
  - Standardized coding for network identifiers and other key issues would enhance data value

- SERFF Access could offer states multiple options for how data is made public (e.g. Excel and XML)
Some Thoughts on the Implications of ACA Repeal/Replace

The role of web developers and consumer tools will become even more critical if the ACA is amended to reduce standardization and make plan comparison more difficult.

- Many repeal/replacement scenarios would present new opportunities and challenges for SERFF
  - Availability of subsidies outside of Marketplaces
  - Less standardization of benefits and cost sharing (changes in EHBs and AV standards)
  - More state-by-state variation in what types of plans are offered

- Consumer tools can help consumers sort through more choices with more product variations as long as there are common metrics to facilitate comparisons
  - A standard metric, such as actuarial value, is more important than limiting AVs to four metal levels

- Aggregated data sets, such as PUFs and HIX Compare, will continue to be vital for web developers and researchers
  - SERFF will continue to be a critical resource for data aggregators
  - The states and NAIC may have an expanded role in the future as leading aggregators
Questions?

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Agenda Item #2

Hear Federal Legislative and Regulatory Update—Sean Dugan (NAIC)

NO MATERIALS
Agenda Item #3

Hear Updates on the Center for Health Insurance Reforms’ (CHIR) Work Related to the Federal Affordable Care Act (ACA)—JoAnn Volk (CHIR, Georgetown Health Policy Institute)
Update on CHIR’s Recent Work and Publications

JoAnn Volk

National Association of Insurance Commissioners
Health Insurance and Managed Care (B) Committee
April 9, 2017
Current Focus of Work

• With funding from the Commonwealth Fund and the Robert Wood Johnson Foundation, CHIR is focusing our work on:
  – Federal legislative proposals and implications for consumers, states
  – Federal administrative action and implications for consumers, states
  – State legislative and regulatory action
Federal Legislative Proposals

• Association Health Plans: “House Proposal to Promote Association Health Plans Poses Risks for Insurance Markets, Consumers”

• To come: posts on Across State Lines legislation, proposals to expand Health Savings Accounts
Federal Administrative Action

• “Loss of Cost-Sharing Reductions in the ACA Marketplace: Impact on Consumers and Insurer Participation”
• “Eliminating Essential Health Benefits Will Shift Financial Risk Back to Consumers”
• Blog series: Marketplace Stabilization proposed rule and issues for states, consumers
• To come: Scope of potential administrative actions and implications for states
State Action, Markets

• “Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices”
• “Efforts to Support Consumer Enrollment Decisions Using Total Cost Estimators: Lessons from the Affordable Care Act’s Marketplaces”
• To come: an update on the small group market paper (2015)
Publications and blog available at: http://chir.georgetown.edu/publications.html and http://chirblog.org/

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Agenda Item #4

Hear a Stakeholder Panel Discussion on Issues and Concerns with ACA Repeal and Replacement Proposals—

- **Industry:** Candy Gallaher (America’s Health Insurance Plans—AHIP); and Paul Brown (Blue Cross and Blue Shield Association—BCBSA)
- **Actuaries:** Shari Westerfield (American Academy of Actuaries—Academy)
- **Consumers:** Timothy Stoltzfus Jost (Virginia Organizing); Katie Keith (Out2Enroll); Sarah Lueck (Center on Budget and Policy Priorities—CBPP); and Claire McAndrew (Families USA)
Insurers’ Comments to the Health Insurance and Managed Care (B) Committee

April 9, 2017
NAIC 2017 Spring National Meeting
America’s Health Insurance Plans (AHIP) is the national association whose members provide insurance coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Accident & Health Business Markets represented by AHIP in the United States:
- Major Medical
- Medicaid
- Medicare Advantage
- Medicare Supplemental Insurance (Medigap)
- Supplemental Health
- Long-Term Care
- Disability Income Insurance
- Dental
- Vision

Candy Gallaher, Senior Vice President – State Policy
Priorities to Promote a More Stable Individual Market

**Legislative Priorities**

- **CSR Funding**: Continued and uninterrupted CSR payments
- **Market Stabilization Funding**: Create Patient & State Stability Fund as recommended in American Health Care Act (AHCA)
- **Health Insurance Tax**: Eliminate HIT that increases premiums

**Administrative Priorities**

- **CMS Market Stabilization Rule**: Finalize proposed rule ASAP
- **Administrative Commitments**: Make good on 2016 reinsurance payments and clarify continued enforcement of individual mandate
- **Future Rule Changes**: Begin work on regulatory changes for 2019
Principles for a Stable Individual Health Insurance Market

Stable Risk Pool

- Support continuity of coverage and care and avoid disruption

Flexibility

- Strike right balance of comprehensive coverage, affordability, flexibility and plan innovation

Stability

- Include mechanisms to strengthen risk pools and address high-risks

Coverage

- Promote individual responsibility and broad market participation

Affordability

- Provide access to a choice of affordable plans with sufficient assistance for low- and moderate-income families
For State Regulators and Policymakers

• **Stable, affordable choices:** Insurers want stable competitive markets that allow them to offer consumers choices and affordable premiums.

• **Avoid breaking up the risk pools:** Recognize that the single risk pool can be harmed if different groups or cohorts are excluded.
  • Association Health Plans (federal legislation), for example, would disrupt the small group risk pool

• **State initiatives to promote stability:** Evaluate whether a state-specific mechanism is feasible to help make premiums more affordable.
  • For example, a section 1332 waiver to reinsure certain high-cost conditions.

• **Support effective pre-enrollment verification:** for special enrollment period coverage to help minimize mid-year adverse selection.
Making Good on Funding Commitments

Protect consumers by funding CSR payments immediately

Provide 2016 reinsurance payments: will help incent 2018 market participation

Affordability

Support additional federal funding

Support state approaches to stabilize the individual risk pool

Repeal the HIT

Risk Pool

Enforce existing standards to promote continuous coverage

Finalize proposed market stabilization rule and work on additional policies for 2019 (e.g., third party payments)

Timing

Act expeditiously: the time for action is now as insurers are developing form and rate filings for 2018

Extend the timelines if needed
Blue Cross Blue Shield Association (BCBSA)

Blue Cross Blue Shield Association is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for one in three Americans. For more information on the Blue Cross Blue Shield Association and its member companies, please visit www.BCBS.com.
Immediate Market Stabilization Needs

Administrative Actions Needed to Address Market Uncertainty

• Confirm that funding for **Cost-Sharing Reductions (CSRs)** will continue for 2018, and beyond

• Confirm that **Continuous Coverage** rules will continue to be enforced

• Finalize **Market Stabilization Rule**
Threats to State Authority

• H.R. 1101, “The Small Business Health Fairness Act of 2017”
  – Association Health Plans (AHPs)
  – Passed House (236-175) on March 24th
  – Referred to Senate Health, Education, Labor and Pensions (HELP) Committee
  – NAIC Opposed

• H.R. 372, “The Competitive Health Insurance Reform Act”
  – McCarran-Ferguson Act Reform
  – Passed House (417-7) on March 22nd
  – Referred to Senate Judiciary Committee
  – NAIC Opposed

  – Interstate Sales of Health Insurance Products
  – In House E&C, E&W and W&M Committees
  – NAIC has opposed idea of interstate sales
Affordable Care Act: 
*Potential Legislative and Administrative Actions*

Shari Westerfield, MAAA, FSA
Vice President, Health Practice Council
A Sustainable Individual Market

I. Individual enrollment at sufficient levels to balance the risk pool
II. Stable regulatory environment that facilitates fair competition
III. Sufficient insurer participation and plan offerings to provide competition and consumer choice
IV. Slow spending growth and high quality of care
Status of Current Individual Market

- ACA dramatically reduced uninsured rates, yet current enrollment is lower than anticipated and enrollees have been less healthy than expected.

- Competing issuers generally face the same rules; but, some rules might disadvantage those participating on the marketplaces compared to off.

- The uncertain and changing legislative and regulatory environment, including legal challenges, allowing pre-Affordable Care Act (ACA) coverage to continue, and constraints on risk corridor payments, contributed to adverse experience among issuers. Issuer participation and consumer plan choice declined in 2016 and is declining further in 2017.

- Experience can vary significantly by state.
Challenges to Market Stability

- The need to increase enrollment among healthy individuals to achieve a more balanced risk pool
- Uncertainty regarding legislative and regulatory activity and potential unlevel playing field
- Sufficient issuer participation in all regions
- Slow spending growth
I. Achieving a Balanced Risk Pool

- ACA individual mandate is weak, but increases enrollment for healthier individuals
  - Strengthening through increased financial penalties, fewer exemptions, and increased enforcement could have impact
  - Eliminating would cause additional adverse selection
- Increasing premium subsidies would increase enrollment of healthier individuals
- Wider age rating limits could attract younger individuals
- Continuous coverage requirement with late enrollment penalties likely would be less effective than a mandate
- External funding for high-cost enrollees would lower premiums and be more attractive to healthier individuals
II. Legislative and Regulatory Activity

- Administration decision to not enforce the mandate would lead to a deterioration of the risk pool.

- Decisions regarding cost-sharing reduction reimbursements (and uncertainty regarding those decisions) will affect insurer participation and premiums.

- Other areas of uncertainty regarding potential regulatory actions:
  - The requirements for essential health benefits
  - The actuarial value requirements
  - Future changes not identified yet
II. Legislative and Regulatory Activity

- Threats to a level playing field
  - Allowing the sale of insurance across state lines could lead to market fragmentation
  - Allowing for association health plans (AHPs) could lead to market fragmentation and solvency concerns
  - Opening up non-ACA compliant plans to new purchasers could lead to market fragmentation

- Each of these could result in increased premiums for plans subject to stricter rules:
  - Younger and healthier individuals would still be able to find coverage
  - Older individuals and those with health problems could find it more difficult to obtain coverage
III. Sufficient Issuer Participation

- The optimal number of insurers likely differs by area and local market conditions:
  - the number of eligible enrollees,
  - the degree of provider concentration

- Rural areas support fewer insurers, for instance, due to low potential enrollment numbers and the presence of sole community providers.
IV. Slow Spending Growth

- As most premium dollars go toward paying medical claims, keeping premiums affordable requires controlling health care costs.
  - Signs that health spending growth rates are beginning to increase
  - Evidence that we are not spending our health care dollars wisely

- Improving health care quality
  - Measured by basing on health care outcomes
Recent Academy Publications

- Letters to Congress on ACA Repeal without Replace
  - (December 2016)

- An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes
  - (Issue Paper, January 2017)

- Selling Across State Lines
  - (Issue brief, February 2017)

- Association Health Plans
  - (Issue brief, February 2017)

- Using High-Risk Pools to Cover High-Risk Enrollees
  - (Issue brief, February 2017)

- Proposed Approaches to Medicaid Funding
  - (Issue brief, March 2017)

- Letter to U.S. House on American Health Care Act (AHCA)
  - (March 2017)

Staff Contact

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March 31, 2017

Commissioner Al Redmer, Jr. (MD)
Chair
Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners
444 North Capitol Street, NW
Suite 700
Washington, DC 20001

RE: Issues and Concerns with Affordable Care Act Repeal and Replacement Proposals

Dear Commissioner Redmer:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists (SLPs); speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. ASHA would like to offer comments to the National Association of Insurance Commissioners’ (NAIC) Health Insurance and Managed Care (B) Committee as it considers proposals related to health care reform in the individual and small group markets.

Specifically, this letter will address the:
- value of habilitative services and devices coverage;
- increased cost-sharing and high deductible plans for low to moderate income individuals and families; and
- interstate health insurance sales.

Value of Habilitative Services and Devices Coverage
The Affordable Care Act (ACA) ushered in important coverage gains for habilitative services and devices. Failing to replace the ACA in a manner that would preserve access to habilitative services and devices would turn back the clock on children and adults with autism, cerebral palsy, congenital deficits, disabilities, and other chronic and progressive conditions. Americans who need habilitative services and devices rely on their health care coverage to keep, learn, or improve skills and functioning for daily living so that they can live as independently as possible. Often, skills acquired through habilitative services and devices lead to breakthroughs in functional ability that would not have been possible without access to timely and appropriate habilitation benefits. This reduces long-term disability and dependency costs to society.

Prior to the ACA, few Americans even understood the meaning of habilitative services and devices, let alone the benefits habilitation brings to those in need. In fact, less than a handful of states adopted coverage requirements for habilitative services. Fortunately, since the enactment of the essential health benefits (EHB), the value of habilitative services has been widely...
acknowledged, and access to these services has been expanded. The Uniform Glossary developed by the NAIC acknowledges that habilitative services are medically necessary. This glossary—adopted by the U.S. Department of Health and Human Services (HHS)—accompanies the Summary of Benefits and Coverage provided to millions of consumers with employer-sponsored and individual plans.\(^1\)\(^2\)

One of the criticisms of the EHB requirement is that it significantly increases premiums; however, evidences suggests that factors, such as community rating, may actually have more of an effect on premiums than EHBs.

As the Committee considers reforms and revisions to the health care system and insurance markets, the following vignettes help to demonstrate the value of habilitation:

**Habilitation Services for Infants and Children: Cleft Palate**
Jessica is a two-year old child with a bilateral cleft palate that was surgically repaired at 11 months of age. She presented with speech sound production errors and excessive nasality that impaired her ability to communicate. Jessica’s care is coordinated by a cleft palate/craniofacial team that includes a plastic surgeon, an orthodontist, an SLP, a pediatrician, and additional providers. The SLP assesses articulation, language, voice, and resonance and determines the presence of articulation deficits and nasal emission that requires speech-language treatment weekly. Treatment goals focus on correct articulatory placement to address sound errors, nasality of speech, and oral airflow. With appropriate speech-language treatment, Jessica will learn techniques to improve her speech intelligibility, allowing her to communicate with others at an age-appropriate level. Professional collaboration with the craniofacial team and a coordinated care plan ensure that Jessica achieves maximum functional communication.

**Habilitation Services for Adults: Cochlear Implants**
Raul was diagnosed with congenital hearing loss as a young child, but did not have access to hearing aids until age ten. He attended a school for the deaf and hard of hearing, and his primary language is American Sign Language. As an adult, Raul decided to undergo cochlear implant surgery and learn spoken language. He works with an audiologist and an SLP on open-set speech recognition with amplification. The prognosis from the interdisciplinary cochlear implant team—based on Raul’s motivation, progress in therapy, and use of lip-reading and technology—is fair for receptive language abilities. His cochlear implant and related new skills will assist him with communication in the workplace and community.

**Increased Cost-Sharing and High-Deductible Plans for Low to Moderate Income Individuals and Families**
Increasing cost-sharing fails to recognize the limited financial capacity of many individuals and families who are enrolled in individual market insurance coverage. While health savings accounts (HSA) and high-deductible plans (HDP) have a significant role to play in increasing consumer attention and focus on health care costs, quality, and effectiveness, applying them to

\(^1\) https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/
\(^2\) https://www.healthcare.gov/sbc-glossary/#medically-necessary
individuals who cannot afford the copayments results in delaying and avoiding health care
services that often help manage and prevent progression to more serious and costly conditions.

Per a December 2016 focus group conducted by the Kaiser Family Foundation, participants
rejected the idea of low-premium, HDPs coupled with HSAs. Among other concerns, they felt
that they would not be able to build up enough savings with an HSA to cover the out-of
pocket costs associated with HDPs.

**Interstate Health Insurance Sales**

While commonly discussed as a means to increase competition and reduce costs, the reality of
interstate health insurance has proven the opposite with larger entities crowding out smaller
plans and reducing overall consumer choice. In addition, current proposals to allow interstate
health insurance sales would propose a threat to consumer protection and access to services
including audiology and speech-language pathology for a variety of reasons.

First, interstate sale of private health plans would reduce the ability of state insurance
commissioners from fully engaging in their consumer protection oversight role and not allow
them the ability to fully enforce the laws within their state to ensure appropriate access to care by
qualified, licensed, health care professionals.

Second, interstate health insurance sales would allow health plans to be established in states with
low coverage criteria and consumer protections and provide those plans for sales in states with
more comprehensive requirements. This would essentially undermine the hard-fought state
mandates achieved for services including autism coverage, habilitation, hearing health care, tele-
practice recognition, and copayment parity.

Ensuring that Americans continue to have access to affordable, high-quality health insurance
coverage that meets their needs must be at the forefront of any discussion surrounding ACA
repeal and replacement proposals. ASHA appreciates the opportunity to submit comments to the
Health Insurance and Managed Care Committee of the NAIC and would like you to consider us
as a resource as you move forward. Please contact me, at 301-296-5651 or by e-mail at
dgrooms@asha.org, if you require additional information or clarification.

Sincerely,

Daneen P. Grooms, MHSA
Director, Health Reform Analysis and Advocacy

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Family Foundation, accessed March 29, 2017; http://kff.org/health-reform/issue-brief/listening-to-trump-voters-
April 9, 2017

Commissioner Al Redmer
Chair, National Association of Insurance Commissioners
Health Insurance and Managed Care (B) Committee
Maryland Insurance Administration
200 St Paul Street, #2700
Baltimore, MD 21202

Dear Commissioner Redmer:

On behalf of the membership of the National Association of Health Underwriters (NAHU), I would like to thank you for inviting our association to participate in the Health Insurance Managed Care (B) Committee’s roundtable discussion by stakeholders about issues and concerns about proposals to repeal and replace all or aspects of the Patient Protection and Affordable Care Act (ACA). Unfortunately, schedules did not permit me to be able to attend the discussion in person, so please accept these written comments instead.

NAHU members are health insurance agents, brokers and consultants, and we represent more than 100,000 benefit specialists nationally. NAHU members experience the realities of the current state of the health insurance market every day. While many people have gained coverage as a result of the ACA, our members are finding it increasingly difficult to help their clients find affordable high-quality health insurance coverage, particularly in the individual health insurance market.

Whether or not parts of the ACA are repealed via reconciliation, using a version of the American Health Care Act or another vehicle, NAHU believes it is imperative that action be taken to enhance health insurance market stability, particularly for individual and small group health insurance consumers. Some should be taken immediately, while others could come into effect over the next few years.

NAHU also hopes that Congress will ultimately address most ACA changes on a bipartisan basis. It is possible to retain provisions of the ACA like guaranteed issue of coverage, no pre-existing conditions, and coverage to age 26 and other important protections while making other significant changes that will bring down the cost of coverage and enhance coverage options. Consideration will need to be given to how we enroll people for coverage and how we encourage them to remain covered. We will need to look at creative solutions to address high-risk individuals in a way that does not discriminate against them but instead acknowledges the increased risk and mitigates it so that it does not increase costs for others who are insured. A most significant concern should remain making sure most people are covered somewhere, either through their own policy or through their employer, and that younger people understand and embrace the importance of continuous health insurance coverage. Continuous coverage can be encouraged and achieved with the right incentives.

Legislatively, some of NAHU’s priorities for market stabilization include:

1. Allowing premium tax credits to be used outside of the Marketplace if there are fewer than two choices offered in a state. Alternatively, this could apply in certain counties within a state.
2. Allowing any person to purchase the catastrophic category of coverage regardless of age or income status. Since market stabilization has not yet been achieved and premium levels are high, many people are priced out of coverage. This provision would allow purchase of some level of affordable coverage for all. We further recommend that the current schedule of ACA tax credits be permitted to apply to this type of coverage.

3. The current structure of open enrollments and special enrollments must be addressed. We recommend changing the current annual open enrollment to a one-time or less-frequent than-annual open-enrollment period. We further recommend that special-enrollment opportunities be tightened significantly to remove subjective eligibility and be allowed only for lifestyle changes such as loss of documented coverage, marriage, divorce, death of a spouse or birth or adoption of a child, and that a person be permitted a maximum 60-day break in coverage.

4. Begin action on allowing and providing funding for states on hybrid high-risk pools (hybrid version to insure risk and not be coverage-issuing pools) to be in effect by January 1, 2019.

5. If ACA tax credits are repealed via reconciliation or some other mechanism, they will need to be replaced with another type of tax credit. NAHU feels that the greatest market stability would be obtained by making these credits income-adjusted, which would provide for a larger credit for those who most need it so that they can afford to remain continuously insured. This income adjustment does not need to replicate what is in place today, but assistance is particularly needed for those below 300% of FPL. If the credit is not income-adjusted, it should, at a minimum, be refundable and advanceable and age-rated with at least five rating categories. Weighting should encourage younger individuals to enroll.

6. Allowing states flexibility in plan design relative to coverage for an essential benefits package but retain coverage for dependents to age 26, prohibition on lifetime limits, mental health parity and prohibition on pre-existing conditions.

Some of the areas where NAHU believes that the new Administration could positively impact health insurance markets via thoughtful and targeted regulatory change include but are not limited to:

1. Limiting special enrollment periods only to those clearly defined in the ACA and should require submission of documented proof by the 15th of the month before coverage will be effective.
2. The extended 90-day grace period for individuals who are receiving premium tax credits should be reduced to the same 30-day grace period for other covered individuals.
3. HIPAA Certificates of Credible coverage, which for many years documented periods of coverage and showed when coverage began and ended, were discontinued in conjunction with the ACA. Immediate restoration of those certificates would facilitate proof of dates of coverage for multiple purposes, including documentation of continuity of coverage and loss of coverage for special enrollment purposes.
4. If the medical loss ratio is not repealed via reconciliation and until it can be repealed legislatively, there should be regulatory action to redefine the formula for MLR to specifically exclude broker commissions in the same way taxes are excluded from the formula.
5. Allowing a more robust form of composite rating in fully insured plans to allow ease of administration for small employers that provide coverage for employees.
6. Removing the requirement for standardized benefit plans to be offered in Marketplaces.
7. Simplifying the structure and burden of IRC § §6055 and 6056 employer reporting requirements.
8. Removing limitations on keeping grandfathered plans to allow greater changes in employee contributions toward coverage, deductibles and other benefit changes based on an annual allowable change vs. lifetime
change.

On the state side, state innovation waivers via section 1332 of the ACA and the also 1115 Medicaid waivers are at our collective disposal. NAHU is very interested in working with state policymakers on innovative proposals, possibly using either or both of those waiver opportunities to stabilize markets at the state level and ensure that more people obtain needed health insurance coverage.

NAHU certainly believes that other actions could be taken at both the federal and state levels of government to improve American access to quality and affordable health coverage, particularly relating to employer-sponsored coverage. However, NAHU sees the items addressed in this letter as important immediate steps to ensuring the affordability and availability of private health insurance coverage for all Americans. We appreciate the opportunity to provide these comments are would be pleased to respond to any additional questions or concerns of the committee. If NAHU can be of further assistance to you, please feel free to contact me at 202-595-0787 or jtrautwein@nahu.org. Also, please feel free to reach out to our Vice President of Government Affairs, Marcy Buckner (mbuckner@nahu.org) or Jessica Waltman, Principal of Forward Health Consulting (jessica@forwardhealthconsulting.com) who are representing NAHU at the meeting in Denver.

Sincerely,

Janet Trautwein
Executive Vice President and CEO
National Association of Health Underwriters

cc: Jolie Matthews, NAIC Senior Life and Health Policy Counsel
Agenda Item #5

Consider Adoption of its March 16 and Feb. 15, 2017 and 2016 Fall National Meeting Minutes  
—Commissioner Al Redmer Jr. (MD)
The Health Insurance and Managed Care (B) Committee met via conference call March 16, 2017. The following Committee members participated: Al Redmer Jr., Chair (MD); Lori K. Wing-Heier, Vice Chair, represented by Jacob Lauten and Sarah Bailey (AK); Leslie R. Hess (AZ); Katharine L. Wade (CT); Dean L. Cameron represented by Kathy McGill (ID); Roger A. Sevigny (NH); Brian Maynard represented by Nancy Atkins (KY); Teresa D. Miller (PA); Todd E. Kiser represented by Tomasz Serbinowski (UT); and Mike Kreidler represented by Molly Nollette (WA). Also participating was: Kevin Dyke (MI).

1. **Adopted Revisions to Model #10**

Mr. Dyke said the Health Actuarial (B) Task Force adopted revisions to the *Health Insurance Reserves Model Regulation* (#10) via conference call Feb. 24. He said the revisions incorporate the 2016 Cancer Claim Cost Valuation Tables (2016 CCCVT), replacing the current 1985 Cancer Claim Cost Tables (1985 CCCT). Mr. Dyke said the 2016 CCCVT were proposed by the American Academy of Actuaries (Academy)/Society of Actuaries (SOA) Cancer Claim Cost Tables Work Group as the basis for a new minimum valuation standard for cancer insurance contracts issued on or after Jan. 1, 2019. He said the revisions also provide that a company may elect to use the 2016 CCCVT for contracts issued on or after Jan. 1, 2018, but if a company does so, it may not revert to the 1985 CCCT.

Commissioner Miller made a motion, seconded by Commissioner Sevigny, to adopt the revisions to the *Health Insurance Reserves Model Regulation* (#10) (Attachment One-A). The motion passed unanimously from those Committee members present and voting, with Alaska, Arizona, Connecticut, Idaho, Kentucky, New Hampshire, Pennsylvania, Utah and Washington voting in favor of the motion.

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

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The Health Insurance and Managed Care (B) Committee met via conference call Feb. 15, 2017. The following Committee members participated: Al Redmer Jr., Chair (MD); Lori K Wing-Heier, Vice Chair (AK); Leslie R. Hess (AZ); Katharine L. Wade represented by Paul Lombardo (CT); Dean L. Cameron represented by Kathy McGill, Wes Trexler and October Nickel (ID); Jennifer Hammer represented by James Stephens (IL); Maria T. Vullo represented by Stephen Wiest (NY); Teresa D. Miller (PA); Larry Deiter represented by Melissa Klemann (SD); Todd E. Kiser represented by Tanji Northrup (UT); and Mike Kreidler represented by Molly Nollette (WA). Also participating were: Kevin Dyke (MI); and J.P. Wieske (WI).

1. Discussed Committee 2017 Activities

Commissioner Redmer explained that in 2016, the Committee focused on health care costs and heard a number of presentations on that topic at each NAIC national meeting. He said that this year, given the debate and discussion concerning the possible repeal and replacement of the federal Affordable Care Act (ACA), he anticipates the Committee focusing on that topic and discussing the various ACA reform proposals as they emerge. Commissioner Redmer said the NAIC officers anticipate using the Committee as a public forum to discuss these issues. He said the Committee also could have to revisit long-term care insurance (LTCI) issues. Commissioner Redmer encouraged Committee members and interested parties to offer any suggestions with respect to the Committee’s 2017 activities.

Commissioner Redmer outlined the Committee’s meeting agenda for the Spring National Meeting. He said the Committee plans to hear a presentation concerning a Robert Wood Johnson Foundation-sponsored project involving “Transparency for Consumers and Regulators.” Commissioner Redmer said the Committee also expects to hear a panel presentation from representatives of various stakeholder groups concerning their issues and concerns with current ACA repeal and replacement proposals being discussed in the U.S. Congress and other forums. He said that related to this, the Committee also plans to receive a federal legislative update.

Director Wing-Heier stressed the importance of the Committee staying apprised of ongoing activities both in Congress and other forums related to ACA repeal and replacement. She suggested that the Committee develop a way to share information that its members receive on these proposals through their communications with their congressional delegations, particularly as to their potential impact on the states and the U.S. territories. Commissioner Redmer expressed support for Director Wing-Heier’s suggestion. He asked for suggestions on what processes and mechanisms could be used to implement this suggestion. Commissioner Redmer said he also would discuss this with the Committee’s NAIC staff support.

2. Heard Updates from its Task Forces on 2017 Activities

a. Health Actuarial (B) Task Force

Mr. Dyke said the Health Actuarial (B) Task Force plans to meet via conference call Feb. 24 to adopt revisions to the Health Insurance Reserves Model Regulation (#10) to include the 2016 Cancer Claim Cost Valuation Tables. He said that if adopted, the Task Force plans to present the revisions to the Committee for its adoption via conference call in order for the revisions to be included on the Executive (EX) Committee and Plenary’s agenda for adoption at the Spring National Meeting. Mr. Dyke said the Long-Term Care Pricing (B) Subgroup plans to continue its work related to more uniform LTCI rate reviews among the states. He said the Long-Term Care Valuation (B) Subgroup plans to continue to work on stand-alone LTCI asset adequacy. Mr. Dyke said the Health Care Reform Actuarial (B) Working Group will be the Task Force group tasked with reviewing any legislation and proposed regulations from an actuarial perspective related to ACA repeal and replace. He also said the Task Force plans to continue its work related to principle-based reserving (PBR) for health.

b. Regulatory Framework (B) Task Force

Mr. Wieske said the Regulatory Framework (B) Task Force’s Accident and Sickness Insurance Minimum Standards (B) Subgroup plans to continue its work to review and consider revisions to the Accident and Sickness Insurance Minimum Standards Model Act (#170) and the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). He said the Model #22 (B) Subgroup will continue its work on revisions to the Health Carrier

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Prescription Drug Benefit Management Model Act (#22). He said the Task Force also would be involved in any ACA repeal and replacement activities that would affect existing NAIC models. Mr. Wieske said that during the Task Force’s Feb. 14 conference call, some Task Force members expressed an interest in discussing the possible development of a consumer disclosure or alert related to health sharing ministries.

Mr. Wieske said the ERISA (B) Working Group is working to complete its revisions to the several existing sections in the Health and Welfare Plans Under the Employee Retirement Income Security Act: Guide to State and Federal Regulation (ERISA Handbook) and new sections concerning association coverage, professional employer organizations (PEOs) and the ACA. He also noted that the Working Group is seeking a new chair.

c. Senior Issues (B) Task Force

Commissioner Miller said the Senior Issues (B) Task Force will continue to monitor the work of its subgroups. She said the Long-Term Care Innovation (B) Subgroup plans to develop realistic policy options for Congress, the states and the NAIC to consider for addressing ways consumers can finance their future long-term care (LTC) needs. Commissioner Miller said the Task Force could submit its recommendations to the Committee for its consideration as soon as the Spring National Meeting.

Commissioner Miller said the Task Force recently completed and distributed a frequently asked questions (FAQ) document to the states on changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651) required by the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). She said the Task Force also would be monitoring state adoption of those changes to Model #651. Commissioner Miller said the Task Force also plans to update the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare and the Buyer’s Guide for Long-Term Care Insurance.

Commissioner Miller said the Task Force may examine the issue of Medicare supplemental insurance (Medigap) re-entry. She explained that Model #651 imposes a five-year penalty period to prevent a company from closing a block of business and immediately offering the same plan at a lower rate. However, this penalty period apparently does not apply to a company that is a separate legal entity from a “parent company.” Commissioner Miller said that if the Task Force decides to examine the issue, as part of that examination, it could consider revising Model #651 to extend the five-year moratorium on re-entry to all legal entities associated with a parent company or organization after a plan of any one of those legal entities is closed to new sales.

Commissioner Miller said the Task Force established a new subgroup to develop a new NAIC model to address LTC insurance policies of short-duration. She said the Task Force plans to disband two of its subgroups, the Medigap (B) Subgroup and the Long-Term Care Consumer Disclosure (B) Subgroup, because both subgroups have completed their charges.

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

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Draft Pending Adoption

Draft: 12/21/16

Health Insurance and Managed Care (B) Committee
Miami, Florida
December 11, 2016

The Health Insurance and Managed Care (B) Committee met in Miami, FL, Dec. 11, 2016. The following Committee members participated: Katharine L. Wade, Chair (CT); Marguerite Salazar represented by Peg Brown (CO); Dean L. Cameron (ID); Mike Chaney (MS); Monica J. Lindeen (MT); Roger A. Sevigny represented by Jennifer Patterson (NH); Maria T. Vullo (NY); Teresa D. Miller (PA); Ángela Wayne (PR); Larry Deiter (SD); Todd E. Kiser (UT); Mike Kreidler (WA); Michael D. Riley represented by Ellen Potter (WV); and Tom Glause (WY). Also participating were: Steve Ostlund (AL); Lori K. Wing-Heier (AK); Perry Kupferman (CA); Rich Robletto (FL); Al Redmer Jr. (MD); Angela Nelson and Mary Mealer (MO); Chlora Lindley-Myers (TN); and J.P. Wieske (WI).

1. Heard a Panel Presentation on Prescription Drug Pricing

Robert Zirkelbach (Pharmaceutical Research and Manufacturers of America—PhRMA) discussed the value and actual cost of medicines, noting how medicines have evolved over the years, from being made of chemical compounds to being made from living cells. He also noted that medicines are the best value in the health care system, accounting for 12% to 15% of health care spending. Mr. Zirkelbach also outlined how a competitive marketplace works to control costs. He noted that payers have significant leverage to negotiate rebates and discounts, debunking the “blank-check” myth. Lastly, he described the right way and wrong way to move forward with respect to transparency, value and coverage.

John O’Brien (CareFirst BlueCross BlueShield—CareFirst) described the U.S. retail outpatient pharmaceutical supply, payment and reimbursement chain between insurers and their members. He noted that how prescription drugs are priced and paid for is not as simple as it seems. In reality, it is a complicated process. Mr. O’Brien also noted that for CareFirst, except primary care physician spending, between 2014 and 2015, among all of the other types of health care-related spending, pharmacy drug spending increased from 28.8% to 32%. He also noted a steep increase in the prices of generic drugs.

Leanne Gassaway (America’s Health Insurance Plans—AHIP) discussed how new and upcoming prescription drugs offer great clinical promise, but are a serious threat to affordability. She said specialty drugs are a significant cost driver. Ms. Gassaway questioned whether high prescription drug costs are a result of research and development or other factors, such as marketing. She also discussed the possible factors driving high prescription drug prices and public reaction to high drug costs. Lastly, Ms. Gassaway offered several suggestions for advancing specific policies to promote market-based solutions for addressing high prescription drug prices and increasing costs with respect to transparency, competition and value.

Scott Woods (Pharmaceutical Care Management Association—PCMA) discussed the role and value of pharmacy benefit managers (PBMs) in the health care system. He said PBMs save plan sponsors and consumers an average of 35% compared to expenditures made without pharmacy benefit management. Mr. Woods emphasized that health plans and PBMs do not have any control over the price the manufacturer sets for a drug, but PBMs have some tools to drive down drug costs. He also discussed the value—with respect to savings for consumers, employers and other payers—of mail-order service pharmacies. Mr. Woods said manufacturers are increasing drug prices for brand-name and generic drugs. He said PBMs play a unique and central role in driving adherence, holding down costs and increasing quality. Mr. Woods said PBM tools deliver savings for plan sponsors and consumers, underscoring the success of the competitive marketplace.

Claire McAndrew (Families USA) highlighted the rising costs of prescription drugs and its impact on consumers. She noted that it is the fastest growing category in health spending, with consumers spending an average of $848 per capita in the U.S. versus an average of $400 per capita in 19 other developed countries. Ms. McAndrew said making prescription drug prices more affordable and lowering drug prices is a top consumer health care priority. She also outlined some of the factors for the high drug costs, particularly the cost of specialty drugs.

Jesse Ellis O’Brien (Oregon State Public Interest Research Group—OSPIRG) discussed state policy solutions to address high prescription drug costs and increasing drug costs, including transparency in drug pricing and mandatory rebates under certain circumstances.

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2. **Heard a Presentation on Health Care Affordability Issues**

Katie Allen (Council for Affordable Health Coverage—CAHC) discussed health care affordability issues, including what the health insurance markets could look like in 2017 and beyond, which could include fewer options and rising costs. She first discussed the threat of rising health costs to the health insurance markets, particularly the individual market. Ms. Allen also pointed out what is happening in the health insurance markets now and its impact in 2017. She highlighted lower enrollment among young, typically healthy, adults, which means greater adverse risk and more expensive premiums, which has led to less competition and declining choice. Ms. Allen also noted that, despite these problems, it cannot be denied that the federal Affordable Care Act (ACA) has benefited consumers all over the country. Because of the ACA, the number of uninsured in the U.S. has reached historic lows and 22% fewer people are struggling with medical debt. She noted that there is considerable downside risk if policymakers are unable to stabilize markets and programs that currently provide coverage for millions of people. Ms. Allen discussed the potential implications of the 2016 election on the future of the ACA and potential post-election congressional action and administrative action. She also discussed the potential opportunities for the states, particularly if the U.S. Congress moves away from the federal regulation of insurance and returns insurance regulation primarily back to the states. Ms. Allen also discussed the implications to the states if congressional reform efforts include a return to high-risk pools. She also noted the possible use of the ACA’s Section 1332 waivers, but in a different form. Lastly, Ms. Allen discussed the CAHC’s core objectives and considerations for successful policy reform.

3. **Heard an Update from the CHIR on its Work Related to the ACA**

JoAnn Volk (Georgetown Health Policy Institute, Center on Health Insurance Reforms—CHIR) provided an update on the CHIR’s work related to the ACA through the State Health Reform Assistance Network, which is a program of the Robert Wood Johnson Foundation (RWJF). She noted the CHIR’s ongoing work, including its Commonwealth Fund project monitoring state action on health reform implementation and its work funded by the RWJF looking at emerging issues in private insurance and health reform implementation. Ms. Volk said the CHIR’s future work will include examining such issues as: 1) how the states and issuers will respond to major changes at the federal level; and 2) what federal policymakers can learn from state experience prior to the ACA. She said the CHIR also plans to examine potential ACA replacement proposals, such as high-risk pools and insurance sales across state lines.

4. **Adopted its Oct. 25 Minutes**

Commissioner Weyne made a motion, seconded by Commissioner Lindeen, to adopt the Committee’s Oct. 25 (Attachment One) minutes. The motion passed unanimously.

5. **Adopted Revisions to AG 47**

Mr. Ostlund said Actuarial Guideline XLVII—The Application of Company Experience in the Calculation of Claim Reserves under the 2012 Group Long-Term Disability Valuation Table (AG 47) deals with the implementation of the 2012 Group Long Term Disability Table (2012 Table), which the NAIC adopted in 2014. He said AG 47 includes a transition period for companies to come into compliance with the 2012 Table’s requirements. But, with the Jan. 1, 2017, Valuation Manual effective date, companies in those states that have not adopted the 2012 Table will lose the benefit of the transition period. Mr. Ostlund said that to address this issue, the Health Actuarial (B) Task Force adopted revisions to AG 47 Nov. 17 via conference call to limit the application of the actuarial guideline if a company does not have a large enough number of claims to require the development of an experience study and adjustment of reserves.

Commissioner Kreidler made a motion, seconded by Commissioner Miller, to adopt the revisions to AG 47 (Attachment Two). The motion passed unanimously.

6. **Adopted Senior Issues (B) Task Force’s Revised 2017 Proposed Charges, a Model Law Development Request and a Medigap Compliance Manual Referral to the Health Actuarial (B) Task Force**

   a. **Adopted Senior Issues (B) Task Force’s Revised 2017 Proposed Charges**

Jolie Matthews (NAIC) said that during its Dec. 10 meeting, the Senior Issues (B) Task Force adopted revisions to its 2017 proposed charges to remove the charge for the Short-Term Health Policies Providing Long-Term Care Benefits (B) Subgroup and add a new charge for the Short-Duration Long-Term Care Policies (B) Subgroup to require the Subgroup to create a model to address long-term care products of short duration that are excluded from the Long-Term Care Insurance Model Act (#640) and the Long-Term Care Insurance Model Regulation (#641), but do not quite fit under the Accident and Sickness...
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Insurance Minimum Standards Model Act (#170) and the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171). Commissioner Miller made a motion, seconded by Commissioner Kreidler, to adopt the Senior Issues (B) Task Force revised 2017 proposed charges (Attachment Three). The motion passed unanimously.

b. Adopted Senior Issues (B) Task Force’s Model Law Development Request

Ms. Matthews said the Senior Issues (B) Task Force, also during its Dec. 10 meeting, adopted a model law development request for the Short Duration Long-Term Care Policies (B) Subgroup to develop a new NAIC model to address long-term care products of short duration in accordance with its 2017 proposed charge. Commissioner Miller made a motion, seconded by Commissioner Kreidler, to adopt the Senior Issues (B) Task Force’s model law development request (Attachment Four). The motion passed unanimously.

c. Adopted the Senior Issues (B) Task Force’s Referral of the Medigap Compliance Manual to the Health Actuarial (B) Task Force

Ms. Matthews said that during its Dec. 10 meeting, the Senior Issues (B) Task Force adopted a motion to have the Health Actuarial (B) Task Force review and consider revisions to the Medicare Supplement Insurance Model Regulation Compliance Manual (Medigap Compliance Manual) that may be necessary as a result of the revisions to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651), which were adopted by the Executive (EX) Committee and Plenary at the Summer National Meeting. She said the Committee needs to adopt the Senior Issues (B) Task Force’s referral before it can be sent to the Health Actuarial (B) Task Force. Commissioner Kreidler made a motion, seconded by Commissioner Miller, to adopt the Senior Issues (B) Task Force’s motion to refer to the Health Actuarial (B) Task Force the review and possible revision of the Medigap Compliance Manual for consistency with the recent revisions to Model #651. The motion passed unanimously.

7. Adopted the Health Actuarial (B) Task Force’s Request for an Extension of Model Law Development for Model #10

Ms. Matthews said the Health Actuarial (B) Task Force is requesting an extension of model law development for the Health Insurance Reserves Model Regulation (#10) to revise the model to reflect appropriate long-term care insurance reserving standards. Commissioner Kreidler made a motion, seconded by Commissioner Miller, to adopt the Health Actuarial (B) Task Force’s request for extension for model law development for Model #10. The motion passed unanimously.

8. Adopted its Subgroup, Working Group and Task Force Reports

Commissioner Kreidler made a motion, seconded by Commissioner Kiser, to adopt the reports of the Committee’s subgroups, working group and task forces: the Consumer Information (B) Subgroup, including its Nov. 18 (Attachment Five) and Oct. 28 (Attachment Six) minutes; the CO-OP Solvency and Receivership (B) Subgroup; the Health Care Reform Regulatory Alternatives (B) Working Group, including its Aug. 26 minutes (see NAIC Proceedings – Summer 2016, Health Insurance and Managed Care (B) Committee, Attachment Five); the Health Actuarial (B) Task Force; the Regulatory Framework (B) Task Force; and the Senior Issues (B) Task Force.

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

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Agenda Item #6

Consider Request for Extension of Model Law Development for the *Health Insurance Reserves Model Regulation* (#10)—Commissioner Al Redmer Jr. (MD)
REQUEST FOR MODEL LAW DEVELOPMENT

This form is intended to gather information to support the development of a new model law or amendment to an existing model law. Prior to development of a new or amended model law, approval of the respective Parent Committee and the NAIC’s Executive Committee is required. The NAIC’s Executive Committee will consider whether the request fits the criteria for model law development. Please complete all questions and provide as much detail as necessary to help in this determination.

Please check whether this is: ☐ New Model Law or ☑ Amendment to Existing Model

1. Name of group to be responsible for drafting the model:
   Long-Term Care Actuarial (B) Working Group

2. NAIC staff support contact information:
   Eric King
   EKing@naic.org

3. Please provide a description and proposed title of the new model law. If an existing law, please provide the title, attach a current version to this form and reference the section(s) proposed to be amended.

   Amend Health Insurance Reserves Model Regulation (#010) to reflect appropriate reserving standards.

4. Does the model law meet the Model Law Criteria? ☑ Yes or ☐ No (Check one)
   (If answering no to any of these questions, please reevaluate charge and proceed accordingly to address issues).
   a. Does the subject of the model law necessitate a national standard and require uniformity amongst all states? ☑ Yes or ☐ No (Check one)
      If yes, please explain why

   b. Does Committee believe NAIC members should devote significant regulator and Association resources to educate, communicate and support this model law?
      ☑ Yes or ☐ No (Check one)

5. What is the likelihood that your Committee will be able to draft and adopt the model law within one year from the date of Executive Committee approval?
   ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)
   High Likelihood Low Likelihood
   Explanation, if necessary:

6. What is the likelihood that a minimum two-thirds majority of NAIC members would ultimately vote to adopt the proposed model law?
   ☑ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Check one)
High Likelihood               Low Likelihood

Explanation, if necessary:

7. What is the likelihood that state legislature will adopt the model law in a uniform manner within three years of adoption by the NAIC?

☐ 1  ☐ 2  ☐ 3  ☐ 4  ☐ 5  (Check one)

High Likelihood               Low Likelihood

Explanation, if necessary: NA

8. Is this model law referenced in the Accreditation Standards? If so, does the standard require the model law to be adopted in a substantially similar manner?

No

9. Is this model law in response to or impacted by federal laws or regulations? If yes, please explain.

No
Agenda Item #7

Hear Senior Issues (B) Task Force Recommendations for Federal Policy Options and Approaches to the Financing of Long-Term Care Needs
—Commissioner Teresa D. Miller (PA)—MATERIALS PENDING
As part of the NAIC’s Retirement Security Initiative and ongoing focus on long term care insurance issues, the NAIC’s Long Term Care Innovations (B) Subgroup (“the Subgroup”) held 14 open calls and meetings, and continues such outreach, to gain insights from stakeholders on various approaches to financing long term care (LTC). The goal of this work is to identify and develop actionable, realistic policy options for consideration by state regulators, state legislators, the NAIC as a body, federal agencies, and Congress, that could increase the number of affordable asset protection product options available for middle-income Americans, potentially paving the way for the private market to play a more meaningful role in financing the LTC needs of our society.

Broadly speaking, some of the issues and questions the subgroup examined include the role for the private market in assisting people in financing their LTC needs; the steps that could be taken to encourage more participation by insurance companies or other innovators in this market; the future design of LTC insurance (LTCI) products; other asset protection products and the role they can and do play in financing LTC; the types of products most appealing to consumers; the types of products insurance companies would be interested in selling; the role employers should play in terms of offering products to assist in financing LTC services; the legal and regulatory barriers that may need to be overcome and any federal or state actions that could be taken to increase the number of options available to consumers to help them finance their potential LTC needs.

Although the focus of the Subgroup is on the private LTC insurance market, it is important to understand that no one is suggesting that private LTC insurance is the answer to the problem of how we as a society are going to finance the LTC needs of our citizens. We still expect Medicaid LTC costs to continue growing and recognize that many of the solutions being discussed by the Subgroup will not fully address long duration LTC needs. But, we believe the private market can be part of the solution.

The following is a list of federal policy changes that have been raised by various stakeholders, submitted to all Subgroup members for a 30-day comment period, vetted in the Subgroup during a 2-hour open conference call and reviewed by NAIC staff. The Subgroup believes these federal policy changes could help to increase private LTC financing options for consumers. Ultimately, any final recommendations to the federal government will need to be approved by the NAIC’s Government Relations Leadership Council. The federal laws primarily identified by stakeholders that would require changes include the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Deficit Reduction Act of 2005 (DRA).
• **Option 1:** Permit retirement plan participants to make a distribution from 401(k), 403(b) or Individual Retirement Account (IRA) to purchase LTCI with no early withdrawal tax penalty. Related considerations include whether premium payments should be made directly from the retirement plan to the insurer; allowing purchase of combination or hybrid products as well as traditional LTCI; whether premium payments would be counted for purposes of satisfying the minimum distribution requirements; and permitting tax-favored contributions and distributions to pay for long term care services and supports or LTC insurance including allowances of LTCI as a plan investment.

• **Option 2:** Allow Creation of LTC Savings Accounts, similar to Health Savings Accounts (HSAs) and/or Enhance Use of HSAs for LTC Expenses and Premiums. HSAs are tax-advantaged medical savings accounts available to taxpayers who are enrolled in a high-deductible health plan (HDHP). The funds contributed to an account are not subject to federal income tax at the time of deposit. Advantages of HSAs include: 1) the account is tax-advantaged, meaning that money goes into the account before tax, thereby incurring savings; 2) the funds roll over from one year to the next; 3) the money can be invested in order to gain returns from stocks or other financial instruments, which helps the account grow more quickly; and 4) money withdrawn (including any investment growth) for approved expenses (which include LTCI premiums under current law) is tax-free. Consideration should be given to stand-alone accounts which could be used for LTC expenses and LTCI premiums. Such accounts should not be conditioned upon having a HDHP, since health insurance coverage generally does not cover LTC costs. Consideration also should be given to enhancing use of HSAs such as allowing an additional contribution (similar to a “catch-up contribution”) to HSAs for owners of LTCI.

• **Option 3:** Remove the HIPAA requirement to offer 5% compound inflation with LTCI policies and remove the requirement that DRA Partnership policies include inflation protection and allow the States to determine the percentage of inflation protection. In an LTCI policy with inflation protection, the LTC benefit increases each year at a specified rate; the aim of inflation protection is to ensure that the value of the benefit keeps up with inflation. Inflation protection substantially increases LTCI premiums. For tax-qualified policies and those governed by the NAIC Model Regulation, a 5% inflation protection option must be offered, although a purchaser may choose not to take it. However, if the purchaser is under 75, they must accept inflation protection in order for the policy to be Partnership qualified. For group coverage, this option must be offered to the group policyholder (usually an employer), but it is not generally required that it be offered to each individual group member, although some states require this as well. Removal of the requirement that insurers offer 5% compound inflation with LTCI policies and the requirement that Partnership policies include inflation protection would increase insurer flexibility when designing products and could lead to lower premium costs. At the same time, consideration should be given to requiring an offering of some type of inflation protection to ensure consumers continue to have the option to protect themselves against increasing LTC costs. [Note: this would require both federal changes, changes to the NAIC models, and adoption of revised NAIC models by states.]

• **Option 4:** Allow flexible premium structures and/or cash value beyond return of premium (HIPAA and DRA). Flexible premium policies with clear consumer disclosures and protections built in could increase consumer choice and flexibility by allowing prefunding for LTC needs under a variety of premium payment patterns. Cash value or cash surrender value is the amount of money the insurance company pays a policyholder or beneficiary when they terminate a life insurance policy or annuity contract that has a cash value feature. Federal law (HIPAA) prohibits tax qualified LTCI policies (but not hybrid products) from containing a cash value feature. Prohibiting cash value creates a “use it or lose it” design for LTCI, because a policyholder only receives a benefit from their policy if they need LTC services. [Note: some flexible premiums structures may be permissible under current federal law, but they are limited by the prohibition on cash value.]

• **Option 5:** Allow products that combine LTC coverage with various insurance products (including products that “morph” into LTCI). Many stakeholders emphasized the need for regulatory changes at the federal level to allow for LTCI innovation and market expansion. One consistent view of stakeholders is the need to expand products that can address a consumer’s needs over time. Products that offer life, disability, critical illness, supplemental, and other benefits could be allowed in various combinations with or for conversion to LTCI, such as after the policyholder reaches a certain age. Legislative changes specifically allowing this type of product would be required for pertinent federal tax and NAIC governing documents.
• **Option 6**: Support innovation by improving alignment between federal law and NAIC models (HIPAA and DRA). HIPAA and the DRA require that LTC policies comply with specific provisions of outdated versions of the NAIC model act and regulation. The NAIC regularly updates its models, and this may result in confusion as the NAIC models evolve while federal law continues to reference old models. Therefore, it may make sense for federal law to reference and require compliance with pertinent provisions of the “current” version of the NAIC model for newly issued contracts (with appropriate transition rules to address model amendments) rather than require compliance with specific provisions of a specific version of the model. This would allow federal law to evolve as the NAIC, a collaborative body with active involvement of consumer and industry representatives, updates the models as needed. This would increase the flexibility of federal law to adapt to the evolving LTC market and regulatory requirements, and reduce confusion and possible inconsistencies between state and federal law.

• **Option 7**: Create a more appropriate regulatory environment for Group LTCI and worksite coverage (HIPAA and DRA). Ideas for consideration could include addressing concerns that may prevent an employer from providing LTCI on an opt-out basis by a) providing a safe harbor to limit the employer’s fiduciary liability and b) allowing an employer to offer expanded “catch-up” contributions; and/or permitting LTCI to be available for purchase through cafeteria plans.

• **Option 8**: Establish more generous federal tax incentives. Ideas for consideration include allowing a full federal tax deduction for LTCI premiums (rather than for expenses over 7.5-10% of Adjusted Gross Income) each year an LTCI policy is in force and/or allowing purchases of LTCI under cafeteria plans and from FSAs (consideration may be given to whether tax incentives should be income-based or means tested to focus on lower and middle-income Americans who may not otherwise purchase a LTCI policy); and/or allowing shorter maximum benefit plans (<1 year) to be tax qualified to incent market expansion through lower-priced, shorter duration products.

• **Option 9**: Explore adding a home care benefit to Medicare or Medicare Supplement and/or Medicare Advantage plans. Medicare provides extensive acute care coverage but more limited post-acute coverage (home health and skilled nursing facility care). Medicare Advantage and Medigap plans fill the gaps in Medicare. But most LTC services are not covered by Medicare, leaving a considerable gap in coverage for post-acute care. The most comprehensive Medicare Advantage and Medigap plans do not cover LTC services, other than the daily Medicare co-payment for the 21st to 100th day of Medicare covered skilled care; they do not cover intermediate care, assisted living, Alzheimer's, custodial or adult day care. Medigap and Medicare Advantage plans only supplement Medicare covered nursing home care on a temporary basis, and help with hospice coverage. There has been discussion of adding either something akin to a long term care benefit or, less extensive, new home and community based benefits either to Medicare (which would affect supplemental carriers) or to Medicare Advantage and/or Medigap plans. If new benefits were provided in supplemental coverage it could make those products more expensive, though that increased cost might be offset by savings from delaying or preventing the use of more expensive institutional care. [Note: this would require federal changes to Medicare, changes to the NAIC models governing Medigap benefits, and adoption of revised NAIC models by states.]

• **Option 10**: Federal education campaign around retirement security and the importance of planning for potential LTC needs. The federal government could provide funding and partner with states to provide education to consumers about retirement security. Such a campaign would focus on encouraging people to think about their future retirement and long term care needs and provide education on the array of private products available to help finance these costs.
Agenda Item #8

Consider Adoption of its Subgroup, Working Group and Task Force Reports
—Commissioner Al Redmer Jr. (MD)

- Consumer Information (B) Subgroup—Angela Nelson (MO)
- Health Care Reform Regulatory Alternatives (B) Working Group
  —Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
- Health Actuarial (B) Task Force—Director Patrick M. McPharlin (MI) and Kevin Dyke (MI)
- Regulatory Framework (B) Task Force—Commissioner Ted Nickel (WI) and J.P. Wieske (WI)
- Senior Issues (B) Task Force—Commissioner Teresa D. Miller (PA)
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Dec. 16, 2016. During its call, the Subgroup:

1. Discussed the continuing need for consumer resources and tool to help consumers improve their health care literacy.

2. Discussed the challenges with developing a consumer-oriented piece in the face of the uncertain future of the federal Affordable Care Act (ACA) reforms.

3. Agreed to meet via conference call to consider how to best move forward with developing consumer-based pieces to help with health insurance literacy.
The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met via conference call Dec. 16, 2016. Angela Nelson, Chair and Molly White (MO); Betty Jo Pate (FL); Cindy Hermes (KS); Mary Kwei (MD); Cherri Mortensen-Brown (MN); R.F. Seaton (NM); Tanji Northrup (UT); and Sue Ezalarab and Barbara Belling (WI) participated. The following Advisory Group members participated: Marty Mitchell (America’s Health Insurance Plans—AHIP); Karen Geiger (Anthem Blue Cross and Blue Shield); JoAnn Volk (Georgetown University); and Peggy Camerino (United Healthcare) Timothy Stoltzfus Jost (Virginia Organizing).

1. Discussed a Guide or Tool to Help Consumers Improve Their Health Insurance Literacy

Ms. Nelson recounted the recent history of the Subgroup. She reminded the Subgroup that after concluding its work on the Summary of Benefits and Coverage, the Subgroup identified a need for additional consumer resources to improve health care literacy. She said the Subgroup reported to the Health Insurance and Managed Care (B) Committee at the Spring National Meeting its intention to develop consumer-based pieces to help with health insurance literacy, consistent with its charge. She reminded the Subgroup that during its Aug. 12 and Oct. 28 conference calls, the Subgroup agreed to focus on developing tools to help consumers use health insurance. She said the Subgroup identified topics that fell into 2 general “buckets:” 1) addressing coverage issues before a person receives care (i.e., coverage-to-care); and 2) addressing issues that arise after coverage is used (i.e., post-care.) Ms. Nelson said on its Nov. 18 call, the Subgroup reviewed a couple samples of tools Ms. Nelson found on the internet that included ideas the Subgroup might want to incorporate into its guide or tool. Ms. Nelson reminded the Subgroup that some ambivalence for moving forward with a guide or tool was expressed on the Subgroup’s Nov. 18 call. She said the Subgroup agreed to identify on its next call whether there is a need for a guide or tool to help consumers improve their health insurance literacy; and if so, how should the Subgroup fill it.

Mr. Jost said he appreciated the desire to develop something to address health insurance literacy, but remains concerned with developing something when no one knows what is going to happen with the ACA under the new administration. Mr. Jost said he assumes that certain things will remain, like coinsurance, copayments, deductibles and networks. Ms. Nelson reminded the Subgroup that these concepts were particularly confusing for the individuals who participated in the NAIC consumer testing for the Summary of Benefits and Coverage. Mr. Jost said that it is possible that the new administration will so disrupt the insurance markets that there will be an even greater need for resources for consumers.

Ms. Nelson listed the reasons identified for not moving forward with developing a guide or tool for consumers: 1) the uncertain future of the ACA; 2) the complexity and variation in health insurance across the states, which is likely to increase under the new administration; 3) there are already a lot of materials on health insurance on the internet put out by private organizations and the federal government; and 4) whatever resource we develop may become obsolete in very short order. Ms. Nelson listed reasons the NAIC should move forward with developing a guide or tool for consumers. She said the mission of the NAIC as an organization includes being a trusted resource for unbiased information for consumers, and currently there is nothing on the NAIC website in this area. Ms. Nelson said it is possible to develop a list of core health insurance concepts that will not change—things like how cost sharing works, grievance and appeals, understanding explanation of benefits, networks and formularies. She reminded the Subgroup that things are always changing in the insurance world, and everything we do should be updated periodically. She reminded the Subgroup that there are other areas in insurance where things are changing and the NAIC has updated its resources. She mentioned that the NAIC has updated several of its guides as a result of the new sharing economy and the advent of companies like Airbnb, Uber and Lyft. Ms. Nelson said the insurance industry and insurance products are always evolving and this is an opportunity for the NAIC to develop something.

Mr. Jost said he would be willing to work on a guide or tool, but did not want it to take away from time needed for other efforts. Ms. Nelson said there is not a deadline like we had with the Summary of Benefits and Coverage, so we can take our time and set it aside when necessary. Mr. Mitchell said he would like to see the list of issues that are likely to remain unchanged and be sure they are issues that are worthwhile topics to work on. He also suggested conducting a thorough literature search before the group spends time working on something. Ms. Camerino suggested surveying the states to see what information already exists. Ms. Nelson agreed that prior to meeting via conference call in mid-February, a survey would be sent to the states asking for links to information on their websites in the area of health insurance information for

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consumers. The Subgroup asked Jennifer Cook (NAIC) to email a call reminder in mid-January including links to state resources and a list of potential topics to address.

Having no further business, the Consumer Information (B) Subgroup adjourned.

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HEALTH CARE REFORM REGULATORY ALTERNATIVES (B) WORKING GROUP
Saturday, April 8, 2017
3:30 – 5:00 p.m.

Meeting Summary Report

The Health Care Reform Regulatory Alternatives (B) Working Group met April 8, 2017. During this meeting, the Working Group:

1. Heard a presentation on the Wisconsin Medicaid Program, which included a discussion of the program's coverage structure in the past and currently. The presentation also included a discussion of federal reform funding considerations, such as a block grant funding, per capita enrollment funding or a hybrid of the two.

2. Heard a presentation on the New Hampshire Medicaid Program and Medicaid expansion, including the impact of its expansion on the individual market and the resulting strengthened relationship and coordination between the Medicaid agency and the state department of insurance (DOI).

3. Heard a presentation on the federal Affordable Care Act (ACA) Section 1332 waivers from Alaska and Oklahoma. Alaska described its process and reasons that led up to it applying for a waiver related to its reinsurance program. Oklahoma described its legislative process and its activities in preparation for submitting a waiver application within the next few months.
Meeting Summary Report

The Health Actuarial (B) Task Force met April 7, 2017. During this meeting, the Task Force:

1. Adopted the report of the Health Care Reform Actuarial (B) Working Group, which included the following action:
   a. Heard an update from the American Academy of Actuaries (Academy) on federal health care reform developments.
   b. Heard an update from the Society of Actuaries (SOA) on federal health care reform research.
   c. Heard an update from the federal Center for Consumer Information and Insurance Oversight (CCIIO) on 2018 federal Affordable Care Act (ACA) rate review requirements.

2. Adopted its Feb. 24 minutes, as well as the Dec. 22, 2016 minutes of the Cancer Claims Cost Tables (B) Subgroup.

3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which included a summary of its Apr. 7 meeting.

4. Adopted a motion to disband the Joint Long-Term Care Guidance Manual (B) Subgroup.

5. Adopted a motion to expose for public comment a proposal to amend VM-25, Health Insurance Minimum Reserve Requirements, for group long-term disability reserving requirements.

6. Heard an update from the Academy Council on professionalism.

7. Heard an update from the SOA on health insurance research.

8. Heard an update from the Academy Health Practice Council.
The Long-Term Care Actuarial (B) Working Group met April 7, 2017. During this meeting, the Working Group:

1. Adopted its 2016 Fall National Meeting minutes, which included the following action:
   a. Heard an update on the Society of Actuaries (SOA) Long-Term Care Insurance Section activities.
   b. Adopted the report of the Long-Term Care Pricing (B) Subgroup.
   c. Adopted the report of the Long-Term Care Valuation (B) Subgroup.


3. Adopted the report of the Long-Term Care Pricing (B) Subgroup, which included the following action:
   a. Discussed a summary of comments on a list of eight questions to state insurance regulators concerning how LTCI rate increase requests are evaluated, which will be discussed further on future conference calls.

4. Adopted the report of its Long-Term Care Valuation (B) Subgroup, which included the following action:
   a. Discussed a revised proposal for a new actuarial guideline with directions for stand-alone asset adequacy testing for blocks of LTCI.
   b. Approved a 30-day exposure for public comment on the revised actuarial guideline proposal.

5. Heard an update from the SOA on LTCI research, which included discussion of the SOA LTCI Think Tank’s work on developing LTCI innovations that will meet consumer needs.
REGULATORY FRAMEWORK (B) TASK FORCE
Saturday, April 8, 2017
11:30 a.m. – 1:00 p.m.

Meeting Summary Report

The Regulatory Framework (B) Task Force met April 8, 2017. During this meeting, the Task Force:

1. Adopted its 2016 Fall National Meeting minutes.

2. Adopted its Feb. 14 minutes, which included the following action:
   a. Discussed its work plan for continuing its work in 2017 on considering revisions to the Accident and Sickness Insurance Minimum Standards Model Act (#170), the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (#171) and the Health Carrier Prescription Drug Benefit Management Model Act (#22). The Task Force agreed that this work would continue to be done through its two subgroups: the Accident and Sickness Insurance Minimum Standards (B) Subgroup and the Model #22 (B) Subgroup, respectively.
   c. Discussed the possibility of the Task Force reviewing and revising any NAIC model affected by federal Affordable Care Act (ACA) repeal, replacement or repair proposals.
   d. Discussed concerns regarding health care sharing ministries.

3. Discussed the Task Force’s possible next steps regarding existing NAIC models potentially affected by ACA repeal, replacement or repair proposals. The Task Force decided to continue the discussion via conference call sometime after the Spring National Meeting.

4. Continued the discussion from its Feb. 14 conference call concerning health care sharing ministries and consumer transparency with respect to these non-insurance products. The Task Force decided to continue the discussion during a future conference call and, perhaps, invite a few of these entities to discuss their activities at the Task Force’s meeting during the Summer National Meeting.

5. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup. The Subgroup has not met since November 2016. The Task Force chair decided to suspend the Subgroup’s meetings in light of the possible repeal, replace or repair of the provisions of the ACA, which could significantly affect the Subgroup’s proposed revisions to Model #170 and Model #171. The Task Force decided to continue to suspend the Subgroup’s meeting for the time being and discuss it again at the Task Force’s meeting during the Summer National Meeting.

6. Adopted the report of the Model #22 (B) Subgroup, including its March 2 and Feb. 14, 2017, and Dec. 10 and Nov. 29, 2016, minutes. The Subgroup took the following action:
   b. Discussed the decision in the case of Pharmaceutical Care Management Association (PCMA) v. Gerhart and what impact, if any, the decision has on the Subgroup’s work to revise Model #22. After discussion, the Subgroup decided that the decision does not impact its work, because the Iowa law regulating pharmaceutical benefit managers (PBMs) found to be preempted under the federal Employee Retirement Income Security Act (ERISA) differs greatly from the provisions in Model #22.
   c. Continued its discussion of the comments received on Model #22 and made preliminary decisions on what revisions to include in an initial draft of proposed revisions to the model. Specifically, the Subgroup discussed Section 5—Requirements for the Development and Maintenance of Prescription Drug Formularies and Other Pharmaceutical Benefit Management Procedures and Section 6—Information to Prescribers, Pharmacies, Covered Persons and Prospective Covered Persons.
d. Discussed revised language based on the Subgroup’s discussions during its Dec. 10, 2016, meeting for Model #22, Section 5—Requirements for the Development and Maintenance of Prescription Drug Formularies and Other Pharmaceutical Benefit Management Procedures. Preliminarily agreed to include the draft revised language for Section 5 in the initial draft of proposed revisions to Model #22.

e. Continued discussion of proposed revisions to Model #22, Section 6. The Subgroup specifically discussed draft language based on its Dec. 10, 2016, meeting and its March 2 conference call for inclusion in Section 6 requiring carriers to provide a complete, current and accurate prescription drug formulary list and other prescription drug benefit information electronically or in some other manner. The Subgroup met March 28 via conference call to review new draft language based on its March 2 discussions intended to clarify disclosure requirements related to the formulary list and other prescription drug benefit information based on whether such information is related to a health benefit plan issued in the individual market or issued in the group market. The Subgroup plans to continue its discussions of the draft language April 25 via conference call.

7. Adopted the report of the ERISA (B) Working Group, including the Working Group’s 2016 Fall National Meeting minutes. The Working Group has released revised drafts of proposed revisions to several sections of the ERISA Handbook based on the comments received on previous drafts, and set a Jan. 31 public comment deadline on its exposure of the revised drafts. The Working Group plans to meet via conference call sometime after the Spring National Meeting to discuss any comments received.
Meeting Summary Report

The Senior Issues (B) Task Force met April 8, 2017. During this meeting, the Task Force:

1. Adopted its 2016 Fall National Meeting minutes.

2. Adopted the report of the Long-Term Care Innovation (B) Subgroup. The report included its April 3, March 23 and Feb. 21, 2017, minutes and Dec. 19, 2016 minutes.

3. Adopted the report of the Short Term Duration Long-Term Care Policies (B) Subgroup. The report included its March 29 minutes.

4. Adopted a long-term care (LTC) federal policy options document and referred it to the Health Insurance and Managed Care (B) Committee for consideration. The Long-Term Care Innovation (B) Subgroup developed a list of federal policy options for Congress to consider in the hope of increasing private LTC financing options for consumers. The Long-Term Care Innovation (B) Subgroup adopted these options on April 3.

5. Disbanded the Long-Term Care Consumer Disclosure (B) Subgroup. The Subgroup completed its work on updating the consumer disclosure and protection provisions in the Long-Term Care Insurance Model Act (#640) and the Long-Term Care Insurance Model Regulation (#641). The Executive (EX) Committee and Plenary adopted the revisions at the 2016 Summer National Meeting.

6. Disbanded the Medigap (B) Subgroup. The Subgroup completed its work on revisions to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (#651) pursuant to the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Public Law 114-10. The Executive (EX) Committee and Plenary adopted the revisions at the 2016 Fall National Meeting.

7. Disbanded the Joint Long-Term Care Guidance Manual (B) Subgroup. The Subgroup completed its work on monitoring and providing assistance to the states on the implementation of the 2000 and 2014 rating practices amendments to Model #641, and the model bulletin adopted by the NAIC in December 2013 regarding Alternative Filing Requirements for Long-Term Care Premium Rate Increases. The Health Actuarial (B) Task Force also disbanded the Subgroup at its meeting on April 7, 2017.

8. Heard an update on federal legislative matters. The update included a report on the status of the federal appropriations process as it relates to the funding for the State Health Insurance Assistance Programs (SHIPs).

9. Heard information from the Interstate Insurance Product Regulatory Commission (IIPRC) regarding the issue of non-duplication or management of benefits under multiple LTC policies and its request for it to be referred to the Senior Issues (B) Task Force.
Agenda Item #9

Discuss Any Other Matters Brought Before the Committee
—Commissioner Al Redmer Jr. (MD)