

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE AND RETIREMENT ISSUES COMMITTEE
PORTLAND, OREGON
JULY 15, 2016
DRAFT MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care and Retirement Issues Committee met at the Portland Marriott Waterfront Downtown on Friday, July 15, 2016, at 3:30 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, AR	Rep. Don Flanders, NH
Rep. Joseph Fischer, KY	Sen. Robert Hackett, OH
Sen. Dan “Blade” Morrish, LA	Rep. Bill Botzow, VT
Rep. George Keiser, ND	Sen. Kathleen Keenan, VT
Sen. Jerry Klein, ND	Sen. Mike Hall, WV
Rep. David O’Connell, ND	

Other legislators present:

Rep. Lewis Moore, OK
Sen. Gary Stanislawski, OK

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, Legislative Director, NCOIL Support Services, LLC

MINUTES

Upon a motion made and seconded, the Committee unanimously approved the minutes of its February 26, 2016, meeting in Little Rock, Arkansas and the minutes of its June 22, 2016, interim conference call meeting.

DISCUSSION OF ACA HEALTH INSURANCE CO-OPS

Sabrina Corlette, J.D., Research Professor, Center on Health Insurance Reforms, Georgetown University Health Policy Institute, spoke first. Prof. Corlette stated that having a discussion about the ACA health insurance co-ops (co-ops) is very important and timely – Oregon is the most recent State to place its co-op in receivership. She had an opportunity to study the co-ops and published her findings in a Commonwealth Fund Paper. The co-ops were conceived with good intentions and were actually based off of the success of agricultural co-ops. However, the design of the co-ops did not anticipate how high barriers to market entry can be. Additionally, a number of direct and indirect effects of the implementation of the co-ops led to further problems and ultimately sealed their fate.

Sabrina stated that during the legislative process some things weakened the co-ops – a.) the grants that were envisioned by Sen. Conrad to fund them were converted to loans; b.) co-ops were prohibited from using federal funds for marketing purposes; and c.) the co-ops were required to generate substantially all of their enrollment from the individual and small-group markets which limited their ability to diversify. Additionally, during implementation, a number of things weakened the program such as: a.) a federal budget agreement slashed the co-ops funds by 2/3 from \$6 billion to \$2.4 billion; and b.) the Obama administration transitional program/grandfathered program allowed insurers to retain pre-ACA enrollees left a sicker risk-pool for those left in the market and that was a decision made in 2013 after insurers had set their 2014 rates. Additionally, another federal budget deal required the risk-corridor program to be budget neutral during 2014 which effectively limited the amount the federal government could remit to insurers for their losses. As a result, marketplace insurers only received 12 cents on the dollar for 2014, which severely affected co-ops, many of which had been counting on those risk-corridor payments.

There were also factors that made it difficult for co-ops to compete: a.) a short time-frame between funding and launch which led to outsourcing of many key functions such as provider directories, customer support, actuarial processes, and claims processing procedures. That outsourcing limited the co-ops ability to control their costs and to manage service quality; b.) many of the co-ops claimed that their benefit designs attracted a sicker risk-pool than competitors – many felt that offering a fairly generous benefit design was core to their mission of a consumer-oriented plan, which they were statutorily mandated to be. For example, half of the co-ops offered platinum level plans which are the most generous but it resulted in attracting sicker consumers than competitors; c.) setting initial prices for plans was probably the most important aspect to get right and it ended up being disastrous. To be clear, pricing was difficult for all in the market, but for co-ops there was no margin for error; and d.) the risk-adjustment program greatly harmed co-ops. Only 7 co-ops remain and it is likely that some of those will also fail.

Chris Condeluci from CC Law and Policy, PLLC then offered his thoughts. Mr. Condeluci began by noting that the ACA actually started out being negotiated on a bi-partisan basis and also stated that the reason why the co-op idea was born was because it was an alternative to the public option. Mr. Condeluci stated that the co-ops were set up to fail mainly because the provisions of the relevant statutes are very constraining, i.e. marketing funds and the loan/grant distinction. Chris stated that once the co-ops saw the restraints, they asked themselves how do we grab our share of the market. One way to do that is to under-price your competitors but if you do that and don't have enough premium revenue for claims and expenses, it is impossible to succeed. The co-ops also placed heavy reliance on the risk-stabilization programs, which have not worked. With regard to the risk-corridor program, HHS thought that the program could be operated on a budget-neutral basis because staff there thought enough insurance carriers requesting a risk corridor payment as a result of insuring higher risk individuals would be offset by the same amount of insurance carriers that insured young/healthy individuals – this did not happen. Also, another issue with that program was that in order to get payments, you need historical data and the co-ops did not have such data because they were new to the market. Mr. Condeluci stated that

ultimately, the risk adjustment charges led to several co-ops being shut down because they were not expecting them.

Eric Cioppa, Superintendent of Insurance for the State of Maine, then spoke and stated many of the co-ops are operating without a guaranty fund, including Maine's. Supt. Cioppa also stated that that a big issue surrounding the co-ops is the business model itself. In Maine, the co-op started out being the largest individual writer in the State in 2014. It made too much money and had to pay a substantial refund, but in 2015 it lost \$30 million – "how can you run a business when you have to do that when profitable but there is nothing to help on the other end if you take huge losses?" asked Supt Cioppa. Also, there is a lack of experience data in order to set rates effectively.

Asm. Cahill then asked the panel, given the multiple failures of the co-ops, what is the best strategy to proceed. Supt Cioppa stated that Maine does not have guaranty fund protection – that is something to look at going forward. It really is a tough decision for each State legislature to make. Also, it is important to note that had the risk-corridor payments been there, as planned, we probably would not be having this conversation. Asm. Cahill noted that even in the States that have a guaranty fund, it probably will not be sufficient for the debts. Mr. Condeluci stated that it depends on what the timeframe is. Sadly, it looks like we will have to deal with the problem head-on because based on how things have gone, the federal government is not going to be helping. Prof. Corlette encouraged States to look at their continuity-of-care rules and to look at deductibles to see if they are allowed to be reset within certain timeframes.

Asm. Cahill recommended to those listening to contact the NAIC and ask what the Commissioners have done and what they plan to do.

Sen. Stanislawski asked how many total individuals were enrolled in the defunct co-ops and is concerned about how many of those are now uninsured. Mr. Condeluci stated approximately 350,000. Prof. Corlette stated that they are typically told they need to switch insurance companies and get a special enrollment opportunity to do so but that does not apply to everyone – some may fall through the cracks. Asm. Cahill stated that in New York, some of the co-op members were transferred to a Fidelis plan but others found another plan that turned out to be unaffordable.

DISCUSSION OF ESSENTIAL HEALTH BENEFITS CAP AND THE USE OF WAIVERS UNDER THE AFFORDABLE CARE ACT

Asm. Cahill first provided some background on this issue. Under the ACA, the essential health benefits plan had to be determined – it was done so by picking a benchmark plan and also a group of essential benefits that the federal government required every plan to have. That plan expires at the end of 2016 – new benchmark plans have to be chosen. The essential health benefits cap essentially says that if it is not included in the essential health benefits plan, either through the benchmark plan or through federal mandate, the States have to pick up the cost of that benefit.

Mr. Condeluci stated that when the ACA was being drafted, the drafters felt there too many benefit mandates existing. There was a desire to make the benefit mandates more uniform among the States. As a result, the essential health benefit list was developed. The drafters actually intended that those be the medical services and that is

it. The drafters wanted to discourage States from not adding benefits by requiring the States to over the bill if they did add a benefit. When HHS was implementing the law, States were concerned about the benefit mandates they already had in place. As a result, HHS said benefit mandates in effect as of a certain date can be considered part of the list. However, if benefits are added subsequently, you have to cover the cost. Many States tried to add additional benefit mandates and characterize them in a different way. HHS has come out in the recent Notice of Benefit and Payment Parameters Rule saying that is not allowed.

Asm. Cahill stated that there a number of benefits to be considered. For example, female war veterans are relatively new and the prosthetic benefit in most States assumes the prosthetic will be with the person for a very long time/the rest of their life. However, if a female war veteran comes home and gets pregnant, it obviously will not fit. One matter to discuss is to determine what is medically necessary. Also, changing certain definitions might help. Lastly, States can go to the federal government and under a waiver, say we want to have this covered as essential – that is essentially a 1332 waiver.

Mr. Condeluci stated that the ACA states that if a State wants a 1332 waiver, there are certain standards it has to meet. First, the waiver program must provide coverage to a comparable number of state residents as would receive coverage without it. Second, it must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are as affordable as would be provided without it. Third, it must provide coverage that is as comprehensive as would be provided without it. Fourth, it must not increase the federal deficit. Mr. Condeluci noted that those are tough standards. Asm. Cahill asked Mr. Condeluci if he was correct in saying to proceed with caution with 1332 waivers. Mr. Condeluci responded yes.

Rep. Kesier asked why Congress didn't provide States with flexibility to gain access to certain benefits. Mr. Condeluci stated that based on his experience, the federal government wanted to be rigid because based on their findings, one of the cost-drivers in the States is a long list of benefit mandates.

Rep. Moore asked when do we accept failure and move on to either a single-payer plan or a return to the private industry. Mr. Condeluci stated he likes to think optimistically and that noted that both Republicans and Democrats agree that there are problems. Accordingly, he thinks that things can be worked on in a bi-partisan way.

DISCUSSION OF REMEDY FOR LONG TERM CARE LAPSED POLICIES: NON-FORFEITURE CARE CREDIT

Mike Kreidler, Washington State Insurance Commissioner, stated that this issue is challenging for legislators and regulators. His office was recently told that for just one company, the upcoming guaranty fund hit for Washington will be \$100 million. Commissioner Kreidler stated that due to many problems, we were left with a product that has had significant rate increases. It is important to deal with the problems facing long term care lapsed policies in such a way that we spread the "pain" equally in that companies are adequately "punished" and policyholders aren't unduly "punished". Commissioner Kreidler stated that one option may might be to state that rather than paying a high rate as the policy term dictates, allow the policyholder to have diminished

coverage. Another possible solution is to say you can stop paying but everything you have paid in thus far is put in an account and as you apply for long term care benefits, whatever is in the account is the maximum amount allowable. That is a way of providing something to the consumer instead of their only recourse being having the policy lapse and have nothing in coverage. Commissioner Kreidler also stated that if he had to urge legislators to act on this issue he would say that it is extremely important to work closely with regulators - because we try to find the fairest way to do a multitude of things. Commissioner Kreidler further stated that there is an upcoming federal meeting on LTC insurance which will most likely focus on the shortcomings of the state-based system. Accordingly, it is important to address the needs of policyholders so that there is not federal encroachment on the state-based system of insurance.

Asm. Cahill asked Commissioner Kreidler how this issue came about so abruptly. Commissioner Kreidler stated that unfortunately this was a case of “kicking the can down the road.”

John Mangan from the American Council of Life Insurers (ACLI) then spoke and acknowledged the concern that is prevalent with LTC insurance. Mr. Mangan stated that ACLI has worked with the NAIC to update its LTC model regulation and to develop a set of guidelines to deal with rate increase issues.

Asm. Cahill then asked Commissioner Kreidler if the solutions to the problems can be done by means of regulation or legislation. Commissioner Kreidler stated that he believes it can be done primarily with regulation.

Dianne Bricker from America’s Health Insurance Plans (AHIP) then spoke and stated that the industry acknowledges there have been bumps in the road on this issue but working with the NAIC was helpful. AHIP encourages states to adopt the NAIC LTC models because they can help solve the problems facing the industry.

Sen. Hackett then stated that Ohio is working on some solutions to the problems and that collectively, we all should have reacted better on this issue – we all kicked the can down the road.

Rep. Keiser stated that what’s really driving cost is that reimbursement for Medicare and Medicaid patients has been re-structured – there is such an emphasis on getting people out of hospitals because after so many days, the reimbursement rate drops. Rep. Keiser stated that rates are going to keep on rising because we are now treating patients in nursing homes and overhead has increased dramatically. Sen. Angel agreed with Rep. Kesier.

Asm. Cahill stated that this problem seems like it will continue to grow and it might be a good issue for NCOIL and NAIC to work on together.

THE “SHKRELI EFFECT” IN DRUG PRICING – FACT OR FICTION

Rep. Mitch Greenlick of Oregon spoke and said the “effect” is real and the issue is what do we do about it. He introduced 2 bills in Oregon – 1 put forward by the insurance industry about price transparency in producing drugs and the other regarding limiting co-pays and how to change tiers on specialty drugs. He put together a task force on certain

issues such as how consumers can stop paying such high copay and deductibles for drugs that are increasingly expensive – we have seen million dollar drugs in the market.

Jim Gardner, Vice President of Gardner & Gardner, and former Oregon State Senator, then spoke on behalf of PhRMA and stated that when evaluating proposals that are looking to solve the problem, it is important to ask, a.) does it help consumers afford medication, b.) does it help avoid a dramatic increase in premium rates and, c.) does it slowing down increasing costs of prescription drugs which is the most difficult issue.

BJ Cavnor, Executive Director of One in Four Chronic Health then spoke and congratulated Asm. Cahill on the work New York has done with drug pricing. Mr. Cavnor stated that the issue with patients is what are we going to do to get access to life saving cures and treatments – with the idea in mind that there is a finite amount of money.

Rep. Greenlick stated that it is also important to note that generic drug prices have risen dramatically and that is presenting numerous issues. Asm. Cahill agreed.

Rep. Greenlick also noted that he is not a supporter of value-based pricing. Mr. Cavnor then stated that it is important to focus on value, not in a financial sense but in a cultural sense – we should provide care for those who are sick and work backwards from there. Mr. Cavnor also stated that we have to consider that there are going to be situations in the future where collectively, we have to reach out to the federal government for assistance.

OLD BUSINESS

Tom Considine, NCOIL CEO, spoke regarding the Notice of Benefit and Payment Parameters Rule for 2017, published on March 8, 2016 by the Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS). Commissioner Considine stated that the regulation will effectively eliminate Health Savings Account (HSA) qualified health plans from the insurance exchanges next year: under the regulation, consumers can either choose an ACA Qualified Health Plan (QHP) or an Internal Revenue Service (IRS) qualified HAS – they would be precluded from selecting a plan that qualified as both, as they can currently. Commissioner Considine stated that NCOIL was concerned about the effects of the regulation and accordingly wrote a letter to HHS Secretary Sylvia Mathews Burwell and CMS Acting Administrator Andy Slavitt. Commissioner Considine further stated that NCOIL received a response from Kevin Coughlin, CEO of Health Insurance Marketplaces and Director of Center for Consumer Information & Insurance Oversight, which basically stated that the regulation would not bar qualifying HAS plans because it did not limit the plans that ACA would “qualify” but rather set forth six that would. Commissioner Considine stated that this issue will be further examined by NCOIL.

Lastly, Asm. Cahill stated that due to time constraints, the Committee will discuss network adequacy standards at the Annual Meeting in November.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:30 p.m.

