

State Network Lessons for Insurance Regulators

NAIC Western Zone Meeting
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State Health Reform Assistance Network
Charting the Road to Coverage



Robert Wood Johnson Foundation

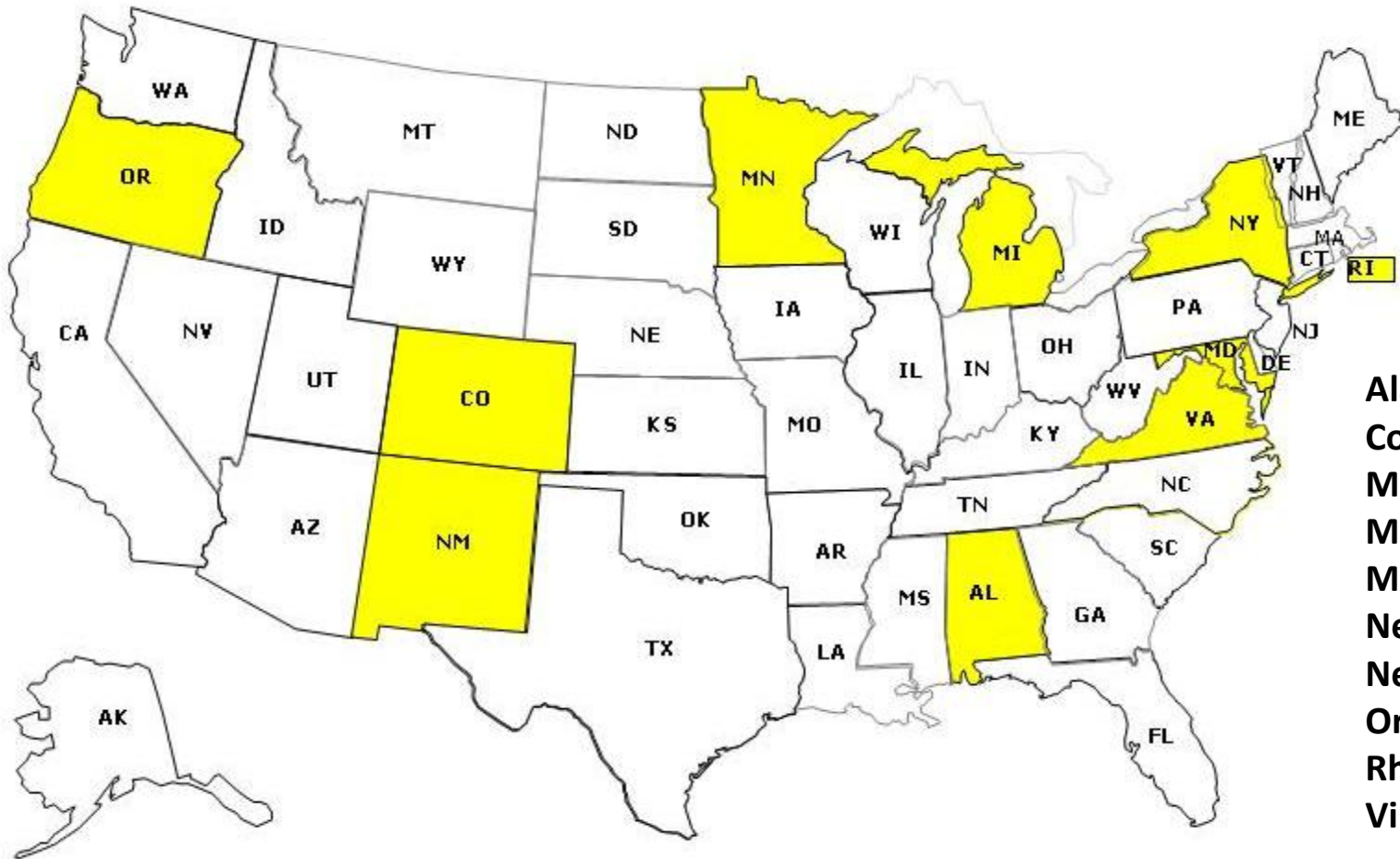
Overview

- About the State Network
- State of the States
- Tools for Departments of Insurance
- Essential Health Benefits
- Other Resources

State Health Reform Assistance Network

- RWJF-funded program providing technical assistance to states to maximize coverage expansions under ACA
- Theory of Change: focus on a diverse group of 10 states to develop successful implementation models and share lessons learned
- Technical Assistance Strategies:
 - Multi-disciplinary team - operational level technical assistance
 - Meet each state where they are
 - Deploy a team of technical experts outside state procurement
 - Facilitate peer-to-peer learning
 - Inform Federal policymaking

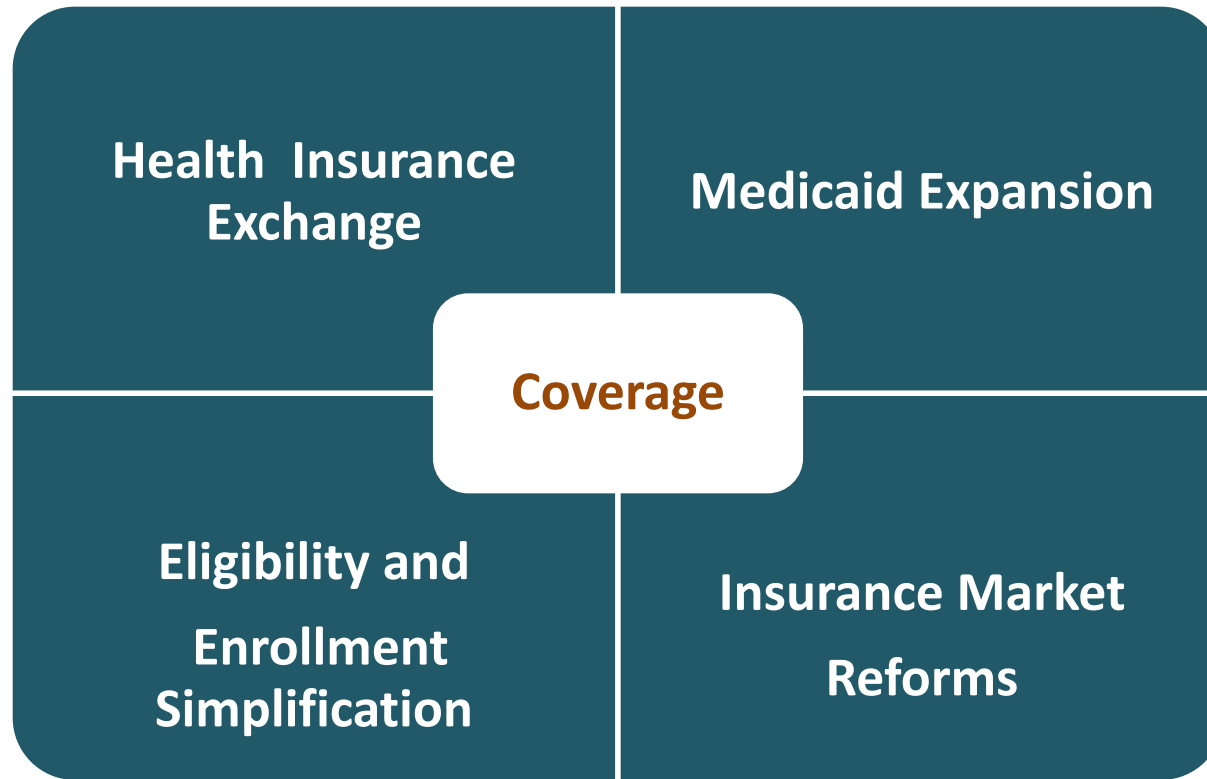
Diverse Group of States



Alabama
Colorado
Maryland
Michigan
Minnesota
New Mexico
New York
Oregon
Rhode Island
Virginia

HI

Focus on ACA Coverage Expansion



Examples of Technical Assistance

- Regulatory analyses of proposed rules on Exchange Implementation & Reinsurance, Risk Corridors, and Risk Adjustment
- Timelines and work plans
- Issue briefs on linking Medicaid and exchanges
- Webinars on Basic Health Program option, Essential Health Benefits, Review of microsimulation models, Native Americans and Health Reform
- MOU's between state agencies

State Network Resources

www.statenetwork.org

STATE HEALTH REFORM ASSISTANCE NETWORK

State Network

CHARTING THE ROAD TO COVERAGE



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ABOUT THE STATE NETWORK

The *State Health Reform Assistance Network (State Network)* is a Robert Wood Johnson Foundation (RWJF) funded program dedicated to providing technical assistance to states in order to maximize coverage expansion under the Affordable Care Act (ACA).

The program and the dissemination of models and lessons learned from this

work are key elements of RWJF's goal of ensuring that nearly all Americans have health coverage by 2020.

The *State Network* is managed at Princeton University's Woodrow Wilson School of Public and International Affairs with significant support from State Coverage Initiatives (SCI), also an RWJF national program, housed at AcademyHealth.

[MORE ABOUT THE STATE NETWORK >](#)

Get Email Updates



Subscribe to periodic email updates from the State Network.

State Network Focus

- Implementation assistance (how to operationalize)
- Menu of options within the ACA to fit different markets, goals, and visions
- Driven by requests from states (governors, exchanges, insurance regulators, Medicaid)
- Experts with on-the-ground experience (former insurance commissioners and regulators, former MA Connector CEO and COO, former federal regulators, former Medicaid directors)

State of the States

- SBE states pushing hard to meet 2014 deadlines
- Political challenges in states that might prefer SBE but end up in Partnership for 2014 (many waiting for election)
 - Partnership as bridge to SBE?
- States actively pursuing Partnership (AR, DE, IL)
- FFE States
- Many insurance departments actively working on plan management, rate review and market reforms despite exchange model and progress

Ongoing Considerations

- Avoiding bi-furcated markets
 - Conforming legislation or bulletins for all markets
 - Insurance department and exchange roles in reviewing/certifying exchange QHPs vs. plans outside the exchange
- Coordinating QHPs or specific plan elements (e.g., benefits, network adequacy, plan transitions) with Medicaid managed care plans for the expansion population (reducing the impact of churn)

Ongoing Considerations

- Open questions regarding federal coordination
 - State certification of plans for sale on FFE?
 - Will federal officials review FFE products for EHB, etc.?
 - FFE guidance forthcoming?
- Federal enforcement – HIPAA model
 - What if states do not implement 2014 reforms for markets outside of the exchange?
 - State notifies HHS it is not enforcing the law's requirements
 - HHS determines that the state is not “substantially enforcing” the law
 - What does federal enforcement look like?

Tools Can Be Used By All States

ACA Implementation Toolkit for Departments of Insurance - <http://www.statenetwork.org/resource/aca-implementation-toolkit-for-departments-of-insurance/>

Self-audit checklist

- Compare existing insurance laws to the ACA's minimum requirements for private health insurance
- Identify inconsistency and areas for legislative or regulatory changes

ACA INSURANCE SELF-AUDIT: PROVISIONS WITHIN TRADITIONAL AUTHORITY OF INSURANCE DEPARTMENT EFFECTIVE 2010

Section		Applicability				State Action
		Group	Group Grandfather*	Individual	Individual Grandfather*	
PHSA §2704	No pre-ex for children under 19	✓	✓	✓		
PHSA §2711	No lifetime limits	✓	✓	✓	✓	
PHSA §2711 + Guidance	Limited annual limits	✓	✓	✓		
PHSA §2712 + Regs	Rescissions prohibited except in cases of fraud or intentional misrepresentation	✓	✓	✓	✓	
PHSA §2713 + Regs	Preventive care ¹ , no cost-sharing	✓		✓		
PHSA §2714 + Regs	Dependent coverage up to age 26 (exception for dependents with job-based coverage before 2014)	✓	✓	✓	✓	
PHSA §2715A	Additional information relating to transparency in coverage to be submitted by carriers and made available to the public (further guidance to be issued)	✓		✓		
PHSA §2716	Prohibition on discrimination based on salary	✓				
PHSA §2719 + Regs	Enhanced external appeals and internal review of coverage determinations and claims	✓		✓		
PHSA §2719A + Regs	Enhanced access to primary care, pediatricians, ER, OBGYN	✓		✓		
42 USC 18011 (PPACA §1251) + Regs	*“Grandfathered plan” defined in Sec. 1251. Guidance and clarification has been issued.					

¹ HRSA women’s preventive care required to be covered for plan or policy years starting on or after Aug. 1, 2012 (final rule released Aug. 11, 2011).

Regulations and guidance are available at: <http://www.healthcare.gov/center/regulations/index.html>

Strategic Planning

- Assess resource needs
- Facilitate/lead in-state planning sessions
- Draft work-plans (high-level to ensure that nothing falls through the cracks)

Workplan Template

Decisions and considerations	Start Date	End Date	Deliverables	Lead	Notes
Activity 1: ACA Standards and Authority Required for Implementation					
Identify and review which state laws must be modified to comply with federal law (see attached ACA self-audit tool: "ACA Provisions within Traditional Authority of Insurance Department" 2010 through 2014 and beyond provisions)					
Identify provisions that <u>must</u> be changed legislatively (if not changed, high risk of federal direct enforcement and a finding that the state has not enacted necessary market reforms)					
2010					
2011					
2012					
2013					
2014					
Identify provisions that <u>should</u> be changed legislatively (if not changed, likely to be able to use existing state authority to enforce but there is risk of a challenge to state enforcement by a carrier or other stakeholder)					
Draft "must-have" legislation to bring state into compliance with federal law					
Draft "should-have" legislation to bring state into compliance with federal law					
CCIIO review of legislative language					
Enact statutory changes					
Identify provisions that could be changed through regulation					
2010					
2011					
2012					
2013					
2014					
Draft/update and issue regulations to bring state into compliance with federal law (or via bulletins)					
Activity 2: ACA Standards Oversight and Plan Compliance					
Identify and analyze current regulatory enforcement and oversight authority including limitations on existing authority, form and rate reviews, market conduct exams, consumer					

Exchange Functions and Inter-Agency Responsibilities and MOUs

Exchange Functions Checklist

- Leverage existing state agencies' expertise (exchange functions)
- Help identify and document functions currently performed and to determine which agencies/entities could perform such functions going forward
- Help determine overlap among agencies
- Ensure that none of the essential functions that an exchange must perform fall through the cracks
- Checklist can be used as a basis for agreements/MOUs among agencies and between exchange and agencies as required.

Exchange Functions Checklist [Departments of Insurance]

(includes minimum and other required functions)

Updated to reflect March 12, 2012 final and interim final guidance

	[DOI] Lead	[DOI] Consult	Notes
Certification of QHPs			
• Establish standards for certification in addition to federal minimum standards if applicable			
• Establish procedures for certification <i>SERFF will support</i>			
• Review rate increase justification (may be a part of rate review) <i>SERFF will support</i>			
• Ensure justification is posted on exchange and issuer websites <i>SERFF will support transfer of information to exchange</i>			
• Collect information from QHPs to meet transparency requirements (claims payment policies & practices, financial, enrollment data, claims denials, rating practices, cost-sharing, enrollee rights) <i>SERFF may support</i>			
• Certify QHPs <i>SERFF will support</i>			
• Provide required licensing information (risk-bearing entities must be licensed)			
• Provide verification of licensed status, including financial condition			
• Provide other information, including consumer complaints, market conduct, etc.			
• Provide information about closed investigations			
• Establish accreditation period			
• Establish and ensure compliance with network adequacy standards <i>SERFF will support</i>			
• Establish recertification process <i>SERFF will support</i>			
• Provide required licensing information (risk-bearing entities must be licensed)			
• Provide verification of licensed status, including financial condition			
• Provide other information, including consumer complaints, market conduct, etc.			
• Provide information about closed investigations			

Form Review Checklists

Checklists for non-grandfathered 2014 products:

- In current toolkit
 - Individual market outside the exchange
- To be added to the toolkit
 - Individual market inside & outside the exchange
 - Small group market outside the SHOP exchange
 - Small group market inside & outside the SHOP exchange
 - EHB package for 2014 individual and small group market products.

Form Review Checklist – Individual Health Insurance (Non-grandfathered – 2014)*

Updated: July 6, 2012

*The following document serves as an example of the Form Review Checklist. To fill out the form, download the editable file [here](#).

Company Name:	
Product Name:	
Plan:	
<input type="checkbox"/>	60% AV (Bronze)
<input type="checkbox"/>	70% AV (Silver)
<input type="checkbox"/>	80% (Gold)
<input type="checkbox"/>	90% (Platinum)
<input type="checkbox"/>	Child-only
<input type="checkbox"/>	Catastrophic Plan (no minimum AV requirement, only available to individuals under age 30 or those with hardship/affordability exemption)

YES: Check this box if all contract provisions in the section meet minimum requirements.

NO: Check this box if any of the contract provisions do not meet minimum requirements, restrict coverage in a way not allowed by law, or for any other reason are inconsistent with the law.

N/A: Check this box if a contract does not have to meet this requirement (e.g., does not use Primary Care Physicians and therefore does not have to include designation of PCP option).

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
<input type="checkbox"/> No pre-existing condition exclusions for child under age 19 <input type="checkbox"/> No pre-existing condition exclusions <input type="checkbox"/> "Pre-existing condition exclusion" means a limitation or exclusion on benefits based on the fact that the condition was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was received before that day. <input type="checkbox"/> A pre-existing condition exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's	PHSA §2704 PHSA §1255 (75 Fed Reg 37188, 45 CFR §147.108)	Attachment: Examples from federal regulations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Category	Federal & State Law	Tips (including problematic sample contract language)	Yes	No	N/A
health status before the individual's effective date of coverage (or date of denial).					
Explanation:					
<input type="checkbox"/> No lifetime limits on the dollar value of Essential Health Benefits (EHB): <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply. Tip: Check benefit maximums and service limitations to ensure no dollar limits for EHBs. Problematic contract language/example: EHB-eligible hospital services limited to \$100,000. This violates the prohibition on lifetime limits on EHB.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					
<input type="checkbox"/> No annual limits on the dollar value of EHB: <input type="checkbox"/> Ambulatory patient services <input type="checkbox"/> Emergency services <input type="checkbox"/> Hospitalization <input type="checkbox"/> Maternity and newborn care <input type="checkbox"/> Mental health and substance use disorder services, including behavioral health treatment <input type="checkbox"/> Prescription drugs <input type="checkbox"/> Rehabilitative and habilitative services and devices <input type="checkbox"/> Laboratory services <input type="checkbox"/> Preventive and wellness services and chronic disease management <input type="checkbox"/> Pediatric services, including oral and vision care	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	Tip: If there are maximum dollar limits, check to ensure that these are not for benefits within one of the EHB categories. Problematic contract language/example: EHB-eligible hospital services limited to \$100,000 annually. This violates prohibition on annual dollar limits on EHB.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Explanation:					
<input type="checkbox"/> No rescissions except in cases of fraud or intentional misrepresentation of material fact	PHSA§2712 (75 Fed Reg 37188,	Tip: Look for insurer's right to cancel to ensure that in a case of retroactive cancellation, the only conditions listed in the contract are fraud or intentional misrepresentation of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Tools

“Cheat sheets”

- Requirements for certified qualified health plans
- External review requirements
- Effective rate review

Future products are in the pipeline and will be shared with all states

State Approaches to EHB Benchmark Analysis/Decision

- Plan comparison charts
- Stakeholder engagement/outreach comments
- Relative premium cost difference analysis
- Decision criteria (e.g. cost v. comprehensiveness)
- Different decision making authorities
- Fallback option (largest small group plan)

Alabama EHB Comparison Chart

Benefits provided by potential benchmark major medical plans in Alabama

Grouped in the 10 categories of Essential Health Benefits required by the ACA ⁽¹⁾

Terms:

AB - Alabama mandated benefit

AO - Alabama mandated offer (not for employers w/ 50 or fewer employees)

FB - Federally mandated benefit

NC - Service not covered per carrier benefit summaries

Benefits ⁽²⁾	BCBS 320 Plan - PPO (Largest Small Group)	VIVA Health VIVA 90 Wellness (Largest HMO)	The State Employees' Health Insurance Plan	FEHBP 1 - Blue Cross Blue Shield Plan Standard (Largest FEHBP)	Alabama Mandate	Federal Mandate
	Covered	Covered	Covered	Covered		
1. Ambulatory patient services						
a. Primary care to treat illness/injury	√	√	√	√		FB
b. Specialist visits	√	√	√	√		
c. Outpatient surgery	√	√	√	√		
d. Chiropractic (therapeutic, adjustive, manipulative)	√ \$600 calendar year max.	√ 25 visits per calendar year	√	√ Limit 12 visits/yr.	AB	
e. Chemotherapy services	√	√	√	√		
f. Radiation therapy	√	√	√	√		
g. Anesthesia by local infiltration	NC	NC	NC	√		
h. Walk-in center services	NC	NC	NC	√		
i. Home health care	√	√ (60 visits per calendar year)	√	√ Limit 25/yr, limit of 2 hr/visit		
j. Access to clinical trials	NC	NC	NC	√		FB
k. Genetic evaluation & counseling	NC	NC	NC	√		
l. Outpatient diagnostic labs, xray, and pathology	√	√	√	√		
m. Infertility treatment services	NC	NC	NC	√		

Minnesota Stakeholder Engagement

- Health Care Reform Task Force – Access Work Group
 - January 2012 - Request for Public Comment on Essential Health Benefits
 - 40 + individuals, organizations, associations submitted comments
 - The Task Force holds monthly, public meetings to review and discuss ongoing issues related to Exchange design and development and the work groups' efforts
 - From August 2012-March 2013 – 68 Town Halls, Webinars, Presentations scheduled to engage citizens

New York Stakeholder Engagement

- Regional Advisory Meetings - to provide advice and make recommendations on the establishment and operation of the Exchange, including recommendations about relevant regional factors.
 - Comprised of representatives of consumers, small business, health care providers, insurance agents and brokers, labor organizations and other stakeholders
 - August 2, 2012: Exchange Stakeholder Meeting: Study of Essential Benefits
 - Received comments from over 70 individuals and consumer groups

Maryland Premium Impact Chart

Benchmark Option	Premium PMPM Impact of Benefit Differences
Small Group 3 - Coventry	\$0.00
Small Group 1 - CareFirst BlueChoice HMO HSA Open Access	\$0.00 - \$0.25
Small Group 2 - CareFirst BlueChoice HMO	\$0.00 - \$0.25
HMO - CareFirst	\$0.00 - \$0.25
FEHBP - BCBS Standard	\$2.50 - \$3.00
State 1 - CareFirst PPO	\$2.75 - \$3.25
State 2 - CareFirst POS	\$2.75 - \$3.25
State 3 - CareFirst EPO	\$2.75 - \$3.25
FEHBP - GEHA Standard	\$9.50 - \$12.00
FEHBP - BCBS Basic	\$10.25 - \$12.75

Colorado EHB Criteria

An optimal plan would:

- Include state-mandated benefits
 - Avoid additional cost to state
 - Maintain consistency with will of legislature
- Provide coverage in required categories
- Be minimally disruptive to the market
- Promote carrier and consumer participation
- Balance comprehensiveness and affordability

Updates on Plan Selection

- Preliminary Recommendations:
 - **Colorado** - Kaiser Ded/CO HMO1200D, largest small group plan
 - **Oregon** - PacificSource Preferred CoDeduct, third-largest small group plan
 - **Rhode Island** - United Health Care Choice Plus
 - **Virginia** - Anthem Small Group PPO

State EHB Resources

- [Colorado Draft Recommendation for Stakeholder Input](#)
- [Michigan Essential Health Benefits Comparison](#)
- [New Mexico EHB Work Group Resources](#)
- [New York Essential Health Benefits Study](#)
- [Oregon Essential Health Benefits Workgroup](#)
- [Virginia Analysis of Essential Health Benefits](#)

State Refor(u)m Tracks EHB Progress



state progress discussions documents blog

Home > State Progress on Essential Health Benefits

State Progress on Essential Health Benefits



*Chart updated on September 13, 2012

Sort table: Click the headers to sort this table by column

Table tip: Click orange text to view relevant source materials

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Recommended benchmark plan	EHB benchmark plan type
AL		X	X	X		
AR	X	X	X		EHB Benchmark Plan: Any of the state's three small group plans (<i>preliminary recommendation</i>)	Small Group Plan
AZ		X	X	X		
CA	X	X	X	X	EHB Benchmark Plan: Kaiser small group HMO plan¹ Pediatric Dental Supplemental Plan: Healthy Families (CHIP) Plan	Small Group Plan
					EHB Benchmark Plan: Kaiser Ded/CO HMO1200D (preliminary recommendation)	Small Group

Questions?

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