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Department of Insurance,  
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# Missouri Health Insurance Advisory Committee

*Meeting - - November 8, 2010*



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## Agenda

1. **Welcome Remarks – *Director Huff***
2. **Comments from Co-Chairs – *Tom Bowser, Andrea Routh***
3. **Medical Loss Ratio (MLR) update – *Mary Kempker***
4. **Definitions/Explanation of Coverage – *Angela Nelson***
5. **Health Insurance Exchanges – *Matt Barton & Molly White***
6. **External Review – *Angela Nelson & Amy Hoyt***
7. **Other Business**
  - **Autism Mandate Implementation – *Angela Nelson***
  - **Under-19 Coverage with No Pre-Existing Conditions – *Mary Kempker***
  - **High-Risk Pool – *Director Huff***
8. **Scheduling of Next Meeting/Closing – *Co-Chairs & Director Huff***



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## Medical Loss Ratio Overview

**The Affordable Care Act directs the NAIC:**

- **to develop the definitions and methodologies**
- **to develop procedures for collecting the data from the carriers**

**If poorly constructed or managed, it could have the potential to destabilize the marketplace and significantly limit consumer choices. It, equally could be rendered useless if the definitions and calculations are too broad.**



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## Medical Loss Ratio

- **On Aug. 17, 2010, the NAIC's Executive Committee/Plenary adopted MLR Blanks Proposal**
- **Blanks are the forms submitted by insurance companies to report financial information to state regulators. Regulators will then review this data to calculate MLR and any rebate required under the new federal law**



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## Medical Loss Ratio

- **On Oct. 21, the Executive and Plenary Committees adopted the MLR Model**
- **Advanced to HHS for certification and publication in the Federal Register; Executive Committee created to address concerns with HHS**



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## NAIC's Model

### Taxes:

- **definition of federal taxes: all federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Public Health Service Act, excluding federal income taxes on investment income and capital gains**
- **Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets**
- **All hospitals must establish and make public a list of its standard charges for items and services, including for diagnosis-related groups**



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## Aggregation

- **The MLR shall be calculated at the licensed entity level within a state, with experience allocated to states based on the situs of the contract, except that for individual business sold through an association, the allocation shall be based on the issue state of the certificate of coverage**
- **Except employer business issued through a group trust, the allocation shall be based on the location of the employer**
- **Experience shall be subdivided into:**
  - individual
  - small group
  - large group plans



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## What is a Small Employer/Large Employer?

**States retain the right to define.**

- Missouri's laws currently remain at 2 to 50 employees in the small employer groups. As of 2014, PPACA requires all states to define small employer groups as 2-100.



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## Broker Impact

**The NAIC also sent a letter to Secretary Sebelius:**

- **recognizing that the role of insurance agents and brokers will be especially important**
- **encouraging the Secretary to recognize the essential role of agents and brokers and to accommodate compensation arrangements in any MLR regulation that is promulgated**



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## Broker Impact

- **While the clear intent of PPACA does not permit the NAIC to adjust the formula to pull out agent compensation from the premiums or the administrative costs, there is significant authority granted to the Secretary to modify the MLR to prevent disruption**
- **NAIC appointed an EX Subgroup to work with the HHS Secretary**
- **Assurances from HHS that discussions can begin right away**



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## Expatriate Plans

- **The NAIC received many letters and comments from insurance companies that sell expatriate policies recommending that these plans be exempt from the MLR limit because the nature of the benefits provided under these plans makes it all but impossible for them to comply with the 80% limit**
- **NAIC concluded that this determination is ultimately the responsibility of HHS to make expatriate plans**
  - **provide coverage in a variety of unique circumstances**
  - **provide unique benefits**
  - **contain inherently higher administrative costs attributable to the additional complexities of administering international coverage**



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## Expatriate Plans

- **The NAIC recommended to HHS that expatriate and international plans be exempt from the medical loss ratio limit and rebate**
- **If not possible, NAIC recommended adjustments be made to their MLR percentage, additional quality improvement activities are identified for these policies, and they be pooled differently to take into consideration their special situation**



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## Transition

**Potential concerns raised that a loss ratio of 80% in the individual market may not be readily achievable by many insurers:**

- **already entered into contracts with agents and brokers**
- **which have expenses associated with underwriting and marketing**

**The Exchanges, rating and market reforms, and other key PPACA provisions designed to reduce administrative costs will not go into effect until 2014.**



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## Transition

- **In the absence of the transitional period, the markets of some states are likely to be “destabilized.”**
- **Section 2718(b) of PPACA states that “the Secretary may adjust [the MLR] percentage with respect to a State if the Secretary determines that the application of such 80 percent may destabilize the individual market in such State.”**



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## Payment of Rebates

- **Rebate payments should be made to the individuals or entities that paid the premiums**
  - If the employer pays the premiums on behalf of the employees, then the rebate check should be sent to the employer for distribution to the enrollees.
  - If the individual pays the premiums directly, then the rebate check should be sent directly to the individual.
- **Recommendation has been made that the Department of Labor provide guidance on the distribution of the rebate payments by employers to ensure the individual employees receive their fair share of rebate**



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## Payment of Rebates

- **Payment of a rebate in the form of either a premium credit against future premiums due or a check to the policyholder**
- **The carriers should be required to make a good faith effort to locate the owner of the rebate check**
- **Such good faith efforts subject to routine market conduct reviews**
- **Failed attempts, returned rebate should be handled under abandoned state property laws**



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**The adopted model states:**

**“Rebates shall be calculated annually by all health issuers using data as of 12/31 of the plan year. Incurred claims to be restated as of March 31<sup>st</sup>. MLRs shall be reported to the states by May 31<sup>st</sup> and refunds paid by June 30<sup>th</sup>.”**



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## Consumer Information Subgroup

- **NAIC charged with development of standards**
  - Consumer information
    - Uniform definitions
    - Explanation of coverage form
  - Exchange enrollment form
  - Applicable to **all** health plans
    - Individual and group; insured and self-insured
- **Participation from wide range of perspectives**
  - Regulators, industry, advocacy groups, medical professionals, limited English proficiency



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## Progress Report

- **Consumer Information – 2 current “Teams”**
  - Uniform Definitions
  - Explanation of Coverage
- **Standardized definitions for 40+ common terms**
- **Development of Explanation of Coverage form**
  - Comparison shopping tool
  - Tool for consumers to understand health coverage



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## Progress Report, cont'd

- **Consumer testing conducted**
  - Consumers Union and AHIP
  - Across the US, including St. Louis
- **Identification of problematic terms/concepts**
  - Need for examples and illustrations
    - Coinsurance, allowed amount for example
- **Working on company instructions for completing forms**
- **Issues unique to self-insured market referred back to HHS/DOL for modification**



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## Health Insurance Exchanges – NAIC Model Act

### Section 2. Purpose and Intent

**The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market.**



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## Health Insurance Exchanges – NAIC Model Act

### Section 4. Establishment of Exchange

**(Drafting Note) States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. The Exchange could also be established as an independent public agency, or a quasi-governmental agency, with an appointed board or commission.**



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## Health Insurance Exchanges – NAIC Model Act

### **Section 6. Duties of Exchange**

**The Exchange shall:**

- A. Implement procedures for the certification, recertification and decertification of health benefit plans**
- B. Provide for the operations of a toll-free hotline**
- C. Provide for enrollment periods**
- D. Maintain an internet Website where comparative information is provided**
- E. Assign a rating to each qualified health plan offered through the exchange**



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## Health Insurance Exchanges – NAIC Model Act

### **Section 6. Duties of Exchange (cont'd)**

**The Exchange shall:**

- G. Inform individuals of eligibility under Medicaid, CHIP or other state or local public program and enroll them if eligible**
- H. Establish and make available a calculator to determine the actual cost of coverage after any applicable tax credits**
- I. Establish a SHOP exchange through which employers may locate health plans for their employers**



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## Health Insurance Exchanges – NAIC Model Act

### **Section 6. Duties of Exchange (cont'd)**

**The Exchange shall:**

- L. Provide employers names of employees who have ceased coverage under a qualified plan and the effective date of the cessation**
- N. Select entities qualified to serve as Navigators in assisting individuals in identifying coverage options**
- Q. Consult with stakeholders relevant to carrying out the activities under the PPACA**



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## External Review Overview

- **External Review is a process by which enrollees can have a third party review a plan's adverse determination**
- **The Affordable Care Act and relevant regulations require state external review processes that, at a minimum, include the consumer protections set forth in the Uniform External Review Model Act promulgated by NAIC**
- **HHS had deemed the current MO law to be compliant until 7/1/2011**



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## Time Frames for External Review Current Law and Procedure

- **No timeframe established for an external review request**
- **No requirement of a formal written request**
- **No requirement to exhaust grievance process**
- **Complaints are received and reviewed by staff**
  - Identification of issues in dispute
  - Review for compliance with policy terms and Missouri law
  - Collect medical information
  - Determine basis for company decision
- **If complaint unresolved, eligibility for external review determined**



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## Current Law and Procedure, cont'd

- **Eligibility:** question as to medical necessity of treatment; efficacy, efficiency or appropriateness of treatment; or a question as to the health care setting or level of care necessary to treat a condition
- **Consumer and company notified of eligibility and opportunity to provide additional medical information**
- **Within 15 *working* days of notice, medical information is sent to IRO**
- **Within 20 *calendar* days of receipt, IRO submits its findings to DIFP**



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## Time Frames for External Review Process – Model 76

- Enrollee has **4 months** from the date they receive notice of the adverse determination to file a **written** request for external review with the Director
- Within **1 business day** of receipt of request, the Director must forward the request to the carrier
- Within **5 business days**, the carrier must conduct a preliminary review



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## Preliminary review

- **Was the individual covered?**
- **Was the service that is the subject of the request a covered service, but for a determination that it doesn't meet medical necessity, appropriateness, health care setting, level of care, or effectiveness requirements?**
- **Has the individual provided the necessary information?**



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## Time Frames

**Within 1 *business day* of completing the preliminary review, the carrier notifies the director and the enrollee whether the request is complete and eligible for external review**

- Notice must explain, in writing, what is needed to make a request complete and eligible for external review

**Within 1 *business day*, the director must:**

- Assign an IRO; and
- Notify the enrollee that the request has been accepted for external review



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## Time Frames

- **The enrollee can submit additional information to the IRO within 5 *business days* and the IRO must consider the additional information**
- **The carrier also have 5 *business days* to provide documents to the IRO**
- **IRO must provide written notice within 45 *days* after receipt of the request for external review of its decision**



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## Expedited Review – Current Law and Procedure

- **Missouri law is silent**
- **Preliminary process is the same as a standard review, but expedited**
  - Identification of issues in dispute
  - Review for compliance with policy terms and Missouri law
  - Collect medical information
  - Determine basis for company decision
- **IRO is required, by contract, to provide findings within three *calendar* days of receipt**



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## Expedited Review – Model 76

- **Applies when the medical condition is such that the timeframe for completion of the standard process would seriously jeopardize the life or health of the covered person or would jeopardize their ability to regain or maintain maximum function**
- **Process is similar to standard external review, but each step must be done “immediately”**
- **IRO must make its determination and provide notice as expeditiously as possible, but no later than 72 hours after receipt of the request**



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## Experimental or Investigational Treatments – Model 76

- **Similar to standard external review**
- **Preliminary review – includes statement from the enrollee’s treating physician providing rationale for the treatment and why it is likely more beneficial than the standard treatment**
- **IRO is required to select clinical reviewers with clinical experience in the past 3 years and be experts in the treatment of the enrollee’s condition**



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## Experimental or Investigational Treatments – Model 76

- **Clinical reviewers must submit written opinions with in 20 days, including medical or scientific evidence and relevant evidence based standards**
- **IRO must make a decision within 20 days of receiving the written opinion**
  - **Expedited External Review – within 48 hours**
- **Model 76 contains multiple new definitions, reflecting the use of evidence based standards and medical and scientific evidence**



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## Binding Nature – Current Law

- **The Director issues a Decision (Adverse Determination Order) based on the findings of the IRO**
- **Decision is binding on the health carrier and the enrollee, subject to limited judicial review**
  - **Action for judicial review must be filed within 30 days of final decision**
  - **Judicial review limited to record before Director**
  - **Scope of review is limited**
    - **Unconstitutional, unlawful, unreasonable, arbitrary or capricious; involves an abuse of discretion or exceeds the statutory authority of the Director**



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## Binding Nature – Model 76

- **Decision is binding on the health carrier and the enrollee except to the extent other remedies are available under applicable law**
- **Enrollee can't file a subsequent request for external review involving the same adverse determination**



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## Autism Bill Overview

- **Mandates coverage for applied behavioral analysis (ABA) for all group health benefit plans and a mandated offer for all individual plans**
- **Effective January 1, 2011**
- **Covers individuals *through* the age of 18 (to 19)**
- **Plans cannot deny or refuse to issue or renew coverage to an individual with a diagnosis of autism spectrum disorder (ASD)**
- **Clarifies coverage for other therapeutic, habilitation and rehabilitative services (e.g, speech, OT, PT)**



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## Applicability

- **Coverage mandate applies to all group health plans (376.1350)**
  - Issued, delivered, continued or renewed in Missouri
    - Written in Missouri or covering Missouri residents
  - All self-insured non-federal governmental plans; all self-insured group arrangements, multiple employer welfare arrangements or other benefit plans
  - All self-insured school district plans
  - Applies to MCHCP
  - Does NOT apply to MOHealthNet
- **Does not apply to accident-only, short-term med, Med Supp, LTC or specified disease or hospital benefit with fixed daily benefit**
- **Individual health policies are required to offer autism coverage** 40



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## The Cap

- **The bill states that the benefits for ABA are capped at \$40,000 per plan year.**
- **Limit can be exceeded if:**
  - Prior approval is obtained from the health carrier; and
  - Treatment is “medically necessary”
    - Could result in an external review situation
- **Judicial interpretations of this limitation of coverage may evolve with time**



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## Implementation

- **FAQs published**
- **Internal training**
- **Preliminary review of network adequacy requirements**
- **Set up tracking systems for complaints**
- **Prepare for policy filings**
- **Licensing regulations for ABA providers**
- **Autism Working Group to advise DIFP**



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## Future Implementation

- **Licensing process on track for January rollout**
- **Insurance Regulations**
  - Data reporting specifications (Spring 2011)
  - Small business coverage waivers (Summer 2011)
  - Network Adequacy (Fall 2011)
- **Insurance Bulletins**
  - Coding issues
  - Any other implementation issues identified
- **Other**
  - Data call (Fall 2011)
  - Legislative report (January 2012)



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## Issues to be Explored

- **Complaint process for policies issued outside of Missouri and self-insured plans**
- **Provider credentialing concerns**
  - 3-6 month process after licensure
- **Guidance on billing and payment processes**
  - There are no procedure codes for ABA therapy
  - Clarification on what services will be submitted through medical or behavioral health



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## Under 19/No Pre-existing

**On June 28, 2010, HHS issued guidelines stating:**

- **Carriers can use underwriting for rating, but not for eligibility**
- **Carriers can underwrite during specific open enrollment periods to be determined by each state**
- **Carriers cannot accept healthy enrollees outside these open enrollment periods without also accepting those with pre-existing conditions**



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## Under 19/No Pre-existing

**As HHS announcement resounded in the market, major carriers started to withdraw from the under 19 or child only policies. Missouri witnessed Anthem, Aetna, CIGNA, HU, UHC and Coventry/Mercy withdrawing from this market. Only one major metropolitan carrier in a specific area remains in the market currently. However, this carrier constantly reviews the viability of continued participation in this market.**



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## Under 19/No Pre-existing

**As with other states, to encourage plans to re-enter this market DIFP issued a bulletin (10-06):**

- **specifies open enrollment periods.**
  - **an initial OE period from 9/23 through 12/31/10**
  - **each year in the month of March with coverage effective April**
- **Carriers cannot underwrite outside of the OE periods**



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## Under 19/No Pre-existing

**During the October National NAIC meeting, the B Committee—Health Insurance Committee, adopted this model law. HHS also announced release of additional guidance on under 19 or child only policies.**



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## **Scheduling of Next Meeting/Closing**