



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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Office of the Commissioner of Insurance Health Advisory Council

Minutes

Tuesday, October 9, 2007

10:00 a.m. – 12:30 p.m.

125 South Webster Street

Room 227

Madison, WI 53703

Council Members Attended: Alice Torti, Chair, Great Big Pictures; Marilyn Windschiegel, WEA Trust; Karen Geiger, Blue Cross/Blue Shield; James Sykes, UW- Madison; Robert Palmer, Dean Health Plan; Mary Ellen Powers, Metropolitan Milwaukee Association of Commerce; Roberta Riportella, Ph.D, UW-Madison; John Torinus, Serigraph, Inc.; Mike Derdzinski, WAHU; John Sheski, WPS; Terry Murphy, East Town Insurance Services, Inc.; Roma Hanson, AIDS Resource center

OCI Representatives Attended: Commissioner Sean Dilweg, Deputy Commissioner Kimberly Shaul, Jennifer Stegall, Eileen Mallow, Sue Ezalarab, and Mary Reines

Others Present: Heather Bruemmer, BOALTC; Ellen Alwin, GHC-SCW, Kathryn Ambelang, WPS; Jodie Tierney, ACS; Bill Toman, Quarles & Brady; Phil Dougherty, WI Association of Health Plans, Louie Schubert, American Family Insurance, Amie Goldman, HIRSP, Vaughn Vance, WEA Insurance; Susan Linck, NAIFA

I. Opening Remarks

Commissioner Sean Dilweg

Commissioner Dilweg thanked committee members for sharing their time and expertise. He indicated that as the committee worked through its agenda, he had particular interest in the following areas: effectiveness of wellness programs, the range of health reform plans that other states are looking at and getting a more complete picture of how insurance markets work in Wisconsin

He also encouraged council members to share their ideas freely.

II. Introductions

Alice Torti, Chair

An introduction of each member in the council was done. Alice thanked the council and opportunity to work together.

III. Group Health Insurance Premiums; Update

Eileen Mallow

Eileen Mallow presented the results of the most recent edition of OCI's "Group Health Index", showing that new business rates declined during the most recent 6 month period. She offered two possible

reasons: Insurers pricing competitively to increase their market share and higher cost sharing with enrollees.

The survey only looks at new business rates, not renewals. OCI does this survey every 6 months and will continue to share results with the council.

Mike- concurs that business rates are flattening. Renewals tend to be across the board, lot depends on the duration of the account with a particular carrier, and what has been the impact of the programs that are in place. There is a trend now to have in the mind of the consumer that the plan in place will continue to evolve over time.

The Council discussed what members are seeing in the market and what the negotiations between insurers and employers have looked like, including longer term premium lockins . The council is interested in seeing more information about the survey and results.

IV. HIRSP Rule: Requirements for Insurers noticing denial of coverage for HIRSP eligibility.

Eileen Mallow presented a summary of a proposed administrative rule that OCI is working on that would provide additional guidance to insurance companies that process applications over the web. OCI is interested in making sure that regulations keep up with changes in the way insurers issue coverage and that proper notices are given, especially the notice of HIRSP eligibility. We are working with the HIRSP Authority on specific language.

V. State and Federal Legislative Update

Jennifer Stegall updated the Committee on state and federal legislative proposals.

State

Healthy Wisconsin

Healthy Wisconsin is a health care plan included in the version of the budget bill passed by the Senate on June 26th (18-15 vote on bill as amended). The version of the budget bill passed by the Assembly on July 10th does not contain the Healthy Wisconsin proposal.

Background

- The plan would provide health care coverage to state residents and employees equivalent to the coverage under the state employee health care plan that is in effect on January 1 of this year.
- The plan would be administered by the Healthy Wisconsin Authority, and funded by assessments on employers, employees, self-employed individuals and individuals without earned income. The assessments would be collected and deposited into the Healthy Wisconsin trust fund and released to the Healthy Wisconsin Board of Trustees for payment to health care networks and providers.

Status:

- A conference committee has been formed to negotiate a budget package that both sides can agree on. On Sept. 21st the Senate Democrats offer to remove Healthy Wisconsin from the budget if the Assembly Republicans agreed to a cigarette tax increase, a hospital assessment and a transfer of \$175 million from the Injured Patients and Families Compensation Fund. Republicans have offered to accept the cigarette tax and the fund transfer but remain opposed to the hospital assessment.
- Conference committee members continue to work on resolving outstanding issues. Leadership from both houses met with the Governor in an effort to move forward. To date budget negotiations are ongoing.

The assembly held a hearing with invited speakers. We would expect that we would to hear something soon but not sure of the timing.

Autism Mandate

Background:

Senate Bill 178 (Robson/Hixson) requires health insurance policies to cover the treatment for autism spectrum disorder if the treatment is provided by the following:

- Psychiatrists;
- Psychologists;
- Social Workers certified or licensed to practice psychotherapy;
- Paraprofessionals working under the supervision of a Psychiatrist, Psychologist or Social Worker licensed to practice psychotherapy; or
- Professionals working under the supervision of an outpatient mental health clinic.

The Senate Committee on Public Health held a public hearing on May 31st. The Committee is scheduled to take executive action on the bill tomorrow 10/10/07 at 10:00 am.

The companion bill, AB 417, was referred to the Assembly Committee on Health and Health Care Reform on June 26th. No further action has been taken.

There is language in the Senate version of the budget requiring the same coverage as that of SB 178 with the exception being that the budget language also requires coverage of services provided by a speech pathologist.

For the most part, the intent of the bill the advocates and authors are trying to get coverage through treatments through professionals.

The members discussed how social and financial impact statements for mandates are prepared.

State mandate for coverage of mental health services

Background:

Language included in both the Governor's budget recommendations and the Senate budget bill changes the minimum amount of coverage that must be provided under a group health policy for the treatment of nervous and mental disorders and AODA problems.

Current minimum coverage amounts compared to those proposed by the Governor and Senate are as follows:

- Inpatient treatment: Currently \$7,000...increased to \$20,250.
- Outpatient treatment: Currently \$2,000...increased to \$3,450.
- Transitional treatment: Currently \$3,000...increased to \$5,200.
- The annual minimum limit on all services: Currently \$7,000...increased to \$20,250.

Status:

The Assembly Republicans did not include these increases to the treatment minimums in their budget.

Cigarette tax

Background

Governor Doyle included a \$1.25 increase in the cigarette tax as part of his budget recommendation. The tax would increase from .77 to \$2.02.

Status

The Joint Committee on Finance and the Senate also included the increase in their versions of the budget. The Assembly did not include the increase.

- As I mentioned earlier, there is some Assembly Republican support for the tax.
- 25 Assembly Republicans have signed a pledge to oppose all tax hikes.
- Recently, 13 indicated they would stick to that pledge while 6 thought they may accept the cigarette tax.

Smoking Ban

Background

Senate Bill 150 introduced by Senator Risser and Representative Wieckert, prohibits smoking in most indoor areas accessible to the public and places of employment. The exceptions include:

- private residences, designated rooms in lodging establishments and certain retirement homes.
- Mass transit vehicles and school buses.
- Schools and other educational facilities.
- Residence halls and dormitories of colleges and universities.
- Day care centers.
- Inpatient health care facilities, such as community based residential facilities and nursing homes.
- Prisons, jails, and juvenile correctional facilities.
- Mental health institutions and hospitals where the primary purpose is the treatment of mental illness, alcoholism, or drug abuse.
- Centers for the developmentally disabled.
- Restaurants and taverns, as described below.
- Retail establishments.
- Public waiting rooms.
- Governmental buildings.

Status

The bill was referred to the Senate Public Health Committee (Carpenter) on April 18th and a public hearing was held on May 31st. No further action has been taken.

Chiropractic mandate

Background

The Senate version of the budget includes language requiring the following:

- If an insurer changes the current procedural terminology code that was submitted by a health care provider, the insurer must include on the explanation of benefits form the explanation for the change.
- Under current law, insurers are required to provide patients and their treating chiropractors a reasonable explanation of the factual basis and of the basis in the policy for the insurer's restriction or termination of coverage.

Language included in the Senate budget bill requires that explanation to be a detailed explanation of the clinical basis for the insurer's decision to restrict or terminate coverage. The bill would also extend this requirement to the treatment of conditions and complaints beyond those treated by chiropractic services.

Status

Parties interested in this mandate are discussing who should be impacted and it sounds like they have agreed it should only apply to chiropractors. They are also working through what insurers specifically have to do when denying a claim.

The council discussed the fine points of the bill and raised issues that OCI will consider as the proposal moves forward.

BadgerCare Plus

Background

BadgerCare Plus is the Governor's policy solution to ensure that all of Wisconsin's children and more adults have access to health care. One goal of the program is to ensure that 98 percent of Wisconsin's citizens have access to health care.

BadgerCare Plus will merge Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families. Coverage will be expanded to eight new populations:

Status:

The Senate included BadgerCare Plus as part of their budget. The Assembly Republicans did not. This is an item under consideration as the leaders from both houses work to find consensus on the budget.

Federal

SCHIP (STATE CHILDREN'S HEALTH INSURANCE PROGRAM)

Background

SCHIP is a \$25 billion national program which provides health insurance for families who earn too much money to qualify for Medicaid but cannot afford to buy private insurance. The current program covers approximately 6.6 million low-income children.

SCHIP funding supports approximately 70% of the costs of services for children and all other adults enrolled in BadgerCare.

Because SCHIP was set to expire on September 30th, the House and Senate each passed legislation to re-authorize and expand the program.

Status

The House version (HR 3162) would increase funding for the program by \$50 billion over 5 years. A .45 cig. tax increase and a reduction in payments to Medicare Adv. Plans would support were proposed to support the increase.

The Senate version (S 1893) proposed increasing funding by \$35 billion over 5 years supported by a .61 cent cigarette tax increase. (total program would be funded at \$60 billion).

During the week of September 24th, the House and Senate agreed to a compromise which adopts the Senate funding level of \$35 billion over 5 years (HR 976).

According to the Congressional Budget Office, the increase would result in about 5.8 million children enrolling in SCHIP and MA, with 2/3rds of them otherwise uninsured.

The President, who proposed a \$5 billion increase for SCHIP, vetoed the compromise legislation. The House will attempt to override the veto on Oct. 18th. The President did sign a continuing appropriations

resolution to make funds available for the program until November 16th while efforts continue to reach agreement on long term funding of the program.

The Council asked staff to find out more information about how Badger Care is working in Wisconsin.

Medicare Advantage

Background

Under the Medicare Advantage program, CMS approves private companies to offer health plan options to Medicare enrollees that include all Medicare-covered services. Many plans also provide supplemental benefits or coverage for items not available under the traditional fee for service program.

- Earlier this year, Commissioner Dilweg testified before the Senate Special Committee on Aging and House Ways and Means Subcommittee on Health regarding the need for state regulatory authority over the companies selling MA plans.
- Currently, OCI has regulatory authority over insurance agents and brokers but has no say in whether a marketing strategy is appropriate. The ability to take corrective action against a company for misconduct would allow insurance departments to prevent the marketing abuses that are occurring.
- In traditional insurance, state regulators can respond to inappropriate agent action by holding the insurance company responsible for the acts of its agents and thereby having it supervise and discipline its agents.
- The Commissioner, in his testimony, also pointed to high reimbursement rates for MA plans creating a strong incentive to sign up as many enrollees as possible.
- The House SCHIP reauthorization bill initially included language directing the NAIC to develop marketing standards and returned regulatory oversight over to the states. It also cut MA reimbursement rates. Unfortunately, these provisions were not included in the final SCHIP proposal.
- Senator Kohl has introduced the Accountability and Transparency in Medicare Marketing Act of 2007 (S.1883) which calls on the NAIC to develop marketing standards and allows for state oversight of those standards. It also requires the NAIC to make recommendations regarding standardized benefit packages.
- As Chairman of the NAIC Senior Issues Task Force, Commissioner Dilweg has formed a Medicare Private Plans Subgroup of insurance industry representatives, insurance agents, consumer representatives, state insurance regulators, CMS, and Medicare law and policy experts. The goal is to have the NAIC, through this group, position itself to quickly respond to any charge it may receive from Congress. The Subgroup met September 11th and Sept. 29th.

The Council discussed national efforts to improve this program including standardization of benefits, greater oversight of agents who are marketing these plans and additional state controls on the plans.

Mental Health Parity

Background

U.S. Representative Patrick Kennedy (*HR 1424*) has introduced the Paul Wellstone Mental Health and Addiction Equity Act of 2007 and Senator Ed Kennedy has introduced the Mental Health Parity Act of 2007 (*S. 558*).

The most recent drafts of these bills provide parity for all mental health and substance abuse related disorder benefits under group health plans.

Neither bill mandates coverage of mental health benefits. The parity requirements in the proposals apply only to businesses with over 50 employees, choosing to offer mental health benefits.

In July, Commissioner Dilweg testified before the Subcommittee on Health, Employment, Labor and Pensions regarding concerns with language in the Senate bill that pre-empted state laws imposing stronger parity standards. Specific to Wisconsin, the concern was preemption of our mandate requiring that mental health benefits be covered when in patient and out patient services for other conditions are covered.

On Tuesday, September 18th, the Senate bill was amended and passed by the Senate. The amendment removed the preemption language Commissioner Dilweg testified against.

Status

On September 26th, the House Ways and Means Committee passed HR 1424. The House Energy and Commerce Subcommittee on Health will vote on the bill tomorrow. A vote by the full committee will be needed as well as a vote by the full House Education and Labor Committee.

It is anticipated House action will be taken in the near future and a conference committee will be convened to develop a bill both houses can agree to. One of the main differences between the two bills causing contention appears to be the definition "mental health benefit."

The Council was told that the President seems willing to sign a bill should one get through Congress.

VI. NAIC presentation: Summary and Update of Health Care Initiatives in Other States.

Josh Goldberg, NAIC

A handout was provided to the council and attendees of Mr. Goldberg's presentation on health reform proposals in other states.

The presentation concentrates mostly on the comprehensive health plans as opposed to the more targeted health plans. Such as Illinois or New York in the last year or so. We will discuss Maine, Massachusetts, Vermont, and California.

Currently about 60% of small employers are offering coverage. We are seeing a significant decrease in small employers offering coverage. There is no prospect for federal action. There is a lot of political disagreement on how to handle health care needs.

Highlights about Maine:

- The Dirigo plan was enacted in 2003. So far only 30% of small employers are participating. Maine is disappointed with their results, due to higher costs. Higher costs are being attributed to 70% of enrollees are individual.
- The reinsurance plan is mandatory and there are no state subsidiaries.
- Dirigo 2.0 did not pass and is highly controversial. They are not reducing premiums.
- Governor is pushing to pass and reform.

Highlights about Massachusetts:

- Low uninsured rate in their state.
- The plan requires the individuals to be below Federal Poverty Level (FPL)
- The bulk of the uninsured will qualify for the program. Plan is good for part-timers with multiple jobs and can take plans with them even if there are changes in employment.
- There is the central question – how effective is the mandate. There is continued political pressure to address market response.

Highlights about Vermont:

- Not as popular as the Massachusetts plan.

- Vermont is starting with diabetes for chronic and trying to intervene

California:

- They have the lowest insured population than any other State
- Won't be on the ballot until 2009 for the state.
- Post claims underwriting is a big issue

Open Questions:

How many states can implement some form of reform?

Cost containment – drugs, mental health, managed care

Strategic to get as many healthy people in the pool as possible

How to set up long term funding streams for these programs.

VII. Closing:

- Next meeting date is January 15th @ 10:00am.
- Members should come to the next meeting prepared to share their experiences and perspectives relating to health care reform initiatives.
- Any agenda items should be sent to Jennifer .
- Jennifer will email the agenda on December 15th.