



# State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

*Jim Doyle, Governor*  
*Sean Dilweg, Commissioner*

*Wisconsin.gov*

125 South Webster Street • P.O. Box 7873  
Madison, Wisconsin 53707-7873  
Phone: (608) 266-3585 • Fax: (608) 266-9935  
E-Mail: [ociinformation@wisconsin.gov](mailto:ociinformation@wisconsin.gov)  
Web Address: [oci.wi.gov](http://oci.wi.gov)

## Office of the Commissioner of Insurance Health Advisory Council

### Minutes

**Tuesday October 14, 2008**

**10:00 a.m. - 12:45 p.m.**

**125 South Webster Street**

**Room 227**

**Madison, WI 53707**

Council Members Present: Alice Torti (Chair), Great Big Pictures; Marilyn Windschiagl, WEA Trust; Karen Geiger, Blue Cross Blue Shield of Wisconsin; James Sykes, UW Madison Medical School; Roberta Riportella, University of Wisconsin-Madison; Mike Meulemans, Write Resources; Mike Derdzinski, Johnson Insurance Services; Terry Murphy, East Town Insurance Services; Kris Seymour, Humana (via teleconference)

Council Members Absent: Robert Palmer, Dean Health Plan; Mary Ellen Powers, Metropolitan Milwaukee Association of Commerce; Roma Hanson, AIDS Resource Center

OCI Representatives Attended: Commissioner Sean Dilweg, Deputy Commissioner Kim Shaul, Assistant Deputy Commissioner Eileen Mallow, Jennifer Stegall, Jim Guidry, Guenther Ruch, Kelli Banks

Others Present: Connie Kinsella, John Toussaint, Mary Haffenbredl, Kathy O'Neil, Ellen Alwin, Ted Osthelder, V. Vance, Lisa Maroney, Ericka Brown, Hannah Lott, Nancy Wenzel, Joanne Alig, Russ Cain, Jordan Lamb, Coral Butson, Bill Toman, Tony Langenohl, Amie Goldman, Kathryn Ambelang, Jon Rauser, Lisa Maroney, Dan Schwartzer

### **I. Approval of the July 15, 2008 Minutes**

Alice Torti, Chair

Minutes were approved.

### **II. Individual Health Insurance Marketplace**

Sean Dilweg, Commissioner

Commissioner Dilweg raised several issues relating to the individual health insurance market. Implementing a standardized individual health insurance form was one issue. The Oregon Standard Health Statement was distributed

to everyone for review as an example of a standard form Wisconsin may want to implement.

The next issue Commissioner Dilweg raised was that that he had received a letter from Representative Waxman who serves on the Congressional Committee on Oversight and Government Reform. Representative Waxman held a hearing in July on the individual health insurance market as it relates to rescissions. NAIC thinks the majority of states will respond to his letter and Commissioner Dilweg indicated he will share his response with the Council. Commissioner Dilweg explained that rescission issues in Wisconsin are not the same as in California, for example. It has been something that has been looked at nationally and is something that Commissioner Dilweg would like to look at in Wisconsin. An independent review process for rescissions may be something to pursue.

Commissioner Dilweg discussed the passage of the mental health parity legislation by Congress which will greatly improve access to mental health and substance abuse treatment services. The legislation was part of the larger Emergency Economic Stabilization Act of 2008. In July Commissioner Dilweg testified before Congress in support of this legislation. Most of his testimony was arguing against the inclusion of preemption language which would have compromised stronger mental health coverage already in place in Wisconsin. Commissioner Dilweg was pleased this preemption language was not included in this legislation and current Wisconsin law requiring insurers to cover a minimum level of mental health and AODA treatment remains in effect.

### **III. Model Audit Rule Update**

Kim Shaul, OCI

Deputy Commissioner Shaul indicated that the Model Audit Rule is through the legislative process and the Commissioner will sign off by the end of the month. We are looking at having an effective date of January 1, 2010.

### **IV. Changes to Medigap and Medicare Marketing (Genetic Information Nondiscrimination Act and Medicare Improvements for Patients and Providers Act)**

Guenther Ruch, OCI

Genetic Information Nondiscrimination Act of 2008 (GINA) was passed in May 2008. The Medicare Improvements for Patients and Providers Act (MIPPA) was passed in July 2008. GINA prohibits the denial, condition, or discrimination in the pricing of a Medicare supplement policy on the basis of genetic information. The effective date for GINA requirements is May 21, 2009 however states have until July 1, 2009 to make regulatory or statutory changes. MIPPA authorizes the revisions to Medigap plans and benefits contained in the model law revision approved by NAIC in March 2007. Wisconsin is a wavered state because we already had standardized benefits. We are in the process of amending our Medicare Supplement regulation rule

(INS 3.39). We are going to have a separate section for the new Medigap benefits. We will amend our riders and core benefit policy to comply with the new Medicare supplement model. We expect to have this done by June 2009. An example of a new benefit is including hospice benefits in the core policy. The effective date for modernized Medigap plans/benefits to be sold is June 1, 2010. MIPPA does not include any significant expansion of state authority or oversight. MIPPA retains the current bifurcated regulatory system, with no state authority over these plans except for licensing and solvency.

## **V. Assignment of Benefits Presentation**

Connie Kinsella, Vice President of Revenue Cycles for UW Health

Ms. Kinsella discussed the increasing frequency of instances when health insurance benefits have been paid directly to the patient rather than the provider despite the presence of the assignment of benefits clause. Ms. Kinsella said that this has become a concern for a number of reasons. Administrative costs become overburdened for both the provider and the payer. Patients are being put in the middle of a transaction between a payer and a provider during a stressful time in the patient's life when they are dealing with health issues. Ms. Kinsella said the most troublesome aspect of this issue is the ability of plans to disregard assignment of benefits by patients. There are currently 19 states that have regulatory provisions or laws in place requiring insurers to honor the assignment of benefits. Ms. Kinsella asked that Wisconsin consider pursuing regulatory or legislative changes that will provide similar protection and services. Ms. Kinsella thinks this is a nationwide problem not a problem unique to UW Health. She thinks it's a tactic used to incent contractual relationships. Karen Geiger added that Blue Cross Blue Shield has established this practice to incent non-contracted providers to contract with Blue Cross Blue Shield. Ms. Kinsella thinks that putting the patients in the middle of this is inappropriate and the administrative costs are becoming overburdened. The end result will be treating these patients as uninsured and will require prepayment which will create an access issue. Commissioner Dilweg said we will look at the 19 states and investigate this issue further.

## **VI. Small Group Health Insurer Subgroup Update**

Jennifer Stegall, OCI

Jennifer reported that the Small Group Health Insurer Subgroup met on August 7, 2008. A presentation was given by Bela Gorman from Gorman Actuarial. Preliminary data showed declining enrollment in the small group market. The reason is unknown. The study also showed a wide variation of premiums across the market. Jason Helgerson from the Department of Health Services gave an update on Badgerchoice and BadgerCare Plus at the Small Group Health Insurer Subgroup meeting. Jennifer indicated the number of children enrolled at the end of September was 365,604 which is 55,814 more since BadgerCare Plus started. Adults enrolled were 186,073 which is

27,580 more. Jason had reported the next step is the childless adult expansion. It is estimated that there are 81,000 individuals in this group.

Amie Goldman from HIRSP also provided a presentation at the Small Group Health Insurer Subgroup meeting and shared some of the information with the Health Advisory Council. Amie provided a handout and briefly explained the HIRSP authority and the population HIRSP serves. Amie said 76% of policyholders were age 45 years or older and a majority of policyholders did not meet their deductible. HIRSP began in the early 1980's with less than 1,000 enrollees and as of 6/30/08 there were 16,330 HIRSP policyholders. The majority of new enrollees sign up for the \$5,000 deductible plan. More data is being collected to better understand enrollment and to better serve those in need. HIPAA eligibles represent almost 60% of new enrollment. A large proportion of HIRSP applicants report being unemployed. Of the enrollees that report full-time employment, most appear to be working for small businesses. HIRSP premiums have not increased as much as compared to the individual market. The average annual premium paid by a HIRSP policyholder in 2007 was \$5,904.

## **VII. Final Report: Independent Review Organizations**

Eileen Mallow, OCI

The Implementation of the Wisconsin Independent Review Process report has been issued. Eileen said that the review of the survey responses indicates that insurers have generally established and implemented procedures where an insured may request an independent review. However, insurers do not all interpret and apply the requirements in the law in the same manner. A copy of the report along with a certified letter was sent to each company surveyed identifying specific areas of improvement that may need to be addressed. OCI will provide additional training to companies and look for opportunities to educate consumers.

## **VIII. Presentation: "Quality in Health Care is an Oxymoron"**

Dr. John Toussaint, President and CEO, ThedaCare Center for Creating Value in Health Care

John Toussaint provided a presentation entitled "Creating a Healthcare marketplace that Rewards Value, is it Possible?" The ThedaCare Center for Health Care Value is an independent organization with a national scope. Dr. Toussaint explained that the healthcare industry has a trillion dollars of waste. He explained that there is little transparency, high error rates, no serious continuous improvement activity and constant fear among providers that they may lose their jobs, get sued or lose autonomy of decision making if they create standard work processes. In addition, Dr. Toussaint claims the marketplace is dysfunctional and it doesn't encourage the delivery of low cost high quality care. Dr. Toussaint reported that the average family premium has gone up. The number of people with employer-sponsored health insurance has gone down. The nonelderly uninsured rate has gone up and uncompensated care has gone up. Dr. Toussaint explained that the goal of

ThedaCare is to bring employers, providers and in some cases payors, together to develop new models of care and payment that result in greater efficiency and expertise for healthcare providers, and greater value for purchasers and patients.

Key metrics will include improved health, improved patient experience and a decrease in cost per capita. Dr. Toussaint explained that one of the problems is that insurance companies incent over utilization. Driving unit prices lower incents physicians to do more individual procedures. The providers have no incentive to improve. Quality data on performance is not transparent or does not exist. The choice in insurance products has led to all providers being included in insurance products, so efficient providers' performance is diluted out and premiums continue to rise. The benefit design does not reward best performers on quality care. Dr. Toussaint also said that employer benefit directors are resistant to change due to employee backlash.

Dr. Toussaint claims that his Collaborative Care Model is what is needed to transform our current health care system. According to Dr. Toussaint his Collaborative Care Model has brought patient charges and lengths of stay down and the quality of care is improved. Dr. Toussaint explains though that the Collaborative Care system is penalized and paid less. Dr. Toussaint explained that employers or insurance companies need to create incentives to promote better quality care at a lower cost.

**IX. Other Business**

None

**X. Next Meeting**

January 14, 2009