

## Joint Commission on Health Care

General Assembly Building – Senate Room A

August 4, 2010 – 10:00 a.m.

### Minutes

#### In Attendance

Delegate Benjamin L. Cline

Delegate Robert H. Brink

Delegate David L. Bulova

Delegate Rosalyn R. Dance

Delegate T. Scott Garrett

Delegate A. T. Howell, Jr.

Delegate Harvey B. Morgan

Delegate David A. Nutter

Delegate John M. O'Bannon, III

Secretary William A. Hazel, Jr.

Senator Linda T. Puller

Senator George L. Barker

Senator R. Edward Houck

Senator William C. Wampler, Jr. (conference call)

**The meeting was called to order by JCHC Chairman, Delegate Benjamin L. Cline.** Delegate Cline reported that Senator Puller wished to step down as co-chair of the Healthy Living/Health Services (HL/HS) Subcommittee since she was now serving as vice-chair of JCHC. Delegate Cline accepted Senator Puller's recommendation to appoint Senator Ticer as co-chair of the HL/HS Subcommittee.

#### **Update on Virginia's Health Reform Initiative**

William A. Hazel, Jr., Secretary of Health and Human Resources

This following is a summary of Secretary Hazel's main points as presented to JCHC (no handout/slide presentation was submitted). Secretary Hazel commented that there are real issues with health care in the U.S.; large businesses with large health care expenses and an unhealthy workforce cannot be competitive globally. In Virginia there are 1 million residents who are uninsured. It makes sense to do what will benefit Virginia regarding health care needs.

On August 16<sup>th</sup>, Governor McDonnell will hold a press conference to announce the appointment of members to the Virginia Health Reform Initiative Advisory Council. The council membership will include several legislators including Delegate Cline and Senator Houck. The council will establish task forces in the following six key areas and hold meetings in August, October, and December.

**Medicaid Reform.** There's been a 1600% increase in Medicaid enrollment since 1985, when the economy goes down enrollment increases. Secretary Hazel remarked that the bleeding can be slowed but the problem cannot be fixed until other parts are fixed. You can be a provider or manage care, but cannot do both. Coordination of care for all Virginians is needed.

**Health Insurance Regulation.** New regulations will be needed to address federal changes, some of which will become effective September 23<sup>rd</sup> of this year. Virginia will need statutory changes to enforce some of the federal provisions. A bigger issue is what to do with the Health Insurance Exchange concept. Individuals and families at 133 to 400% of the federal poverty level will be eligible to receive insurance through the exchanges. Note that what is required is different from what Massachusetts is doing now.

**Delivery System Reform.** The federal bill's primary focus is on access; however, it is hard to focus on access without fundamental improvements in how care is delivered. An example is whether to align incentives through accountable care organizations or primary care homes. Michelin's Spartanburg plant found that 1750 employees have Type II diabetes. The plant is working with these employees as it is difficult to work 12-hour shifts and address diabetes needs at the same time.

**Workforce Capacity.** It costs \$450,000 to train a doctor at Virginia Commonwealth University, and VCU has some of the lowest State funding for any medical school in the U.S. The legislature set up the Health Workforce Advisory Committee some years ago; however it has been unfunded. The Advisory Committee recently applied for federal funding to fund their operations.

**Technology.** Applications have been submitted for health grants to assist in implementing Virginia's Health Information Exchange.

**Purchasers Group.** Depends heavily on employer-based insurance.

A number of questions were addressed including when reports could be expected from the task forces. Secretary Hazel indicated he plans to have a report in December including whether to continue the Advisory Council. Several task force reports may come earlier, and it is anticipated having the Medicaid and Health Insurance reports released first.

### **Health Insurance Reforms Under the Patient Protection and Affordable Care Act**

Alfred W. Gross, Commissioner of the Bureau of Insurance gave a brief description of the Bureau's role and oversight with regard to health insurance reform and how the federal law includes new requirements for product offerings.

Jacqueline A. Cunningham, Deputy Commissioner, Life and Health Division of the Bureau of Insurance discussed the health insurance reforms required by federal health reform and presented a timeline for implementation of the reforms. At the request of a JCHC member, Ms. Cunningham provided a written summary of her comments which has been attached to the minutes as an addendum.

### **Meeting the Challenge of Health Reform**

Dr. Stephen Horan, President of Community Health Solutions works primarily with foundations, health systems, free clinics, and community health centers regarding health promotion and the quality of health care. Dr. Horan's presentation addressed the following subject areas:

- Problems with health care today
- Ideals of health care reform
- Forces influencing the feasibility of health reform
- Stakeholders influenced by health reform
- Challenges for Virginia

#### **Concluding Suggestions:**

- Make Virginia the best state in the nation for starting or expanding a business under health care reform.
- Challenge every stakeholder – including government - to engage in critical self-analysis, proactive accountability, and strategic innovation.
- Use this window of time to influence the regulatory implementation of the federal legislation.
- Remember the safety net!

Shirley Gibson, President of the Virginia Nurses Association stated health reform could provide over 1 million Virginians coverage and enhanced access to health care. She stated nurses are essential to the delivery of quality, safe care but there is a looming nursing shortage. Some facts concerning the shortage of nurses in Virginia:

- By 2020, 1 in 3 Virginians will not receive the health care needed because of the shortage of registered nurses. The demand for full-time equivalent nurses will be 69,600 and the actual number of employed nurses will remain relatively constant at 47,000. This is a 32% shortfall.
- Beginning in 2015, it is forecasted that the number of retiring RNs will exceed the number of new RN graduates entering the workforce.
- New research conducted by the Department of Health Professions' Healthcare Workforce Data Center shows that 1 in 4 nursing faculty plans to retire in the next five years.

Ms. Gibson stated that the current shortage impacts nurses, patients, the vitality of Virginia's health care system, and quality of life in the Commonwealth. Nursing scholarship and loan repayment programs will increase patient access to nurses in underserved areas and help pay for those applicants who now are in schools, this investment will not increase the number of nursing students or graduates, or the number of nurses in the Commonwealth without investment in nursing faculty salaries and capacity.

There being no further business, the meeting was adjourned. The next JCHC meeting will be held October 6, 2010.

Prepared by: Sylvia A. Reid

Date: August 25, 2010

Attachment

## Immediate Health Insurance Reforms

Jacqueline A. Cunningham, Deputy Commissioner  
Life and Health Division, Bureau of Insurance, State Corporation Commission

**Important Note:** The rules under which many of these reforms apply are dependent on whether or not the health insurance plan involved is considered to be grandfathered or not, (refer to information in *italics* at the end of each category of reform requirements).

Generally effective for plan or policy years on and after 9/23/10:

- **No lifetime limits:** Plans may not establish lifetime limits on the dollar value of essential benefits. Details about essential benefits are still to be determined by HHS, but we do know generally that they include the following:
  - Ambulance
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance abuse disorder services
  - Prescription drugs
  - Rehabilitative services and habilitative services and devices
  - Lab services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

HHS released interim final rules addressing lifetime limits on 6/21. Anyone who previously lost coverage because of having reached lifetime limit must be given a special enrollment period. *All plans*

- **Restricted Annual limits:** Annual limits are limited as they apply to essential benefits, and the limits vary depending on the plan year, ranging from \$750,000 in 2010 to \$2 million in 2012. *All plans except individual grandfathered plans*
- **Restrictions on Rescissions** – coverage may only be rescinded for fraud or intentional misrepresentation of a material fact. Prior notification of cancellation must be provided to the policyholder. HHS released interim final rules addressing this on 6/21. *All plans*
- **First Dollar Coverage of Preventative Health Services** – a number of preventative care services and immunizations must be provided without cost sharing, (no deductibles, coinsurance, etc.), except that cost sharing may be applied when these services are provided by out-of-network providers for network plans. HHS released interim final rules addressing this on 7/9. *All non-grandfathered plans*
- **Extended Dependent Coverage** – for adult children to age 26. Very liberal requirements – no dependency criteria at all, other than in terms of the relationship between the child and the plan participant. For example, conditions like financial dependency, student status, or residency with the participant can not be used. In the case of a child whose coverage previously ended, the insurers must provide that child with at least a 30 day period to enroll. This requirement became effective 9/23, and it essentially applies to plans or policies on the beginning of their first plan or policy year following that date, but many carriers voluntarily implemented this extended coverage earlier. HHS released interim final rules on 5/13. *All plans*
- **Internal/External appeals** of adverse coverage decisions – interim final rules addressing internal and external reviews were released on 7/22. We are still reviewing these rules, but it does appear that the processes in place in Virginia will be significantly impacted, particularly as they relate to external appeals. We do have a grace period until 7/1/11, though, under which existing state requirements for external appeals are applicable. *All nongrandfathered plans*

- **No preexisting conditions for Children:** no exclusions (including denial of coverage) can be imposed on individuals under age 19. HHS released interim final rules on 6/21. *All plans except grandfathered individual market plans*
- **Disclosure of Justifications for Premium Increases:** Effective this year, insurers will be required to report to HHS and to the states justifications for “unreasonable” rate increases prior to implementing the increase. The states are working collaboratively on providing to HHS, for consideration, a format for reporting these increases. The term “unreasonable”, though, has not yet been defined.

### MLRs and Rebates:

Medical loss ratios and rebates – No later than 1/1/2011, carriers will be required to report to HHS a medical loss ratio relating to their fully insured plans. The components of the MLR are still being discussed, but they must account for clinical services, activities that improve health care quality and non-claim expenses, including federal and state taxes, licensing and regulatory fees. If the percentage of premium 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 market, a rebate to consumers will be required. *All fully insured plans including grandfathered plans.*

The medical loss ratio calculation contemplated by the federal act is very different from the loss ratio requirement currently required with individual health products in Virginia. This is perhaps the most debated and discussed provision in the federal act so far. The debate focuses primarily on the components of the loss ratio calculation – what is considered to improve quality of care, what is considered to be cost containment measures, and what is considered to be administrative costs, for example. All the states, Virginia included, are working collaboratively through the NAIC to develop recommendations for HHS’ consideration relating to the components of the medical loss ratio. This issue is not yet finalized at this point.

### In 2014:

#### **Exchanges**

By 1/1/2014, a health insurance exchange must be operational in each state to facilitate the purchase of qualified health insurance plans and assist small employers in enrollment of their employees in qualified health insurance plans. Essentially, by 2013, each must have made a definitive decision as to whether or not the state will operate its own exchange. In the event the state chooses not to operate an exchange the federal HHS secretary will contract with an entity to operate the exchange.

There are a number of alternatives available to states, such as merging the individual and small employer exchanges and offering regional exchanges among states. At this point, it is obviously too early to provide many specifics about where Virginia may go with this initiative.

#### **2014 Market Reforms:**

- **Guaranteed issue:** insurers will be required to accept every employer and every individual that applies for coverage except that they will be permitted to restrict enrollment to special enrollment periods. *Non grandfathered fully insured plans*
- **No pre-ex Condition Exclusions for adults.** Insurers will not be permitted to apply any pre-existing condition exclusions (right now that requirement applies to individuals under age 19, but the prohibition will extend to everyone in 2014) *All plans except grandfathered*
- **Rating Rules:** Premium variation will only be permitted based on age, tobacco usage, geographic rating areas and whether or not the coverage is for an individual or for a family. *Non grandfathered fully insured small group and individual plans and fully insured large group plans sold through the exchange.*
- **Essential Benefit plans:** In order to be certified as a “qualified health plan” for the exchange, the plan will have to provide the essential benefit package, among other things. Details about essential benefits are still to be determined by HHS, but we do know generally that they include the following:

- Ambulance
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative services and habilitative services and devices

Lab services  
Preventive and wellness services and chronic disease management  
Pediatric services, including oral and vision care

There will also be restrictions on cost sharing and deductibles. There will be 4 levels of coverage through the exchange, which are defined in terms of the benefits provided: bronze, silver, gold and platinum.

- **No annual limits for Essential Benefits:** The annual restricted limits that currently apply to essential benefits under the “immediate reforms” will be removed.

#### **What has the Bureau done so far?**

- We have enhanced our website to include a special link to health care reform issues. <http://www.scc.virginia.gov/division/boi/>
- We have provided information to HHS to facilitate the development of a web portal for individuals to find available health insurance plans in Virginia: <http://www.healthcare.gov/>
- We have convened an internal working group to review processes and procedures and, most importantly, to identify potential conflicts with state law. This project is ongoing.
- We are developing outreach materials to insert into some of our publications to alert people to the changes that are upcoming.
- We are sitting on numerous working groups within the NAIC to provide input in the development of uniform language for policies and policy summaries, to review the rating requirements, and to generally follow the reform activities.
- We have submitted an application for a \$1 million grant to enhance and strengthen our rate review processes.