Quality is Our Bottom Line

Insurance and Real Estate Committee

Public Hearing Agenda

Thursday, February 16, 2017

Connecticut Association of Health Plans
(Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim, United)

Testimony regarding

Proposed S.B. No. 116 AAC DISPUTES BETWEEN HOSPITALS AND INSURERS.

Proposed S.B. No. 490 AA REQUIRING THE CONNECTICUT HEALTH INSURANCE EXCHANGE TO POST CURRENT AND ACCURATE PROVIDER NETWORK INFORMATION ON ITS INTERNET WEB SITE.

Proposed S.B. No. 494 AAC HEALTH INSURANCE COST-SHARING REQUIREMENTS FOR PRESCRIPTION CONTRACEPTION.

Proposed S.B. No. 584 AAC A STUDY OF THE HEALTH REINSURANCE ASSOCIATION.

Proposed S.B. No. 585 AA REQUIRING HEALTH INSURANCE COVERAGE FOR BREAST PUMPS AND PROTECTIONS AFFORDED TO WOMEN BREASTFEEDING IN PLACES OF EMPLOYMENT.

Proposed S.B. No. 586 AA REQUIRING HEALTH INSURANCE COVERAGE FOR PREVENTIVE CARE PROVIDED TO FEMALE ENROLLEES AND ACCESS TO PRESCRIPTION CONTRACEPTIVE METHODS.

Proposed H.B. No. 6619 AAC HEALTH INSURANCE COVERAGE FOR USED WHEELCHAIRS.

Proposed H.B. No. 6623 AA ESTABLISHING A WORKING GROUP TO EXAMINE WAYS TO MITIGATE HEALTH INSURANCE PREMIUM INCREASES.

Proposed H.B. No. 6887 AA EXPANDING COVERAGE FOR MENTAL HEALTH CARE SERVICES AND SUBSTANCE ABUSE SERVICES.

280 Trumbull Street 27th Floor Hartford, CT 06103-3597 860.275.8372 Fax 860.541.4925 www.cahp.com

On behalf of the Connecticut Association of Health Plans, we respectfully urge that the Committee reject the legislation listed above. Things are changing rapidly at the federal level with respect to the Affordable Care Act (ACA), and until it's better understood what the new landscape looks like, Connecticut needs to resist the temptation to adopt additional any new legislation. The Connecticut market is highly regulated with numerous consumer protections already in place. The state is in a strong position. What the market needs now is stability and predictability, to the extent that's possible, and the best thing that the Connecticut legislature can do is to hit the "pause button" on new mandates and any substantive rewrites of statute. Please consider the following:

SB 494 Cost-Sharing for Contraception, SB 585 Coverage for Breast Pumps and SB 586 Coverage for Female Enrollees and Access to Prescription Contraception Methods:

- All provisions are already required in Connecticut and this legislation is simply not necessary. The Department of Insurance has issued the attached bulletin (HC 111) clarifying the requirements in place under the ACA and holding Connecticut's health carriers accountable for the stated coverage of services. The ACA is still in force and Connecticut's bulletin stands regardless. Any response to changes in the ACA at the federal level need to be done in a comprehensive manner with all the facts before us. Piecemeal adoption of various provisions creates unwelcome instability in the market.

  http://www.ct.gov/cid/lib/cid/HC-111-CoverageForPreventativeServices.pdf

SB116 Disputes between Hospitals and Insurers.

- Both health plans and hospitals are sophisticated entities capable of bringing established expertise and economic power to the negotiating table. Subjecting their disputes to binding arbitration will not only prolong the process, but also harm consumers in the event that an arbitration results in higher than necessary fees. Health plans and hospitals are embarking on new and innovative reimbursement models that focus on value and quality over fee for service incentives. This legislation would stifle innovation and keep Connecticut from maturing and advancing in this new changing environment.

SB 490 Posting Provider Network Information on Exchange Web Site.

- Connecticut just passed last year a comprehensive NAIC model act around network adequacy provisions. That act has been in effect for less than a month. To the extent there are concerns with any provisions, we would respectfully suggest that the issues could be addressed outside the context of legislation.

SB 584 Study of the Health Reinsurance Association.

- Back in the 1980's, Connecticut was one of the earliest adopters of reinsurance through the establishment of both the Health Reinsurance Association (HRA) and the Connecticut Small Employer Health Reinsurance Pool (CSEHRP). Both were successful programs and were used as models across the nation. The success of HRA and CSEHRP speak to

the importance of reinsurance in establishing market stability. With the adoption of the ACA, however, the HRA has been scaled back considerably - although it does still exist. Any conversations about its future need to be had within the scope of a more comprehensive dialogue about the future of the ACA. For better or worse the health care delivery system and the coverage options available are now all intricately interconnected and taking action on one element without consideration of how that will impact on the rest of the system is ill advised. Connecticut's approach in terms of responding to what's happening in D.C. needs to be thoughtful, fact-based and thorough with an underlying sensitivity to the effect that any new measures will have on market stability.

HB 6619 **Coverage for Used Wheelchairs.**

- The focus of this legislation is misplaced on insurance carriers. Instead it should be directed at the Durable Medical Equipment (DME) provider to disclose whether or not a wheelchair is "used" in nature and the DME provider should be held accountable for the performance of the equipment.

HB 6623 **Working Group to Examine Ways to Mitigate Health Insurance Increases.**

- Health insurance premiums are merely a reflection of health care costs. Premiums are already subject to rigorous rate review and carriers are held to strict Medical Loss Ratio (MLR) standards in terms of how much of the premium dollar must be spent on associated medical costs - 80% in the small group market and 85% in the large group market. We would respectfully suggest that the conversation be shifted toward ways to mitigate health care costs. Pharmaceuticals, in particular, have skyrocketed with the costs of various drugs increasing 600% overnight. We would strongly urge the legislature to focus its sights on these issues rather than focus on premiums which are already subject to substantial regulation.

HB 6887 **Mandating Coverage for Mental Health and Substance Abuse Treatment including Peer Supports and Case Management.**

- Carriers abide by both the federal and state mental health parity laws and have been pleased to participate in a number of ongoing conversations and strategy discussions about how to improve quality in these areas. Many of the carriers are moving into unique and innovative arrangements with providers for such services that are outcome based. While carriers may already cover case management and/or peer support services, mandating their coverage removes a carrier's flexibility to design benefit packages based on their success. Furthermore, HB 6887 would be considered a new mandate and the cost therefore would have to be picked up by the state generating a fiscal note that Connecticut can ill-afford. Please consider the OLR statement attached to other mandates last year:

  "Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state's health insurance exchange to offer benefits beyond those included in the required "essential

health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates a state enacts after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date."

Thank you for the opportunity to comment. We also ask that you to keep ever present in your mind the fact that these proposals would only impact the small employer community in Connecticut as large employers tend to be self-insured and therefore exempt from most of the legislation that comes before you. Small employers are the one's least able to afford the associated premium increases that follow these types of proposals. Over 50% of Connecticut's market is now self-insured as employers speak with their feet.

Thank you for your consideration.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Bulletin No. HC-111
March 2, 2016

TO: All Health Insurance Companies and Health Care Centers Authorized to Conduct Business in Connecticut

RE: Health Insurance Coverage for Preventative Services

This bulletin repeals and replaces Bulletin HC-100 issued on November 3, 2014.

This bulletin clarifies the requirements under the Patient Protection and Affordable Care Act. Pub. L. 111-48, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (collectively "ACA") and Connecticut mandates as they apply to issues of preventive and wellness services , with particular focus on women's health and are applicable to plans as of January 1, 2015.

Section 1001 of the ACA which amends § 2713 of the Public Health Service Act, requires that all non-grandfathered group health plans and health insurance issuers offering group or individual coverage must provide coverage of certain preventive services with no cost sharing requirements. While neither the statute nor associated regulation, 45 CFR § 147.130, set the specifics for what is actually required they instead refer to the Health Resources and Service Administration Agency ("HRSA") of HHS and the United States Preventive Services Task Force ("USPSTF") as the entities charged with identifying the appropriate benefits. When referring to USPSTF, the ACA requires only compliance with A and B recommendations.

The Institute of Medicine ("IOM)") in a July 19, 2011 report identified recommendations for Preventive Services. Based on the IOM recommendations, HRSA published guidance in 2011.The USPSTF A and B recommendations are updated as the organization sees appropriate.

GENERAL GUIDANCE

For the designated medical services identified in the HRSA guidelines and USPSTF A and B recommendations, there is no cost sharing allowed under the ACA nor are limits permitted, except where those guidelines/recommendations identify such explicit limits, such as indicating the guideline recommends covering an annual visit. However, reasonable medical management may be applied to all services and only medically necessary medical services are required to be covered.

Reasonable medical management should be based on the statutory definition of "medical necessity" which provides in Conn. Gen. Stat. § 38a-482a:

> Medical Necessity means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

WOMEN'S HEALTH

The guidelines and recommendations are heavily weighted with respect to women's health services. When determining what women's preventive services must be covered and to what extent, it is necessary to review each of the referenced authorities and in the case of ambiguities, the Connecticut Insurance Department ("Department") has interpreted eligible coverage requirements to the benefit of the consumer.

With respect to the following topics:

Breastfeeding Support – The ACA requires coverage of breastfeeding supplies, and support and counseling without co-payments, deductibles, or co-insurance, for the duration of breastfeeding. In addition, this would include lactation support and counseling in conjunction with each birth for the duration of the postpartum period. In Connecticut, we have group and individual statutory mandates (See Conn. Gen. Stat. § 38a-503c(d)and Conn. Gen. Stat. § 38a-530c(d)) which provide that in the event a mother and baby are released early from the hospital there shall be a follow up visit within forty-eight hours of discharge and a second follow up visit within seven days of discharge. The Connecticut mandate indicates that follow up services shall include assistance and training in breast or bottle feeding. While no specified period is provided in the statute, insurers have in the past been permitted to limit the support and counseling to specified sessions. The HRSA guidelines indicate that under the ACA, coverage will be required for the duration of breastfeeding, with lactation support and counseling for the duration of the postpartum period. As in the ACA, neither the associated regulation nor HRSA guidelines offer a definition of the term "postpartum period." Since there is no generally accepted medical definition of "postpartum period", medical management should be used to define "postpartum period" for each woman as it relates to breastfeeding support and the Department will no longer permit insurers to limit breastfeeding other than based on medical necessity.

Contraception – The ACA requires that plans cover the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling without patient cost-sharing for all women with reproductive capacity. The Connecticut statutory mandates for group and individual policies require all insurance policies covering outpatient prescription drug coverage to not exclude coverage for

prescription contraceptive methods approved by the FDA. (See Conn. Gen. Stat. § 38a-503e (a) and Conn. Gen. Stat. § 38a-530e(a)) Although policies and contracts have generally not included any cost sharing for these services, there have been some contract provisions that appear to be contradictory. For example, sterilization is often a separate benefit listing outside of contraceptive coverage and may include sterilization procedures for men. In addition, there is typically a general exclusion for all over the counter drugs. Because the ACA's prohibits cost sharing for sterilization procedures for women only, and patient education and counseling, all FDA-approved contraceptive methods for women, including over the counter drugs must be covered. Companies may need to clarify such provisions in their contracts. Sterilization for men is not covered by the ACA under the women's contraception provisions, but may be covered by an insurance company separately. Utilization of these services may be limited based on medical necessity.

Maternity Coverage - The ACA requires that plans cover prenatal care as part of the well woman visit, without patient cost-sharing. Plans must also cover United States Preventive Services Taskforce (USPSTF) A and B recommended services without cost-sharing, including many routine prenatal screenings for women. The HRSA Guidelines specifically include preconception and prenatal care as elements of the well-woman visits and directs coverage for age and developmentally appropriate preventive services and other screening services as identified by the USPSTF. Services related to maternity that are not preventive may be subject to cost sharing e.g. ultrasounds. The HRSA guidelines provide direction on frequency and limits for preventative services. In the absence of guidance, preventative services may be subject to medical necessity.

Consistent with prior filing submissions, language should reference HRSA, USPSTF or IOM rather than list all preventive services. The Department recommends that all Certificates of Coverage include explicit language indicating that not all preventive services are listed and that certain diagnostic services provided in relation to the preventive and wellness services will require cost sharing. The Department further recommends that all Certificates of Coverage should include any appropriate links or advise members to contact their member services representatives for any questions relating to coverage or cost sharing of specific services.

If previously approved filings do not accurately reflect these women's preventive services as described in this bulletin, companies will need to file through SERFF amendatory language to conform to CID interpretation. The cover letter should reference the previously approved filings to which such amendments would apply and the dates previously approved.

Please contact the Insurance Department Life and Health Division at cid.lh@ct.gov with any questions.

Katharine L. Wade
Insurance Commissioner