

Florida Health Insurance Symposium

A Summary Report

November 4, 2003



Florida Department of Financial Services
Office of Insurance Regulation



INTRODUCTION

The problem of finding and accessing affordable health insurance coverage is a national issue, affecting all age groups and income groups. In Florida, for example, premiums for small employer health insurance rose on average by 16% in 2000, 24% in 2001 and by almost 30 percent in 2002. Barriers to accessibility, even for the employed, continue to mount. According to the 1999 Florida Health Insurance Study, 50 percent of the non-elderly uninsured in Florida was employed either full-time or part-time. Combine the lack of employer sponsored insurance plans with individual factors such as a person's ethnicity or citizenship status; income levels; ability to shoulder the cost of increased premiums and employee-cost sharing; pre-existing medical conditions; age and even consumer attitudes and you arrive at 2.8 million Floridians who are without health insurance coverage and an insurance market with enrollment figures that continue to decline.

Numerous efforts have been made to try to fix the insurance markets, including legislation that: eliminated any restrictions against including cost sharing features in the design of benefit plans, allowed carriers to offer discounts to healthy groups, provided a means for employers to form alliances to negotiate discounted rates as a result of lower carrier administrative expenses and restricted abuse of the guaranteed issue rights offered in the small employer market. In addition, Treasurer Tom Gallagher appointed a new small employer benefit plan committee to revise the standardized benefit plans that must be offered by all carriers in the small employer market. These new benefit plans provided increased cost sharing features to accommodate consumer driven benefit plans.

While each of these initiatives is recognized as positive efforts, health insurance market conditions continue to deteriorate. There is general agreement that any more comprehensive solutions to affordability and accessibility of health insurance will only be achieved by involving all of the stakeholders in the decision process. To this end, on September 22-23, 2003, the Florida Department of Financial Services and the Office of Insurance Regulation hosted a Symposium to address the issues of health insurance and to propose new strategies and proposals to address these issues. The Symposium brought together a group of national speakers, elected officials, regulators, insurers, insurance agents, medical care providers and other experts on health insurance policy. Following some expert testimony on the subject, facilitated panel discussion sessions were conducted to identify those things that are driving health care costs up and to discuss and suggest possible social and regulatory actions to address the health insurance crisis.

This report provides the results of these discussions as well as summaries of the presentations provided to the panels to facilitate their discussion. Copies of the complete presentations can be found at http://www.fldfs.com/companies/insurance_symposium/presentations.htm

SUGGESTED INITIATIVES

The Symposium's facilitated panel discussions resulted in a very broad range of suggested initiatives, some of which can simply be implemented by the interested parties while others will require legislation. These suggested initiatives are given below.

Medical Care Practice Considerations

- Redesign medical practices to include improved:
 - Case management
 - Coordination of care across multiple providers
 - Evidence based practices
 - Chronic disease prevention and/or management
- Address health care industry labor shortages (i.e. nurses, technicians) and the resultant impact on the cost of care
- Eliminate or reduce defensive medicine costs (unnecessary testing)
- Discourage inappropriate use of high cost trauma centers
 - Provide alternatives for evenings and weekends
 - Encourage use of cheaper, more appropriate settings for non-emergency care
 - Educate consumers to appropriate care setting
- Facilitate additional health flex plans
 - Expand health flex program eligibility to less than 250% of federal poverty level

Benefit Plan Design Considerations

- Design health care benefit plans that provide incentives for healthy life styles
- Encourage expansion of consumer driven health care plans
 - Medical savings accounts
 - Health reimbursement accounts
- Revisit mandated benefits to avoid conflict with consumer driven health care plans

Market Reform Considerations

- Seek balanced market reforms involving all the stakeholders in the decision making process
- Provide a residual market (High Risk Pool) for persons who are uninsurable
 - Learn from Florida's history and the experiences of other states
 - Ensure adequate funding for now and in the future
 - Spread the risk and costs broadly
 - Use appropriate benefit plans
 - Provide consumer choice
 - Evaluate programs and funding mechanisms used by other states
 - Seek concurrence with stakeholders
 - Maintain ongoing communication with carriers
 - Collaborate, not compete with private sector
 - Seek/consider federal funding for risk pool seed money
 - Infrastructure for federal funding is already in place (Trade Act Amendments)
 - Alternative of guaranteed issue individual coverage would need to be considered very carefully to avoid problems encountered in other states
- Require standardized policies to be offered in the individual market
 - Ensure availability of adequate coverage
 - Provide basis of comparison shopping
- Modify the small group market to provide more participation and affordable coverage
 - Require all employers to offer a base plan to all employees to increase the participation of healthier employees
 - Require employers to "pay or play"

- Provide coverage to employees or
 - Contribute to residual market funding
- Include all micro-groups (five employees or less) in a reopened risk pool
- Modify pooling requirements
 - Presently one life vs. all other
 - Consider five or less employees vs. all other
- Use a re-opened risk pool for all persons eligible for guaranteed issue coverage as a result of HIPAA
- Modify Medicaid accessibility requirements to be more inclusive
- Assure appropriate funding levels for good existing public health programs Use them as models for expanded coverage to the uninsured
- Encourage and enhance full racial and/or ethnic participation
- Do comparison of Florida markets and products to other states with similar demographics

Other Considerations

- Recognize that consumer behaviors will only change when they are forced or modified by rewards
- Provide consumer with cost and reimbursement data needed to make appropriate choices
 - Improve data collection and sharing (within the privacy guidelines) of all stakeholders
- Advocate for federal change to allow rollover of flexible spending account funds from year-to-year
- Educate employees on health insurance options the same way they are educated on retirement options
- Educate consumers and agents on the guarantee issue rights provided by the federal HIPAA laws and on the consumer requirements to protect and/or take advantage of those rights
- Increase in funding for Department of Financial Services and the Office of Insurance regulation for regulatory responsibilities
- Address variability of hospital charges by payer
 - The lack of insurance or fact that a service is not covered should not result in higher charges
- Study how much does government presently spends on health care and where and how it is spent
 - Is there presently "Universal Health Care?"
 - Is the public sector in competition with private sector or vice versa?
 - Should private sector enrollees encouraged to enroll in public sector programs or vice versa?
 - Do the government sector actions damage the private sector markets?

Emerging Issues

- Address the problems associated with "Discount Cards"
 - Educate consumers to understand what they are purchasing
 - Provide consumer protection from being misled and/or overcharged
 - Require certification of the discount card networks
 - Ensure providers are aware that they are a part of the marketed network
- Address the issue of mandatory arbitration clauses in insurance contracts
 - Balance consumer rights to the court system with the costs and problems resulting from class actions suits
 - Consider expansion of the HMO Consumer Panel to other lines of insurance
 - Study actual experience where mandatory arbitration clauses are used
- Continue to address unauthorized entities selling insurance
 - Prosecute offenders in conjunction with new legislation (Pete Orr Act)
 - Educate consumers to "Never buy insurance from a yard sign"

NEXT STEPS

The initiatives identified and presented herein will be presented to the Governor's Task Force on Access to Affordable Health Insurance and the House Select Committee and other legislative committees, as appropriate.

The Office of Insurance Regulation will also be developing and presenting specific legislative recommendations to those bodies, as appropriate, on those initiatives that are within its scope of authority.

HIGHLIGHTS OF PRESENTATIONS

by

KEYNOTE SPEAKERS

Monday, September 22, 2003

Current Market Trends and Overview

John Gabel, Health Systems Studies at the Health Research & Educational Trust

Mary Beth Senkewicz, National Association of Insurance Commissioners

Rich Robleto, Office of Insurance Regulation

Improving the Current System

Brian Klepper, Center for Practical Health Reform

Current Market Trends and Overview

Jon Gabel, Vice President, Health Systems Studies at the Health Research and Educational Trust

Mr. Gabel provided a detailed, statistically supported analysis of the following themes:

- The state of job-based insurance
- Trends over the past year and past 15 years
- Trends in underlying health care costs
- The state of consumer-driven health care
- The immediate future of job-based health benefits

Mr. Gabel reported that, nationally, 66% of all firms currently offer health benefits to their employees. This is up from the low of 55% in 1998, but down from a high of 69% in 2000. Only 46% offer benefits to part-time employees and 7% offer coverage to temporary employees. Eighty-one percent of the employees are eligible in firms that offer coverage. This results in 68% of all workers receiving job-based health benefits.

Despite rising health care costs, 81% of covered workers continue to enjoy the same levels of benefits in 2003 as they did in prior years. Seven percent of covered workers received higher levels of benefits in 2003, while 13% saw a decrease in the levels of benefits provided by their employers.

In regard to health insurance premium trends, Mr. Gabel explained to the group that in 2003, health premiums rose an average of 13.9% nationally, while workers earnings rose 3.1% during a period of 2.2% overall inflation.

Mr. Gabel closed his presentation with a report on the state of consumer-driven health care. He reported that presently only 10% of firms are currently offering high deductible plans. However, 33% of the firms surveyed stated that they were likely to change the firm's health plan to a high deductible plan within the next 2 years.

Mary Beth Senkewicz, Senior Counsel for Policy, National Association of Insurance Commissioners

Ms. Senkewicz provided the Symposium attendees a summary report of recent efforts by the National Association of Insurance Commissioners to address the accessibility and affordability of health coverage. She reported that:

At the June 2002 National Meeting, Commissioner Steve Larsen (MD) (Chair of the NAIC Health Insurance Committee) proposed an NAIC health care Symposium to take a proactive look at the health care marketplace. The primary question was whether there are ways insurance regulators can improve that marketplace to make insurance more accessible and affordable. The Symposium was to look at cost drivers - both regulatory (i.e., the impact that regulatory consumer protections have on cost increases) and systemic (i.e., the cost and utilization of medical care).

The Symposium was held in early May in Chicago. The speakers included some of the leading voices in health care policy.

One notable presenter, **Paul Ginsberg** from the Center for Studying Health System Change, addressed the most important cost drivers and the underwriting cycle. His center has found that the number one cost driver is hospital care. Both utilization and

price are contributing to the hospital-spending trend. While prescription drug costs are still rising rapidly, they have slowed.

Ginsberg identified the following aspects of the current marketplace that are driving costs in the short term: 1) retreat from tightly managed care; 2) hospital consolidation and capacity restraints; 3) labor shortages; and 4) new drugs and advertising.

The long-term drivers include: 1) new technology, which is the dominant driver; 2) new procedures; 3) new applications for old procedures; and 4) innovations that reduce unit costs but increase volume.

He noted that insurance regulation is not one of the cost drivers.

Other trends in the current marketplace mentioned by other speakers included: 1) a shift to more patient cost-sharing with higher deductibles, copays and coinsurance requirements, and tiered copays and networks; 2) consumer-driven health plans; 3) a desire for more consumer information on quality and price.

Additional themes addressed by the NAIC's Symposium participants and speakers:

- Insurance regulation is about distribution of costs and is not intended to address the underlying costs
- Recent small market reforms have not yielded major changes in small firms offering health insurance (even microfirms)
- High risk pools are becoming more popular, but is there a way to use them more effectively in the small group market
- There is a need to move more quickly to an evidence-based system where the payment structure is used to induce good behavior - both on the part of the consumer and the caregivers. Chronic disease management has demonstrated some success. However, caution is needed as the medical advances sometimes move very quickly. There is also a need for greater and more effective use of outcomes measures.
- Product design is key to controlling costs. Consumer-driven health plans have been somewhat effective, but creation of sophisticated cost-sharing is the key to these plans.
- There also remains the concern in any managed plan that people receive needed health care services despite the economic incentive not to receive those services with higher patient cost-sharing.

These themes were followed up by the NAIC at another Symposium in Charleston, SC in August 2003. NAIC will continue to look at the health care marketplace proactively to see if regulators can contribute more to cost stability. In particular, the Health Insurance and Managed Care (B) Committee will be looking at uniformity issues regarding external review at the Winter 2003 National Meeting in December.

Rich Robleto, Bureau Chief, Life and Health Forms & Rates, Office of Insurance Regulation

Mr. Robleto's presentation included an overview of the general demographic characteristics of the Florida population, including age, employment levels and relationship to the Federal Poverty Level (FPL). He illustrated that in Florida: 50% of the population is either over 65 or under 18 years old; 22% of households have no one working either full or part-time; and that 11% of Floridians are living below 200% of the Federal Poverty Level.

The focus of his presentation then turned to Florida insurance statistics. He showed that the 4.8 million Floridians in the insurance market represented only about 30% of Florida's 16.1 million citizens. He explained that as many as 4.3 million more or 27% were self-insured and therefore not subject to Florida's Insurance Code. The remainder of Florida's population is covered by Medicare (2.5 million - 16%) and Medicaid (1.7 million - 11%); or they are uninsured (2.8 million - 17%).

Finally, Mr. Robleto explained the mechanics and trends of the individual, small group, and large group insurance markets. He reported that the individual market enrollment was growing slightly while both the small group and large group market enrollment was declining.

For each market, he also presented an overview of the market mechanics and trends, including premium, carrier participation levels, the types of benefits offered and recent legislative and regulatory activities which have affect the market under discussion.

Improving the Current System

Brian Klepper, Founder and Executive Director, Center for Practical Health Reform

Mr. Klepper's presentation was entitled: "Saving American Health Care: Steps to a More Stable, Improved Health System." He provided the attendees with background information about the existing threat of instability; the erosion of Florida's current market enrollment and the need to reframe the reform discussion.

According to Mr. Klepper, "It is NOT about finding a way to cover the uninsured. It IS about preventing the rapid erosion of our mainstream coverage vehicles - Employer Coverage and Medicaid - and re-enfranchising the uninsured in the process." Mr. Klepper outlined the Center for Practical Health Reform's 10 Principles for Change as listed below:

Coverage

1. Assure Essential Care for All Americans.
2. Assure Opportunities For Choice Through Supplemental Care.

Private Sector Orientation

3. Maintain An Accountable Private Sector Health Care System, With Incentives for Performance and Innovation.

Information & Quality

4. Promote Compatible Information Technologies That Permit Secure, Private Information Sharing Throughout Health Care.
5. Adopt, Publish, Update and Promote Evidence-Based Practice Improvement Processes.
6. Promote Continuity and Coordination of Care.

Accountability

7. Publicly Disclose Quality Information on Professionals, Institutions and Procedures.
8. Publicly Disclose Risk-Adjusted Pricing Information for Patients.
9. Promote Individual Awareness Of and Responsibility For Choices Affecting Health Care.
10. Reduce Medical-Legal Liability Through Litigation Reform Greater Accountability and Practice Standards Throughout The Care System.

Mr. Klepper stated that the Center endorsed these principles because they are generally considered robust enough to do the job, essential for the stability of the market, and approximately equally unpalatable, (but ultimately acceptable) to everyone.

HIGHLIGHTS OF PRESENTATIONS

at

CONCURRENT BREAKOUT SESSIONS

Monday, September 22, 2003

Affordability -- Cost Drivers

*Robert A. Wychulis, President, Florida Association of Health Plans, Inc.
"Cost Drivers, an Overview"*

*Marvin O'Quinn, President & CEO, Jackson Health System
"Hospital Costs"*

*J. Patrick Rooney, Chairman & CEO, Medical Savings Insurance Company
"Hospital Charges"*

Accessibility

*Bruce Abbe, Vice President, Communicating for Agriculture
Michelle Robleto, Executive Director, Florida Comprehensive Health Association
"Risk Pools"*

*Jim Bracher, Executive Director, Florida Reinsurance Pool
"Small Group and Individual Reinsurance Pools"*

*Janie Miller, Insurance Commissioner, Kentucky
"Kentucky's Experience with Individual Guarantee Issue"*

Affordability - Cost Drivers

Robert A. Wychulis, President, Florida Association of Health Plans, Inc.
Cost Challenges

Mr. Wychulis provided a presentation addressing three important questions facing Floridians seeking solutions to the issues of health insurance affordability:

1. What are the costs challenges confronting the health insurance market?
2. How have employers and consumers responded to rising costs?
3. How are health plans responding?

Mr. Wychulis indicated that the main factors driving the rising costs in premiums include, in priority order, Rx and medical advances, general inflation, rising provider expenses, government mandates and regulation, increased consumer demand, litigation and risk management. He provided statistics to show that health plan profits were less than 10% of premium and therefore not a major contributing cost driver.

He continued that health plans are actively targeting underlying cost drivers by:

- Promoting evidence-based practice and rewarding quality
- Intervening early with high-cost users (Disease management)
- Making health plan members better consumers

In addition to detailing the issues described above, Mr. Wychulis also presented some possible solutions to rising costs, *if all* stakeholders commit to:

- Converting to an evidence-based, not an opinion-based, health care system
- Supporting care coordination through chronic disease management
- Paying for quality and effectiveness, not for overuse, misuse and under use
- Promoting transparency and public disclosure of health plan and provider performance
- Supporting health plan innovation

Marvin O'Quinn, President & CEO, Jackson Health System
Hospital Costs

Mr. O'Quinn spoke to the group concerning the factors that effect hospital charges. He noted that nationally, health expenditures are growing 3 times faster than the rate of inflation. He noted that while hospital as a percentage of total health care expenditures was increased recently to 31%, it is down from 36% as recently as 1997.

Among the reasons provided for the increases in hospital expenses were:

- (1) An increase in the number of uninsured patients, (The uninsured account for 7% of admissions and 25% of Emergency Room visits. And, result in about \$1.5 billion in uncompensated care for Florida hospitals.
- (2) An increase in claims from fixed price payors, such as Medicare and Medicaid, that frequently pay less than cost.

Looking at the issue from a different perspective, Mr. O'Quinn reported that the increase in hospital expenses can be broken down as follows:

- 55% - More service provided due to population growth (21%) and increased utilization (34%)
- 45% - Increased cost to provide care due to higher wages & benefits (39%), pharmaceuticals and other supplies (24%), and offset by increased efficiencies (-18%)

J. Patrick Rooney, Chairman & CEO, Medical Savings Insurance Company
Hospital Charges

Mr. Rooney addressed the Symposium on the subject of hospital charges, and, in particular, their negative impact on uninsured. He noted that with the discounts that hospitals provide to the fixed payers of Medicare and Medicaid and the discounts that are negotiated by carriers that include the hospital in its network, the final charges to people without insurance coverage are the highest. He noted that, as a result, the profit margin on charges to the uninsured are the highest.

Accessibility

Bruce Abbe, Vice President, Communicating for Agriculture
Michelle Robleto, Executive Director, Florida Comprehensive Health Association
Access to Health Insurance for High Risk Individuals

Ms. Robleto and Mr. Abbe presented and led a discussion of

- How other states provide access to care
- What are risk pools & how they are funded
- What federal legislative initiatives are available to help states

They noted that 32 states have high-risk health insurance pools; that Tennessee provides access to high risk individuals through an expansion of its Medicaid program; and that twelve states use open enrollment or guarantee issue programs; and finally that six states offer no access to coverage to high risk persons. They pointed out that Florida should be considered a state without access since its Pool has been closed to new members since 1991. Florida enrollment is presently down to 525 members and that a functional Florida pool would cover at least 16,000 people.

They provided the following 2002 Statistics on risk pools:

- National enrollment (29 pools) grew 13% to 172,845
- National claim costs grew 24% to \$1 billion
- National premiums grew 30% to \$638 million

The speakers discussed risk Pool Funding, noting that:

- Funding remains the number one issue
- Member premiums cover 40% to 50% of operating costs - the remainder must be subsidized
- Pools overall are small - funding is small compared to size of industry
- Key is spreading costs equitably
- Methods used by states include:
 - Assessments with partial or full tax credits
 - Assessments with no tax credits
 - Assessments on a per covered life basis
 - Allocation from state funds
 - Service charge on providers or services
 - Premium and state funded stop loss coverage
 - Although each of these methods have their pros and cons, the assessment on a per covered life basis is presently the most popular.

Finally, the speakers discussed Federal legislation that support risk pools:

- Trade Adjustment Assistance Act which provides:

- \$20 million for risk pool start-up costs
- \$40 million in matching funds for qualified risk pools in 2003 and 2004
- H.R. 1110: Extension of the Federal Cost Share Funding for State Health Insurance Risk Pools
 - Extends federal cost-sharing for risk pools from 2004 to 2009
 - Raises the annual appropriation to \$75 million each year

Jim Bracher, Executive Director, Florida Reinsurance Pool
Florida Health Reinsurance Program

Mr. Bracher spoke about Florida's Reinsurance Programs and how they could be used as stop loss vehicle to markets.

He pointed out that the Florida Health Reinsurance Program is a cooperative reinsurance program that provides a risk spreading mechanism for companies providing coverage in Florida's Small Employer and Individual health insurance markets.

The Program was established in 1992 to promote the availability of health care coverage to small employers regardless of their claim experience or their employees' health status. It was expanded in 1997 to include coverage provided to individuals eligible for coverage under provisions of state law implementing the Health Insurance Portability and Accountability Act (HIPAA). The Program is a nonprofit entity governed by a Board of Directors representing companies that provide coverage in Florida's Small Employer and Individual Health Insurance markets. In addition to providing reinsurance coverage, the Program is also charged with making recommendations for improving the Small Employer and Individual insurance markets.

This voluntary Program works by allowing companies to purchase reinsurance on selected groups and/or individual lives from groups insured in the small employer market and on selected HIPAA eligibles. Premiums are paid only for the groups or individuals selected for coverage.

Premiums are established at levels designed to cover approximately 2/3 of estimated claims costs. The remaining 1/3 is recouped through assessments on participating companies based on their pro-rata share of total premium in the respective market.

The Honorable Janie Miller, Insurance Commissioner, Commonwealth of Kentucky
Kentucky's Experience with Individual Guarantee Issue

Commissioner Miller presented an overview of her state's efforts to ensure accessibility and affordability of health insurance benefits. She provided a detailed description of the reforms enacted and their consequences. Commissioner Miller also shared her insights on the lesson to be learned from the recent past of the Kentucky health insurance market.

Commissioner Miller explained that in 1994, Kentucky passed significant health insurance reforms designed to: remove financial barriers to affordability of health insurance by spreading the risks; address inadequate access to insurance and, thereby, reduce the number of uninsured; increase competition on the basis of service and price rather than risk selection; and achieve efficiency in delivery and financing of health care services.

A comprehensive package of reforms was enacted including:

- Providing modified community rating (MCR) with rating bands in all markets
- Providing guarantee issue in all markets
- Establishing limits on exclusions for pre-existing conditions

- Providing guaranteed renewability of policies
- Establishing standardized health benefit plans that all carriers must offer
- Creating of a State Health Policy Board and Purchasing Alliance
- Creating a risk adjustment process for insurers in the Purchasing Pool

Commissioner Miller then described the sequence of events that took place in response to these reforms:

- Associations filed suit and became exempt from the reforms, return to risk-rating
- Kentucky Health Purchasing Alliance (community rating) becomes effective and state employees enroll
- Association exemption erodes the MCR rated market, denying that market the numbers needed to achieve spreading the risk and lowering of rates
- Young, healthy individuals drop out of the market, which further erodes the MCR market and causes further escalation of rates
- Legislature enacts a rate cap, making it difficult for carriers to raise rates as needed
- Carriers begin to exit the individual and small group market
- Market disruption occurs as carriers non-renew insureds, limiting choice and competition
- Commissioner requires HMOs to hold open enrollment to improve access for the individual market
- Profitability of carriers diminish, many lose money
- Within two years of enactment, 40+ insurers exited the individual market
- Only 2 insurers remained in the individual market (Anthem Blue Cross/Blue Shield and Kentucky Kare, the state employee self-insured plan which was opened up to individuals and small groups)
- Kentucky Kare begins to lose money and raises rates by 28% for individuals
- Reforms began to unravel in the implementation phase
- As a result of pressure by associations and employers, a number of reforms were not implemented or were repealed
 - By Executive Order, groups were not required to renew into standard plans
 - In successive sessions of legislature,
 - Returned to gender rating (adjusted MCR)
 - Expanded the rating bands
 - Repeal of standard plans, insurers sell others
 - Repeal of Purchasing Alliance and State Health Policy Board
 - Repeal of Risk Adjustment Process
 - Demise of Kentucky Kare (Fund became insolvent)
 - Repeal of modified community rating and return to full experience rating
 - Adopt a modified pay or play program for individual market designed to cover losses for those issuing guarantee issue policies
 - Repeal of guarantee issue in individual market and creation of Kentucky Access, a high risk pool
 - The only consumer protections of the original reforms that remain are rating bands, limits of pre-existing condition exclusions, renewability and portability

The Commissioner suggested that there were many lessons to be learned from Kentucky's reform experience. Though the enacted policies and programs addressed accessibility, rating band reforms merely redistributed the cost, but did not reduce the underlying health care costs. MCR must have a certain mass in order to spread the risk and protect enrollees from sharp premium increases when their health status changes. However, Kentucky has a small insurance market and with associations exempted, the market was too small. Aggressive use of mandated benefits (33 mandates), new privacy rules, HIPAA and other consumer protection laws which increased costs of doing business for insurers and providers served to increase premiums and add fuel to the fire.

Commissioner Miller ended her presentation by discussing Kentucky's current efforts to enact consumer protections and address other market issues including:

- Enacting Insurance Purchasing Outlets (IPO). These entities would be registered with the Department, collect premiums and value of vouchers on behalf of outlet members; offer health benefit plans to members and handle all administrative activities; and become the policyholder or contract holder of any health benefit plan on behalf of outlet member (group coverage).
- Allowing basic health benefit plans without mandated benefits
- Elimination of network adequacy and network standards for plans with less than 5000 enrollees
- Permitting previously uninsured employees access into high risk pool, with rates determined on an actuarially sound basis

HIGHLIGHTS OF PRESENTATIONS

at

CONCURRENT BREAKOUT SESSIONS

Tuesday, September 23, 2003

Innovative Benefit Designs and Market Reforms

*Michelle Newell, Assistant Director, Florida Office of Insurance Regulation
"Envisioning our Future by Reviewing our Past"*

*Donald C. Brain, President, Lockton Benefit Group
"The New Consumerism"*

*Harry Spring, Florida Director Government Relations, Humana, Inc.
"Engaging the Consumer: The Smart Suite Plans"*

*Thomas Warring, Agency for Health Care Administration
"Health Flex Plans"*

*Mary Beth Senkewicz, National Association of Insurance Commissioners
"Federal Initiatives"*

Emerging Consumer Issues

*Elsie Crowell, Consumer Advocate, Department of Financial Services
"Discount Cards"*

*Steven Roddenberry, Deputy Director, Office of Insurance Regulation
"Unauthorized Entities"*

*Steven Roddenberry, Deputy Director, Office of Insurance Regulation
"Standardized Individual Benefits"*

*Steven Roddenberry, Deputy Director, Office of Insurance Regulation
Jeff Liggio, attorney, Liggio, Benrubi & Williams
Kelley Cruz-Brown, Principal, Carlton Fields
"Mandatory Arbitration"*

Innovative Benefit Designs and Market Reforms

Michelle Newell, Assistant Director, Florida Office of Insurance Regulation
Envisioning our Future by Reviewing our Past

Ms. Newell's speech stressed that by melding today's visions and ideas with the successes already experienced and that by learning what not to do from the less successful programs, it is possible to meet Florida's future health insurance needs in a creative and balanced way.

An example of this type of thinking is to take the concept of Association Health Plans - a somewhat controversial proposal from Washington - and combine it with the concepts of the Healthy Kids Program, one of Florida's most successful health care initiatives.

Newell cautioned that we also look at one of Florida's unsuccessful health care initiatives, the Community Health Purchasing Alliances, to educate ourselves on measures to avoid in any proposal: an overload of administration and government bureaucracy; lack of market enterprise and competition, poor timing of any initiative and private sector antipathy.

The vision Newell described would be to take the AHP concept but impose oversight by a public/private Board of Directors. The concept would in pooling individuals and small groups to provide large group efficiencies and risk-spreading benefits; maximize market tenets such as competitive bidding; and maintain a lean administration.

A successful purchasing alliance model for the insurance market could then be adopted to address the problems of the uninsured population. This would involve instituting the combined federal, state and personal funding used to pay for Healthy Kids, Inc. and pegging it to a percentage of the federal poverty level -- All the while maintaining the pooling concepts and market forces of our concept model.

Newell contends that while we look to think outside the box, we have to remember what we already have in the box - both the good and the not so good.

Donald C. Brain, President, Lockton Benefit Group
The New Consumerism

Mr. Brain's presentation centered on the topic of Consumer Driven Health Care (CDHC). He discussed the market conditions that have led to the movement of CDHC, its impact on employers, employees, and providers; the potential for unintended consequences; and other issues to consider in regard to the implementation of CDHC.

He noted that the current system is dysfunctional and is generally unsatisfactory to all stakeholders. The combination of the managed care backlash, escalating costs, favorable employer experience with defined contribution retirement plans, and recent favorable IRS rulings have ushered in the Consumer Driven Health Care era.

Mr. Brain proposed that the objectives of implementing a CDHC are to:

- Change participant behavior
 - Health and health care purchasing
- Create price transparency
- Give participants more control over managing their own healthcare and related costs
- Provide education and tools to participants to create informed healthcare consumers

- Reduce costs for chronic conditions through health risk assessment, disease management and treatment compliance
- Reduce costs by utilizing incentives for good health

Mr. Brain next provided a description of CDHC product attributes:

- Health Reimbursement Account
 - Typically offered with high deductible plan
 - Seeded with Employer dollars
 - Unused dollars can be carried forward
 - Motivates consumer to manage account as if it were their money
 - Typically includes decision support tools
- Benefit Design
 - Benefit design encourages consumerism
 - Hybrid of high deductible for discretionary items and first dollar for non-discretionary
 - Selection of co-payments and benefit levels
- Decision Support
 - Provides information for consumers to manage their healthcare
 - Tracks and analyzes where healthcare dollars are spent
 - Electronic storage of personal health information
 - Numerous easy-to-use online tools, health programs and information
- Health Plan Catalog Models
 - Employer offers multiple health plans to each employee
 - Employee chooses one plan for entire family with cost based on plan selected
- Advance Selection Network
 - Sponsoring Payor with Point of Service coverage for non-network medical expenses
 - Choice and Control
 - Consumer chooses co-payments and/or picks their own providers (personalized network)
 - Providers set their own fees

The advantages of CDHC's on employers, include: (1) Improving employee relations and satisfaction; (2) Raising employee awareness of true costs of insurance and health care services; (3) Turning employees into more cost-conscious and efficient users of care; and (4) Reducing health benefits expenses.

However, there are also employer risks including:

- Employee delays care or treatment resulting in more catastrophic condition and increased costs
- Employer costs go up due to healthy employees receiving HRA funds
- Employee acceptance/dissatisfaction
- If total replacement, may be considered a "takeaway"

Benefits for employees include (1) the ability to fund benefits not usually available in traditional plans; (2) the opportunity to tailor benefits to expected needs on a yearly basis; (3) the ability to build the HRA by rolling over funds to future years; (4) the tools to help make effective and informed benefit decisions; and (5) the satisfaction of becoming more personally involved with their health care choices. The risks include:

- Dissatisfaction for those with chronic conditions
- May have out-of-pocket expenses that are difficult to budget for once HRA funds are exhausted
- May not want the increased consumer role with decision-making responsibility
- May skip necessary and/or preventive care in order to save money

3. Compare discounts offered by the card program with other discounts that may be offered directly by the pharmacy
4. Call the Department of Financial Services' toll-free HELPLINE at (800) 342-2762 or visit the department's website at www.fldfs.com for assistance.

Ms. Crowell closed her presentation by stressing that private entities are attempting to fill a void due to the lack of accessible, affordable health care. She continued that the proliferation of advertisements of Health Care and Prescription Drug Cards is confusing for consumers. The variables make it next to impossible for consumers to select a plan which best suits their needs. Discount Cards are not the solution to adequate health care insurance coverage. Florida must evaluate its current authority to effectively protect consumers from misleading and deceptive practices, and the advertising of health care discount cards. (16 states have enacted statutory provisions).

Steven Roddenberry, Deputy Director, Office of Insurance Regulation
Unauthorized Entities

Mr. Roddenberry detailed the past and present problems caused by unauthorized insurers underpricing legitimate health plans and then leaving policyholders with unpaid claims when the math turns against them. He provided figures showing that since 2001 four of the largest unauthorized entities left nearly 100,000 people with approximately \$85 million in unpaid medical bills.

Roddenberry said that over the past 30 years there have been three waves of this type of activity that shared two common causes: ambiguous federal legislation which allowed bogus health plan operators to evade state oversight and dramatically increasing coverage costs.

Roddenberry then talked about federal and state efforts to shut down and prosecute these operators in a variety of ways: education and training of businesses, individuals and agents; increasing penalties for the operators and agents who market unlicensed plans and consumer outreach. In Florida, the Office of Insurance Regulation has shut down over 150 entities, agents and affiliates and some of the more egregious cases are being prosecuted criminally.

Under recent Florida legislation, the penalties for this type of activity have been increased: up to a first-degree felony for the operators of unauthorized entities and the agents who sell the plans can be charged a felony and have to pay restitution for unpaid claims.

Finally, Roddenberry detailed the Department of Financial Services Verify before You Buy program. Consumers can either go to www.fldfs.com or dial 1-800-342-2762 to verify if an insurer or agent is authorized. The program has also employed an aggressive public relations outreach effort.

Steven Roddenberry, Deputy Director, Office of Insurance Regulation
Standardized Individual Benefits

Mr. Roddenberry discussed the fact that since the regular Individual Market is not Guaranteed Issue (GI), the selection of the right policy and carrier is critical because a person may not be able to change later. He noted that HIPAA does not provide Guaranteed Issue to certain applicants to Individual Market: those exercising their continuity of coverage rights from a self-insured plan and those whose individual carrier has left the market. As a result of HIPAA, many carriers have "dumbed down" their benefit plan and make benefits like maternity or prescription drugs only available as a rider. He suggested that a requirement that all carriers must offer their applicants a standardized benefit plan similar to the small group market, and then any street plan offered would:

- Help individuals compare carriers when purchasing,

- Help individuals understand what is or is not included in their plan if they purchased a street plan since they could ask how it differs from the standardized plan, and
- Ensure that HIPAA-eligibles have access to an adequate benefit plan.

Steven Roddenberry, Deputy Director, Office of Insurance Regulation
Mandatory Arbitration

Mr. Roddenberry also introduced the issue of mandatory arbitration clauses in Life & Health insurance contracts. He noted that this is a very controversial issue in Florida and one that is receiving national attention (NAIC).

Carriers argue that a policy provision that mandates the use of arbitration to settle disputes is a win-win situation. They suggest that arbitration is more accessible, less costly, and more consumer-friendly than the use of courts. Further, they suggest that a "mandatory arbitration" policy provision protects the company from class action suits that can threaten the solvency of the company.

Consumers and others, most notably the Trial Bar, argue that mandatory arbitration is a violation of individuals' right to the use of the courts.

Present Florida law very specifically protects a policyholders' right to the courts for disputes involving:

- Unfair Claim Settlement Practice
- Illegal Dealings in Premium
- Refusal to Insure

Otherwise, the law is not clear on this issue. Alternatives to consider are:

- Expanding the above list by completely prohibiting mandatory arbitration.
- Expanding the authority of the Office of Insurance Regulation to address such disputes. A condition precedent to any class action suit is that persons must have exhausted all other remedies available to them.
- Requiring that policyholders be given the opportunity to positively choose a policy with mandatory arbitration. If, as suggested earlier, this would be a win-win situation, one would expect the policy with mandatory arbitration to have a lower price or other incentive to its purchase.
- Clarify that mandatory arbitration provisions are acceptable policy provisions.

Mr. Roddenberry then introduced the next speakers for a point-counterpoint discussion of the issue.

Jeff Liggio, attorney, Liggio, Benrubi & Williams
Kelley Cruz-Brown, Principal, Carlton Fields
Mandatory Arbitration

Mr. Liggio and Ms. Cruz-Brown debated the pros and cons of mandatory arbitration as applied to settle disputes arising from health insurance coverage and use of managed health organizations.

