MISSISSIPPI INSURANCE DEPARTMENT

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

J. MARK HAIRE
Deputy Commissioner of Insurance

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, Mississippi 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 359-2474
WATS: 1-800-562-2957 (Incoming-USA)

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The Honorable Lamar Alexander
Chairman, Senate Committee on Health, Education, Labor and Pensions
Washington, D.C. 20510

VIA: ELECTRONIC-DELIVERY, USPS

Dear Chairman Alexander and Committee Leadership:

Thank you for your December 2nd letter and the invitation to provide general suggestions on how America's health insurance system can be improved. We also appreciate the opportunity to provide specific feedback on Mississippi's commercial health insurance market.

Rising healthcare costs are an important issue that has been overlooked when discussing healthcare reform. Therefore, I strongly encourage Congress and the new Administration to consider this issue and to search for a way to reduce medical service and prescription drug costs, without price controls.

Please find our responses to your questions and supporting documentation enclosed herein.

Sincerely,

Commissioner Mike Chaney

Cc: The Honorable Thad Cochran
United States Senator, MS

The Honorable Roger Wicker
United States Senator, MS

The Honorable Trent Kelly
United States Congressman, MS

The Honorable Gregg Harper
United States Congressman, MS

The Honorable Steven Palazzo
United States Congressman, MS

The Honorable Bennie G. Thompson
United States Congressman, MS

The Honorable Phil Bryant
Governor State of Mississippi, MS

The Honorable Tate Reeves, Lt. Governor, MS
The Honorable Phillip Gunn, Speaker, MS

1. **What legislative and administrative actions do you recommend be taken in order to stabilize the individual and group insurance markets for the 2017, 2018, and 2019 plan years? In what timeframe would such actions need to be taken in order to stabilize the market?**

Allow Transitional Policies to Continue Indefinitely

- This can easily be accomplished with a Department of Health and Human Services ("HHS") bulletin if released prior to December 31, 2017. Beginning January 1, 2018, Mississippi policyholders will see average rate increases of 66.2 percent in the Individual Healthcare Market and 15.6 percent in the Small Group Market. As a result of such rate increases, the majority of over 200,000 Mississippians will be unable to afford their healthcare coverage and will likely join the ranks of the uninsured. By allowing transitional policies to continue indefinitely, this impact can be avoided (See Exhibit A - Transitional Relief letter sent to Senator Cochran and Senator Wicker).

Reconsider the Interstate Selling of Health Insurance

- Interstate sales do work when policies are issued subject to State regulations and the insurer is licensed in the state where policyholders reside (purchaser).
- Most State markets are in turmoil with health insurance premiums rising and health carriers leaving. Allowing the interstate selling of insurance in a manner intended by the current administration would cause further market instability and large risk. It may also create consumer protection issues and further deteriorate State-based regulation.
- Allow interstate Compacts for the interstate selling of Health Insurance.

Allow States to Continue Regulating Network Adequacy

- Mississippi has its own regulation (See Exhibit B - Regulation 19 Miss. Admin. Code, Part 3, Chapter 14) ("Regulation") and review process that allows the annual monitoring of companies' network adequacy plans. The purpose and intent of this Regulation is to establish standards for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility and quality of health care services offered under a managed care plan. In doing so, the Regulation establishes requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.

Replace Advanced Premium Tax Credits with Refundable Age Adjusted Tax Credits

- The current Advanced Premium Tax Credit ("APTC") eligibility criteria under the Affordable Care Act ("ACA") failed to consider the possibility that states, such as Mississippi, would not expand their Medicaid programs. Consequently, the APTC criteria created the "Medicaid Gap" where individuals cannot afford or even obtain health insurance coverage because they do not make enough money to qualify for APTC's or they make too much money to qualify for Medicaid. A simple fix would be for Congress to provide all individuals with refundable age adjusted tax credits that could be used to purchase health insurance coverage in the individual market (See page 1 of Exhibit C – Section by Section Overview of Tom Price's Empowering Patient's First Act).

Consider Eliminating Health Insurance Marketplaces Altogether

- The APTC criteria mentioned above are overly restrictive because APTCs are only provided if health insurance is purchased through a State or Federal Health Insurance Marketplace (the "Marketplaces"). Doing away with Marketplaces altogether, and allowing the use of refundable age adjusted tax credits to purchase any major medical coverage available in the entire individual market will increase consumer choice, foster health insurer competition, and lower premium costs.

Limit the Abuse of Special Enrollment Periods

- When properly implemented, special enrollment periods ("SEPs") are a valuable tool that ensures consumers are treated fairly as they shop for insurance. The current regulatory framework allows consumers to enter the health insurance market only when they need medical care, driving up costs. There are several steps that can be taken to ensure SEPs are not abused. The Mississippi Insurance Department ("MID") agrees with the position taken by America's Health Insurance Plans ("AHIP") in their December letter to Governors (See Exhibit D) recommending the implementation of "effective pre-enrollment verification for consumers who sign up for coverage during [SEPs]." Mississippi health insurers have identified and recommended other ways for Congress and/or the Trump Administration to prevent the misuse of SEPs. These include but are not limited to: requiring consumers to have prior coverage and show proof of eligibility prior to enrolling; allowing states to set grace periods for non-payment of premiums; establishing waiting periods (e.g. 6 months) for those who do not maintain continuous coverage; and requiring verification of residency prior to enrollment.

2. What steps could be taken to improve the health of risk pools and ensure that high costs incurred by some do not lead to substantial premium increases for others in the pool?

Mississippi presently operates a high-risk pool, the Mississippi Comprehensive Health Insurance Risk Pool Association ("MCHIRPA"), as a special 501(c)(26) tax exempt organization. MCHIRPA is still in operation and serves as the managing body of Mississippi's Small Business Health Options Program or "SHOP" exchange for small businesses. MID would be open to working with MCHIRPA and other State officials to explore the possibility of utilizing federal funds to help operate the risk-pool and ensure that low cost individuals are not impacted by the high costs of others.

For example, Title II of Representative Tom Price's Empowering Patients First Act recommends using high-risk pools for subsidizing the purchase of personal health insurance for certain eligible individuals and provides grant funds to states for this purpose (See pages 4-6 of Exhibit C). MID has worked with our risk-pool in the past under very similar circumstances and would be prepared to do the same if these or similar reforms are adopted by Congress and the Trump Administration.

3. How would your state define "Essential Health Benefits" if it were given the freedom to define those requirements?

The health insurance markets in all fifty states are different and unique due to the varying makeup of each state's population. In turn, the health related needs of a population and the solutions necessary to address such needs are different from state to state. The current Essential Health Benefit ("EHB") format not only reduces consumer choice, it also drives up the cost of health insurance. Allowing each state to specifically define EHB would provide each state with the flexibility to address the specific needs of its population as well as generate additional health insurance choices at much lower costs.

If Mississippi were given the freedom to define what EHB means for its specific population, it would create a special task force and conduct hearings in order to balance the needs of all interested stakeholders. Because such efforts have yet to begin, it is too early for Mississippi to define or even project what the exact EHBs would be.

4. Do you view the Section 1332 State Innovation Waivers as a workable option for providing state flexibility? If not, what changes in the law and regulations would you recommend? How long would it take your state to implement a Section 1332 Waiver?

A Section 1332 Waiver ("Waiver") permits a state to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance. However, a Waiver is currently not an

option for Mississippi. A state must have authorizing legislation in place before a state can apply for such a Waiver, and Mississippi has yet to pass such authority. In order for Mississippi to request and implement a Waiver in the near future, the application process would need to be streamlined. Based on previous research, Waiver applications have been projected to take states up to 400 hours to finalize and can cost upwards of $18,000. Also, HHS and the U.S. Department of Treasury ("DOT") would need to drastically reduce the timeframe they are allowed to review such applications. Currently, HHS and DOT have 180 days to review such applications. Instead, Mississippi believes that 45 days is sufficient for approval.

5. **What is your vision of a modern private health insurance market in your state? What would you do to lower health care costs, provide more individualized plan choices, and innovate, and what additional authorities would the states need from Congress to do so?**

- Reduce Federal control
- Allow Transitional Plans and Policies to continue indefinitely
- Allow the use of Health Savings Accounts ("HSAs")
- Consider an adjustable tax deduction cap on Businesses for employee contributions, which should be a minimum of $10,200 for individuals, per annum and $25,400 for family coverage, per annum
- Allow defined contribution plans to be combined with HSAs

Mississippi believes that health insurance is better regulated at the state level, as opposed to the national level. Specifically, state regulators which draw on years of experience handling state specific issues are better equipped to create and implement innovative solutions that meet the needs of their respective populations. There has been a clear trend of increased Federal control over the health insurance market. This has led to a reduced number of health insurance options at higher prices and needs to be reversed as soon as possible.

Repeal the Employer Mandate

- The employer mandate has had an adverse effect on businesses both small and large and needs to be repealed. Large employers have struggled with the complex reporting requirements and have taken on additional administrative costs even when in full compliance with the law. Small businesses have seen a reduction in their opportunities for growth and in many cases have been forced to downsize to avoid the costs associated with the employer mandate. Employers should

not be over-regulated and should be granted the flexibility to make health insurance decisions based on free market principles.

Eliminate the Cadillac Tax

- The "Cadillac Tax" was conceived and implemented as a means of slowing and/or reducing the ever-rising cost of healthcare. In theory, tax preferences for employer-sponsored plans depress wages and contribute to rising healthcare costs by providing overly generous healthcare benefits. In reality, the labor market is very complex and implementation of such a tax could have unintended and unforeseen consequences. There is no doubt that the Cadillac Tax will lead to a reduction in health benefits for some American workers while healthcare costs will continue to rise and no guarantee of increased wages. Further, under the current structure of the tax, any amounts contributed to flexible spending accounts ("FSAs") and HSAs count towards the Cadillac Tax cap. This could hinder the increased use of HSAs and FSAs as tools to lower premium costs as recommended by both the Price and Ryan plans (See Exhibit E - A Better Way, Pg. 15).

Simplify the Small-Business Tax Credit

- Under the ACA, tax credits are made available to small businesses when coverage is purchased through a Small Business Health Options Program or "SHOP" Exchange. This tax credit is only available for two years and is very complex to the point of business owners needing to hire an accountant to know if their business will qualify. Assuming this tax credit is retained by the new administration in a budget neutral manner; it should be simplified and made available to all small groups on an ongoing basis.

Altering Current Community Rating Factors

- The nationwide rise in health insurance premiums is largely attributable to health insurers' lack of ability to realistically account for an individual's projected risk. In order to stagnate and/or reduce such rate increases, individual healthcare rating factors should be allowed in determining an individual's premium.
- Theoretically speaking, such rating factors would need to fall between current rating practices (i.e. age, family size, tobacco use, location, and plan category) and pre-ACA rating practices. This would allow companies to calculate fair premiums that would in turn reduce carrier losses and future premium increases. For example, the current age-rating ratio could be changed from 3-to-1 back to the standard 5-to-1 ratio (See Exhibit E - A Better Way, Pg. 21).

Federally Fund State All Payer Claims Databases

- Federal funds should be used to help states develop All Payer Claims Databases ("APCDs"). APCDs would provide states with the ability to create greater price transparency, which in turn would allow individuals to make better informed decisions on cost-effective healthcare. Ultimately, this will help stabilize or drive down rising health care costs.

Take Action to Reduce Health Care Cost Trends

- There are several underlying factors that are major drivers in rising health care costs. Insurance providers are the only healthcare cost-saving mechanism available to the consumer and the only protection consumers have against high healthcare cost. No one else can help control healthcare costs except for insurance providers through networks. Medicare and Medicaid are usually the starting point for network reimbursement costs by insurance companies. AHIP has documented that pharmaceutical cost reimbursements are 30% of the premium cost for health insurance.

- The increase in costs of medical services and prescription drugs, referred to as a medical trend, is not only based on the increase in per-unit costs of services, but also changes in health care utilization and services received. Medical spending will continue to grow and costs for prescription drugs, in particular, are expected to increase as more high-cost specialty drugs come to market. Also, changes in health care use and provider networks will play a role in how healthcare costs are affected. Shown below are several solutions that may pause or reduce rising healthcare costs:

    - Telemedicine arms health systems with resources needed to reduce medical spending through preventive outreach and better staff utilization.
    - The reason our nation suffers from extraordinarily high medical costs is that the customary business standard of "legitimate pricing" is not applied to the healthcare industry. To slash costs, Congress need only mandate that all hospitals, physicians and labs publish legitimate prices—like all other businesses. They can continue to set their own rates, but a different rate for each patient must be prohibited. When legitimate rates are set, patients will be able to shop for good healthcare value and providers will be forced to compete.
    - Congress should support efforts in reducing Medicare cost by reining in increasing prescription drug costs.

Allow States to Regulate Air-Ambulance Balance Billing

- Surprise medical bills can be due to "balance billing." Typically, health plans negotiate fee schedules, or allowed charges, with network providers that reflect a discount from providers' full charges. Network contracts also typically prohibit providers from billing patients the difference between the allowed charge and the full charge. Because out-of-network providers have no such contractual obligation, patients can be liable for the balance bill in addition to any cost-sharing that might otherwise apply.

- Balance billing occurs when you receive services from a health care provider that does not participate in the patient's insurer's network; the health care provider is not obligated to accept the insurer's payment as payment in full and may bill the patient for any unpaid amount. In Mississippi, balance billing has become an issue when it comes to the utilization of air ambulance providers ("AAP"). The AAP subsequently "balance bills" patients the difference between the carrier's payment and the total billed charge. Some states have attempted to step in and regulate AAPs' "balance billing" practices but are preempted by the Airline Deregulation Act of 1978 ("ADA"), which prohibits states from regulating airline and helicopter rates. Federal legislative action is necessary to give states the authority to address this issue.

- State insurance regulators support legislation that would provide states with the flexibility to protect consumers from excessive out-of-network charges by regulating how AAPs are reimbursed, participate in networks, balance bill, and/or make information transparent to consumers.