

**Louisiana Health Care Commission Meeting Minutes**  
**Poydras Building Hearing Room**  
**Baton Rouge, Louisiana**  
**March 23, 2018**

**Members present:** Lauren Bailey, Rick Born, Katie Brittain, Diane Davidson, Dr. Rachel Durel, Dr. William Ferguson, Beau Fourrier, Dr. John Fraiche, Lisa Gardner, Arnold Goldberg, Dr. Faye Grimsley, Linda Hawkins, Jennifer Katzman, Dr. Jesse Lambert, Dr. Eva Lamendola, Darrell Langlois, Barbara Morvant, John Overton, Stephanie Phillips, Patrick Reed, Dr. James “Butch” Sonnier

**Members absent:** Robelynn Abadie, Jeff Albright, Korey Harvey, Dr. Marlon Henderson, Rep. Mike Huval, Randal Johnson, Jesse McCormick, Jennifer McMahon, Andrew Muhl, Ronnell Nolan, Ed Parker, Katie Parnell, Clay Pinson, Dr. Anthony Recasner, Debra Rushing, Elizabeth Sumrall, Bryan Wagner, Senator Rick Ward and Lacosta Wix

**Staff present:** Crystal M. Stutes and Julie Freeman

Chairperson Fraiche called the meeting to order at 9:05 a.m.

Dr. Fraiche asked for a motion to approve the minutes from the November 17 meeting. Arnold Goldberg moved to approve the minutes; Dr. Ferguson seconded the motion, and with no objections, the minutes were approved.

Roll call was conducted and a quorum was noted for the record.

Mr. Darrell Langlois, Mr. Beau Fourrier and Dr. Shondra Williams (absent) were introduced as the commission’s newest members.

Ms. Darie Jordan, Legislative Liaison for Department, presented LDI’s legislation package.

- HB 206 – Provides for the admission of convicted felons in the insurance business in certain circumstances at the discretion of the Commissioner of Insurance to grant or deny the waiver, authorizing the employment of those convicted for a felony offense, under certain circumstances pursuant to 18 U.S.C. 1033

- HB 227 – Provides for the reapplication of a producer’s license subject to revocation. Currently, whenever the LDI revokes a license reapplied for within one year, unless the licensee appeals the revocation to the Department of Labor and loses, one would have to wait five years. This bill would remove that five-year waiting period and allow for re-application within one year.
- HB 244 – Provides for the Commissioner to co-regulate Medicaid MCOs with the Louisiana Department of Health.
- HB 246 – Provides for the reinsurance of the individual insurance market, allowing the state to apply for a state innovation waiver to establish a state-based reinsurance program giving the Commissioner the authority to establish a commission and regulate it.

Mr. Jeff Drozda of Louisiana Associated Health Plans reported that the individual insurance marketplace currently represents 18 percent of the population that is bearing the burden of increased premiums.

Mr. Darrell Langlois of Blue Cross added that the federal government is not going to provide additional funding, but rather move funds in in the form of subsidies and tax credits into a reinsurance pool that provides the state with those funds at a 3:1 ratio. The funds will be moved through subsidies and tax credits, placing them into a reinsurance pool, which takes care of the more challenged health care members of our state. The idea is to provide more coverage for more people at a reduced premium and account for those who are challenged by health through a re-insurance pool all the while taking advantage of what the federal government will provide for and not lose any of those funds. CMS requires that in order for you to pursue that pool, a waiver must be in place. The pool will consist of those who are challenged due to their health conditions.

For this to become law, there would need to be a match of state and federal dollars, according to Darie Jordan.

Mr. Langlois further clarified that this would be a “fee” and not a “tax” to the consumer.

- HB 247 –Seeks to provide for the expansion of the Surplus Lines market to include accident and health insurance, offering Louisiana residents the option to obtain coverage such as excess disability and legally provide accident and health coverage without the necessity for authorizing legislation for specific lines of insurance.
- HB 267- Seeks to prohibit a convicted felon from receiving profits from agency ownerships.
- HB 330- Removes bail bond producers from pre-licensing requirements.

- HB 363 – Clarifies that any person who holds one or more of the positions of member, partner or officer directly or who controls directly or indirectly ten percent or more of the business shall register under the business entity's license.
- HB 366 – Removes the requirement that the board of directors of nonprofit funeral services associations must be members in good standing.
- HB 436 – Provides for the regulation of PBMs. This bill prohibits gag clauses in PBM and pharmacy contracts. It increases transparency in how PBMs create the maximum allowable cost and requires PBMs to notify similarly situated pharmacies of successful appeals.
- HB 615 – Provides that the commissioner shall provide the division of administrative law judge with a copy of a demand for a hearing by the aggrieved party within five days of receipt of the original.
- HB 641 – Permits an administrative deactivation of a business entity license when the responsible producer ceases to be licensed and permits the reactivation of the business entity license once the non-compliance is remedied.
- HB 642 - Sets out the requirements for the bail bonds apprenticeship program and the supervising producer to notify the LDI of any changes of information. It requires the apprenticeship program to terminate after six months. The producer would have three (3) days to send the information for the apprenticeship termination program.
- HB 644 – Relates to the licensing of third-party administrators. The purpose of this bill is to ensure that the Commissioner can deny a TPA license for the same reasons he would suspend or revoke a license, typically for misleading or false information. The same standards would be used for suspending or revoking a license to determine whether or not a license will be issued or denied.
- SB 35 – Removes the requirement that the commissioner “shall” fine and replaces it with “may” fine for the failure to comply with a consumer complaint directive.”
- SB 36 – Relative to the continuing education requirements for a producer, it clarifies that a non-resident licensee is not required to complete CE requirements as long as they meet the requirements of their home state.
- SB 37 – Makes a technical correction by replacing the word “license” with “registration.”
- SB 86 – Provides adjusters a first-time renewal exemption from completing continuing education requirements to insurance producers.

- SB 87 – Clarifies that the Commissioner may accept all licenses in the form of electronic fillings.
- SB 324 – Prohibits any contract entered into this state between an insurer, a pharmacy benefit manager, or any other entity and a pharmacist or pharmacy from containing a provision prohibiting the pharmacist from disclosing any relevant information to an individual purchasing prescription medication.

Mr. Jeff Drozda also presented the following legislative summary which included health legislation that may be of interest to the commission:

- HB 134 – Deals with an issue from the last legislative session in working with the Louisiana Dental Association and Louisiana dental plans. The ID cards indicated “non-ERISA” that conflicts with the interpretation of what law enforcement may do. This bill seeks to change that information to “fully insured.”
- HB 194 – Provides a time period after payment of a claim during which an insurer may dispute and recoup the amount paid.
- HB 369 – Provides for mediation of the settlement of out-of-work network health benefit claims involving balancing billing that occurs whenever going to a hospital and the hospital is in the network but other providers (i.e. radiologist, etc.) may not be in the network. Several other states provide for this measure.
- HB 429 – Deals with the denial of dental claims. LAHP is currently working with the Louisiana Dental Association on this bill. This is applicable to a situation whereby a dentist calls in for prior approval and obtains approval from the dental health plan only to discover 30 days later that it is not covered. This bill seeks to improve communications between the dentist’s office and the dental plan.
- HB 460 – Provides that mammography examinations be conducted through digital tomosynthesis. There is concern for the rural communities that may not have access to this technology.
- HB 556 – Provides relative to out-of-network balance billing.
- HB 689 – Provides for coverage for fertility preservation for individuals diagnosed with cancer.
- HB 690 – Provides for coverage for subsequent preventive tests for certain individuals diagnosed with breast cancer. Once a person is diagnosed past that fifth year of being cancer free, this bills seeks to ensure certain preventive tests are included in health plan coverage.
- SB 29 – Provides relative to a single uniform prescription drug prior authorization form.

- SB 272 – Provides for health insurance policy coverage of incarcerated persons prior to adjudication.
- HB 282 and 283 – Both bills seek to address price transparency – whether it be with the industry, consumer or elected officials, the goal is trying to get as much transparency as possible.
- SB 285 – Prohibits a health insurance issuer from denying a non-opioid prescription in favor of an opioid prescription.
- HB 334 – Provides for implementation of Medicaid managed long-term care services and support system. This bill would allow LDI to release an RFP dealing with long term care or in some shape or form have the department direct the discussion and possibly have a pilot program for long term care.
- HB 357 – Provides relative to Medicaid managed care for individuals receiving long-term services and supports.
- HB 362 – Provides for the state’s system of Medicaid-funded long term care.
- HB 436 – Provides relative to the regulation of pharmacy benefit managers. This is an issue of whether it’s contractual or based on reimbursement.
- SB 130 – Provides for Medicaid pharmacy benefit management services.
- SB 283 – Provides relative to pharmacy benefit managers.
- HB 243 – Prohibits a manufacturer or wholesale distributor from engaging in price gouging in the sale of an essential off-patent or generic drug.
- HB 384 – Creates and provides for a state prescription drug importation program. The waiver is for drug importation from Canada that is a controversial bill in terms of going across the international boundaries to acquire drugs. There are four or five states seeking a waiver from the federal government to establish this program.
- HB 339 – Provides relative to the practice of telemedicine insofar as providers and consumers seeking the benefits in telemedicine and telehealth. This is a matter of addressing the regulation from the Board of Medical Examiners and ensuring the same standard of care that would take place both in the doctor’s office and via telemedicine.

Dr. Richard Vath, Senior Vice President and Chief Clinical Transformation Officer for Health Leaders Network (HLN) next presented on *Volume to Value Care*.

He stated Health Leaders Network is a wholly owned subsidiary of FMOL Health System with an established board and committee that drive performance. It includes a small analytics team that works with payors and data to analyze where opportunities lie and to

determine where it needs to drive quality to improve costs on a regular basis. Competition must be in effect in order to deliver a high quality of care for a more predictable outcome. When looking at the future of the state of health care, providers and physicians must be willing to share some risks with insurers in addition to others in or to manage a population across all access points.

Dr. Vath cited CMS Risk Contracts are driven by:

- Risk adjustment
- Quality
- Clinical programs
- Network
- Technology

Currently, institutions, ambulatory care providers and home health care do their own sort of management, losing track of the patient. HLN's goal is to deliver the better population health outcomes, better patient experience and lower costs with the idea of providers managing risks for a population. Hence, the need to form a clinically integrated network. Clinical integration is defined in 1984 by the Federal Trade Commission as an ongoing and active program to evaluate and modify practice patterns by the network physician participants to create a high degree of interdependence and cooperation which doesn't always control costs and ensure quality. To have a successful clinically integrated network, there must be an established IT infrastructure to capture clinical and financial data and track it over time. An entire group must manage different providers whether it is a PCP or home health or skilled nursing facility. A program must be established to manage patients at all access points.

Finally, Brian Burton provided a CMS/Marketplace Enrollment Update, reporting again after five enrollment periods on the outcome of the ACA in Louisiana.

He stated the biggest changes that occurred in 2018 with the ACA was that the Open Enrollment date changed from November 1 to December 15. Years before it ended in January, however, after working with consumers, there was not an issue with this date change.

Other changes included third party vendors. There were different sites that consumers could go to beyond the healthcare.gov platform to be able to enroll and make changes with in-person assistance. Prior to Open Enrollment, there were two navigator entities in Louisiana; however, CMS did a massive budget cut that required the elimination of 13 navigators, leaving one navigator for Lake Charles; one for Alexandria; one for Lafayette; one for Baton Rouge and one for New Orleans. Another service in Baton Rouge received a 99 percent cut for approximately half a million dollars for services in the capital area. Moreover, \$10,000 was given back to CMS. Mr. Burton stated there was also a much better working relationship than in the past with agents and brokers with CMS. With a large number of new web brokers in the federal marketplace, there were many platforms formed by healthcare.gov that allowed a more streamlined enrollment process for consumers, enabling them to compare plans and decide what was working best for them.

On October 12, 2017 Cost Sharing Reductions (CSR) ended. CSRs are payment subsidies that the executive branch hands out to health care companies across the nation to compensate for losses that insurance companies may have taken on by covering more people. This was used as an incentive to keep health care plans low and available to as many as possible. CSRs were paid out by the executive branch on a monthly basis and were estimated by the CMS to be approximately 7 billion dollars in 2017. Mr. Burton explained that while CSRs ceased after the President issued his executive order, it still remained legal in effect for those who were between 138 percent of the Federal Poverty Level and would have access to those cost savings reductions and not be out-of-pocket for those costs or co-payments. They would still also have access to those cost savings, but at the same time the insurance company would not be reimbursed for providing those CSR's. Insurance companies anticipated this would happen throughout the year, so when they filed for their rates, they factored that into it.

In Louisiana only Blue Cross and Blue Shield and Vantage remained in the individual marketplace in Louisiana. The effect of this on the consumer turned out to be much better than was anticipated so the advanced premium tax credit was the subsidy that consumers received by those who were between 138-400% of the Federal Poverty Level (FPL).

Mr. Burton stated that the advanced premium tax credit was based on the second lowest level of the silver level plan so that when premium rates went into effect on those plans, it raised them very high and simultaneously raised the amount of tax credits those consumers would get to the point where consumers would come into the 2018 marketplace and see identical plans from years before that were much less due to the subsidy. In 2018 consumers got more for less; however, the further those consumers went up on the FPL chart, the less those subsidies came and the more the consumers began to feel the pinch of those premium increases.

With regard to Outcomes with Enrollment, Mr. Burton stated that CMS should have these numbers available in April, therefore the impact cannot be estimated for each parish, but overall in 2018, there were 111,373 consumers insured through the Federal Marketplace.

Finally, he reported 50,000 consumers went on the Medicaid roll as a result of Medicaid expansion, resulting in 20,000 uninsured people uninsured in Louisiana.

With no further business, Chairperson Fraiche asked for a motion to adjourn the meeting. Dr. Ferguson moved to adjourn and Ms. Lisa Gardner seconded the motion. Hearing no objections, the meeting was adjourned at 11:00 a.m.