

2003-04 SESSION  
COMMITTEE HEARING  
RECORDS

Committee Name:

Senate Committee on  
Health, Children,  
Families, Aging and  
Long Term Care  
(SC-HCFALTC)

Sample:

Record of Comm. Proceedings ... RCP

- 03hrAC-EdR\_RCP\_pt01a
- 03hrAC-EdR\_RCP\_pt01b
- 03hrAC-EdR\_RCP\_pt02

➤ Appointments ... Appt

➤ \*\*

➤ Clearinghouse Rules ... CRule

➤ \*\*

➤ Committee Hearings ... CH

➤ \*\*

➤ Committee Reports ... CR

➤ \*\*

➤ Executive Sessions ... ES

➤ \*\*

➤ Hearing Records ... HR

➤ 03hr\_sb0515

➤ Miscellaneous ... Misc

➤ \*\*

➤ Record of Comm. Proceedings ... RCP

➤ \*\*

*Wisconsin Association  
of Health Plans*

SB  
515  
3/2/04  
Kale/C  
Public  
hearing

March 2, 2004

To: The Honorable Senator Roessler, Chair, Senate Committee on Health  
Children, Families, Aging and Long Term Care  
Honorable Committee Members

From: Kelly M. Rosati, J.D., Consultant  
Louie Schubert, J.D., Director of Government Affairs

Re: Support for SB 515

The Wisconsin Association of Health Plans supports SB 515 because it will eliminate an unnecessary and duplicative government regulation on health plans, thereby reducing overall health care costs.

SB 515 is part of Wisconsin's Healthier Choices for Affordable Health Care, a set of health care reform proposals offered earlier this year as a collaborative effort of the Wisconsin Association of Health Plans, the Wisconsin Hospital Association and Wisconsin Manufacturer and Commerce. SB 515 is a component of our recommendations regarding "cutting red tape, controlling costs."

SB 515 will reduce state quality assurance reporting requirements for health plans if plans have received accreditation from a private national accrediting organization approved by the federal Centers for Medicare and Medicaid Services for establishing quality assurance standards.

The National Committee for Quality Assurance, commonly known as NCQA, is the industry gold standard for health plans. NCQA conducts independent, objective reviews against a set of standards. Based on that review, NCQA develops information that is then made publicly available to inform consumers' and employers' enrollment or contracting decisions.

NCQA's standards are rigorous. Accreditation reviews involve both an on- and off-site component and are conducted by teams of physicians or other health care providers and managed care experts. An independent oversight committee analyzes the teams' findings and organization's clinical performance and then assigns an overall accreditation outcome.

Plans are reviewed against more than 60 different standards designed to evaluate the health plan's clinical and administrative systems related to such issues as consumer protection, confidentiality, and customer service. Plans must also report on their clinical

performance using a measurement tool known as HEDIS, the Health Plan Employer Data and Information Set. HEDIS measures fall into five broad categories: 1) Access and Service; 2) Qualified Providers; 3) Staying Healthy; 4) Getting Better; and 5) Living with Illness.

The Wisconsin Association of Health Plans believes once a plan has successfully undergone such a rigorous external review and been accredited that there is no need for the Office of the Commissioner of Insurance nor health plans to waste staff time and resources repeating the process.

Under this proposal, health plans that have not been accredited by a private national accrediting entity would be required to continue compliance with both the statutory and regulatory mandates in this area.

The continuing escalation of health care costs demands solutions. Cutting red tape by eliminating duplicative regulation is a simple yet substantive move in the right direction. Wisconsin Health Plans encourage you to support SB 515.



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor  
Jorge Gomez, Commissioner

Wisconsin.gov

125 South Webster Street • P.O. Box 7873  
Madison, Wisconsin 53707-7873  
Phone: (608) 266-3585 • Fax: (608) 266-9935  
E-Mail: [information@oci.state.wi.us](mailto:information@oci.state.wi.us)  
Web Address: [oci.wi.gov](http://oci.wi.gov)

Testimony to Senate Health, Children, Families, Aging and Long-Term  
Care Committee on SB 515  
By Eileen Mallow  
Assistant Deputy Commissioner

March 2, 2004

Thank you Senator Roessler and members of the Committee for the opportunity to testify on SB 515, which includes an amendment of the requirements for quality assurance requirements for defined network plans (also known as HMOs). Commissioner Gomez is unfortunately not available this morning but I am Eileen Mallow, Assistant Deputy Commissioner of Insurance, here testifying for information on this bill.

I will limit my comments to Sec. 11 of the bill, as that is the only section that affects the Office of Commissioner of Insurance (OCI).

The Office of Commissioner of Insurance has a clear statutory mission, outlined in s. 601.01, Wis Stat. A specific charge under that section is "To keep the public informed on insurance matters." We take that charge seriously and have actively worked to provide Wisconsin consumers with all possible information on insurance products they may wish to purchase.

Legislative changes, adopted as 1997 Wisconsin Act 297, included direction that managed care plans develop comprehensive quality

assurance plans to identify, evaluate and remedy problems related to access to, and continuity and quality of care. Representatives of Wisconsin's managed care plans participated in the development of this statute. Administrative rules adopted by the agency to implement this statute (Ins 9.40 Wis. Adm. Code), direct managed care plans to submit a quality assurance plan consistent with the statute to OCI by April 1 of each year. We allow managed care plans considerable discretion in the content and format of the quality assurance plans they submit.

However, one item that is specifically required by our office is a limited report of HEDIS and CAHPs data. Attached is the data reporting form, which as you can see, is less than 2 pages. It is data that is already collected by HMO insurers for accreditation by national bodies. In fact, the data elements we collect were evaluated with the assistance of health plans to determine which would be the most meaningful to consumers. Data collected from this report was first published in 2003, and documents that our HMO insurers exceed national averages in most of the categories. I have included one of the charts summarizing the data we have collected for your information.

As an agency, we have prided ourselves on being efficient regulators. In fact, our department is the second smallest among all the states for the ratio of department staff to number of domiciled companies. We continuously look for ways to streamline the regulatory process to make sure we are only collecting data we need to be able to effectively regulate the market or to assist consumers in purchasing quality insurance products.

7-8  
9A14

Under this bill, HMO insurers who have been accredited by another review body that has been approved by the federal Centers for Medicare and Medicaid Services (CMS) will only have to file a statement to that effect with OCI. No longer will the HMO insurer be expected to provide information on how they are meeting the quality assurance needs of their consumers to our office. In fact, a strict reading of the proposal would suggest that the Commissioner would no longer be able to request any quality of care information from insurers who meet CMS standards.

As I mentioned earlier, OCI considers informed consumers to be crucial to making reasonable choices about their insurance. One of the reasons we publish the available data that we have is to inform the process. We do not advise that quality numbers are the only basis for comparison among plans; in fact, we encourage consumers to look at issues such as available benefits, whether or not specific providers are included in networks, and grievance and complaint statistics as part of their decision making process.

 But who wouldn't want to know, if they had a choice between health plans, which one received higher quality ratings? The only way to guarantee that the information continues to be made public is to require that it be submitted to a public body.

The regulatory bodies, such as the National Committee on Quality Assurance (NCQA), that are most often cited as the accrediting bodies are, for the most part, self-policing. Members insurers pay significant fees to the organizations as part of the accreditation process. While no one can find fault with the thoroughness of the reviews currently conducted by accrediting bodies, there is certainly no guarantee that they will continue

this careful scrutiny, or that our consumers can influence the standards by which they review health plans.

We are also concerned about transferring authority to review managed care plan activities from the state to the federal government, which this bill would do. Should this bill be adopted, we are ceding our state authority to evaluate the needs of Wisconsin consumers to the federal government.

We want to be able to maintain the high level of quality that is currently provided to Wisconsin residents. OCI is concerned that this bill will affect our ability to continue to do that.

I would be happy to answer any questions you may have. Thank you for your time.

*Quality*  
Assurance

Plans

**HMO Data Collection**



State of Wisconsin  
 Office of the Commissioner of Insurance  
 P.O. Box 7873  
 Madison, WI 53707-7873  
 (608) 266-3585

Ref: Section Ins 9.40 (5), Wis. Adm. Code

Company Name	
Name and Title of Individual Completing Form	Telephone Number

Complete the following with the numbers that were submitted to NCQA for your latest HEDIS survey. Rotated data may be submitted if allowed according to NCQA standards and if it is clearly identified as rotated data.

HEDIS Data Element	Numerator	Denominator	Score	Indicate admin or hybrid data
Women age 52-69 who have had a mammogram within the past 2 years				
Women age 21-64 with at least 1 pap smear in the last 3 years				
Number of Type 1 and Type 2 diabetics with an eye exam (use HEDIS guidelines)				
Members age 6 and over who were hospitalized for a mental illness and had an ambulatory visit with 7 days or within 30 days of discharge	(7 days)			
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Children age 12-24 months with at least one visit to a primary care practitioner during the past year				

Complete the following with the number of respondents who chose each response option. The HMO should either follow NCQA guidelines for the CAHPS survey, or report any variations in its survey process.

**CAHPS Survey Results**

Total number of valid responses: \_\_\_\_\_ Response rate: \_\_\_\_\_

Satisfaction with the time spent with the physician:

Number of valid responses : \_\_\_\_\_ Response rate: \_\_\_\_\_

Never	Sometimes	Usually	Always

Overall satisfaction with the health plan:

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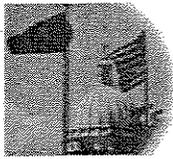
Response rate: \_\_\_\_\_

0	1	2	3	4	5	6	7	8	9	10

**CERTIFICATION OF DATA SET**

I, \_\_\_\_\_ (name), an officer of \_\_\_\_\_  
(company name), hereby certify that I have authority to bind and obligate the company by filing this data form. I further certify, pursuant to s. Ins 9.40 (5), Wis. Adm. Code, that, to the best of my knowledge, information, and belief, the submitted data was collected according to HEDIS and NCQA guidelines [with the reported variations].

Signature	Title	Date



*State of Wisconsin  
Office of the Commissioner of Insurance*

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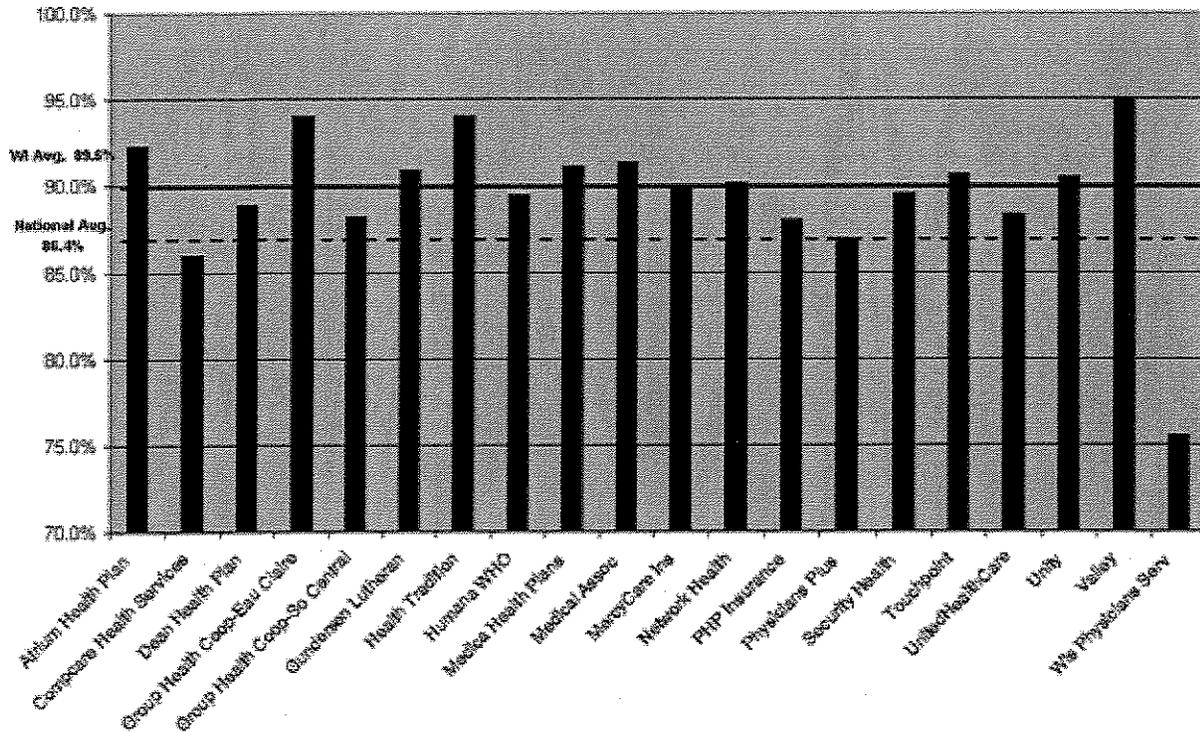
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Time Spent with the Physician



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*only 2 page report - don't feel it is an onerous burden*

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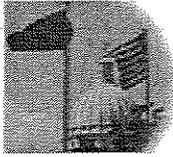
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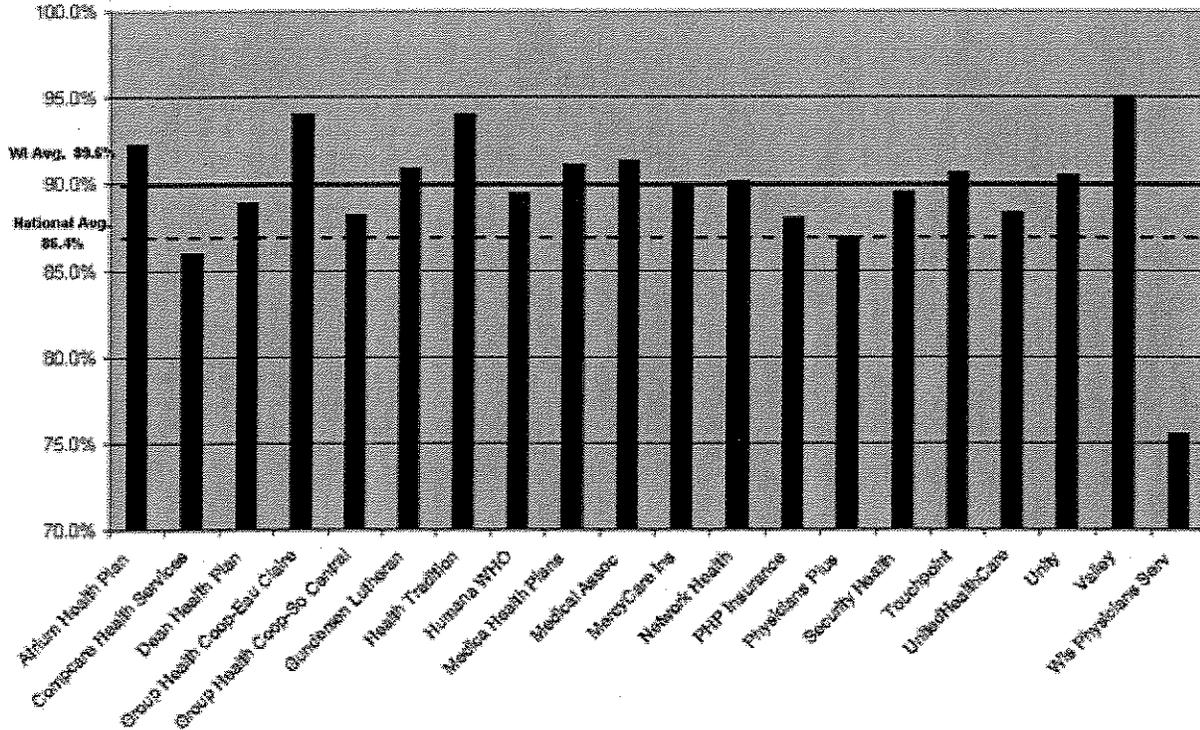
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# *Wisconsin Association of Health Plans*

March 2, 2004

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Children, Families, Aging and Long Term Care  
Honorable Committee Members

**From:** Kelly M. Rosati, J.D., Consultant  
Louie Schubert, J.D., Director of Government Affairs

**Re:** Support for SB 515

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