

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
PHILADELPHIA, PENNSYLVANIA
JULY 12, 2009
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Marriott Downtown in Philadelphia, Pennsylvania, on Sunday, July 12, 2009, at 9:15 a.m.

Sen. Ann Cummings of Vermont, chair of the Committee, presided.

Other members of the Committee present were:

Sen. Ralph Hudgens, GA	Rep. George Keiser, ND
Sen. William Haine, IL	Rep. Donald Flanders, NH
Rep. Susan Westrom, KY	Sen. Carroll Leavell, NM
Rep. Tommy Thompson, KY	Assem. Joseph Morelle, NY
Rep. Robert Damron, KY	Sen. Jake Corman, PA
Rep. Ronald Crimm, KY	Rep. Brian Kennedy, RI
Rep. Barb Byrum, MI	Sen. Mike Hall, WV

Other legislators present were:

Rep. Perry Thurston, Jr., FL
Rep. Dennis Horlander, KY
Sen. William Brady, IL
Sen. Travis Holdman, IN
Rep. Marc Corriveau, MI
Rep. Robert Godshall, PA

Also in attendance were:

Susan Nolan, NCOIL Executive Director
Candace Thorson, NCOIL Deputy Executive Director
Michael Humphreys, NCOIL Director of State-Federal Relations
Jordan Estey, NCOIL Director of Legislative Affairs & Education

MINUTES

The Committee voted unanimously to approve the minutes of its February 27 meeting in Washington, D.C.

JULY 9 BALANCE BILLING ROUNDTABLE

Sen. Cummings briefly reviewed a Thursday, July 9, Committee roundtable on healthcare balance billing regulation and solicited legislator input on Committee action. Rep. Westrom suggested that NCOIL staff research state activity and provide language for Committee review at the November Annual Meeting. Upon a motion made and seconded, the Committee unanimously supported the idea.

STATE LONG-TERM CARE PARTNERSHIP PROGRAMS

Rod Perkins of Genworth Financial reported that uninsured adults that require long-term care often exhaust their personal assets to qualify for public assistance, which, he said, will eventually deplete state Medicaid programs and challenge budgets. He recapped the enabling federal 2005 *Deficit Reduction Act* (DRA), which he said empowered states to develop public/private long-term care insurance policies known as “partnership programs.” He said the programs encouraged consumers to purchase long-term care insurance to provide financial security and protect their assets, while easing Medicaid spending for a state.

Mr. Perkins said that 30 states had filed state Medicaid plan amendments with the U.S. Department of Health and Human Services (HHS) since the DRA became law. He reminded legislators that once HHS approved a state plan, partnership policies could be sold in that state. He said HHS had approved 28 of the 30 proposals and policies were being sold in 26 states. He also discussed, among other things, state agent training requirements and education campaigns to protect consumers and raise awareness about long-term care benefits.

Mr. Perkins reported that the federal government had recently developed reciprocal standards to recognize partnership policies between states and had established an information clearinghouse to track the number of policies being sold and potential long-term Medicaid savings, among other things. He said the reciprocal standards between states were in place for all new plans, but that states could opt out.

INSURANCE RESCISSIONS/THIRD PARTY REVIEW MODELS

Commissioner Joel Ario of the Pennsylvania Insurance Department reported on National Association of Insurance Commissioners (NAIC) efforts to protect consumers from abusive health insurance rescissions. By way of explanation, he said insurance companies, by law, could cancel an individual insurance policy for fraud or misrepresentation, but regulators were concerned that certain companies were abusing this business practice to cancel coverage after someone had filed an expensive claim.

Commissioner Ario said the NAIC was working with Rep. Henry Waxman (D-CA), Chair of the U.S. Energy and Commerce Committee, to review the scope of abuse and the need for additional consumer protections. He said Congress and state regulators were alerted by several 2008 legal cases in California alleging company abuses. He said California law, unlike most states, required insurance carriers to prove fraudulent intent before a policy could be canceled, which had spawned more legal cases and media coverage. He said state regulators and insurance companies were working to implement independent external review processes for consumers of rescinded policies, through model regulation. He added that Congressional health reform proposals, if enacted, would eliminate rescission abuses by mandating coverage and eliminating risk-selection issues that had left some consumers vulnerable to these abuses.

Rick Ramsay of America’s Health Insurance Plans (AHIP) discussed model legislation to provide independent third party reviews of health insurance rescissions. Mr. Ramsay said California had the largest individual insurance market, which also contributed to a large number of issues experienced there. He said an AHIP model would give state insurance commissioners discretion to have a rescission decision reviewed by an independent party, at

the insurance company's expense. He said the AHIP model was derived from an NAIC *External Review Model*, but focused exclusively on policy cancellations.

Kevin Wrege on behalf of the Council for Affordable Health Insurance (CAHI) said AHIP and American Legislative Exchange Council (ALEC) models would provide additional safeguards for consumers. He said insurance carriers were reluctant to rescind a policy without justification and discussed confidentiality provisions in the federal Health Insurance Portability and Protection Act (HIPPA.) He said HIPPA prevented companies from discussing an individual's policy because of privacy, thus prohibiting company comment on highly-publicized rescission cases. He said this resulted in a one-sided and biased debate.

After Committee discussion, Sen. Cummings asked NCOIL staff to review various models and approaches for November Annual Meeting consideration.

MEDICARE ADVANTAGE

Commissioner Ario reported on anticipated cuts to Medicare Advantage plans which, he reminded Committee members, were administered by private insurers and subsidized by the federal government. He said Congress and the Obama Administration wanted to cut government payments to private insurers but insurance companies argued that cuts would lower patient benefits.

Commissioner Ario also discussed the need for increased state oversight of the Medicare Advantage plans. He said that the Centers for Medicare and Medicaid Services (CMS) does a good job of regulating large-scale fraud issues, but that it struggles to protect individual consumers from marketing and sales abuses. He said the NAIC would continue to work with Congress to return oversight to the states.

FEDERAL HEALTHCARE REFORM

Commissioner Ario reported on comprehensive health reforms pending in Congress. He said reform approaches generally included insurance market reforms, cost controls, and financing. He said Republicans and Democrats increasingly agreed that reforms should require people to purchase health insurance or pay a penalty. He said that an individual mandate, from an insurance perspective, was a necessary part of reforms because it would bring young and healthy Americans into the insurance pool and enable companies to stop denying sick people coverage or charging them significantly more for insurance.

Commissioner Ario said federal proposals would establish so-called health insurance "exchanges," where consumers could review, compare, and purchase coverage. He said exchanges would likely be established at the state, regional, or federal levels. He said state regulators could better run these programs than a federal bureaucracy.

Commissioner Ario discussed cost-drivers in the U.S. healthcare system, including volume-based physician payments and chronic illnesses. He said federal reform proposals focused on health information technology, primary care and preventative medicine, and value-based healthcare centered on treatment best practices to control costs.

In response to a comment from Rep. Keiser relating to federal reforms and reduced hospital reimbursements, Commissioner Ario said the reduced payments were a cost savings to the system. He said federal law required hospitals to treat uninsured patients, regardless of their ability to pay. He said if health reform was passed and everyone required to obtain insurance, hospitals would provide less uncompensated care and could afford the lower reimbursements.

David Korsh with Blue Cross Blue Shield Association (BCBS) said his organization supported insurance market reforms to expand access and affordability, but cautioned that regional or national exchanges could further erode state insurance regulation. Specifically, he said, federal or regional health insurance exchanges would create large bureaucracies, preempt strong state regulator oversight and eliminate state flexibility and innovation.

Sally McCarty of the National Hemophilia Foundation supported the creation of a government-sponsored health insurance plan as part of federal healthcare reforms. She said this so-called “public option” was a modest proposal and referenced a growing number of people who supported a single-payer federal government system. She said a public option could be administered by the government, but would operate much like private insurance companies by charging premiums and maintaining provider networks. Among other things, she said the public option could compete with private insurance companies on benefits, price, quality, and customer service, which would benefit all insurance consumers.

Ms. McCarty cited, in her opinion, the scope of various consumer problems caused by the current U.S. health insurance system, including sparse insurance markets with little competition and overwhelming numbers of Americans facing bankruptcy as grounds for a public option. She said a public option would help, not harm, uninsured and underinsured Americans.

Mr. Korsh disagreed with Ms. McCarty’s position on the need for a public insurance option and said it would limit, not expand, health insurance access. He said the private insurance marketplace was already competitive, with over 1,500 insurers operating in the U.S. This competition, he said, would disappear with the advent of a public plan, as a public plan would have competitive advantages over private insurers, including an ability to dictate physician reimbursements and participation. He said a public plan option would also benefit from state solvency, network adequacy, and grievance procedure regulations.

After legislator dialogue, the Committee deferred further discussion until the November Annual Meeting in New Orleans.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:30 a.m.