

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH INSURANCE COMMITTEE
DUCK KEY, FLORIDA
NOVEMBER 19, 2004
DRAFT MINUTES

The Health Insurance Committee of the National Conference of Insurance Legislators (NCOIL) met at Hawks Cay Resort in Duck Key, Florida, on Friday, November 19, 2004, at 8:00 a.m.

Rep. Geoffrey Smith, Vice Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Robert Damron, KY
Rep. Don Pasley, KY
Rep. Karen Carter, KY
Rep. Edward Gaffney, MI
Sen. Alan Sanborn, MI
Rep. Fulton Sheen, MI
Rep. Dan Ward, MO
Sen. Carroll Leavell, NM
Rep. George Keiser, ND
Rep. Brian Kennedy, RI
Rep. Gene Seaman, TX
Rep. Larry Taylor, TX
Del. Harvey Morgan, VA
Rep. Virginia Milkey, VT

Other legislators present were:

Rep. Bob McClusky, CO
Sen. Joe Crisco, CT
Rep. Mike Ripley, IN
Rep. Matthew Whetsone, IN
Rep. Susan Westrom, KY
Rep. Shirley Bowler, LA
Rep. Scott Hummel, MI
Rep. Mary Ann Middaugh, MI
Rep. Greg Davids, MN
Sen. Ann Cummings, VT
Del. Lidella Wilson Hrutkay, WV

Also in attendance were:

Susan Nolan, NCOIL Deputy Executive Director
Fran Liebich, NCOIL Director of Legislative Affairs & Education, Life and Health
Insurance

MINUTES

Upon a motion moved and seconded, the Committee voted unanimously to approve, as submitted, the minutes of its July 16, 2004, Committee meeting in Chicago, Illinois.

CONSUMER-DRIVEN HEALTH PLANS (CDHPs)

Scott Kipper of America's Health Insurance Plans (AHIP) said that there had been a nationwide increase in the number of carriers that offer health savings accounts (HSAs). He said that states needed to update their laws to allow the sales of HSAs for indemnity carriers and for managed-care style products. He said that AHIP was collecting data on the type of employers that offer HSAs and sales trends. He said he would report the findings at a future NCOIL meeting.

Wes Cleveland of the American Medical Association said that pay-for-performance incentives that accompany CDHPs "incentivizes" patients to choose hospitals, physicians, or other health care services that provide quality and efficient care. He said that legislators should consider that:

- if a plan depends on individuals making informed choices on efficiency and quality of a provider, patients receive accurate and meaningful interpretations of data
- measures used to determine quality need to be evidence-based, whenever possible
- quality measures used must have actual physician input
- quality standards should be universally applicable across plans

Mr. Cleveland said that states may not be asked to render judgment on the legitimacy of types of CDHPs in the 2005 legislative session, but he said, that states would be asked to examine their quality as a means of cost control.

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)

David Korsh of Blue Cross Blue Shield Association (BCBSA) reported that the National Association of Insurance Commissioners (NAIC) had adopted changes to its *Medicare Supplement Model Regulation*. He said changes were made to, among others, plans K and L, dealing with high-deductible plans, and that the drug provisions in H, I, and J were removed. He said that the NAIC, as part of a required review, was undertaking an actuarial study of the Medicare supplemental program. He said that the Centers for Medicare and Medicaid Services (CMS) were considering 10 to 50 state-based regions for the Medicare Advantage Program. He said that BCBSA and AHIP had asked for 50 state-based regions for implementation of the preferred provider organizations (PPOs) within the Medicare Advantage Program.

STATE RISK POOLS AND THE UNINSURED

Brad Anderson of Allianz Healthcare said that risk pools served as a valuable tool in reducing the uninsured population, but, he said, managing a risk pool is a difficult task given the nature of risk and available funding resources. He said that a consortium of employer stop-loss carriers were interested in working with NCOIL to look at issues impacting risk pool funding relating to employer groups. He said that assessments to carriers and its effects on employers should be examined. He said that employers face

significant costs of medical increases. He said that these increases may lead employers to drop medical benefits if state assessments become too high.

Rep. Bowler asked what his recommendations were as to how plans should be assessed. Mr. Anderson said that industry preference is not to have per head assessments. He said that another option was broad-based funding and taking a percentage of premiums. Rep. Sheen asked how many states employed stop-loss practices and how many employed the percent of premiums. Mr. Anderson said that he would look into it.

STATE HEALTH INSURANCE BEST PRACTICES

Ms. Liebich said that NCOIL had been collecting legislation for a best practices report on cost-containment in health insurance. She said that a case study on the South Dakota risk pool for the uninsured was a result of collecting the data. She said that, among other things, the report highlighted that South Dakota had saved within nine months of implementation over \$300,000 with a disease management program. Ms. Liebich encouraged the Committee to continue to look at state risk pools. She said that the National Association of State Comprehensive Health Insurance Plans (NASCHIP), which she said was an organization of state risk pool directors, had volunteered to work with NCOIL.

Without hearing any objections, the Committee moved that NCOIL continue its efforts to examine state risk pools for the uninsured.

Mr. Kipper said that AHIP had developed an affirmative legislation package of 16 draft bills that were collected to address a wide variety of issues and that the report would be forthcoming. He said that among the legislation was a draft bill on risk pools that called for broad-based funding of pool losses. Rep. Damron asked whether anyone was monitoring risk pools and fiscal solvency on a national basis. Mr. Kipper said that NASCHIP and Communicating for Agriculture produced such information.

MEDICAL MALPRACTICE AND PATIENT SAFETY

Rep. Keiser reported that the Property-Casualty Insurance Committee had previously adopted a resolution supporting certain tort reforms for medical malpractice. He said that on November 18, the Property-Casualty Insurance Committee began considering a working draft of a proposed model act aimed at improving patient safety in order to promote quality medical care and lower premiums. Rep. Keiser said that he looked forward to working with the Health Insurance Committee in this endeavor. He said that among other things, the proposed model focused on three issues: mandatory reporting of medical errors by hospitals, ambulatory surgical centers, and mental hospitals; mandatory reporting of hospital infection rates; and guidelines for establishing an effective state medical board.

DIRECT-TO-CONSUMER (DTC) DRUG ADVERTISING

Matthew Vanhook representing the Pharmaceutical Research Manufacturers of America (PhRMA) said that DTC advertising is strictly regulated. He said that the Food and Drug Administration (FDA) had developed guidance reports on DTC advertising that required product advertisements to be truthful, not misleading, and to have scientific substantiation, including associated side effects.

Mr. Vanhook said that in 2003 the pharmaceutical industry spent \$33 billion dollars on research and development and, by comparison, \$25.3 billion on combined promotional activity. He said that of the \$25.3 billion, \$3.3 billion was spent on DTC advertising and that \$16 billion was spent on samples. DTC advertising, he said, represented 10 percent of research and development and two percent of overall drug revenues. Mr. Vanhook said DTC advertising is valuable to consumers in that it increases patient awareness, stimulates doctor visits, and helps identify undiagnosed conditions. Furthermore, Mr. Vanhook said that an FDA study indicated that 87 percent of patients that go to a doctor because of DTC advertising were found to have a condition, and he noted that a Harvard study reported that 25 percent of patients who went to the doctor because of an advertisement were newly diagnosed.

Rep. Gaffney asked whether DTC advertising led people to demand medications that were not necessary. Mr. Vanhook said that there were no documented reports to that effect and that doctors ultimately had control of the prescription pad. Rep. Gaffney asked why companies advertised products without indicating the illness to be treated by them. Mr. Vanhook said that the ads were called reminder ads, but that all ads should indicate the correlating illness.

Rep. Smith said that it was hard to believe that DTC advertising did not raise drug prices. Mr. Vanhook reiterated that there were no studies indicating that DTC advertising increased drug prices. Rep. Smith asked whether DTC advertising led patients to self-diagnose themselves. Mr. Vanhook said that, to a measurable extent, studies did not support that conclusion.

Rep. Milkey asked how DTC advertising of new prescription drugs rather than generics impacted the increased cost of medicines. Mr. Vanhook said that it was a physician's judgment as to what prescription was best for the patient, and that generics represented over 50 percent of sales in the country.

Dr. Elizabeth Wennar of United Health Alliance said that advertising does not drive down the cost of unit price for a prescription drug, as it does in other markets, and that the purpose of marketing and advertising is to increase sales. She recommended that the Committee look at both marketing and advertising globally in the industry. She said that it was a company's right to advertise a product, but that DTC advertising should be truthful, not misleading, and provide consumer education.

Rep. Kennedy said that during a meeting of Insurance Legislators Foundation, legislators had discussed the possibility of funding a study to look at pharmaceutical marketing practices that would include DTC advertising.

PROPOSED RESOLUTION REGARDING DRUG IMPORTATION

Rep. Kennedy overviewed a proposed NCOIL *Resolution Encouraging Congress to Pass Legislation Providing Safe, Accessible, and Affordable Prescription Drugs*. He said that the resolution called on Congress to address the significant price disparity in the international trade of brand name prescription drugs by creating a safe and legitimate program for prescription drug reimportation, or by negotiating trade agreements with other industrialized nations.

Mr. Vanhook suggested that the Committee defer consideration of the resolution to the next meeting pending results of a federal drug importation safety report to be released by the Department of

Health and Human Services in December. He said that there was bipartisan concern about the safety of prescription drug importation. He said that there was the potential for prescription drug counterfeiting.

Dr. Wennar suggested that the Committee proceed with consideration of the resolution. She said that immediate action is being taken by the American consumer who only wants affordable medications and does not care about the legal implications of prescription drug importation. She said that individuals who reimport medications do not consider Canada to be a third-world country. She encouraged the Committee to petition Congress to establish a nonpartisan commission to look at the high cost of prescription drugs in the United States broadly by addressing:

- brand versus generic issues
- marketing and advertising globally and how it affects cost
- quality and safety issues having to do with chain of custody
- pharmaceutical benefit manufacturers
- importation as a possibility
- the future role of the FDA
- quality and oversight
- pharmacies and their position

George Keleman of the American Association of Retired Persons (AARP) said that AARP had supported bipartisan federal legislation sponsored by Senators Byron Dorgan (D-ND) and Olympia Snow (R-ME) because it contained language that would enforce penalties on companies that limited supplies to Canadian pharmacies reimporting medications to U.S. consumers. Mr. Keleman encouraged the Committee to include this language in the resolution.

Rep. Keiser said that NCOIL should be careful in making a decision and asked the Committee to defer action on the model resolution to the NCOIL Spring Meeting pending the findings of the federal drug safety report.

Upon a motion moved and seconded, the Committee voted unanimously to defer consideration of the NCOIL *Resolution Encouraging Congress to Pass Legislation Providing Safe, Accessible, and Affordable Prescription Drugs* until the 2005 NCOIL Spring Meeting.

PROPOSED DRUG RETAIL PRICE DISCLOSURE MODEL ACT

Ms. Liebich overviewed the proposed NCOIL *Drug Retail Price Disclosure Model Act* and said that the model would support the Committee's charge regarding cost-effective state approaches to affordable prescription drugs. She said the model was based on a New York law. She said the model would require drug retail pharmacies to disclose and post prices of the 150 most prescribed medications, update the list weekly, and offer generics where available for brand name drugs.

Diane Darvey of the National Association of Chain Drug Stores (NACDS) said that NACDS shared the Committee's charge to help the under-insured and uninsured afford prescription drugs. But, she said, NACDS had serious concerns about price disclosure lists because drug retail pharmacies do not control prices of prescription drugs. She said that prescription drugs go from the manufacturer to wholesalers and then to intervening suppliers. She said that net pharmacy profit is one to two percent. Depending on the

market, she said, prescription drug costs change too frequently. Ms. Darvey said that the NACDS would work with the Committee to find other ways to support its charge.

Rep. Kennedy recommended that the Committee defer consideration of the proposed model legislation to the next meeting to allow the sponsor of the model, Rep. Kathleen Keenan, to be present and to consider substitute language submitted by Del. Morgan. Del. Morgan said that he may not be able to attend the NCOIL Spring Meeting, but that he would submit comments and substitute language prior.

Upon a motion moved and seconded, the Committee voted unanimously to defer consideration of the model to the 2005 NCOIL Spring Meeting.

2005 COMMITTEE CHARGES

Ms. Liebich said the proposed 2005 Committee charges were to:

- Investigate state high risk insurance pools in order to develop a best practices report
- Support effective state approaches to rising costs of prescription drugs
- Report on and research the issue of the nation's growing uninsured population
- Work with the Property-Casualty Insurance Committee to establish a joint model act on issues regarding medical malpractice and patient safety
- Investigate and report on consumer-driven health insurance and issues with HSAs in order to take an NCOIL position
- Support the repeal/amendment of state statutes based on the NAIC Uniform Accident and Sickness Policy Provision Law (UPPL) and Robert Wood Johnson Foundation Study
- Review and renew opposition to Association Health Plans (AHPs) and communicate position to Congress

Upon a motion made and seconded, the Committee unanimously adopted the proposed 2005 Committee charges.

ADJOURNMENT

There being no further business, the Committee adjourned at 9:45 a.m.