

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH INSURANCE COMMITTEE
NEWPORT, RHODE ISLAND
JULY 8, 2005
DRAFT MINUTES

The Health Insurance Committee of the National Conference of Insurance Legislators (NCOIL) met at the Hotel Viking in Newport, Rhode Island, on Friday, July 8, 2005, at 8:00 a.m.

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

Other members of the Committee present were:

Rep. Ronald Crimm, KY	Assem. Nancy Calhoun, NY
Rep. Robert Damron, KY	Sen. William Larkin, Jr., NY
Rep. Susan Westrom, KY	Rep. George Keiser, ND
Rep. Ed Gaffney, MI	Sen. Harvey Tallackson, ND
Rep. Scott Hummel, MI	Rep. David Evans, OH
Rep. Leslie Mortimer, MI	Sen. Jake Corman, PA
Rep. David Robertson, MI	Rep. Robert Godshall, PA
Sen. Alan Sanborn, MI	Sen. Stewart Greenleaf, PA
Rep. Fulton Sheen, MI	Rep. Brian Kennedy, RI
Sen. Bob Dearing, MS	Del. Harvey Morgan, VA
Rep. Donald Flanders, NH	Rep. Virginia Milkey, VT
Sen. Carroll Leavell, NM	

Other legislators present were:

Rep. John Coghill, AK	Assem. William Barclay, NY
Sen. Joe Crisco, CT	Rep. Anthony Melio, PA
Rep. Steve Fontana, CT	Rep. Craig Eiland, TX
Rep. Shirley Bowler, LA	Rep. Gene Seaman, TX
Rep. Frank Wald, ND	

Also in attendance were:

Susan Nolan, Nolan Associates, NCOIL Executive Director
Candace Thorson, NCOIL Director of Legislative Affairs and Education,
Property-Casualty Insurance
Erik Olson, NCOIL Director of Legislative Affairs & Education,
Health, Life and Workers' Compensation Insurance

MINUTES

Upon a motion moved and seconded, the Committee voted unanimously to approve, as submitted, the minutes of its March 4, 2005, meeting in Hilton Head, South Carolina.

UPDATE ON PROPOSED PATIENT SAFETY MODEL ACT

Ms. Thorson summarized the current status of the proposed *Patient Safety Model Act* (working draft) since the Spring 2005 joint meeting of the Property-Casualty and Health Insurance Committees in Hilton Head, South Carolina. She noted that the working draft of the model act remained a live issue that would be taken up again at the 2005 Annual Meeting in San Diego.

INTERSTATE HEALTH INSURANCE SALES LEGISLATION

J.P. Wieski of the Council for Affordable Health Insurance (CAHI) expressed his organization's support for the Health Care Choice Act (H.R. 2355), sponsored by U.S. Rep. Shadegg of Arizona. Mr. Wieski said that CAHI supports Rep. Shadegg's bill because the regulatory environment in some states made health insurance all but unaffordable. He said Rep. Shadegg's bill would permit insurance companies to sell products across state lines and designate a "primary state" whose regulations would govern the policy.

In response to a question from Rep. Kennedy regarding practical effects of cross-border sales on state regulation, Mr. Wieski said that the policy must follow the mandates and requirements of the "primary state," meaning the "state where the policy is filed." He said that policies purchased in "secondary states," defined as any other state, would still follow the mandates and requirements of the primary state.

Mr. Wieski noted that the secondary state's regulations would apply in some circumstances. As examples, he listed claims settlement practices, protections for collecting premium taxes, financial disclosures, solvency protections, and licensed agent requirements. Addressing concerns of a resulting "rush to the bottom" in insurance regulation, Mr. Wieski asked the legislators to consider the uninsured in their deliberations: "Do we just leave them out in the cold?"

Mary Beth Senkewicz, Senior Counsel for Health Policy, National Association of Insurance Commissioners (NAIC), summarized the effects of the Shadegg bill as generally pre-empting secondary state law, although not on some issues. Ms. Senkewicz expressed concern with the potential for insurers to "cherry pick" the healthy among potential insureds. Under the Shadegg bill, Ms. Senkewicz observed, an insurer could choose a state with less regulation as its primary state and market its insurance products to healthier persons in states with higher levels of regulation. She concluded that, in the secondary state, this would "leave the sick out in the cold, by themselves," which has been a problem in the small group and individual markets for the last 15 years.

Ms. Senkewicz noted that the primary state regulator would retain jurisdiction to enforce its laws on a policy sold in a secondary state. Ms. Senkewicz observed that most state regulators face a lack of funding. She concluded that the insurance regulator of the primary state would most likely not have the resources to assist an insured from a different state. As an example, Ms. Senkewicz explained that the Wyoming Insurance Commission has only one person to address health insurance complaints. She noted that if Wyoming were to become a

popular state in which to file policies, the state insurance commission would not be able to handle the influx of complaints from insureds in secondary states.

Ms. Senkewicz disagreed with Mr. Wieski's assertion that secondary state law would continue to govern claims settlements. She noted that the secondary state would not have licensed the insurer. Under unfair claims settlement acts, Ms. Senkewicz continued, a state may only sanction an unlicensed insurer by stopping that insurer from selling insurance products. She characterized this situation as a conundrum, because the Shadegg bill would expressly permit the sale of health insurance products in states where the insurer is unlicensed. Therefore, Ms. Senkewicz concluded, secondary states would have difficulty enforcing their unfair claims settlement acts.

Ms. Senkewicz said that the secondary state's ability to collect premium taxes would be questionable because the secondary state would have to identify the insureds located in that state in order to collect premium taxes on a policy. Ms. Senkewicz acknowledged that the bill would require the insurer to file the same financial statement with the secondary state that it filed in the primary state. However, Ms. Senkewicz observed, those financial statements would only identify the premium taxes on policies issued in the primary state, not the geographic location of individual policyholders.

Rep. Sheen asked whether states with lower health insurance costs have benefited from increased competition. Ms. Senkewicz said that higher costs in some states result from policy decisions that favor the spreading of insurance risks among the most people, but observed that the Shadegg bill does not address those costs. Ms. Senkewicz added that the NAIC is investigating the possibility of greater uniformity and standardization among health insurance lines to make them easier to sell nationwide.

Rep. Keiser noted that he did not support the Shadegg proposal, and he questioned whether an appropriate solution to rising health care costs would result from uniform regulation. Ms. Senkewicz agreed that health insurance regulation reflects many local concerns and that the NAIC uniformity efforts were focusing on the timely approval of insurance products but not "blanket uniform products." She noted that health insurance is only one factor in rising health care costs and that a solution would have to address more than health insurance regulation.

Rep. Crimm expressed concern that the federal government would override state authority in insurance regulation and impose its own solution. He then noted the practical problem that states would face in federal solutions, namely, the transfer of premium tax dollars to the federal government from the states.

In response to a question from Rep. Seaman regarding the Shadegg bill's impact on state high risk pools, Ms. Senkewicz said that high risk pools often receive their funds from assessments based on the number of insureds in the state. Ms. Senkewicz said that states would have difficulty in figuring out an insurance company's share of the high risk pool fund, because the secondary state would not be able to determine from the insurer's financial statements how many residents were insured.

FEDERAL AHP AND RELATED LEGISLATION

Krista Donahue from the Office of U.S. Sen. Richard Durbin of Illinois observed that pending health insurance bills in Washington focus on preempting state insurance regulatory mandates to control health care costs. She stated that Sen. Durbin's bill (S. 637) mimics the federal employees benefit plan and would permit small businesses to pool their risk. Ms. Donahue acknowledged that the bill's proposed national plans would preempt state benefit mandates and rating rules. For plans located in a single state, she noted that the bill would not preempt state law on benefit mandates, state licensing requirements, network adequacy laws, or claims settlement statutes. Ms. Donahue said that the bill follows the NAIC adjusted community rating model and permits rating by geography, age, and family composition.

Rep. Kennedy asked whether insurers would want to use the program. Ms. Donahue expressed the belief that the bill would create an attractive market for large insurers. She noted that the bill would apply to employed persons and contains provisions for tax breaks and a reinsurance scheme for high risk insureds.

Rep. Kennedy commented that the Rhode Island Department of Health sets guidelines for health insurance providers as to the required size of the proposed network that often function as market barriers for smaller carriers. He asked whether the bill would trump state law for such guidelines. Ms. Donahue answered that these state laws would not govern insurers operating as a national plan under the bill.

Rep. Milkey observed that the plan seems to attempt to reduce costs by removing state benefit mandates. She further noted that even where health insurance does not include necessary care, persons still get that care, but someone else pays for it. Rep. Milkey commented that this may reduce the cost of purchasing insurance, but it does not affect the cost of health care. She noted that health care costs may even increase through cost shifts. Ms. Donahue acknowledged that the bill does not seek to reduce underlying health care costs. Instead, she noted, the bill would permit smaller businesses to spread their insurance risks through pooling.

David Korsh of Blue Cross/Blue Shield thanked NCOIL for its opposition to Congressional legislation involving Association Health Plans (AHPs). He said that he did not want to directly comment on the Durbin bill but did want to speak about AHPs generally. Mr. Korsh noted Blue Cross/Blue Shield's concern about the potential effects of AHPs on the health insurance market. He identified these effects as higher premiums, more uninsured persons, and an increased potential for fraud and abuse. He also directed the legislators' attention to an upcoming report on the increased potential for fraud and abuse with AHPs through the "regulatory vacuum they might create," written by Professor Mila Kofman of Georgetown University.

HEALTH INSURANCE REIMBURSEMENT TRANSPARENCY ISSUES

Dr. Jim Rohack of the American Medical Association (AMA) said that many physicians have problems with reimbursement because of

- a bargaining power disparity between physicians and health plan payers
- a lack of transparency in reimbursement by insurance payers

- an unregulated secondary market in leasing discounted payment rates to payers

Dr. Rohack explained the bargaining power disparity between physicians and payers. He described how a health insurer with a large market share may have a “take it or leave it attitude with a physician or a hospital” regarding network participation. Doctors face restrictions by payers on out-of-network physicians, continued Dr. Rohack, which provides a negative incentive for doctors to question proposed reimbursement contracts with them. Dr. Rohack noted that if a doctor does not sign the reimbursement contract, the fear is that the physician will be considered out-of-network and lose business from patients within that payer network.

Dr. Rohack said that antitrust laws exacerbate reimbursement problems. He noted that antitrust laws prohibit physicians from sharing their payer rate information with each other and from acting collectively to address payment-related issues. According to Dr. Rohack, this aggravates problems in states with insufficient regulatory oversight of payer activities.

Regarding a lack of transparency in reimbursement, Dr. Rohack explained that when a payer reimburses a physician, the physician does not know which procedure is being reimbursed. As an example, Dr. Rohack mentioned a situation where a doctor sees a patient for one service but determines a need for a second, unrelated service that day. He said the physician would report this second service through a modifier on the reimbursement forms. The problem, noted Dr. Rohack, lies in the fact that neither the patient nor the physician can determine what procedures the insurer had reimbursed because some insurers ignore these modifiers.

Rep. Eiland noted a practical problem that patients face, where a physician will schedule three visits for three procedures on three consecutive dates to ensure that the physician will be able to track whether the payer has provided reimbursement for all three procedures. He identified this situation as part of the inequities of the system.

Dr. Rohack also identified an expanding and unregulated secondary market as a problem for the medical profession. Dr. Rohack noted that the secondary market contains repricers and rental network PPOs that lease discounted payment rates to payers. He said that patients do not know whether their health insurance provider uses a repricer. Dr. Rohack observed that the patient might end up paying the difference between the discounted payment rate and the standard reimbursement rate.

Dr. Rohack stated that the AMA would like to work with NCOIL to help create model standards to promote transparency, to create fairness in contracting with the payers, to stress the importance of prompt payment, and to regulate the secondary discount market.

Rep. Young asked if Health Savings Accounts (HSAs) might help with the problem. Dr. Rohack answered that this might be true until the HSA funds had been used and the patient turned to the secondary insurer.

UPDATE ON MEDICARE ISSUES

Ms. Senkewicz of the National Association of Insurance Commissioners (NAIC) reported that Medicare Part D, the Medicare prescription drug benefits plan (PDP), would not come into effect until January 1, 2006. In terms of its effects on the states, Ms. Senkewicz said, the *Medicare Modernization Act* preempts all state laws with respect to prescription drug plans except for licensing and solvency. She identified licensed health insurers as the primary sellers of prescription drug plans. Although state solvency requirements would apply to licensed health insurers, Ms. Senkewicz said the Centers for Medicare & Medicaid Services (CMS) permits waivers to state requirements. She said that the most important of these waivers are for insurers operating in states with solvency standards different from those developed by CMS. Ms. Senkewicz stressed that states permitting limited health insurance licenses have lower solvency standards than those that do not permit them. She noted that some states are looking at enacting legislation similar to limited health insurance licenses for PDPs so that their solvency requirements would coincide with the CMS requirements. For those states that only permit a full license, Ms. Senkewicz concluded, the solvency standards are probably higher than the CMS requirements, meaning that grounds exist for a waiver.

OTHER BUSINESS

Rep. Sheen presented a proposal for an expedited process of drug patent approval so that patients would have access to life-saving drugs before the final approval of the FDA. Several legislators expressed concern with the proposal.

Sen. Crisco asked whether the Health Insurance Committee could address the problem of health insurance accessibility and availability for the uninsured.

ADJOURNMENT

There being no further business, the Committee adjourned at 9:15 a.m.