

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
WASHINGTON, DC
FEBRUARY 27, 2009
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Hyatt Regency on Capitol Hill in Washington, DC, on Friday, February 27, 2009, at 10:15 a.m.

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

Other members of the Committee present were:

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| Rep. Kurt Olson, AK | Sen. Keith Faber, OH |
| Sen. Ralph Hudgens, GA | Sen. Jake Corman, PA |
| Sen. William Haine, IL | Rep. Brian Kennedy, RI |
| Rep. Ronald Crimm, KY | Sen. David Thomas, SC |
| Rep. Susan Westrom, KY | Rep. Hubert VO, TX |
| Assem. William Barclay, NY | Sen. Mike Hall, WV |
| Sen. William Larkin, Jr., NY | Sen. Joseph Minard, WV |
| Assem. Joseph Morelle, NY | |

Other legislators present were:

Rep. Charles Kleckley, LA
Sen. Neil Breslin, NY
Sen. John Sparks, OK
Rep. Charles Curtiss, TN

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 November 19 and November 21, 2008, meetings in Duck Key, Florida.

SCHIP REAUTHORIZATION

Megan Mamarella of the National Association of Health Underwriters (NAHU) reviewed the *Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009*. She said the law was signed by President Barack Obama on February 4, 2009, and that it sought to increase health insurance coverage for an additional 4.1 million children in low-income families. She said the reauthorization increased funding by \$32.8 billion and expanded the matching state-federal income eligibility levels from 200 to 300 percent of the federal poverty level. She said the new law also made funding available for states to streamline registration and increase enrollment among eligible populations. She said the program was

reauthorized until 2013 and would be financed through a 62 cent per pack federal tobacco tax increase.

MEDICARE ADVANTAGE PLANS/MEDIGAP MODEL CHANGES

Brian Webb, on behalf of the National Association of Insurance Commissioners (NAIC), discussed likely changes to Medicare Advantage Plans (MAPs) under the new Administration. He reminded Committee members that the *Medicare Improvements for Patients and Providers Act (MIPPA)* made several changes to federal MAP regulations in July 2008, including increased penalties and stricter marketing standards.

Mr. Webb said the new Administration would likely build on these 2008 changes in the 111th Congress by lowering federal MAP subsidies and further increasing marketing standards. He said the NAIC believed state insurance regulators, however, were best positioned to regulate the marketplace for MAPs and prescription drug plans. He said the Commissioners would push for state regulation of MAP plans.

Mr. Webb also reminded Committee members that states had to amend their Medigap laws and regulations to reflect changes in the *Genetic Information Nondiscrimination Act (GINA)* and MIPPA by July 1, 2009, and September 24, 2009, respectively. He said the NAIC had revised its model regulations in 2008 to comply with the federal laws and urged legislators to work with their insurance departments to implement these model changes.

STIMULUS PACKAGE HEALTH PROVISIONS

David Korsh with the Blue Cross Blue Shield Association reviewed the recently enacted *American Recovery and Reinvestment Act of 2009 (ARRA)*. He said the new law, which had been popularly dubbed “the stimulus package” by the media and Congress, contained a number of health-related provisions that are important to state lawmakers. He said that, among other things, the ARRA:

- included a temporary 65 percent subsidy for employer-sponsored COBRA coverage
- provided for subsidized COBRA coverage to laid-off workers for up to nine months
- provided nearly \$87 billion in matching federal funds for state Medicaid and CHIP programs
- made available \$2 billion for health information technology advancement
- made available \$1.1 billion for comparative effectiveness research

HEALTH INSURER RESCISSIONS

Cheryl Fish-Parcham with Families USA said improper health insurance rescission was a growing problem. She cited several cases where a consumer had his/her policy cancelled after filing an expensive medical claim. She said individual insurance contracts allow insurers to deny coverage or revoke a policy in cases of fraud or intentional misrepresentation. She said, however, that recent findings in several states demonstrated a need for stronger consumer protections.

Ms. Fish-Parcham said state lawmakers could protect consumers from improper rescissions by, among other things:

- requiring insurers to complete medical underwriting and resolve any questions at the time of application
- prohibiting insurers from limiting or revoking coverage after policies are issued unless the consumer demonstrates willful intent to deceive
- requiring independent third-party reviews before a policy can be cancelled

Rick Ramsay of America's Health Insurance Plans (AHIP) said insurance companies were proactively trying to address these problems by developing an independent third-party review process for consumers. He said that it was important for consumers and companies to look at the issues carefully and allow for all disputes and issues to be heard.

Mr. Webb said the NAIC Health Insurance and Managed Care (B) Committee had sent a survey out to individual state insurance departments to gather information on their rescission laws and related market conduct data. He said the Committee was working with AHIP and consumers to develop a third-party review model.

Kevin Wrege with the Council for Affordable Health Insurance (CAHI) said the media's coverage of alleged improper rescissions made the practice seem more severe and widespread than it actually was. He said roughly one percent of individual insurance policies were reviewed by insurance companies for fraud and misrepresentation, and even fewer of those policies were actually rescinded. He said federal privacy laws prevented companies from commenting on any of the cases, so the public was exposed to only one perspective on the issue.

Mr. Wrege said CAHI supported a thorough internal company review process for every claim under consideration for rescission. He said that patients should also have access to independent external reviews before a policy could be revoked. He agreed with Mr. Ramsay and Ms. Fish-Parcham that consumers should have access to an independent and external review process where a third party can take an unbiased look at a consumer's case and make a decision. He said AHIP and the American Legislative Exchange Council (ALEC) had both developed third-party review models. He urged the Committee to look at the models at future meetings.

Rep. Curtiss said third-party reviews were the best way to solve this problem for consumers. Sen. Cummings asked staff to bring forward the various model bills at the Summer Meeting for the Committee to examine in further detail.

RETAIL CLINICS & ACCESS TO HEALTHCARE

Caroline Ridgway with the Convenient Care Association (CCA) discussed the growing number of healthcare clinics located in retail-based settings. She said convenient care clinics were small healthcare facilities in retail settings like Walgreens, Walmart, and CVS. She said the clinics had become popular because they provided transparent pricing, a flexible schedule, and increased access to routine medical treatment. She said the clinics were primarily staffed by board-certified nurse practitioners or physician assistants who adhered to evidence-based guidelines and third-party certified quality and safety standards. She noted

that most of the clinic's customers were between the ages of 18 and 44, lacked a primary care provider, and were enrolled in consumer-directed health plans or health savings accounts.

In response to a question from Sen. Hudgens, Ms. Ridgway said retail clinics provided care for routine medical problems that required consultation but not an extensive visit to a doctor or emergency room. She said that clinics commonly treated colds, flu symptoms, pinkeye, and sunburns, among other things. She said that services usually cost patients between \$40 and \$70 dollars, and that most insurance plans were accepted.

Ms. Ridgway said Blue Cross Blue Shield of Minnesota had recently waived co-pays for its insured patients for routine services at clinics instead of at normal healthcare settings. She said the insurance company cited cost savings and consumer demand as reasoning for the incentive. Ms. Fish-Parcham said if insurers decide to waive patient co-pays in retail clinics, than similar incentives should also be offered in other primary care settings.

In response to a question from Sen. Breslin regarding hospital and other healthcare provider perspectives on the clinics, Ms. Ridgway said most hospitals and healthcare providers had been supportive. She said hospitals and emergency rooms recognized the role clinics could play in helping to reduce burdens in their settings, while some primary care physicians felt there was a mutually beneficial relationship that could be created through referrals.

Kai Sternstein with the American Medical Association (AMA) discussed several concerns the medical provider community had with retail clinics, including physician-patient relationships, physician extenders, continuity of care, and scope of practice issues. She also reviewed the AMA's nine guiding principles for retail clinics and discussed several state initiatives related to retail clinics.

After a series of questions and answers from interested parties and legislators, Committee members asked to receive future reports on retail clinics and their role in healthcare reform discussions.

BALANCE BILLING INITIATIVES

Ms. Fish-Parcham said that consumers struggled with balance billing problems in a number of ways. She said emergency room patients were often unknowingly treated by providers outside of their health plan's insurance network and billed for services beyond a co-payment or deductible.

Ms. Fish-Parcham said consumers' financial responsibilities are also not clear when they seek treatment at in-network facilities but are later assigned to ancillary providers, such as anesthesiologists, or when they are assigned to a subcontracted wing of the hospital not in their insurance network.

Ms. Fish-Parcham also said that, in some cases, healthcare facilities will ask patients, such as Medicaid beneficiaries, to sign financial responsibility statements before they are admitted, even when they have no legal responsibility for a bill. She said that it should be illegal for a health facility to require Medicaid patients to sign such forms.

Ms. Fish-Parcham briefly reviewed various state initiatives regarding balance billing and described different approaches that NCOIL could take to address the problem. She said that, among other things, balance billing should be banned in emergency settings and in situations where a patient has no discretion. She said consumers should be held harmless whenever payment rates are disputed between providers and hospitals, and that hospitals and other facilities should be required to inform patients when the hospital assigns providers not in the same insurance network.

Ms. Fish-Parcham said lawmakers could also mandate that hospitals require all subcontracting facilities and nondiscretionary service providers to be in their insurance networks. She said, alternatively, insurers could be required to contract with all providers of nondiscretionary services in a healthcare facility.

Louisiana Insurance Commissioner James Donelon discussed his efforts to address balance billing issues in his state. He agreed with Ms. Fish-Parcham and said that consumers shouldn't be asked to pay unreasonable or unexpected portions of their medical bills. He said insured consumers who had done the right thing by maintaining coverage should not be hit with medical bills they don't anticipate or be put in situations they can't control.

Commissioner Donelon said he had introduced legislation in 2008 to prohibit balance billing in all emergency room settings. He said his bill would also mandate insurance coverage of all reasonably anticipated services by ancillary providers, such as anesthesiologists, pathologists, and radiologists. He said the mandate would protect consumers by forcing hospitals and insurers to negotiate and guarantee contracts among inter-hospital providers.

Dr. Robert Wah with the AMA discussed the managed care model and the different payment methodologies for in-network and out-of-network providers. He said the term "balance billing" didn't accurately characterize the Committee's discussion because it encompassed a number of other, and what he felt were much larger, issues. He said the insurance industry's out-of-network reimbursement system was fundamentally flawed. He referenced a recent probe by the New York State Attorney General that found that insurance companies underpaid out-of-network providers. He said these inadequate reimbursements resulted in consumers paying a greater percentage of their healthcare bills than agreed upon in contract.

Dr. Wah echoed the statements of Commissioner Donelon and Ms. Fish-Parcham, agreeing that more could be done to promote transparency in situations where a patient believes he/she is in network but later receives a bill for out-of-network treatment. He said a lack of transparency was the primary reason patients received unexpected out-of-network bills and that it was important for consumers to be aware of their financial responsibilities. He said insurance companies had created a complex out-of-network system that he believed benefited insurers at the expense of consumers. He said any solution to the balance billing problem should require clear insurer disclosures of the scope and limitations of any out-of-network benefit they will provide. He said the disclosures must be meaningful and understandable to the average consumer.

Mr. Ramsay of AHIP said that insurance companies fundamentally disagreed with Dr. Wah's positions on network adequacy laws and on what usual and customary out-of-network reimbursement rates should be. He said that due to time constraints, however, he would defer those comments until the next meeting to have a more in-depth discussion about the issues.

Mr. Ramsay said in-network balance billing was banned in all fifty states. He said the issues discussed by the various speakers were centered on transparency for consumers in out-of-network situations. He suggested that any future NCOIL discussion should feature all interested parties, including providers, patients, insurers, and hospitals. He said that AHIP believed that consumers should have access to transparent information necessary to make their own healthcare decisions. He said that AHIP stood ready to work with NCOIL and interested parties in creating meaningful transparency legislation.

Dr. Michael Gerardi with the American College of Emergency Physicians (ACEP) also discussed balance billing and its impact on patient access to emergency medical care. He said emergency care providers worked under different rules, regulations, and philosophies than other healthcare providers and it was important to recognize these differences as part of the broader discussion and any subsequent NCOIL model legislation.

Dr. Gerardi said that the federal *Emergency Medical Treatment & Labor Act (EMTALA)* required emergency room physicians to treat every patient without regard to their insurance status or ability to pay. He said any prohibition on balance billing, especially in emergency room settings, would be a huge benefit to insurers and give them rate-setting authority over emergency physicians.

After brief Committee discussion, Sen. Cummings directed NCOIL staff to schedule a hearing for the Summer Meeting to further discuss balance billing problems and an NCOIL solution.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:45 a.m.