NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
BOSTON, MASSACHUSETTS
JULY 10, 2010
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Park Plaza Hotel & Towers in Boston, Massachusetts, on Saturday, July 10, 2010, at 8:00 a.m.

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

Other members of the Committee present were:

Sen. Ralph Hudgens, GA
Sen. Vi Simpson, IN
Sen. Ruth Teichman, KS
Rep. Ron Crimm, KY
Rep. Robert Damron, KY
Rep. Susan Westrom, KY
Rep. Barb Byrum, MI
Rep. Marc Corriveau, MI
Rep. George Keiser, ND
Rep. Don Flanders, NH
Sen. Carroll Leavell, NM
Assem. Nancy Calhoun, NY
Sen. William J. Larkin, Jr., NY
Sen. James Seward, NY
Sen. Keith Faber, OH
Sen. Jake Corman, PA
Rep. Brian Kennedy, RI
Rep. Charles Curtiss, TN

Other legislators present were:

Rep. Steven Riggs, KY
Sen. William Haine, IL
Sen. Travis Holdman, IN
Sen. Jerry Klein, ND
Sen. Dave Thomas, SC
Rep. Craig Eiland, TX
Sen. Mike Hall, WV

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 March 6, 2010, meeting in Isles of Palms, South Carolina.

FEE SCHEDULES FOR UNCOVERED DENTAL SERVICES

Mr. Estey reported to the Committee on a proposed *Model Act Concerning Fee Schedules for Uncovered Dental Services,* which he said was introduced in November 2009 and based on a first-of-its-kind Rhode Island law. He said the model would prohibit dental insurers from requiring dentists to accept mandated reimbursements for things not covered under a dentist-insurer contract.

Mr. Estey said that, in an attempt to address legislator concerns from the Spring Meeting, Rep. Kennedy had approved and brought forward a substitute amendment that used alternative language from newly enacted Virginia and Washington laws and a pending California bill. Rep. Kennedy noted that 15 states had passed similar laws since 2009 and that a new "covered services" definition from either California or Virginia alternatives would address concerns regarding potentially higher prices for services that would be otherwise covered but for annual maximums.

Representatives of dental insurers and plans who opposed the model included Rick Ramsay with America's Health Insurance Plans (AHIP), Rick Lantz with Delta Dental of Michigan, Michael Hickey of MetLife, and Kris Hathaway with the National Association of Dental Plans (NADP). In opening statements, they made the following points, among others:

- Mr. Ramsay called the model "anti-consumer," said that it would hamper employers' ability to determine employee benefits, and add costs and administrative burdens for dentists.
- Mr. Hickey said that MetLife had used these types of contract provisions for over a decade and that, if passage was imminent, legislators should ensure uniformity across states to ease compliance costs and burdens for large employers.
- Mr. Lantz said that the model was soundly defeated in several states; that its passage would raise prices for consumers, and that dentists could freely choose not to contract with a dental plan if they don't like terms.

In response, Dr. Stephen Ura of the American Dental Association (ADA) and Patrick Quinlan of the Rhode Island Dental Association said that, among other things:

- the ADA preferred the original Rhode Island language, but thanked the Committee for its efforts to develop model legislation that would be favorable to the status quo
- dentists have no bargaining power with insurers in contract negotiations because of anti-trust laws
- the issue being debated was a new, not a long-standing, insurer/plan practice
- if legislators didn't act, long-standing relationships between dentists and patients would be ruined
- as well as 15 other states that had passed new laws, New York had declared the practice illegal

The Committee then reviewed the two state alternative definitions of covered services. Upon a motion made by Rep. Curtiss and seconded, and after brief discussion, the Committee voted unanimously to include California language, which would define covered services as "any service that is or would be reimbursable under contract if not for application of certain limitations such as deductibles, copayments, coinsurance, and annual or lifetime maximums," among other contract terms.

The Committee discussed substitute language in Section 3(A) taken from a new Washington State law, which would ban dental plan contractors/insurers from requiring fee schedules in contracts for any uncovered services.

The dental insurer/plan representatives in opposition to the model made the following arguments, among others

- Proposed fee schedules would only impact dentists that willfully sign a contract to participate in a plan's network and that dentists could freely choose not to do so.
- The model would force dental plans away from one universal contract for employers into more nuanced decisions about coverage and benefits.
- Non-participating dentists could still see Delta Dental and other plan enrollees.

Dr. Ura and Mr. Quinlan supported the model and made the following arguments, among others

- This was an issue of unfair competition and that government had precedent—often in utilities and insurance law—to step into contract matters.
- It would be "financial suicide" for a participating dentist to leave a dental network.
- It would increase costs for those without dental insurance, including many senior citizens.
- Plans, because of their bargaining power, frequently change contract terms, effectively dictating prices and the provision of services.
- Non-participating dentists are disadvantaged and struggle with assignment of benefit payments from insurers, among other things.

Notable legislator comments included, among others, the following

- Sen. Leavell, Sen. Corman, and Rep. Corriveau all commented that legislatures shouldn't be involved in private contract matters.
- Sen. Cummings commented on insurer/dental plan market share, noting that dentists could be forced to join a network or risk losing their practice.
- Rep. Byrum said that many dentists in her district don't contract with the large networks but are doing well financially, and urged the Committee to look more closely at price and benefits impacts.
- Rep. Milkey said that this was a state-by-state issue and that an NCOIL model bill wasn't necessary.
- Sen. Seward said the Committee should hear from employers and labor unions before any final action is taken.

Upon a motion made and seconded, the Committee resolved to hear from business and labor representatives at the November 2010 Annual Meeting in Austin, Texas.

BALANCE BILLING DISCLOSURE MODEL ACT

Mr. Estey updated legislators on the Committee's efforts since November 2009 to develop a proposed *Healthcare Balance Billing Disclosure Model Act.* He said the model was based on a 2007 Texas law and would require disclosure from hospitals and healthcare facilities, facility-based providers, and health insurers about bills from non-participating providers that may treat insured patients at in-network hospitals.

Mr. Estey said that a Subcommittee on Healthcare Balance Billing had been formed in January and held two conference calls to consider interested party comments and make changes prior to the March Spring Meeting in Charleston, South Carolina. He said the full Committee approved those changes in March, which exempted emergency care from the model's scope, among other things. He said the Subcommittee had continued a review of the model during two conference calls in June, and had recommended several changes that were reflected in the draft model up for Committee consideration.

The Committee then reviewed Subcommittee-approved revisions to Section 6 and 7 dealing with facility-based provider and health benefit plan disclosure requirements. The Committee voted unanimously

- to add language to Section 6(A) on facility-based provider disclosures to further clarify that balance bills sent to consumers are for things "not covered under the insurance plan and that are not related to co-pays, coinsurance, or deductibles"
- to revise Section 6(A)(6) and give patients 30 days after receiving a final billing statement or six months after receipt of medical treatment to finalize a payment plan for bills over $200, whichever occurs first
- to revise Section 6(B), regarding payment plan compliance, to give patients a 45-day—instead of a proposed 90-day—window before they're considered "out of compliance" with a payment plan
- to strike Section 6(C) that would have allowed for a consumer mediation process for balance bills over $1,000 and to add a drafting note in its place
- to change Section 7(C) to require health plans to identify all healthcare providers within the provider network
- to revise Section 7(E) to allow for written or electronic correspondence disclosures

The Committee also voted unanimously to revise Section 5(A)(1)(b) dealing with healthcare facility disclosure of facility-based provider status. During the Isles of Palms Spring Meeting, the Committee had voted to require facility disclosure, if applicable, that a facility-based provider scheduled to provide services to a consumer is not a participating provider with the same insurer as the facility.

Among other concerns, several legislators and interested parties felt that hospitals and other healthcare facilities can't determine which providers or provider group will provide services at any given date and time because of emergencies and other scheduling conflicts. The Committee voted to revise this subsection to require healthcare facility disclosure to consumers that a facility-based provider may not participate with the same insurers as the hospital, and that the consumer could be balance billed.

The Committee also voted to strike from the model Section 7(F), which would have required health plan estimates to consumers, with an understanding that estimate language be revisited and be applicable to healthcare facilities and facility-based providers as well.

Upon a motion made and seconded, the Committee voted to continue interim Subcommittee conference calls prior to the Austin Annual Meeting.

ADJOURNMENT

There being no other business, the Health, Long-Term Care & Health Retirement Issues Committee adjourned at 10:00 a.m.

k:/ncoil/2010documents/2006998a.doc