NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES COMMITTEE
SAN FRANCISCO, CALIFORNIA
NOVEMBER 20, 2014
MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Grand Hyatt in San Francisco, California, on Thursday, November 20, 2014, at 2:30 p.m.

Rep. Pete Lund of Michigan, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Kurt Olson, AK	Sen. Jerry Klein, ND
Sen. Jason Rapert, AR	Sen. David O'Connell, ND
Sen. Travis Holdman, IN	Rep. Don Flanders, NH
Rep. Peggy Mayfield, IN	Sen. Carroll Leavell, NM
Rep. Joseph Fischer, KY	Assem. Kevin Cahill, NY
Sen. Ronnie Johns, LA	Rep. Bob Hackett, OH
Sen. Dan "Blade" Morrish, LA	Rep. Marguerite Quinn, PA
Rep. Ken Goike, MI	Rep. Brian Kennedy, RI
Rep. Don Gosen, MO	Rep. Bill Botzow, VT
Rep. George Keiser, ND	Rep. Sarah Copeland Hanzas, VT

Other legislators present were:

Sen. Matt McCoy, IA	Rep. Heather Bishoff, OH
Rep. Janis Cooper, ME	Rep. Mike Henne, OH
Rep. Anthony Forlini, MI	Sen. John Sparks, OK
Rep. Matt Lori, MI	Sen. Ronnie Cromer, SC
Rep. Joe Atkins, MN	Rep. Mike Gambrell, SC
Sen. Michael Parson, MO	Sen. Robert Hayes, SC
Sen. John Horhn, MS	Rep. Poncho Nevarez, TX
Assem. Craig Coughlin, NJ	Rep. Sarah Copeland Hanzon, VT
Sen. Joe Hardy, NV	Rep. Willem Jewett, VT
Sen. Kevin Bacon, OH	Rep. Kathie Keenan, VT

Also in attendance were:
Susan Nolan, Nolan Associates, NCOIL Executive Director
Candace Thorson, Nolan Associates, NCOIL Deputy Executive Director
Molly Dillman, Nolan Associates, NCOIL Director of Legislative Affairs
Andrew Williamson, Nolan Associates, NCOIL Director of Legislative Affairs

MINUTES
Upon a motion made and seconded, the Committee unanimously approved the minutes of its July 12, 2014, meeting in Boston.

HEALTH EXCHANGE NAVIGATORS

In the absence of a representative of the National Association of Insurance Commissioners (NAIC), discussion of this item was deferred until the next meeting.

OBESITY, CHRONIC ILLNESS, AND STATE HEALTHCARE COSTS

Dr. Ken Thorpe of the Partnership to Fight Chronic Disease reported on the role that obesity plays in chronic illness and rising healthcare costs at the state level. He asserted that obesity has a direct impact on rising healthcare costs for Medicare, Medicaid, and private insurance. He noted that an overwhelming amount of spending in healthcare is due to chronic illness, and that rising rates of obesity equate to rising rates of spending for chronic diseases. Dr. Thorpe said that approximately 83 percent of healthcare expenditures, or $3 trillion relate to chronic disease care.

Dr. Thorpe noted that there is a direct correlation between obesity and diabetes, hypertension and other related conditions. He stated that some 28 percent of seniors are diabetic and that over 50 percent are pre-diabetic.

Dr. Thorpe said that this situation presents major challenges, as the obese patient spends more on healthcare than a patient of normal weight, and the year-to-year growth of costs for an obese patient (some 1.5 percent) versus a normal weight patient is cumulative and thus mounts up dramatically over time.

Dr. Thorpe asserted that medical costs are just one aspect of the problem, as there is also a financial impact on employers. He stated that for every dollar spent on medical care, approximately four dollars in productivity are lost, amounting to $2 trillion in total. He also noted that obese adults incur approximately $2,700 more in medical costs than a person of normal weight, and this adds some 21 percent in costs to the normal healthcare bill. Dr. Thorpe stated that obesity leads to multiple chronic diseases across a broad spectrum of conditions, posing complex treatment issues. He noted that some 78 percent of Medicare spending is for patients with five or more chronic conditions.

Dr. Thorpe noted that as a nation, through the Affordable Care Act, America has expanded the number of people receiving healthcare coverage, which is positive, but this step alone has not changed the manner in which care is provided. He observed that a treatment plan is usually formulated after diagnosis of the condition rather than before. He used Medicare paying for amputation of a diabetic patient's leg or treatment of blindness as an example, and noted that a similar approach is taken by most private plans. He stated, however, that this does not get to early prevention of the condition.

Dr. Thorpe noted possible options to be developed at the state level, which would emphasize prevention or earlier detection of disease. He said that such options could include expanding the weight loss medications that are covered under plans to give clinicians a broader range of treatment options. Dr. Thorpe also urged that there be more team-based approaches developed in the primary care network at the state level to facilitate the discovery, treatment, and follow-up for patients to ensure success. He referenced programs being utilized in Vermont, Minnesota, and North Carolina that were proving effective.

After the conclusion of Dr. Thorpe's presentation, a motion was offered to waive the 30-day deadline for the introduction of resolutions. The motion was approved on voice vote.

A resolution was then offered to encourage states to emphasize wellness programs and essential health benefits; implement disease management, Medicaid and other state-run programs; and to encourage state exchanges to embrace prevention plans. During Committee discussion, concerns were expressed regarding cost issues for the states as well as coverage issues relating to chronic diseases. The resolution failed to pass on roll call vote. Mr. Lund observed that most members seemed in agreement on the concept, but many were concerned over the mandate issue. He indicated that these issues could be resolved and the matter considered again at the next meeting.

STATE ACTION ON TELEMEDICINE

Kristin Schleiter of the American Medical Association (AMA) stated that telemedicine has grown rapidly and is expected to continue developing to keep pace with improvements in the telecommunications field. She said that the AMA wants to ensure that telemedicine protects both patients and outcomes.

Ms. Schleiter stated that the AMA supports state-based licensure to protect patients by having physicians being licensed in the state where the patient receives telemedical care. She noted that issues regarding standards of care, malpractice, and related lawsuits, together with conflicts of law, can arise when a physician is not licensed in the state where services have been provided. She said that the AMA is in favor of simplification of the licensure process and will work with state medical associations to enact laws that will be based on the AMA model.

Ms. Schleiter then noted that the AMA is also focused on reimbursement for telemedicine, indicating that the biggest barrier to the adoption of telemedicine is a lack of reimbursement. She asserted that 40 percent of healthcare executives reported this as a problem, a view shared by physicians and state medical associations. Ms. Schleiter said that 20 states and the District of Columbia have adopted laws providing for reimbursement for telemedicine. She also stated that most states allow for reimbursement of telemedicine under Medicaid. She reported that Virginia regulates telemedicine offered by private insurance plans and that the AMA is using this legislation as a model in working with other state medical associations to have similar legislation adopted to ensure reimbursement to physicians practicing telemedicine.

She advised that the AMA is also concerned with patient safety and consumer protection, noting that the trust between physician and patient is a key factor. She explained that some important questions with regard to the doctor/patient relationship are present in connection with telemedicine, such as when face-to-face meetings between patient and doctor become necessary; the point at which doctor/patient relationship established; the prescribing of drugs, particularly controlled substances; maintenance of records; and issues of potential fraud and abuse. She indicated that since telemedicine constitutes medical practice, normal medical practice guidelines apply, such as obtaining a patient history, directing lab tests, and doing a physical exam, when warranted.

Ms. Schleiter stated that the AMA is working with national specialist associations and state medical societies in order to establish standards for practices that will ensure protection of patients and proper patient care, such as compliance with state and federal regulations

governing medical records, informed consent by patients, and protection of patient privacy. She noted that the AMA was not seeking to create undue burdens in this regard but wanted to ensure sound medical practice for the sake of both doctor and patient.

In respond to a question from Rep. Lund, Ms. Schleiter stated that a physician did not need to be located in the state where treatment of the patient occurred so long as he or she was licensed in that state. As a follow-up, Rep. Lund inquired about malpractice issues in such situations. Ms. Schleiter responded that the AMA was studying this area but noted that doctors should ensure that they are covered by their malpractice policy in states where telemedicine is practiced by them. Rep. Keiser questioned whether licensure would be required in all instances of telemedicine, citing the sometimes unique situation of radiologists. Ms. Schleiter stated that there can be different requirements for unique situations and that it was possible for states to pursue other options in appropriate circumstances.

IMPACTS OF DISABILITY INSURANCE ON STATE BUDGETS

Dianne Bricker of America's Health Insurance Plans (AHIP) stated that their members offer a broad range of insurance in the health insurance marketplace. She said that AHIP members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored health coverage, individual and small group markets, and public programs such as Medicare and Medicaid.

Referencing information presented at the last meeting in Boston, Ms. Bricker said there is one disabled worker for every 16 employed workers, and, in some counties, the number is one in four. She reported that the growth in disability is much faster than the growth in the economy. She observed that payments by Social Security Disability Insurance (SSDI) were $92 billion in 2006, but seven years later, in 2013, that number had risen to $140 billion. She stated that for the U.S. economy such increases are unsustainable.

Ms. Bricker said that to supplement the data from the earlier meeting, she was now providing information to illustrate how private group disability protection has reduced the drain that disability has made on the federal budget. She also noted that a similar report will be presented in the future to show the impact that disability coverage has had on specific state budgets.

Ms. Bricker stated that last year AHIP asked the economists at Charles River Associates to examine whether, and to what degree, private disability insurance and associated return-to-work programs provided cost savings to SSDI and other federal programs.

Chuck Piacentini, Vice President of State Legislative Affairs for UNUM, described the findings by the Charles River Associates study. He stated that there is a significant body of information regarding the impact that disability has on the ability of Americans to work. He indicated that information has been developed at the state level to show the extent of savings that the utilization of private disability coverage has meant for state budgets, as well as benefits to individual employers and employees.

Mr. Piacentini noted that SSDI is the primary source for disability payments that typically take more than a year to be approved. He stated that on average, such payments amount to $13,000

per year for an individual, but most Americans do not have even $10,000 to survive a disability in the short term, so when SSDI payments are received they provide far from a living wage.

Mr. Piacentini stated that AHIP and Charles River Associates have developed a matrix to illustrate the positive impact that any increase in the number of people covered by private disability insurance has on state budgets. He indicated this data will be a key element for legislators to demonstrate the impact on insurers, covered individuals and state budgets.

Ms. Bricker said that this information will be a positive benefit for both state budgets and the consumer. She stated that currently, only one in three workers has access to private disability coverage. She said that individuals who are working at age 20 have a one in four chance of becoming disabled for a three-month period during the course of their working life. She explained that with limited savings, these individuals quickly fall into financial hardship. She said that, typically, private disability coverage is affordable with premium costs being approximately $30 per month.

Ms. Bricker cited federal statistics to the effect that there are some 65,000 employees not receiving SSDI because they are enrolled in private programs, saving some $30,000 per person. She noted that this adds up to about $2 billion per year in federal savings, with projected reductions in expenditures of some $25 billion over the next ten years. Ms. Bricker concluded by noting that, in the future, AHIP will be examining how such savings play out at the state level.

PROPOSED 2015 COMMITTEE CHARGES

At the request of the Chair Ms. Thorson read the proposed Committee charge for 2015 as follows:

- analyze affordable care act (ACA) implementation issues and offer state guidance as needed
- examine cost, coverage, and other items related to emerging telemedicine and respond to potential regulatory gaps
- explore issues regarding Medicare and Medicaid costs
- continue to investigate impacts of obesity and chronic disease on current/future insurance markets
- monitor developments re: balance billing in light of NCOIL model act and offer guidance as appropriate
- continue effort to educate states pursuing opioid-related insurance reforms, i.e. NCOIL best practices (*in conjunction with the Workers' Compensation Insurance Committee*)

Rep. Keiser offered an amendment to the third element of the charge to provide a more focused goal and statement of purpose. He suggested that the phrase "Explore issues regarding Medicare and Medicaid costs" be revised to read "Explore the impact on state budgets from costs associated with aging, poverty, disability, chronic disease and other issues that affect health status."

Rep. Botzow then offered an amendment to this revision to add “mental health” to the other factors, as this is a significant issue to the states. Mr. Botzow’s addition to the amendment was then approved by voice vote.

As revised, the proposed amendment to the third bullet point was then approved by voice vote.

As approved, the third bullet point reads as follows: “Explore the impact on state budgets from costs associated with aging, poverty, disability, chronic disease, mental health and other issues that affect health status.”

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

ADJOURNMENT
There being no further business, the Committee adjourned at 3:25 p.m.