NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
HEALTH INSURANCE COMMITTEE
CHICAGO, ILLINOIS
JULY 16, 2004
DRAFT MINUTES

The Health Insurance Committee of the National Conference of Insurance Legislators (NCOIL) met at the Hotel Inter-Continental in Chicago, Illinois, on Friday, July 16, 2004, at 9:45 a.m.

Rep. Kathleen Keenan of Vermont, chair of the Committee, presided.

Other members of the Committee present were:

Rep. Jay Bradford, AR
Rep. Ronald Crimm, KY
Rep. Robert Damron, KY
Rep. Edward Gaffney, MI
Sen. Alan Sanborn, MI
Rep. Fulton Sheen, MI
Sen. John Loudon, MO
Rep. Donald Flanders, NH
Rep. Dan Foley, NM
Sen. Carroll Leavell, NM
Sen. William Larkin, Jr., NY
Sen. James Seward, NY
Rep. George Keiser, ND
Rep. Brian Kennedy, RI
Rep. Gene Seaman, TX
Rep. Larry Taylor, TX
Rep. Virginia Milkey, VT

Other legislators present were:

Rep. Steve Nappen, AR
Rep. Bob McClusky, CO
Rep. Carl Domino, FL
Rep. Greg Davids, MN
Rep. Robert Godshall, PA
Rep. Craig Eiland, TX
Del. Harvey Morgan, VA

Also in attendance were:

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

MINUTES

Upon a motion moved and seconded, the Committee voted unanimously to approve, as submitted, the minutes of its February 27, 2004, Committee meeting in San Antonio, Texas.

ASSOCIATION HEALTH PLAN (AHP) LEGISLATION

J.P. Wieske of the Council for Affordable Health Insurance (CAHI) clarified the difference between AHPs and association group plans. He said that AHPs are federally regulated while association group plans are state regulated. He said association group plan benefits are sold by licensed insurers registered in each state. He said 46 states have laws governing association group insurance covering hundreds of thousands of insureds.

Joan Gardner of Blue Cross Blue Shield Association (BCBSA) said over 1200 national organizations opposed federal AHPs. She recommended that NCOIL remain vigilant in opposition to these plans. She referred to the recent opposition letter NCOIL sent to Congress.

In response to a question asked by Rep. Crimm regarding whether a national protective valve existed for the small employer relating to uninsured funds, Ms. Gardner clarified that there was no national uninsured fund. She said BCBSA supported initiatives including tax credits, and public and private partnerships. She said that a viable competitive market in the states was key to supporting affordable policies for employers.

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

Barbara Levy of the Pharmaceutical Care Management Association (PCMA) said that 73 approved discount cards had been offered nationally and regionally by contractors such as Pharmaceutical Benefit Managers (PBM), health plans, pharmaceutical manufacturers, and retail pharmacy groups. She said the Center for Medicaid and Medicare Services (CMS) oversaw the contractors, had strict reporting requirements, and maintained fraud enforcement authority. She said 3.7 million beneficiaries had enrolled in the discount drug cards. She said that enrollment represented half of the total eligible enrollees and that CMS planned to boost enrollment by working with outreach programs. She said Connecticut, Maine, Massachusetts, Michigan, New Jersey, New York, and Pennsylvania had auto enrolled 400,000 people.

Kevin Simpson of the Health Assistance Partnership of Families USA said MMA had been problematic and that it should be examined before the fully funded benefit was put in place. He said consumers were not signing up for the discount cards and that using the Internet and the CMS website was difficult. He said the website contained inaccuracies and that the customer service line had been shut down repeatedly. He said CMS had been advertising the cards heavily, but was not providing non-biased information. He said changes ahead were frightening for most beneficiaries due to potential difficulties in decision-making. He said that Part D of Medicare provided for penalties if consumers did not sign up in time. He said that MMA required drug benefits to be removed from the Medi-Gap policies and had introduced high cost-sharing policies to the market. He said that consumers might turn to these high cost-sharing policies. He said that consumers should be made aware of their state health insurance assistance partnerships (SHIPs) in order to make informed decisions regarding Medicare. He said that SHIPs exist due to an appropriation through MMA and said that the funding would end after 2006.

MANAGED CARE ISSUES

Mr. Kipper of Americas Health Insurance Plans (AHIP) said prompt-pay time periods were being shortened. He said with prompt-pay periods, carriers are required to pay claims quickly and that this could be costly if claims are unwarranted or if fraud was involved. He said health plans had historically supported state-based plans such as risk pools. He said that assessments used to subsidize risk pools were bleeding over into fraud investigation units, causing shortfalls in programs like state Medicaid. He said the insured population was subsidizing risk pools and paying higher costs in premiums as a result. He asked that legislators look at broad-based funding solutions. He also said AHIP would be developing affirmative legislation in September.

In response to a question from Del. Morgan, Mr. Kipper said that approximately 95 percent of claims were paid within 30 days and that recovery costs could be significant if health plans were forced to pay for fraudulent claims.

Del. Morgan said that he knew of insurers that waited for months for payment due to computer glitches. He said that he felt altering prompt-pay time periods would be disastrous. Mr. Kipper said he felt that insurers were asking for a reasonable amount of time to ensure that questionable claims are not fraudulent or unwarranted.

Wes Cleveland of the American Medical Association (AMA) said that the physicians' community was concerned with managed care accountability in state legislation. He said AMA supported patient protection. He said medical necessity decisions needed to be based on what a prudent physician would do in accordance with appropriate medical practices and not on economic benefits that a plan, physician, or provider might receive. He said that independent review organizations should be put in place to review appropriateness of medical necessity decisions and, if necessary, to overturn denials.

Mr. Cleveland said AMA supported federal and state legislation that imposes liability on managed care organizations that negligently decide on medical necessity. He said the market was shifting due to health plan mergers and acquisitions, which was creating a disparity in the relationship between the physician and the patient. He referred to a June 2004 Supreme Court ruling in Texas, where a statute that imposed tort liability on managed care organizations for negligent medical necessity decisions was preempted by the Employee Retirement Income Security Act (ERISA). This ruling, he said, allowed managed care organizations the ability to potentially make negligent medical decisions. He said the AMA recommended that state legislators further structure lawmaking to protect patients, such as looking at ways to:

- extend current independent review laws to PPOs and utilization review organizations
- extend traditional patient protection laws like gag clauses and mandatory disclosure, beyond HMOs to PPOs and utilization review organizations
- build on fines or penalties in ILO legislation for plans that have a certain percentage of medical necessity denials overturned on review

Rep. Foley said the Federal Trade Commission (FTC) was contemplating imposing sanctions on independent physicians' associations regarding HMO, PPO, and provider price-fixing. He asked what the AMA was doing to self-regulate and police the situation before it became a bigger issue. Mr.

Cleveland said that changes in the federal law would create a more level playing field, but that until the law was changed, AMA's plan was to educate the states on price-sharing parameters.

STATE HEALTH INSURANCE BEST PRACTICES

Ms. Liebich said that NCOIL was preparing a best practices report for the Annual Meeting in November that would include a compilation of laws relative to cost-containment in health. She encouraged the health insurance industry to provide input.

THE NATION'S UNINSURED POPULATION

Donna Novack of the American Academy of Actuaries (AAA) said that resources were available on the uninsured and referred to websites provided in her handout for more information. She said state programs were investigating and identifying the uninsured. She said 25 large companies were pooling employees to help access cost-effective benefits.

PROPOSED DRUG RETAIL PRICE DISCLOSURE MODEL ACT

Rep. Keenan overviewed the proposed *Drug Retail Price Disclosure Model Act* and said the model supported the Committee's charge as a cost-effective state approach 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.

Sen. Larkin made a motion to waive the 30-day rule to adopt technical amendments to Section Two and Section Three of the model. Upon a motion moved and seconded, the Committee voted to waive the 30-day rule.

Mr. Simpson of Health Assistance Partnership (HAP) said that he supported the model and that it would help consumers make better decisions when buying prescriptions. Jack Geisser of PhRMA said that he supported the model and consumer awareness of prescription prices, but argued that the model would benefit the uninsured rather the insured. Rep. Kennedy said the model would benefit consumers, including the insured, because it would educate insureds with only partial coverage as to price disparities in various pharmacies.

Del. Morgan said that the model needed to be debated further. He said that he had been a practicing pharmacist in Virginia and that price posting led to administrative problems there. He said the model would burden pharmacies. Rep. Keenan said that the model was current practice in New York and that no administrative problems had been reported. She said Vermont was implementing a similar law.

Rep. Kennedy said Rhode Island considered similar legislation that would have required pharmacists to post prices of prescribed medications on pharmacy walls. He said that the model up for consideration would be much simpler to implement.

Upon a motion moved and seconded, the Committee voted to adopt the *Drug Retail Price Disclosure Model Act*, and referred the model to the NCOIL Executive Committee for consideration later that day.

DIRECT-TO-CONSUMER (DTC) DRUG ADVERTISING

Mr. Geisser said that he was unaware of significant data linking DTC spending to rising costs of prescription drugs. He said DTC spending totaled $2.6 billion dollars, less than 10 percent of the $31 billion dollars that the pharmaceutical industry has spent on research and development. He said the General Accountability Office (GAO) reported overall DTC spending was 12 percent of U.S. sales. He said the GAO, Food and Drug Administration (FDA), and Federal Trade Commission (FTC) had reported on benefits of DTC advertising. He said a GAO study in 2002 showed that advertised drugs accounted for an increase of six percent in prescription drug costs, and that drugs not advertised accounted for an inverse increase of nine percent.

Dr. Elizabeth Wennar of Health*Innova* said that states could be doing a lot to educate consumers with the $2.6 billion that was indicated in Mr. Geisser's presentation. She argued that DTC advertising reinforces bad behavior and does not educate consumers. She referred to the TV advertisement of the purple pill for indigestion and said that it inferred that after taking the pill for indigestion an individual could continue his or her bad eating habits.

PRESCRIPTION DRUG IMPORTATION

Ms. Liebich overviewed state and federal legislative activity relating to prescription drug importation, and distributed a report to Committee members regarding current practices and municipality action. She said states were turning to drug importation due to escalating costs of prescription drugs.

Rep. Kennedy said that Rhode Island recently passed legislation allowing drug importation that required importers to become licensed by the state.

UNIFORM ACCIDENT AND SICKNESS POLICY PROVISION LAW (UPPL)

Ms. Liebich said that the NAIC adopted the UPPL as a model law in 1947 and that the model was enacted in 42 states. She said that the NAIC in 1997 repealed the provision excluding insurer payment for alcohol and narcotic-related injuries for persons involved in accidents. She said that the provision still exists in 36 of the 42 states. She said that as of April 2004, Washington, Maryland, North Carolina, Iowa, and Vermont had repealed the provision. She distributed a report on the UPPL that summarized details of a study authored by Dr. Larry Gentilello of University of Texas Medical Center. She said that it included results of surveys sent to NCOIL legislators. She said study showed that legislators were overall in favor of repealing the UPPL provision, but that 53 percent were not sure if the UPPL existed in their state. She said 64 percent of legislators who indicated the UPPL did not exist in their state were incorrect.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:20 a.m.