

# Health Insurance Issues Interim Study Committee

## Study Assignment

A comprehensive study of health insurance coverage available to all segments of South Dakota's population. Components of this study will include: (a) an examination of the coverage available to private citizens, individually, as members of small groups or as members of large groups; (b) an examination of any potential barriers, including regulatory, to the entry of health insurance carriers into the South Dakota market; and (c) the availability and effectiveness of appropriate incentives to entice more carriers to provide coverage in South Dakota.

## Summary of Interim

### *Current statistics*

The Health Insurance Issues Interim Study Committee began its study with a historical perspective of the availability of health insurance and an overview of the coverage currently available. The presentation, provided by the Division of Insurance, included a discussion of the risk pool. Since the enactment of the risk pool, the number of carriers writing individual major medical policies remains constant at eight. The number of small group carriers and large group carriers each increased. There are currently 16 small group carriers and 11 large group carriers. A 2004 study found that the uninsured rate for adults in South Dakota was approximately 8.5 percent, well below the national average of 19.2 percent. The uninsurable rate in South Dakota is 1.06 percent or approximately 6,020 individuals.

### *Expansion of the state employee health plan*

The issue of adding other entities to the state health insurance plan was raised by the Association of Community Based Services, which requested that adjustment training centers be allowed to join the state health insurance plan. Representatives of the Bureau of Personnel addressed the issues surrounding such a decision. First, the state plan is self-insured; therefore, the state bears the risk of paying the claims. Also, the plan pays dollar-for-dollar so that any entity joining the plan would be responsible for paying their portion of claims. Further, users pay a portion of the costs through co-payments and deductibles, about 35 to 40 percent, and any other entity joining would have to adopt the same cost-sharing mechanisms. In addition, it must be noted that the state is not immune from rising costs but has implemented disease management programs to minimize cost increases. The biggest advantage may be increased purchasing power and leverage, but it would make the state more like an insurance company and less like its current position of employer. The issue is further complicated since a portion of federal monies received by the state are utilized to pay the costs of the plan. Federal grants accept this as an allowable charge but a complex allocation process is involved to utilize federal dollars for this purpose. Allowing another entity to join may jeopardize federal funding. Federal regulations prohibit any inequitable costs being redistributed to the federal government, and it was noted that it may be difficult to convince the federal government that it was not negatively impacted by the addition of other entities.

### *Association group insurance*

Some representatives of the insurance industry, specifically those from the Council for Affordable Health Insurance (CAHI) and Golden Rule Insurance Company, presented information to the committee regarding the benefits of association group health insurance, noting that in most states there are two options in the individual market, a true individual plan and association group insurance. Association group insurance involves associations negotiating with companies to provide benefits to their members only and is a hybrid between individual and group coverage. Associations are subject to a variety of regulations in the states, with many states allowing general purpose associations. Current rules do not allow

general purpose associations in South Dakota. It was suggested that South Dakota redefine association in its statutes and rules to allow general purpose associations to do business in the state, arguing that this change in terminology would bring more carriers into the individual market place and lower costs.

The position of the Division of Insurance is that if an association has no common purpose other than that of insurance, there is no assurance that the association will look out for the best interests of the insured. The whole purpose behind true group laws is to ensure that the association has a vested interest in the insured since it has the authority to make the decisions for the insured. Those decisions may include reducing coverage or increasing premiums. Further, if the insured becomes dissatisfied with the plan, it is difficult to switch individual plans unless the person is very healthy.

### *Disease management*

The committee requested information from representatives of Wellmark on the subject of benefit design, disease management, and case management. When managing health benefits, Wellmark seeks to reduce costs and improve the health status of consumers. About twenty percent of the consumers use eighty percent of the available health care dollars. These individuals are identified through claims data and enrolled in disease management programs. The results show cost savings, decreased absenteeism from work, and member satisfaction.

### *Other issues: Medical liability, mandates, risk pool*

Public testimony provided by Wellmark identified two barriers to health insurance carriers – rising health care costs and increasing federalization of the insurance industry, but added that neither were limited to South Dakota.

A representative of America's Health Insurance Plans (AHIP) provided an overview of a variety of issues surrounding health care costs. Among the issues discussed were medical liability, mandates, and risk pools. Methods to limit frivolous lawsuits were discussed. The issue of mandates was raised but even representatives of Wellmark remarked that South Dakota has been reasonably prudent in the adoption of mandated benefits, noting that some insurance companies would provide mandated benefits anyway because it is just good medicine. Members generally agreed that mandates were not onerous in the state, some arguing that many are preventative and result in cost savings. Finally, some industry representatives suggested that the eligibility for the risk pool be expanded but all agreed that such a decision required financing.

### **Listing of Legislation Adopted**

None.

### **Summary of Meeting Dates & Places and Listing of Committee Members**

The committee met on June 17, September 1, and November 16. Each meeting was held in the State Capitol in Pierre.

Committee members were: Representative Don Van Etten, Chair; Senator Tom Hansen, Vice Chair; Senators Jerry Apa, Mike Broderick, Jason Gant, Gil Koetzle, and Dan Sutton; Representatives Jamie Boomgarden, Pat Haley, Jeffrey Haverly, Gary Jerke, Deb Peters, Tim Rave, Elaine Roberts, Tim Rounds, and Bill Thompson.

Staff members were: Jacquelyn Storm, Principal Legislative Attorney; and Kris Schneider, Legislative Secretary.