Legislative Research Council
SouthDakota

MINUTES

Health Insurance Issues Interim Study Committee

Second Meeting | **LCR 1&2**
2005 Interim | **State Capitol Building**
Thursday, September 1, 2005 | **Pierre, South Dakota**

The second meeting of the Health Insurance Issues Interim Committee was called to order by Representative Don Van Etten, Chair, at 9:03 a.m. on Thursday, September 1, 2005, in Legislative Conference Room 1 and 2 of the State Capitol Building in Pierre, South Dakota.

A quorum was established with the following members answering the roll call: Senators Jerry Apa, Mike Broderick, Jason Gant, Tom Hansen (Vice-chair), and Gil Koetzle; and Representatives Jamie Boomgarden, Pat Haley, Jeffrey Haverly, Gary Jerke, Tim Rave, Elaine Roberts, Tim Rounds, Bill Thompson, and Don Van Etten (Chair). Senator Dan Sutton and Representative Deb Peters were unable to attend.

Staff members present included Jacquelyn Storm, Principal Legislative Attorney, and Rhonda Purkapile, Supervisor of Text Editing.

A list of guests present during all or part of the meeting is on file with the master minutes.

(**NOTE:** For sake of continuity, the following minutes are not necessarily in chronological order. Also, all referenced documents are on file with the master minutes).

Approval of Minutes

SENATOR BRODERICK MOVED, SECONDED BY REPRESENTATIVE RAVE, THAT THE MINUTES OF THE JUNE 17, 2005, MEETING BE APPROVED. MOTION PREVAILED ON A VOICE VOTE.

Benefit Design, Disease Management, and Case Management

Ms. Janet Griffin, Wellmark Blue Cross Blue Shield, responded briefly to questions asked at the previous meeting. She stated that Wellmark Blue Cross Blue Shield does provide pricing information to its providers but that information is not posted on its website. Ms. Griffin noted that every $250 increase in a deductible translates roughly to a two percent savings in premiums. Finally, Ms. Griffin expressed her concerns with the various factors driving health care costs and the movement by the federal government to attempt to control those costs **(Document 1)**.

Dr. Mike Pekas, Wellmark Blue Cross Blue Shield, briefed the committee on the Wellmark Blue Cross Blue Shield plan of integrated medical management to effectively improve cost,

care, and quality **(Document 2)**. Dr. Pekas noted that he is one of four medical directors working for Wellmark Blue Cross Blue Shield.

Dr. Pekas reported that Wellmark Blue Cross Blue Shield does have a management strategy when managing health benefits to help in reducing costs while improving the health status of consumers. He stated that twenty percent of the individuals in the health care continuum will eat up about eighty percent of the money available. Dr. Pekas reported that they utilize disease management programs for individuals that are chronically ill. Ten to fifteen percent of the population has chronic conditions, which eats up a lot of health care dollars. These individuals are identified through claims data. The disease management personnel try to build a trusting relationship with all parties involved in disease management and strives to address the whole patient and all of their health care needs because all kinds of problems can develop with the advent of a single core medical problem.

Dr. Pekas testified that this has resulted in an average savings of $41 per member per month. It has decreased absenteeism from work and the members are very satisfied with this program.

Dr. Pekas reported that Wellmark Blue Cross Blue Shield utilizes complex case management for those patients with severe and complex diseases. They are piloting a pay for performance program in Iowa (four locations) and in South Dakota (four locations). Interested physician groups will set their own care parameters and decide where they set their bench marks. High quality providers will be paid a bonus based on meeting those performance bench marks. The response to date on this program from the physicians has been very positive.

Representative Rounds asked how long these pilot programs have been in place. Dr. Pekas replied that the program in Iowa has been in place for two years, and the program in South Dakota was started eight months ago. He added that they have discovered that reducing practice variations is not only good medicine, but helps to provide a healthier population. Representative Rounds then asked if this would be more difficult to implement in rural areas. Dr. Pekas responded that it could be, but noted that many times small rural practices are more innovative when it comes to managing their practices.

Wellmark Blue Cross Blue Shield has introduced a pharmacy benefits program and has been able to reduce costs by encouraging the use of generic drugs, Dr. Pekas reported.

Chair Van Etten asked how it is determined which members are entered into the managed care programs. Dr. Pekas replied that the members are automatically enrolled in the disease management programs if they have chronic medical conditions, and they would have to opt out to not participate.

Senator Apa asked what can be done for those patients in the program refusing to follow medical directives. Dr. Pekas replied that you cannot force people to take care of themselves. However, he noted that if you have people continually calling them through the management

program and reminding them to go to the doctor, and follow through with other appointments, this encourages them to actually see the doctor more often than they normally would, thus resulting in those patients receiving more frequent medical care.

Representative Haverly asked if the ten to fifteen percent statistic on chronic medical conditions is a national statistic, and Dr. Pekas responded affirmatively.

Representative Jerke asked Dr. Pekas if there are any laws that should be repealed in order to have a favorable impact on health care costs. Dr. Pekas replied that the only one that comes to his mind would be the mandated benefits provisions. Ms. Griffin added that South Dakota has been reasonably prudent when it comes to adopting mandated benefits. She noted that in many cases some of the mandates relate to benefits which the insurance companies would provide anyway simply because it is good medicine. Chair Van Etten asked Ms. Griffin if she would agree that most of the South Dakota mandates relate to screening tests and procedures that actually save insurance companies money in the long run. Ms. Griffin agreed that those would be things that would improve the health of the patient and that the insurance industry would probably want to include those in coverage.

Association Group Insurance and General Market Improvements

Mr. JP Wieske, Director of State Affairs, Council for Affordable Health Insurance (CAHI), presented information to the committee on the benefits of association group health insurance **(Documents 3, 4, and 5)** and spoke from prepared remarks **(Document 6)**.

Mr. Wieske reported that South Dakota is the ninth highest state with regard to costs of health insurance, while North Dakota is tenth from the bottom. One of the main issues driving these costs, Mr. Wieske stated, is choice. He stated his belief that more choices for the consumer with regard to health insurance will result in better prices for the consumer.

Mr. Wieske stated that large group insurance markets have a choice between ERISA and fully insured plans. Small groups also have that option, and in some cases can choose ERISA if they are large enough. In most states, with the individual market, there are two options—a true individual plan or association group insurance. Association group insurance is only available to its members. These plans are available on a national basis, attract new insurers to the insurance market, and provide innovative coverage options.

Mr. Wieske noted that the federal proposal would allow associations to offer coverage to small businesses on a guaranteed issue basis, which CAHI does not support. Association health 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 most states allowing general purpose associations that follow the state's guidelines and regulations. Association health plans are also subject to regulation including the licensure of both insurers and agents. Because current rules do not allow general purpose associations, association health plans are not available in

South Dakota, Mr. Wieske reported. He suggested that South Dakota redefine "association" in its statutes and regulations to allow them to do business in the state. Mr. Wieske noted that this change in terminology would bring more carriers into the individual market place and lower costs. Because these plans are available in many other states, it makes it easier for people to move from state to state and maintain health insurance.

Chair Van Etten noted that legislation was passed last year dealing with associations and asked if that did not take care of this problem. **Mr. Randy Moses**, Division of Insurance, replied that that particular legislation dealt with multiple employer market and not individual market, which this discussion involves.

Representative Jerke asked why association health plans are not allowed in South Dakota if they are such a good deal. Mr. Wieske replied that many of them left the South Dakota market because the rules and regulations related to the associations required guarantee issue. Representative Jerke continued by asking if South Dakota is making every effort possible to allow insurers to come into South Dakota and offer insurance. Mr. Moses replied that South Dakota is fairly competitive with other states with regard to health insurance rates. With regard to association health plans in South Dakota, Mr. Moses stated that the Division of Insurance looks at specific criteria when approving or disapproving licenses for health insurance carriers to do business in South Dakota. The whole purpose behind true group laws is ensuring that the company has a vested interest in that individual when it is the one making the decisions with regard to that individual. If it is an association that anybody can belong to, the division does not believe that the association is looking out for the best interests of the policyholder. The division looks at the association for some common purpose outside of the insurance aspect. The big difference between individual and association plans is that association plans are not subject to prior approval of rates. Association plans can charge what they want and raise rates when they want. Mr. Moses stated that it is not a level playing field between individual and association plans. If the state does anything, perhaps it should make it a level playing field between all players in the insurance industry.

Mr. Wieske stated that from his perspective, he has a hard time understanding how consumers are harmed when they voluntarily sign up for a plan which gives them individual choices. He noted that in Wisconsin, where he is from, association plans are allowed, and there are numerous groups in the insurance market competing for business. He reported that CAHI has found that states with a less regulated environment tend to have much lower insurance costs.

Senator Gant asked why the state of South Dakota would be against an association plan whose only purpose was to provide insurance. Mr. Moses responded that once you are in the association plan you are stuck. It is not very easy to switch individual plans unless you are a very healthy individual. The contract is between the association and the insurance company. The association can make decisions about reducing coverage or increasing premiums. The division has a concern with associations making decisions for individuals for whom they have no vested interest.

Mr. Wieske added that some of the controversy has been with the very limited benefit plans. He noted that these tend to be smaller carriers and the reality is that no association is going to dominate any particular market.

State Employee Health Plan

Mr. Eric Hales, Director of Employee Benefits, Bureau of Personnel, spoke from prepared remarks **(Document 7a)**. Mr. Hales reported that entities that wish to provide health insurance can be either fully-insured or self-insured. With a fully-insured plan, the entity pays a premium to an insurance company and the insurance company bears the risk for paying all claims. With a self-insured plan, the entity bears the risk for paying the claims. The money to pay the claims comes from the entity itself, thus the amount of money the entity pays for health insurance will vary from month to month. A self-insured entity will often hire a company to administer the claim-paying function of the plan. It is difficult for a small entity to be self-insured because larger entities can more easily spread the risk. Also, a self-insured plan allows entities more flexibility to manage their plan.

Mr. Hales reported that the state of South Dakota's health insurance plan for its employees is completely self-insured and the state pays two other companies to administer the claims-paying function of the plan. The state's self-insured plan pays claims dollar-for-dollar, Mr. Hales reported, so any entity wishing to join this plan would be responsible for paying their portion of the claims, as well as the appropriate administration costs associated with those claims.

Mr. Hales reported that the state of South Dakota is not immune to rising health care costs. Because the state is completely self-insured, it is particularly vulnerable to large catastrophic claims. He noted that the state has seen an average increase in claims of nine percent per year since fiscal year 2001. Through plan management, the state has been able to minimize the cost increases of the plan over the years **(Document 7b)**. As a result of the state's plan management programs, health care costs have gone down and hospital stays have been reduced.

Mr. Hales testified that the state's plan is also designed for the users of health care to pay a portion of those costs through co-pays and deductibles. Through these co-pays and deductibles, he concluded that the state employee pays somewhere between 35-40 percent of the health insurance plan. If other entities were to come into the plan, they would be expected to accept the plan as is, and adopt the same cost-sharing mechanisms already in place.

Mr. Hales noted that the biggest advantage to the state in expanding the self-insured plan to include other entities would be in increased purchasing power and leverage. It may allow the state to negotiate lower rates with providers; however, the existing provider contracts that the state has may not allow participation by non-state employees. The state's plan must remain cost neutral, so any other entities that would come on board would have to absorb any

additional costs associated with them joining the plan. The state's plan is an employer plan designed as such and there is no guarantee that it would work or provide a cost savings to other entities coming on board. A move to include other entities would make the state more like an insurance company and less like an employer. Mr. Hales stated that to ensure the integrity of the plan, if the county, city, and school employees were to join, they should join as a whole group and not on a voluntary basis or the plan would be overwhelmed with the high risk cases and costs would escalate.

Mr. Jim Neiles, Bureau of Finance and Management, testified that there are group costs that are collected which are associated with providing health insurance and divided among the number of employees currently on the state payroll. This is billed to each department. This is an allowable expense for federal dollars, so a portion of federal monies received by the state are being utilized to pay the costs of the plan. He stated that the process of setting premium rates involves actuarial analysis, and an annual negotiation based on the actuarial analysis takes place with the federal government to determine the percentage of federal funds utilized in this effort.

In response to committee questions, Mr. Neiles stated that once the costs of the plan are run through the allocation process, it becomes a direct charge for federal grant purposes, which allows federal dollars to be utilized for the plan. Federal funding is utilized for 20 percent of the plan. About 38 percent of the funding for the plan comes from other funds, with many of those funds also having federal funds tied to them. All federal grants accept this as an allowable charge. Mr. Neiles stated that he did not know how this process would be affected by bringing other entities into the plan.

Ms. Sandy Zinter, Commissioner, Bureau of Personnel, testified that this is a very complex process and the state must go through a very stringent set of rules and regulations to utilize federal dollars for this purpose. Before any other entities are brought on board, the state must ensure that the federal funding would not be jeopardized. Mr. Neiles added that any time there is a change to the plan, the state would have to renegotiate the federal participation in the plan. Regulations prohibit any inequitable costs being redistributed to the federal government. Mr. Neiles felt it would be difficult to convince the federal government that they would not be negatively impacted by bringing other groups into the plan. Commissioner Zinter added that other entities joining the plan would also require additional administrative staff within the bureau.

Representative Roberts asked Commissioner Zinter if she has had inquiries from other entities to join the plan. Commissioner Zinter replied that she has had three to four phone calls over the years. She noted that she refers school districts to the Associated School Boards of South Dakota because they have developed their own plan.

The committee recessed at 11:15 a.m. and reconvened at 11:30 a.m.

Public Testimony

Mr. Neal Chaplin, Golden Rule Insurance Company, spoke from prepared remarks **(Document 8)**. Mr. Chaplin testified that in the mid 1990's, Golden Rule Insurance Company was the largest carrier in the individual market in South Dakota. They ceased marketing in South Dakota as of January 1, 2001, but still cover 1,388 individuals as of May 31, 2005. Golden Rule presently offers coverage to individuals in 25 states almost exclusively through an association. The volatility of the individual market has caused many carriers to exit the individual market. Volatility factors are affordability, legislative initiatives, and regulation. Mr.

Chaplin stated that inequities in availability and affordability of coverage have not gone unnoticed by the federal government, and Congress is considering several initiatives.

Mr. Chaplin testified that the individual market is voluntary and transitional in nature. The average individual policy is in effect for three years, with most of those lapsing after the first year. The individual market is a transitional market because people access it when they are between jobs, when they are no longer eligible for Medicaid or Medicare, or when they can no longer afford health coverage. The individual market in South Dakota is about 10 percent of the population, or 80,000 individuals.

Mr. Chaplin stated his opinion that contributing factors to the deterioration of the individual market in South Dakota are HIPAA compliance, the Division of Insurance policy regarding association group coverage, regulatory inconsistencies, and rating restrictions. He noted that the Division of Insurance in South Dakota would not approve the Golden Rule product for association group coverage so the company left the South Dakota market. Golden Rule could not do business in South Dakota under the existing business model. He stated that South Dakota exceeded the HIPAA guaranteed issue requirements, and that South Dakota is the only state that has promulgated a rule to restrict the eligibility of associations.

Mr. Chaplin testified that the primary protection against adverse selection is the preexisting condition limitation of a policy. He stated his opinion that the protection against adverse selection has been eroded by the Division of Insurance by the promulgation of a rule with regard to an ordinarily prudent person in preexisting condition clauses. This has turned objective criteria into subjective criteria, which is not how this issue is handled in other states.

Mr. Chaplin testified that the Golden Rule also had difficulty with the administration of mental health parity when South Dakota decided to take a biologically based mental health illness approach. The definition of a "biologically based mental health illness" in South Dakota is consistent with laws they have seen across the nation. However, the application by the Division of Insurance of this definition has been inconsistent, according to Mr. Chaplin.

Mr. Chaplin noted that South Dakota requires prior approval of rates, noting that almost one-half of the states do not regulate premium rates. Implementing a rate increase is a very complex and time consuming process and having to file a rate for approval can delay the rate increase. Rating restrictions affect a company's willingness to remain in the market.

Mr. Chaplin recommended the following: 1) allow insurers to market their products through associations; 2) repeal the "ordinarily prudent person" in existing condition clauses; 3) expand the risk pool definition to include uninsurable individuals; 4) repeal rate approval authority by the Division of Insurance; and 5) repeal the requirements of rate review for the impact of fraud prevention units.

In response to committee questions, Mr. Chaplin indicated that Golden Rule Insurance changed its market focus from the individual market to the association group market. They

also decreased their presence from 46 states down to 25 states because that was all they had the capability of administering.

Chair Van Etten recessed the committee at 12:20 p.m. for lunch and reconvened the committee at 1:32 p.m.

Mr. John Hartnedy, speaking on behalf of the Council for Affordable Health Insurance (CAHI), presented the committee with background information on his experience in the insurance industry **(Document 9)**. Mr. Hartnedy testified that the health insurance market needs to be invigorated. States should be consistent with insurance regulations so as not to impede multi-state carriers, and so the federal government does not become involved in the insurance process. States should follow NAIC rules when licensing insurance carriers to do business. Fair trade practices should be sufficient to protect consumers. Mr. Hartnedy noted that when he was the Director of Insurance in the state of Arkansas, they took a very liberal approach to allowing companies to operate within the state in order to ensure that there was enough coverage and that people had adequate access to insurance. The primary requirement of health insurance should be whether or not it is being sold through a licensed agent. He suggested that South Dakota make it easer for insurance companies to do business in the state of South Dakota. Mr. Hartnedy advocated that the more companies in a state selling their product, the more competitive the market becomes.

Mr. Hartnedy acknowledged that there are some association group insurance companies that have caused problems. He noted that the main problem encountered in Arkansas was that people did not know what they were buying. He stated that his concern as a regulator was the question of whether or not the company properly conveyed to the consumer what they were buying. He noted that the state has to take risks in an effort to allow coverage to the most people. He expressed his concern that the federal government will take this choice away from the states if they continue to disallow insurance companies to sell in their states.

Mr. Hartnedy reported that a problem for many insurance companies is that they have to administer each state's mandates differently. Any mandate passed by a state makes it harder for the individual and small employer to afford coverage. Mandates cost money, they do not save money. He noted that South Dakota has a unique interpretation of "ordinarily prudent person", which many insurance companies do not want to deal with because it costs too much to administer.

Mr. Hartnedy testified that any time you place a rate restriction upon a company, you basically force the young and healthy to pay for the elderly and sick. The problem with this is that the largest numbers of uninsured are the young and healthy. If more people are insured, then the rate increases should be smaller.

Mr. Hartnedy suggested that the state try full parity for state employees with mental health claims and require a report of the impact.

Senator Broderick asked Mr. Hartnedy if he agreed that preventive health care saves on future health care costs. Mr. Hartnedy replied that wellness and defensive care should be provided by the employer as a benefit and not provided by the insurance company. These items raise the costs of insurance because you have people utilizing preventive care who do not really need to do so. The insurance product can be made more affordable by not mandating certain items.

Ms. Phyllis Arens, a member of the National Alliance for the Mentally Ill (NAMI), testified that one in five families are affected by mental illness. Unfair treatment limitations placed on mental health services is not fair. Managed care is an important factor in managing costs when implementing mental health parity. Ms. Arens testified that brain disorders deserve the same coverage as other medical disorders. She questioned who will cover mental health costs if insurance companies do not.

Ms. Nancee Johnson, representing Treatment Assistance Card, presented information to the committee on the use of treatment assistance cards **(Document 10)**. She noted that this is an electronic storage and retrieval method of your personal medical information. This is a mechanism to control costs, reduce liability, and provide effective treatment and better decision-making through quick access of your medical history and information. The treatment assistance card costs $30 per year, with a family discount option. Ms. Johnson encouraged the Legislature to make this available for state employees, legislators, and Medicaid and Medicare recipients.

Mr. Dave Hewett, South Dakota Association of Healthcare Organizations, testified that when the health insurance risk pool was developed in South Dakota, the real issue was making sure the state had enough health insurance providers offering coverage. Insurers agreed to maintain the people they currently had in their guaranteed programs but were allowed to increase their rates. Policyholders pay 150 percent of the average premium, employers pay a twenty-five cent per enrollee per month fee, and the providers agreed to accept less payment for medical services. Mr. Hewett noted that all of the dollar levels are pretty fixed except for the discounted rates of the medical providers, which is why the providers feel vulnerable with the risk pool. One thing that has not yet occurred with the risk pool is a major case, but it is only a matter of time. Health care is incredibly complex and expensive and the providers cannot continue down this same road, Mr. Hewett stated. He noted that one percent of the population in this country consumes thirty percent of the health care dollars. He stated his belief that the key is ensuring that everyone has access to health insurance.

In response to committee questions, Mr. Hewett stated that it would only take four or five catastrophic health care cases to bankrupt the risk pool. He also noted that the physicians are providing more in reduced rates than are the hospitals.

Mr. Mike Shaw, representing American Family Insurance, testified that the state needs to be very careful in any discussions about expanding the risk pool. He did not feel it would be fair

to single out certain providers to bear the brunt of paying for the risk pool. He suggested that the state continue to look for solutions to the guaranteed issue problem.

Committee Discussion

Chair Van Etten suggested that the next meeting include a discussion of the public/private plan with an expert from the America's Health Insurance Plans.

Representative Haley asked about consistency between states with insurance rules and regulations. Mr. Moses, Division of Insurance, replied that there is a degree of consistency from state to state through the NAIC rules and regulations. However, each state has its own unique needs, so this becomes a constant challenge.

Representative Haley said that he would be interested in hearing information on whether or not other states have expanded their state employee programs to include other governmental entities.

Chair Van Etten asked the committee members to notify staff by September 15 if they had any topics or legislation they wanted to see at the third meeting.

Chair Van Etten adjourned the meeting at 3:20 p.m.

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