1999 HOUSE HUMAN SERVICES

HB 1178

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1178

House Human Services Committee

❑ Conference Committee

Hearing Date 1-26-99

Tape Number	Side A	Side B	Meter #
2	x		3.4
2		x	20
Committee Clerk Signature	Lisa Stoner		

Minutes:

HB 1178 Relating to health care service utilization review, accident and health insurance, small employer health insurance, and preferred provider organizations.

Chairman Berg opened the hearing on the bill.

Chris Edison, General Counsel, ND Insurance Dept., introduced and testified in support of the bill.

(see attached written testimony)

Questions and discussion followed.

Mr. Rod Larson, Blue Cross Blue Shield, testified in support of the bill to include the proposed amendments that have been presented.

Mr. Bruce Levi, Legal Director for ND Medical Association, testified in support of the bill to the extent that it clarifies the intent of the bill. The Amendment to the bill was handed out and provide protections.

Chairman Berg closed the hearing on the bill.

Moved by Representative Klein to adopt amendments, Second by Representative Kempenich

By voice vote, all yes, 0 no, motion carried.

Moved by Representative Klein for do pass as amended, Second by Representative Koppang

By roll vote, 14 yes, 0 no, 1 absent motion carried.

Representative Koppang will carry the bill.

Prepared by the North Dakota
Insurance Department
January 26, 1999

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1178

Page 1, line 2, after "to" insert "medicare provider-sponsored organizations and" and remove "and paid-up life insurance policies"

Page 1, line 5, replace "sections" with "section

Page 1, line 6, after the comma insert "subsection 8 of section 26.1-47-01," and after "and" insert "section"

Page 5, line 29, after "commissioner" insert "within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the commissioner may declare the contract void and disapprove the preferred provider arrangement" and remove "approval of"

Page 6, after line 2, insert:

"**SECTION 9. AMENDMENT.** Subsection 8 of section 26.1-47-01 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

8. "Preferred provider ~~agreement~~ arrangement" means a contract between the health care insurer and one or more health care providers which complies with all the requirements of this chapter."

Page 6, line 2, after the period insert "This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 that are not tied to specific medical decisions with respect to a patient."

Renumber accordingly

North Dakota Medical Association
North Dakota Medical Group Management Association

January 26, 1999

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1178

Page 5, line 24, after "contract" insert "without cause"

Renumber accordingly

Date: 1-26-99
Roll Call Vote #: 1

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1178

House Industry, Business and Labor Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken do pass as amended

Motion Made By Klein Seconded By Koppang

Representatives	Yes	No	Representatives	Yes	No
Chair - Berg	/		Rep. Thorpe		
Vice Chair - Kempenich	/				
Rep. Brekke	/				
Rep. Eckstrom	/				
Rep. Froseth	/				
Rep. Glassheim	/				
Rep. Johnson	/				
Rep. Keiser	/				
Rep. Klein	/				
Rep. Koppang	/				
Rep. Lemieux	/				
Rep. Martinson	/				
Rep. Severson	/				
Rep. Stefonowicz	/				

Total (Yes) 14 No 0

Absent 1

Floor Assignment Koppang

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1178: Industry, Business and Labor Committee (Rep. Berg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1178 was placed on the Sixth order on the calendar.

Page 1, line 2, after "to" insert "medicare provider-sponsored organizations and" and remove "and paid-up life"

Page 1, line 3, remove "insurance policies"

Page 1, line 5, replace "sections" with "section"

Page 1, line 6, after the first comma insert "subsection 8 of section 26.1-47-01," and after "and" insert "section"

Page 5, after line 2, insert:

"**SECTION 9. AMENDMENT.** Subsection 8 of section 26.1-47-01 of the 1997 Supplement to the North Dakota Century Code is amended and reenacted as follows:

8. "Preferred provider ~~agreement~~ arrangement" means a contract between the health care insurer and one or more health care providers which complies with all the requirements of this chapter."

Page 5, line 24, after "contract" insert "without cause"

Page 5, line 29, after "commissioner" insert "within ten days of implementing the arrangements. If the preferred provider arrangement does not meet the requirements of this chapter, the commissioner may declare the contract void and disapprove the preferred provider arrangement" and remove "approval of"

Page 6, line 2, after the underscored period insert "This subsection does not prohibit a preferred provider arrangement from including capitation payments or shared-risk arrangements authorized under subdivision a of subsection 1 which are not tied to specific medical decisions with respect to a patient."

Renumber accordingly

1999 SENATE INDUSTRY, BUSINESS AND LABOR

HB 1178

1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB1178

Senate Industry, Business and Labor Committee

❑ Conference Committee

Hearing Date February 15, 1999

Tape Number	Side A	Side B	Meter #
1		x	1890-5030
Committee Clerk Signature			

Minutes:

Senator Mutch opened the hearing on HB1178. All senators were present.

Chris Edison testified in support of HB1178. His testimony is included.

Senator Mutch asked him there was anything already in the federal requirements. Mr. Edison said no there was not.

Dave Pesky, North Dakota Medical Association, testified in support of HB1178.

Senator Mutch closed the hearing on HB1178.

Senator Klein motioned for a do pass committee recommendation on HB1178. Senator Krebsbach seconded his motion. The motion carried with a 6-0-1 vote.

Senator Klein will carry the bill.

SR-2253F

Date: 3/30
Roll Call Vote #: 1

1999 SENATE STANDING COMMITTEE ROLL CALL VOTES
HOUSE BILL/RESOLUTION NO. 1178

Senate INDUSTRY, BUSINESS AND LABOR COMMITTEE Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS

Motion Made By KLEIN Seconded By KREBSBACH

Senators	Yes	No	Senators	Yes	No
Senator Mutch	X				
Senator Sand	X				
Senator Krebsbach	X				
Senator Klein	X				
Senator Mathern	X				
Senator Heitkamp	X				
Senator Thompson					

Total (Yes) 6 No 0

Absent 1

Floor Assignment KLEIN

REPORT OF STANDING COMMITTEE

HB 1178, as engrossed: Industry, Business and Labor Committee (Sen. Mutch, Chairman) recommends **DO PASS** (6 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). Engrossed HB 1178 was placed on the Fourteenth order on the calendar.

1999 TESTIMONY

HB 1178

HOUSE BILL NO. 1178
TESTIMONY BEFORE THE HOUSE
INDUSTRY, BUSINESS AND LABOR COMMITTEE

CHRIS EDISON
GENERAL COUNSEL
NORTH DAKOTA INSURANCE DEPARTMENT

Good afternoon, Mr. Chairman and members of the House Industry, Business, and Labor Committee. My name is Chris Edison and I am General Counsel for the North Dakota Insurance Department. I appear today on behalf of Commissioner Pomeroy in support of House Bill No. 1178 and urge its favorable consideration by this committee.

The North Dakota Insurance Department spends a significant amount of time between each legislative session determining what, if any, updates the insurance code, Title 26.1 of the North Dakota Century Code, needs for each area of insurance we regulate. The Department keeps a legislative file into which staff make suggestions for future legislation. The Legal Division then reviews these proposals to determine which ones are of the highest priority and should be proposed as legislation. House Bill No. 1178 is the final result of this process in the area of health insurance.

House Bill No. 1178 contains a number of sections that relate to health insurance. I would like to go through each individual section and talk a little bit about the problem the Department is looking to address with each proposed change.

SECTION 1

The Problem

In 1997, Congress passed, and President Clinton signed, the Balanced Budget Act of 1997 ("the BBA"). The Act allows entities known as Provider Sponsored Organizations ("PSOs") to market what are referred to as Medicare+Choice ("M+C") products if the PSO is licensed by the Insurance Department in the state in which it will market the M+C product. A PSO is defined as a entity established by health care providers, which provides a substantial proportion of health care items and services directly through affiliated providers who share substantial financial risk. It is roughly equivalent to a health maintenance organization ("HMO") set up by providers devoted specifically to marketing M+C products. Essentially, under an M+C product, the PSO provides enrollees with Medicare coverage as if it were the federal government, along with coverage more commonly covered under a Medicare supplement policy. However, the BBA allows the PSO to obtain a waiver of state licensure if the Insurance Department of the state in which the PSO seeks a license imposes a discriminatory requirement on the PSO. The federal rules regarding PSOs also outline certain solvency requirements that states must apply to the PSO which are not currently in state law.

The Solution

In order to retain regulation over certain aspects of PSOs, the Department needs to insure that nothing we do will entitle the PSO to apply to the federal government for a waiver of state licensure requirements. State law does not currently envision any license specific to PSOs. The closest license we have is for an HMO. The Department is proposing in Section 1 of House Bill No. 1178 rulemaking authority which allows the Department to clarify how PSOs will be treated in this state and avoid the federal government granting a waiver to PSOs doing business in this state.

SECTIONS 2 AND 3

The Problem

Through our Market Conduct Division, it has recently come to the attention of the Department that certain insurers did not realize they were subject to North Dakota's utilization review chapter, North Dakota Century Code Chapter 26.1-26.4. They had not certified to the Commissioner that they were acting as utilization review agents in accordance with the law nor had they filed the elements of their appeals procedures as required. They were not aware of the provisions of Chapter 26.1-26.4 or did not believe they were subject to its requirements

The Solution

Section 2 adds a definition of health care insurer that is used in Section 3. The Department feels these two sections, taken together, do two things. First, by implication, it clarifies that a health care insurer is subject to the provisions of the utilization review chapter. Secondly, it clarifies that if a health care insurer contracts out its utilization review activity, the Commissioner will still hold it as responsible for the determinations made by the contracting utilization review agent as if it would have done the utilization review itself. I am aware that at least one other bill that will be proposed this session will advocate similar statutory changes.

SECTION 4

The Problem

In the area of major medical health insurance, the use of preexisting condition exclusions by health insurers has been severely restricted by both state and federal law over the past few years. In general, companies are limited to a 12 – 18-month preexisting condition exclusionary period and can only apply the exclusion to those conditions which have received care, treatment, or diagnosis within this six months immediately preceding the effective date of coverage. However, health insurance coverage besides major medical coverage which is issued in North Dakota is still allowed to apply a preexisting condition exclusion that extends for two years from the effective date of the policy and they are allowed to impose the exclusion to conditions which first manifested themselves within the five years preceding the effective date of the policy. This is out of line with the trend for other types of health insurance and makes it difficult for

constituents of yours who have a health condition to obtain this coverage.

The Solution

The Department is advocating a reduction in the five-year "look-back" period to two years to bring it more in line with what is allowed for major medical coverage. To accomplish this change, Section 4 amends N.D. Cent. Code § 26.1-36-04(1)(d). In fact, 95 percent of these types of policies already comply with a two-year look back provisions. The proposed change would give the Department the ability to force all companies to comply with this industry standard.

SECTIONS 5, 6, 7, AND 8

The Problem

In the last legislative session, the Legislature passed House Bill No. 1168, which was originally heard by this committee. House Bill No. 1168 was proposed by Commissioner Pomeroy to implement the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). House Bill No. 1168 was a rather lengthy bill and, unfortunately, there are a few provisions that need to be tweaked in order to stay in compliance with the federal act. Sections 5, 6, 7, and 8 propose these changes.

The Solution

Section 5 clarifies that a person who turned down employer coverage when initially eligible because they were covered under another plan has 30 days to request enrollment after losing the other coverage or they will be considered a late enrollee and be subject to an 18-month preexisting condition exclusion.

Section 6 clarifies that a small employer may not modify any of its health benefit plans to restrict coverage for certain diseases or medical conditions otherwise covered by the plan. Under HIPAA, group carriers are not allowed to discriminate based on health status and any modification to restrict coverage would violate HIPAA's anti-discrimination provisions.

Section 7 clarifies that small employer plans offered through associations are not subject to guarantee issue requirements but are subject to all other small employer provisions.

Section 8 clarifies that an 18-month preexisting condition exclusion may be applied to a late enrollee in the large group market, just as it would in the small group market. Without this change, only a 12-month preexisting condition exclusion may be applied.

SECTION 9

The Problem

Congress is considering a raft of new measures which generally come under the heading of a

"Patient's Bill of Rights". These patient protection measures are meant to address some of the abuses by managed care entities cited by consumer advocates in other states. Though they all put in place various important protections for consumers, these patient protections have one other element in common–they have the potential to preempt state law regarding health insurance in some fashion.

The Solution

Section 9 of House Bill No. 1178 is intended to be a "North Dakota" patient protection measure. It is based on current law in North Dakota regarding health maintenance organizations, provisions from model laws promulgated by the National Association of Insurance Commissioners, as well as provisions of some of the federal proposals being discussed by Congress. We think Section 9 of House Bill No. 1178 accomplishes two things. First, it brings North Dakotans key patient protection measures. Second, it has the added benefit of helping to fend off some of the talk about the states' failure to implement patient protections measures which fuels the fire for an additional federal presence in the area of health insurance.

Section 9 amends N.D. Cent. Code Chapter 26.1-47 relating to preferred provider arrangements. Essentially, it does six things:

1. Provides a covered person is not liable to the physician for any amounts owed to the physician by the health insurer. This section is substantially the same as N.D. Cent. Code § 26.1-18.1-12(4) relating to health maintenance organizations.

2. Provides that if a health insurer becomes insolvent, a physician must continue to provide services to a covered person in accordance with the contract. This provision is largely the same as N.D. Cent. Code § 26.1-18.1-12(5) relating to health maintenance organizations.

3. Provides a 60-day notice before a party may terminate a preferred provider arrangement.

4. Provides that all preferred provider arrangements must be filed with the Insurance Commissioner.

5. Provides that preferred provider arrangements may not provide any incentive for a provider (physician) to provide less than necessary care. For example, under this section, a preferred provider arrangement could not provide an incentive for a physician to recommend a less expensive covered service instead of a more expensive covered service the physician felt was medically necessary to maintain or improve the health of a patient.

6. Provides that a health insurer may not penalize a physician for, in good faith, reporting a practice or policy of the insurers that the physician feels jeopardizes patient welfare.

I am aware that at least one bill to be considered this session will cover many of the same

provisions addressed in House Bill No. 1178. At this point, I am not aware of the bill number or the house in which the bill will originate.

AMENDMENTS

The Department is also proposing a short set of amendments to House Bill No. 1178 as introduced.

First, as I discussed earlier, Section 9 of the bill amends N.D. Cent. Code § 26.1-47-02 to provide that a health insurer may not offer a physician an inducement to provide less than necessary care to a covered person. Carriers became concerned that physician contracts which contained what are known as "capitation" or "shared-risk" arrangements may be considered in violation of this provision. Capitation arrangements involve a monthly or annual, fixed payment to a physician that does not change no matter how many covered services or procedures are utilized. Under these arrangements, a physician shares in some of the "risk" of the utilization of his or her services. These arrangements are generally considered an acceptable element of managed care and it is not the Insurance Department's intent to make capitation or other risk sharing arrangements illegal. To make that explicit, the amendment proposes the following language be added to Section 9, at page 6, line 2: "This subsection does not prohibit a preferred provider arrangement from including capitation arrangements or shared-risk arrangements that are not tied to specific medical decisions with respect to a patient." Capitation arrangements are already specifically provided for in subsection 1(a) of Section 26.1-47-02. However, industry felt more comfortable with capitation being specifically mentioned in this section as well.

Second, as drafted, House Bill No. 1178 requires health insurers to file all preferred provider arrangements with the Department on a prior approval basis. In other words, the Insurance Department must approve the arrangements prior to their use in this state. This is identical to the process in place for the filing and approval of insurance policies. Carriers were concerned that a prior approval requirement may hinder their ability to use preferred provider arrangements in a timely manner. In order to address this concern, the Insurance Department is proposing House Bill No. 1178 be amended to impose a "use and file" requirement for preferred provider arrangements rather than prior approval. Under this "use and file" requirement, a health insurer would be required to file the preferred provider arrangement with the Insurance Department within 10 days of the arrangement implementation. After review the Commissioner could declare the contract void and prevent its continued use, if the Commissioner finds the arrangement does not meet the requirements of Chapter 26.1-47. Essentially, the Commissioner would not be required to give prior approval to the arrangement but could withdraw the arrangement from the market, if necessary.

The proposed amendments also clean up a part of the relating to clause in the introductory portion of the bill.

Lastly, the proposed amendments add a new section to the bill. This section changes the defined term "preferred provider agreement" to "preferred provider arrangement". When I was drafting the original bill, I maintained the term used in the body of Chapter 26.1-47, which is preferred provider arrangement. I noticed later that the defined term was "preferred provider agreement". This amendment cleans up an existing inconsistency in the terms used in Chapter 26.1-47.

NATIONAL PATIENT ADVOCATE FOUNDATION

A Network for Healthcare Reform
780 Pilot House Drive, Suite 100-C Newport News, Virginia 23606
TEL: 757.873.6668 FAX: 757.873.8999 E-MAIL: ndepaf@pinn.net INTERNET: http://www.npaf.org

December 11, 1998

Dear Senator,

Please find enclosed a Resolution that we are requesting that you introduce before your Senate for immediate vote in the earliest days of your 1999 General Assembly opening. We urge your support of this Resolution that calls for regulation of ERISA plans to be restored to the State Insurance Commissioner and State Attorney General with joint reporting to The U. S. Department of Labor as originally required by the 1974 ERISA law. Due to the fact that 62% of all insured Americans are now in ERISA plans for which there is no provision currently in State or Federal law that provides for relief to individual consumers whose insurance benefits have been denied under ERISA. The Federal ERISA law of 1974 requires that no punitive damages be awarded in ERISA suits and that no compensation to the attorney representing the patient or the patient's representative be provided by the court. Additionally, ERISA cases fall in the Federal court jurisdiction. If initiated in State courts, the suits are routinely removed to Federal jurisdictions which further limits the consumers ability to seek remedy when denied coverage.

Please find enclosed a summary of items that are currently not addressed as consumer protection in any of your state's health laws. Please note also the total number of Insured Persons in your state and the total Citizens Enrolled in ERISA Plans in your state and than note the total number of citizens that would benefit from any change in state health law. The majority of insured are enrolled in ERISA plans that are exempt from any state law; thus the only remedy available is through Congressional action in the reform of the ERISA law of 1974, which is what our enclosed Resolution requests.

Please note on page three of the enclosed Resolution the statement that provides specific immunity for employers for any liability in this matter: "WHEREAS Employers shall be immune from prosecution within an ERISA claim and shall have the right to remain self-funded without of liability through ERISA plans." .

We appreciate your thoughtful consideration of this request. As a national organization and the newest member of The Cancer Leadership Counsel of America, we have been advised by Congressional members actively seeking passage of the Patient Bill of Rights that hearing the voices of State General Assemblies that pass the enclosed Resolution, in fact, will offer significant support to the National Patient Bill of Rights. We urge that you and your State support this initiative. Please contact our office to inform us of your position on this matter.

Respectfully submitted:

Nancy Davenport-Ennis

Nancy Davenport-Ennis
Founding Executive Director

NORTH DAKOTA

North Dakota does NOT provide the following protections:

- Prudent Layperson Standard for E.R. Services
- Referral to Out-of-Network Providers
- Specialists as Primary Care Providers
- Standing Referrals to Specialists
- OB-GYN Direct Access
- Continuity of Care When Physicians Leave the Plan
- Access to Non-formulary Prescriptions
- Independent External Review
- Independent Ombudsmen Program for Consumers
- Prohibition of Physician Financial Incentives
- Access to Clinical Trials
- Right to Sue Health Plan for Damages

Total Privately-Insured:	400,000
Covered Under Self-Insured ERISA Plans:	126,000
Covered Under All ERISA Plans:	280,000
Not Covered For Substantive Protections Under Nickles Bill[1]:	274,000
Not Covered At All Under Nickles Bill[2]:	120,000

In contrast, the Democratic *Patients' Bill of Rights* (S. 1890) would ensure that all privately-insured patients in North Dakota receive all of these protections.

1 Includes those with individually purchased insurance, State/local government employee plans, and ERISA fully-insured plans (total privately-insured minus self-insured ERISA).

2 Includes those with individually purchased insurance and with State/local government employee plans (total privately-insured minus total ERISA).

All estimates are based on figures provided by DOL. DOL figures are estimated from EBRI tabulations of 1997 CPS and RWJ Foundation survey.

A RESOLUTION memorializing the U.S. Congress to amend ERISA to grant authority to the several states to regulate self-funded employer-based health plans.

Whereas, the McCarran -Ferguson Act, passed by the U.S. Congress in 1945, established a statutory framework whereby responsibility for regulating insurance and the insurance industry was left largely to the states; and

WHEREAS, the Employee Retirement Income Security Act of 1974 (ERISA) significantly altered this concept by creating a federal framework for regulating employer-based pension and welfare benefit plans, including health plans; and

WHEREAS, ERISA preemption effectively prohibits states from directly regulating most employer-based health plans, which are not deemed to be "insurance" for purposes of Stark laws which results in ERISA preemption from state regulation and

WHEREAS, over the past twenty-four years, state governments have gradually come to realize that ERISA is an impediment to ensuring adequate consumer protections for all individuals with employer-based health care coverage and to enacting administrative simplification and cost reduction reforms that could improve the efficiency and equity of their health care markets; and

WHEREAS, available data suggests that self-funding of employer-based health plans is increasing at a significant rate, both among larger and smaller businesses; and

WHEREAS, between 1989 and 1993, the General Accounting Office estimates that the number of self-funded plan enrollees increased by about six million individuals; and

WHEREAS, approximately 40-50 % of employer-based health plans are presently self-funded by employers, who retain most or all of the financial risk for their respective health plans; and

WHEREAS, as self-funding of health plans has grown, states have lost regulatory oversight over a growing portion of the health market; and

WHEREAS, as this phenomenon continues, state governments are slowly but surely losing their ability to manage their health care markets; and

WHEREAS, given the improbability of federal reforms to achieve universal health coverage in the near future, many state legislatures are seeking an active role in expanding the number of individuals covered by an insurance plan and in controlling health care costs and regulating abuses; and

WHEREAS, in a very real sense, ERISA preemption is an obstacle to the states adopting a wide range of health care reform strategies; and

WHEREAS, employers are increasingly adopting funding methods for their health plans that blur the distinction between self-funded and fully insured, including more extensive use of stop-loss coverage and risk-sharing arrangements with managed care organizations; and

WHEREAS, these innovative funding methods have so blurred the distinction between self-funded and fully insured health plans that many experts argue that there is no real distinction at all; and

WHEREAS, the states' inability to protect consumers enrolled in self-funded health plans from employers or plans who fail to provide the consumers' anticipated level of health care is gradually eroding the public's confidence in government, even as self-funded plans are afforded an unfair advantage over traditional health insurance providers due to lack of state or federal accountability, regulation or remedy for the individuals members of ERISA plans confronting insurance denials; and

WHEREAS, many ERISA plan participants and their dependents have died or been permanently injured because courts have narrowly interpreted ERISA's remedy provisions and broadly interpretated ERISA's preemption provisions, thereby creating a substantial, economic incentive for plan administrators to deny medically necessary benefits legitimately covered under ERISA plans;

WHEREAS, the time has now come for the several states to aggressively seek changes in ERISA to give them more flexibility in regulating health plans at the state level and to increase access to health care and to lower health costs; now, therefore,

BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE State of California ,THE SENATE CONCURRING, that this General Assembly hereby memorializes the U.S. Congress to amend the Employment Retirement Income Act of 1974 (ERISA) to grant authority to all individual states the ability to monitor and regulate self-funded employer-based health plans in the interest of providing greater consumer protection and effecting significant health care reforms at the state level through the office of the State Insurance Commissioner and with the legal enforcement through the State Attorney General's offices. Additionally, there shall be cooperative receipt of referral of complaints from the United States Department of Labor to the State Attorney General and the State Insurance Commissioner for regulation and timely enforcement.

WHEREAS Employers shall be immune from prosecution within an ERISA claim and shall have the right to remain self-funded without risk of liability through ERISA plans.

ERISA section 502(a)(1)(B) currently reads as follows:

"(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

Add the following resolution language:

The [organizations endorsing the resolution] urge the United States Congress to amend ERISA section 502(a)(1)(B) as follows:

(B) to recover benefits due to him under the terms of his plan, [to recover from the fiduciary compensatory damages caused by the fiduciary's failure to pay benefits due under the terms of the plan,] to enforce his rights under the terms of the plan, or to timely authorize assurance of payment and clarify his rights to future benefits under the terms of the plans;

BE IT FURTHER RESOLVED, That this General Assembly most fervently urges and encourages each state legislative body of the United States of America to enact this resolution, or one similar in context and form, as show of solidarity in petitioning the federal government for greater state authority in regulating self-funded employer-based health plans.

BE IT FURTHER RESOLVED, That the Chief Clerk of the House of Representatives is hereby directed to transmit enrolled copies of this resolution to the President of the United States; the Secretary of the U.S. Department of Labor; the Speaker and the Clerk of the U.S. House of Representatives; the President and the Secretary of the U.S. Senate, each member of the [State] Congressional delegation; and to the presiding officer of each house of each state legislative body in the United States of America.

HOUSE BILL NO. 1178
TESTIMONY BEFORE THE SENATE
INDUSTRY, BUSINESS AND LABOR COMMITTEE

CHRIS EDISON
GENERAL COUNSEL
NORTH DAKOTA INSURANCE DEPARTMENT

Good morning, Mr. Chairman and members of the Senate Industry, Business, and Labor Committee. My name is Chris Edison and I am General Counsel for the North Dakota Insurance Department. I appear today on behalf of Commissioner Pomeroy in support of House Bill No. 1178 and urge its favorable consideration by this committee.

The North Dakota Insurance Department spends a significant amount of time between each legislative session determining what, if any, updates the insurance code, Title 26.1 of the North Dakota Century Code, needs for each area of insurance we regulate. The Department keeps a legislative file into which staff make suggestions for future legislation. The Legal Division then reviews these proposals to determine which ones are of the highest priority and should be proposed as legislation. House Bill No. 1178 is the final result of this process in the area of health insurance.

House Bill No. 1178 contains a number of sections that relate to health insurance. I would like to go through each individual section and talk a little bit about the problem the Department is looking to address with each proposed change.

SECTION 1

The Problem

In 1997, Congress passed, and President Clinton signed, the Balanced Budget Act of 1997 ("the BBA"). The Act allows entities known as Provider Sponsored Organizations ("PSOs") to market what are referred to as Medicare+Choice ("M+C") products if the PSO is licensed by the Insurance Department in the state in which it will market the M+C product. A PSO is defined as a entity established by health care providers, which provides a substantial proportion of health care items and services directly through affiliated providers who share substantial financial risk. It is roughly equivalent to a health maintenance organization ("HMO") set up by providers devoted specifically to marketing M+C products. Essentially, under an M+C product, the PSO provides enrollees with Medicare coverage as if it were the federal government, along with coverage more commonly covered under a Medicare supplement policy. However, the BBA allows the PSO to obtain a waiver of state licensure if the Insurance Department of the state in which the PSO seeks a license imposes a discriminatory requirement on the PSO. The federal rules regarding PSOs also outline certain solvency requirements that states must apply to the PSO which are not currently in state law.

pages missing

constituents of yours who have a health condition to obtain this coverage.

The Solution

The Department is advocating a reduction in the five-year "look-back" period to two years to bring it more in line with what is allowed for major medical coverage. To accomplish this change, Section 4 amends N.D. Cent. Code § 26.1-36-04(1)(d). In fact, 95 percent of these types of policies already comply with a two-year look back provisions. The proposed change would give the Department the ability to force all companies to comply with this industry standard.

SECTIONS 5, 6, 7, AND 8

The Problem

In the last legislative session, the Legislature passed House Bill No. 1168. House Bill No. 1168 was proposed by Commissioner Pomeroy to implement the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). House Bill No. 1168 was a rather lengthy bill and, unfortunately, there are a few provisions that need to be tweaked in order to stay in compliance with the federal act. Sections 5, 6, 7, and 8 propose these changes.

The Solution

Section 5 clarifies that a person who turned down employer coverage when initially eligible because they were covered under another plan has 30 days to request enrollment after losing the other coverage or they will be considered a late enrollee and be subject to an 18-month preexisting condition exclusion.

Section 6 clarifies that a small employer may not modify any of its health benefit plans to restrict coverage for certain diseases or medical conditions otherwise covered by the plan. Under HIPAA, group carriers are not allowed to discriminate based on health status and any modification to restrict coverage would violate HIPAA's anti-discrimination provisions.

Section 7 clarifies that small employer plans offered through associations are not subject to guarantee issue requirements but are subject to all other small employer provisions.

Section 8 clarifies that an 18-month preexisting condition exclusion may be applied to a late enrollee in the large group market, just as it would in the small group market. Without this change, only a 12-month preexisting condition exclusion may be applied.

SECTION 9

This section changes the defined term "preferred provider agreement" to "preferred provider arrangement". When I was drafting the original bill, I maintained the term used in the body of Chapter 26.1-47, which is preferred provider arrangement. I noticed later that the defined term was "preferred provider agreement". This amendment cleans up an existing inconsistency in the

meet the requirements of Chapter 26.1-47. Essentially, the Commissioner would not be required to give prior approval to the arrangement but could withdraw the arrangement from the market, if necessary.

5. Provides that preferred provider arrangements may not provide any incentive for a provider (physician) to provide less than necessary care. For example, under this section, a preferred provider arrangement could not provide an incentive for a physician to recommend a less expensive covered service instead of a more expensive covered service the physician felt was medically necessary to maintain or improve the health of a patient. Section 9 of the bill amends N.D. Cent. Code § 26.1-47-02 to provide that a health insurer may not offer a physician an inducement to provide less than necessary care to a covered person. However, the section specifically allows for contracts known as "capitation" or "shared-risk" arrangements. Capitation arrangements involve a monthly or annual, fixed payment to a physician that does not change no matter how many covered services or procedures are utilized. Under these arrangements, a physician shares in some of the "risk" of the utilization of his or her services. These arrangements are generally considered an acceptable element of managed care and are already specifically provided for in subsection 1(a) of Section 26.1-47-02. It is not the Insurance Department's intent to make capitation or other risk sharing arrangements illegal.

6. Provides that a health insurer may not penalize a physician for, in good faith, reporting a practice or policy of the insurers that the physician feels jeopardizes patient welfare.

Senate Bill No. 2400 also covers some of the same provisions addressed in Section 10 of House Bill No. 1178. They will need to be reconciled by the Legislative Council should both bills pass.