2011 Legislative Update

Most state legislatures have adjourned for the year. This report summarizes the actions taken by state legislatures in response to the Patient Protection and Affordable Care Act (PPACA).

It begins with an overview of where the states are in the process of developing their exchanges and an update on states that have requested waivers for the medical loss ratio (MLR) requirement.


State Health Insurance Exchange Implementation

PPACA sets forth guidelines for states to establish exchanges for individuals and small groups to purchase coverage.

During the 2011 legislative sessions, states were faced with the decision of whether to take steps toward establishing state-based exchanges. If states choose not to establish an exchange, or their exchange does not meet Health and Human Services (HHS) standards, HHS will establish the exchange for the state.

States are at varying stages of readiness related to their exchange development.

- 14 states (CA, CO, CT, HI, IL, MA, MD, NV, OR, UT, VT, VA, WA and WV) have enacted legislation establishing an exchange.
- Massachusetts and Utah have exchanges that are fully operational.
- California passed legislation in 2010, though its exchange is not yet operational.
- The New Mexico Legislature passed an exchange bill, but it was vetoed by the Governor.
- Alabama, Georgia, Indiana, and South Carolina issued executive orders to establish their exchanges.
- Nine states (AR, MD, MS, MT, ND, UT, VA, WI and WY) chose to enact study legislation that will require recommendations.
- 12 state legislatures defeated their exchange bills (AK, AL, AR, AZ, GA, IN, MO, MN, MT, OK, TX and SC).

The Federal government has made a significant investment in the states through exchange-planning grants. Some states have refused the grant money (Alaska, Florida and Minnesota), or have decided to return the funds (Louisiana, Wisconsin and Oklahoma).
Medical Loss Ratio (MLR) Requirements

Beginning in 2011, PPACA requires health plans to meet MLR requirements of 85 percent in the large group market and 80 percent in the individual and small group markets. Insurers must report to each state their total premiums, total expenses for claims and quality improvement, and total dollars spent on non-claims costs (excluding taxes and fees). Health plans must issue a rebate to each enrollee if their MLR does not meet or exceed the required percentage.

The National Association of Insurance Commissioners (NAIC) was charged with making recommendations to HHS for the implementation of MLR requirements. The NAIC gave its final approval to a model MLR regulation on October 21, 2010. HHS issued an MLR Interim Final Rule on November 22, 2010 that incorporated most of the NAIC’s model provisions. The rule included provisions related to Federal reporting requirements, handling of mini-med plans and waivers should the MLR requirements threaten to destabilize the individual market.

During testimony on the proposed rule, the American Academy of Actuaries predicted that there will be significant disruption in the state individual health insurance markets if the current MLR formula remains in place. Despite vocal opposition, administrative expenses such as fraud and abuse expenses, network and contracting fees, broker commissions and other activities were excluded from the “quality improvement” calculation in the final rule.

In order to preserve solvency, minimize disruption and enable competition, 15 states and Guam have taken advantage of the waiver provision and have formally requested a variance to the MLR requirements:

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<thead>
<tr>
<th>State/Territory</th>
<th>Request</th>
<th>Date Submitted</th>
<th>Action Taken</th>
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</thead>
<tbody>
<tr>
<td>Delaware</td>
<td>65% for 2011, 70% for 2012, 75% for 2013, 80% for 2014+</td>
<td>5/11</td>
<td>Public comments were received 7/21/11</td>
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<tr>
<td>Florida</td>
<td>2011–2013: 65% for insurers, 70% for HMOs, 80% for 2014+</td>
<td>3/11/11</td>
<td>Pending</td>
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<td>Georgia</td>
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<td>Indiana</td>
<td>65% for 2011, 68.75% for 2012, 72.5% for 2013, 76.25% for 2014, 80% for 2015+</td>
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<tr>
<td>Iowa</td>
<td>65% for 2011, 70% for 2012, 75% for 2013, 80% for 2014+</td>
<td>3/21/11</td>
<td>Partially Approved</td>
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<tr>
<td>Kansas</td>
<td>70% for 2011, 73% for 2012, 76% for 2013, 80% for 2014+</td>
<td>4/29/11</td>
<td>Pending</td>
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<td>Kentucky</td>
<td>65% for 2011, 70% for 2012, 75% for 2013, 80% for 2014+</td>
<td>2/16/11</td>
<td>Partially Approved</td>
</tr>
<tr>
<td>Louisiana</td>
<td>70% for 2011, 75% for 2012, 80% for 2013+</td>
<td>3/29/11</td>
<td>Pending</td>
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<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Request</th>
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<tr>
<td>Maine</td>
<td>65% for 2011–2013, 80% for 2014+</td>
<td>12/16/10</td>
<td>Approved with changes 3/8/11</td>
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<td>Michigan</td>
<td>65% for 2011, 70% for 2012, 75% for 2013, 80% for 2014+</td>
<td>7/28/11</td>
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<tr>
<td>Nevada</td>
<td>72% for 2011, 80% for 2012+</td>
<td>2/9/11</td>
<td>Amended and approved 75% for one year</td>
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<tr>
<td>New Hampshire</td>
<td>70% until 2014, 80% for 2014+</td>
<td>1/12/11</td>
<td>Amended and approved 72% in 2012, 80% in 2013</td>
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<td>North Carolina</td>
<td>72% for 2011, 74% for 2012, 76% for 2013</td>
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<tr>
<td>North Dakota</td>
<td>65% for 2011, 70% for 2012, 75% for 2013, 80% for 2014+</td>
<td>3/18/11</td>
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<td>Oklahoma</td>
<td>65% for 2011, 70% for 2012, 75% for 2013, 80% for 2014+</td>
<td>9/1/11</td>
<td>Pending</td>
</tr>
<tr>
<td>Texas</td>
<td>71% for 2011, 74% for 2012, 77% for 2013, 80% for 2014+</td>
<td>7/29/11</td>
<td>Pending</td>
</tr>
<tr>
<td>Guam</td>
<td>2011–2013: 65% for individual, 70% for small group, 80% for large group</td>
<td>4/15/11</td>
<td>Denied – All issuers presumed to meet or exceed the 80% MLR standard</td>
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</table>
MLR Requirements (continued)

States have the authority to increase MLR thresholds and related requirements, such as consumer notification and additional reporting. Fifteen states had MLR requirements prior to the passage of PPACA. During the 2011 legislative session, 15 states considered 24 separate proposals related to MLR, though most were specifically related to conformity with PPACA.

The Federal government and the NAIC continue to further define the scope of the MLR regulations. The NAIC issued a preliminary report that included an assessment of what rebates would have been in 2010 if the rebate requirement had been in effect. The report also indicated that broker commissions have decreased since the introduction of the MLR requirement.

There will continue to be a great deal of activity related to implementation of MLR requirements. Several more states are considering waivers. Texas recently collected market data to substantiate the need for a state MLR waiver. In addition, the broker community continues to advocate for the ability to change the way broker commissions are treated in the MLR calculation.

Rate Setting

On May 19, The Centers for Medicare and Medicaid Services (CMS) issued final rate review regulations for individual and small group policies as part of PPACA.

Beginning in September 2011, insurers proposing rate increases of at least 10 percent will be subject to rate request disclosure and must justify the increases. Beginning September 1, 2012, the 10 percent threshold will be replaced with a new state threshold.

States will have the primary responsibility for reviewing rate increases and have already received a combined $46 million from the Federal government to strengthen their rate review mechanisms. Only five states (AK, GA, IA, MN and WY) chose not to apply for the grant funding.

The Federal government will review rates in states that fail to adapt their process to comply with PPACA. HHS does not have the authority to deny rate increases, though states are taking steps to further strengthen their authority to reject “unreasonable” rate increases. According to HHS, seven states (AL, AZ, ID, LA, MO, MT and WY) do not have effective rate review programs for either individual or small group plans, so Federal officials will conduct reviews in both markets. In three other states (IA, PA and VA) the Federal government will review proposed rate increases for small groups and will allow states to review individual rates.

According to the NAIC, 29 states already have prior approval of rates authority. Over half of these states already have broad authority that applies to nearly all regulated policies, not just small group and individual plans (CO, FL, IA, KY, MD, MA, MN, NM, NY, NC, ND, OH, PA, RI, VT and WV).

- During the 2011 legislative sessions, 21 states addressed premium rate review changes (AR, CA, CT, HI, IA, IL, KS, ME, MA, MT, ND, NM, NY, OK, PA, RI, TN, UT, VT, WA and WV).
- Ten states have enacted Legislation related to rate review (HI, ME, ND, NM, NY, OK, TN, UT, VT and WA).
- The Connecticut Legislature passed a rate review bill that was vetoed by the Governor. Leadership is working toward a compromise.
Health Care Compacts and Cross Border Insurance Sales

Insurance companies are protected from interstate competition by the Federal McCarran-Ferguson Act of 1945 which allows states to regulate health plans within their state.

States fight vigorously to maintain their regulatory authority, which has led to ongoing discussion about ways to grant authority to the states, while still allowing competition across state lines. In addition, PPACA allows states to offer nationwide qualified health plans in the individual and small group markets.

Democrats responded by including a provision to allow states to pass enabling legislation that would establish health care choice compacts beginning in January 2016. Compacts must meet Federal minimum requirements established by PPACA. In addition, the policies would be governed by the laws of the state in which the policies were issued.

In 2010, 16 states considered legislation to allow cross-border sales. In the 2011 legislative sessions, 27 states considered proposals. Nearly all of these states’ bills deviate from PPACA by not requiring that the coverage be governed by the laws of the state in which the policy was issued.

- Georgia, Maine and Utah passed legislation taking an independent approach to allowing the sale of insurance in other states.
- Washington and Wyoming passed legislation that took the compact approach.
- Legislation has been approved in Alaska and is awaiting the Governor’s approval.
- The Arizona Legislature passed a bill, but it was vetoed by the Governor.

Anti-Competitive Most Favored Nation (MFN) Clauses

CIGNA is working with doctors, hospitals and employers to maintain a competitive marketplace that allows insurers to negotiate the most favorable rates in a fair and consistent manner.

MFN clauses traditionally require a health care professional to give the payor the lowest rate that it gave to any other comparable payor. The availability of MFN clauses is somewhat limited because they are usually attainable only by the largest payors.

MFN clauses produce marketplaces in which new competitors are unable to survive. They permit sellers to maintain artificially high floor prices that suppress competition and increase rates.

As a result of the detrimental impact these clauses create in the marketplace, several states have taken steps to ban all MFN clauses. At least 19 states have laws on the books prohibiting or restricting the use of MFN clauses.

Attorneys General and Insurance Commissioners in Connecticut, Georgia and Michigan are investigating the issue. The increased scrutiny has prompted the Department of Justice to begin investigating the issue. In April 2011, the Department of Justice asked BCBS plans in at least six states (MO, SC, NC, WV, MD and VA) and the District of Columbia for information related to their use of MFN clauses.
Key Legislation by State

ARIZONA

The 2011 Arizona legislative session adjourned on April 20. Although several bills related to health care reform were heavily debated in each chamber, the state ultimately was unable to enact any meaningful legislation. Most notably, the legislature opted to stall legislation designed to create a state exchange that was fairly well-received by stakeholders.

KEY LEGISLATION SIGNED BY GOVERNOR BREWER

Tax Credits: HB 2556 establishes individual and employer tax credits for health savings account contributions and contributions to high deductible health plans.

CALIFORNIA

The 2011 California Legislature adjourned on September 9. The most contentious piece of legislation relevant to the insurance industry was a bill that would have granted state regulators the authority to approve or reject individual and group medical rates. Ultimately, however, this rate regulation legislation was shelved in 2011 for potential reconsideration in 2012. Governor Brown has until October 9 to take action on legislation approved at the end of the session.

LEGISLATION SIGNED BY GOVERNOR BROWN

Transparency: Effective January 1, 2012, SB 751 prohibits contracts between HMOs/insurers and facilities from containing clauses that restrict the ability of the HMO or insurer to provide enrollees or insured individuals with information on the range of costs or quality of procedures and services provided by the facility. The bill requires insurers to provide hospitals or facilities the opportunity to review data and methodologies for validation at least 20 days before information is provided to patients. It also requires online disclosures informing enrollees that hospitals or facilities may disagree with the information and stating factors that could affect validity.

KEY BILLS APPROVED BY THE LEGISLATURE AND AWAITING APPROVAL BY GOVERNOR BROWN

Autism Mandate: SB 946 mandates HMOs and insurers to cover the treatment of pervasive developmental disorders and autism effective July 1, 2012. Specifically included are requirements to provide coverage for applied behavioral analysis and other intensive behavior programs, as well as a requirement to maintain an adequate network of autism service providers.

Maternity Mandate: AB 210/SB 222 (AB 185) require individual and group health insurance policies to provide coverage for maternity services beginning no later than July 1, 2012. Maternity services are defined to include prenatal care, ambulatory care, involuntary complications, neonatal care and inpatient hospital care (including labor, delivery and postpartum care). The bill specifies that this definition of maternity services is effective until final regulations or guidance define the required scope of maternity benefits under the PPACA.

Medical Loss Ratio: SB 51 requires HMOs and insurers to comply with provisions of PPACA prohibiting lifetime and annual limits and mandating rebates for failure to meet required loss ratio standards. The bill references the federal requirements specifically and applies to all HMOs and health insurers. Rulemaking authority is provided and clarifications are included to specify that the provisions are to be implemented to the extent required by federal law, and must comply with, but not exceed, the scope and requirements of the PPACA and rules or regulations related to the PPACA provisions.

COLORADO

The Colorado General Assembly adjourned sine die on May 11, ending a session marked by intense debates over redistricting and proposed implementation of Federal health care reform provisions. Redistricting remains unresolved and will be referred to the courts to make final determinations on district boundaries. At the close of session, legislators reached agreement and finally passed a bill to establish a health benefit exchange in Colorado.

LEGISLATION SIGNED BY GOVERNOR HICKENLOOPER

Exchange: SB 200 establishes a nonprofit entity to operate the exchange, governed by 12 board members. The bill also establishes a Legislative Health Benefit Exchange Implementation Review Committee to oversee the implementation process. The bill stipulates that all carriers meeting PPACA minimum requirements will be allowed to participate in the exchange and that the new entity may not duplicate existing regulatory functions.

Child-only Coverage: SB 128 requires all carriers in the individual market to provide at least one child-only health plan for children up to age 19, without regard to pre-existing conditions. The plan(s) must be offered during two open enrollment periods, the first being the month of August 2011 and subsequent enrollment periods being January and July. Enrollment periods must be followed by a 30-day waiting period for the child-only plans to take effect.
Insurance carriers must also accept applications for child-only plans received within 30 days after a qualifying event. Carriers may deny coverage if other creditable coverage is available and may impose a 12-month 50% surcharge for previously enrolled individuals who dropped coverage.

**Small Group Coverage:** SB 19 would allow a small employer who does not provide, and has not in the previous 12 months provided, a small group health plan to his or her employees to reimburse employees through wage adjustments or a health reimbursement arrangement for any portion of a premium for health insurance.

**CONNECTICUT**

The 2011 Connecticut legislative session adjourned on June 8. Prior to adjourning, the legislature passed SB 11, creating a new rate review process, which was vetoed by Governor Malloy on July 5. The legislature chose not to override the veto and instead reached a compromise that will allow the Healthcare Advocate to request up to four public rate review hearings per year.

**KEY BILLS SIGNED BY GOVERNOR MALLOY OR EFFECTIVE WITHOUT HIS SIGNATURE**

**Exchange:** SB 921 creates the Connecticut Health Insurance Exchange, a quasi-governmental entity governed by a 14-member board of directors.

**Omnibus Health Care Reform:**

HB 6308 creates the Office of Health Reform and Innovation and the Sustinet Health Care Cabinet. The bill also implements several provisions included in PPACA (e.g., rescissions, MLR). HB 6308 also institutes new claims data reporting requirements, sets forth network adequacy standards and repeals the existing Sustinet law.

**Most Favored Nation Clauses:** HB 6471 prohibits contracting health organizations from including an MFN clause in a contract with a doctor, dentist or hospital (SB 1083).

**FLORIDA**

The 2011 Florida legislative session adjourned on May 6. The session convened with the expectation of the two chambers advancing a more conservative agenda with their respective supermajorities and a Governor aligned with the goal of lowering spending and taxes. The session adjourned with a significantly reduced budget due to the $4 billion deficit and significant major policy overhauls. The Scott Administration decided not to implement the Federal health care reforms until the courts have ruled on the constitutionality of the individual mandate.

**CONSTITUTIONAL AMENDMENT**

**Individual Mandate:** S.J.R. 2 proposes an amendment to the State Constitution prohibiting laws or rules compelling any person or employer to purchase, obtain or otherwise provide for health care coverage. It permits a person or an employer to purchase lawful health care services directly from a health care professional and permits the provider to accept direct payment from a person or an employer for lawful health care services. A proposed Constitutional amendment will be placed on the November 2012 ballot.

**KEY BILLS SIGNED BY GOVERNOR SCOTT**

**Health Care Compact:** HB 461 requires Georgia to join a health care compact with other participating states in accordance with the terms of the compact. Congress must consent to the creation of the compact. By consenting to this compact, Congress authorizes each member state to enact state laws that supersede any and all Federal laws regarding health care within its state.

**Wellness or Health Improvement Programs:** HB 445 authorizes health plans to offer voluntary wellness or health improvement programs and to encourage participation in such programs by offering rewards or incentives to health plan enrollees. The bill allows health plans to require customers not participating in these programs to furnish verification that their medical condition prohibits participation in such activities in order to receive rewards or incentives. The programs and related incentives must be disclosed in the policy or certificate. Finally, the bill clarifies that such programs are not a violation of the unfair trade practices statutes.

**GEORGIA**

On April 16, the Georgia Legislature adjourned the 2011 regular session. The legislature devoted the majority of the session to the challenging fiscal climate and immigration and tax reforms. With the GOP divided on their approach to health care implementation, Georgia was unable to enact any legislation to address reform.

**KEY BILLS SIGNED BY GOVERNOR DEAL**
Federal and state law regarding health care will remain in effect unless a member state expressly invokes its authority under this compact. This bill also creates an Interstate Advisory Health Care Commission among the compact member states.

**Cross Border Sales:** HB 47 requires the Insurance Commissioner to approve for sale any individual policy that has been approved for issuance in another state where the insurer is authorized to transact insurance. Additionally, any insurer authorized to transact insurance in Georgia may offer an individual policy with benefits equivalent to those in any policy approved for sale in Georgia, provided that any such policy complies with actuarial standards set forth by the NAIC and any regulation promulgated by the Commissioner consistent with such standards.

**Prompt Pay/ERISA Plans:** HB 167 extends the current prompt pay laws to ERISA plans and TPAs. The bill establishes a 95 percent threshold of claims processed timely before interest can be assessed. The bill also includes language that removes the minimum number of employees that must be included in an association health plan.

**ILLINOIS**

The Illinois General Assembly adjourned on May 31 after an intense session focusing on numerous health care-related bills. During the legislative session, Insurance Director Mike McRaith was picked by the U.S. Treasury to run the newly created Federal Insurance Office. No replacement has been named.

**KEY BILLS SIGNED BY GOVERNOR QUINN**

**External Review:** HB 224 is intended to bring Illinois into compliance with the external review standards of PPACA. The bill changes the definition of “adverse determination” in the Health Carrier External Review Act to include rescissions of coverage determinations. In some cases, the bill deviates from the NAIC External Review Model legislation.

**Recoupment:** HB 1193 makes changes to the information required to be displayed on the remittance advice or written document containing the insurer’s demand for recoupment or offset. The bill also provides that any appeal of a recoupment or offset by a health care professional must be made within 60 days after receipt of the remittance advice. It also provides that no recoupment or offset may be requested or withheld from future payments 18 months or more after the original payment is made, except in certain cases.

The Illinois Legislature adjourned on April 29 after a raucous legislative session fueled by a new Republican majority and a resulting five-week walk-out by Democratic legislators. As a result, very few bills passed.

**INDIANA**

The Indiana Legislature adjourned on April 29 after a raucous legislative session fueled by a new Republican majority and a resulting five-week walk-out by Democratic legislators. As a result, very few bills passed.

**KEY BILLS APPROVED BY THE LEGISLATURE**

**Budget Bill:** HB 1001, the budget bill, includes several changes to Medicaid and the Indiana Comprehensive Health Insurance Association. The bill also requires universities to participate in the state health plan if required by the budget agency.

**Pathology Services:** HB 1071 prohibits a health care professional from soliciting payment for an anatomic pathology service unless the service is rendered or supervised by the health care professional.

**MARYLAND**

The Maryland General Assembly adjourned the 2011 regular legislative session at midnight on April 11. The budget and $1.5 billion shortfall dominated the legislative session, but health insurance received significant attention with efforts to implement Federal health care reforms. Less than 12 hours after adjournment, Governor O’Malley conducted his first bill signing ceremony with HB 166/SB 182 (Maryland Health Benefit Exchange) and HB 170/SB 183 (Federal implementation) leading the list of bills obtaining his signature.

**KEY BILLS SIGNED BY GOVERNOR O’MALLEY**

**Health Care Exchange:** HB 166/SB 182 establishes the Maryland Health Benefit Exchange as a public corporation with the option to convert to a nonprofit entity.
HB 166/SB 182 creates separate individual and small group exchanges. Carriers contracting directly with the exchange are prohibited from serving on the nine-member Exchange Board of Trustees. However, insurers may serve on an Advisory Committee comprised of carriers, health care professionals, brokers, employers, public employee unions and individuals.

The Board is permitted to contract with entities experienced in individual and small group insurance, or facilitating enrollment in those plans, to assist creating the exchange. The exchange may not exercise any powers or duties until it studies the additional legislation necessary to carry out its functions and provides recommendations to the General Assembly for the 2012 legislative session.

**Federal Reform Implementation:**
HB 170/SB 183 implements several PPACA reforms. HB 170/SB 183 establishes the following: 1) expands the definition of dependent coverage to age 26; 2) limits annual and lifetime dollar limits on essential benefits; 3) prohibits rescissions except in cases of fraud; 4) requires coverage of preventive health and wellness services without cost-sharing; 5) permits the selection of an OB/GYN or pediatrician as a primary health care professional for women and children; and 6) prohibits pre-existing condition exclusions for individuals under age 19.

**Electronic Health Records Incentives:**
HB 736/SB 772 requires incentives for the adoption and use of electronic health records to be paid in cash, unless a specific payor and health care professional agree on an incentive of equivalent value. HB 736/SB 772 requires the Maryland Health Care Commission to conduct a study and report findings to the General Assembly on or before January 1, 2013.

**MINNESOTA**
The Minnesota Legislature adjourned on May 23 without passing any significant health care legislation. All budget bills passed by the legislature were vetoed by the Governor, and the session ended without approval of a state budget for the next two years.

The Republican-controlled legislature and Democratic Governor Dayton continued to negotiate on a plan to resolve the state’s $5 billion budget deficit. When they failed to reach a budget agreement by June 30, the Minnesota state government shut down all but essential services effective July 1. A budget agreement was reached on July 20, and state government employees returned to work on July 21.

**MISSOURI**
The Missouri General Assembly adjourned on May 30. Governor Jay Nixon must act on legislation by July 14 or it becomes law. The effective date for all non-emergency legislation is August 29. This session focused on the creation of an exchange through HB 609, which ultimately failed to pass. Additionally, CIGNA spearheaded an effort to pass a bill prohibiting Most Favored Nation clauses, which was ultimately stalled in committee.

**MONTANA**
On April 28, the Montana Legislature adjourned the 2011 regular session. Unlike most states, Montana started its session in the enviable position of not facing a budget shortfall for 2011.

**Mandate Review and Transparency:**
SB 62 allows an insured to request cost-sharing information for specific services and establishes a mandate review mechanism for any proposed mandated benefit legislation.

**Key Legislation by State (continued)**
NEVADA

The Nevada Legislature adjourned the 2011 regular session on June 7. Incoming Republican Governor Brian Sandoval expressed that opposition to Federal reform was a top priority in 2011, but with the legislature not scheduled to meet in 2012, the need for action on implementation issues was greater in Nevada than other states that meet annually. The legislature pushed through bills related to reform, but some of these bills (such as enhanced rate regulation) were vetoed by the Governor.

KEY BILLS SIGNED BY GOVERNOR SANDOVAL

Health Insurance Exchange: SB 440 establishes the Silver State Health Exchange containing the basic framework and structure for the exchange and requiring an implementation plan to be developed by the end of 2011. However, while the bill contains general duties and requirements to comply with the PPACA provisions relating to exchanges, many substantive matters have been left undefined. Issues not addressed include long-term funding sources, the means of selecting or identifying participating health plans, and any additional requirements for participation (if any).

Omnibus Insurance Bill: SB 278 requires health insurers seeking to modify a contract with a health care professional to provide notice of any modification at least 45 days prior to the date on which it becomes effective and would require the insurer to disclose to a health care professional upon request a fee schedule demonstrating any changes. The notice and disclosure requirements would also apply to contracts between dentists and dental care organizations.

KEY BILLS VETOED BY GOVERNOR SANDOVAL

Reimbursement of Emergency Services: SB 115 establishes standard payment methodologies for out-of-network doctors and hospitals providing emergency care for insured individuals. Exceptions are included that would permit hospitals or doctors to deny the standard payment as payment in full if 1) the insurer or health plan's network does not meet adequacy standards developed by the Nevada Department of Health and Human Services; 2) the payer has not filed necessary quarterly adequacy reports; 3) the payer did not participate in a negotiation or mediation; 4) the individual does not pay the required deductible or cost-sharing; 5) the payer does not submit payment within 30 days of receipt of the bill (or after the conclusion of negotiation, mediation, etc.). Balance billing prohibitions are included.

NORTH CAROLINA

On June 18, North Carolina adjourned its regular legislative session. Bills that did not pass will be carried over for the 2012 legislative session, including the exchange bill (HB 115) and the prohibition of Most Favored Nation clauses (SB 517).

KEY BILLS SIGNED BY GOVERNOR PERDUE

Prior Approval/Minimum Loss Ratio/Child Only: HB 298 requires prior approval of small group health insurance rates and prohibits premiums from being excessive, inadequate or unfairly discriminatory. HB 298 requires the Commissioner to approve or disapprove premium rates within 60 days of receipt of a complete filing.

The bill requires the Commissioner to adopt rules to prevent the Federal pre-emption of health insurance regulation. Additionally, the rules must establish medical loss ratios in accordance with accepted actuarial practices. The bill requires an insurer offering nondependent child coverage to offer open enrollment either continuously throughout the year or for the months of January and July of each year.

Health Information Exchange: SB 375 creates a voluntary statewide Health Information Exchange Network intended to improve the quality of health care delivery within North Carolina. The exchange will provide for the secure electronic transmission of individually identifiable health information among health care professionals, health plans and health care clearinghouses in a manner that is consistent with HIPAA. The exchange will be a nonprofit corporation with a board selected by the Governor.

Pharmacy Audits: HB 644 requires each entity conducting a pharmacy audit to provide an appeal mechanism for an unfavorable preliminary audit report. The bill prohibits recoupment of any disputed funds before the final internal disposition of an audit and sets forth a refund process.
SOUTH CAROLINA

On June 2, South Carolina adjourned their regular legislative session. Prior to adjournment, legislators approved a limited-agenda session convening June 14 to address a list of unfinished issues, such as redistricting and state appropriations. Neither health insurance issues nor health care reform implementation were a priority for the legislature during the regular session. South Carolina joins several southeastern states that have not enacted legislation creating a health insurance benefit exchange. The health insurance bills on the June 14 limited agenda are limited to state appropriations issues affecting Medicaid and the State Employee Health Plan.

KEY BILLS SIGNED BY GOVERNOR HALEY

Tort Reform: HB 3375 provides limits on the award of punitive damages and sets procedures and requirements for the awarding of such damages.

KEY BILLS AWAITING ACTION BY GOVERNOR HALEY

Pre-existing Condition: HB 3344 expands the definition of unfair discrimination to include an insurer denying, refusing to issue or renew, cancelling, restricting or excluding coverage. The bill also prohibits adding a premium differential to a policy or certificate of coverage on the basis that an applicant or insured has been the subject of abuse. In addition, the bill prohibits imposing pre-existing condition exclusions based on abuse status, use of abuse status in the underwriting of a policy, or termination of group coverage after divorce or separation because coverage was originally issued in the name of the abuser.

TENNESSEE

The Tennessee General Assembly adjourned the 2011 legislative session in a late night floor session on Saturday, May 21. Although health insurance was not a significant issue this session, the General Assembly voiced its displeasure with Federal health care reform. Consistent with several southeastern states, Tennessee enacted legislation prohibiting any law from compelling an individual to purchase health insurance. In addition, Tennessee did not enact legislation establishing a Health Care Benefit Exchange.

KEY BILLS SIGNED BY GOVERNOR HASLAM

Tennessee Health Care Freedom Act: SB 79/HB 115 declares that every Tennessee individual is free to choose or to decline to choose any mode of securing health care services without penalty or threat of penalty. Also, the bill declares that every person within Tennessee has the right to purchase health insurance or to refuse to purchase health insurance. SB 79/HB 115 specifies that the government may not interfere with a citizen’s right to purchase health insurance or a citizen’s right to refuse to purchase health insurance, or impose a form of punishment for exercising either of these rights.

Rate Review: SB 1539/HB 2005 establishes requirements for the approval and disapproval of policy forms, premium rates and classifications of risk by the commissioner of the Department of Commerce and Insurance for any individual or small group insurance offered by an issuer of accident and sickness insurance, nonprofit hospital, medical service corporation or health maintenance organization. The Department of Commerce and Insurance felt SB 1539/HB 2005 was necessary in order to implement the rating provisions of PPACA.

Wellness Programs/Promotional incentives: SB 1119/HB 682 authorizes insurers to use incentives and rewards to encourage or reward participation in a health promotion program with merchandise, gift cards, debit cards, premium discounts and incentives having to do with copays or deductibles.

Dental Contracts/Non-covered Services: SB 1464/HB 1779 prohibits a contract between a dental insurer and a dentist from requiring a dentist to accept an amount set by the dental insurer as payment for dental care services that are not covered dental services under the covered person’s dental plan.

TEXAS

The Texas Legislature adjourned on May 30 and was not scheduled to meet again for a regular biennial session until January 2013. This is critical as Texas chose not to enact exchange legislation and will not have another opportunity to comply with Federal implementation timelines. During the final hours of the regular session, agreement was not reached on the budget, prompting Governor Perry to call a special session to address education funding. The call also includes redistricting and health care issues, including a measure establishing parameters for Accountable Care Organizations, an all-payer claims database and cross-border health insurance sales.

KEY BILLS APPROVED BY THE LEGISLATURE

Dental Contracts: SB 554/HB 1776 prohibits carriers from applying discounts to non-covered services.

Discretionary Clauses: HB 3017 prohibits insurers from using discretionary clauses.
Prescription Drugs: HB 1405 removes the exemption for small group health plans in the requirement for disclosure of prescription drug formulary coverage information. Modifications requiring notice include removing a drug from a formulary; adding a requirement that an enrollee receive prior authorization for a drug; imposing or altering a quantity limit for a drug; imposing a step-therapy restriction for a drug; and moving a drug to a higher cost-sharing tier unless a generic drug alternative to the drug is available.

Prompt Pay: HB 2292 (SB 1211) requires an insurer, HMO or pharmacy benefit manager that administers pharmacy claims to make payment within 18 days. For non-electronic claims, the deadline is 21 days after the date on which the claim was affirmatively adjudicated.

Exclusive Provider Organizations (EPOs): HB 1772/SB 1430 allows for the sale of EPOs. EPOs are plans in which an insurer excludes coverage to an insured for some or all services, other than emergency care provided by a non-participating health care professional.

UTAH

On March 10, the Utah Legislature adjourned the 2011 regular session. Despite having a short session and ongoing budgetary concerns, the Republican-dominated legislature devoted considerable time to developing and approving comprehensive health care reform legislation.

KEY BILLS SIGNED BY GOVERNOR HERBERT

Omnibus Reform Bill: HB 128 is comprehensive reform legislation that, among other things, makes numerous changes to the existing Utah exchange, implements various PPACA reform provisions, expands small employer rating factors, charges the Utah Insurance Department with conducting actuarial reviews of small employer rates, directs the Departments of Health and Insurance to convene stakeholder groups to coordinate and monitor progress on demonstration projects for delivery and payment reform, amends requirements affecting the state’s All Payer Claims Database, expands electronic information transparency, eliminates the current basic health plan standard and defines a basic benefit plan as a federally qualified high deductible health plan, amends existing requirements for small employer mental health coverage offerings, permits the inclusion of formularies or preferred drug lists, and prohibits insurers providing alternative coverage to COBRA or mini-COBRA (such as NetCare) from using certain risk factors.

Abortion Coverage: HB 354 prohibits offering health plans, both outside and inside the exchange, that provide coverage for abortions unless the abortion is classified as a "permitted" abortion.

Rebating: HB 333 prohibits inducements that are not specified in or directly related to the insurance contract, and prohibits insurers from knowingly allowing an insurance agreement that is not clearly expressed in the contract to be issued or renewed. The bill notes that it does not prohibit reduced premiums because of expense savings, approved incentives to participate in programs to reduce claims or expenses, or premium payment by installment. Also not prohibited are “social courtesy” of the usual kind, limited human resources services, enrollment/billing assistance, health fairs or assistance with COBRA requirements.

A lengthy list of exclusions to the rebating/inducement prohibition is included in the legislation.

VERMONT

The 2011 Vermont legislative session adjourned on Friday, May 6. The state’s efforts to create a “single-payer” system for health care dominated the agenda and generated media interest nationwide.

KEY BILLS APPROVED BY THE LEGISLATURE

The Promise of a “Single Payer” System:

This bill was signed by Governor Shumlin on May 26 amidst some fanfare. This bill represents the major policy initiative for Governor Peter Shumlin and the Democratic/Progressive majorities in both houses of the legislature.

The bill would create a single Health Benefits Exchange for individuals and small group employers within the Department of Vermont Health Access that will “become the mechanism to create a single-payer health system.” The bill would establish the Green Mountain Care Board (Board) responsible for benefit levels in the Exchange and the Green Mountain Care program. The ultimate intention of the bill is for this Board to economically regulate the delivery of health care services within the state, similar to a public utility. The bill would require carriers to charge the same premium for a qualified health plan whether it was offered by a carrier inside or outside of the Exchange.

The bill defers a large number of policy decisions regarding the implementation of a single payer system to future study, reports and recommendations. Chief among these decisions is the financing of this system, and the bill directs the Secretary of
Key Legislation by State (continued)

Administration to recommend a fiscal policy and/or new taxes by January 15, 2013. The bill also contemplates the need for a Federal waiver for certain requirements under Federal law. Once a single payer system is in place, the bill does not require individuals to terminate private coverage; however, private insurance companies will be prohibited from selling health insurance policies that cover services also covered by Green Mountain Care.

The Green Mountain Care Board will be charged with the responsibility to review and approve any rate increase. The bill would set forth a public process for proposed rate increases of 5% or greater filed after January 1, 2012. The 5% threshold applies to any accumulation of proposed rate increases over a 12-month period. The bill would require insurers to file a plain language summary of any 5% or greater proposed rate increase with the Board in the format required by the Federal government for proposed rate increases above 10%. The bill would require the insurer to post these summaries on their website as well.

Midwives Coverage Mandate: This bill (S.15) would require plans that provide maternity benefits to cover services by licensed midwives or certified nurse midwives, whether provided in a hospital or at home. This mandate applies to plans issued or renewed after October 1, 2011. The bill would permit carriers to require in-network agreements for these midwives. The bill also requires the Commissioner of Health to undertake an annual report to be completed each year no later than March 15, analyzing the activities of midwives in an effort to regulate the quality of care provided for home births.

Insurance Taxes: This bill (S.436) is an omnibus tax bill that contains a provision to levy an “assessment” on health insurers of 0.8% on the dollar amount of all claims paid by the insurer for its Vermont members. The assessment was enacted to close the state’s budget gap for FY2012 (beginning on July 1, 2011) and is estimated to generate close to $12 million. It becomes effective on October 1, 2011 and is based on the claims paid in the previous fiscal year (ending June 30, 2011).

Payments will be paid in quarterly installments on November 1, January 1, April 1 and June 1. A list of insurers subject to the assessment will be published by September 1, 2011 by the Secretary of Administration, in consultation with the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA). This assessment is in addition to the 0.199% claims assessment enacted in 2009 to finance the health information technology initiative.

VIRGINIA

On February 26, the Virginia General Assembly adjourned the 2011 regular session. Republican Governor McDonnell signed several health care bills, including an Exchange study, an autism mandate and various amendments implementing PPACA provisions (e.g., rescissions, expansion of dependent coverage, independent review and annual/lifetime limits).

KEY BILLS SIGNED BY GOVERNOR MCDONNELL

Federal Reform Implementation:

HB 1958 implements several reforms consistent with PPACA. HB 1958 contains the following: 1) expands the definition of dependent coverage to age 26; 2) limits annual and lifetime dollar limits on essential benefits; 3) prohibits rescissions except in cases of fraud; 4) requires coverage of preventive health and wellness services without cost-sharing; 5) permits the selection of an OB/GYN or pediatrician as a primary health care professional for women and children; and 6) prohibits pre-existing condition exclusions for individuals under age 19.

Health Benefit Exchange: HB 2434 states that the intent of the General Assembly is to create and operate a state health benefits exchange compliant with the provisions of PPACA. The bill requests that the Governor, through the Bureau of Insurance and Health and Human Resources, work with the relevant experts and stakeholders to provide recommendations for consideration by the 2012 Session of the General Assembly regarding the structure and governance of an Exchange.

Autism Mandate: HB 2467 requires health insurers, health care corporations, HMOs and the state employee plan, on or after January 1, 2012, to provide coverage for the diagnosis and treatment of autism spectrum disorder (including behavioral health treatment) from age two to six with a $35,000 annual maximum benefit. The bill permits carriers to review a treatment plan for such disorders not more than once every 12 months unless agreed to by the individual’s doctor. Autism spectrum disorder treatment is not subject to visit limits, differences in cost sharing, lifetime limits or medical necessity determinations different than those that exist for other illnesses or conditions.
Key Legislation by State (continued)

WASHINGTON

The 2011 Washington Legislature adjourned the 2011 regular legislative session on April 24. Despite a huge budget deficit of $5.7 billion (approximately 18% of the state's operating budget), Governor Gregoire was committed to implementing PPACA in Washington and supported various reform bills, including a bill establishing a state exchange.

KEY BILLS SIGNED BY GOVERNOR GREGOIRE

Health Insurance Exchange: SB 5445 establishes the Washington Health Benefit Exchange as a public-private partnership governed by a board of nine members appointed by the Governor and including representatives of employee benefits, actuarial sciences, small business and consumer advocacy. Other members of the board would be required to have expertise in identified areas of the health care system, but the bill does not specifically require health insurer representation. A stakeholder committee would be established to provide input to the board from the health care industry, and the board would be permitted (but not required) to establish further technical advisory committees. Absent specific grants of power, the powers of the Exchange and its governing board are specifically limited to those necessary to apply for and administer grants, establish an IT infrastructure and undertake additional administration functions necessary for the Exchange to begin by January 2014.

Federal Reform Implementation: SB 5122 implements market reforms contained in PPACA pertaining to child coverage, pre-existing conditions, elimination of lifetime and annual benefit limits, internal appeals and external review, and dependent coverage to age 26. The bill also eliminates provisions regarding the state medical loss ratio requirements and includes provisions amending high-risk pool requirements to reflect the eventual phasing out of the pool.

Rate Regulation: HB 1303/SB 5398 repeals statutory provisions that sunset the Insurance Commissioner's authority to review individual rates (effectively continuing the Commissioner's rate review authority).