House
Legislative
Analysis
Section

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HMO AND HEALTH INSURANCE REFORM

House Bill 5573 (Substitute H-1)
Sponsor: Rep. Lauren Hager

House Bill 5574 (Substitute H-2)
Sponsor: Rep. Sandra Caul

House Bill 5575 (Substitute H-2)
Sponsor: Rep. Gerald Van Woerkom

House Bill 5576 (Substitute H-3)
Sponsor: Rep. Charles LaSata

Committee: Health Policy
First Analysis (5-23-00)

THE APPARENT PROBLEM:

Under current law, Health Maintenance Organizations (HMOs) are regulated by the Department of Community Health under the Public Health Code and by the Office of Financial and Insurance Services (OFIS). All other health care plans and health insurers are regulated by the OFIS. Though the different types of health plans and carriers offer similar services and assume the same types of risks, HMOs are not treated in the same way as the other plans. One difference is that HMOs can be licensed with little capital or net worth. This increases the risk that a plan could become insolvent if it experienced shortfalls in investments or a financial setback from paying claims. When an HMO goes out of business, its enrollees face hardships in finding another plan to cover them and having to change doctors if their current doctors are not affiliated with the new plan. Further, other than revoking an HMO's license, there is little action that the commissioner of OFIS can take against an HMO for violations of current law. Since revocation of an HMO's license may not be in the best interest of residents who are enrolled in the HMO, state regulators have little leverage to encourage health plans to better serve consumers or to encourage compliance with state regulations short of an all-out shutdown. Another weakness in the laws pertaining to HMOs regards rate changes. Currently, a requested rate change can only be approved or disapproved. If the rate change was disapproved because the increased rate would still be below expected losses, the HMO would have to operate with inadequate rates while a new proposal was drafted and submitted. This practice increases the risk that an HMO experiencing some difficulty may become insolvent. At the prompting of the OFIS, legislation is being offered to address these and other concerns.

In a separate but related matter, health carriers in Michigan are required to establish an internal grievance process to handle disputed claims. If the dispute cannot be resolved to an insured person's satisfaction, the person can appeal the decision to the commissioner of OFIS (or his or her designee) or, in the case of a person enrolled in an HMO, to a task force appointed by the Department of Community Health. Further, the internal grievance process can differ between Blue Cross Blue Shield, commercial health insurers, and HMOs. This dual arrangement for external reviews, coupled with the differing internal review processes, can be confusing to consumers, especially for those who change health plans, and health care providers who are trying to provide their patients with needed care. Legislation based on proposals by OFIS has been proposed to create a uniform appeals process for both internal and external review procedures.

THE CONTENT OF THE BILLS:

House Bill 5573 would shorten the time frame for Blue Cross/Blue Shield of Michigan for internal reviews of disputed claims. House Bill 5575 would amend the Insurance Code to repeal Part 210 of the Public Health Code and transfer the regulation of health maintenance organizations (HMOs) to the Insurance Code, and House Bill 5574 would amend the Public Health Code

to remove references to HMOs that are no longer appropriate in light of the transfer. (Currently, regulation of HMOs is overseen by the Department of Community Health and regulated under Part 210 of the Public Health Code.) House Bill 5576 would create the "Patient's Right to Independent Review Act" to create a uniform external appeals process for all health carriers. Specifically, the bills would do the following:

House Bill 5573 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1404), which regulates Blue Cross Blue Shield of Michigan, to make changes to the internal grievance procedure. Currently, a member is entitled to a managerial-level conference with representatives of the corporation to settle disputes over benefits or claims. If the dispute cannot be settled, the member is also entitled to a hearing with the commissioner of the Office of Financial and Insurance Services. The bill instead would specify that if the dispute cannot be resolved during the conference with BCBSM representatives (or if a conference was not provided within 30 days of the member's request), then the member would be entitled to a review, beginning October 1, 2000, before an independent review organization under the Patient's Right to Independent Review Act, which would be created by House Bill 5576.

Currently, the final determination in a dispute resolution must be made in writing by BCBSM within 90 days after the member submits a written grievance. The bill would reduce this time frame to 45 days. When an adverse determination is made, the bill would require BCBSM to provide, in writing, a statement with the reasons for the adverse determination, along with a written notification in plain English that the member has the right to request an external review under the Patient's Right to Independent Review Act. Under current law, BCBSM must have a method in place to provide summary data on the number and types of complaints and grievances that are filed. Beginning April 15, 2001, the bill would require summary data for the prior calendar year to be filed annually with the commissioner on forms provided by him or her.

The bill would delete a provision allowing a member to request further review by BCBSM or by the commissioner for an adverse determination of an expedited internal review, thus bringing the act into conformity with provisions in the Patient's Right to Independent Review Act. Further, the bill would clarify that a member could give written authorization to any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding.

House Bill 5574 would amend the Public Health Code (MCL 333.20106 et al.) to make technical changes regarding HMOs in light of the transfer of the regulatory framework pertaining to HMOs from the Public Health Code to the Insurance Code.

House Bill 5575 would amend the Insurance Code (MCL 500.102 et al.) to, among many things, add Chapter 35, entitled "Health Maintenance Organizations". Part 210 of the Public Health Code (MCL 333.21001 to 333.21098), which currently regulates HMOs, would be repealed. Under the bill, all of the provisions of the Insurance Code that apply to a domestic insurer authorized to issue an expense-incurred hospital, medical, or surgical policy or certificate, including, but not limited to, Section 223 (application for initial or renewal certificate of authority, fee, and deposit), Chapter 34 (disability insurance policies) and Chapter 36 (group and blanket disability) would apply to an HMO unless specifically excluded or otherwise provided for in the bill. However, Chapter 77 (Michigan Life and Health Insurance Guaranty Association Act) and Chapter 79 (Property and Casualty Guaranty Association Act) would not apply to HMOs, nor would several sections pertaining to capital, surplus, or assets; loans and investments; corporate powers; and authority for domestic, alien, and foreign insurers to transact insurance in the state. Oversight would be provided by the commissioner of the Office of Financial and Insurance Services (OFIS). Some of the more significant changes are as follows:

• An HMO would be required to receive a certificate of authority (instead of a license) before issuing health maintenance contracts. A license issued under Part 210 of the Public Health Code would automatically become a certificate of authority on the bill's effective date.

• The bill would change the process by which an HMO's net worth is determined, and would increase the net worth and working capitol requirements. HMOs licensed on the bill's effective date, and which have unimpaired net worth as currently required, would have to come into compliance with the new levels no later than December 31, 2003. For HMOs that contract or employ providers in numbers sufficient to provide 90 percent of the HMO's benefit payout, the minimum net worth would be the greater of $1.5 million, four percent of the HMO's subscription revenue, or three months' uncovered expenditures. For an HMO that does not contract or employ in numbers sufficient to provide 90 percent of the HMO's benefit payout, the minimum net worth would be the greater of $3 million,

ten percent of the HMO's subscription revenue, or three months' uncovered expenditures.

• HMOs applying for a certificate of authority or wishing to maintain a certificate on or after the bill's effective date would have to maintain a deposit in an amount determined adequate by the commissioner, but not less than $100,000 plus five percent of the annual subscription revenue up to a $1 million maximum deposit.

• An HMO would have to hold assets in its own name and not commingle funds and assets with affiliates or other entities.

• The bill would incorporate National Association of Insurance Commissioners model legislation pertaining to insolvency. HMOs would have to have a plan in place to handle insolvency that would allow for the continuation of benefits for the duration of the contract period. The bill would prescribe criteria for satisfying solvency requirements. If an HMO that contracted with a state funded health care program (e.g., Medicaid) became insolvent, the commissioner would have to inform the state agency responsible for the program of the insolvency. Enrollees of an insolvent HMO covered by a state funded health care program could be reassigned in accordance with state and federal statutes governing the particular program.

• The bill would incorporate numerous provisions currently contained in departmental rules and would also incorporate provisions contained in model legislation proposed by the National Association of Insurance Commissioners (NAIC). For example, the bill would incorporate credentialing criteria that are part of the NAIC credentialing model act for health professionals who contract with HMOs.

• The bill would make changes to the grievance procedure for insurers and HMOs. The time frame in which a determination for an internal review is to be issued would be reduced from 90 days after the insured or enrollee submitted a formal grievance to 45 days. Beginning October 1, 2000, a notification of an adverse determination would have to include a written notice in plain English that the insured or enrollee could request a review by an independent review organization under the Patient's Right to Independent Review Act (House Bill 5576). An insured or enrollee could authorize, in writing, any person (including a physician) to act on his or her behalf during the grievance proceeding. Currently, summary data on the number and types of complaints and grievances filed is collected. Beginning April 15, 2001, the data for the previous year would have to be filed annually with the commissioner of the Office of Financial and Insurance Services on forms provided by the commissioner.

• The regulatory fee for HMOs would be calculated using the same formula as for other insurers. Other fees paid by insurers that would be applicable to HMOs include a $25 filing fee and a $5 agent's appointment fee.

• Each HMO would have to develop and maintain a quality assessment program to assess the quality of health care provided to enrollees and a quality improvement program to design, measure, assess, and improve the processes and outcomes of health care as identified in the program. The quality improvement program would be under the direction of the HMO's medical director.

House Bill 5576 would create the "Patient's Right to Independent Review Act", which would enable persons with health insurance to request a review by an independent review organization to resolve disputes over covered benefits. The bill would apply to all health carriers (defined as entities that are subject to the state's insurance laws which provide a plan of health insurance, health benefits, or health services) that perform utilization reviews. Policies or certificates that provided coverage only for accident or accident-only coverage, long-term care insurance, or for supplemental policies would not be affected by the bill. (See the bill for a complete list of exemptions. Though not specifically mentioned, the federal Employee Retirement Income Security Act [ERISA] would most likely exempt self-insured plans from the requirement to provide an external review process.) Under the bill, once a person had exhausted all the internal appeal processes with his or her health carrier, he or she could request an external review of an adverse determination from the commissioner of the Office of Financial and Insurance Services (OFIS). A written request would have to be submitted within 60 days of receiving the adverse determination from the health carrier (currently, a person has up to two years to request an external review). An "adverse determination" would be defined as an admission, availability of care, continued stay, or other health care service that had been reviewed by a utilization review organization and been denied, reduced or terminated. Failure by a health carrier to respond in a timely manner to a request for a determination would constitute an adverse determination.

External review. The bill would establish the procedure and time lines for an external review and set

time frames for an independent review organization (IRO) to review a case and make recommendations. The commissioner would have to first conduct a preliminary review to see if a request met criteria for an external review, assign the case to an IRO and notify the health carrier that the case has been referred to an IRO, review the recommendation of the IRO to ensure that it is not contrary to the terms of coverage under the person's health benefit plan, then provide written notification in plain English to the person and the health carrier of the decision to uphold or reverse the recommendation of the IRO. Except for any remedies available under existing and applicable state or federal law, an external review decision and an expedited external review decision would be the final administrative remedies available under the bill.

In situations where a person's health would be seriously jeopardized by a delay in treatment, a person could request, within 10 days of receiving an adverse determination, an expedited external review to be conducted. The request for an expedited external review could be filed simultaneously with a request for an expedited internal review. An expedited external review would have to be completed within 72 hours of the commissioner assigning the case to an IRO. If the person had not first completed the internal appeal process available with his or her health carrier, he or she could be required to do so before the commissioner would assign the case to an IRO. Health carriers would have to provide required information within 12 hours of notification that a request for an expedited review had been granted. Once the case for an expedited review was assigned to an IRO, the IRO would have to make its recommendations to the commissioner within 36 hours; the commissioner would then have up to 24 hours to review the recommendation and make a determination. Health carriers would be required to give members and enrollees information in plain English regarding the internal grievance and external review procedures, including the right to request such reviews and the commissioner's toll-free phone number and address.

Independent review organizations. IROs would have to be approved by the commissioner (IROs could not own or be a subsidiary of a health plan, or have a material professional, familial, or financial conflict of interest), and the commissioner could charge an application fee for both initial approval and reapproval. An approval would be effective for two years, and could be terminated by the commissioner if the IRO did not meet minimum standards set under the bill. The minimum standards would include adhering to strict reporting criteria and adopting written policies governing the external review process that would have to, at a minimum, include a quality assurance mechanism. The bill would also establish standards and criteria regarding clinical peer reviewers assigned by IROs to conduct external reviews. Neither an IRO nor a clinical peer reviewer working on behalf of an IRO would be civilly liable for damages for opinions rendered in the course of an external review unless the opinion was rendered in bad faith or involved gross negligence. Further, the IRO would have to maintain for three years written records (in aggregate form and by health carrier) of the requests for external reviews conducted in a calendar year. An annual report would have to be submitted to the commissioner that included, among other things, the total number of requests for external review, the number of requests resolved and the breakdown as to whether the adverse determination was upheld or reversed, and the average length of time for cases to be resolved. Health carriers would be required to keep similar information and would also have to submit an annual report that was nearly identical to the one required of IROs.

Violations. Upon finding that a violation had occurred, the commissioner would have to serve the violator with a cease and desist order along with a written copy of the findings. In addition, the commissioner could levy a fine up to $500 for each violation (up to $2,500 for each violation if the person knew or should have known that he or she was in violation of the bill), but fines would be capped at $25,000. License sanctions could also be taken. A person who violated the bill could request a hearing before the commissioner under the Administrative Procedures Act. Violation of a cease and desist order could result in an additional fine of $10,000 for each violation, license sanctions, or both. Fines collected under the bill would be credited to the general fund. Further, the commissioner could apply to the Ingham County Circuit Court for an order to enjoin a violation of the bill.

The bill would take effect October 1, 2000.

BACKGROUND INFORMATION:

Executive Order No. 2000 - 4, which took effect on April 3, 2000, reorganized the state's regulation of insurance, financial institutions, and securities into one office. The powers, duties, and functions of the Insurance Bureau and the Financial Institutions Bureau have been transferred to the newly created Office of Financial and Insurance Services (OFIS), as well as the securities functions of the Corporations, Securities and Land Development Bureau. The Office of Financial and Insurance Services comprises the Division of

Insurance, the Division of Financial Institutions, and the Division of Securities.

FISCAL IMPLICATIONS:

Fiscal information is not available for House Bills 5573 and 5574, but according to departmental analyses by the Division of Insurance dated 4-27-99 and 4-25-00, House Bills 5575 and 5576 will result in a need for additional staff to perform duties required under the bills. The revised assessment amounts and the licensure fees under House Bill 5575 should help mitigate costs for additional staff required to implement the provisions under the bill. The unified external review process established under House Bill 5576 would increase duties of staff within the Division of Insurance, also necessitating the addition of staff to fully implement the bill's provisions.

ARGUMENTS:

For:

The package of legislation as a whole, including House Bill 5572 (which would create an HMO report card and which was previously reported from committee), would help to make HMOs more user friendly. The regulation of all insurance carriers and health plans would be under one roof, rather than being divided between two state agencies. Further, the bills, especially House Bill 5575, would restructure the regulations of HMOs, making them consistent with regulations that apply to the rest of the state's regulated health plans. In addition, House Bill 5575 would address weaknesses in the HMO laws that put HMOs at greater risk for insolvency. For instance, under the bill, the net worth, statutory deposit, and working capital requirements for HMOs would be increased, thus providing greater financial stability. Placing the regulation of HMOs under the Insurance Code would allow the commissioner of OFIS to approve a rate change with modifications, instead of denying a requested rate increase because the increase wasn't great enough to cover expected losses, as is currently required under the Public Health Code. This would allow HMOs to continue to operate using rates that were deemed appropriate by the commissioner for the HMO's risk assumption.

House Bill 5575 also would allow more options for the commissioner when enforcing compliance with state laws. Currently, the commissioner has little choice other than to take license sanctions against an HMO, even though such a severe action may not be in the best interest of consumers. Under the bill, the commissioner could levy civil fines in addition to obtaining a cease and desist order to stop the HMO from engaging in undesirable actions. Further, if an HMO should become insolvent and close down, the commissioner could order other carriers who may be covering an affected group to offer a 30-day open enrollment period to the subscribers of the insolvent HMO. The commissioner could also assign enrollees to other HMOs in a service area if there were no available carriers involved with the affected group. In short, the consolidation of regulatory functions under one administrative roof, consistency and continuity of regulations across all health carriers and health plans, and setting solvency standards will increase protection to consumers and create a more level field for health carriers competing to offer quality health care plans.

Against:

A major weakness of the insurance and HMO reform package is the exclusion of a provision that would allow a person who suffers damages to directly sue an HMO. Under current law, a person can only sue an HMO for vicarious liability, meaning that if a doctor failed to prescribe proper treatment, the person could sue the doctor for malpractice and could also sue the HMO for vicarious liability because of the contractual relationship between the doctor and the HMO. However, if a HMO denies coverage for a treatment that was prescribed by the doctor for a patient, and the person suffers harm from the lack of treatment, the person cannot sue the HMO. Many feel that the only way to ensure fairness and discourage HMOs from denying coverage based on lack of medical necessity for procedures that should be covered is to statutorily create a cause of action whereby a person can directly bring a lawsuit against an HMO that wrongfully denied treatment and receive compensation for damages (e.g., loss of wages, loss of consortium, and so forth). This would not be a punitive measure, for Michigan law prohibits lawsuits seeking punitive damages; however, creating liability for HMOs would enable those who have suffered loss to collect damages based on those losses.

Response:

Some believe that having an external review process in place has a "sentinel effect". They feel that the existence and utilization of such external review mechanisms encourages health carriers to be more cautious in basing treatment decisions on clinical standards. Further, the new reporting standards created under the bill package in regards to the number of disputed claims going to the external review process and the statistics on how many adverse determinations are overturned should provide greater oversight of health plans by the commissioner. If a plan is denying coverage, and those decisions cannot be supported by external review, it should trigger an investigation by the commissioner, as well as the likelihood that enrollment numbers would drop as consumers take their business elsewhere.

Rebuttal:

The fact that a health plan might have a drop in profits as consumers shop elsewhere is little comfort to a person who has suffered financial loss as a result of not being able to work because he or she did not receive timely medical treatment, nor is there comfort for a family who has lost a loved one due to delays in treatment when forced to challenge one denial of coverage after another for treatments for a serious illness such as cancer. Health plans and health carriers, like most businesses, respond to issues that affect their pockets. States that allow people to sue HMOs have seen only a handful of lawsuits filed over several years. Therefore, it would seem that creating liability for HMOs does indeed encourage them to be cautious about denying appropriate treatment without opening the floodgates to lawsuits. Besides, apparently people can bring actions against the other types of health insurers in the state, so this would create parity between HMOs and other health insurers.

For:

Currently, all health insurers and HMOs operating in the state have both an internal grievance process and a procedure for external reviews for disputed claims. However, time lines and procedures for the various health plans can differ somewhat, leading to confusion for consumers, especially if people change health plans. For example, external reviews are handled by a task force under the oversight of the Department of Community Health for HMOs, but Blue Cross Blue Shield members and members of other insurance plans can request a hearing before the commissioner of the Office of Finance and Insurance Services. House Bill 5576 would instead create one process by which consumers could request an external, independent review of a disputed claim. Under the bill, all persons covered by health insurance could request the commissioner for an independent review of disputed claims. Further, the bill would standardize internal grievance procedures and cut in half the current allowable time for insurers to process internal reviews from 90 to 45 days.

The reporting standards required by the bill would help the commissioner and consumers to identify those health carriers that may not be making treatment decisions based on reasonable standards. The commissioner could identify and investigate those plans that were having more of their decisions questioned and reversed, and consumers could look to see, when choosing a plan to best fit their needs, if a particular plan was recorded as having had a large number of grievances and problems.

The bill would make other improvements. It would prohibit a business or individual with a conflict of interest from being approved as an independent review organization or a clinical peer reviewer. The bill would also establish stiff financial penalties, in addition to license sanctions, for health carriers that did not comply with the new internal and external review procedures. All in all, the bill should create a process that would make external grievance procedures and expedited external grievance procedures more efficient for consumers, health carriers, and health providers.

Against:

Though a step in the right direction, House Bill 5576 remains flawed. First of all, though the internal grievance procedures are being shortened in the bill package, the external review process still remains too long. Estimates of the process, including time lines specified in the bill and time needed for the various notifications to travel through the mail, could be as long as 75 to 78 days. Though the bill does provide for a streamlined expedited review process for the seriously ill, many who would not fit the strict criteria for an expedited review may nevertheless be in urgent need of treatment. At 75 to 78 days, Michigan will remain a state with one of the longest turnaround times for external reviews in the nation. If time cannot be shaved from the external review process, then the internal grievance process should be eliminated. The internal review process is redundant, unnecessary, and its elimination could save health plans money.

Secondly, the Employee Retirement Income Security Act of 1974 (ERISA), a federal law that regulates employee pension and benefit plans, generally preempts self-insured and self-funded health plans

from regulation under state laws. (Church and governmental self-funded and self-insured plans are exempt from regulation under ERISA, meaning that these self-funded plans would be subject to state insurance regulations.) Therefore, since the majority of persons in Michigan with health insurance are covered by self-insured or self-funded plans, the external review process under the bill is likely to be available for only a small percent of covered persons. The issue of whether or not ERISA would preempt a state external review law for self-funded and self-insured plans is currently being litigated in federal courts. A recent Texas federal court case (*Corporate Health Insurance Inc., et al* v *Texas Department of Insurance*, which is currently under appeal, held that ERISA did indeed preempt a Texas law requiring external review procedures. According to a 1998 report prepared for the Kaiser Foundation that provided an overview of key program features of external review programs, "existing case law could support arguments for and against ERISA's preemption of such laws"; however, should more federal courts follow the lead of the Texas district court, only those covered under individual plans or governmental and church self-insured plans would be able to receive any benefits of the external review process created by the bill.

Under current law, consumers with disputed claims can request a hearing with the commissioner and persons in HMOs can come before the task force appointed by the Department of Community Health to resolve disputes. Under the bill, this face-to-face contact would be eliminated and replaced by a paper review. Also, a person currently has two years in which to request an external review of an adverse determination; the bill would reduce this time frame to 60 days. In addition, the bill is not clear about who would bear the financial burden of providing the external reviews. Though the commissioner could set a fee for independent review organizations to be approved under the act, it is doubtful that the revenue collected would be sufficient to support the cost of the reviews. Finally, though the bill does set fines for those health carriers found to be violating the bill, in some situations it may be cheaper for a health carrier to pay the fine than to pay for the treatment. Therefore, many feel that the penalty section of the bill should contain stricter penalties.

Response:

It is true that the courts are still deciding issues relating to what types of state regulations are preempted by ERISA for self-insured and self-funded health plans; however, Michigan was one of the first states to establish an external review mechanism in statute. Though House Bill 5576 would add greater continuity and consistency between the various types of health plans and health carriers, the concept and practice of external reviews is not new to the state. For over twenty years, Michigan residents have been able to appeal disputed claims to an external reviewer. In addition, the availability of an independent, external review is seen by many health carriers as being beneficial, as it increases consumer confidence that the plan is working toward serving the enrollee or member in a fair manner. Therefore, whatever is decided in federal court is not expected to have a great impact on health carriers' compliance with external review regulations.

Apparently, the bill would be a shift to a paper review, but currently, most reviews are at present conducted in that manner. In fact, appeals to the commissioner are currently handled by staff within the Division of Insurance. Under House Bill 5576, it would be doctors making the determination of medical necessity. Input by the division staff would be limited to reviews of contractual language to verify that the person's plan covers any IRO recommended treatments and to monitor the health carrier's compliance with the external review recommendations. Indeed, the process established by the bill offers far more consumer protection than what is currently available.

And, it should be noted that the bill package does shorten the time frame for internal grievance processes from 90 days to 45 days. Before judging the time lines to be inadequate, some time should be given to allow the bills to take effect and to see how the process functions. As information is disseminated to educate consumers of their right to appeal adverse determinations, it is not known at this time what impact the bills will have on the number of requests for external reviews. Once the process is up and running, it should become clearer if the time lines set in statute need to be adjusted further. It should also be remembered that the time lines specified in the bill are maximums, not minimums. Hopefully, both internal and external appeals will be handled as quickly as possible and well under the specified maximums.

POSITIONS:

The Michigan Health & Hospital Association supports the bills. (5-19-00)

The Michigan Association of Health Plans supports the bills. (5-19-00)

The Michigan Chamber of Commerce supports the bills. (5-19-00)

The Office of Finance and Insurance Services supports the bills. (5-19-00)

The Michigan State AFL-CIO opposes the bills in their current form. (5-19-00)

The Michigan Partners for Patient Advocacy opposes the legislation in the current form. (5-19-00)

The Michigan Psychiatric Society opposes the bills. (5-18-00)

Analyst: S. Stutzky

■This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.