

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 13, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Marriott Newport Beach Hotel on Saturday, July 13, 2019 at 10:15 a.m.

Assemblywoman Pam Hunter of New York, Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Sen. Jerry Klein (ND)
Rep. Martin Carbaugh (IN)	Asw. Maggie Carlton (NV)
Rep. Matt Lehman (IN)	Asm. Kevin Cahill (NY)
Sen. Dan "Blade" Morrish (LA)	Asm. Andrew Garbarino (NY)
Rep. Michael Webber (MI)	Sen. Bob Hackett (OH)
Sen. Paul Utke (MN)	Rep. Tom Oliverson, M.D. (TX)
Rep. George Keiser (ND)	

Other legislators present were:

Rep. Colleen Burton (FL)	Sen. Brian Feldman (MD)
Rep. Tammy Nichols (ID)	Asw. Ellen Spiegel (NV)
Rep. Deanna Frazier (KY)	Rep. Wendi Thomas (PA)
Rep. Edmond Jordan (LA)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Rep. Martin Carbaugh (IN) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 15, 2019 meeting in Nashville, TN upon a Motion made by Asw. Maggie Carlton (NV), and seconded by Rep. Carbaugh.

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL DRUG PRICING TRANSPARENCY MODEL ACT

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee, stated that before beginning he would like to provide the Committee with an update on how the Model has changed since the Committee's last meeting in March. The changes made were a direct result from Rep. Oliverson's experience in Texas with TX HB 2536 which itself changed dramatically when navigating between both chambers but at the end of the day emerged as a bill that everybody is proud of and meets the objectives of ensuring that

policymakers are doing everything they can to help states understand why prescription drug prices are increasing.

Rep. Oliverson stated that in Section 4(b)(1) of the Model he changed the thresholds which trigger reporting requirements for drug manufacturers. The thresholds have been changed to 60% or greater over the preceding five calendar years or 15% or greater in the preceding twelve months. The dollar threshold for the wholesale acquisition cost which triggers reporting requirements has also been changed to \$70 or more for a thirty-day supply. Language was also added to what is now Section 4(b)(1)(G) requiring drug manufacturers to include in their report a statement of rationale regarding the factor or factors that caused the increase in the wholesale acquisition cost. The rationale could just be that the company wanted to make more money but there could also be the situation where maybe supply costs went up so it provides them an opportunity to explain the increase.

Also, in Section 5(a)(1)(D) – there is now language that requires a pharmacy benefit manager (PBM) to submit in their report the aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were retained as revenue by the PBM as opposed to being passed to the plan subscriber. That was an issue that was gaining significant attention at the state and national levels so it was important to include that to ascertain where the price increases were coming from.

Rep. Oliverson noted that one thing that is not included in the Model but will be included in the final version is that in Section 5 and 6, as far as the requirement to submit a report to the commissioner, all of the data that is gathered from the PBMs and health plans need to be aggregated across the entire class before it gets reported to the general public. That is a good way to prevent disclosure of proprietary or confidential information that might incentivize one member of that class to essentially enter into an anti-competitive bidding practice with another member and would be like playing football and handing over your playbook to the other team before the game starts. That would not be fair for one PBMs' data to be published very specifically so that everyone else, not just in that group but also folks that might be engaging in negotiations with them to know what others are paying. That was not the intent of the legislation, so aggregating the information in a way that protects proprietary and confidential information is important.

Before turning it over to the panel, Asw. Pam Hunter (NY), Chair of the Committee, provided a story of a constituent calling her office last week saying that two months ago her prescription with her insurance cost \$3.50 and now it costs \$9.75. The constituent told Asw. Hunter that when she spoke with the insurance company it told her that the reason for the price increase was because it can. Asw. Hunter stated that is not an explanation that anyone should be told and accordingly, she is looking forward to having this discussion today to get more clarity on these issues.

Jim Parker, Senior Advisor to the Secretary of Health and Human Services (HHS) for Health Reform, stated that he cannot speak to the specifics of the Model but can share the general perspective that Secretary Azar and the current Administration has with respect to transparency generally, and with respect to drug pricing. The Administration and HHS have taken a number of steps to increase the efficiency and effectiveness of the prescription drug markets. The rebate rule that was proposed and recently been withdrawn was one example of that. Another example were efforts taken with respect to

disclosing the price of drugs that were advertised in direct to consumer advertising. Unfortunately, the courts have recently weighed in to say that HHS did not have the regulatory authority to do that but did not speak to whether or not that policy was something that could be achieved through Congressional action so the Administration will continue to move forward to explore ways that it can bring greater general consumer awareness of the cost of prescription drugs into the consumer marketplace.

Mr. Parker stated that the Administration believes that it is particularly important in today's market for many of the reasons mentioned in Asw. Hunter's anecdote. Individuals are being asked to play a much greater role in participating in the funding and financing of prescription drugs and their out of pocket expenses are much higher than they might have been in prescription drug benefits five, ten, or fifteen years ago. Mr. Parker stated that he has experienced this first hand with this children in that you can get into the rhythm of expecting what a prescription drug is going to cost and either because you move in or out of a deductible or because your plan changes or frankly just because the price of the drug from the manufacturer has changed, you can pay a significantly different and often much greater price for that drug than you did just the month before and it almost always comes without any awareness or understanding prior to being asked to pay that price. For all these reasons, the Administration believes that bringing greater transparency to prescription drug pricing is particularly important in this era in which consumers are paying a much greater out of pocket share for prescription drugs and the Administration applauds this Committee's work on these issues.

Steve Moore, PharmD, Legislative Chair and Incoming President of the Pharmacist Society of the State of New York (PSSNY), stated that the Committee's work on these has issues has great meaning, and thanked the Committee for its work regarding PBM model legislation. To date, six states have passed legislation based on NCOIL's PBM model act and legislation is pending in two more states. Mr. Moore thanked Asw. Hunter, Asm. Andrew Garbarino (NY), and Asm. Kevin Cahill (NY), for their work in passing what PSSNY feels is some of the strongest legislation in the country – it passed the Assembly 116-0 and PSSNY is incredibly excited about it.

Mr. Moore stated that Condo Pharmacy is the oldest independent pharmacy in Plattsburgh, NY and probably the oldest in Northeastern NY. In addition to traditional prescriptions, it fills specialty prescriptions, takes care of long-term care (LTC) patients, has a compounding laboratory on its second floor, and tries to take care of each individual patient's healthcare needs. The pharmacy offers delivery services to patient-charge accounts but also looks to the future and utilizes technology such as patient apps and a robotic counting device that handles 60% of oral solid medications. The pharmacy's pharmacists are some of the most accessible healthcare providers in Plattsburgh within its own walls but they also team with local physicians to see patients in the physician's offices outside of the pharmacy. Mr. Moore stated that the point is that the pharmacy is a true community pharmacy and tries its best to meet the healthcare needs of patients in and around Plattsburgh, but it is getting harder and harder to do that every day and that feeling is echoed by pharmacy colleagues in NY and also throughout the country.

Mr. Moore stated that he believes it is fair to say that most independents will tell you that the vast majority of their difficulties are related to the practices of PBMs. Restrictive distribution channels, overburdensome prior authorization practices, preferred networks, contractually mandated pharmacy gag clauses, artificially depressed professional

dispensing fees, below cost reimbursements, an assortment of misaligned incentives, and a lack of transparency associated with this industry have made providing patients with the care they both need and deserve incredibly difficult. While all of this is going on, patient deductibles are increasing, employer premiums are rising, and taxpayers are responsible for more and more dollars in the Medicaid and Medicare spend. Data gathered over the last year from NY tells a story that mirrors that of states around the country such as Ohio, Michigan, West Virginia, Texas, and Kentucky. This story is one of lower below cost pharmacy provider reimbursements that for some strange reason is not currently resulting in decreased pharmacy costs for patients, insurers, or taxpayers.

A January 2019 white paper commissioned by PSSNY and a subsequent NY Senate investigation regarding PBM practices has resulted in calls for the state's regulatory bodies to conduct a full audit of NY's Medicaid program and Mr. Moore is happy that the calls have been answered. Mr. Moore stated that as a healthcare provider, it is frustrating because we should not need these audits. That does not mean that we should not have oversight of prescription spending or healthcare spending, but as someone who is one the frontline of patient care, it is incredibly frustrating to see patients forego or delay care that they need due to unnecessary obstacles. Physicians and other prescribers who already deal with their own workflow issues, struggle to keep track of what medication is covered for which patient, and what it is going to cost for each patient. All the while, PBMs, at least in NY, are taking advantage of the lack of transparency to collect hundreds of millions of dollars through practices such as spread pricing. This is a practice that is so prevalent and egregious that this past May, CMS issued guidance to states regarding transparency and the reporting of spread pricing in an effort to curb its effort on Medicaid spending.

Mr. Moore stated that is why the work of this Committee is so important and the drug pricing transparency Model is so timely. It is incredibly rare, and for good reason it turns out, for an industry to have unlicensed and unregulated players with the ability to act as both price setters and price collectors. NCOIL model language and suggested best practices for individual states will allow for everyone to learn from one another and more quickly put into place legislation and practices that will effectively serve to align incentives and to hold all participants in the delivery of healthcare to the same standards of accountability and excellence. Mr. Moore stated that PSSNY has comments on the Model, which it will submit in writing, primarily in relation to the dollar amounts and unites suggested as triggers for reporting. Mr. Moore stated that as he has learned from his friends at 46 Brooklyn, it is best to err on the side of over-collecting data as it can tell a great story. Mr. Moore encouraged everyone to follow the work of 46 Brooklyn and the work they are doing regarding looking at the Medicaid spend. Mr. Moore stated that he and the National Community Pharmacists Association (NCPA) are ready to serve as a resource to this Committee on these issues going forward. Mr. Moore also encouraged everyone to tour their local pharmacy as it would be very beneficial to all.

Carl Schmid, Deputy Executive Director of the AIDS Institute, stated that the AIDS Institute is a national public policy and advocacy organization that focused on the wellbeing and health of people living with HIV and hepatitis and obviously access to medications is extremely important to those people and so many others living with chronic illnesses. Mr. Schmid stated that the most important thing he would like to emphasize is what concerns patients is what they pay at the pharmacy. There is a lot of focus on list prices but what is important to the patient is what they pay. It is getting harder for patients to pay as there is a greater use of deductibles, more coinsurance

instead of copays, and high cost-sharing that leads to drug abandonment and adherence, which really impacts people's health. Because of high copays, there is assistance and there is also efforts states can take to limit patient cost sharing.

Mr. Schmid then noted a study from Kaiser Family Foundation (Kaiser) that looked at people who said they or a family member have, in the past year, either postponed or put off care, treated at home instead of seeing a doctor, avoided doctor-recommended test or treatment, or did not fill a prescription or skipped doses. For the last situation described with people with a chronic condition, the percentage was 23%, but for people with a high deductible, the percentage was 35%. Mr. Schmid then pointed to data from Kaiser that focused on employer-sponsored insurance and 21% of those polled have a deductible of over \$3,000 and for families it was \$5,000. Looking at out-of-pocket costs for the different healthcare services, nationwide spending for the patient at the hospital is 3%. For doctor services, it goes to 8.5% of the total spent. But when you look at prescription drugs it goes to 14%. So, it is no wonder why people are complaining about the high cost of drugs as they are being saddled with a lot of the out-of-pocket costs.

Mr. Schmid then pointed to a Robert Wood Johnson Foundation study which looked at every single silver plan in the individual market. For preferred specialty drugs, 69% of the plans use coinsurance and that is a median of 40%. It is important to remember that patients pay the full price of a drug until the deductible is met. Mr. Schmid then pointed to an IQVIA study which showed that even with \$40 to \$50 of cost-sharing, 20% of people are abandoning their brand name drugs. When the cost-sharing goes up to \$250+, about 70% of people abandon their medications. Mr. Schmid stated that people abandon their drugs mostly due to high deductibles. That is where co-pay assistance really comes into play as people are spending about \$61 billion in out-of-pocket costs for prescription drugs. Co-pay assistance from manufacturers and others account for \$13 billion. Mr. Schmid pointed to a study that stated if it was not for co-pay assistance, the drug abandonment rate would increase almost threefold.

With regards to what states are doing to address these problems, Mr. Schmid stated that NY prohibits specialty tiers, which is great. Several states have copay caps like CA, DE, LA, MD, and Washington DC – which are still a little high, but at least there are caps. The unfortunate thing is that they are all applicable after the deductible, which is a barrier to access. Some states like CA, have standardized medical plans with copay caps, separate drug deductibles, and they require plans to place at least one drug on tiers 1 to 3 when multiple drugs are available for chronic conditions. Some states have tinkered with benefit plan designs like CO, which requires that: not more than 50% of the drugs to treat a certain condition can be on the highest tier; at least 25% of the plans in each metal level must use copays; copays not be subject to the deductible; and that copays be spread throughout the year so that you are not paying a huge amount in the beginning of the year.

Mr. Schmid stated that with regards to copay assistance, he has heard in the past year the growing use of copay accumulators, which is when a patient's cost sharing they get from the manufacturers or others, do not count towards the deductible or maximum out-of-pocket cost. This is harmful to patients as they frequently don't know that it is happening to them. The AIDS Institute was pleased to see that the federal government stepped in, and in the 2020 Notice of Benefit and Payment Parameters, it is going to limit the use of copay accumulators and require copay assistance to count in most situations such as when brand name drugs have no generic, when access to a brand name drug

that has a generic has been gained through exceptions or appeals process, and maybe for a brand name drug when a generic exists. A couple states have stepped in and passed their own legislation that requires copay assistance to count: AZ, IL, VA and WV. Other legislation is pending.

With regards to transparency, Mr. Schmid stated that he believes the most important thing for patients is that they really need to know how much the drug costs when they go to the pharmacy. Copay is easy but when you are in the deductible phase you really need to know how much that drug is going to cost so the list price is important there. The most important thing is because of the use of coinsurance, people need to know what that coinsurance stands for – is it 50% of \$100, \$1,000, or \$10,000? Mr. Schmid stated that it is good that the Model is looking at the increase in wholesale acquisition cost (WAC) prices but it would be interesting to see what the increases in net prices would be. Mr. Schmid stated that he supports the provisions of the Model relating to rebate information. With regard to the health plans, it is great that the Model is looking at the percent increase in drug spend in impact on premiums but it would also be interesting to compare that to other health services. In addition to utilization management, it would also be good for the Model to ask for the amount of drugs that have coinsurance and how many of them charge the list price until the deductible is met.

Leeanne Gassaway, Senior VP of State Affairs and Policy at America's Health Insurance Plans (AHIP), first thanked the Committee for its work on the Model and stated that it is a greatly improved version from the first version. AHIP has said from the beginning that reporting for reporting's sake is not great because it will not tell you much but if it is meaningful and useful then it does help legislators help empower regulators to understand what is happening in a particular state who can then bring solutions to legislators to enact further policy to address any issues.

With regard to the reporting thresholds, AHIP is pleased to see the changes that were made to the Model to bring it into alignment with Texas HB 2536, but AHIP believes the 15% threshold should be lower to align it with other states such as Oregon, Nevada, and California, in addition to being in alignment with commitments and pledges that pharmaceutical companies have made publicly to what they will raise their prices year over year. AHIP believes that price should be 10% as the threshold. In January 2018, several pharmaceutical companies publicly pledged that they would not raise prices more than 10% per year. AHIP believes the Model should hold them to that pledge. Moreover, Wells Fargo just published a report this week that said that drug prices have increased in 2019 10.5% which is four times the rate of inflation, and in June alone drug makers raised prices 27% on average. By putting the threshold at a higher rate we are basically saying "go ahead and raise this 14.9% every year which would be six times the rate of inflation and we are ok with that."

Ms. Gassaway stated that the Model should also address newly launched drugs. Most drugs have been on the market for a very long time but it is the newer drugs that are coming onto the market some of which have astronomical price tags to them. We now have a drug in the U.S. that costs \$2.1 million and we have regular bread and butter cancer medications that come off the shelf at six figures or more. It is worth having a threshold requirement for newly launched drugs so we know where we are starting and why they are launching at the prices they are launching at. If the reasons are R&D costs or recouping company expenditures then at least those are explanations but to be able to put a \$2.1 million drug on the market with no explanation is something that AHIP

believes policymakers have a right to know. Ms. Gassaway stated that other states have addressed this and AHIP would be happy to submit model language for consideration.

Ms. Gassaway thanked Rep. Oliverson for his comments regarding aggregating information. That is an important amendment to the Model because we do not want to manipulate the market any more than we need to. Ms. Gassaway then noted a suggested amendment to Section 4(b)(1) of the Model. There was a provision in the Texas bill that stated not only do you have to explain the factors that went into price increase but also the role that the factor played. For example, was it largely R&D costs and slightly a supply problem or vice versa? Just by saying the reason for the increase is R&D, which has been the common excuse up to this point, is not enough to really understand what is going on. Ms. Gassaway closed by stating that AHIP believes the Model is head in the right direction, and AHIP is prepared to work with the Committee as the Model gets adopted and brought to the states.

Saiza Elayda, Director of State Policy at the Pharmaceutical Research and Manufacturers of America (PhRMA), stated that PhRMA does have some concerns with the latest version of the Model and thinks that the changing of the threshold numbers are simply punitive and do not help the consumers and could create some significant compliance complications for companies. Lowering threshold numbers and requiring justifications really do not do anything for the patients and PhRMA feels that patients do need to have some transparency into what they are paying at the pharmacy counter but you also have to keep in mind that the manufacturers are not selling directly to the patient. There are very complex discussions and negotiations with insurers and PBMs who are also very sophisticated contractors who also have control over their benefit design and have P&T committees that look at the clinical side of things before they decide whether or not to put a drug on their formulary. They have a vast amount of data looking at their experience with drugs and enrollees.

Ms. Elayda stated that manufacturers already disclose a large amount of information publicly and have R&D expenses which include the clinical development costs, the cost of R&D through mergers or acquisitions with other companies, as well as information about drugs in the pipeline being worked on. Manufacturers also report the aggregated data cost on manufactured goods produced and sold, and have data on marketing costs, costs associated with patient assistance programs and ACA prescription drug fee. Manufacturers also report aggregate information on rebates as well as the cash discounts and other discounts. Lastly, manufacturers have information that they report on the gross and net sales and the net earnings and losses.

Ms. Elayda stated that while PhRMA does appreciate that there are PBM and insurer aggregate disclosures, the Model stops short of helping patients. The transparency should focus on supporting policies and reforms that work in the best interests of patients when they are at the pharmacy counter. PhRMA does believe that the system needs to be shaken up a little bit and states are the perfect area where that can occur. For example, PhRMA supports supply chain reforms that could align system incentives to deliver a greater share of the savings to patients – these are the savings that the insurers and PBMs gain through negotiations with manufacturers on where the drug is going to be put on the formulary, or if it will at all.

Lastly, PhRMA is willing to work with the various stakeholders present today and all Committee members to pursue policies to decrease the legal or regulatory barriers so that states can have voluntary alternative payment models that can be tested at the state level to see what works. PhRMA's member companies are open to discussing what can work to see what is a good policy and what is a bad policy. This is not going to be a quick fix and there will be failures in the various payment models that can be tested but PhRMA is happy to be part of working to find solutions.

J.P. Wieske, VP of State Affairs at Horizon Gov't Affairs spoke on behalf of the Pharmaceutical Care Management Association (PCMA) and stated that PCMA is appreciative of the work that Rep. Oliverson and the Committee have done on the Model, particularly with regard to the aggregating amendments mentioned earlier. The movement of this Model is important for transparency across the country and PCMA believes that this is a huge step forward and part of understanding where we are going to go in the future is starting with the data that is being proposed in the Model. Mr. Wieske stated that as we move forward, he believes we are going to see changes in how the industry operates. Technology will increase in health and every other line of insurance. Things such as real time benefit checks, which would allow consumers in the doctors office – not just in the pharmacy – to be able to understand all of their pricing options. There are some significant IT issues that are surrounding that and it continues to be worked on. As we sit here today, Mr. Wieske stated that this is an important transitional Model to get us to the next level and to understanding what is operating in the industry at large. PCMA is happy to work with the Committee moving forward.

Asw. Hunter thanked the panel for their comments and noted that medical costs are one of the leading causes of bankruptcy in the country. Asw. Hunter will return to the constituent she mentioned earlier to say that she is working on drug pricing transparency and costs but at this point she does not have an answer for her.

Rep. Oliverson asked Ms. Gassaway to elaborate on her comments regarding newly launched drugs, and also asked the rest of the panel to comment as well. Ms. Gassaway stated that there are a couple of different approaches that have been discussed. From an administrative perspective, one thing that NCOIL does in building a Model is allow multiple states to adopt it so there is one set of rules for companies to abide by which can reduce administrative costs. Looking at CA, OR, NV and VT which are four states collecting drug price information, they are collecting information on newly launched drugs and have set that threshold at the same definition as the Medicare specialty drug threshold which is roughly \$670 a month which is roughly \$8,000 per year. AHIP had previously suggested \$10,000 which is not a magic number but there is a shock value to it of thinking that if there is a drug that is going to cost more than \$10,000 maybe we should ask why. Accordingly, Ms. Gassaway suggested any requirements on newly launched drugs in the Model to be aligned with the states she mentioned in order to be less administratively burdensome.

Mr. Wieske stated that coming from an insurance department where he collected data and looked at how the department used it, the idea is that you need to have a baseline and understand where trends are going to go. Understanding where drugs are starting at will be important to understanding what is going on at the market at large. That has consistently been seen with insurance department's gathering of data.

Ms. Elayda stated that a lot of this information is already out there. When drugs are in the pipeline stage you can go to any manufacturer's website and see what they are working on and see what stages of clinical trials the drugs are on and see if they have had to start over again. Accordingly, such information may be duplicative.

Rep. Oliverson asked Mr. Wieske and Ms. Gassaway to comment on Mr. Schmid's comments relating to cost sharing abandonment with respect to copay assistance counted towards the deductible. Ms. Gassaway stated that those are very important issues and health plans have been challenged with the deductible balance of premiums. Deductibles and premiums go in balance as we are trying to serve the customers that buy insurance or employers that buy insurance. Ms. Gassaway stated that she does not believe any health plan likes high deductible plans, they just realize that they have a purpose in the marketplace because there is a need from a premium perspective to give somebody that protection they need if they do have a medical issue.

Ms. Gassaway stated that it is important to step back a little bit from the deductible issue and talk about list price because list price does matter and that is one thing that is missing from this. AHIP had Milliman conduct a report on real rebate data for six health plans and the report stated that 64% of brand name drugs have no rebate being applied to them. If 64% of those drugs have no rebate, that is the price of the drug that the health plan, PBM, and customer is paying. When a lot of the talk focuses on the fact that the list price doesn't matter and the parties involved are sophisticated negotiators that are getting great discounts and not passing them on to patients, it is simply not true. AHIP is doing the best that it can to get the lowest net price it can for consumers but for 64% of the time, they may have a monopoly on the market and do not need to give plans a discounts – the drugs are going on the formulary and they can charge whatever they can and there is no control over that.

In the generic space there are no rebates so when you have a generic drug that starts at \$3 and then the market moves and now the pharmacy is being charged \$9 for that same drug, health plans and PBMs have no control over that – that is the market and list price the drug maker has set for that drug. That price matters and we have to stop thinking that it is somehow an illusory price because it is not. And you should not need a coupon to buy your drug. Coupons are a market manipulation to keep brand name drugs being prescribed when there are other cheaper alternatives on the market. Going back to the Milliman data, we are actually getting big rebates when there is brand to brand or brand to generic competition, but when there is only a brand out there they are going to try and hold on to that market share as long as they can. So when you have a coupon you are actually raising the price.

Ms. Gassaway stated that there was an incredible study done by Massachusetts and New Hampshire as MA banned copay coupons for a period of time. They looked at the dispensing of generic drugs between those two states and found that generic utilization went up in MA as it banned coupons because all of a sudden it was better for folks to take the generic version of the drug instead of taking the brand with a coupon. We need to stop market manipulation, and bring down the cost of the drug so that people can afford it because an unaffordable drug is not an accessible drug. We need to have reporting that matters but if I report that this many people used a copay coupon, most of the health plans have no idea those coupons are being used unless they have put a copay accumulator in place which has an amazing amount of technology behind it. The pharmacy processes the claim and for the health plan it looks like the member paid that

full claim. The plan has no idea that the coupon was being paid for by the pharmaceutical drug maker. Accordingly, that data may not even be reportable since half the time it is not known it is being used. Conversations moving forward need to focus on lowering the list price.

Mr. Wieske stated that from PCMA's perspective, this is a consistent policy in everything else in medical, not just drugs. There is an expectation that if a doctor or dentist advertises that they will give you a free exam then it will in fact be free and not be billed to the insurance company separately. There is a piece of that that makes sense. There is an expectation from an insurance standpoint that the deductible is the cost paid by you and in most insurance policies that is in fact how it is defined. If not defined that way, that is an issue with the insurance company and how they are issuing their policies but that is a fairly consistent definition in policies. Mr. Wieske stated that you have to be very careful if you are opening up that discussion that you are freeing up the type of issues that lead to fraud in the other areas we have seen where these sort of free things end up being charged significantly to the insurers down the road in a variety of ways – that is seen ad nauseum. It is intended to circumvent the system that the insurers have put together with the P&T committees and driving the drug formularies in order to lower the costs and those higher costs are being passed on to the insurer, they are not just being paid by the patient. Mr. Wieske stated that he is certainly cognizant of Mr. Schmid's comments and the issues his colleagues are dealing with as there are significant costs passed to them as well.

Mr. Schmid stated that he agreed with Ms. Gassaway that it would be if we did not have coupons but if we did not have them there would be greater drug abandonment and it is unclear who would pay for all of those costs in the deductible and high cost sharing. If we set lower copays then we would not have a problem. Most of the copay assistance goes for brand name drugs without a generic by far and also the plans are still collecting the money – if it is not from the patient it will then be from the drug manufacturer copay assistance so they are still collecting the money and with copay accumulators they are double dipping. Ms. Gassaway stated that plans do not collect that money – the money goes straight from the pharmacy back to the drug maker.

In response to the comments regarding the significant technological advances made and how a lot of data is already accessible, Asw. Hunter stated that there are still many people who do not have reliable internet access.

Asm. Kevin Cahill (NY), NCOIL Secretary, stated that the fact that the information is out there is sort of the answer to everything since the internet is so pervasive but what Rep. Oliverson is trying to accomplish is to transform that information so that it can be used by people. There is a benefit to people who are trying to hide things to make it confusing even if it is out there. Regarding Ms. Gassaway's comments that drug prices are real, Asm. Cahill recalled his first exposure to the average wholesale price (AWP) and saying it is not average, not wholesale, and not the price. That is where we are as consumers – we don't know what the drug prices are. By consumers, Asm. Cahill means states as well as NY's Medicaid program is the biggest drug buyer in the state.

Regarding the issue of the balance of premium versus deductible and copay, Asm. Cahill stated that most of the time plans will tell us that copays are a management tool and not necessarily a cost tool and that it is a way that they encourage people to be cautious when they are using their benefits and it is important to have some skin in the

game. However, there does come a point where a copay or deductible is so great that in fact the benefit is illusory and does not really exist – it is just on paper. If somebody cannot pay for something it is not a benefit. So the idea that we are balancing off a premium does not make sense if that premium is paying for a product they are not getting. Asm. Cahill asked Mr. Schmid and Mr. Moore to discuss the human element in this regarding what it really is like to tell someone that their drug has suddenly become unaffordable.

Mr. Schmid stated that healthcare is so critical to stay alive each and every day and access to drugs is more and more critical. Mr. Schmid stated that he represents people living with HIV and hepatitis and if they did not have their drugs they would not be alive. Coupons are extremely critical as Mr. Schmid stated that he has been doing this for 15 years and that is simply those with HIV get their drugs because of the high cost and high cost sharing. It really is an issue of life or death if they do not have access to their drugs.

Mr. Moore stated that it is the most difficult part of what he and his colleagues do. You have a prescription from a doctor that is covered by the insurance company and it comes back with a high copay that the patient is not able to afford. The patient says “what do I do now?” While copay cards and patient assistance are extremely important, Mr. Moore stated that he and his colleagues cannot use those cards for Medicare Part D patients. So if you have a patient who is in a federally funded plan those copay cards don’t do any good so while they are important and do help you cannot overstate their role. Mr. Moore stated that every day he and his colleagues deal with patients who come in and they have come out of their deductible or have gone through the doughnut hole in Medicare Part D and are in catastrophic coverage and they are almost relieved that they have spent so much money and it is not a win-win for anybody at this point.

The beginning of the year is incredibly difficult when formularies and plans change and everybody comes in sort of wondering what the damage will be in January. Information is important and having it be accessible online is great but we have to remember that a large percentage of our population does not have meaningful, if any, internet access and therefore the information needs to get to them in a manner in which they are going to be able to utilize it and make something of it. With seniors in particular, Medicare Part D likes to put everything on line but it is not effective. During open enrollment every year patients come in to the store asking what they should do and what plan they should sign up for and they have to be very careful about how they answer those questions and the answer “go look it up online” just doesn’t work for a lot of patients.

Asm. Cahill asked if the people walk out of the store when they are told that or do they do something else. Mr. Moore stated that they try to sit down with them and help them navigate the information the best they can and often they will set up appointments to bring them in to show them the CMS website with a plan finder but you have to be careful with how you present plans because it can be seen as steering by the pharmacy which can result in trouble if the plan pointed out is better for the pharmacy so it is a tough situation.

Asm. Cahill stated that during the Committee’s discussions on PBMs, and elsewhere, it has been said that independent pharmacists are sometimes required to charge less than a drug actually costs the pharmacy. Asm. Cahill asked how that occurs in a contract or elsewhere and how might the Model effect that in a positive way. Mr. Moore stated that

they are paid according to a contractual basis, usually on a list-minus model or an AWP-minus a certain percentage for a generic drug and as we know, AWP doesn't necessarily have any correlation to the actual cost of the prescription and what the pharmacy pays. So if according to the terms of the contract I am reimbursing at AWP minus 80%, if my acquisition cost is higher than that I am still required to dispense that prescription. The difficulty with that is that it is an issue of being able to even afford stocking and carrying those prescriptions and it is becoming a greater percentage of the prescriptions seen – about 16% of Mr. Moore's pharmacy at this time.

Asm. Cahill asked if this is a situation where the dispensing fee can make up the difference or is it significantly more than that. Mr. Moore stated that in the case of Medicaid managed care the dispensing fee could make up the difference in a lot of situations with generics but for some of the brands it might not depending on the percentages and other numbers.

Rep. Martin Carbaugh (IN) stated that he has a lot of concern with copay and deductible coupons counting towards the deductible on a plan especially when you look at it from the standpoint of other concepts that are being brought forward. There was a bill in Indiana this year that would have limited the ability of the insurance company to switch people from a current drug to a different and maybe lower cost drug. Essentially, if you pull back and look at it from a 30,000 foot view, we want to help pay the upfront costs so the client has no out of pocket cost at the pharmacy counter, which sounds great for consumers. Then they get past their deductible because all of the coupons count towards it and then the insurance industry has no ability to switch the drug throughout the year to a lower cost if there is a lower cost drug that could work. So we have to be very mindful of the ramifications and some other concepts that are built around this.

In Indiana there was a Committee hearing and no vote about the idea of coupons counting towards the deductible and the Ranking Minority Member of the Committee, a Democrat, simply asked "why not lower the price? Why is the price setter offering a coupon and then now they want that to count towards the deductible?" Rep. Carbaugh stated that is very dangerous that and the fact that it is already occurring the industry may not know is something the Committee may need to look at because ultimately we cannot just concentrate on the cost at the pharmacy counter – we have to look at the actual cost of the drugs.

Asw. Maggie Carlton (NV) first thanked those on the panel that cited Nevada's work on these issues and then stated that she understands where PhRMA is coming from but Nevada has a great professional staff and people who have one of the most comprehensive health insurance plans – a union health and welfare trust in NV – cannot figure out the data and why insulin went up 700% over 20 years and became unaffordable. The data may be available but you need a Ph.D. to understand it. Asw. Carlton stated that she is proud of the drug pricing transparency legislation that was passed in NV in 2017, and in 2019, there is a similar game plan for asthma medications. With regard to the coupon issue, Asw. Carlton stated that they discussed it in NV and a Republican colleague of hers asked if it really matters who is paying the deductible, whether it is a coupon or a 30 year old who cannot afford it and asks Mom and Dad to pay for it. The deductible is being paying for either way. Coupons in some cases can save that 30 year old from making that call to their parents asking for an extra \$600 to pay for a prescription.

Rep. George Keiser (ND) asked Mr. Wieske to elaborate on his earlier comment regarding the Model being a transitional bill, meaning that if this is a transitional bill, what is the optimal bill? Mr. Wieske stated that he does not believe there is an optimal bill but in terms of where the industry is going technology-wise, in a number of years we may be able to see a doctor being able to figure out exactly what a specific drug for a specific patient on a specific plan costs both from inside their plan and if they were able to pay a cash pay price. Mr. Wieske stated that he does not believe we are that far away from that.

Rep. Wendi Thomas (PA) stated that it is her understanding that there are coupons that come from drug manufacturers and then there are coupons that other pharmacies distribute to get business. Rep. Thomas asked if we are only speaking about the drug maker coupons. Ms. Gassaway stated that by and large those are the coupons being discussed today. She noted that you can download them off the internet easily from a variety of websites, either from the drug maker or a third party, but they are all backed by the drug maker. The drug maker issues them and is basically paying the pharmacy to dispense that drug instead of the member. Put another way, this would be the equivalent of a hospital issuing a coupon to have your baby at that hospital instead of another hospital because they will waive your deductible because they will essentially pay the deductible for you. We don't allow hospitals or doctors to do that but we do allow pharmaceutical manufacturers to do that. Mr. Schmid stated that there are also a number of non-profits that also help with assistance.

Ms. Elayda stated that manufacturers do report the amount that they have provided per year in their SEC filings for patient assistance. Ms. Elayda stated that she cannot speak to what each individual company's patient assistance program looks like but they are all different and take into account various things. It is a little bit of a stretch to say that manufacturers are even paying for the third party and non-profits and all the coupon systems out there.

Asw. Ellen Spiegel (NV) stated that she has been noticing increased consolidation of pharmacies and PBMs and insurers are buying them and it is getting harder for an independent pharmacist to stay in business. Asw. Spiegel asked if when the insurers own the PBMs if they are looking at each line of business separately or looking at it in a consolidated way in which case there is more room to provide relief to consumers.

Ms. Gassaway stated that there has been so much consolidation in the industry but from an insurer's perspective, insurers have been by and large partnering with the PBM industry for at least the 25 years she has been doing healthcare policy work. The first plan that Ms. Gassaway worked for owned its own PBM and built it from the ground up because it needed that specialized expertise to administer the pharmacy benefit as it became more and more integrated into the medical benefit. Many forget that 15 years ago, prescription drugs were not a covered benefit in an insurance policy. You maybe got generics but you did not get brand name drugs. Now we have such comprehensive coverage which allows us to do whole person care. As health plans approach that from the care continuum they are looking to get those synergies and the companies that do have a common parent do have to have silos between their insurance business and their PBM business because their PBM typically has business with other insurance companies that their insurance company cannot know about. Ms. Gassaway stated that there are a couple of PBMs that own pharmacies or have the same parent but that is not the norm at least right now. The synergies between the health plan and PBM are

growing more intricate because of the fact that the pharmacy benefit is so important to whole person care that you cannot treat it separately anymore.

Mr. Moore stated that it is the PBMs buying the health insurers in a lot of situations and there is a reason for that. Pharmacists have a lot of concerns with that and what is going on with the integrations. The exchange of data reports shows that patients have been contacted by the PBMs to transfer their prescriptions from not only independent pharmacies but smaller chain competitors within NY and those patients have never stepped foot in another chain. That is something that Mr. Moore and his colleagues are very concerned about as providers and healthcare professionals and the PBMs are the ones coming up with the money to purchase the health insurers.

Rep. Oliverson thanked everyone for the comments and stated that it is important to remember that the Model is a transparency model and not a “thou shall not do this” bill. The purpose of the Model is not to tell stakeholders how they must conduct business – the purpose is to find out how their business practices effect the cost of prescription drugs. Legislators want to be armed with the facts before they start peeling back the onion and take any action to try and lower prescription drug prices. Rep. Oliverson stated that he and Sen. Dan “Blade” Morrish (LA), NCOIL President, look forward to working with everyone to make improvements to the Model and have it adopted at the NCOIL Annual Meeting in December.

DISCUSSION ON HEALTHCARE SHARING MINISTRIES

Rep. Carbaugh began by stating that in the interest of full disclosure, he does of a contract with a health care sharing ministry (HCSM) as an agent and has sold a couple of policies, although they are technically not “policies.” When dealing with HCSM’s, there is a lot of language to change because there are no claims and there is no premium and there is no contract. There are allotments and no deductibles and annual household portions. Many of them look and feel like health insurance but are not. Rep. Carbaugh stated that what prompted him to bring this topic forward for discussion was that a friend of a friend called him about some health insurance and asked about some options mid-year and he did not have many because of the enrollment period. Rep. Carbaugh mentioned a HCSM as a possible solution although he always prefaces that recommendations with all disclosures.

The friend said that they had already tried that and had an unpleasant and unexpected experience – his wife got pregnant and when the baby was born, the baby had some pre-existing birth defect conditions and all of the medical bills to treat the baby were not eligible to be shared with the HCSM they were working with. Rep. Carbaugh stated that as a Christian that did not seem very Christ-like but he also understands the concept of the no pre-existing condition language and that is why the monthly pricing can be competitive. Rep. Carbaugh stated that other stories are starting to come out and as in every industry of every kind there are going to some bad players and some well-established good players. Rep. Carbaugh stated that the story he shared was with one of the well-established HCSMs.

The Honorable Dave Weldon, former Congressman and President of The Alliance of Health Care Sharing Ministries (Alliance), stated that the Alliance now represents two HCSMs, as the third recently left to do their own gov’t affairs work. The remaining two are Christian Care Medishare and Christin Healthcare Ministries. They represent close

to 50% of Americans in HCSMs. When the third HCSM left, the Alliance was representing about 2/3 of Americans in HCSMs. Cong. Weldon stated that the work that he does, which is gov't relations work at the federal and state level, ends up affecting all of the people who are using a HCSM as an alternative to insurance. Additionally, there are about 150,000 Mennonites using healthcare sharing and for them they do not believe in using insurance. Some of them are required to have car insurance in their state but if they get into an accident and they are at fault they typically pay cash to resolve it. One of the HCSMs that is Mennonite has about 10,000 members. The concept of healthcare sharing is also ancient and goes back hundreds if not thousands of years. Indeed, one can say the concept is rooted in the scripture and verses in the scripture.

Cong. Weldon stated that HCSMs are not businesses but rather 501(c)(3) tax deductible charitable institutions. Some of them are actually run by ministers and not businessmen per se. Cong. Weldon stated that he is a physician and served in Congress from 1994 – 2008 and was on a number of healthcare committees. He was asked to be on the board of Medishare and then later asked to step in and run their gov't affairs operation. The HCSMs are also religiously diverse in the sense that there are Catholics, Protestants, and recently a new HCSM that caters to Jewish people (mainly orthodox). Some HCSMs will accept multiple faiths but some are limited to one only. Regarding Rep. Carbaugh's remarks on pre-existing conditions, most of the HCSMs have temporary pre-existing condition exemption and when talking about this issue it is well worth saying that pre-existing illness exclusions are there to protect the rate payers that are paying insurance from the people who wait until they get sick and then get health insurance. Cong. Weldon stated that when he practiced medicine he saw that firsthand and it drives everyone's premiums up. HCSMs typically have a temporary pre-existing exclusion, typically 2 or 3 years and usually never permanent.

Cong. Weldon stated that HCSMs have grown quite a bit and they do settle some very large bills. Some of the biggest payments when he was on the board of directors at Medishare were for premature babies and frequently they settled bills in six figures and occasionally seven figures. Recently, there has been a lot of concern about a HCSM called Alera in the media and allegations have been raised that they have not been paying claims as they come in. Cong. Weldon stated that Alera is not a member of the Alliance and it is not clear to him whether it is actually a HCSM. When he talks to the leaders of the HCSMs they have had a great deal of concern for a long time that somebody could get into this space and start engaging in a HCSM but not have the proper motives. By and large, there are mostly Christian HCSMs and if you go to their offices you will frequently hear people talking to others on the phone with illnesses and actually praying with them. The Christian roots of being engaged in the process of healthcare delivery are ancient. The concept of a hospital was an institution that was created by the Catholic church 1,000 years ago. For many years it was all rooted in charity and it was mostly led by the Catholic church and then the Protestants began to engage in it. In many regards it makes sense because a health crisis can be one of the biggest if not the biggest crisis one faces in their life and the involvement of the church has traditionally been a strong part of it.

Cong. Weldon stated that the President recently released an Executive Order entitled "Improving Price and Quality Transparency in American Healthcare to Put Patients First." In that EO, the President called for regulations to be promulgated by the Departments of Labor, Health and Treasury to allow participants in HCSMs to take advantage of section 213d of the U.S. code. There is also reference to members of

HCSMs having access to an expanded form of health savings accounts. Cong. Weldon stated that the Administration is interested in this because we have seen tremendous price inflation and there are serious concerns about pricing. Cong. Weldon has seen these problems firsthand when treating patients. Innovation is good and HCSMs represent a form of innovation. The HCSMs also help a lot of people who are very low income. One HCSM Cong. Weldon represents has 50% of its members at or below 400% of the poverty level. The Alliance feels that those in the HCSM sphere are providing a vital service and meeting the needs of critical Christian and non-Christian families that are struggling with healthcare needs. The Alliance is eager to make sure that consumers are protected and fully informed and that it is fully disclosed that this is not health insurance.

Joe Guarino, Health Care Sharing Consultant for Nelson Taplin Goldwater Group (NTG), stated that health care sharing (HCS) involves families helping families pay their medical bills voluntarily with financial gifts. There are six large national HCSMs of variable sizes. There are also many very small church-based local or regional HCSMs that are mostly Mennonite. Mr. Guarino then walked through a hypothetical to explain how HCSMs work. In a given month 3,000 medical events come into one particular HCSM and after adding them up they total about \$30 million dollars. They then divide that \$30 million among the households that are participating in that ministry. The next month the HCSM will send out a newsletter with an insert that says "Joe, this month send your share (which is a gift to help pay for medical expenses) to Sally in Des Moines, Iowa." Joe then writes a check and sends it to Sally along with sending a get-well card and praying for Sally because in the newsletter there is a brief description about what the medical event is that Sally is experiencing.

For Sally, if her medical event cost \$5,000, she will submit original bills to the HCSM and the HCSM divides that up between lets say 23 families in the HCSM. The HCSM sends a check list to Sally and Sally waits for those checks to come in. If there are any members that do not send a check, Sally will then inform the HCSM and the HCSM will re-allocate those shares to someone else the following month. Ultimately, Sally will get enough money to pay all of her medical providers. The process typically takes 30 to 60 days from the time someone submits a bill to receiving checks to paying the medical bills. HCS promotes fiscal responsibility. Kaiser puts out a yearly report on the cost of employer-sponsored health benefits and in 2018, the average annual employer-sponsored family premium was \$19,616. One HCSM average annual share for a traditional family of three or more is \$5,490.

Mr. Guarino stated that HCS also engenders personal responsibility because to participate in a HCSM you must abide by lifestyle requirements based on the Bible: sex within biblical marriage; no drunkenness; no illegal drugs; and no smoking. There were nine exemptions in the ACA and HCSMs received one of them which means HCSM participants did not have purchase health insurance and they would not be penalized for not having health insurance. With the penalty being eliminated in the federal tax code a few years ago some states have begun to reimpose a mandate to buy health insurance but that is another issue for another time.

The Honorable Glen Mulready, Commissioner of the Oklahoma Department of Insurance, stated that since HCSMs are not regulated, they may choose to cover or not cover almost anything. Several HCSMs have grown substantially of late and the difficulty in that is that we do not know that the impact is because they are not required

to report data at all to anyone. Most recently, some regulators and Attorneys General have taken action against some HCSMs. The state of Washington has issued a cease and desist order to Alera. There was also requesting a temporary restraining order against Alera, and Georgia has just recently started an investigation with the FBI. Cmsr. Mulready stated that when he started as OK Insurance Cmsr. six months ago, his concern was helping folks and if people called the department asking if a HCSM was insurance he was told that they should be told that the department does not regulate HCSMs so they need to call the HCSM directly. Cmsr. Mulready stated that within the week hopefully his department will be putting on its website a list of HCSMs that it knows of that are doing business in OK with a link to their contact information along with a disclaimer that they are not regulated by the department. Cmsr. Mulready also noted that as you can imagine, depending on what state you are in, views on HCSMs can fall on political ideological lines.

Cmsr. Mulready stated that he grew up in MA and had never heard of HCS despite being in the insurance business, but his father in law in OK who was sick at the time was not able to get individual health insurance (this was pre-guaranteed issue) and he was able to join a HCSM and have his costs covered. He had hundreds of thousands of dollars of medical bills with multiple open heart surgeries and multiple amputations. Cmsr. Mulready stated that in his state he believes it is about freedom of choice but noted that NCOIL is uniquely qualified to put forth some basic items for HCSMs to abide by and Cmsr. Mulready suggested a notification/registration process in each state with contact information and perhaps an annual report with information stating how many people are being served and what kind of healthcare expenses are being taken care of. Also, HCSMs are required to do a basic audit for CMS so requiring that to be submitted to the insurance department could be beneficial.

Rep. Oliverson stated that he is all for more choices in the marketplace but he is always mindful of the fact that regulation is developed not to regulate good actors but rather bad actors. Rep. Oliverson asked the panel if it would destroy the business model if HCSMs were brought into the purview of the insurance department. Cong. Weldon stated that when he began his current position at the Alliance he immediately began discussing with HCSMs both in and out of the Alliance that it would be really good to regulate themselves. That occurs in a whole host of areas with academic accreditation being a great example – you have some standards on educational accreditation but mostly, at least in the southeast – it is handled by the southeastern association. Getting the HCSMs to move forward with that concept has been difficult as some of them are quite small and have limited resources. The subject of registration has been brought up and discussed. Cong. Weldon stated that the vast majority of the players in this field are very much interested in working with legislators and the gov't to put in place some sort of regime to deal with the issue of credibility and accountability. What that is right now is not clear.

Cmsr. Mulready stated that in OK they are trying to set up a process of when a call comes into a regulator trying to get in contact with a HCSM, the consumer assistance area can connect the call to some sort of “elevated” call to that HCSM because if someone is contacting a regulator it is at an elevated level. Rep. Oliverson stated that his biggest fear in this is that he does not want to see it go the way of association health plans (AHPs) where they sort of came on the scene largely unregulated and had some pretty bad actors that did some pretty awful things so the ACA pretty much abolished them. The bad actors should not drag the whole market down.

Sen. Bob Hackett (OH) stated that he has been in the business a long time and when things go bad, they go bad quickly. When things go bad and costs go way above average, the healthy people leave even though religious pressure may keep them. Sen. Hackett also stated that it is often easy to close one down and open up another and create some pre-existing condition provisions where you do not get bad claims. There was a case in Kentucky in the 1980s with a company which was a non-ERISA trust and the insurance commissioner gave them an award and a year later the insurance commissioner said any agent that put business with that company should consider having their license revoked. They didn't have the backup of being a fully-insured plan and when it turned bad it turned bad quickly. Accordingly, Sen. Hackett asked if there is any sort of system in place, analogous to the guaranty system, to guard against when things go bad because the rates look good but they can change overnight.

Cong. Weldon stated that is a broad question but to answer it narrowly, there was not a lot of controversy surrounding HCSMs two or three years ago and that is because they were sharing in everything they said they would share as when you join a HCSM you are told what will be shared and what won't. There were not a lot of complaints flooding in, and now because of one HCSM, which may not actually be one, there has been a lot of media reports about people having medical expenses that were not shared. Cong. Weldon stated that HCSMs have been talking internally about this sort of bad scenario for years. That is why Cong. Weldon feels that something needs to be done whether at a state or federal level. It is also important to keep in mind that most of the people in this space are good people and are sharing millions of dollars. Some actually refer to HCSMs as business trees because there is so much money coming in and out the door but notably there are no stockholders and they are run as a charity as a 501(c)(3) and most file 990s. The ACA requires that they issue an audit and make it accessible to the public so you can put audits and 990s on department websites.

Sen. Hackett stated that one problem is that someone may go without health insurance and then when a problem arises and they try to get it they have no records. Sen. Hackett knew a client who could not join a HCSM because he had no records and there was no way to determine any pre-existing conditions.

Sen. Dan "Blade" Morrish (LA), NCOIL President, asked if the dollars paid are paid through the individual or through the HCSM. Cong. Weldon stated that they all vary and the description Mr. Guarino gave was how Samaritan ministries work – they actually mail checks around though they are trying to do it in a different way. The money goes to the person with the claim who puts it in their account and then writes a check to his hospital. The biggest ministry, Christian Healthcare Ministries (CHM), actually pools all their funds and then ask the member if they want the money to be sent to them so they can pay the hospital or do you want us to pay them directly – most of the members request that they be paid directly. Medi-Share has a very unique operating system where every member opens a checking account at a credit union in CA called America's Christian Credit Union and if you have a medical event the money is moved electronically into that person's account and then transitioned out to pay the providers. There are other ministries operating of which Cong. Weldon stated he does not how they handle payment. Sen. Morrish stated that he passed legislation on this in LA in 2014 and at the time he believes it was set up like the credit union scenario described.

Asw. Hunter asked if HCSMs pre-screen applications with physicals to make sure they do not smoke or drink. Mr. Guarino replied no – it is self-attestation, however, you have to get your pastor to sign off saying that you do not live your life under those bad lifestyles. Asw. Hunter asked if HCSMs cover mental health and substance abuse. Mr. Guarino stated that most do not.

Rep. Carbaugh stated that he believes this topic is worthy of discussion by this Committee with an eye towards possibly developing some type of model legislation. Rep. Carbaugh stated that the pre-existing condition exclusion are fine for someone like himself but not ok for a baby with a hole in its heart and he does not believe everyone understands that. Cong. Weldon stated that most HCSMs will pay those claims and noted the story referenced earlier by Rep. Carbaugh – if you sign up for sharing and you are already pregnant then the product of that pregnancy is not allowable to be shared on but if you join and then you get pregnant and that baby is born with a hole in its heart, most HCSMs will pay that bill. Cong. Weldon stated that one HCSM uses a 300 day rule so if your wife gives birth less than 300 days after you signed on then the product of the pregnancy is not shareable. That is to protect people who pay in every month from those people who wait until their wife gets pregnant and then joins a HCSM. Cong. Weldon stated that when he was on the board of Medi-Share he would be shocked at some of the share amounts, particularly for newborns with health problems and bills for \$700,000 to \$900,000 were frequently settled almost every few months.

Rep. Carbaugh thanked Cong. Weldon as he did not know of that 300 day rule and noted that to be fair, he has had people tell him that they have had large sums shared in HCSMs. Rep. Carbaugh stated that he does not believe HCSMs are bad and does not want to stifle innovation but does think overall disclosures, including already required audits, and registrations are a good thing. Rep. Carbaugh stated that he looks forward to working with everyone on this.

DISCUSSION ON DEVELOPMENT OF SHORT TERM LIMITED DURATION INSURANCE MODEL LAW

Rep. Carbaugh stated that the draft NCOIL Short Term Limited Duration Insurance (STLDI) Model Law (Model) is basically the bill that he authored and passed in Indiana. Before their session started in January, the federal gov't released guidance saying states could expand their short term health options and Rep. Carbaugh stated that that is a small piece of innovation healthcare that all states should look at. As the Exchange programs become more unaffordable, this could be a potential alternative and really it is something that can help people. Rep. Carbaugh stated that he has clients where one spouse is Medicare age and the other is in that two to three year time window where they have to keep working because the spouse at 65 is the insurance holder.

STLDI could fill the window in that example and could fill the window of a small business person not wanting to spend a ton of money on healthcare and instead put as much money as they can back into their business. STLDI can help college students as well and obviously those in between jobs or in jobs without benefits. The Model extends STLDI plan to the greater of 36 months or the maximum period permitted under federal law. The idea is that at the time of application you would declare how long you want the contract to last – anywhere from one month to three years and the underwriting would be done upfront because technically STLDI must be 364 days so it will renew but it will renew without further underwriting requirements if you declared a longer term than that.

Once that declared term is up, then you would have a new contract and you would have underwriting requirements. Rep. Carbaugh stated that his Ranking Minority Member came up with the idea for disclosures about STLDI not covering the ten essential benefits of the ACA as it is important that consumers know what they are buying and what they are not buying. There has been a suggestion from Blue Cross Blue Shield (BCBS) to specifically list those benefits and Rep. Carbaugh stated that may not be a bad idea.

The Model requires the plans to require at least \$2,000,000 in annual benefit which is a departure from current practice but it is important that if the plans are being bought for a longer period of time that there be a substantial sum there as we see healthcare costs continuing to rise. The Model also requires four benefits to be covered and when you think about STLDI traditionally, those four benefits are what you think about: ambulatory patient services; hospitalization; emergency services; and laboratory services. That does not preclude a company from offering more services and Rep. Carbaugh encouraged companies to do that and advertise and create a market for that but the more we make these look like ACA plans in terms of mandates, the more we take away some of the advantages that come along with them.

Mr. Parker stated that HHS promulgated a rule last year to make short term plans more viable as an alternative for individuals who, until 2016, could have used these policies in a much broader way but the last Administration as one of their final acts implemented a rule that significantly restricted individual's ability to purchase these plans. You can now use these plans as a coverage vehicle for up to three years – that time duration was chosen because it is generally consistent with the amount of time available to an individual who might otherwise be on COBRA. Mr. Parker stated that one thing that HHS felt was particularly important was, because these plans are not ACA compliant and therefore not required to cover the ten essential benefits, that the notification and disclosure provisions be very strong. HHS believes that there is a need in the market for these plans - for people who have a need for short term coverage whether they be in between jobs or a student just coming into the workforce or for other reasons, these can be an attractive and more affordable alternative for someone who might otherwise go into an ACA compliant plan.

Mr. Parker stated that the unfortunate reality is that for some individuals who earn too much to qualify for premium assistance and who might otherwise choose to go without coverage entirely, the premium price point for these policies often convinces that perspective buyer to come in to the market with at least some measure of coverage whereas they would have no coverage if they could only choose from an ACA compliant policy.

Jan Dubauskas, VP, Senior Counsel at Health Insurance Innovations (HII), stated that HII is a technology platform that resides between the carrier and broker or consumer and connects them. HII carries products on its platform. HII works with consumer directly and it has an online consumer website which is agilehealthinsurane.com and HII also has a free site which is healthpocket.com which offers medical and health information to consumers as a resource. HII conducted a survey aiming to find out how people were using STLDI because one of the big concerns was that it was being used instead of ACA plans. However, the survey showed that overwhelmingly people are using STLDI between jobs or if their employer does not offer a major medical plan. There are some people that choose STLDI instead of an ACA plan, along with people who are coming off

a STLDI plan and buying another one, along with people who were uninsured and would prefer to have some coverage.

Ms. Dubauskas stated that there are many benefits to developing a STLDI Model Law. One of the things that is important is that consumers understand what they are buying and when every state has different disclosures and offerings then it becomes burdensome to figure out what to tell consumers, but when there is standardization we can improve efficiency and disclosures. Ms. Dubauskas noted that she was speaking to the NAIC about this last year and the CA insurance commissioner stated that he would like HII's brochure to be on its website. Ms. Dubauskas stated that is great but if the CA brochure is posted, she has to be careful about posting other state's brochures and a consumers in different states looking at the wrong brochure. Standardization can improve the communication to consumers and also improve efficiency across the states. Today the departments of insurance have approximately eight to ten carriers in each state that sell STLDI so standardization can help them review and approve flings and work with carriers if there are any issues. Brokers and TPAs would love to see standardization for many reasons and HII is very encouraged by this NCOIL Model.

Ms. Dubauskas stated that the typical STLDI policy today has a maximum limitation range of \$500,000 to \$1,000,000 which helps bring the cost down which is a big reason why people buy these policies. HII engage its actuarial team which stated that the price difference depending on the product could be 3% to 14% if we limit up to \$2,000,000. Accordingly, it is worth considering with the Model that the \$2,000,000 limit has an impact and may discourage some from buying the policy. Also, if you look at the claims there really are very few people who even get to the \$1,000,000 amount. Ms. Dubauskas also noted that today we have a simplified underwriting process which is typically accept/reject. There are questions about heart conditions and hypertension and things like that. Then the rating will be based on age, gender and zip code. As STLDI progresses and companies become more innovative you may see it go to tiered underwriting. Today with life insurance you have the opportunity for underwriting and it can be guaranteed issue, tier 1 or tier 2 based on medical health. That is not currently happening with STLDI but could happen in the future so you could have even improved pricing for your very healthy and for those who may have otherwise been rejected maybe they have a guaranteed issue policy and it is all on the same application. That would be innovative and easy for the consumer – you answer these questions and this is what you get. Accordingly, the underwriting should leave room for that type of innovation in the community.

Jeff Smedsrud, President of Pivot Health, stated that he has been in the health insurance business almost 40 years, first setting up risk pool for those denied coverage for medical reasons. For the last 30 years he has run several companies including short term insurance companies. Mr. Smedsrud stated that it is important to dispel the myth that has become so prevalent that some think its true: short term insurance is junk insurance. As a cancer survivor who has been covered by STLDI, that is far from the truth. There are a number of niches for STLDI and the market at any time is about 1 million 1.25 million people – not as large as many people think and also not as small. Some myths about STLDI include that it is hard to get but the reality is that nearly nine out of 10 people that apply are accepted for coverage. A second myth is that STLDI tends to rescind coverage and deny claims after the fact but in the last year Pivot Health had just over 70,000 claims and just under 50 times in which there was material misrepresentation resulting in a rescission of coverage – that happens in every part of

the insurance industry. There is also a myth that there are more complaints about STLDI but if you look at the NAIC's record of complaints you will find the opposite to be true – there are more complaints about other types of insurance. That being said, one complaint is one too many and everyone needs to work together to improve the market. Lastly, another myth is that only young people buy STLDI. However, experience has shown that the fastest growing part of the market is the 60-65 age group which should not be surprising because the fastest growing segment in the self employed market and the fastest growing segment of those paying for their own insurance are those aged 60-65.

Mr. Smedsrud stated that markets are imperfect and noted some things that could be included in a STLDI Model law. Right now some states allow a five year look back to see whether or not a person had a medical condition that might disqualify them from coverage. Frankly, that has been a standard for a very long time and is not necessary to look back five years and would be more friendly to consumers to look back one or two years – more companies are starting to voluntarily do that. It is also important to have good disclosures but it should also be recognized that the way people buy insurance these days is on their phone and the display of information is equally important to the disclosure of that information because you have to display the relevant points very large and very simply. Mr. Smedsrud agreed with Ms. Dubauskas that a \$2,000,000 limit may have the unanticipated result of increasing costs and an industry that likes to keep costs down will probably move to \$20,000 deductibles to go along with that \$2,000,000 and when you have that high of a deductible you are suddenly outside of the savings of 67% of the people who buy health insurance. Mr. Smedsrud also encouraged standardization because if we do not promote coverage in rural states you are going to have very few in the individual market and that is a discrimination against rural states that should not be allowed to stand.

Mr. Smedsrud then discussed the story of one of his clients: a 60 year old single Dad with 17 and 18 year old sons who was struggling to pay for health insurance. He looked at STLDI and at ACA plans for this two children. He bought a STLDI plan and three weeks later this 17 year old child was diagnosed with Leukemia. Pivot Health paid \$700,000 in benefits. Accordingly, this is not junk insurance but priceless as he was allowed to make a decision that fit him.

Michelle Lilienfeld, Sr. Attorney at the National Health Law Program (NHLP), stated that NHLP is a national public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. STLDI plans were originally intended to fill short gaps when people transitioned between coverage but a 2018 federal rule changed the definition of STLDI and as a result, the plans which were limited to a three month contract can now be sold as a replacement for year-round comprehensive coverage. However, STLDI plans are not subject to the consumer protections of the ACA and can exclude people with pre-existing conditions. Therefore, the premiums for such plans can be significantly lower and draw healthy individuals away from the individual and small group markets leaving a costlier group behind and increasing premiums for traditional comprehensive health coverage.

Also, depending on how STLDI plans are marketed and sold they can be risky for consumers who buy them mistakenly believing that they are as comprehensive as traditional ACA plans and can expose consumers to financial liability if they have an unexpected medical event. States maintain primary authority to regulate STLDI so

states do have the authority to set strong standards to protect consumers. Ms. Lilienfeld stated that among the ACA's coverage protections are guaranteed issue and community rating but STLDI plans do not have to apply that and can deny coverage to any applicant for any reasons including current or past health status or risk of future health expenses. STLDI plans can also issue policies that exclude coverage for pre-existing conditions and can rescind coverage through post-claim underwriting and can charge a higher premium based on a persons' health status or a person's personal characteristics such as gender and age. In terms of rescission, if that were to occur, generally that is not going to be considered as qualifying for a special enrollment period to enroll in an ACA compliant plan so that individual would have to wait until the next open enrollment and potentially exposed to a gap in coverage.

The ACA contains several consumer protections related to benefits. STLDI plans do not have to cover the ACA's essential health benefits which are a core set of basic services. A 2018 Kaiser study found significant gaps in STLDI plans with 43% of them not covering mental health services, 62% not covering substance abuse disorder treatment, 71% not covering outpatient prescription drugs, and none covered maternity care. Given the attention and focus on issues such as rising drug prices, the opioid epidemic, and mental health awareness, these are plans that generally do not cover those services and individually who need those services would have to pay for them out of pocket or go without the care they need. Ms. Lilienfeld stated that preventive services are also critical for an effective healthcare system both in terms of health status and cost control, are also not required to be covered by STLDI plans. Such plans also do not have to provide a standardized summary of benefits and coverage which has shown to help consumers understand plan details and directly compare plan options. Research findings have shown that a lack of availability and clarity of plan documents for STLDI plans as being problematic in terms of knowing what is covered by the plan.

Ms. Lilienfeld stated that much of the money that consumers pay for STLDI plans goes towards plan administration, marketing, and profits rather than the enrollee's health care. A report from the NAIC last year showed that the top three companies selling STLDI plans based on premiums earned paid a low percentage of premiums collected from enrollees on actual medical claims. By comparison, the ACA requires individual market insurance plans to pay at least 80% of premiums on medical claims or health quality improvement. In terms of costs, the ACA has protections on annual and lifetime limits in cost sharing but those protections do not apply to STLDI plans which can include a dollar cap on covered services and stop payment on medical bills once that cap is reached. On the other end, STLDI plans do not have to cap an enrollee's out of pocket expenses which can result in high out of pocket costs for people who need care. STLDI plans also typically charge high deductibles and cost sharing for the benefits that are covered.

In terms of consumer understanding, Ms. Lilienfeld stated that a group of NAIC consumer representatives contracted with the Kleimann Communications Group to test consumers on their understanding of marketing brochures for a popular STLDI plan. The goal was to assess whether the consumer could understand the benefits offered by the plan, the limits on the benefits, and the out of pocket costs. Among the findings were that most consumers struggled to understand the STLDI plan's coverage of benefits and limitations, in part because they became accustomed to and now expect their health insurance to reflect the ACA's consumer protections. Another interesting finding was that the federally mandated disclosure went largely unnoticed and was not effective at

reducing consumer confusion especially in warning consumers about the limitations of STLDI plans.

Ms. Lilienfeld stated that states have taken action to protect their consumers and insurance markets: 4 states ban the sale of all or most of STLDI; 22 states limit the initial plan duration of an STLDI plan to less than the federal limit of 12 months; 2 states requires coverage of the essential health benefits; 5 states prohibit rescissions; and 11 states have a minimum medical loss ratio requirement. With regard to the NCOIL draft STLDI Model, more robust standards to protect consumers are needed. For example, the Model would allow STLDI plans to last for longer than a short term and as mentioned earlier several states have set limits at three or six months. The Model's section on renewal and underwriting can be more explicit in specifying that both pre existing condition exclusions and rescissions are prohibited so that once a person is enrolled in a plan they don't have to worry about suddenly losing the coverage or having treatment for a condition excluded from coverage.

Also, as drafted, the Model almost encourages people to stack coverage and buy multiple STLDI policies upfront in order to get the protection against underwriting. In terms of coverage requirements, it is great to require benefits that must be included as there are STLDI plans that do not cover hospitalization but there are still a lot of basic services missing including prescription drugs. Also, for the network adequacy section it is unclear why mental health and substance abuse treatment providers were carved out and excluded from that requirement. If those services are covered by a plan, having an adequate provider network for those services would be critical as well. In terms of disclosures, it is great to have strong consumer disclosures and it may be beneficial to possibly include something that says the disclosure has to be read to potential enrollees by agents and brokers or to require the consumer to sign a statement saying that they have read the disclosure. Ms. Lilienfeld also noted some other provisions that could be included in the Model that states have implemented such as those relating to limiting stacking and adopting a minimum medical loss ratio.

Cmsr. Mulready stated that states still regulate STLDI plans and CA, MA, VT, RI, NY and NJ have banned STLDI plans so you can see political ideology has a role in this. OK passed STLDI legislation to match up with the federal STLDI regulations. The NAIC recently amended Model Act #170 to add language regarding STLDI plan notification requirements. The NAIC does not have a position on the length of STLDI plans but does require that notification. The NAIC is now working on Model Regulation #171 to establish minimum standards for STLDI plans and Cmsr. Mulready is co-Chair of that Working Group. The NAIC is also developing a data call that will likely take place in August seeking information from which carriers are selling STLDI plans, where and how they are selling them, and what benefits and protections are being provided.

Rep. Carbaugh thanked everyone for their comments and stated that he believes the Model addresses some of the concerns raised. You can go all the way down to a \$1,000 deductible for a STLDI plan, maybe even lower. Rep. Carbaugh stated that when he has sold STLDI plans the clients typically choose deductibles much lower than what they can choose on the federal exchange. The Model also contains important and strong disclosures for consumers which is a big concern for Rep. Carbaugh and he would be open to discussing how to strengthen that section – requiring the consumer to sign off on the disclosure is not a bad idea. With regard to the \$2,000,000 limit, Rep. Carbaugh stated that he ran a quote while the panel was talking: for a six month plan for

a 59 year old female in Wisconsin, a \$5,000 deductible, 60/40 coinsurance for another \$10,000 out of pocket, a \$250,000 max benefit for those six months is \$175.20; the same plan with a \$2,000,000 benefit is \$188.40. Rep. Carbaugh stated that in his opinion it is malpractice to sell \$250,000 for that same period for that little price difference. Rep. Carbaugh stated that he strongly encourages the Model to maintain the \$2,000,000 benefit especially as we extend terms – people need to have the coverage in case something happens. With regard to the \$700,000 leukemia claim. Rep. Carbaugh does not want to stifle innovation but wants to make sure that the plans do not get a bad reputation. Rep. Carbaugh stated that he looks forward to discussing this further at the NCOL Annual Meeting in December.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:00 p.m.