

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 17, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Francis Marion Hotel on Saturday, April 17, 2021 at 1:30 P.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*	Asm. Kevin Cahill (NY)*
Sen. Jason Rapert (AR)	Sen. Bob Hackett (OH)
Asm. Ken Cooley (CA)*	Rep. Carl Anderson (SC)
Rep. Matt Lehman (IN)	Rep. Tom Oliverson, M.D. (TX)*
Rep. Deanna Frazier (KY)*	Rep. Jim Dunnigan (UT)
Rep. Jim Gooch (KY)*	Del. Steve Westfall (WV)
Rep. Bart Rowland (KY)	
Sen. Paul Utke (MN)*	
Sen. Paul Wieland (MO)	

Other legislators present were:

Sen. Mathew Pitsch (AR)	Rep. Justin Hill (MO)
Rep. Matt Dollar (GA)	Sen. Dean Kirby (MS)
Sen. Bandon Smith (KY)	Sen. Walter Michel (MS)
Rep. Edmond Jordan (LA)*	Rep. Kevin Hardee (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Del. Steve Westfall (WV) and seconded by Asm. Kevin Cahill, NCOIL Treasurer, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Del. Westfall and seconded by Rep. Deborah Ferguson (AR), Vice Chair of the Committee, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's December 10, 2020 meeting.

CONTINUED DISCUSSION ON NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT (MODEL)

Asw. Hunter, sponsor of the Model, thanked everyone for their work thus far on the Model. The Model still remains a work in progress but I am confident that we will get it to a place where everyone can support it. There will be no vote today - hopefully the Model will be ready by either our July meeting or our November meeting. I do want to make one point before going any further. A lot of the discussion on the Model thus far has centered around the issue of payment parity and I'm sure many here have discussed that issue in their states as well as we had a lengthy discussion in NY during budget discussions dealing with telehealth coverage expansion. The Model is in your binders on page 302 and the reimbursement language is in Section 4(D) on page 304. By using the words "on the same basis" we're not calling for payment parity, but rather payment equity. For example, there is reimbursement language in a pending Iowa telemedicine bill which says "a health carrier shall reimburse a health care professional and a facility for health care services provided by telehealth on the same basis and at the same rate as the health carrier would apply to the same health care services provided in person." Such language is a great example of strict payment parity, which differs from the language you see in the Model. I just wanted to make that clear before we proceed further.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), stated that he has spoken on this issue three times now before NCOIL so he is not going to go through everything he said before. I commend you as I think there are a lot of good things in the Model and I know you have been working hard on it and giving deep consideration. With respect, we do not read that language about payment parity the same way that you are reading it and we have significant concerns with that language. We do believe it requires payment parity. One thing I want to point out is that we've had a lot of discussion about the value of telehealth as an additional method of accessing medical services and we think that is absolutely correct and one of things we've discussed with you as this is seen as a potentially lower cost option and it has been priced accordingly in benefit design. We want to make sure that we keep the consumer in mind when moving forward with this and that's why we think it's important to leave it to negotiation between carriers and providers on the payment rates and we don't believe that the model should be speaking to payment rates at all so we would request that that language be removed. I will leave it there and say I appreciate comments that legislators have made and if you are not comfortable removing the parity language we would ask for specific language saying that this does not require payment parity.

Rep. Jim Dunnigan (UT) asked Mr. Peppard if he had suggested language or example language. Mr. Peppard stated that they do not but they would be happy to work on some with the sponsor if she is amenable to that. My recommendation is that section be removed but we are happy to work with the sponsor however she would like. Asw. Hunter asked Mr. Peppard if he knows if there are any AHIP members who are in agreement with the Model language. Mr. Peppard stated that he has not heard from any AHIP members who are ok with the language. Rep. Dunnigan stated that payment equity implies equitable payment for similar services so if we are going to reimburse a provider if I'm seeing him in person in an office is that the same equity as if I'm getting a telemedicine visit from him - I don't think so. I think it's important to recognize the cost savings and lower price point for telemedicine to make it more cost productive and cost effective for consumers so hopefully we can take a look at that.

Rep. Tom Oliverson, M.D. (TX) stated that he thinks the way the language is structured essentially makes it clear is what we're talking about here is equal pay for equal work. It is about value but telemedicine is not about just making things cheaper, it's about primarily in state's like mine leveraging the existing provider pool we have to be able to provide the same level of services at places that are distant and difficult to access or communities that are small that would not necessarily support specialty providers in those communities. I think for those of

us that represent states that have a lot of rural communities I think its important we recognize its not just about saving money, its about expanding access and the degree to which we can entice more providers to embrace the technological advances of telehealth in order to expand access to underserved communities should be the most important thing we look at there. This isn't about making healthcare cheaper per se. That doesn't meant that there aren't circumstances where services provided over telehealth are not of equal quality or level of service in other words if I have someone coming in and I'm just doing a medication follow up to their diabetes mgmt. I would argue that the same level of services could be provided electronically as provided in person however if someone is coming in for a new diagnosis of heart failure or something that would require me to physically examine the patient in order to accurately assess what is going on that is not the same level of service. So I think the model that you have before you does strike that balance and so I think its important we recognize that this is really about whether or not the same conditions and level of service is provided which is what I think that language does.

Asm. Kevin Cahill (NY) stated that he disagrees with Mr. Peppard that it's a good idea to leave to contract as that will just perpetuate the uneven relationships that exist between health plans and providers. There are places where there are few providers who could extract a premium for telemedicine and in fact force a patient into telemedicine where that might be the appropriate venue for their care. Just as likely there are places where health plans are dominant in a marketplace and they can force if a provider wishes to participate a circumstance where they would have to accept a significantly reduced telehealth rate even if it was not warranted. The one thing I have said in the past when we discussed this is that to do this bill alone and I hope between now and July and November we can do this – to do it alone without a companion of network adequacy would be a large mistake. We have to put the check in there to make sure its the patient that comes first in every instance and this is not about making healthcare necessarily cheaper its always about making sure healthcare is accessible and quality in every instance and yes of course affordability is also a consideration. I would urge against what Mr. Peppard said in terms of leaving it to contract and I would also suggest that it should not be done at all without a companion bill for network adequacy.

Sen. Bob Hackett (OH) stated that we have been working on this for a long time in Ohio and one of things we've done is postponed getting the final bill passed because we are still in the pandemic and there was no expert that forecasted how much telehealth was going to be used that was close to being right. The amount of telehealth used in OH is phenomenal compared to what it was so a lot of it depends on the quality of the healthcare and its still too early to tell how well telehealth has done. One of the reasons I support the AHIP model is because when you talk to some of the providers they talk about the initial cost of setting up the telehealth system and sometimes you will see examples of cases where the providers will be ok with payment parity in a situation otherwise it wouldn't get done and I agree with Rep. Oliverson's points the way he said that. But by the same token we still have to look at the type of system because I think the providers can work it the other way also. You give the ability to the provider to make the final decision and that's dangerous in itself because many times they're going to look at to say we want paid equal dollars for what we're doing. That's why OH has delayed making a decision on telehealth because all of the rules that we were going to pass in the bill had been passed administratively – our Medicaid rules and commercial rules so all we're doing really is codifying administrative rules that have been passed since last fall. That's the only question I say is I'm a proponent to let providers and plans negotiate to work it out because I can show you examples of cases where the provider will have it equal and I can show you examples of cases where it doesn't make sense. We just have to be really careful how we set the model up.

Rep. Ferguson stated that Arkansas already has a telemedicine bill that requires parity for in person and telemedicine visits. There is already a framework for paying this – it's called CPT codes. The CPT codes define exactly what payment is prescribed for a 15 minute visit and what goes on in that visit so there are already prescribed elements to doing a CPT code for whatever visit it is so there really is no reason to penalize someone for doing that visit telemedicine instead of in person.

Asw. Hunter thanked everyone for their comments and stated that the Committee has work to do and it will continue to work towards completing the Model.

CONTINUED DISCUSSION ON NCOIL MODEL ACT REGARDING AIR AMBULANCE PATIENT PROTECTIONS

Asw. Hunter stated that we had a great discussion on this Model at our last meeting in December. Since then, there is much to talk about as the Model has been introduced in several states, and it also may be impacted by the new federal balance billing law, the No Surprises Act, as well as a recent Eight Circuit Court of Appeals opinion. The Model is in your binders on page 307, and the Eighth Circuit opinion is on page 310. Asw. Hunter stated that you may have received an e-mail in the past hour from NCOIL staff containing some proposed amendments to the Model which will be discussed today but nothing will be finalized today and nothing will be voted on. I'll now turn it over to the sponsors of the Model for some introductory remarks before going to our speakers.

Del. Westfall stated there certainly has been a lot of action surrounding this issue since we last met. As Chair Hunter noted, in addition to the enactment of the federal balance billing law, the Eight Circuit Court of Appeals did in fact issue an opinion which ruled that a North Dakota statute seeking to regulate air ambulance membership products as insurance was preempted by the federal Airline Deregulation Act (ADA). However, and I'll let the speakers we have here today address this specifically, I believe that in its opinion, the Eighth Circuit laid out how a statute such as this Model could survive federal preemption. Accordingly, I have introduced amendments to the Model which you have before you today that I believe align with the Eighth Circuit's opinion. I've introduced this Model in my home state of West Virginia with language similar to these amendments and it passed with overwhelming bipartisan support and is currently pending on the Governor's desk.

Rep. Oliverson stated that I have also introduced the Model in Texas and we are still working on it in good faith with all the stakeholders. I think at the end of the day what we will probably pass in TX may differ somewhat from the Model in that it will primarily focus on disclosure language or what we're sort of referring to as the cigarette warning label for lack of a better term although I don't mean that in any derogatory way that's just what it reminds me of. I've heard from folks in my large rural state here of TX on both sides of this issue and I think the general feeling my colleagues in TX have is we want to be clear that this Model is designed or legislation in TX would be designed to just inform consumers that they can make decisions and let them know about their options but at the same to acknowledge that these are two competing business models and that the state is essentially very neutral on that issue and we're not here to pick winners and losers but we just want to make sure consumers know what they're getting into ahead of time. I think that's the direction we're heading and my only ask of the Committee today would just be to ask that we postpone the adoption of the Model as a whole until after the legislative work in TX has had a chance to play out because I think that will give us a good perspective as a committee having legislation passing in two different states addressing the issue and I think that would be very informative to the model when it gets to its final form.

Asw. Hunter stated that based on your comments and the Eighth Circuit opinion I want to reiterate that there is not going to be a vote on the Model today and based on our bylaws and some of the comments put forth I'm not going to be putting forth a vote on the amendments as well as I think it will give everyone an opportunity to take a look at the amendments and see what happens in TX as WV has already had their vote and we want to be purposeful and doing our due diligence on the model going forward.

Chris Myers, Executive Vice President, Reimbursement and Strategic Initiatives at Air Methods Corporation (AMC), stated that he appreciates the opportunity to appear before you again to continue discussion on this important topic. Since we last met there has been a key development that directly affects the Model and how consumers interact with membership products. The NSA was voted into law and will become effective on 1/1/22. This law significantly changes the landscape of the U.S. healthcare system and dramatically decreases the financial risk for patients as it prohibits the practice of balance billing. To be clear at the outset I am not here today to argue against the prohibition of memberships but instead for the appropriate regulation of them so that consumers are not deceived with what they are purchasing. AMC continues to believe that the best way for the patient to solve patient financial burden is to go in network with payers. We have led the industry in doing just that and have led the industry with in network agreements with almost every payer in every major state and we continue to work very hard to bring the three big payers, United, Aetna and Cigna, in network as well.

The implications of the NSA make this Model even more important because of the following: memberships are largely obsolete starting 1/1/22 as they have been marketed to cover patient's financial exposure to balance bills which again will be prohibited in less than 9 months. These products are now marketed to cover only copays and deductibles so one must ask how does this factor into the federal gov't's prohibition on routine waiving of copays and deductibles under the false claims act, anti kickback statute and the civil monetary penalty law. Given emergency air medical transport is also bookended by a continuum of care and value to consumers in covering copays and deductibles is actually determined by the insurer its subject to when an air ambulance claim is submitted and what amount of financial responsibility remains on a consumer's policy. Memberships offer far less financial value to customers previously since they now only cover copays and deductibles. Companies that sell memberships believe these products operate above state law however states can and do regulate air ambulance subscriptions. Good examples of this are FL, NY and most recently in WV.

Importantly, there are several areas of consumer protection for state regulators to consider: payment to cost ratio decreasing - will consumers be charged fair premiums of memberships with patients main health insurance policies – how will regulators ensure that these products add financial value to the policyholder and are not merely duplicative coverage; sales of memberships to consumers who have no real need to purchase them – we already know that 35% or more of consumers who purchase these re Medicare beneficiaries. When comparing the data that was provided to NCOIL with the data from NAIC and AHIP on the U.S. medigap market, the largest membership project in the U.S., air med care network is the 2nd largest medigap product sold in the U.S., 2nd only to united healthcare. But without any regulatory oversight at the state or federal level whatsoever what about the additional consumers who truly will not have any out of pocket financial risk starting in January because of the NSA.

Because membership policies are completely unregulated there is no state or federal oversight to prevent consumers from being taken advantage of by being sold membership products by fraudulent companies. The last time I spoke to the committee we discussed Helimedic which

masquerades as an air ambulance provider and air carrier but doesn't seem to actually exist yet you can google their website right now buy a membership from them that claims to cover you and your family from anywhere in the U.S. Confusing and deceptive practices vary within the fine print of memberships should be reviewed to determine if they are in the best interest of the policyholders. For example, disclosures for Medicare beneficiaries shift the burden from the consumer to certify they are Medicaid beneficiaries – what about adding disclosures for the NSA? Membership contracts sign away the consumer's first lien rights so that any settlement received from an auto or homeowners policy for example must first go to pay the full billed charges of the air medical bill. Terms and conditions also allow for auto renewals in perpetuity without consent or refunds. How will consumers that realize that they no longer can be balanced billed next year be able to get a refund after the NSA is enacted and to which state agency do they go for recourse if they cannot get a refund.

Some of the policyholders have been so scared to the potential financial burden of the balance bill that they have actually delayed care to be transported by their membership provider in a medical emergency based on the most closest and most appropriate provider. Memberships are indemnity products. Copays and deductibles are set by a third party – the payer, not the provider. In fact, a January 6 handout entitled “HR133 membership matters talking points – global medical response (GMR) states no air ambulance company can predict individual out of pocket costs as those are determined by insurance companies.” Indemnifying the policyholder against costs determined and set by a third party entity is dispositive of the insurance question – air ambulance memberships engaging in this activity clearly fall within the business of insurance. The data filed in Air Evac vs. Dodrill in February of 2021 shows that these products are pooling risk like an insurance product, not pre paying for services. The patient cannot call for an air ambulance and has no choice in the matter. For a membership to be considered pre - payment the consumer has to have a reasonable expectation that they will utilize the product yet you and I have a higher likelihood of dying from heart disease than we do by being transported by an air ambulance.

Air Evac vs. Dodrill showed similar utilization among consumers who had purchased an air ambulance membership. In this case, 0.2% of these individuals in WV used their membership. There has been a lot of confusion about the recent appeals court decision in the Eighth circuit. State legislators and regulators have been told that this decision prohibits them from taking any action on regulating memberships because of the ADA. However this is not completely accurate. The Eighth circuit opinion found that a state law enacted “for the purpose of regulating the business of insurance” falls under the reverse preemption under McCarran-Ferguson Act. Hence, legislation like the proposed Model including the amendment before you today are permissible and appropriate ensuring meaningful consumer protections for air ambulance membership products. The proposed Model and the amendment takes a targeted narrow approach to appropriately regulate the business of insurance and protect consumers from predatory marketing and sales tactics. If membership products are simply pre-paid services then they should be just that and the economics should support it however, after 1/1/22, the only possible pre payment is for the copay and deductible. It's important to remember that based on the timing of service, when the claim is filed that there may be no copay or deductible. Additionally, when the provider seeks reimbursement for these services from a third party then they become a medigap product.

One final point to make is that there are much better ways to solve the financial burden that a patient may face. At AMC the average out of pocket expense for all is less than \$165 and in the case where an individual cannot afford to pay that amount we use specific financial info from the patient to qualify them for appropriate discounts. We continue to support the model and the

amendment is a way to give states a tool to help consumers to ensure that the coverage they are buying is not duplicative or deceptive. The proposed model takes a targeted and non prohibitive approach to a appropriately regulating the business of insurance and to protect consumers from predatory marketing and sales tactics.

On behalf of GMR, Eleanor Kitzman, former South Carolina and Texas Insurance Commissioner, stated that GMR opposes the Model as originally filed and as amended that has been discussed today. This is simply not insurance and its not an insurance contract and the Eighth circuit has said expressly that. GMR operates the air medical care network (AMCN) as the largest membership program in the U.S. with 3.5 million members in 38 states with 320 locations. A copy of the application and terms and conditions has been provided to you. Many of you have seen it before but I wanted you to be able to see the fine print referred to by Mr. Myers for yourself. I particularly want to draw your attention to a few things. The first is in section 2 that asks for the names of all names of the household because a single membership covers all members of the household for the same price. The 2nd is in section 3 the membership and payment options. Monthly members cost is only \$9 and annual membership is \$85 or \$65 for applicants over 60 years of age. In addition to the terms and conditions that are printed on the application I've given you a large copy because there are some important aspects of that that I want to highlight as well

The membership ensures the patient will have no out of pocket expense if flown by a company providing pre paid protection against a company's air ambulance costs that are not covered by a members insurance or other benefits or 3rd party responsibility. The patients medical condition, not membership status, will dictate whether air ambulance transport is appropriate and required. An AMCN provider air ambulance service may not be available when requested. In return for payment of the membership fee, the AMCN provider will consider its costs that are not covered by any insurance or other 3rd party payer to have been fully pre paid. Memberships are not an insurance policy and neither the company nor the AMCN will be responsible for payment of services provided by another air ambulance service. By applying for a membership the applicant certifies that they are not Medicaid beneficiaries.

I want to also point out what is not in the application and terms and conditions. Any restrictions on the number of transports; any questions regarding health condition of applicant; any question on health insurance that could provide a source of payment to the air ambulance provider. In summary this means that everyone in the memberships household is a member that could receive unlimited life or limb saving air ambulance transports for as little as \$9 per month whether or not the patient is more likely to require transport based on the medical condition or has insurance. The NSA has ben mentioned as an important development and it is and GMR was involved in discussions on that legislation and that is a good thing for consumers. But it only eliminates one component of healthcare cost sharing features. That is any balance bill of any amount that the air ambulance provider has billed to the insurance company that is not paid by the insurance company. It does not eliminate or reduce the deductibles copays or coinsurance and it provides no protection to consumers who are injured or whose transports are deemed not medically necessary.

AMC has argued that going in network is the better way to reduce out of pocket expenses but being in network and having a membership is not mutually exclusive and membership still provides valuable benefits. We are in network with 139 insurers and negotiate with companies on a regular basis to go in network even more but that only affects the amount paid by the insurer to the air ambulance provider, it does nothing to reduce deductibles and copays which will continue to apply. AMC has also argued that deductibles and copays exist as a means to

discourage overutilization and should not be routinely waived or forgiven. I'm not exactly sure how life or limb saving services that are dispatched by a 3rd party could be overutilized by a consumer but I also disagree with the premise that disallows a consumer to voluntarily purchase a product that could protect his or her family from the potentially high cost from the deductibles and copays over which they have no control. This seems a much better option for consumers than relying on charitable funds for patients to assist with out of pocket medical expense as promoted by air methods on its website.

Speaking of deductibles and copays there is another cost sharing feature contained in many health insurance policies that has not been mentioned and that is called coinsurance. Coinsurance is an amount, usually a percentage of the covered amount of the claim, that is coinsured or required to be paid by the patient in addition to any deductible or copay. According to the Kaiser Family Foundation (KFF) the average coinsurance requirement in 2019 was 18%. Also according to KFF, 81% of health plans have a deductible and 24% of those are high deductible plans. The average out of pocket expense for high deductible plans for each air ambulance medical transport is \$4,332. Again, deductibles, copays and coinsurance apply regardless of how successful an air ambulances negotiations with an insurer may be. AMC has also argued that a Medicare enrollee does not need a membership plan because Medicare fully covers air ambulance services. This is only true if the patient has purchased Medicare part b which is optional and there is still a 20% copay which based on Medicare's average payment for air ambulance service averages \$1,160 which is over 17times the \$65 membership fee for seniors – Cmsr. Kitzman acknowledged that math may not be correct.

It is possible that a Medicare supplement policy could cover the copay and we include a FAQ on our website encouraging consumers to check their coverage. Again, according to KFF 6.1 million Medicare beneficiaries had no source of supplemental coverage. Our programs provide enormous benefits with little to no downside to consumers. If a member is transported by a 3rd party his or her membership does not apply and they are not disadvantaged by their membership agreement. If they are transported by a network provider and insured we pursue payment for reasonable cost of transport from the member's insurer only. The member will never receive a balance bill and payment of the deductible, copay and coinsurance which would be far more than the cost of memberships are cancelled or waived. If a member is uninsured the entire transport is covered by the membership agreement.

I also want to address what has been said about the need for consumer protections. Supporters of the Model will claim that is needed to protect consumers from purchasing a product that they do not need or understand. We believe that our 3.5 million members who have made a decision to purchase the piece of mind provided by memberships are capable of assessing their needs. The overwhelming majority of new memberships are not purchased face to face through a pushy salesman rather they are purchased through direct mail or digital or other channels in which the consumer has ample opportunity to make a decision without any sales pressure. Over 45% of our members have had their memberships for over 5 years. In fact 800 of air evac's original 5,000 members still have their memberships today. It would be insulting to imply that our members have been duped all these years.

Supporters of the Model have also made a lot of allegations about unscrupulous and misleading sales tactics and confusion among consumers and delays on transport using the arsonist firefighter analogy. These allegations are always couched as this is something that could be happening and might have occurred and consumer may think and the like. They have not cited a single specific example of any of these things actually occurring. I've listened to testimony in some of the states where similar bills are pending most recently in WV where there was a

physician who testified and I listened to his testimony a couple of times because I thought if anyone would be able to cite a specific example he would be the one but again it was couched as this could happen. As a former regulator one of my biggest concerns is complaints and when I took on representation of GMR and AMCN that was one of the first things I made sure of both internally and externally. I'm not saying there has never been a complaint anywhere but I haven't found the evidence and apparently neither has anyone else.

We believe the more appropriate way to address consumer protection especially with respect to a product that has been around since 1985 and that does not endanger a consumer's life or health is through robust disclosures which we support in the model and we have been working with Rep. Oliverson's office in TX. Some of these disclosures are already in our terms and conditions and we support making them more prominent. Insurance is not the only way to provide disclosures. Finally, there has been mention of the Eighth circuit opinion and there is the WV amendment that has been offered by Del. Westfall – that has been interpreted in such a way as to involve this reverse preemption under the McCarran-Ferguson Act and to achieve the result that they would like as represented by Mr. Myers. But what's being ignored is the courts' express language that "subscription agreements are not insurance contracts." The Eighth Circuit reversed the lower court holding that there was reverse preemption under McCarran-Ferguson. An insurance contract is the starting point for reverse preemption under McCarran-Ferguson but it's only the starting point. The statute must be enacted for the purpose of regulating the business of insurance. The purpose of this bill is not the regulation of the business of insurance it's for the purpose of regulating a business model that some do not like or agree with. We believe that is wholly inappropriate and we support all of the consumer protection disclosures and the like and are happy to work with the states and with this committee to fully protect consumers but we believe that consumers should have the option and we should not be going about taking choices away from consumers when we are talking about very high expense so we again we would very much like to see the version of the model as along the lines that Rep. Oliverson outlined.

Rep. Jim Gooch (KY) stated that my question is for Chris Myers and it's you're in favor of the model and advocates believe that passing the Model will help your organization with some financial value so I'm just wondering is that based on your belief that it might help with competition as competing with other air ambulance providers or is it your ability to negotiate with providers to some contractual arrangement – does it have to do with reimbursement rates? What do you see as the benefit of the Model as far as AMC is concerned. Mr. Myers stated that we see this as an issue that is been pervasive for the industry like a lot of the historical practices in the industry whether that was aggressive billing practices, balance billing, or this because it fans the flames of the financial uncertainty for patients so our interest is around the financial impact for the patients. And that is why 5 years ago we started a patient advocacy program and why we stopped balance billing well before there was any discussion about the NSA and it's why we continue to go aggressively in network and it's why our numbers speak for themselves – you don't have to buy a membership in order to have a low out of pocket which for us is \$165. We believe it's a bad practice for the industry regardless of what that may mean for AMC specifically – it creates fear for patients around a situation that probably won't occur given the 0.2% utilization rate which is unnecessary and unproductive and we think capitalizing on that fear of individuals is not good.

Del. Westfall stated that the proposed model is not a prohibition on air ambulance membership products and does not aim to restrict the ability to sell them to consumers but is it your opinion/position that states cannot regulate air ambulance membership products in any way. If yes, based on what and if no based on what kind of state consumer protection regulations are

appropriate for these products. Cmsr. Kitzman stated that I think we're oppose to regulation as insurance because we believe that its not insurance. We also believe as courts have held many times that the ADA preempts any state regulation of anything related to rates routes or service and beyond that there aren't cases dealing precisely with this issue but we have and are supportive of the consumer protections and disclosures in the model. There are laws in other states that have provided some disclosure requirements and consumer protections. WY recently amended their statute which a few years ago had classified membership products as disability insurance but they have amended that statute and no longer deem it is an insurance product and there are quite a few disclosure requirements and consumer protections in there and GMR was involved in the discussions and negotiations on that bill in WY.

Del. Westfall asked if air ambulance membership subscriptions cover a patient's copay and deductible associated with air ambulance transports. If yes, are copays and deductibles determined and set by a 3rd party such as an insurance provider. Cmsr. Kitzman stated that we don't set them and what GMR does is if it's a membership whatever the insurance company pays for that transport that's the end of the transaction there is no negotiated with the member and no further action that is taken. Any charges that might otherwise have applied are cancelled or waived.

Rep. Bart Rowland (KY) stated that I appreciate Dell. Westfall pointing out that nothing in the model says that these products could not continue to be sold in the future all it does is attempt to increase transparency which I'm glad to hear Cmsr. Kitzman is in favor of and it adds regulatory authority to our state regulators which I don't understand why we wouldn't be for that. Its good that we don't have bad actors today but what if we had future bad actors entering into this product and we should give our state regulators the ability to get a handle on them. My question is we're all familiar with products sold by Aflac, colonial life, and Transamerica and we've all seen them and they're sold to take care of very particular incidences – you buy an accident plan to take care of an accident; you buy a cancer policy and it pays you in the event you come down with cancer; you buy an intensive care rider or gap policy and you get paid should you have a heart attack or stay in the hospital – how would you describe an air ambulance membership which is bought for the very specific event of a ride on an air ambulance – how do you draw the distinction between one of those supplemental policies and a membership. Cmsr. Kitzman stated that those policies provide indemnification of expenses incurred by the policyholder to a 3rd party and AMCN does not provide indemnification of a third party and does not provide indemnification of the member in any way – it provides a service – period. Yes, we support the consumer protection disclosures and increased transparency – it doesn't have to be an insurance product to do that there are other ways to provide some oversight onto that which we believe is a better less onerous way to do it especially since in my opinion it just doesn't not meet the definition of insurance and the Eighth circuit agrees with us.

Mr. Myers stated that regarding potential bad actors, they exists today. The Helimedic example I raised I would encourage you to go on their website as it's a company that has no real air ambulance operations selling memberships to individuals today without any real ability to provide the service so we are living already with bad actors in this space. Cmsr. Kitzman stated that after hearing about Helimedic we also have tried to find out more about them and we have been able to find out very little however we already have laws on the books as there is already a remedy for what they appear to be doing and it its through Attorneys General and fraud statutes and unfair trade practices (UTPA) laws that are already on the books and if what they are doing is as is being alleged or implied there are already laws against that and they are in violation of them - calling this an insurance product is not going to deter an operation like that.

Rep. Deanna Frazier (KY) stated that some states like FL regulate these products as prepaid limited health service programs. Does GMR view FL's regulation of air ambulance membership products appropriate or do you plan to pursue legal action against FL. Cmsr. Kitzman stated I have no idea of what legal actions anyone may or may not be considering. I believe NE also regulates it as a discount medical product. GMR operates membership programs in both of those state I believe so the extent of the regulation is such that we have been happy to comply with it and are able to operate there under our usual business model.

Sen. Paul Wieland (MO) stated that a follow up is would you be comfortable with other states adopting what FL has done. Cmsr. Kitzman stated I have not studied the FL statute specifically so all I'm saying is that GMR is operating in FL and I think there are probably a number of state laws if we were targeting reforms from scratch that's not the way we would do it but our business model works under a number of different approaches states have taken.

Rep. Jim Dunnigan (UT) asked what the loss ratio is on the product. Cmsr. Kitzman stated that because it is not an insurance product I don't believe that loss ratio is something that is calculated in the way that you would for an insurance product but I actually don't have knowledge of that so I cant answer it but I would note that's an insurance concept and this is not an insurance product. Rep. Dunningan stated let me ask it another way – if you took your subscription fees and subtracted your claims what's the ratio. Cmsr. Kitzman stated I don't have that information. Rep. Dunnigan asked if that information could be provided. Cmsr. Kitzman said I certainly will look into it. Rep. Dunnigan asked if you think the legislators are precluded form perhaps expanding some of the pieces of regulation on this so it could be considered insurance under McCarran-Ferguson. I'm just reading the Eighth circuit case which is interesting – some of the things they are talking about like balance billing they are all integral parts of insurance so I guess my question is do you think the legislators are precluded from fleshing this out so it looks more like insurance and calling it insurance would that qualify under the Eighth circuit rational Instead of just going after balance billing could we regulate different pieces of it.

Cmsr. Kitzman stated that I don't think so because just calling it an insurance product doesn't make it an insurance product but even if it would meet a definition for an insurance product or insurance contract that's not enough for McCarran-Ferguson. The statute has to be enacted for the purpose of regulating the business of insurance and this is not. We are not in the business of insurance. The membership product is incidental to our business its a part of our business but its not an insurance product and we are not in the insurance business so I don't think that further attempts to shoehorn this into some definition of an insurance contract really gets supporters of this model where they want to get to.

Rep. Carl Anderson (SC) stated that it appears that you are afraid of something could you tell us what we you are afraid of. Cmsr. Kitzman stated that is not a matter of being afraid of something its that we just don't believe that its an insurance contact I don't think anyone is going around asking to be regulated as something that they are not. It would also create a situation where some air ambulance providers are regulated as insurance and others are not and we believe having been in this business for a very long time having a very good track record with it having lots of happy customers seeing no evidence of companies or anyone actually delaying transport or medical care that this is worse than a solution in search of a problem it's a competitor in search of an advantage. We have a business model that they do not and that some do not agree with and that's their prerogative but going back to what I said earlier it would be highly unusual to prohibit a product that has been around as long as this with the track record it has and that when we have what's being called by supporters of the model, not any

consumer that we're aware of, can be handled in a less onerous way and certainly we want our members to be informed. We want them to buy this product because they believe it adds value and I think the fact that 45% of our members have been with us for 5 years or more speaks volumes. I think anyone that deals with consumers would be very happy with that.

Asw. Hunter stated I am asking NCOIL staff to put together some sort of legal panel relative to the impact of this Eighth circuit decision and perhaps the likelihood of a U.S. Supreme Court action. We could do an interim zoom meeting or hold to July.

Mr. Myers stated that he would like to respond to Rep. Anderson – this is not about competition. We can sell memberships if we wanted to today. Historically AMC did have some memberships but we choose not to sell them so this is not about us not wanting to compete we are happy to compete on service every day this is about not promoting a bad practice and taking advantage of peoples fear of a potentially devastating financial issue and that's why we don't do it.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, asked if there are there any current actions right now in this space being handled right now by the Attorney General under deceptive trade practices or are there even any active cases? Cmsr. Kitzman stated we are not aware of any. Sen. Rapert stated we always need to be careful of picking winners and losers in states and this venue. This body has the absolute ability and willingness to get out there and make sure there is a fair and level playing field but I've never seen the body getting into picking winners and losers and deciding what is good or not on the free market. I look forward to more information on this and I appreciate all the work done thus far.

Rep. Oliverson stated we've heard this three times and I want to let committee members know that in our testimony in Texas when we heard this bill the issue of Helimedica was brought up and within a very short amount of time we reviewed a letter from their CEO identifying them as a European company with a long track record that is seeking to do business. I have been to their website and I don't know how to buy a membership on their website, I've tried but I cant. Cmsr. Tom Considine, NCOIL CEO, has a copy of the letter I received and I want to be clear that if we are going to use a company as a specific example like that they should have the opportunity to defend themselves. They have attempted to do that by reaching out to my office and I think its fair for committee members to hear from them as well. It's regretful that we keep on bringing them up as an example – they have reached out to me in TX and have been very upset with the things that have been said about them.

I think this model boils down to a couple of things. I think we're all in agreement that at the end of the day we don't want to pick one side over the other we simply want consumers to know what they are getting into. If a consumer thinks there is value in a membership so be it but the consumer should also be aware that they may be signing up for something that they don't actually need and that should be made clear to them. And I think the second point related to the Eighth circuit decision which by the way TX is not bound by nor is the majority of the U.S. is whether or not something has to be classified as insurance in order for state law governing disclosures to have any real teeth behind it. I think that's the question and I fully support a decision to get some legal advice and counsel because I can tell in TX we are trying to work through I think we know what we want to do and I think both sides don't really object to the idea of disclosure the question is really whether or not disclosure is meaningful without conversations about insurance and that's what we need to focus on the next couple of months. I appreciate all of the work thus far and the stakeholders have been respectful of me and my office and tried to be constructive. I think if we continue to work on this we will have something we will be proud of.

DISCUSSION ON ALL COPAYS COUNT COALITION ACCUMULATOR ADJUSTMENT PROGRAM STATE MODEL LANGUAGE

Asw. Hunter stated that before we begin, I want to note that this model language is not before you for consideration today as an NCOIL model law. Rather, this is model language developed by the All Copays Count Coalition (Coalition). This discussion is meant to be educational only.

Steven Schultz, Director of State Legislative Affairs at The Arthritis Foundation, stated that he is representing the Arthritis Foundation and also the Coalition which is a group of patient provider organizations that's working on a solution to accumulator adjustment programs across the country on both the state and federal level. Likely a lot of you have heard about accumulator adjustment programs but they are not necessarily like they sound so I am happy to review them. Many chronic disease patients use copays systems such as copay cards or manufacturer assistance to be able to afford their life saving medications. Very recently in the last several years copay accumulators have become kind of common in insurance plans that really prevent any such assistance from 3rd party payments from counting towards cost sharing such as a patient's deductible or annual out of pocket maximum. The example that we often share is that a patient will continue to utilize their assistance and pay at the pharmacy counter and eventually that assistance is going to run out and at that point they are going to find out at the pharmacy counter or wherever they are getting their medication that they still owe all of that cost sharing usually in the middle of the plan so usually it's a surprise to them because it's usually not in bold language in terms of disclosure to the patient so then the patient has to figure out how they will afford likely some of the time very expensive medications like in our field they tend to be biologic medications which are thousands of dollars.

So likely because of that issue of affordability patients will have to make a decision of going in debt themselves to find another way to pay trying likely another high price medication or just not being adherent on their medications. All situations are not extremely good. Just going through some of the trends we are seeing – these have become increasingly utilized. The AIDS Institute partners with the Coalition and has been tracking these types of protocols and programs very recently and they have shown that all the states that don't have a prescription on the program there is at least one plan that has a copay accumulator in their policy. Fourteen states have them in every single policy so there is not even a case where a patient who is educated about these types of programs can shop around and see and purchase a plan that doesn't have one. Thirty two states have at least two thirds of plans that have accumulator adjustment programs and lastly only three states have fewer than half of their plans that have accumulator adjustment programs so it's extremely prevalent and growing. There is also a study that shows a trend where even when discussing with the health insurers as far as their medical and pharmacy directors they in addition to the patient provider groups there is a sense that this is being put in place to shift the cost on the patients as posed to the other folks in the supply chain.

The solution that we've adopted at the Coalition is model language and is probably the simplest bills that you are going to see out there and it tends to be the shortest bill introduced in the states and they are just as simple as no matter who is paying for these funds whether it's pharmaceutical manufacturers, copay systems, a go fund me page, aunt or uncle, those funds and 3rd party payments should be counting towards a patient's cost-sharing requirements. This language has been endorsed by our partners like the American Medical Association, American Cancer Society Cancer Action Network, AIDS Institute, National Hemophilia Foundation, Cancer Support Community, American Kidney Fund and many others.

Regarding the landscape of where they have been introduced we've seen a great deal of success over the last couple of years having it enacted in VA, WV, IL, AZ and GA and this past year KY took action just last month and there are a few months that are closing in on enactment as it is currently on the Governors' desk in OK and close to the Governor's desk in AR and just has one last procedural hoop and a shout out to Sen. Rapert who was the Senate lead on the bill. It also passed a chamber in the house of MI and in OR and closing in on floor votes in NY OH and TN. Also, Rep. Oliverson heard this bill in committee this past week so it's becoming one of the most introduced bills and talked about throughout the country. Because of that, what we hear in the discussion at hearings in opposition is that it tends to focus on assistance and the merits of assistance rather than the merit of introducing and implementing these types of programs that shift the cost to patients and more about a discussion about just the assistance. We also hear about the notice of payment parameters from U.S. Health and Human Services (HHS) which does allow states to put these programs into place but usually not mentioned is the fact that in the same payment parameters they give the power to the states to enact legislation like the states that have enacted it and have really pointed to the states saying if you don't want to have these types of programs then pass legislation accordingly. We also often hear about plan design and how this type of assistance could circumvent plan design which is not true in the sense that to get on these types of plans that need assistance you need approval from your insurance and need to go through things like prior authorization and step type therapy that step your way through lower cost alternatives including generics to be able to use assistance towards your insurance which is the point of this type of bill that we want to see this type of assistance applied to insurance so of course it has to be a medication that's approved by the insurance plan.

We also often hear about generics that this is gearing patients off of generics not brand name drugs and we often state that 99.6% of the drugs that have this type of assistance are for medications that don't have a generic and are just brand names that don't have a generic yet and likely can't have a generic because they are biologics that can only have a biosimilar. Also, there is the element of plan design that plans have plan design elements like utilization design tools to walk patients through lower cost alternatives before getting onto these type of medications that would have this type of assistance that is the real heart of the problem that we are trying to solve. There are also discussions about issues that block this type of assistance like Medicare and Medicaid which are gov't entities likely not able to be like for like comparison with private insurance and then other states that have done this in this space as far as copay assistance. I'll mention MA which has had some discussion about restricting assistance and often it's pointed to it as a state that bans assistance which is not true as the state each year or every other year allows assistance to take place and sunsets just because of identifying that assistance is crucial for patients to stay adherent and even 7 of 9 plans in MA have an accumulator adjustment program. CA is my state and I'm a constituent of Asm. Cooley and there a couple of years ago enacted legislation that restricted assistance for patients having gone through step therapy and prior authorization or generic equivalents as a way of that argument of steering patients onto brand name drugs. The result of that you would think is no accumulators in CA but that is incorrect as a majority of health plans in CA have such programs and so that dismisses the argument that this is more about accumulator adjustment programs or more about steering patients onto generics rather than brand name drugs because if that was the case CA would have no accumulators in their state regulated plans.

Lastly, we often hear that this will somehow drive up premiums if we ban accumulator adjustment programs but since these are new programs that were just recently implemented in the last 5 years or so you can look at where the status quo was before assistance was being utilized without these programs and nothing is demonstrably shown that premiums have gone

down as a result of these programs and even analyzing the states that have enacted legislation like VA or AZ we have not seen premiums go up as a result of enacting legislation.

Mr. Peppard stated that since this is not going to be developed into an NCOIL model and since there is another agenda item I'm not going to get into a detailed discussion about this ill just simply say that right now as Mr. Schultz alluded to, Medicare and Medicaid consider copay coupons to be an illegal kickback and their position is that copay coupons induce a patient to use a specific drug with the rest of the cost picked up by the taxpayer and our thought is that we should not be tying the hand of the commercial market because that would disallow them from being able to similarly be responsible with those consumer dollars which they pay.

Sen. Rapert stated that we just passed this bill in AR and AHIP sent lobbyists to AR to oppose the bill so I want to ask why is that you want to disallow consumers and individuals some of which are paying outrageous prices for drugs for insurance someone with hemophilia. Why is it your concern that you want to disallow them the opportunity to be able to reduce their own expenses for the benefit of their family when there are rebates that are given directly from drug manufacturers to help people and often it is their physician to provide them the ability or at least a connection to get a rebate. Why is it that you are going around the country and fighting people when we know the cost of insurance and medications are so high – why would AHIP take this position.

Mr. Peppard stated that you are correct in saying the cost of medication is tremendously high and we are not opposed to reducing the cost of medicine. Sen. Rapert said my question is why would you want to disallow individuals and families to get the benefit of the rebate which is what it was intended for. Mr. Peppard stated that the rebate is coming from the drug pharmaceutical company and as I mentioned in the gov't programs these are considered an illegal kickback and considered inappropriate. We don't believe that commercial plans should be treated any differently. Sen. Rapert stated that I ran into this language in AR and I take great exception to you saying that a mom and a dad that have a child with hemophilia that are forced to be on a high deductible plan that you are saying that they get an illegal kickback because they use a rebate coupon. I know that's been stated with Medicare and Medicaid but it so happens that this is not even the issue and focus of this particular proposal. It's not dealing with Medicare or Medicaid it is only dealing with commercial plans so would you please stay off of trying to make them sound like criminals because they are trying to save money for their family. Why is it that you need to intervene and stop individuals from getting the benefit of those rebate coupons. Mr. Peppard stated that I was not suggesting that those individuals are engaged in an illegal kickback – it is the pharmaceutical manufacturers who are inducing them to purchase a more expensive drug and it is being considered an illegal kick back in those federal programs and so that's why I'm referring to that because you're right that this proposal does not deal with those, this deals with the commercial market and I'm making the argument that the commercial market should be treated similarly.

Mr. Schultz stated that the like to like comparison between Medicare and Medicaid with this is that Medicare and Medicaid ban this type of assistance and accumulator adjustment programs are not banned on this type of assistance. The patient is still allowed to use that type of assistance and the other members of the supply chain are still able to take in the funds but they are just not crediting the funds so its not necessarily a like to like comparison even if we were getting down the road of Medicare and Medicaid.

Sen. Rapert stated that I appreciate the Chair making this a discussion item and after dealing with this issue and some of the information I've learned in the past few weeks if you don't have

anyone that is in a position to sponsor this language for an NCOIL model I would be happy to get it started and also happy to partner with anyone that would want to do that because this is an issue that is very familiar and I think we need to take a stand on it.

Asw. Hunter stated that we probably will need that sponsorship and discussion after what we heard today.

Rep. Ferguson stated that I want to reiterate what Sen. Rapert said – my understanding from my discussion in AR is that the coupons were given primarily for drugs that doctors already had the patients on they weren't encouraging the use of higher cost drugs and they are not required to get the drug if its not already on the drug formulary. I think this is worth looking at for model legislation and AR had a pretty good bill.

Asw. Hunter stated that we will continue this discussion in some fashion in July and Sen. Rapert will reach out to Committee members about potential sponsorship as well.

CONSIDERATION OF RE-ADOPTION OF MODEL LAW

Asw. Hunter stated that per NCOIL bylaws, all NCOIL Model laws must be considered for re-adoption every 5 years or else they sunset. The Model law scheduled for re-adoption starts on page 322 in your binders - the Employer Sponsored Group Disability Income Protection Model Act (Originally Adopted November 2016). Some amendments may be made to the Model after this meeting so the Motion to re-adopt, if agreed to by the Committee, will be to re-adopt until the Summer Meeting, not the full five years. Upon a Motion made by Rep. Anderson and seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to re-adopt the Model until the Summer meeting in July.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Cooley and seconded by Rep. Anderson, the Committee adjourned at 3:00 p.m.