

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES
COMMITTEE
CHARLESTON, SOUTH CAROLINA
APRIL 16, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Francis Marion Hotel on Friday, April 16, 2021 at 10:15 A.M. (EST)

Senator Bob Hackett of Ohio, Chair of the Committee, presided.

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

Rep. Deborah Ferguson (AR)*	Sen. Kirk Talbot (LA)
Sen. Jason Rapert (AR)	Rep. Brenda Carter (MI)
Asm. Ken Cooley (CA)*	Sen. Neil Breslin (NY)*
Rep. Matt Lehman (IN)	Asm. Kevin Cahill (NY)*
Rep. Joe Fischer (KY)	Sen. Roger Picard (RI)
Rep. Bart Rowland (KY)	Del. Steve Westfall (WV)

Other legislators present were:

Sen. Mathew Pitsch (AR)	Sen. Paul Utke (MN)*
Rep. Matt Dollar (GA)	Rep. Justin Hill (MO)
Rep. Terri Austin (MI)	Asm. Ken Blankenbush (NY)
Rep. Jim Gooch (KY)*	Rep. Brian Lampton (OH)
Sen. Stewart Cathey (LA)	Sen. Ronnie Cromer (SC)
Rep. Sarah Anthony (MI)	Rep. Kevin Hardee (SC)
Rep. Kyra Bolden (MI)	Rep. Jim Dunnigan (UT)
Rep. Kevin Coleman (MI)	
Sen. Lana Theis (MI)*	

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 Sen. Roger Picard (RI), Vice Chair of the Committee, and seconded by Del. Steve Westfall (WV), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Sen. Hackett stated that if there are no comments or questions regarding the minutes of the Committee's December 10, 2020 meeting, the minutes will stand as read. Hearing no comments or questions, the minutes stood as read.

DISCUSSION ON NEW FEDERAL BALANCE BILLING LAW – THE NO SURPRISES ACT

Before beginning the discussion, Sen. Hackett noted that Ohio is one of the states that has passed balance billing laws and since the enactment of the No Surprises Act (NSA), a lot of questions have been coming in as to how the state and federal laws will work together. Chris Garmon, PhD, Senior Consultant at Compass Lexecon and Assistant Professor of Health Administration at the University of Missouri, stated that the NSA protects patients from surprise, out of network (OON) medical bills and regulates the payment disputes between health plans and OON providers. So, what is a surprise medical bill? A surprise OON medical bill is when a patient receives treatment unexpectedly or involuntarily from an OON provider and then they are sent a bill requiring that they pay the difference between the insurer payment and the provider's full charges.

This can occur in a number of situations. The most common that you hear about in the press is say you break your leg and need to go to the ER for the nearest hospital in your network but it turns out that the physician treating you is not in your network and you end up getting a balance bill later on. One of the first examples from the past six years or so that got a lot of press was from the New York times – Elizabeth Rosenthal documented a case of an elective OON bill. The patient was very experienced with how our health system works and he needed an elective neck surgery. He made sure the hospital was in network and his surgeon was in network and even went so far to ensure that the anesthesiologist on call that day would be in network. He goes into the surgery, is put under general anesthesia and the surgeon calls in a secondary surgeon and it turns out that he was not in the patient's network and a few weeks later the patient got sent a bill for over \$110,000. So, surprise OON medical bills can occur in elective situations and they can also occur with emergency transport with either ground or air ambulances.

So, how often does this occur? Dr. Garmon stated that his research found that with ambulance cases it can occur quite often and with air ambulance roughly 60% of the time there is the potential for an OON balance bill and for ground ambulances about 50% of the time so it's like flipping a coin if you need emergency transport with an ambulance. Emergency room cases are somewhere between one quarter and one fifth of the time but even with elective in-patient cases such as obstetrics cases roughly 9% of the time you can have a surprise OON medical bill. The financial burden for patients with these bills can be extensive. Research recently published last week shows that for emergency room cases they end up paying on average over 10 times more than other emergency room patients where all of the care was in network.

This has understandably led to a bipartisan push for recognition that we need a solution and many states have passed balance billing laws but of course they only cover a certain portion of the commercially insured population. The federal government finally responded by passing the NSA which is a federal prohibition on surprise OON bills and it was included in the omnibus COVID relief bill in December of 2020. It protects patients from balance bills in emergency situations, in elective procedures where there are for instance an OON physician in an in-network hospital even for a scheduled surgery when there is not prior approval for that OON physician and even in that case there are exceptions where certain specialties like anesthesiologists and radiologists are prohibited from balance billing with or without prior approval. And it also prohibits balance billing in air ambulance cases as those balance bills can be quite extensive and extreme. Patients are not protected from ground ambulance balance bills so that is one area that is not covered by the NSA. The NSA establishes an independent dispute resolution (IDR) process subject to baseball style final offer arbitration. These protections won't start until January 1 of next year.

With regard to the IDR process, the first step of that after a patient is treated by an OON provider is that the insurer must send payment to that provider within 40 days. It's important to note that many of you may be aware of the greatest of three rule that was part of the Affordable Care Act (ACA) that regulated OON emergency payments from insurers to providers. That no longer applies. The NSA amends the portion of the Public Health Services Act that the greatest of three rule was a part of so this process supersedes the greatest of three rule so that will no longer apply. So, the insurer could send any payment, it could be very small or all of the charges – there is no regulation as to what the initial payment is. If the provider is dissatisfied with that initial payment the provider can initiate the IDR process. It starts with a 30-day negotiation period followed by the baseball style arbitration where the arbiter has to pick one of the two proposals – the arbiter can't select an amount in between them.

The claims can be bundled as long as they involve the same provider, the same insurer and the same service. The losing party pays the cost of the arbitration and then then arbitration cannot be used for another 90 days after an arbitration hearing for the same provider, insurer service combination. So, the IDR process in the NSA is really designed to get the parties to the table and settle before arbitration. The hope is that arbitration will be rarely used and that these disputes will be settled beforehand. So, what factors can the arbiter consider? First, the arbiter in the legislation is specifically prohibited from relying on charges including percentiles of the charges, the usual customary and reasonable rate (UCR), and Medicare and Medicaid rates. The arbiters can rely on the median in-network rate and there is a lot in the NSA that suggests this will be the benchmark that arbiters will often use. They can also rely on prior contracted rates between the insurer and provider that are the subject of the arbitration hearing; market shares of either or both parties; patient severity of that case; and the provider's training and experience quality (if a hospital), teaching status of the hospital, and case mix of a hospital. So, there are many things the arbiter can rely on but not the charges, or Medicare or Medicaid or the UCR rates.

There are a few other things that in air ambulance cases the arbiter can rely on such as the vehicle type and the population density of the pickup location. Air ambulance providers will be required to submit cost and charge data to the federal government and the NSA also establishes an advisory committee on air ambulance quality and safety. So, how does this relate to state laws? As many of you already know, state laws only apply to those health plans that are state regulated – the fully insured health plans. The NSA will apply to all health plans, fully insured and self-insured and it preempts state law with certain exceptions. The exceptions are the methods for determining OON payment. If a state has its own IDR process or it uses its own benchmark for OON payment the state can continue to do that and fully insured health plans in that state can continue to do that and use the state's process for determining that OON payment. If a state already regulates provider directories of the fully insured health plans then state can continue to follow that regulation. And a state law is allowed to exceed the patient protections set forth in the NSA so for instance if a state law prohibits balance billing for ground ambulance cases, then the state can continue to do that. The NSA does not preempt state law when that state law exceeds the protections of the NSA.

There are still many remaining questions. The final rules have not been set for how this will work in practice. We are still waiting to hear from the Department of Labor (DOL), Treasury and Health and Human Services (HHS) how this will work and be implemented. One question centers around what about state law for insurance in Virginia that allows self funded plans to opt-in – could those self-funded plans choose the payment dispute resolution process that they find most favorable? The legal scholars that Dr. Garmon has read suggest that the regulations

from HHS and DOL will probably come down and say no and they have to follow the federal IDR process but that is still an open question until we see the final regs. What about a state like Missouri where its arbitration process is optional or non-binding – would the NSA preempt state law in that case? What happens if a patient residing in one state sees an OON provider in another state? That seems like a perfect example of where federal law would apply but it's not clear from the statute itself whether the provider's state law, if it's a fully insured plan, would apply or whether the patient's state law would apply or whether the federal law would apply.

And then of course there are many parts in the IDR process that will have to be detailed by DOL, HHS and Treasury. For instance, how are the arbiters supposed to weigh market share? How will they weigh the different factors in picking a payment from the providers and insurers? Lastly, there has not been a lot of research on the effects of the NSA on state law yet. Probably the best research that Dr. Garmon knows of is the Zach Cooper paper last year looking at NY's surprise billing law which found that it led to a reduction in OON bills and a 15% reduction in in-network cases. That is the only paper so far that has looked at how a state law has affected the negotiations between providers and insurers in that in-network price because it can – it can affect the leverage of one side or another and the paper found that it did result in a 15% reduction. However, their data is only using one insurer and they only had $\frac{3}{4}$ of data after the implementation of the NY state law so there is still room for more research on the NY state law.

And in particular, Loren Adler looked at the arbitration awards from the NY state law and found that the mean arbitration award exceeded the 80th percentile of charges which suggests that NY's law should be inflationary and should lead to an increase in in-network prices which contradicts the prior paper and suggests more research needs to be done on the NY law. Loren Adler and others also looked at California's surprise billing law and found that it led to a drop in the number of OON claims and they have ongoing research on some of the other effects of CA's law. Ben Chartock looked at NJ's arbitration awards and found that they cluster around the 80th percentile which is no surprise because the arbiters in NJ are shown the 80th percentile of charges and that's one of the things that they can use in choosing which proposal to accept. Finally, in the past few weeks, Sabrina Corlette and others at Georgetown have looked at NJ, TX, CO and WA's IDR processes and found that NJ and TX handled thousands of arbitration cases whereas in CO and WA it was rarely used. The only difference in those two sets are that NJ and TX in those cases the arbiter can rely on the provider's charges which suggests that providers are using that more often to settle disputes.

Sen. Hackett stated that he was really involved in developing Ohio's balance billing law and one of the things that they like about their IDR process is that they wanted to make sure negotiations went on strongly and when it got to the arbitrator they had to submit their last offer. They didn't want it to go back to the parties because if you had wide differences when you start, in reality you are making winners and losers. Sen. Hackett believes that the Ohio system is successful because they didn't want to create an arbitration system where everybody is running to arbitration all the time. The Ohio Insurance Commissioner did a phenomenal job of bringing everyone together and the providers and plans got together and finally agreed on things. One thing that really helped with the emergency room was the ability to go back and look at previous network charges because one concern was that they would have a network phase and with the new network they didn't have any negotiations and the network charges were reduced so the arbitrator has the ability to look back over the last several years and see what was paid in network.

Sen. Hackett asked if, with baseball arbitration, the NSA takes the last offer? Dr. Garmon stated that it is final offer arbitration and they have to choose either the provider's offer or the

insurers offer and they can't split the difference. Prior contracted rates are one of the things that arbitrators can consider. The hope is that the arbitration process will be rarely used and we'll have to wait and see as to how often it is used. I think its been designed with a 30 day cooling off period and a prohibition on going back in within 90 days so it has been setup to encourage a settlement beforehand so the arbitration will be rarely used.

Sen. Hackett stated that in Ohio its broken down as to who pays for it $\frac{3}{4}$ one side and $\frac{1}{4}$ on the other and asked Dr. Garmon how the NSA deals with that issue. Dr. Garmon stated that the losing party pays the cost of arbitration. Both parties will pay a fee to cover the costs of administrating the system but the losing party pays the arbiter's costs.

Rep. Jim Dunnigan (UT) asked if a state could enact protections that are less than what the NSA provides for. Dr. Garmon replied no – in those situations in which the federal law applies and the state's does not then the federal law would preempt. Rep. Dunnigan stated that so if one party is unhappy with the federal law they couldn't try to enact a law that would water down the federal law. Dr. Garmon stated that is his understanding. The only area of uncertainty is in the cases of where there is a self-funded law to opt-in and we'll have to wait and see as to whether its possible for the self funded health plan to basically pick and choose which system depending on which it sees as more favorable for payments. But in terms of patient protections, a state cannot pass a law that would protect patients less than the federal law. The federal law would preempt in that case.

Rep. Dunnigan asked if the NSA applies to non-network emergency room treatments. Dr. Garmon replied yes – it applies to OON ER providers, whether facilities or physicians, and elective OON providers for instance physicians it applies to them as well. All of that applies without prior approval but for certain specialties it applies in a blanket fashion such as for anesthesiologists. An anesthesiologist cannot get prior approval to bill OON so it applies to them regardless of prior approval. Rep. Dunnigan stated that with regard to air ambulance, he believes many air ambulance providers do not have contracts and are not in-network so how does that work if the majority of them are not contracted at all? Dr. Garmon stated that in an air ambulance case, the insurer would send a bill to the air ambulance company within 30 days and then if the air ambulance provider is not satisfied with that payment they can initiate the IDR process. Since most air ambulances are OON it will be interesting to see how HHS and DOL determine that median in network rate that would be one of the things the arbiter can consider. I also forgot to mention that the median in network rate is what will determine how much the patient owes so their typical in-network cost sharing will be based on the median in-network rate so it will be interesting to see how the agencies determine that rate for air ambulances since so few of them are in-network – we will have to wait and see what rule they will use for that.

Asm. Kevin Cahill (NY), NCOIL Treasurer, asked with regard to the tools the arbiter has available to determine the appropriate amount, is he to understand that they cannot refer or use as guideline UCR or Medicare or Medicaid? Dr. Garmon replied yes. Asm. Cahill asked what the logic is behind that. Dr. Garmon stated that this was all politics from his understanding. The health plans obviously would like for Medicare and Medicaid rates to be considered since they tend to be lower than commercial rates; the providers would like to have their charges used as benchmarks because they tend to be higher. In order to get the bill passed the big compromise was to explicitly include in the bill that arbiters cannot rely on charges and cannot rely on Medicare and Medicaid and cannot rely on UCR.

Asm. Cahill asked if a state has a more comprehensive system, one that gets past federal preemption, could that state use Medicare and Medicaid and UCR and other things that could

lead to a balanced determination by the arbiter to arrive at the appropriate conclusion. Dr. Garmon replied yes – the state can use its own method for determining the OON payment for those fully insured health plans that the state regulates. The NSA explicitly includes that exception to the blanket preemption of state law. Asm. Cahill asked if there are any other restraints upon state regulators and legislators to regulate state plans beyond the things that have been stated. Dr. Garmon stated no. The state can use its own method for determining the OON payment. If the state has its own regulation of provider directories for fully insured state regulated plans it can continue to do that. If the states protections go beyond the NSA it can continue to have those protections – the state could pass a law that is less protective of patients than the NSA but in those cases where they don't overlap the NSA would preempt state law.

Asm. Cahill stated that as a quick aside, he got a surprise bill a few months ago and he chose instead of just calling the provider he filed a claim just to see how it would work and it was like kryptonite. The provider and insurer worked to resolve it and it all worked out. These programs do actually work and are taken seriously by both providers and insurers and it behooves us to fill in any gaps to make sure the consumer is out of the middle. Dr. Garmon stated that one thing he failed to mention is that the NSA explicitly prohibits the provider from even sending a bill to the patient so a patient should not even be aware of what's going on. After Jan 1 of next year patients should be unaware of anything and should not get a bill in the first place.

Sen. Hackett stated that ground ambulances were not included in the NSA but they were included in Ohio's law and there was a major push at the end to try and get them to opt out. Sen. Hackett asked Dr. Garmon if he knew the thought behind why the ground ambulances were not included. Dr. Garmon stated he is not sure but what he's heard is that because in many jurisdictions ground ambulances are provided by local gov't entities that it was legally tricky to prohibit ground ambulances but again he is not fully understanding that because some states have been able to do it so for whatever reason they are not included in the NSA but the bill does require a committee to be set up and study ground ambulance cases and calls on agencies to submit reports on ground ambulance balance billing but it doesn't protect patients.

Sen. Hackett stated that the biggest complainers were the private companies because of the ones that were tied to the local government and fire departments and many times they had levies and different negotiations and different deals so they didn't think it was a level field so they are actually talking about brining legislation back. Dr. Garmon stated that he hopes so as that is the big missing piece in the NSA – patients aren't protected from ground ambulance balance bills.

DISCUSSION ON U.K. SUPREME COURT'S DECISION ON BUSINESS INTERRUPTION COVERAGE TEST CASE

Matt Brewis, Director of General Insurance and Conduct Specialists at the Financial Conduct Authority (FCA), stated that when he last spoke to the Committee in September, the FCA had just received a judgment from its high court which then went to the UK Supreme Court so today it will be helpful so summarize what has happened to date and discuss the main issues that have come out of the case. To recap, in the early days of the pandemic a number of issues were brought to the FCA's attention about business interruption insurance policies and how insurers were handling claims. Many businesses were seeing closures and disruptions and were making claims under policies expecting to be covered. The handling of claims however resulted in insurers rejecting them out of hand and that raised serious concerns about the contracts when it wasn't explicitly clear in the coverage about covering pandemics. So, the FCA determined that the best and quickest course of action would be to ask a court and judge to

interpret contracts with clauses in them which could be read different ways. Accordingly, the FCA took eight insurers wordings and chose those not necessarily because they were the most egregious cases but because their language was similar to language used by the 60 or 70 other firms that write business interruption coverage in the UK.

So, those wordings were used and delivered to a court to get clarity one way or the other as quickly as possible. The test case focused on non-damage business interruption clauses. Many policies in the UK are damage policies so if you have a fire or a car goes through the window of your shop. But non damage clauses typically refer to if your restaurant and chef get salmonella or there is a murder on the street that your shop is in and therefore you can't get access to the building – those are typical, local reasons why people might have such coverage but as stated it was not apparent that those policies did not allow coverage for a pandemic.

In September, the high court had just handed down its judgment in the test case and the high court decided that most of the clauses centered around diseases and prevention of access were and should have provided coverage. So, on the big elements of the case the FCA won and therefore an agreement was sought with the insurers but for a number of reasons six of the insurers decided that they would like to make an appeal. The UK has a process where if certain conditions are met you are able to leapfrog various layers of the court system and you can go straight to the UK Supreme Court which heard the case in December. In January they handed down the verdict which effectively upheld every element the FCA had won on at the high court and the elements the FCA had appealed were decided favorably for the FCA as well. To a very significant extent, for those elements taken through the courts the Supreme Court decided in favor of the policyholders.

So, what does that mean? First, lets discuss the trends clause. In the UK, the prime minister went on the news and said don't go out anymore but the legislation that stopped business from opening didn't start for another fortnight so what insurers were doing were saying if you take the two weeks prior to when your business was closed, i.e. when you were forced to close by the government, your restaurant was at 30% of normal volume and therefore we will payout at 30%. The Supreme Court said no, that's not right – our view is that COVID was the cause of the disruption and therefore you should take into account the full impact of COVID and that includes things such as the prime minister's announcing that people shouldn't go out so you should compare it to the same kind of period a year previously as opposed to two weeks prior to lockdown. The Supreme Court also decided a number of issues such as if you were a restaurant and you had been forced to close because of the government, if before you were forced to close you had a takeaway business then coverage wasn't provided whereas if you started up the takeaway business during the pandemic then you were covered. The Supreme Court threw that argument out and said partial closure of premises as well as full closure should be covered.

Probably the biggest impact on the insurance industry has been the Supreme Court overturning the Orient Express case which related to a hotel in downtown New Orleans which was damaged by Katrina back in 2005 but was repaired more quickly than the surrounding area and when it tried to open it didn't have any business because of the damage to the infrastructure around it. The insurers said you may be open but no one is going to be coming anyway therefore its not valid and that was upheld at the time by the courts. The Supreme Court found that such decision was incorrect so from a UK perspective now it relates not just to the immediate cause but the causation of why the business was forced to close. This will have an impact on clauses in insurance contracts written in the UK that relate to wide area damage like hurricane, flood and pandemics.

Insurers are now making payments and the FCA is publishing the number of claims on a monthly basis that insurers have received and the amount they have paid out. As a result of the Supreme Court judgment they have paid so far about \$1 billion and over 50,000 policies have been accepted but the total number is yet to be decided so they will grow. More broadly one of the lessons learned is contract certainty is a big issue. In our minds whether it's a pandemic or cyber insurance which is still relatively new you can imagine a similar situation happening with a big cyber attack so how can we ensure contracts are written clearly to provide certainty without being 400 pages long with exclusions. That is an issue the global industry is focused on.

Sen. Hackett asked if the policy said clearly that pandemics were excluded then the court judgment could not affect that – it was only in cases where it wasn't mentioned, is that correct? Mr. Brewis said yes – some had explicit lists of coverage that for example said SARS but not COVID and there were arguments that SARS is similar to COVID but yes if pandemic was excluded that wasn't part of the case.

DISCUSSION ON ERISA-PREEMPTION IN LIGHT OF SCOTUS DECISION IN RUTLEDGE V. PCMA

Professor Elizabeth McCuskey of the University of Massachusetts School of Law stated that she is delighted to speak to the Committee about some good news for state healthcare regulation and the Employee Retirement Income Security Act of 1974 (ERISA) preemption puzzle from the Supreme Court in December of this year – the Rutledge case. For this case, we're basically starting with the old ERISA law, a federal statute passed in 1974 with extraordinarily broad preemption language that has been an obstacle to state health reforms of all different kinds since then because the statute preempts any and all state laws that relate to any employee benefit plan. The Supreme Court and federal and state courts try to apply that inscrutably broad phrase and have developed a very complex and opaque set of precedents that makes litigation against state health reforms or at least the threat of it inevitable and unpredictable. Even state laws that withstand ERISA preemption often face the headwind of litigation.

Enter a state law from Arkansas that regulates pharmacy benefit managers (PBM) reimbursement practices to pharmacies. This was a law that essentially requires PBMs to pay pharmacies no less than the pharmacies acquisition cost for the covered drug. In other words, it was an effort primarily to save independent and rural pharmacies from bankruptcy for underpayment of the PBM intermediaries on behalf of health plans. In retrospect the emphasis on how to prop up independent and rural pharmacies plays an even more important public health effect when we look at the success that particularly West Virginia had in rolling out its COVID vaccine strategy using independent and rural pharmacies. The question about this seemingly rather narrow state law was litigated all the way to the Supreme Court on an ERISA-preemption challenge - namely whether ERISA preempted Arkansas from enforcing the PBM reimbursement practice.

With that setup to the Supreme Court, NCOIL should be applauded as it participated with an amicus brief and had a very persuasive amicus brief explaining to the Supreme Court the ways in which ERISA frustrates health policy at the state level and the ways in which ERISA jurisprudence should not apply to the case. The Supreme Court agreed with NCOIL, at least in the holding of the case, in a unanimous opinion authored by Justice Sotomayor stating that the Arkansas state law was not preempted because it did not sufficiently relate to the employer sponsored insurance plans that were challenging its application. The holding at the Supreme Court indicates the Court's unanimous view on how much federal uniformity ERISA demands

and the answer was not that much. The Supreme Court explained that ERISA preemptive effect creating federal uniformity is primarily targeted at plan structure, benefit choices and beneficiary status – core aspects or central features of plan administration. The Supreme Court said that ERISA does not preempt state regulations that merely increase costs or alter incentives for ERISA plans without actually forcing those plans to adopt a particular scheme of coverage.

This is an important clarification of a notoriously opaque area of Supreme Court precedent and it gives states some running room to enact all kinds of different healthcare regulations that are aimed at cost control and affordability for patients which are typically the primary aim of state healthcare regulations these days. In particular, the Court notes that crucially, not every state law that affects an ERISA plan or causes some dis-uniformity in plan administration has an impermissible connection with an ERISA plan and it particularly singles out state regulations that merely effect the cost of administering a particular plan. Ultimately, the logic of the decision and the way the Supreme Court approached it reanimates a 1995 case called Travelers which was about state regulation of hospital billing rates and said that was not preempted and it expands the logic of Travelers and explicitly says the logic of Travelers dictates the outcome of this case and in doing so it really outlines a broader category of state regulation that is outside the bounds of ERISA preemption, namely healthcare cost regulation.

It provides a very good Supreme Court precedent and explanation of why healthcare cost regulation might not sufficiently relate to these core functions of plan administration and therefore might not be preempted. It also focuses on the role of the PBM as an intermediary or contractor with the plan itself and explains that state regulation of the intermediary of the PBM as opposed to the actual plan does not directly regulate health benefit plans at all. The opinion seems also to carve out space for state regulation of health plan intermediaries as opposed to direct regulation of the health plan itself. Perhaps most useful and maybe most important in the logic of the opinion is that it singles out issues that are not covered by ERISA regulations as a space in which states should feel more confident in filling in their own regulations. This is a slightly different approach to ERISA preemption than several of the most recent Supreme Court opinions.

ERISA does not fill in the entirety of the field of employer health plan regulations – it leaves a lot of gaps and many issues have no federal law at all outside of ERISA. The broad language of the ERISA statute seems to say that states can't regulate in that space either but this opinion and Justice Thomas' concurring opinion made clear that the thrust of ERISA preemption is to make sure that states are not conflicting with ERISA regulations and there should be additional space to fill in areas that ERISA doesn't actually cover. This is also important because it narrows the holding of the Gobeille opinion of the Supreme Court in 2017 which held that VT's effort to collect all payer claims data from an employer's self funded plans third party intermediary was preempted but the Supreme Court in Rutledge clarifies that's mostly because the claims data is a core feature of plan administration and most importantly the claims data collection is covered by some ERISA regulations and could be administered by the federal DOL so there is less space for a state to regulate there than on the PBM regulation.

Thinking more broadly about the implications for state healthcare regulation of this unanimous Supreme Court opinion, the categories of state efforts that would be well served to rely on the logic and language from the Rutledge case include PBM regulation writ large so there are all kinds of things that states may want to regulate about PBMs and there are 45 different state regulations on PBMs and they range from PBM gag clauses to transparency on rebates to limits on patient cost sharing and spread pricing. The language and logic of Rutledge arguably puts PBM regulation outside of the shape of ERISA preemption because its not directly regulating a

health plan but rather a contract and a third party intermediary. In addition, by focusing on cost control regulation, or the mere impact of cost, the opinion suggests that there is a broad category now of healthcare rate regulation that would be outside of ERISA preemption and that broader category includes provider rate regulation from the 1995 Travelers case and the slightly broader category that would include also Supreme Court prescription drug rate regulation after the Rutledge case.

Other aspects of state healthcare regulation aimed at cost control that might have some indirect economic influence on the cost or administration of plans also would fit within the sphere of protection that the Rutledge case offers which includes all kinds of consumer financial protection laws in healthcare that states have passed including surprise billing legislation, air ambulance legislation, and as Dr. Garmon explained the NSA offers a federal floor on what the protections for consumers would be against surprise bills but it leaves room for states to add protections. The adding of protections on top of the NSA would ordinarily be subject to ERISA preemption analysis and the NSA explicitly says it is not altering ERISA preemption but the language of Rutledge and its logic would suggest that even though the NSA forgoes any effect on ERISA preemption that there is space for states to add on top of that. More broadly, the state efforts of cost control and affordability that have become so urgent for state regulation in particular over the last decade are well served by the language and logic of Rutledge which takes cost control and puts it well within the state sphere of authority and also explains that some influence on the cost or administrability of an employer sponsored plan does not lead to ERISA preemption.

Of course, Justice Sotomayor reminds us that actual benefit requirements, beneficiary status and the core features of plan administration or the actual forced choice of a plan to adopt a particular coverage are still preempted by ERISA but there is a lot of important stuff that is even bigger than consumer financial protection that might fit within the language of Rutledge, particularly state regulation of third party administrators and possibly even the state establishment of public access plans and attempts to collect contribution from employers. This is good news and some running room for states and the case gives states more latitude by cutting the limit of ERISA preemption and leaves states more space to pursue healthcare cost control measures and improve affordability for consumers without facing the headwinds of ERISA that they used to. Overall, Rutledge is a pretty unbelievable win for state regulation but leaves the underlying obstacle of ERISA's underlying statutory language in place and it leaves in place four decades of maddeningly incoherent attempts to apply it so there is still a need for Congress to revisit ERISA by perhaps including a waiver or giving states some explicit statutory room to ask the DOL to give permission for particular state experiments and remove the remaining uncertainty of ERISA preemption litigation. ERISA preemption reform is a drum that I beat every time that I am on stage so that is why I am beating it again.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated that NCOIL should be recognized because for the first time in many years NCOIL offered an amicus brief and weighed in on a national level which was a big decision. Sen. Rapert said we know the impact on PBMs but asked Prof. McCuskey how she sees this impacting other areas because this case has the potential to impact many different areas. Prof. McCuskey stated that NCOIL' brief was targeted at the really important core policy level of the need for states to regulate their own healthcare systems, particularly for cost control. Implications can include healthcare rate regulation which I think is on the table as states have Rutledge as a shield that should deter some litigation and in particular the broader effort of states to try and control costs including Supreme Court prescription drug reimbursement, prescription drug pricing and any other state public access plans have some additional ammunition from the Rutledge opinion and logic because it explains how those state efforts are not within the contemplated uniformity that the original statute was

passed under and it explains the ways in which the relationship between those kinds of state rate regulation, surprise billing consumer protection laws is too much of a tangential relationship to the actual core features of a benefit plan to trigger ERISA preemption. Importantly, it takes those state efforts outside the ambit of ERISA preemption so you don't have to get into the secondary argument as to whether those things are pushing up against self funded plans as opposed to fully funded plans.

ANY OTHER BUSINESS

Roderick Scott of the Flood Mitigation Industry Association (FMIA) stated that he comes from a historic coastal Louisiana community with no levy protection as there were 14 floods in 15 years. He is the board chairman of the newly formed FMIA. This country is facing unprecedented threats from natural hazards and the dangers to our building is increasing and as a result insurance rates are increasing through the roof. We are headed for a massive asset devaluation according to the banks and two years ago I sat in the Treasury building where the banks estimated \$1.5 trillion dollars are at risk of the rising threat of flooding and insurance rates. We told the banking industry and Treasury and FEMA that its about \$600 billion of retrofit to elevate and flood-proof the buildings so that we can manage our way through this changing climate and not have flooded buildings. My town is 86% elevated – it takes a week to recover from a flood now and we are the most advanced mitigation community in the world as far as we can tell.

On January 1, the holy grail of financing for this adaptation was signed into law by former President Trump called the STORM Act which is a state revolving loan program and at that meeting at Treasury I watched the banking community commit to the government and our nation \$600 billion in financing to fix these buildings. They cant loan it directly to the communities but can loan it to the federal government back down to the states and to the taxing authorities and attach it to the taxes to be repaid over 20/30 years. People cannot afford to do this but we can afford to finance it and then people can pay it off. We have to adapt to a changing environment to reduce our losses that are increasing every year. We were introduced to NCOIL and have come before you to ask for some help – you are the legislators and in order to pass this money through from FEMA there will have to be enabling legislation created in each state to create a state revolving loan program. Our industry is ready to expand 2,000% in the next 20 years and hire an additional 500,000 construction trade people to build our way through this adaptation which we call the next moon project. We have to do this. Millions of buildings are at risk. We're asking NCOIL to entertain healing our industry – we know how to fix the buildings but we don't know how to write the legislation and we need state enabling legislation for every state and territory to be able to create the pathway for financing to come to its citizens. I look forward to seeing you again in Boston and we're willing to make the investment to create this model legislation for each state.

Sen. Hackett stated that this topic will be on the Committee's agenda at its next meeting.

ADJOURNMENT

Heating no further business, the Committee adjourned at 11:30 a.m.