NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 18, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin Kierland Hotel in Scottsdale, AZ on Thursday, November 18, 2021 at 10:00 a.m.

Assemblywoman Pam Hunter, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Sen. Mathew Pitsch (AR)
Sen. Jason Rapert (AR)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Jonathan Carroll (IL)
Rep. Thaddeus Jones (IL)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Derek Lewis (KY)
Rep. Bart Rowland (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Susan Westrom (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Sen. Charles Younger (MS)
Sen. Michael McLendon (MS)
Asm. Kevin Cahill (NY)
Sen. Pamela Helming (NY)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Doug Gutwein (IN)
Sen. Travis Holdman (IN)
Sen. Beverly Gossage (KS)
Rep. Rachel Roberts (KY)
Sen. Robert Mills (LA)
Rep. Kyra Bolden (MI)
Rep. Kevin Coleman (MI)
Sen. Lana Theis (MI)
Sen. Walter Michel (MS)
Rep. Hank Zuber (MS)
Sen. Jim Burgin (NC)
Asm. Ken Blankenbush (NY)
Sen. Jay Hottinger (OH)
Sen. Eric Nelson (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH), and seconded by Rep. Deborah Ferguson (AR), Vice Chair of the Committee, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Del. Steve Westfall (WV), and seconded by Sen. Hackett, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 17, 2021 meeting in Boston, MA.

DISCUSSION ON 340B DRUG PRICING PROGRAM

Asw. Hunter stated that, in general, the 340B drug pricing program (program) was created by Congress to help certain categories of healthcare providers, referred to as covered entities, purchase covered outpatient drugs at a reduced price. And over the years we have seen problems arise with the program and some states have taken action. In New York, I actually used to work for a federally qualified health center and the program really was instrumental and the rebates that the health centers were able to keep really helped with their operational costs. Obviously, the states want that money back for themselves and we were able to push it off for a year but next year that money is going to be going towards the state. I note that today is just a preliminary conversation and there's no model in front of us or any language. We just want to get started because we will have an enhanced conversation about this at our next meeting.

Jeremey Crandall, Director of Federal and State Policy at the National Association of Community Health Centers (NACHC), thanked the Committee for interest in this topic. I know that you have a lot of competing topics that you have to consider each and every meeting so we deeply appreciate you considering this one. Before we discuss the program itself I just want to tell you a little bit about NACHC and the Community Health Centers. We are the National Membership Organization for FQHCs, federally qualified health centers. There are approximately 1,400 health centers total in the United States across 15,000 sites. They are in all 50 U.S. states and territories and in nearly every U.S. Congressional District. I found out yesterday that there's one or two that we are not in. And ultimately we serve 29 million patients, all of whom live in medically underserved communities. Finally, and most importantly, it is our mission and our mandate under federal law that we have to serve every patient that comes through our door regardless of ability to pay or their insurance status. And I really emphasize that last point because it has a direct link to the issue that we're going to talk to you about here today – the program.

It is no overstatement how much I can emphasize the extent to which program providers, they're called covered entities, health centers, as well as others rely on the program both to reduce the cost of prescription drugs and to fund and sustain core services. I'm going to touch on a little bit of the background about the program itself. It was established in 1992 as a part of the Federal Public Health Service Act. Specifically, the program enables certain safety net providers, community health centers, Ryan White HIV AIDS clinics, certain critical access in disproportionate share hospitals that treat a high number of low income patients, the ability to purchase prescription drugs, certain outpatient drugs, for its patients at significantly reduced cost.

At the time Congress created the program they specifically stated it's intention was to enable eligible providers to "stretch scarce federal resources as far as possible; reaching more eligible patients and providing more comprehensive services." In practice here's how it works. Drug manufacturers that participate in Medicare and Medicaid are required under federal law to provide discounts on certain drugs to program providers. For insured patients whether on public or private plans they pay their normal co-pay that they otherwise would and their insurer reimburses the pharmacy at their normal payment. But that delta between the reimbursement

and what program covered entity ultimately pays for the drug, that savings ultimately goes to that provider and then program providers use these savings to fund core services.

There are several constructs of the program that I want to share with you that I think are really important. Number one, only providers that serve a large number of low income patients, or those in rural areas, are even eligible to participate in the program. Number two, all participants operate under strict federal guidelines governing the program itself. This includes registration, annual recertification, being subject to federal audits, specific rules about avoiding duplicate discounts if a program drug also has Medicaid rebate attached to it, and then finally, appropriate use of the savings itself. I said a moment ago how critical the program is and I thought it was really important for you to not hear from me but also hear directly from health centers themselves. One element that health centers pride themselves on is the ability to deliver both core and wraparound services that enable us to treat the whole patient.

And so, I asked for a couple of snapshots about what the program means. From a health center in western Michigan: "The 340(b) program is essential not only to keep the pharmacy afloat but it enables us to hire additional community health workers to go into neighborhoods to promote healthy living and ensure patients are keeping their appointments and we are also able to offer pregnancy centering programs for expectant mothers. We even use some of the savings to help purchase a mobile medical unit." From Shenandoah Community Health in West Virginia: "340(b) is enabling us to subsidize additional care services including mammography, prescription delivery and Hepatitis C treatment."

I just want to leave you with a couple final thoughts. First of all, specific to community health centers we are required under both federal law and regulation to reinvest every penny of program savings that we have directly back into patient care. That's in the Health Resources and Services Administration (HRSA) Compliance Manual that is our regulator essentially for FQHC's. Second, there are significant conversations happening right now at the federal level about this program, what it's going to look like now and into the future. We are a part of those conversations, 340(b) and they're very important and we think they need to continue. But ultimately, the reason we're here is that you all do have significant levers at your disposal to protect this program as well and that's why we're here to talk to you today.

Maureen Testoni, President and CEO of 340(b) Health, thanked the Committee for the opportunity to speak and said that our association represents hospitals that participate in the program. We represent almost 1,500 hospitals all over the country. We only focus on the program as that is our key hospital focus. Just to give you a little bit of background on what hospitals do with the program, I have some statistics to share with you. Program hospitals are responsible for about 60% of the uncompensated hospital care provided in this country. They are also responsible for 75% of hospital Medicaid inpatient care in this country. This is to give you a sense of their contribution to treating people with low income. Also, an important aspect of the program are the critical access hospitals. The rural hospitals that participate and many of them say the program is what really helps them keep their doors open. There's also a lot of services that do not technically qualify as uncompensated care because they're not traditionally reimbursed by insurers or by Medicare and program hospitals also have a very high rate of providing services like transportation, translation and things like that.

So, over the last several years, we have seen some actions by payers to reduce reimbursement to program providers and some actions have specifically targeted program providers for things like lower reimbursement but also different types of claims identification or even potentially trying to sway patients to go to certain types of providers. It's a big concern for the hospitals we

represent because it really takes a lot of the savings that are intended for these kinds of safety net providers and diverts them to other types of organizations. Fundamentally, what the program is really about and the intent of the program is to subsidize these providers, these safety net providers that really focus on providing care to low income and rural individuals. So, it is a big concern when we see that there is a diversion of those savings to organizations that don't have those kinds of strict federal requirements to focus on care for low income people.

So, states have started to take action here and I've just listed some of them just to give a sense of the types of things that states are getting active in around the program. So, they're prohibiting the discriminatory actions by pharmacy benefits managers (PBM's) and payors like lower reimbursement, claims identifications, keeping program entities out of networks and that type of thing. And the reason that they're doing this is because there's no federal law that exists right now that really addresses reimbursement and those types of things for commercial insurance. There's just nothing there at all. And so, as a result the federal government has said that they can't step in right now when there's discriminatory actions, so states have had to do so. So far at least 14 states have enacted legislation to prohibit discriminatory actions by PBM's and other payors and a number are also considering passing such laws. So, there's a lot of activity and we get contacted regularly by states asking us what other states are doing and how it's working. We get contacted a lot also by providers that are active in advocacy in their state. So, we see this as something that has really grown just even over the past two to three years. So, that just gives you an overview on it and there is my contact information and we keep a lot of information on state actions on what they're doing in this area that we're always happy to share with you as well.

Melodie Shrader, Vice President of State Affairs at the Pharmaceutical Care Management Association (PCMA), stated that I want to start with where I'm going to end, which is that PCMA supports the original goal of the program to be a safety net for the vulnerable and uninsured patients and we're neutral on any proposed legislation on the program except in instances where it erodes any of the PBM tools that we use to help keep the costs low for our clients. And I think as the two speakers before me have said, the program is a federal program and a lot of these issues are going to lie with the federal government. But with that being said, the program is a complex program and we are very appreciative of being invited here today to be a part of the beginning of this conversation and we appreciate the fact that NCOIL is committed to education and a longer conversation.

So, many of you know, but I'll start with what a PBM is - we are a company that contracts with plan sponsors, insurers, labor unions, that remit programs, etc. They hire us, we're a vendor that performs a variety of services to ensure for the cost effective and efficient delivery of prescription drugs to consumers. There are a number of PBM's in the marketplace today, over 66 in the US and they vary in size and footprint, and offering, and expertise in the market. We negotiate manufacturer rebates and that is one of the key components of the way we keep drug costs low when it comes to manufacturers. And at this time, there's not an alternative to that as far as the manufacturers set the drug price and we negotiate those rebates in order to keep that price low. And that is going to be I think a part of this conversation as we go forward.

The speakers have already talked about the program but I think it's important that we do understand that it was indeed started to stretch those federal resources and the two speakers before me have already said that. And PhRMA has to participate in that if they are going to actually participate in the Medicaid program and there's a couple of important terms that we're going to be using over and over again and I think as you all go forward with this conversation it's important that we really focus on those two terms which is covered entity and contract pharmacy.

I think we'll be using those terms a lot as we continue with this conversation. The covered entity is as the two speakers before mentioned it is a nonprofit hospital or the community health programs or the Ryan White clinics. But the contracted pharmacies are ones that you're also going to be talking a lot about. Covered entities actually contract with pharmacies in your community. And the next slide that I'm going to show you begins to see how complex it gets and anything in healthcare, as you all know, gets very complicated.

And as we continue this conversation and we walk down this road together, I think we're going to see that there's a lot of complexities here and I think it's really great that you're asking experts to come and talk to you about this because it really does start to get complex. And as I started to try to understand this, I realized in my own community in Kentucky, I live in a small community of about 35,000 and the total in our county is about 50,000. Our hospital is owned by a larger hospital system from southern Indiana and it is a program entity. It has 11 hospitals in their system, they cover three states and they have over 500 doctors in their system. In our community, they have probably 20 doctors in their system.

When we talk about a covered entity, our hospital is a program hospital. To be a program prescription, it just has to be written by that covered entity. So, all of a sudden my community, most of the prescriptions written in our community is written by that program entity. So, it becomes very complex in our community and it becomes a very big conversation. So, I really appreciate the fact that you all are taking on this conversation. When we talk about the contracted pharmacies, I looked it up last night and I had no idea the Walmart, the two Walgreens, the Rite Aid and the two largest independent pharmacies are all contracted pharmacies in our community. So, therefore, most of the prescriptions in our community are probably written by the covered entity. And most of the prescriptions are filled at one of those contracted pharmacies. So, it's a pretty big conversation in just my little community so I think we really look forward to this conversation and look forward to being a part of this conversation and we really appreciate this opportunity. As I said at the beginning, I'll end where I started. PCMA supports the original goal of the program as it is a safety net for the vulnerable and uninsured. PCMA is neutral on legislative proposals on the program except in the instances where it erodes the PBM tools to help protect our commercial clients. And any changes to the program are probably going to have to be a discussion at the federal government level but we appreciate the opportunity to be part of this conversation.

Rep. Tom Oliverson, M.D. (TX) stated that he really appreciates this timely conversation and this has sort of got on my radar screen recently as well. One of the things I wanted to hear from each of you or whoever wants to comment on this is there seems to be some data out there and some studies now that seem to indicate that there's enhanced profitability for not for profit hospitals that are operating in the program compared to those not in the program and there's allegations that there are prescriptions being filled simultaneously under both Medicaid and the program, which is sort of double dipping and it is my understanding is not lawful to do. And at the same time, some of these facilities actually provide less charity care then non contracted program entities, so as we look to these things, as we look at this program, I know obviously this is a safety net program and this is not a program designed to make people money or make people profitable. This is designed to help the most in need. I'm a huge advocate for FQHCs and I think they do yeoman's work in my community and in medically underserved communities across the state of Texas. Many of our rural areas, which are hard to get healthcare resources to are covered by FQHCs but it concerns me when I read things about enhanced profitability for not for profit entities and the possibility that these programs are being abused. So, I was wondering if you all could comment on that.

Ms. Testoni stated that I'm happy to at least start since I'm representing 340(b) hospitals. So, you raised a number of important points. Let me just start by saying my organization and others outside of my organization have done a lot of research on this issue of what is going on with the program in hospitals. And I think the focus has been on the hospitals because they are the biggest users of the program. They have the most patients, they do the most expensive services such as cancer treatment and lots of things like that. So, we have a lot of research now to be able to show exactly what is going on with the program.

On the issue of profitability, we find that program hospitals have lower profit margins than non program hospitals across the board. So, we compare big hospitals to big hospitals, small hospitals to small hospitals and across the board we see they have lower profit margins. For small rural hospitals, like critical access hospitals, a lot of them will say they are what helps us keep the doors open. So, from the perspective of how the program works, it is a situation where you pay less for the drug and you get paid like the regular price, as if you didn't get that discount and so that does go towards helping to fund your services. So, it's just critical, especially for those rural hospitals, as it does help them keep their doors open, there's no question. In terms of double dipping, that is something that is not permitted under federal law and we don't see a lot of it under fee for service Medicaid because the federal government has set up some rules for how to prevent that that providers have to follow. That doesn't apply for Medicaid Managed Care as that's a situation where the states are not allowed to get rebates if a drug has gone through the program. So, it's not so much that it's double dipping per se, but it's a situation where the manufacturer, if a drug is purchased by the program and the state seeks a rebate, then they're basically paying it twice. The hospital doesn't profit or get anything extra that way at all but the states are actually prohibited from engaging in that as they are not supposed to be getting those rebates.

And then third a comment that you made was about charity care. Charity care is one part of a bigger calculation in that a lot of what they use in the federal law is our compensated care, not just charity care since that's one piece. But even on charity care, it is very rare that you would find a hospital to have higher charity care generally than program hospitals. That's definitely not the norm. But then when you put in all of the other things, the uncompensated care which is, like underpayment by Medicaid, tremendous for hospitals that are providing 75% of the Medicaid care, there's just no question that program hospitals again, across every category, when you compare big hospitals to big hospitals, small to small, in every category program hospitals are providing more of that type of care than the non program hospitals. And I would be thrilled if you were interested, to at least show you know some of the studies that we've done. We've paid for other people to do them independently outside of us and then others have done it just all on their own and published that as well.

Mr. Crandall stated that for FQHCs, we're very aggressive in making it clear to FQHCs that they essentially run a very tight ship with their 340(b) programs, especially on avoiding the duplicate discounts. It's not perfect but they very much understand that they have to be very tight on duplicate discounts because we are regulated very closely by the Health Resources and Services Administration.

Sen. Bob Hackett (OH) stated that in Ohio I'm probably known as the program legislator. I've fought for the FQHCs and I actually carried related legislation in Ohio. An issue which really surprises me is why the history of the program wasn't provided because when the program was originally started, it was the expansion in the hospitals by President Obama that really brought in all these additional hospitals. And then regarding the profit issue, there were really strict guidelines of how they can use the money. I was on a board of a hospital, and hospitals are

primarily non profit and deal with non profits. So, they know how to work the system probably as good as anybody in the world so the issue of the expansion of the hospitals into the program has somewhat created the problem. The FQHCs and the veterans and other hospitals have been there from the beginning and they were the ones that we wanted to protect. So the issues that we deal with is the additional hospitals that came into the program and I'm not criticizing that, because during COVID they were the great players in Ohio. They worked with us and they did everything the state asked them and they were really good. And so, we have kind of protected the hospitals but that's an issue and it's not a state issue, it's a federal issue if that's going to get changed. But we have to protect our FQHCs.

Ms. Testoni thanked Sen. Hackett for his support of the program and stated that what happened under President Obama with the expansion of the program was it expanded to rural hospitals. So, those included rural referral centers, sole community hospitals and by far the biggest group were critical access hospitals which frankly about doubled the number of hospitals in the program. But according to HRSA, those hospitals are responsible for maybe 10% of the total program because they are so small. So, there's looking at the number of hospitals, then there's looking you know at other aspects of the program. And it is true that they did double the number of hospitals but they are really tiny hospitals that came into the program and they're in more isolated rural communities. So, it limits how much actual impact that they would be having on the program from that perspective.

There's definitely been allegations that the program has grown since it started in 1992, and there's no question that it has. In terms of the number of claims that go through the program, the number of claims for which manufacturers have to provide a discount is much bigger now than it was in 1992. A lot of that though I believe comes from the big shift that we've seen since 1992 from inpatient settings to outpatient settings. And I think that is one of the biggest things that we have seen. So, you know, chemotherapy in 1992 often was provided in the inpatient setting. And now, it's provided in the outpatient setting. And sometimes, it's not even provided at the hospital. There's now chemotherapy pills that people can pick up at their pharmacy and do in their own home.

So, we've seen a real shift in how care is provided. We've seen a lot of growth in outpatient drugs. That's where a lot of the big patents are going into outpatient drugs. And that is something that was not the case when the program was started, and then now there's been these changes. So, we are definitely seeing more claims go through but another part of the growth is the high price of prescription drugs. The program is built so that if a manufacturer increases it's drugs higher than inflation, there's a penalty. That increases the discount that manufacturers have to give. So, we're definitely seeing more in discounts. But a lot of that is because of manufacturers raising the prices. And there's been some research that shows that the program because of that inflationary penalty it's actually had an impact on keeping prices lower than they would otherwise be, even for non program drugs but obviously it's not enough to really keep the prices way down.

Sen. Hackett stated that we did the legislation in Ohio because the PBMs basically said, "Hey fine, don't use us for this one drug thing." But you must realize that PBMs, if you pull out some of the big players you're creating deserts in Ohio. The program is going to conflict at times with your formula of the way PBMs operate and that's what they did in Ohio - they backed out. They were going to come in and say, "Hey if you don't want to deal with us, don't deal, we'll pull this one drug company." I don't know if it was Walmart or Walgreens which one it was. But we needed that across the state because it would have created deserts so you have to realize when you look at FQHCs, you know they need to have outlets where their people need to be able to

get the prescriptions filled and if you come in and say, “Hey it conflicts with our formula to protect our clients” you’ve got to realize you’re going to kill the FQHCs. So, you have to work with the FQHCs and that’s the way the federal law was there. So, that’s why we did the legislation in Ohio. I didn’t think we needed it. But then the PBMs came in and tried to fight us. And we just said, “Hey we’re going to pass legislation to allow the PBM’s to do it.” So, you know I don’t know how you want to comment on that but by nature you’re going to have that conflict between your formula and how FQHCs operate cause they need those those pharmacies to be able to have their people to go to them.

Asw. Hunter stated that there is going to be a more extensive conversation on this in March and if there are any comments, questions or concerns please send them to NCOIL staff and we’ll make sure that the panel that we choose is reflective of the conversation that you all want to have.

CONSIDERATION OF NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT (Model)

Asw. Hunter thanked everyone for their work and input on this Model. I’m proud to have sponsored this. We’ve worked on this for a lengthy period of time over the past year. I’m proud that the organization has been involved with such an important issue during an important time. Telemedicine certainly didn’t start with the COVID-19 pandemic but I do think that it showed us all it definitely will be more frequently utilized in years to come.

If you would please in your binder take a look on page 41. I note that since our last meeting in July I’ve made a couple of changes to the Model, in the form of a new section six titled Network Adequacy and Limitation. If you recall, last meeting we had a conversation about network adequacy. Thanks to my colleague, Asm. Kevin Cahill (NY), NCOIL Treasurer, for pointing out the issue that needed to be addressed in the Model. The new language will state “an insurer shall not use telemedicine or telehealth to satisfy network adequacy requirements with regard to a healthcare service.” And I’d like to thank America’s Health Insurance Plans (AHIP) for pointing out that the language could be interpreted as prohibiting insurers from using telemedicine or telehealth at all in meeting network adequacy requirements. But that certainly is not the intent and it’s certainly not meant to be incomprehensible as AHIP contended in a letter forwarded to our office. Accordingly though, I agree with AHIP’s suggestion to simply add the word “solely.” So it will read, “an insurer shall not solely use telemedicine or telehealth to satisfy network adequacy requirements with regard to a healthcare service.”

The other new language you see is also straightforward and also addresses an issue that I know the Vice Chair of this Committee, Rep. Deborah Ferguson (AR) feels strongly about. The language simply states that “an insurer shall not limit coverage only to services delivered by select third-party telemedicine or telehealth organizations.” If a patient's existing doctor provides telemedicine services the patient should not be forced to use a totally different service with a one -time provider he or she has never seen before and will never see again. Last but certainly not least, I would be remiss if I did not again mention the issue of payment parity. As the sponsor of this Model and Chair of this Committee I am again stating that the Model does not require dollar for dollar payment parity. I understand that concerns have been raised, mainly by AHIP that the language should be changed to ease their concerns but I don’t know much clearer I can be than saying the Model does not require payment parity. If a state adopting the Model wants to alter the language that is certainly okay and frankly encouraged as the NCOIL philosophy with model laws is that they should be adapted to meet states needs and marketplace realities. But as sponsor of the Model and Chair of the Committee I am comfortable with the language as is. With

that said I know that AHIP would like to make a few final comments and then I will open it up for questions or comments from legislators before we move forward to vote on the Model.

Miranda Motter, Senior Vice President pf State Affairs at AHIP, thanked the Committee for the opportunity to speak and stated that I appreciate this Committee's work on telehealth. This Committee is certainly working to advance the strides that we have made during COVID. Asw. Hunter you talked about the strides that were made during COVID and I think health plans are now laser focused on how we can continue those strides and advancements and so I applaud you for that work.

Let me first say, we have talked to some of you about our concerns about the new section. And we certainly appreciate the intention in terms of the language to make sure that telehealth can be utilized and brought in as we think about telehealth moving forward. I also appreciate the comments relative to payment parity that we have had some concerns around that. We certainly appreciate the intent and the recognition that the language is not intended to require payment parity. I would say that to the extent that you are willing, but certainly understand the statements, any sort of clarification to that would also be appreciated. But in closing let me say again, we appreciate this Committee's work as telehealth is an incredibly important service. We know that it's been an incredibly important service during COVID and it will be moving forward as we look to make sure that it is clinically appropriate and provided to Americans as they need it.

Sen. Lana Theis (MI) stated that she appreciates the comments about reimbursement as well but the way that I'm reading this language implies to me financial parity. So, I do have a concern with that.

Ms. Motter stated that I think we have a difference of interpretation in terms of how those words on the page can be read. As many of you know, this issue has been debated in states all across the country even down to the detail of an exact word and exact comma. Our interpretation is that it could be interpreted to mean reimbursement parity but again, we want to recognize the multiple comments made in this Committee that the intent is not to require payment parity. As I said, as a result we would love to see the language with that intent done through a drafting note or done through a simple statement in the policy section. But again, I hear the intent that it is not intended to be payment parity but this issue is really being debated as we look forward to make sure that telehealth is being brought into the healthcare system in a way that is providing clinically appropriate care, that is providing affordable care and making sure that individuals that don't have access can continue to access those critically important services.

Asm. Cahill stated that I think our intention, if I'm not mistaken, is to encourage the development of telehealth and to make it available to the people we represent in our various states where it is appropriate to be used, but not to create a path towards substitution of telemedicine, telehealth for brick and mortar healthcare. My concern is twofold. First, to allay concerns about the issue of parity, parity is not the same as equality. Equality would mean if you pay a doctor $5 for a visit, you'd pay a doctor on telemedicine $5 for a visit, even if the nature of the visit was not necessarily qualitatively equal. Parity, in my understanding, is that all things being equal that the reimbursement would be also equal. But if all things are not equal then of course it shouldn't be. I can envision many instances where telehealth could be more valuable than an in person visit. If you have the opportunity for example, to talk to the leading specialist in the country on a specific area, you may want to pay that specialist more than you would a community specialist who you know practices in just your own community. On the other hand, if we are using it as is often the case with the early COVID stuff, the preliminary to an actual visit, it might end up being just something that raises cost without raising quality.

So, I think it is a complex issue and one that needs to be delved into. I do want to specifically focus on section six and the proposed language change by AHIP to insert the word solely. All due respect, I think that's the camel's nose in the tent. I think that's the beginning of allowing health plans to substitute telehealth inappropriately where brick and mortar healthcare is what we prefer. I think it will have a dramatic negative effect on the development of networks, particularly in our rural areas as we go forward. And I would suggest a word other than solely. I think it was suggested informally that the word predominantly would perhaps better express the sentiment of this Committee and of this body than the word solely. Solely is a pretty low bar. If a health plan comes forward with a network that has one provider where it is more appropriate to have five in-person providers and then also has a telehealth component that's not solely anymore. So, they've complied with that standard. I would ask for consideration of using a different word. Or leaving the section as it is written in our book.

Rep. Stephen Meskers (CT) stated that I think the intent of the bill in telemedicine and beginning of the regulation oversight is important. I think the question of parity and the question of equity are valuable questions. But I sit both on the finance committee in the state of Connecticut and in the insurance committee and I think the problem becomes either a state issue for the state employee plans and tax payer issue or a consumer issue as a purchaser of insurance policies. We sit here in the regulatory function at the state level with the ultimate goal of regulating the industry but also providing the industry with the adequate tools to control costs for the delivery of services in the state.

And some large part the problems are regulatory and at the federal level. When I looked at the chart from the PBM and I've been looking at charts for 35 years, I couldn't figure out which way the cash was flowing on that model and I always worry if I can't figure out the cash flow. Here it looks like, what we're trying to do is figure out how to allocate telemedicine. In the onset of the pandemic all of our business models were broken down in terms of remote work and telemedicine And I think we're at the beginning phase of figuring how to adequately use telemedicine as a component of our healthcare. I'd prefer to see a relatively generous interpretation to allow the industry to wrestle with our hospitals and our pharmaceutical companies to figure out how we deliver this service, and whether we can do it in an effective way. So, I appreciate the changes to the bill, I appreciate the work that the committee's done in drafting it. So, I'm a little confused about whether I want parity or equity but I'm looking for lower cost pricing, and if this helps us get there I'm in support.

Rep. Tammy Nuccio (CT) stated that looking at this from the perspective of cost in healthcare, I know I had a lot of encounters with constituents during the COVID period where doctors were requiring them to do a telehealth visit prior to coming into the office. Which then brings me to the case of inflating healthcare costs by doing a telehealth visit and then saying, "You know we can't really help you with that and now you need to come into the office." So, from the parity perspective I think we need to be cognizant of the fact that we're recognizing the differences in service between a telehealth call and in in patient brick and mortar payment scheme here to make sure that we're adequately covering it.

They are definitely services I think we can cover from a telehealth perspective that will help reduce the cost of healthcare but if it's simply being put in as an option, and reading this very quickly I didn't see a mention in here to double visits, or consumer protection to make sure that people aren't being directed to do a telehealth call and then have to go in and do a subsequent office visit. So, if there was some kind of way to say, if this does not generate an office visit within X amount of period of time, maybe you would change the coding at that point to a

telehealth call to a brick and mortar but not having the ability to do both or double dip. I think we need to be cognizant that this is a new model and make sure that we are regulating how it's being used so we're not just seeing increases to healthcare cost across the board as a new way to bill.

Rep. Matt Lehman (IN), NCOIL President, stated that I hate to disagree with my fellow officer and good friend from New York, Asm. Cahill, but I do think not adding the word solely actually creates more problems and I think solely is not a low bar, I think it can be a high bar. Because coming from a rural area, I think if you could interpret this as a prohibition, then I get no telemedicine which I need in my rural areas. If we put solely in, it says you're going to give me some options with brick and mortar and telehealth. So, solely I think in this case is a high bar. I would support the Chair in saying that I think the change of this to solely does make this a better amendment.

Hearing no further comments or questions, Asw. Hunter stated that we are going to move forward with a motion to vote on the amendment and I just want to state again that a state adopting a model, if they want to alter the language it's certainly ok for them to do that. This is a model for you to take back to states and integrate into the fabric of your state's needs. Upon a Motion made by Rep. Ferguson and seconded by Rep. Lehman, the Committee voted by way of a voice vote to adopt the amendment introduced today. Then, upon a Motion made by Rep. Lehman and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted by way of a voice vote to adopt the model as amended.

CONSIDERATION OF NCOIL MODEL ACT REGARDING AIR AMBULANCE PATIENT PROTECTIONS (Model)

Asw. Hunter stated that we are moving forward to consideration of the air ambulance Model on page 46 in your binders. I'll start off by saying thank you to everyone that has worked on the model. Notably, Del. Steve Westfall (WV) is prime sponsor and Representatives Thaddeus Jones (IL), Deanna Frazier (KY) and Tom Oliverson, M.D are co-sponsors. This model, I must tell you has been one of the most contentious models I've worked as my time as Health Committee Chair. And I must say, things really escalated in these last couple of weeks. Prior to that, we were having a respectful exchange of ideas on an important issue of insurance public policy but that really changed when an email was sent out to certain members of this committee.

I know Del. Westfall will have further comments on this but I'll just say that I, as Chair, am disappointed in the behavior of the opponents of this model. NCOIL is a respected National Legislative Organization that is always willing to have open and frank discussions on insurance public policy issues. NCOIL is not the forum for sending inaccurate emails out to only a select group within a committee which encourages constituents to reach out to us based on false information they have been provided. So, I'd like to turn this over to Del. Westfall for a few words.

Del. Westfall stated that I'll start by noting that the changes to the model since our last meeting are largely intended to avoid any threat of federal preemption and uphold the state's right to regulate the business of insurance. The new purpose section illustrates that intent and makes clear that the model is intended to help preserve the longstanding jurisdiction that states have to regulate the business of insurance as expressly established by the McCarran-Ferguson Act and to affirm the ability of states to regulate the business of insurance without threat of federal obstruction. I note since the model was distributed in the 30-day materials that purpose section

has been redrafted to make it stronger, and the language appears in a separate document before you.

Before closing, I would like to make a couple points on the email referred to by Asw. Hunter. In that email the opponent to this model states that the model would eliminate consumers' ability to obtain their air ambulance membership. This is totally false. Some states have indeed tried that approach i.e. banning the sale of air ambulance memberships. The model does not do that. Rather it clarifies such memberships as insurance products and provides the state insurance department the authority to regulate them to protect consumers in their states. The email also intentionally mislabeled the title of the model. The email referred to the model as the Air Ambulance Membership Plan Model Act. As you can see before you the title of the model is the Model Act Regarding Air Ambulance Patient Protections. It's certainly not a mistake that the opponents of the model decided to remove the words patient protections from the title and instead invent their own title.

Lastly, the email states that an alternative model has been offered that is consumer friendly rather than focusing on picking sides between competitors and that there has been no response to that alternative which is concerning. Again, this completely misrepresents the model and the actions that have gone on over the past several months. A document with the names of the opponent lobbyists on it containing several suggestions and ideas for the model were sent to Asw. Hunter who then forwarded to NCOIL staff. NCOIL staff then reached out with some questions, but staff did not receive a response. That can hardly be characterized as either an alternative being offered or that there has been no response.

Rep. Jones thanked Asw. Hunter for the opportunity to speak and stated that when a similar bill came before us in Illinois it was nasty and contentious as well. And there were several issues that were raised one of which does the legislature have the authority to make sure that we can regulate this business and the products. And part of our contention in Illinois was that we do have the right to regulate this business and we wanted to make sure that we were at the forefront of this. The bill was HB 317 that passed the House but then got stalled. And part of what we said was that the legislation did nothing to prohibit the sale of air ambulance memberships as that was the key contention but it was also that it provides much needed help to consumers and that's what our sole obligation is to our consumers in Illinois and around states who want to address this issue. So, I feel that it's important that we not only address this but it's no surprise that this issue is contentious here because it is strongly contentious in Illinois and I'm looking forward to supporting it and looking forward to hearing concerns today about it.

Rep. Oliverson thanked Asw. Hunter and stated that he has profound appreciation for Del. Westfall for doing the yeoman's work on this and getting this going, as well as his fellow co-sponsors. This is an important issue and I would have to say unfortunately I was not terribly surprised by the email. You may recall that we had an episode in Texas where a company was essentially fabricated and presented to our committee feigning outrage which ends up not being a legitimate registered to do business company in our state. So the whole thing was a essentially a ruse to destroy the work product that we were working on Texas. I have also been very dissatisfied and really unhappy with the way in which stakeholders have approached their opposition to this. Rather than work together towards a model which I think allows for consumer protections, which ultimately is the responsibility of every lawmaker sitting here, they seem to be more interested in just winning at all costs I guess and I just want to say I'm terribly frustrated.

So, I'm looking forward to passing the model and I believe that this will withstand legal scrutiny. I look forward to that and I think it's much needed. People should know what they're getting into

and they should know that and perhaps they may or may not actually need a product like this and they should be informed about it. And I think that is our responsibility, so congratulations to Del. Westfall, and I look forward to seeing this become model policy and I appreciate everyone's strong efforts, including Asw. Hunter because I know this has been a contentious difficult issue to preside over and referee on and I appreciate your patience with all of us on this.

Asw. Hunter stated that we will next hear from The Honorable Nat Shapo, Partner at Katten Muchin Rosenmann, LLP and former Director of the Illinois Department of Insurance. At our last meeting in July the opponents of the model had hired Professor Dan Schwarcz of the University of Minnesota Law School to prepare a report laying out the reasons why they believe the model if adopted by states would be subject federal preemption. Dir. Shapo has been hired by the proponents of the model to respond to the conclusions Prof. Schwarcz made in his report and in his testimony to this committee at our last meeting. A copy of Dir. Shapo's report was previously emailed to the committee by NCOIL staff and is also on the conference app and the NCOIL website.

Dir. Shapo thanked Asw. Hunter for the introduction and for her leadership on the committee on this and all other issues. And I also wanted to acknowledge Rep. Jones who is well known at home in Illinois for his commitment to strong and effective regulation and his remarks earlier I thought were quite consistent with that. I've been retained by Air Methods Corporation to review and offer my analysis of Prof. Schwarcz's prior presentation. His basic conclusion was, that it is virtually certain that federal courts will continue to conclude that the sale of air ambulance subscriptions does not constitute the business of insurance under the McCarran-Ferguson Act. I won't go into all the details of preemption and reverse preemption but that is the essential question before you - whether the regulated activity here is the business of insurance under McCarran.

I respectfully disagree with Professor Schwarcz's conclusions. He's an eminently credentialed professor and a thoughtful scholar but I do respectfully but strongly disagree with his conclusion of virtual certain preemption here. The hook for his report were the opinions in West Virginia and North Dakota. I -went through those and I've concluded those are highly distinguishable. They're much different substantively as North Dakota's was a ban and West Virginia's was essentially a delegation to the regulator and it didn't have the same kind of level of detail and substantive work that the model has. Also, it's clear and for instance in the West Virginia opinion that the court there had an issue with the fact that there had been prior litigation in the case and this was the next litigation. The court literally quoted the famous Yogi Berra quote, "It's déjà vu all over again." The core model would come to a court and probably receive a more kind of balanced review. I note in my report that you've had four extensive hearings over a year and there's twenty-something pages of minutes that demonstrate the substance behind this which I think complies nicely with the standard under Fabe that McCarran laws are protected when they possess the end intention or aim of adjusting, managing or controlling the business of insurance.

And getting to that standard, the Fabe case is a so-called first clause case in McCarran and the standard there is a state law would be reviewed under the standard that McCarran established of Congress' primary objective of granting the states broad regulatory authority over the business of insurance. There's kind of a skirmish as to whether or not the standard that I just quoted would be applicable here under the so-called first clause versus second clause. You can read about that in my report if you'd like but I think the language in the controlling Fabe opinion is clear that the broad language that I just quoted will be an overlay over any review of the state law.

The Pireno case has three factors and I address them in length and the most important factor is the first factor of whether the law regulates a practice that is effectively transferring or spreading policyholders risk. Even the language in Prof. Schwarcz's report is very clear that that's the case here. With the second and third factors under Pireno, I think something that was missed in the earlier report was that the review is of the "particular practice" that's being regulated. This model regulates the particular practice of the subscriptions, which Prof. Schwarcz's report itself concedes do transfer and spread risk.

The model is not regulating and not going behind the curtain and it's not getting into balance billing questions for instance. In the Pireno case, the issue was chiropractic peer reviews that control costs. This case is not like that. This case only regulates the transferring of risk issue which is the subscriptions. So, the particular practice here under the second and third prongs is the subscriptions which transfer risk. The model does not get into controlling the costs on the other side and does not get into the health insurance questions. So, I believe under the second and third prongs you'd be protected. And therefore, I think as the guardians of McCarran, as the people who are responsible for meeting the broad standard in Fabe, Congress' overriding interest in protecting the states' ability to regulate the business of insurance, that if you feel this is a risk transfer practice that needs consumer protections than you'd be within your boundaries of pursuing it and you would not be irresponsibly passing something that's virtually certain to be preempted.

Christopher Hall, Program Director of Gov't Affairs and Industry Relations at PHI Health LLC, thanked the Committee for the opportunity to speak and stated that PHI is headquartered in Phoenix, Arizona and we've been providing air ambulance services through our lines of business which is PHI Air Medical and Air Evac Services. Air Evac Services has served the citizens of Arizona for over 50 years. We also offer PHI Cares membership service. Our membership has two aspects. It allows members of a community to take action to support the availability of air ambulance services in their community and it provides a means for consumers to pre-pay any patient cost sharing imposed on them by their insurance companies.

I'd like to speak first to the former aspect of our membership which is community support. I've not always worked for PHI Health. In my career I worked for a hospital based air ambulance service in Miami, Florida, for a private ground ambulance service in Oregon and as a transporting paramedic and firefighter for an all resources department in a municipal department in Oregon. However, my first job as a paramedic was for the oldest private non-profit air and ground ambulance service in our country, Mercy Flights Incorporated, in Southern Oregon. A little bit about Mercy - it started in 1949 which is coincidentally when PHI pioneered the use of helicopters in Southern Louisiana. Mercy began when an air traffic controller from Oregon witnessed the needless death of friends and family traveling to Portland, Oregon for Polio treatments. At the time the road system in Oregon was a patch work of pavement and dirt road requiring between six to eight hours depending on road conditions and weather to travel by what we consider a primitive ground ambulance from Medford to Portland. Many Polio patients died on that ride prompting the man to begin providing air ambulance service for safe transportation by air. Unfortunately, the man didn't own a plane, and he didn't have the means to buy one. He recognized the need but did not have the financial resources to address the need.

Asw. Hunter stated that I appreciate all of your commentary but we need to be able to let our colleagues ask some questions so is there anything specific to the model that you'd like to make a statement about?

Mr. Hall stated that I think what you're dealing with here is this has come down to a matter of two competing business models: membership versus non-membership. And this goes well beyond AMC versus GMR. There are membership services across this country in Ohio and Louisiana and in the pacific northwest that are there so that their citizens can help support the availability of the service being there. And they have the benefit of being able to pre-pay costs imposed on them by insurers. What you have now in front of you is what could not pass in the last two years based on its merits and has now been turned into a battle of states rights. It doesn't need to be. The shared goal here is consumer protection and transparency. We can do that. That's something we can all rally behind and we can all support because that's what we want is informed consumers. Pitching this into a states battle breeds one contentious battle after another contentious battle after another contentious battle. And I would encourage this body to not adopt this model legislation in its current form but to focus on the consumer transparency and education that we all are seeking.

Hearing no further comments or questions, upon a Motion made by Asm. Cahill and seconded by Del. Westfall, the Committee voted by way of a voice vote to adopt the revised purpose section. Then, upon a Motion made by Asm. Cahill and seconded by Rep. Lehman, the Committee voted by way of a voice vote to adopt the Model as amended.

CONSIDERATION OF NCOIL ACCUMULATOR ADJUSTMENT PROGRAM MODEL ACT (Model)

Asw. Hunter stated that Model is on page 49 in your binders. Asw. Hunter thanked everyone who's worked on this model as it has clearly struck a chord since several states have recently introduced such legislation and several states I'm told have plans to do so next year. That's why I feel it's very important that we adopt this model so that states have an NCOIL model to look at when they consider their own bills. Before we go any further, I'd like to offer the prime sponsor of the model Sen. Jason Rapert, NCOIL Immediate Past President, the opportunity to say a few words.

Sen. Rapert thanked Asw. Hunter for all of her work on this and for allowing him to comment. Sen. Rapert stated that he is proud to sponsor this model law as it closely resembles a piece of legislation that I sponsored in Arkansas that was signed into law earlier this year. As noted by Asw. Hunter, this type of legislation has been enacted in several states the past couple of years. I'm hopeful that states looking to enact such laws during their upcoming legislative sessions can look to the NCOIL model for guidance. As a reminder and for those who may not have been present during past committee meetings, the issue that such legislation like this model deals with is that it seeks to prohibit accumulator adjustment programs which prevent copayment assistance that helps patients pay for high cost prescription drugs from counting towards their annual deductible or maximum out of pocket costs.

Accordingly, the model and the laws across the county simply state that no matter who is paying for these funds, whether it's pharmaceutical manufacturers, copay systems, even a go fund me page, or an aunt or an uncle, those funds and third party payment should be counting towards the patient's cost sharing requirements. What's great about this issue as I've noted before is that it truly is bipartisan. Both red states and blue states have enacted legislation on this issue and I'm thrilled that my colleagues and committee members from both sides of the aisle have joined me in sponsoring this model. I also want to acknowledge that obviously with my schedule being as it is there were some folks that had contacted me about amendments to this. I wanted to make sure that those amendments had an opportunity to be heard and so I deferred on those

amendments on adding them directly to the model before today. But obviously, Asw. Hunter, you have been able to step up and offer those amendments.

And I appreciate the membership and also the staff for understanding that by my deferring I think it gave everybody a chance to make their case and get all of that heard as we've neared the end of this. And I'm proud of the fact that we're now approaching the end of this so as I leave with my comments for now before making a motion, I just want to say Asw. Hunter that I appreciate what you've done on this with the amendments that will get us closer to putting this to rest.

Asw. Hunter stated that as noted, I do have some proposed co-sponsor amendments to the model which have been distributed to everyone in a separate document. The amendments I believe make this model much stronger and even more consumer friendly and I'll briefly walk through them. First, section 2(I) is proposed to be deleted simply because I don't believe there was or is any evidence in the record to support that assertion. Next, several additions to section 4 have been made. The first deals with limiting accumulator adjustment programs to covered drugs that have no other lower cost alternative. This type of language appears in several state accumulator laws and I think it makes sense as the original language was very broad and could have been read as applying to third-party payments for all drugs, services or devices and used to bypass a formulary.

The second change, new section 4(B), requires that: a person that pays any amount on behalf of an enrollee for a covered prescription must notify the enrollee prior to the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available; and may not condition the assistance on enrollment in a specific health plan or type of health plan to the extent permitted under federal law. I believe this is a very consumer friendly amendment and makes sense as it simply requires more information about the assistance to be provided to the consumer and removes any unnecessary conditions for the assistance to apply. Lastly, new section 4(C) addresses the issue of those with health savings account (HSA's). This amendment simply ensures that the model would not disqualify an otherwise qualified state resident from funding an HSA to help manage her or his out of pocket medical costs. Several states have included this type of language in their accumulator laws.

Brendan Peppard, Regional Director of State Affairs at AHIP, thanked the Committee for the opportunity to speak and stated that it's nice to actually see all of you in person instead of as a box on Zoom. This is my first travel in about a year and a half and it's really nice to actually be here. I had a whole set of prepared comments but I think I'm going to skip them and just say thank you for all of the work that has been done on this. We still have concerns with the model as we don't think it's exactly what we would like to see but we do believe it has been made stronger. One point I will make on what we've been calling the fair and equitable amendment which was referenced as new section 4(B) - we believe that you incorporated two of the three points we had in there. We think that all three are very important and we would urge you to consider also including the provision that requires that any assistance be provided through the entire year. But other than that we really appreciate all the work that's gone into this.

Steven Schultz, Director of State Legislative Affairs at The Arthritis Foundation and Co-chair of the All Copays Count Coalition, stated that the Coalition has helped worked on these types of bills and has created model language around this. I want to just say thank you to the Chair, the Vice Chair, Sen. Rapert, and the co-sponsors of this Model for your continuous work on it. Also, thank you to the staff of NCOIL for your work on it. I think Sen. Rapert did a great job of outlining the issue and the amendments were covered in detail. I think for the most part I just want to say

thank you to the numerous members of this committee that have voted on this language across the states where it's been introduced in thirty plus states and enacted in twelve.

Like Asw. Hunter said, and Sen. Rapert said, it's likely to be introduced in a vast majority of states next year. So, I acknowledge that NCOIL model language will only assist in guiding legislators as they prepare for that. Also, I would like to thank Del. Westfall who has helped enact this legislation in WV. As for the amendments, two of them are pretty straightforward and solving issues that have come up throughout this process. And that would be the amendment around the generic equivalent which is something that I often call the Arizona language and is a very common sense kind of way to meet in the middle on the issue. And the second one is the HSA amendment which we hope solves this issue for the states that hopefully have enacted this already and move forward to enact this that would cover it and ease concerns from Departments of Insurance across the country and any legislators that might have concerns about the language. The third amendment that AHIP just acknowledged, the one thing I'll say about it is that, in the thirty plus states that we've seen this introduced, that amendment hasn't been included in any of them. So, there's just concerns about the fact that this hasn't been introduced and had that day in the hearing rooms to discuss and work through it throughout the process in the states. And so, we're talking about model language that would be something that I would just acknowledge some concerns about. But the other two are pretty straightforward and agreed upon absolutely.

Kevin McKechnie of the American Bankers Association (ABA) HSA Council, thanked the Committee for the opportunity to speak and for the chance to explain ourselves in Boston and for the work that went on between then and now. And thank you to the sponsor for working so closely with our team. And thank you to NCOIL staff for doing the best you could. In the interest of time, I'll stop and just say I'm here to answer any questions you might have and I think we can move forward.

Rep. Lehman stated that I'm going to voice one concern on this entire process. Not relating to process - on the bill. And that is while I agree with Sen. Rapert that we're allowing all these entities to provide towards that deductible, we're now introducing an entity that controls the cost of those drugs. And I think that to me begins this process of okay, so if right now it costs $600 for a drug they're going to give me a $400 or $500 coupon - I pay $100 out of my deductible, out of my own pocket and the entity provides that $500. It now becomes a $600 credit. If that drug becomes a $1,500 credit, or drug and now a $1,400 credit, now I pay a $100 but now my deductible's been met to the tune of $1,500, not $600. So, my only concern moving forward is, we're introducing not grandma and grandpa helping out Junior with his deductible, but we're actually bringing into the formula the people who set the price of the drug. And I just think that opens up a potential for a long term discussion of that we kind of went down this path with the PBMs. We bring them in as the fixer of this problem and now they're part of the problem in a way. So, I just want to say cautionary that while I agree with conceptually in a way what we want to do is help people, I think it's a little bit concerning to me that we're now bringing in an entity that I have some concerns with being the payor or partial payor of the deductible.

Rep. Meskers stated that I want to echo those comments, and my concerns as I look at the bill, I'm glad we've addressed the issue relating to high deductible plans and the potential for the HSA impact on the IRS. I'm glad we're addressing that. I want to salute the drafters of the bill, in terms of its intent, and I have the same concerns. The intent is to provide access to people to high cost drugs and provide them with a coupon that gets them there. In terms of their deductibles it provides the savings directly. But both drugs are part of the formulary and there's a perverse incentive on the coupon to pick the more expensive drug over the generic. And

eventually, when the coupon disappears, it's going to end up in the baseline cost of our healthcare, and we're going to socialize the cost because the consumers are going to demand that it be included and push for a different formula on the deductible. So, I have the same concern that we're allowing the pharmaceutical companies to dictate the coupon policies that the consumer's going to receive in their mailbox and apply directly for their benefit. And we may be distorting a process and ultimately increasing our overall healthcare cost. But I'm not in opposition to the bill as it stands, I'll probably vote in support. But I think there may be a question of review as we move forward and to get testimony from the insurance companies about you know what's the percentage of uptake of non-generic drugs by couponing. And I think the suggestion of a twelve month cycle along with the formulary that the drug has covered raises the cost of the coupon to the pharmaceutical company, and maybe we can see some accuracy versus a bait and switch or pushing to force the insurance companies to cover it at a better rate, a very expensive drug.

Sen. Beverly Gossage (KS) stated that both comments that were just made were part of my comments, so I will just finish by saying I've been a health insurance agent for 19 years, my company is HSA Benefits Consulting as I helped pioneer HSAs, so I appreciate the addition and the amendment to clarify for HSA's.

Rep. Nuccio stated I too appreciate the amendments but do find value in the one that was left out regarding providing it for the full year. I think what we're going to see here is there is definitely a drive to go to these higher cost prescriptions. And then as Rep. Meskers said, people come to say, this is the prescription that works best for me, when I guess we need to determine our intent. Is our intent to handle the financial aspect of this or is the intent to drive down the cost of healthcare? Because, if we're driving down the cost of healthcare then we should be driving people towards the equivalent generics that cost significantly less and you don't need a coupon for.

The other part of this too is where my weariness comes in with the accumulator bills here is that we are kind of going around the bush on insurance in general. An insurance policy is provided by an employer to an employee, it's a contract to provide services. And part of that with a high deductible health plan is that the cost of the care is going to be split between the employer and the employee. A high deductible health plan is a cheaper premium plan than a lower deductible health plan because the assumption is that the employee's going to assume that risk. When we inflate what people are paying and apply coupons when they're not actually paying out of pocket, you are fulfilling that copay requirement quicker which means the employer has to start paying a higher portion of the expenses quicker, which means you're just inflating the cost of healthcare. Because as the employer pays out quicker their cost is going to increase and then the premium is going to go up. So, the snake is continuously eating its tail here. Either we're going to push people toward generics and lower cost of a product or we're going to continue to drive with PhRMA having high cost drugs and us finding ways to supplement it, which is then just going to increase the cost of healthcare. So, I guess my frustration is we're looking at legislation to help the consumer without addressing the underlying issue. So, I'm not quite sure where I stand on it just from an overall perspective but we definitely need the language in here for the HSAs because we're seeing across the board if you're going to pass this you need to account for the IRS regulations.

Sen. Hackett stated that the only thing I can say is, the proponents always say it won't drive up the cost of healthcare, that's what they've said for everything that's been involved in healthcare for the last 40 years. And everything drives up the cost of healthcare. But I just want to thank Asw. Hunter as the amendment really helps the patients and it expands more to make more

people eligible for the rebates. But I agree that we have to be really careful that we're not driving up the cost of healthcare.

Rep. Ferguson stated that I think the whole generic argument is a little moot because by the time a patient is offered a coupon the doctor has already decided what to prescribe, whether to prescribe a biologic or some drug instead of a generic. So, that's a little bit of a moot issue. But I do have a question for Mr. Schultz - you said you had some concerns about one of the amendments and reacting to the plans so can you sort of expand on that and explain to us your concerns with that amendment.

Mr. Schultz stated that I think that the biggest element of it has been that this is an amendment that really hasn't been in place in any state. Like I said, there's been thirty states that have introduced this language and none of them have added that language, even into a bill that didn't get passed. So, there hasn't been that opportunity for the insurers and patient groups to sit down in a state and kind of say, "Hey, what's going on right now?" And to talk about the elements of what happens when a patient does get on this assistance program, what information is disclosed to them, and sent to them by the manufacturer or the third-party. I think that's the biggest concern that I would have as far as I think the other amendments are ones that we've have seen in other states, whereas this one it may take a little bit more time and it may be worthwhile to have a little bit more discussion especially as we may see it in states moving forward so we have that opportunity to have those stakeholder meetings around that type of language. And I appreciate your comments around the generic equivalent. These types of assistance programs only come into play once the patient has been approved for the medication and the new language kind of solves the generic equivalent language because it really requires the patient having gone through any generic equivalent, being approved by the health plan to get on that higher cost maybe biologic before any cost sharing or assistance programs comes into play. So, I think that hopefully we'll ease some concerns of some folks.

Sen. Rapert stated that I appreciate all the comments and I will say that at this point it's interesting to me that we get to a point where all of the people that have been involved in the amendment process have stated their amendments. That doesn't mean we still can't have questions, and that's important to remember that. That's a part of the process. I do want to restate a couple of very important things about this issue. Number one, even in the minutes from the last meeting, this model deals with seeking to prohibit accumulator adjustment programs which prevent copayment assistance that help patients for high cost prescription drugs from counting towards their annual deductibles and maximum out of pocket costs. And as you all know, one of the great things about this organization is that we come from many different angles. I'm very well known for my conservatism. But it's a compassionate conservatism. And we've worked very, very hard here to make sure that we remember that we aren't just moving around bullet points and bits and pieces for the sake of argument. These are real people. And when I sit down, it's not often that I've been able to sit down and have the American Medical Association, The American Cancer Society Action Network, The AIDS Institute, The National Hemophilia Foundation, The Cancer Support Community, the American Kidney Fund and so many others that have said, we need this legislation. And we heard that in Arkansas and some of you have done it in your other states. And what I would remind everybody on this, is that the people that were at the table that said that they had issues have now said that they have agreed. So, I would ask the body and the committee to move forward.

And the last comment is that you never know what a day would bring. I didn't know that just before this meeting that I would get a phone call from my wife, that my oldest daughter was headed to an emergency room back home. I've called to check on her, she's stable. But they're

doing rounds of tests, they don't yet know what's wrong with her. And again, I don't want to over-dramatize it to make it an emotional vote. But I want to tell you that we've dealt with a lot of loss in this nation over the last few years. We've seen costs, we've seen stresses, but what I hope that we can remember as legislators is that yes this is policy that affects people. And when you have one of those couples at home who have a child with hemophilia that are paying tens of thousands of dollars, I am not going to withhold from them the opportunity for a coupon. Which by the way, the doctor doesn't seek someone in order to use a coupon. The doctor makes a diagnosis, prescribes what the doctor thinks is appropriate and then the coupon may or may not come into play.

So, I would ask this body today, to make a vote that helps the individual moms and dads that are out there as they take care of their families. And with that I would make a motion for adoption of all of your amendments as stated, Asw. Hunter. And then we can vote on the model itself.

Asm. Cahill seconded the Motion made by Sen. Rapert. The Committee then voted by way of a voice vote to adopt the amendments. Then, upon a Motion made by Sen. Rapert and seconded by Del. Westfall, the Committee voted by way of a voice vote to adopt the Model with the amendments.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Ferguson and seconded by Sen. Hackett, the Committee adjourned at 11:30 a.m.