NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
SAN DIEGO, CALIFORNIA
MARCH 12, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin San Diego Gaslamp Hotel on Sunday, March 12, 2023 at 9:00 a.m.

Delegate Steve Westfall of West Virginia, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. Rachel Roberts (KY)
Sen. Robert Mills (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)

Other legislators present were:

Sen. Jesse Bjorkman (AK)
Rep. Rita Mayfield (IL)
Rep. David LeBoeuf (MA)
Del. Nic Kipke (MD)
Rep. Kristian Grant (MI)
Rep. Julie Rogers (MI)
Rep. Zach Stephenson (MN)
Sen. Nellie Pou (NJ)
Rep. Mark Tedford (OK)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH) and seconded by Sen. Robert Mills (LA), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Mills and seconded by Rep. Matt Lehman (IN), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 17, 2022 meeting in New Orleans, LA, and the Committee's February 17, 2023 interim Zoom meeting.

CONTINUED DISCUSSION ON NCOIL BIOMARKER TESTING INSURANCE COVERAGE MODEL ACT

Del. Westfall stated that we will start today with the continued discussion on the NCOIL Biomarker Testing Insurance Coverage Model Act (Model), sponsored by Asw. Pam Hunter (NY), NCOIL Treasurer, and co-sponsored by Sen. Paul Utke (MN), NCOIL Secretary. You can view the model on the website and on the app and in your binders on page 302. We will not be voting on the model today as we're still in the information gathering and development phase but I think a vote is likely at the summer meeting in July. But before we go any further I'll turn this over to Asw. Hunter for a few remarks. Asw. Hunter stated that I am looking forward to continuing the discussion on this model. As many know, I do have a similar bill introduced in the New York State Legislature currently. As was noted, we are not voting on this model today and hopefully we'll be concluding in July as we've been having several discussions about this model. And thank you Sen. Utke for being a co-sponsor. I think that shows that this bill does have bi-partisans support. This model is consumer oriented and it has struck a chord as it has been enacted in Arizona, Illinois, Louisiana, Rhode Island, and introduced in California, Minnesota, New York, Ohio and Washington. I also want to mention because there may be some confusion that this model is really intended to deal only with post diagnosis to determine the most effective treatment options. So we're not just talking about just having testing at any time. I'm always open to opinions and if there are any options to make language changes please make sure you forward them to myself or send them to NCOIL staff and we'll take a look at them. We want to make sure that this is the strongest model possible that you could bring back to your states.

Adara Citron, MPH, Policy Analyst at the California Health Benefits Review Program (CHBRP) thanked the Committee for the opportunity to speak and stated that last year we analyzed California Senate Bill 912, which is similar to the model, at the request of the California legislature and today I'll just give a quick overview of who CHBRP is, a little bit about the bill we analyzed, key deliverables and findings, what happened to the legislation and then a couple of thoughts wrapping it up. CHBRP is an independent analytic resource at the University of California. We provide multidisciplinary evidence-based and nonpartisan analysis at the request of the California legislature. We do not make recommendations about legislation or the language and we conduct our analyzes within 60 days, usually before the policy committees hear the legislation. Our charge really is to provide a holistic view of potential impacts of legislation. We start with a policy context and also a lay person's interpretation of the bill language. We provide background on the impacted test treatments or services, and a review of the medical effectiveness based on peer-reviewed and published literature. So this is, does the test treatment or service work? We look at benefit coverage, both baseline benefit coverage and how the legislation would result in changing benefit coverage, and then any potential cost impacts so increases in utilization, changes in premiums, and potential cost savings. And then we wrap it up with an overview of public health impacts for the California population for whom this bill would impact. So SB912 was introduced in early 2022 and really it would have required coverage of biomarker testing for the purposes of diagnosis, treatment and appropriate management or ongoing management of an enrollee's disease or condition. The key thing here is that it only would have required coverage for biomarker testing as supported by medical and scientific evidence and the bill language includes several definitions of what medical and scientific evidence is. It includes label indications from the U.S. Food and Drug Administration (FDA) or an indicated test for an FDA approved medication, a national coverage determination from Medicare as well as nationally recognized clinical practice guidelines and consensus statements.

The definition also includes definitions of biomarker and biomarker testing and the definition of biomarker is really similar to the FDA's definition. The definitions encompass a vast array of biomarkers and biomarker tests and these definitions really encompass traditional biomarker tests such as white blood cell counts and ranging to biomarkers for genetic variations and could

potentially use whole genome sequencing. So traditionally with CHBRP's analytic approach and so as I mentioned before we're looking at medical effectiveness, benefit coverage and changes in utilization. And when we started to look into biomarker testing we identified more than 500 biomarker tests that would likely fall under the purview of SB912. We excluded some of the more traditional biomarker tests like white blood cell count so this is really more advanced biomarker testing and within our 60 day timeline it just wasn't feasible to provide analysis on 500 different biomarker tests. So we adopted a modified approach and we examined biomarker testing generally. So I want to acknowledge that there could be gaps in our analysis but because the world of biomarker testing is so broad we really weren't able to drill down more specifically. So to review the clinical practice guidelines that are out there, there are so many clinical practice guidelines that would be included in the definition of SB912 and without doing a side-by-side comparison of every single clinical practice guideline it's really hard to tell are all of these guidelines in agreement? Do they conflict with each other? There are a wide array of diseases and conditions for which biomarker testing is appropriate and also, biomarker tests can be used for multiple purposes. So for example the brackaging for breast and ovarian cancer it's commonly performed for screening purposes, it can also be performed when someone is diagnosed to help guide treatment decisions.

So, as I said before we looked at benefit coverage really broadly and generally what we heard from health insurance carriers in California is that if biomarker testing is supported by medical and scientific evidence, they cover it. Now that's not to say there aren't other barriers to coverage. So prior authorization requirements may be in place for some biomarker tests. Carriers can also vary in which clinical practice guidelines they use. Some develop internal guidelines, some purchase external guidelines and some rely heavily on externally published guidelines. So SB912 could result in some change to benefit coverage but likely it's at the margins and doesn't represent a substantial change in benefit coverage. When we looked at the utilization of biomarker tests among the 24.5 million Californians whose insurance would be subject to SB912, more than 300,000 Californians had received biomarker testing and the cost of the biomarker test really ranges and there's some differences between the cost for commercial enrollees and those enrolled in the Medicaid program. So, one case study we did looked into medications with biomarker indications and the theory is if you use biomarker tests you can impact healthcare utilization and expenditures. So there has been literature that's found biomarker testing can be cost effective if you identify the best treatment from the onset. You could avoid putting someone through unnecessary treatments or less effective treatments. So there are some medications that require or indicate that biomarker testing should be performed prior to use but then there are other medications that say this medication is associated with these biomarker tests but testing is not routinely performed for those medications. So the number of users who use the medications far exceeds the number of users who receive biomarker testing who are using these medications. So there's clearly a mismatch somewhere. And also just a note about the medications, the cost of the medications really vary depending on whether it's covered under the medical benefit or the pharmacy benefit and this really has to do with the type of medication, the frequency and whether the medication is clinician or self-administered.

And so the cost of these medications range substantially between about $4,000 annually to almost $150,000 annually. So the biomarker testing landscape is really changing rapidly. New biomarkers are being identified, tested and approved for clinical use every year. New medications or therapies with biomarker indications are also being identified and released under FDA approval. And then the reasons for biomarker testing, it really does vary depending on screening purposes and what treatments are available. And also enrollee characteristics, there is literature out there that indicates that there are disparities in biomarker testing by race and ethnicity, age and socioeconomic status and one of the big things that I want to highlight is that

there are some substantial clinical barriers to whether patients receive biomarker testing and some of these barriers include clinician familiarity with guidelines and knowledge of best practices and their expertise in genomic testing and then access to multidisciplinary teams. So SB912 was vetoed by Governor Newsom at the end of 2022 and his veto note was that the guidelines may conflict with each other and conflict with existing guidelines put out by the federal Medicaid program. A new bill was just introduced in 2023 in California, SB496. The bill language was very similar to SB912 and this bill will likely be heard by the Senate Committee on Health in April of this year. So just a couple of final thoughts, evidence-based analysis of really broad legislation like this is challenging within a short period of time. We were able to provide some helpful information to the legislature and it did help craft the conversations in California. The reference in the legislation to multiple forms of clinical guidelines can result in conflicting requirements and broad guideline requirements like this are also a challenge for regulators to implement and confirm compliance with the legislation. And then something you all know I'm sure is that some Californians have insurance not subject to state regulation so even if this bill were to pass there's still a subset of Californians for whom these requirements would not apply. Thank you very much - my contact information is on the slides and the analysis we did on behalf of the California legislature is available on our website as well.

Scott Lippman, M.D., Distinguished Professor of Medicine and Associate Vice Chancellor for Cancer Research at UC San Diego thanked the Committee for the opportunity to speak and stated that I will focus the talk on oncology specifically because that's what I do and know best but certainly as you know the same issues of biomarker testing exist in other diseases, rare genetic diseases and certainly other diseases that the biology detected by the biomarker of the disease can be targeted by drugs and the goal in cancers is to make precision medicine relevant for every cancer patient. Dr. Lippman then stated his potential conflicts of interest including being a co-founder of i09 and being on the scientific advisory board of Biological Dynamics but noted that he will not discuss any off label uses. So precision cancer medicine has a profound impact on patient survival. There are two components to precision medicine - genomic testing, biomarker testing, and then matching drugs targeting the actual genomic alterations that the biomarker testing can detect. And I'll show you some recent data but the field's very aware of this so called gap in genomic testing. Genomic testing in cancer is the single most important factor in treating cancer patients and when I mentioned recently there was actually a perspective in the New England Journal of Medicine about three or four months ago that actually was titled "Closing the Gap in Genomic Testing." It was the first time we understood the magnitude of the problem. We always knew that biomarker testing and uptake wasn't perfect but this was a very sobering study of 38,000 patients in the U.S. And I'll show you the data as it's really stunning in terms of genomic testing where the gap was much larger in various underserved communities.

So this shows you the impact on survival I mentioned and this is a fairly recent paper from the University of Colorado Cancer Center, one of the top centers for lung cancer in the world. And they show the results for lung cancer which is the number one cause of cancer mortality worldwide and in the U.S. there are about 2.2 million cases a year. And just to orient you to this is the way we plot outcome often in cancer with the overall survival on the vertical axis the percentage and the time the patients are alive on the X axis. So if you look at the top white curve this is the outcome of again this is real patient data in large numbers that had genomic testing and matching drugs. And the red is patients that do not have genomic testing and therefore no matching during the same time and you can look at this several ways but it's really dramatic patients that get genomic testing and match drugs, 60% of the patients were alive at five years compared to 2% in unmatched patients. The median survival is nine months in unmatched patients and almost seven years in match patients so this shows that dramatic effect. Lung cancer happens to be the poster child for precision therapy and cancer and 40% to 60% of

patients have actionable targets and FDA approved drugs. So this is the data from that large New England Journal report that I mentioned and the data is that only 22% of cancer patients in the U.S. ever receive FDA approved companion diagnostics. So we're talking about recommendations in the package insert for the drug. It really allows the drug to be given and yet it's 20%, one of five patients in the U.S. I can tell you these figures are much worse in some other countries and certain underserved populations in this country. Biomarker legislation will go a long way to changing this. And then I'll just finish with sort of the polar opposite. The lung cancer and that's head and neck cancer this is what I do and this is what we're faced with in the clinic. I'm a medical oncologist and see head, neck and lung cancer patients. So, as opposed to lung cancer, head and neck cancer there are no biomarkers to test for. There are no companion diagnostics. There are no actionable targets in this disease. And the treatment for patients with your current disease is that virtually 100% of patients will be offered immunotherapy, immune checkpoint therapy, which has really revolutionized the treatment of solid tumors the past five years or so.

But as you see here in the same way we got the survival on the vertical axis and months on the horizontal axis, the top curve are the patients that were treated with immunotherapy and the bottom were not treated with chemotherapy and you can see this long-term survival in about 10% to 15% of patients. So you're talking about treating 100% of patients, 15% of whom will have the durable benefit. And so this is the opposite. So what we really need here mostly is markers that help narrow down who to treat so called resistance biomarkers as opposed to the lung cancer situation I just showed. When you have a situation like this we're treating 100 patients and 15 benefit, the consequence is profound. There's loss of time in many cases. The median survival may be three to six months. There's increasing costs and unnecessary toxicities which can be quite severe and so there's really a need to develop that and there's recent work in biomarker testing head and neck that illustrate the importance of resistance markers, who not to give a certain therapy and give an alternative therapy. And this is the challenge in the cancer happens to be in human papillomavirus negative head, neck cancer which is the most frequent. Head, neck cancer worldwide there are about 900,000 cases and 300,000 deaths a year. So I mentioned on the left you can see that the cure rates are about 15%. So on the left identifying the 85% primary immunotherapy resistance, primary meaning before you treat the patient you know ahead of time by these biomarker testing has huge financial and quality of life and toxicity implications. The classic biomarkers on the bottom left that work for some other diseases do not work and are not FDA approved companion diagnostics for head neck cancer.

So in the last slide or two I put up to make a couple points that biomarker testing, again this is that head and neck cancer the one where you know we have no biomarkers and everyone's treated. Looking for biomarkers and feeling confident and valid is if it relates to the biology of the disease and in the bottom middle where it says immune hot and cold, you may have heard of these terms these are very commonly used in immunotherapy of all diseases. Immune hot on the left means those little dots get into the tumor. You can see those dots get into the tumor. But on the right with immune cold this is what it looks like under a microscope. The tumor is invisible to your immune cells so your cytotoxic cells that attack and kill tumors cannot see immune cold tumors. And there's a lot of ways that happens one of which involves a chromosomal alteration loss of a region of the short arm of chromosome 9 so called 9P. And I won't go into detail here other than to make the point that when you look for new biomarkers, there's a very active field you want to be sure it ties to the mechanism of immunotherapy efficacy as immunotherapy virtually never works in tumors that are immune cold. And then in the last slide you can just see on the right and pick the bad color with the red curves but the capital mark curves on the right are just meant to show that the idea that when we talk about biomarker testing in precision therapy we're talking about biomarkers that predict the benefit or resistance

of a certain class of drugs. Not all drugs, not all situations, it's very specific to that drug. And that's the difference actually between prognostic and predicted biomarkers. So predicted biomarkers are like this and you can you see in the right that patients that are treated with immunotherapy do very poorly in red if they have this deletion of a region of chromosome 9. Whereas on the left when the patients with the same disease are treated with chemotherapy, not with immunotherapy the curves overlap. So this is a classic example of a predictive biomarker.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that we heard at the very beginning from Asw. Hunter that this is not intended to be a predictor but more of a post for treatment but yet multiple times you talked about predictive. What's the reason for not moving this towards predictive? Dr. Lippman stated that in cancer this bill is virtually entirely focused on predicted markers and what that means is patients who have a tumor and they get a biopsy at diagnosis, before treatment have these biomarker tests on that tissue and in some cases blood. So it's before treatment so they can predict outcome. Now there's roles that biomarkers have on treatment to monitor the effects and so on but the main usage is in precision medicine and the definition of precision medicine really is predicted biomarkers - a biomarker test that will tell you likely whether a patient will likely respond or be resistant to a certain therapy or classic therapies before you treat them.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, stated that I just heard from patients that sometimes if they begin on the wrong therapy and didn't have biomarker testing, that it's very difficult to get a second line of therapy approved. Is that true with most insurance or is that just coincidentally people I've talked to? Dr. Lippman stated that I don't know whether insurance approves that but I can tell you that if you don't do biomarker testing in the first line and up front before they treat it and try to make it up later, patients do not do as well and there's actually a lot of work Guardant Health did with patient advocacy groups to start a campaign in 2020 called "stop, test, and wait" to have anyone with cancer wait and get the biomarker testing first because if you wait until you start something else and then try to test markers patients don't do as well. Rep. Ferguson stated that I guess are we gradually phasing out chemotherapy - is the standard of care becoming immunotherapy for most cancers? Dr. Lippman stated that I don't know for sure but I strongly believe that chemotherapy will continue to be a backbone of therapy going forward and that immunotherapy and target therapies will add to that but immunotherapy is extremely complicated and we don't really understand the kind of effects. We've done trials where adding chemotherapy to immunotherapy is worse than immunotherapy alone and then we've seen where it's better. So I think it will have a key role as well but I think chemotherapy is going to also have a role. And just to mention, we use chemotherapy broadly but certain drugs like platinum salts which have been used for 50 years as a backbone, we now have new genomic tests for ovarian and breast cancer that actually help you personalize platinum therapy. So it's one of my concerns that we sort of lump everything to chemotherapy but there are clearly different types and some of our so-called chemotherapy can actually be targeted to certain genomic events and BRCA one, two is an example. And for homologous recombination deficiency, Myriad has a test. So I think even although platinum has been around we've only realized recently in the past few years that actually there are predictive genomic markers, biomarkers that help us decide whether to give platinum but again that doesn't apply to other types of chemotherapy.

Sen. Robert Mills (LA) stated that it sounds as though biomarker testing should be done immediately after a diagnosis. How available is biomarker testing around the country? I come from Louisiana so sometimes we're the last to know and the last to have. Dr. Lippman stated that you bring up a very key issue. We're focused on reimbursement because we believe that is an important factor on whether biomarker testing is done but there are other issues. This field,

as was mentioned, is moving so quickly so there's really an issue of education for patients, families and doctors in the community and also being more efficient with the way we do biomarker testing. In some cases for instance the actual testing of a biomarker can take a number of weeks and certain patients you can't wait that long. A classic example is a study in pancreatic cancer which is sort of again the prototype of the most refractory aggressive human cancer that actually used this genomic marker with platinum combination and it was very effective. But they concluded, this is Sloan Kettering, that it wasn't feasible or ethical clinically because it took three to six weeks to get the test and the survival in pancreatic cancer happens to be three to six months. So you bring up the fact that there are a number of issues that account for these very low uptakes but you try to take one at a time and there are educational programs and different things but we do think that the cost certainly has an effect on whether the test is ordered.

Rep. Julie Rogers (MI) stated that the analogy I would use is using a sledgehammer instead of a screwdriver to fix a problem. Customized medicine is the way of the future and I appreciate the presentation. My question is for the legislation - can you talk a little bit more about the conflict that arose with Medicaid and do you think it might be beneficial in other states looking to adopt this to possibly have two bills and have one Medicaid specific and one that's for commercial insurance? Ms. Citron stated that is a good question and one of the challenges with Medicaid is it really is a state and federal partnership and the Centers for Medicare & Medicaid Services (CMS) doesn't usually make coverage determinations at the federal level other than broad sweeping brushes. You could break it up but I don't know that it would improve the legislation because you still have the conflict of clinical practice guidelines even within the commercial sphere. As we heard there's really good evidence in cancer but if you move outside of cancer there are less well known sources at the national level. The National Comprehensive Cancer Network (NCCN) is really well known and really well respected but are there other associations that have a really comprehensive set of clinical practice guidelines for biomarker testing - no. That’s one of the biggest issues. Dr. Lippman stated that I don't know if doing two bills would have increased the chance of SB912 passing. I was actually asked to testify in the California Senate onSB912 and it was approved unanimously and also through the Assembly I believe so we were very surprised when it was vetoed and I got a ton of calls and emails asking what happened and I had no idea. I can tell you what I heard but it was certainly really surprising to hear that. I don't think it'll solve all the problems as was just mentioned but I do think that it’ll make an impact.

Asw. Hunter stated that I appreciate everyone's comments and I think Dr. Lippman’s slide was very poignant regarding the folks who did not get this biomarker testing. I do hope that when we get to July that we get some more information from anyone out there who has questions or concerns. But I do think that as we are having conversations about preventative medicine that there's a lot of research and development going on. This is what is going to be helping us in the healthcare industry going forward and we need to make sure as we're bringing these bills in all of the states that all of our constituents have equal access. And I hear Sen. Mills talking about how it shouldn't be only the wealthy, it shouldn't be only a very small percentage and hopefully by introducing and enacting bills like this it will be broader so that more people who are affected by cancer and any other diagnosed issues will be able to get the expansive comprehensive healthcare that they deserve. Thank you and I look forward to this being voted on in our July meeting.

Del. Westfall thanked everyone and stated that as Asw. Hunter noted this will probably be voted on in July so if anybody has any more information on the topic, bring it to Asw. Hunter, myself, or NCOIL staff.

INTRODUCTION AND DISCUSSION ON NCOIL MEDICAL LOSS RATIOS (MLR) FOR DENTAL HEALTH CARE SERVICES PLANS MODEL ACT

Del. Westfall stated that next on the agenda is the introduction and discussion of the NCOIL Medical Loss Ratio (MLR) for Dental Healthcare Services Plans Model Act (Model) which I am sponsoring. You can view the model on the website or on the binder on page 305. As you may know I am sponsoring a near identical piece of legislation in my home state of West Virginia. I've decided to hold that bill to see what NCOIL comes up with. I'm a pretty strong believer in what NCOIL comes up with is a pretty good idea. So, I'm still committed to the issue and I'm looking forward to working with everybody on the model. Similar to Asw. Hunter, I'm certainly open to any remarks and comments about the model. In fact, the bill in West Virginia looks a lot different than when it was first introduced. There will not be a vote on the model today. We'll hear from our list of speakers and determine the best procedure to move forward with on the model.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA) thanked the Committee for the opportunity to speak and stated that I'm joined here today by Dr. Robert Hanlon who will give the patient provider perspective on this issue. We have another doctor here who is a an oral maxillofacial surgeon and he sees both the major med plans that have an MLR and dental plans. I could speak about that maybe after in the lobby. The model's purpose is to ensure commercial dental coverage offers good value to dental patients. An MLR is the percentage of insurance premiums that is spent on actual patient care rather than on overhead costs like executive salaries and administration. The model does three things. First it adds transparency to dental insurance by requiring carriers to report their MLR annually to the state insurance commissioner. Second, it sets a minimum standard for dental insurance MLR at 85%. In other words, dental insurance carriers would have to spend at least 85 cents of every dollar they collect in premium on patient care. And finally if a carrier does not meet the 85% threshold they will be required to refund the difference to covered patients and groups. This is a policy that has been successfully implemented on medical insurance and many dental insurers already report maintaining an MLR at or above the standard. Dentists and patients agree that this standard is important for dental insurance. So if you haven't heard, late last November there was a ballot initiative on this very issue in Massachusetts and it was approved by voters by an overwhelming 72%. And so just to show you once voters were educated on this issue they came that way in a big way and we'll go into that a little bit more later. I expect you to hear from dental insurers that they cannot possibly meet a minimum dental MLR, that it will drive them out of business or out of states that pass this law.

My contention would be that there's nothing further from the truth. First, this policy has been in place for 10 years for major medical insurance and insurers continue to be profitable as we well know. Second, many dental insurers already meet the MLR standards being included in these laws. This policy is something to nudge them in the right direction. You will also hear from the dental insurers that this policy will force them to raise premiums. This model does not require insurers to raise premiums and insurers have other options to choose from including making operations more efficient rather than ask patients for more money. Now you may have heard one of the panelists today speak yesterday about changing more to electronic communication to patients. That's one way to save money. MLR would encourage the plans to engage in that kind of activity. Because most consumers do not have the freedom to switch carriers, this is not an issue that can simply be left to the free market without additional protections for consumers. Most people get their dental insurance through their employers. The only way to protect patients is to ensure that all dental insurance is good value. And finally I want to be very clear that MLR is not a partisan issue. The ballot initiative in Massachusetts had a win margin of eight points higher than the Democrat candidate for Governor. At least 10 states to date in this session have

seen bill's filed with Republicans and Democrats, red or blue states if you will: Arizona, New Hampshire, Oklahoma, and Connecticut have all seen bills filed on this. During COVID, dental insurers continued to collect premium without having to pay out for patient care. Major medical plans around the country had to provide rebates for customers. This was not so for dental plans. Having an MLR statute in place would ensure patients with dental plans have true assurance that they are receiving value for their dollars. So let me give you an example of how MLR can have a positive effect on the access to care side. According to the National Association of Dental Plans (NADP) own data, roughly 50% of dental plan subscribers don't go to the dentist for routine care in a calendar year. Establishment of an MLR will incentivize the plans to encourage their subscribers to get the care they need. More subscribers going to the dentist means the plans are better able to meet, this MLR percentage. And what's the result? Patients end up with better oral health. That's just one outcome.

Dr. Hanlon, member of the Board of Directors of the California Dental Association (CDA), thanked the Committee for the opportunity to speak and stated that I'm a practicing endodontist and I've been providing dental care in Escondido, California for the past 25 years. Prior to that I was a general dentist in the U.S. Navy for 10 years and I've seen first hand for years the negative effects on my patients that a lack of value in dental insurance can have. California has been at the forefront of the MLR discussion for a decade trying to increase the value that dental plans provide to the enrollees and ensure that patients can get the care that they need. In 2014, California passed the first national dental MLR reporting requirement and we have nine years of data on these dental MLRs. There is a wide variation in the MLRs, for some over 85% to many under 50% and some shockingly low with MLR percentages in the teens or twenties. What that means is that for every dollar a patient spends on their premiums 75 cents or more goes to plan profits or overhead and in some cases less than 20 cents of that dollar goes toward patient care. This wide range in dental MLRs raises an important question about what value dental plans are providing to patients especially when you consider that compared to medical insurance dental plans essentially operate in a wild west environment and have much less oversight or regulation than what has been applied to full service health plans. Dental plans have no standardized benefit, no caps on patient out-of-pocket costs and lack many of the patient protections that exist with medical insurance.

Dental plans cap out a patient's maximum benefit of typically $1,500 to $2,000 annually as a total amount a plan will pay toward a consumer's dental needs in a calendar year. Although premiums have gone up the average annual dental maximum has not significantly increased since the 1970s. When adjusted for inflation a $2,000 annual maximum benefit in 1970 would be equivalent to $15,745 in 2023 dollars. There's a reason people think dental care is expensive and it's based on how little dental insurance actually covers for most patients. Because I provide a major restorative service many of my patients are shocked when they realize how little their dental plan will pay towards towards the treatments or that their actual annual maximum comes nowhere near close to covering the cost of their total care. When patients need it the most, dental insurance still leaves them on the hook for the majority of the cost. One of the big lessons for me during and after the pandemic is the number of patients I saw who deferred or delayed dental treatment. Small to moderate lesions that could have been successfully treated with simple restorations were now enlarged to a point where patients needed a root canal and a crown. Many patients could not absorb these out-of-pocket costs and decided to have the tooth extracted. That's no way to improve their oral health and no way to improve their overall health. I want to thank you for the opportunity to come speak with you about the frustrations that both providers and patients are seeing with dental insurance. I urge your consideration of this model as an MLR requirement for dental plans is a key element of a comprehensive reform strategy needed to make dental insurance a really meaningful benefit.

Jeff Album, VP of Public & Gov't Affairs at Delta Dental of California, thanked the Committee for the opportunity to speak and to explain why my good friend Mr. Olson, as good a person as he is, is just wrong on this issue. I want to begin by thanking Del. Westfall for delaying the legislation in West Virginia so that this conversation could happen and ensure what we go forward with is a very informed and educated understanding of what a loss ratio is or isn't specifically for dental. Because dental is not medical. It is different in every way and we're going to do a little seventh grade fractional math to begin to understand why a loss ratio for a low premium product does not provide the assurance particularly of value that it might for medical at almost 20 times the cost of dental. And the next 10 minutes of my presentation can be summarized this way - I'm holding here a tape measure and a bottle and this tape measure absolutely will define how tall this bottle is. It will tell you how wide it is. It's a very trusty worthwhile metric to measure width and length. What this tape measure does not do, is it does not tell you what's in this bottle. This could be wine, this could be water, this could be booze, it could be anything. It doesn't tell you what the quality of the water is in here. There's nothing about the tape measure that gives you the particular measurements of the purity of the water. And I say all of this because what this tape measure is to this bottle of water is what a dental loss ratio is to a dental plan and I'm going to explain myself and why that is. It certainly does not measure value as my colleague Mr. Olson opened his conversation with. So let's begin with where MLRs came from. They've not been around for very long. They were introduced as part of the Affordable Care Act (ACA) in 2010. They never existed previously and MLRs were a very small element of a very large and radical restructuring of the entire healthcare marketplace and the way health benefits are provided. The ACA overhauled the entire thing. It took millions and millions of taxpayer dollars and gave them to low-income Americans so that they could afford to buy a health product from a health plan. It completely structured and standardized the benefits that health plans offered going forward from 2010.

So apples to apples, every plan is offering either a gold, platinum, silver, bronze product in all of these new public health exchanges. One in every state. Some are administered by the federal government, others by the state itself. But these new places, taxpayer dollars in the millions, were created and millions of Americans who were previously uninsured were now insured thanks to those changes. And what the MLR did was it was a way of providing some accountability for health plans who are all offering the same product across the board to ensure that when you compare their price and you look at their administration it's patients who are getting the majority of those dollars in terms of care, etc. None of this happened for dental as it's not an essential health benefit (EHB). There's no such thing as essential dental benefits except for children under the ACA. So this really is a solution in search of a problem. Dental carriers are not making excessive profits. I know what my plan makes and I've taught and I know what my colleagues make and if you even just go to Google and ask what is the net average net profit for a dental insurer, it's somewhere between 2.5 and 3 cents for every premium dollar that's charged. I don't know a lot of businesses that can exist or do exist for 2.5 to 3 cents but the very low net profit is predicated on high volume and take up of dental in the dental benefits marketplace. Now we don't have any problem with take up from large companies and when you look at these loss ratio numbers I'm going to show you what you'll see is that the many dental plans offered to large employers come in at 85%, 88%, even 90%. Sure no problem, as others have referred to other dental plans here.

But the people who don't have dental, there's 50 million Americans without dental insurance today. There's another 20 or so million who I would say marginally have dental insurance and I say marginally not because their plan is bad but because it depends on them spending their own money without the benefit of a group benefit manager, without the benefit of a company sponsoring those benefits. They're paying their own money. And whether they're going to

continue to buy that dental plan year after year depends entirely on its cost. And it's the cost of dental benefits that I am worried about if this approach goes forward and I'll explain why. So first of all let's look at the radical difference between medical and dental plans. And this has to do with the denominator that's going to be in that loss ratio. A medical plan at $600 a month per person, some of them are more, has about $120 to spend on both profit and administration because it's premium, its denominator is $600. The average dental plan can run anywhere between $15 and $50 per person per month and let's just take $25 as being a medium average premium for dental plans and you see at 85%, you only have $5 a month and if you had lowered it to 70% because I've heard people say well let's just lower the number would you accept it then? Well you can go all the way down to that and you've only left the dental plan $7.50 a month to administer the plan. And remember the profit's only 2%. So we can give up profit not that that would be very smart and still not come anywhere near as close to having the amount of dollars that are necessary to sell and to administer a dental plan. Now in California where this idea of setting an MLR for dental plans was discussed ad nauseam about five years ago, we agreed to do transparency and by the way we still favor transparency on this issue. We agreed to transparency and to report our numbers by market segment because a loss ratio for a large preferred provider organization (PPO) plan is a lot different than a loss ratio for either an individual or small plan or for a dental health maintenance organization (DHMO) plan in the individual and small group market. And there's a reason for that. The loss ratio does not report the value of small premium to these people who are marginally insured or have to pay for it with their own money, and it has absolutely no measurement of what the savings are to the patient when they purchase this plan and how much money do they save on dental care and how much more often are they prompted to visit the dentist as a result of having a low premium product. You are not going to see that here. So again, these are the actual numbers. There is no reason to believe these numbers would be significantly different in any other place of the country. There are a lot of states that don't have DHMO because they're too rural in nature and there aren't enough dentists able to participate in that model. By the way another aspect of DHMO is a loss ratio doesn't capture the amount of patient care that is paid for in these services because the dentist actually performed services for which the dental plan doesn't pay but the dentist is collecting a monthly capitation amount that allows them to do better in subsequent years as the patient's health gets better. So patients are receiving a lot more than what is shown in this chart but the model simply doesn't lend itself to being reported on similar to what I've showed you about the bottle water and the tape measure.

I want to dissuade the group from this idea that administrative cost is evil in a dental plan. What do we do with what we spend on administration? We make our call centers faster. We pay our dentists faster. We offer more online services so that patients can see what their cost will be beforehand and understand their benefits. We manage the utilization of these benefits to make sure that the services that they are being offered are the services they actually need and are in accordance with professional standards. We have all these compliance issues, the same ones as the medical. This is not the wild west. Dental plans are regulated to the teeth in every state where I am and I've been here 30 years. We have to comply with almost every regulation and bill that's been passed for health plans. We are generally not exempted from most healthcare legislation and certainly we run an appeal and grievance process so a dentist has somewhere to go if he or she doesn't like the way we adjudicated the claim. We have quality management programs. We have to pay a broker or we won't sell the darn thing in the first place. And that broker commission by the way takes up a greater percentage of premium, because our premium is so low, than it does for medical plans. So medical plans did not face the same fallout of having to put broker premium in the administrative pile when they report on these lost ratios. If I were a broker I would be concerned about this issue because that's going to be one of the first things dental plans cut if they're going to have to try and get their numbers up.

I've already mentioned all state laws but I really wanted to call attention to two things here. The quality management program which ensures and protects the patient and also cuts down on fraud, waste and abuse which happens quite a bit in dentistry. I hate to say it but there is a small minority of dentists who greatly affect the overall cost and price of dentistry because they are not practicing to the standard. And secondly, the negotiated rates. The work we do to maintain networks of dentists at rates below their normal price resulting in patient savings. These all add up to greater access to care. Let's take a look, I'm going to go with a low premium product here to show you why a very good product might come in with a dental loss ratio if you looked at it by itself and not in connection with other higher price products, why it might come in at a low MLR of only 53%. So the cost of acquisition, marketing broker commission would probably would be $1.50 out of this $15 monthly premium. The profit is only 50 cents. So we're making less profit than brokers are actually making on commission on this particular product. The operations and maintaining the networks is going to cost around $5 and that leaves about $8 that will be spent on claims, which will go into the denominator. So we have a ratio here of eight to 15. Now we could go to a higher loss ratio product and take a look at it. It wouldn't be a $15 product, it'd probably be a $50 product and because the denominator is so large, the administration, the cost of operations, networks, could be twice as much in real dollars but it will be a smaller percentage as a numerator. And for that reason you have a more expensive product that spends more on administration that comes in at a higher MLR than this $15 product. Just a quick word about rebating. Because we're dealing with such a low denominator, premiums that can be $12, $15, $20 per person per month, for some plans that are marginally under the loss ratio whether it's 80% or 70%, I don't care what number you pick, we're going to end up with rebates of 32 cents or other very small numbers. And by the way the cost of an envelope, printing, paper and postage, this does not include the cost of time and paying people to calculate all this stuff and execute the rebating. But just the paper and postage is $1.27. That’s self defeating and it just drives up the cost of administration further. So the act of rebating drives your loss ratio lower again because we're dealing with premiums that are so low.

I'm not going to spend a lot of time on these two charts. I’m just going to tell you what the point is when you look these and what they show you is that a PPO plan for an individual at 58%, these are actual plans we offer in Covered California today - this product that costs $155 total for the year actually will yield this enrollee savings of $3,200 over the retail cost of care that he could choose to receive. In fact if they do nothing but see the dentist twice and get their x-rays they are going to more than double what the cost of the premium was. They get their premium back and plenty more afterwards. Here's a much higher, more expensive plan. It's a higher MLR at 65%, it's a PPO also offered to individuals and with the same services acquired this patient is only going to save $2,300, $1,000 less over the retail cost of the dentistry they received. However, it's still a good plan. If they see the doctor twice they are still going to get back their premium and then if there's anything that the dentist finds that needs to be treated that's going to be savings on top of that. In West Virginia we ran a scenario of meeting an 80% and I know the proposal is 85%, that seems so absurd, I just had to go with 80% but 80% is absurd also. In the West Virginia Public Exchange we would have to double the cost of our current basic product from $11 to $23 to meet that loss ratio and this is with zero profit. We've already eliminated the profit in order to hit this number. So the only conclusion you ought to draw from all of these examples is that dental benefits today are more affordable, offer more benefits without some of them having an annual maximum, and they're more often selected by people who would otherwise be uninsured. Under an MLR we're going to have to increase premium and increase benefits beyond what the market is willing to pay and that's going to result in fewer patients to dentists. Everyone loses: enrollees and patients. We're going to consolidate so there will be less competition. Plans that don't have large group and specialize in small group are going to go away and there will be fewer of us trying to solve the problem of people without dental insurance.

Jill Rickard, Regional VP of State Relations for the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated that ACLI is very much in agreement with Mr. Album's remarks. We would reiterate everything that he has said but there are some points that are specific to our members who are life insurers who do often offer supplemental products like dental. We have 280 life insurance member companies who offer a wide range of products that protect people through all stages of life. This includes not only life insurance and retirement products but also Paid Family and Medical Leave (PFML), long-term care (LTC), disability income insurance, as well as supplemental insurance products like dental benefits and vision care. Our members typically include dental benefits as a small but vitally important part of the portfolio of financial products that they make available to employers and individuals. Imposing a loss ratio on dental plans as Mr. Album presented will not equate with more dental care and will decrease the availability of affordable dental coverage. Families without dental insurance are less likely to visit a dentist for regular cleanings and preventative exams which increases the chance not only for poor oral health but overall health outcomes. First, with respect to life insurance companies, there are complexities to the financial reporting, solvency requirements and administrative and delivery functions of life insurance versus their health and dental insurance counterparts. We would request that these be carefully considered in any loss ratio or financial reporting public policy discussions. Life insurance must build and maintain reserves differently from health and dental only carriers because of the different nature of their risk. As you all know, unlike health and dental claims that tend to be paid closer to the issue date of the policy, life insurance claims are usually larger and also paid many years after a policy is issued. Because of this, life insurers report their financial solvency using a formula and forms that are different from health and dental insurance. We are finding this to be a problem in Massachusetts where the ballot initiative did not recognize the differences so life insurer’s risk is being put at a disadvantage which will increase the cascade of bad outcomes. Importantly, as Mr. Album touched upon there is a huge variation in costs of administration between large groups, small group and individual plans. It is more difficult to administer a loss ratio the smaller a group gets as there obviously are fewer economies of scale and other points that go into the calculation of administration.

My second point is that life insurers rely heavily upon brokers and agents to present a package of financial production products to employers. Dental insurance is a small but important part of this package because of its high demand. Imposing a loss ratio on dental will make it difficult for life insurers and all dental insurers to compensate their brokers for their important services not only in selling the products but in educating employers and individuals about their dental coverage choices and servicing the products they choose. And there aren't insurance exchanges or navigators at least in most states to replace these vital agent and broker services and these brokers and agents are people who make their living in your communities selling insurance and they contribute to local economy so this is an important consideration. And then finally I'll reiterate that we agree with Mr. Album that there are better ways to address this issue. It is premature to oppose a loss ratio and we would respectfully suggest that a better first step toward effective policy development is to require loss ratio reporting over a period of years similar to the approach adopted recently in Maine as well as in California. Allow the regulator to review reporting and identify any outliers and then empower it to conduct remediation if necessary for those outliers. It's important to note that after reviewing the comprehensive reports of the myriad of dental benefit carriers offering plans in one of the nation's largest marketplaces over a long period of time, the California Department of Insurance determined not to recommend a dental loss ratio. Thank you and we look forward to working on alternatives in West Virginia and here at NCOIL.

Rep. Ferguson stated that in full disclosure I'm a retired dentist but to Mr. Album's point, they are very different than medical plans. Medical plans have unlimited lifetime and annual maximums. Dental plans actually cover very little in terms of services. To your point the value of a dental plan for a patient is the negotiated rate that instead of paying what I charge, you're paying a reduced allowable amount so I don't think it's unreasonable to have an MLR when a dental plan is actually not covering much dental care. I have dental insurance and it has an annual maximum of $5,000 or $6,000. Mr. Album stated that dental plans cover exactly what the people who purchase us ask us to cover. I would love nothing more than to sell you a dental plan that covers 100% of all the services that your patient needs over the course of the year and the price of that dental plan is unacceptable to corporate America. and it's not what they're willing to purchase, it's not what they are willing to do. And again it's not the dental plan that is determining this. What they are willing to do is to buy a product that makes the patient more than twice as likely to visit the dentist to receive diagnostic and preventive care at 100% of coverage and to cover most of their basic services and then to greatly cut down on the cost of those major services that they need and they might not otherwise get. Rep. Ferguson stated that some of these small plans pretty much just cover having your teeth cleaned and having X-rays and maybe simple fillings. They really don't cover any restorative services. Mr. Album stated that there are a lot of dental plans that only cover diagnostic and preventive, California doesn't allow it. Many regulators don't and that brings up an excellent point that in states all over this country we're required to file and approve the products that we're selling, what we cover and what we don't and at what price we're paying it and we're required to send all of our financial data to the regulator. In Nevada for instance we have to file and approve products and from time to time a proposed rate increase is rejected because they look at our loss ratio and they say, "no you didn't buy enough patient care last year we're not going to approve" so in effect there's actually loss ratio thresholds happening in regulatory departments all across the country today.

Mr. Olson stated that there are two things to say, one is the quirk of dental insurance and how it's constructed currently, it's a quirk of historical inertia. And as Dr. Hanlon pointed out the annual maximums have not gone up and that's kind of I think what you're getting at as well Rep. Ferguson. So in real dollar terms these plans have got increasingly less value since the 1970s. Giving less and less to patients in terms of actually paying for care and instead really just selling a network discount. I think what a dental loss ratio would do is nudge them in the right direction toward incentivizing them to pay for more patient care and rethinking their plan designs. The so-called 180/50 plan where a major service is only covered at 50% and then the patient is responsible for the rest, does not provide a lot of value to a patient that has real severe needs.

Rep. Rita Mayfield (IL) stated that she agrees with Mr. Olson and asked if anybody introduced any legislation that would require that the out-of-pocket expense be either removed or dramatically reduced. Mr. Olson stated that plan designs currently are with a lot of patient cost sharing certainly. What an MLR would do is sort of nudge in their very direction reconsideration of major services. As Mr. Album said, preventive services are usually covered 100% by these plans but then it reduces pretty significantly after that.

Rep. Lehman stated that the one big concern here is what the MLR has done to the healthcare world and to use Indiana as an example, we have I would call it a duopoly in Indiana between Anthem and United Healthcare and part of it is I can't be a million dollar company and be forced to push 85% of my revenue out the door. I can't be a billion dollar company. I have to be $180 billion. In United's case I have to be $286 billion and now 4% profit or 2% profit looks really good to my investors. I understand the MLR issue. My concern is do we only create an alternate problem which is now we push the little guys out because I can't survive with having to push money out the door. I like the idea of the disclosure so I can see as a consumer what

percentage is being used. But if we go to the 85/15 I'm afraid some of those who want to be disruptors in the marketplace won't be able to compete. Mr. Olson stated that I and the ADA would be happy to talk with the plans about solutions to that very concern and in some cases I've actually talked with Del. Westfall about them. Some of them could involve perhaps only a certain number of covered lives for the insurer in the state in the implementation of an MLR for dental plans. I think there could be a graduated approach to or maybe something akin to the ACA where there's a tier between small group and large. I think that there are several solutions that could still get to this good reform that would still apply an MLR. I will tell you that when it comes to the size of plans and profitability, transparency is excellent but we haven't seen a lot of change in California in terms of behavior of the plans since the reporting has taken place and that's why a rebate incentivizes a change of behavior which again is about nudging in the right direction.

Del. Westfall thanked everyone and stated that we will move forward on this in some fashion. Anybody that has any suggestions or information please reach out to me or NCOIL staff.

INTRODUCTION AND DISCUSSION ON NCOIL HOSPITAL PRICE TRANSPARENCY MODEL ACT

Del. Westfall stated that next on our agenda is the introduction and discussion of the NCOIL Hospital Price Transparency Model Act (Model) sponsored by Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, and co-sponsored by Rep. Rachel Roberts (KY), Vice Chair of the Committee. You can view the Model on the website and the app and in your binders on page 308. We will not be voting on the Model today. I'll turn it over to Rep. Roberts for remarks.

Rep. Roberts stated that I'm very proud to co-sponsor this model alongside Rep. Oliverson. For those of you that were at our meeting in New Orleans this past November you may have sat in on the session focused on hospital price transparency. We all price compare when we shop for things for our family and we use that information and the reviews associated to make the best decisions and that's really what we're driving at here. People want and deserve to know how much a hospital procedure is going to cost them and it shouldn't be so complex and so vague to find those answers for patients. The model you see before you represents a combination of the laws passed in Texas and Colorado and as you'll hear from our speakers today a lot of the state action in this area stems from a federal hospital price transparency regulation that hospitals unfortunately have been very slow to comply with. So states and NCOIL are stepping up to say to the hospitals that if you don't comply with the federal rule you'll also be violating state laws. That may have more teeth and more ability to help incentivize these businesses to comply and while hospital compliance has increased slightly over the past several months we still have a long way to go to get to a number that is close to full compliance.

Jonathan Wolfson, Chief Legal Officer and Policy Director at the Cicero Institute, thanked the Committee for the opportunity to speak and stated that the Cicero Institute is a state focused policy think tank. We're headquartered in Austin, Texas and our objective is to design entrepreneurial solutions to the toughest public policy problems. And we've been talking a lot at Cicero about how to take price transparency that members like Rep. Roberts and others have been talking about and really making it useful for patients. So I'm going to take kind of the next step and just talk about why price transparency really matters to our patients and the communities that we live in. And so the promise of price transparency as Rep. Roberts already mentioned is that patients will know how much care is going to cost before they show up. They'll be able to shop for the treatment they want and compare prices. And that doctors can compete on price and quality just like every other professional. Lawyers do this, dentists even are doing this. There's lots of people who do this. Lots of complicated marketplaces where these things

exist. And this has been the promise of price transparency. I've been writing about this since the early 2000s when I was in the Bush Administration. This has been a conversation people have been having for a long time but time after time after time we don't really see the outcome that patients are using these data. And so this is the promise and we all want to get there but the problem is that patients often have little incentive to use price transparency information to make health care decisions. Now sometimes there are barriers to price transparency problems. That is the information is not available. You know there are some interesting studies talking about even though there are federal rules and regulations that require hospitals to post their prices and all this information they haven't necessarily done so. There's obviously a fight over how much of that has happened but it does appear that there's a lot of data that are not available that when I was at the Trump Administration writing some of those price transparency rules the expectation was it would be currently produced.

Some of that information is hard to use. Sometimes it exists but it comes in a really complicated, really large file format. It's not easy for patients to access that information. Sometimes patients just don't know that they have the ability to ask. We haven't built this culture in our country where you can ask. You know, if you go into a law firm it's not uncommon to say how much is this going to cost me? Or if you go to the mechanic shop you're going to ask how much is it going to cost? But people have been trained over the years to walk into their doctor's office, present their insurance card, and be told we'll let you know how much this is going to cost and what you owe some time in the future. Go get your care and it's all going to work out okay. Only to have those people find out months, even years later that they've actually got really large expenses and unfortunately patients actually their actual individual out of pocket costs for a treatment can vary very little because of insurance. Now insurance is a wonderful tool and it really does help patients but it does hinder price transparency promise because if a patient knows that the difference between finding a lower cost option is going to save them $5, even though the insurance company is going to save $5,000, the patient doesn't necessarily have a big incentive to use that information. Often doctors don't have the information of how to use this price transparency information. They've got a really complicated electronic health record in front of them and they don't necessarily have the ability to say, “hey did you know that if you don't go to CVS for this drug but if you go to Walgreens you can actually save on this prescription?” A lot of that information is not yet available for doctors and ultimately insurance will punish patients who save money if they don't stay inside of networks because it doesn't get covered. And so even if you know that there is a doctor's office that'll do a knee replacement down the street for $25,000 less than the more expensive facility where you're currently sitting, if you go outside of the network your insurance company says congratulations you owe the full $10,000 for that treatment whereas if you'd gone in network to a significantly more expensive location you would be paying less out of your own pocket.

So these are all barriers that exist to price transparency promise in our market and so the Cicero Institute we think about how do we evaluate these problems and then try to build model policies and then we have an arm that has lobbyists on the ground in various states. We’ve said what could be done to try to incentivize patients and especially the highest cost patients because these are the folks who know at the very beginning of the year that they're going to exceed they're out of pocket max. I had a secretary when I was in private law practice who was on a couple of injection treatments. She knew no matter what happened, no matter what decision she made in the year that the only thing that mattered to her were two numbers. The number of her total premium for the year and her out-of-pocket max because she was going to pay the full amount of both of those things no matter what happened that year. If her kid broke her arm that's what she was going to pay. If everybody in her family was totally healthy other than the injection regimen she was on she was going to have to pay that amount and so she had no

incentive to look for lower cost options. If her kid broke her arm she can go to the most expensive place in town regardless of whether the quality was any better or whether the treatments were any better for her kid. She could go there because her total cost for the year wasn't going to change. Now sure there's a possibility that if she found lower cost options and lots of people in our network in our group made smart decisions, she might see a premium reduction over time but that was the only possibility of a savings that she could see in the future if she was making wise decisions that we would all talk about.

Now unfortunately one other piece of information we should all remember is that almost every study that's been done says that higher cost and higher spending health care does not usually correlate with better quality care. In almost every study that's been done it is either been the reverse or it has been found to have absolutely no bearing on the quality. And so if the story was our healthcare expenses are going way up but we're getting way better care then maybe none of this matters. Maybe we don't want to incentivize people to shop because maybe they'll shop for lower cost options that save them money but ultimately make them less healthy. But none of the evidence indicates that. And whether you look at the Surgery Center of Oklahoma or other organizations that have gone into business and have said we're going to be a cash option and they've provided high quality care, we see that there are opportunities for people including high cost patients to find lower cost options. So our patient's right to save proposal has three specific prongs. The first is to require cash rate disclosures for all shoppable services, so this is not going to be emergency heart attack treatments but cash rate disclosures from all providers. This would not just be as the federal rules with hospitals but this would be all providers. So if you have a doctor's office you would need to provide the cash rate disclosures for the treatments that you offer at your facility. Secondly, we say that any patient who finds a lower cost direct pay price than the lowest negotiated rate from their insurance company can go to any provider pay the cash price for that treatment whether that doctor is in or out of network and the insurance company would then be required to provide deductible credit for that treatment. And then finally, for those patients who exceed their deductible they not only get those expenses if they find that lower cost out of network option or in network option at a cash direct pay price, if they find that lower cost option they not only get it counted toward their out-of-pocket maximum but they also get a cost share savings with the insurance company. So go back to that knee replacement if somebody finds a knee replacement for $10,000 less at a direct pay price, again in or out of network, then the insurance company would get $5,000 of extra profit and the patient would get to take that extra $5,000.

So if we go back to my secretary now she would have an incentive to go and find a lower cost injection facility that's going to offer her a cash option because she pays cash she gets reimbursed by your insurance company not just for the cost she expended if it's an excess of pocket maximum but she's also going to have the opportunity to have a saving sharing with the insurance company. So what are the benefits of this policy if it were to go into effect? First of all, providers would save time and money on paperwork as we've already discussed a little bit and as we all know from talking to doctors a huge chunk of doctor’s time and resources are spent not on providing care but on having interactions with insurance companies, seeing whether things are in network, having a fight over that. All of those things move outside of the doctor's office because the patient can get pre-authorization and then you move straight ahead. You don't have to go back and forth for the doctors and the insurance companies. Second, patients are free to visit the best providers at the best price. If they have a next door neighbor who got a great treatment but that doctor happens to be outside of their network, if that doctor offers a direct pay price, they have that option. Patients have the opportunity to save money and it's not going to cost the insurance companies any extra money either. The highest cost patients will indeed as I already mentioned have the highest incentive to shop for care because they under the current

system have zero incentive to do it. If you give them some sort of cash savings option of sharing that savings with the insurance company they'll have incentive to shop. And insurers have an incentive to encourage shopping because especially for those patients at the higher echelon where there's that cost savings, if this is worded correctly, it would not and I'm going to go to the MLR because that's what we were just talking about it would not have to count against the MLR as far as administration. It could count toward care costs. And so this is a way for insurance companies to actually make additional money counted toward care but in encouraging the market to move toward a functioning marketplace just like we see in so many other areas of the market. So the bottom line is that patients right to save incentivizes patients to make price transparency work by rewarding patients who shop for lower cost high quality care will reduce healthcare spending, reduce premiums and empower the patients to build a marketplace like we all say that we really want in healthcare.

Aaron Wesolowski, VP of Policy Research, Analytics and Strategy at the American Hospital Association (AHA) thanked the Committee for the opportunity to speak and stated that today I'd like to cover a couple things. I want to just provide some background on exactly what the federal requirements are around transparency and also level set to where hospitals actually are and complying with those rules. And I think that's important in terms of entertaining state level requirements as well. First the AHA's position on transparency, our number one priority is pursuing price transparency efforts that actually help patients access clear and accurate cost estimates when they're preparing for hospital care. We also support streamlining price transparency requirements as you'll see in my slides. Even at the federal level there's a fairly complex web of federal transparency requirements so it’s important to understand that when contemplating state requirements on top of those federal requirements. We're going to continue to work with hospitals and with CMS on improving compliance and as you'll see compliance is actually come quite a long way in the two years that the requirements have been in place at the federal level. And I do want to just sort of address there has been a lot of coverage of hospital compliance and CMS has actually helped clear the record recently in terms of saying where hospitals are at in terms of compliance. Hospitals are generally much further along than some organizations have claimed. So first at the federal level, again on January 1, 2021 hospitals were required to comply with the new hospital transparency rule. The key component of that is that they're required to post machine readable files of five standard charges, gross charges, payer specific negotiated rates, de-identified minimum and maximum negotiated rates and discount of cash rates. They're also required to provide patients with either an out-of-pocket cost estimator tool or payer specific negotiated rates for at least 300 shoppable services. So obviously the rates that payers pay hospitals are highly complex as these various requirements outline there isn't typically a single standard rate for a single standard service. It can be driven by a number of factors. Some services are bundled. Some rates are affected by the overall volume of care and obviously the number of services in the acuity of care can play a role in those rates as well. So it's highly complex.

In addition to those federal requirements the federal No Surprises Act (NSA) requires hospitals and providers to share good faith estimates with uninsured self-pay patients for most scheduled services. And the NSA also includes a provision for advanced explanations of benefits that insurers will be required to provide to enrollees and implementation of that is still pending. There's additional rule making coming on that. But hospitals are going to have to provide good faith estimates to health insurers for them to operationalize that policy as well. So again this sort of highlights the fact that patients face a range of sources when pursuing pricing information. Some of this information as I noted with all the standard charges and the good faith estimate and eventually the advanced explanation of benefits have a number of different rates and they really depend on the circumstances. So consumers are potentially faced with complex and even

conflicting information. Information that doesn't necessarily apply to their specific care scenario. Again they have access to the machine readable files which by design are not consumer friendly. They will have access to either the hospital's online patient cost estimator or the list of shoppable services and again those eventual advanced explanation of benefits and good faith estimate. And that is in addition to whatever state level policies may exist that direct patients to a variety of other price estimating tools. So it's a fairly complicated matrix of pricing information so it's important to keep that in mind especially if the end goal is to actually provide patients with clear information about pricing. So in terms of implementation considerations, hospitals have been working towards providing more accurate estimates. I'll just note that that implementation date of January 1, 2021 came at the height of the pandemic in the middle of a surge so not optimal timing in terms of when to implement an entirely new administrative requirement.

So admittedly hospitals got off to a slow start. They were managing surges, managing vaccine administration in 2021. A lot was happening at that period in time and these requirements require administrative effort and cost to implement. These are fairly complex technology solutions that are pulling from a variety of different sources and putting them on the website is not as easy as flipping a switch. So important to acknowledge that and again, I noted that it's not as simple as just putting a single standalone rate. These rates are highly complex. They are subject to negotiations with health insurers and they can be applied in a number of different ways depending on the care scenario. I noted the large investments in staff time and resources and during this period the last two years CMS has been working with hospitals closely on compliance. They've done a couple of assessments which we'll talk about in a moment. They've increased their enforcement. They've increased penalties. So CMS has been pretty engaged while also acknowledging that implementation didn't happen at the most ideal time for this requirement. They have been working with hospitals and with the AHA on increasing compliance. So in terms of the actual implementation status, hospitals have come a long way. Just in the last month CMS issued the results of their second compliance assessment and what they found was that in the key categories of compliance hospitals have made really tremendous progress. On the machine readable file requirement, the first assessment they did for 2021 they found that 30% of hospitals were in compliance. In 2022 that number was 82%. The consumer friendly display website assessment criteria in 2021, 66% of hospitals were in compliance and that number is also at 82%. And across both requirements the consumer friendly and the machine readable requirements CMS found that in 2022 70% of hospitals were in compliance compared to 27%. So that demonstrates real progress over just two years of implementation so there’s no reason to suspect that won't continue into the future. CMS noted when they released those assessment requirements that they're going to continue their enforcement efforts, ramp them up as I noted they've already increased the penalties for non-compliance. They're also going to look at streamlining reporting and improving enforcement.

So again it’s important to note that CMS is in addition to hospitals working through implementation of a new requirement. So it’s important to acknowledge that especially as states are contemplating adding additional enforcement mechanisms on top of what CMS is doing. CMS has been engaging in that and ramping that up over time and it's showing real results. CMS isn't the only organization that's found increased compliance. Turquoise Health is a health tech company that's been seen as a central resource for information about transparency. They mine these transparency files and produce analysis for consumers and for employers to use that information. What they found is that compliance has increased by about 150% or so since the first year. They're seeing 63% of hospitals with posted cash prices, 65% of hospitals with negotiated rates and 76% of hospitals have posted machine readable files. They produce a transparency scorecard and determine whether individual hospitals and systems are compliant, mostly compliant, etc. What they found is that about 80% of hospitals have mostly complete or

complete information. So again the picture is tremendous improvement in terms of compliance so our recommendations to all policymakers whether at the federal or the state level is to first of all understand what requirements exist and have a focus on reviewing and streamlining those existing transparency policies so as not to increase patient confusion and also to minimize unnecessary regulatory burden on providers. We would like to see folks continue to take an eye towards taking a patient center approach. And we'd also like to see folks look at other ways of streamlining the billing and patient financial experience process in ways that look at things like prior authorization denials, delays in care and that sort of thing. So there are a lot of opportunities for streamlining here.

Rep. Roberts stated that as a provider myself, I just want to also say as people are crafting legislation in this space we absolutely need transparency. I appreciate you outlining the federal requirements that we already have but we want to also make sure that we're looking at quality. So when you for example look at a really complex thing like spine surgery you don't want to just go with the lowest price. And there's a lot of things to consider including outcomes, including safety, including infection control rates. So it's a really tricky thing when you're looking at price, what does price mean?

Sen. Mills stated that this is obviously important. We've talked about it for several years and we are making progress and as a legislator I'm trying to be patient but we're a long ways from where we need to be where a common person could actually use a tool and understand what they're potentially looking at in terms of exposure. But I guess my biggest concern is, is it realistic for us to expect that we're going to have an effect long term on pricing and in the equality of those pricings. If a procedure's the same one hospital to another but the list price is $60,000 at one and $25,000 at another, are we going to be able to with public pressure or with disclosure to bring those numbers down to ultimately affect the cost of healthcare in America or are we just dreaming? Mr. Wesolowski stated that I'll be honest I think we are skeptical as to whether or not these transparency efforts are really going to drive down cost. I think transparency can have the biggest impact in terms of arming patients with understanding what their actual out of pocket costs are going to be. Whether or not they actually drive down costs I don't think that there's a tremendous amount of research to show that's going to happen in healthcare because of how complex pricing and services are. Sen. Mills stated that I was afraid that was the answer.

Mr. Wolfson stated that I'll take a slightly contradictory view. We've seen Lasik quality go way up, prices go way down. Things that people are allowed to be part of the market instead of the insurance kind of being the main driver of the market has worked. And we've seen those costs go down and we're seeing kind of the opposite in veterinary because now people are getting veterinary insurance and the cost of veterinary's going up. I mean in some ways the MLR, I'm not taking a position on the, on the federal level for health insurance has just caused everybody to say well it's cheaper for me as the insurance company, I can make more money as an insurance company if I let the prices go up because my MLR allows me to do it. I mean there's some interesting arguments. I absolutely agree with Rep. Rogers that quality needs to be part of these conversations but if patients are given that information and they're incentivized financially to make these decisions we can bend those cost curves. Sen. Mills stated that I think we've got to stay the course and I'm certainly not giving up but it's going to be a long term process and I want CMS and I want the AHA to stay on top of this and report to us on an annual basis.

Rep. Roberts thanked everyone and stated that I'll go back to the comment about quality. So a really good example if you haven't had a chance, I'd invite you to look at the Center for Improving Value in Health Care (CIVHC) in Colorado at civhc.org. They have a really great marketplace in Colorado that lets you shop for instance a knee MRI and it will show you, I just did it while we

were sitting here, so if I live in Aspen, Colorado and I need an MRI I can go to Aspen Valley Hospital it's $2,600. If I'm willing to drive three hours to Denver, that MRI is $220. There's still going to be additional costs for the radiologist who reads it and all of those things but that's a pretty big amount of information and power for me as a consumer to have in that way. So I think this is a great conversation. We all want to make sure that our consumers, our clients, the customers have as much information as possible to make the best decisions for themselves but also to keep our overall healthcare costs down. So thank you again for keeping this conversation going. I look forward to our next conversation around this hopefully very soon.

Del. Westfall thanked everyone and stated that we will continue to discuss this model and if there are any questions on the topic or if anyone would like to provide any information please contact myself, Rep. Oliverson, Rep. Roberts, or NCOIL staff.

CONSIDERATION OF RE-ADOPTION OF NCOIL PHARMACY BENEFITS MANAGER (PBM) LICENSURE AND REGULATION MODEL ACT

Del. Westfall stated that last on our agenda is consideration of the readoption of the NCOIL PBM model act (model). A copy of the model is in your binder on page 329. Per NCOIL bylaws all models must be readopted every five years or they sunset. As a reminder, we discussed this model at this Committee's interim meeting last month for the purpose of soliciting any feedback before we voted on readoption today. We didn't hear any comments opposing readoption during the interim meeting and neither me or the NCOIL staff received any comments since then. Accordingly, I'll entertain a motion to readopt the model. Hearing no questions or comments, upon a Motion made by Rep. Lehman and seconded by Sen. Mills the Committee voted without objection by way of a voice vote to readopt the Model.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Asw. Hunter, the Committee adjourned at 10:45 a.m.