NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 20, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Thursday, July 20, 2023 at 2:00 PM.

Delegate Steve Westfall (WV), Chair of the Committee, presided.

Other members of the Committee present:

Rep. Deborah Ferguson, DDS (AR)
Asm. Tim Grayson (CA)
Rep. Dafna Michaelson Jenet (CO)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Linda Chaney (FL)
Rep. Rod Furniss (ID)
Rep. Jonathan Carroll (IL)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Sen. Julie Raque-Adams (KY)
Rep. Rachel Roberts (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Rep. Liz Reyer (MN)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Asw. Pam Hunter (NY)
Sen. Pam Helming (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Brian Lohse (IA)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Sen. Michael Fagg (KS)
Rep. David LeBoeuf (MA)
Sen. Pam Beidle (MD)
Sen. Arthur Ellis (MD)
Del. Mike Rogers (MD)
Sen. Walter Michel (MS)
Rep. Amy Walen (WA)
Del. John Paul Hott (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Rachel Roberts (KY), Vice Chair of the Committee, and seconded by Rep. Matt Lehman (IN), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Lehman and seconded by Rep. Jonathan Carroll (IL), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 12, 2023 meeting in San Diego, CA, and the Committee's May 19, 2023 interim Zoom meeting.

PRESENTATION ON NEW AT-HOME ADDICTION TREATMENT PROGRAMS

Brian Holzer, M.D., President & CEO of Aware Recovery Care (ARC), thanked the Committee for the opportunity to speak and stated that ARC is the country's only scaled in home addiction treatment company and what that means is sending real people in a people first, in home first care model. We have no facilities. We have no treatment centers. Our treatment center is the home of the client that we're treating and the program is delivered in four phases over a 12 month period of time. So, we're sending care teams into the home over a 12 month period of time and that allows the time and opportunity to peel back the onion and address over a period of time, the source traumas, the environmental conditions in many cases, the families in crisis. And we have dedicated staff working with the family and I use the word family loosely to mean friends, allies, constituents and supporters. And through that period of time, you're able to repair the family relationships, ultimately creating strength around a platform of recovery, dive into source traumas that in many cases are contributing to the addiction and ultimately repair and create a foundation for sustained recovery. If you look at the state map, you'll see that in the darker color those are the states that we're in. It's worth noting that this company was founded in 2011.

In the state of Connecticut, as of 2016, seven years ago, the company had 50 employees and 100 clients in the Connecticut area, all being treated in a fee for service situation. In 2016, Anthem of Connecticut came to the table and we were able to negotiate a bundled payment rate so that we receive a bundled payment on a monthly basis for the totality of our services for the client. For the client, what that means is a single copay rather than individual co-pays for the various fee for services that they would be receiving in order to receive the totality of our care model. So seven years ago, 50 employees, 100 clients, one state. We are now 900 employees, 11 states. We've treated over 7,000 clients in the last three years alone. We have 16 bundle payment contracts with various commercial insurers only to support this and we have about 1,800 clients on census. I'll quickly note because my background is actually traditional home healthcare, certified home health - this is not home healthcare. For those of you familiar with traditional home healthcare that is a nurse therapist model, which essentially you're sending a nurse and a therapist, and it's carefully considered in that the acuity of the patient finds how many visits. And I'm a big fan of home health. But the reality is those models make the most sense financially when visits are rationed. When you look at our model on the right you see a total whole person approach to the care team model and because we're in a bundled payment arrangement, we're able to deliver the right amount of services customized to the needs of the client for an extended period of time.

There's three parts to the wheel. There's a client focused component to our care teams. We have both peer coaches, family educators and therapists dedicated to the client. In the yellow we have a family focused track to our program in which each family is assigned a family

education facilitator. And we broker family systems therapy to begin working on the repair of the family unit. All of this is underpinned in medical oversight, in which we have an addiction psychiatrist that is involved in the care team meetings, a health service systems director, and nurse practitioners that will provide bridge medication and ongoing medication-assisted treatment (MAT) services. You may have seen the proliferation of MAT and e-prescribing going on in this space. That is not our business model. That is a feature of our model. This is an integrated care model that provides continuation between the prescribing of medications brokered and overseen by real people delivering the care which I believe is a much more effective model though e-prescribing is again something I'm very pro and something that's very important in this particular segment. So what you're looking at is a medical, behavioral and psychosocial approach to care. Again, I have not seen this. I've been in healthcare my entire career. I have never seen a model that provides this amount of services over an extended period of time, really breaking down the barriers and providing a sustained approach to addiction recovery.

I also don't think this should be specific to addiction. As a side note, this is my view of the way we should be approaching all chronic diseases. We have a sick care system that ultimately chooses to stabilize. We don't have a system in healthcare that chooses to repair and create a foundation to allow for sustained recovery. On the American Society of Addiction Medicine (ASAM) scoring scale for those of you that are familiar and I'll just sort of take away those fancy terms and say that this is a lower acuity residential model all the way down to an outpatient model. Two thirds of our clients are actually coming from residential treatment. So ultimately because residential treatment programs in our country are really about stabilizing, not necessarily creating sobriety much like post acute, which is my background, we stabilize in hospitals and then we kick them out too early and then we rely on disconnected fee for service entities to try and work together, which they don't, to create a continuous care model post hospitalization. As I shifted to addiction, I saw the same thing. Instead of hospitals, we got residential treatment programs and we have all different levels of care that are not connected and we rely on someone in crisis to navigate those levels and an addiction where there's periods of disengagement and engagement. People go up and down on the acuity scale and there's no one there to hold their hand through the levels of care. ARC was grounded and founded on the concept of creating a 12 month integrated care program to allow someone to flow through those levels of care from lower intensity residential all the way through outpatient.

We actually aim for 150 total visits over a 12 month period of time. The color is essentially mapped to the types of resources that are available and the cadence that they go into the home. Without worrying about all the words essentially what you're looking at is each client will be assigned two peer coaches and one care coordinator and there will be a nurse or social worker on the first home visit. The peer coaches are designed to alternate and be in the home twice a week for all 52 weeks. The nurses provide virtual support every four weeks. Family therapy for the client will start very early in the phases. Family systems therapy will roll in. And all of this is grounded in the medical oversight from an addiction psychiatrist and nurse practitioner. In the interest of time let me skip to some outcomes. First, our outcomes are a reflection of our payer contracts. We are not in Medicaid at this point in time. We are all commercial. And you can see the logos on the bottom in terms of commercial insurers that support our operations in the 11 states. We essentially contract with an insurance company with those bundled rates before we enter a state. We entered the great state of Kentucky in December and in Georgia and the Atlanta area this past month and we'll be entering the New York area as our 12th state early next year. We aim to get into the Medicaid side of the equation. It's a more complicated segment because the pressures on the actual bundle will be real and we think though that there's an opportunity through shared upside on sort of a total per member per month (PMPM) savings

basis given the amount of savings that we deliver, there's an opportunity to make the model work on the Medicaid side as well. From an outcomes basis, you're not going to see anything like this - not only addiction, but anywhere in healthcare. At least I haven't seen anything close to it. The average length of stay is 250 days. You can see the retention rates and this is not just someone answering a phone or a telemedicine app. They continue to welcome us into their home. Two-thirds of the clients are with us at six months and a full almost 50% of the clients complete the full 12 month program. That data is encompassing those that will complete the program early because they reach their treatment goals and so our goal is not to drive length of utilization. Our goal is to drive outcomes and meeting of treatment goals.

In terms of data, this is actually not our data, this is Elevance's health data. The right is an expression of our outcomes on a PMPM basis, which is a merge of both medical and behavioral impacts. The medical impacts are driven by inpatient and emergency department (ED) reductions and the behavioral impacts are measured by partial hospital days and intensive outpatient days (PHPIOP). What you see is during the year that they're on our program those are the reductions in PMPM savings compared to the cohort before they started our program. It takes a look at about 300 clients. What were their costs both medical and behavioral prior to starting, what were their cost reductions during the program? And even the year after they are off our program, what were the cost reductions? There is a tail on this program which I've never seen in healthcare. Usually things work while you're doing something, you remove that something, they tend to regress to the mean. Here, it sustains. And when you convert it to the PMPM's on the right, we have a 50% medical PMPM reduction in the year that they're on a program. They're simply using less inpatient ED care because we're resolving what causes a lot of that which is behavioral condition. When we stop our services and they complete the program you are still seeing a tail of 60% plus reduction in behavioral PMPM spend. Never seen it. Why? Because we're creating an environment for sustained recovery and ultimately if they're seeking care it will be outpatient or not at all. This is just a slide showing our Medicaid experience in a pilot in New Hampshire. If you look at the slide before this one, you'd see that our medical PMPM savings are actually better.

Rep. Roberts stated that I appreciate your presentation. I think this is really exciting and I appreciate the time you and I have had to speak about this. Am I correct in assuming that part of the reason you're here is because you're looking for more insurance partners in this realm? If you could please speak to that a little bit. And then my second question - I was impressed that you are not seeing provider shortages so can you actually also speak to some of the success on the provider profession side of this as well? Dr. Holzer stated that the challenge with this model is it's new and new things in healthcare take time and again, to be a bit of a naysayer, we talked a lot about the shift of value and I think we're a lot further from that than we like to talk about us being. Because in order to create a value based healthcare model you need participation and partnership between providers and payers. And risk based reimbursement and payment models require data and partnership between providers and payers. Our ability to get towards a bundle type model is one giant step towards a full sort of value based risk based model where you put a percent of the bundle at risk, deliver outcomes and receive further upside based on impacts on PMPM savings. Anthem has been to date the only insurer that sort of has leaned into this on the commercial side in a big way and has recently become an investor.

We have had less success with some of the other large commercial insurers simply because when you look at our costs, which are about $40,000 over the course of a full year, it appears to be sticker shock because most, and I worked for insurance companies, tend to look at sort of the ability to control for cost and time in a finite period of time and don't like necessarily long term utilization expense for which this is. It's a shift in mindset, but it's a shift towards exactly

where we all want to go or where we're stated to go in terms of payment models. I would certainly support in the states that we're in and we're not in the ability for members here to facilitate introductions and meetings with representatives from large commercial health insurance companies. This needs to be in more homes in more states. The reality is we're not disrupting, we're adding a new level of care, providing more access in a form which does not exist today. The ability for people to continue working, go to school, not have to worry about childcare responsibilities. We come to the home and schedule our visits around the needs of clients. This has got a great application to labor and trade. They don't get paid unless they work, and the labor employer does not enjoy turnover. This has got a very significant impact to employers from the standpoint of alleviating the need for Family and Medical Leave Act (FMLA) and allowing the workers to continue receiving treatment while working. And so I would certainly appreciate any help and guidance with regards to more connections with more commercial insurance executives so that we can get this into the homes of more clients. From a provider standpoint, we hire locally if your definition of providers is our care team providers – 80% of our 900 employees are in recovery themselves. Our company becomes a place of therapy for our employees as well. They are on their recovery journey and this helps them because they're helping others. We are an employer of difficult to employ or impossible to employ people and we will hire folks with felony convictions, previous incarceration, no bachelors degree. We provide tracks for people to essentially get upskilled and have career pathways. From a provider standpoint we help the communities in terms of growing jobs and ultimately those jobs of being people that are transitioning from not being employed or being difficult to employ.

Rep. David LeBoeuf (MA) stated that I have two questions about your model. One, when you reference visits, do those include telemedicine visits? And then second, when you reference about intensive outpatient program (IOP) and partial hospitalization program (PHP) days, those are typically functions performed in a group setting - does your company have your own provision of that? What is the linkage between other services and the cost associated with that? Dr. Holzer stated that we're transitioning a bit on the in person versus virtual as COVID taught us that virtual does work. Prior to COVID almost 100% of the care was delivered in the home across all the resources. The shift is going to be our peer coach model is designed to be in the home. That is the tip of our sphere. And you're ultimately sending someone into the home that was previously in addiction and has sort of walked the walk and when you send someone in that was the client, that immediately sort of takes the friction out of a white coat going into a home or a nurse that hasn't been through what they've been through. They know all the tricks. They know that the alcohol in the shampoo bottle is not going to be shamed as they did the same thing. And so the peer coaches in the home will stay in the home. We are relying on more virtual connectivity with our other care team supports, the nurses, the social workers. Because a lot of what they do will be the care coordination work making sure they have their follow-up physician visits and that they have access to whatever they need in terms of their medical care, and so the answer to your question is almost 100% of the peer coach work will be in the home, maybe 75% to 100%, and then a lot of the other work will be virtual. For your second question, I'm not in recovery but I'm surrounded by people that are and so I learn from them every day. What I have been told is that group therapy ends up being an inhibitor for many people to seek treatment particularly under the commercial insured professional side of the equation in that it's very difficult for someone to raise their hand in a group setting of strangers and say I have a problem and so it keeps people actually from seeking treatment. Ultimately, what ends up happening is we work with PHP and IOP. We'll be the tail on a PHP stay. And there is the ability for us to co-treat people that are receiving therapy with IOP and also our in-home healthcare model. What ends up happening is folks resolve from their active addiction towards the later part of our stages, people realize they need help and be surrounded

by people who have gone through the same thing. They become a little bit more open to group therapy and we will facilitate the interactions with alcoholics anonymous (AA) and narcotics anonymous (NA) and various therapists if they don't have one. So we sort of work through that initial stage where our program allows them to receive treatment confidentially to when if they want group therapy, we will help facilitate that because our goal is when we wind down, we left them with the connectivity in their communities that will allow for a lifelong sobriety.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that I wanted to know does your program deal with or work with Veterans with post traumatic stress, and what kind of facilitation do you do with the Dep't of Veterans Affairs (VA)? Dr. Holzer stated that we don't have a contract with the VA – we would love one. We are working to employ more Veterans, particularly those in recovery because again the model is predicated on sending someone in the home that looks and feels like the person we're trying to treat. I'm sure we have Veterans on census. We don't have a dedicated approach to that at this point. We've been more focused on first responders. We've hired quite a few first responders and ultimately I try very hard to sort of gender story match our client to the degree possible and we have dedicated programs and relationships with various police associations, firefighters and such in various states and transition programs from incarceration. One of our first clients in Kentucky was actually referred by the police because we're trying to sort of hardwire in the communities when police goes to call and they ultimately see someone, the worst place that they need to be is incarcerated and the real issue is addiction. We serve as potential for that individual to obviate the need for incarceration and ultimately seek the care they need in their home. And so these relationships with first responders are where we've been very focused on the last couple of years. We would love to get more involved with Veterans.

Rep. Dafna Michaelson Jenet (CO) stated that I'm curious about wages. Are you able to pay competitively for your people? Also, have you tried to work with Medicaid and has it just not worked yet? Dr. Holzer stated that I've been here 15 months and Medicaid was on the road map when I got here. It's now on the road. We don't have a Medicaid provider and no number at this point because we're looking for dance partners before we jump into a bunch of states. We need to negotiate a new rate and have to figure out a care model and so on and so forth. We are very eager to bridge the gap into Medicaid. With our Anthem relationship they're also eager and I think it's probably within the next 18 months we're going to have some pilots up and running inside. We pay more than anyone else in the industry, period. Not even close. And that's by design. Our peer coaches currently are W2. We're likely to move them to hourly with the ability to receive benefits if they work over 30 hours so hourly non exempt. That hourly wage would translate to something 20% higher than anything we've seen in the industry and some. We have a 401K matching. We offer benefits that are first in class and so on and so forth. These peer coaches have been completely neglected, quite honestly, with all of the models that are starting to rely on them - $16 an hour or $14 an hour and we're into the low to mid $20's with regards to an hourly wage. We want those folks, our peer coaches, to be competitively paid above anything else they can get anywhere else. It's the most important part of our program, the standpoint of creating that credibility.

Del. Westfall thanked Dr. Holzer and stated that if you would stay around, I think some other people might have some questions afterwards and I'd like to talk to you also.

CONTINUED DISCUSSION ON NCOIL MEDICAL LOSS RATIOS FOR DENTAL HEALTH CARE SERVICES PLANS MODEL ACT

Del. Westfall stated that next on our agenda is a continued discussion the NCOIL Medical Loss Ratio (MLR) for Dental Health Care Services Plan Model Act (Model), a Model which I'm sponsoring. You can view the Model on the website and also in the binder on page 96. As you may know, I am sponsoring similar legislation in my home state of West Virginia but I decided to wait on moving that to see what NCOIL does. I'm also glad that Rep. Rita Mayfield (IL) has signed on as a co-sponsor of the Model which shows the bipartisan support that this issue has. We had a productive discussion on the Model at our meeting this past March in San Diego and I'm looking forward to continuing to work on the Model and get it across the finish line either in November or in April. I'm certainly open to making changes to the Model. In fact, I know that today we're hearing about a different approach that some states have taken with respect to the issue. There will not be any vote on the Model today. We will hear from our speakers and then determine the best way to proceed.

Michael Adelberg, Executive Director of the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that there's been a lot of time invested on NCOIL on this issue. We do appreciate it. We do want to remind you that dental and medical are of course very different in a number of ways, particularly beginning with one being a high premium product and one being a low premium product. We'd refer you to the National Association of Insurance Commissioners (NAIC's) significant work in that area over the years. As you already know, for medical plans there's been a required MLR since the passage of the Affordable Care Act (ACA). As part of the ACA, there were a lot of provisions impacting health plans. Health plans ultimately supported, by in large, the ACA. One of the reasons that they did was they received 30 million federally subsidized new lives. So, when we talk about applying an MLR to the dental world it's important to note that there is no great public policy trade off here, we're simply talking about applying a new set of requirements. Del. Westfall, you did note that a number of states had moved toward reporting and remediation requirements in the last couple of years. My colleague here today will discuss that as well. I wanted to level set on where we are with dental benefits and make sure that the Committee is aware of progress being made in dental benefits. First of all, dental premiums are barely rising - less than 1% a year over the last few years and that compares very favorably to premium increases in medical and of course, the inflation rate. Similarly, the question has come up, are there improved consumer protections built into dental plans? The answer to that is yes. We have positive trend lines in that direction. We note that the percentage of enrollees in plans with low deductibles has gone from 22% to 41%. This is among the preferred provider organizations (PPOs) but PPO's are 90% of the market. Similarly, the question of annual max has been discussed at prior meetings and the question is are annual max's rising? Again, the answer is yes. And the percentage in plans with high annual max's has gone up from 5% to 17% since 2017. Also, the dental insurance market generally has robust competition across the states and competition, of course, holds down prices and also increases the leverage of providers determining rates and who they want to do business with.

Owen Urech, Director of Gov't Relations at NADP, thanked the Committee for the opportunity to speak and stated that next we wanted to take a little bit of time to go through some of the activity that we've seen since the March meeting and through 2023 as it relates to dental loss ratio (DLR) bills that have been introduced In the states. So, since we last spoke on this issue at the March meeting, there have been 14 states this year that have introduced legislation related to DLR. Most of these bills originally in their form represent a similarity to the Massachusetts ballot initiative which passed last year. In nine of those 14 states those bills were introduced and either did not move forward at all, were not heard in committee, or they ended up not being signed by the end of their legislative session. So that's nine of the 14. In four states you saw compromise legislation or adjusted legislation passed, the first of which

being Arizona, which started out as an 80% loss ratio requirement for every dental plan in the state. That ended up being a bill that included reporting requirements for dental plans in the state. In Colorado, which we'll touch on in just a second as well, there was a structure that included not only reporting but additional requirements that outlier dental plans or plans that are outside of the norms for loss ratios within the state would have to conduct some form of remediation with the department.

New Hampshire also passed a reporting structure for their DLRs. And lastly, Nevada was a state that had a loss ratio included within their rate filing process so it was prospective loss ratio that they re-upped in a piece of legislation after it had been on the books for several decades as part of their rate filing process. And we still have one state left that's potentially thinking about DLR legislation this session at this point, that's Pennsylvania, which introduced a reporting only bill. So all of these bills that have ended up in different places, what we're trying to show is a little bit of a contrast to the loss ratio ballot initiative that passed in Massachusetts. So for those of you who may not have seen this ballot initiative, it set an 83% loss ratio for all dental plans within the state of Massachusetts in order for them to exist in state. So, that's not only in the larger market, that's also plans that are for individuals or in the small group market as well. They set that number across the board. Before this ballot initiative was passed NADP worked with Milliman to get an analysis of what the impact of that ballot initiative would be on our members. And there were some concerns over what we saw when we got that data back. And most in particular the impact would be strongest in the small group market where there was the potential in some circumstances for there to be an up to 38% increase in premiums. So we're talking about a 38% increase in premiums for plans that are being offered to small groups, small businesses of under 50 size. And that any impact on any potential rebating, which is one of the kind of main structures of MLR under the ACA, most of the rebates that would be given out would be de minimis. They would be below ACA requirements for them to be issued. So there would be a lot of administrative activity that would be done, but at the end of the day, there would not be a significant return to the consumer for meeting that loss ratio. In some cases there would be a concern that the cost to send out the rebate checks would exceed the amount of the rebates.

So since the ballot initiative is passed, we did that analysis and we've continued to monitor the situation. There have been significant difficulties in moving towards implementation of this loss ratio requirement. The Department of Insurance within Massachusetts continues to work on a proposed rule to implement the loss ratio. And we have seen even before seeing that rule that some of our members, these are national multiline carriers that are in these small group space, that at least two of those carriers have decided to leave the market in Massachusetts. And we have not even gotten to the implementation. And one of our primary concerns heading into 2024 in Massachusetts, with this loss ratio requirement is that. We're going to continue to see that reduction in the competition. Particularly within the small group space for dental plans. And as Mike pointed out earlier in his presentation, that is one of the things that keeps the dental benefits market in states robust. That you have a large amount of plants that are vying for these different groups and for the individual and small and large group markets. And if we saw a reduction in that competition, then the premium levels that have been kept well below inflation for the past two decades could potentially increase as well as some of the impacts that we saw in the actual implementation of the loss ratio. So, those are kind of the dueling concerns. The potential increase in premium and then also the potential for the loss of competition within the dental benefits market.

And this is just a map to illustrate some of the activity that you can see on there. I'll point out as well New Mexico also set a loss ratio for their plans at the end of 2022. That was through a

regulatory process and not through legislation. They set a 65% loss ratio across the board after having essentially two decades of data from rate filings within that state that they were able to look at that information and say that that number made sense. And this is where we think an alternative to the existing draft of the Model comes in. So Maine in 2022 passed LD1266, which was a structure that allowed not only reporting of DLRs for these plans, but also empowered the Department of Insurance to take remedial action against plans that were designated as statistical outliers. So you would have not only the reporting that's been in place in states like California or Washington for a number of years but you would also have this additional enforcement capacity in those states that would be tailored to the data within those markets. So, you would split out the measurements by the individual, the small group and the large group markets, and then over a three-year measurement period in order to determine validity you would look and say what are the outliers from these plans? And then the Department would be able to go in and check those plans, conduct financial examinations, or require them to adjust their premiums or do other forms of remediation. And this allows the Department as well as the people who pass the legislation to kind of really get into the details of what is happening with these plans. Why are there loss ratios outside of the normal bounds of the market? And what can we do to make sure that these plans present value to the people who were purchasing them? And we really think that the approach in Maine and LD1266 is something that gives them a direction for them to be able to take those actions while preserving the competitiveness that has kept the dental benefits market healthy.

And we saw an example of this type of legislation being implemented in this past legislative session. Colorado passed SB 23179. This was a bill that started out as an 80% loss ratio requirement but after considerable discussions with the sponsor who is the Majority Leader of the Senate, as well as with provider groups and consumer groups and the plans within the state, there was a consensus reached to adopt a reporting and outlier remediation structure that was signed into law on June 2nd. I will also point out that there were additional reporting requirements that were included in the Colorado bill that are not included within the Maine structure. This includes requirements that plans disclose how many people reach their out of pocket maximum every year and then also what the average out of pocket maximum is for their plans in each market segment. So adding on some additional requirements to plans in order for them to report to the Department, make that public, and then also empower the Department to take those actions against outliers in the state. And, if necessary, if the average loss ratio in each market segment is declining then it also empowers the Department to set a minimum floor based on that information.

Mr. Adelberg stated that we ask you as you consider this important issue to think about unintended consequences. And an arbitrarily applied loss ratio that is not based on practices in that state is going to change dental plans in that state potentially very, very significantly. Dental plans are going to have to look at lowering their administrative costs potentially dramatically. When that happens it’s important to remember what is included in a administrative costs. It’s call centers for providers and for consumers. It’s processing claims. It’s maintaining broad networks. It's detecting fraud and abuse and a variety of other things that we consider to be very good expenses. The point here is that when you hear the word administrative cost, there’s an assumption that it’s just someone at the office somewhere with a stapler. These are vital operations and operations that make plans successful. It's also worth noting that consumer satisfaction with their dental plan according to J.D. Power, which does national surveys, has increased to 18 points higher on a 1,000 point scale than it was last year. Mr. Urech also mentioned unintended consequences in the form of plan pullouts if it’s an arbitrarily applied high number and the loss of competition and the consolidation that would result. So where do we go from here? We’ve asked NCOIL to consider that first of all, there are significant successes in

the dental insurance market today. We're holding down premiums. We have significant competition. The margins being generated by dental plans are unremarkable and consistent with other lines of business. Having said that, if NCOIL believes a Model is necessary, we do think that a reporting and remediation model as a number of states have adopted and are considering adopting is a vastly better approach than arbitrarily selecting a number that has no bearing in the existing practices in that state. And lastly we would just ask you again, to remember that because something is done to medical, a high premium product with a $600 a month premium does not mean that that automatically ports to a dental product with a $40 a month premium and many of the same fixed or quasi fixed administrative costs. The NAIC has long recognized the need to treat low premium and high premium products differently.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), thanked the Committee for the opportunity to speak and thanked the NADP for their presentation. I'm here today to convince you about what a good policy MLR is with some additional ingredients to the ones identified by the NADP. I'd like everybody to think about the fact that there has been an inflection point in dental plans and it was the Massachusetts ballot initiative. I know it's uncomfortable for the dental plans to talk about or maybe even it's uncomfortable to talk about it because it is an inflection point. They know that things have changed. The landscape could potentially change. And they would like things to stay in the status quo. But inertia has not worked in the favor of consumers. And when we talk about competition, which they did extensively, we have to focus on who is benefiting? Keeping the premiums low. Who has it ultimately benefited? Who has value out of their products? I would argue that the patients do not get a value out of it. What we have from years and years of competition, basically, is an upper limit of $1,000 is all that the American should deserve or get. That's what this competition has resulted in. And I know that there was some discussion of maybe the annual limits are going up slightly. But the truth is that there are mechanisms built into dental plans that do not allow you to get benefits, you know, major services for greater than 50%. That's built into the cake. And that's why most people don't reach their annual maximums. So how do we address dental plans in a way that focuses on the future? I liked what Dr. Holzer said about let's look at the trends and how we can impact a product so that it is more valuable to people that matter the most, which are the patients. This is a pro consumer initiative.

Okay, what is MLR? I'm not sure if that was explained earlier. Just to be clear, it is setting a ratio that this is the amount of money that has to be spent on care and the rest can be collected by the insurance company, the dental benefit plan and administrative salaries, etc. This was highly successful in Massachusetts. Nearly 72% voted in favor of this. Because I think it is shocking to most people to find out that the healthcare product has the ability to collect, say, 50% in premium and then, you know, keep 50% of that. That's shocking to most people. And when they found out about it, they voted in a big way. So how does this benefit it? It adds transparency, which I heard from my colleagues at the NADP that they support. But establishing that minimum percentage holds the carrier's feet to the fire and requires carriers that do not meet the threshold to refund the difference. I'm going to talk about rebates in a little bit in the presentation and I'm glad that NADP brought it up. So how does this help patients? It improves the value for employers and patients that they get out of their premium dollars. It makes dental insurance more reliable. It ensures patients get the care they need when they need it and incentivizes dental insurers to cover needed care. I talked about this last time but just to bring it up again, the current incentive structure for dental plans is out of whack. It is that if you de-incentivize patients from getting care, the insurers make more money. That doesn't exist on the health plan side. And there's a reason for that because a health product is a little bit different. It should be focused on helping these people get the care they need. Incentivizing the dental plan to change the cost structure where they say the patient is responsible for 50%

and even adjusting that up to 60% would mean a great deal to somebody that has to get an extraction. It would mean they could afford it that year. That's what we want out of a dental plan.

So I'm going to go through some responses to the opposition for MLR. Number one, the claim is that the insured patients currently have excellent access to dental care. We want dental plans to not check the box and say we've done enough. Even if you have insurance, it is still too costly. It still costs people too much and they delay care. How can we change these products so they're focused on the patients and focused on getting the access to the care they need today? The claim is that a large portion of the dental premiums go to administrative costs, which is good for patients. Our argument is when too large a portion of the dental premiums go to administrative costs it takes away from the patient care. And Mr. Adelberg stated that it's more than a person stapling in the backroom and we know there's more to administrative costs. We're for administrative costs that makes sense. We're just for more of those costs and in incentivizing dental plans to become more efficient. That's what the ACA has done and we're asking for that same thing when it comes to the dental plans. I'm going to talk you through some California data because we have it available and I wanted to walk you through that because I want to address a couple of things. One is it would be impossible for the dental plans to meet this - that's not what's borne out by the data. And also I want you to see that without something like the rebate system that exists, during COVID dental plants collected premium and did not have to pay out in care. How do we alleviate something like that? So let's take a look real quick. This is the large group market and you can see there's a little grid down at the bottom where if a plan is over 80%. You can see that a number of large employers are able to meet that. I will say to the members of this Committee, if you'd like to see the entire scan of all the plans that were available in California I can certainly provide that to you just let me know. But this is just reflective of the fact that this is possible for the dental plans to meet and it will not kill competition automatically. And shouldn't we incentivize these plans to be better? I frequently use this analogy, I'll do it again, this should be like fuel economy standards. Where we're nudging dental plans in the correct direction. This is what this type of policy would do. Mr. Adelberg also mentioned that the small group is a little lower and difficult to do. Again, there are those that can meet it, and I would be very interested in talking with NADP about a tiered system where there was a different percentage maybe set for the small group market. Here's the averages of the California DLR. You can see that dipped down during COVID. Again, if there were policy in place that was set up, that money would go back to the patients or whoever was paying the premium. That's why this is good policy.

The other thing I will let you know is there are a number of plans in California that have very low MLRs really could you even call them a true dental benefit plan? That's something this policy would also address. Finally, the claim that rebates are self defeating and cost too much to generate. I think that there are options for a state that's addressing this. They mentioned that the checks would have to be cut, the juice is not worth the squeeze but what if it's a reduction in the premium that the patient has to pay the next year. You know that makes the dental benefit more affordable. There are technical options that can make this amenable to all the parties involved. NADP would like us to stop at the definitions in transparency here but these, we feel, are the four essential components of an MLR bill. Good definitions - making sure this fits in with statute that you're working with. Good transparency - and that's where NADP would like us to stop. A refund/rebate - everybody knows about incentives here. If there's nothing that's going to hold you to the fire, you're going to get the California data again which basically stayed the same in 10 years that it's been there. Finally - rate review and approval requirements. There was mentioned that the Milliman report said that there would be an increase of 38% for the small group market. Remember in that same report they said because of the rate review that's

inherent in the ballot initiative, because of that rate review requirement that says that the dental plans rate increases are automatically disapproved if they go over dental services consumer price index, they admitted that they didn't take that into account when they put out that 38% increase. So that's another essential component that we see.

Michael Flynn, DDS, a practicing Minnesota dentist, thanked the Committee for the opportunity to speak and stated that I'm going to be talking about your insurance. There's about 40 of you just sitting around the table here and if you're the average citizen in Minnesota I know 30 of you have dental insurance. So I'm going to talk about your dental insurance. Now the first thing it's been mentioned is the unusually low maximum annual payment. I think Mr. Olson mentioned $1,000 but $1,500 is common. I want you to think of what yours is. I have dental insurance. I'm lucky my wife's working too, and she's the one that pays for it along with her employer. And mine is one of the highest there is, it's $2.500 which is pretty good. But you think about your dental insurance and you can tell I've been in this business for several decades. Back in the 1980s the maximum payments were about the same. I had $1,500 back in 1983. It's 2023 and we still have $1,500. Back in 1983 your preventative services in my office for the year, if you came twice a year would have been less than $100. Today they're $500. So you're losing on that maximum benefit if you need any care you're going to go over the maximum benefit and it doesn't take much to do that. Now, the other thing I want to incorporate into this is the new technology you've had the last 40 years, it's nice. Now last year I cracked a tooth and I lost a tooth because when you split the root you cannot salvage it. So I had two options. I could do a bridge or I can do an implant. I chose to do an implant and with my $2,500 maximum after my preventative services, it covered about 20% of my expenses. My point is, we're behind the times on what we should be. If you go back to 1982 at $1,500 to now, that would be $500 back then. Our inflation has gone up at least three times if not more. Even though our industry of dentistry has been one of the lower medical fields that has held the line on costs. We actually are very efficient at holding the line on costs. And again, if you're in 2023, if you want an implant or if you will need a root canal or maybe you need partials or dentures or think about your care and what you need. Isn't it kind of embarrassing that whatever you pick out of those major areas it's only partially covered because you've reached your max? So my position here is this has to change, we need to make the max higher and I've heard that there's a lot of difference between medicine and dentistry. Well there is in how we deliver. But we all know if you don't have a healthy mouth you don't have a healthy body, right? Dentistry is not optional if you want to live a wholesome life and a good quality of life. We do know that of our nursing home patients when I graduated, 40% had complete dentures and today it's less than 20%. Isn't that great? It means we have to maintain those teeth they have for quality of life.

So in conclusion I'd just say without a doubt dental insurance will change to meet the current needs of our insured. And from what I've heard and what I watched on the slides, I don't see it's meeting the current needs. Outdated policies need to become current. I think having a standard like an MLR will help meet this need. I really do. Now, whether you're a dentist like me, basically retired from this larger practice for five years, or if you're middle-aged teacher, block layer, cement worker, truck driver, pick your occupation, they want quality dental care. They want adequate care and not just a minor supplemental benefit and that's where we are right now. So my position is to change the way we're marketing our insurance and I appreciate them trying to keep the cost down but below inflation hasn't helped because inflation kept going. And now we have an opportunity to alternatives. Now think about when you go to the dentist and what it costs you out of your pocket. You want real dental insurance, right? So that's what I'm promoting and I want to thank you for your time.

Sen. Bob Hackett (OH) stated that I have a number of dental clients and when you ask dentists what is the most important coverage that they have they'll say preventive. And they pay 100% of preventive. 80% of basic and 50% of major. And you ask them why is that the most important? Because it gets the people to go to the dentist twice a year. And then they find out and they save on cavities as they don't have as much cavities and they make sure things are done and they get the cleanings and things are done. So when you talk to dentists, I would say many times they're worried about driving people away from not seeing them. I agree with you that it's basically a preventive care basic plan. It's not even 50% by the time you get to it and you don't have that much left. So my question is don't you think the number of people that go to a dentist and get under the plans will decrease if you offer much higher benefits at a much higher cost, etc.? The key is you want to get people to the dentist. So when you ask dentists, what's the reason why you haven't had the big increase in the benefits - it's because they don't want to drive people away from going under the plans and having those two visits a year.

Mr. Olson stated that my response to that is dental tourism is happening and there's a reason it's happening. They're going to places like Mexico to seek care because it's too expensive. And I think that there is a real potential with a policy like that to change the paradigm without the severe reduction like you're saying. I don't think dentists are satisfied with the current crop of plans. They would like to see more and I don't know if Dr. Flynn would like to comment on that but that's what I hear at the ADA – products should be out there that support more than just the bare minimum. It is good that people come to the dentist because of these products and that's not what we saw in MLR on the major med side so I don't anticipate a real big drop in coverage. I'll also point out and NADP can be specific about the numbers, but the number of covered lives by dental has only shot up exponentially in the last 10 to 15 years. So if there is some sort of tailing off because the plans are not adequate and then everybody adjusts because this policy takes root and then these are great products nationwide, I think that's an overall good for Americans.

Sen. Hackett stated that my district is not a super affluent district. If you're a dentist in a high affluent district of course the people want better coverage. But if you're an average district, you're going to drive people away from going to the dentist if you don't give 100% of preventative. You don't give them the incentive. Dr. Flynn stated that I hope I never implied that we didn't want to get preventive. My position was in 1982 the cost of preventative care, meaning your cleanings and X-rays, was approximately $100. In 2023 we do want preventative care, but it now costs about $500 so if you need something more than preventative care, you are really short. And they want better services. I do a lot of pain management when it comes to that and they might do their routinely, but you're going to have people like myself who are chewing on something you probably shouldn't have been chewing on split a tooth in the middle of the root and I needed extended care. When we got to that care, I have one of the best plans in the state of Minnesota, and it still only covered about 20% of it. And I'm saying that people today want better dental health. They demand it. The dental IQ now is way different than it was 40 years ago. They don't consider their teeth optional. They consider their teeth necessary. And they're going to do whatever they can to preserve their dental health and sometimes that's more than preventative care. And I never saw a plan that came in my office that was "just for preventative care." I mean, that's great. We want to get them in. But I practice in a small town of 1,400 people. I knew every one of them and I knew who couldn't afford care and I knew who could. And I never kicked anybody out of my office that couldn't afford care. And I don't need to tell you I was the only dentist in town and you treat the community. From what you said I have a feeling your community is that same way.

Mr. Urech stated that I can briefly respond to this from the plan perspective as well. I think you're absolutely right that preventive care is what keeps people going to the dentist and we absolutely share the value that Dr. Flynn pointed out - that is one of the most important parts of people's continuing oral health that they have access to a dental home. I will say from our plan's perspective is that when they were designing the products that they are offering to a small business or to an individual that they want that emphasis on the preventive coverage. But also these groups or these individuals are coming with a budget of what is the type of plan that I am able to offer to my employees so that they have dental coverage? And in those conversations particularly in the small group market, they are looking for a low premium that they can keep so that they can offer and people can maintain thar coverage and they can get that preventive treatment. And that is first and foremost one of the most important things that the dental plan can provide for them. So we absolutely agree and our major concern is that if you see an increase in premium I mean the economics data is clear on this that for dental plans in particular, people are extremely price sensitive on the premiums. When they're shopping for benefits they are looking for that premium in particular and that's one of the key decisions that they make and so our plans work very hard to work with those groups to say what is your budget, what can we accommodate, what types of plans can we build for you? And that focus on prevention is always critical to those designs.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that I have some feedback. I've sat here and listened to this now for a couple of different sessions and I have family in the dental world and they're saying it is causing some service issues because I may refer you to a completely different dentist because the reimbursement from the dental plan is less than my cost. So I'm not going to provide that service. And that's troubling. But if we talk about an MLR as the solution, I'm going to go back to the ACA. The MLR is what everybody wanted in the ACA. I had 16 health insurance carriers in 2009. Now I have two. So if you push this pendulum too far in the other direction, you're going to limit the amount of carriers that can be out there. So, I think moving forward as we continue this discussion, I've heard about Maine and other places. Are there ways that we can find this so we can help providers but also not injure the industry or put them out of business because we've seen what that's done via the ACA.

Mr. Urech stated that one thing I would add on to that is to elaborate a little bit more on the structure that Maine and Colorado have passed. As Mr. Olson mentioned earlier discussing the California reporting data which has been utilized since 2014, it does show a spread of loss ratios in all of the different markets. But what we think is effective about utilizing the Maine or Colorado language is that it empowers the Department to look at those plans and to say what benefit is this showing? What benefit is this providing to the people who have enrolled in it? And utilizing that data and making sure that it's specific to its state so that you can develop regulations that are going to be tailored to your state and to the needs of the plans and the individuals in your state and we think that's going to be the most portable approach.

Mr. Olson stated that I think one thing I would focus in on is that you said something about more money going to the providers and I admit that it would but I think the more important thing to focus on is the buying power of the patient. The ability to buy the services that he or she needs. That's the real focus and why this is such an important consumer issue. And then addressing your comments on competition. I think there is some wiggle room and this is something that I had talked a little bit with Del. Westfall about, where you could have a covered lives limit where if you had under that certain number of covered lives in the state, the MLR would not apply and that would increase the competition and the ability of new entrants to come in. But once you've

gone over that threshold, then you would have to abide by that MLR and again, this is nudging payers in the right direction where they're incented to get the care out.

Rep. Stephen Meskers (CT) stated that I think the MLR and DLR are complicated issues. The biggest problem I have with the MLR or DLR is it incentivizes the insurance carriers to increase prices. Because I don't care whether the limit is 15% or 12% or 20%. On every dollar of premiums I'm making twelve cents, fifteen cents, twenty cents. So the only way I make money is in an increase in premiums, which is driving the increase in costs. So I worry that the unintended consequence is going to increase the cost of service. It's also going to drive out the number of the insurance carriers because they're going to have to have that regulated framework. I'm not convinced that we get to the right level of practice and I'm not sure we're in the crisis I'm hearing other than the question is whether the policies and the demands of the public are to have larger premiums so you can cover more expensive procedures. But I'm with my colleague that the first thing is preventive medicine. And I'm not sure that this is going to do anything to reduce costs. In fact, everything I see in the medical profession tells me it's been an abject failure in the MLR's. Because we have no control over costs in the medical profession. Our insurance rates are going through the roof. It's becoming unaffordable. So it's not addressing my constituents problems in the medical profession, and now I'm importing it into the dental profession where I'm not hearing the problem. I'm very worried about it. I don't know if there's a question there or a statement but I don't understand how I keep control of costs under a DLR. And if I can't regulate it at the medical side, what makes it unique that I'm going to be able to do it on the dental side? Maybe you can explain what the differences are on MLR versus DLR and how you envision it?

Mr. Olson stated that I would point you to that fourth bullet that I had in the essential parts where the state had the authority to disapprove rates, and that's what happened in the Massachusetts ballot initiative. The state has the ability to disapprove rates. I understand certain members of the Committees have concerns about competition and want to maintain that but I think that there's the ability of insurance companies that are staffed by a bunch of smart people to adjust and continue to offer products I think it's remarkable. And to see even the broad swath of carriers that offer products in places like California - they will be able to adjust. And I will also say as NADP indicated there is some reduction in the number of carriers that may be offering in Massachusetts, I think we're going to have to see. That is a very rich market and they will continue to offer coverage there. If it is applied to all then all will adjust.

Mr. Adelberg stated that it's been discussed that establishing an arbitrarily determined MLR is a nudge. It's kind of pushing the market off a cliff as opposed to a nudge. What a nudge would be is more along the lines of what Colorado is doing. Where there will be transparency, but on top of transparency there will be remediation powers given to the regulator. And if there are outliers, the regulator can nudge the outliers. That's a nudge. Taking a number that has no history in the state and assigning it to the state is spinning a roulette wheel. There have also been comments made about the basic benefit structure and where annual maximums get set. Just note that dental plans talk to their customers and dental plans are quite happy to sell more expensive products when there's a customer that wants to buy a more expensive product. There are plenty of no annual max group plans out there. They're not predominant in the market because most employers won't pay for them. But employers who want the no annual max product can get one. Employers who want the product where unused benefit gets rolled over in the following year to compound the annual max next year - employers who want to pay for that get that. There are also dental plans that further incent preventative care by adding to the annual max the following year for people who are getting their preventive care appropriately.

So, a number of the comments being made about common or historically common benefits structures are in fact there - there's a good deal of innovation in the market currently.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, stated that it would certainly be my hope that if you have an MLR that instead of necessarily giving rebates as you pointed out it might be expensive to send out for the small carriers so you could instead increase the dental benefit. In response to Sen. Hackett, preventative is very important. Don't get me wrong, but I'm a dentist, and I would see people all the time in my practice and they would come in and have preventive care and you say, "well you need a crown on this tooth." Then they used up all their benefit for other things. It was going to pay very minimally. And you would offer all kinds of incentives to go on and get it done and in payments, but then they would drag their feet because they would find other things more important than having dental care. And then they come back six months later instead of a crown they now need a root canal and a crown. So, it's not just preventative it's about being able to afford the care. And hopefully the difference in the MLR you would make up in expanding the annual maximum or those kind of things.

Mr. Urech stated that we absolutely sympathize and agree that making sure that people are in the chair and getting the care that they need is incredibly important. I think really the difficulty of this and where we see a mandated MLR coming in and becoming an issue for these people that may not be able to afford their care generally is that even if in circumstances that Mr. Olson discussed where there may be a cap or an ability for the state to deny rates, we're already seeing in Massachusetts that that means that those plans are potentially going to leave the market if they think that it doesn't make sense for them or they're not even able to offer the plans that they originally have had in the state. And we know that that means a perpetuation of issues for those people to be able to find coverage. And I think that our underlying concern is that in kind of setting a higher loss ratio that's not based on the data or the market within the state is that you're going to see more of those plans leave and that you're going to then have the cascade effect on people's oral health that they're not going to be able to get the coverage they need. And I think that our members and the ADA as well know that there's a broader conversation about oral health in the U.S., and we know that dental coverage plays a critical role to that but we just don't think that as currently drafted the proposal would make sense to meet those needs. Rep. Ferguson stated that I hate when people leave the market, but with any insurance, it's only as good as it is when you need it and maybe if those plans are worthless to start with it's better they leave the market.

Mr. Olson stated that I think the reason this policy is such a good one to look at and again, we urge your adoption with those four parameters that I outlined, is because this is about getting people to good oral health. And preventative only plans as Sen. Hackett put out that would get people's butts in the chairs but it does not get them to good oral health. And I think that is why this is a worthy policy for everybody to examine. Let's look at the value of these dental benefit plans and how to incentivize them to pay out the patient care that is needed. That's the opportunity here today and I encourage you to endorse.

Sen. Beverly Gossage (KS) stated that I've been a health insurance agent for 20 years. I help write dental plans. But I often talk more people out of dental plans than buy them. And that's partially because they don't necessarily understand them, particularly employers who just ask how much is the premium and say ok we'll have our employees pay whatever portion that may be. But yes, they have options. You can have the $5,000 total out of pocket. You can have the $25. You can put endodontics and periodontics into basic and pay 80% of that. But the premiums are going to be a lot more. They just would have to be. And so most of the employers and most of the individuals don't choose that option, even though it's offered. I'm

concerned that oftentimes government becomes the problem rather than the solution. And if we were to try to do what happened with MLR we could see problems like what happened in my state. We went from 17 carriers to three when they implemented the ACA and what I see right now is a vibrant dental insurance market. We have lots of wonderful dentists. I personally for 30 years have never had dental insurance. I just have a relationship with my dentist. He doesn't have to file insurance. He doesn't even take it. And then we can just work directly together. Do I think dental insurance is wicked? Not at all. I think this is an option that people can have and we need to have these options. We need to have a vibrant market where they have a lot of different competitors. And we have that now. So I would not be in favor of model legislation that would do MLR in my state.

Del. Westfall thanked everyone for speaking and stated that we'll probably have an interim meeting of this Committee sometime before our November meeting. If anybody has any ideas or comments or suggestions please reach out to me or NCOIL staff. Hopefully we'll vote on this in November or April.

CONSIDERATION OF NCOIL HOSPITAL PRICE TRANSPARENCY MODEL ACT

Del. Westfall stated that next on our agenda is the consideration of the NCOIL Hospital Price Transparency Model Act sponsored by Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, and co-sponsored by Rep. Roberts. You can view the Model on page 99 in your binder and on the website and on the app. We will be voting on this Model today. The American Hospital Association (AHA) has been involved in discussion with this Model for the past several months, but they have declined to send a representative to this meeting.

Rep. Oliverson stated that I'm very proud to sponsor this Model alongside my colleague Rep. Roberts and I also have to give a shout out to my colleague, Rep. Meskers, who gave me the idea to introduce this in the first place by speaking up a couple of meetings ago so I appreciate you both for your support in this. As you know, this is something that the federal government has taken on, the idea that a consumer should be able to know in advance for a shoppable service what their insurance company is going to pay the hospital or service that's elective that's shoppable that's going to be provided and they ought to be able to shop around. We can do this in pretty much every single segment of our economy, except for healthcare. And so federal regulations have been enacted on hospital price transparency and what we saw in my state and what I think Colorado simultaneously saw was a desire to ignore the rule and so what this Model does and what I think it will solve is it actually increases the financial penalties on non-compliance to the point where hospital systems can no longer ignore what is already required by federal rule. And it also simultaneously requires that at the state level and it does that through a series of escalating what I call tiered penalties, where every day of non-compliance is compounded by an additional violation. And so essentially there's logarithmic growth in the size and scope of the administrative penalty that's assessed. And we felt like that's the best way to bring some of these extremely large tax-exempt, some would call not for profit healthcare systems, into compliance because they were the bad actors by and large on this while at the same time respecting that there are may be small healthcare entities out there that don't have an extensive IT department and compliance may be more difficult.

So our Model actually takes that into account and it creates a different tiered penalty structure for non compliance based on total revenue of a facility. We added to that some excellent language from our colleagues in Colorado which actually would prohibit a hospital that is in non-compliance with this Model from being able to send a patient to collections for the non-payment of medical services that have been received. If you're not willing to show your prices upfront, is

it really reasonable to be able to send someone to collections and take them to court after the fact on something that you weren't even able to give them advanced warning of what they're out of pocket would be? So I think this is just a common sense thing. We've talked a lot about the cost of healthcare. To my way of thinking, transparency and pricing upfront is literally the best antidote we have to the ever increasing cost of healthcare. And I do strongly believe that the average American citizen is smart enough that given information about price in the areas of places where they could go for services that they will begin to shop with their feet. They will select services based on what they can afford based on what seems good to them. And studies have also shown that when patients are able to ask questions about price and they start seeing price and they want to compare those prices they also began to ask questions about quality. And so that's something else that is sort of a hidden benefit by adopting this Model is that we actually arm consumers with pricing information, which stimulates their interest in quality as well. Which those are sort of, in my mind, the two legs of the two legged value stool.

JP Wieske, VP of State Affairs at the Council for Affordable Health Coverage (Council), thanked the Committee for the opportunity to speak and stated that the Council is a broad-based advocacy alliance with a singular focus on bringing down the cost of healthcare for all Americans. We've been fighting for hospital transparency since our founding in the early 2000s. And I just want to heartily endorse the Model. The work here to extend the federal actions and to ensure that there's compliance is going to bear fruit over time and we want to thank you for introducing this and we give it a strong endorsement.

Rep. Tim Barhorst (OH) stated that in Ohio we just passed a hospital transparency bill off the floor about five weeks ago. It was bipartisan with 90 yes votes and five no votes. So, we're going to get that over to the Senate this Fall. But we did the simple codification of the federal rule like you did and we had three provisions of non-compliance saying that there's no third-party debt collection allowed for 12 months, no credit score hit, and no private right of action to sue you for your assets to collect that debt. So, the consumer and a patient does owe these bills, but we're just trying to get the time out so they have time. If you won't give them the price, you got to give them the time to get through it. So I commend you on that. And our bill is based on the Colorado law more than yours. What I do like about yours is the total revenue and the penalty structure. Can you tell us how you're enforcing it over there? We have a Department of Health and an oversight of the state auditor as well in there and some of the challenges we'll have in the next step is to make sure everything is being followed.

Rep. Oliverson stated that we did spend a fair amount of time with our Health and Human Services Commission in Texas making sure that they understood exactly what we were trying to do. It is simply written but it's one of those word problems in math that really requires you to break out a pencil and a piece of paper in order to really understand kind of how it works because of its stacking structure where every separate day of a violation triggers a brand new penalty which compounds daily. So it really does increase over time like a pyramid. The reason we did it that way, quite frankly, is that the number one reason why the federal rule was ignored for so long is just simply because the penalties were a fraction of even the daily revenue that the facility is able to get. And by sort of hiding behind this cloak of non disclosure, it was a simple business decision. It's cheaper to pay the penalty than it is to be compliant and actually post your prices. And so we fixed that. So our mechanism for the largest tier you're talking about a multi million dollar administrative penalty that's assessed annually. And so we felt like that's really the size that was needed. Now the way that our Department decided to implement that in a way that was crystal clear to everybody, which I thought was rather ingenious, is they just gave examples literally like algebra problems. They literally just said so hospital A is in violation and here's how many days and they just calculated it out in plain math so that there's

zero ambiguity and everybody could see here's the situation. Now you'll notice in the Model that there are considerations and in our statute as well that good faith efforts as far as compliance and trying to get their previous history of violations of this same chapter, these are all things that should be taken into consideration. One of the things that we ran across early in implementation with this law is that our law also is pretty aggressive in terms of looking at websites, making sure that you can get to it within one click from the home page and if you can't do that then you're in violation. We didn't want this buried on some back page that nobody could navigate to. Our Department was sending out letters of non compliance based on the fact that they went to the website and they couldn't find it, not receiving a response from the hospital to their certified letter, and then just saying, "well see this just proves that they're not compliant because they never responded." So there are some implementation challenges that go along with this but so far it's actually worked well. In Texas now we're over 80% compliant with the federal rule after less than a full calendar year of the implementation of this law.

Rep. Barhorst stated that some of the surprises I had in this bill in Ohio is a lot of the smaller rural systems were scared because the federal rule and the penalties with that were significant to them. So I've got some of them fully compliant that I've met with and sat down with. And several of them are just a couple steps away. So let's say they're 80% or 90% compliant and it's just the big ones that have literally done nothing and just laugh at you and say we're not going to. So that's the impetus of trying to do this. And then the one thing that we ran into is they create complete confusion of what price transparency is versus what estimators are. Estimators are not price transparency, they have no binding and that's all full of small print. And don't let estimators get stuck in your argument as fulfilling compliance and that's the part we had to push back at the most.

Rep. Linda Chaney (FL) stated that we took a swing at this legislation last session and it didn't get through, but conversations are continuing. Part of the conversation were we also included in this requiring hospitals to identify themselves as hospitals. Which seems crazy. But there's a lot of small hospitals popping up that look like these walk-in clinics and so patients were going in thinking they were going to one of these walk-in clinics and would get billing that way and instead they would be receiving hospital billing. So that's something to consider. Rep. Oliverson stated that it is interesting that Colorado and Texas also share a distinction that I think we're the only two states that have a free standing emergency room (ER), as well. And so that was another issue for us as to separate it out and work through because a lot of these charges could concern services provided in an ER so the free standing ER's how are they going to be participating in this. That's sort of a constant frustration in Texas. It's sort of a friction between the acute care hospitals and free standing ER's and the insurers, and unfortunately, the patients get ground up in the gears there. So, I hope that you give it another shot and I'm happy to come help you.

Hearing no further questions or comments, upon a Motion made by Rep. Roberts and seconded by Rep. Jonathan Carroll (IL), the Committee voted without objection by way of a voice vote to adopt the Model. Del. Westfall thanked everyone and stated that the Model will be brought up Saturday in the Executive committee for final adoption.

CONSIDERATION OF NCOIL BIOMARKER TESTING INSURANCE COVERAGE MODEL ACT

Del. Westfall stated that next on the agenda is the consideration of the NCOIL Biomarker Testing Insurance Coverage Model Act, sponsored by Asw. Hunter and co-sponsored by Sen. Paul Utke (MN), NCOIL Secretary. We will be voting on the Model today.

Asw. Hunter stated that I will be brief as we've been discussing the Model for many meetings. I just wanted to add a few points and note a few changes to the Model that have been made since we met last and since the conversation we had at our interim meeting. The Model is in your binders on page 92 and is on the website and app. As many of you know, I did pass a bill last month that I sponsored in my home state of New York that is based on the Model and it passed with near unanimous support in both chambers and is now awaiting the Governor's signature. The bill passed unanimously in the Senate and passed the Assembly by a vote of 143 to two and we have 150 assembly members in New York. Also, after many collaborative discussions with the New York Health Plan Association, they did not actively oppose the bill due to some amendments being made, many of which I have now included in this Model. And I really thank them because they were really hand and hand with me in making amendments to get them passed in the state of New York. With this bill passing in New York that marks 10 states, both blue and red, that have adopted similar legislation, and another 10 states have introduced similar legislation. So with this issue, we're certainly talking about a national trend that I think is important for NCOIL to be a part of. As you can see in the latest version of the Model I have made some changes most of which aim to reinforce that the Model is only meant to apply post diagnosis. I know many see the word “diagnosis” in the Model and it causes some agita, but the language that follows “of a covered person's disease or condition” means that the testing is being conducted on someone with an existing disease or condition, not someone just walking off the street and ordering a test. In furtherance of the Model only applying post diagnosis I have added language saying that “nothing in the model should be construed to require coverage of biomarker testing for screening purposes” and testing is only meant to be covered when it guides treatment decisions and clinical utility. Taken together, both of these amendments aim to make it crystal clear that the Model is only meant to apply post diagnosis to people with already existing diseases or conditions. And I'm going to stop there. I really appreciate everyone's work and everyone's been really supportive. We know that this has been a hot topic issue and I'm asking for all of your support in pushing this forward.

Hilary Gee Goeckner, Director of State & Local Campaigns, Access to Care at the American Cancer Society Cancer Action Network, thanked the Committee for the opportunity to speak and thanked Asw. Hunter and Sen. Utke for their support and leadership on this issue as well. I will be very brief. We've discussed this at length at previous meetings. This will allow more patients to access proven tests that are necessary to guide their treatment, improve outcomes and often avoid unnecessary or ineffective treatments. We appreciate the amendments that have been made to address questions raised at earlier discussions. As Asw. Hunter noted, this is not a partisan issue. Many of you have supported similar legislation in your states already. This is now passed in 13 states, including many of those that you represent and we urge your support.

Rep. Lehman thanked Asw. Hunter for the amendments and stated that my only concern is do we have a clean version of that? I’m still looking at the Model that’s in the binder and I’m seeing biomarker testing “for the purposes of diagnosis” and I think you use the term post diagnosis. I want to make sure we’re very clear that we’re not talking about an initial diagnosis but we’re talking about after that. For example, if I think I have cancer, I don't want someone saying, you know what, let's just do a biomarker test on you, not a biopsy. I think the whole thing of biomarker testing is once I'm diagnosed, there's different paths of treatment I can get and I'm very supportive of that. I just want to make sure I'm very clear my understanding is that this language will be in its final format, showing it as post diagnosis. I'm referencing the language in Section 3(a).

Ms. Goeckner stated that diagnostic testing is a broad category that includes a lot of biomarker testing that's used to guide the treatment of cancer and other conditions and so I believe from

your comments it sounds like the concern is about screening or looking for disease in an otherwise healthy person. And so that's covered by the language that was added about not being construed to require coverage of screening testing. One of the very common uses of biomarker testing is to subtype their cancer and determine which mutations are responsible for that. That would be considered diagnostic testing typically and so we wouldn't want to exclude that and miss out on a lot of opportunities to get people on the right treatment early or avoid treatments that will be ineffective and have better, more efficient care delivery. Rep. Lehman stated that I think you answered my question but I want to make sure I'm very clear. I don't know how this was worded in New York, but if I would use biomarker testing for an initial diagnosis then I could make the argument this would require them to pay that. Ms. Goeckner stated that there are the purposes for when testing is appropriate that "diagnosis, treatment, ongoing monitoring of a disease or condition" and those are all included in the 13 states that have passed this to date. But there are also sources of evidence that must be met in order for a test to qualify. So, being supported by nationally recognized clinical practice guidelines or a Food and Drug Administration (FDA) approved or cleared test. So, this is something that's being done for a patient who's already in a provider's care for a disease or condition as Asw. Hunter noted and this is maybe refining the diagnosis. There might be a suspected lung cancer and biopsy tissue is sent for biomarker testing which confirms an ROS1 positive mutation that's driving that lung cancer.

Rep. Lehman stated that again, I believe you've answered my question but I'm still not hearing maybe clearly that there is no benefit for a first time initial diagnosis. Ms. Goeckner stated that I think it depends on the specifics of a patient and what testing is being done. Rep. Lehman asked if an example could be provided where biomarker testing would be used as the initial test to see whether or not I have cancer. Ms. Goeckner stated that I think the question would be, is this is a screening that someone is going for? So, are you going to have a screening mammogram? Or genetic testing to see if you're at risk for later developing a certain cancer? There are early detection tests for cancers that are being developed. Those would be screening tests that might find a cancer diagnosis. But if you have a biopsy done for lung tumors and that tissue from the biopsy is sent for testing. That testing may include biomarker testing that would confirm the suspected case of lung cancer because you have tumors in your lungs. Rep. Lehman stated that I have no problem with. I'm going back to in lieu of a biopsy I'm going to put you through some biomarker testing because yeah normally we do a biopsy but I'm going to bypass that and just use a biomarker test. Ms. Goeckner stated that many biomarker tests are actually done with tissue from a biopsy and some are done with a blood draw so there isn't a single way to do a biomarker test. But often it's actually done with that tissue from a biopsy sample to look for particular markers in cancer cells. Rep. Lehman stated that I'll leave it at that and I'm going to defer back to Asw. Hunter and I trust her greatly with her post diagnosis assurance.

Sen. George Lang (OH) stated that I appreciate the opportunity to speak in opposition to this Model. I share Rep. Lehman's concerns about the language is confusing and I do appreciate the clean-up language but it still says "for the purposes of diagnosis" - it doesn't get very much clearer than that. And if the goal of this is to get early diagnosis I can appreciate that. In 2017 I was diagnosed with Stage IV colon cancer. It ended up being stage II but it was a three-year battle for me. Had I discovered it in stage I, my guess is it would have been an inconvenience for me rather than a battle. So, I appreciate the intent of doing that but the reality of this is I still would not have gotten tested earlier. That's not who I am. I waited until it was late in the process and 27% of people that have health insurance never use it. That's how health insurance works. There's a lot of people paying into the system that don't use it to benefit those 5% of participants that typically are 60% of the claims. So this is not going to change behavior.

But what it will do is it will add cost to the system because it's an unfunded mandate. I trust free markets and free people to get it right. I wish the health insurers would offer this. Some of those will. Some of those do. Oh, and by the way, in my situation I have the coverage available because I'm under that state of Ohio's plan which is governed by the Employee Retirement Income Security Act of 1974 (ERISA) but for those health insurers that want to offer this to small employers, they can price it into their plan and those employers can then use that as an incentive when they're recruiting employees. We're going to give you better healthcare coverage if you come to work with us. So, I trust free markets and free people to get it right. Another problem I have on this is that it's only going to affect our small employers. Our pass-through entities. If you're a large, self-funded employer you come under ERISA, we cannot regulate you under ERISA, so we're going to pass this burden on to the small guys. The heart and soul of each one of our communities. The guys that are there for your charities and for your little league. This is not going to affect the big guys. It's going to affect the little guys who are all struggling now with high inflation and with workforce development issues and with supply chain issues. These are the ones that are going to suffer. I trust the health plans to get it right. They will enjoy the benefits of good decisions or suffer consequences of bad decisions. And I cannot support an unfunded mandate on the private sector. And I believe over time the private sector will handle this and they'll handle this in a way that the sponsor of this bill who I commend for bringing it forward would like to see happen. I just trust the private sector to do it far better than the public sector and I urge my colleagues to join me in voting no.

Rep. Carroll stated that I'm going to slightly disagree with Sen. Lang. We actually did this in Illinois and we were the first state to do this and I will tell you right now that we saw some real benefits from doing this. The standpoint is that we're screening people early and finding out certain things that they're dealing with. And it really offers technology to where patients can be matched with the right precision treatment without taking the shotgun approach. So I appreciate what Sen. Lang is saying but I disagree because I think the ability of us to know what we're dealing with can't just be one size fits all. We have to have specific things that come into place and this is certainly one of those. So I'm very supportive of this legislation. And this will bring costs down. The cost of these tests are not astronomical. I do understand the unfunded mandate part of this but I don't think this is an unfunded mandate that's not tolerable because the cost of this is not as high. So, I'm very supportive of this and I hate disagreeing with my colleagues but we'll get along on other things but I think this is very important to the future of healthcare and I stand in strong support of it.

Sen. Hackett stated that I am going to echo some of Rep. Lehman's remarks. So, you have a situation where let's say you have one incident, your grandmother had breast cancer. And so you decide as a woman to get tested and even though the test comes back negative you decide at that time to have a mastectomy because you say it's cheaper and I'll go through less and I won't have the problems, etc. I don't totally agree with that costs will always go down and the problem is that we pass this to everybody. So we were told that this testing in the Model would only apply to a person with an existing disease or condition. But how do you answer the breast cancer scenario I just described? A person doesn't have a condition. Someone in the family had it. So how would you respond? Because the way I read this, it's not clear. Ms. Goeckner stated that in that scenario, that would not be biomarker testing as defined in this legislation. That would be genetic screening that someone may go through and that, depending on their family history, may already be covered to have that screen test to determine if they are later at risk. Sen. Hackett asked why doesn't it say that it doesn't apply to genetic screening? Ms. Goeckner stated that's one of the amendments that Asw. Hunter added after the May interim meeting – "nothing in this legislation should be construed to require coverage of testing for screening purposes." So that excludes anything for early diagnosis or risk. We love early

diagnosis and detection, but that's not what this is about. This is about getting people connected with the right treatment for a condition or disease that they have. And so often in cancer that means allowing people to avoid aggressive treatments or treatments that will be dangerous to them or ineffective. And avoiding trial and error with different chemotherapies that many of you may have experienced or known people who go through treatment after treatment trying to find something that works. And this provides more information to patients and their healthcare providers to match them with the right treatment. This is not 23andMe. This is sophisticated testing that's being ordered by a treating professional only when it is supported by these sources of evidence and for the purposes spelled out in the Model.

Sen. Lana Theis (MI) stated that one of the things I wanted to mention was that on page 94 in the binder, Section 3(d) and Section 4(d) both have that language that "nothing in this section shall be construed to require coverage biomarker testing for screening purposes." Sen. Hackett acknowledged that language. Sen. Theis stated that what this would do is help to define what it is that they found in the screening and then better aim the arrows at the issues that are there particularly with respect to anything that is cancer related. But I have questions with respect to the statistics. In the states where this is passed already, do you have any statistical evidence that speaks to the number of people that this change actually affected and what that cost could look like? Ms. Goeckner stated that unfortunately there is quite a lag when the legislation is passed. It's then usually at least six to 18 months before that takes effect and then another year or more before there's sufficient claims data to analyze. However, there is ample evidence of the benefits of biomarker testing when it's used for these purposes and supported by the evidence and the guidelines. Allowing people to live longer and improving quality of life and often significantly reducing costs by avoiding ineffective treatments or treatments that are completely unnecessary. So, we have a volunteer in California who received a biomarker test to predict the risk of metastasis and recurrence with her breast cancer. Her insurance would not cover that but she was able to pay $1,000 out of pocket to cover that and that showed she would not benefit from further chemotherapy and she was able to avoid significantly more expensive treatments by having that information and having the means to put that out of pocket or take the risk that insurance would not cover it.

Rep. Chaney stated that I and the State of Florida are not real keen on unfunded mandates but having said that my husband and I ran a mobile mammography business for five years and definitely have seen the benefit of early detection and the best technology that you can have for that which I believe biomarker testing is. But to address costs I was given some information by the American Cancer Society on tests on studies that were done by CVS Health and Millman, and their projection is an increase in premiums of between 14 and 51 cents per member per month and a savings of as much as $8,500 per member per month in total cost of care. Now this is somebody who's obviously been diagnosed with the disease and as a result of more optimal treatment and that does not account for any potential cost savings from avoiding ineffective treatments, which was just addressed. So I just wanted to throw those data points out.

Sen. Arthur Ellis (MD) stated that I was the Senate sponsor of a similar bill in Maryland and I just want to say it passed in the Senate 46 to zero and was very bipartisan and there was a lot of support and it passed in the House 132 to three. And we worked with all the interest groups and with the Cancer Society and with our insurers and the drug companies and it was a lot of work but the Model here is very similar to what we ended up with in Maryland which is very successful. We worked with the Department of Health to fund it so basically, this was not an unfunded mandate for us. We worked it out where everything fit perfectly into budget and our insurance carriers were very supportive of that.

Rep. Liz Reyer (MN) stated that I am the sponsor of a similar bill that just passed in the Minnesota House and in Minnesota we are required to have an assessment done if we are possibly going to have a mandate added to our insurance package. So, looking at the material that we received from the actuaries and from the team that did this analysis, the monthly expenditures, if you assumed 1.2 tests per 1,000 individuals, would increase monthly premiums by one cent per member. So, clearly the risk of an unfunded mandate would be offset. The other thing I want to add that we haven't touched on is the impact of providing this coverage to address the disparities in healthcare outcomes. We know that black and brown people in our society have much poorer access to healthcare. Much less and much, much worse outcomes. So, this is a valuable tool that we really have a responsibility in my opinion to be furthering and promoting.

Rep. Michaelson Jenet stated that first I wanted to disabuse anybody of the notion that any woman is quickly making the decision to get mastectomies. As a survivor of breast cancer and having had a bilateral masticate it's not pleasant and it is very distressing to a woman. So I'm not worried that people are going to quickly make the decision to get mastectomies. That being said, maybe prostates are more your speed. My husband was recently diagnosed with prostate cancer and through biomarker testing we found the right exact treatment for him, which meant that he missed no work that he is already had his first prostate-specific antigen (PSA) test that has shown a reduction in his cancer levels. And we know this because of biomarker testing. It's 2023 and we have this amazing tool at our fingertips. Why should we not do everything in our power to make sure that our constituents get access to it as well?

Asw. Hunter stated that I just want to thank all of my colleagues. This has been very thorough and well thought out and the conversation about healthcare disparity is very real as are the conversations relative to quality of life when someone has been diagnosed with cancer or some other disorder, knowing that we want to be able to give them the best type of treatment possible. I understand the concern about business and we're talking about finances and we never want to be in a position to put any company out of business. We're talking about quality of lives for our constituents, our family members, our friends. My husband had cancer. My mother died of cancer. Both my sisters have had cancer. I'm not using this as a tool for them but for someone in the future. This could be used on someone to have the best quality of life possible without having to go through some unnecessary treatments. I appreciate all my colleagues on both sides of the aisle for being very diligent and thoughtful about supporting this legislation.

Hearing no further questions or comments, upon a Motion made by Rep. Carroll and seconded by Rep. Roberts, the Model passed via a voice vote with Del. Westfall determining that the yes votes clearly outnumbered the no votes. Del. Westfall thanked everyone and stated that this will be on the Executive Committee agenda for final ratification on Saturday.

INTRODUCTION OF RESOLUTION IN SUPPORT OF EMBEDDED PROVISION IN THE STATE INSURANCE CODE TO PROTECT HEALTH SAVINGS ACCOUNTS-QUALIFIED HEALTH INSURANCE POLICIES FROM CERTAIN STATE BENEFIT MANDATES

Del. Westfall stated that last on the agenda is the introduction of a Resolution dealing with health saving accounts (HSAs). We will not be voting on this today. We will briefly introduce it and further discuss it during our next meeting. I'll recognize Sen. Jerry Klein (ND), sponsor of the Resolution, for brief remarks. Sen. Klein stated that the Resolution is an encouragement for an amendment to state law that's going to help ensure that when we adopt certain types of laws in our states that they don't inadvertently cause people to lose access to their HSAs. Several

states have already made such an amendment to their code with my state of North Dakota being one of them.

Kevin McKechnie, Executive Director of the HSA Council at the American Bankers Association thanked the Committee for the opportunity to speak and thanked Sen. Klein for his support. We look forward to this being discussed and debated over the course of the next couple of months. The NCOIL Accumulator Adjustment Program Model Act was amended to make it HSA friendly. Sen. Klien's proposal does the same thing to all the other state health benefit mandates and we look forward to discussing it with you.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lehman and seconded by Rep. Ferguson, the Committee adjourned at 3:45 PM.