NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 20, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Thursday, July 20, 2023 at 11:30 AM.

Representative Brenda Carter (MI), Vice Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. Pam Helming (NY)
Rep. Ellyn Hefner (OK)
Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Dafna Michaelson Jenet (CO)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Linda Chaney (FL)
Rep. Brian Lohse (IA)
Rep. Rod Furniss (ID)
Rep. Camille Lilly (IL)
Sen. Michael Fagg (KS)
Sen. Beverly Gossage (KS)
Rep. David LeBoeuf (MA)
Sen. Pamela Beidle (MD)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Gary Dahms (MN)
Rep. Liz Reyer (MN)
Sen. Walter Michel (MS)
Sen. Vickie Sawyer (NC)
Asm. Erik Dilan (NY)
Asw. Pam Hunter (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. George Lang (OK)
Rep. Bob Peterson (OH)
Rep. Forrest Bennett (OK)
Rep. Carl Anderson (SC)
Sen. Mary Felzkowski (WI)
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 Sen. Jerry Klein (ND) and seconded by Sen. Pam Helming (NY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Klein and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 10, 2023 meeting in San Diego, CA.

PRESENTATION ON RECENT FEDERAL HEALTHCARE REFORM PROPOSALS

Joey Mattingly, PharmD, Ph.D., MBA, Associate Professor & Vice Chair for Research, Department of Pharmacotherapy, University of Utah, thanked the Committee for the opportunity to speak and stated that I'm a pharmacist and health economist at the University of Utah. I also own my own research analytics firm. Real quickly I want to share a conflicts of interest review as I think it's important to know where my salary and everything is paid from so you understand where my conflicts are as we talk about this policy. I have research funding from the Food and Drug Administration (FDA) and my wife is a full time employee of the FDA. Also in the past 12 months, I received consulting fees from both the Arnold Foundation and the Pharmaceutical Research & Manufacturers of America (PhRMA). And then I've been an unpaid consultant to the Centers for Medicare & Medicaid Services (CMS) for the implementation of the Inflation Reduction Act (IRA). In all my presentations on health policy I always start with the basics and it's not to insult anyone, it's just so we're all using the same language. And then I'm going to jump into some federal legislation. I kind of categorize this as a Pharmacy Benefit Manager (PBM) focus as well as drug pricing focus and things really like copay capping and whatnot. And then I want to hit on a couple myth busting if you will and some myths that are full myths and partial myths, I guess I'll say. So I start every presentation, as I said with some basics and I start with the premium equation. Everything we talk about in healthcare policy and health insurance should come back to this and a lot of members and the people in this room fully understand this. That on the left hand side if we're talking about estimating and calculating a premium. On the right hand side we have things like the administrative costs of administering a plan and profit. We have things like coinsurance, co-payments. What I always tell with my students is look at the direction of the signs. Right, we think about the math. So, you see a negative sign in front of the C? That means that it's an inverse relationship with the premium. So as we increase co-payment, coinsurance we can keep premiums down. If we reduce co-payment, co insurance, we may have put pressure on the premium.

Similarly, if the price of something goes up that we're paying for it's a positive relationship to the premium and both can go up. And then same as we increase the units of healthcare dispense, so it might be more patients treated or patients receiving more medication, the premium goes up. We've always got to start here and every health policy, in my opinion, should be evaluated through this lens. Similarly, we have a drug supply chain. It really should be simplified and I try to simplify it and I do a basic supply chain first. We have a drug manufacturer, a manufacturer sells to the wholesale distributor, a wholesale distributor distributes drugs to the pharmacies, pharmacies distribute medications to patients. And not to get into all the acronyms this morning, although I had to learn a lot of new insurance acronyms attending my first NCOIL meeting but we got a lot of acronyms in drug pricing as well. Things like wholesale acquisition costs (WAC), average wholesale price (AWP), usual and customary. When we add an insurance company or third party payer to the mix, it gets way more complicated, right? So this is where we start seeing legislation trying to address some of these relationships. So instead of just a fee from the manufacturer going to the wholesaler, we have to consider potential rebates and discounts that may go back to the payer for formulary replacement. We also recognize that there's a relationship between the payer or PBM and the pharmacy distributor and how that pharmacy is reimbursed. And again so me as academic when I'm trying to estimate these things sometimes

it's hard for me to evaluate when we talk about transparency, what's the actual price being paid? And then as we start talking about things like vertical integration, that's become a hot topic in the PBM space. A pharmacy, not to pick on CVS, it's just one of the big ones, thinking about a payer PBM that may also own a pharmacy, then how does that change the equation?

So I like to start there to get some of those things out of the way. Again, I feel like those three slides can earn you a Ph.D. so I'm trying to trying to bring it all down to just the basics. So let's talk about some of the federal legislation on the horizon. So if we talk about PBM focused legislation, several of the states in this room are well further ahead than the federal government in my opinion. The states have really pushed the issue on regulation and PBM reform. I will the one thing I found interesting about this and you look at the current bills, so the PBM Transparency Act, the PBM Reform Act, and the Patient Act, led by Senators Cantwell and Grassley, Sanders and Cassidy, McMorris Rodgers and Palone, I think the thing that I've been watching is just how bipartisan it is. Recently I've been thanking my friends in the PBM industry for helping unite the country. With that said, as you go into what are some of the provisions, there are similar provisions across these bills as we're thinking about what has the chance of passing. With all of these bills they have these similar things that we all tend to agree on. We want to pass through drug rebates. So any manufacturer rebates that are coming from branded pharmaceuticals, we want to pass those on to the plans or to the ultimate payer. We want to prohibit things like spread pricing. From a PBM perspective, they don't refer to that as spread pricing. It's risk mitigation pricing. It's a differential pricing. It's basically like if I buy a cell phone, I don't pay the cost of the cell phone, I pay the price that the cell phone company is charging me. And you can call it a spread if you want, it's their gross margin. So there's challenges here in terms of I think we've seen cases of you hear this one drug, this spread price is $10 but over here it's $100. What's the difference? The product or service is the same. Why is this spread such a big deal? Also, you hear things like clawbacks or direct and indirect remuneration (DIR) fees. This is an area that seems to be where there's a lot of traction as well. The contract with pharmacies typically have situations where if you earn $100 on a claim for reimbursement on that claim at the end of the year anywhere from 3% to 10% may be due back to the PBM.

As I share with my friends in the pharmacy business, if you get rid of the DIR fees, do you think your total reimbursement will be higher or lower? And the response is overwhelmingly, “Oh yeah, we'll probably just get less money upfront.” So I think the challenge is okay, DIR is kind of a bad guy right now but just because you get rid of DIR doesn't necessarily mean pharmacies are going to make more money. And then additionally, part of the bills we also see annual reporting. It's a little mix on whether it will go to Federal Trade Commission (FTC) or the Government Accountability Office (GAO) and then the reports go to Congress. So the final bills will be interesting in terms of what they will ultimately look like. I want to touch on a couple of different things on drug price focus legislation. So we have the SMART Prices Act with Senator Klobuchar leading and as of earlier this week, I did not see any Republican co-sponsors and I don't really expect any because this bill is expanding the drug price negotiation program in the IRA. That's very partisan right now and I don't know where you land on the IRA and what it's doing with drug price negotiation but it doesn't seem to me that there's a lot of support in expanding it just yet. That may change in a new Congress. I don't know. In terms of the Expanding Access to Low Cost Generics Act, Senators Smith and Braun have introduced that bill to reduce the practice of parking. Parking is when a brand manufacturer essentially is agreeing not to sue the first generic company that's coming to market. So I'm just kind of working on that deal to delay that release of the generic. I think that's something that seems to be bipartisan that folks can get around. And then another bill that Senators Warnock and

Kennedy are behind is the Affordable Insulin Now Act, which is taking that $35 cap that we saw with the IRA and trying to get that to private plans.

And this is where it's like I don't know how many degrees I need to figure this stuff out but figuring out how are we actually going to pay for that? If we cap a price what's it going to do back to the premium? What's it going to do to the ultimate price we're paying for it if it's not actually lowering the price of insulin? So that's why I want to jump into myths. The first myth is about PBMs. When I see the term middleman, I immediately think you're either biased or you don't know what a PBM does. And that's just how it is. So when I saw the FTC headline "deepens its inquiry on prescription drug middleman" I said, "oh well, either the FTC is biased right now or it doesn't fully understand what a PBM does." To lump them into a pejorative term like middleman is totally ignoring the service that they've done and developed over 70 years. I think the first PBM's were developed in the early 1960s or late 1950s and they have evolved on services that we asked for. The second myth is that vertical integration is always bad. It's always like "oh vertical integration this terrible thing." Does anybody own an iPhone or an Apple product? This company has built a multi trillion dollar company off of a vertical integration model. Vertical integration in itself may or may not be a bad thing. It's just we need to evaluate when vertical integration may or may not hurt consumers. So the real question should be when is vertical integration bad? So maybe it's not a myth. Maybe it's a partial myth. The third myth is that PBM's are not transparent. This seems to be a big kick about we just need more transparency. I showed you a supply chain earlier with the manufacturer, wholesaler, pharmacy, PBM. If we're asking for transparency from the PBM, PBM's are responding to requests for proposals (RFP). They're responding to what payers and employers want. I believe that they're transparent with their customer - they're saying, "Okay, we responded to what you want, so put it in the RFP if you want it". I think PBM's will respond to that. So, I think they are transparent with the agreements that they make. What's probably challenging is, as a general public, it's so convoluted in terms of what we're paying for what we're getting.

And I've always been frustrated about how many degrees do I need to understand my benefits? I don't know if I can get another degree to understand this anymore. And it's still confusing when I go to the pharmacy or even in October when it's sign up period for your new plan. So maybe those are things that we need to work on and how we talk about transparency. And then what's the role of transparency for the other members of the supply chain? Pharmacies, wholesalers, and whatnot. Now we also have some drug price myths. I'll cover these and then go ahead and pass on to the next speaker. Myth one, and this might be controversial, maybe it's a partial myth - the U.S. pays too much for prescription drugs. I've done analysis on brand and generic drugs and the biggest misnomer is that we pay the most for drugs. For generics we pay the lowest of our comparative countries - Organisation for Economic Co-operation and Development (OECD) countries. We have for many, many years. But what we've done in this country, we've made a trade off since the 1960s that if you bring a new drug to market we grant you a monopoly for a period of time, and then you charge us monopoly prices. You charge us very high prices when you have a branded product. So we see these huge prices for the brand drugs. That is true. So both are true. So we have to be careful when we throw out things like drug prices because on the generic side we're seeing drug shortages. Drug shortages may be a function of a supply chain that's not supported. Myth two is that co-payment caps lower prices. They do not lower prices. They lower the price to the patient that's exposed to it. I explain copayments and premiums to my students as the co-payment is a tax on the person using the insurance. Or the sick. The premium is the tax on the whole population. I think you have to explain it that way. And so if you're not doing something to lower the actual price, then the co-payment cap isn't necessarily lowering prices. And the third myth is that price transparency will lower prescription drug costs. I'm sorry, this is also a myth. If you have a rare

disorder that can only be cured by a certain drug, your demand for that drug is inelastic. It does not change. And you will pay whatever it takes to get that drug. If you are having a heart attack and you get into the ambulance and the EMT pulls out an iPad and starts giving you prices for the nearest hospitals your decision making is not going to change a whole lot. Get me to the first hospital that can fix my heart. So my point is some drugs actually do have elastic demands and price transparency can help but some drugs it's not going to matter.

David Root, VP of Gov't Affairs at Prime Therapeutics, thanked the Committee for the opportunity to speak and stated that I feel compelled to say that in 15 years of working in the PBM business I have not witnessed a more balanced presentation of how the program works so let me take a moment to say thank you to Dr. Mattingly. I can assure you that I have never met him but I think we will be talking again soon. I think it's really important to take what you heard here a moment ago and try to derive some questions and hopefully you'll have some questions for us. I was asked to sort of talk about the legislative state of play at the federal level. So let's go ahead and walk through that a little bit and see how that comports with what we've just heard. So here are the issues that are in play through a variety of bills. I just want to read them off to you. A ban on spread pricing, FTC regulation of PBM's, mandatory rebate pas through, public reporting of drug pricing codifications, delinking of PBM's compensation to the list price, expanding FTC studies of PBM's, PBM's required to be fiduciaries, formulary tiering, pharmacy DIR fees which is an interesting prospect in itself because CMS fixed that last year and it takes effect next year so it's been addressed, yet we have five bills in Congress right now readdressing it. And we have Employee Retirement Income Security Act of 1974 (ERISA) preemption, step therapy restrictions, issues around biosimilars, rebates for highly rebated drugs, particularly insulin, and cost sharing for insulin. Those are the issues. Now, what are the rules? The rules are that you need 60 votes in the Senate to pass anything so even if the House bill comes over they have to get 60 votes to pass and right now, the House hasn't been able to organize itself to make those things happen around any particular piece of legislation and the Senate has multiple committees of jurisdiction that are vying for their version of healthcare reform.

Now, which one's going to come out we don't know and how they're going to get there, it's going to be hard to tell. There are 14 days left between now and the August recess and they come back and next year starts and is an election year. Is there enough time to do this? Only Senator Schumer, who's in charge of the Senate, will be able to determine that and then once they figure out the time, they have to be able to get to the number 60. We all want lower drug prices. The problem is that list of issues I just read don't represent lower drug prices. As we just heard in the previous statement, there are consequences for every action, so I love the equation. You take an equation everybody remembers from chemistry class. If you do one you have to do the same thing on either side of the equation. If you lower the out of pocket cost, you're going to have to raise the premium because none of those issues address the overarching issue and the overarching issue is that the manufacturers are the ones and the only ones that set the list price and have the ability during the course of any given year, to raise the list price as they see fit. And we have proof of that now as we've seen over the years, the three major insulin manufacturers have finally come out publicly and said we're going to lower the cost of insulin to between $35 and $50 depending on which manufacturer it is. Well come on in guys, join the water. We've been in that pool for the last five to six years. For the last five or six years the majority of the PBM membership whether they are employer groups or plans have not paid more than between $35 and $50. The highest in the $55 category usually being the people in the high deductible health plan space but we've been able to even mitigate that. The people that are exposed to the list price are the insured. That is a problem, but that exposure is to a price that is not set by the PBMs and it is an exposure that is not addressed in any of those

issues in any of those bills. There have been 11 hearings in Congress so far. Not a single one of those hearings has addressed the single question of why does that drug cost so much? Why is that the list price for a new drug? There's this wonderful category I like to call the “me too drug.” So, you take a category like multiple sclerosis (MS) and there are a ton of drugs in the MS category, they all have roughly the same value in that they treat MS in the same way with roughly the same level of side effects and the same potential amount of side effects. But there's a new drug and the only difference between that new drug and the other 19 drugs in that class is that the new drug costs 20% more than the last one that entered the class.

And so the PBM's job is to come along and negotiate with the manufacturer and say, “we want a better price. Your drug is no more efficacious than the other drugs. Give us a better price and we'll prefer that product and we'll help drive our members, the individuals and the benefit sponsors, to the lowest possible cost for the healthcare, the lowest possible cost for the product.” That’s the role that the PBM’s play in the supply chain. We force pharmacies, we force community pharmacies to compete on price and service which is directly extended to the member at the counter. And we force manufacturers to compete on price and efficacy which is again towards the benefit of the consumer. All of this legislation is being driven by those two entities because they don't want to be forced to compete. They don't like it, and I understand that. But the bottom line is if we don't force them to compete, they continue to drive healthcare costs up and up and up with the manufacturers driving it up with launch prices and ever increasing price structures for existing drugs. And you take the pharmacy's, it’s a simple question - if I take my benefit to a pharmacy today and it costs me $20 at that pharmacy and a state passes a piece of legislation and I now go back to that pharmacy a month later and I get the same product and it now costs me $30 for that product, how has that lowered my healthcare costs? It hasn't. It's just transferred more of that healthcare dollar away from the consumer and away from the health plan and giving it to the community pharmacy. Now, there may be people here that share the attitude that we need to protect community pharmacies and we need to do this and that and that's your right to talk about that. But I'll suggest that you need to be very careful. That's a slippery slope. If you're going to protect that group, then what are you going to do for the used automobile salesman? Or what are you going to do for the hardware store because Walmart came to town? Or the food store because ALDI came to town? So you need to really think about the consequences as you go through those actions and you need to ask yourself, “are we really lowering the cost of healthcare or are we just transferring money?” And more often than not we're not lowering the cost of healthcare, we're just shifting money from one entity to another and it's away from the consumers.

Rep. Stephen Meskers (CT) stated that I'm going to start off with an observation and then the question. The last comment you made was that we're transferring money around and I would challenge you on that’s probably an inaccurate assessment. But that's what we're doing now with the entire PBM and pharmaceutical money. We're transferring the money of my constituents into the pockets of pharmaceutical companies and into PBMs. And in the U.S. we’re paying three or four times what they’re paying in the OECD countries for pharmaceuticals which tells me that our pricing mechanism is broken and that if I have to look at a PBM model and I spent enough time on Wall Street to know that if I can’t figure out the model, someone’s got their hand in my pocket. So, if the model is broken, the question is how do we fix it? The most logical model for me is to use a negotiated price and the negotiated price for our pharmaceutical industry versus the OECD countries is a premium to make sure research, development and technology stays in the U.S. So I don't know if that's a 20% premium over Switzerland or England or Holland, or you name the countries in the OECD, and a premium to keep the development here. But the U.S. should no longer be subsidizing cheap European and international drug prices at the expense of our constituents. And the question is, how do we get

more transparency where I'm not paying four times what my Canadian colleagues are paying for drugs? Because I'm subsidizing the world? And that's research and development, stock buybacks, executive compensation, etc. I'm not against any of those but I'm not sure why I'm footing the entire bill for that in the industry and I don't think PBMs solved the problem. And all of the bills I see before Congress, I feel like they chase me down a rabbit hole that gets me nowhere in terms of generating the fundamental problem. I thought what we did at the national level in the Infrastructure Act to require some negotiated drug prices was the first salvo in saying transparency in pricing. And I'm not sure if any of the rest of this gets to that point. And so, I guess the question is, shouldn't we be negotiating our drug prices at some premium to keep the industry here? And isn't that the best way to improve the model?

Mr. Root stated that's exactly what the PBMs do is negotiate those drug prices. If you feel as though we're subsidizing the rest of the world, that's a question to ask of manufacturers. And in some respect, I don't disagree with you. We are. If you look at a manufacturer bringing new drugs to the world market, they have a very specific way in which they bring that drug to market across the globe all designed to be able to increase its price when they get to our market and North America and a few other industrialized countries. So we are subsidizing that. You're asking that question frankly to the wrong person. We would agree with you that we need a better way to make them accountable for those drug prices and to get them to be more realistic because I think what you're actually saying is that for the most part a lot of these new launch prices are not realistic. Not only are they not realistic, but they're not sustainable. But without our ability to leverage the lives because that's what a PBM does, it leverages lives and we go to the manufacturer and say you've created this great new product. That's fine. We've got 140 million lives and we want to be able to have those lives have access to your product but we can only do that if you give us a better price because your list price isn't going to cut it.

Rep. Meskers stated that I guess that's the observation I'm making is that the PBM is trying to negotiate a drug price in a market that lacks both negotiating strength and strategy from the point of view of the fact that we're paying three and four times what OECD countries are paying. So if it was effective, and it's not an attack on PBM's, it's the structural problem. If we don't negotiate drug prices at the national level we're always chasing some hope in the future for rational drug pricing in the U.S. and everyone else is benefiting and that's the observation. Mr. Root stated that's a fair observation and I would argue that from my perspective, I would say that the PBM negotiations do work. I would say in the interest of honesty, there's one place where they don't and that is where we have no leverage and that is orphan drug status - the rare orphan drug disease where there's one drug in the class, there's no competition and we therefore don't have the ability to leverage the two competitors against each other to get a better price. So in that respect, we do fall down as an industry. That is a place where we don't negotiate very well, not because we can't but because there just isn't any leverage to drive that market competition.

Sen. Pam Beidle (MD) stated that my question is about the independent pharmacies for Mr. Root. I am a little confused by your comments about the independent pharmacies. What my pharmacists are telling me is they have no cost of distribution. They're actually losing money when they distribute and sell certain drugs. So how do we answer them about lack of cost to actually do the distribution of the drugs? Mr. Root stated that a great question. The first answer to that is to be intellectually honest and say that yes, they are losing money on some of the drugs that they dispense. Our reimbursement to them is designed to be two things. It's designed to be a total basket of reimbursement so cherry picking an individual drug where you might have lost $100, 50 cents or even $250 serves an illustration, but does not actually represent the whole. The second issue is that our reimbursement incentivizes them to be

judicious purchasers of those products. Generic drugs, especially generic drugs, are available in the marketplace from a variety of different sellers, wholesalers and manufacturers. We try to incentivize through our reimbursement to make those pharmacies buy those products at the cheapest possible place so that our members can then have that savings. And when they don't, it becomes a problem for that pharmacy. When they are not buying that drug at the most judicious location or in the best possible way, that is causing a problem for them but our reimbursement is specifically designed to do both of those things because both of those things put downward pressure on the price of the product for the consumer when at the counter.

Dr. Mattingly stated that we're studying pharmacy closures in the U.S. at the University of Utah. The independent pharmacy closures situation is quite complex. In a period of where pharmacies net grew in the country from like 68,000 to 69,000 over about a 10 year period, still we had about 12% of pharmacies would close in any given year. So there's a lot of churn. Also in my former life, I was a district manager for the Kroger company, which had a $4 list. For every drug on that list, if I got $4 from a patient, the drug may cost pennies, but the operational cost to put that prescription together and pay the pharmacist and pay the overhead and all the technicians was typically $6 or $7. Every single product that left that pharmacy was at a loss. Pharmacies have selectively done this on purpose because when a patient comes in with their generic blood pressure medication they might also have a more expensive product that I make $200 on and so that's probably more just cutting to it. Pharmacists, my own people, have sold at a loss strategically and now we're saying that differentially, when your patient population changes like maybe a certain drug goes generic and then it goes to that low price all of a sudden that used to be a big money maker for you. It’s not. And so I think what we're seeing is that as patients change, as communities change, the pharmacy that’s been there for 75 years is now covering a patient population that's not profitable to them anymore and then those pharmacies without any carrot or anything else close. And that’s why I think it’s complex and also part of during my time as a district manager we had a pharmacy in a small town in Southern Illinois that closed. It was devastating for the community. So again it's complex. The problem is when we start talking in aggregate and who's making what, the nuances gets lost.

Rep. Forrest Bennett (OK) thanked the speakers for their presentations and stated that I enjoyed hearing you talk about wanting to lower the cost of drugs and I have been educated well on PBM's and this whole chain. I think on behalf of my constituents and consumers, I would love to see us lower drug prices significantly and my general question is, my colleague from Connecticut was much more detailed, but I struggle to understand how anyone in this chain is actively invested in lowering the cost. Because your bottom lines depend on it. A PBM negotiating a lower price still needs that initial price to be very high in order for them to make a profit. So I would love to know where you see the spots in this chain that are ripe for reform, that will actually lower drug prices as opposed to what you said, which is true, which is moving money around. Dr. Mattingly stated that you're absolutely right. Every part of what you just said is accurate. If our reimbursement to pharmacies, if our payment of drugs is a function of the drug price, every contract in that supply chain is a function of that drug price. And if you're making 3% or 4% on that product, you'd rather have it be a $1,000 product than a $20 product. So I applaud you for calling that out. So if you disaggregate that then the question is okay then do we pay a cost for the drug and then how do we figure out what is the value of the pharmacist service? What is the value of the wholesaler maintaining a cold supply chain to make sure the insulin is not sitting in a hot factory somewhere? How do we disaggregate that? And it's messy, but I'm willing to jump into it because I think what you're getting at is really important. But one thing I have to keep going back to is our drug prices aren't always high and if we're not willing to address patent law, if we're not willing to address that, then we're not touching that piece and I don't know what else to say besides we'll just leave it there and we'll just keep

dancing around this issue of we're going to incentivize the innovation and then we're going to reward that company for billions of dollars. And some will say, “well, what's your marketing cost? What’s your research and development (R&D) cost?” It's not the R&D cost of that drug, the billions of dollars that go to that drug company fund the R&D for the other 20 drugs in their pipeline. And they have to pay for the failures too. So I hate it because I'm an economist that also is calling it out that I want it to be lower, but also if I get a disease that's not cured yet I'd like there to be a product in a few years for that to be there. So unless we're willing to have that conversation, I don't know how to answer it.

Mr. Root stated that was a great question and actually very insightful. Patent reform we would argue is critical. That is something that would begin to lower the price. The pay for delay program that manufacturers engage in with generic manufacturers that actually pay them to not bring their generic to market so they can keep their branded product, their monopolized branded product in the market a year longer. And when we say maybe a year longer, let's make sure we understand what the dollars are. One drug, Humira, made $4 billion last year. So when we talk about just 12 more months, 12 more months can be a lot of money. A lot of money. And they're willing to do that. We need to see FDA reform. We need to see them reforming the citizens petition which is another form of pay for delay that the manufacturers engage in. I think it was just at the beginning of this year or in the middle of last year, one manufacturer, in order to extend the life of their monopoly, sold the patent rights to their product to an Indian tribe. Because they were going to get out of the federal monopoly law and be able to continue to be the sole proprietor for that product for another period of time. That was overturned but they tried it. Those things have a direct impact on the list price of the product. They will lower that price. And we know, as I said before, that the manufacturers have the ability to do it. The three top insulin manufacturers just did it and so starting I think in September of this year, you're going to see $35 insulin. And further to that point, within the PBM space, every PBM has figured out a way to get that insulin preferred on their formulary and get that $35 insulin to their members. So the idea that we won’t go after the low cost product, that's not true. The one comment I would have to your question that I would say is not really accurate - our contracts with payers are performance contracts and performance in the PBM space as it relates to payers means getting them the lowest net cost for the drug. So we have to deal with the high list prices that the manufacturers set because only they can set them but we use market tools and market leverage to ultimately get those prices lower so that's the lower price that the benefits sponsor and the consumer actually pay. So our contracts are driven, we profit, we make money when we provide the lowest net cost for each of the products. Not when we provide the highest. Think about that. If you were going to put out an RFP to build a road would you award it to the person who added a $1 million cost to the building of that road? Or would you award it to the company that took $1 million out of the cost of building that road? That’s what we do. We do not add costs to the system. We reduce the initial cost of the product. Do we make a profit when we do that? Do we make money when we do that? Yes, we do. We’re a business. If we did this and it didn't make money we wouldn't be a business, we’d be a charity.

Sen. Bob Hackett (OH) stated that in Ohio, our big companies are really called the Business Roundtable and when you look at the rebate, that rebate between the companies is never disclosed. We've been trying to get that rebate. The state of Ohio won't give the amount of the rebate. So the PBM's do a tremendous job for the big companies but when you saw that federal legislation that's pending that all the rebate would go through, for the smaller and mid-sized companies, they are not giving them the same rebate that they give major companies. So the PBM is keeping that rebate because they're getting that rebate from the drug manufacturer because it's based on the volume of that. So the question is, will that legislation be the solution? How do we get out of that problem? Because the big companies don't want to

change the system, they love the PBM system because PMB's negotiate for them and they get huge rebates. But the smaller guy doesn't. The mid size doesn't and the PBM pockets that. And I realize once again their costs are higher. So how do you react to the rebates that the PBM keeps?

Mr. Root stated that's a great question and it draws a level of specificity. When a PBM negotiates rebates, they negotiate the rebates with the drug manufacturers for their entire book of business which includes the large companies and the small companies. Each company gets their portion of the rebate as it's allotted to the total slice. So if you're 13% of the total rebate aggregation, you're going to get 13% of the rebates that are negotiated. That's how that works. Many of those mid-sized to small companies are also working through a health plan and so we're taking all of those lives and we're negotiating that and their contract is not with the PBM. Their contract is with the health plan and their portion of that rebate is negotiated with that health plan. If they don't like that negotiation, we encourage them to go with another health plan or reinvigorate their negotiation or go direct to a PBM. If you're a mid-sized company, you can go directly to a PBM without going through an insurer but a lot of them go through insurers because the insurers are able to do a lot more for them and they're able to aggregate a lot more if there are other benefit issues. So they actually are getting that. The PBM's aren't keeping that rebate. You can't just keep money and not claim it and hide it. That's not how it works, especially with for profit PBMs they have financial disclosures. Every dollar has to be accounted for. Sen. Hackett asked so why does the federal legislation say that all the rebate should pass back to the plans? It doesn't now. Mr. Root stated that it does that now. We don't have a problem with that legislation, the fact that you have legislation that says that 100% of the rebates have to pass through to the benefit sponsor. The only question with 100% of the rebates passing through the benefits sponsor is a lot of those smaller mid-sized companies that don't have the cash available to pay for the quality benefit that they offer their employees, will offset payment for that by allowing the PBM to keep 2% of the rebates that they collect for them. And that is a form of payment for them. So if you take that away in the legislation and say 100% of the rebates have to go back to the plan sponsor, we're fine with that. But then that means, as Sen. Mitt Romney said in the last hearing, that you're now eliminating a flexibility option for that mid-size employer to offer benefits for their employees.

Rep. Linda Chaney (FL) stated that I sponsored a PBM bill in Florida so I got pretty deep in the weeds on this stuff and the one question I never got answered meeting with the Pharmaceutical Care Management Association (PCMA) and PBM's like yourself is they constantly said that they are not a middleman and that they provide a service to reduce drug costs for the consumer. Yet, drug prices have gone up 180% and three PBMs control 80% of the market, and are number five and six on the Fortune 100 list. So how can you say that you are not a middleman because you don't manufacture. You don't warehouse, you don't touch the product. You're basically pushing paper, negotiating that appears to be for the benefit of your profits, not the discount to consumers based on how drug prices have increased and how your value as a company has increased. So my first question is what is a PBM if you're not a middleman? And your purpose is to reduce cost to the consumer, yet there's no evidence of that. Help me with that. Mr. Root stated that I would go back to the presentation that we heard earlier from Dr. Mattingly and say that we are a middleman, I don't shy away from that. But I don't use that term with the derogatory intention. We are in the middle between the consumer and the manufacturer and the pharmacies. So yes, we are in the middle and we aggregate those lives and we negotiate with manufacturers and pharmacies to create networks and create prices for those drugs that ideally are sustainable. I might ask that question another way. So looking around this room, there is not a single state that's represented in this room either up here or behind us that hasn't passed some version of the bills that we just listed off and many of the

states have had these versions on the books and many of them in the past few years. And I agree with you, prices haven't gone down. I agree. This year alone, the manufacturers in the first quarter of the year did what they always do, the top 25 manufacturers came out with the top 200 drugs that they raised the price of between 9% and 15% across the board. I agree with you. But that has nothing to do with us. We take that raise, we take that price and we negotiate with the manufactures with the lives that we have to ultimately have payers and consumers pay a lower price other than what they've said is the list price. So I think we do our job well. If you want to look at it try looking at modeling a world where there isn't anyone between your pocketbook and PhRMA.

Rep. Chaney stated that so with the rebates that you require the drug manufacturer to add on top of the cost of the drug that goes to the PBM how is that reducing drug costs for the consumer? Mr. Root stated that well, first of all, we don't require the rebate. The rebate is offered to the PBM price. Rep. Chaney asked isn't that required to be on the formulary though? Mr. Root replied no, we do not and the case of point will be the three insulin drugs. Those three insulin drugs will not have rebates. They'll be $35, they'll be the lowest net cost and they'll be the preferred product in those classes. So again, the manufacturers offer us the rebates in order to gain that favor. Rebates were a construct of the manufacturers, not the PBM's. They wanted to be able to create that level of preference on the formulary. Rep. Chaney stated that one of the biggest battles I had with the bill was specialty drugs, which there's not a definition for specialty drugs. Best we can tell, specialty drug means that it's a high price drug with a high profit. So our bill defines specialty drugs. But if the PBM again is focused on lowering drug prices, why fight so hard to protect the margins in the specialty drugs? Mr. Root stated that because the cynical way that specialty drugs were defined is not really accurate. So there are some definitions for specialty drugs. CMS has a specialty drug definition that talks about price, it talks about storage, it talks about the issues that center around the utilization of the drug. And so a drug on a specialty drug list is dependent upon all of those things. What kind of administration does it require? There is a price component to it. The shipping. The access to the product. And then ultimately it's a product of the decision between the benefit sponsor. There are different benefit sponsors in this room, represented by the various state health plans where you will have a drug on one state health plan that will not be considered a specialty drug, but that same drug on another state health plan will be considered a specialty drug. And that is not a product of the PBM. That is a product of the health plans' decision in how they created their formulary. So we administered that formulary.

Rep. Carter stated that we have to move on to handle the other topics on the agenda. This conversation has been very beneficial. I am going to follow up personally with you both.

OVERVIEW OF MINNESOTA'S "BASIC HEALTH PROGRAM"

Rep. Carter stated that next on our agenda is a presentation on Minnesota's basic health program which will focus on which states have them and what has and has not worked for these states. In your binder on page 51 is some background information that you might want to look at for this presentation. This is also on the conference app and website.

Julie Marquardt, Acting Assistant Commissioner and State Medicaid Director at the Minnesota Department of Human Services, thanked the Committee for the opportunity to speak and stated that I am going to speak to our basic health program in Minnesota. Its name is MinnesotaCare and that would be the name that all Minnesotans know it by. Mmost Minnesotans don't know it's a basic health program. Just to go back to the history of MinnesotaCare. The program itself predates any federal opportunities for having basic health programs. The program was

originally established in 1992. It was established as a subsidized program. It was for families who are making too much to qualify for the state's Medicaid program but were really still struggling to afford health coverage. It had bipartisan support. It was established under a Republican governor with bipartisan legislative support and it has enjoyed quite a large amount of bipartisan support since then. It is a statewide program. It is offered in all 87 counties in Minnesota. If you don't know Minnesota, there's kind of seven counties that are considered our metropolitan area and then there are 80 counties that are often referred to as Greater Minnesota. More than 50% are in Greater Minnesota that are served by this program so it has a large reach across our entire state. In 1995, CMS, which had a different name at the time, still allowed states to operate under a waiver and so we were able to bring this program under a waiver. So instead of having all state funds we were to finally get some federal Medicaid matching funds. It didn't cover all the population but we were able to receive some federal funding to help support the program. Ultimately it was a program that covered children and families that otherwise could not get coverage but it expanded eventually over time to include adults without any children.

As I mentioned, today it operates as a basic health program under federal law. We established our program in 2015. We were the first to establish our program, New York also established their program in 2015 but we launched ours a little bit ahead of theirs. It is a state and federal program. It is not part of our Medicaid program. It operates under a different authority and I just give for reference the section of the Affordable Care Act (ACA) that authorized this and it allows states to purchase coverage directly for people. The way that it's funded is by pooling the premium tax credits and cost sharing reduction subsidies that they would have otherwise received had they gone through the exchange. As I mentioned there's two states, Minnesota and New York who operate basic health programs. And I mentioned for now, because Oregon is a state that is looking to expand and include a basic health program and I know that work is underway and that study is underway. There have been other states that have studied it. I don't know that there's any state other than Oregon that's getting close but there have been states who have been interested in setting up basic health programs. So, going back to the population today, it serves more than 100,000 Minnesotans. It is mostly adults over 18. Many of them are parents whose children may be on our Medicaid program. The income level they are making between 133% and 200% of the federal poverty guidelines and just to give a context that's somebody making no more than $27,180 annually and for a family of four they are not making more than $55,500 annually. The coverage that we offer under our MinnesotaCare program is comprehensive. It has additional benefits that are not typically available under most of the individual market plans. We do have to cover the essential health benefits that are offered in the market plans but we also have dental for adults and children. We have eyeglasses coverage and we have a broader array of behavioral health benefits than the typical exchange product would. This program offers low cost sharing. We have a 94% actuarial value and certain populations are exempt from any cost sharing. So that would include, for instance, children under 21, American Indians or Alaskan natives are all people who are exempt from cost sharing under the program. The way that the services are offered is through our managed care organizations that are contracted with our department. This is required under the basic health plan regulations. You have to offer it in kind of a managed care construct. Also, within the regulations we have to offer at least two health plan choices to individuals on our Minnesota year program. We have nine health plans that are currently contracted with us and Minnesota has a broad array of health plans that do business in this state. We have five licensed private health maintenance organizations (HMO's.) We have one licensed county owned HMO which is Hennepin County, our largest county. And then there are three county based purchasing organizations that offer a county based purchasing plan and that exists in 33 rural counties. And so there is a wide array of options for people to choose from. We leverage our Medicaid

contracts and we negotiate this as part of those offerings but this is operating as a separate program but it includes the same organizations that we contract with in our Medicaid program. As I said, the financing comes from the state and federal government. For the federal funds as I said, it's 95% of the tax credits that would otherwise be available to those individuals. With state funds the state has a healthcare access fund, which is funds that are derived essentially from a state tax on hospitals and other providers. We also have to use state funds to pay the administrative costs to operate the program. So those tax credits that we draw down from the federal government cannot be used to pay for any of the administration that we have to operate the program in our state.

So our healthcare access funds, which are derived from those tax sources are what we use to fund our administration and then there are enrollee premiums. That's the third source of financing for the program and that is based on a sliding scale and ranges from $0 to $80. And I have January of 2024 there because during the Public Health Emergency we charged no premiums and our legislature last session extended that through our resumption of renewals for Medicaid because MinnesotaCare when we kept continuous coverage, MinnesotaCare was included in that continuous coverage. So we are restarting renewals for our MinnesotaCare program this year too but we will not be charging premiums until January of 2024. So there is a lot of learnings that continuously go on with our program and a lot of it is just to understand the marketplace and the populations and that has changed over time. It's changed a lot since 1992 and it's changed a lot since 2015 and really figuring out how does the basic health plan fit into our marketplace, really understanding who are the uninsured populations. What does your Medicaid program coverage look like? Each state has different Medicaid programs that cover different populations with different benefits. So, really understanding who's left out there when you've put together your individual market, your Medicaid program and what are you trying to accomplish with it? And then financial considerations and relationships - knowing that you have to cover administrative costs. How are you going to do that? What is the impact of bringing a basic health plan into that continuum on the individual market? What does that do to your Medicaid program? And trying to understand that and mitigate any unintended consequences if you can. Then there's a whole question about benefit design. What benefits are you going to offer? There's the 10 essential health benefits that you have to offer but when Minnesota stood our program up, I would say it is more like a Medicaid benefit. We kind of leverage our Medicaid benefits and our rates but other New York perhaps has leveraged more of a commercial in their marketplace versus using some other metric. You could use Medicare as a metric.

Essentially, you have to provide those essential health benefits, and then you have to market to a benchmark plan and there are a variety of options for benchmarking. The one that Minnesota happens to use is the Federal Employees Program and then you have to determine cost sharing and 94% actuarial value is the lowest that you can go. So Minnesota has adopted the highest amount of cost sharing that we can apply but that's a consideration of also, we have some benefits that don't have cost sharing that apply to them as well so anyone who accesses certain benefits will not have cost sharing that applies and many of those are in the behavioral health spectrum of care. With anything, there are opportunities. So there are economies of scale. In Minnesota, we leverage our Medicaid program. In other states, they may consider leveraging their marketplace infrastructure but one way or another, you need to be able to negotiate rates with health plans. You need to have an infrastructure where you can do benefit design, where you have policy development. But that can exist in other places than a Medicaid program. Minnesota used our Medicaid program infrastructure to really leverage our operations for our basic health program. But we operate the MinnesotaCare program out of our department. So unlike our Medicaid program, which is kind of distributed to the seven counties, eligibility occurs

there. For the MinnesotaCare program it's centralized at our department and that was just a decision that was made for efficiency, to make the administration cheaper to operate. As I said, we leveraged our purchasing power with our health plans and negotiate with those nine health plans both for their business in Medicaid alongside their participation in MinnesotaCare.

And then policy development. Whenever new benefits come on to our Medicaid program we have to think about what does that mean for MinnesotaCare? Are we going to include coverage in MinnesotaCare? If we make rate changes in our Medicaid program is that going to impact the cost of our MinnesotaCare program? And if it is then we have to factor that in and so sometimes we do make strategic different decisions about things to cover because understanding the populations, the MinnesotaCare population is not the same as our Medicaid population. So it's not an automatic that everything we cover in Medicaid is covered in our MinnesotaCare program. It is not. Then, as I said, we aligned our programs so that people who move from one program to another as families incomes change, they see the same health plans that are available and in a perfect world, we would align Medicaid, our basic health program and the individual market so someone can move across and find the same health plan available to them. That would be ideal. We have a lot of overlap. We're fortunate in that way that people do find those options between Medicaid and our basic health program. There is a tremendous amount of overlap so that is something we're very fortunate to have. There are opportunities to expand to other populations. Once you have a program stood up, Minnesota has used the program to expand to some of our undocumented residents in Minnesota. We offer under MinnesotaCare with state funding and premium payment and cost sharing to people who are covered under Deferred Action for Childhood Arrivals (DACA), for instance.

There is also a great amount of conversation in our state around public options and does the basic health program fit into that? We don't have that today, that is not something that's offered, but there is a lot of conversation. It comes up almost annually as a question and we are doing some research and study to help policymakers and legislators know what the options might be. What those costs might look like and choices that they may have available to them. And then for us it just becomes part of improving the health overall in our state. Really working to help lower uninsurance rates - we enjoy a low uninsurance rate. We hope to continue to enjoy a low uninsurance rate. And also improving access to care so people have affordable coverage that they can actually go and use. And then this is my last slide and these are just two quotes from people who are on our MinnesotaCare program. We had put out a publication a few years ago that included information on our Medicaid program and our MinnesotaCare program and I'm not going to read them to you but essentially this program is covering entrepreneurs. It's covering farm families. It's covering people who work jobs that maybe don't have employer sponsored coverage or people who are working several part time jobs. So they don't qualify for their employer sponsored coverage. So to us, we can build any program and we can get everything we think is right but if the people who it serves don't like it or don't think it serves them well, then it's not a success. And so the quote on the left is actually from a woman who is married to a farmer and the importance of that program to making sure their family had coverage. And the quote on the right is from a person who works multiple jobs, likes all of them, can't get coverage from any of them. So this program fits in. And so, as I said, this isn't the Medicaid population. These are folks who are working and some of them working really, really hard and they're important in their contributions to the state so I just wanted to make sure we gave them the final word here.

Rep. David LeBoeuf (MA) stated that I'm curious especially with the Medicaid redeterminations - we don't have county systems. Our counties really don't mean anything, everything is centralized. What I'm curious about is how that's functioning or what role does this plan play in

regards to kind of helping that population out? Ms. Marquardt stated that every state is doing redeterminations differently. Minnesota is doing our Medicaid population in 12 cohorts. So, we're doing one cohort per month over a 12 month time period. MinnesotaCare will renew all at once just like they always did, they were always for January 1st coverage. So, what will happen during our redetermination periods are we're going to have families, I'm certain, whose income has changed in the last three years who now may become eligible for MinnesotaCare. So, they are redetermined let's say in this month, they were to be redetermined eligible they move on to the MinnesotaCare program and then we'll have a redetermination that again in November but it will originate from the state and come back to the state. There's a lot of coordination we have to do between counties and the state of Minnesota and we have a really good working relationship with our 87 counties to make all of this work. So you do have to coordinate because families move between these two programs but there is going to be a difference for how that fits in. But we will see people move on to the MinnesotaCare program until we reach that redetermination for all of MinnesotaCare and then we'll see some MinnesotaCare people move off of that program, who may have received employer coverage during this time period too.

DISCUSSION ON INTERNAL REVENUE SERVICE (IRS) PROPOSED REGULATION ON CAPTIVE INSURERS

Rep. Carter stated that last on our agenda is a presentation on the recent proposed regulation from the Internal Revenue Service (IRS) that deals with captive insurers. In your binder on page 54 is an opposition letter that NCOIL submitted to the IRS that you may wish to look at, it's also on the conference app and website.

James Kendrick, First Vice President, Accounting and Capital Policy at the Independent Community Bankers of America (ICBA), thanked the Committee for the opportunity to speak and stated that we're talking about captive insurance transactions. You may or may not know that the IRS is looking for money and we're $32 trillion in debt and probably going higher soon and so they're looking for any way to expand upon sources of revenue with taxpayers. And small banks are in the crossfire there through captive insurance companies. So small banks set up captive insurance companies. They create a sub. They generally are set up to protect against unfunded risk. So you think about cyber risk, you think reputation risk, fraud risk. There are insurance policies there all over the country through different issuers for those types of risks but there are many different reasons why a small bank can't be involved in those products. They are very expensive. There's a hurdle to getting to those products and various other issues there. So the banks want to cover unfunded risk. There's a piece of the tax code that allows for that. The bank can set up what's called a captive insurance company and there are many other industries and types of businesses that create these insurance companies. The bank pays the premium to the insurance company. The bank can take a tax write off for that premium. It's paid to the child entity and the child entity is not taxed on that premium. They're only taxed on investment income. That's section 831 of the Internal Revenue Code. But that's sort of where we've been thus far. This industry has become much larger and there are a lot of third party players that have encouraged and assisted many different banks in getting involved in these types of activities.

And banking is not a high risk business but it's a managed risk business and risks are always there so insurance is very important. So of course the U.S. Treasury and IRS have concerns. They're always looking for abuse and the IRS has come out and said these transactions between the bank and its related party could be considered a micro captive transaction and as such it could be what's called a listed transaction of interest. And so when it becomes flagged as that type of transaction you have to report it. You have to tell the IRS that you're engaging in

that transaction. If you do not report to the IRS of course there could be penalties involved and that's never good. So, IRS came out with a with a notice that basically said if your premiums don't cover 70% of the losses you could have what's called the listed transaction or transaction of interest and you have to report that. Of course this was fought very harshly in the courts. For those of you that don't know, at the federal level, there's something called the Administrative Procedures Act (APA). Every federal agency that wants to come out with a rule has to propose the rule. They have to allow for public comment and they have to take the public comment into consideration and issue a final rule. Of course, the IRS did not do that when they issued these notices, so there are some key court cases here - Mann Construction, Inc. v. U.S. in the Sixth Circuit held that when the IRS imposes a new duty on the taxpayer they have to follow the APA. CIC Services, LLC v IRS in a District Court held that this notice that we just mentioned was invalid because it failed to follow the APA.

So now what we have is that the IRS has come around again with an official APA notice and they basically said that these micro captive transactions may be listed transactions or transactions of interest. It's really the same as what they came through with before except this time that 70% ratio has been brought down a little bit to 65%. And then of course, if you're an advisor to a taxpayer now you have to report if you've got one of these listed transactions or transactions of interest. You all have sent comments on this. We have sent comments on this. This is a big deal. Obviously if you think about a community bank it's a managed risk business from a lot of different aspects. But your catastrophe so to speak or your risk events don't happen on an annual basis. For example, if you're insuring against cyber risk you may go two, three, four, five years with no cyber events and then you can have one big cyber risk event that comes to fruition. That's why you have the insurance. It's the rainy day fund so to speak. So we've been very vocal on that front from the standpoint of a small bank, these are very small enterprises, many of them are family owned, they've been in business for 100 years or more. They're not trying to cheat anybody. They're not trying to make a huge profit. They're just trying to serve the people in their specific area and this is really straightforward. There's no need for all of this craziness with getting involved with the tax code for tax items that have been around since the 1980s. So that's kind of where we are now. There was a hearing yesterday on this. The notice of proposed rulemaking, the time limit is up on that so they'll be issuing the final rule on that and hopefully they will consider our comments.

ANY OTHER BUSINESS

Rep. Carter stated that I have one more piece of business to address. You may have seen the news last week that the Federal Departments of Health & Human Services, Treasury and Labor have released their proposed regulations dealing with issues such a short term limited duration (STLD) and fixed indemnity plans. In 2016, similar regulations were proposed and NCOIL submitted a comment letter which you can view on the website and on the app. Also, in 2020, NCOIL adopted an STLD insurance Model Act. Accordingly, following this conference NCOIL leadership and staff will review the proposed regulations and it's likely that NCOIL will comment in some manner. It is also possible that the NCOIL Health Insurance & Long Term Care Issues Committee will hold an interim Zoom meeting in September to discuss the proposed regulations and their implications. If you have any questions on this, please reach out to NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Klein and seconded by Rep. Ferguson, the Committee adjourned at 1:00 PM