NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2023 NCOIL ANNUAL MEETING – COLUMBUS, OHIO
NOVEMBER 16, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Renaissance Columbus Downtown Hotel in Columbus, Ohio on Thursday, November 16, 2023 at 10:00 a.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Brenda Carter (MI)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. Shawn Vedaa (ND)
Asm. Erik Dilan (NY)
Asw. Pam Hunter (NY)
Asm. Jarett Gandolfo (NY)
Sen. Pam Helming (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Larry Walker (GA)
Rep. Brian Lohse (IA)
Rep. Chad Aull (KY)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Jane Pringle (ME)
Rep. Helena Scott (MI)
Rep. Stephanie Young (MI)
Rep. Bob Titus (MO)
Sen. Walter Michel (MS)
Asm. Ken Blankenbush (NY)
Rep. Bob Peterson (OH)
Rep. Sharon Ray (OH)
Rep. Forrest Bennett (OK)

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 Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Carl Anderson (SC), and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 20, 2023 meeting and the minutes of the Committee's October 6, 2023 interim Zoom meeting.

DRUG SHORTAGES AND SUPPLY QUESTIONS: A POLICY AND DATA OVERVIEW

Andrew Barnhill, Head of Public Policy at IQVIA, thanked the Committee for the opportunity to speak and stated that I appreciate the opportunity to kick things off today with a topic of general interest to many of us as legislators and across the health sector as a whole and that is drug shortages. IQVIA is the world's largest clinical research organization. We're also a very large healthcare data organization and so the focus of my conversation this morning for a few minutes will be looking at prescription data and giving you some observations about trends related to drug shortages. Shortages have been an ongoing issue in the U.S. healthcare system for more than a decade and it really is something that matters to all players across the ecosystem. One of the ways and data sources that we want to take a look at this morning is the National Prescription Audit (NPA) which IQVIA conducts and it's the industry standard source of all national prescription activity for pharmaceutical products. It measures the demand for those products, including dispensed pharmaceuticals to consumers across three unique channels. And that's retail, mail service and long-term care pharmacies. And IQVIA as part of this process collects new and refilled prescription data daily that represents over 92% of all outpatient prescription activity in the U.S. So, a lot of these observations are coming from that data set. As of the most recent audit, earlier this fall, there are 132 molecules in the U.S. market with an active shortage and those impact a range of therapeutic areas everything from pain and anesthesia to oncology to central nervous system and infectious disease and diabetes drugs as well. Over the past five and a half years, three times as many new molecule shortages have occurred as have been resolved with those shortages typically lasting more than a year or so. So, that fact right there is really what's leading to a lot of the discussion and concern if you will, surrounding perceived shortages and actual shortages in the U.S. today.

I want to sort of demystify a little bit about what's going on with some of these shortages. First of all, they tend to be in generics, about 84% of them are generic products and they tend to also be injectable drugs. 67% of molecules on shortage today come from injectables and are more frequently multi source products. And this is a big difference from even back a decade ago where you were largely talking about single source products. The market of the shortage concerns largely remains concentrated in a few suppliers which really impacts the ability to readily resolve those shortages when you know one or two leading suppliers is affected. But there are several categories that I think you've probably seen in your research or in news reporting that I want to hit on this morning to give us a closer look at what's going on. One is in the oncology space. So, although oncology shortages have really only impacted a small share of overall volume, the inspection driven disruptions in some market exits have led to significant shortages in older chemotherapeutics and particularly platinum based ones. So, in effect, treatment for some cancer patients has been quite impacted and might be delayed by some of these chemotherapy shortages. And this is why the oncology concerns have really drawn our attention recently. There have also been some mental health molecules that have been on shortage since 2018. So, that's not a new thing with some classes of drugs in the mental health space that have been showing a sharp increase in shortage largely due to demand in the past five years. Another that you've probably heard about a bit recently have been anesthesia drugs as anesthetic shortages have been persistent since 2017, driven by a lidocaine shortage. But this is something that has continued, particularly as these medicines became utilized by patients

of COVID-19 who were hospitalized. That resulted in some shocks to the supply chain that drove up the volumes substantially during that time and have continued as a shortage to date.

Two other categories, one in the antibacterial space. We certainly had a number of public health measures during COVID-19 that disrupted the normal seasonal pattern of bacterial infections, particularly in children, and we've started to see a return in late 2022. And certainly now in 2023, a return to those normal historic infection levels. And so, as a result, we saw a shortage in pediatric particularly the oral liquids antibacterials as the pandemic at the same time was resulting in this unpredictable demand. We've also seen that some of these shortages can lead to concerns about antimicrobial resistance (AMR). So, we want to keep a close eye on this issue with antibacterials as we move along because there is more than just domestic concern here. There's potentially some significant global concerns about antibacterials. The final category is one you're probably hearing arguably the most about in the press right now, which is GLP-1's. So, the GLP-1 agonists are a novel mechanism and this illustrates to us since we're hearing about shortages, that shortages can also affect new drugs prior to the patents expiring. So, it's not just something that you're going to see on generics or those that have been on the market for a long time. But this is a little bit of a different issue and I want to explain the difference here for a moment. So, the first GLP-1 agonist for treatment of type 2 diabetes launched in 2005. However, the attention surrounding this class of drugs really spiked since the launch of Ozempic in 2018 and then the subsequent launch of Wegovy as a treatment for obesity outside of just diabetes in 2021. So, since that launch, Wegovy new prescriptions are up 181% for diabetes, GLP-1 indications, and 257% for obesity GLP-'s in just this very short period of time. So, Wegovy, Ozempic, Trulicity, Mounjaro, all the ones currently on market are experiencing shortages from sort of a different set of reasons as new patients are demanding access across diabetes and obesity. And we see an outpacing of supply potentially causing difficulties in filling prescriptions for patients already on therapies. And what you're seeing is a lot of pharmacy hunting taking place with individuals trying to find those products and going out of their normal neighborhoods or local pharmacies in order to get them. So that's a little bit different than the true shortage issues that we're mentioning earlier, such as in the oncology drugs and in the anesthesia drugs.

But the GLP-1's have shown significant progress for people living both with diabetes and obesity. That's more than doubled since the end of 2020, driven by new patients across those categories. And so this surge is showing us that we are potentially going to see as new innovative medicines come on market that some of the initial levels of shortage might become a recurring issue in our pharmacy ecosystem that we have to wrestle with as time goes on. But final takeaways for us and this group today I think are one that shortages have different causes depending on the market dynamics that are at play and they require a different set of solutions - a variety of solutions and participation from all the stakeholders in the healthcare ecosystem including legislators to resolve and prevent future shortages from occurring. But we should also think about the shortage environment as one that's requiring a careful balancing of patient access with availability, making certain that we can collectively do everything we can as partners in the healthcare ecosystem to eliminate barriers to patient access even in the midst of shortage concerns. So hopefully that provides you an overview about some of the different aspects we're seeing in the shortage landscape and might even elicit more questions for you as time goes on.

AMAZON'S ENTRY INTO THE U.S. HEALTHCARE MARKETPLACE

Tanvi Patel, Director & General Manager of Partner Services at Amazon Pharmacy, thanked the Committee for the opportunity to speak and stated that I'm excited to come here and share what we at Amazon have been up to in our health services space and answer any questions you

might have. So, Amazon Health Services, which encompasses Amazon Pharmacy, Amazon Clinic and now One Medical also, is relatively new but our vision is very clear. They are just much like what we do in all of Amazon we're very customer obsessed. We're focused on the customer. Working backwards. A lot of invention. A lot of iteration, a lot of learning. And then investment in the right places to ensure that our patients that are coming to Amazon for their healthcare can trust Amazon for that healthcare whether it be primary care services through One Medical, digital health services through Amazon Clinic or getting their medications and staying healthy through Amazon Pharmacy. So, I wanted to share a little bit about what we've been working on and the progress we've made to date and then really what our objectives and goals are in this industry and then open it up to any questions you might have. Back in 2018, which is probably when our healthcare journey started with the acquisition of PillPack. PillPack is a service that does compliance packaging for medications for patients that are multi chronic that may have two, three or more medications and they need packets to make sure that they're taking them when they need to take them several times a day, potentially, and which medications, including potentially even over the counter medications they may be taking with that. In 2020 we built Amazon Pharmacy on top of PillPack, which is a multi service, full service pharmacy, which serves home delivery of pharmacy, whether it be acute medications, if you need an antibiotic today. In several geographies we're delivering same day or early the next day. Or if it's your chronic medications for maintenance management which many in the industry have been using potentially for a long time. Getting faster and faster allows us to really serve with convenience where there may be pharmacy deserts and accessibility and affordability of those medications.

And then we launched Amazon Care. Many of you might have heard of that. We learned from what Amazon Care was in terms of how patients were looking to Amazon for that convenient digital healthcare and then we iterated on that and turned it into Amazon Clinic last year. Amazon Clinic is leaning into what Amazon does well in terms of meeting customers where they have needs with providers who can provide those needs. It's a marketplace for digital health. So, it serves about 36 or 37 different chronic conditions. It allows patients to come to Amazon, answer a few questions and then matches them with a third-party digital health provider who can help take care of those medical needs for them and then go on to prescribe or point them in another direction to make sure that they're continuing to stay healthy. One Medical was acquired in March of this year, which is a member based primary health service provider. We have about 200 locations across 28 geographies and growing. Just this year or just last week in fact, we launched a $9 a month for One Medical membership for prime members and about $199 a year otherwise. So, all of these combined really allow us to serve our patients and our customers to get care, find care and then stay healthy. The goals that we have in this space are really around price transparency, ensuring that customers know what they may be paying before they get into it, and affordability and accessibility. So, I wanted to speak a little bit more deeply just about what we're doing in pharmacies specifically to these goals. A couple programs that we've launched recently, we launched Rx Pass earlier this year. Rx Pass is $5 a month for prime members and we have about 60 to 65 formularies on the list of generic medications that are available to the members of Rx Pass, unlimited on that list but the formulary is created such that it covers medications that 150 million Americans take today.

This has been a very great program especially for Americans who are either underinsured or uninsured to make sure that they have the continuity of care on these commonly used generic medications. If they change an employer, if they are not employed but they know that they can continue to get the medications they need to stay healthy in those case. Another program that we launched is Rx Coupon. We work directly with manufacturers for manufacturers sponsored coupons to bring down the price of very popular medications that customers and patients need to stay healthy. For example, diabetes monitors, or insulin down to $35. So, we continue to work

with many of our manufacturer partners for these. And as Mr. Barnhill mentioned, GLPs are another one. We're definitely trying to bring down the price of GLP's as they're dispensed on Amazon to make sure that our patients can get the better affordable prices. Another way that we are thinking about the way folks buy medications in this country is with price transparency. So, when a customer goes to Amazon to buy their medications and they enroll with Amazon Pharmacy or they're working with their physician to say I would like my medications to be sent to me through Amazon Pharmacy whether it be today, tomorrow or two days from now - they are able to see upfront what that pricing may be. So, we're leaning into technology where we can to estimate the price of a medication that that member may pay through their insurance provider. We work with most major insurance providers to make sure that we're serving the majority of the country or we might have a price program. We have a Prime Rx program where many generics are 80% off price and then a lot of brands are 40% off. And then we have the coupon programs in Rx Pass. So, we're able to expose that pricing to the customers so that they are aware of what they may be paying ahead of time. As we're thinking about more and more what we can do in this industry, we're working with health systems providers. We're starting with One Medical understanding what are those customer pain points at that point of care to see how we could help influence the industry to make sure that our Americans continue to stay healthy and get the medications that they need.

Sen. Jerry Klein (ND) stated that this may go back to Mr. Barnhill because one of the things we hear about the shortages is we're depending on foreign imports. Are we as a country getting behind that and figuring out that we don't want to depend on our foreign, some would suggest adversaries, for this basic product that many people are needing? My daughter is a pharmacist and is suggesting that it's a battle to keep up with the prescriptions because they continually are running in short supply. So you talked about shortages. I'm more interested in solutions and how you perceive the industry moving forward. Ms. Patel stated that from a pharmacy standpoint, we work directly with the wholesalers and manufacturers here in the U.S. or elsewhere to make sure that we're getting the right selection of medications for patients. I do agree that we do run into shortages and it is something that we also are trying to influence in terms of are there ways to ensure that the customers who need them are receiving pricing at the right time? Mr. Barnhill stated that I'll also add to your point about some questioning sources of products as well. I think most manufacturers are spending a lot of time and effort right now to diversify their sources of their products and where their manufacturing takes place. And there's certainly a willingness to adapt and I think if you look at where manufacturers are basing a lot of their operations and importing now you've seen some trends shift over the past two to three years so I think we'll continue to see some progress there.

DISCUSSION AND CONSIDERATION 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 next on our agenda is the consideration of a resolution dealing with health savings accounts (HSAs). We will be voting on the resolution today. You may recall that we briefly discussed the resolution during our July meeting and this deals with a very straightforward issue regarding HSAs. You can view the resolution on the website and on the app and your brochure on page 56. I'll recognize Sen. Klein, the sponsor of the resolution, for brief remarks.

Sen. Klein stated that as mentioned, the resolution is very straightforward. It's just meant to encourage an amendment in state law that would ensure that when certain types of laws are

passed, we aren't inadvertently causing people to lose their access to their HSAs. Our state has already enacted this type of carve out and the idea is this resolution would help encourage more states to do so. There is a technical amendment to the resolution that has been distributed that I and all interested parties involved agree to. I encourage the committee to support this resolution.

Kevin McKechnie, Executive Director of the HSA Council at the American Bankers Association (ABA), thanked Sen. Klein and the Committee for considering the resolution and thanked the co-sponsors, Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President; Sen. Beverly Gossage (KS), and Rep. Rachel Roberts (KY), Vice Chair of the Committee. As Sen. Klein described, the resolution in front of you is designed to sit in your state's insurance code and ensure that benefit mandates managed in the insured marketplace which you manage in your state, coordinate with federal internal revenue service (IRS) rules which you don't manage. And that challenge has to be addressed at some point. Just to give you a brief survey of the field. There are somewhere around 45 different bills in the U.S. Congress addressing HSAs. There are something on the order of 750 bills that would impact HSAs across all U.S. state jurisdictions and that field means we have to monitor all of those bills to make sure that they don't propose health benefit mandates that would be in conflict of federal rules. And we do that to protect the people insured by state managed HSA qualified insurance. And that number of people is large and growing. We insure about one in three working Americans. The ABA represents about 95% of all the HSAs in the U.S. This is tens of millions of people and I can't tell you exactly how many of those Americans are in insured plans versus Employee Retirement and Income Security Act of 1974 (ERISA) plans. We know that in smaller states that number tends to be higher. We know that in the larger states it tends to be lower. We have individual examples in many of your states where a benefit mandate was passed that did not have coordination. And probably a lot of you felt the hand of your State Bankers Association as they reached out to try to coordinate and solve that problem. Which is to say not to oppose. First of all, you're right to manage insurance within your state laws any way you wish. And second of all, not to oppose any of the benefit mandates that you may consider meaningful. Our only purpose is to figure out exactly how HSA rules managed at the IRS can coordinate with your state insurance code. And as Sen. Klein pointed out, eight states have already done that and they are Arkansas, Kentucky, North Dakota, Oregon, Pennsylvania, Rhode Island, Texas, and Utah. And what we're suggesting is this is very good legislative structure and it protects the millions of people that rely on insured health plans in your states.

Hearing no questions or comments, upon a Motion made by Rep. Roberts and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the resolution with the technical amendment. Del. Westfall thanked everyone and stated that the resolution will be the presented to the Executive Committee of final ratification on Saturday.

CONTINUED DISCUSSION OF NCOIL MEDICAL LOSS RATIOS FOR DENTAL (DLR) HEALTH CARE SERVICES PLANS MODEL ACT

Del. Westfall stated that last on our agenda is a discussion on the NCOIL Dental Loss Ratio (DLR) Model Act (Model). We are not voting on the Model today. I wanted to vote on it today but we are not and the intention is to have some remarks from interested parties and legislators today and then have an interim Zoom meeting of the Committee sometime in January to vote on some version of the Model legislation so that we will have something going forward as a lot of us have a session starting in January and February. So it's important that we can have some kind of Model to use for next year's legislative year.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), thanked the Committee for the opportunity to speak and stated that I'm so pleased that we have continued this discussion. Thank you to Del. Westfall for pushing the discussion forward. I think the great news is that we've got I think some language on the table and in discussion that we can move forward on where the parties were very far apart. Rep. Deborah Ferguson, DDS (AR), NCOIL President, said in her opening remarks the best thing about NCOIL is dealing with a tough issue and then bringing it together and balancing the needs of the insurers against consumers. And I think this is an issue that is very pro patient. We continue to argue that a DLR will set up the plans to be more valuable if the DLR is established. It will be more valuable to the consumers purchasing the plans and that I think is the end goal - dental plans that work for the patients and give them coverage that they need.

Owen Urech, Director of Gov't Relations for the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that I want to echo that we look forward to continuing the conversation on the Model. I know there's been a lot of back and forth in consideration of different options. As we stated in the summer meeting in Minneapolis, we've seen a lot of success in the regulatory framework that was developed based on the language that passed in Colorado. That would create a reporting and outlier remediation structure for DLR so that your regulators in your state can have a holistic look at a dental plan and the value that it presents and also use loss ratio in that consideration but looking broadly at the value of the plan and how people are utilizing it and moving forward from there so that we have a consideration of what that looks like. So that is our position is that we think Colorado is extremely workable policy but we are happy to continue the conversation and also think that there's a lot of areas where we can have discussions and build a more positive direction on this language.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that we've been having this conversation for a year and it seemed like we were going along at a good clip and then we kind of got off track and then we were going along again and I was a little exasperated the other day because the amount of calls and texts and emails that I've gotten about this has been crazy. But I think that we need to wheel it back here and bring it back and really identify if it's the Colorado model or the Massachusetts model. The percentage model is obviously a concern. Plans moving out of the state because of the percentages obviously, we don't want employers leaving. We don't want people to not have coverage. This assessment model, which sounds great and we're talking about looking and review and remediation later - that doesn't necessarily solve any of the dentist problems with getting increased rates until after an assessment. I'm still trying to figure out how we are helping the consumers with access to care and maybe this is not even the conversation about that. But it seems like dental care is important and equal to healthcare and we minimize how important dental care is. I would like if we could just get back to the basics of what is the problem that we're trying to solve with this model and then how do we move forward. And I know you've had many conversations and we had an interim meeting. The interim meeting produced a different version of the model, and then there's subsequent issues after that. So, I'm hopeful that there will be other legislators to speak up but I feel like we've gone down this rabbit hole for a year and we're back to kicking it down to another meeting which is fine because we want to make sure we have the best model possible but those are the concerns I have. I don't want plans leaving states. I am concerned that this Colorado version seems like a great compromise but again, that doesn't help with increased rates for the dentists. And we can't have all things for all people, of course but I'm worried about consumers not getting the access to care that they need and out of pocket money that they're paying for dental. And it's Medicare reenrollment time and I don't know how many commercials you see every five minutes on TV about you can get dental care and the only dental care you're getting is a fillings and cleanings and one exam per year. I feel like that bigger conversation actually needs to be had in addition to this. So, I just

went a long way in saying I think that we need to just get back to basics with this legislation and see what is the problem we're trying to solve. And we can't be all things to everyone and I'm very concerned about employers leaving and consumers not having access to care and obviously the dentist getting the reimbursement that they deserve.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that similar to what Asw. Hunter said, we seem to be going around and around on this issue and I know when we were in Minneapolis I raised this point but when we talk about medical loss ratio (MLR) I guess I go back and think when that term was used during the whole Affordable Care Act debate it was, if you have MLR it's going to help the consumer. It's going to put more money into the pocket of the providers, etc. Because we're limiting what the carriers can hold and pushing everything else out. The problem I saw in the healthcare side was we went from having probably 15 companies that would write health insurance to two. And now they have just become behemoths in the industry. So how do we make sure that we're not putting our finger on the scale of the market and I don't know how many members you have in your health plans - are there 22 companies that'll provide dental coverage? Or is there eight or two? And so the MLR is going to have an impact on those members, which the end result is we do want to put quote unquote "more money back into the pockets of the consumers" and the people providing the services. But that balance concerns me as to what happens if that MLR as it has done in the medical world forces out the competition.

Mr. Olson stated that I think that the view of the ADA is that the competition right now between dental plans is predicated only on providing a low rate quote to employers. And that is not the benefit of the end users, the patients. Competing around the true value of the plan's MLR is one way to get there. To Asw. Hunter's point, I think where we're heading is giving some flexibility saying to set an MLR and each state would be able to determine what it should properly be to balance some of the things you're talking about, Rep. Lehman, without saying, it has to be this. And that's why we're open to a discussion about percentages being determined by the state instead of necessarily being mandated. And I think that would address some of your concerns as well, Asw. Hunter. So that's I think kind of where the conversation is going on the compromise side from our view. Again, one more last thing with the focus on competition, benefiting patients at the end of the day and not just employer prices. That has resulted among the industry in a race to the bottom. If you're only point of competition is to keep the rates low for employers, you're not providing a good benefit and that's why dental benefit coverage is different.

Mr. Urech stated that to offer a little bit different perspective, I think where there's some opportunities for us to have some alignment is to say, if regulators through this process, through language that we can develop at NCOIL or based off of what other models have been proposed, can look at all of the value that a dental plan is bringing to somebody that you have loss ratio as part of that conversation that's important. But we are also extremely concerned about what the impact is going to be on competition. We've seen what's happening in Massachusetts, and they haven't even finalized the regulations there yet. We have five plans already at this point leaving the small group market. And I think speaking to a little bit of what Mr. Olson said, it is true that when dental plans are quoting a price to an employer, when they are bringing those benefit options to them those employers are dealing with their narrow budgets and trying to provide dental coverage to their employees to make sure that they can get the care that they need. And ultimately, we want to have a conversation about value. But also we know that from just the studies that have been done and from the market experience that people are extremely price sensitive on their dental benefits and we want to make sure that's protected. We want to make sure that the premiums stay at a place where people can afford them and that moving forward

people are able to utilize the care that they need. I think that's the ultimate goal for both of us is that people get the dental coverage or get the dental treatment that they need and they can stay healthy. Oral health is incredibly critical to overall health as Asw. Hunter said earlier.

Rep. Ferguson stated that as a person who's all about compromise, I think for us to get to a reasonable model bill maybe both of you have to be unhappy at some point. I mean, obviously the dentists want a Massachusetts model where you're actually putting in DLR percentages. The dental plans don't want any percentages put in the bill. I would like to see you get together and both agree to be unhappy and that the compromise that we've looked at is not only reporting like Colorado does but to also after a three-year period look at all that for the states themselves to decide what those DLR percentages are. That will give states time to look at the data. It will give them time to look at what other outcomes have been in different states that have already passed legislation. I just don't understand why that wouldn't be a reasonable compromise for both of you. I know neither of you will be happy. You're not getting everything you want, and you have to go back to your membership and say I compromised and this is our model bill. But as we said, NCOIL is all about state regulation and by allowing the DLR to be set by the states I think that's a very reasonable compromise. Mr. Urech stated we are absolutely open to compromise and discussion on this issue. And I know that there's a lot of room between NADP and the ADA on a lot of these issues but I think we've made progress and we're happy to continue talking about that and I know getting into the nitty gritty of those details is one of the things that we're going to need to do.

Sen. George Lang (OH) stated that Asw. Hunter asked a great question - what is the problem we're trying to solve? And is it a problem created by legislators or is it a market driven problem? And I think it's fair that we consider the impact on consumers. I think it's incumbent upon us to do that but it is equally incumbent upon us to consider the impact on the industry. And I don't want to do anything that is going to harm the industry. The more we try to turn the industry into a commodity, and that may not be a fair analogy, but the more we try to do it, the more we're going to drive out innovation. The more we're going to drive out competition. And I'm worried about the unintended consequence of driving prices ultimately higher if in fact that occurs. And I'm also concerned about the fact as Rep. Ferguson pointed out, this only impacts companies that are regulated by the state, not those that fall under ERISA. And are we in fact going to put small employers at a huge disadvantage if the states are regulating in a way that the plans that fall under ERISA, the self-funded plans, the large employers are not. And what is the long term negative impact this is going to have on the industry? And how may that translate into a negative impact on the consumer? I'd appreciate that perspective from the dental plans on that.

Mr. Urech stated that building off some of the things that we've said already, we want to make sure that anything that is passed through NCOIL is looking at the value of a dental plan holistically in the activities that it's doing. We've talked a lot about Colorado at this meeting and also at the previous meetings. I think our endpoint is if we're creating a model that is showing the demonstration of value, that loss ratio is not the end all be all in that conversation that is going to be had with regulators, with legislators. So, I know there's a lot more dialogue to go on that but I think that's one of our priorities is to make sure that's part of the conversation.

Mr. Olson thanked Sen. Lang for bringing it back to Asw. Hunter's key question which is what's the end goal? I think the end goal is to create an environment where the plans are serving the consumers more than the employers only. And you asked what's the situation? Why is this occurring? I would go back to my earlier analysis that competition is not resulting in a good benefit to the consumers. Right now the plans, as I've said before, have had a $1,000 to $1,500 annual maximum and then the consumer pays out of their own pocket. And that has not

changed since the 1980s. That is what competition has produced. So, I think that as Mr. Urech said, there's a lot of options. What DLR does is it forces the conversation to be more about how do we provide value for patients? And then the last thing I'll say about plans leaving Massachusetts. The history of the ACA shows that while plans may have some initial changes to their structures, etc. and considerations on whether they can continue to pursue a market, we've also seen that they've been successful, the major medical plans under the auspices of an MLR. I know the industry on the dental side pretty well. I know it's peopled by smart people and I know that they can innovate. And there was an article that wrote about Guardian I think leaving a certain segment of the small group in Massachusetts. In that same article there was another plan saying, "We're ready to take up the slack." And I think that's the beauty of the industry as you talked about innovation. Once a good floor is set that is going to get to the benefit of consumers, I'm confident the plans will respond in kind.

Mr. Urech stated just a quick note on the ACA, I think something that's worthwhile to point out is that when the ACA passed MLR requirements for medical plans that was a barometer for the other reforms that were done in the ACA which were the essential health benefits (EHB) and the employer mandate which expanded the scope of medical coverage and drastically changed that market. And then the loss ratio was kind of one of the parameters that the regulators were using to look at the effects and the requirements and the compliance from the medical plans. That's one of the reasons that the loss ratio was included within the ACA was to measure those others. I think as we've discussed in some of these other meetings, dental still is a voluntary benefit and it is something that there's lots of price sensitivity. You don't have that same requirement for complete and full coverage and that drives the market factors for why people are buying dental coverage and what employers are looking for in them. I'll just share one last thing about Massachusetts - we're concerned that, yes, there may be one plan that hasn't entered the market yet in Massachusetts that may be looking at it, but five plans leaving in the market, plans that have those experience that have been working with those brokers and those small businesses. We heard in the regulatory hearings for the implementation of this loss ratio that businesses in Massachusetts are really concerned about what their prospects look like for their dental plans in the state and we want to make sure that there's not a harm to access there.

Sen. Bob Hackett (OH) stated that I appreciate what my colleagues have been saying but one of the things to remember is, we can't solve a problem the way we try to solve it in medical. The greatest thing about dental plans is that it's a preventative benefit. We've been promised preventive benefit for 40 years in healthcare. All they do is pay claims. But we have preventative benefits and the dentists will tell you the greatest thing about the dental plans is it forces them to go every six months and develop a preventative benefit, the cleaning and the situation like that. On the other side I can see where the dentists want a better reimbursement because of the limited reimbursement. We understand the problem there. I'm okay with the Colorado plan, but I don't want to be forced into a decision at the end of three years. I'm not sure that the MLR will solve any problem and it might drive companies out of business. I think the "may" and "shall" words should be changed where they "may" do it in three years but they're not required to do it in three years. But don't destroy the difference in dental care versus healthcare. You do provide preventative benefits where healthcare doesn't and it makes people healthier. It makes people have less cavities and less crowns. So that's the only thing I say is I know it's a tough problem to solve and we don't want to run companies out of business but be careful. And I've done dental and medical care for years. They are totally different animals. The cost is so much lower in dental. So I can see why the plans would be upset by forcing loss ratio on them. And I do not want to see less people going to the dentist. That would be the worst thing that can happen and this may cause that.

Mr. Olson stated that regarding the preventive argument, if there is an MLR set that would mean that the plans were incentivized to encourage people to go to the dentist. Currently, even people with coverage only 50% to 60% of them ever access their dental plan. If you have an MLR, suddenly those plans are incentivized to encourage their subscribers to go. You can see this occurring on the Medicaid side. Currently, according to federal regulation on the Medicaid side, a managed care organization (MCO) is required to meet an 85% MLR. We know from experience that dentists have in the states that those MCO's, the companies that usually administer for them, are encouraging subscribers to go get preventive care because of them having to meet the MLR. We also see from the California data that there is no incentive to change the MLR over time. No trend. This is reporting only. So I would say the answer to your question is, yes, the plans are concerned about this. I think they are always concerned about reforms and will always point to this is going to hurt our business. Balancing the consumers' needs and getting a better value is so important. And the last point I'll make is yes, preventive is important, but these plans again are providing sometimes no coverage really beyond two cleanings and one restoration and then it's nothing more. MLR changes the incentive game. It says, we have to now meet an MLR that's really aimed at getting people to good oral health and that should be the goal of everybody. I hear your concerns on the business being destroyed. I just don't buy it. As I said about Massachusetts, there's going to be probably some consideration of we need to look at our business model and how we can exist and then I think just the same thing that happened with the ACA, there'll be people coming back into the market and coverage being better. And the last point I'll make is great dental coverage provided by three carriers versus not great coverage provided by seven. What's better at the end of the day? I think for consumers to have those three options that is better.

Mr. Urech stated that I want to echo the point that the preventive benefit that is included within dental plans is critical to the structure of it. And even speaking outside of the MCO market where you have the different requirements related to being part of the government program that within the commercial market there is a lot of activity that these plans go into making sure that they are incentivizing folks to go get care, to go get their cleanings every six months. Because that saves them money in the long run and that keeps their teeth healthy and that keeps their body healthy. Frankly, a lot of those activities that would be utilized would be considered potentially an administrative cost under some of the loss ratio requirements that have been proposed in some of the states that we raised concerns about. Particularly in Massachusetts, there's been a lot of back and forth about plan activities, trying to make sure that people are utilizing their care. So, I think what we want to do is make sure that the market stays healthy, that there are other areas that are being looked at for the value that a dental plan has coverage. I don't think that it has been borne out that raising the DLR for a plan necessarily intrinsically leads to somebody utilizing care more. It doesn't necessarily mean that the plan is going to provide a richer benefit. There are plenty of other things that they may potentially do. They may cut costs on some of these activities that are beneficial to people and their plans to make sure that they're utilizing care because they would be disincentivized to do so under some of the loss ratio proposals. I think we maybe need to decouple the conversation from saying higher loss ratio equals better value. I don't think that's the case. There have been a couple of presentations to why that have been given to this committee about what dental plans do and what they offer and what coverage range looks like for different types of dental plans that may be impacted by this. But again, that gets back to having a broader conversation about what structures for the market makes sense.

Del. Westfall asked is the broker's commission included in that MLR? Mr. Urech stated currently broker commissions I believe would be included as an administrative expense in the denominator of a loss ratio. So, it's not something that you could count towards an MLR or DLR. And that's the case in as far as I know all the states that have passed a loss ratio bill to this point.

Del. Westfall asked if the broker commission should be included Mr. Urech stated that it hasn't been included up to this point so I don't think that it's something that has necessarily been discussed but it may be part of a later conversation. Mr. Olson stated that I think that there could be some discussion that could be a point where for example, and I'm throwing an idea out and don't hold me to it, if there's a way to maybe instead of it being counted as paying out for care, if an MLR is instituted we want to keep it at the numerator which is the claims paid out remains truly claims paid out but if there was some sort of deduction from the denominator on premium collected then that would allow plans to more easily meet the MLR while keeping the agents remunerated. Mr. Urech stated that we already see deductions from the denominator on state taxes and fees and based on the ACA precedent there's activities to improve care quality that are added on to the numerator in most of those instances because those are the types of things that benefit consumers.

The Hon. Tom Considine, NCOIL CEO, stated that just to follow up on Del. Westfall's point a little bit for clarification because maybe I see a nugget here. On the medical side, it's been 12 years since we wrote these regulations when I was in the National Association of Insurance Commissioners (NAIC). Things like nurses and help lines, they're denominator issues but they count because they reduce the other part of the denominator. Cmsr. Considine asked if he was correct on that. Mr. Urech and Mr. Olson replied yes. Cmsr. Considine stated so the argument would be that since so many people don't have dental, including broker fees in the denominator would be an access to care issue so it would make sense to include it in the denominator to address the access to care issue. Is that something where maybe you both could reach a compromise on? Mr. Urech and Olson replied that they would be open to further discussions on that.

Del. Westfall stated that it is my intention is to have an interim meeting of this Committee in January and vote on either the new version of the Colorado version or whatever we can come up with. I'm going to introduce the Colorado version in West Virginia just to have something to work off of. I think this is an important issue – otherwise I wouldn't be the sponsor of the Model.

ANY OTHER BUINESS

Rep. Ferguson stated somewhat related, since ERISA was brought up, for the new members and maybe members who don't know - we just went to D.C. and educated Members of Congress and staff about the benefits of a waiver process in ERISA. As most of you know, we have waivers for Medicare and Medicaid and the ACA and other federal programs. And ERISA really continues to undermine state based insurance so I think it's very reasonable that all of you when you talk to your Members of Congress that you advocate for a waiver for ERISA to make sure that all plans abide by all of these laws that we fight so hard to pass to protect consumers.

ADJOURNMENT

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