NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2024 NCOIL SPRING MEETING – NASHVILLE, TENNESSEE
APRIL 14, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Sunday, April 14, 2024 at 9:00 a.m.

Representative Jim Dunnigan of Utah, Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Justin Boyd (AR)
Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Rep. Edmond Jordan (LA)
Rep. David LeBeouf (MA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Peggy Mayfield (IN)
Rep. Patrick Penn (KS)
Rep. Bill Sutton (KS)
Rep. Michael Sarge Pollock (KY)
Rep. Jerry Neyer (MI)
Rep. Bob Titus (MO)
Sen. Natasha Marcus (NC)
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. Mary Felzkowski (WI), and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Brenda Carter (MI) 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 November 16, 2023 meeting, and the minutes of the Committee's January 26, 2024 interim meeting.

THE STATE OF HEALTHCARE COST TRANSPARENCY REQUIREMENTS (INCLUDING CONSIDERATION OF RE-ADOPTION OF NCOIL HEALTHCARE COST TRANSPARENCY MODEL ACT)

Rep. Dunnigan stated that today we're going to start our discussion on the topic of the state of healthcare cost transparency requirements. To provide a little bit of background, in 2019 NCOIL adopted a healthcare cost transparency Model Law which you can view in your binders on page 269 and on the website and the app as well. The model requires drug manufacturers, pharmacy benefit managers (PBM's) and health insurers to report certain cost related information to the Insurance Commissioner. And then that information is made public on the Department's website. Per NCOIL bylaws all model laws must be readopted every five years, or else they sunset. Given the importance of this topic and the constant state of change in the overall healthcare marketplace we're going to use the model being up for readoption as an opportunity to discuss the innovations and trends in the drug pricing and healthcare cost transparency arena since 2019 in an effort to see if any changes to the model should be considered or if it should remain as is. Before we go any further, I'm going to turn things over to the NCOIL President and sponsor of the model, Rep. Tom Oliverson, M.D. (TX).

Rep. Oliverson stated that I'm very pleased to see the progress that we've made on price transparency and pharmaceuticals since this model was first adopted. It's clearly struck a chord and I know for a fact that in Texas it has more than served its purpose in terms of informing legislators about what the ultimate disposition of rebates are and providing some clue as to why prices suddenly go up and things like that. And so, I feel like it's been a very good and informative model and we certainly have more information to make better decisions than we did five years ago. With that being said, I would like to offer one technical amendment which I believe you have in front of you. And all it does is clarify that what we're talking about here are health carriers, health insurers and we were not intending to loop in workers compensation or automobiles, or personal injury policy coverage. So, that's just a technical cleanup that was brought to me ahead of time before the meeting that I have agreed to take, assuming the Committee is good with that and so I look forward to hearing from everybody today and I'll turn it back to you, Mr. Chairman. Rep. Dunnigan stated that he wanted to mention that the Model or something substantially similar to it has been adopted in 16 states.

Lisa Joldersma, Strategic Advisor at Avalere Health thanked the Committee for the opportunity to speak and stated that Avalere is a health policy consulting and analysis firm that has been advising clients across the healthcare market for more than 25 years. We do not lobby. And we aspire to be a neutral voice among stakeholders by publishing fact based timely insights into state and federal health public policy deliberation. In recent years, of course, many of these deliberations have centered on ways to lower prescription drug costs for payers and patients. State policymakers like yourselves have, of course, prioritized legislation to increase drug price transparency through mandatory manufactured reporting of pricing information or advanced notification when prices increase above the specified amount year over year. Some states have pursued a more holistic approach, like the NCOIL model that includes reporting requirements for health insurers and PBMs. While difficult to name a single cause for what impacts a market, we have seen moderation in price increases in recent years and we do think that this is in part because of the reporting that would be triggered in the case of a price increase. For example, the Medicaid program explained in a 2020 report that compared to 2016 there was a 79% decline in the number of drugs reaching the states per year price increase reporting threshold. The program report concluded that fewer manufacturers are excessively increasing the price of drugs.

Similarly, Oregon's transparency program reported that compared to its first year of implementation in 2019, the program received 70% fewer reports for price increases in 2020. However, during that same time, Oregon saw a 15% increase in the number of drugs with high launch prices. And that's another matter to keep in mind here. Vermont and Oregon's findings align with what drug pricing researchers have found generally which is from 2016 to 2020, the amount of wholesale acquisition cost (WAC) price increases among brand medicines have declined. Federal penalties that have been enacted more recently, including inflation penalties in Medicare and removal of the cap on rebates and Medicaid could also further bolster the trend. Earlier this year, a pharmaceutical pricing analysis by 46brooklyn Research reported fewer brand drug pricing increases taken in January of 2024 versus prior years and even noted some drugs had taken price decreases. The analysts characterized 2024 as quote “a noteworthy departure from the norm”, marking a significant shift in the statistical trends since 2012 when they first began tracking prices. Focusing on these trends, of course, does not address prevalent concerns with the launch prices of newly approved medicines or with generic drug pricing increases and shortages. Transparency legislation historically has impacted brand manufacturers, more so than generics and existing products rather than newly approved products. The same can be said about the federal approach to negotiating prices and Medicare. It remains to be seen what options the market and/or policymakers may advance to address these additional issues. One thing is clear, however, and that is that patient groups become extremely concerned with policies targeting the new products that may represent their hope against untreated diseases. And we saw that play out, for example, in Colorado last year when they declined to declare a breakthrough product for cystic fibrosis unaffordable and that was in large part due to extreme patient concern. In sum, the evidence suggests that transparency measures have had an impact on brand drug price increases year over year. Sunlight on PBM and payer practices is more recent but also gaining momentum. It may have a more direct impact on patient cost for medicines going forward.

Scott Woods, Vice President of Policy and Research at the Pharmaceutical Research and Manufacutrers of America (PhRMA) thanked the Committee for the opportunity to speak about prescription drug pricing, transparency and improving patient access to medicines. PhRMA has been a longtime supporter of meaningful transparency, that is transparency that helps patients, employers and other stakeholders make better decisions in the marketplace without infringing on the ability of the private marketplace to operate efficiently. And second, we've supported efforts to improve transparency throughout the supply chain. I want to thank NCOIL and Rep. Oliverson for their leadership in adopting this model back in 2019. It has set the bar high for accountability and transparency throughout the supply chain. And as Ms. Joldersma mentioned, many states since that adoption have passed various transparency measures, some focused on just manufacturers, some focused on other parts of the supply chain. But really, we've seen many states that have taken on more comprehensive measures and in fact Congress which oftentimes follows the lead of the states passed The Lower Costs, More Transparency Act in December 2023 which actually looks fairly similar to the NCOIL model in that it looks at entities across the supply chain. Now as we look at what has happened in the marketplace and as you're considering action in this space, I just want to point out a couple of facts and figures for you to keep in mind. At the macro level, spending on prescription drugs accounts for just 14% of total healthcare spending in the U.S. And this comes from the National Health Expenditures survey that's conducted looking at not just prescription drugs but costs for providers for durable medical equipment, all sorts of things. Everything that goes into the pot in terms of healthcare spending in the U.S. And I think what really illustrates that the prescription drug market is working the way as intended is that throughout the course of this decade we expect, and this is not just PhRMA’s analysis this is IQVIA’s, that spending on both retail medicines that you get at your corner pharmacy and non-retail medicines, some medicines that you get at the physician’s office or in a

hospital or other type of facility, t's projected to remain relatively stable throughout the decade. And an analysis that was conducted looking at the Medicare Part D program, which is the part of Medicare that provides prescription drug benefits to seniors and those with disabilities, found that the vast majority of Part D spending is for medicines that have competition, whether that's brand-on-brand competition or brands with generics. So, the market is working.

So, now I want to shift slightly to talk a little bit about where we at PhRMA have been focused and where we've seen a lot of state action and federal activity in recent years, and that's on patient cost sharing and access to medicines and what transparency really helps us to see where there are some issues in the healthcare system. So many of these types of panel discussions can turn into a food fight between industries and we can lose focus on what really matters most and that is patients, your constituents. And I'm sure across the country in hearing rooms and around tables you have probably been confused and somewhat frustrated at times wanting to just get the answers to why patients are struggling at the pharmacy counter and I would say that a principal reason for that is that there are many entities in the supply chain that have an impact on the cost of prescription drugs at the end of the day for the patients and one major entity are PBMs. Our friends at the Pharmaceutical Care Management Association (PCMA) will say that it's PhRMA that sets the price of drugs and that's the end of the story but really PBMs and insurers play a really key role in determining whether a medicine is covered by an insurance plan and how much the patient is going to pay out of pocket for that. Is it going to be on a lower tier or is it going to be on a higher tier? Are there going to be various access barriers? Are there going to be prior authorization or other types of utilization management - fail first or step therapy that a patient is going to have to encounter as they are trying to get access to their medicine? And the top three PBMs, I'm sure you all know this statistic very well, CVS Caremark, Express Scripts and Optum RX are the top three PBM's in the marketplace. And they control about 80% of the prescriptions in the U.S. and that is significant market power, one which that many of your states are taking a look at as well as the Federal Trade Commission (FTC) because this impacts the prices that patients pay at the end of the day.

Now we've reached a critical inflection point where brand manufacturers, the companies that do the bench research, do all the research and development and bring drugs to market are now making less on those products than all other stakeholders. So, hospitals, the government, state and federal governments, providers, pharmacies, insurers and PBMs combined are now making more at the end of the day after all the dust has settled, after all the accounting is done, than the brand manufacturers who actually make those products. And you can see on the right-hand side of the slide that total brand medicine spending again, after everything is accounted for, payers are now making 180% more than they did roughly a decade ago. But the key question is, are patients benefiting from the discounts, rebates, everything that is going to payers? And despite increasing levels of rebates, discounts and fees that are paid by manufacturers to payers, patients are often exposed to more costs, especially those in the commercial marketplace where nearly half of commercially insured patients are paying for brand medicines based off the undiscounted list price of the medicine. Now that's very different than the medical benefits. So, I'm sure when you've gone to the hospital or you've gone to your physician's office even if you're in the deductible phase of your benefit you're paying off the negotiated rate that the insurer has come to the agreement with for that provider. That is not the case oftentimes for the drug benefit. So, even if a patient is paying in the deductible phase or they're paying a coinsurance, which is a percentage-based cost sharing arrangement, they're paying oftentimes based on the list price of the medicine even though in many cases the insurer or PBM may be getting a rebate on that medicine.

So, this is a very serious concern for a patient's ability to afford their medicines and of course this has an impact not only on pricing. And I think we have in these types of discussions a lot of conversations about pricing and facts and figures but again, it's important to bring it to the patient experience. You know, patients that when they get that high sticker price at the pharmacy counter because they're in their deductible phase, because they're paying a coinsurance based off the list price of a medicine, they are nearly four times as likely for patients who are in the deductible phase to abandon their treatment than patients who are paying based on a fixed copay. The traditional sort of $5, $10, $25 predictable type of cost sharing that we might be accustomed to. And when a patient abandons the prescription at the pharmacy counter that not only has an impact on future healthcare spending, a patient that might be returning to the physician's office or to the hospital because they haven't been taking their medicine, but it also has an impact on health equity and patient outcomes. And I wanted to share this slide because I think it just kind of crystallizes the importance of these conversations that it's not just about the facts and figures but it's about the real patient impact. And if you look across the various disease states – diabetes, asthma, chronic obstructive pulmonary disease (COPD), behavioral health, hypertension, and HIV - the rates of abandonment. So this is for the first fill of a medicine with an out-of-pocket cost of a $125 or more which is not something that's completely unheard of especially if the patient is in the deductible phase or paying coinsurance. The rates of abandonment are quite high for African American patients but really for white patients as well and this just illustrates why benefit design really matters.

So, I never like to leave these types of conversations without talking about solutions. So, what do we do about it? I want to quickly just wrap up with some of our patient-oriented solutions that we have been advocating for across the country and really this comes down to five kind of key policy ideas. First, sharing the savings, the significant rebates and discounts that manufacturers negotiate with PBMs and insurers. Patients who are taking those rebated medicines should benefit from those savings directly at the pharmacy counter. Second, making coupons count. So, many patients rely on some type of cost sharing assistance whether that's a copay coupon or some other type of patient assistance and there are many barriers that insurers and PBMs put in place whether that's accumulators which are now banned in something like 19 states, maximizers and alternative funding programs, which really target assistance in patient assistance programs. And we want to make sure that patients have the ability to use those types of cost sharing assistance without any barriers in the way of that. Third, offering lower cost sharing options. So, rather than benefit designs that rely on deductibles and coinsurance, providing more options for predictable cost sharing in the form of defined co-pays. Fourth, covering medicines from day one. So, rather than a patient that is paying their premium every month but not getting the benefit of the insurance from day one, making sure that more of that coverage is offered from the first date that a patient has their insurance benefit. And then lastly, hard dollar cost sharing caps. Some of your states have put in place these types of programs for patients who are taking insulin. That's a really wonderful idea and these types of cost sharing caps will really help patients be able to afford their medicines from day one.

Jonathan Buxton, Senior Director of State Affairs at PCMA, thanked the Committee for the opportunity to speak and stated that PCMA is the national association representing PBMs. The role of the PBM is to apply pressure on prices. We apply pressure on pharmaceutical manufacturers to provide the best net rate available for those drugs. We apply pressure on pharmacists to fill those drugs at an affordable rate. And the benefit is to the patient and payer. There is no other aspect of the supply chain that actually is putting the downward pressure on the price of drugs and so that's the role we fill. And a lot of people like to call this the middleman. We are in the middle. We are standing in the gap trying to make things more affordable. And I know that everybody loves to hate us. But insurers, employers, Medicaid plans, the government

plans, everybody uses a PBM because there's a benefit there. And so, this transparency model has done a great job of bringing in both PhRMA and PBM's. I think there are over 28 states with some form of transparency reporting requirements. Not all of them include all sides, but over 28 states have some level of PBM pricing transparency. And that's good.

But transparency has got to be to the right people for the right reasons. The right information needs to go to regulators that they know that the costs are being shared in a fair way and done right. Transparency to employers and payers so that they know how to purchase better plans, find ways to get those plans with lower cost sharing that make it easier for patients. Driving around last night after dinner, we were talking about how much a crane operator would make with all the construction here. Their average is $33 an hour working in those high-rise cranes. The average crane operator does not care where the rebate goes or how much we're making as different members of this supply chain for the pharmaceuticals. They care how many hours they're going to have to work to afford their insurance. How many hours they're going to have to work to pay for the copay or they don't care which pharmacy they go to. They just want to know which one is the easiest to get to and which one is the cheapest to get to. So, providing transparency to the right part of the purchasing chain is more important than providing lots and lots of information. There was a state recently that had to roll back some of the PBM transparency reporting requirements because it was too much data. They didn't even have the internal systems to be able to process it and collect the data. And so, the pricing model transparency here at NCOIL does a good job of saying we're going to get high level aggregated data so we can make informed choices as legislators. Which is important. And also, so our regulators can make sure that things are being done right. And so, in short, we support the model. We think the amendment makes a lot of sense as not all plans are the same and so carving out those is ideal. We do thank Rep. Oliverson and this Committee for the work on the Model. Like I said, 28 states are doing it. A lot of them followed your recommendations and so we would encourage you to readopt the model.

Bailey Reavis, Manager of Gov't Relations at Families USA and head of our state and federal drug pricing work, thanked the Committee for the opportunity to speak and stated that Families USA is a nonpartisan, nonprofit organization that for 40 years has served as one of the leading voices for healthcare consumers. The high and rising costs of prescription drugs in the U.S. is both a profound health problem and a significant economic burden for our nation's families. Millions live in fear of not being able to afford their life-saving medications and one third of people are not taking their prescriptions as prescribed because they are too expensive. The financial burden of high drug costs is clearly felt by those taking prescription drugs but it's even being felt by those that don't. When a drug company increases its prices, the amount the insurance company pays increases and the monthly premiums are going to increase right along with it for everyone regardless of if they are taking prescription medications. That also means if you're taking a prescription drug your price is going to increase at the pharmacy counter potentially but you are also paying that higher premium cost. You're getting hit twice, potentially with the same price increase. For 176 million people in America who get their health coverage from the private market, drug prices account for almost a quarter, 25%, of monthly premiums. Additionally, as health care costs continue to increase, companies and employers cannot provide the same increase in wages in order to offset those costs. Meaning, as drug prices increase, we see wages rising more slowly as a result. The incentives in our prescription drug market are clearly broken. Drug companies are incentivized to getting market exclusivity and ensure that they don't face serious competition allowing them to raise costs year over year. Meanwhile, PBMs who exist to provide plans with relief from high costs are too often incentivized to consolidate and obfuscate the real prices being paid.

In the end, the people stuck in the middle are the millions of families who end up paying the cost of these broken systems. Greater transparency requirements are a key first step to unveil those realities and bring down drug costs. Families USA believes that efforts such as the 2019 NCOIL transparency model that take a comprehensive look at the prescription drug market are a key tool for states to understand and track a variety of data points on how drug prices are increasing and how that is driving costs at the pharmacy counter and beyond. Specifically, we believe that data points such as post WAC requiring justifications for price increases and requiring plans to report on how drug costs are specifically impacting premiums and other healthcare costs are key metrics. We believe that there are also some opportunities to expand the model to make it even more effective including improving the WAC reporting threshold to require a drug maker to report rationale for any price increases above the rate of inflation, ensuring public reporting of data provides as much detail as possible to help lawmakers, researchers and the public hold the entire drug market accountable and ensure competition across the drug market. And finally expanding the model to require plans to report net price pay in order to determine if out of pocket costs are based on net price rather than list price. In addition to building out transparency in the drug market, we believe that there are additional reforms that states can implement to help address the broken incentives that drive these costs. Reforms can include creating prescription drug affordability boards with unfair payment limits, enacting inflation rebates, when possible, that create penalties when prices are raised above the rate of inflation, and when possible ensure that 100% pass through of rebates and cost sharing that PBMs negotiate are passed on to consumers so that they are paying based on the actual price paid rather than the list price.

It is important to note that there are key reforms happening at the federal level that impact changes and opportunities at the state level. In 2021, as part of the Inflation Reduction Act, there were key changes made to reduce the cost for the millions that rely on Medicare for their healthcare. These major reforms, several of which are going into place the next few years, include this year the final negotiated rates for the first 10 drugs will be announced at the end of the summer. The Centers for Medicare and Medicaid Services (CMS) will also be releasing some information about how that price was decided and negotiated. We are hopeful that this information can be helpful to private payers and state payers to better negotiate their own prices. Those final negotiated rates for the first 10 drugs go into place in 2026. Additionally, next year, Medicare will put into effect a $2,000 out of pocket cap and smoothing which allows Medicare payers to pay that $2,000 over the course of the year. Additionally, on top of these existing reforms, Congress has been considering a variety of additional bipartisan policies that could be enacted sometime before the end of the year many of which, as was noted, hinge on some of these transparency pieces as well. That includes reforms to PBM incentives such as including improved transparency around negotiated prices, gross PBM profits, cost effectiveness of the PBM drug prices and spending patterns. All this would help reduce drug benefit costs by increasing competition between PBM's and empower the clients of PBM's to negotiate better contract terms.

Additionally, Congress is also considering some bipartisan patent reforms that would crack down on things like patent thickets, product topping and pay for delay. These federal reforms could dramatically change the broken incentive systems that lead to year over year increases from companies. However, in closing, I think it's really important to underline the importance of state action to address these costs even while federal action is ongoing. As administrations and congressional majorities change the priorities and opportunities can potentially change as well. However, all of the legislators in this room have the ability to ensure that the people in your state can get relief from these high and rising drug costs. Addressing these costs is overwhelmingly popular across the country, which I'm sure you're all aware of as you hear about it constantly from constituents. But in August of 2023 a Kaiser Poll found that 73% agreed governments

aren't doing enough to regulate the price of prescription drugs and when broken down, that will be true for over 65% regardless of political party. That is the level of consensus that again, as we are all aware is extremely difficult to come by on any given issue. We've seen dozens of states from all over the country regardless of makeup or location from California to North Dakota to Texas to New Hampshire pass some form of legislation to get transparency and insight into high drug costs. There should be no reason that every state cannot advance further reforms to address high drug costs including the transparency model under discussion here today if there is the will to move it.

James McSpadden, Senior Policy Advisor at AARP's Public Policy Institute, thanked the Committee for the opportunity to speak and stated that AARP is a nonpartisan, nonprofit that fights for what matters most for the more than 100 million older adults and their families. And at the AARP Policy Institute we do research and analysis to support those efforts. At the Public Policy Institute, my work focuses on a range of health issues including prescription drug pricing, utilization and access. I'm grateful for the invitation to speak here today since prescription drug prices definitely impact older Americans. As a population, older adults take more drugs than adults of other ages. We know that among adults 65 plus, 42% take five or more drugs a month and 18% take 10 or more. And among the 50 to 64 more than two thirds of this age group take one or more drugs. Midlife Medicaid enrollees take on average 3.3 drugs a month and prescription drug utilization among this age group enrolled in employer sponsored insurance has increased 10% in the past five years. Additionally, older adults may not have the resources to absorb high and increasing prescription drug prices and many are facing the real possibility of being unable to afford the medications they need. We know that the median income of adults 50 plus is just over $30,000. The median income of Medicare beneficiaries is lower than that, around $26,000. Many don't have financial assets to absorb these high costs. So, because of this vulnerability many older adults are concerned about being able to afford their prescription drugs. Our research has shown that more than half of all older adults are concerned with adults 50 to 64 more likely to be very concerned than adults 64 and older. With little recourse to address the high prices, individuals have been forced to make tough choices. Some 20% of older adults have not filled a prescription in the last two years due to cost and others have skipped doses, cut pills in half or otherwise adjusted their prescription medications. Another reason that AARP has supported drug price transparency is because older adults themselves want change. Two thirds of adults 50 plus say the drug prices are unreasonable and an overwhelming majority support price transparency legislation that requires manufacturers and others to disclose how prices are set. The NCOIL model gets to the root of concern, drug prices. While the model importantly addresses both launch prices and annual price increases, I wanted at hone in a little bit on the ladder in my time. AARP has been paying particularly close attention to annual pricing trends. For more than 10 years we've produced a series of price watch reports to track the price of drugs most commonly used by older adults. In our most recent report released earlier this year, AARP examined over 900 drugs, including brand, generic and specialty that are widely used by older Americans. The report examined both retail drug prices and price increases for these drugs. The report found that the average annual cost of therapy reached a little over $26,000 per drug and that drug prices have consistently grown faster than the rate of inflation.

Cumulatively, the average retail price of drugs has increased nearly 280% over 15 years. We also produced a report looking specifically at high price specialty drugs used to treat chronic conditions and widely used by older Americans. This report found specialty drugs are the largest driver of price increases. In 2020, the average annual cost of therapy for these drugs was more than $84,000. More than 40% of specialty drugs increased greater than 8% in 2020 and the prices for 11 chronic use specialty drugs that have been on the market for 15 years increased

cumulatively by an average of 230%. These reports also show the average annual increase of drugs widely used by older Americans alongside the rate of inflation and you can see here that in 2020 the average annual retail price of drugs was 3.1% whereas inflation was 1.3%. If prices had been limited through a rate of inflation the annual cost of therapy would have been considerably less. In 2020 it would have been less than half, around $12,000 compared to $26,000. Because price transparency is an important form of prescription drug reform we have supported passage of the model across the country. AARP state offices have worked closely with legislators and other stakeholders to pass it in at least 10 states. In one of those states, Texas, which certainly based its law on the NCOIL model, AARP was very active in support, and our Texas state office made enactment of the legislation a centerpiece of its advocacy in 2019.

In North Dakota, another state that utilized the NCOIL model, AARP has been involved in implementation. We've analyzed the data for the first year and provided a report to the state noting that manufacturer participation was inconsistent, the data reported was incomplete and we made recommendations about how to improve reporting processes and accountability. AARP has supported price transparency not as a final solution, but rather as a final step toward additional prescription reforms. The implementation of enacting legislation and collecting of drug pricing data transparency can provide critical information for further analysis. Information can show pricing trends and have shown pricing trends, planned spending trends and insights into pricing behavior. Additionally, this data ultimately can be used by states to consider reforms that can bring down the price of drugs for state programs and for consumers. A few of those additional reforms we've supported at the state level are prescription drug affordability boards, anti-price gouging legislation, interstate and intrastate bulk purchasing and international reference pricing. So in conclusion on this five-year anniversary it’s worth noting that the presence and proliferation of the NCOIL model demonstrates that current prescription drug pricing trends remain unsustainable. Thoughtful efforts by states can help provide evidence and direction to prescription drug reform and importantly, can help ensure that all patients have affordable access to the drugs they need to get and stay healthy.

Sen. Justin Boyd (AR) stated that one of the practices I hear a lot of complaints about as far as PBMs and price transparency is that, basically, national average drug acquisition cost (NADAC) is a public number. Anybody can just go look up what NADAC is on any given day and so with that one of the tactics that seems to happen is PBMs still pay below the cost of drugs. I'm not going to name PBMs or anything like that. They've all done it at some point in time but one in particular really targets on brand name drugs and pays below that NADAC. And so, I guess my question is, is this really a tool to keep prices down or is this something that is couched to the legislators and other people who signed PBMs up such as commercial insurers to really just move the marketplace to their mail order owned pharmacies?

Mr. Buxton stated that the way PBMs reimburse pharmacies is determined by the contract they have with the payer. And so, the PBM enters into a contract for a pharmacy and they agree to certain reimbursement rates. Anytime we end up paying a pharmacy more to fill a script then it costs the payer and the plan and the patient more in premiums or in co-pays. So, they use lots of tools to find the most affordable way to get a script filled and in some states I know NADAC reimbursement is the floor and so that's the least PBMs can pay as long as they're a state regulated plan. Sen. Boyd stated that I guess the follow up though is, there are three major PBMs who control 80% of the market. How does the family-owned pharmacy really compete with that? Or is that really the drive is we don't need them let's just drive them out of business and then we'll fill up more prescriptions on our own mail order pharmacies.

Sen. Beverly Gossage (KS) stated that I'm just curious of the states that have implemented this, what percentage of citizens actually access this data? My next question is, what kind of a cost is it to the PBM's, to the pharmaceutical companies, to the state to implement something like this, especially if it doesn't seem to be being used? Finally, I write Medicare for clients all the time and the Part D premiums last year due to some of the laws that were passed on the federal level went up by 50%. Some of them went up by 75%. So, we can say we're going to bring down the cost of the true out of pocket costs for the prescription drugs which is typically now $8,000 total but very few people ever get to that donut hole. Those that do oftentimes will hit it in February and then they're in the donut hole and they try to get out of the doughnut hole. They're out of the donut hole in November and then they go right back and start this all over. So, the slamming down and saying, you know, we're not going to have people paying more than $2,000 or insulin is going to cost $35 all sounds really good, but then you're charging everyone more to pay for their prescription drug plan. Could someone address that?

Ms. Reavis stated that I think that what we're seeing is actually Medicare will be able to bring down those premium costs which have been rising year over year, partially due to the high cost of prescription drugs that Medicare is paying. The billions and billions of dollars that they are paying every year. And by the ability to negotiate drugs, it'll be 10 this year, but it will go up year over year up to somewhere around 75 I think by the end. By negotiating the prices of those drugs and paying a less amount they are able to clamp down on those premium prices that we're talking about. And we actually at Families USA do have some concerns with capping the price at the pharmacy counter if you're not addressing that underlying price, but we think that's why the Inflation Reduction Act handled that really well by providing an opportunity to reduce the cost that the payer is paying. And also then pass that along to the person at the pharmacy counter. We think that having both of those is a critical tool to address the cost because otherwise, as you say, we'll just have increasing premiums if we're not reducing the actual price paid. Sen. Gossage replied, yes, and I would also say a small percentage of those are using those very expensive medications. Tier one and Tier two drugs are zero cost for most folks and then they may pay 20% for a very expensive drug at the Medicare cost. So, it would be those outlier medications that very few people take. I'm glad to see where it's going to try to do something about that but also, that's a lot less expensive than what it would cost to have a heart transplant or something else if they weren't taking the pharmaceutical medications.

Rep. Bill Sutton (KS) stated that I think this question would probably go to Mr. Buxton. We saw earlier on one of the slides that 50% of the savings that's generated isn't going to the end payers. And could you elaborate a little bit about first, is that accurate? And secondly, where the system is broken that would allow that to happen? Mr. Buxton stated that slide was from PhRMA and its research that they've conducted looking at the spending for medications. If you have $100, who gets what? And they are right in this latest report. PhRMA and the manufacturers who make the drugs on average are getting $49 out of that $100. The rest is spent on us, on health insurers, on pharmacy reimbursement, on hospital reimbursement. Incidentally, the reimbursement rates for independent pharmacists in that same study have gone up year over year. PBM reimbursement has stayed flat around 3%, I think. And so that's basically everybody that takes a bite of the medication dollar and how it breaks down. PhRMA still gets just under half and our spending has been flat on that at around 3%.

Rep. Michael "Sarge" Pollock (KY) stated that this is a great conversation and that he would like to hear the answer to the earlier question regarding pharmacists from Sen. Boyd. Someone mentioned the term drug price gouging and I'm going to speak on behalf of the independent pharmacists because I'm in Kentucky and the majority of our area is the rural area. These independent pharmacists, we're at close to 60 closing the doors because they cannot keep the

doors open. And as crazy as it sounds their production of providing the service to their communities in rural areas is doubling so it's not like they're not providing a service. Their service is doubling and they're losing money. That is a huge, huge problem. And the rural areas that I'm speaking on, they just want to go to have a conversation with their local pharmacist who they trust. And it's not all about making the dollar. It's about taking care of your people. It's about putting your pharmacy name on the back of a Little League jersey and those type of things. And so, it's kind of personal because I talked to these people all the time and we passed a bill this past session and we're trying to keep the playing field level right now. They told me they're shooting on a 12 foot goal and PBMs are shooting on an eight foot goal and so I hope you hear my passion about that but I'm speaking on behalf of them. It is a huge, huge issue. Thank you for bringing this as a model. We need to make this right. We need to fix it and make it right all the way for everybody.

Rep. Dunnigan staetd that I have a question for Mr. Buxton and anybody else who wants to weigh in, go ahead - what are your thoughts on point of sale rebates where the consumer goes and gets it at the pharmacy? Mr. Buxton stated that the vast majority of rebates are passed back to the plan sponsor based upon the contract they have with the PBM. Those rebates are typically used to either offset premiums so that the patient is paying less in premiums or to offset cost sharing and things like that. When you get to point of sale rebates, you're taking those rebates out of the pool that's reducing premiums and you're putting it to just a pool for reducing cost sharing for select patients. And so the problem with point of sale rebates is they overall will drive up the cost of the premium. It will not reduce the cost sharing for all patients. It will only reduce the cost sharing for those patients that are taking those drugs and it will increase the premiums and the cost sharing for all other patients on that plan. Rep. Dunnigan stated that I understand that concept.

Mr. Woods stated that we have heard this refrain from payers a number of times. So, looking at the commercial marketplace, which is where state regulators would be able to implement this type of policy, there are a few states that have already taken this step. Arkansas, Indiana and West Virginia. West Virginia was the first state. Looking at the rate filings for when West Virginia passed this bill, I think it was in 2021, they have not seen anything out of the ordinary in terms of premium increases in the commercial marketplace in that state. And what we've seen in the preliminary research from Arkansas and Indiana is the same is the case for those two states in the commercial market. Milliman did a study that looked at if you did pass along rebates at the point of sale the premium increase would be less than 1%. Now there are figures that are different for the Medicare benefit because it's just a drug benefit rather than being a medical and a drug benefit. So, saying that we can't do point of sale rebates because it's going to increase premiums, that's the answer that insurers are going to give about any type of reform to insurance. It's going to increase premiums. But really the way that insurance should work is that healthy people are subsidizing people who have illness. That's just the general principle of insurance. But when you're looking at these types of rebates, it's really sick people that are subsidizing the premiums of healthy people and that's just an inverted way of insurance. So, a patient that's taking a very heavily rebated drug and could benefit significantly at the pharmacy counter, saying to that patient well we're going to take your rebate and we're going to spread it across the whole pool, that doesn't help that patient that's trying to afford their medicine. Especially as I illustrated through the data that we've shown that those patients are increasingly subject to skyrocketing deductibles, skyrocketing cost sharing in terms of coinsurance. So, it's the payers are saying well we can't do this because it's going to increase premiums but then they're also increasing cost sharing exposure for patients. The question remains why aren't you doing it? Especially when, Express Scripts, Optum Rx, CVS Health are making these types of programs widely available in some instances in the commercial marketplace. It's just an answer

that we can't do this because it's going to raise premiums. Their own members are providing this type of benefit and they wouldn't be providing that benefit in the commercial marketplace if it in fact were increasing premiums and their employer clients wouldn't want to take that option.

Rep. Oliverson stated that I really appreciate all the comments that we received and I will say that I do believe this model has been very successful as is and I heard a lot of good things. I would not at this time be inclined to open the model back up and do a whole lot with it. I think Mr. Buxton and Mr. Woods both being in favor of this, for those of you that weren't here when we were working on this, it underscores the degree to which this took a lot of work to get them on the same page on something that has clearly as we heard had a positive effect on lowering the cost of prescription drugs and educating lawmakers as far as where those costs are going and particularly where the rebate dollars are going which had previously had been entirely a black box. I know now in Texas at least that 98% of manufacturer rebates tend to stay either with the PBM or with the health plan. I don't know what they do with it, but I know that's where they go because I know that's what they report to the Insurance Department so, I have that information. It's useful to me. With respect to Sen. Gossage's comments, we never really intended for this model to provide useful information direct to the patient because the information is being provided in an aggregate format but it was more an opportunity on one hand, that the manufacturer would think twice about just artificially raising the price of the drug for no other reason than just because they could because it would trigger reporting requirements. But also on the other hand that the other players in the market the health plan, the PBM, that they would be able to have to have some reporting requirements for the things that they were doing which may be affecting cost. So, the fact that it's not consumer friendly was not really the intent of it per se but it was more to inform us. It was more to provide useful information to interested parties like AARP and others that would be concerned about the cost of prescription drugs. So, I would move that we adopt this model for a five-year cycle with the one technical amendment that I'm proposing. I would also like to say, though that I don't believe that our work in this sphere is finished.

And Mr. Chairman, I would support any efforts that you might undertake in future meetings to have a more robust discussion on pharmaceutical pricing. I heard several topics that I think would be worthy of discussion including the cost of generics, launch prices, the effect of copay assistance cards particularly as it relates to the value of rebates and where they go. I think also we haven't actually heard in this discussion from our pharmacy friends. The pharmacists are obviously part of this discussion as well and I know that there's some concerns that have been raised to me with respect to third-party discount cards that are being used which are on top of essentially what the in network price would be. And Mr. Woods and Mr. Buxton you may want to cover your ears but I would tell you that my personal bias is having worked on this issue for years that if I could eliminate all manufacturer rebates tomorrow and force these guys to negotiate directly with one another based on a number of covered lives discount per plan, I would do it. But that would require a change to federal law because I do think that the main cost driver that is accelerating the unaffordability of prescription drugs is the rebate itself and the fact that that rebate never seems to find its way back into the hands of the consumer. So, I thought, Mr. Chairman, that your question about the point-of-sale rebate was a very interesting question because the reality is that these rebates very often don't benefit the consumer when you look at what Medicare does with the rebates that they get on insulin rather than give those rebates to the people who are taking the insulin. They tend to use those rebates to keep everyone's Part D premiums down which kind of supports Mr. Woods supposition that you have the sick essentially subsidizing the healthy which is not really the point. So, I think rebates are terrible. I wish we could abolish them. That's my personal bias. You may not want me to have any other models on this but that is my personal preference. And then the patent thicket issues and the pay for

delay things are also worthy of discussion by this group although that would be probably more appropriate at a setting of our Joint State-Federal Relations & International Insurance Issues Committee since we can't control what the FTC does but there is a tremendous need for reform there.

Upon a Motion made by Rep. Oliverson and seconded by Sen. Lana Theis (MI), the Committee voted without objection via a voice vote to adopt the technical amendment to the Model. Then, upon a Motion made by Rep. Oliverson and seconded by Rep. Pollock, the Committee voted without objection to re-adopt the Model with the technical amendment for a full five year cycle.

PRESENTATION ON SITE-NEUTRAL PAYMENT REFORMS

Rep. Dunnigan stated that next on our agenda is a presentation on site-neutral payment reforms. For some brief background on the topic, last year, NCOIL adopted a hospital price transparency model law which requires hospitals to disclose certain pricing information in a clear and understandable manner. People want and deserve to know how much a hospital procedure is going to cost – it shouldn't be a complex and vague thing to deal with. And patients deserve to know how much care is going to cost before they show up. So, building off that topic, we're now going to discuss another hospital pricing related issue: site-neutral payment forms. Generally, these types of reforms focus on requiring one price for a procedure wherever it is performed, whether the procedure is done in the doctor's office, a hospital or clinic or clinic owned by a hospital or different entity.

Randi Chapman, Managing Director, State Affairs, Policy & Advocacy at Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and stated that I'm going to start today with a quick story. This is a story of Kyoung Yu Lee. Ms. Lee suffered from arthritis in her finger joints and received periodic steroid injections as treatments for that. She received those treatments from the same physician in the same place for years at her out of pocket cost at about $30. One day she went in for her injection appointment as usual but one thing was different. Her doctor's office was now on a different floor – the same building, same doctor, different floor. But once she received her medical bill, there was one more difference and instead of $30 that she usually paid out of pocket, her portion was now over $350 - ten times more than what she had paid in the past. That sounds outrageous to me. And it is. And from the perspective of BCBSA, which my colleague here today and I represent, we think that type of scenario occurs all too often. So, before we unpack how Ms. Lee ended up owing over ten times more for the same service from the same doctor and the same building, I'll very quickly provide some background on BCBSA. BCBSA is a national federation of independent community based and locally operated Blue Cross Blue Shield Companies and collectively we serve and support and cover one in three Americans in every ZIP code in all 50 states and Puerto Rico. BCBSA and BCBS companies are committed to advancing common sense solutions that can improve care and lower costs and we're committed to tackling the key drivers of the rising costs and ensuring access to high quality affordable health coverage for the 150 million Americans that we serve.

So let's get back to how Ms. Lee got here. Well, we think and research shows that key drivers of increased costs are provider consolidation and hospital billing practices. And for years we have seen a growing trend of corporate hospital systems taking over independent doctor's offices and often after the hospital takes control what was the doctor's office is now considered a hospital outpatient department. And with that change, the hospital is able to charge higher rates. So, care designated as being delivered in a hospital setting costs up to 300 times more than care delivered in an office space setting which leads to situations like that of Ms. Lee's where patients

can receive the same care in the same room from the same doctor that have a much higher price. Our colleagues at Blue Health Intelligence recently performed a national analysis of over 123 million member claims for 34 commonly administered procedures that occurred between 2017 and 2022. And through that research, they discovered that hospital outpatient department prices grew rapidly at a 27% average increase compared to an 11% average increase for care that's provided in an ambulatory service center (ASC) and a 2% increase over care provided in physicians' offices. The prices for common procedures performed in hospital outpatient departments (HOPDs) are substantially higher, sometimes five times more expensive than might be performed at an ASC. And while there's some variability in prices and costs by site of care across census divisions the HOPD prices and costs were always higher. And the research also found that policies aimed at creating site neutral payments could result in substantial savings for patients, businesses and employers. And now I'll turn to my colleague.

Stuart Hagen, Managing Director, Health Policy Analytics, Policy & Advocacy at BCBSA thanked the Committee for the opportunity to speak and stated that over the next few slides, I'm going to go over some examples of what we see as a broader trend in general. And this comes from the Health Care Cost Institute and they do research on the commercial claims of insurers like BCBS as well as a handful of other of the large national insurers. And in this example for an endoscopy from 2009 to 2017, the price in the office setting went from $463 to $527, an increase of 14%. That's over nine years. That's a good amount of time. At the same time, there are two things going on with that price in a HOPD. First of all, the prices start at a much higher level and then they grow more rapidly. So, in this case, went from about $1,500 in 2009 to nearly $2,700 in 2017. That's an increase of 73% compared to 14% for the same procedure delivered in the office setting. Now this is an example, this is from research that is just on BCBS claims and as Ms. Chapman mentioned, this is some work that we did with our colleagues at Blue Health Intelligence and it's the results of a couple of studies that we did this past Fall. One study was published in September and the other in December. And this is what we have seen broadly with many different procedures and we're just going to give you some examples here. So, in this case, let's look at the office again and similar to what Health Care Cost Institute found from a somewhat earlier period, the price of a corticosteroid injection for back pain was much lower if it was delivered in the physician office. In 2017 it was $394. Five years later, it was $426.

So, this is considered by far the lowest of the three different sites. And then what we see is a similar kind of not very fast growth in the price if this procedure was delivered in an ASC but if it was delivered in an HOPD, then we see this big increase in price over time as well as the prices themselves being quite high. So, in 2017, $1,350 if it was delivered in an HOPD compared with that $394 if the same procedure was in a physician's office. By 2022, the price was nearly $1,800 so it went from $1,350 in five years to $1,800. So, what we're seeing in general is that HOPD prices have been considerably higher to start with and then over this period they're getting even higher compared with other sites of care. Let me just show one last example. This is the price for a chest X-ray, a very common procedure. In a physician office in 2017 the price was $44. Now we're not showing it in ASC because that happens very rarely so we just are excluding it from this one. In this case, the price did jump quite a bit in 2020 for the office. It went from $44 to $95 and then settled down and it's at $101 in 2022. In the HOPD by comparison it starts out at $126 in 2017 then quickly jumps up to $335 and then to $341 in 2022. So, these are all common procedures, but they're also common examples of what we have seen when we looked at many different procedures over the course of these two studies that we did last Fall.

Ms. Chapman stated that when hospitals acquire physician offices, they often change the way that the practice bills insurance and when they do this, they do this by using the hospital national provider identifier or NPI number and the hospital claim forms. And then the insurer, payer will

reimburse at the hospital rates. And so, the insurer has no way of differentiating between the more expensive care provided in a hospital versus care provided in a physician office setting which is less expensive. And more importantly, it's difficult to apply the correct cost sharing for patients which often results in higher prices which means higher costs for consumers and that's how Ms. Lee ends up with a bill ten times greater than what she was paying before the hospital bought her physician practice. And as always we want to offer solutions and not just come to you all with a problem and as we think about our shared role as insurers, as payers and you as legislators, that role is to protect consumers and patients from unreasonably high healthcare costs and to expand coverage. So, for example, we applaud the work that is being done on affordability and proposals to prohibit facility fees for services delivered in non-hospital emergency department settings. But we think there's an opportunity to build on that and even go one step further towards site-neutral type policies in the commercial space. And so, we support state actions that would require hospitals to use appropriate billing forms and NPI numbers based on the site of care, not based on who owns that site of care. And that would allow payers to correctly identify the site of service and the claim and then provide the appropriate reimbursement rate. And we welcome the opportunity to partner with NCOIL and continue talking with you all about these issues and talk about our shared mission to lower costs and increase affordability for patients.

Joanna Hiatt Kim, Vice President of Payment Policy at the American Hospital Association (AHA), thanked the Committee for the opportunity to speak and stated that the AHA represents almost 5,000 hospital and health systems across the country. To start with some level setting, I want to state that access to quality care is the top priority of hospitals. To achieve this, we need appropriate healthcare system financing that covers costs and provides some room for capitalization. Part of this is healthcare coverage that is adequate and affordable for the individual's circumstances. Site-neutral payment is part of this equation vis-a-vis the adequate financing part of the equation. The term refers to policies that purport to pay the same amount for the same service no matter the setting. However, in reality the services provided in different settings is not the same. The standard and level of care provided in different settings is not the same. And the patient served in these different settings is also not the same. Hospitals have unique characteristics and capabilities that we all have an interest in maintaining. First, regarding the services provided not being the same in each setting. Chief among these is hospital's provision of emergency services, 24/7 to all who need it regardless of their ability to pay. It's among the most, if not the most important function that we provide. But emergency services are provided via standby capacity. What that means is that physicians, nurses and other clinicians are standing by waiting for patients to come through the door for care. They're waiting for responses to natural disasters like tornadoes, hurricanes, wildfires. They're waiting for infectious disease outbreaks, of course, such as COVID-19. And standing by at every moment of every day necessarily means that there will be times that there are not very many patients needing care. What that means is that standby capacity is not something that is explicitly reimbursed. It is funded through the reimbursement for other services. And as such, it is in danger by cuts to reimbursement including site-neutral cuts. Hospitals, of course, provide a lot of other specialized unique capabilities that are also endangered by cuts. This includes the burn units, the neonatal units, infection control and disaster preparedness. Some of these are very costly services because they're so specialized and they are not completely reimbursed by the payment rates. Some of them are in the vein of standby capacity where there is no explicit reimbursement for them and so they are funded through the reimbursement for other services.

Regarding the care provided in different settings. As I said, site-neutral is based on the idea that the care is the same. But this is false. Let's take the example of a 40 year old woman who needs an MRI. She is having trouble swallowing. It's getting worse, and her internist sends her

to a freestanding imaging center. She gets her MRI. Easy-peasy. She's in and out. Compare that to an 80 year old man at a care facility who has dementia. He throws up. But he cannot tell anybody why he might have done that. And the care facility is concerned that perhaps he swallowed something. They send him to the ER which is a very typical response at these facilities. He's disoriented. He's agitated. The technicians help him get into his gown and everyone decides that a light sedation could help get the MRI accomplished. What this means is that must take place in an open MRI machine. Which is a more expensive machine because the technicians will need to hold his hand, reassure him, remind him to keep still. Even so, it may take two, three tries to get a clear, still image. The technicians help them get dressed and help him get back to the care facility. This has taken four times as long and many more resources. But in the claims and the coding, it looks exactly the same. Regarding another example, obstetric ultrasounds. These are very rarely done in, let's call it an a la carte manner in hospitals because they're very commonly done in other settings which means that when they are done in a hospital it's because somebody is generally coming through the ER. They have pain. They don't feel right. And it's not that they come in and say I need an ultrasound and then it's given to them. What it initiates is an entire diagnostic procedure that involves clinicians trying to determine what's wrong. And maybe they do eventually conclude that an ultrasound is needed. But again, this has taken more resources and more time and it's not an equivalent service.

And then finally, I'll give the example of infusion therapy. This is a different, higher standard of care when it's provided in a hospital. Hospitals provide sterile conditions with a licensed pharmacist. They use barcoding to ensure that medication errors are not made and they are overseen by, to name a few, the U.S. Food and Drug Administration (FDA), the U.S. Pharmacopeia and The Joint Commission. Finally, the patients served in different settings are also not the same. Hospitals provide services that are not always otherwise available for historically marginalized and low income patients who are more likely to be duly eligible for Medicare and Medicaid, more likely to be for example non-white. Medicare beneficiaries with cancer are four times more likely to seek care in an HOPD versus a physician office. And again, they are more likely to be duly eligible and non-white. Diving into the specifics on why cuts would endanger patient access to care. Medicare, of course, is one of the largest payers of hospital care and it is not even remotely covering the cost to provide care to Medicare beneficiaries. Hospital Medicare margins have hit a record low. The Medicare Payment Advisory Commission estimated that in 2022 Medicare hospital margins were almost negative 13%. And in 2024 they will fully reach negative 13%. We estimate that mega Medicare payment shortfall totals almost $800 billion annually. And of course other payers do not fully reimburse the cost of providing care to their patients either. Medicaid across the country pays $0.87 on the dollar which nets us another $31 billion annually in underpayments. Hospitals provide quite a bit of uncompensated care either to uninsured or underinsured patients and commercial payers are becoming a huge challenge for hospitals. They routinely deny appropriate care and delay payments.

In fact, 50% of our hospitals report that they have $100 million in accounts receivable that are older than six months and that is the environment we are currently operating in without additional site-neutral cuts. Any additional cuts would be hugely detrimental to patient access to care. For example, some proposals would siphon $180 billion out of hospitals and health systems over the next 10 years. To give you a little bit more magnitude and context, these are some state level cuts of what actually is one of the smaller scale proposals in Congress right now. And you can see that for many states this would yield an excess of $100 million over 10 years in lost funds coming to your state. Of course, payments are one side of the equation and on the other side is costs. The pandemic and subsequent inflationary environment has been a huge challenge for hospitals. Our input costs have risen substantially. Leading the way is acquisition cost of

pharmaceuticals, which has gone up almost 37% over three years. Patients are also staying longer in the hospital because of workforce challenges at downstream discharge destinations that cannot accept as many patients as they used to. And then patient acuity has also gone up as delayed and deferred care is working its way through the system after the pandemic. Hospitals are also economic engines in their communities, so hospital cuts could not only result in loss of access for patients but also job and economic losses for the broader community. To circle back to the beginning, providing high quality care is a hospital's top priority but they need adequate financing to ensure that they can do this. They're already facing gaps in reimbursement and site-neutral cuts will make that significantly worse. Hospitals cannot continue to provide the full scope of their critical unique care if payment is less than cost. Access will be reduced and this is particularly true for rural and underserved communities that tend to rely disproportionately on hospital care.

Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, stated that I'm completely sympathetic to the hospital situation, I just think that it was unfortunate that whenever this policy of site disparity was created that it was done on the backs of patients and private care. I think Ms. Chapman said how much the employed physician has increased and what has driven this for those who have not been involved, I saw it first in cardiology. A patient would go to the cardiologist and get an echocardiogram and it would cost $160. And if you don't follow insurance, there's a professional fee and there's a facility fee and the facility fee is where the real differential comes in. So, that exact same cardiology office, the exact same quality of care, the exact same ultrasound machine, she went back to have the same echocardiogram. After the hospital bought the practice it was $6,000. We're not talking about inpatient care. I realize they see more acute patients. We're talking about hospital outpatient care. And what that has done is it really forced private practice to sell to hospitals. And so now even the American Medical Association (AMA) is reluctant to take a position because more of their members are employed physicians than they are in private practice. So, the hospital employed physicians who were forced to sell their practice because they couldn't get reimbursed at the hospital rate are now scared to not take the hospital position on site-neutrality because they're concerned their salary will be reduced. So, that's where we are. If a patient has a $2,500 deductible, they're paying all of that fee differential. So, I used to say Marcus Welby's dead and we killed him. And the other thing that bothers me about all this and this was the concern when private practice started advocating for site-neutrality is the $80 billion that was to be saved and payment neutrality, we were hoping we would have some leveling of payments. But instead of leveling of payments, they're just reducing everybody. And if any of you have had parents, it's very difficult to find a specialist much less family practice people to see a Medicare patient these days. You may have your family practice person but when you get ready to be referred to a specialist it's almost impossible to find somebody. So, I know you're not Medicare, but I guess my concern with CMS is take this $80 billion and start doing some levelized of payments particularly in the outpatient setting. I think your inpatient hospital argument is valid. But I think hospitals have to find another way to be compensated. And the other thing I think the uncompensated care is not based on actual uncompensated data but maybe if you can have a comment on that.

Del. Steve Westfall (WV) stated that I have a concern with this because it might be site-neutral but it is not equal. In West Virginia we have about 75% of our people on Medicaid and Medicare. And then we have the Public Employees Insurance Agency (PEIA) which only pays 10% more than what Medicare does. Our private option pays about 19%. Our hospitals struggle now. If you did this, we would put some hospitals under. I just don't see this. It's apples and oranges to me. It's not the same because the hospital is there 24/7, 365 where a physician's office is 9 to 5. The cost is totally different and this would really hurt hospitals in West Virginia.

Sen. Bob Hackett (OH) stated that I was on a hospital board for a long time and we went in the periods where you never had hospital employees and then the same consultants would come back and say now we want hospital employees. But the movement today by far in Ohio is the doctors are hospital employees. The biggest problem and I don't know why the AHA doesn't say this is you have to buy their building to get them in as employees. And why you won't say that? I mean, when you come in to see me about hospital facility fees, I just say to them, why do you pay so much for the building? And they laugh. They say you're right, that is a big problem in that scenario. So, I wish you would say that. I agree with everything else you said but I wish you would say the second point is hospitals have greater negotiated factors than doctors do. So that's a big thing. It's much easier for hospitals to get their fees approved and network fees approved with the insurance companies than it is for the doctors because the hospitals can collectively come together. The doctors can't unionize and I'm not saying they should, but they can't unionize. But the only thing I wish you would say is you have to buy the doctor's building. The doctor won't come in and be an employee and you don't want their building. But you have to buy their building to bring them in. So, I just want people to realize when employees come in, the hospital buys the doctor's building and their ability to charge a facility fee. They don't even want the building. I mean the building, I don't even know if it qualifies. There's ways to say it doesn't qualify but you're going to say it's an ROI. We get a bigger fee by charging that. But that's the problem is we have to buy the building of the doctor to bring them in as an employee.

MEDICAID REDETERMINATIONS – HOW HAVE STATES DONE?

Next, we're going to go hear a quick update on how states have done with regard to Medicaid redeterminations post pandemic. We have Miranda Motter, Senior VP of State Affairs & Policy at America's Health Insurance Plans (AHIP) with us here today. We've had updates on this topic throughout the past few years and now that we're fully removed from the pandemic, we thought we'd get another update to hear the latest data.

Ms. Motter thanked the Committee for the opportunity to speak and stated that I am privileged to talk about three quick things this morning. One, I wanted to just provide a quick update relative to the data that we are seeing from March to December of 2023 relative to what is happening with redeterminations and I will quickly say that this is data that is being reported in a uniform way from states into CMS. So, I know that there is a lot of different kinds of reporting out there but this is what we're focused on today and this link that is included here provides specific information for states if you're interested and I'm more than happy to pull that moving forward. Essentially, where we are with having to redetermine 94 million individuals, we're about two-thirds of the way through. Coverage is renewed for about 53% of Americans that have had their coverage renewed through Medicaid. The coverage levels in terms of terminations is at 24%. So, 13.7 million Americans have lost their coverage. Some of that has been because of procedural terminations. That is hovering currently at around 70%. That is varied in certain States. And I will tell you some states have actually paused those terminations to make sure that they can do additional outreach for individuals.

The second bucket of data that I wanted to share is where are individuals going that no longer have Medicaid. So, as of October 2023, you can see here in federally facilitated marketplaces nearly four million Americans who lost their Medicaid went through some level of process in the marketplace. And I guess I would point your attention to the four million that went to the marketplace and then to the bottom number of the one million consumers that actually selected a qualified health plan. So, that means they actually selected a health plan in the federally facilitated marketplaces in states where there is a state-based marketplace. Again, that data is as of December 2023. Again, I would call your attention to the four million individuals that went

to that marketplace in those States and then half a million individuals actually selected a qualified health plan. Obviously there are levels in the marketplace given the application process and who may be eligible for subsidies that all differs. And so again, I would call your attention to those two numbers. The last thing just quickly I wanted to provide a quick update on. Since this group last had an update about redeterminations there has been a number of guidance that have been issued by CMS. Just very quickly, a special enrollment period. So, individuals who lost coverage as a result of this have a special enrollment period in the marketplace through November of 2024. There has been general guidance issued by CMS to states really outlining ten different areas reminding states what the federal rules are as it relates to eligibility and enrollment. There has been guidance issued to states to really continue to encourage them to work with managed care plans relative to contact information, relative to transitions. Really helping individuals complete those application forms. There are new resources for families that may be, and individuals that may lose that Medicaid coverage through the fair hearing process. And then last, in December of 2023, CMS did issue additional guidance given that there is a high level of kids that are losing coverage. About four in ten that are losing coverage are children of those states that are reporting ages and so CMS did issue some specific information to states to make sure that kids could continue to remain covered, reminding them of the requirements and then also providing some strategies and flexibilities through waivers that states could apply for.

INTRODUCTION OF NCOIL VALUE BASED PURCHASING MODEL ACT

Sen. Mary Felzkowski (WI), stated that I will be very brief as this just is meant to be an introduction of the Value Based Purchasing Model Act that I am sponsoring and then we can fully discuss it at our next meeting. You can view the model in your binders on page 275 and on the website or app. I'm very supportive of this model and I sponsored an identical piece of legislation in my home state of Wisconsin. The model is very straightforward. It simply creates authority for states to enter into a value based purchasing agreement with a drug manufacturer. Importantly, there is no requirement to enter into these agreements, the model just creates the authority if the state wants to do this. And what we're mainly driving at here is the fact that our medical treatments continue to advance. It's opened the door to a wide variety of medical solutions, especially when dealing with very rare diseases. But the cost of these treatments are extremely high. Sometimes these treatments can actually exceed upwards of $1 million. So, a value-based purchasing agreement aims to ensure that the cost of the treatment is based on the value that it provides to the patient and this is done through an agreed upon metric between the state agency and the manufacturer stating what benchmarks need to be met in order to receive the full payment. I'll stop there and just say I look forward to working on this model throughout the year and hopefully it will be ready for consideration by November.

JP Wieske, VP of State Affairs for the Campaign for Transformative Therapies, thanked the Committee for the opportunity to speak and stated that four gene therapies were approved at the end of last year. Each one of those will likely cost in excess of $2 million for the treatment. Now, they're covering extremely rare, debilitating diseases like sickle cell and hemophilia. These arrangements will allow your Medicaid agency to look at this as an issue and to pay for value when they're effective and make these decisions and align the incentives between the drug companies and Medicaid in the right direction. We're strongly in support of this.

Rep. Dunnigan thanked everyone and stated that we look forward to further work on this in our coming meetings. If you have any questions, I'd invite you to reach out to Sen. Felzkowski.

ANY OTHER BUSINESS

Rep. David LeBOeuf (MA) stated that I would like to propose at a future meeting that we have a conversation about innovations in maternal health. There's definitely been some new practices that have been evolving including birth centers, in home visits, and some of the insurance related matters that our practitioners are facing.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Paul Utke (MN), NCOIL Treasurer, and seconded by Rep. Oliverson, the Committee adjourned at 10:45 a.m.