NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2024 NCOIL SUMMER MEETING – COSTA MESA, CALIFORNIA
JULY 18, 2024
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin South Coast Plaza Hotel in Costa Mesa, California on Thursday, July 18, 2024 at 2:00 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Dafna Michaelson Jenet (CO)
Sen. Larry Walker (GA)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Rep. Cherlynn Stevenson (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Rep. David Silvers (FL)
Rep. Joseph Gullett (GA)
Rep. Martin Momtahan (GA)
Rep. Matt Lockett (KY)
Rep. Dennis Bamburg (LA)
Rep. Gabe Firment (LA)
Sen. Franklin Foil (LA)
Rep. Brian Glorioso (LA)
Rep. Chance Henry (LA)
Rep. Shaun Mena (LA)
Sen. Kirk Talbot (LA)
Sen. Bill Wheat (LA)
Sen. Arthur Ellis (MD)
Sen. Kevin Hertel (MI)
Sen. Jeff Howe (MN)
Rep. Bob Titus (MO)
Sen. Waler Michel (MS)
Sen. Brian Rhodes (MS)
Sen. Joseph Thomas (MS)
Asm. Alex Bores (NY)
Rep. Greg Scott (PA)
Sen. Patty Kuderer (WA)
Del. Walter Hall (WV)

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a Motion made by Sen. Hackett and seconded by Rep. Edmond Jordan (LA), NCOIL Secretary, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's April 14, 2024 meeting.

CONTINUED DISCUSSION ON SITE-NEUTRAL PAYMENT REFORMS

Rep. Dunnigan stated that at our last meeting in April we had a good discussion on this topic that we're going to address again now. And recently we've had some draft model language shared with us and it's been distributed before you. The language that's before you is simply a rough draft and for now, it's really meant to just start the conversation and get the discussion going and continue what we did in April. We're not intending to take any action on this item today and not this year. If we do it will be next year. So, at this point I'm going to turn it over to Rep. Deborah Ferguson, DDS (AR), NCOIL Immediate Past President, and she's agreed to sponsor the language for introductory purposes.

Rep. Ferguson stated that I wanted to make sure that I got this model started now as most of you know I will be leaving the legislature at the end of December. So, I wanted to make sure we got the process started and then I have already talked to some people about taking over as sponsor since I will no longer be a legislator. I don't want to preempt anything the speakers are going to say but really, the goal of this is to save healthcare costs and to save money for patients and to create a fairer process for private providers who are competing with hospitals in an outpatient setting where the exact same procedure is being done at drastically different costs.

Randi Chapman, Managing Director of State Affairs at the Blue Cross Blue Shield Association (BCBSA), thanked the Committee for the opportunity to speak and stated that I really appreciate the willingness to continue this conversation about healthcare affordability for consumers. And of course, you all know BCBSA and our companies as well. I'm sure many of you have a blue card in your pocket or your wallet or purse right now but I wanted to say that our mission is simple. We want everyone to have access to high quality affordable healthcare and that's why we're here to talk about that today. So over the last 20 years, the U.S. has made really great strides in expanding access to health insurance and nearly 92% of Americans have coverage right now. And that's a historic high. But where we need to continue to work is with regard to healthcare costs. Those costs continue to grow and they threaten affordability for American families and businesses. And the reason for this affordability crisis is clear, rising prices for healthcare services driven by higher healthcare spending. And that's why BCBSA developed our affordability policy platform last year which you see a snippet of here on the slide. These policy solutions, if implemented in total, would save patients, seniors and taxpayers $767 billion over the next 10 years. And the draft language that you see that we're talking about today focuses on policy solutions found under the first prong of that platform. The prices for our healthcare services have significantly increased and that's due in part to the trend of big hospitals and health systems acquiring physician practices and that often results in reduced provider competition and excess cost and those excess costs can show up for consumers as facility fee charges which fuels the post-acquisition service cost disparities that we discussed this past spring. Excess costs also show up as higher cost sharing for consumers due to inappropriate billing practices.

So, let's break this down a little bit. What are facility fees? On its face, a facility fee is meant to compensate hospitals for standby capacity required for emergency department and inpatient services. And when we talked about this at the spring meeting, hospitals provide 24/7 care and emergency service to all who need it regardless of their ability to pay. And that requires

personnel to be at the ready and able to handle high acuity in merchant inpatient services needed by patients who come to the hospital. And to be clear, the model is not about that. We aren't talking about inpatient overnight hospital care or emergency rooms. We're talking about hospital facility fees being charged to consumers who receive routine diagnostic outpatient services off the hospital campus. So, how do facility fees show up for American consumers? Well often it seems as these headlines indicate, that they are unexpected and unwanted. I've seen facility fees described as a cover charge for just walking in the door. Or even recently as a hospital resort fee kind of like the hotel resort fees that we have to pay even if you don't use the services. And these fees show up for common outpatient services. They show up even for telehealth services, where there's no facility involved. They raise costs for services that used to cost less for consumers and they hit patients across the country from Seattle to Mississippi where it counts, in their wallets. This model proposes reasonable limits on facility fees in three areas. Those fees shouldn't be collected for services provided at off campus locations for outpatient services using evaluation and management codes or for services provided via telehealth. So seven states, as you'll see on this map, have enacted or are considering bills to limit the imposition of facility fees. The National Academy of State Health Policy (NASHP) tracks this issue across the country and has identified 16 laws in 12 states that have been enacted. NASHP also has its own facility fee model language that some legislators have looked to in order inform their efforts in states.

And I want to spend a little time talking about campus and how that's defined in the language and then this concept of on campus versus off campus. So, the model language uses the Centers for Medicare & Medicaid Services (CMS) definition of campus and that's used in many federal and state laws and regulations. And it sets the on campus parameters at 250 yards around the hospital's main buildings. This is again the same definition used in several state facility fee limitation bills including bills in Colorado and Connecticut, but not limited to those. So, let's consider a couple of examples of what on and off campus might look like under the CMS definition. So, this diagram can provide some perspective on how that's practically applied. So, it might be hard to see, but if you see there's a blue line around the hospital in the middle and the two little buildings on the side there. So, you can have the situation where there's a hospital, there's one main building and then perhaps there are a couple of facilities on the outside of those buildings, but still within that 250 yard radius. So, that's considered on campus. And then the two building figures that you see outside of that blue circle those would be considered off campus as they're outside of that 250 yard radius, as defined under the CMS definition of campus. And we have another example here where you might have a health system that has four main buildings or five or sometimes the hospital systems have buildings across a state or across an area. I used to live in Maryland and I think of Johns Hopkins that has one big hospital in Baltimore but then there are several hospitals around the state of Maryland that Johns Hopkins owns. And they are full-on hospitals but in a case like that you would have the 250 yard radius around each main building and that's how you would classify what is on campus versus what facilities are off campus. So, the proposed language also requires certain notice provisions to ensure that consumers and patients are empowered with knowledge that a facility fee might be charged and also of the grievance dispute and fee waiver processes, if any. The language also requires hospitals and health systems to clearly identify facility fees in healthcare bills.

And moving on to the second prong of the model, this addresses the need for honest or appropriate billing and reimbursement that will ensure consumers are not paying higher copays and cost shares. Patient cost share should not be in some instances, based on the hospital rate, but should instead be based on the appropriate outpatient provider rate which is lower than the hospital rate. And the bottom line here, and this is kind of behind the scenes back-end stuff, but if we can help payers properly identify where a service is taking place then the correct and

appropriate consumer cost sharing can be applied and appropriate reimbursement rate can be applied. One way to do that is to compel hospitals and health systems to have separate National Provider Identifiers (NPI's) for off campus facilities, those that are outside of that 250 yard radius, and to use place of service codes on claim forms. And so the NPI is the National Provider Identifier number. This is a ten-digit number that CMS assigns to providers and practitioners. And what that allows payers to do again it designates where a service took place so a payor is not in a position of paying hospital reimbursement rates for services that actually happened in a doctor's office. And again, there's a pretty significant disparity in what those rates can be depending on the services as we discussed in the spring. And so with that I will wrap up and again, I do want to thank Rep. Ferguson for the support and the entire NCOIL membership for willingness to discuss this important issue. And I look forward to working with you all to help improve affordability for patients.

Francis Gibson, CEO of the Utah Hospital Association, thanked the Committee for the opportunity to speak and stated that for 14 years I was a state legislator so I understand where you're at in some of the many challenges that you have even though you're from different states and I bet many of the challenges are the same. I would like to just share a little bit about my career background for a moment. You might know of the various areas in healthcare that I've served in my career. The first three years of my career I grew up in Texas. I worked in College Station in a primary care administrator. We had a women's clinic, pediatric clinic and HIV and AIDS clinic. A Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program. And the majority of the patients that we served were either Medicaid or low income or noninsured. Following that I moved to Utah and for 15 years I served as an ambulatory surgery center developer and creator owner. And I understood what it meant to be able to run an ambulatory surgery center and actually competed against hospitals for 15 years. For the last 12 years, I've served as a hospital CEO and running the day-to-day operations of two different hospitals in a regional operator for a bigger tertiary care center as well. And I served as a state legislator in the Utah State Legislature, four years as the Majority Leader, four years as the majority whip, and as various different committee chairs as well. As a legislator sitting through various committee hearings over those 13 years I saw many PowerPoint presentations and I would like to just kind of not use a PowerPoint today and just speak about some of the challenges that hospitals have and my experiences as an ambulatory surgery center person and then in my experiences as a legislator as well and just kind of speak from the heart if I may.

Today I hope to share a little bit of my experience working in these settings while representing nearly 7,000 hospitals in the U.S as I sit here representing the American Hospital Association (AHA) though I work in Utah. Every day in a hospital, there are hundreds or even thousands of inputs that arrive daily in that facility depending on the size of the hospital that are required to make hospitals work. When hospitals successfully function, they serve the communities and your constituents across this country very well. Each of these inputs are a cost and cannot be avoided and the costs continue to rise year after year. You're probably thinking what are some of those costs? Surgical, medical supplies, pharmaceuticals, med gas, food and beverage, cleaning supplies, medical devices, imaging equipment. And the most important are the caregivers themselves with nearly seven million caregivers in the U.S. that work at hospitals. All of these things, and hundreds of more, cost money. Many of the companies that supply such inputs at hospitals are from publicly traded companies. What happens every quarter with a publicly traded company? Earnings reports are due and made public, and every shareholder or investor wants a bigger return on their investment. Thus, prices are moved accordingly to achieve a greater return. Medical device companies, pharmaceutical companies - all of these different things continue to rise every single year. Hospitals are the last stop for care. No one wakes up in the morning and says, “I get to go to the hospital. I'm so excited to be there.”

Nobody does that. I can think of only one person who's excited to go to the hospital, a mother waiting to give birth. I know that you've heard that there are places in the hospital that are required to be open 24/7. Well, this is true. Emergency rooms, infusion services, lab departments, rehab services, med surge floors are all critical for the comprehensive care for patients. And they make very little, if anything, to cover the cost to run those units. Every hospital or health system that I know of have been actively working to lower the cost of care while raising the outcomes to patients. Quality measures, which are federally mandated and measured by CMS, are strict regulatory requirements that are required of hospitals to ensure great quality. I know you've heard that enacting some sort of site neutral payment system will lower the cost of healthcare to patients. As I mentioned earlier, the costs continue to rise in hospitals while reimbursement for services continue to decrease both from commercial payers and government payers. Many of our commercial payers are publicly traded companies. There needs to be a return on their investment.

And how do they do that? They're able to shift costs. When certain services within hospitals are more profitable than others those profits are taken and they move to the areas which are not meeting their costs. This is not unique. Insurance companies, both property & casualty and health insurers, shift costs as well. When we have healthy patients who continue to pay their premiums and they do not use them, those costs are shifted to the higher cost patients, maybe a cancer patient, terminally ill patient. That happens all the time. It does happen in hospitals as well. For nearly 15 years of my career, I worked and led and developed ambulatory surgery centers (ASCs). I would partner with surgeons and would declare the ASC as an extension of their office within the bounds of stark laws. And they would partner with these ASC's and then drive patients to the ASC's for services. Patients would then be taken care of and care would be at a cheaper cost than in the hospital. And I would use this mantra with Rep. Dunnigan when we served together - “hey, we are cheaper than hospitals. Why aren’t we driving more care there?” However, patient selection in these facilities is very important. If you're obese, if you're a diabetic, if you have a cardiology problem or any other medical comorbidity that we consider you at risk, those patients are not taken to surgery centers. Those are shifted to the hospital. Why? Because hospitals have the ability to take care of those comorbidities and those other risky issues. And at what cost? It costs more to take care of sicker patients and that's why hospitals are there. ASC's are not required to have the same services. They are not required to have many of the different things that hospitals are required to have. So, taking care of a sick patient is not beneficial to the business model of an ASC. I developed, ran and operated ASC’s for 15 years. I did not want to see Medicaid patients. I did not want to see patients who can't have any other source to pay. Or patients that may potentially run risk of complication. I know that this bill that we're talking about is focused on facility fees. As an ASC, I charged a facility fee. Physician offices charge facility fees. So, just being able to say that hospitals cannot charge facility fees, I would broaden that if that is the direction of this committee to say no one can. I think it is appropriate to charge the fees to take care of the patients for what needs to happen. But please don't be confused, ASCs and other off-site centers do charge facility fees.

Finally, I understand the hard work you do as legislators as I used to be in your shoes. I would hear about healthcare costs rising all the time and what things can be done. I was blessed to serve in the highest leadership positions in the Utah House of Representatives. I know that you're all looking to lower those healthcare costs and healthcare is expensive. And I agree we need to find ways to lower those costs. I'm asking that you look at the cost in its entirety. When was the last time any of your insurance premiums went down? How about your constituents and businesses? Publicly traded companies like device manufacturers, PhRMA, and some insurance plans who supply the needed inputs into a hospital daily have never showed up and said I'd like to lower the cost of those supplies for the hospital today - I think we've been charging

you too much, can we lower those costs? It's never happened. The nearly seven million hospital caregivers nationwide have never went to their bosses or the hospitals and said, “You know what I don't need to raise this year. I think we're making enough money.” It's never happened. Many hospitals in this company operate on a low single digit profit margin. Some are barely breaking even, while health insurance companies who do not lower premiums have double digit profit margins. Device manufacturers and especially PhRMA continue to have double digit profit margins. Hospitals are needed in your communities to serve those folks who are sick. Hospitals are a major employer in your communities. Site neutral payment reform will negatively impact hospitals and hospitals will close. Probably not in every community, but is that hospital closed in your state or in your community? Maybe. If we're going to look at cost cutting, I'm asking that you look at everything. Can you assure that the payers and the savings that may come from this legislation or any other site neutral legislation that may be discussed nationally or within your states go directly to the very people that cause you to raise the question? Those payments will hit hospital pocketbooks immediately. Will they be translated into lower premiums for the people that you represent? Just saying that I'm not going to raise your premiums is not a cost savings. Because these companies are making money today. If you're going to enact something to save the $766 million will that translate into a lower premium for our folks? I just want to thank you for your time. You sit in very difficult shoes. You're going to try to draft model legislation that could potentially be drafted in the various states that you go back into. But these are questions that should be asked. I know that every state has a Hospital Association. Many of you may have met with your Hospital Association leaders. And if you’ve not I would encourage you to do so and understand what are facility fees in my state? I'm not here to talk about what may happen in New Jersey or Nebraska or California. I don't know all of that. But I can tell you it is very difficult to be able to run hospitals. And to see the continued decline in reimbursement built from government commercial payers while every other input increases, there are tough decisions. We ask that the AHA be part of drafting a bill on these issues from its inception.

Rep. Ferguson stated to Ms. Chapman to please address that we're not talking about getting rid of facility fees across the board, right? My husband's a radiologist, for instance, and he charges a facility fee because we own the facility and a professional fee because we have very expensive radiology equipment. So, those outpatient centers would be able to continue to charge a facility fee. I think you might explain the facility fee removal and who that is being removed for. And just on another note with health care inflation at over 3% even if we don't raise premiums for insurance, we save consumers money because it's very difficult for all of us to keep up with the health inflation. But please address the facility fee and I told you all this before my husband does a echocardiogram and he can do it in his office for $264. And you go to the hospital outpatient center and it's $6,000. So, I mean that's the differential we're talking about. And I completely support acute care in hospitals. I understand all that, and I'm for them continuing their disparity and fees. But when we're talking about similar facilities, if we're talking about apples and apples I think that's a different matter. Please explain the facility fee so that we understand that we're not eliminating the facility fee.

Ms. Chapman stated that's exactly right. I think the example that you raised again, going back to our presentation in the spring is just that what we see and I'll get to the answer to your question, but just to reiterate what we see is, you have a hospital or health system that purchases a physician’s office and then what happens is due to fees or due to reimbursement coding the services that are provided in the doctor's office goes up exponentially. And so, what happens is consumers in effect are being saddled with the extra cost after this acquisition takes place. But this doesn’t all deal with facility fees in certain circumstances. And so, we're talking about healthcare services that are provided at off campus locations and we talked about the definition of campus. We're talking about outpatient services using evaluation and management codes.

And then we're talking about outpatient services using the evaluation and management codes that are provided via telehealth. And so again there are many instances where the facility fees are appropriate and do make sense because of the type of care that's provided at the facility.

Rep. Tom Oliverson, M.D. (TX), NCOIL President, stated that I appreciate the panelists being here and having this conversation. Like Rep. Ferguson, I also have a direct connection to the healthcare industry so I see this at the ground level and as an anesthesiologist I've worked in many surgery centers. The thing I hope everybody else gets out of this is there is a fundamental disconnect happening here in that we're charging the facility fee in a doctor's office for a service that essentially 20 years ago the same exact service was provided with no facility fee of any kind. And the kind and quality of the service that's being provided hasn't changed at all. It's just another source of revenue. It's another way to monetize essentially for no additional benefit we're adding an additional cost to the system. And we talk about healthcare costs going up, healthcare costs staying the same. It stands to reason that if you add a charge where previously there was no charge, that's going to increase costs. The second thing is that this type of financial arrangement which is typically happening through, at least in my state, our larger we use the term not-for-profit but really it's tax-exempt hospital systems where they're building a brand new tower essentially every year with the excess revenue that they have in order to keep their tax exempt status I guess. But the problem is that these physician practices that are purchased by these hospital systems now the hospital system owns the patient’s medical record and the patients care. So, it's not just that there's an additional fee being charged, but now there's complete vertical consolidation in the patients care pathway where the patient is essentially trapped into having to use that hospital system for every additional ancillary service that they may require because their physician has a contract requirement as being an employee of that facility now being paid by that facility and doing well financially, having a lot less overhead and headaches, a whole other conversation. Now every MRI has to be done at the hospital whereas before it could be done at the outpatient imaging center for less than half the cost. Every lab has to be done there. Every physical therapy appointment has to be there. So really, the game here and I hate to use the word game but really the overarching theme is not just the facility fee itself it's control of the physicians, referral patterns and the ability of the patient once they're seeing a patient in that system to never be able to escape to find value anywhere else in the system, which is essentially completely the antithesis of what we've been working so hard for in hospital price transparency and other transparency measures where we're trying to give patients the right to compete in the right to shop.

My question is this is just like the conversation that we've had in the past. In my impression, when we talk about doing away with healthcare facilities ability to go after a patient for collections an unpaid bill and now that patient's going to be sued in order to pay that bill. Medical debt is actually one of the leading causes of bankruptcy in America and yet it always seems to me that the defense mechanism that's employed or the reason that we have to have this is that the hospitals are barely scraping by and so they need the ability to be able to sue patients who are unable to meet their financial obligations. While at the same time, we as state lawmakers are dumping copious buckets of money into these systems for disproportionately under resourced care and all of these other buckets of state supported funds which are supposed to be taking care of these very things and I guess I have to ask is it really that tough out there? Because as a doctor sort of seeing it from the inside it doesn't seem to me like anyone's hurting. In fact, it seems to me like everywhere I turn, there's a parking lot being converted into a brand new building with 500 more shiny new beds and the new MRI scanner being bought every month. And it just doesn't compute. So, I guess where is the disconnect that I'm not seeing there in terms of are we really with the exception of rural hospitals, where I understand that is a special bucket, but that has more to do with payer mix and the fact that there just aren't that many

patients. But not where I live. Not in the Houston area. I don't see a lot of facilities going out of business because they can't charge a facility fee for something that was essentially provided in the office 20 years ago with no facility fee. And so I guess where's the problem? What are we missing here? That's my question.

Mr. Gibson stated that I grew up in Houston my whole life, so I'm very familiar with the area where you work. There are lots of things in your comments to address. I heard lots of things about physician practices. Many physician practices because reimbursement is going so low, they are joining health systems because now they can get a solid set salary. They know what that means. But in order to run that practice there's a cost there. Are the facility fees that are charged inside those practices for dermatology or whatever other office procedures may be done? Possibly. And I'm not going to say that's not true because it probably is true in many places but in some places it's not. I think to exclude a free standing facility that may be outside the 250 yards but is independent from charging a facility fee, how would that be any different from charging a facility fee or the inability to charge a facility fee for a building that's outside the 250 yard marker? I think if we're going to compete, that should all be the same. If reimbursement is going to be the same there should be the ability to charge that facility or no one charge the facility fee. That's the crux of it. Just because there's an investment there and you need to recruit that by charging facility fee that same investment is made by whoever the owner is whether it be a hospital system or whether it be a group of radiologists who put together a freestanding imaging center. So, if a facility fee is not important, then facility fees shouldn't be important. We shouldn't charge it to anyone. The disconnect, Rep. Oliverson, I don't know what that means. I do know that there are costs inherent in running physician practices and they should be looked at when a physician chooses to join a system. There are certain rules there that he or she chose when they came into that system. We talked about the direct ability of patients in ASC's all the time. Why do they direct patients to ASC's? They're only three reasons a surgeon takes a procedure to a surgery center. Number one, he's an owner and he's financially vested. Number two, he's an owner and he's financially vested. Number three, he's an owner and he's financially vested. That would be an easy way to say it. But from practicing I would say number one, he's financially invested. Number two, our continuity of care. He gets the same surgical staff every time. And number three, typically turnover times are easier and faster. Those are the three reasons why they go to a surgery center.

That being said, number one, he is financial invested and there is a return on that investment. So, in some ways, there's a perverse incentive to be able to take them over there. The other two reasons, I would never argue about those and that is turnover times and continuity you get the same surgical staff every time you go. And you, being the anesthesiologist and working in ASC's you see that every day. And I could speak with you all day long because that's what I did for a long time. I don't know what the discount is, I'm not going to pretend to know that. But I will tell you, the example that Rep. Ferguson used of the big difference in price, that's stupid. I don't know what that looks like. I would love to be able to see what that looks like. I would love to see the Arkansas Hospital Association sit down with you and you share that with them if you have not already and let them talk and understand what that looks like. That seems to be way out of bounds. There may be a difference in rates but I would argue that your lower rate cited is probably just the professional fee to have it done because by the time the facility fee is tacked on that disparity is not going to be that big. Rep. Ferguson stated that is the global fee. Mr. Gibson stated that's a great deal.

Sen. Mary Felzkowski (WI) stated that this is directed towards Mr. Gibson. You sit there as a previous lawmaker and say we have a hard road ahead of us to try to get in line with healthcare costs. But I think as a legislator and insurance agent before that, "if" can also be the biggest

word in the dictionary. If there was transparency in pricing. If hospital systems voluntarily were upfront with costs to consumers and we saw the patient mix. We saw the payer mix. It would be a little easier I think for the legislators in all 50 states to kind of come to terms with what was actually happening. But with the secrecy in pricing that we see in our systems it's very hard to have sympathy when we are watching our constituents not going to the doctor, delaying care because they're more afraid of the debt than the diagnosis. And it always comes back to what other major purchase do you make where you have no idea the cost is until the bill is sent to you? No one across the U.S. wants to see our hospitals go under or not have them make a fair return on the investment that they have but until that transparency is evident, it's just really hard as a lawmaker to make a lot of those decisions and that's why I think you see legislation like this. And until the AHA steps up and come to terms with that transparency I think you're going to see more and more legislation like this.

Mr. Gibson stated that’s a great point and I think one of the things that concerns me is what does that transparency look like? There are states that already have transparency legislation on the books that have to show what that looks like - an MRI’s this much, an ACL is this much. An ACL is a good example, I may quote you $4,500 for an ACL. We get into the operating room and an ACL typically the first choice would be to possibly harvest something from your hamstring. I've seen it happen before where a hamstring is in very bad shape. We go to the back of the operating room and they take that hamstring and they re-stretch it and make it tight and they reinsert it in your knee. If you have a bad hamstring though and we can't harvest that, I quoted you $4,500 but now I'm going to do something different, something artificial which is an additional $4,000 or $5,000 and you've been under anesthesia longer than anticipated. And now that bill goes from $4,500 initially to an $11,000 quote. Or I can quote you a straight vaginal delivery $6,500 for example. All of a sudden you get in there and something is going wrong and we have to do a C-section. But the only thing the patient remembers is the $4,500 quote. Or the only thing they may understand is that $6,500. And then the trouble to collect becomes different. I'm not saying that we can't do more with regards to transparency and pricing but what I am saying is that not every quote may wind up being the same because of the different variables that may go into in order to treat you. Sen. Felzkowski stated that I don't disagree with you, but that's a standard. I don't want to compare getting my roof repair to having surgery but if I have rotten sheeting now that $18,000 quote for my roof is no longer $18,000. I don't think that the American public is that naïve. I would give the American public much more credit than that because we do quotes all the time in this world.

Rep. Ferguson stated that I knew this would probably be a little contentious when I brought it forward but the bigger question for me is how we got here. I know that doesn't solve the problem but I'm not sure how CMS ever decided that this was a good way to support hospitals as a permanent payment modality and in making patients pay more and consolidating private practice to get vertical with hospitals. But I look forward to the discussion and someone else sponsoring the language in the future.

Rep. Dunnigan thanked everyone for their comments and stated that if anyone has additional comments or ideas that you'd like considered for this model you can send it to myself, Rep. Ferguson or NCOIL staff.

CONTINUED DISCUSSION ON NCOIL VALUE BASED PURCHASING MODEL ACT

Rep. Dunnigan stated that next on our agenda is a continued discussion on the NCOIL Value Based Purchasing Model Act (Model). You can view the model act on page 79 in your binders

and on the website and the app. And before we hear from our speakers I want to turn to Sen. Felzkowski, sponsor of the Model.

Sen. Felzkowski stated that we introduced this model very briefly at our last meeting in Nashville in April and I look forward to continuing the discussion today. I sponsored a nearly identical piece of legislation in my home state of Wisconsin and the concept here is very straightforward as it simply creates authority for states to enter into a value-based purchasing agreement with a drug manufacturer. The speakers we have here today will provide us with some information as to what exactly a value-based purchasing agreement is and how it works but what we're looking at here is the fact that while our medical treatments continue to advance, the cost of those treatments are extremely high, and these types of purchasing agreements can be used as a tool for the state to ensure that the cost of treatment is based on the value provided to the patient. I'll stop there so we can hear from our speakers but I obviously support this model and encourage my colleagues to do so as well and hopefully we can have something ready for consideration at a November meeting.

JP Wieske, VP of State Affairs at the Campaign for Transformative Therapies (CTT), thanked the Committee for the opportunity to speak and stated that CTT is a group that is looking for solutions to this cost problems that we see. This may be the most important slide you see. This tells you what is coming. What is coming is an explosion. On the good side we have gene therapies that are going to change the way patients interact with their diseases. And there may be durable cures for it. On the other hand, there are really significant financing issues we'll get into in a little bit. Medicaid will have to cover these treatments. Under federal rules, these high costs would leave the potential to significantly limit access. This Model is one of many possible solutions to this explosion that's coming. To highlight here, spinal muscular atrophy, hemophilia, sickle cell disease all have gene therapies that potentially have a cure that are available on the market as we speak now. Now the cost of these therapies, at least in the case of hemophilia are $2 to $3 million dollars for a treatment. It's a one time treatment and it promises that the patient will functionally no longer be a hemophiliac. There are 30 gene therapies so far that have been approved. There are 56 currently in clinical trials. We expect more than 60 by 2030. And there are over 2,000 in development across the country. So, these are coming. They are going to be expensive and they're going to change the way medicine works. It’s important to understand when we look at financing for Medicaid there are a couple of ways Medicaid looks at specific drugs and medical treatments. Access is one of their key drivers. We're aware of one state that has effectively maneuvered to ensure gene therapies will not be available through their state Medicaid department. It's technically available, but you would never get through to it as they also use utilization review, managed care, pharmacy benefit managers (PBM) contracting issues and a number of other preferred drug lists.

When you're looking at these you also have a national standard as far as what Medicaid pays for the drug. So, there is a minimum standard that attaches. These rebates that we're talking about are on top of that minimum standard. So, this does not change that and states are free to do whatever they want to do with it or not but the existing rebate structure continues. Value based payments are intended to align the incentives in the correct way. So, you negotiate with Medicaid, the drug company negotiates on access and they agree to a rebate if the drug is not effective. Now, if you have really broad patient access and you have a rebate structure your rebates will outpace, and the drug company will no longer be able to make a profit because that's not effective under the terms. And the same thing for Medicaid. They want to have access and they want to limit cost. But this ensures that their interests are the same as the drug, they're perfectly aligned from a structure standpoint. And this is what we're talking about and my

colleague will talk a little bit more about Medicaid but we believe that state policymakers need solutions that balance both the access and the costs.

Michael Heifetz, Principal at Infinite Policy Solutions and former Wisconsin Medicaid Director, thanked the Committee for the opportunity to speak and stated that I was also a former state budget director and CEO of a Medicaid health plan for a time as well. And I also worked in a provider based integrated health system so I've been on pretty much every side of the payer provider component here and this just becomes a larger and larger issue as we go. A quick summary of what these are. It's really a contractual arrangement between the manufacturer and the Medicaid program. So again, it's voluntary. As Sen. Felzkowski indicated, the model simply allows states to pursue this. It doesn't require them to do so. So, it essentially then rolls into a contractual arrangement where they would mutually agree to the terms, the definitions, the access components of it and the measurements for success or what is deemed as not success. So you can see those boxes there. The medium sized box on the right is very important because terminology is often mixed in this realm. So, you'll hear outcomes based performance, pay for performance, alternative payment arrangements and a number of things. You'll hear value-based care. Things like that that also crossover into other realms. So, just keep that in mind as we go but it's really at its essence a contractual agreement. So, for patients with rare disease, this can be very important to them because it can increase access. So, part of why the manufacturing community and I'm not saying it is the whole of the manufacturing community, but some members of the manufacturing community are pursuing these or are in favor of the ability to pursue these to address the access issue and to really battle through some of the components that my colleague just mentioned on how treatments can be restricted or limited or analyzed and delayed through some of those other utilization mechanisms that are common in Medicaid programs from the payer side.

So that's a large piece of this is that the manufacturer then knows that the patients who need this will get that access without those steps in between that are often costly to fight through and often difficult for patients to address. So, the other side of that is reducing the wasteful spending that comes from treatments that aren't helping or simply getting at a return on investment in a crass way on using some of these newer therapies that have some incredible impacts. In some cases, they monetarily work out very favorably for the payer side. In some cases they don't. But obviously they have massive impact on the patients and their families and their lives going forward. My colleague mentioned sickle cell. The average patient, according to some studies, with sickle cell disease only lives into their low 50s. And that's a dynamic that has to be thought of through all of this. So, as we talk about statistics and clinical studies and all these things that sound pretty lofty and remove the patient, really in some cases, we have to think about what that really means to the patient. Obviously, we have providers here on this committee today so that won't be lost here but sometimes when we talk about it, it sounds a little insensitive and it's not meant to be that way because these are massive patient impacts that we're talking about.

As mentioned, it's a contract between the two parties. It's addressing access and cost and the risk structure and we're ensuring through that contractual mechanism that these treatments are going to the right patients. Patients that are likely to succeed. Patients that generally without me getting overly clinical since I'm not a clinician, but patients that resemble the clinical testing that the treatment went through to gain approval from the federal folks and the regulators. So, there's that component of it and then there's the tracking and the data gathering of the success or not success of these treatments. So, it can be helpful in that public policy realm as well. Some of these are approved with different clinical trial results. Some of them are extremely successful on a percentage basis and some of them a little less so. So, that dynamic does come into play and it's measured. And how it's measured is determined through that contractual arrangement. And

again, we love this balancing meme, I guess you could call it or logo. But anyway, these are aimed at ensuring the access issues and balancing that with the cost. And as my colleague mentioned, states will have to pay for these through the Medicaid programs. This gives them a mechanism to at least manage that cost and give it some accountability that the manufacturers previously typically have not come forward with. So, it's not going to balance a Medicaid budget per se but it's going to pay for the performance of the product of the treatment and if it's not working as intended, then there will be a payback of some kind. That's a broad term. It will be spelled out contractually and there will be some transparency in that regard.

You can see up here all of the 24 states that have state plan amendments which is a relatively simple process that states file for their Medicaid programs to the federal government for approval. These are turned around relatively quickly by the federal government. They're very familiar given that it's 24 states. I think California was the most recent. We know of others that are exploring the issue. Wisconsin is soon to be filing its state plan amendment with the feds. We're hopeful of it. And it's giving flexibility in this regard. So, in some cases we have seen where legislation is needed for a state Medicaid agency to move forward with these. In other places the state Medicaid agency has its own independent authority in that regard but sometimes wants legislation so that there is full buy in and transparency of the process. But we've done this roadshow for a while, my colleague and I, and the 24 states, it used to be 13 then 16, then 18, and it is clearly growing as states explore this. And again, that doesn't mean every state is doing it but they want that authority, and they want to be able to talk to the manufacturers about how to approach this. Anecdotally, when I was Medicaid director, there was only one of these treatments around for spinal muscular atrophy. It was SPINRAZA. And it was at that point a one off for us from a clinical and a financial dynamic. It was about $500,000 to $750,000 but we only had two to three members in the Medicaid program that would have been eligible for it from a clinical perspective. So, in a $9 billion combined federal and state funds budget that $1 or $3 million would not have really caused us a major problem but when you look at the numbers that my colleague presented earlier, it becomes entirely different with sickle cell being $3 million or something in that neighborhood and having a much larger population of patients. You can do the math pretty quickly and then all of a sudden all of you as appropriators have a different dilemma in front of you besides the normal Medicaid dilemmas that you have in front of you. So, it's a significant issue. I was in a position where we didn't have to really debate it because it wasn't yet this advanced and I certainly did not want to play clinician or higher and say yes or no on my own. So, we were able to say yes but this dynamic gets more difficult as more of these come out and the price is what it is today. So, the volume is significant and that's really why this legislation is here. A few years ago it may not have been necessary and today it's a different world in this regard.

Rep. Ferguson asked if the eligibility process could be explained. Is there a national criterion or are all states doing the same thing for the same diseases? Who establishes those? Mr. Wieske stated that we expect there are a few states that have agreements in play. It is going to be literally a one-off agreement for each drug. It's a separate agreement and separate eligibility requirements. There are issues like tracking of the specific outcome. So, for example, for somebody who's a hemophilia you may have a pretty clear tracking whether or not they need to go continue on factor so that's a pretty easy one. Others may be a little bit more complicated because it's more of a systemic issue that may not be as clear. So, we expect that it's going to be a one off relationship for each contract, each drug manufacturer will have to negotiate with each Medicaid agency for that. We do expect that by and large there'll be some, once they get agreement with a couple of states it will be a little bit more cookie cutter, but the agreements will differ on a drug to drug basis.

Sen. Paul Utke (MN), NCOIL Treasurer, stated that on the slides you had the outcome based reimbursements. Can you give us a couple examples or an example of how that's affected things. I would guess you you've got to have results or they don't get paid or they get a lower payment or how does that work and what have we seen? Mr. Wieske stated that one of the manufacturers that we were working with inside CTT, as it includes manufacturers, insurers and others and patient groups, but one of the manufacturers is offering contracts for one of the hemophilia drugs where if there's a failure in the first year they expect they're going to rebate back the entire cost of the drug which is $2 to $3 million. And then the second year there'll be a smaller percentage. The third year there'll be a little bit smaller percentage as they move on and maybe it's a five year or a ten year outset. But they will be rebating some portion of it back depending on what it does.

Sen. Arthur Ellis (MD) stated that you have a chart up there with all the states and it's color-coded. You said 24 states have this agreement and California was listed and it was the same color code as Maryland and Maryland was not in there so is that intentional or accidental? Mr. Wieske stated that was because California was late in the process and my computer skills were unable to re-color California in time. Sen. Ellis stated that I'm also really interested in the issue of social equity and when you talk about the cost for these very expensive cures I was sitting here and with the example used about when the population is so much higher and the treatment price will be cost prohibitive I said I bet you will say sickle cell and you did say sickle cell. And so that feeds into what a lot of my constituents say that when it comes to treating in certain populations the product becomes a problem. So, I know Johns Hopkins and others have come up with a cure for sickle cell and they're close to it and the cost is there and the issue is how we pay for it. And so you stated the problem, but what is the possible solution to take care of that problem and do you think it's bigger than we can handle?

Mr. Heifetz stated that globally, it may be larger than we're prepared to handle at the moment but I don't know that we're unable to handle it forever, so to speak. I'm trying to illustrate that when you have this many coming it becomes a much more difficult problem financially. For sickle cell, again, it's a more common of a rare disease, so to speak. So these kind of outcome based arrangements can address it. It means you as a legislator and appropriator can say, "Look, we do need to finance these. This needs to be a priority in our Medicaid program and in our state budget." But at the same time, if these very expensive treatments are not working as we think they should or as clinically as we think they should, then there will be some repercussions from the manufacturer. So, it helps balance out that dynamic of just cost with another side of that equation. Today, it's largely just a cost and hopefully all of these treatments work. Or it's difficult to get them as a patient and as a family because of prior authorization, other utilization reviews and other mechanisms. So, this type of arrangement gets at that and removes some of those hurdles potentially so that your constituents and others can receive the treatment and your constituents statistically, it's just very difficult in the publicly paid healthcare programs to get some of these treatments. And the data on life expectancy that I mentioned earlier is pretty harsh. So, this can address a lot of that while still getting at that cost component but I think underlying your point is there's still a significant financial commitment that will have to be made in the short term and perhaps in the long term. Again, this is meant to balance that out, with the point being access so that you don't have to have this kind of debate routinely and that your constituents and others around the country, whether it's sickle cell or hemophilia or something else can get the treatments that their physicians and providers thinks will benefit them the most. Mr. Wieske stated that and the other bit here I think is important to remember is that these are horrific diseases in a lot of cases. There are significant issues and it might be in the short term that the adoption will take some time to trust the system for the gene therapies that will lead to a better result and so part of this as well is going to be proving that they in fact work and that they

are in fact effective and that is of the interest of the drug manufacturer as well. They'll have data to prove that it is in fact effective, safe, and it in fact works. So, that's a piece of this as well.

Sen. Felzkowski thanked everyone for their comments and stated that I would like everybody to really take a serious look at this so that we can aim for considering it in November. Rep. Dunnigan stated that if anyone has any questions or comments, please reach out to me, Sen. Felzkowski, or NCOIL staff.

PRESENTATION ON POLICIES TO SUPPORT MATERNAL HEALTH

Amy Chen, Senior Attorney at the National Health Law Program (NHLP), thanked the Committee for the opportunity to speak and stated that I'll be sharing a little bit about state efforts to expand access to doula care. So, a little bit first about my organization for those who might not be familiar, we're a national nonprofit law firm that works to protect health rights for all and improve health access, health equity and quality of services, especially for low income and underserved individuals and families. We do our work through litigation, policy, advocacy and education. We have offices here in California where I'm based, North Carolina and Washington. DC. And we work closely with legal aid attorneys and health advocates across the 50 states as well as in Washington DC. I've been working on reproductive health law and policy at NHLP for almost 10 years now and prior to NHLP I worked as a legal aid attorney providing direct legal services to low income clients in and around Oakland, California. So, first of all, what is a doula? Just to provide some background information about what doulas are and what doula care is. Doulas are birth workers who provide health education, advocacy and physical and emotional support through different aspects of reproductive health. Doulas can provide care before, during, and after childbirth as well as support during miscarriage, stillbirth and abortion. Doulas do not provide medical care. They do not replace medical providers such as physicians, midwives and nurses. Rather, doulas provides support in places and in contexts where medical providers do not and ideally, supplements the care provided by a pregnant person's medical care team.

So, as you all probably know, the U.S. is in the midst of a maternal mortality crisis. New Centers for Disease Control and Prevention (CDC) data released just last year found the maternal death rate in the U.S. rose again in 2021 with the rates of maternal death among black, pregnant and birthing people 2.6 times or more than twice as high as those of white pregnant and birthing people. Meanwhile, extensive research supports the proposition that doula care increases positive health outcomes. Pregnant and birthing people receiving doula care have been found to have improved health outcomes for both themselves and their infants including higher breastfeeding initiation rates, fewer low birth weight babies and lower rates of cesarean births. Doulas can also help reduce the impacts of racism and racial bias in healthcare settings by providing individually tailored culturally appropriate and patient centered care and advocacy. While doulas alone are not the solution to addressing America's maternal mortality crisis, they do offer one critical intervention. So, just a quick personal side, I have three kids. I had doulas at all three of my pregnancies, and I'm so grateful to my doulas for having supported me through my own pregnancies and also during my labor and delivery. At the same time when I returned to my work as a legal aid attorney after my parental leave it was really obvious to me how much my own legal aid clients could benefit from doula services but how painfully few of them could actually afford them. All of my clients as a legal aid attorney, they were on California's Medicaid program so very few of them could actually afford the $1,500 to $2,000 that was then the standard rate for doula services in the San Francisco Bay area. The rates for doula care across the country vary, but in most places the market rate for doula care is at least $1,000 and in many places is easily upwards of $2,000 to $3,000. At the same time, we know that low income,

pregnant and birthing people are higher risk for poor birth outcomes and as I mentioned earlier, because of the high cost are less likely to be able to afford doula care out of pocket.

Meanwhile, Medicaid covers up to half of all births nationally so an intervention, such as doula care for pregnant and postpartum Medicaid enrollees really has the potential to make a tremendous impact on maternal and infant health across the country. So, my organization's doula Medicaid project, which was launched in May 2019, seeks to improve health outcomes and address inequities in maternal health by ensuring that all pregnant and postpartum people who want access to a doula can have one. Our starting point in this work is expanding access to sustainable, equitable and inclusive programs for Medicaid coverage for doula care.
You can read more about our work on the website at the link below on the bottom of this slide. Suffice to say that we provide technical assistance, information sharing and other support to doula policy advocates and other stakeholders across the country. Our ultimate goal is to help identify and overcome barriers to sustainable equitable and inclusive programs for Medicaid coverage for doula care. We are also creating published resources and manage multiple avenues to share state and regional updates. My organization's focus is on expanding access to full spectrum doula care which includes doula support not just for prenatal, postpartum and labor and delivery but for all the ways in which your pregnancy can end including abortion, miscarriage and stillbirth. Lastly, I want to note that at NHLP we're lawyers, we're researchers and policy advocates. We do not have any doulas on our team. So, we've sought to do our work in partnership and with the guidance of community doula groups, doula collectives and individual doulas, especially doulas representing groups most impacted by disparities in care. So, I also have a map as of July 2024 there's currently a total of 44 States and Washington, DC that have taken some action towards Medicaid coverage of doula care including either direct implementation or some adjacent action aimed at ultimately implementing Medicaid reimbursement. There are 15 states plus Washington, DC that have already implemented coverage so those are the states that you see on the map with the red stars. Another 14 states are in process, those are the yellow stars. And a lot of these states with the yellow stars will be implementing coverage later this year, some early next year. And then another 16 states, the blue stars have taken some other adjacent option. For example, state funded doula pilot programs, creation of doula advisory boards or doula advisory committees or recruiting other mechanisms for doulas to be certified by the state. 2023 saw four states rolling out Medicaid coverage for doula care: Michigan, California, Oklahoma and Massachusetts. 2024 thus far, we've seen three states, New York, Kansas and Colorado implementing coverage. I do have New Mexico marked as having implemented coverage with the red star but that was a little bit premature. They don't yet have an approved state plan amendment (SPA), they just have the proposed SPA that is currently out. And the Colorado star should also be red. I just found out last week that they implemented coverage on July 1 and I did not have time to change my slides.

So, how are states implementing coverage? Perhaps the most common way the states implement coverage is through just straight up legislation requiring coverage of doula care as a Medicaid benefit, typically followed by an SPA. Legislation has also sometimes been used to create, as I mentioned earlier, doula advisory boards or doula advisory committees, something along the road to ultimate implementation of full Medicaid coverage for doula care. Other states have started with the legislation and even in situations where that legislation is not passed, sometimes they nonetheless have implemented Medicaid coverage for doula care. Oftentimes, the state Medicaid agency will kind of take it upon themselves. Doula care can also be added as a benefit through the state budget or funding initiatives. So, for example, here in California, doula care was initially included as part of SB-65, our California Omnibus maternal health bill. But then it was later included in the Governor's 2021 to 2022 budget and so that piece was taken out of the legislation since it had already been funded in the budget. And the last slide as I

mentioned earlier, state Medicaid agencies can also decide to include doula care as a Medicaid benefit on their own. So, for example, in Michigan, there was legislation introduced in 2020. The legislation did not pass, but it did launch discussions in the Department of Health and Human Services and that department did end up adding doula care as a new benefit on their own in 2022. So, just a couple of trends to watch. First of all, I am seeing a growing number of states being really more thoughtful about achieving a sustainable and equitable reimbursement rate for doulas. This follows Rhode Island implementing a $1,500 Medicaid reimbursement rate starting in July 2022 and Oregon implementing a $1,500 reimbursement rate after languishing for many years at a reimbursement rate of $350. California just this year recently implemented a new doula Medicaid reimbursement rate of $3,100. This is for the entire package of services. And in 2023, both Minnesota and Nevada increased their reimbursement rates to $2,000 and $1,500, respectively. Second, I'm seeing an increase in efforts to expand access to doula care in the private insurance context as well. So, at present, there's only one state, Rhode Island, that requires private health insurance plans to cover doula care which they passed as a requirement in 2021 alongside the Medicaid coverage for doula care requirement. Last year, in 2023, Louisiana passed legislation to expand doula care in the private insurance context. And also, in 2023 Utah passed legislation to include doula coverage and access to birth centers specifically for state employees.

And in April of this year Virginia's Governor signed into law SB 118, which will also require private insurance coverage of doula care. So, they're still in process. And then thirdly, in terms of trends, many of the states that have implemented or are implementing Medicaid coverage for doula care have also seen the growth or emergence of doula groups, co-ops, associations that are really self-organizing to help alleviate some of the burden that entails to become a Medicaid provider. There's obviously a lot of bureaucracy, paperwork, billing challenges, coding that's involved with Medicaid billing and reimbursement and many doulas were new to Medicaid as a system are just really finding that they're needing support not just to navigate the system, but also to be successful in seeking reimbursement as Medicaid providers. Lastly, just a couple of recommendations I wanted to share that I am currently working on in a document distilling a series of best practices that have come from our work over the years with doulas and advocates across the country. I think there should have been a link to my sort of draft version of the best practices document in the meeting materials. If you didn't get it, you can e-mail me. There's my e-mail address on the slide. Second, I really encourage legislators, doulas, policy advocates, agency staff, those that will be implementing Medicaid coverage for doula care to really make sure that at every step in the process community-based doula groups who are already serving low income and Medicaid enrollees are really front and center in crafting the policy language and determining how it's implemented. Some state Medicaid agencies and health plans have really struggled on this piece, not for lack of intent, but in some cases just lack of experience working in real partnership with stakeholders. This is really a new relationship for many of those involved and it's also no small task to figure out how to incorporate a brand new category of provider. And lastly, don't reinvent the wheel - follow what's happening not just in your state, but in other states. For example, there are five states that have implemented statewide standing recommendations for doula services: Michigan, California, Massachusetts, Minnesota, New York. These standing recommendations state that any Medicaid enrollee who's pregnant or was pregnant within the past year would benefit from receiving doula services and it obviates the need for Medicaid enrollees to obtain specific recommendations from licensed Medicaid providers on an individual basis. This was something that had not been done before Michigan issued their statewide standing recommendation but once they did it, other states learned from that effort.

Ms. Chapman stated that I just wanted to highlight that BCBSA recently launched a report on postpartum care to amplify our efforts to raise awareness about maternal health care and

maternal health inequities and when it was mentioned to me that there was interest here at NCOIL in talking about maternal health we were really excited to hear that and we hope this conversation continues. You should have a copy of the report available online in the materials and if not please let me know and I'll make sure you get it. In short, this report demonstrates that the risk of childbirth does not end at delivery. There are many dangerous and unexpected birth complications or health related events that are categorized or called severe maternal morbidity. And those events can take place during labor and delivery as well as during the postpartum period, which is considered six weeks after giving birth. And these events have sometimes long-lasting consequences and even death. Our research shows that as many as one third of all severe maternal mortality events occurred during that postpartum period and black patients are at much higher risk of experiencing these events even more so than their white and Latina counterparts, even after the delivery of the child. So again, I just want to reiterate, we do have that report available and I hope that we'll continue discussing these issues here at NCOIL.

Rep. Ellyn Hefner (OK) thanked the speakers and stated that I think we need to put more time towards this topic. I know the statistics are not getting any better for moms that have babies. We're not finished after we have them and doulas are such a great way to help moms connect. We bring up Medicaid and I would love to ask how many in here have applied for Medicaid? I have a child with a disability and it's one barrier after another and so I think that we need doulas. I'm working on community healthcare legislation for designation so we can pay them because it's more than just wanting them or needing them, which our moms need. It's workforce, we're not paying them enough to do the job of taking care of a mom who's carrying kids, who may need that help to access doctors. In Oklahoma, we do have it set up but we just don't have the payment system there that gets them to where they need to. We have very few doctors that are OBGYN's that are in our rural areas and we have some urban challenges as well that are the same as rural. So, I'm so happy that you're bringing this here to give us all this great information. I do wish that we could spend some more time on what our individual states could do to help moms that need that extra care because it's not a one and done as we all know. I appreciate NCOIL bringing this up and as Rep. Oliverson said earlier today, preventative care is the best and if we have doulas at the beginning we know that we will have better outcomes so we won't be paying for certain things later in our budgets in our states. Some of the statistics about maternal morbidity cited are awful and we need to get those better and this is one of those preventative things that can really help save some mom’s lives.

Rep. Greg Scott (PA) stated that I just wanted to acknowledge the committee for bringing this issue up. This is an issue that hits close to home for me personally. I know that there's a lot to be said around adding Medicaid for those services and we've done that in Pennsylvania and Pennsylvania like the rest of the country, we have a maternal mortality crisis. But with everything I try and look at it through an equity lens and when America has a cold, the black community gets the flu. In Pennsylvania black women are 3.5 times as likely to die for what should be the most joyous event of their lives, bringing another human being into this earth. And so we've taken an all hands on deck approach to this issue in Pennsylvania. A few of my colleagues have created the Pennsylvania Black Maternal Health Caucus which really shined a light on this issue. We got the Governor to pay attention to it by bringing his wife to a few clinics to showcase this issue. We got some real dollars in our budget last year to study this issue. Those studies are in the process of being evaluated and the Governor directed our Health and Human Services Dep’t to have Medicaid accept it. We also have legislation for Medicaid as well as for private insurance to cover doula care. My question to you is really about what about the other postpartum care that data shows works for example, postpartum mental health services. Sending moms home with a blood pressure kit to check blood pressure a couple times a day. What about neonatal kits? Where are we seeing other states around the country with adding those things in

legislation? I know some of the insurance companies are sending them home from their wellness perspective but where are we at with that kind of stuff?

Rep. Oliverson stated that he really appreciated the presentations and stated that if $3,000 for doula services is what is being sought, I think that's more than double what the OBGYNS make in California from the Medicaid system. Ms. Chen stated that in California, the reimbursement rate for doulas is now $3,100. Rep. Oliverson stated that the OBGYN gets $1,300 and that doesn't seem proportional to me. Can you explain that? Ms. Chen stated that I think what would be helpful is I have some resources on our doula Medicaid project website that I can share but I think you really have to think of the scope of work that a doula does is very different. A doula is not providing medical care, not providing medical services and so what that means is that the time that a doula spends with a pregnant patient is very different. The type of work and care they're providing is very different. As I mentioned earlier, I have three kids. I love my OBGYN, and she spent about maybe 15 to 20 minutes with me at each of those prenatal appointments. She was there kind of at the end during labor and delivery when the baby was coming out. My doula came for a number of prenatal and postpartum appointments, 60 to 90 minutes for each of those appointments. She came to my house when I started having contractions hours before I went to the hospital, stayed with me during my entire labor and delivery, stayed with me after the baby was born and I was trying to figure out breastfeeding, stayed with me during that very early immediate postpartum recovery period. And not until I was settled this is hours after did she go home. And then there were a couple of additional postpartum appointments that were again about 60 to 90 minutes each. So I think if you think about the scope of services that's important. I know just looking at the $3,100 versus $1,500 is different and the training is obviously different, but I think you really have to think about the nature of the care and the scope of care.

PRESENTATION ON BILLING PRACTICES IN THE GROUND AMBULANCE SERVICE INDUSTRY

Nadia Stovicek, Research Fellow at the Center on Health Insurance Reforms at the McCourt School of Public Policy at Georgetown University, thanked the Committee for the opportunity to speak and stated that I'm also a former legislative staffer so I have a sincere appreciation for all the work you're doing here today. Today I'll be talking about the No Surprises Act (NSA) and what states and the federal government are doing to protect consumers from being balanced billed when using ground ambulances. And I also would be remiss if I didn't thank our sponsors Arnold Ventures and the Commonwealth Fund for supporting this project. The NSA is a federal law that protects consumers with private insurance from being balance billed or facing a surprise bill. A balanced bill is when the provider bills the patient for the balance due, the difference between the provider's charge and how much the insurer is willing to pay. The NSA bans balance billing for out of network costs in emergency situations when using an air ambulance or receiving care at an in-network facility but using an out of network provider and it went into effect two years ago. While it's still relatively new, a recent study of ours found that it is by and large accomplishing the goal of protecting consumers from having to pay out of network costs for an emergency situation or when they expect to only receive in network care. It also removes consumers from any dispute between the cost of care between the provider and the insurer. If there's a disagreement on the billed charge, then the provider's insurers have to use an independent dispute resolution (IDR) process to agree on a price. But a major gap in the NSA is that ground ambulances are not protected despite them being crucial in emergency situations.

So, why is it important to fill the ground ambulance gap? Many of us can probably recall a time when we or a loved one had to call 911 for an ambulance because of an emergency health situation. With time being of the essence, it would make sense that consumers are eager for the

quickest ambulance ride to take them to the hospital. But in emergencies, consumers often don't have time to determine if a provider is in network and they often don't even have a choice in a provider. On top of that contracting as an in network provider is an administrative burden for ground ambulances. Carriers also struggle to contract with providers for various reasons such as inability to reach an agreement or being unable to contact someone who handles the contract negotiations. Thus, it is common for ground ambulances to be out of network. But we know that ground ambulances don't just transport people to the hospital. They can administer crucial life support depending on the level of EMS staff, treat patients on site without needing to bring them to the hospital, and move patients in between facilities. Currently, providers do not get reimbursed for these treat no transport cases. So, how many people arrive to the ER via ground ambulance? Well, 10% of ER visits by privately insured people are by ambulance which is about three million people annually. There is a significant patient affordability issue with ground ambulance costs. A recent poll found that about a quarter of people have decided not to use an ambulance because of the fear of cost. And data from 2021 found that one third of insured patients cannot afford a surprise medical bill of $1,000 or more and almost half of insured patients cannot pay an emergency expense over $400 without borrowing money or selling assets. This puts the burden of balance billing on consumers who are more likely to incur medical debt as a result which could have lasting consequences. Ambulance providers also struggled to recoup the costs for their services. Washington State collected data on what type of ground ambulance coverage exists for consumers with private insurance. As we can see in this table for Washington, insurers are more likely to cover emergency transport but leave out other forms of care. The majority of ambulances are publicly owned. The ground ambulance industry consists of small operations connected to a town's fire department to completely privatize ambulances that a local government outsources care to. This chart shows with the lighter blue color on the right that public sector ground ambulance agencies provide almost two thirds of ground ambulance rides. This is significant since state and local regulation and the high rates of publicly operated ground ambulances were reportedly two reasons that Congress did not include ground ambulances in the NSA. As the table shows, 85% of emergency transports are delivered out of network meaning that emergency care is mostly likely out of network and 28% of those transports can result in a surprise bill. We see in this slide here the breakdown of charges for a ground ambulance ride from data from 2017. The bill charged for a public sector ambulance is more than $1,000. The allowed amount is what insurance pays. Insurance is willing to pay almost 80% of that amount and consumer paid $207 in cost sharing. But if insurers do not pay the allowed amount, the consumer could have to cover the potential surprise bill on top of cost sharing. This makes a total out of pocket cost unaffordable for the majority of Americans.

I know I've just whipped up a lot of information and thrown it at you guys and I wanted to pause and reflect on what I just covered. I know that the ground ambulance rides are not covered by the NSA but it is likely for these rides to be out of network and unaffordable for consumers. Now, we'll talk about what states are doing to protect consumers from ground ambulance balance billing charges. I'd also want to mention that while federal regulations would cover a lot more people, it's still very important for states to pass protections to ensure that some people can be covered now. As many of you know, states have been taking action before and after the NSA to protect consumers from surprise ambulance bills and four states this year, Indiana, Mississippi, Oklahoma and Washington all passed laws. Here's a bunch of information on how states differ on consumer protections and rate reimbursement in these laws. So let me break down this information for you because I know it can seem overwhelming. As you can see on the box on the left all of the states that have ground ambulance protections protect consumers from surprise bills but some only cover emergency services and others only offer protection space on the ownership type of the ground ambulance. I'll skip through specific examples for the sake of time. Now, I'll talk about rate reimbursement guidance. So, while states all have some form of

rate reimbursement guidance, some provide more detailed guidance than others. As you can see on the slide there are a variety of factors to consider for creating state-based ground ambulance protections. States can decide to include coverage based on if the provider's public or private. If the ground ambulance is used in emergency and non-emergency situations. If coverage exists for interfacility transport and treat but no transport cases. And states would also have to consider if they would like to forgo a negotiation process like IDR and if so, how would they like to set up a reimbursement rate. Ultimately from a consumer perspective the broader the coverage, the better it is. A federal advisory committee called the Ground Ambulance and Patient Billing Committee will publish its report to Congress to prevent ground ambulance balance billing soon. This committee was created as part of the NSA to develop a solution for federal ground ambulance protections. The Committee voted on recommendations but have yet to send the report to Congress but we're hoping that it's going to happen soon, maybe by the end of the month.

Since only the federal government can regulate self-funded employer sponsored insurance, where 65% of workers in the U.S. get their coverage, federal coverage would cover a lot more people. So, let's go through the recommendations very quickly. Consumers would be protected from balance billing for emergency transports responding to 911 calls and interfacility transports. Both public and private providers will be covered, as well as treat no transport cases. The most a consumer would pay out of pocket would be the lesser of $100 or 10% of the payment rate which is a far cry from the $260 average cost sharing charge many consumers currently experience with the potential surprise bill of $734 for private sector transport. Unlike the NSA's approach to payment, the federal Committee agreed on specific reimbursement standards to inform payment amounts similar to what many states have done. Thinking through the prospects for expanding protections to ground ambulances we know federal action could significantly increase the number of consumers protected from ground ambulance balance billing and it has a lot of bipartisan support but it is unlikely that the federal government will act on these recommendations in the short term. Unfortunately, it's hard for Congress to pass much in general these days which is why continued state action is still so valuable and to consider the breadth of services covered. Eighteen states have already taken action and this is crucial for the consumers who are covered under state regulated insurance. So, what can states do going forward? They don't need to wait on the federal government to take action. They can look out for the federal committee report, which would be out soon and consider how to best protect consumers and include specific rate reimbursement guidance on their bills. That concludes my presentation. I've included my contact information and I'd also like to offer the services of the Center on Health Insurance Reforms for any states who are looking to consider introducing bills on ground ambulance balance billing protections.

Sen. Ellis thanked Ms. Stovicek for the presentation and stated that I'm trying to keep up with your acronyms - the NSA is the No Surprises Act? Ms. Stovicek replied yes. Sen. Ellis asked if that is a state initiative or federal? Ms .Stovicek replied it's a federal initiative. Sen. Ellis asked if the law passed. Ms. Stovicek replied it did pass in 2022 to protect consumers from having to pay the difference between what the provider charges and what insurance is willing to pay. Sen. Ellis asked if states are taking additional action. Ms. Stovicek replied yes some states have taken additional action and they're able to if the state goes above and beyond what the federal regulations are, they're able to supersede that. But the significant point of the NSA is that they didn't cover ground ambulance protections even though that's a very common way for consumers to be balance billed, i.e. pay the difference between what the provider is charging and what the insurance is willing to pay. Sen. Ellis stated so if any actions need to be taken with ground ambulances it's up to the states because the NSA did not cover ground ambulance? Ms.

Stovicek replied yes, and the government is trying to work on it through this committee I mentioned.

Rep. Scott asked if the NSA mainly covered hospitals and doctor's visits? Ms. Stovicek replied yes. Rep. Scott stated so the object here is that if you add ground ambulances about to the balance billing protections then that would help. When people have implemented these in these states, where are these volunteer EMS services making up that shortfall? Is there also a line item when you add these balance billing bans for them to come up with this money? And is there a rate structure in place to display the amount of these things ahead of time? Ms. Stovicek stated that it doesn't seem like there's been a huge differentiation in terms of what providers are getting paid eventually because right now there's no standard for what providers are being paid. And with a lot of state legislation, there's specific guidance on that but otherwise a lot of these services are just out of network so they have out of network charges. Rep. Scott stated where I come from, the majority of our ambulances are provided by volunteer services by a wide swath of the state. We have very minimal pockets where there's full time career staff, especially government run full career staff and so the question ultimately is how do we pay for this, especially with banning the balance billing. A lot of them they make up their money from the balance billing. Ms. Stovicek replied that is a great question and she will look into it further.

Rep. Dunnigan thanked everyone and stated that this issue is a valid concern for me. In Utah worked on surprise billing for a number of years and the federal level finally stepped up in the space but they didn't cover ground ambulances.

ANY OTHER BUSINESS

Rep. Dunnigan stated that we have one more item of business under other business. Julian Roberts, President & CEO of the American Association of Payors and Administrators and Networks (AAPAN) will provide some brief remarks.

Mr. Roberts thanked the Committee for the opportunity to speak about an access to care issue in regards to hearing healthcare. In August of 2022, the U.S. Food and Drug Administration (FDA) promulgated regulatory changes establishing over the counter hearing aids as a new category of medical devices while classifying non over the counter hearing aids as a prescription or medical devices. So previously there was no need for a prescription for hearing aids and now there is a new prescription requirement for non over the counter hearing aids. This has created a lot of confusion in the various states as to who can write the prescription for these and who cannot. Approximately 20 states have passed legislation to provide clarification to ensure audiologists and hearing aid specialists can both prescribe non over the counter hearing aids. I might also add that in these 20 states where we passed legislation it was passed with both payers and providers supporting these bills which is kind of a rarity. We look forward to further discussions on this issue at future meetings.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Rep. Lehman, the Committee adjourned at 3:45 p.m.